volume 13
SUPPL. 2
2019 May

pISSN 1877-9344
eISSN 1877-9352

SOCIETÀ SCIENTIFICA DI MEDICINA INTERNA
FADOI
FEDERAZIONE DELLE ASSOCIAZIONI DEI DIRIGENTI OSPEDALIERI INTERNISTI

Italian Journal of Medicine

A Journal of Hospital and Internal Medicine

The official journal of the Federation of Associations of Hospital Doctors on Internal Medicine (FADOI)

Editor in Chief
Giorgio Vescovo

XXIV Congresso Nazionale della Società Scientifica FADOI

Firenze, 11-14 maggio 2019

Presidente: A. Fontanella

Guest Editors: A. Crespi, L. Bizzarro, A. Valerio

pagepress

www.italjmed.org

SOCIETÀ SCIENTIFICA DI MEDICINA INTERNA
FADOI
FEDERAZIONE DELLE ASSOCIAZIONI DEI DIRIGENTI OSPEDALIERI INTERNISTI

Italian Journal of Medicine

A Journal of Hospital and Internal Medicine

The official journal of the Federation of Associations of Hospital Doctors on Internal Medicine (FADOI)

Italian Journal of Medicine

A Journal of Hospital and Internal Medicine

SOCIETÀ SCIENTIFICA DI MEDICINA INTERNA
FADOI
FEDERAZIONE DELLE ASSOCIAZIONI DEI DIRIGENTI OSPEDALIERI INTERNISTI

The official journal of the Federation of Associations of Hospital Doctors on Internal Medicine (FADOI)

Editore: PAGEPress srl, via A. Cavagna Sangiuliani 5, 27100 Pavia, Italy - www.pagepress.org

Direttore Responsabile: Camillo Porta

Stampa: Press Up s.r.l., via E.Q. Visconti 90, 00193 Roma, Italy

Registrazione: Rivista trimestrale registrata al Tribunale di Pavia n. 11/2013 del 8/4/2013

Poste Italiane SpA, Sped. in Abb. Postale DL 353/2003 (conv. in L. 27/2/2004 n. 46) art. 1 comma 1, DCB Milano - Taxe percue

SOCIETÀ SCIENTIFICA DI MEDICINA INTERNA
FADOI
FEDERAZIONE DELLE ASSOCIAZIONI DEI DIRIGENTI OSPEDALIERI INTERNISTI

SEGRETERIA NAZIONALE

Via Felice Grossi Gondi, 49 - 00162 Roma
Tel. +39.06.85355188 - Fax: +39.06.85345986
E-mail: segreteria@fadoi.org

Società Scientifica FADOI - Organigramma

PRESIDENTE NAZIONALE
Andrea Fontanella, Napoli, Italy

PRESIDENTE ELETTO
Dario Manfellotto, *Roma, Italy*

PAST PRESIDENT
Mauro Campanini, *Novara, Italy*

SEGRETARIO
Micaela La Regina, *La Spezia, Italy*

SEGRETARIO VICARIO
Andrea Montagnani, *Grosseto, Italy*

STAFF DI SEGRETERIA
Comunicazione Claudia Tieri, *Bari, Italy*
Ricerca Roberta Re, *Novara, Italy*
Formazione Maurizia Gambacorta, *Todi (PG), Italy*

TESORIERE
David Terracina, *Roma, Italy*

STAFF DI TESORERIA
Francesco D'Amore, *Roma, Italy*

PRESIDENTE FONDAZIONE FADOI
Mauro Campanini, *Novara, Italy*

COORDINATORE
Giuseppe Augello, *Canicattì (AG), Italy*

DIPARTIMENTO PER LA RICERCA CLINICA FADOI
Direttore Francesco Dentali, *Varese, Italy*
Supervisor per la Ricerca Giancarlo Agnelli, *Perugia, Italy*

DIPARTIMENTO PER LA FORMAZIONE E AGGIORNAMENTO
Direttore Mauro Silingardi, *Bologna, Italy*

COORDINAMENTO FORMAZIONE AREA CENTRO-NORD
Francesco Orlandini, *La Spezia, Italy*

COORDINAMENTO FORMAZIONE AREA CENTRO-SUD
Generoso Uomo, *Napoli, Italy*

COORDINATORE COMMISSIONE GIOVANI
Flavio Tangianu, *Luino (VA), Italy*

MEMBRO FISM E RESPONSABILE PER L'INNOVAZIONE IN MEDICINA INTERNA
Antonino Mazzone, *Legnano (MI), Italy*

ITALIAN JOURNAL OF MEDICINE
Editor in Chief Giorgio Vescovo, *Padova, Italy*

RESPONSABILE DEI QUADERNI DELL'ITALIAN JOURNAL OF MEDICINE
Paola Gnerre, *Savona, Italy*

SUPERVISOR EDITOR DEI QUADERNI DELL'ITALIAN JOURNAL OF MEDICINE
Roberto Nardi, *Bologna, Italy*

DELEGATO FADOI ITALIAN STROKE ORGANIZATION E CONSULTA CARDIOVASCOLARE
Michele Stornello, *Siracusa, Italy*

RAPPORTI CON EFIM
Antonio Brucato, *Bergamo, Italy*
Gualberto Gussoni, *Milano, Italy*
Ombretta Para, *Firenze, Italy*
Giorgio Vescovo, *Padova, Italy*

RESPONSABILE SITO NAZIONALE
Salvatore Lenti, *Arezzo, Italy*

RESPONSABILE SISTEMA GESTIONE QUALITÀ
Franco Berti, *Roma, Italy*

RESPONSABILE CLINICAL COMPETENCE
Antonino Mazzone, *Legnano (MI), Italy*

RESPONSABILE AREA ECOGRAFIA
Francesco Cipollini, *Ascoli Piceno, Italy*
Marcello Romano, *Catania, Italy*

RESPONSABILE MEDICINA DI GENERE
Cecilia Politi, *Isernia, Italy*

RESPONSABILE AREA NUTRIZIONE
Roberto Risicato, *Siracusa, Italy*
Massimo Rondana, *Pordenone, Italy*
Luciano Tramontano, *Praia a Mare (CS), Italy*

RESPONSABILE AREA DI CLINICAL GOVERNANCE
Giovanni Iosa, *Cesenatico (FC), Italy*
Stefano De Carli, *Udine, Italy*

AREA SLOW MEDICINE
Roberto Frediani, *Chieri (TO), Italy*
Luigi Lusiani, *Castelfranco Veneto (TV), Italy*

AREA DOLORE
Domenico Panuccio, *Bologna, Italy*
Giuseppe Civardi, *Piacenza, Italy*

AREA CRITICA IN MEDICINA INTERNA
Carlo Nozzoli, *Firenze, Italy*

RESPONSABILE AGGIORNA FADOI
Giuliano Pinna, *Asti, Italy*

Italian Journal of Medicine

A Journal of Hospital and Internal Medicine

Fondazione FADOI - Organigramma

PRESIDENTE FONDAZIONE

Mauro Campanini, Novara, Italy

COORDINATORE

Giuseppe Augello, *Canicattì (AG), Italy*

DIPARTIMENTO PER LA RICERCA CLINICA FADOI

Direttore Francesco Dentali, *Varese, Italy*
Supervisor per la Ricerca Giancarlo Agnelli, *Perugia, Italy*

SEGRETERIA

Grazia Panigada, *Pescia (PT), Italy*

DELEGATO SIF

Francesco Rossi, *Napoli, Italy*

DELEGATO ANÍMO

Alberto Dal Molin, *Novara, Italy*

RESPONSABILE AREA MALATTIE CARDIOVASCOLARI

Paolo Verdecchia, *Assisi (PG), Italy*

STAFF AREA MALATTIE CARDIOVASCOLARI

Cecilia Becattini, *Perugia, Italy*
Pierpaolo Di Micco, *Napoli, Italy*
Fernando Gallucci, *Napoli, Italy*
Alessandro Squizzato, *Varese, Italy*

RESPONSABILE AREA MALATTIE INFETTIVE

Ercole Concia, *Verona, Italy*

STAFF AREA MALATTIE INFETTIVE

Anna Maria Azzini, *Verona, Italy*
Gianluca Giuri, *Castelnovo ne' Monti (RE), Italy*
Matteo Giorgi Pierfranceschi, *Piacenza, Italy*
Carlo Tascini, *Pisa, Italy*

RESPONSABILE AREA MALATTIE RESPIRATORIE

Leonardo Fabbri, *Reggio Emilia, Italy*

STAFF AREA MALATTIE RESPIRATORIE

Bianca Beghè, *Reggio Emilia, Italy*
Gaetano Cabibbo, *Modica (RG), Italy*
Francesco Corradi, *Firenze, Italy*
Francesco Ventrella, *Cerignola (FG), Italy*

RESPONSABILE AREA MALATTIE REUMATOLOGICHE

Carlo Salvarani, *Reggio Emilia, Italy*

STAFF AREA MALATTIE REUMATOLOGICHE

Paola Faggioli, *Legnano (MI), Italy*
Laura Morbidoni, *Senigallia (AN), Italy*
Nicolò Pipitone, *Reggio Emilia, Italy*
Tito D'Errico, *Napoli, Italy*

RESPONSABILE AREA MALATTIE METABOLICHE

Roberto Vettor, *Padova, Italy*

STAFF AREA MALATTIE METABOLICHE

Tiziana Attardo, *Agrigento, Italy*
Giovanni Gulli, *Savigliano (CN), Italy*
Ada Maffettone, *Napoli, Italy*
Maurizio Nizzoli, *Forlì, Italy*

RESPONSABILE AREA ORGANIZZATIVA IN MEDICINA INTERNA

Antonio Greco, *San Giovanni Rotondo (FG), Italy*

STAFF AREA ORGANIZZATIVA IN MEDICINA INTERNA

Marco Candela, *Jesi (AN), Italy*
Giovanni Mathieu, *Pinerolo (TO), Italy*
Valentino Moretti, *San Daniele del Friuli (UD), Italy*
Filomena Pietrantonio, *Brescia, Italy*
Elisa Romano, *La Spezia, Italy*

DIRETTORE DIPARTIMENTO PER LA FORMAZIONE E AGGIORNAMENTO

Mauro Silingardi, *Bologna, Italy*

COORDINAMENTO DI AREA FORMATIVA CENTRO-NORD

Francesco Orlandini, *La Spezia, Italy*

COORDINAMENTO DI AREA FORMATIVA CENTRO-SUD

Generoso Uomo, *Napoli, Italy*

STAFF DIPARTIMENTO PER LA FORMAZIONE E AGGIORNAMENTO

Roberto Frediani, *Chieri (TO), Italy*
Marco Grandi, *Sassuolo (MO), Italy*

SEGRETERIA DIPARTIMENTO PER LA FORMAZIONE E AGGIORNAMENTO

Luigi Magnani, *Voghera (PV), Italy*

BOARD SCIENTIFICO

Clelia Canale, *Reggio Calabria, Italy*
Fabrizio Colombo, *Milano, Italy*
Giuseppe De Matthaeis, *Città Sant'Angelo (PE), Italy*
Massimo Giusti, *Torino, Italy*
Luca Masotti, *Cecina (LI), Italy*
Andrea Montagnani, *Grosseto, Italy*
Nicola Mumoli, *Livorno, Italy*
Maurizio Ongari, *Porretta Terme (BO), Italy*
Ruggero Pastorelli, *Colleferro (RM), Italy*
Fulvio Pomero, *Savigliano (CN), Italy*
Roberto Risicato, *Siracusa, Italy*
Antonio Sacchetta, *Treviso, Italy*
Giancarlo Tintori, *Pisa, Italy*

COMMISSIONE TECNICHE E METODICHE INNOVATIVE DI FORMAZIONE E VERIFICA

Responsabile dell'Innovazione in Medicina Interna
Antonino Mazzone, *Legnano (MI), Italy*

STAFF

Francesco Dentali, *Varese, Italy*
Andrea Montagnani, *Grosseto, Italy*
Filippo Pieralli, *Firenze, Italy*

DIRETTORE SCIENTIFICO FONDAZIONE FADOI

Gualberto Gussoni, *Milano, Italy*

Italian Journal of Medicine 2019; vol. 13, supplement 2

XXIV Congresso Nazionale della Società Scientifica FADOI

Firenze 11-14 maggio 2019

Presidente: A. Fontanella – Guest Editors: A. Crespi, L. Bizzarro, A. Valerio

SOCIETA' SCIENTIFICA DI MEDICINA INTERNA
FADOI
FEDERAZIONE DELLE ASSOCIAZIONI DEI DIRIGENTI OSPEDALIERI INTERNISTI

Index

ORAL COMMUNICATIONS

Index

Index

POSTERS DISCUSSION

Index

Index

Index

Index

Index

Index

Index

Index

ABSTRACTS SUBMITTED

Index

Index

Index

Index

Index

Index

Index

Index

Index

Index

ORAL COMMUNICATIONS

Use of the specific antidote Idarucizumab in a case of initial splenic laceration: real-life experience

S. Accordino[1], M. Masotti[1], S. Bertolazzi[1], P. Formagnana[1], S. Provini[1], E. La Boria[1], C. Canetta[1]

[1]Medicina Generale e di Accettazione Urgenza, ASST Crema, Italy

Introduction: Idarucizumab is a recently approved specific antidote indicated for reversal of dabigatran's activity. We report our experience in a case of a patient with splenic laceration under anticoagulation with dabigatran.
Case report: A 72-year-old man came to our urgency medical unit following a motor vehicle crash. His previous history included arterial hypertension, diabetes mellitus, COPD and chronic atrial fibrillation for which he was taking dabigatran 150 mg bid. First level examinations (chest X-ray, abdominal ultrasound and brain CT) showed only a fracture of the 10th left rib. The day after the patient developed hematuria; an abdomen ultrasound showed a small perirenal effusion. A CT scan showed a small renal hematoma and an initial splenic laceration. Vital signs remained stable, but the hemoglobin value dropped 2 g/dl in few hours. After collegial discussion with the interventional radiology and surgical unit, the endovascular approach proved to be the most appropriate. The last dose of dabigatran had been administered 4 hours before; after the infusion of idarucizumab blood dabigatran's values were almost zeroed. The patient safely underwent splenic arterial embolization. The next day antithrombotic prophylaxis was introduced and after observation dabigatran was resumed.
Conclusions: Our patient developed a life-threatening condition; idarucizumab allowed a safe procedure of embolization. The use of the antidote is simple; clinical studies have documented its effectiveness and safety. Further reports on real-life experience are however necessary.

Two-year outcomes of dabigatran etexilate treatment in patients with co-morbid heart failure and atrial fibrillation: the GLORIA-AF registry

R. Benedetti[1], S. Dubner[2]

[1]Centro Emostasi e Trombosi, SC Medicina Interna, Ospedale Civile, Piacenza, Italy; [2]Clinica y Maternidad Suizo Argentina, Buenos Aires, Argentina

Background: Heart failure (HF) and atrial fibrillation (AF) are common cardiovascular conditions independently associated with poor outcomes; when they occur concurrently, the risks of thromboembolic events is more than additive.
Objectives: To describe baseline characteristics and 2-year outcomes in AF patients with and without HF who were treated with dabigatran etexilate (DE) in a prospective, global registry program (GLORIA-AF).
Methods: Newly diagnosed non-valvular AF patients with a CHA2DS2-VASc score ≥1 were consecutively enrolled. Baseline characteristics of the total group and clinical outcomes in patients prescribed DE were assessed according to presence or absence of HF at enrollment time.
Results: A total of 15,308 patients were enrolled, 3679 of which (24.0%) with HF. Patients with HF had higher rates of prior myocardial infarction (18.8% *vs* 7.8%), coronary artery disease (31.6% *vs* 16.7%), greater proportions of symptomatic (39.5% *vs* 24.6%) and permanent AF (15.2% *vs* 9.7%) compared to patients without HF. Of 4873 patients prescribed DE, 1169 (24.0%) had prior HF. Atrial fibrillation patients with HF, have increased rates of mortality compared to patients without HF (4.6 *vs* 1.8/100pt/year); major bleeding (1.1 *vs* 0.9/100pt/year) and stroke (0.8 *vs* 0.6 /100pt/year) rates, were similar between groups DE treated.
Conclusions: These results highlight that the DE treatment appears associated with long-term safety and effectiveness in an high cardiovascular risk population as AF patients with co-morbid HF.
Study funded by Boehringer Ingelheim.

Complications of peripheral inserted central catheters in Azienda Sanitaria Locale Biella (ASL BI): a prospective observational cohort study

F. Bertoncini[1], M. Biancato[1], G. Busca[1], M. Casarotto[1], A. Croso[1], C. Gatta[1]

[1]ASL Biella, Italy

Background and Aim: Peripheral Inserted Central Catheters (PICC) are devices whose use has been increasing in recent years in hospital medical setting. There are different type of PICC: closed tip, open tip or power catheter. Our data describe how and which complications occur for each type of catheter.
Methods: We conducted a prospective observational cohort study on adult patients admitted in our hospital during 2015 – 2018, patients for whom a PICC was required to be placed. The authors examined, for every type of catheter: numbers and rate of complications like infection, displacement, occlusion, thrombosis.
Results: Our cohort included 1164 patients undergoing placement of PICC. In the sample there are 316 closed tip PICC, 196 open tip PICC and 652 power catheter PICC. Global complication rate are 42.09%: of these complication 15.72% that needed a PICC removal, while 18.9% are positioning complications like arterial puncture, missed puncture, immediated displacement or failed progression of seldinger or catheter, this last are common in power catheter. The most common complication of closed tip PICC are displacement (7.4%); in open tip the higher complication are occlusion (6.6%) and in power catheter PICC the 5.2% are positioning complications and 3.3% displacement.
Conclusions: In qualitative considerations of this study, the reporting bias to suppression of information it's to be considered. This report allows organization to monitor proper nursing management about selection of best device to placement and define guidelines for correct use of PICC.

Role of galectin-3 in patients with heart failure with preserved ejection fraction and atrial fibrillation: correlation with natriuretic peptides and left atrial volume

M. Bertoni[1], A.M. Traini[2], A. Celli[3], A. Giani[1], I. Bracali[1], M. Bernetti[1], L. Guarducci[1], P. Lotti[1], R. Martini[1], T. Restuccia[1], F. Risaliti[1], A. Tammone[1], S. Zanieri[1], M.E. Di Natale[1]

[1]SOC Medicina Interna 2, Ospedale S. Stefano, Prato; [2]SOC Cardiologia, Ospedale S. Stefano, Prato; [3]UO Analisi Chimico-Cliniche, Ospedale S. Stefano, Prato, Italy

Background: Galectin-3 (Gal-3) is a biomarker of fibrosis which plays a role in promoting fibrosis both in patients (pt) with atrial fibrillation (AF) and pt with heart failure with preserved ejection fraction (HFpEF). Aim of our study was to analyse the relation of serum Gal-3 levels with both NTproBNP levels and an echocardiographic index of structural remodeling (left atrial volume index - LAVI) in pt with HFpEF and AF (HFpEF-AF).
Methods: Both HFpEF and AF diagnosis were made according to 2016 ESC guidelines. Patients underwent both measurement of serum Gal-3 and NT-proBNP levels by enzyme-linked fluorescent assay,and echocardiographic assessment of LAVI. A comparison of such parameters was made between 34 pt with HFpEF-AF and

48 age- and gender-matched pt with HFpEF and sinus rhythm (HEpEF-SR).
Results: Gal-3 and NT-proBNP levels as well as LAVI were significantly increased in HFpEF-AF (mean age 83.5±7.6 years,11 men) compared to pt with HFpEF-SR (23.1±7.3 ng/mL *vs* 20±9 ng/mL,p<0.05; 3067.8± 1969.9 *vs* 1517.8±1486.7 pg/mL,p<0.01; 40.81±9.6 ml/m^2 *vs* 28.4±7.3 ml/m^2;p<0.01, respectively). Linear regression analysis showed a significant correlation of Gal-3 levels with both NT-proBNP levels and LAVI in both HFpEF-AF (r=0.5,p<0.02; r=0.36,p<0.05, respectively) and HFpEF-SR (r=0.58,p<0.01; r=0.29,p<0.05, respectively).
Conclusions: Gal-3 is related with greater NTproBNP elevation and left atrial remodeling in HFpEF-AF compared with HFpEF-SR. These data raise interest on the possible role of a progressive increase of Gal-3 in pt with HFpEF-SR as a potential predictor of AF onset.

Incidence of unknown venous thromboembolism in patients admitted in Internal Medicine department for dyspnoea and/or respiratory failure

R. Bonometti[1], M. Bellan[1], G. Comola[1], E. Avitabile[1], S. Strada[1], M.G. Cittone[1], E. Boin[1], F. Bobbio[2], S. Pittau[2], G. Zaccala[2], M. Rubin[3], M. Girino[3], M. Campanini[2], M. Pirisi[1]

[1]Dipartimento Medicina Traslazionale, Novara; [2]AOU Maggiore della Carità, Novara; [3]Ospedale Santo Spirito, Casale Monferrato (AL), Italy

The diagnosis of pulmonary embolism (EP) is notoriously underestimated. Compression ultrasound (CUS) is characterized by a sensitivity >90% and an approximate 95% specificity for symptomatic DVT. In the present study, we aimed to evaluate the potential additional diagnostic value of CUS in patients hospitalized in an internal division because of dyspnoea and/or respiratory failure, with a diagnosis of acceptance other than EP. We recruited 157 patients (83 females; 52,9%); the median age was 84,0 [75,7-88] years. We reported a positive CUS in 19 (12,1%) patients. Out of them 18 patients showed a proximal vein involvement, while 1 patient had solely bilateral paraneoplastic distal thrombosis. The Wells score for PE indicated an unlikely diagnosis (≤4) in 14/19 patients (73,7%). Following the positive result of CUS, 9 patients underwent a CT scan wich confirmed PE in 6 subjects (3.8% of the whole population). The Wells score for PE indicated an unlikely diagnosis in 5/6 patients (83.3%). This study confirms that the prevalence of PE in patients admitted for dyspnea/respiratory failure is largely underestimated and suggests that the current risk scores are probably inadequate when applied in clinical practice. The routinary use of CUS in respiratory failure might significantly contribute in improving the diagnostic accuracy.

Changes in markers of atherosclerosis in patients with familial hypercholesterolemia treated with PCSK-9 inhibitors: A prospective cohort study

I. Calcaterra[1], M. Tripaldella[1], M. Gentile[1], G. Marotta[1], A. Di Minno[1], G. Iannuzzo[1], C. Pagano[1], P.O.F. Rubba[1], M. Di Minno[1]

[1]Università degli Studi di Napoli Federico II, Napoli, Italy

Background and Aim: Protein convertase subtilisin kexin type 9 (PCSK9) inhibitors demonstrated efficacy in LDL-C reduction and in the prevention of cardiovascular events. We evaluated changes in endothelial function and in lipid profile in patients with severe hypercholesterolemia during treatment with PCSK-9 inhibitor.
Materials and Methods: Patients with severe hypercholesterolemia starting a treatment with PCSK-9 inhibitors were included. Endothelial function (flow-mediated dilation [FMD], reactive hyperaemia index [RHI] and carotid stiffness) and lipid profile were evaluated at baseline and after 12 weeks of treatment with PCSK-9 inhibitor.
Results: We enrolled 25 subjects (52% males, mean age 51.5 years) with severe hypercholesterolemia. After 12 weeks of treatment, patients reported 35% reduction in TC, and 49% reduction in LDL-C. LDL score was reduced of 44%, and Lp(a) of 52%. FMD changed from 4.78%±2.27 to 10.6%±5.89 corresponding to a 147.0% increase (p <0.001) and RHI changed from 2.37±1.23 to 3.76±1.36 (+108.1%, p <0.001). In parallel, carotid stiffness changed from 9.26±3.09 at baseline to 6.70±1.74 at $T12_w$ corresponding to a change of 24.2% (p <0.001).
Conclusions: Treatment with PCSK-9 inhibitor was associated to a significant improvement in endothelial function in patients with severe hypercholesterolemia accompanied by a reduction in LDL score and Lp(a).

The new definition of sepsis: assessment in an internal medicine ward

C. Cappugi[1], A. Faraone[1], L. Tofani[2], A. Fortini[1]

[1]Medicina Interna, Ospedale San Giovanni di Dio, Firenze; [2]Statistica, AOUC Careggi, Firenze, Italy

Introduction: Sepsis has been recently defined as an infection associated to organ dysfunction, identified as an acute change in total SOFA score ≥2, with a mortality risk of approximately 10% in the hospital population. The aim of this study is to evaluate the prevalence and hospital outcome of patients (pts) with sepsis in an Internal Medicine ward.
Materials and Methods: We retrospectively reviewed the electronic charts of all pts discharged over 2 months from our Internal Medicine ward and we calculated the SOFA score of the pts admitted for any infective disease. Pts with sepsis (SOFAs≥2) were compared with those without sepsis regarding hospital mortality and ICU admission.
Results: Of the 635 pts discharged, 279 (43.9%) 279 appeared to have an infection. We could calculate the SOFAs in 254 pts and it was ≥2 in 93 (36.6%). We counted 14 deaths in the group of pts with SOFA ≥2 (15.05%), against 4 deaths out of 161 pts without sepsis criteria (2.48%) (p<0.001). The negative predictive value of the SOFAs was 97.5%, regarding to mortality. One patient in the group with sepsis was transferred to ICU, while no one in the group without sepsis. Considering pts with SOFAs ≥4, ≥6 and ≥8, hospital mortality was 36%, 62% and 100%, respectively.
Conclusions: The number of pts with sepsis was very high in our Internal Medicine ward (about 14% of the admissions). Patients with sepsis, diagnosed according to the new definition, showed a high hospital mortality (15%) and increasing values of SOFAs were associated with increasing mortality rate.

Seven-year efficacy and safety of azathioprine treatment in the maintainance of steroid-free remission in inflammatory bowel disease patients

C. Cassieri[1], R. Pica[2], E.V. Avallone[1], G. Brandimarte[3], M. Zippi[2], P. Crispino[1], D. De Nitto[2], G.P. Lecca[3], P. Vernia[1], P. Paoluzi[1], E.S. Corazziari[1]

[1]Internal Medicine and Medical Specialties, "Sapienza" University of Rome; [2]Unit of Gastroenterology and Digestive Endoscopy, Sandro Pertini Hospital, Rome; [3]Internal Medicine, "Cristo Re" Hospital, Rome, Italy

Background and Aim: Azathioprine (AZA) is widely used for induction and maintenance of remission in steroid dependent patients with inflammatory bowel disease (IBD). We investigated its efficacy and safety in maintaining steroid-free remission in steroid dependent IBD patients seven year after the institution of treatment.
Methods: Data from consecutive IBD outpatients referred in our Institution, between 1985-2016, were reviewed and all patients treated with AZA were included.
Results: Out of 2802 consecutive IBD, AZA was prescribed to 433 patients, 236 (54.5%) were affected by Crohn's disease (CD) and 197 (45.5%) by ulcerative colitis (UC). One hundred and seventy-nine patients with a follow-up <84 months were excluded from the study. Two hundred and fifty-four patients were evaluated, 141 (55.5%) with CD and 113 (44.5%) with UC. One hundred and thirty-nine (54.7%) were male. Seven year after the institution of treatment, 127 (50%) patients still were in steroid-free remission (83 CD *vs* 44 UC, 58.8% and 38.9%, p=0.0024), 71 (27.9%) had a relapse requiring retreatment with steroids (29 CD *vs* 42 UC, 20.6% and 37.2%, p=0.0047), 56 (22.1%) discontinued the treatment due to side effects (29 CD *vs* 27 UC, 20.6% and 23.9%). Loss of response from 1st to 7th year of follow-up was low, about 20%.

Conclusions: Seven years after the onset of treatment 50% of patients did not require further steroid courses. The maintenance of steroid-free remission was significantly higher in CD than in UC patients. The occurrence of side effects leading to the withdrawal of AZA treatment has been low.

Acute idiopathic pericarditis: controversial issues in treatment strategies

A. Castrovilli[1], G. Piazzolla[1], S. Savino[1], A. D'Introno[1], C. Sabbà[1], A. Perrone[1]

[1]Medicina Interna Universitaria "C. Frugoni", Bari, Italy

Background: The therapy for acute pericarditis includes aspirin/non-steroidal anti-inflammatory agents (ASA/NSAIDs) or steroids plus colchicine. Prednisone, especially at high-dose, has been associated with a higher recurrence rate.
We evaluated the efficacy and safety of high-dose ASA/NSAIDs and prednisone in acute and recurrent idiopathic pericarditis.
Methods: A retrospective design was used. The patients were treated with high dose ADA/NSAIDs or prednisone at variable doses.
Results: The cohort included 276 patients aged 17-76 years, mean age 45.4±12.7 years. Sixty-one patients (22.1%) were treated with prednisone and 215 with high-dose ASA/NSAIDs (77.9%). 171 patients experienced at least one recurrence (62%). No difference in recurrence rate was observed (p=0.257) between the groups treated with prednisone (55.7%) *vs* ASA/NSAIDs (63.7%). All recurrences were treated with steroids. Steroids alone were administered in about 80% of patients, while in the remaining 20% of cases they were associated with ASA / NSDAIDs or colchicine. Most of recurrences were treated with low dose steroids and particularly gradual tapering, the dose reduction was much slower as the number of relapses experienced by the patient was higher. As a result of this recurrence treatment scheme, approximately 90% of patients had a very favorable course, that is no more than 2 relapses. In addition to this result, no patients presented serious side effects and in no-cases preventive treatments were administrated. Patients who, instead, had a less favorable prognosis, relapsing ≥3 times, constituted only 10% of the total. By evaluating first-line therapies, these subjects had been treated with particularly high-dose steroids or had a shorter tapering. In these subjects, colchicine was added to steroids. All of these patients had no more recurrences except one that had 5 relapses.
Conclusions: Steroids at low dose with a very gradual tapering may be considered a successful and safe treatment for acute and recurrent idiopathic pericarditis.

A rare case of paroxysmal hypertension in urinary bladder paraganglioma

M. Celi[1], V. Bisogni[1], L. Petramala[1], G. Oliviero[1], M. Bonvicini[1], M. Mezzadri[1], A. Concistrè[1], F. Olmati[1], G. Iannucci[1], A. Ciardi[2], G. De Toma[3], C. Letizia[1]

[1]Department of Translational and Precision Medicine, Unit of Secondary Arterial Hypertension, "Sapienza" University of Rome; [2]Surgery Department, "Pietro Valdoni" "Sapienza" University of Rome; [3]Department of Radiological Sciences, Oncology and Pathology "Sapienza" University of Rome, Italy

Background and Aim: Primary bladder paragangliomas (PGLs) are rare ectopic chromaffin-cells derived tumors. Clinical manifestations include micturition hypertension, palpitations, syncopes and urinary tract infections. These symptoms are often paroxysmal and non diagnosticated.
Case description: A 21 yrs woman referred to our Unit complaining, for about 4 years, of recurrent micturition episodes of throbbing frontal headache, increased blood pressure (BP) values, palpitation, nausea, and flushing of legs. She had no family history for PGL. At the 24-h ambulatory blood pressure monitoring (ABPM) BP values were normal, but showed paroxysms during micturination. We performed a screening for secondary hypertension without finding any pathological evidences; several measurements of 24-h urinary metanephrines were also normal. The patient underwent abdominal magnetic resonance (MR) that showed a thick-walled left adnexal mass abutting the urinary bladder and confirmed by ^{123}I-MIBG scintigraphy as strongly uptaking mass. The mass was surgically removed and an histological diagnosis of bladder PGL was confirmed. The genetic testing for SDH genes was negative for mutations. After 12-months the patient is completely asymptomatic and her BP is normal.
Conclusions: Our case showed that extra-adrenal PHEOs often are not associated with increased value of 24-h urinary metanephrines, especially when the over secretion is stimulated only in particular situations. Thus, it is mandatory, whether clinical manifestations are suggestive, to perform further investigations in order to avoid late diagnosis.

Pulmonary embolism and gender: an observational study

T. Ciarambino[1], M. Cirillo[2], C. Fatini[2], C. Politi[3], A.M. Moretti[4]

[1]Hospital of Marcianise, Department of Internal Medicine, ASL Caserta; [2]Department of Experimental and Clinical Medicine, University of Florence, Florence, Italy; [3]Hospital of Isernia, F. Veneziale, Department of Internal Medicine, ASREM; [4]President of GISeG, Italian Group of Health and Gender, Italy

Pulmonary embolism (PE) is a major cause of mortality, morbidity, and hospitalization in Europe, but few studies have highlighted sex differences in PE. The aim of this study is to analyze the gender differences in patient hospitalized with a principal diagnosis of PE. This is a retrospective population-based cohort study. Data for all patients discharged with a principal diagnosis of Pulmonary Embolism (ICD-9 415.1) by Apulian hospitals between 2010 and 2016 were retrieved from the National Hospital Discharge Register Database. 4795 patients were discharged with a principal diagnosis of PE during the inclusion period. The majority of which were females (2762; 57.6%). Mean age was significantly higher in women (73.0 *vs* 67.9, p<0.001). Females showed an higher prevalence of hypertensive heart disease (41.1% *vs* 32.9%, p<0.001), arrythmia (16.3% *vs* 13.9%, p=0.023), diabetes mellitus (14.8% *vs* 11.7%, p=0.002) and obesity (6.6% *vs* 3.5%, p<0.001) and a lower prevalence of chronic obstructive pulmonary disease (COPD) (10.0% *vs* 18.0, p<0.001), lung failure (11.1% *vs* 13.7%, p=0.006) and cancer (15.3% *vs* 22.9%, p<0.001). The overall incidence rate (F:17.4 *vs* M:13.8; AR=+3.6; p<0.001) and the overall mortality rate (F:1.3 *vs* M:0.9; AR=+0.3; p<0.001) were higher in women compared to men. The overall case fatality rate was not different between women and men (p=0.92). Findings from our study showed significant sex disparities for age of hospitalization, comorbidities distribution, incidence and mortality, but no differences in the fatality of the disease.

The identification of sepsis in Emergency Department by macro and micro-indicators of tissue perfusion: the development of a new ultrasound score for early diagnosis

G. Cioni[1], E. De Curtis[2], G. Manco[2], A. Baldini[2], S. Magazzini[2]

[1]Università degli Studi di Firenze; [2]ASL Centro, Ospedale Santo Stefano, Prato, Italy

Background and Aim of the study: In this study we identified indicators of the volemic state, such as serum lactate levels, diameters of the inferior vena cava (IVC) and pulmonary ultrasound pattern, in order to evaluate their predictive power in the early diagnosis of sepsis, in population of patients enrolled in the Emergency Department.
Materials and Methods: We enrolled 97 patients with clinical suspicion of sepsis, according to current guidelines. Each patient underwent clinical, laboratory, and radiological evaluation; serum lactate level was assessed by arterial blood gas analysis. The pulmonary pattern and diameters of the IVC were evaluated according to standardized ultrasound protocols.
Results: Diagnosis of sepsis was confirmed in 46 patients. Elevated serum lactate levels and reduced diameters of IVC were associated with the presence of sepsis, also after correction due to the presence of hypotension, tachycardia, respiratory insufficiency, elevated PCR values, elevated creatinine values, presence of comorbidity according to the Charlson Comorbidity index. According to ROC curve analyses, predictive power of hyperlactacidemia, and

reduced diameters of the IVC, was significantly increased by the presence of A pulmonary pattern, all elements collected in a 3-point-score, we have called "SUN" score (Sepsis-Ultrasound-assessmeNt score) (AUC 0.9, CI 95% (0.84-0.95); p<0.0001). SUN score values>2 was associated to bad prognosis.
Conclusions: The SUN score, born from the joint evaluation of macro and micro indicators of volemia, early identifies septic patients and with poor prognosis.

The results of a survey on smoking conducted among the members of the Italian Scientific Society of Hospital Internal Medicine (FADOI)

A. Crespi[1], G. Gussoni[1], F. Pieralli[2], A. Fontanella[3]

[1]Research Department, FADOI Foundation, Milan; [2]Department of Internal Medicine, Hospital "Careggi", Florence; [3]Department of Internal Medicine, Hospital "Fatebenefratelli", Naples, Italy

Background: Considering the relevant impact in terms of morbidity, mortality and social costs caused by smoking, FADOI has decided to investigate, among its Members, some attitudes towards this habit.
Methods and Results: The survey involved 528 Physicians (total sample n=2092) and showed that 67% of them are non-smokers, being the others regular (7.5%), occasional (6.0%), or former smokers (18.5%). Among the current smokers, 73% use traditional cigarettes. Ninety-four percent of former smokers quit smoking without pharmacological or psychological support. Almost the totality (97.5%) of the Physicians reported that during visits they ask patients about their smoking habits. The most shared attitudes are to advise the patient to stop smoking (72.5%) and highlight the correlation between the patients' disease and smoking (47.5%). Recently, modified risk tobacco products (MRTP) became available on the market: 58% of the Physicians interviewed were aware of them, and most responders declared themselves not able to give an opinion (44%) or possibilistic (32%) regarding these products. Ninety-five percent of the respondents consider that the interest of Scientific Societies and Patients Associations with respect to MRTP is a correct attitude.
Conclusions: The goal of Physicians and Scientific Associations must be a smoke-free world. Nevertheless, even considering the results of this survey, it seems reasonable and not conflicting to simultaneously pay attention to options which could reduce the damage caused by cigarettes, especially for those people who refuse to quit smoking.

A difficult diagnosis of a demyelinating disorder

D. D'Ambrosio[1], M.A. D'Agostino[1], V. Vatiero[1], A. Petrillo[1], A. Benincasa[1], S. Giovine[2], F. Ievoli[1]

[1]UOC di Medicina Generale, PO "G. Moscati" Aversa (CE), ASL CE; [2]UOC di Radiologia, PO "G. Moscati" Aversa (CE), ASL CE, Italy

Case report: A 33-year-old male presented to our hospital due to left brachial and crural hyposthenia. The biochemical tests were normal. Cerebral CT scans showed multifocal cortical hypodense lesions. Total body CT scans excluded neoplasms. CSF studies showed oligoclonal bands (OCBs) without pleyocitosis. A subsequent Brain MRI depicted large (>1 to 3 cm) lesions that are multifocal, hyperintense, and located in the supratentorial white matter regions. Differential diagnosis between acute disseminated encephalomyelitis (ADEM) and tumefactive multiple sclerosis (MS) was difficult for the lack of specific disease markers. The patient was treated with IV methylprednisolone at a dose of 1000 mg for 5 days, followed by an oral taper over 4-6 weeks and we observed a recovery to baseline within one month. He is actually in close follow-up with a MRI scheduled for 3 months.
Discussion: Tumorlike demyelinating lesions are reported in association with both ADEM and MS. Detection of OCBs may be helpful in predicting a diagnosis of MS, but the true utility is unknown because many cases with ADEM initially have OCBs. The role of biomarkers, including autoantibodies, is currently under debate. As such, they should be listed in the differential diagnosis of "butterfly" lesions, with glioblastoma multiforme and lymphoma. Most of these patients were diagnosed only after biopsy.
Conclusions: Multicenter studies are required to provide more information with regards to pathogenesis, biomarkers, differential diagnoses, and therapeutic options in demyelinating disorders.

Immunological effects of Eribulin mesylate administration in advanced breast cancer patients

M. Danova[1], G. Comolli[2], A. Olgiati[1], C. Cavalli[1], S. Zanirato[1]

[1]UOC Medicina Interna a Indirizzo Oncologico, ASST di Pavia, Vigevano (PV); [2]Laboratori di Ricerca Biotecnologie e UOC Microbiologia e Virologia, Fondazione IRCCS San Matteo, Pavia, Italy

Background: Experimental evidence suggest that some chemotherapy (CT) drugs generate stimulation of the immune system that accounts for clinical response, however demonstration of the immunostimulatory power of CT continues to be a challenge. Eribulin mesylate is an analog of halichondrin B with multiple non-mitotic effects on tumor biology.
Patients and Methods: To explore the role of CT on the immune system we studied the effect of EM on different T-cell populations in ABC. FOXp3+ *Treg* populations, sub-populations of cytotoxic CD8+ T-cells and CD57+ NK cells were analyzed in 17 ABC pts (median age 60, range 40-75 yrs) undergoing a 3rd or 4th line of treatment. Ten healthy subjects matched for sex and age were utilized as control.
Results: There was a progressive decrease in absolute numbers of leukocytes, lymphocytes and CD8+ T-cells during CT. Starting from the 3rd EM course, *Treg* populations, that initially were increased compared to the healthy controls (p<.001), significantly decreased (p<.001). Among the T-cells, there was a lower CD8-/CD8+ ratio in pts compared to controls. The proportion of CD28-CD57+ cells also remained higher among pts with cancer throughout the study duration.
Conclusions: In pre-treated ABC, EM elicits several changes of some immune-related parameters including the composition of immune cells. Regulatory activities in T-cells were increased through decreasing FOXp3+ *Treg* cell populations. These features may be taken into account in view of the use of this drug in combination with the new immune chekpoint blockers.

NAFLD and cognitive decline in older adults: a 7-year longitudinal study

E. Fabbri[1], D. Magalotti[2], G. Bianchi[2], A. Muscari[2], M. Zoli[2]

[1]Dipartimento di Scienze Mediche e Chirurgiche, Università di Bologna, Bologna; UOC Medicina Interna, Ospedale Morgagni-Pierantoni, Forlì (FC); [2]Dipartimento di Scienze Mediche e Chirurgiche, Università di Bologna, Bologna, Italy

Background and Aim of the study: While Nonalcoholic Fatty Liver Disease (NALFD) in middle age is a risk factor for dementia, whether a positive association between NAFLD and cognitive decline holds also at old age and even longitudinally is unclear. This study tests whether NAFLD at baseline and/or its change (progression or regression) over 7-year follow-up predict cognitive decline over the same timeframe in older adults.
Materials and Methods: 457 men and women aged 65 to 87 (mean±SD: 70.9±4.1) years are included and followed for 7 years. Cognitive status is evaluated using Mini-mental State Examination. Hepatic steatosis is assessed by abdominal ultrasound and categorized as absent, mild, moderate or severe. Participants are classified into three subgroups according to hepatic steatosis progression, stability or regression overtime. Generalized estimating equation models are used to test longitudinal associations. Covariates include demographics, functional status, body composition and comorbidities.
Results: No significant associations are found between baseline NAFLD and cross-sectional cognitive status or longitudinal cognitive decline. Participants who undergo NAFLD regression overtime present accelerate cognitive decline compared to the rest of the population, independent of covariates and even when adjusting for change in body mass index or weight (β=-0.04, P=.03).
Conclusions: Although further studies are required to fully under-

stand the underlying mechanisms, in elderly NAFLD regression rather than progression is associated with accelerated cognitive decline.

Risk of pneumonia and exacerbations with single inhaler extrafinetriple therapy compared to indacaterol/glycopyrronium: post-hoc analysis of the TRIBUTE Study

L. Fabbri[1], A. Papi[2], A. Piraino[3], G. Micarelli[3], S. Petruzzelli[3]

[1]Sahlgrenska University Hospital, Gothenburg, Sweden; [2]Università degli Studi di Ferrara, Ferrara, Italy; [3]Chiesi Farmaceutici s.p.a., Parma, Italy

Background and Objectives: the use of ICS-containing medications is recognized to be associated with an increased risk of pneumonia. With this post-hoc analysis of the TRIBUTE study, our objective was to evaluate the risk/benefit balance of extrafine BDP/FF/G *vs* IND/GLY by comparing the incidence of pneumonia and exacerbation events.
Methods: 1532 COPD patients aged ≥40 years, with FEV_1<50% of the predicted normal value, ≥1 moderate/severe COPD exacerbation in the previous year, CAT score ≥10 were randomized in a 1:1 ratio to either BDP/FF/G or IND/GLY. COPD exacerbation was defined according to GOLD criteria. A plot presenting the study day *versus* the cumulative number of events was generated.
Results: In the BDP/FF/G group the number of recorded events was 433 exacerbations and 32 pneumonias whereas in the IND/GLY group there were 485 exacerbations and 29. Overall, treatment with BDP/FF/G reduced exacerbations by 52 events compared to IND/GLY (adjusted rate ratio: 0.848 95% CI: 0.723 to 0.995, p=0.043) but, importantly, the rate of pneumonia was comparable with a similar incidence in the two groups. 18 serious events of pneumonia were reported in each groups and no fatal pneumonias occurred regardless of the treatment.
Conclusions: This analysis shows that the superior clinical benefit of single inhaler triple therapy with extrafine BDP/FF/G in reducing exacerbations compared to IND/GLY is not associated with an increased risk of pneumonia.

Inappropriate use of carbapenems in the Internal Medicine ward: impact of a carbapenem-focused antimicrobial stewardship program

A. Faraone[1], C. Cappugi[2], S. Bartolini[3], L. Tofani[4], G. Nenci[5], F. Picca[6], A. Crociani[1], A. Fortini[1]

[1]Medicina Interna, Ospedale San Giovanni di Dio, Firenze; [2]Medicina Interna, AOU Careggi, Firenze; [3]Farmacia Ospedaliera, Ospedale San Giovanni di Dio, Firenze; [4]Dipartimento di Neuroscienze, Psicologia, Area del Farmaco e Salute del Bambino, Università degli Studi di Firenze, Firenze; [5]Medicina Interna, Ospedale San Jacopo, Pistoia; [6]Direzione Infermieristica, Ospedale San Giovanni di Dio, Firenze, Italy

Background: Overuse of carbapenems is a major drive for the emergence of carbapenem-resistant *Enterobacteriaceae*. In May 2016, a restrictive antimicrobial stewardship program (ASP) was implemented at our Internal Medicine unit, with the aim of limiting inappropriate use of carbapenems.
Materials and Methods: We assessed the impact of the ASP by measuring the appropriateness of carbapenem prescriptions and the proportion of inpatients treated with carbapenems before (from October to December 2015) and after (from May 2016 to July 2018) the ASP implementation. Moreover, we compared the carbapenem use density (DDD/100 patient-days) and the prevalence of inpatients infected/colonized by carbapenem-resistant *Klebsiella pneumoniae* (CRKP) in a 1-year pre-intervention period (from May 2015 to April 2016) and in a 2-year post-intervention period (from May 2016 to April 2018).
Results: The proportion of patients prescribed carbapenems decreased from 3% (30/988) to 0.97% (84/8619) (p<0.0001); rate of inappropriate carbapenem prescriptions significantly declined, from 63.3% (19/30) to 29.7% (25/84) (p=0.0025). Carbapenem use density declined from 5 DDD x 100 patient-days to 1.5 DDD x 100 patient-days. The prevalence of patients infected/colonized by CRKP did not change significantly.
Conclusions: the implementation of a carbapenem-focused ASP was effective to limit inappropriate carbapenem drugs prescriptions. Such effect was sustained during a 27-month post-intervention period and resulted in a significant decrease in carbapenems consumption.

Noninvasive ventilation for community acquired penumonia with acute respiratory failure: lights and shadows

R. Ferrari[1], D. Agostinelli[2], G. Negrini[2], C. Praticò[2], M. Cavazza[1]

[1]Medicina d'Urgenza e Pronto Soccorso, Policlinico Sant'Orsola Malpighi; Dipartimento dell'Emergenza Urgenza, Azienda Ospedaliero Universitaria di Bologna; [2]Medicina Interna Policlinico Sant'Orsola Malpighi, Università degli Studi di Bologna, Italy

Background: Community acquired pneumona (CAP) keeps high in-hospital mortality rates, mainly due to sepsis and respiratory failure (RF). We aimed to assess the role of noninvasive ventilation (NIV) in real-life CAP treatment, focusing on early predictive factors.
Materials: Observational study, during 16 months, including every consecutive patient treated in the Emergency Department of a university teaching hospital with NIV because of RF due to a newly diagnosed CAP. Failure was defined as tracheal intubation (TI) or death during the hospital staying.
Results: 122 CAP patients were treated with NIV: media 81.6 years of age; 72 with success (59.0%); the cause of failure was TI in 15, death in 44; 4 cases failed immediately, 13 early (1 to 48 hours), 33 lately. SOFA score, CURB-65, NIV as ceiling treatment, GCS, Kelly-Matthay scale, respiratory rate, heart rate, arterial blood gas parameters (bicarbonate and pH at start; lactates after 2 hours; pH, P/F and PaCO2 after 6 hours), red blood cells, white blood cells, natremia, calcemia, significantly related to the outcome.
Conclusions: In our unselected fragile population of elderly patients with high rate of end of life cases, we documented a high rate of NIV failure in CAP, mainly due to in-hospital mortality after 48 hours. We identified some useful criteria to early recognize patients at risk of failure. It is now mandatory to set and share early clear criteria for an accurate risk stratification and patient selection to start and stop NIV in CAP cases with RF, with the aim to avoid both a delay in TI and therapeutic fury.

Severe intestinal and renal small- and medium-size vessels vasculitis with IgA deposition in adult patient treated with anti-TNF alpha agent for rheumatoid arthritis

A. Ferrarini[1], L. Manfredi[1], D. Menghini[1], L. Perini[1], D. Olivari[1], A. Festa[1], G. Pomponio[1], A. Gabrielli[1]

[1]Clinica Medica, Università Politecnica delle Marche, Italy

Henoch-Schönlein Purpura (HSP) is an immune complex vasculitis affecting small vessels with dominant IgA deposits. Cutaneous purpura, arthralgia, acute enteritis and glomerulonephritis are among clinical manifestations. Renal involvement represents the main cause of morbidity and mortality in adults. We report the case of a 67-year-old woman with a 3-year history of seropositive (RF+, ACPA+) rheumatoid arthritis, undergoing etanercept therapy, who developed a purpuric rash, abdominal pain with gastrointestinal bleeding, macroscopic hematuria and severe proteinuria (6g/24h). Blood count, chemistry, C3 and C4 levels were normal. ANA, anti- DNAds, anti-ENA , ANCA, cryoglobulinaemia were negative. Increase of serum IgA (430mg/dl) was found. Skin biopsy revealed inflammation and focal fibrinoid necrosis of vascular wall (small and medium size vessels) with leukocytoclasia and C3 deposition. Esophagogastroduodenoscopy showed multiple superficial ulcers and mucosal inflammation with ischemic necrosis at biopsy. Intravenous methylprednisolone was started (1 mg/kg). After 1 month, for persistence of hematuria and proteinuria (6,25g/24h), kidney biopsy was performed, showing mesangial glomerulonephritis with C3 and IgA deposits. Cyclophosphamide was initiated, and resolution of clinical signs, proteinuria and hematuria was observed. Although current literature reports few other systemic HSP following anti-TNF treatments, this case is peculiar for sev-

eral reasons: 1. unusual histological pattern; 2. Severity of intestinal and renal involvement; 3. Absence of evident infectious trigger.

KPC-producing *Klebsiella pneumonia* colonization in Medical Wards

M. Galiè[1], E. Pistella[1], P. Marinelli[1], L. Emili[1], A. Siddu[2], A. D'Acci[2], C. Santini[1]

[1]UOC Medicina Interna, Ospedale Vannini, Roma; [2]UOC Laboratorio Analisi, Ospedale Vannini, Roma, Italy

Background: Klebsiella pneumonia carbapenemase (KPC)-producing K pneumonia(KPC-Kp) has become one of the most important contemporary pathogens and its infection is associated with high mortality.KPC -Kp enteric colonization is a major risk factor for developing infections in hospitalized patients. The aim of the study was to evaluate the prevalence and spread of KPC-Kp in three medical wards (Medicina I, Medicina II, Medicina III) and identify risk factors for KPC-KP enteric colonization.
Methods: A prospective observational study of 95 patients admitted in the medical wards was conducted during December 2017-2018.Rectal samples were obtained from all patients at admission, day 7 and 15 and after once weekly.
Results: Two patients (2.1%) had positive rectal samples at admission: these patients had been hospitalized several times with more co-morbidities. Forty-two patients underwent rectal samples at day 7: Fourteen of them (33.3%) had positive rectal samples (n:7 in Medicina I, n: 2 Medicina II, n: 5 Medicina III). The major risks factors, evaluated in all patients colonized (n: 14) and no colonized (n: 28) were: old age, malignancy , abdominal drainage.
Conclusions: The low prevalence on admission, the high increase after a week of the patients colonized and the difference among the three medical wards could highlight a not correct infectious control measures. An adequate knowledge about this topics would lead to a reduction in the spread of KPC-KP improving preventive hygenic measures and an early identification and isolation of such carriers.

Para-perirenal distribution of body fat is associated with reduced glomerular filtration rate regardless of other indices of adiposity

G. Geraci[1], M.M. Zammuto[1], G. Augello[2], S.A. Cantarella[2], G. Cavaleri[2], A. Arces[2], A. Trento[2], T. Attardo[2], S. Cottone[1], G. Mulè[1]

[1]Dipartimento di Medicina Interna e Specialistica, Università di Palermo; [2]PO "Barone Lombardo" di Canicattì, UOC Medicina Interna (AG), Italy

Background and Aim: Obesity is a well-known risk factor for the development and progression of CKD. Recently, para-perirenal ultrasonographic fat thickness (PUFT) has shown to correlate with both total and visceral fat better than body mass index (BMI), waist circumference (WC) and other indices of obesity. Moreover, a local paracrine and mechanical action of the PUFT on kidney has been described in recent studies. Aim of our study is to assess the relationship between glomerular filtration rate (GFR) and PUFT in comparison to other anthropometric and ultrasonographic indices of adiposity.
Methods: 296 hypertensives were enrolled. PUFT, cutis-rectis thickness and rectis-aorta thickness were obtained by ultrasonography. Anthropometric measures of adiposity were also measured.
Results: Higher PUFT values were observed in patients with impaired renal function ($p<0.001$), whereas no differences in BMI and WC were shown between groups divided by GFR. PUFT significantly correlated with GFR in all subjects ($p <0.001$), with no differences in groups divided by gender, diabetes or BMI. This association held in multivariate analyses also after correction for confounding factors, including other adiposity indices ($p <0.001$). When receiver-operating characteristic curves were built to detect eGFR<60 ml/min/1.73 m2, a PUFT value<3.725 cm showed a negative predictive value of 94.0%, with the largest area under the curve (AUC: 0.700).
Conclusions: The relationship between PUFT and GFR seems to be more accurate and less infl uenced by the bias affecting traditional indices of adiposity.

Age-related burden and characteristics of embolic stroke of undetermined source in the real world

E. Grifoni[1], A. Dei[1], M. Baldini[2], M.L. Bartolozzi[2], A. Del Rosso[3], D. Giglio[1], G. Guazzini[1], S. Cinotti[1], E. Cosentino[1], A. Cozzi[1], F. Dainelli[1], S. Di Martino[1], A. Giordano[1], C. Giulietti[1], E. Latini[1], F. Maggi[1], G.S. Murgida[1], M. Romagnoli[1], E. Schipani[1], L. Masotti[1]

[1]Medicina Interna II, Ospedale S. Giuseppe, Empoli (FI); [2]Neurologia, Ospedale S. Giuseppe, Empoli (FI); [3]Cardiologia, Ospedale S. Giuseppe, Empoli (FI), Italy

Background and Aim: Embolic stroke of undetermined source (ESUS) is a well defined but relatively new clinical entity, and few data are available on age-related burden of ESUS in the real world practice. Therefore, the purpose of our study was to provide information about it.
Methods: We prospectively analyzed data of patients consecutively admitted to our Stroke Unit (SU) along one year (2017, November 1st - 2018, October 31st). The etiology of stroke was defined according to TOAST criteria. ESUS was considered as a subset of cryptogenic stroke, and defined according to the international recommendations.
Results: In the analyzed period, 306 patients (52.3% females), mean age±SD 77.9±11.9 years, were discharged from our SU with diagnosis of ischemic stroke. Age distribution was: 12.4% <65 years, 20.3% 65-74 years, 67.3% ≥75 years. In-hospital mortality was 7.5%. Overall, in 80 patients (26.1%) the etiology was undetermined; in 25 (8.1%) it remained undefined because of death or severe comorbidity, making further diagnostic work-up not worthy. Cryptogenic stroke occurred in 55 patients (18%), and ESUS criteria were satisfied in 39 (12.7%). According to age, cryptogenic stroke was diagnosed in 21.1% (21.1% ESUS) of patients <65 years, 24.2% (19.4% ESUS) of patients 65-74 years, 15.5% of patients ≥75 years (9.2% ESUS).
Conclusions: In the real world practice, prevalence of ESUS in patients suffering from acute ischemic stroke is not negligible, and seems to decrease according to age.

Assessment of cerebral blood flow with SPECT 99m Tc-ECD in patients with primary antiphospholipid syndrome: comparison with MR Imaging and correlation with clinical and laboratory findings

A. Mameli[1], L. Indovina[2], F. Cocciolillo[3], A. Serra[4], F. Marongiu[1], D. Barcellona[1]

[1]Department of Internal Medicine, Cagliari; [2]Department of Radiological Sciences, Rome; [3]Institute of Nuclear Medicine, Rome; [4]Nuclear Medicine, Cagliari, Italy

Background: Antiphospholipid syndrome is a multiorgan disease often affecting the central nervous system. Objective of this research is to observe the abnormalities of regional cerebral blood flow by SPECT in APS patients to evaluate differences with Magnetic Resonance imaging and its correlation to the clinical manifestations of the disease.
Methods: Twenty-five patient (19 women and 6 men) with APS were studied. On the basis of clinical history the patients were divided into two groups: group 1 with Stroke (11 patients) and group 2 with DVT (14 patients). A complete antiphospholipid profile (βeta2-GPI IgG and IgM, anticardiolipin antibodies, dilute Russel Viper Venoum Time (dRVVT) and Silica Clotting Time (SCT)) was performed. The patients underwent cerebral MRI and 99Tc-ECD-SPECT. SPECT data were evaluated with statistical Parametric Mapping SPM99 software implemented in MATLAB (Mathworks, USA).
Results: 15 patients showed abnormal findings at MRI: 6 patients with a diffuse alterations and 9 with focal alterations. Perfusion SPECT showed a significant decreased in rCBF in all 25 patients: the severity of hypo-perfusion was, greater in patients with DVT. A significant decrease in rCBF was identified in patients with DVT in thalamus, cerebellum, frontal lobe and basal ganglia while patients with stroke showed a significant decreased in rCBF in parietal, occipital and temporal lobes.

Conclusions: Cerebral abnormal perfusion is present in patients with APS independently from the thrombotic event and the degree of abnormal laboratory tests. Patients with DVT show cerebral ischemic lesions and abnormal perfusion comparable to those with stroke. SPECT is more sensitive compared to MRI particularly in evaluating diffuse presentation.

Adult langerhans cell histiocytosis and immunomodulatory drugs: review and analysis of 34 case reports

E. Mauro[1], F. Gherlinzoni[1]

[1]UOC di Ematologia, Dipartimento di Medicina Interna, Ospedale Ca' Foncello, Treviso, Italy

Background: Langerhans Cell Histiocytosis (LCH) is a rare neoplastic disease of dendritic cells. Multiple organs may be involved. LCH is classified as single system (SS) and multisystem (MS). There is no standard of care in adults. We analyzed efficacy and safety of IMiDs in LCH.
Materials and Methods: A PubMed/MEDLINE search for case series with IMiDs (as first or second line of therapy) from 1987 until 2018 has been conducted. The response was defined: non-active disease (all signs/symptoms resolved) (NAD), active disease regressive (improvement of symptoms/signs) (ADr), or stable (persistence of symptoms/signs) (ADs), finally progressive disease (PD).
Results: 21 female and 13 male have been included: 17 SS and 17 MS, mean age was 45.3 years. The involvement was: skin in 32 cases, lung 3, pituitary gland 8, bones 6, lymphonodes 2, spleen/liver 2, other sites 2. Thalidomide has been used in 32 cases, lenalidomide in 2. Mean follow-up was 11.6 months. Adverse events: somnolence 9 cases (22.5%), neuropathy 6 (15%), constipation 1 (2.5%), thrombosis 1, neutropenia 1. Overall response rate (NAD+ADr) was 73.5%, ADs 20.5%, PD 6%. In SS NAD+ADr was in 16 cases (94%), PD 1 case (6%). In MS NAD+ADr was in 9 cases (53%), ADs 7 cases (41%), PD 1 case.
Conclusions: IMiDs should be only considered for adults with cutaneous SS involvement; considering the response rate in MS (53%), they should be used only in limited cases for patients not eligible for more aggressive treatments.

Hemorrhagic risk in coagulopathic patients during urgent internal jugular central venous catheter placement in an Internal Medicine Department: a prospective observational study

M. Mereghetti[1], M. Barberio[1], R. Capra[1], N. Mumoli[1]

[1]Department of Internal Medicine, Magenta Hospital, Magenta (MI), Italy

Background: Coagulation disorders are frequently a controindication to placement of central venous catheters. We determined the incidence of bleeding complications after urgent internal jugular central venous catheter placement (JCVC) in patients who had severe coagulopathy and identified potential risk factors for bleeding.
Study design: From April 2016 through December 2018 we included all JCVCs inserted in our Medical Wards, reporting on hemorrhagic complications in relation of abnormal coagulation testing results. Severe coagulopathy was defined as a reduced platelet count of 50 × 109/L or less, and/or an elevated international normalized ratio of 1.5 or greater, and/or a partial thromboplastin time of 45 seconds or greater.
Results: In total, there were 285 catheter insertions, including 83 in patients with severe coagulopathy that was not corrected before procedure. The bleeding incidence varied from 0 to 1% and it was not statistically significant between patients with and without coagulopathy (p=0.71). The severity of coagulopathy did not predict the risk of bleeding. Our analysis confirmed retrospective observational studies which suggested that no preprocedural correction is required up to a platelet count of 20 × 109/L and an international normalized ratio of 3.0.
Conclusions: The incidence of major bleeding complications after urgent internal jugular central venous catheter placement is low, even in coagulopathic patients. However, well powered randomized controlled trials will be necessary to determine the minimal coagulation setting that is safe before central venous catheter insertion.

An unusual cause of hypoglycemia

M.T. Migliano[1], N. Reggidori[1], S. Lorenzini[1], A. Gramenzi[1], P. Caraceni[1], N. Daddi[2], V. Vicennati[3], M.G. Pirini[4], F. Trevisani[1]

[1]Medical and Surgical Department (DIMEC), Internal Medicine, University of Bologna; [2]Medical and Surgical Department (DIMEC), Thoracic Surgery, University of Bologna; [3]Medical and Surgical Department (DIMEC), Endocrinology, University of Bologna; [4]Anatomy, Pathological Histology Operative Unit, Sant'Orsola-Malpighi, Bologna, Italy

Background: Solitary fibrous tumor (SFT) is an uncommon type of mesenchymal tumor that can occur anywhere in the body. A typical molecular feature is a NAB2-STAT6 fusion, that enhances cellular proliferation. Symptoms are often related to the mass effect exerted by the tumor, but paraneoplastic syndromes can also occur. Among them, Doege-Potter syndrome, characterized by refractory hypoglycemia due to an overexpression of IGF-II, occurs in <5% of cases. Surgical resection of the tumor is the mainstay of treatment.
Case report: A 60 years-old male patient was admitted to the hospital because of severe unexplained recurrent hypoglycemia. Endogen insulin, C-peptide and ACTH levels were below the lower limit, serum cortisol was low-normal. Ca125.5 and NSE were slightly elevated. Total body CT-scan revealed, in the right lung, a large mass (cranio-caudal extension 17 cm) dislocating the adjacent structures. [18]FDG-PET and 68Ga-DOTATOC-PET showed soft focal uptake by the tumor. During diagnostic work-up, hypoglycemia was treated with steroid administration. Patient underwent surgical resection, and histological specimens showed CD34+ and STAT6+ cells, confirming the diagnosis of SFT. Hypoglycemia resolved after tumor removal, coherently with the Doege-Potter syndrome.
Conclusions: Hypoglycemia can be the single symptom of malignant tumors. It is most frequently seen with insulinomas, but in our case, it was associated with an SFT, a tumor with uncertain biological behavior. Therefore, different causes must be ruled out in patients presenting with refractory hypoglycemia.

A new risk assessment model for the stratification of the thromboembolism risk in medical patients: the TEVere Score

M. Monti[1], S. Timpone[2], G. Murdolo[3], I. Fusco Moffa[1], P.D. L'Angiocola[4], F. Borgognoni[1], G.M. Vincentelli[3]

[1]USL Umbria 1; [2]Fatebenfratelli Hospital, Rome; [3]AO di Perugia; [4]Ospedale di Gorizia, Italy

Background: In hospitalized medical patients, the venous thromboembolism (VTE) risk is notable. Nevertheless, the available assessment model (TPF) is generally underused. In this work, we propose an ex novo risk assessment model based on the elaboration of the clinical data exhibited by the VET patients. Differently from previous studies, the proposed approach does not exploit pre-established models, resulting in a more valid and easy-to-use score.
Methods: We performed a double case-control observational study. For each case of VTE, we enrolled two consecutive patients without VTE of equal sex and age group.
Results: We analyzed the data of 1215 patients, 409 with VTE and 806 case-control. 365 patients (30%) were in charge to the EM department, while 850 patients (70%) to the IM one. The VTE risk factors with more statistical significance (P<0.01) are: previous VTE, active cancer, known thrombophilic condition, immobilization, chronic venous insufficiency, hyperhomocysteinemia, central venous catheter, recent hospitalization. Obesity, recent surgery, family history of VTE, hormone therapy and treatment with drugs that stimulate hematopoiesis are resulted at intermediate statistical significance (P<0.05 but >0.01). A multiple logistic regression was used with robust standard errors and forward selection of the candidate variables using the Bayesian information criterion. A new score is developed, the "TEVere Score", which shows a higher specificity and sensitivity (respectively 43.3 and 87.5, with accuracy 72.1) compared with the Padua, the Kuscer and the Chopard Score. TEVere Score also exhibits a greater predictive validity for thromboembolism risk (AUROC 0.7266; 95%

CI: 0.71 to 0.73) than the Kuscer Score (AUROC 0.6891; 95% CI: 0.67 to 0.70) (P=0.0093).
Conclusions: The TEVere Score has proven to exhibit a higher accuracy than the other scores commonly used in clinical practice to stratify the thromboembolism risk.

Hyponatremia in lung cancer: not only SIADH

F. Morando[1], M. De Rui[1], M. Boni[1], E. De Menis[1]

[1]UOC Medicina Generale, Dipartimento di Medicina, Ospedale di Montebelluna (TV), Italy

Background: For years hyponatremia in lung cancer had been considered a classic paraneoplastic syndrome, due to ectopic secretion of ADH (SIADH). Indeed, hyponatremia may be due to different causes as dehydratation, infections, supportive drugs as opioids, and classic chemotherapeutic agents. In the last few years immune checkpoint inhibitors have represented a great advance in lung cancer treatment, but different and unusual adverse effects are increasingly been reported.
Case description: We present a man affected by lung cancer who had severe relapsing hyponatraemia after II line therapy with PD-1 monoclonal antiboy nivolumab, an immune checkpoint inhibitor. A detailed evaluation of hyponatriemia disclosed the occurence of primary adrenal failure, not due to metastasis. Substitutive therapy with hydrocortisone and fludrocortisone quickly and steadly corrected hyponatraemia.
Conclusions: Immune checkpoint inhibitors are now commonly used in oncology practice. Enhanced immune response is useful towards cancer, but may be directed towards unaffected organs too. The spectrum of autoimmune diseases caused by these drugs is wide and the endocrine system is involved quite frequently, in particolar thyroid and pituitary glands. Primary adrenal failure, as in our case, had been reported in a few patients. This case underlines that Internists should be aware of these new intriguing side effects of immunotherapy and their proper management.

Unusual haemolytic anemia linked to EBV induced haemoagglutinin in a case of Pneumococcal pneumonia

L. Moretti[1], R. Bresciani[1], C. Formaini[2]

[1]ASST Franciacorta, UO Subacuti Medicina, Orzinuovi (BS); [2]ASST Franciacorta, UO Cure Palliative, Orzinuovi (BS), Italy

Background: Haemolysis is associated with autoimmune disorders, lymphocytic leukemias, infections or drugs, seldomly linked to inherited RBC disorders. In case of anemia it is not often obvious to think about it, especially in older people.
Case report: A 71 year old female with Pneumococcal pneumonia, affected by local advanced appendicular adenocarcinoma (treated with oxaliplatinum and capecitabine) and HCV positivity, developed worsening macrocitic anemia (Hb 13,5 to 8,9 g/dl, MCV 108 fl), WC and platelet count and creatinine being normal. When Hb values fell to 8,1 g/dl, patient was transfused. Indirect Coombs was negative and reticolocyte count was high (7,1%), like unconjugated bilirubin (1,97 mg/dl) and LDH (1.107 U/L); haptoglobin was consumed corroborating diagnosis of haemolysis. Pneumococcal HUS and oxaliplatinum-linked haemolysis were excluded (absence of acute renal failure and thrombocytopenia). Direct Coombs was mildly positive with modest levels of cold haemoagglutinins; anti-mycoplasma pn. IgM were negative; cryoglobulins were present, but C3 and C4 normal. Finally IgM antiEBV EA were positive. Patient was observed for a week: bilirubin and LDH fell down while Hb remain stable. Patient was discharged in good status with hematologic follow-up and limiting exposure to cold.
Conclusions: Cold haemoagglutinin hemolytic anemia is often linked to acute infections, included EBV, not so obvious in this case. They usually not need steroid and spontaneously tapered.

Characteristics of patients admitted for bleeding complications to Internal Medicine Units

A. Pani[1], F. Scaglione[1], M. Senatore[1], A. Romandini[1], F. Agnelli[2], D. Pastori[3], F. Colombo[2]

[1]Postgraduate School of Clinical Pharmacology and Toxicology, Department of Oncology and Onco-hematology, University of Milan; [2]Department of Internal Medicine and Medical Specialties, ASST GOM Niguarda, Milan; [3]Department of Internal Medicine and Medical Specialties, Sapienza University of Rome, Italy

Background: Bleeding is a frequent reason for hospital admission. Little is known regarding characteristics of patients hospitalized for bleeding.
Methods: Retrospective cohort study of 144 consecutive patients admitted to the Internal Medicine Units of ASST GOM Niguarda in Milan, for bleeding complications during the year 2018.
Results: Mean age was 77.0±11.6 years and 35.4% were women. Overall, 55 minor and 89 major bleeding were registered. AF was present in 27.8%, hypertension in 58.3%, a previous stroke in 9.7%, a previous hemorrhage in 38.9%, PAD in 25.0%, cardiovascular disease in 54.9%, liver cirrhosis in 10.4%. Active cancer was present in 20.8% and a history of cancer in 18.8%. Concomitant drugs included PPIs in 45.1%, heparin in 12.5%, OACs in 16.7%, NSAIDS in 9.0%, antiplatelet in 45.1%. Patients with major bleeding were older (78.9±10.9 *vs* 74.1±12.2, p=0.015), and more likely to have cardiovascular disease (61.8 *vs* 43.6%, p=0.039), PAD (30.3 *vs* 16.4%, p=0.075), atrial fibrillation 33.7 *vs* 18.2%, p=0.055), and to be treated with OACs (24.7 *vs* 6.0%, p=0.005), as compared to patients with minor bleeding. Overall, 23 (16%) deaths were registered: 18 intrahospital and 5 at 30 days from hospitalization. Patients with major bleeding had numerically higher intrahospital deaths (15.7 *vs* 7.7%, p=0.200). Most frequent bleeding sites were gastrointestinal and intracranial, respectively 52,4% and 18,9%.
Conclusions: Patients admitted for bleeding complications have multiple comorbidities and treatments and are at high risk of short-term mortality.

Extrafine formulation of beclometasone dipropionate, formoterol fumarate, glycopyrronium and exacerbation recurrence: post-hoc analysis of the TRINITY study

A. Papi[1], L. Fabbri[2], G. Micarelli[3], A. Piraino[3], S. Petruzzelli[3]

[1]Università degli Studi di Ferrara, Italy; [2]Sahlgrenska University Hospital, Gothenburg, Sweden; [3]Chiesi Farmaceutici, Parma, Italy

Background and Objectives: Analysis of time to first COPD exacerbation provides a suboptimal evaluation of treatment effect, since it is restricted to the first event. Recurrent event analysis helps to overcome this limitation. We report the results of a post-hoc analysis of the TRINITY study comparing BDP/FF/G *vs* Tiotropium or *vs* extrafine BDP/FF+Tiotropium in COPD patients.
Methods: We applied Wei, Lin, Weissfeld (WLW) method for multiple failure time data; Cox proportional hazard model was restricted to two strata (*i.e.* only the 1st and 2nd events were considered) due to low number of patients experiencing 3 or more exacerbations (3.3%) during the study. We present both combined estimates and stratum-specific estimates.
Results: Compared to Tiotropium, extrafine BDP/FF/G significantly prolonged time to first exacerbation (p=0.015) and even more time to second exacerbation (p=0.006). In addition, when the combined estimate is considered, the time to exacerbation (1st or 2nd) is confirmed to be prolonged with BDP/FF/G compared to Tiotropium (p<0.001). When comparing extrafine BDP/FF/G *vs* extrafine BDP/FF+Tiotropium the HR did not show any statistical significant difference.
Conclusions: These results complement the already available evidence showing a superior effect of extrafine BDP/FF/G pMDI in prolonging time to first exacerbation *vs* Tiotropium alone by showing that importantly this effect is extended and enlarged to the subsequent event.

Risk factors and outcome of new-onset atrial fibrillation in hospitalized patients: a retrospective study

O. Para[1], L. Corbo[1], L. Caruso[1], E. Blasi[1], M. Finocchi[1], G. Zaccagnini[1], F. Pieralli[2], C. Nozzoli[1]

[1]Medicina per la Complessità Assistenziale 1, AOU Careggi, Firenze; [2]Suintensiva di Medicina Interna, AOU Careggi Firenze, Italy

Background: Atrial fibrillation (AF) is frequent in Internal Medicine,

however the characteristics of patients who develop new-onset AF during hospitalization are not known. The aim of our study was to identify the risk factors associated with the onset of new-onset FA during admission in Internal Medicine and to evaluate its outcome as in-hospital mortality

Materials and Methods: We conducted a retrospective case-control study between January 2010 and June 2018 on a cohort of 14˙179 patients admitted to an Internal Medicine department. We included all patients who did not have an anamnestic history of AF and who developed a new onset atrial fibrillation during hospitalization. For each of these were enrolled two controls. Then we conducted a univariate and multivariate analysis both in relation to the risk of developing FA and to the outcome as in-hospital mortality.

Results: The patients included in the study were 600, including 200 cases and 400 controls. The demographic characteristics denoted an elderly population (mean age 79.96 years±9.23). Patients who developed AF during hospitalization had significantly more comorbidity than controls. The most frequent causes for hospitalization were pneumonia and sepsis. From the results of the multivariate analysis, the factors related independently to the development of FA were the presence of a number of comorbidities ≥3 (OR=1.47; p=0.34), sepsis as a reason of hospitalization (OR=2, 17; p=0.001), acute respiratory failure at the entrance, highlighted by a Horowitz index <260 (OR=4.25; p <0.001), and glycemic value at the admission ≥130 mg / dL (OR=1.50; p=0.030). Both the length of hospital stay and in-hospital mortality were greater in the group of patients who developed FA, with a statistically significant difference compared to controls (p <0.001).

Conclusions: The onset of AF has proved to be an independent prognostic factor of mortality, associated with a longer duration of hospital stay.

Integrated efficacy results from the Phase II and Phase III Studies with caplacizumab in patients with acquired thrombotic thrombocytopenic purpura

F. Peyvandi[1], S. Cataland[2], M. Scully[3], P. Coppo[4], P. Knobl[5], J.A. Kremer Hovinga[6], A. Metjian[7], J. De La Rubia[8], K. Pavenski[9], J. Minkue[10], F. Callewaert[10], H. De Winter[10]

[1]Angelo Bianchi Bonomi Hemophilia and Thrombosis Center and Fondazione Luigi Villa, Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, Milan, Italy; [2]Division of Hematology, Department of Internal Medicine, The Ohio State University, Columbus, OH (USA); [3]Department of Haematology, University College London Hospitals NHS Trust, London, UK; [4]Department of Hematology, Saint-Antoine University Hospital, Paris, France; [5]Department of Medicine 1, Division of Hematology and Hemostasis, Vienna University Hospital, Vienna, Austria; [6]Department of Hematology and Central Hematology Laboratory, Inselspital, Bern University Hospital, Bern, Switzerland; [7]Division of Hematology, Duke University School of Medicine, Durham, NC; [8]Hematology Department, Universidad Católica de Valencia Hospital Dr. Peset, Valencia, Spain; [9]Department of Laboratory Medicine and Pathobiology, St. Michael's Hospital/Research Institute, Toronto, ON, Canada; [10]Ablynx NV, Zwijnaarde, Belgium

Background: The current treatment of acquired thrombotic thrombocytopenic purpura (aTTP) is plasma exchange (PE) and immunosuppression. Here, we present the integrated efficacy results of caplacizumab from the Phase II (TITAN) and Phase III (HERCULES) studies in aTTP patients.

Methods: All randomized subjects were included. Subjects had a single-blind (SB, TITAN) or double-blind (DB, HERCULES) treatment period followed by 30 days follow-up.

Results: 220 subjects were randomized. Time to platelet count response was lower for caplacizumab (p<0.001; platelet normalization rate ratio [95% CI] of 1.65 [1.24, 2.20]). Caplacizumab resulted in a 72.6% reduction of aTTP related death, recurrence of aTTP, or at least one major thrombotic event in the DB/SB period *vs* placebo (p<0.0001), as well as in a 84.0% and 49.4% reduction in aTTP recurrences in the DB/SB treatment period (p<0.0001) and the overall study period (p<0.005), respectively. No subjects in the caplacizumab group had refractory aTTP *vs* 7 (6.3%) in the placebo group (p<0.01). Mortality was lower for caplacizumab *vs* placebo during the DB/SB period (0 *vs* 4, p<0.05) and the overall study period (1 [during follow-up, unrelated to caplacizumab] *vs* 5). In the SB/DB treatment period, caplacizumab reduced the mean number of PE days by 3.9 days.

Conclusions: Caplacizumab reduces time to platelet count response and (i) the percentage of subjects with aTTP-related death, recurrence or at least one major thrombotic event during treatment; (ii) mortality; (iii) aTTP recurrence overall; (iv) refractoriness; and (v) PE days.

Temporal trends in outlier admissions to an Internal Medicine Unit 2015-2018 and impact on patient outcomes

P. Piccolo[1], V. Tommasi[1], D. Manfellotto[1]

[1]Medicina Interna, Ospedale San Giovanni Calibita Fatebenefratelli Isola Tiberina, Roma, Italy

Background: Patients in need of urgent admission to Internal Medicine Units are often placed in outlier beds for lack of availability in medical wards, causing excess workload for physicians. The aim of this study was to analyse temporal trends and outcomes of outlier admissions in a secondary hospital in Rome.

Methods: All admissions 2015-2018 were prospectively recorded with demographic data, diagnosis, length of hospital stay and outcome. Outlier patients were either placed on gurneys in the Medical ward or in any bed/gurney in non-Medical wards. Hospital stay duration and outcomes were compared with non-outliers.

Results: Of 3066 admissions (48.8% male, mean age 75.9±15.2 years), 1836 (59.9%) were outliers; 777 (42.3%) spent at least one night on a gurney. Mean outlier duration was 1.9±2.1 days before re-entry to the Medical ward; however, 214 (11.7%) were discharged directly from the non-Medicine Unit. Highest rates (>60%) of outliers were observed from October through March, with a peak in January (82%); lowest (<50%) were from June to September. Mean length of stay did not differ between outliers and non-outliers (10.5±9.2 *vs* 10.7±8.1 days respectively, p=0.35). Negative outcomes (in-hospital mortality and hospice care, transfer to intensive care unit) did not differ between the two groups.

Conclusions: Outlier medical patients have become routine in clinical practice. In our cohort, these patients have similar outcomes to non-outliers, however the burden for physicians especially during winter months should be taken into account for efficient allocation of resources.

The use of wireless monitoring to improve outcomes of poly-pathological patients in Internal Medicine Unit: preliminary results of the LIMS pilot prospective randomized multicenter study

F. Pietrantonio[1], A. Bussi[2], S. Amadasi[2], E. Bresciani[2], A. Caldonazzo[2], P. Colombini[2], M.S. Giovannini[2], G. Grifi[2], L. Lanzini[2], P. Migliorati[2], P. Perini[2], A. Politi[2], F. Soldati[2], O. Meneghetti[2], E. Tyndall[3], R. Bellocco[4], R. D'Amico[5]

[1]UOC Medicina Interna, Ospedale dei Castelli, ASL Roma 6; [2]UO Medicina Interna, Ospedale di Manerbio, ASST-Garda; [3]Clinica Villa Stuart, Roma; [4]Università Milano-Bicocca, Cattedra di Statistica Medica; [5]Università di Modena e Reggio Emilia, Cattedra di Statistica Medica, Italy

Background: According to preliminary studies, 27% of hospitalized patients, of which 15% have major complications (MC), are critical, and require monitoring. Wireless vital parameter continuous monitoring (WVPCM) is compared to regular nurse monitoring in order to provide data on the clinical and economic impact of critically ill patients (CIPs) in Internal Medicine Units (IMU).

Materials and Methods: Pilot prospective randomized controlled open-label multi-center study (Manerbio, Roma, Palermo) with WIN@Hospital wearable wireless system creating alerts on portable devices (ipad).

Results: Enrolled 100 and evaluable 89 patients (35 M/54 F), mean age 80.5 years, Comorbidity: Cumulative Illness Rating Scale CIRS-CI: 4, CIRS SI: 1.8. About 38% scored BRASS (Blaylock Risk Assessment Screening Score) ≥20 indicating need for discharge planning requiring step-down care. More than 50% of patients presented high dependency from nursing assistance (IIA index >3). Nurses saved a minimum of 49,6 minutes to a maxi-

mum of 58,1 minutes on time spent monitoring each patient per day. A trend towards reduction of MC in experimental group appears to be seen (31% in experimental arm *versus* 45% in the control), a decrease in re-admissions (7% *versus* 11%) and mortality (7.3% *versus* 23.9%) has been observed. More than 30% of the patients meet the criteria defining end stage disease (42.5% in experimental, arm, 33.3% in the control).
Conclusions: WVPCM, detecting early deterioration in CIPs, may facilitate timely response in at-risk patients, increasing safety and reducing costs.

Early systemic sclerosis and Raynaud phenomenon: impact on daily activities during a year of follow-up

C. Pintaudi[1], D. Addesi[1], S. Mazzuca[2], M. Pintaudi[3], A. Tramontano[4], R. Cimino[1]

[1]AO Pugliese-Ciaccio, Catanzaro, UOC di Medicina Generale; [2]Casa di cura "Villa del Sole", Catanzaro, UO Medicina Generale; [3]Facoltà di Medicina, Università di Siena; [4]Presidio Ospedaliero di Praia a Mare, ASP Cosenza, UO di Medicina Generale, Italy

Background: The Raynaud phenomenon (RP) is the clinical expression of the imbalance between vasoconstriction and vasodilating factors and it is present in more than 90% of patients with Systemic Sclerosis. Attacks are often associated with limitations of daily activities and impaired health-related quality of life. These limitations are often assessed through the "Health Assessment Questionnaire", but this mainly assesses the limitations related to mobility and muscle strength, so patients' diaries provide complementary evaluations. The aim of this study was to investigate frequency and duration of RP attacks.
Materials and Methods: Fourteen patients were enrolled in the study. Every 7 weeks they completed a 7-day diary attesting frequency, duration of the attacks, triggering factors and how patients handled them. The patients also noted difficulties whit RP using a 0-10 ordinal scale according to the Raynaud's condition score.
Results: Ninety-eight RP diaries were analyzed. The median number of RP attacks per week, and the median score that reflects the difficulty associated with attacks varied between 2.0 and 2.9. No differences were found in the number of attacks during winter, spring and autumn. Fewer attacks and less difficulties were reported in August ($p<0.05$). All patients reported RP attacks during shopping or handling food. The use of heating devices varied during the follow-up.
Conclusions: Difficulties resulting from RP are present throughout the year and this underscores the importance of an intense vasoactive therapy and-different pharmacological strategies.

Clinical diagnostic and prognostic application of biomarkers in septic and septic shock patients

E. Pizzolato[1], R. Frediani[1], G. Mengozzi[2], E. Lupia[3], S. Battista[3]

[1]Department of Internal Medicine, Ospedale Maggiore di Chieri, Chieri (TO); [2]Clinical Biochemistry Laboratory, Città della Salute e della Scienza, University Hospital Turin; [3]Emergency Medicine Department, Città della Salute e della Scienza, University Hospital, Turin, Italy

Background and Aim: Sepsis is a life-threatening disease caused by dysregulated host response to infection. Organ dysfunctions may remain occult and SOFA score items may not promptly identify organ failures. The aim of the study was to compare the diagnostic accuracy and the prognostic capability of new biomarkers (presepsin, galectin-3 and copeptin) with those of PCT in order to improve the ability of stratify the disease severity.
Materials and Methods: In this multicenter, prospective and observational study, patients presenting to the ED with suspected sepsis or septic shock, were divided up into three groups: sepsis, septic shock and controls. Biochemical data were collected at the first medical evaluation. ROC and AUCs curves were used to evaluate diagnostic accuracy; to define prognostic capability biomarkers were first matched with in-hospital mortality rates at 7, 30, 60 and 90 days after enrollment and then included in the Cox regression.
Results: 405 patients with sepsis, 317 with septic shock and 238 controls were enrolled. PCT confirmed her high diagnostic capability. While presepsin differentiates controls from sepsis, galectin-3 and copeptin significantly identify septic shock from sepsis. Galectin-3 and copeptin correlate with 7-days mortality; all biomarkers are related with poor prognosis at 30, 60 and 90 days. In Cox regression analysis, galectin-3 resulted the only statistically significant independent predictor of patient survival.
Conclusions: Multi-markers approach could improve diagnostic and prognostic powers of one biomarker alone.

The orthogeriatrics model of care: risk of institutionalization in post-hip fracture patients. Experience of last five years in "Infermi" Rimini's Hospital

B. Pula[1], G. Bianchini[1], E. Silingardi[2], A. Franco[1]

[1]Struttura Complessa di Geriatria, Ospedale Infermi di Rimini, USL Area Vasta Romagna; [2]Dipartimento Cure Primarie e Medicina di Comunità di Rimini, USL Area Vasta Romagna, Italy

Background: Hip fracture (HF) is a common serious complication of osteoporosis, which is associated with high morbidity and mortality. Older adults with hip fracture have a 5- to 8-fold increased risk for all-cause mortality and much higher risk of institutionalization. From 2013 to 2017 in Rimini's "Infermi" hospital an orthogeriatric pathway (OP) based on comprehensive geriatric assessment (CGA) has been applied to inpatients (IP) with HF. The outcomes are: to evaluate the risk of institutionalization in this population.
Methods: In this analysis a total of 877 IP with HF in 5 years (from 2013 to 2017) were submitted to OP in orthopedic ward by a multiprofessional team (geriatrician, orthopaedist, anesthesist, case-manager nurse and physiatrist). A database was created to keep a record of age, provenance, functional status pre-fracture, destination.
Results: (see Table 1): our results confirm high risk of institutionalization in IP suffering HF. In our experience, the chance of getting home increases from 2013 to 2017; the in-hospital mortality it's reduced and the percentage of IP send in rehabilitation od intermediate/acute care decreases. The OP program includes a CGA focusing on the patient's premorbid function, cognition, comorbidities, and risks is followed by a comprehensive care plan design. This systematic approach reduces the risk of in-hospital mortality, prevent later complications and future institutionalization.

Table 1.

Year	Provenance (%)		Destination (%)		
	Home	Nursing home	Home	Nursing	Other*
2013	88,6	11,4	40	13,2	45,9
2014	92,7	7,3	67	6,6	25,9
2015	91,6	8,4	60,1	5,9	32,8
2016	93,1	6,9	65,1	8,6	25
2017	92,3	7,7	67,3	10,2	21,2

*rehabilitation centers, intermediate care, acute care.

Citation: Martinez-Reig, M *et al.* The Orthogeriatrics Model of Care: Systematic Review of Predictors of Institutionalization and Mortality in Post-Hip Fracture Patients and Evidence for Interventions. J Am Med Dir Assoc (2012) 13, 770-777.

Non-traumatic splenic rupture in amyloidosis as a rare evolution of multiple myeloma

E. Quaquarini[1], L. Perrone[1], L. Gervaso[1], E. Bosco[1], F. Serra[1], D. Presti[1], F. Sottotetti[1], A. Bernardo[1]

[1]UO Oncologia Medica, ICS Maugeri IRCCS, Pavia, Italy

Background: Non-traumatic splenic rupture (NSR) is a rare event and occurs in neoplastic patients due to infiltration of the spleen with changes in its histologic structure, splenic infarcts, and coagulation disorders. It is an unusual event in multiple myeloma (MM); otherwise amyloid light-chain (AL) amylodosis is an established risk factor of NSR. About 10% to 15% of patients with MM may develop AL amyloidosis while approximately 10% of patients with MM have coexistent AL amyloidosis at diagnosis.

Case report: We report the peculiar case of a 64 years-old man with a diagnosis of IgG lambda multiple myeloma (MM) symptomatic for bone lesions for which he received autologous stem cell transplant after induction treatment and high-dose melphalan, thalidomide and lenalidomide therapy. Twelve years after the diagnosis, he had an unexpected and acute onset of abdominal pain with signs of hypovolemic shock. A computer tomography scan was immediately performed and demonstrated a splenic rupture. A splenectomy was performed but, a week after, the patient developed an acute respiratory distress syndrome and died. After pathological evaluation of the spleen, non-traumatic spleen rupture due to amyloidosis was our final diagnosis.
Conclusions: AL amyloidosis can be an evolution of MM. Survival improvement in the treatment of MM due to new available therapies increased the patients' probability to develop MM - associated amyloidosis. Clinicians should be aware of this possibility and monitor patients for amyloid - induced organ damage.

Personalized prediction of invasive candidiasis in the Medical Ward: a machine learning approach

A. Ripoli[1], E. Sozio[2], F. Sbrana[1], G. Bertolino[3], C. Pallotto[4], S. Meini[5], C. Tascini[6]

[1]UO Lipoaferesi, Fondazione Toscana "Gabriele Monasterio", Pisa; [2]1. Emergency Department, North-West District, Tuscany Health Care, Spedali Riuniti Livorno; [3]Department of Public Health, Clinical and Molecular Medicine, Università degli Studi di Cagliari; [4]Infectious Diseases Section, Department of Medicine, University of Perugia, Perugia; [5]Internal Medicine Unit. Santa Maria Annunziata Hospital, Florence; [6]First Division of Infectious Diseases, Cotugno Hospital, Azienda Ospedaliera dei Colli, Naples, Italy

Background and Aims: Invasive candidiasis is a highly lethal infection; prompt and accurate diagnosis of invasive fungal infection is crucial so that appropriate antifungal therapy can be started rapidly. Several scores have been developed to assist the diagnosis process in ICU patients, and, recently, a logistic regression model has been proposed for medical patients. Aim of this work was to assess the predictive accuracy and the discrimination power of machine learning algorithms for early detection of candidiasis in the medical ward.
Methods: A set of 41 potential predictors was acquired in a sample of 295 patients (male: 142, 48%; age: 72±15 years; candidiasis: 157, 53%; bacteremia: 138, 47%). A classic stepwise multivariate logistic regression models and 4 different predictive algorithms (lasso, ridge, elastic-net and random forest regression) with 76 different choices of the hyperparameters, were built and compared with a ten-fold cross-validation method; predictive performance was assessed by C-statistics, while calibration was evaluated by Hosmer-Lemeshow statistics.
Results: The random forest algorithm demonstrated excellent discrimination (C-statistics=0.86) and calibration, markedly higher than the ones guaranteed by the classic stepwise logistic regression (C-statistics=0.82), correctly identifying 5 more candidiasis cases and 10 more bacteremia cases.
Conclusions: Machine learning algorithms accurately predict candidiasis in medical patients, allowing to take advantage of the ever increasing amount of data collected in the electronic health records.

Observational study on prevalence and severity of NAFLD: occasional sonographic finding in a cohort of patients admitted to Internal Medicine

M. Rosselli[1], G. Zannelli[1], F. Cei[1], V. Barbaro[1], A. Valoriani[1], S. Dolenti[1], G. Vannini[1], D. Coletta[1], R. Tarquini[1]

[1]Medicina Interna 1, Ospedale San Giuseppe, Empoli (FI), Italy

Background and Aims of the study: Until a few years ago NAFLD was considered a relatively benign condition. Recent epidemiological data predict that NAFLD related-cirrhosis will be the most common cause for liver transplantation. Further awareness and early diagnosis of this epidemic burden is urgently warranted. We aim to highlight the prevalence and severity of NAFLD by means of non invasive assessment among the general population.
Patients and Methods: Over a 1-year period we randomly recruited 200 patients admitted to an Internal Medicine ward who underwent an abdominal ultrasound scan. Hepatic steatosis was graded sonographically. FLI and NFS were used to assess hepatic steatosis and related fibrosis.
Results: 35% of patients had hepatic steatosis of which 67.1% had metabolic syndrome. 85.7% of these were unaware of the diagnosis. Diabetes mellitus and waist circumference independently correlated with steatosis. Diabetes indipendently correlated with fibrosis. FLI predicted steatosis in 75.7%, and NFS predicted fibrosis in 32.8% patients. FLI failed to predict steatosis in 24.3% of patients since they were found to have steatosis grade 1 on US. In this group 2.8% had a high NFS compatible with hepatic fibrosis.
Conclusions: There is a high prevalence of NAFLD but the majority of patients (85.7%) and GPs are unaware of its risks since 67.1% of patients despite having metabolic syndrome were never screened for NAFLD. Diabetes is sufficient for undergoing NAFLD screening since FLI might fail to predict steatosis. Fibrosis is independent from the severity of steatosis.

A new model of eldery falls care in acute geriatric setting

V. Sebastiani[1], R. Cancelliere[1], M. Magnani[1], A. Franco[1]

[1]AUSL Romagna, Distretto di Rimini, UO Geriatria, Rimini, Italy

Background: To evaluate evidence on Multifactorial Falls Risk Assessment (MFRA) in reducing incident falls (F) and preventing poor outcomes associated with inpatients falls.
Methods: MFRA is an assessment with multiple components that aims to identify the elderly's risk factors for F and to implement interventions. In a cohort of 855 inpatients (age over 75 ys) admitted to the Geriatric Unit (from January to december 2018), with high comorbidity/fragility (IC>3 to the CIRS) we focused history of previous F, Performance Status (ADL), Incident Delirium (CAM), Cognitive Status (SPSMQ), reduced mobility and change/withdrawal drugs. We compare data into A period (first 6 months) and B period (second six months) of observation.
Results: We detected 29 F (15 male/14 female), 24 (82.7%) of them in E with previous F at home. 19E (65.5%) had Moderate-Severe Dementia and 28E (96.5%) with Gait and Motility Disorder. In A period 17 E fell into the ward, 12 in B period. Delirium (D) occurred in 11E (64,5%) in A period and in 6 E (50%) in B period. 24E (82.7%) had politherapy (>3 drugs), 27E (93%) received cardiac therapy and 12E (41.3%) psychiatric therapy.
Conclusions: MFRA is a good tool to reducing incident F and preventing poor outcomes. Revision drug therapy is primarily associated with D reduction and decrease F. We hypothesized that MFRA has better clinical outcomes for E inpatient compared to usual care. It improves staff knowledge and may be trasposed across various settings where F could be happen.

Hepatocellular carcinoma: comparison between two decades

M. Soresi[1], L. Giannitrapani[1], B. Giuseppe[2], T.V. Li Cavoli[1], Z. Maddalena[1], A. Terranova[1], M.G. Minissale[1], L. Mirarchi[1], F.A. Montalto[1], M. Galia[2], G. Montalto[1], A. Licata[1]

[1]Dipartimento di Promozione della Salute, Materno-Infantile, Medicina Interna e Specialistica di Eccellenza (PROMISE), Università di Palermo; [2]Dipartimento di Radiologia (DIBIMED) Università di Palermo, Italy

Aims: To analyze the main etiological factors and some clinical features of patients with Hepatocellular Carcinoma (HCC) diagnosed at our center in the last ten years and to compare them with those we observed ten years ago.
Materials and Methods: 132 patients were included in Group 1 (decade 1999-2088), while 208 patients were included in Group 2 (decade 2009-2018). For all patients age, sex, serum markers of hepatitis B and C viruses, alcohol consumption, serum alpha feto-protein (AFP) levels and the main liver function parameters at HCC diagnosis were recorded. Diagnosis was performed according to EASL and AISF guidelines.
Results: Mean age was 69.0±8 years in Group 1 and 71.0±9 in Group 2 (P<0.05). HCV was responsible for 75.5% of HCC cases in

Group 2 *versus* 80.3% in Group 1 (P=ns). Prevalence of HBV in Group 2 was higher *vs* Group 1 (11.1% *vs* 8.3%, P=ns), co-infection with HCV+HBV decreased, but not significantly. In both groups no patient had an underlying normal liver. Non viral etiology was higher in Group 2 *vs* Group 1 (17% *vs* 9%; p<0.05). Child Pugh class did not differ between the two groups. AFP serum levels were normal in 37% of cases in Group 1 and in 67% in Group 2 (P=0.0001). Staging of HCC according BCLC score correlated inversely when patients of Groups 1 and 2 were compared (P<0.005).
Conclusions: This study shows that over the last decade a number of features of patients with HCC in our region have changed, particularly age at onset and staging of HCC.

High incidence of adverse events for patients at risk for polypharmacy: an observational study

V. Spuntarelli[1], A. Meccariello[1], F. Aiello[1], P. Amoriello Lamberti[1], A. Martocchia[1], P. Martelletti[1]

[1]Dipartimento Medicina Interna, AO Sant'Andrea, Roma, Italy

Background: Polypharmacy is very common among older adults, and it can lead to inappropriate prescribing, adverse drug events (AE) and potential drug-drug interactios (DDIs). Electronic prescription softwares may help to prevent these events. The primary end point of our study is to evaluate the incidence of AE and DDIs in polypharmacy.
Methods: 144 elderly patients (aged over 65 years) were enrolled: one sample of 98 ambulatory care patients and one sample of 46 hospitalized medical patients. Multidimensional geriatric assessment, clinical and pharmacological evalutation were performed, and the anticholinergic effects were analyzed. Intercheck was used to analyze potential DDIs.
Results: 71% of the ambulatory sample were women, with mean age of 80,0±6,6 years. 58% of the hospitalized patients were women, with mean age of 81,6±8,4 years. In 85% of ward patients and in 75% of the ambulatory patients a risk indicator was present (Intercheck classes A, B, C, D isolated or combined). In the 41% of ward patients and 24% of ambulatory patients (P=0.059) a high risk indicator was present (class D combined with any other class). AE related to polypharmacy were found in 45% of ward patients and 11% of ambulatory patients (P<0.001). Relative risk for classes higher than B or C isolated is 9,667 times compared to patients with a lower risk class.
Conclusions: A computer-based application, such as Intercheck, may help to reduce polypharmacy related AE, when used in primary care setting and associated with a clinical and functional evaluation of elderly patients.

The Annurca apple polyphenols is effective on intermittent claudication in patients with Peripheral Artery Disease

G.C. Tenore[1], M. D'Avino[2], G. Caruso[3], D. Caruso[4], C. Acampora[5], G. Buonomo[6], C. Simone[6], E. Novellino[1]

[1]Department of Pharmacy, University of Naples, Federico II, Naples; [2]Department of Internal Medicine, AORN A. Cardarelli, Naples I; [3]Department of Emergency, AORN A. Cardarelli, Naples; [4]Department of Internal Medicine, AORN A. Cardarelli, Naples; [5]Unit of Radiology, AORN A. Cardarelli, Naples; [6]Coop. Samnium Medica, Benevento, Italy

Background: Peripheral arterial disease (PAD) is an atherosclerotic process involving both modifiable and non-modifiable risk factors.Prospective cohort studies show that patients with PAD have a sixfold higher risk of death from cardiovascular disease than those without PAD.
Methods: The study was a randomised, double blind, single centre, placebo-controlled trial, involving 180 patients, aged 35-75, assigned to stage II and stage III classification.The subjects were randomly divided into two groups.One group underwent 24 weeks of nutraceutical treatment consisting in the administration of four capsules of Annurca apple polyphenolic extract (AMS)/day (a total of 2000 mg AMS).The placebo group was administered with identically appearing capsules containing only maltodextrin.Primary outcome measures were: WA, Ankle Brachial Pressure Index (ABPI), Acceleration Time (AT).Secondary outcome measures were vascular abnormalities of lower limbs, such as paresthesia, cold limbs, cold toes, and trophic lesions.
Results: In the AMS group WA was increased on average by 69% (P <0.05), while slighter effects were registered as regards ABPI (+25%; P <0.05) and AT (-3.6%; P <0.05), when compared to baseline. Moreover, on 36 subjects complaining paresthesia with low degree of severity, 26 subjects declared full disappearance of the symptoms. Placebo group revealed no significant differences (p<0.05).
Conclusions: Our preliminary results may indicate AMS product as a promising natural and safe tool for a novel approach to the treatment of symptoms related to peripheral arterial diseases.

POSTERS DISCUSSION

Assessment of nutritional status in elderly hospitalized patients in a endocrinology department

G. Accarino[1], F. Carcarino[1], F. Coretti[1], R. Giannettino[1], A. Iavarone[1], S. Ippolito[1], A. Lombardi[1], O. Romano[1], C. Sepe[1], R. Muscarielo[1], V. Nuzzo[1]

[1]UOSD Endocrinologia, Malattie del Ricambio e della Nutrizione, Ospedale del Mare, Napoli, Italy

Background and Aim: Malnutrition is a frequent component is found in about 50% of hospitalized patients. This condition determines an increase in mortality and a deterioration in quality of life. The assessment of nutritional status must be considered an integral part of the clinical evaluation. The present study aims to evaluate the prevalence of malnutrition among elderly patients admitted to the Endocrinology Department of Ospedale del Mare in Naples.
Materials and Methods: In a period of 6 months all elderly patients admitted to the Endocrinology Department of "Ospedale del Mare" in Naples were selected . Patients in artificial feeding and with motor difficulties such as to prevent anthropometric measurements were excluded from the study. For the assessment of nutritional status, the Mini Nutritional Assessment (MNA) questionnaire was used. Threshold values under 17 points identify malnourished patients.
Results: About one third of the patients analyzed are malnourished, and more than an half are at risk of malnutrition. Women are more predisposed to malnutrition. Parameters positively correlated to malnutrition are: female sex, having suffered from psychological stress, taking more than 3 drugs a day, and perception of health status worse than peers.
Conclusions: Malnutrition has a high prevalence in patients admitted to Endocrinology Department; in particular, it correlates with polypharmacy, a typical characteristic of the elderly patients. Adequate evaluation and monitoring of nutritional status is therefore essential in elderly hospitalized patients.

A strange back pain

S. Acciai[1]

[1]Continuità Assitenziale ASL Sud Est, Arezzo, Italy

Background: Bedside ultrasound is a very useful tool in family medicine. One of the most common symptom presented in general population is back pain. The management of chronic back pain is often a challenge for the physician. We present a case of chronic back pain associated with notalgia paresthetica in a young woman with no previous medical history of spinal damage, associated with incidental finding of chronic cholelithiasis at bedside ultrasound examination.
Case report: A young woman, under forty years old, mother of two, came to the medical office in order to evaluate a chronic back pain associated with left subscapular hyperpigmented macula (notalgia paresthetica). The pain was referred in the subscapular left paravertebral region, T10-L2. Previous medical history showed mild depression successfully treated. There were no records of previous spinal injuries, and no chronic illness like HCV, haematologic diseases, type 2 diabetes, hypertension or dyslypidemia, no obesity or metabolic syndrome, no oestrogen therapies ongoing. There was no family history for gallstones. During the medical consultation was offered an abdomen ultrasound scan, that showed cholelithiasis, associated with mild gallbladder wall thickening and small echogenic spots in the lumen.
Conclusions: Chronic back pain is sometimes due to underlying medical condition. Notalgia parestetica is a disease of unknown etiology, usually referred as a neurologic disease, often presented as a pain in the left subscapular region associated with a hyper or ipopigmented macular area. Cholelithiasis pain can be referred as a back pain in right subscapular region (Collin's sign). We report a case of chronic left back pain associated with subscapular notalgia paresthetica and coincidental unknown cholelithiasis with mild cholecistitis. We need further investigations in order to find how these findings could be associated medical conditions.

A rare syndrome with hypotension, hypoalbuminemia and oliguria in young patient

C. Agabiti Rosei[1], M. Rossi[1], P. Cravarezza[1], G. Montani[1], D. Bettoni[2], G. Podda[3], A. Salvi[1]

[1]UO Medicina 3, ASST-Spedali Civili, Brescia; [2]Farmacia, ASST-Spedali Civili, Brescia; [3]UO Medicina 3, San Paolo, ASST-Santi Paolo e Carlo, Milano, Italy

Idiopathic systemic capillary leak syndrome(ISCLS) is a rare disorder with severe hypotension, hypoalbuminemia, hemoconcentration. The patient is a 37 years old, black man with obesity and hypertension. On February 2016 he was admitted to the Division of infectious diseases owing to myalgia at lower limbs, increase of Creatine-kinase and hematocrit (Hct 60%) and the diagnosis of viral myositis at discharge. On October he went to our division of medicine because of myalgia of lower limbs and abdominal pain. Laboratory examination showed an increase of white cell count(WCC)(18,32x10^3/uL), hemoglobin (20,5 g/dl), Hct, creatinine and C-reactive protein concentration. The instrumental examinations resulted normal. On day 3 the patient's systolic blood pressure (SBP) fell to 70mmHg despite one-liter of crystalloid i.v. Hypoalbuminemia was also detected.Heart rate was 105 bpm, SBP 80mmHg, with oliguria. The i.v. administration of four liters of saline solution was not helpful. The diagnosis of ISCLS was formulated. The treatment with i.v. boluses of hydroxyethyl amide were administered with progressive improvement of hemodynamic and humoral parameters. However, others attacks of ISCLS were occurred and the treatment with hydroxyethyl amide, boluses of 4% albumin, norepinephrine and finally intravenous immunoglobulin (IVIG) (1g/kg/day) for five consecutive days were delivered with progressive improvement. After the last episode, prophylactic therapy with monthly infusions of IVIG was administered. No new attacks two year later were observed.The diagnosis of this rare disease should be considered in case of unexplained syndrome with hypotension, hypovolemia and haemoconcentration. Further research is needed in order to identify the most appropriate treatment, although prophylactic treatment with IVIG seems beneficial.

Diabetes and hypotension: a frequent association

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

[1]Dipartimento di Medicina Interna Polispecialistica, Grande Ospedale Metropolitano Niguarda, Milano, Italy

Background and Aim of the study: Hypotension identification is among the indications for ambulatory blood pressure monitoring (ABPM) and diabetics show quite often both disautonomy and orthostatic hypotensions. Aim of this study: evaluate hypotension prevalence in diabetic subjects undergoing ABPM.
Methods: 887 diabetics (treated or untreated with anti hypertensive drugs) undergoing ABPM (with any clinical indication) from 2009 to 2018 were considered. Subjects were divided in two groups (hypertensives/normotensives) according to 24 hours mean BP > or <130/80 mmHg. Hypotension was arbitrarily defined as systolic BP (SBP) during daily activity <100 mmHg. Event's symptomacity was not taken into account. Additional pa-

rameters recordered: BP variability (BPV), dipper / non-dipper status, pulse pressure (PP), AASI (ambulatory augmentation stiffness index).
Results: Hypotensions are quite frequent in diabetic subjects (45%) despite significative differences in BP control. BPV, PP, dipper status and AASI did not show significative relation with hypotensions. Significative increase in BPV and non dipper status was observed in hypertensives despite the number of anti hypertensive drugs.
Conclusions: Hypotensive episodes are quite frequent in diabetics regardless of pharmacological treatment and mean BP control. ABPM proves once again to be a useful tool in clinical follow-up of diabetics to detect symptomatic or even asymptomatic hypotensions; this should always be considered before any increase in anti hypertensive treatment in diabetic subjects.

Small intestinal amyloidosis: a case report

A. Al Refaie[1], F. Cavaleri[1], L. Luschi[1], C. Caffarelli[1]

[1]AOU Senese, Siena, Italy

Background: This case report describes a rare case of gastrointestinal amyloidosis.
Case report: A 54-yrs-old woman presented to our hospital with a 2 yrs history of asthenia, weight loss, and abdominal distension. In history only diagnosis of sarcoidosis, evidenced from a chest TC and a transbronchial biopsy. At a physical examination she presented a soft, round, bloated abdomen and intestinal sounds were normal. Laboratory testing revealed anaemia, elevation of platelets, hypoalbuminemia. An immunofixation urine test showed kappa free light chains. A serum protein electrophoresis revealed elevated serum free kappa light chains, low free lambda light chains and elevated kappa/lambda ratio. A chest and abdomen TC showed multiple lymphadenopathies. Lower and an upper gastrointestinal endoscopies were performed and showed diffuse congestion and thickening of the small and large intestine. Biopsies evidenced the presence of extracellular matrix deposition that corresponded to amyloid. A bone marrow aspiration showed an increased cellularity with 30-40% plasma cells. We made diagnosis of multiple mieloma and amyloidosis that involved gastrointestinal tract and kidney. Chest granulomas were not a sign of sarcoidosis but they were simil-sarcoidosis granulomas a manifestation that very rarely was associated to tumors.
Conclusions: We describe a rare manifestation of intestinal amyloidosis and give an important message: in case of abdominal distension, malabsorption, asthenia, rarely amiloydosis is considered in differential diagnosis, so that treatment is delayed.

Livelli circolanti stagionali di Vitamina D

K. Ampatzidis[1], D. Ampatzidi[2], S. Borzì[3], A.R. Bisicchia[4], F. Finocchiaro[5]

[1]Università degli Studi di Catania, AO Cannizzaro, UOC Geriatria, Catania, Italy; [2]Social Worker (MSc), Society of Psychosocial Research and Intervention (S.P.R.I. – EPSEP in Greek), Ioannina, Greece; [3]Direttore Sanitario Maria Regina, Centro Assistenziale per Anziani, Sant'Agata Li Battiati, Catania, Italy; [4]Infermiera Professionale, Maria Regina, Centro Assistenziale per Anziani, Sant'Agata Li Battiati, Catania, Italy; [5]Università degli Studi di Catania, AO Cannizzaro, Tecnico di Radiologia, Catania, Italy

Background: La carenza di Vit. D è un problema particolarmente frequente in Italia, dove è stata più volte documentata negli ultimi anni, specie negli anziani e durante i mesi invernali. Scopo dello studio è quello di valutare i suoi livelli nella popolazione di Catania e provincia
Materiali e Metodi: Sono stati studiati 572 pazienti. Nessuno di loro era affetto da patologie del metabolismo fosfo-calcico e da insuff. renale. Nessuno aveva assunto una supplementazione di vitamina D. L'analisi descrittiva è stata condotta calcolando media e DS per i dati distribuiti normalmente; mediana e range interquartile per i dati non distribuiti normalmente. Per confrontare i gruppi è stato utilizzato il test Kruskal-Wallis.
Risultati: *Età media:* 68,15±10,07DS, *livelli di vit.D:* Normale 25,7%, Insuff. 43,8%, Carenza 30,6%. *Livello di vit.D per fasce di età: <65 anni:* Normale 28,1%, Insuff. 41,4%, Carenza 30,5%; *65-74 anni:* Normale 28,1%, Insuff. 39,6%, Carenza 32,3%; *≥75 anni:* Normale 20,4%, Insuff. 50,8%, Carenza 28,7%. *Stagioni e livelli di vit.D (Mediana):* Inverno 23,24ng/ml, Primavera 24,4ng/ml, Estate 27,7ng/ml, Autunno 25ng/ml.
Conclusioni: Alta prevalenza di ipovitaminosi D nel 74,4% del nostro campione. In particolare la carenza è stata riscontrata nel 30,6% e l'insufficienza nel 43,8%. La stagione del prelievo ematico è un predittore significativo dello stato vitaminico; l'inverno e la primavera sono associate a valori mediani di vit.D più bassi. La quantità di vit. D prodotta e immagazzinata da maggio a settembre probabilmente non è sufficiente a garantire uno stato vitaminico ottimale.

L'incidenza di pancreatite acuta nell'isola di Ischia: dati del 2017 e confronto con l'incidenza attesa

M. Arcopinto[1], A. Castagliuolo[2], A. Russo[3], G. Scherillo[4], U. Balestrieri[5], C. Arturo[6], C. Di Gennaro[6]

[1]Medicina Interna DEA, AORN A. Cardarelli, Napoli; [2]AOU Medicina di Laboratorio, PO Rizzoli, Lacco Ameno (NA); [3]Coordinamento infermieristico, PO Rizzoli, Lacco Ameno (NA); [4]AOU Medicina Interna, PO Rizzoli, Lacco Ameno (NA); [5]AOU Radiologia, PO Rizzoli, Lacco Ameno (NA); [6]AOU Medicina Interna, PO Rizzoli, Lacco Ameno (NA), Italy

Background: L'esperienza clinica presso il PO "A. Rizzoli" di Lacco Ameno (NA) alimenta il sospetto di un eccesso di incidenza di pancreatite acuta (PA) nel territorio rispetto a quella attesa. In assenza di riscontri in letteratura, scopo di questo studio è quello di verificare l'effettiva incidenza di PA nel 2017.
Materiali e Metodi: E' stata condotta una analisi retrospettiva su dati di citolisi pancreatica e radiologici ed una revisione sistematica delle relazioni di dimissione dei soggetti accettati in PS con sintomo di ingresso "dolore addominale" dal 1/1 al 31/12/17. La diagnosi di PA è stata assegnata in presenza di: 1. dolore addominale (sintomo dominante); 2. Amilasemia >3 v.n. (>400 mg/dl) o Lipasi >3 v.n. (>200 mg/dl); 3. TC addome positiva. La perdita di casi è da considerarsi virtualmente nulla per la presenza di unico PO sull'isola.
Risultati: 3.278 soggetti sono stati accettati per "dolore addominale". Di questi, 42 (1.12%) venivano ricoverati per sospetta PA, poi accertata. 5 soggetti erano temporaneamente presenti sull'isola e quindi esclusi dall'analisi. Dei 37 soggetti, 46.8% erano uomini, età media 66 anni (IQR 53-75 anni), 49% presentavano patologia colecistica, l'8% storia di etilismo attivo. Considerando una popolazione stabile di 64.115 abitanti, l'incidenza di PA nell'isola di Ischia nel 2017 è stata di 37/64.115 casi, ovvero 57.8/100.000 abitanti. Questo valore è circa il doppio rispetto al dato di incidenza in altre regioni italiane e colloca l'area di interessa, tra i paesi europei con più elevata incidenza (>40/100.000).
Conclusioni: Questo studio preliminare dimostra una incidenza annuale di PA tra gli abitanti dell'isola di Ischia notevolmente superiore a quella di altri studi italiani ed in linea con quanto riportato nei paesi europei a più elevata incidenza. Studi prospettici sono necessari per confermare il dato e per la ricerca di fattori di rischio per PA presenti nella popolazione di riferimento.

An uncommon Systemic Lupus Erythematosus flare-up: a case report

G. Argiolas[1], M. Lillu[1], W. Cordeddu[1], M.N. Mura[2], D. Firinu[1], F. Marongiu[1]

[1]Department of Medical Sciences and Public Health, University of Cagliari, Cagliari; [2]Internal Medicine, Allergology and Clinical Immunology, University Hospital "Duilio Casula", AOU Cagliari, Monserrato, Cagliari, Italy

Introduction: A 27-year old woman with SLE in treatment with prednisone was admitted to our Department with fever and purulent pharyngotonsillitis. She had been treated at home with clarithromycin without benefit.
Case report: On admission, she presented enanthema; her vital signs were in normal range except for fever. A complete blood count showed a WBC count of 1300/mm^3 (NE 4%, LY 64%, MO 29%), Hb 9.1 g/dL and PLT 39000/mm^3. Serum chemistry showed AST 114 IU/L, ALT 118 IU/L, LDH 981 IU/L, PCT 0,03

ng/ml, PCR 5.8 mg/dL. The autoimmunity showed ANA positive 1:320 homogeneous pattern while anti-SSA and dsDNA antibody were positive. IgM and IgG for CMV were both positive, supporting by a recent CMV infection. Bone marrow aspiration was negative for pathological alteration. She underwent to methylprednisolone 500 mg/die for two days and IVIG (30 g/day) and filgrastim (60000 U/day) for five days with notable clinical and lab improvement; she was then discharged and follow up with underlying corticosteroid therapy.
Conclusions: The primary infection with CMV is usually asymptomatic or it may also be associated with mononucleosis syndrome. Our report, such as others in the literature, shows that a CMV infection may reactivate SLE. IVIG can have beneficial effects on disease activity in the short term, but it has to be continued with intermittent courses to achieve sustained benefit and for steroid sparing properties. The association of corticosteroid therapy, IVIG and leukocyte growth factors allowed a fast resolution of the patient's hematological and clinical picture.

MIMO STUDY (Malnutrition of Internal Medicine Olders)

T.M. Attardo[1], M.T. Rago[2], L. Gucciardino[3], G. Augello[1]

[1]UO Medicina Interna, Ospedale Barone Lombardo, Canicattì (AG); [2]Tesista, UO Medicina Interna, Ospedale Barone Lombardo, Canicattì (AG); [3]Servizio di Neurologia, Ospedale Barone Lombardo, Canicattì (AG), Italy

Background: The caloric-protein malnutrition in the elderly is correlated with the risk of morbidity and mortality, duration of hospitalization and bad outcomes. Statistical data show that the rate of malnutrition among patients in Italy is 31%. This study sought to analyze the nutritional status and factors associated with malnutrition in our elderly admitted.
Methods: Were enrolled patients aged 65 or over admitted consecutively during latest semester. They were subjected to the following tests: MMSE (53 patients), GDS (51 cases), ADL and IADL; nutritional evaluation was performed with the MNA.
Results: 373 patients were enrolled (mean age 80 ys), coming in most cases from their home. Only 9% of women and 19% of men were completely autonomous, whereas the remaining were totally or partially dependents. More than 60% of patients had a good masticatory capacity, but more than 50% were assisted during meal. In 62% we found a score MMSE less than 26; the GDS score was greater than 11 in 57% of cases. More than 50% showed a BMI less than 20, while the remaining percentage was normal or overweight. More than 60% of patients had a MNA<17 and more than 30% had an MNA at risk of malnutrition; less than 2% of patients were well fed.
Conclusions: The elderly admitted showed a worrying prevalence of malnutrition. It is necessary an early identification and application of interventions in the implementation of strategies able to prevent and/or reduce the state of malnutrition.The assessment of depression and cognitive impairment should also be an integral part in addressing this group.

An acute inflammatory demyelinating disorder complicated the diagnostic process of a case of primary hyperparathyroidsm

G. Barbarisi[1], M. Zavagli[1], P. Mercatelli[1], F. Crudele[1], E. Martinelli[1], G. Bandini[1], C. Marchiani[1], M. Gagliano[1], I. Bertoletti[1], E. Cioni[1], N. Palagano[1], P. Bernardi[1], A. Moggi Pignone[1]

[1]Medicina per la Complessità Assistenziale IV, AOU Careggi, Firenze, Italy

Background e Case report: GBS is an acute onset polyradiculoneuropathy, typically presenting with sensory symptoms, hyporeflexia and weakness over days, often leading to quadriparesis. Diagnosis is suspected clinically and is confirmed through EMG and CSF analysis that shows an elevated protein level. We describe a case of GBS occured during the diagnosic flow of patient with hypercalcemia.
Case presentation: A 52-year-old woman was admitted to our hospital for a progressive diffuse muscoloscheletrical pain that had led to immobility in 2 months. The only significat result at the blood tests was a confirmed hypercalcemia (13,1mg/dl). We set up a diagnostic flow that showed a primary hyperparathyroidsm. The US, the CT scan and the MIBI scintigraphy showed multiple nodules, highlly suspected for parathyroid adenoma. During hospitalization she presented a sudden bilateral and flaccid limb weakness with areflexia. The history was positive for flue-like synthoms a week before the admission. We therefore suspected an acute inflammatory demyelinating disorder. The EMG detected a slow nerve conduction velocity with evidence of segmental demyelination. The CSF showed an albuminocytologic dissociation. We immediately started IVIg and the patient remained stable during the whole hospital stay, without plasma exchange therapy.
Conclusions: GBS is an acute syndrome that can complicate any diagnostic process. Diagnosis can be delayed, especially if synthoms are measleded with the worsening of previous clinical synthoms. With appropriate therapy, most patients may have a very good complete recovery.

Septicemia from *Aeromonas sobria* in an immunocompromised patient with erysipelas: an atypical clinical case in southern Italy

G. Barile[1], A. Matarrese[2], F. Lillo[1], D. Renna[1], F. Guardavaccaro[1], A. Grimaldi[1]

[1]UOC Medicina Interna, PO Monopoli (BA); [2]UOS Patologia Clinica e Microbiologia, PO Monopoli (BA), italy

Background: Gram-negative bacilli of the *Aeromonas* genus are autochthonous in the aquatic environment, prevalent in developing countries and Southeast Asia. They may be responsible for a wide spectrum of human infections, although septicemia remains uncommon, especially in Italy. We describe the case of a skin infection with severe septicemia due to *Aeromonas sobria* in an immunocompromised patient.
Case report: A 83-year-old man with a history of myelodysplastic syndrome was admitted for fever with confusion. The first evaluation showed leukocytosis, increased PCR and anemia. On clinical examination, an erythema of the left leg was found without signs of trauma or injury. Following the execution of blood and urine cultures, empiric antibiotic therapy with ceftriaxone was initiated. After 48 hours, clinical conditions worsen with development of septic shock and increase in procalcitonin. Blood culture on the third day identified *Aeromonas veronii* biovar sobria and antibiotic therapy was targeted with intravenous ciprofloxacin.
Conclusions: This is a rare case of septicemia from *Aeromonas sobria*, in Italy: in literature only sporadic cases of septicemia are reported because they aren't typical of our geographical area and not associated with erysipelas. Furthermore, the isolated strain isn't common for human infections caused predominantly by *Hydrophila*. In this case, timely isolation and targeted therapy allowed for good clinical development. It is possible that the infection was caused by exposure to an undetected wound, to contaminated water from a never-cleaned cistern.

Ibrutinib in atypical presentation of chronic lymphocitic leukemia

A. Bellodi[1], E. Harusha[1], F. Caserza[1], C. Casini[1], N. Fallani[1], F. Rossi[1], S. Feltrin[1], A. Minetti[1], A. Ballestrero[1]

[1]Clinica di Medicina Interna ad Indirizzo Oncologico, Ospedale Policlinico S. Martino, Genova, Italy

Background: Chronic lymphocitic leukemia (CLL) is a hematological disorder of internistic interest due to frequent systemic complications.
Case report: A 68 years old woman arrived to our observation for dyspnea and chest pain. Her past medical history showed CLL-B lasting for two years presenting with thoracic lymphoadenomegalies and treated with 6 cycles of rituximab+fludarabine+cyclophosphamide with complete response. At physical examination bilateral pulmonary crepitation and respiratory distress requiring oxygen therapy (arterial gas analysis: pH 7.41, SO2 88%, pO2 54.7mmHg, pCO2 41.5mmHg, lactate 5.6mmol/L, bicarbonate 26.2 mmol/L). Laboratory showed WBC 34,10 x10E9/L (lymphocytes 16,00 x10E9/L), Hb 14.1 g/dL, PLT 269x10E9/L, C reactive protein 24.3mg/L, troponin-I<0.015 µg/L, NTproBNP 172ng/L. No abnormalities in renal and liver function. Patient was initially

treated with diuretics and antibiotic with no improvement. Perfusion lung scintigraphy was negative for embolism and CT scan showed thoracic lymphoadenomegalies and mild disventilative bibasal alterations. Broncho-alveolar lavage was performed showing alveolar hemorrhage and immunephenotype coherent with CLL-B (19% of small B lymphocytes CD19+, CD20+/-, CD5+, CD23+/). Ibrutinib 420 mg daily was started with progressive improvement on respiratory function (on day15: pH 7.38, SO2 94.5%, pO2 80.7mmHg, pCO2 39.5mmHg).
Conclusions: Haemorragic alveolitis is a rare complication of CLL, requiring caution and rapid onset of therapy. Ibrutinib proved efficacy and safety in this setting.

West Nile Virus and Good Syndrome...not so good

C. Benatti[1], M. Bertesi[1], M. Devetak[2], S. Amidei[2], L. Manzini[1], C. Pavesi[1], M. Santangelo[2], C. Di Donato[1]

[1]UO Complessa, Medicina Interna, Ospedale di Carpi (MO); [2]UO di Neurologia, Ospedale di Carpi (MO), Italy

West Nile virus (WNV) has emerged as the most common cause of epidemic meningoencephalitis. Neuroinvasive disease occurs in less than 1% of cases and neuroinvasive presentations are various. Good Syndrome (GS) is characterized by the simultaneous presentation of thymoma and severe immunodeficiency. A 60-year-old man admitted for fever, astenia and ten days' confusion. His medical history included thymectomy for thymoma, recurrent infections and inflammatory bowel disease. Brain Computer Thomography and Chest X-ray was negative but the electroencephalogram showed a non-convulsive epileptic status. Rachicentesis pointed out a positive PCR for WNV (viral RNA) and at the laboratory test we observed severe hypogammaglobulinemia. The medical history, clinic and all investigations allowed us to make a diagnosis of WNV encephalitis in patient with GS. WNV is a mosquito-borne flavivirus, and humans are a dead-end host in this kind of infection. Encephalitis and meningitis develops in about 1 out of 150 infected humans, especially in elderly populations or immunosuppressed patients. GS is a rare condition with fewer than 200 cases reported in literature. Classically it is defined as a triad of thymoma, hypogammaglobulinemia, adult-onset immunodeficiency. The patients often present recurrent infections, autoimmune and hematologic conditions. Adequate surgical resection remains the key to favorable outcomes, whereas immunotherapy helps reducing postoperative complications and may improve survival. The immunodeficiency dosen't regress with surgery but rather sometimes worsen.

Abdominal mass in a patient with multiple myeloma: differential diagnosis

D. Benfaremo[1], O. Burattini[2], G.P. Martino[2], F. Marconi[2], G. Bitti[2], S. Angelici[2]

[1]Dipartimento di Scienze Cliniche e Molecolari, Università Politecnica delle Marche, Ancona; [2]Medicina Interna, Fermo, Italy

A 83-year-old man presented with abdominal pain. His medical history was notable for Multiple Myeloma (IgG-Kappa) in current chemotherapy treatment. Blood tests demonstrated inflammatory markers and BNP elevation. Chest X-Ray did not show pathological lesions, whereas abdominal ultrasound demonstrated a solid formation in the epigastric region of uncertain significance. A subsequent CT scans described the formation as pertaining to the omentum and detected other formations attached to the perirectal 'fascia', a paraortic lymphadenopathy and extensive retroperitoneal malignant tissue. In order to better characterize the epigastric mass, a biopsy was performed and the staining of the tissue demonstrated extra-medullary localization of MM. Multiple Myeloma is defined by the presence of 10% or more of clonal plasma cells in the bone marrow and by the evidence of organ damage (CRAB: hypercalcemia, renal insufficiency, anemia, bone lesions). In most cases of MM, the plasma cells proliferation is restricted to the bone marrow, but a small percentage of MM patients may develop extramedullary MM. At the time of MM diagnosis, extramedullary MM is found in 6% to 8% of patients. Up to 30% of patients may be involved as the disease progresses, with a positive association with an adverse prognosis. The most common locations of extraosseous MM is the abdominal cavity including liver, pancreas, mesentery, adrenal glands, and retroperitoneum. Abdominal MM should be considered in the differential diagnosis of a patient with Multiple Myeloma presenting with an intra-abdominal mass.

Sindrome di Lemierre esordita con sepsi

V. Bernardis[1], S. Rondinella[1], M. Balbi[1]

[1]Medicina Interna, Ospedale San Vito al Tagliamento (PN), italy

Premesse: Caso di sindrome di Lemierre esordita con stato settico.
Caso clinico: Una pz di 69 aa accede al PS per stato confusionale, agitazione psicomotoria, iperpiressia; riscontro di iponatriemia, elevazione della flogosi e TC capo negativa per acuzie. Storia di: disuria, disfagia, faringodinia, dolore sottomentoniero destro e laterocervicale. Ricoverata per stato settico, grave agitazione psicomotoria, che richiede sedazione e contenzione. Le emocolture sono positive per *Streptococcus agalactiae* totisensibile, urocoltura negativa. TC capo, esame ORL, eco addome, ecocardio negativi. TC collo: nulla a carico di ipo-orofaringe; non ascessi né linfoadenomegalie; difetto di riempimento nella vena giugulare interna di destra. Doppler TSA: presenza di trombo flottante, non occludente, della vena giugulare interna destra. RMN cerebrale e del tronco: minuti esiti ischemici cronici, no trombosi dei seni venosi durali. Fundus oculi: non segni di vitreite/vasculite, endoftalmite. Si conclude per sindrome di Lemièrre ad esordio con stato settico. Alla iniziale terapia antibiotica parenterale con amoxi clavulanato, viene associata moxifloxacina per una migliore penetrazione; avviata terapia anticoagulante con eparine a basso peso e di seguito con warfarin. Doppler TSA predimissione: iniziale remissione del processo trombotico, completamente risolto dopo tre settimane. Sospende antibiotico e poi anche warfarin, dopo terzo mese di terapia.
Conclusioni: La terapia anticoagulante, assieme ad antibiotico ad alta penetrazione, ha favorito rapida risoluzione del trombo, in assenza di embolizzazioni.

A case of Thrombotic Thrombocytopenic Purpura: the unpredictable clinical developments

I. Bertoletti[1], M. Zavagli[1], G. Barbarisi[1], C. Marchiani[1], G. Bandini[1], N. Palagano[1], E. Cioni[1], P. Bernardi[1], M. Gagliano[1], F. Crudele[1], E. Martinelli[1], P. Mercatelli[1], A. Moggi Pignone[1]

[1]Medicina per la Complessità Assistenziale IV, AOU Careggi, Firenze, Italy

Introduction: Thrombotic Thrombocytopenic Purpura (PTT) (also know as Moschcowitz disease) is an infrequent disease related to congenital or acquired severe deficiency of ADAMTS-13, the specific Von Willebrand Factor(vWF) cleave protease. The lack of enzymatic activity forms platelet-rich microthrombi that can embolize and occlude arterioles.
Case report: A 38 year-old man was admitted to our hospital with some small cutaneous purpuric lesions. He also complained of headache and fever for several days. Blood tests showed low platelets(17000/microL) and anemia(Hb 9.1g/dl) with increased total bilirubin(1.7mg/dl) and LDH(690U/L), the haptoglobin was indosable; all signs are consistent with a hemolytic etiology. Serum creatinine was increased(1.25mg/dl). The peripheral blood smear highlighted the presence of schistocytes. Thus in strong suspicion that it could be a PTT, we have performed the therapeutic plasma-exchange(TPE) procedure. A few hours after TPE the patient showed confusion, seizures and prolonged loss of consciousness requiring orotracheal intubation. In the following days the platelets have increased and we have witnessed a recovery of the patient's state of mind. Then suddenly, after seven days from TPE there was a new fall in platelet count values, in addiction the indexes of hemolysis were significantly raised. We have detected a high titre of inhibitory antibodies of ADAMTS-13 and an enzymatic activity <5%.
Discussion: Acute TTP episodes are medical emergencies: despite the therapeutic and resuscitation measures taken, the immediate and long term outcome might not be predictable.

Yellow Nail syndrome quale sindrome paraneoplastica

M. Bianchi[1], S. Vernocchi[1], A. Aceranti[2]

[1]ASST Lombardia Ovest-MI; [2]Istituto Europeo di Scienze Forensi e Biomediche, Gallarate (VA), Italy

Premessa: La Yellow Nail Syndrome (YNS) è un disordine molto raro (400 casi in letteratura) che colpisce gli over 50 di entrambi i sessi, la cui diagnosi di basa sull'alterata colorazione delle unghie di mani e piedi che paiono spesse, fessurate e facilmente sede di onicomicosi. La YNS costituisce una triade, che si associa a alterazioni pneumologiche tra cui versamento pleurico e linfedema agli arti inferiori, talvolta compare anche sinusite.
Caso clinico: Uomo 56 anni, presenta versamento pleurico dx comparso da 4 mesi in YNS comparsa 3 anni or sono, estesa alle unghie di mani e piedi. La YNS è stata trattata con vit E con beneficio parziale ma peggioramento del versamento che al momento dell'osservazione occupa il terzo inferiore dell'emitorace dx. In APR: mai fumatore né bevitore, dall'età dai 19 ai 29 anni contatto con amianto. In APP: reflusso gastro esofageo con eritema interaritenoideo, sinusite cronica etmoidale e sfenoidale, iperomocisteinemia trattata con acido folico. La TC torace eseguita poco prima dell'osservazione evidenzia versamento pleurico destro, assenza di masse pleuriche o polmonari. Viene proposta indagine Pet Whole-Body che mostra ipercaptazione alla pleura viscerale dx; la biopsia conferma mesotelioma pleurico nella varietà di carcinoma sarcomatoide. La toracoscopia mostra infiltrato a carico della pleura viscerale con quadro di carcinosi pleurica. Siccome la patologia è già avanzata si esclude l'opzione chirurgica e si propone chemioterapia.
Conclusioni: Si conferma la caratteristica di sindrome paraneoplastica della YNS.

A case of pelvic and carotid paraganglioma with paroxysmal hypertension

V. Bisogni[1], F. Olmati[1], L. Petramala[1], G. Oliviero[1], M. Bonvicini[1], M. Mezzadri[1], A. Concistrè[1], M. Celi[1], V. Saracino[1], G. Iannucci[1], A. Ciardi[2], G. De Toma[3], C. Letizia[1]

[1]Department of Clinical Sciences and Translational Medicine, Unit of Secondary Arterial Hypertension, "Sapienza" University of Rome; [2]Department of Radiological Sciences, Oncology and Pathology, UOC Anatomia Patologica, "Sapienza" University of Rome; [3]"Pietro Valdoni" Surgery Department, "Sapienza" University of Rome, Italy

Introduction: Pheochromocytomas (PHEOs) and paragangliomas (PGLs) (together as PPGLs) are neuroendocrine tumours arising from chromaffin-cells of adrenal medulla and paraganglia of the sympathetic and parasympathetic nervous system, respectively. PPGLs secrete excess of catecholamines, leading to hypertension, headache, palpitations, and diaphoresis. Rare PPGLs have shown to be multiple and recurring after surgical treatment.
Case report: A 76-year-old woman referred to our Centre complaining of paroxysmal hypertension. She had no family history of PPGL. Hormonal screening test showed increased levels of 24-hours urinary metanephrines. A computed tomography (CT) scan showed a mass of 52 mm in the right pelvis. Strongest uptake of ^{123}I-Metaiodobenzylguanidine deposed for a pelvic PGL. Patient underwent successful laparotomy surgery to remove the pelvic mass, without complications. Histologic examination confirmed PGL diagnosis. At 6-months follow-up the blood pressure values were controlled without medications. Although, during a ultrasonography evaluation of carotid arteries, an incidental oval mass of 20 mm, closed to right carotid siphon, was found and confirmed by CT scan, as a tumour compatible with a carotid-PGL. Unfortunately she refused surgical remove of this mass. The genetic testing of SDHx genes was negative for mutations.
Conclusions: It is important, in presence of PPGLs, to look for any other multiple lesions. A genetic screening is mandatory to exclude hereditary syndromic PPGLs, in order to establish a proper treatment and follow-up.

Paraneoplastic limbic encephalitis

C. Bologna[1], M.G. Coppola[1], G. Oliva[1], M. Lugarà[1], P. Tirelli[1], P. Madonna[1], F. Granato Corigliano[1], S. Ascione[2], G. Cerullo[2], E. Grasso[1]

[1]UOC Medicina Generale Ospedale del Mare, Napoli; [2]UO Neurologia Ospedale del Mare, Napoli, Italy

Background: Limbic encephalitis is a rare disease often associated with small cell lung cancer.
Case report: Patient of 76 years, suffering from heart failure from chronic ischemic-hypertensive heart disease in hypokinetic phase with severe EF depression (35%); mitral valvular disease treated surgically; FA permanent in TAO; pulmonary asbestosis; IRC stage III K-DOQI, hospitalized for hyponatraemia likely to be secondary to high-dose diuretic therapy (at the entrance 114 mEq / l, treated with 3% hypertonic); the laboratory tests this morning highlight: creat. 2.7 mg / dl; azot. 111 mg/dl; Na 122 mEq/l; K 4 mEq/l. At EO no angorno dyspnea at rest, sleepy patient responds to verbal stimuli; PA 120/70 mmHg; presence of declining edema but in clear reduction. Access to the PS of this hospital by confusional state in hyponatremia (confirmation at the entrance of INR 4.93), He practiced between 29.09 and 01.10 two cranial CT scans with evidence of 'hypodense lesion at the site of a temporary left mesial temporo'. The brain MRI with sequence in DWI shows limbic encephalitis. It therefore performs TC Total body with Mdc and PL for the detection of anti-HU antibodies, anti Ma, anti NMDA for Limbic encephalitis. The PET study shows pathology with a high metabolic activity in the pleural and lymph node. Hypermetabolism focus on site intestinal. Widespread glucose hypometabolism in the encephalic center. Solid nodular formation at polylobate margins (Dtrv max 65x48mm; IM: 3-251), corresponding to the medial segment of the LM, poorly dissociable from the parietal pleural profile and from the relative pericardial profile and ipsilateral cardio-frenico breakthrough. Needle aspiration is performed with a 21G needle to the known right madial nodule.
Conclusions: It must be emphasized that limbic encephlitis occurs at an erly stage can lead a better outcome.

An intricate cryoglobulinemia

R. Boni[1], M.S. Barone[1], C. Coronella[1], F. Fico[1], M.R. Poggiano[1]

[1]UOC Medicina Interna 1, AORN A. Cardarelli, Napoli, Italy

Background: Waldenstrom macroglobulinemia (WM) is a lymphoproliferative B-cell disorder, characterized by both an IgM monoclonal component (MC) in the serum and lymphoplasmacytic cells in the bone marrow. Sometimes WM is associated with type I cryoglobulinemia (CG), that is totally monoclonal and usually asymptomatic. On the other hand mixed type II CG consists of IgM CM and polyclonal IgG. Type II CG causes a systemic vasculitis and is usually secondary to HCV infection.
Case report: 73 y.o. male affected by WM since 3 years, type 2 diabetes mellitus and hypertension. He was admitted for transient confusion, arthralgias, skin hyperpigmentation, weakness and lower limbs paraesthesia. Serum electrophoresis with immunofixation showed monoclonal IgM/k, cryoglobulin screen was positive (typing: monoclonal IgM/k and polyclonal IgG), HCV titer was high. An anti-viral therapy was prescribed, but unluckily the patient died within a month because of a stroke.
Conclusions: The finding of an IgM monoclonal gammapathy is often a diagnostic challenge. Our case spurs on searching and specially on typing cryoglobulins: just the evidence of a type II CG in course of WM induced us to look for HCV infection. WM/HCV-related CG comorbidity is extremely rare, so we have no treatment guidelines. We gave the priority to anti-viral therapy, instead of haematologic treatment. Like WM, HCV-related type II CG is associated with chronic lymphoproliferation and paraprotein production; the WM/type II CG association found in our case suggests a possible role for HCV infection in the development of WM.

Evaluation of therapeutic education on knowledge of correct use of insulin pen in inpatients: the CUIP Study

A. Bosio[1], E. Roberto[1], A. Carello[1], G. Di Bella[1], C. Marcellino[1], G. Monaco[1], A. Omusoru[1], S. Polegato[1], V. Porporato[1], S. Sannuto[1], S. Trentacoste[1], C. Trovò[1], C. Viottini[1], E. Scalabrino[1], C. Pascale[1]

[1]SC Medicina Interna, Ospedale Cottolengo, Torino, Italy

Introduction: Diabetes mellitus (DM) is linked to high risk of micro/macroangiopathy, which reduces both life quality and ex-

pectation. Therapeutic education can improve adherence to correct lifestyle and therapy so reducing diabetic complications.
Objectives: Evaluate in insulin treated inpatients: knowledge of Correct Use of Insulin Pen (CUIP); efficacy of therapeutic education in improving CUIP.
Methods: Cohort prospective study. Used tool: 10-step checklist with correct insulin injection (step: 1,9 hand hygiene; 2,3,7,8 needle use and management; 4,5,6 injection technique; 10 pen storage; correct=point 1, wrong=point 0, the higher the score the better the knowledge). CUIP evaluation at admission (T0); therapeutic education during hospitalization; CUIP evaluation at discharge (T1). Exclusion criteria: no insulin therapy; need for caregiver; critical illness. Data analysis by descriptive analysis and t-test.
Results: 167 patients with DM admitted from january to december, 51 enrolled (age 77.78±7.51 years, male 49.02%). Interval T0-T1 7.84 days. CUIP score: men T0=7.84±1.62, T1=9.32±1.03 (P<0.001); women T0=7.92±1.38, T1=9.38±0.85 (P<0.001); overall T0=7.88±1.49, T1=9.35±0.93 (P<0.001). No difference between gender.
Discussion: Though a good score at baseline, hospital education improves significantly CUIP regardless of gender. Short T0-T1 interval might explain this. Limits of study: small sample; short interval between evaluations.
Conclusions: As inpatient education seems to improve CUIP, time should be spent on it. A larger sample and a later further evaluation are needed.

Una fotografia della Medicina Interna

A. Bovero[1], S. Cesio[1], R. Piccardo[1], R. Goretti[1], D. Mela[1]

[1]Ospedale Santa Corona, Pietra Ligure (SV), Italy

Premesse e Scopo dello studio: Analizzare il livello di complessità dei pazienti della Medicina Interna.
Materiali e Metodi: Abbiamo analizzato i pazienti ricoverati dal PSM nell'Unità Operativa di Medicina Interna. I pazienti sono stati classificati con lo score MEWS per la stabilità medica ed allo score IDA per la dipendenza assistenziale. L'associazione dei 2 score (TriCo) ha ulteriormente identificato 3 classi di complessità: alta, media e bassa.
Risultati: Il nostro reparto di Medicina Interna ha 52 posti letto ed i malati ricoverati sono stati analizzati per 45 giorni consecutivi; il numero totale di ricoveri è stato pari a 225 con un'età media dei pazienti di 76 anni. Lo score medio Mews è stato di 1,6 (massimo 9, minimo 0) e lo score IDA medio di 19,03 (massimo 27 minimo 9). Il numero di pazienti con bassa intensità è stato di 64 (28,4% del totale di cui 37 con problematiche sociali o demenza avanzata), con media intensità di 144 (64% del totale) e con alta intensità di 17 (7,6% del totale).
Conclusioni: La maggior parte dei pazienti rientrano secondo lo score TriCo nel livello "medio" che comprende una eterogenea popolazione; una piccola percentuale (7%) ricade nell'alta intensità con patologie acute e alta dipendenza (patologie respiratorie, oncologiche avanzate, stati settici). Molti dei pazienti a bassa intensità sono invece malati con problematiche croniche o sociali il cui ricovero ospedaliero dovrebbe essere evitato. Lo score pur nella sua validità globale non tiene conto di fattori importanti quali età, tipo di patologia e stati terminali di malattia.

Cateterismo venoso bedside nel setting 2B: l'esperienza della Medicina Interna 2 di Prato

I. Bracali[1], F. Risaliti[1], S. Lenzi[1], M. Perrella[1], P. Lotti[1], T. Lazzarotto[2], V. Panetta[2], S. Tombelli[2], V. Vigna[2], M. Bernetti[1], M. Bertoni[1], A. Foschini[1], A. Giani[1], L. Guarducci[1], R. Martini[1], T. Restuccia[1], A. Tammone[1], S. Zanieri[1], M.E. Di Natale[1]

[1]SOC Medicina Interna 2, Nuovo Ospedale Santo Stefano di Prato; [2]Università degli Studi di Firenze, Italy

Premessa: Nei pazienti ricoverati in Medicina Interna la terapia endovenosa è la procedura invasiva più comune; le indicazioni internazionali pongono enfasi sull'utilizzo di un approccio "proattivo" che preveda una precoce valutazione e gestione medico-infermieristica del patrimonio venoso del paziente.
Materiali e Metodi: A partire dal 2015 la SOC Medicina Interna 2 dell'Ospedale di Prato ha avviato un percorso formativo finalizzato al posizionamento di cateteri venosi periferici e centrali con tecnica ecoguidata. Il gruppo iniziale, costituito da due medici e un infermiere, si è progressivamente allargato con un processo a cascata.
Risultati: Da ottobre 2015 a gennaio 2019 (40 mesi consecutivi) sono stati posizionati 233 dispositivi vascolari in 220 pazienti (età media 77.6 anni, range 22-103, di cui 96 uomini). I cateteri venosi centrali erano 73 (6 bilumi per dialisi, 1 PICC, 4 giugulari, 62 femorali) e quelli periferici 160 (87 midline e 73 cannule lunghe); 186 cateteri sono stati posizionati da medici, 107 (periferici) da infermieri. In 9 casi si sono verificate complicanze immediate intra-procedurali, mentre in 8 casi (3.4%) vi sono state complicanze tardive che hanno richiesto terapia mirata e/o rimozione del catetere.
Conclusioni: La tecnica eco guidata è risultata sicura, efficace e di facile apprendimento. La gestione del patrimonio venoso dovrebbe essere inserita nella pianificazione terapeutico-assistenziale già nelle prime fasi del ricovero integrando competenze mediche ed infermieristiche.

Interatrial Block as electrocardiographic predictive sign for atrial fibrillation

G. Bragagni[1], C.H. Chen[1], F. Lari[1], G. Magenta[1]

[1]UO Medicina Interna, Ospedale di S. Giovanni in Persiceto (BO), Azienda USL Bologna, Italy

Introduction and Purpose of the study: The Interatrial Block (IAB) has received confirmations as a predictor for atrial fibrillation (AF), but it is still underused in clinical practice. Aim of this study was to evaluate the correlation between IAB and the onset of AF in hospitalized patients.
Materials and Methods: Among 4361 patients, 110 (group 1) were identified with electrocardiograms both in sinus rhythm and AF, and 123 (group 2) constantly in sinus rhythm. In both we analyzed: the presence of partial (P≥120 ms) or advanced (P>120ms and biphasic in D2, D3, aVF) IAB, and the main electrocardiographic and clinical features. The differences between the two groups were compared with the Chi-square test, and the correlation between IAB and AF with the Pearson test.
Results: Age and gender between the two groups were similar. IAB was present in 89/110 (80.91%,) in group 1 and 26/123 (21.13%) in group 2 (p=<0.01); partial in 50/110 (45.45%) and 19/123 (15.7%) in group 1 and 2 respectively (p <0.01), advanced in 39/110 (35.45%) and 7/123 (5.69%) (p <0.019). Among the comorbidities only heart failure (p <0.01), valvulopathies (p <0.02) and ischemic heart disease (p <0.004) were significantly higher in group 1. The correlation between IAB and AF was significant (p <0.001); out of 55 patients with atrial echo dilatation 36 (65.4%) had IAB and 14 (25.4%) had Deep terminal negativity of P-wave in V1(DTNPV1)>0.1mV (p <0.01).
Conclusions: IAB represents a reliable predictor of AF; moreover the sensitivity of the IAB in detecting atrial dilatation is higher than the DTNPV1>0.1mV.

Clinical bedside ultrasound in sepsis management in Internal Medicine

A. Bribani[1], F. Tesi[1], A. Tesei[1], R. Terenzi[1]

[1]Medicina Interna, Figline Valdarno (FI), Italy

Sepsis is increasingly a challenge for the internist in the aisles with increasingly complex patients. Ultrasonography has a very important role not only for the search for the source but for the cardio-circulatory and respiratory function assesment, for monitoring and for procedures that can be run in security as drainage of collections and obtaining vascular access arterial and venous ultrasonography in primary and secondary evaluation (head-foot) identifies the 75-85% of septic tanks, together with the clinic. The impact of ultrasound is reflected right on definition diagnostic, prognostic evaluation, identification of locations for microbiological investigations and subsequent material, guidance for the choice of antibiotic therapy initial empirical support for surgical or percutaneous intervention to control the source, defining the level of monitoring and the best setting for the treatment of patients.

L'impatto dell'Antimicrobial Stewardship sul governo clinico della terapia antibiotica

A. Briozzo[1], F. Vitale[1], M. Marcato[1], C. Marengo[1], E. Cerutti[1], E. Pennone[1], B. Parola[1], S. Masucci[1], A. Gasco[1], C. Norbiato[1]

[1]SC Medicina Interna, AO Ordine Mauriziano, Torino; [2]SC Farmacia, AO Ordine Mauriziano, Torino; [3]Direttore SC Farmacia, AO Ordine Mauriziano, Torino; [4]Direttore SC Medicina Interna, AO Ordine Mauriziano, Torino, Italy

Premessa e Scopo dello studio: In base ai contenuti dal Piano Nazionale di Contrasto dell'Antimicrobico-Resistenza (PNCAR) 2017-2020 e all'obiettivo 5.1.6 della DRG 26/18 affidato ai Direttori generali delle Aziende Ospedaliere piemontesi, l'Antimicrobial Stewardship (AS) assume un ruolo fondamentale per sorvegliare e controllare le infezioni da germi multiresistenti e per sorvegliare l'uso appropriato ed il consumo di antibiotici, riducendone, come richiesto dall'obiettivo nazionale, l'impiego entro il 2020 del 10% in ambito territoriale e del 5% in ambito ospedaliero, con particolare attenzione all'impatto degli antibiotici di classe J01 (daptomicina, carbapenemi, tigeciclina).
Materiali e Metodi: Nel nostro Ospedale (448 posti letto) è stato implementato il team di AS che comprende il farmacista di reparto, 2 infettivologi e e 2 ICI e sono stati identificati i reparti a maggior impatto prescrittivo: Unità di Terapia Intensiva Generale (UTIG) e Cardiovascolare (UTICV) e Chirurgia Generale. Sono stati realizzati e distribuiti ai reparti manuali di terapia antibiotica empirica ed eseguite valutazioni infettivologiche proattive settimanali dei pazienti degenti e sono stati comparati i dati di consumo, di appropriatezza prescrittiva e la durata delle terapie del 2° semestre 2017 con il 2° semestre 2018.
Risultati e Conclusioni: Consumi di daptomicina (-34%), levofloxacina (-37%), meropenem (-34%), tigeciclina (+11%) con uso più mirato anche in ambito di carbapenem-sparing strategy e riduzione dei giorni di terapia (-36%) con durata media delle terapie da 2 a 7.72 giorni.

Complex hematological case: revised diagnosis after 60 years

L. Brivio[1], C. Marchesi[1], C. Ferrari[1], M.T. Lavazza[1], E. Ricchiuti[1], S. Speroni[1], A. Mazzone[1]

[1]UO Medicina Interna, Ospedale di Legnano, ASST Ovest Milanese, Legnano (MI), Italy

We report the case of a 78 years old man presented to our Hematology department for anemia and thrombocytopenia. He was known to be subjected to splenectomy when he was 18 years old for severe thrombocytopenia suspected for Werlhof's disease and gastrectomy for cancer when he was 50 years old. He was also affected by chronic renal failure. At blood sample: normocitic anemia (Hb 6.7 g/dl), thrombocytopenia (70.000/mm3), normal leukocyte count, VES, PCR, ANA, ENA, C3, C4 were negative, ALP, GGT, bilirubin, protein electrophoresis, serum immunoglobulin levels and glycemia were normal. High levels of ferritin and beta 2 microglobulin were detected. Abdominal sonographic and CT scan imaging were normal like chest radiography. Bone marrow biopsy showed increased cellularity, dysplasia of the erythroid series, hyperplasia of megakaryocytes, increase of the reticulinic plot, presence of JAK 2 mutation. He reffered about his great grandson affected by X-linked thrombocytopenia (XLT-mutation V75M WAS gene). Family history of more maternally related males with a *WAS*-related phenotype or disorder was identified and also our patient was affected by XLT. We describe the case of thrombocytopenia X linked misdiagnosed as having Werlhof's disease. X-linked thrombocytopenia (XLT) is a bleeding disorder that primarily affects males caused by mutations of the gene WAS. Affected individuals often have thrombocytopenia with low mean platelet volume and increased susceptibility to malignancies and autoimmune disease due to immune system malfunctions and attacks the body's own tissues and organs.

Efficacia e Sicurezza del regime antivirale Pangenotipico (glecaprevir/pibrentasvir) in 120 pazienti HCV positivi (Studio Real-life)

N. Buccianti[1], G. Zaccardo[1], M. Licchelli[1], A. Carbonella[1], M. Lofrano[1], N. Mecca[1], M. Pace[1], V. Pascale[1], D. Ferrante[1]

[1]AO San Carlo, UOC Medicina Interna, Potenza; [2]Scuola di Specializzazione in Medicina Interna, Salerno; [3]Medico di Continuità Assistenziale, Potenza, Italy

Premesse e Scopo dello studio: L'obiettivo del nostro lavoro è dimostrare in real-life l'efficacia terapeutica e la safety della terapia antivirale pangenotipica (glecaprevir-pibrentasvir) in una coorte di 120 pazienti HCV positivi residenti in regione Basilicata.
Materiali e Metodi: Il periodo di arruolamento della popolazione HCV positiva è compreso tra febbraio ed ottobre 2018. La durata del trattamento è di 8 settimane (short-therapy) o 12 settimane (long-therapy) sulla base del grado di fibrosi valutato attraverso l'elastometria epatica (fibroscan) eseguita presso la nostra unità operativa.
Risultati: La risposta virologica sostenuta (SVR) –viremia non rilevabile- è valutata a 12 settimane dopo la sospensione del trattamento antivirale nel 100% della popolazione trattata. La risposta virologica sostenuta è identica nei due regimi di trattamento a prescindere dal grado di fibrosi, dall'età e dal sesso. La safety dei farmaci antivirali è assoluta (assenza di eventi avversi).
Conclusioni: L'efficacia terapeutica e la safety del regime antivirale pangenotipico ((glecaprevir-pibrentasvir) è assoluta anche in real-life. La clearance del virus è in grado di modificare la storia naturale dell'epatite cronica HCV positiva che, nel tempo, è gravata da severe complicanze (ascite, epatocarcinoma, scompenso metabolico epatico) che riducono l'aspettativa di vita.

Indagine su batteri produttori di biofilm in pazienti ricoverati portatori di cateteri vescicali a permanenza e possibile impatto sulle scelte terapeutiche

M.A. Burgio[1], T.M. Attardo[1], G. Augello[1]

[1]UO Patologia Clinica, Ospedale Barone Lombardo, Canicattì (AG); [2]UO Medicina Interna, Ospedale Barone Lombardo, Canicattì (AG); [3]UO Medicina Interna, Ospedale Barone Lombardo, Canicattì (AG), Italy

Premesse e Scopo dello studio: Le cellule batteriche possono esistere come cellule singole (plancton) o come biofilm. Le cellule del biofilm differiscono dalla controparte planctonica per un diverso pattern di espressione genica e per una maggiore resistenza agli antibiotici per cui in ambiente ospedaliero i biofilm possono essere causa di infezioni persistenti, favorita dallo stato di immunocompromissione del paziente, da una precedente infezione e/o da esposizione ad antibiotici. Scopo del nostro lavoro era quello di valutare nelle urine di pazienti cateterizzati a permanenza la presenza di microrganismi e la capacità dei microrganismi gramnegativi di produrre biofilm.
Materiali e Metodi: Sono stati esaminati 150 campioni di urine di pazienti cateterizzati a dimora ricoverati presso la nostra UO. Per i saggi di adesione sono stati utilizzati terreno LB diluito 1:4 e colorazione con cristalvioletto.
Risultati: 96 campioni sono risultati positivi,30 negativi, 24 contaminati (campioni con più di 2 microrganismi isolati). L'88% degli isolati erano microrganismi gramnegativi e il 55% dei microrganismi gramnegativi isolati è risultato in grado di produrre biofilm.
Conclusioni: L'utilizzo di un terreno povero nutrizionalmente e di un supporto sintetico permette di realizzare un modello sperimentale *in vitro* che riproduce ciò che accade *in vivo*. L'alta percentuale di batteri in grado di formare biofilm pone, in questa tipologia di pazienti, il problema di una terapia diversa da schemi terapeutici convenzionali e maggiormente rivolta ai biofilm in quanto più tolleranti agli antibiotici.

A misleading aortic ectasia and an unusual jaundice: diagnosis of a case of IgG4-related disease

F. Busetti[1], C. Ferrara[1], A. Galioto[1], M. Ziliotto[2], A. Fantin[3]

[1]Reparto di Medicina, Ospedale di Dolo (VE); [2]Radiologia, Ospedale di Dolo (VE); [3]UOC Gastroenterologia, AO Università di Padova, Italy

Introduction: IgG4-related disease (IgG4-RD) is a systemic inflammatory and fibrous condition with multi-organ involvement. It is characterized by tissue edema, fibrosis, infiltration of IgG4-positive plasma cells. It often causes obstructive jaundice due to pancreatic edema, but salivary glands, retroperitoneal space and the aortic wall can be involved. Diagnostic criteria include swelling of organ/soft tissue masses, serum IgG4 ≥135 mg/dL, histologic evidence of lymphoplasmacytic infiltrates/fibrosis.

Case report: A 55-years-old man was admitted to our ward for jaundice and itch. His anamnesis was significant for previous HBV-hepatitis, liver steatosis, diabetes, aortic ectasia with thrombotic apposition. Levels of conjugated bilirubin and GGT were high. Ultrasound and MRCP detected dilation of intrahepatic bile ducts, gallbladder and common bile duct microlithiasis, hyperdensity of pancreatic body. In order to study this issue, he underwent a MR with contrast: the Radiologist described a retroperitoneal fibrosis with aortas involvement that, together with dilated bile ducts and hyperdensity of pancreas, led to the hypothesis of IgG4-RD. IgG4 levels (134,5 mg/dL) and Endoscopic UltraSonography (thickening of bile duct wall, hypoechogenic pancreas with calcifications) were coherent with the suspicion. Therapy with glucocorticoids was started with relief of symptoms.
Conclusions: IgG4-RD is an often misdiagnosed pathology, that requires different approaches to be detected. Cooperation among specialists is crucial to provide these patients a correct diagnosis and therapy.

Un caso di acidosi lattica indotta da β_2 Agonisti

A. Caff[1], E. Cacciola[1], E. Delli[1], C. Gatta[1], D. Impellizzeri[1], E. Lombardo[1], M. Mangiafico[1], P. Banna[1]

[1]I Medicina, AOU Policlinico Vittorio Emanuele, Catania, Italy

Premessa: L'Acidosi Lattica, marcatore clinico di sepsi e shock è caratterizzata da concentrazione di lattati (Lat) >4 mmol/L. E' tipicamente suddivisa in due forme (A e B) per la presenza o assenza di ipossia tissutale. L'AL tipo B riconosce varie cause patogenetiche tra cui i β2Agonisti.
Case report: Paziente di 36 anni, diabetica in terapia insulinica, ricoverata per spasmi muscolari e parestesie indotti da grave ipocalcemia conseguente a ipoparatiroidismo post-chirurgico (asportazione di adenoma paratiroideo). Al momento del ricovero EGA: ph 7.41 pCO2 37.7 HCO3 23.6 K 2.9 Na 135.6 Cl 105.3 Ca 0.55 AG 7.4 Lat 2.2. Terapia: Ca gluconato in infusione, calcitriolo e insulina. Per comparsa di bronchite acuta con severo broncospasmo praticata terapia con Salbutamolo (1125 mcg tid) e cortisonico per aerosol. Dopo 2 giorni incremento dei Lat, EGA: ph 7.41 pCO2 27 HCO3 17.5 K 4.4 Na 137 Cl 106 Ca 1.13 Lat 5.1. Eseguiti: Rx Torace, Ecocardio, emocolture (negativi), monitorati indici di flogosi (GB e PCR normali, procalcitonina negativa), glicemia e chetoni (nella norma, assenza di chetoacidosi). Si decide di sospendere il β2Agonista e dopo meno di 24 ore si assiste alla normalizzazione dei Lat (2.3).
Conclusioni: I β2Agonisti stimolando la glicolisi aerobica determinano aumento del piruvato che convertito in Lattato può determinare AL. Nella nostra paziente diabetica, l'ipocalcemia, aumentando l'eccitabilità muscolare, può avere incrementato la fatica dei muscoli respiratori aggravando l'AL.

Correlazione tra densità minerale ossea mediante la tecnica REMS e Trabecular Bone Score in una popolazione femminile con e senza fratture

S. Camarri[1], V. Francolini[1], M.D. Tomai Pitinca[1], C. Caffarelli[1], S. Gonnelli[1], R. Nuti[1]

[1]Dipartimento di Scienze Mediche, Chirurgiche e Neuroscienze, Università di Siena; [2]Consiglio Nazionale delle Ricerche, Istituto di Fisiologia Clinica, Lecce, Echolight S.p.A., Lecce, Italy

Premesse e scopo: La densità minerale ossea (BMD) misurata con densitometria (DXA) è la base per diagnosticare l'osteoporosi, ma non è in grado di valutare la microarchitettura ossea. Il Trabecular Bone Score (TBS), software integrato alla DXA, permette di superare questo ostacolo. Recentemente è stata introdotta una tecnica ecografica (REMS) che è in grado di valutare il tessuto osseo sia qualitativamente che quantitativamente. Il nostro scopo è stato quello di valutare la correlazione tra i valori densitometrici misurati con DXA, TBS e REMS.
Materiali e Metodi: Sono state reclutate 199 pazienti di sesso femminile con e senza fratture da fragilità, misurando in ciascuna la BMD a livello lombare e femorale con metodica DXA, TBS e REMS.
Risultati: La BMD è risultata ridotta nelle pazienti con fratture rispetto a quelle senza, sia se misurata con DXA, TBS che con REMS. Abbiamo riscontrato una correlazione fortemente positiva tra i valori di BMD misurata con metodica DXA, REMS e TBS. Infine, combinando le variabili predittive il rischio di fratture, è stato osservato come il TBS rappresenti il parametro migliore per la stima del rischio di frattura, ma che anche la REMS presenta una buona associazione con esso.
Conclusioni: Le metodiche DXA e REMS sono in grado entrambe di discriminare le pazienti con e senza fratture ed esiste un'ottima correlazione tra la BMD valutata con le tre metodiche. Infine sia il TBS che la REMS sono predittori indipendenti delle fratture da fragilità: tuttavia il TBS rappresenta la modalità più affidabile per la stima del rischio.

Aortitis and systemic inflammation as risk factors for aortic rupture in elderly patient on oral therapy with levofloxacin: a case report

P. Campana[1], L. Ferrante[1], G. Gerundo[1], C. Napolitano[1], C. Russo[1], N. Ferrara[1]

[1]Università di Napoli, Federico II, Napoli, Italy

Background: Recent studies highlight that fluoroquinolones induce matrix metalloproteases (MMP) activity inhibiting extracellular matrix (ECM) protein biosynthesis and stability. These effects have been associated with an increased risk of aortic dissection and rupture. We describe a case of an elderly patient with abdominal aortitis and elevated systemic inflammation, who experienced aortic rupture after therapy with levofloxacin.
Caso clinico: An 80-year-old man was admitted for fever of unknown origin. Blood samples revealed systemic inflammation with an increase of C-reactive protein, leucocytosis with neutrophilia, elevated serum ferritin, and elevated D-dimer and fibrinogen. A first total body computed tomography showed abdominal aortitis and pneumonia. Thus, the patient started oral therapy with levofloxacin 750 mg/die. After five days of therapy the patient was apyretic, but he presented increasing pelvic pain. He underwent abdominal ultrasonography followed by abdominal angiography tomography, revealing an abdominal aortic contained rupture which was treated with the implantation of endografts.
Conclusions: Aortitis and systemic inflammation could be considered risk factors for aortic rupture in elderly patients on oral therapy with levofloxacin. The presence of these predisposing factors could trigger the activation of ECM remodelling and an increase of MMP activity related to fluoroquinolones. For this reason, oral therapy with levofloxacin should be used with caution in patients with aortitis and systemic inflammation, especially in elderly patients.

Absence of interaction between edoxaban, tacrolimus and everolimus in renal transplant recipients anticoagulated for proximal deep vein thrombosis

G. Camporese[1], C. Tonello[1], G. Avruscio[1]

[1]UOC Angiologia, Dipartimento di Scienze Cardiache, Toraciche e Vascolari, AOU di Padova, Italy

Background: No data available on edoxaban use for the treatment of deep-vein thrombosis (DVT) in renal transplant (RT) patients, not included in registrative clinical trials and on its surmised interaction with immunosuppressive drugs (tacrolimus or everolimus) which share the same metabolic pathways.
Case report: Male patient, aged 70, RT in 2015, good renal function, immunosuppressive therapy with tacrolimus and everolimus. In august 2018 diagnosis of symptomatic proximal DVT, initially treated with LMWH. Patient rejected embrication with warfarin. Being not possible a prolonged treatment with LMWH for administrative reasons, a treatment with edoxaban has been proposed, after giving information about the lack of data on potential interaction between edoxaban and immunosuppressors and about the advantages of edoxaban in DVT treatment. Patient decided to start treatment with edoxaban. After control of blood tests, a creatinine clearance <50 ml/min suggested the use of the dose of 30 mg. Patient is currently on treatment without onset of any bleeding,

with full DVT recanalization, preserved renal function (stable creatinine clearance between 32 and 42 ml/min), normal blood concentration of the immunosuppressors, and his great satisfaction
Conclusions: In RT recipients edoxaban given for DVT treatment does not seem to interact with immunosuppressors. Both anticoagulant and immunosuppressive effects seem warranted, without effect on the graft function, and with the expected antithrombotic effect without bleeding complications. Further data are needed to support this findings.

Medical buffer unit effectiveness on reorganization of in-hospital patient flow logistics

C. Canetta[1], S. Accordino[1], S. Passera[2], E. La Boria[1], G. Arosio[1], S. Bertolazzi[1], S. Provini[1], M. Masotti[1], P. Formagnana[1], S. Cacco[1]

[1]Medicina Generale e di Accettazione Urgenza, ASST Crema; [2]Medicina di Accettazione Urgenza, ASST Crema, Italy

Background and Objectives: Epidemiological transition has brought to increasing number of elderly multimorbidity patients admitted to hospitals entailing prolonged boarding in Emergency Departments (ED) and overcrowding, with increase in bed occupancy rate and outlying phenomenon. Consequences are longer hospital staying and escalating clinical risk. Aim of our study is to analyse the impact of the introduction of a high technology and time-limited medical buffer unit (Medical Admission Unit - MAU) on *in*-hospital patient flow logistics and clinical governance in a first-level ED hospital.
Methods: All patients admitted to MAU in one-year (Dec 2017 – Nov 2018) have been included; data regarding inflow and outflow, length of stay (LoS), main diagnosis, high care setting (monitor, NIV and NEWS) and mortality have been analysed.
Results: 1194 patients have been considered, 96.2% from ED and 3.8% from other wards (clinical instability). 27.4% were directly discharged (or died), the others were transferred to General Medicine (GM) or specialty wards (47.6% and 25% respectively). Despite a 31.4% increase in medical admissions (GM+MAU) compared to the previous year we observed a reduction in LoS (10.3 *vs* 11.2 days), mortality (7.4% *vs* 10%) and outlier/overall bed days (7.9% *vs* 10.9%), particularly in surgical area (6.8% *vs* 12.2%).
Conclusions: Reorganization of patient flow has shown an interdepartmental positive effect reducing outlying phenomenon. Patient-centered and problem-oriented approach to complex patients' management has shown a decrease in LoS and clinical risk.

Procalcitonin: more than sepsis!

A. Carbone[1], F. Liboà[1], S. Ghilotti[1], P. De Cata[1], R. Fonte[1], L. Chiovato[1]

[1]UO Medicina Interna ed Endocrinologia, ICS Maugeri, Pavia, Italy

Background: Procalcitonin (PCT) is the most reliable biomarker of bacterial infection and sepsis. In particular, PCT is used for early detection, correlates with the severity of infection and is used to monitor response to antimicrobial therapy. PCT is the precursor of calcitonin (CT), which instead is produced by thyroid parafollicular C-cells and represents the main serological marker of medullary thyroid carcinoma (MTC).
Description: A 69 years old man was referred to our Unit for poor glycemic control and chronic limphoedema. His medical history only revealed III grade obesity and type 2 diabetes mellitus in therapy with metformin, pioglitazone and dulaglutide. C reactive protein (PCR) was slightly positive (1.04 mg/dl), while PCT was elevated in two measurements (98.95 ng/mL and 90.18 ng/mL) in absence of clinical evidence of neither acute bacterial infection nor sepsis. Suspecting a thyroid origin of PCT secretion, CT was measured and appeared to be elevated (9400 pg/ml). Thyroid ultrasound was performed revealing a 4.8 cm, almost completely mediastinal, thyroid nodule with pathologic homolateral left lymphadenopathy. Total thyroidectomy with bilateral lymph nodes dissection was performed and histological analysis confirmed the suspect of MTC.
Conclusions: Internist should suspect a thyroid disease (in particular, MTC) when high levels of PCT are not related to infectious disease. Recently, PCT has been evaluated as an alternative biomarker for MTC: serum PCT has a strong negative predictive value to exclude MTC and PCT assays have fewer technical limits than CT measurement.

Heart failure in the real world and International Guidelines: marriage or divorce?

F. Cardoni[1], A. Capodanno[2], R. Cesareo[1], C. Cianfrocca[1], D. Bavoillot[1], V. D'Alfonso[1], A. Maietta[1], F. Marrocco[1], G. Zeppieri[1], G. Campagna[1]

[1]Internal Medicine Unit 1 "S. M. Goretti" Hospital, Latina; [2]Corso Specialistico Medicina Generale, Regione Lazio, Italy

Background: Heart Failure therapy in real world deviates from International Guidelines for the presence of comorbidity pts that limit its use.To this end, we examined the therapy of pts admitted for HF in our Internal Medicine Unit in 2017 in a retrospective study.
Materials: 714 pts hospitalized, 348M 366F, 69died (10%), 4voluntary discharge,641ordinary discharge.193 with Renal Failure (RF) of various degrees, 448 non-RF. Re-hospitalizations (into 3 mounths post-discharge) were12,6%.
Results: Therapy was in all pts: diuretics 76%, MRA 35%, b-blockers 58,3%, Ace-I 26%, ARB13,3%, Ca-chann-block 5%, F-Chan-Inhib11%, ARNI 3,2%. Association therapy was in 448 pts without RF: Diuretic+MRA 29%, Diuretics+b-block 38,7%, b-block+MRA 14,1%, Diuretics+b-block+MRA 13,8%, ACE-I/ARB+b-block+diuret+MRA overall in 35%. In 193 pts with RF: Diuretics+MRA 35%, diuretics+b-block 50%, b-block+MRA 18,6%, diur+b-block+MRA 18,1%, ACE-I/ARB+b-block+diuret+MRA overall 29%. Re-hospitalization was more frequent in pts treated with Diuretics+MRA (17%); less frequent in pts treated with ACE-I/ARB+Diuretics+b-block-MRA (5,1%).
Conclusions: Our study shows,on the one hand,a deviation from the International Guidelines in heart failure therapy in the real world, especially regarding use of ACE-I and ARB,linked to the presence of comorbidity (for ex RF and COPD);on the other hand, for these reasons,it indicates the need to set up an integrated HF Center with Internal Medicine Management that can implement adherence to International Guidelines in order to improve the prognosis, quality of life and the re-hospitalization of HF pts.

Impact of a program for rapid identification and antimicrobial susceptibility results on the clinical management of patients with septic shock

P. Carfagna[1], P. Placanica[2], M. Gaudio[3], A. Tarasi[1]

[1]Medicina Interna, AO San Giovanni Addolorata, Roma; [2]Microbiologia, AO San Giovanni Addolorata, Roma; [3]Patologia Clinica, AO San Giovanni Addolorata, Roma, Italy

Introduction: In patients affected by septic shock, prompt diagnosis and initiation of appropriate antimicrobial therapy can improve mortality. Rapid diagnostic tests that can accurately identify the pathogen causing an infection and the antimicrobials that are effective against that infection would increase the likelihood that patients are treated appropriately. Rapid diagnostic tests can also be used to help clinicians discontinue unnecessary antibiotics or de-escalate broad-spectrum antimicrobial therapy to a narrower-spectrum options. The Accelerate Pheno system is a new diagnostic device that can provide rapid bacterial identification and antimicrobial susceptibility results.
Methods: At San Giovanni hospital of Rome, starting from May 2018, we have activated a protocol for the management of patients with septic shock, using Accelerate Pheno system. In this study we analyze the preliminary results of 11 cases of septic shock, from May to November 2018.
Result: The rapid identification system allowed obtaining a response from the microbiology laboratory after an average of 1.09 days, *versus* an average of 3 days of the standard system. We did not find any identification errors. In 63.6% of cases, it was possible to establish a targeted therapy, in 18.2% of cases a descalation could be performed.
Discussion: In the septic patient, this method proves to be a very effective method to obtain not only a rapid and accurate microbiological diagnosis, but also to optimize antimicrobial therapy in the context of a correct application of the antimicrobial stewardship principles.

Association between global cardiac calcification and osteoporosis

P. Carrai[1], T. Picchioni[1], M. Alessandri[1], A. Incirsore[1], C. Caffarelli[1], S. Gonnelli[1]

[1]Dipartimento di Medicina, Chirurgia e Neuroscienze, Università degli Studi di Siena, Italy

Background and Aim: Literature suggests the relationship between bone and vascular system. Osteoporosis and atherosclerosis are two prevalent major healthcare concerns that frequently coexist. Several studies reported correlation between lower values of Bone Mineral Density (BMD) and cardiovascular events. Furthermore literature suggests that cardiac calcification (assessed by Global Cardiac Calcium Score, GCCS) is associated with cardiovascular events and mortality. This study aimed to evaluate if cardiac calcium deposit was correlated with BMD.
Methods: In 36 subjects assessed for bone fracture risk (mean age 72±5,7 yrs) we measured BMD at lumbar spine (BMD-LS) at femur (Neck: BMD-FN; Total: BMD-FT) and we assessed with echocardiography a GCCS. GCCS is a semi-quantitative score, witch assigns points for calcification in the aortic root and valve, mitral annulus and valve and sub-mitral apparatus, and points for restricted leaflets mobility(1).
Results: We found a significant inverse correlation between BMD-FN and BMD-FT with GCCS (r=-0,285, p<0,05 and r=-0,376, p<0,05 respectively); while there wasn't significant correlation between BMD-LS and GCCS. Dividing patients based on presence of bone fragility fractures (13 patients with fragility fractures and 23 without) we observed that GCCS was higher in patients with fragility fractures (2,54±1,3 *Vs* 2,30±1,5) but not statistically significant. Moreover, dividing patients based on the presence of sarcopenia (9 with sarcopenia and 27 without) we found that GCCS was higher in sarcopenic patients (3,0±1,4 *Vs* 2,1±1,4) even though the difference didn't reach statistical significance.
Conclusions: Our data suggest link between osteoporosis and cardiac calcification. The burden of cardiac calcium seems to be higher in patients with fragility fractures, confirming that osteoporotic patients have higher risk of cardiac and vascular calcification and then greater risk of cardiovascular events.
(1) Lu ML *et al.* J AmSocEchocardiogr. (2016).

A challenging diagnosis of pulmonary vasculitic involvement: a case report

G.F. Casciaro[1], R. Landi[1], M.G. Cittone[1], M. Bigliocca[2], S. Pittau[2], G. Zaccala[2], F. Bobbio[2], M. Bellan[1], M. Pirisi[1], M. Campanini[2]

[1]SCDU Medicina Interna 1, AOU Maggiore della Carità, Novara; [2]SCDO Medicina Interna 2, AOU Maggiore della Carità, Novara, Italy

Background: Granulomatosis with polyangiitis (GPA) is an antineutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis, typically involving the respiratory tract, kidneys, and less frequently skin, eyes and nervous system.
Case report: An 82-year-old Caucasian male was admitted to our department because of a recent onset dyspnea, dry cough and fever with chills. Blood pressure was 135/80 mmHg, heart rate 119 bpm and oxygen saturation 90% on room air. Physical examination revealed basal crackles on both lungs, and a tachycardic pulse. Blood cell count was normal, as well as creatinine and urinalysis. C-reactive protein was elevated (17.76 mg/dl) and the blood gas analysis revealed a type 1 acute respiratory failure. A chest X-ray was performed, showing multiple bilateral medio-basal pseudo-nodular areas associated with pleural thickening. Despite three lines of antimicrobial regimen, the patient remained febrile with high inflammatory markers. A high resolution-CT scan reported multiple small not-calcific nodules in both lungs with central excavation. Blood cultures and procalcitonin were negative; PR3-ANCA were positive (93.9 UI/ml; normal range 0.0-5.0). Given the high suspicion for GPA, we started iv steroids, with remission of fever and clinical improvement, allowing the discharge after 29 days of hospital stay.
Conclusions: This case shows how challenging the diagnosis of a rare disease can be, especially when a single organ or system is involved, when a large variety of differential diagnosis should be considered.

Outcome of patients and incidence of *Neisseria meningitidis* admitted in Emergency Wards: results from two-years retrospective study in a large teaching italian hospital

L. Castellani[1], A. Battaglini[2], I. Barberis[2], F. Grammatico[2], A. Ferrazzin[3], M. Spadaro[1], M.G. D'Angelo[1], M. Morfino[1], E. Arboscello[1], P. Costelli[1], A. Orsi[2]

[1]Dipartimento di Emergenza, Ospedale Policlinico San Martino Genova; [2]Dipartimento di Scienze della Salute, Ospedale Policlinico San Martino Genova; [3]Dipartimento di Medicina Specialistica, Ospedale Policlinico San Martino Genova, Italy

Introduction: Invasive meningococcal disease (IMD) is a significant clinical condition in Emergency Room (ER) and its burden is also an important issue in public health. Sometimes patients have access to ER with aspecific septic signs, such as fever, and often diagnosis is delayed. We evaluated incidence of IMD and outcome of patients over a 2-year period in our hospital.
Methods: A retrospective study was conducted on patients admitted to Policlinico San Martino, a tertiary adult acute-care teaching hospital in Genoa. From 1.1.2017 to 31.12.2018, all patients with a confirmed diagnosis by molecular or microbiological tests for *N. meningitidis*, were identified through the hospital laboratory database. Time of hospitalization and mortality rate were also analyzed.
Results: We found 14 confirmed cases. The median age was 52 years. The average length of stay was of 13,5 days (1-43). We observed 4 cases in 2017 and 10 in 2018. Eight (57%) patients were hospitalized in Intensive Care Unit and 6 (43%) in Infectious Diseases Ward. One was transferred in Cardiology Unit for a rare case of meningococcal myocarditis.
Conclusions: According to the literature, our study confirms that IMD is a rare infectious disease with high mortality and morbility. We observed an increase of IMD cases in the last year with some unusual presentations. Considering these data, we developed a specific protocol that recommend to suspect IMD in all patients with aspecific septic signs and to use fast diagnostic tests as RT-PCR, in order to optimize the management of IMD patients.

Less is more: not always

C. Cattabiani[1], B. Petroboni[1], F. Toffolon[1], N. Rizzi[1], M. Giorgi Pierfranceschi[2]

[1]UO di Medicina Interna, Ospedale Maggiore, ASST Cremona; [2]UO di Medicina Interna, Ospedale Maggiore, ASST Cremona, Italy

Background: Autoimmune pancreatitis (AIP) is a disease with characteristic clinical (obstructive jaundice, pancreatitis), radiological (enlarged pancreas or mass), and serologic features (elevated serum IgG4) affecting the pancreas with the ability to involve other organs. Given the clinical presentations, the exclusion of cancer is necessary before considering AIP.
Case report: Male, 50 yr old, entered for abdominal pain, diarrhea, weight loss and sudden appearance of jaundice. Blood samples confirmed a total bilirubin of 12,5 mg/dl (direct Bil 7,3 mg/dl, ALT 244 U/L, AST 124 U/L) and abdominal US reveals a dilated biliar ways. The patient underwent abdominal CT scan which highlighted dilated biliar ways due to a concentric lesion of choledochus and dyshomogeneity of pancreas. CA 19.9 was 627 U/ml. The diagnostic hypothesis was cholangiocarcinoma; but because the uncommon characteristics of the lesion, we decided to proceed with an echoendoscopy and the suspect of AIP emerged. Patient underwent abdominal RM and IgG4 dosage. High dose steroid therapy (0.75 mg/kg) was started and imaging tests were repeated 2 weeks apart, demonstrating an improvement of the radiological, together with clinical and laboratoristic findings. IgG4 was increased, so the disease was classified as typel AIP, with extra-hepatic IgG4-related cholangitis.
Conclusions: Given the clinical features of AIP, the differential diagnosis with the neoplastic cause must be considered. Imaging can be misleading, so in suspicion of autoimmune inflammation, one more investigation is better than one less!

Are the diagnostic algorithms contained in the syncope guidelines applicable to patients admitted to Internal Medicine?

R. Cattaneo[1], S. Colombo[1], A. Mazzone[1]

[1]ASST Ovest Milanese, Medicina Interna, Ospedale di Legnano, Legnano (MI), Italy

In the syncope guidelines, the hospitalization is expected only in a small percentage of cases and, if indicated, in specific hig-observation departments (the Syncope Units). However, in the daily clinical practice a significant number of patient with syncope is allocated in the departments of Internal Medicine. The recent guidelines propose various diagnostic algorithms and risk scores for syncope. The use of Holter ECG is not considered first choice anymore because considered of low diagnostic power. Instead, if necessary, are indicated more complex and not free of risk procedures, such as carotid sinus massage or loop recorder implantation. However, we wanted to verify the usefulness of a simple and non-invasive test like the ECG-Holter on real patients, admitted to observation in the Internal Medicine Department with diagnosis of syncope. We performed Holter monitoring on 74 consecutive patients, admitted to our department, with the diagnosis of syncope, over a period of 16 months. In 5 cases (6.7%) the examination was positive for pathological pauses and the patients underwent PM implantation. In 1 case (1.3%) episodes of ventricular tachycardia occurred; in 3 cases (4.05%) a paroxysmal supraventricular tachycardia, in 3 cases (4.05%) a paroxysmal atrial fibrillation. Overall patients who had a pathological report were 12 (16.1%). Even in the smallness of our case studies, we can see that in patients admitted to the medical department, with syncope diagnosis, a simple and inexpensive ECG-Holter test can diagnose a non-indifferent percentage of abnormal heart rhythms.

An atypical case of dilated cardiomyopathy with severe mitral regurgitation

F. Cei[1], D. Di Stefano[1], S. Brancati[1], S. Dolenti[1], I. Micheletti[1], R. Tarquini[1]

[1]Medicina Interna 1, Ospedale San Giuseppe, Empoli (FI), Italy

Background: Differential diagnosis of dilated cardiomyopathy is challenging. The most common etiologies are ischemic and hypertensive cardiomyopathy, but also toxic, infective, and congenital forms should be excluded in adult with acute heart failure.
Case report: A black homeless man aged 49 came to our observation for dyspnea, chest pain and nonproductive cough. He had history of chronic gastritis. He was hospitalized few months before in cardiology division for dilated cardiomiophaty with reduced EF (36%); a negative coronary angiography was performed. At admission, he was haemodynamically stable, afebrile; at ABG he had mild normocapnic hypoxemia, Nt-pro-BNP was 2600 pg/mL. Alcoholic myopathy was suspected, but repeated sonography showed dilated left ventricle with apical and lateral trabeculation, basal akinesia, severe left atrial enlargement and severe mitral regurgitation, with moderate pulmonary hypertension (PAPs 50mmHg), picture compatible with ventricular noncopaction. Therapy with bisoprolol, ramipril and potassium canreonate was begun. Post-discharge cardiac MRI was performed and diagnosis was confirmed. He was transferred to a cardiac surgery division, and cardiac transplant was recommended, but stopped for the finding of unknown pulmonary neoplasm.
Conclusions: Noncompaction cardiomiopathy is a rare condition, cause of severe mechanical and functional disease. In mild to moderate cases of dilated forms, guidelines now suggest the same medical therapy of reduced EF heart failure. Mechanical complication can lead to invasive and surgical treatment.

Continuous *vs* Discontinuous dual antiplatelet therapy in patient with recent drug-eluting coronary stent implantation and massive bleeding of duodenal ulcer, in hp-infection: a case report

C. Cerasi[1], P. Vertolli[1], M. De Feo[1], E. Biferi[1], E.G. Onori[1], A. Viscido[1], C. Ferri[1]

[1]Università degli Studi dell'Aquila, Dipartimento MESVA, Coppito (AQ), Italy

Introduction: The double antiplatelet therapy (DAPT) is currently a certitude after medicated coronary stent implantation. The dilemma of clinicians is to monitor the risk of gastrointestinal bleeding (GIB), choosing the PPI that less interferes with antiplatelet activity. When GIB occurs, becomes difficult to balance the risk of re-thrombosis and that of re-bleeding.
Case report: A 55-year-old man, recently underwent a medicated coronary stent implantation, in DAPT with ASA and clopidogrel, in ranitidine use, come to our Division for hypovolemic shock, due to massive upper GIB. Hb was 9 g/dl. An EGD showed duodenal ulcer with visible vessel endoscopically treated. The patient was treated with PPI IV, blood transfusion until hemodynamic stabilization. At 48 hours ASA was reintroduced. The search for H.Pylori was positive, so he started eradication. Eight days after the event, for the stabilization of Hb, clopidogrel was reintroduced with pantoprazole.
Discussion: The combination of antiplatelet drugs after PCI with stent implantation, is associated with an increased risk of bleeding, with an incidence of 0.7-2.4% at 30 days. The greatest risk in case of suspension of DAPT is that of stent thrombosis. The decision whether and for how long to interrupt DAPT is the most controversial point in the management of the patient with GIB after PCI, because there is no evidence about it. There is no doubt in the literature about the recommendation to resume ASA-therapy as early as possible. Risk minimization of future GIB is possible with eradication of HP and appropriate use of PPI.

Gli effetti renali di Sacubitril-Valsartan nel paziente con scompenso cardiaco acuto da sindrome nefro-cardiaca

M. Chiappalone[1], N. Laganà[1], S. Caruso[1], G. Lorello[1], A. De Gaetano[1], M.C. Tringali[1], D. La Rosa[1], F. Mamone[1], C. Quartarone[1], V. Natale[1], F. Napoli[1], A.G. Versace[1]

[1]AOU Policlinico, Dipartimento di Medicina Clinica e Sperimentale, Messina; [2]AOU Policlinico, Dipartimento Medicina Clinica e Sperimentale, Messina, Italy

Premessa e Scopo dello studio: Obiettivo dello studio è valutare gli effetti renali di Sacubitril/Valsartan in soggetti con scompenso cardiaco a FE ridotta e sindrome cardio-renale cronica.
Materiali e Metodi: Sono stati arruolati 15 pazienti affetti da scompenso cardiaco a FE ridotta trattati con Sacubitril/Valsartan in OMT da almeno 6 mesi. All'inizio del trattamento (T0), dopo 3 mesi (T3) e dopo 6 mesi (T6) sono stati valutati i seguenti parametri: classe NYHA, funzione renale (secondo CKD-EPI), FE tramite ecocardiogramma, pressione arteriosa sistolica. Di questi 15 pazienti: 8 assumevano Sacubitril/Valsartan 24/26 mg bid; 5 Sacubitril/Valsartan 49/51 mg bid; 2 Sacubitril/Valsartan 97/103 mg bid.
Risultati: Degli 8 pazienti in trattamento con Sacubitril/Valsartan 24/26 mg: 2 hanno sospeso il trattamento a T6 per il peggioramento della clearance; in 4 la clearance si è mantenuta stabile, in 2 c'è stato un miglioramento della stessa dopo 6 mesi di trattamento. Nei 5 pazienti in trattamento con Sacubitril/Valsartan 49/51 mg: 4 hanno avuto un lieve peggioramento della clearance; 1 un miglioramento della stessa. Nei 2 pazienti in trattamento con Sacubitril/Valsartan 97/103 mg, in 1 la clearance è lievemente peggiorata e nell'altro è lievemente migliorata. In tutti c'è stato un lieve miglioramento della FE T3, risultata notevolmente migliorata dopo T6 di terapia. Al fine di valutare l'effetto di Sacubitril/Valsartan sulla clearance, abbiamo messo in evidenza le loro comorbidità nefropatiche: tutti i pazienti avevano già compromissione della clearance, 5 avevano anche DMT2, 5 avevano anche Ipertensione Arteriosa, in 2 coesistevano tutte le suddette patologie.
Conclusioni: Il trattamento con Sacubitril/Valsartan ha migliorato i parametri emodinamici con aumento della FE, migliorato la qualità di vita dei pazienti con riduzione della classe NYHA, peggiorato leggermente la clearance, soprattutto in coloro i quali la funzionalità renale era già compromessa.

Chronic obstructive pulmonary disease. The contribution of the Guidelines to a "good practice" of a new care model of management and costs of this chronicity

A. Ciamei[1], G. De Filippi[1], G. De Riggi[2], M. Lallini[1], D. Cepiku[3]

[1]MD Internal Medicine, Hospital Velletri, ASL RM6 Lazio; [2]Internal Medicine, Hospital Velletri, ASL RM6 Lazio; [3]Associate Professor Public Management & Governance Department of Management and Law University Tor Vergata, Rome, Italy

Background and Aim of the study: COPD (Chronic Obstructive Pulmonary Disease) is chronic disease involving high morbidity and mortality. Correct diagnosis and pharmacotherapy improve quality of life reducing COPD exacerbations. In Italy COPD affects 6 million people, his economic cost on public health exceeds 10 billion euros. Aim of the study is to analize the clinical and managerial effect, according the GOLD guidelines, of a new care management model "network based" of patients whith COPD at the baseline and for 1 year. The clinical data from a prospective cohort have involved healthcare professionals (HCPs) from Hospital, Local Health Organization and Primary Care in 2 countries of the Latium Italy.
Materials and Methods: 187 COPD patients 59% male mean age 70 years are given CAT test to collect clinical and anamnestic data. Both the severity degree, evaluated by the study board by all HCPs of the program and compared the observed severity distributions, and the patient's pharmacologic treatment was performed according the GOLD guidelines.
Results: 65% of patients showed cardiovascular comorbidity, evaluation of HCPs swowed trend of concordance in classification in 43%, gravity was undervalued from primary care HCPs in 46% and overvalued in 11%. Moreover at 1 year we have observed no hospital admission for COPD esacerbation.
Conclusions: This innovative health care program may contributes to the appropriateness of diagnosis and care of COPD representing a goal for a "good practice" of chronicity management, reducing hospitalization moreover of COPD costs.

Correlation TR velocity-Miller Score. "Risco" Study: comparative analysis with student test in 30 patients with venous thromboembolism. Three-years experience (2016-2018)

M.M. Ciammaichella[1], R. Maida[1]

[1]Medicina d'Urgenza, AO S. Giovanni, Roma, Italy

Premises and Purpose of the study: The "RISCO" study, acrostic deriving from "tRicuspidal regurgitation - mIller SCOre", enrolled 30 patients with venous thromboembolism admitted in the three-year period January 2016-December 2018. In all patients, pre- and post-lyses the Miller angiographic score (Miller Score and the TR pre-lysis was measured.) The study proposes the following objectives: to verify possible relationships between the values of the TR velocity pre-lysis and of the Miller Score pre-lysis and verify the statistical significance found by applying the Student's "t" test.
Materials and Methods: The test then calculates the relative value (VR) of the t index to be associated with the difference found according to the following formula: $t=(M1-M2)/\sqrt{DS12/N1 +DS22/N2}$.
Results: Student's "t" test applied to the 30 patients shows a highly significant correlation ($p < 0.001$) of the two variables examined and, therefore, not attributable to the case. In fact, the value of "t" obtained is 30.64 and the VC (critical value) of "t" for $p=0.001$ is 3.659 with GL=29.
Conclusions: The "RISCO" study showed that in the group of 30 patients there is a highly significant correlation between the two variables considered: TR velocity pre-lysis and Miller Score pre-lysis. This correlation shows an absolute positive concordance according to the Student's comparative analysis "t" test and is an expression not of a random association but of a close correlation between the pre-defined TR velocity values and the pre-arranged Miller Score values.

Isolated ophthalmic IgG4-related disease: a case report

S.A. Ciampi[1], A. Cirulli[1], S. Noviello[1], M. Prete[1], A. Vacca[1]

[1]Medina Interna "G. Baccelli", Policlinico di Bari, Italy

Background: IgG4-related disease (IgG4-RD) is a fibro-inflammatory condition with a tendency to form tumors, which may affect virtually every organ and tissue. Ophthalmic disease may present as dacryoadenitis, myositis or involvement of other orbital tissue. The diagnosis is based on clinical presentation, laboratory test, radiological characteristics and distinct histopathological features. Corticosteroids and immunosuppressive drugs represent the mainline treatment.
Case report: A 46 year-old man was admitted to our Department for left proptosis. He referred proptosis of right eye associated to diplopia nine year before our evaluation, resolved after surgical intervention. The patient did not refer systemic symptoms. Study of inflammatory indices, test for infectious diseases or autoimmunity were negative, thyroid hormones were in normal value. The patient underwent head MR demonstrating involvement of inferior rectus muscle with edema and contrast enhancement. Total body CT did not show other alterations. A biopsy of orbital tissue was performed to exclude malignancy: histological examination revealed fibrosis of the muscle. Serum IgG4 was twice the normal value. A diagnosis of ophthalmic IgG4-RD was made and therapy with Prednisone and Methotrexate was administered with resolution of symptoms.
Conclusions: Proptosis can be caused by a variety of condition. IgG4-RD could be one of this and require prompt suspicion and differential diagnosis approach, because of its chronic and progressive development if immunosuppressive therapy is not administered.

Visceral leishmaniasis

R. Cipriani[1], M. Papa[1], G. Cadau[1], L. Anticoli Borzi[1], C. D'Ambrosio[1], E. Anzalone[2], P. Fabrizi[2], G. Farinelli[2], K. Casinelli[2]

[1]Internal Medicine Department, Frosinone Hospital, Frosinone; [2]Infectious Disease Department, Frosinone Hospital, Frosinone, Italy

Background: Visceral leishmaniasis (VL) also known as kala-azar, is the most severe form of leisahmaniasis and, without proper diagnosis and treatment, is associated with high fatality.
Case report: We describe a case of a 77-years-old male patient from the southern part of Lazio that came to our observation for 2 months history of fever, anemia, weight loss and skin itching. The medical examination showed splenomegaly, confirmed by sonogram, and laboratory test showed pancytopenia and hypergammaglobulinemia; blood cultures were negative and hearth sonography was normal too; urine culture was positive for *Klebsiella pneumoniae* and specific therapy was started without improvement of fever. The patients started hematologic screening for pancytopenia and splenomegaly; HIV serology tested negative. Anti-Leishmania Antibodies were tested too and they resulted positive with a title of 1:320 and the patient was started on liposomial amphotericin B; within 48 hrs from treatment the patient became afebrile, amphotericin was continued for 5 days and repeated on day 14th and 21th . The patient was seen 1 month later in good clinical and laboratory parameters.
Conclusions: The clinical picture of visceral leishmaniosis is variable and often indistinguishable from that of other diseases including hematologic disorders. In endemic areas the presence of fever, weight loss, massive splenomegaly, anemia, leukopenia and hypergammaglobulinemia is highly suggestive of visceral leishmaniosis and should prompt specific investigation since it can be a deadly disease if not diagnosed and treated.

Valutazione delle principali correlazioni con la mortalità nei pazienti ricoverati dal Pronto Soccorso per polmonite: studio multicentrico presso il Pronto Soccorso dell'Ospedale San Paolo e dell'Ospedale Niguarda, Milano

L. Colombo[1], S. Pasini[2], P. Pugliese[3], S. Colombo[3], G. Rossignoli[1], E. Clerici[1], I. Rusconi[1], A. Macheda[1], F. Castagna[1], F. Silini[1], F. Panizzardi[1]

[1]Pronto Soccorso, DEA Ospedale Santi Paolo e Carlo, Presidio San Paolo, Milano,; [2]Medicina Interna, Ospedale Maggiore di Lodi, ASST Lodi; [3]Pronto Soccorso, Medicina d'Urgenza Ospedale Niguarda, Milano, Italy

Premesse e Scopo dello studio: La stratificazione del rischio di mortalità nel paziente ricoverato dal Pronto Soccorso con polmonite non è adeguatamente predetta dagli scores abitualmente in uso, come il CURB65 ed il PSI: il primo ha bassa sensibilità, il secondo bassa specificità. Scopo dello studio è di valutare le principali correlazioni con la mortalità entro un mese, nei pazienti ricoverati dal PS per polmonite.
Materiali e Metodi: Di un studio prospettico che ha valutato i ricoveri dal PS per infezione di qualsiasi origine (in totale 542 pa-

zienti >18 anni), tra il marzo e giugno 2017 negli Ospedali San Paolo e Niguarda di Milano, abbiamo valutato quelli per polmoniti (criteri clinici e radiologici), quindi abbiamo considerato le principali variabili correlate alla mortalità.
Risultati: 214 pazienti (62.1% maschi), divisi in due gruppi 181 dimessi e 31 morti (14.4%): le variabili correlate alla mortalità sono state: età (71.2 *vs* 82.7anni, p<0.001), allettamento (18.1% *vs* 51.6%, p<0.001), utilizzo di antibiotici nel mese precedente (32.4% *vs* 54.8%, p<0.01), recente ospedalizzazione (<1 mese) o provenienza da una RSA (15.5% *vs* 32.2%, p<0.05), creatininemia (1.2mg/dL *vs* 2.1mg/dL, p<0.001). Inoltre un qSOFA <=2 all'arrivo in PS aveva un'elevata specificità (91.1%).
Conclusioni: Nel contesto del PS per la stratificazione del rischio di mortalità nei pazienti ricoverati per polmonite, riteniamo essenziale valutare adeguatamente le predisposizioni di base del paziente, il qSOFA a cui aggiungere la funzionalità renale. Lo studio proseguirà per ampliare la casistica.

Management in Medical Department of patients at end of life: a prospective cohort study of consecutive terminal patients

G. Conte[1], A. Roveda[1], A. Gallo[1], E. Salsano[1], M. Lucchini[1], F. Dentali[1]

[1]Dipartimento di Medicina e Chirurgia, Varese, Italy

Background and Aim of the study: Care of dying people should be aimed at their comfort, avoiding interventions that may cause discomfort or pain. However, physicians are often in trouble in deciding when and which drugs interrupt. Hence, we have conducted a prospective cohort study in order to evaluate end-of-life management in medical patients.
Methods: We have selected 10 consecutive terminal patients treated in medical department of the Varese hospital. We have collected information about basic features, comorbidities, medications in use within 7 days to death or to transfer to the palliative care unit, and reason for the end of life.
Results: Among the 10 patients (mean age 80.3 years), 7 died during hospitalization and 3 were sent to palliative care unit. Terminal illness was haematological cancer in 3 patients, heart failure in 3 patients and advanced dementia in 2 patients. Besides sodium chloride e.v solution and analgesic drugs, patients were treated with a mean of other 8 drugs. Nine patients were treated with antibiotics, 7 with an antithrombotic drugs, and 5 with protonic pump inhibitors. Parenteral nutrition was maintained in 6 patients and 3 patients underwent transfusion of blood products; 2 patients were treated by NIV. All the patients had at least two blood tests during the period of observation. The vast majority of patients had at least one instrumental examinations including computer tomography and magnetic resonance imaging.
Conclusions: Besides palliative care, a lot of inappropriate treatments and examinations were performed in terminal patients.

Fattori di rischio per fibrillazione atriale di nuova insorgenza e prognosi in una coorte di pazienti BPCO ricoverati in Medicina Interna

L. Corbo[1], O. Para[1], N. Pasqui[1], F. Bacci[1], M. Finocchi[1], M. Ronchetti[1], E. Blasi[1], G. Galante[1], F. Pieralli[1], C. Nozzoli[1]

[1]AOU Careggi, Firenze, Italy

Lo scopo del nostro studio è quello di determinare i fattori di rischio per lo sviluppo di FA di nuova insorgenza e di identificare i fattori prognostici in relazione all'outcome inteso come mortalità intraospedaliera in una coorte di pazienti con rilievo anamnestico di BPCO ricoverati presso un reparto di Medicina Interna. Abbiamo condotto uno studio prospettico osservazionale arruolando consecutivamente pazienti con storia di BPCO in anamnesi che non avevano mai avuto episodi di FA e che erano in ritmo sinusale all'ingresso in pronto soccorso e in reparto e suddiviso i pazienti in due gruppi sulla base dello sviluppo di un primo episodio di FA durante la degenza. Abbiamo quindi confrontato le caratteristiche demografiche, cliniche, laboratoristiche dei 2 gruppi. Abbiamo infine identificato i fattori di rischio per lo sviluppo di FA e i fattori prognostici. Abbiamo arruolato 194 pazienti con BPCO, 45 con insorgenza di FA durante il ricovero e 149 senza insorgenza di FA. La nostra coorte era rappresentata da pazienti affetti da multiple comorbidità (51,55% affetti da più di 3 comorbidità, CHADVASC medio=4 nei due gruppi).L'insorgenza di FA durante il ricovero era associata ad una maggiore durata della degenza (8,47±5,35 *vs* 7,93±5,01 giorni) e ad un aumento della mortalità intraospedaliera (OR=3,06 *vs* OR=0,46). All'analisi multivariata i fattori di rischio per lo sviluppo di FA di nuova insorgenza sono risultati: sepsi (OR=3,57, p=0,0289) e scompenso cardiaco (OR=6,38, p=0,005) come motivo di ingresso, pregresso stroke in anamnesi (OR=2,86, p=0,027), valori di Proteina C reattiva >36,5 mg/L (OR=2,78, p=0,036) e glicemia >135,5 mg/dL (OR=2,42, p=0,023) all'ingresso in reparto. Per quanto riguarda i fattori prognostici, all'analisi multivariata sono risultati significativamente associati ad un outcome avverso: l'insorgenza di FA durante il ricovero (OR=4,310, p=0,043) ed un valore di PCR maggiore di 56,5 mg/L (OR=6,33, p=0,029) all'ingresso.

Neurotoxoplasmosis

L. Corbo[1], M. Giampieri[1], C. Florenzi[1], G. Galante[1], E. Blasi[1], L. Maddaluni[1], F. Rocchi[1], V. Turchi[1], M. Ronchetti[1], C. Nozzoli[1]

[1]AOU Careggi, Firenze, Italy

A 35-year old female patient was admitted to our hospital with fever and hematuria. The patient's history included previous thyroidectomy and chronic myeloid leukemia with onset as a blast crysis. She had undergone allogeneic bone marrow transplantation (BMT) 1 month before admission. She was on ciclosporin and posaconazole regimen. Her neutrophilic count at admission was $2{,}02x10^9$/L. Hemocolture and urinocolture were negative. No sign of infections was seen on thorax x-ray, abdominal ultrasound and echocardiography. Cytomegalovirus DNA and BK DNA quantitative *PCR*s were positive on blood. She was treated with meropenem and valganciclovir without defervescence. After 15 days of hospitalization, because of the persistence of fever and a new-onset headache, a brain computer tomography (CT)-scan was performed. The CT-scan showed two low-density lesions. Multiple space occupying lesions with ring enhancement involving the cerebellum, brainstem and cerebrum were seen on magnetic resonance imaging (MRI), suggestive for neurotoxoplasmosis. We started therapy with trimethoprim/sulfamethoxazole with defervence, disapparance of headache and transferred the patient to an infectious diseases ward. A rachicentesis was also performed: Toxoplasma DNA qualitative PCR was positive. Toxoplasma gondii is a ubiquitous obligate intracellular protozoan parasite which causes an asymptomatic infection or fever and lymphadenopathy (primary infection) in immunocompetent patients. In immunocompromised patients, it may cause life-threatening infection, such as disseminated infection and neurotoxoplasmosis. Toxoplasmosis after BMT is a rare complication due to the reactivation of latent infection. The most frequently involved organ is the central nervous system, but also disseminated infection is common in immunocompromised patients. Diagnosis is made on serology, CT/MRI scans (for neurotoxoplasmosis) and PCR on blood or Cerebro Spinal Fluid.

Sepsis caused by producing of extended-spectrum β-lactamases *Klebsiella pneumoniae*: a case report

M. Costa[1], G. Marchese[1], L. Scuotri[1], R. Borghi[1], E. Bernero[1], G. Querci[1], L. Incerti Vecchi[2], M. Carrieri[3], L. Camellini[4], S. Artioli[1]

[1]SC Medicina Interna, POU del Levante Ligure, ASL 5, La Spezia; [2]SSD Medicina Fisica e Riabilitazione, ASL 5, La Spezia; [3]SC Radiologia, ASL 5, La Spezia; [4]SC Gastroenterologia e Endoscopia Digestiva, ASL 5, La Spezia, Italy

Background: It is known that systemic infections caused by gram-negative bacteria can cause organ failure and microcirculatory alterations.
Case report: A 68 year old man was admitted to the Department of Internal Medicine for fever, pain in the left lumbar region, signs of distal hypoperfusion at the hands and feet bilaterally. In anamnesis: smoker, previous bladder neoplasm. Blood tests: WBC 12 x $10^3/\mu$L, CRP 19 mg/dl, PCT 19 ng/ml, DDimer 16.000 ng/ml,

Creatinine 1.5 mg/dl. Culture tests: isolation of producing ESBL *Klebsiella Pneumoniae* on blood and urine. Trans-thoracic echocardiogram: no endocarditic vegetations. Thorax-abdomen CT: signs of pyelonephritis left kidney. FDG-PET: high FDG uptake in the abdominal aorta lateral wall suggestive for infectious aortitis, in the cervical spine and ascending colon. NMR cervical spine: signs of spondylodiscitis. Colonoscopy: polyposis of the ascending colon. Targeted antibiotic therapy was established, firstly, with Meropenem and Tigecycline, successively with Meropenem and Cotrimoxazole obtaining defervescence and reduction of inflammatory indices; signs of critical ischemia persisted. The immunological screening excluded autoimmune vasculitis. In the suspicion of obliterative thromboangioitis therapy was established with acetylsalicylic acid and prostaglandin analogs obtaining gradual improvement of symptoms.
Conclusions: pyelonephritis can be complicated by distant phlogistic outbreaks (in our case spondylodiscitis and aortitis); the septic state, in predisposed subjects, can support inflammatory thrombosis of small vessels.

The Citimem Study: citicoline plus memantine in aged patients affected with Alzheimer's disease and mixed dementia study. Preliminary data

A.M. Cotroneo[1], S. Putignano[2], P. Gareri[3]

[1]ASI Città di Torino; [2]ASI Napoli; [3]ASP Catanzaro, Italy

Citicoline can have beneficial effects both in degenerative and in vascular cognitivedecline; it works through an increase in acetylcholine intrasynaptic levels and by promotingphospholipid synthesis, cellular function, and neuronal repair. Memantine is an N-methyl-D-aspartate (NMDA) receptor antagonist used for the treatment of mild to moderate Alzheimer's disease (AD). When coadministered they could have a synergistic action inpatients affected with AD and mixed dementia (MD) too. The aim of the present study was to show the effectiveness of oral citicoline plus memantine in patients affected with AD and MD. This was a retrospective study between 2015 and 2017 on 120 patients consecutive patients aged 65years old or older affected with AD or MD. 58 patients were treated with memantine (group A), 62 patients with memantine plus citicoline1g/day given orally (group B). In both groups memantine dosage was 10-20 mg/day according to itstolerability. 22 patients of group A and 27 patients of group B were affected with MD. Cognitivefunctions were assessed by MMSE, daily life functions by ADL and IADL, behavioral symptoms by NPI,comorbidities by CIRS, and mood by GDS-short form. Tests were administered at baseline (T0), after 6(T1), and 12 months (T2). The primary outcomes were the effects of combined treatment *versus* memantine alone on cognitive functions assessed by MMSE. The secondary outcomes were possible side effects or adverse events of combination therapy *versus* memantine alone, influence on daily lifefunctions and behavioral symptoms. Patients treated with citicoline plus memantine showeda statistically significant increase in MMSE between T0 and T1 (16.6±2.69 *vs* 17,4±2.71; p=0.000)and between T1 and T2 (17,4±2.71 *vs* 17.7±2.8; p=0.000).Since it is important tomaximize the present pharmacological means in AD and MD, this study encourages the role ofcombined administration of memantine plus citicoline in disease management by slowing disease progression.

Noninvasive ventilation in acute respiratory failure: Trento/Rovereto experience

S. Cozzio[1], L. Lenzi[1], F. Pugliese[1], E. Vettorato[1], F. Caliari[1], W. Spagnolli[2]

[1]APSS Medicina Interna, Rovereto (TN); [2]APSS Medicina Interna, Trento, Italy

Background: Noninvasive ventilation (NIV) use has become more common as its benefits are increasingly recognized. Conditions known to respond to NIV are: exacerbations of chronic obstructive pulmonary disease complicated by hypercapnic acidosis, cardiogenic pulmonary edema, acute hypoxemic respiratory failure. NIV appears to decrease incidence of nosocomial infections and reduces the frequency of invasive ventilation (IV). In Trentino the use of NIV in Internal Medicine hospital wards started in 2014, with the intensity of care based reorganization, with full self-management of NIV by internists.
Methods: Analisys of diagnosis-related group (DRG) 87-88-89, referred at 2017. From these data, we considered only 244 patients of Internal Medicine of Trento and Rovereto, where the unit has a high intensity care section. In 2017, after 3 years, the team stability of High Intensity ward (physicians and nurse staff) was performed. The staff training continued.
Results: During a period of 12 months 137/244 (56%) patients were treated with NIV. Inhospital mortality was 18% (24 p), 8% (11 p) needed IV in Intensive care unit and 102 patient (74%) were discharge without serious complications.
Conclusions: Currently many patients are treated with safe and effective NIV in Internal Medicine with high care organization. The success rate could be high also among do-not-intubate patients, despite their comorbidity. These results encourage the prompt use of NIV and the implementation of the selection of acute respiratory patients who need intubation.

Chronic thromboembolism and pulmonary hypertension

M.C. Crisci[1], S. Neri[1], I. Timpanaro[1], C. Sgroi[1], D. Morana[1], L. Incorvaia[1], C. Virgillito[1], C. Di Mauro[1], I. Morana[1]

[1]Medicina Area Critica ARNAS Garibaldi, Catania, Italy

Pulmonary hypertension (PH) is present in multiple clinical conditions which have been classified in five groups. The aim of our overview is to follow-up patients affected by PH (group 1) and by chronic thromboembolic pulmonary hypertension – CTEPH- (group 4). 172 patients diagnosed with pulmonary embolism and hospitalized in our division from 2014 to 2017 will be admitted to our case study. The recruitment of patients will happen in collaboration with 20 general practitioners from the Catania area. The main requirements for suspected PH are: patients with known hearth and pulmonary diseases, with severe dyspnea; patients without a diagnosis of left-sided heart failure and pulmonary diseases but with dyspnea and severe hypoxemia; a group of symptoms (dyspnea, asthenia, easy fatigue, syncope) in patients affected by PH, pulmonary embolism and deep-vein-thrombosis. Selected patients will undergo a 6-minute walking test (so as to assess the tolerance to physical activity), echocardiogram (to evaluate tricuspid regurgitant velocity), spirometry (to exclude pulmonary parenchymal injuries). Patients diagnosed with CTEPH will be referred to second-level and third-level centers for surgical treatment. Patients either not suitable as surgical candidates, or with persistent or recurrent CTEPH, will be treated with RIOCIGUAT. Untreated CTEPH can lead to progressive right-sided heart faillure and death, therefore it is crucial to recognize this underdiagnosed pathology in time.

Proton pump inhibitors treatment not influenced the incidence and outcome in patients with acute ischemic stroke with risk of reflux-related lung disease

P. Crispino[1], D. Colarusso[1]

[1]Unit of Internal Medicine and Urgency, San Giovanni Hospital, AOR San Carlo, Lagonegro (PZ), Italy

Background: Proton pump inhibitors (PPI) are commonly used in patients with acute ischemic stroke to prevent anticoagulant and antiaggregants-related gastro-intestinal bleeding. Oropharyngeal dysphagia and the resultant aspiration are for these patients an important life-threatening risk for reflux-related lung disease. There is little data to support a positive or negative PPI influence in outcome of these patients. Infact this therapeutical approach had potential benefit and the potential risk of opportunistic pneumonia. The aim of this study was to determine if there is an association between hospitalization risk in these patients with oropharyngeal dysphagia and treatment with PPI.
Methods: Records of 300 acute ischemic stroke patients with dysphagia recovered in our center site of stroke team were reviewed. Participants included 193 man and 103 women with evidence of aspiration or penetration on swallow clinical study.
Results: A total of 300 patients with a mean (SD) age of 88.4

(10.4) months were retrospectively studied in a time of 38 months and included in the analysis. Patients treated with PPI in basis to HAS-bleed score had a similar rates of pulmonary complications in comparison to patients not treated (Hazard ratio [IRR], 2.47; 95% CI, 1.76-2.68) and [IRR], 2.51; 95% CI, 1.36-3.02) and mortality (Incidence rate ratio [HR], 1.61; 95% CI, 1.26-1.96 and [HR], 2.01; 95% CI, 1.24-2.31).
Conclusions: Patients with risk of aspiration and reflux-related lung disease who are treated with PPI have the same risk of hospitalization compared with untreated patients. These results support the positive results obtained applying HAS-bleed score in these patients .

Skin reaction of Cytomegalovirus reactivation in immunodepressed subject

F. Crudele[1], E. Martinelli[1], P. Mercatelli[1], M. Zavagli[1], G. Barbarisi[1], I. Bertoletti[1], E. Cioni[1], N. Palagano[1], C. Marchiani[1], G. Bandini[1], P. Bernardi[1], M. Gagliano[1], A. Moggi Pignone[1]

[1]Medicina per la Complessità Assistenziale 4, AOU Careggi, Firenze, Italy

Cytomegalovirus (CMV) is a member of the *Herpesviridae* family, that usually causes an asymptomatic infection. Afterward, it remains latent throughout life and may reactivate when an immunodepression occurs. CMV disease can affect almost every organ of the body and also rare cases of skin involvement have been described in the literature: in particular skin lesions such as vesicles and ulcers preceded a disseminated CMV infection. A 77-years-old Italian woman was transported to the emergency room because she was sore and confused in the last days. At the entrance she was alert, oriented, apiretic, with normal cardio-thoraco-abdominal objectivity. There were only skin lesions described as herpetiform vesicles in the gluteal region, which appeared about 15 days earlier. The patient was treated for recurrence of pulmonary neoplasia in the brain, undergoing radiotherapy and corticosteroid therapy. During the hospitalization she developed a multiorgan organ failure (MOF) secondary to reactivation of CMV. The patient was treated with ganciclovir and supportive therapy but despite significant reduction in the number of viral DNA copies, she died. We reported about the case of an immunosuppressed patient with vesicular skin lesions compatible with early manifestation of CMV reactivation, which subsequently led to MOF. This case shows that although rare and difficult to diagnose, the cutaneous manifestations of CMV must be taken into account in an immunodepressed subject in order to set up a targeted and early therapy capable of improving the patient's outcome.

Early impairment of cerebral circulation in patients affected by metabolic syndrome

P. De Campora[1], A. Fontanella[2], M. Amitrano[3], R. Sangiuolo[1]

[1]UOC Cardiologia Ospedale Fatebenefratelli, Napoli; [2]UOC Medicina Ospedale Fatebenefratelli, Napoli; [3]UOC Medicina, Ospedale Moscati, Avellino, Italy

The Metabolic Syndrome (MS) is a complex pathology that determines a greater risk of incurring cardiovascular events. Objective of the work, study with Trans-Cranica Ultrasound (TCCD) possible impairments of morphology and hemodynamics of cerebral arteries in a group of patients with MS (SM Group), compared to a control group (Group N).
Methods: The 2 groups, each consisting of 50 male patients (age 50+10), with no previous cardiovascular events - underwent transcranial ultrasound. The examined TCCD parameters were sampled at the right middle cerebral artery level.
Results: In patients with MS, TCCD showed alterations in the morphology of the middle cerebral arteries in the absence of hemodynamic impairment. In 6 MS patients, haemodynamic parameters were coexisting in group N, absence of parietal alterations.
Conclusions: Metabolic Syndrome is a pathological condition that predisposes to the risk of incurring cardiovascular events. It can be considered that the coexistence of pathologies among which arterial hypertension can directly determine and with activation of the renin-angiotensin system, of inflammatory processes and by neuro-humoral factors, an early compromise of vascular morphology. This could result in a subsequent impairment of the cerebral hemodynamics predisposing to stroke. TCCD, allows non-invasive monitoring of multiple parameters that allow the study of cerebral circulation.

Strange case of membranous glomerulonephritis and tubulointerstitial nephritis: IgG4-related disease

S. Dell'Anna[1], M. Di Norcia[1], I. Scopacasa[1], L. Salvati[1], N. Cervelli[1], D. Grassi[1], G. Properzi[1], B. Mancini[1], C. Ferri[1]

[1]Dipartimento MESVA, Università degli Studi dell'Aquila, Italy

Background: IgG4-related disease is a recently recognized immune-mediated fibroinflamatory condition which can affect multiple organs. Major features include tumor-like swelling of involved tissues, lymphoplasmacytic infiltrate enriched in IgG4-positive plasma cells with a variable degree of fibrosis and elevated serum IgG4 levels. The majority of patients have a rapid response to glucocorticoids, particularly in early stages of disease. Kidneys are frequently affected and the various renal lesions are collectively referred to as IgG4-related kidney disease.
Case report: A 65-year old woman presented with weakness, lower-limb edemas and axillary lymphadenopathy. Laboratory tests reported renal impairment and nephrotic-range proteinuria, reduced C3 levels and elevated total IgG and IgG4 serum levels. Renal ultrasound showed increased diffuse kidney enlargement. CT scans provided no evidence of morphologic or structural damage. Renal biopsy demonstrated membranous glomerulonephritis with tubulointerstitial nephritis, with histopathological pattern positive for IgG4-RKD. Oral prednisone therapy resulted in both clinical and laboratory improvement. These findings supported the final diagnosis of IgG4-RD.
Conclusions: IgG4-RD is a complex disease often mimicking distinct clinical entities, such as autoimmune rheumatic diseases and tumors. The early assessment and differential diagnosis are essential to start a prompt treatment, in order to induce remission, preserve organ function and schedule an appropriate follow up.

Non invasive ventilation in frailty elderly inpatient with acute respiratory failure

A. Di Monte[1], P. D'Amore[1], F. Sabbatini[1], M. Minardi[1], A. Franco[1]

[1]AUSL Romagna; Distretto Rimini, UO Geriatria, Rimini, Italy

Background: To evaluate the risk of invasive ventilation in frailty (F) elderly patients with ARF undergoing NIV.
Methods: In this analisys 60 E (27 male and 33 female), mean age 87 ys, were admitted in geriatric ward between january and december 2018 with hypercapnic respiratory failure due to chronic obstructive pulmonary disease (COPD, 24E), heart failure (HF, 19E), pneumonia (P, 13E) and cancer (C, 4E). All E were assigned to NIV. For the assessment of F we used Clinical Frailty Scale (CFS). CFS ≥5 was equal to frailty. Outcomes were reduction of hypercapnia and no use of invasive ventilation (IV).
Results: All E had CFS ≥5. Average hospitalization 13.5 days, 3 E did not tolerate NIV (5%) and 4 E (6.6%), all with C, died before discharge from geriatric ward. In 49 E (81.6%) with severe ARF (mean PaCO2 76 mmhg, mean pH 7.28) NIV allows an improvement in emogasanalysis (mean PaCO2 50 mmHg, mean pH 7.42) and no use of invasive ventilation. Moreover, we implemented NIV in 4 E (6.6) with severe respiratory acidosis (pH <7.20) as an alternative to IV. One of these underwent secondary IV.
Conclusions: NIV is a feasibility model of care in frailty E with ARF in order to avoid invasive ventilation. We can also consider NIV in E with severe respiratory acidosis and as a palliative purpose in C.

Moyamoya disease: an unusual cause of stroke

M.E. Di Natale[1], M. Bertoni[1], I. Bracali[1], M. Falcini[2], L. Kiferle[2], R. Martini[1], T. Restuccia[1], M. Bernetti[1], A. Foschini[1], L. Guarducci[1], P. Lotti[1], A. Giani[1], F. Risaliti[1], A. Tammone[1], S. Zanieri[1], A. Caruso[2]

[1]SOC Medicina Interna 2, Nuovo Ospedale Santo Stefano, Prato; [2]SOC Neurologia, Neurofisiopatologia, Stroke Unit, Nuovo Ospedale Santo Stefano, Prato, Italy

Background: Moyamoya disease (MMD) is a chronic, progressive occlusion of the circle of Willis arteries that leads to the development of characteristic collateral vessels seen on imaging, particularly cerebral angiography. MMD is found all over the world, but it is more common in East Asian countries. As a result, it can be under-recognized as a cause of ischemic and haemorrhagic strokes in Western countries.
Case report: A 51-year-old Asian man was admitted to our Division with symptoms of fluctuating and progressive right arm weakness. His past medical history was clear; he was a heavy smoker and drunk alcohol occasionally. Initial head computed tomography did not reveal any acute findings. Laboratory investigations, complete blood count and echocardiogram were normal. On echocolor doppler bilateral internal carotid arteries (ICAs) stenosis were found (45-50%). Subsequent magnetic resonance angiography and imaging revealed acute ischemic changes in the left frontal-parietal and right frontal areas. Furthermore, aspect of proximal ICAs was filiform with occlusion at the terminal portion and adjacent proliferation of collateral vessels miming a "puff of smoke". Findings were generally compatible with progressive vascular occlusive process that can be seen in MMD. Aspirin 100 mg was started and the patient was transferred to Stroke Unit.
Conclusions: MMD should be considered in the etiologic diagnosis of stroke, especially in Asians patients. Medical treatment of ischaemic stroke in MMD includes antiplatelet agents and surgical revascularization.

Effects of the integrated multidisciplinary approach and the use of VGM on the indication and tolerability of radiotherapy treatment in elderly cancer patients

A. Di Palma[1], F. Todi[2], S. Rotunno[3]

[1]Radioterapia Oncologica, Ospedale S. Pietro Fatebenefratelli. Roma; [2]Oncologia, Ospedale S. Pietro Fatebenefratelli, Roma; [3]Geriatria, Ospedale Fatebenefratelli, Roma, Italy

Background and Aim: The elderly cancer patient is in a state of fragility whose lack of classification can invalidate the success of oncological therapies. In radiotherapy (RT), being able to have a forecast of both acute and chronic toxicity is essential because the first is a potential cause of interruption of RT, while the second could fall on the long term on the functional reserve of organs with consequences on quality of life (QoL).
Materials and Methods: From June 2017 to January 2019 at the multidisciplinary geriatric surgery (oncologist, geriatrician and radiotherapist), 57 patients (36 M; 21 F) were evaluated. 75.4% were affected by non-metastatic while 12% by metastatic disease. All were subjected to VGM on first visit.The evaluation of acute and chronic toxicity was performed using the RTOG/ EORTC scale. The QoL was evaluated at the end of the RT and at each follow-up.
Results: Following the VGM, for 87.7%. more studies were requested 78.9% patients were assessed with a second (88.8%), or third (11.1%) subsequent visit. 5.26% were not started at RT. 98.2% concluded the RT up to the intended dose. 89.4% required temporary suspension; 96.4% had acute toxicity RTOG=1; 23.5% acute toxicity RTOG=2; 0% acute toxicity RTOG=3. 1.75% patients required medical management for chronic toxicity. No one needed hospitalization.
Conclusions: The VGM on first visit allowed a clinical risk classification essential for the confirmation of the indication to the RT but above all for the prevention and management of the acute and chronic side effects of the treatment.

Delirium su sindrome Tako-Tsubo in una ultranovantenne

F. Di Rienzo[1], I. Carbone[1], A. Achilli[1], M. Ippolito[1], M. Cacciafesta[1], C.A.M. Lo Iacono[1]

[1]Geriatria, Policlinico Umberto I, Roma, Italy

Introduzione: Il Delirium è una sindrome geriatrica reversibile, con deficit dell'attenzione e disfunzione cognitiva, su patologia acuta. Fattori di rischio sono età avanzata e demenza mentre dolore, disidratazione, infezioni, ictus e chirurgia sono gli scatenanti più comuni. In questo caso il Delirium è atipica presentazione di Sindrome Tako-Tsubo (TTS) in un'anziana.
Caso clinico: Paziente di aa 93 giunta in PS per sopore alternato ad agitazione psicomotoria. TC Encefalo: atrofia cortico-sottocorticale e leucoencefalopatia multinfartuale. ECG: inversione onde T su V1-V4. Enzimi cardiaci: T Us 0,438 mcg/L Mio 454 ng/ml CKMB 11,6 UI/L. EcoCardio: ipocinesia setto-apicale del Vsn e ipercinesia dei segmenti basali. Studio emodinamico cardiaco conferma reperti ecocardiografici in assenza di stenosi coronariche significative, quadro compatibile con diagnosi di TTS. La pz è posta in osservazione per 72h in UTIC, con ecocardio seriati e supporto emodinamico con risoluzione graduale delle alterazioni ecocardiografiche e conseguente miglioramento dei disturbi del comportamento.
Conclusioni: Nell'anziano fragile le modifiche age related determinano presentazioni atipiche di malattia con rischio di ritardo diagnostico-terapeutico. Il delirium è in questo caso unica manifestazione di TTS, usualmente definita da una clinica sovrapponibile ad una SCA. Si evidenzia quindi l'importanza, nei pazienti di età avanzata, di una valutazione multidimensionale e di una diagnostica differenziale ad ampio spettro.

Il quoziente di normalizzazione per la selezione dei pazienti ipertesi. Studio su 4605 report ABPM

G. Di Santo[1], G. Ranaldo[1], M. Di Resta[1], B. Ciaramella[1], F. Di Santo[1], G. Malgieri[1]

[1]UOC Medicina Interna, AO "San Pio", PO Sant'Agata de' Goti (BN); [2]Casa di Cura "Alma Mater – Villa Camaldoli", Napoli; [3]Centro Ipertensione, AO "San Pio", PO Sant'Agata de' Goti (BN), Italy

Scopi: Scopo dello studio è caratterizzare pazienti con pressione arteriosa elevata, ma non ipertesi, utilizzando il calcolo del rapporto della pressione arteriosa media per la frequenza cardiaca media.
Materiali e Metodi: In questo studio prospettico abbiamo analizzato i report ABPM di 4605 pazienti, dividendoli in 4 gruppi: gruppo A con PA <130/80 mmHg; gruppo B con PA >130/80 mmHg; gruppo C con PA sistolica (PAS) >140 mmHg; gruppo D con PA sistolica >150 mmHg. Sono stati calcolati: PAS e PAD, Pressione arteriosa media (PAM); DS della PAM; la frequenza cardiaca media (FCM) e la sua DS. Abbiamo calcolato il rapporto PAM su FCM (QN, avendo la PAM per ogni battito cardiaco e superando così il problema della sindrome da camice bianco.
Risultati: Per tutti i gruppi è stata verificata la differenza statistica per p <.0001 tra le medie di PAS, PAD, PAM, QN, CV, età.
Avendo ricavato dal gruppo dei soggetti non ipertesi (gruppo A) il valore medio del QN. Abbiamo sottratto dagli altri 3 gruppi patologici (A,B,C) tutti i soggetti con un QN uguale o inferiore a quello del gruppo A, ricavando un altro gruppo (gruppo E), con valori pressori significativamente più alti che nel gruppo A, ma con QN significativamente più basso che negli altri gruppi, così come anche l'età, mentre una FCm ed una DS_{FCm} significativamente più alte.
Conclusioni: Vi sono pazienti catalogati come ipertesi e che ipertesi non lo sono, ma hanno solo un aumento del tono adrenergico che incrementa sia la frequenza cardiaca che la pressione arteriosa. Il quoziente di normalizzazione è uno strumento per individuarli.

Multicentric Castleman's disease: report of two different clinical cases

R. Di Stefano[1], M. Calvani[1], C. Ricci[1], C. Trotta[1], N. Barone[1]

[1]UOC Medicina Interna, Ospedale San Paolo, Bari, Italy

Castleman's disease (CD) is a rare atypical lymphoproliferative disorder. IL-6 pathway and HHV8 infection appear to play an important role in the etiopathogenesis of the disease. It may present as a localized or multicentric form (MCD). We report 2 different clinical cases of MCD.
Case 1: A 81 yr-old woman hospitalized in our Internal Medicine Unit for fever, asthenia, weight loss. The physical examination exhibited pale skin, peripheral edema, axillary lymphadenopathy and multiple cutaneous patches or plaques of left distal lower extremity. Laboratory analyses showed anemia, increase in inflammatory indices, polyclonal gammopathy, negative serological markers, including HIV. A CT showed widespread lymphadenopathy. Biopsy of axillary lymph node and skin lesions were collected with the di-

agnosis of MCD hyaline vascular and plasma cell types with positive determination for HHV8 marker and Kaposi's sarcoma.
Case 2: A 72 yr-old woman, with a 6-month of lumbar pain and no other symptoms was hospitalized in our Unit for CT appearance of axillary, mesenteric and celiac lymphadenopathy and an FDG PET/CT scan showed high FDG uptake value in the same regions. Biopsy of axillary lymph node showed features of MCD negative for HHV8. In this case laboratory investigations showed only a polyclonal gammopathy and increase of serum erythrocyte sedimentation rate, negative serological markers for HIV, HBV, HCV.
Conclusions: The clinical MCD heterogeneity may be caused from different disease stages, interplay between different etiologic cytokines and associated viruses including HIV, KSHV/HHV8.

Converting to insulin degludec/liraglutide is efficacious regardless of pre-trial insulin dose in patients with type 2 diabetes uncontrolled on insulin glargine U100

O.E. Disoteo[1], L.F. Meneghini[2], E. Jaeckel[3], L. Leiter[4], I. Lingvay[2], J. Harvey[5], K. Begtrup[6], K. Chandarana[6], G. Lastoria[7], T. Vilsboll[8]

[1]Centro di Diabetologia, Ospedale Niguarda, Milano, Italy; [2]University of Texas Southwestern Medical Center, Dallas, TX, USA; [3]Hannover Medical School, Hannover, Germany; [4]University of Toronto, Toronto, ON, Canada; [5]Bangor University, Wrexham, UK; [6]Novo Nordisk, Søborg, Denmark; [7]Novo Nordisk, Medical Affairs, Italy; [8]Gentofte Hospital, Hellerup, Denmark

This post-hoc analysis of DUAL V investigated the safety and efficacy of initiating IDegLira once daily at 16 units (U) (16 U IDeg; 0.58 mg liraglutide) in adults with T2D uncontrolled on 20-50 U IGlar, *vs* continued IGlar up titration, across pre-trial daily insulin dose groups. With IDegLira, A1C reductions from baseline to end of trial (EOT, week 26) were significantly greater *vs* IGlar for all dose groups. Compared with IGlar, IDegLira was insulin sparing and resulted in body weight loss *vs* body weight gain and lower rates of hypoglycemia, for all dose groups ($p<0.05$, all treatment contrasts). There were no clinically significant increases in self-measured plasma glucose levels when converting from any dose group to 16 U IDegLira, and no withdrawals due to hyperglycemia with IDegLira in first 8 weeks. Fasting plasma glucose reductions were similar between treatment arms for all dose groups. For all endpoints except EOT insulin dose, treatment effect was consistent across dose groups. In conclusion, regardless of pre-trial dose group, IDegLira resulted in significantly greater A1C and body weight reductions and lower hypoglycaemia rates *vs* IGlar at a lower EOT insulin dose and importantly, with no loss of glycemic control when converting from any dose between 20-50 U of IGlar to the starting dose of 16 U IDegLira.

Listeriosi e miastenia. Case report

M. Dorato[1], G. Meini[1], V. Cuomo[1], R.A.N. Ranucci[1]

[1]PO S. Maria delle Grazie, Pozzuoli (NA), ASL Napoli 2 Nord, Napoli, Italy

Introduzione: Le *listerie* sono bacilli Gram-positivi, non-acidoresistenti, privi di capsula, asporigeni, β-emolitici, aerobi e anaerobi facoltativi. La *listeria monocytogenes* è l'unico patogeno per l'uomo. La forma tossico-infettiva con incubazione di poche ore dà sintomi simil-influenzali: febbre, brividi, cefalea, dolori muscolari, nausea e diarrea. La forma invasiva con incubazione fino a tre mesi dà sintomi variabili: reazioni cutanee, encefalite, meningite, endocardite, peritonite. La *listeria m.* è trasmessa con cibi contaminati crudi o poco cotti. I soggetti a rischio sono i neonati, gli anziani, gli immunodepressi, gli adulti in terapia cortisonica prolungata, le donne in gravidanza.
Caso clinico: Donna di aa 51 ricoverata per febbre elevata, nausea, vomito, mialgie. Nell'anno precedente diagnosi di timoma infiltrante, stadio III/Masaoka, con miastenia e ipogammaglobulinemia. In terapia con glucocorticoidi ed anticolinesterasici. Gli esami mostravano: GB 12.000, N 92%, PCR: 11,26 mg/l. Dopo emocoltura veniva iniziata terapia antibiotica empirica compatibile con la miastenia: Ceftarolina Fosamil 600 mg x 2 e Fluconazolo 200 mg/die dopo dose iniziale di 400 mg. L'emocoltura risultava positiva per *Listeria monocytogenes*. Dopo 4 giorni di terapia con Piperacillina/Tazobactam 2+0,25 g x 3 scomparsa della febbre, rapido miglioramento clinico, PCR: 0.49 mg/l, GB: 5.390, N: 76.1%. La paziente veniva dimessa con Ampicillina 2g/die per altri 10 giorni e indicazioni di igiene alimentare.
Conclusioni: Il caso è interessante per la sua infrequenza e poiché gli antibiotici di scelta per la listeriosi non possono essere utilizzati nella miastenia per cui sono state impiegate dosi ridotte di penicillina risultate egualmente efficaci. Nei casi di immunodepressione diventa di importanza strategica la prevenzione alimentare.

A strange case of ascites

B. Farneti[1], M. Barletta[2], I. Tartaglia[2], P. Di Giuseppe[3]

[1]Ospedale Perrino, Malattie Infettive, Brindisi; [2]Ospedale Perrino, Medicina Interna, Brindisi; [3]Ospedale Perrino, Medicina Interna, Brindisi, Italy

Female patient with ascites, adnexal masses and elevated CA125 levels are typically presumed to have advanced ovarian carcinoma with carcinomatosis. Tuberculous peritonitis can occur in a similar way and respond well to medical treatment. We present the case of young woman suffering from abdominal distension, weight loss, ascites and low-grade fever. At first, the cytology of ascites was negative for malignant cells, while *Mycobacteria* could not be demonstrated on direct preparations. However, the quantiferon-tb test was positive. An FDG-PET/CT scan showed multiple hypermetabolic foci in the mesentery and peritoneum with further increase of FDG uptake on the delayed scan, mimicking peritoneal carcinomatosis. The subsequent laparoscopic biopsy showed granulomatous inflammation, with epithelioid cells and Langhan's type giant cells. There were a few discriminating features in this clinical case suggesting a diagnosis of tuberculous peritonitis rather than ovarian carcinoma. As a matter of fact, the patient responded well to antituberculosis therapy with normalization of CA125 levels, confirming the diagnosis of peritoneal tuberculosis and FDG-PET was negative after six months.

Atypical fibroxanthoma as a rare cause of superior vena cava syndrome: a case report

S. Feltrin[1], A. Bellodi[1], F. Rossi[1], A. Ballestrero[1]

[1]Clinica di Medicina Interna ad Indirizzo Oncologico, Ospedale Policlinico San Martino, Genova, Italy

Introduction: Atypical fibroxanthoma is an uncommon superficial sarcoma that develops on the sun-exposed head and neck area of elderly patients due to ultraviolet light. The incidence is increased in immunosuppressed populations but local recidive occurs in about 6-10% of cases.
Case report: A 69-year-old man came to our attention due to left hemithorax pain and paraesthesia of the ipsilateral upper limb. In anamnesis, systemic lupus erythematosus currently treated with azathioprine/prednisone and excision of atypical fibroxanthoma of the head 3 years ago, with local relapse the following year surgically removed. At clinical examination, turgor of the jugular veins, plethora of the face and neck, onychomycosis. Upper limb venous ultrasound showed extrinsic compression of the left brachiocephalic venous trunk, chest CT demonstrated voluminous left pulmonary polylobate mass (9*9*16 cm). Positron emission tomography proved standardized uptake value (SUV) of 20. Pulmonary biopsy CT-guided was performed and diagnosis of distant metastasis of atypical fibroxanthoma was made.
Conclusions: Superior vena cava syndrome usually resulted from external compression or invasion of the vessel from structural pathology within the mediastinum, the first cause being non-small cell lung cancer in 50% of all cases. Atypical fibroxanthoma has very rare metastatic potential, with rare description of lymphnodes, parotid gland and subcutaneous tissue metastasis. Immunesuppressed patients with previous local relapse may thus develop aggressive disease with atypical clinical presentation.

Opportunistic evaluation of stroke prevention in atrial fibrillation during admissions

P. Fenu[1], A. Bellizzi[2], L. Paoletti[3], N. Mumoli[4], M. Cei[5]

[1]UO Medicina Interna, PO Cecina, USL Nord-Ovest Toscana; [2]UO Medicina Interna, PO Piombino, USL Nord-Ovest Toscana; [3]Direzione di Presidio, PO

Cecina, USL Nord-Ovest Toscana; [4]UO Medicina Interna, Ospedale Giuseppe Fornaroli, Magenta (MI); [5]UO Medicina Interna, PO Cecina, USL Nord-Ovest Toscana, Italy

Background and Aim of the study: We hypothesize that admissions in Internal Medicine Units may be used opportunistically to revise stroke prevention with anticoagulants in patients with atrial fibrillation or flutter (AF).
Methods: Accordingly to ICD-IX-CM coding, we systematically recorded secondary diagnosis of anticoagulant (V5861), aspirin (V5866) or antithrombotic (heparins or other antiplatelet agents) treatments, along with the presence of AF (42831 or 42832 codes) for all discharged patients throughout 2018. The setting is a 51-bedded Internal Medicine Ward.
Results: 294 patients presented with a diagnosis of AF. Only 155 (52.7%) were already on anticoagulant therapy, 9 (3.1%) were on aspirin prophylaxis, and 13 (4.4%) received other treatments (mainly clopidogrel and occasionally LMWH). 117 patients (39.8%) did not receive any treatment at admission.
Conclusions: A large proportion of patients admitted to Internal Medicine units with AF did not still receive any stroke prophylaxis, and an even larger proportion did not receive guidelines recommended therapy. Admissions should be used to increase the proportion of anticoagulated AF patients.

Hypercalcemia and splenic lesions: do not always think of lymphoma

P. Fenu[1], S. Gori[2], G. Occhipinti[3], F. Marrelli[4], L. Mannocci[5], M. Cei[6]

[1]UO Medicina Interna, PO Cecina, USL Nord-Ovest Toscana; [2]UO Medicina Interna, PO Cecina, USL Nord-Ovest Toscana, [2]UO Medicina Interna, PO Livorno, USL Nord-Ovest Toscana; [4]UO Pneumologia, PO Livorno, USL Nord-Ovest Toscana; [5]UO Chirurgia, PO Cecina, USL Nord-Ovest Toscana, [6]UO Medicina Interna, PO Cecina,USL Nord-Ovest Toscana, Italy

Background: Hypercalcemia with low parathormone (PTH) is suspected to be neoplastic in origin. Sarcoidosis, a well-known cause of hypercalcemia, usually presents with mediastinal lymphadenopathy and/or pulmonary infiltrates. Here we report a case of sarcoidosis presented with isolated splenic lesions.
Case report: A 71 yo woman presented with mild neurologic symptoms and renal failure, and was found to have hypercalcemia (12.1 mg/dl) with suppressed PTH (6.3 pg/ml). She underwent an extensive workup that was remarkable only for multiple splenic lesions; splenectomy was performed in the suspect of lymphoma. Pathologic studies revealed sarcoidotic granulomas. Subsequent staging failed to show any other organ involvement. The patient did well with prednisone after three months follow-up.
Conclusions: In cases of hypercalcemia with isolated splenic lesions the diagnosis of sarcoidosis should be kept in mind. Splenectomy is warranted to obtain a correct diagnosis.

Elderly patients: ankle-brachial index and frailty status

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

[1]Dipartimento di Medicina Interna Polispecialistica, Grande Ospedale Metropolitano Niguarda Milano, Italy

Background and Aim of the study: Frailty can be defined as a state of vulnerability secondary to poor recovery of homeostasis after stressor events and is a consequence of an overall decline in many physiological systems, including the cardiovascular one. Atherosclerosis causes a chronic reduction of vascularization of tissues, contributing in this way to the functional and cognitive decline of the elderly. The Ankle-Brachial Index (ABI), obtained by the ankle/brachial blood pressure ratio, as an indicator of atherosclerosis, could be used as a marker of frailty. Aim of the study was to evaluate possible relations between ABI and various frailty indexes in elderly subjects.
Materials and Methods: 100 patients ≥65 years old (mean 80±6.9) hospitalized in the Internal Medicine department of our Institution were evaluated with ABI and frailty indexes (death, hospitalization length, delirium, falls, cognitive impairment, ADL and I-ADL).
Results: The only significant correlations with ABI were represented by cognitive impairment and ADL index. At the subsequent multivariate regression, ABI remained a statistically significant determinant of cognitive impairment but not of ADL.
Conclusions: Lower ABI associates with worse cognitive performances in elderly, possibly because of long-term exposure to atherosclerotic disease. This would accentuate the functional disability even in the simplest daily actions, and support the hypothesis that ABI could be considered as a useful marker of frailty in elderly hospitalized subjects.

Elderly patients with acute heart failure in Internal Medicine: the role of comorbidities

A. Fioranelli[1], N. Tarquinio[1], L. Falsetti[2], G. Viticchi[3], F. Picchio[1], A. Martini[1], M. Mariottini[1], L. Marconi[1], F. Pellegrini[4], M. Burattini[1]

[1]UOC Medicina Interna, PO di Osimo "S.S. Benvenuto e Rocco", INRCA-IRCSS; [2]Medicina Interna Generale e Subintensiva, AOUR "Ospedali Riuniti", Ancona; [3]Clinica di Neurologia, AOU "Ospedali Riuniti", Ancona; [4]Libero professionista, Osimo (AN), Italy

Introduction: Acute heart failure (AHF) affects elderly patients affected by several comorbidities.
Aims: To evaluate the association of comorbidities to in-hospital death in a retrospective cohort of AHF-affected subjects.
Materials and Methods: All patients admitted for AHF (Department of Internal Medicine, Osimo-INRCA) in the timeframe 01/2015-01/2019 were retrospectively evaluated; we collected age,sex, echocardiographic parameters(ejection fraction and diastolic dysfunction),serum uric acid at admission (SUA) and the number of comorbidities; outcome was defined as in-hospital death. Continuous variables were compared with t-test, dichotomous variables with ^{2}-test.
Results: We obtained a sample of 460 patients (mean age 83.9±8.02 years; males 56.6%), observing HFpEF in 27.4%,HFmrEF in 22.8%,HFrEF in 49.8% of the patients, with no significant association with outcome (p=0.931); diastolic dysfunction was found in 17.2% of the sample, with no significant association with in-hospital death (p=0.856); age (83.5±8.18 *vs* 87.28±5.73; p=0.008), SUA (6.92±2.55 *vs* 8.43±3.63; p=0.001) and the number of comorbidities (4[1] *vs* 6[3]; p=0.008) were significantly associated with the outcome.
Conclusions: In a cohort of elderly and comorbid patients, age and number of comorbities seem to be associated to in-hospital death. SUA, a marker of metabolic dysfunction, chronic diuretics use and chronic kidney disease, was higher among patients undergoing to in-hospital death. The management of patient's complexity should be always taken into account in elderly subjects admitted for AHF.

Severe diarrhea associated with celiac-like syndrome: remember olmesartan

C. Fischetti[1], A.M. Schimizzi[1], C. Polloni[1], V. Ramazzotti[1], M. Cavina[1], M. Candela[1]

[1]UOC Medicina Interna, Ospedale Carlo Urbani-Jesi, Area Vasta 2, ASUR Marche, Italy

Background: Olmesartan is a an antihypertensive drug, which acts by blocking angiotensin II receptors (ARB). An association between olmesartan use and debilitating diarrhea with severe sprue-like enteropathy is described in a series of cases. The first case of olmesartan-induced enteropathy was described by Rubio-Tapia *et al.* in 2012
Case report: A 63-years man presented with an 8 week history of severe diarrhea associated a weight loss of 15 kg. Serologic testing for celiac disease was negative, serum albumin, 2,1 g/dL, serum creatinine 8,27 mg/dL, low serum zinc. Small intestinal biopsies showed villous atrophy with intraepithelial lymphocytosis. A gluten-free diet was found to be ineffective. Clinical symptoms resolved quickly after cessation of olmesartan and his blood test improved.
Conclusions: Olmesartan-associated enteropathy is an underestimated entity and an important differential diagnosis in patients with chronic diarrhea and the syndrome should be suspected in patients with this medical drug and negative markers of celiac disease. Its pathogenesis remains unclear; however, it is reported that olmesartan can perturb the immune system of the digestive system.

Un insolito caso di ipotensione ortostatica

V. Gallina[1], A. Pieri[1], P. Marschang[1]

[1]Azienda Sanitaria dell'Alto Adige, Comprensorio Sanitario di Bolzano, Italy

Premesse: Con il termine amiloidosi si identifica una patologia caratterizzata da accumulo di materiale proteico fibrillare definito come amiloide. La clinica dell'amiloidosi è variabile e sfumata e mette alla prova le capacità diagnostiche del medico.
Caso clinico: Uomo di 66 anni, si ricovera per ripetuti e transitori episodi lipotimici con vertigini, sudorazioni, tremori diffusi e confusione mentale. Si confermava la grave ipotensione ortostatica, anche mediante il monitoraggio pressorio nelle 24 ore. L EMG mostrava un'alterata conduzione delle fibre colinergiche del simpatico cutaneo a livello degli arti inferiori. Per un quadro di lieve demenza il paziente eseguiva PET-TC cerebrale, che non mostrava significative alterazioni del metabolismo glucidico. La captazione del radiofarmaco a livello dei nuclei della base e dei talami era conservata. Il paziente veniva inoltre sottoposto a *tilt training*, eseguito tentativo con midodrina e calze elastocompressive. Nonostante tali provvedimenti, persistevano gli episodi sincopali. L' ecocardiogramma evidenziava aumento dell'ecorifrangenza e pattern amiloidotico. La biopsia del grasso periombelicale confermava la diagnosi e il paziente veniva inviato ad un centro di riferimento per l'amiloidosi.
Conclusioni: L'amiloidosi primaria è una patologia rara. Nonostante la neuropatia periferica sia una comune manifestazione, l'insufficienza autonomica è un evento assai raro. È di vitale importanza eseguire un'attenta valutazione del paziente per giungere prontamente ad una diagnosi e quindi ad una terapia in quanto queste forme di ipotensione ortostatica avanzata sono altamente invalidanti. Recenti studi hanno dimostrato dati confortanti riguardo l'utilizzo di Onpattro, farmaco indicato nell'amiloidosi ereditaria in adulti affetti da polineuropatia allo stadio 1-2 ed e' stato dimostrato come sia stato ben tollerato dall'intera popolazione (Studio APOLLO), registrando un rallentamento della progressione di malattia ed un'inversione di tendenza dopo 18 mesi di terapia.

Videocapillaroscopic pattern in Raynaud's phenomenon: results of a large ambulatory series

F. Gallucci[1], R. Buono[1], A. Carnovale[1], C. Mastrobuoni[1], A. Parisi[1], R. Russo[1], G. Uomo[1]

[1]UOC Medicina Interna 3, Dipartimento Medico Polispecialistico, AORN Cardarelli, Napoli, Italy

Background: Nail videocapillaroscopy (NVC) patterns represent one of the official diagnostic criteria for Systemic Sclerosis and an indispensable tool to evaluate Raynaud's phenomenon.
Materials and Methods: During 2018, 569 patients presenting with Raynaud's phenomenon were studied (mean age : 43.5 years (range 4 – 87), 113 males (mean age 38.8; range 4 – 73) and 456 females (mean age 44.6; range 9 – 87), to assess the presence of the following patterns: "normal", "non-specific minor abnormalities", "non-specific major abnormalities", "scleroderma pattern" (SP) (early, active o late). We utilize Videocap 3, with optical probe (enlargement 200x) and with specific software (DS Medica, Milano).
Results: Normal NVC pattern was observed in 194 patients (34.1%); 9.8% (56 patients) presented non-specific minor abnormalities; 195 (34.3%) non-specific major abnormalities; 124 cases (27.2%), SP: in particular, 65 patients with SP early; 55 SP active; 4 SP late. No statistical difference was observed in male/female distribution as concerns the different patterns. Mean age resulted significantly greater in patients with NVC scleroderma pattern.
Conclusions: In our experience NCV has been proved very useful for the diagnostic assessment of the microcirculatory involvement in Raynaud's phenomenon.

Real life of direct antiviral agents in HCV infected patients: our experience

E. Garlatti Costa[1], R. De Rosa[2], M. Ghersetti[1], A. Berto[2], G. Dettori[1], N. Boscato[1], S. Fumagalli[1], S. Grazioli[1], A. Grembiale[1], M. Avolio[2], A. Camporese[2], M. Tonizzo[1]

[1]Department of Internal Medicine, Pordenone; [2]Department of Microbiology and Virology, Pordenone, Italy

Introduction and Aim: Even if several data on antiviral drugs for HCV infection are reported, hepatologists should continue to monitor results. The aim is to assess in a real-life cohort of patients with chronic hepatitis C the efficacy and safety of DAA-based therapy.
Materials and Methods: We retrospectively reviewed the data of HCV patients treated in our Institute from January 2015 to May 2018.
Results: We treated 540 patients (275 males). Median age was 63. Genotype 1 infection was most prevalent (57%), followed by genotype 2 (23%), genotype 3 (11%), genotype 4 (7%), genotype 5 (1%) and myxed genotypes infections (1%). Cirrhosis (liver stiffness≥12 kPa) was present in 40% of patients, moderate chronic hepatitis (liver stiffness≥10 kPa) in 22% and mild liver disease in 38%. Treatment with DAAs for 8 weeks was prescribed in 72 patients, for 12 weeks in 374, for 16 weeks in 8 and for 24 weeks in 86. HCV RNA at fourth treatment week was undetectable in 44% of subjects. The main side effects were asthenia (20%), headache (13%) and insomnia (11%). 537 patients completed antiviral. 13 (2.4%) patients did not reach sustained virological response. Median value of ALT after 24 weeks of the end of therapy decreased (83±68 *vs* 26±17, p<0.0001). In cirrhotics, liver stiffness reduced too (20±10 *vs* 14±9, p<0.0001). We detected 10 deaths (6 related to liver disease). De novo HCC was diagnosed in 9 patients, recurring HCC in 5 while extrahepatic tumors were found in 7 subjects.
Conclusions: Real life of DAAs confirms their long term safety and efficacy to obtain HCV elimination.

Recovery of dysphagia after immunoglobulin administration in scleroderma myositis overlap syndrome

C. Gelardi[1], D. Menghini[1], V. Pedini[1], F. Guidotti[1], F.L. Galli[2], A. Gabrielli[1], M.G. Danieli[1]

[1]Clinica Medica, Università Politecnica delle Marche e Ospedali Riuniti, Ancona; [2]Clinica di Neuroriabilitazione, Università Politecnica delle Marche e Ospedali Riuniti, Ancona, Italy

Background: Idiopathic inflammatory myopathies (IIM) constitutes a rare neuromuscular disorder characterized by immune mediated inflammation, which involves primarily the skeletal muscles. The overlap of IIM with systemic sclerosis, or scleromyositis, is characterized by IIM and scleroderma features with a typical antibodies pattern (anti Pm Scl antibodies in 90% of cases). Esophageal involvement in scleromyositis occurred in about 25% of cases. Due to the rarity of the disease, treatment, monitoring and therapy are based on case reports or case series.
Case report: We here described the case of a 60-year-old Caucasian woman with scleromyositis presenting proximal hypostenia and sclerodactylia associated with severe dysphagia and dropped head. The logopedic examination (grade 2 of the Dysphagia Outcome Severity Scale, DOSS) and the videofluroscopic examination, with aspiration and penetration of liquid bolus and stagnation with solids, confirmed the severity of the dysphagia. We used intravenous immunoglobulin (2 g/kg monthly for 6 months). After 3 months, we observed a significant clinical (DOSS 3) and radiological improvement. Also muscular strength and dropped head improved consistently.
Conclusions: Dysphagia is a severe complication of IIM and overlap related disorders, which can provoke fearsome consequences, such as aspiration pneumonia. In patients with scleromyositis with severe gastrointestinal involvement, the use of intravenous immunoglobulin can improve symptoms and reduce dysphagia complications.

La valutazione ecografica dello stato volemico: un strumento per gestire lo scompenso cardiaco in ospedale

R. Giacosa[1], L. Zerbini[1], A. Guariglia[1]

[1]Casa di Cura Città di Parma, UO Medicina 2, Parma, Italy

Premesse e Scopo dello studio: La valutazione dello stato volemico e delle pressioni di riempimento centrali si basa prevalentemente su parametri clinici, esami bioumorali e studi radiologici sul torace. L'ecografia bed-side toracica ha dimostrato maggiore sensibilità della radiografia standard negli stati edematosi. Abbiamo elaborato uno strumento per la valutazione dello stato volemico (VESV) mediante ecografia: scopo dello studio pilota è

valutare la fattibilità di prendere decisioni terapeutiche utilizzando di routine la VESV, eliminando il ricorso alla radiografia standard del torace.
Materiali e Metodi: Dal gennaio 2018 è stata studiata prospetticamente una coorte di 20 casi ricoverati in un Reparto di Medicina Interna con la diagnosi di scompenso cardiaco acuto. In tutti i pazienti è stata effettuata la VESV che prevedeva l'integrazione di parametri cardiaci (contrattilità e geometria di camera), di parametri polmonari (linee B, versamento pleurico, atelettasia) e di parametri emodinamici (collassabilità cavale). Sono stati valutati come parametri di efficacia: 1) la necessità di ricorrere alla radiografia/TC del torace per guidare i cambiamenti di terapia; 2) la presenza di cambiamenti di terapia indotti dalla VESV.
Risultati: In nessun caso è stato necessario ricorrere ad una radiografia/TC del torace; in tutti i casi la terapia veniva modificata subito dopo l'acquisizione dei risultati della VESV; in 5 casi su 20 l'ecoscopia toracica permetteva di riscontrare significativo versamento pleurico (non inferiore a 500 cc) che non veniva evidenziato con la clinica; una diagnosi di cardiopatia dilatativo-ipocinetica veniva fornita con la VESV per la prima volta in 5 casi su 20.
Conclusioni: La gestione ospedaliera dello scompenso cardiaco può avvalersi di un nuovo strumento ecografico di valutazione della volemia (VESV), senza ricorrere a radiazioni ionizzanti, per guidare efficacemente le scelte terapeutiche. Inoltre, la metodica consente di riscontrare precocemente versamenti pleurici ed eventuali cardiopatie dilatative misconosciute.

What's behind pulmonary hypertension

M. Giampieri[1], C. Florenzi[1], L. Maddaluni[1], M. Ronchetti[1], G. Zaccagnini[1], M.S. Rutili[1], E. Antonielli[1], S. Baroncelli[1], F. Pieralli[2], C. Nozzoli[1]

[1]Careggi, Medicina Interna, Firenze; [2]Careggi, Subintensiva di Medicina, Firenze, Italy

Background: Pulmonary hypertension (PH) is defined as an elevated mean arterial pressure ≥25 mmHg at rest. PH has several etiologies and can be a progressive, fatal disease, if untreated.
Case report: A 72 years-old woman was hospitalized for worsening dyspnea. She referred exertional dyspnea for months; history of minor stroke. At the HRCT scan bilateral pleural effusion, some fibro-disventilating parenchymal bands and thickening of interlobular septa.The echocardiogram showed normal left ventricle size and wall thicknesses, interventricular septum and apex hypokinesis and severe pulmonary arterial hypertension. A coronarography and right heart catheterization were performed with evidence of multi-vessel coronary artery disease and pre-capillary PH. During hospitalization she was symptomatic for Raynaud phenomenon. Lab tests were positive for ANA antibodies (1:1280) with a nucleolar pattern highly suggestive of systemic sclerosis (SSc).
Conclusions: Patient was discharged with diagnosis of "limited cutaneous SSc determining severe PH". Pulmonary vascular disease, primarily pulmonary arterial hypertension, occurs in 10 to 40 percent of patients with SSc and is more common in those with limited cutaneous disease. Vascular disease may occur with or without concurrent interstitial lung disease. Most commonly, cardiac complications are secondary to pulmonary arterial hypertension, but primary cardiac involvement has been increasingly recognized.The manifestations of primary cardiac involvement in SSc include microvascular disease and myocardial infarction**.** Diagnosis of PH requires right heart catheterization. Patients with connective tissue disease are rarely vasoreactive and as such vasoreactivity testing is not absolutely necessary in that population.

Gender-related violence: an observational study

M. Giordano[1], I. Sanzo[2], I. Boccagna[2], R. Ferrucci[1], C. Iuliano[2], T. Ciarambino[3]

[1]Department Internal Medicine, Hospital of Marcianise, ASL Caserta, University of Campania; [2]Women 'Space Association; [3]Department Internal Medicine, Hospital of Marcianise, ASL Caserta, University of Campania, Italy

Background: The Istanbul Convention (2011) is the first binding instrument on preventing and combating violence against women and domestic violence.
Objectives: It is to put in place the actions in favor of women victims of male violence through a multifactorial approach.
Materials and Methods: We enrolled 26 women with an average age of 53±3 years, who arrived at the Sessa Aurunca First Aid Route, in the period 2016-2018 for gender-related violence
Results: The study population consisted of 24 women of Italian origin and 2 of non-EU origin. Of these, 38% were married, 32% separated, 10% unmarried, 10% widowed, 10% divorced. Over 50% of cases were victims of family violence. In particular, in 15% of cases it was psychological violence, in 38% of cases of stalking, in 25% of cases of relational conflicts, in 22% of cases legal problems. In over 50% of cases the perpetrator of violence was a husband or a former husband. The interventions carried out by the multidisciplinary team contributed to send 4% of cases in a hospitalization, 4% of cases in shelters and 92% of cases to support victims of violence with specialist advice from internists, gynecologists and psychologists.
Conclusions: It is therefore essential to prevent the phenomenon of violence against women using as primary tools information and awareness of the community, strengthening the awareness and culture of men and young people

When it's not what it seems... An insidious TB diagnosis

V. Giosia[1]

[1]UO Medicina Interna, Ospedale Fatebenefratelli, Milano; Università degli Studi di Milano, Italy

Background: TB may have various clinical and imaging features. Differential diagnosis includes neoplasia, infections, infiltrative diseases.
Case report: A 78 year-old man with history of prostate cancer, in remission after CT-RT treatment, presented with recent onset normocytic, normochromic anemia and mildly elevated CRP, associated with significant weight loss. Recent diagnosis of duodenal ulcer with negative histology for cancer cells, and suspect esophageal fistula (not confirmed at following EGD) was made.
CT scan showed numerous necrotic-colliquating adenopathies in mediastinum, thorax and abdomen, with pleural and peritoneal effusion and nodular lesions in the left lung. Besides, hypodense pancreatic lesions suspect for neoplasia were found, accompanied by suspect peritoneal carcinosis. Given the high suspicion of neoplasia, an endoscopic US-guided FNAB was performed, negative for neoplastic cells but showing giant histiocytic, inflammatory cells. Serum tumor markers were negative. Bronchoscopy with BAL was negative for cancer cells, with negative Ziehl Neelsen stain. A thoracic wall biopsy was performed showing granulomatous, giant-cellular, chronic inflammation. Given the aspect of the lesion, PCR for M.Tuberculosis was asked on bioptic sample, resulting positive. Patient referral to Infectious Disease Unit was carried out.
Conclusions: TB infection incidence is rising in developed countries. Whenever several biopsies are negative for neoplasia but signs of chronic inflammation are found, TB should be looked for, with cultures and genome search in bioptic samples.

Statin therapy and ambulatory blood pressure parameters: a propensity score analysis

F. Giulietti[1], F. Spannella[1], A. Filipponi[1], C. Di Pentima[1], B. Bernardi[1], R. Sarzani[1]

[1]Università Politecnica delle Marche, Clinica di Medicina Interna e Geriatria IRCCS-INRCA, Ancona, Italy

Background: Statins are cornerstones of cardiovascular (CV) therapy. Previous studies found an association between statins and lower office blood pressure (BP). We studied the effect of statins on ambulatory BP in unselected hypertensives.
Methods: Retrospective study on 1827 consecutive hypertensives evaluated with 24h-BP monitoring. Treatment intensity score (TIS) of anti-hypertensive therapy was calculated to compare drug classes. We compared two equally-sized cohorts of patients (treated with statins or not) with similar characteristics, using a propensity score (PS) analysis. We included these variables in the score: age, sex, smoke, body mass index (BMI), estimated

glomerular filtration rate (eGFR), diabetes mellitus, TIS, mean 24h-pulse pressure.
Results: Mean age: 58.1±13.8 years; male sex: 55%. Patients on statin therapy: 22%. Statin therapy was associated with lower systolic and diastolic 24h (-2.8/-7.0 mmHg), daytime (-3.3/-7.5 mmHg) and nighttime (-2.5/-6.0 mmHg) BP (all p<0.001). Patients on statin therapy had better 24h, daytime and nighttime BP control, even after adjusting for age, sex, BMI, eGFR, diabetes mellitus and TIS (all p<0.001). The analyses on the PS matched groups (218 treated patients *versus* 218 untreated patients) confirmed these results.
Conclusions: Statin therapy is associated with significant lower ambulatory BP regardless anti-hypertensive treatment intensity and other major CV risk factors. The CV benefit of statins is mainly due to the lowering of cholesterol. Further studies are needed to establish their role on BP values.

Hepatitis C in injection drug users: it is time to treat!

A. Grassi[1], C. Peramezza[2], N. Celli[1], G. Donati[1], A. Fabbri[1], S. Maccariello[1], G. Ballardini[1]

[1]Medicina Interna ed Epatologia, Ospedale Infermi, Rimini; [2]SERT, AUSL Romagna, Sede di Rimini, Italy

Injection drug users (IDUs) are at risk of hepatitis C virus (HCV) infection, due to needle and syringe sharing. IDUs (with or without) opioid substitution therapy are still often considered to be poor candidates for HCV treatment. We treated 67 IDUs with HCV related disease with peginterferon+ribavirin (P+R) or new direct antiviral agents (DAA). Patients characteristics were: M/F: 40/27, median age (range) 46 (21-65), 42% with cirrhosis, genotype (G)1 28, G3 36, G4 3. Fifty patients (22 P+R, 28 DAA) completed 12 weeks post treatment follow up, 39 (78%) were sustained virological responders (SVR), 5 relapsed post treatment, 3 suspended treatment, 3 did not respond to therapy. SVR rate was 77% in cirrhotic and 79% in non cirrhotic patients, respectively (p=NS). SVR rate was significantly lower in G1 patients (55%) *vs* non-G1 patients (93%), p=0.0036. SVR rate resulted higher with DAA therapy (86%) *vs* P+R therapy (68%), (p=0.28). In patients treated with P+R, SVR rate was significantly higher in non-cirrhotic (78%) *vs* cirrhotic patients (25%), p=0.020. On the contrary in patients treated with DAA, SVR rate was similar in cirrhotic (89%) and non-cirrhotic patients (80%), p=0.60. In patients treated with P+R, SVR rate was significantly lower in G1 (25%) *vs* non-G1 (93%), p=0.0023, while in patients treated with DAA SVR rate in G1 (75%) *vs* non-G1 (93%) was not significantly different (p=0.28). When considering 22 cirrhotic patients only, SVR rate was significantly higher in patients treated with DAA (89%) *vs* patients treated with P+R (25%), p=0.024. When considering 20 G1 patients only, SVR rate was significantly higher in patients treated with DAA (75%) *vs* patients treated with P+R (25%), p=0.041.
Conclusions: Antiviral therapy against HCV appears to be effective and well tolerated in IDUs. DAA appear to be effective also in patients considered "difficult to treat" (cirrhotic and G1 patients). So that, treatment of HCV related disease should be advisable for IDUs patients.

Is the Italian payment system reliable for reimburse the complexity of the Internal Medicine Department?

A. Greco[1], S. Patrizi[2], F.F. Paris[1], F. Addante[1], M.G. Longo[1], L. Cascavilla[1], P. Chiarelli[3]

[1]Dipartimento di Scienze Mediche, UOC Geriatria, IRCCS "Casa Sollievo della Sofferenza", San Giovanni Rotondo (FG); [2]Dipartimento di Scienze Mediche e Chirurgiche, Università degli Studi di Foggia, Foggia; [3]CEO Staff IRCCS "Casa Sollievo della Sofferenza", San Giovanni Rotondo (FG), Italy

Background and Study objective: Internal Medicine Department (IMD) usually cope with patients who are becoming more complex and comorbid. To succeed in this hard task fair reimbursement is needed. Actually clinical features of the IMD's inpatients are changed suggesting some possible pitfalls in the reimbursement fares associate to DRG classifications system. Hospital Activity Based Costing (HABC) approach is a reliable method for costs computation. Aim of our study is to verify if Italian reimbursement is fair in the IMD setting.
Materials and Methods: We studied 1532 patients who have been admitted and discharged in 2017 from the Medical Department of the IRCCS "Casa Sollievo della Sofferenza". Mean age, gender, DRG distribution, DRG's Relative Weight (RW), total real costs, and reimbursement fares were evaluated for each patient. RW was used to summarize DRGs in four categories of severity: 1:Low (RW<1); 2: Moderate (RW=>1 and RW<1.5); 3: Severe: (RW=>1.5).
Results: Patients mean age was 78.5±9.6 years. 63% of them were female. Respiratory and heart failure showed the highest prevalence. Mean RW was 1.46 ±0.20. RW subgroups were:Low12.3%; Moderate 54.7 ; Severe 33.0%.The differences between costs an fares were positive for low/moderate subgroups+€ 416±624; +€1274±717; and negative for the severe -€1004±1243.
Conclusions: Overstimating the low/moderate complexity and underestimating the severe subgroups may create a possible bias in financing the IMD. This could be a possible discouragement for coping with high complexity patient.

Recurrence of vasculitis cryoglobulinemic after treatment with the new direct antiviral agents for HCV: a case report

A. Grembiale[1], M. Ghersetti[1], A. Ermacora[1], M. Tonizzo[1], C. Mazzaro[2]

[1]Internal Medicine Department, General Hospital, Pordenone; [2]Clinical of Experimental Onco-Haematology Unit, CRO Aviano National Cancer Institute IRCCS, Aviano (PN), Italy

Background: Recently, many studies reported the efficacy of DAAs in the treatment of HCV–related crioglobulinemic vasculitis (CV). However some authors noticed the recurrence of the vasculitis despite HCV eradication.
Case report: We present the case of a 68-year old female, with a history of hypertension. In 2012, this patient developed recurrence palpable purpura and burning on both legs and fatigue. Liver function test was normal, reumatoid factor (RF): 124 U/L;C4:2 mg/dl, cryoglobulins type II IgMk/IgG 2%. HCV-RNA/2a :3.476.000 IU/ml;HbsAg and anti-HIV: negative.Fibroscan: stage 1 fibrosis. The patient was treated with metilprednisolone 16 mg/day reduced at 4 mg/day plus colchicine 1 mg/day during wich purpura disappeared temporarily. From August to November 2016, the patient was treated with sofosbuvir 400 mg/day plus ribavirin 1000 mg/day. The patient had undetectable HCV-RNA viremia after one month of therapy and remained undetectable until the 9th month of follow-up. At the end therapy, we observed regression of purpura, reduction of cryocrit and RF; C4 remained low. At 9th month of follow-up, a new relapse of purpura on the legs was observed. The patient was treated with corticosteroid, during which her purpura disappeared. Since September 2018, the patient is currently in follow-up and asymptomatic without therapy. Cryocrit is absent,RF<12, C4 4, HCV-RNA:undetectable.
Conclusions: Our case demonstrated that DAAs therapy in HCV-related CV was effective for virological response but obtained recurrence of vasculitis. These finding indicated that immunocomplex production with C4 consumption and resurrence of vasculitis had become independent of the virus replication.

West Nile virus infection: scaremongering or reality?

A. Grembiale[1], S. Venturini[2], A. Berto[3], A. Rosso[1], S. Grazioli[1], E. Garlatti Costa[1], A. Camporese[3], M. Crapis[2], M. Tonizzo[1]

[1]Department of Internal Medicine, AAS5, Friuli Occidentale, Pordenone; [2]Department of Infectious Disease, AAS5, Friuli Occidentale, Pordenone; [3]Department of Microbiology and Virology, AAS5, Friuli Occidentale, Pordenone, Italy

Introduction and Aim: West Nile virus (WNV) infection is a significant burden for public health in Europe. WNV is a neurotropic mosquito-borne virus belonging to the Flavivirus genus and it is maintained by an enzootic cycle involving birds and mosquitoes. Humans are dead-end hosts that may be incidentally involved in the cycle. While most infections are asymptomatic, about 25% of

patients develops symptoms and less than 1% severe neurological disease. On 2017, no cases of WNV infection in Western Friuli Venezia Giulia were found. We described the cases and the epidemiological features of WNV infection on 2018 in our District of Pordenone.
Materials and Methods: Throughout 2018, patients with WNV infection were registered. Infection was diagnosed by detection of WNV-specific antibodies in serum and WNV RNA in plasma and urine.
Results: 35 cases of WNV infection were identified, 17 were males (48%) and mean age was 56 years. More frequent symptoms were fever (60%), headache (45%), asthenia (42%), myalgia (37%), rash (36%) and gastrointestinal disorders (8%). Neuroinvasive infection was present in 4 subjects (12%). 3 patients (9%) were asymptomatic blood donors. Finally, 33 patients completely recovered (94%), 2 patients died and none was affected by neuroinvasive sequelae. August and September were the months with the highest number of cases of WNV infection.
Conclusions: On 2018, in Western Friuli Venezia Giulia there has been an increase in the number of cases of WNV infection compared to 2017. Epidemiological data can help clinicians to implement preventive measures.

Left ventricle mass and atrial volume is related to disease activity in Systemic Lupus Erythematosus

M. Guarascio[1], S. Cicco[1], L. Crudele[1], V. Racanelli[1], A. Vacca[1]

[1]Dipartimento di Scienze Biomediche ed Oncologia Umana, Sezione di Medicina Interna, Università di Bari "Aldo Moro", Bari, Italy

Introduction: Systemic Lupus Erythematosus (SLE) is a chronic inflammatory disease caused by autoimmunity. One of SLE damage is due to vascular inflammation. That's why we looked for a correlation between disease activity, evaluated by SLEDAI score, and heart involvement.
Materials and Methods: We evaluated 23 SLE patients (22 women) and 1 man, aged 43.74±11.98 years) between 01/01/2015 and 31/12/2017. Patients came in follow-up for revaluation and therapy adjustment. We divided the sample according to SLEDAI score: 13 mild-to-moderate (SLEDAI<12) (12 women, 1 man; aged 44.36±14.40 years) and 10 severe (SLEDAI≥12) (all women, aged 41.75±8.57 years).
Results: We highlight that patients with severe SLEDAI had an increased left ventricular mass (MLV) both as absolute value (MLV: severe 215.4±61.5 *vs* mild-to-moderate 169.3±34.6 gr., p<0.05) and MLV indexed (MLVi) for body surface area (BSA) (MLVi: severe 133.3±45.2 *vs* mild-to-moderate 101.8±15.6 gr/m^2, p<0-05). At the same time also left atrium (LA) results increased in both as volume absolute value (LAV: severe 65.4±20.1 *vs* mild-to-moderate 47.5±14.9 ml; p<0.05) and LA volume indexed (LAVi) for body surface area (BSA) (LAVi: severe 39.9±15.5 *vs* mild-to-moderate 28.6±8.4 ml/m^2, p<0-05).
Conclusions: These data show a significant increase of LAV and MLV in patients with severe SLEDAI, compared to mild-to-moderate SLEDAI patients. This could suggest heart damage related to SLE disease activity, but further studies are needed to better understand the pathophysiology of this phenomenon.

An unexpected diagnosis: Kikuchi-Fujimoto disease

E.A.R. Ialleni[1], G. Muscillo[1]

[1]Università "Tor Vergata", Roma, Italy

Introduction: Kikuchi-Fujimoto disease, also called histiocytic necrotizing lymphadenitis is a rare, idiopathic, generally self-limited cause of lymphadenitis, usually accompanied with mild fever and night sweats. The most common clinical manifestation is cervical lymphadenopathy. Clinically and histologically, the disease can be mistaken for lymphoma or systemic lupus erythematosus (SLE).
Case report: A 34-year-old man went to the emergency room because of a hyperpyrexia lasting about two weeks, resistant to antibiotic therapy. The patient was affected by psoriasis, complicated by arthritis, on active immunosuppressive therapy. A chest CT scan showed ilo-mediastinal lymphadenopathy and splenic enlargement. Several investigations were performed to identify an infectious or autoimmune cause of the fever, persistent despite adjustments of antibiotic treatment and accompanied by intense myalgias at limbs; however all tests resulted negative. Moreover, the protracted use of paracetamol triggered a toxic hepatitis treated with N-acetylcysteine. A PET-CT scan revealed pathological contrast uptake at the level of axillary, paraortic, obturator, iliac and inguinal lymph nodes; therefore a lymph node biopsy was performed with the later evidence of necrotizing histiocytic lymphadenitis or Kikuchi's disease.
Conclusions: This clinical case underlines the importance and implications of an accurate histological examination that in this situation changed the therapeutic approach, but it always requires a correct interpretation in view of clinical and laboratory data.

Multidisciplinary approach in patient with indeterminate thyroid nodules

S. Ippolito[1], G. Antonelli[2], R. Muscariello[1], M.G. Esposito[2], O. Romano[1], F. Carcarino[1], E. Sirica[1], E. Borriello[1], E. Nocerino[1], S. Spiezia[2], V. Nuzzo[1]

[1]UOSD Malattie Endocrine, del Ricambio e della Nutrizione, Ospedale del Mare - ASL Na 1 Centro, Napoli; [2]Chirurgia Endocrina ed Ecoguidata, PO Ospedale del Mare, ASL Napoli 1 Centro, Napoli, Italy

Background: Guidelines suggest the role of fine-needle aspiration (FNA) as a milestone in the diagnostic-therapeutic approach of patients with thyroid nodules. The management of the indeterminate thyroid nodules (TIR3) in clinical practice, however, is still a matter of debate. The classification of TIR 3 in two categories: TIR 3A(low-risk) and TIR 3B(high risk), with different risks of malignancy, and the use of molecular testing are useful to address patients to correct conservative or surgical management.
Methods: Patient with thyroid nodules attending the outpatients and hospitalized in Department of Endocrinology were submitted to thyroid ultrasound evaluation and, where necessary, to FNA, according whit the ultrasound (US) criteria of malignancy. Patients with TIR3B and TIR3A and suspicious clinical or US findings were submitted to thyroidectomy. A conservative strategy by repeating FNA and performing molecular tests was considered for TIR3A nodules.
Results: The repetition of FNA cytology confirms a wild type TIR3A in the 84% of the patients that were addressed to a surveillance program. The 10% of the patients presented a TIR3A associated with NRAS e HRAS mutations. They were submitted to thyroidectomy and the histological examination revealed a NIFTP. The 6% of the patients presented a TIR3A associated with BRAFV600E mutation and papillary cancer at the histological evaluation.
Conclusions: Only a multidisciplinary approach based on clinical risk factors, sonographic features, and results of the molecular tests allowed the correct indeterminate lesion's therapeutic approach.

Alcoholic cardiomyopathy: it is worth the internistic management!

A. Lasagni[1], E. Zola[1], B. Girolami[1], I. Zanella[1]

[1]UOS Alcologia UOC Medicina Generale, AO Università di Padova, Italy

Introduction: Alcoholic cardiomyopathy (ACM) counts about 40% of cases of idiopathic dilated cardiomyopathy. A targeted treatment for alcohol use disorder (AUD) is crucial to strengthen abstinence, which recovers cardiac function.
Case report: A 58yo woman, complaining dizziness and accidental fall was admitted to our unit. Her history was relevant for AUD, a transient ischemic attack. A first evaluation showed anasarca and upper extremities tremors. Laboratory tests showed severe hyponatremia, acute hepatitis, normal troponin and very high BNP levels. Chest x-ray revealed cardiomegaly and pleural effusion, ECG sinusal tachycardia and left bundle branch block. Cardiac ultrasound showed a dilated left ventricle with severe loss of the ejection fraction (EF 20%) and ECG-Holter a run of non-sustained ventricular tachycardia. History and clinical data were suggestive for ACM. She was treated with furosemide, ramipril, carvedilol, spironolactone but also with B1vitamin and antiwithdrawal therapy. Still admitted, she started an AUD rehabilitation program. The good compliance to the cardiologic and alcohologic follow-up with

full abstinence maintenance, was followed by progressive cardiac recovery: EF 35% after 1 month, 39% after 3, 44% after 6. She didn't need an implantable cardioverter defibrillator (ICD).
Conclusions: Early internistic management, including abstinence support, leads to an effective cardiac function recovery, sparing device implantation (ICD, CRT). However, ACM remains often unknown and the only cardiac treatment is not able to change the disease history.

IDegLira improves glycaemic control in subjects with type 2 diabetes uncontrolled on basal insulin without deterioration despite discontinuing pre-trial sulphonylurea

G. Lastoria[1], A. Janez[2], R. Silver[3], T. Vilsboll[4], R. Gron[5], N. Halladin[5], P. Orsy[6], N. Harris[7]

[1]Novo Nordisk Medical Affairs, Italy; [2]University Medical Center Ljubljana, Ljubljana, Slovenia; [3]Southern New Hampshire Medical Center, Nashua, USA; [4]Steno Diabetes Center, University of Copenhagen, Copenhagen, Denmark; [5]Novo Nordisk A/S, Søborg, Denmark; [6]Novo Nordisk, Søborg, Denmark; [7]Western University, London, Canada

As combining sulphonylurea and insulin can elevate the risk of hypoglycaemia. This can lead to a deterioration of glycaemic control. The DUAL II trial compared the efficacy and safety of IdegLira *versus* insulin degludec, both plus metf, in subjects with poor glycaemic control previously treated with met±SU/glinides and basal insulin. This sub-group analysis compared clinical findings in subjects discontinuing SU to those not taking SU pretrial. Change from baseline in HbA1c, FPG and body weight, and end of trial insulin dose after 26 weeks of treatment were analysed. Treatment-emergent confirmed hypoglycaemia was analysed using a negative binomial regression model. IDegLira resulted in greater reductions in HbA1c, FPG and body weight from baseline and lower rates of hypoglycaemia compared with degludec in both pre-trial SU users and non-SU users. Minor differences were seen in EOT insulin doses. Treatment effect was consistent between the two groups, with no statistically significant interaction between randomised treatment and SU use for all endpoints. As insulin dose was reduced at randomisation from a mean of 27–32U to 16 U and pre-trial SU stopped, a non-clinically relevant increase in mean self-measured fasting plasma glucose was seen in weeks 0–3 in both arms in the pre-trial SU users. This had returned to baseline by week 4, with a general decrease continuing until the EOT. Mean SMPG decreased from week 0 until EOT with IDegLira in the non-SU users group. In subjects who reduced their insulin dose and discontinued SU at IDegLira initiation, no clinically relevant deterioration in glycaemic control was seen. For all endpoints analysed, regardless of SU use pretrial, IDegLira showed better results in all metabolic parameters *versus* degludec. The clinical findings were consistent between pre-trial SU users and non-SU users.

Fever and high procalcitonin don't mean always bacterial infection: think about it!

L. Lenzi[1], G. Aquilina[2], M. Giannone[2], A. Gatti[2], A. Pollastri[1], P. Caciagli[2], S. Cozzio[1]

[1]APSS Medicina Interna, Rovereto (TN); [2]APSS Patologia Clinica, Rovereto (TN), Italy

Background: High fever is a common problem in Emergency Room (ER). Other symptoms, use of laboratory test, including procalcitonin (PCT) and radiologic exams help for the differential diagnosis of bacterial *versus* viral infections.
Case report: We describe a 32 years old male from Pakistan presented to the ER complaining of fever with chills and urination pain for 8 days. Blood pressure was 116/60 mmHg, heart rate 130 beats/minute and temperature 38.7 °C. Past medical history was negative; no history of recent travel. From 8 months he lived in Italy. Lab tests demonstrated thrombocytopenia (68.000/mm^3), INR 1.69, PCR 76 mg/L, PCT 32.42 ng/mL. It was made diagnosis of acute urinary tract infection. After admission, he was treated with ceftriaxone 2 g/die. Surprisingly the next day, examination of a peripheral blood smear, performed due thrombocytopenia, showed trophozoites schizont, gametocytes of *P.* vivax. A rapid test loop-mediated Isothermal Amplification (LAMP) resulted positive for *Plasmodium spp.* The BinaxNOW Malaria Test was also positive in T2 for malaria protein antigen. Epidemiology and morphology lead to *Plasmodium vivax* infection. Treatment with artemisinin-piperaquine was effective and safe. After 2 weeks, primachine was required to eradicate the dormant hypnozoites.
Conclusions: Prompt and accurate diagnosis of malaria is critical for appropriate treatment. PCT levels can be elevated by non-bacterial causes, also by uncomplicated non-falciparum malaria infections. PCT has limited role as an indicator for severity in malaria.

Sindrome delle apnee ostruttive nel sonno nella popolazione geriatrica: differenze di genere

C.A.M. Lo Iacono[1], A. Sarno[1], E. Reali[1], R. Rondinelli[1], E. Amato[1], D. Tonietti[1], S. Stefanini[1], M. Cacciafesta[1]

[1]DAI Medicina Interna e delle Specialità Mediche, AOU Policlinico Umberto 1, Roma, Italy

Premesse e Scopo dello studio: Nell'età adulta vi è una prevalenza dell'OSAS nel maschio rispetto alle femmine, le donne presentano prevalentemente sintomi non specifici associati a più comorbidità. Nelle donne l'OSAS è sottodiagnosticata a causa della diversa presentazione clinica rispetto agli uomini (russamento, apnea). Lo studio si propone di esaminare le differenze di genere sulla sintomatologia e le comorbidità associate all'OSAS.
Materiali e Metodi: 450 pazienti sottoposti a Poligrafia basale, di 283 pazienti geriatrici sono stati valutati parametri metabolici e misure antropometriche e somministrati l'ESS, la GDS, indagata la qualità del sonno e la presenza di comorbidità.
Risultati: Sui 283 pazienti (M 146;F 137), il 76% delle femmine è affetta da insonnia, il 59% dei maschi da OSAS. E' stata riscontrata maggiore prevalenza della sindrome metabolica tra gli OSAS (65%) rispetto agli insonni (52%) e significatività statistica tra sesso femminile e sindrome metabolica ($p<0,007$) e ipertensione arteriosa ($p<0,02$). E' stata dimostrata l'associazione tra sesso femminile e maggiore probabilità di depressione ($p<0,01$) e di utilizzo di ipnoinducenti ($p<0,0001$). Il sesso maschile, invece, risulta correlato al russamento ($p<0,0001$) e a bassi livelli di HDL ($p<0,001$) e sembra esserci una significativa correlazione tra basso HDL e roncopatia intensa e OSAS. L'obesità e la circonferenza collo, invece, si confermano fattori di rischio per OSAS indipendentemente dal sesso.
Conclusioni: Anche in età geriatrica nei pazienti con OSAS persiste una differenza di genere: nella espressione clinica della malattia (insonnia che prevale nel sesso femminile e la sonnolenza diurna e la roncopatia nel sesso maschile), nell'associazione con le comorbidità (maggiore nel sesso femminile). La differenza di genere può influenzare l'approccio alla diagnosi ed al trattamento. Si dovrebbero sviluppare dei questionari specifici per riconoscere la malattia nel sesso femminile e ridurre la sottodiagnosi di OSA.

A rare manifestation of paraneoplastic syndrome

F. Lunati[1], M. Dugnani[1], M. Campanini[1]

[1]AOU Maggiore della Carità, Novara, Italy

It is known that paraneoplastic neurologic syndromes recognize cell-mediated or antibody-mediated immune pathogenetic mechanisms. An 86-year-old male, comes to our attention due to severe dysphagia with absolute inability to oral feeding; with diagnosis of cardiac incontinence and biopsy posivite for reflux oesophagitis. Medical history: arterial hypertension, vocal cord polypectomy, narrow channel syndrome; follow up for diffuse large B-cell lymphoma stage IV for skeletal localizations, chronic ischemic and atrophic encephalopathy with progressive cognitive decay. Total body CT scan with evidence of anterior peripancreatic site of a lymph node conglomerate compressing the pancreas body and tail and the venous axis splenic, expression of disease recurrence. The CT scan has not clarified the etiology of dysphagia; negative otolaryngology visit. Due to the particular characteristics of the dysphagic phenomenon, fatigue, and in the hypothesis of possible Myasthenia has performed encephalic NMR with negative result, EMG facial muscles with evidence of myastheniform neuromuscular plaque alteration; research positive anti-acetylcholine antibodies. We

started therapy with pyridostigmine with rapid and complete remission of dysphagia. The clinical case induces to pay particular attention to the need for adequate diagnostic investigation of the etiopathogenesis of dysphagia in the elderly subject, avoiding the possible error of not considering clinical conditions certainly not frequent, such as myasthenia, however potentially responsible for severe dysphagia.

When the heart clouds the mind

L. Maddaluni[1], M. Ronchetti[1], G. Zaccagnini[1], C. Florenzi[1], G. Galante[1], E. Antonielli[1], L. Fedeli[1], G. Degl'Innocenti[1], M. Finocchi[1], C. Nozzoli[1]

[1]Medicina Interna e d'Urgenza AOUC Careggi, Firenze, Italy

Introduction: In elderly patients endocarditis often has an atypical onset. Neurological abnormalities may be the only presenting signs/symptoms.
Case report: A 79 year-old woman has come to our attention for fever associated with neck pain and altered mental status. To the medical examination she was pyretic, awakening only at painful stimulus, with signs of neck stiffness. A 3/6L systolic murmur was audible at cardiac auscultation. The blood tests revealed neutrophilic leukocytosis and elevated PCR; TnI and TSH were in range. The ECG showed FA at high FVM; head-CT revealed signs of chronic vascular leukoencephalopathy. Considering the progressive worsening of neurological status, we performed a vascular-CT that revealed non-critical carotid atheromasia. A transthoracic echocardiogram was unremarkable. The liquor from lumbar puncture was limpid without findings of bacterial infection; moreover HHV and Tuscany virus PCR were negative. No epileptic elements were found at EEG. Brain MR showed blurred signal hyperintensity of the encephalic white matter of non specific meaning. The neck-thorax-abdomen CT evidenced an abscess in the right paravertebral site and splenic ischemic lesions. Meanwhile has arrived the result of blood cultures, positive for MSSA. Thus we performed a transesophageal echo that demonstrated a large endocarditic vegetation on posterior mitral leaflet.
Conclusions: Neurologic manifestations occur with a higher frequency in patients with native mitral valve infection. Endocarditis should be considered among the causes of altered mental status.

A particular case of ischaemic stroke treated successfully with systemic thrombolysis

V. Maestripieri[1], I. Fiordelli[1], M. Palazzi[1], C. Bazzini[1], T. Sansone[1], A. Alessandrì[1], G. Panigada[1]

[1]Ospedale SS Cosma e Damiano, Pescia (PT), USL Toscana Centro, Italy

A 44 yo man refferred to ER for dysarthria, 7th cranial nerve deficiency, hypoaesthesia and hemiparesis of upper right limb (NIHSS 5), begun 2 hours earlier. He reports migraine without aura, smoke habits, denies drugs or alcohol abuse. An angioCT of supra-aortic trunks and intracranial vessels do not show early signs of ischemia or occlusion of large vessels. The patient undergoes systemic thrombolysis with improvement of neurological status (NIHSS 0). Multiparametric and electrocardiographic monitoring show no noteworthy changes. Blood tests were in the normal limits. A second brain CT was negative both for ischemic lesions and hemorrhagic complications. A transthoracic echocardiogram showed a hyperechoic mass adherent to the non-coranic aortic valvular flap. Suspecting endocarditis, antibiotic therapy was started and the patient was transferred to Cardiac Surgery Unit to remove the mass. Histological examination demonstrated the presence of fibroelastoma. Antiplatelet therapy was prescribed and the patient was discharged with normal neurological status. Fibroelastoma is a rare tumor, most frequently localized on aortic valve. Protocols for systemic thrombolysis do not require echocardiography before the procedure. In young person without cardiovascular risk factors we must consider a possible cardioembolic origin due to endocardial vegetations or intracardiac tumors. Only a few cases of thrombolysis are described in patients with endocardial tumors, however, given the low number of registered complications, fibroelastoma doesn't to appear an absolute contraindication to thrombolysis.

Brown tumor of a phalange: un unusual first sign of primary hyperparathyroidism

E. Magnani[1], A. Balestrieri[2], M. Bruschi[3], B. Praticò[1]

[1]UO Medicina Interna M. Bufalini, Cesena, AUSL Romagna; [2]Servizio Endocrinologia, Dipartimento Internistico M. Bufalini, Cesena, AUSL Romagna; [3]Servizio Reumatologia, UO Medicina Interna M. Bufalini, Cesena, AUSL Romagna, Italy

Background: The diagnosis of hyperparathyroidism HPT is often incidental, after a serum calcium blood test, but brown tumours are a very rare detection in patients affected by HPT.
Case report: A 43-year old woman referred to our Rheumatologic Service because of a swelling of the tip of her fourth finger of left hand; besides she reported pain in the metatarsal area of her left foot. X-rays showed areas of osteolysis in both sites. Further asymptomatic osteolytic lesions of the skeleton were documented by scintigraphy. Differential diagnosis exams for lithic lesions were performed, such as neoplastic, haematological and metabolic bone disorders. In particular, high level of serum calcium (13.5 mg/dl) and PTH (884 pg/ml) were detected. A huge parathyroid adenoma was discovered and surgically removed. A progressive reduction of bone swelling was documented after. Histology of bone lesion described the presence of vascularized fibrous tissue.
Conclusions: Brown tumours (BTS) are generally rare and late clinical signs of a severe and long-standing Hyperparathyroidism. They represent a consequent and exuberant repair process of areas of bone resorption by vascularized fibrous connective tissue. BTS appear as cystic images at radiography. Brown tumours are solitary or multiple, frequently localized in jaws and long bones, rarely at the phalanges. We describe this unusual manifestation as a first sign of HPT in a young italian woman.

Differenti caratteristiche tra ipertesi di età inferiore e superiore a 55 anni. Studio su 4605 casi ABPM

G. Malgieri[1], G. Ranaldo[1], M. Di Resta[1], D. Di Santo[1], A. Di Santo[1], G. Di Santo[1]

[1]Centro Ipertensione, AO "San Pio", PO Sant'Agata de' Goti (BN); [2]UOC Medicina Interna, AO "San Pio", PO Sant'Agata de' Goti (BN); [3]Casa di Cura "Alma Mater – Villa Camaldoli", Napoli; [4]Università degli Studi di Roma "Tor Vergata", Roma; [5]Università degli Studi del Molise, Campobasso, Italy

Scopo: Scopo dello studio è verificare se c'è una differenza statisticamente significativa tra ipertesi giovani e anziani.
Materiali e Metodi: Sono stati esaminati 4605 report ABPM comprendenti 1215 pazienti normotesi e 3390 ipertesi, questi ultimi sono stati suddivisi in 2 gruppi: n. 1551 di età <55 anni; n. 1839 di età >55 anni. Dei 2 gruppi è stata valutata: PAS e PAD medie delle 24 ore, la pressione arteriosa media (PAM) delle 24 ore, la frequenza cardiaca media (FCM) delle 24 ore, il rapporto PAM/FCM (QN), la variabilità della PAM e della FCM (DS_{pam} e DS_{fcm}), il rapporto DS_{pam}/DS_{fcm} (CV), la somma del QN con la differenza indicizzata delle variabilità: $QN+(DS_{pam}-DS_{fcm})/12$. Si sono calcolate le differenze statistiche con il t di Student con $p<0.0001$.
Risultati: Vi è una differenza statisticamente significativa tra le diverse variabili considerate tranne che per la variabilità della PAM. Considerando tutti i pazienti ipertesi vi è una correlazione diretta tra variabilità della FCM e PAD e tra PAM e la sua variabilità con la FCM e la sua variabilità. Vi è una correlazione inversa tra FCM ed età.
Conclusioni: I pazienti più giovani hanno PAM, FCM, DS_{fcm} e PAD significativamente superiori, mentre hanno QN, CV, PAS, PAS/PAD ed il carico pressorio significativamente inferiori. Vi è una correlazione lineare positiva tra DS_{fcm} e PAD e negativa con l'età. In definitiva la DS_{fcm} è un marker riconosciuto dell'attività adrenergica, abbiamo che i più giovani hanno la PA più elevata per un tono simpatico più pronunciato ed una PAD più alta per conservazione delle proprietà elastiche dei vasi.

L'ischemia cronica "critica" degli arti inferiori

G. Manca[1], A. Spinelli[1], S. Marini[1], D. Riccio[1], M.V. Corriga[1], D. Viale[1], A. Caddori[1]

[1]UOC Geriatria, SS. Trinità, Cagliari; [2]UO Radiologia Interventistica, SS. Trinità, Cagliari, Italy

Premesse e Scopo dello studio: L'ischemia cronica degli arti inferiori (CLTI) determina aumentato rischio di amputazione maggiore, incremento di mortalità, costi elevati. L'appropriatezza della rivascolarizzazione può comportare miglioramento degli esiti e riduzione delle complicanze. Scopo dello studio è promuovere la valutazione multidisciplinare migliorando i risultati locali (ulcere e dolore) e globali (amputazione maggiore, eventi maggiori cardiovascolari, disabilità, miglioramento della qualità della vita).
Materiali e Metodi: Pazienti con CLTI sono stati inviati nell'ambulatorio di geriatria da servizi territoriali e valutati da geriatra esperto, radiologo interventista, psicologa del reparto. Gli esami preoperatori sono stati effettuati in preospedalizzazione; i pazienti sono stati ricoverati 24 ore prima della procedura.
Risultati: Sono stati sottoposti a procedura 39 pazienti (41 procedure), 34 diabetici, 8 in emodialisi. La rivascolarizzazione ha determinato nella maggioranza dei pazienti miglioramento di lesioni e dolore. Si sono osservate poche complicanze periprocedurali (un NSTEMI, quattro ematomi in sede di accesso vascolare, una gastrite erosiva).
Conclusioni: La valutazione geriatrica multidisciplinare migliora l'inquadramento della malattia, ottimizza la terapia medica peri e post procedurale, migliora la proporzionalità dell'intervento, quindi l'appropriatezza, in relazione alla condizione globale sia per l'outcome "salvataggio dell'arto" che nel ridurre le complicanze e gli eventi maggiori.

A "crazy paving" pattern on CT scan in a patient treated with Pembrolizumab

C. Mancini[1], S. Ramponi[1], L. Balzarini[1], M. Marvisi[1]

[1]Casa di Cura Figlie di San Camillo, Cremona, Italy

Background: Programmed cell death protein 1 (PD-1) and its ligand, PD-L1, have shown great promise in clinical practice and have been incorporated into standard management of NSCLC. Pneumonitis is a serious autoimmune toxicity associated with the use of anti-PD-1/PD-L1 antibodies, resulting in significant morbidity and mortality.
Case report: We described the case of a 73-year-old woman with no history of smoking developing exertional dyspnea four months after taking Pembrolizumab. High resolution contrast CT scan (HRCT) presented a unilateral "crazy paving" pattern, and bronchoalveolar lavage (BAL) an important lymphocytosis (20% of total cell count). The patient reached clinical stability after the administration of systemic steroids (2mg\Kg\die), and was discharged with long term oxygen therapy.
Conclusions: Pulmonary toxicity is frequent when using PD-1 inhibitors, resulting in significant morbidity and mortality, often resulting in the discontinuation of therapy. Clinical presentation is usually protean and HRCT pattern nonspecific. This is the first case presenting a "crazy paving" pattern associated with BAL lymphocytosis. Oncologists, pulmonologists, radiologists and general practitioners have to consider PD-1 and PD-L1 inhibitor pneumonitis as a potentially disabling and fatal event.

Thrombolysis in acute ischemic stroke and early transfer from the emergency department to the Internal Medicine ward

G. Mancini[1], R. Margheriti[1], D. Aureli[1], F. Muzzi[1], G. Pauletti[1], A. Pisani[1], F. Tiratterra[1]

[1]UOC Medicina Interna, Ospedale G.B. Grassi, ASL Roma 3, Italy

Background and Aim of the study: Both intravenous thrombolysis and mechanical thrombectomy demonstrated to reduce global disability and mortality of acute ischemic stroke if practised within the first hours from the onset. However the appropriate allocation of these patients after the initial treatment is still a matter of debate, given the need for monitoring in an intensive care unit for the first 24-48 hours.
Materials and Methods: We analysed a continuous series of patients presenting to our emergency department within the first four hours from the stroke onset, comparing the clinical outcome of those who were transferred in a ward of Internal Medicine with those who went to other typology of hospital ward.
Results: We admitted 32 consecutive patients (17 males,15 females, mean age 72,9 years, range 46 - 95) to the i.v. thrombolytic treatment with rtPA with an average door-to-needle time of 76 minutes and an average time from the stroke onset of 177 minutes. Two patients were transferred to the Hub center for mechanical thrombectomy. After an average intensive care observation of 36 hours, 18 patients went to the Internal Medicine ward and 12 patiens went to an Emergency Medicine Ward. No difference in the outcome at the first month was observed between the two types of Medical Wards.
Conclusions: The General Medical Ward can be a valid alternative to Emergency Medicine (stroke unit) after the first 24-48 hours from the intravenous thrombolytic treatment of stroke.

Idiopathic *vs* iatrogenic edema

L. Manzini[1], C. Benatti[1], M. Bertesi[1], C. Di Donato[1]

[1]UO Complessa Medicina Interna, Ospedale di Carpi (MO), ITALY

Idiopathic edema (IE) is a fluid retention syndrome of face, hands, trunk and limbs swelling occuring in women in absence of cardiac, hepatic, endocrinological or renal diseases. A 38 years-old woman was admitted with right back pain and fever, reporting use of loop diuretic for apsecific edema. Lab tests showed increase in inflammatory indexes, with positive coltures for E. Coli. Abdomen ultrasound showed right nephritis. Patient began ceftriaxone and ketorolac, with good initial clinical response. After a few days, widespread edema appeared on face and limbs with 8 kg weight increase. A body tomography was performed showing bilateral pleural and ascitic effusion with edema of adipose tissue. Autoimmune, biochemical, endocrinologic, trombophilic profile were negative, as ecocardiogram. Patient started furosemide with 5 kilogram weight loss. IE was unveiled by suspension of diuretic with concomitant use of ketorolac due to vasoconstriction on afferent arteriola and the enhancement of reninic activity. Three theories can explain pathogenesis: capillary leak, refeeding and diuretic-induced edema. In the last option edema can be induced by chronic use of diuretics through activation of sodium-retaining mechanisms. If diuretic is then stopped, patient may be unable to acutely shut off this hormonal adaptation, resulting in rapid edema formation. Maintenance without diuretics for some weeks often restart spontaneus diuresis with edema resolution. The diagnosis of IE may be considered when there's no evidence of concomitant cardiac, hepatic, or renal diseases.

L'ecoscopia bedside nel paziente internistico: un acceleratore diagnostico-terapeutico

C. Marone[1], V. Sbolgi[1], M. Spadaro[1], G. Fontana[1], L. Di Carlo[1], M. Lordi[1], S. Mandetta[1]

[1]Policlinico Umberto I, UOC Geriatria, Roma, Italy

Premessa e Scopo dello studio: Il paziente internistico è spesso fragile e complesso, poco visitabile e con dati anamnestici incompleti. Scopo dello studio è di valutare se l'ecoscopia condotta al letto del paziente (bedside) nelle prime 48 ore dal ricovero possa modificare il processo diagnostico e terapeutico.
Materiali e Metodi: Lo studio è stato condotto su 338 pazienti, ricoverati nella UOC di Geriatria, nel periodo compreso tra il 1/7/17 ed il 30/9/18 con patologia cardiorespiratoria, gastrointestinale, urologica ed oncologica. Abbiamo in tutti i pazienti effettuato un'ecoscopia, come integrazione all'esame obiettivo, valutando referti anatomici come da metodologia già descritta in letteratura.
Risultati: Lo studio ha messo in evidenza che nel 24% dei casi, dopo ecoscopia, la diagnosi d'ingresso è stata modificata, in quanto non sospettata o non riferita. Le diagnosi modificate hanno riguardato per il 26% dei casi la patologia pleuropolmonare, per il 20% la patologia cardiaca, per il 23% patologie addominali, per il 21% la patologia uro-nefrologica e per il 10% la TVP. Nel 21% dei casi l'iter diagnostico è stato ridotto attraverso l'accelerazione dei tempi di richiesta di indagini strumentali. Nel 55% dei casi l'ecoscopia è stata utilizzata anche per il monitoraggio terapeutico.

Conclusioni: Dalla nostra esperienza si può ipotizzare che un utilizzo estensivo dell'ecoscopia, come integrazione all'esame obiettivo, possa ridurre il numero delle indagini diagnostiche ed il tempo di ospedalizzazione con vantaggi sia per il paziente che per l'economia sanitaria.

An uncommon case of partial Horner syndrome in a young woman

A. Masi[1], D. Di Girolamo[1], A.C. Rostagno[1], L. Fallai[2], L. Poggesi[1]

[1]Università degli Studi di Firenze; [2]AOU-Careggi, Medicina per la Complessità Assistenziale 3, Italy

Background: Partial Horner syndrome (miosis, ptosis, enophtalmos without anhidrosis) is an uncommon manifestation of internal carotid artery (ICA) dissection. Spontaneous ICA dissection can be associated with partial Horner syndrome, focal neurologic symptoms and ipsilateral pain in face or neck. Genetic predisposition (Marfan syndrome, etc.), risk factors (hypertension, smoke and migraine) and precipitating events (hyperextension of the neck) may lead to its development.
Case report: A 42 yo woman presented to the ED because of right ptosis and miosis after few days of massive physical effort during bricklaying at home. She had no medication on daily basis and history of smoking and recurrent headache. She also reported persistent right face pain after a recent right tooth extraction. Physical examination revealed right partial Horner syndrome, no other neurological symptoms. Brain CT and angio-CT revealed an abrupt reduction of the right ICA caliber. The patient was treated with ASA 300 mg/day and showed progressive reduction of symptoms. A MR angiogram revealed hyperintensity of the right ICA wall due to an intramural hematoma. Echocardiography, thoracic angio-CT and abdominal vessels ultrasound excluded mitral valve prolapse, aortic aneurism and renal artery fibrodysplasia.
Conclusions: Spontaneous ICA dissection should be suspected in patients with partial Horner syndrome. Prolonged physical effort, hyperextension or rotation of the neck can determine a spontaneous ICA dissection. Dental surgery may also play an important role in its development.

Long term follow up of chronic benign pancreatic hyperenzymemia: features from an ambulatory register

C. Mastrobuoni[1], G. Di Monda[1], L. Ferrara[1], F. Gallucci[1], L. Tibullo[1], U. Valentino[1], G. Uomo[1]

[1]UOC Medicina Interna 3, Dipartimento Medico Polispecialistico, AORN Cardarelli, Napoli, Italy

Introduction: CBPH is a condition that affect the 1-3% of the population in western Countries; it consists of an intermittent, fluctuating, increase of pancreatic serum enzymes (amylase, more rarely lipase) without any pathologic findings of the pancreatic function neither parenchymal damage in asymptomatic patients. In clinical practice, the finding of a serum enzymes increase lead to a repeated diagnostic exams and it constitutes a reason of unmotivated anxiety both for patients and physicians.
Materials and Methods: During a period of 18 years (2000-2018), in a dedicated ambulatory we observed 128 patients presenting with CBPH: 72 females and 56 males (median age 53 years, range 18-76). Median follow-up was 8.4 years (range 7 months-16.7 years); pancreatic hyperenzymemia was present before our observation in a median of 25 months (range 6-32 months). Diagnostic exams (ultrasound, CT scan, NMR, ERCP, echoendoscopy) were 5 as median in the whole series and laboratory determinations at least performed 5-6/each year before our observation. Fluctuation of the serum enzyme levels (with very frequent reentry in normal value) was observed in all subjects. Amylase was elevated in all subjects, with a prevalence of iso-p fraction, associated with lipase increase in 50 patients (39%).
Conclusions: Physicians should familiarize with CBPH, that is not associated with previous, actual or evolutive pancreatic damage, with the aim to avoiding useless, expensive and frequently invasive diagnostic procedures.

Has the management of atrial fibrillation changed in the geriatric subject (with the advent of NOAC)?

F. Mastroianni[1], M. Amodio[1], S. Errico[1], P. Mangini[1], A. Venezia[1], L. Bonfrate[1], G. Baldassarre[1]

[1]UOC Geriatria, EE Ospedale Generale Regionale "F. Miulli", Acquaviva delle Fonti (BA), Italy

Purpose of the study: Check whether, with the advent of NOAC, the management of NVAF in the geriatric patient has changed.
Materials and Methods: The retrospective analysis of the medical records concerned all the subjects suffering from NVAF admitted for any cause in the Geriatrics Unit, of the "F. Miulli" Regional Hospital of Acquaviva delle Fonti (BA), in 3 surveys: the years 2012, 2015 and the first 9 months of 2018
Results: Data of years 2012-2015: 367 subjects affected by NVAF, M 156 (42.5%) and F 211 (57.5%), average age of 83.68 years. Data of year 2018: 121 subjects affected by NVAF, M 49 (40.5%) and F 72 (59.55), mean age 83.8 years. In years 2012-2015: 18.6% of the total admissions examined (1972) were affected by NVAF. In year 2018, 14.1% of the total admissions examined (856) were affected by NVAF. In 2015, 31% took NOAC. In 2018 30.5% assumed NOAC.
Conclusions: In three years the number of patients with NVAF treated with NOAC has not changed (about 30% of all patients treated). The patients treated with Warfarin maintain a high share (39% in 2012 and 35% in 2018). Among the NOAC, Apixaban is the most used, increasing in 2018 compared to 2015 (51% *vs* 48%), Dabigatran almost halves its use (32% *vs* 18%) in favor mainly of Edoxaban (which in 2015 was not yet fully marketed). Rivaroxaban is stable (19%).

Il progetto di miglioramento per la gestione clinico-organizzativa del paziente con piede diabetico nella provincia di Modena

M. Maurantonio[1], C. Castellano[1], F. Marra[1], M. Sarti[1], A. Bedini[1], S. Donatiello[1], L. Roncucci[1]

[1]Dipartimento Integrato di Medicina Interna, Generale, d'Urgenza e Post-Acuzie AOU Modena, UOC Medicina Interna Metabolica, OCB Modena; [2]Dipartimento Integrato Interaziendale Nefro-Cardio-Vascolare AOU Modena, UOC Chirurgia Vascolare, OCB Modena; [3]Dipartimento Interaziendale di Medicina di Laboratorio e Anatomia Patologica, SSD Microbiologia Clinica Provinciale AUSL, OCB Modena; [4]Dipartimento Integrato di Medicine Specialistiche AOU Modena, UOC Malattie Infettive, Policlinico Modena; [5]Dipartimento Integrato Interaziendale di Diagnostica per Immagine AOU Modena, SC Radiologia, Italy

Premessa: Il diabete è gravato da maggiori costi sanitari diretti ed indiretti. Il piede diabetico è una complicanza in cui neuropatia, ischemia, infezione e co-patologie incidono su prognosi. La diagnosi si fonda su elementi clinici, bioumorali, radiologici e microbiologici. In RER la prevalenza di diabete è il 6.9%; il 3% sviluppa ulcera.
Metodi: E' stato analizzato il percorso di cura del paziente affetto da piede diabetico nella provincia di Modena attraverso le schede SDO prodotte dall'Ospedale di Baggiovara e del Policlinico nel triennio 2015-2017.
Risultati: Sono stati ricoverati 910 pazienti (795 presso OCB, 115 presso Policlinico) con età media 71.9 anni e 11.520 giornate di degenza. La degenza media è risultata pari a 12.7, con spesa pari a 5.428.032 euro. Le amputazioni sono state il 13%, le procedure di angioplastica il 29%. Tra le raccomandazioni clinico-organizzative desunte: a) identificazione di un team multidisciplinare e Ambulatorio multidisciplinare dedicato; b) un PDTA integrato per la tempestività di accesso ai diversi Livelli di cura; c) formazione comune; d) educazione del paziente; e) case-management.
Conclusioni: La letteratura suggerisce un approccio multidisciplinare nella cura del piede diabetico. Grazie ai risultati del progetto di miglioramento e alla sperimentazione gestionale unica tra i due Ospedali di Modena è stato possibile identificare il Team dedicato e definire il PDTA AOU Modena (Livello 3), ad integrazione del PDTA Provinciale per il miglioramento dell'assistenza coerentemente con quanto suggerito nella Circolare RER 5/2017.

Cost-effectiveness of rosuvastatina/ezetimibe in fixed-dose combination in hypertensive patients with uncontrolled hypercholesterolemia compared to a previous simvastatina/ezetimibe treatment

A. Mazza[1], G. Torin[2], C. D'Amicis[3], A.P. Sacco[4], L. Schiavon[4], C. Rossetti[4], S. Lenti[5], S. Cuppini[4]

[1]ESH Excellence Hypertension Centre, Unit of Internal Medicine, AULSS5 Polesana, Rovigo; [2]Unit of Internal Medicine C, Department of Medicine, University of Verona, Verona; [3]Freelance, Master in Statistics, Bologna; [4]Unit of Internal Medicine, S. Maria della Misericordia General Hospital, AULSS 5 Polesana; [5]Hypertension Centre, Internal Medicine and Geriatrics, San Donato General Hospital, Arezzo, Italy

Introduction: Combination therapy helps achieve low-density lipoprotein cholesterol (LDL-C) goals in high-risk patients. The role of Rosuvastatin and Ezetimibe (RE) has not been characterized in high-risk hypertensive outpatient subjects. The aim of the study is to evaluate the cost-effectiveness of RE in fixed-dose combination in patients with uncontrolled hyper-cholesterolemia by a Simvastatin and Ezetimibe (SE) therapy and to compare the costs between the two therapies.
Materials and Methods: 32 subjects (46.8% men, mean age 67.8±11.1 years) with uncontrolled LDL-C levels (109.4±14.2 mg/dL) and treated with SE (40 mg and ezetimibe 10 mg daily, 56.3% in fixed-dose combination), were switched to once-daily fixed-combination therapy with RE 10/10 mg (n=18) or 20/10 mg (n=14). The monthly cost for treating patients with SE and RE was estimated using pharmacy dispensing records. The change of LDL-C level, the tolerability analyses (AST, ALT and CPK values) and the costs of treatment were compared using parametric and non-parametric statistic tests.
Results: After a median time of 76 days, RE treatment were associated with significant decrease of LDL-C levels (-25%, Wilcoxon signed-rank test p<0.001) and costs reduction (-39.4%). The LDL-C target (*i.e.* <70 mg/dL) value was reached in 32% of cases. The average cost of RE therapy is also lower than the minimum cost of the SE combination (26.64 *vs* 33.76 €, p<0.01). No adverse event was observed.
Conclusions: RE in fixed-dose combination therapy was safe and cost-effective on improving LDL-C levels.

A case of disseminated Herpes Zoster in a patient with chronic lymphocytic leukemia

P. Mercatelli[1], N. Palagano[1], E. Martinelli[1], F. Crudele[1], E. Cioni[1], G. Barbarisi[1], M. Zavagli[1], I. Bertoletti[1], G. Bandini[1], C. Marchiani[1], P. Bernardi[1], M. Gagliano[1], A. Moggi Pignone[1]

[1]Medicina per la Complessità Assistenziale IV, AOU Careggi, Firenze, Italy

Background: Reactivation of Varicella-Zoster Virus normally presents itself with dermatomal herpes zoster. Atypical presentations and complications are more common in immunocompromised hosts, due to the reduced T cell-mediated immunity. In these patients a rare but misleading presentation is disseminated cutaneous HZ, defined as an eruption of at least 20 widespread vesciculo-bullous lesions outside the primary and adjacent dermatomes.
Case report: A 76 year old man with a history of CLL previously treated with Bendamustine and Rituximab was admitted to our hospital with a painless nonpruritic rash starting as an erythematous maculopapular lesion on the top of his head and rapidly spreading as vesicles to his chest and back in a nondermatomal pattern. He also had headache, eye swelling, hypoacusis and fever. The eye and the ear examination were negative; though we preventively prescribed Gangiclovir eye gel. The vesicles progressed to pustules and the ones on his head became superinfected. The consultant Dermatologist diagnosed an Atypical Disseminated Herpes Zoster and the patient was successfully treated with i.v. Acyclovir, Amoxicillin Clavulanate and Metilprednisolone.
Conclusions: Disseminated HZ is a severe complication of VZV reactivation. It can lead to a diagnostic and therapeutic delay with an increase of complications and morbidity. Early treatment can reduce visceral involvement and bacterial superinfections. As it is impossible to vaccinate immunocompromised patients, prompt treatment with antiviral drugs should be applied at the minimal clinical suspicion.

An unusual case of pneumonia

L. Minetola[1], D. D'Arcadia[1], L. De Marchis Preite[1], D. Tariciotti[1], F. Tiratterra[1]

[1]UOC Medicina Interna, Ospedale G.B. Grassi, ASL Roma 3, Italy

Background: Chronic eosinophilic pneumonia (CEP) is a rare idiopathic disorder with typical peripheral alveolar infiltrates on imaging, due to an accumulation of eosinophils in the interstitium and alveolar spaces of the lung. It is characterized by the finding of eosinophilia in bronchoalveolar lavage (BAL). CEP is highly responsive to oral corticosteroid therapy. Women are affected twice as often as men, and the patients are often nonsmokers.
Case report: We report a case of a 69-year-old woman who developed gradual onset symptoms (improving dyspnea and cough in approximately one month), respiratory signes (auscultatory findings of wheezing and crackles), peripheral blood eosinophilia, total IgE elevation, iron deficiency anemia and chest imaging (CTscan) findings of peripheral, nonsegmental, ground glass opacities and centimetric mediastinal lymphadenopathy. A BAL was performed, showing eosinophilia. We assessed as being an idiopathic CEP form, since we excluded other causes of pulmonary eosinophilia. We started glucocorticoid therapy (prednisone at a dose of 0.5mg/kg/day) with rapid clinical improvement and CTscan abnormalities reduction after four weeks.
Conclusions: CEP is a rare disease and it is more frequent in women. The diagnosis is based on the combination of clinical elements, chest imaging and a BAL showing eosinophilia; surgical lung biopsy is rarely necessary. CEP is highly responsive to corticosteroid therapy and the outcome for most patients is excellent.

An intriguing neurological syndrome due to ciguatera intoxication in Emergency Medicine!

E.G.M. Mondati[1], G. Gasbarrini[2], G.A. Piccillo[3]

[1]Department of Internal Medicine and Systemic Pathologies, University of Catania; [2]Professor Emeritus of Internal Medicine, Catholic University of Rome; [3]Emergency Department, Cannizzaro Hospital, Catania, Italy

Background: Ciguatera poisoning (CP) is the most common form of non-bacterial food-poisoning from fish worldwide (10 000-50 000 cases/year), which produces a wide range of neurological, cardiovascular and gastrointestinal symptoms. There is currently no clinical diagnostic test for Ciguatera poisoning and diagnosis is based on presenting symptoms and recent history of reef fish consumption.
Case report: A 43 aged men presented to our Dept due to nausea, vomiting, watery diarrhoea, lethargy and generalised weakness which lasted for 48 hours after to have spent a 2-week holiday journey in Hawaii. He had presented vomiting and diarrhoea 12 hours after eating the fish (parrotfish) and 36 hours later he had developed neurological symptoms as extremity pruritis, paraesthesia of mouth, hands and feet, myalgia and cold allodynia. Laboratory data, cardiologic evaluation with EKG, Brain-CT and MRI no pointed out any alterations. Management was symptomatic on oral hydration and antihistamines. The majority of the neurological symptoms had subsided by 16 weeks. Our patient is currently healthy with no long-term symptoms.
Discussions: Ciguatera poisoning is caused by ingesting reef fish whose flesh is contaminated by ciguatoxins produced by dinoflagellates of the genus *Gambierdiscus* which live on algae in coral reefs. Neurological, cardiovascular and gastrointestinal symptoms can last for several days, weeks or even months and, although rarely fatal, the illness can be quite disabling. Since there is no standard treatment regime for CP, the mainstay of treatment is only supportive.

Our "big fat" case of acute pancreatitis

L. Montillo[1], F. Riccomi[1], M. Sampaolesi[1], F. Fulgenzi[1], M.N. Piersantelli[2], T. Gentili[2], C. Nitti[2], A. Salvi[2]

[1]UNIVPM Ancona, Medicina d'Urgenza; [2]Ospedali Riuniti Ancona, Medicina d'Urgenza, Italy

Background: Acute pancreatitis is a life-threating inflammatory disease of the pancreas. Several conditions are associated with

acute pancreatitis: gallstone, alcohol, hypertriglyceridemia (HTG) are the commonest

Case report: A 52-year-old man refers to the ED of a peripheral hospital for vomiting and epigastralgia. From haematochemical and radiological exams: hypertriglyceridaemia (10761 mg / dl), hypercholesterolemia, hyperbilirubinemia, hyperlipasemia (1665U/l) and edema of the pancreatic parenchyma. A diagnosis of acute pancreatitis secondary to hypertriglyceridemia was therefore made, so insulin therapy was started and the patient was transferred to our department. He repeated blood tests (triglyceridemia>4000 mg /dl) with evidence of strongly lipemic serum. We confirmed the diagnosis of acute pancreatitis secondary to hypertriglyceridemia, so we started plasma exchange (PEX), medical therapy with omega3, fenofibrate and insulin/20% dextrose infusion. After 3 sessions of PEX, triglyceridemia was 526 mg / dl, so we suspended apheresis and insulin therapy. The patient's condition improved rapidly so it was possible, already on the fifth day, to transfer him to a hospital closer to his home with oral hypolipemic therapy.

Conclusions: HTG is a significant risk for acute pancreatitis when levels are >1000 mg/dL. Early clinical recognition is important to provide appropriate therapy and to prevent further episodes. We have confirmed that the early implementation of PEX in this setting is crucial for the rapid resolution of the clinical picture.

Influence of HIV infection and antiretroviral therapy on aortic stiffness: a meta-analysis

G. Mulè[1], G. Geraci[1], T. Attardo[2], G. Augello[1], S. Cottone[1], A. Cascio[3], G. Mulè[1]

[1]Dipartiamento di Medicina Interna e Specialistica, Università di Palermo; [2]PO "Barone Lombardo", Medicina Interna, Canicattì (AG); [3]UO Malattie Infettive, Università di Palermo, Italy

Background: Growing body of evidence indicates that risk of CV events is higher in HIV-infected patients (HIV+) when compared to HIV-uninfected persons (HIV-). This enhanced risk may in part be mediated through markers od arterial damage such as large artery stiffness assessed by measuring aortic pulse wave velocity(PWV). Several studies examined arterial stiffness in HIV+ with inconsistent results. We performed a new meta-analysis with the aim to evaluate the influence of HIV infection and its therapy only on aortic PWV.

Methods: A literature search was performed in PubMed, Google Scholar, Web of Science and Medline for articles, concerning the effect of HIV infection and ART on aPWV. The standardized mean difference (SMD) and corresponding 95% confidence intervals were calculated for aPWV in different comparison groups, which contained naive HIV+ *versus* HIV-, HIV+ receiving ART *versus* HIV- and HIV+ receiving ART *versus* naïve HIV+.

Results: In a total of 11 studies, naive HIV+ (n=566) showed increased aPWV compared to HIV- (n=816): SMD=0.386 (0.197–0.575), p <0.001. Nine studies were identifi ed comparing HIV+ treated with ART (n=631) to HIV- (n=637) showing higher values of aPWV in the former than in latter: SMD=0.681 (0.396–0.967), p <0.001. In 8 studies HIV+ treated with ART (n=599) exhibited greater aPWV values than those of naive HIV+ (n=325): SMD=0.259 (0.006–0.512), p<0.04.

Conclusions: Our meta-analysis seems to suggest that HIV infection per se and even more ART may impair aortic distensibility.

Abdominal ultrasound in nasogastric tube placement: a multicenter, prospective, cohort study

N. Mumoli[1], M. Barberio[1], M. Mereghetti[1], M. Cei[2], A. Cresci[3], G. Rotiroti[1], J. Vitale[4], F. Dentali[5]

[1]UO Medicina Interna, Ospedale Magenta (MI); [2]UO Medicina Interna, Ospedale Cecina (LI); [3]UO Medicina Interna, Ospedale Livorno; [4]UO Medicina Interna, Ospedale di Mendrisio (CH); [5]UO Medicina Interna, Ospedale Luino (VA), Italy

Background: The nasogastric tube (NGT) is an essential inpatient tool to confirm correct NGT placement. Chest X-Ray (CXR) is universally accepted as the method of choice, but it may request time and resources. We believe that bedside ultrasound (US) can be equally useful in displaying correct placement of the NGT with the advantage of being more rapid, cost-effective, and practical.

Materials and Methods: With bedside abdominal US we prospectively evaluated all consecutive inpatients with new NGT placement. For the purpose of diagnosis we used two criteria. First, we search in hypogastrium or in left hypochondrium the correct visualization of the NGT, imaged as hyperechoic line with acoustic shadow. Then, if we do not see the classic image, we give 40 mL of air to visualize a real-time echo-contrast. Diagnostic accuracy was calculated using CXR as the gold standard. Every operator (physician, nurse, radiologist) was blind to each other and for US we contemplated three possible answers: correct, incorrect or uncertain.

Results: We enrolled 606 patients. The NGTs were confirmed with US to be correctly in the stomach in 422 cases. The accuracy of the abdominal US oscillates according to the different assignment of the uncertain cases. Considering the worst analysis, where the uncertain cases were negative because not clearly visible, the US ultrasound keeps anyway a good accuracy with a sensitivity of 93.0% (90.8%-95.1%), specificity of 75.2% (71.7%-78.8%), positive predictive value (PPV) of 94.0% (92.0-96.0%), while the negative predictive value (NPV) was 71.9% (68.2%-75.6%).

Conclusions: We have demonstrated a reliable approach for confirming placement of NGT using ultrasound in the hands of an operator with limited training. Our method maintained a good positive predictive value and accurately confirmed correct positioning when compared to CXR.

Epidemiology of thyroid nodule in a highly polluted area of Campania: results from the "Ambiente e Salute" project

R. Muscariello[1], E. Badolati[2], E. Borriello[1], M. Bruschini[3], L. Di Ruocco[1], R. Giannattasio[4], S. Ippolito[1], E. Nocerino[1], O. Romano[1], R. Ruggiero[5], T. Spinosa[6], F.S. Tripodi[7], V. Nuzzo[1]

[1]UOSD Endocrinologia, Malattie del Ricambio e della Nutrizione, Ospedale del Mare, Napoli,; [2]Specialista Ambulatoriale Endocrinologia e Malattie del Metabolismo, Asl Napoli 1 Centro, Distretti 29-30-33; [3]Dipartimento Attività Ospedaliere, Asl Napoli 1 Centro; [4]Referente per l'Endocrinologia, Presidio San Gennaro, Asl Napoli 1 Centro; [5]Direzione Sanitaria Aziendale, Asl Napoli 1 Centro; [6]Direttore Distretto 5, Asl Napoli 1 Centro; [7]Specialista Ambulatoriale Geriatria, Asl Napoli 1 Centro, Distretto 28, Italy

Background and Aim of the study: There is an association between thyroid nodules and environmental pollution. In the area around Naples, Campania, there is an environmental problem because of abusive landfills hidden in the soil. The aim of the study is to evaluate thyroid nodule epidemiology in this highly polluted area of Campania, known as "Terra dei Fuochi".

Materials and Methods: Outpatient echography screening clinics have been set up in districts 26-28-30-31-32 of "Asl Napoli 1 Centro". We collected information about pathologies, families, environment and nutrition about all patients; we built a common database recording anamnestic informationand number and dimension of thyroid nodules.

Results: We enrolled 477 outpatients (94 M e 383 F, mean 43.6 years old); we found 241 nodules (50%). Nodular pathology is not associated neither to proximity to landfills nor to vegetables consumption. We found a statistically significant correlation between family history for goiter and thyroid nodules.

Conclusions: Thyroid nodular pathology in this highly polluted area is near to national data; our results confirmed the association between thyroid nodules and both female sex and family history positive for goiter.

Pre and post-capillary pulmonary hypertension. Case report

R. Muscherà[1], G. Di Monda[1], L. Ferrara[1], F. Gallucci[1], U. Valentino[1] G. Uomo[1]

[1]UOC Medicina Interna 3, Dipartimento Medico Polispecialistico, AORN Cardarelli, Napoli, Italy

Background: Nowadays in Italy are present 150000 adult patients suffering from various congenital cardiomyopathy. The great majority of them are patients diagnosed at childhood which become adults but many cases were diagnosed for the first time at adulthood also.

Case report: A 62-years-old female was admitted because of central venous retinal artery thrombosis Anamnesis revealed : hypertensive cardiopathy, atrial fibrillation, chronic obstructive peripheral arteriopathy, chronic real failure, obesity and talassemic trait. At admission the patient presented hypo-regenerative anemia, atrial fibrillation, carotid bilateral tickening, and a diffuse leuko-encephalopathy (NMR), Echocardiography showed dilation of the right cameras, pulmonary trunk and vena cava; in addition (doppler-jet) an interventricular septum defect (0.8 cm, *pars membranacea*) and moderate stenosis of pulmonary artery plus tricuspidal insufficiency (estimated systolic pulmonary pression 90 mmHg) were observed. Cardiac angiographic catheterism showed: a) dysplasia of the pulmonary *valvula* leading not-significantly stenosis due to systolic doming; b) combined pre and post-capillary severe pulmonary hypertension with reduced cardiac index and elevated pre-capillary resistance (PCR). Treatment in the specific case resulted challenging: there is controindication for surgery with possibility to utilize Ambrisentan (endotelin-receptor inhibitor). The drug was started and the follow up is ongoing.

Primary hyperparathyroidism in a patient with a history of recurrent nephrolithiasis and multiple ostheolytic lesions

L. Naletto[1]

[1]Università degli Studi di Firenze, AOU Careggi, Firenze, Italy

Backgrounds: Primary hyperparathyroidism(HPT) is a disorder in which excess parathyroid hormone (PTH) is secreted from one or more of the parathyroid glands. Common clinical manifestations are nephrolithiasis, muscle sickness, impaired bone mineralization, and neuropsychiatric symptoms. A pathognomonic rare sign of HPT is Brown Tumor,a benign lesion caused by localized osteoclastic turnover of bone.
Case report: A 66-yrs-old man with a history of recurrent nephrolithiasis and renal failure was referred to our department for further evaluation of suspected HPT.A follow-up scan-TC revealed an osteolytic lesion on the pubis bone. Addition PET/TC showed increased bone metabolism in multiple areas, at first suspicious for metastasis or myeloma. At blood tests tumor markers were all within normal limits and absent monoclonal components. Furthermore, creatinine 2.7 mg/dl, serum calcium 12.8 mg/dl and PTH levels were markedly increased to >2000 pg/mL.US of neck revealed a ca. 3 cm mass in the inferior aspect of the right thyroid gland, suggestive of a hypertrophic parathyroid. The patient underwent right parathyroidectomy and histology confirmed the presence of pathological parathyroid tissue.
Discussion: In this case, the elevated PTH in a patient with renal failure could be evocative a tertial HPT. However,the systematic analysis of findings carry out to suspected a primary form, confirmed by the post-surgical histology. Moreover,in differential diagnosis of osteolytic lesions,taking account of the new evidence, Brown Tumor caused by HPT was considered the most likely diagnosis.

The surprise of the Japanese restaurant...

O. Nannola[1], P. Amorelli[2], M. Arcopinto[1], M. Carafa[1], F. Cataldi[1], D. D'Auria[1], M. Giordano[1], L. Guadagno[1], B. Russo[1], P. Morella[1]

[1]UOC Medicina DEA, AORN A. Cardarelli, Napoli; [2]Scuola di Specializzazione in Medicina Interna, Università degli Studi di Napoli Federico II, Napoli, Italy

Introduction: Liver abscess is quite infrequent in Western countries, its diagnosis is not difficult with the currently available imaging tecniques, the microbiological agent is usually identified, while the entry point often remains undetermined.
Case report: A 35 years old male is hospitalized for high fever for two days, vomit, diarrhea and abdominal pain. The patient's conditions appear serious for hyperpyrexia, prostration and hypotension. The patient's medical history was devoid for any major diseases; he reports a recent meal with raw or nearly-raw fish in a Japanese restaurant. Abdominal CT shows a liver abscess of the left lobe (on the second hepatic segment with TD 6x4 cm). The patient's conditions quickly improve with medical therapy (based on hydration, and antibiotic therapy with piperacillin-tazobactam and metronidazole) and eco-guided drainage; 12 days later, the CT shows a significant reduction in size of the liver abscess. The cultural exam of the abscess liquid is positive for Group B beta haemolyticus Streptococcus (Streptococcus agalactiae), whilst it is negative for amoeba.
Conclusions: Even if uncertain, the link between raw fish consumption and the subsequent development of liver abscess seems highly likely, considering the patient's immunocompetence and the reports in literature, especially in Asia, about epidemics caused by Streptococcus agalactiae after consumption of raw fish and occurred with different clinical onset.

Acute bowel ischemia related to portal and superior mesenteric vein thrombosis: report of a complex case with multidisciplinary management

L. Natale[1], A. Mameli[2], M. Musu[1], A. Pisanu[3], G. Finco[1], D. Barcellona[2]

[1]Intensive Care Unit, University of Cagliari; [2]Department of Internal Medicine, University of Cagliari; [3]Department of Surgery, University of Cagliari, Italy

Background: Portal and superior mesenteric vein thrombosis (PVT /SMVT) is a rare condition in non cirrhotic patients but potentially fatal when associated with intestinal ischemia. Early anticoagulation with low molecular weight heparin (LMWH) showed to minimize the risk of serious complications but, in unstable patients with renal failure, the accumulation of LMWH may be harmful.
Methods: An obese 57-year-old female, with a medical history of psychosis in chronic treatment with olanzapine and haloperidol, presented because of abdominal pain, vomiting lasting three days and drawsiness. A CT scan showed PVT and SMVT associated with intestinal ischemia, bilateral aspiration pneumonia and segmental pulmonary embolism.
Results: In ICU the patient underwent intubation and mechanical ventilation, then an urgent laparotomy was performed, with a segmental resection of the small bowel (50 cm) and an ileo-jejunal anastomosis. Anticoagulation treatment was started the same day of surgery with high dose of enoxaparin (180 mg daily). A worsening renal failure and the onset of epistaxis and hematemesis from variceal bleeding led to suspicion of LMWH overdose and the dosage of plasma anti-Xa activity within the therapeutic range (0.6-1 IU/ml) allowed sub-therapeutic doses of LMWH until improvement of renal function and stop bleeding. Because of extension of pulmonary infiltrates, weaning from ventilation has been possible only after 22 days and the patient was discharged from ICU 5 days later, in a stable condition in Medicine Department to study causes of thrombosis.
Conclusions: Acute bowel infarction is a major complication in patients with PVT and SMVT that requires immediate resection of the involved segment and intensive care to manage complications and organ dysfunction. Early anticoagulation is mandatory and plasma anti-Xa activity in clinical practice could be a guide for LMWH dosing regimen in clinical complex cases, while an interdisciplinary team sinergically balance prevention of thrombosis and risk of bleeding.

Proton pump inhibitor associated with severe electrolyte impairment

R. Nersita[1], G.C. Del Buono[1], G. De Bartolomeo[1], C. Mancini[1], E. Masia[1], M. Mordenti[1], A. Bianchi[1], C. Politi[1]

[1]UOC Medicna Interna, ASREM, PO Isernia, Italy

Background: It is thought that PPI impair the expression of the Transient Receptor Potential Melastatin cation channels 6 and 7 that increase gut and colon Mg^{++} absorption in case of low Mg^{++} intake. Hypocalcaemia, instead, is secondarily induced by low Mg^{++} functional hypoparathyroidism.
Case report: A 78 year old woman was admitted to our IM Unit for the suspicion of diabetic neuropathy since she repeatedly referred to the ER for transient paresthesia at the lower limbs and epigastric pain. Her clinical history included T2 diabetes and hypertension. The laboratory tests performed at admission revealed low serum levels of Mg^{++} (0.6 mmol/l), Ca^{++} (2.76mEq/l), K^{+} (3.29mEq/l); kidney function, PTH, 25(OH)VitD, HbA1c were within normal range. We immediately switched the PPI treatment started years before for referred gastritis and dyspepsia to H2R antago-

nists; Mg^{++}, Ca^{++} and K^{+} supplementation was administered until correction of serum levels and contemporary healing of the initial symptoms. Normal electrolyte serum levels were maintained after the interruption of the initial supplementation. The patient was discharged free of symptoms.
Conclusions: PPI induced Mg^{++} deficiency is a rare (<1%) side effect that produces an array of cardiovascular features (including life threatening arrhythmias) as well as neuromuscular symptoms (tremors, weakness, tetany and convulsions). Greater concern to this side effect should be given when such symptoms occur in patients at higher risk (elderly with concomitant diuretic use and PPI treatment >1 year).

Superiorità dell'ecografia toracica bedside rispetto alla radiologia convenzionale nella diagnosi di polmonite: studio prospettico in un reparto di Medicina Interna

C. Norbiato[1], S. Marengo[1], A. Briozzo[1], E. Cane[1]

[1]AO Ordine Mauriziano, Torino, Italy

Premesse e Scopo dello studio: Lo studio confronta l'ecografia toracica bedside con la radiologia convenzionale nella diagnosi di polmonite in pazienti ricoverati in Medicina Interna
Materiali e Metodi: Sono stati inclusi 79 pazienti con segni e sintomi suggestivi per polmonite. Si sono confrontate le diagnosi ecografica e radiografica con la diagnosi di dimissione (Gold Standard):sono state valutate la singola performance diagnostica e la combinazione delle due indagini
Risultati: La diagnosi di dimissione ha confermato la polmonite in 62 pazienti (78%). L'ecografia ha mostrato una sensibilità pari a 0,935 (IC 95% 0,85-0,97), una specificità di 0,706 (IC 95% 0,47-0,87), un valore predittivo positivo di 0,921 (IC 95% 0,83-0,97), un valore predittivo negativo di 0,750 (IC 95% 0,51-0,90) ed un Likelihood Ratio positivo pari a 3,1806 (IC 95% 2,44-3,92). Per la radiografia invece la sensibilità è risultata pari a 0,500 (IC 95% 0,38-0,62), la specificità a 0,824 (IC 95% 0,59-0,94), il valore predittivo positivo a 0,912 (IC 95% 0,77-0,97), il valore predittivo negativo a 0,311 (IC 95% 0,20-0,46) ed il Likelihood Ratio a 2,8333 (IC 95% 1,78-3,89). Combinando le due indagini strumentali si è ottenuta una sensibilità di 0,984 (IC 95% 0,91-1,00), una specificità di 0,588 (IC 95% 0,36-0,78) ed un Likelihood Ratio positivo di 2,3894 (IC 95% 1,82-2,96)
Conclusioni: L'ecografia toracica bedside è risultata superiore alla radiografia convenzionale nella diagnosi di polmonite in termini di sensibilità, valore predittivo negativo e di Likelihood Ratio positivo.

A case of Fournier's gangrene

M. Novelli[1], A. Tosadori[1], A. Pilato[1], A. Cataldi[2], A. Tribocco[1], M. Rossetto[1], E. Magro[1], S. Savoldi[1]

[1]Department of Internal Medicine, General Hospital Ciriè, ASL TO4, Torino; [2]Department of Radiology, General Hospital Ciriè, ASL TO4, Torino, Italy

Fournier's gangrene is a rare high mortality infection that affects the subcutaneous tissue with a rapid progressive necrosis. An 86 year old female patient with no previously medical history or trauma related, presented pain, fever, and local hyperaemia in sacral region. She evolved with maintenance of febrile peaks and local edema, in addition to skin fluctuation followed by drainage of a purulent secretion through a small orifice. The leukogram presented WBC 19,000/mm3 and CRP 309,6 mm/dl. The therapy approach started with intravenous antibiotic combination of piperacillin-tazobactam 4,5 gr and clindamycin 600 mg every 8h. At this stage, the patient was assigned to our medical service on Internal Medicine Department with an extensive lesion on sacral region (20 cm), sepsis, bone exposure and extensive necrosis of the skin surrounding the wound. No neurovascular alterations were observed. Computed Tomography showed inhomogeneous solid tissue with paramedian bilateral localization extending from the anal canal anteriorly to gluteal muscles, subcutaneous fat, dermis and epidermis posteriorly. Magnetic Resonance confirmed the same findings. The infectious disease team requested a surgical debridement to collect culture material and confirms the antibiotic therapy already in use. The patient presented an important clinical improvement after the surgical approach, and was discharged from the sub intensive care unit three days after admission. She evolved with a reduction of the WBC and inflammatory markers. After the initial debridement, a special dressing was done in an operating room every other day. The borders of the lesion ceased to evolve with necrosis; the raw area was without purulent secretion and forming granulation tissue. The final bone and soft tissue culture results were negative. On the 30th day after admission, when the patient presented normal laboratory tests results, a skin graft was planned by the plastic surgery team.

A non-autoimmune ANA positive serositis with elevated CA125

D. Olivari[1], G. Calogerà[1], A. Ferrarini[1], M. Cardinali[1], L. Biondi[1], D. Benfaremo[1], G. Pomponio[2], L. Manfredi[2], A. Gabrielli[1]

[1]Clinica Medica, Università Politecnica delle Marche, Ancona; [2]Clinica Medica, Ospedali Riuniti di Ancona, Italy

Background: Pseudo-Meigs' syndrome is a rare disease characterized by ovarian tumour, hydrothorax and ascites, whereas Pseudo-pseudo Meigs (Tjalma syndrome) is a rare manifestation of systemic lupus erythematosus defined by ascites, pleural effusions and elevated CA125 level.
Case report: A 58y woman was admitted to our department for bilateral pleural effusion since 10 months. Her medical history was unremarkable. Immune serology (ELISA method) showed ANA and anti-dsDNA positivity (4 X UNL); CA125 was doubled. Pleural fluid was an exudate, with negative cytological and microbiological analysis. In the hypothesis of a lupus pleuritis (Tjalma syndrome) high doses steroids (prednisone 1mg/kg) were administered without benefits. Laboratory findings showed absence of proteinuria, complement consumption or hypergammaglobulinemia. Antiphospholipid antibodies resulted negative. Repeated tests in immunoblotting confirmed only ANA positivity. Pleural biopsies highlighted chronic aspecific pleuritis. Hence in the hypothesis of a proliferative or infectious disease a thoracic-abdominal CT scan and a total body positron emission tomography were performed, finding an adnexal mass, which was removed. Histological examination showed a teratoma. Since then, pleural effusion decreased and remained stable at 6 months follow-up.
Conclusions: Despite the suspicion of Tjalma Syndrome, absence of other lupus manifestations, unresponsiveness to steroids and disappearing after teratoma removal led us to diagnose an atypical Pseudo-Meigs Syndrome with ANA positivity and elevated CA125.

Acute liver injury: not only hepatitis

C. Oliveri[1], L. Lenzi[1], R. Falzone[1], T. Biasion[1], L. Gomarasca[1], S. Cozzio[1]

[1]APSS Medicina Interna, Rovereto (TN), Italy

Background: Drug-induced liver injury (DILI) is a clinical problem refers to liver injury induced by all types of prescription (marketed drugs) or non prescription drugs, includes small chemical molecules, biological agents, traditional Chinese medicines (TCM), natural medicines (NM), health products (HP), and dietary supplements (DS).
Case report: We describe three young Caucasian males, in previous good health. No alcohol intake, no chronic administration of drugs except for recent therapy with sildenafil, atorvastatin and TCM/NM. They presented with jaundice, abdominal pain, itching and acholic stools. Laboratory tests showed acute liver abnormalities. Autoimmune, viral markers and hereditary liver disease tests were negative. Radiology exams showed normal biliary tract and the liver biopsy cholestasis-hepatopathy. The history, time between the exposure and liver failure, exclusion of concomitant liver disease support our hypothesis of DILI. The outcome was different with slow- self-limiting liver injury after drug withdrawal in two cases and death in one case.
Conclusions: DILI incidence could increase due to the more common use of natural medication, supplements and health products. The clinical manifestations and the histological changes of acute DILI are usually not specific and currently doesn't exist a biomarker. DILI remains an exclusion diagnosis and a high index of

suspicion is often necessary, because men are less susceptible to DILI than women.

Analysis of short-term blood pressure variability in patients affected by catecholamine-producing tumours

F. Olmati[1], V. Bisogni[1], L. Petramala[1], G. Oliviero[1], M. Bonvicini[1], M. Mezzadri[1], A. Concistrè[1], V. Saracino[1], G. Iannucci[2], G. De Toma[3], A. Ciardi[4], C. Letizia[1]

[1]Secondary Hypertension Unit, Department of Translational Medicine and Precision, "Sapienza" University of Rome; [2]Department of Internal Medicine and Medical Specialties, "Sapienza" University of Rome; [3]"Pietro Valdoni" Surgery Department, "Sapienza" University of Rome; [4]Department of Radiological, Oncological and Anatomy-Pathological Sciences, "Sapienza" University of Rome, Italy

Introduction: Data on short-term blood pressure variability (BPV), whose changes represent a well-established cardiovascular risk factor, in pheochromocytoma and paraganglioma (PPGLs) is still lack and conflicting.
Materials and Methods: We retrospectively evaluated PPGLs patients referred to our Hypertension Unit from 2010 to 2018 with the aim to analyse 24-hours ambulatory blood pressure monitoring (ABPM)-derived short-term BPV markers, before and after successfully surgical treatment. PPGLs diagnosis was assessed according to guidelines and confirmed by histologic examination after surgery. 24-h ABPM-derived markers of short-term BPV were assessed, including systolic (SBP) and diastolic (DBP) blood pressure, circadian pressure rhythm (dipping pattern), and 24-hours, daily, and night-time average real variability (ARV).
Results: 24 patients of 52±19 yrs. (7M, 17F) were evaluated at baseline and after 27±25 months of follow-up (FU). Mean 24-hours metanephrines was 457.6±61.9 μg/24-h at baseline *vs* 62.9±29.0 μg/24-h at FU (p=0.04). After treatment we did not find significant changes in circadian pressure rhythm. However, we observed a significant decrease in 24-hours SBP ARV (8.8±1.9 *vs* 7.7±1.6, p=0.05), and a decreasing trend in 24-hours DBP ARV. On a multivariate analysis, 24-h metanephrines values resulted predictors of average 24-hours SBP SD (r^2=0.59, p=0.009) and night-time DBP SD (r^2=0.49, p=0.024).
Conclusions: In patients affected by catecholamine-producing tumours there is a reduction of short-term BPV indexes after successfully treatment.

Nail videocapillaroscopy in fibromyalgia: preliminary results

A. Parisi[1], R. Buono[1], F. Gallucci[1], F. Grieco[1], C. Mastrobuoni[1], P. Nocella[1], G. Uomo[1]

[1]UOC Medicina Interna 3, Dipartimento Medico Polispecialistico, AORN Cardarelli, Napoli, Italy

Background: Recent studies, on the simply clinical background, revealed an elevated frequency of Raynaud's phenomenon (RP) in patients suffering from fibromyalgia (FM) but videocapillaroscopic, objective, features are still lacking on this context. Aim of the present study was to evaluate microcirculatory pattern in patients with FM by using the reference method on this field that is nail videocapillaroscopy (NVC).
Materials and Methods: A group of 23 patients (21 F, 2 M; mean age 46 years, range 19-61) suffering from FM were enrolled. Diagnosis was in accordance with ACR criteria 2010-13; control group consisted of 20 pair matched for sex and age patients presenting with primary RP. NVC was performed by using Videocap 3, with optical probe (enlargement 200x) and with specific software (DS Medica, Milano).
Results: NCV revealed a normal pattern in 8 FM patients (34.8%); 15 patients (65.2%) presented non-specific microcirculatory abnormalities (dilation of capillary loop in prevalence); none of the patients presented features typical of scleroderma pattern (early, active o late). No statistical difference was observed comparing the data of FM patients *versus* controls.
Conclusions: Our preliminary results confirm that there is not a significant derangement of the microcirculatory vessel in FM patients and this seems to be in accordance with the prevalent "functional" pathogenesis of FM.

An unusual thoracic swelling: the role of POC ultrasound in Medicine ward

P. Pasquero[1], L. Chasseur[1], A. Marchisio[1], P. Lyberis[2], E. Ruffini[2], M. Porta[1]

[1]Dipartimento di Scienze Mediche, Città della Salute e della Scienza, Torino; [2]Dipartimento Cardiovascolare e Toracico, Città della Salute e della Scienza, Torino, Italy

Background: The cause of thoracic swelling can be difficult to identify, CT scan being the gold standard approach. Thoracic point of care ultrasound (POCUS) is a new diagnostic tool that allows to discriminate chest wall from pleural alterations. In this case POCUS showed a pulmonary hernia using a new sign[1]: the push out sign (POS).
Case report: A 67 year old man was admitted to Emergency because of dyspnoea and thoracic pain. A left apical lobectomy performed 8 months before to treat emphysematous COPD was complicated by respiratory failure requiring tracheostomy and pleural drainage. A small left intercostal swelling was noted, associated with reduced vesicular murmur and expiratory groans. The patient was tachypnoeic with hypercapnic hypoxemic respiratory failure at blood gas analysis. Chest X-ray showed a COPD pattern. Treatment was by oxygen supplementation and bronchodilators only. Clinical observation confirmed a 3-cm deformity at the 7th intercostal space. POCUS was able to identify the pleural line coming back from the intercostal space to subcutaneous tissue, or POS. A CT scan confirmed intercostal lung herniation on top of moderate pneumothorax in bullous lung disease. Pleural drainage was placed with slow progressive clinical improvement.
Conclusions: POCUS helped to clarify the cause of an unusual thoracic swelling. POS is a new promising ultrasound sign which allowed to identify a pulmonary hernia, thus directing diagnostic management.

1 Iaboli L *et al.*, Diagnosi ecografica di ernia polmonare: il "PUSH OUT sign". SIMEU 2018.

Efficacy of semaglutide *vs* dulaglutide across baseline HbA1c in SUSTAIN 7

R. Pastorelli[1], R.E. Pratley[2], J.P. Frias[3], H. Kumar[4], J. Petrie[5], W.E. Schmidt[6]

[1]Medicina Interna, Colleferro, Roma, Italy; [2]Florida Hospital Translational Research Institute, Orlando, FL, USA; [3]National Research Institute, Los Angeles, CA, USA; [4]Centre for Endocrinology and Diabetes, Amrita Vishwa Vidyapeetham, Kochi, India; [5]Institute of Cardiovascular and Medical Sciences, University of Glasgow, Glasgow, UK; [6]Department of Medicine I, St. Josef-Hospital, Ruhr-University Bochum, Bochum, Germany

Semaglutide, a new GLP-1 analog for T2D, showed significant and clinically meaningful HbA1c and body weight (BW) reductions across the SUSTAIN clinical trial program. This post hoc analysis of the phase 3b SUSTAIN 7 trial evaluated once-weekly subcutaneous semaglutide 0.5 mg *vs* dulaglutide 0.75 mg and semaglutide 1.0 mg *vs* dulaglutide 1.5 mg by baseline (BL) HbA1c subgroups in subjects with T2D. At week 40, improvements in HbA1c and BW were similar or favored semaglutide *vs* dulaglutide across subgroups (p-value for interaction: HbA1c, p<0.03; BW, p>0.05); estimated treatment effects were similar or favored semaglutide. More subjects with BL HbA1c >9% achieved HbA1c targets with semaglutide *vs* dulaglutide. Semaglutide was associated with similar or greater HbA1c and BW reductions *vs* dulaglutide in all subjects regardless of BL HbA1c. 'On-treatment without rescue medication' data. The post-baseline responses for 'all subjects' were analyzed using an MMRM with treatment and country as fixed factors and baseline value as covariate; subgroups were analyzed with treatment and baseline HbA1c subgroup as fixed factors, interaction between treatment and baseline HbA1c subgroup, and baseline HbA1c (%) as covariate, all nested within visit. Mean estimates were adjusted according to observed baseline distribution in each subgroup. CI, confidence interval; ETD, estimated treatment difference; MMRM, mixed model for repeated measurements; n, number of subjects contributing to analyses at end of treatment.

Desensibilizzazione a farmaci nelle reazioni di ipersensibilità agli anticorpi monoclonali, alla chemioterapia, antibiotici

V. Patella[1], G. Florio[1], D. Magliacane[1], A. Rubano[1]

[1]Dipartimento di Medicina Ospedale Civile Santa Maria della Speranza di Battipaglia (SA), ASL Salerno, Italy

Introduzione: La desensibilizzazione a farmaci è la procedura mediante la quale i pazienti possono tollerare di nuovo farmaci che hanno precedentemente indotto reazioni di ipersensibilità.
Metodi: Studio retrospettivo sulle desensibilizzazioni effettuate negli ultimi 5 anni, presso l'Ambulatorio di Allergologia e Immunologia Clinica del Dipartimento di Medicina, in pazienti con storia di ipersensibilità (ADR) a chemioterapici e farmaci biologici. La desensibilizzazione era eseguita solo in pazienti per i quali nessun farmaco alternativo poteva sostituire adeguatamente il farmaco causa dell'ADR.
Risultati: Sono state effettuate 42 desensibilizzazioni in pazienti con storia di reazione Anafilattica, di cui 40 portate a termine: Infliximab (11 pazienti); Rituximab (8); Cetuximab (6); Trastuzumab (2); Taxanes (4), Platinum Drugs (3), Doxorubicin (2), Asparaginase (2) and Epipodophyllotoxins (2).
Conclusioni: Inizialmente utilizzato nel trattamento ADR agli antibiotici, la desensibilizzazione è stata utilizzata nel contesto dell'allergia ai farmaci chemioterapici e biologici, estendendo così l'applicabilità clinica di questa procedura che si è dimostrata abbastanza sicura ed efficace nel migliorare la prognosi, principalmente permettendo ai pazienti di effettuare la terapia definita di prima linea.

What is the real cause of cerebrospinal fluid hypertension?

L. Pavan[1], B. Cattaneo[1], A. Grittini[1], E. Venegoni[1], P. Mantegazza[2], G. Patruno[2], A. Romorini[2], N. Mumoli[1]

[1]Medicina, Magenta (MI); [2]Neurologia, Magenta (MI), Italy

Introduction: Cerebrospinal fluid hypertension results from many causes: increase of production (choroid plexus papilloma or inflammation), downflow obstacle (in ventricles or subarachnoid spaces for tumours or inflammation even in outcome), decrease of reabsorption (for inflammation, arachnoid hemorrhage or thrombophlebitis), arterial or venous hypertension.
Case report: A 81-year-old woman, suffering from talassemia minor and previous paroxysmal atrial fibrillation, for headache underwent brain CT and angioMR which were negative. After admission in Hospital was confirmed the hypothesis of cerebrospinal fluid hypertension by measurement during rachiocentesis. Fluid tests resulted negative for infections or tumours. Brain and spinal cord MR was negative. So an extraneurologic cause was searched. Because of CEA increase with dyspepsia, a gastroscopy was performed with diagnosis of a great ulcered lesion of stomach which resulted to be adenocarcinoma. One could conclude the case: gastric cancer with paraneoplastic cerebrospinal hypertension. Whole body CT and PET did not detect metastasis so, after oncologic and surgical examinations, gastrectomy was proposed but the patient refused. Therefore a Palliative Care examination was performed and then the patient was transferred in a Hospice, where she died.
Conclusions: Certainly diagnosis was difficult for the rarity of relation between cerebrospinal fluid hypertension and gastric cancer. In our Medicine Unit all neurological causes were searched with the Neurologist Consultant but the real cause was found by the clinical status.

A case report of ingravescent hypothyroidism treated with levo thyroxine in softgel formula in a patient receiving nivolumab therapy for non-small cell lung carcinoma

C. Peirce[1], A. Maffettone[1], O. Maiolica[1], T. D'Errico[2], G. Italiano[3], M. Rinaldi[4], S. Di Fraia[1]

[1]UOC Medicina Cardiovascolare e Dismetabolica, AO Specialistica dei Colli, Napoli; [2]UOC Medicina, Ospedale SMDP degli Incurabili, ASL Napoli 1 Centro, Napoli; [3]UOC Medicina, AORN S. Anna e S. Sebastiano, Caserta; [4]Ex UOD Metabolica, AO Specialistica dei Colli, Napoli, Italy

Background: Nivolumab is a monoclonal antibody that binds to receptors on tumor cells (anti PD-L1) or immune cells (anti PD-1). It is used as a second-line therapy in locally advanced or metastatic non-small cell lung cancer. Among the side effects of the endocrine system, thyropathies are very frequent, both as thyroid hypofunction and/or hyperfunction.
Case report: A histological diagnosis of pulmonary squamous carcinoma (pT3N1M1) was given to a 70-year-old male patient. After the failure of chemotherapy, he began nivolumab therapy. At the beginning, he showed normo thyroid function with antibody negativity. After three months, "mild" subclinical hypothyroidism was detected with positive antibodies (AbTPO and AbTg); levo thyroxine (LT4) therapy in tablets was started. After 6 weeks, hypothyroidism shifted from subclinical to the full-blown form. The therapeutic switch to the liquid formulation was proposed, but due to lack of palatability, the patient refused it. A switch was then made to the softgel formulation and, after about 3 months, a good balance of thyroid function was found even if at a supraphysiological dosage (1.9 mcg / Kg / day).
Conclusions: Before and during immunotherapy with nivolumab, it is important to monitor thyroid function. In case of hypothyroidism, LT4 replacement therapy should be performed according to the guidelines. In case of poor response to conventional tablets therapy, physician should consider the use of other LT4 formulations.

Un raro caso di ipoalbuminemia

G. Peruzzi[1], F. Travasoni[1], F.M. Piani[1], L. Rasciti[1]

[1]AOU Policlinico Sant'Orsola Malpighi; [2]AUSL di Bologna, Italy

Premesse: La sintesi dell'albumina avviene nel fegato ed è promossa da ormoni quali insulina, cortisolo e GH ed inibita da citochine infiammatorie come l'IL-6. Nella mielofibrosi, l'alterazione del pathway JAK-STAT causa un'iperproduzione di IL-6. Studi clinici dimostrano come l'inibitore JAK-2 Ruxolitinib determini una riduzione dell'IL-6 e un aumento dei livelli plasmatici di albumina.
Caso clinico: Paziente donna, 52 anni, affetta da mielofibrosi JAK-2+ secondaria a rischio intermedio-2 secondo l'IPSS e in trattamento con Ruxolitinib a dosaggio ridotto per pancitopenia periferica, ricoverata nella nostra U.O. per riscontro di focolaio broncopneumonico. Il quadro clinico si complicava con un importante stato anasarcatico secondario a severa ipoalbuminemia scarsamente responsiva a terapia sostitutiva. Escluse le principali cause di ipoalbuminemia quali insufficienza epatica, sindrome nefrosica e protidodispersione enterica, in considerazione della patologia neoplastica di base, si dosava l'IL-6 che risultava marcatamente elevata nonostante la risoluzione del processo flogistico polmonare.
Conclusioni: In pazienti con patologia onco-ematologica, per la DD delle cause di ipoalbuminemia e stato anasarcatico, può essere utile dosare i livelli di IL-6. Elevati livelli di citochina possono, oltre ad inibire la sintesi di albumina, determinare un aumento della permeabilità capillare, dando vita ad un circolo vizioso che causerà e manterrà una grave condizione di anasarca, scarsamente responsiva alla terapia.

La Medicina Interna organizzata per intensità di cura: il setting ad alta intensità di cura nel miglioramento della cura del paziente con instabilità clinica

D. Peterlana[1], S. Dorigoni[1], M. Rigoni[1], G. Gasperi[1], A. Nardelli[1], C. Mazzonelli[1], S. Toccoli[1], G. Nollo[1], W. Spagnolli[1]

[1]UO Medicina Interna, Ospedale di Trento, APSS del Trentino; [2]Progetto Ricerca Clinica in Sanità, Provincia Autonoma Trentino, Fondazione FBK, Italy

Premesse e Scopo dello studio: L'organizzazione in Medicina interna (MI) per intensità di cura migliora gli esiti clinici dei pazienti. Lo studio si è proposto di valutare a 5 anni gli esiti ottenuti da tale organizzazione in presenza di una Area ad alta intensità di cura (AIC) *vs* non AIC.
Materiali e Metodi: Sono stati analizzati i ricoveri in MI dell'Ospedale di Trento confrontando gli esiti della modalità di assistenza non-AIC (2.846 casi, anni 2012 e 2013) con quelli della modalità AIC con ricovero in diversi setting in base alla gravità clinica (7.528 casi, anni 2014-2018). Esiti analizzati: trasferimenti in reparto intensivo e mortalità, numero di ricoveri in AIC ed instabilità clinica (National Early Warning Score, NEWS), incidenza di casi trattati con ventilazione non invasiva (NIV) o con amine.
Risultati: L'organizzazione AIC *vs* non-AIC ha permesso di migliorare gli esiti dei pazienti ricoverati in modo significativo e costante

negli anni riducendo il numero dei trasferimenti in reparti intensivi (dal 4.2 al 1.5%, p<0.001) e la mortalità (8.7 al 6.4%, p<0.010). In AIC sono stati ricoverati 535 pazienti anno (35% del totale ricoveri) con NEWS medio di 5.4: il 17% dei pazienti è stato trattato con NIV ed il 6.3% con amine, trattamenti non utilizzati nel modello non AIC.
Conclusioni: Il modello organizzativo con AIC ha migliorato stabilmente gli esiti dell'assistenza nei pazienti ricoverati in MI rispetto alla modello non AIC. Il setting AIC ha premesso una migliore gestione dei pazienti instabili con benefici di esito ed organizzativi.

Management of fibromyalgia: a monocentric experience

E. Pigatto[1], D. Zara[1], E. Grespan[1], M. Barazzuol[1], A. Scarpa[1], F. Cozzi[1], M.G. Schiesaro[1]

[1]UO Medicina Interna, Ospedale Classificato Villa Salus, Venezia, Italy

Background and Objectives: Fibromyalgia (FM) is a chronic disease characterized by musculoskeletal diffused pain. Diagnosis and management remains a challenge for patients and doctors. The aim of the study is to evaluate the efficacy of a multidisciplinary approach for patients with FM (rheumatologist, physiotherapist and psychologist), according to recent evidence-based guidelines (ACR/EULAR).
Methods: We enrolled 20 patients with FM and they were evaluated by specialists at baseline (T0) and every 3 months (T3, T6, T9). After medical examination we administered validated questionnaires (physical and emotional impact of FM). We elaborated 3 steps program with individualized graded physical exercise (FKT): aerobic and anaerobic exercise and stretching. Patients underwent to 2 cycles of FKT for 10 days for 1 hour (T0, T6).
Results: Patients had a significant improvement of tender points (*p=0.0025*), severity of symptom (*p=0.0030*) and affected areas (*p=0.0040*). Good compliance, improvement of the resistance to stress and reduction of perceived fatigue have been detected during FKT. Patients had a significant improvement of night rest, management of common activities of daily life, problem solving and coping strategies.
Conclusions: We tried to focus to patient education, pshysical therapy with individualised graded FKT and pshycological therapies. This multidisciplinary approach with specialists who interact with each other to find an appropriate FKT and psychological path could be a target for improving outcome, performance activity, disease severity and quality of life in FM.

Stroke in Internal Medicine: the experience of the stroke area within the Hospital for Intensive Care in Pescia's Hospital

G. Pinto[1], I. Chiti[1], A. Alessandrì[1], I. Fiordelli[1], M.C. Giovacchini[1], M. Palazzi[1], L. Teghini[1], G. Panigada[1]

[1]Ospedale SS Cosma e Damiano, Pescia (PT), USL Toscana Centro, Italy

Inside the intensity of care hospital model, Stroke Areas (SA) are multiprofessional-managed high-intensity areas where to treat acute cerebrovascular diseases. Those areas are different from the classic neurovascular units (NU) for resources and personnel. Specific data are lacking in literature: our intent has been to verify if the Internist's management of SA meets the standard of literature. We analyzed retrospectively 81 records of patient admitted for stroke in the Internal Medicine of Pescia Hospital from December '17 to May '18.The average stay was 7 days, 34% of patients presented at least one complication. 20% of patient performed systemic fibrinolysis with good functional results in 12/14 cases. In-hospital mortality was 8.6%, while disability at discharge was minimal (mRS 0-1) in 44%, with differences between the two groups. 45% of patients started a rehabilitation program. At discharge, antiplatelet therapy was prescribed in 67% of patients with stroke while anticoagulant therapy in 20%. The 3-month follou-up showed 10.9% of death, severe disability (mRS 3-5) in 31,5% and slight disability (mRS 0-2) in 57,6% of patients. These data on SA management are in line with those detected in literature for the NU, better than those detected in general ward. Although the limits of the study temporal extension and size do not permit more detailed statistical studies, these results seems to show that SA management were comparable to the standards present in literature. Future studies with larger case history will therefore be necessary to confirm the results of our observation

A "collection" of upper extremity deep vein thrombosis

A.M. Pizzini[1], V. Camaggi[1], R. Di Giulio[1], G. Elmi[1], M. Silingardi[1]

[1]Dipartimento Medico, Ospedale Maggiore, Bologna, Italy

Background: Upper extremity deep vein thrombosis (UEDVT) constitutes around 10% of all deep vein thrombosis (DVT) and can cause pulmonary embolism and post-thrombotic syndrome. UEVDT is classified as primary (idiopathic, related to anatomical abnormalities, "effort thrombosis") or secondary in all other cases. Current guidelines (ACCP 2012) suggest using anticoagulant treatement as well as for lower extremity DVT. The use of direct oral anticoagulant (DOAC) in this setting has not been sistematically evaluated but it is often included in clinical practice.
Methods: We retrospectively evaluate 20 UEDVT trated with DOAC during the last year: 4 primary (2 idiopathic, 1 related to throacic outlet syndrome and 1 "effort thrombosis") and 16 secondary UEDVT (device, cancer and infection).
Results: Patients with primary UEDVT are younger than patients with secondary UEDVT (37.5 *vs* 64 years). Secondary UEDVT is often multifactorial and most involved risk factors are represented by devices (75%), sepsis (25%), cancer (31.25%) and hypomobilization/trauma (18.75%). DOAC have been used without bleeding or thrombotic progression, even in the most fragile patients. In particular, given the greater number of cancer patients (5/16) in this setting, Edoxaban was the most represented.
Conclusions: DOAC can be used for UEDVT treatment with acceptable recurrence and bleeding rates, even in cancer patients.

Hyponatriemia and Brugada ECG pattern: a case report

A. Pizzuto[1], C. Ferrante[1], S. Pantaleoni[1], S. Sipari Merlo[1], A. Casella[1], G. Montrucchio[1]

[1]Medicina Interna 2 U, AOU Città della Salute e della Scienza, Università di Torino, Italy

Introduction: Brugada syndrome (BrS) is a life-threating channelopathy due to genetic alteration in cardiac sodium channel with tipical ECG pattern. The term "Brugada phenocopy" (BrP) is used to describe a Brugada-like ECG pattern due to various conditions (*e.g.* electrolyte disturbances) without genetic mutation. We report a case of BrP induced by hyponatriemia.
Case report: A 90-years-old male presented with confusion and disorientation. He assumed thiazidic diuretic for arterial hypertension. No personal or familiar history of syncope, arrhythmia or sudden cardiac death. Physical examination was unremarkable. Blood tests only showed hyponatremia (114 mmol/L). ECG displayed a new "coved pattern". After fluid replacement and diuretic withdrawal, we observed normalization of sodium value with simultaneous clinical improvement and ECG coved pattern disappearance.
Discussion: To our knowledge only six other cases described an association between hyponatriemia and BrP, and just in four of them hyponatriemia was the only electrolyte alteration. Hyponatriemia can induce a Brugada-like ECG pattern via reduction of inward sodium current by decreasing its gradient, even in non-mutated channels. Our clinical case can be classified as a type 1B BrP according to classification system proposed by Gottschalk *et al.,* since provocative testing with a sodium channel blocker has not been performed because the patient declined. We would like to point out that BrP is a benign and reversible condition, so it is important to perform drug challenge to rule out a real Brs.

Hepatic angiomyolipoma misdiagnosed as a liver metastasis of malignant melanoma

G. Poggi[1], B. Montagna[1], C. Picchi[1]

[1]UO Medicina Generale, Istituto Clinico Città di Pavia, Gruppo San Donato, Pavia, Italy

Introduction: Hepatic angiomyolipoma (HEAML) is a very uncom-

mon mesenchymal tumor that contains a variable proportions of 3 components, namely smooth muscle cells, adipocytes, and blood vessels the proportions of which vary between individual tumours and between different parts of the tumour**.** These cells can express positive immunostaining for HMB45, but are negative for hepatocyte paraffin 1(Hep-Par1) and S100 protein. This heterogeneity makes the diagnosis difficult.

Case report: An 49-year-old healthy woman was occasionally discovered having a hypo-echoic hepatic lesion during an US examination. Liver tests were normal and liver US showed a normal parenchyma. Gadobenate dimeglumine (Gd-*BOPTA*)-enhanced MR showed an high signal intensity in the arterial phase, and a reduced signal intensity in the portal venous phase; a lack of uptake was noted in the hepatobiliary phase. A US-guided needle biopsy showed undifferentiated epithelioid cells expressing melanocyte markers like S-100 protein, MART-1 (Melan-A), HMB45 and Vimentin diagnostic for metastatic melanoma. After a thorough clinical evaluation no evidence of cutaneous or mucosal melanoma was found. We required a revision of the histological biopsy specimens with additional immunohistochemical stains including CK-PAN and tyrosinase that were negative. Based on the results of immunohistochemical staining the final diagnosis was liver angiomyolipoma.

Conclusions: HEAMLs are benign mesenchymal tumors characteristic for their positivity for melanocytic markers that can generate diagnostic difficulties.

Peripheral oxidative burst correlates with serum VEGF levels in idiopathic pulmonary fibrosis: effect of anti-fibrotic drug therapy

G.E. Polistina[1], S. Zanotta[2], G. Rea[3], A. Coppola[1], D. Galati[2], M. Bocchino[1]

[1]Department of Clinical Medicine and Surgery, Federico II University, Naples; [2]Department of Hematology and Innovative Therapies, National Cancer Institute, IRCCS G. Pascale Foundation, Naples; [3]Department of Radiology, Ospedale Monaldi, Naples, Italy

Oxidative stress plays a key role in the pathogenesis of idiopathic pulmonary fibrosis. Although the anti-oxidant treatment did not produce the desired results, interfering with the pathological mechanisms associated with oxidative stress still represents a stimulating challenge together with the identification of valid biomarkers. The aim of our study was to analyze the peripheral oxidative stress (OB) levels in a cohort of 35 patients with a new diagnosis of IPF, clinically stable, in 25 patients in treatment with anti-fibrotic drugs and in 30 healthy control subjects comparable for sex and age. Quantitative determination of the leukocyte OB and serum levels of a panel of soluble mediators, including IL 6 and 10, TNF a and VEGF, were measured in cytometry at flow (Phagoburst and Cytometric Bead Array, Becton Dickinson) and analyzed with the FCAP (BD) software. The median levels of OB were significantly increased in IPF patients incident compared to controls ($p < 0.0001$). The OB level was further reduced in patients receiving anti-fibrotic drugs ($p=0.006$), but without correlating with the type and duration of therapy. Serum IL-6, IL-10, TNF-a and VEGF levels were also higher in patients with untreated IPF compared to controls ($p < 0.005$ in all cases). The only VEGF levels correlated with the OB ($p=0.036$; $r=0.41$), while they had a significant inverse relationship with the functional indicators (paO2, FVC and DLCO) Equally, the only VEGF levels were significantly reduced in patients in anti-fibrotic treatment ($p=0.036$). Our preliminary data suggest that the peripheral levels of OB and VEGF are significantly elevated in IPF, correlating with each other, and are equally modulated by treatment with anti-fibrotic drugs. Oxidative stress and VEGF, measured at the peripheral level, would represent attractive biomarkers both in the diagnostic phase and in therapeutic monitoring. However, longitudinal confirmation studies are needed on larger cases.

Encephalitis with onset with SIADH

M. Ponte[1], M. De Fabris[1], V. Bonasia[1], M. De Carli[1]

[1]PO S. Maria Misericordia, Udine, Italy

Background: Autoimmune encephalitis is difficult to diagnose since clinical, imaging and laboratory findings have similarities with many others autoimmune disorders involving the central nervous system as well as with infectious encephalitis. Patients generally have impaired memory and cognition over a period of days or weeks.

Case report: A 67-year-old female with history of arthralgia was admitted to our Hospital with confusion and fever. Temporal and spatial disorientation were present, and the Mini-Mental State Examination (MMSE) scored 5 (normal score 18-30). Hyponatremia, low blood urea nitrogen and normal urinary osmolality were consistent with the presence of SIADH. Endoscopy, total body CT, and PET/CT were normal. EEG showed slow and diffuse abnormalities which were more prominent in the left areas. The spinal fluid analysis documented increased levels of lymphocytes and proteins, and an oligoclonal type II pattern related to intrathecal synthesis of IgG; microbiological tests were negative. ANA antibodies were positive both in blood and in spinal fluid. Anti-Ro52 and anti-ribosomal p antibodies were detected in the blood. Within one month -without specific therapy- MMSE raised to 28 and EEG reversed to a normal pattern. In light of the spontaneous resolution, we decided for clinical follow-up and therapy with low doses of acetylsalicylic acid.

Conclusions: An autoimmune encephalitis should be considered in patients with sudden disorientation and hyponatremia. The possible role of anti-ribosomal p antibody in psychiatric disorders is still controversial.

Insulin degludec has lower hypoglycemia risk than insulin glargine U100 in older people with type 2 diabetes

F. Provenzano[1], S.R. Heller[2], J.H. Devries[3], C.H. Wysham[4], C.T. Hansen[5], M.V. Hansen[5], L. Salvi[6], B.M. Frier[7]

[1]Ospedale Civico Partinico, Palermo, Italy; [2]University of Sheffield, UK; [3]Academic Medical Center, University of Amsterdam, Amsterdam, Netherlands; [4]Rockwood Clinic, Spokane, WA, USA; [5]Novo Nordisk A/S, Søborg, Denmark; [6]Novo Nordisk, Rome, Italy; [7]The Queen's Medical Research Institute, University of Edinburgh, Edinburgh, UK

Background and Aims: Vulnerability to hypoglycemia increases with age. To further assess the safety of insulin in older patients, the risk of hypoglycemia was investigated post-hoc in the SWITCH 2 treat-to-target, 64-week, crossover trial.

Materials and Methods: Patients with T2D and high risk of hypoglycemia were randomized, double-blind, to either degludec or insulin glargine U100±OADs. The primary endpoint was the number of positively adjudicated severe (external assistance) or symptomatic hypoglycemic events (plasma glucose <56 mg/dL) during the two 16-week maintenance periods.

Results: For patients ≤65 (n=450) and >65 (n=270) years, baseline median [range] diabetes duration was 12.0 [1-40] *vs* 15 [1-54] years, mean A1C was 7.7 *vs* 7.4%, and mean eGFR was 87.0 *vs* 63.7 mL/min/1.73m^2. No significant differences in A1C reduction (degludec *vs* glargine U100) were seen for patients ≤65 and >65 years. During the maintenance period, degludec had a lower risk of hypoglycemia (overall/nocturnal symptomatic) *vs* glargine U100 in patients ≤65 (31/43%) and >65 years (30/41%) (Figure). The number of severe hypoglycemia episodes was not significantly lower. The adverse event rate was 3.2 and 3.3 events/patient-year for ≤65 years and 3.5 and 4.1 events/patient-year for >65 years, for degludec and glargine U100, respectively.

Conclusions: Degludec was safe and effective, and the frequency of hypoglycemia was lower than glargine U100 in patients ≤65 and >65 years with T2D.

Rhabdomyolysis due to citalopram overdose

M. Pugliesi[1], A. Lopardo[1], A.C. Cocola, V. Mamdouh[1], A. Lo Preiato[1], S. Sunseri[1], S. Rinalduzzi[2], A. Fiorani[3], F. Martire[3], S. Ziyada[3]

[1]Family Physician Asl Roma 2, Rome; [2]Neurology and Neurophysiopathology Care Unit, Sandro Pertini Hospital, Rome; [3]Internal Medicine Department, Sandro Pertini Hospital, Rome, Italy

Introduction: Citalopram is a selective serotonin reuptake inhibitor (SSRI) antidepressant that is widely used to treat depression, anx-

iety and obsessive compulsive disorder. It selectively inhibits the neuronal reuptake of the neurotransmitter serotonin (5-HT) in presynaptic cells in the central nervous system. Common adverse reactions are headache, nausea, insomnia, tiredness and dizziness. Here we report the development of rhabdomyolysis after Citalopram overdose.
Case report: A 89-years-old woman was admitted to the emergency department with acute respiratory insufficiency and depression mental status after citalopram overdose. After three days she developed symmetrical limbs weakness. Laboratory findings showed elevated creatine phosphokinase (CPK) (15297 U/L), electromyography and skeletal muscle MRI showed muscle injury compatible with rhabdomyolysis.
Discussion: Rhabdomyolysis is characterized by muscle necrosis and release of intracellular muscle constituents into plasma with CPK elevation, muscle pain, myoglobinuria, electrolyte imbalances and acute kidney injury. Possible causes of rhabdomyolysis are trauma, myopathies, metabolic disorders and infection but even medications, alcohol and illicit drugs. In our Patient rhabdomyolysis was due to Citalopram overdose. It may be related to median raphe nucleus serotoninergic stimulation but also direct injury of muscle cell membrane can be involved. In conclusion, more caution should be taken when prescribing SSRI, considering pre-existing diseases and drugs that can predispose patients to develop this complication.

Persistent headache: a case of post-traumatic cerebral venous thrombosis

G. Recinella[1], E. Pirazzoli[1], E. Evangelisti[1], R. Falcone[1], E. Bartoli[1], M. Zoli[1]

[1]Stroke Unit, Policlinico S. Orsola-Malpighi, Bologna, Italy

Introduction: Post-traumatic cerebral venous thrombosis (CVT) is a rare and often misunderstood complication. Only few reports describe association between CVT (as a complication of a head injury) and an intraparenchymal hemorrhage.
Case report: We present a case of a 32 years old male with persistent headcache after an head trauma. A computed tomography without contrast showed hemorrhage in the right cerebral lobe and no fracture lines. Computed tomography angiography showed cerebral venous thrombosis. Despite the intraparenchymal hemorrhage, an anticoagulant therapy was started and the patient's clinical condition progressively improved.
Conclusions: CVT as a complication of a head injury represents a rare clinical entity that is often underdiagnosed. An early diagnosis is essential to promptly undertake appropriate treatment and improve the patient's prognosis. CVT should be treated with anticoagulant even in the case of intraparenchymal hemorrhage.

Role of FDG-PET/CT in FUO: a clinical case

M. Renis[1], M.T. De Donato[2]

[1]UOC Medicina Interna, PO Cava de' Tirreni, AOU Salerno; [2]UOC Medicina Interna, PO Ruggi, AOU Salerno, Italy

Introduction: Fever of unknown origin (FUO) is commonly defined as fever higher than 38.3°C on several occasions during at least 3 weeks with uncertain diagnosis after a number of obligatory investigations. The diagnostic path is not always easy, representing one of the most complex chapters of Internal Medicine.
Case report: Man, 65. Nothing significant in anamnesis. For one month: fever with asthenia and myalgias. Blood tests: non-specific indices of inflammation positive; normocytic anemia; within limits all the other parameters, including cultural, virological, quantiferon and autoimmunity. Instrumental tests, in particular echocardiogram and TAC TB, not useful for diagnosis. PET-CT scan, prescribed at discharge, documented "aortitis", with definition of the diagnosis: vasculitis of the large vessels. Hence, steroid therapy was initiated with resolution of the clinical and laboratory framework.
Discussion and Conclusions: The differential diagnosis of FUO can be divided in four categories: infections, malignancies, non-infectious inflammatory diseases, and miscellaneous causes. In most cases of FUO, there is an uncommon presentation of a common disease. FDG (fluorodesossiglucose)-PET/CT is a sensitive diagnostic technique by facilitating anatomical localization of focally increased FDG uptake, thereby guiding further diagnostic tests to achieve a final diagnosis. FDG-PET/CT should become a routine procedure in the workup of FUO. It appears to be a cost-effective routine imaging technique in FUO by avoiding unnecessary tests and reducing the duration of hospitallization

An unusual endobronchial ultrasound procedure

E. Ricchiuti[1], G. Bonardi[1], L. Perfetti[1], S. De Rosa[1], C. Ferrari[1], L. Brivio[1], A. Mazzone[1]

[1]UO Medicina Interna, Ospedale di Legnano, ASST Ovest Milanese, Italy

Bronchogenic cysts represent congenital malformations deriving from an abnormal development of the primitive foregut during embryogenesis. These lesions are rarely found and they are most frequently localized in the mediastinum, or in lung parenchyma. Surgical treatment is the best option if the patient is symptomatic even if minimally invasive approaches with aspiration needle technique are described in literature. We report a case of a 45 year old man referred to our Emergency Department for chest pain and low grade fever. Physical examination was normal. Blood samples showed leukocytosis, elevated inflammatory markers, cardiac enzymes and d- dimer test were negative. Chest radiograph showed increase in diameter of the upper mediastinal shadow. In suspicion of aortic dissection patient underwent to computed tomography that showed a mediastinal mass measuring 4 X 4 cm starting from the superior mediastin. Subsequent endobronchial ultrasound showed a fluid mass similar to a bronchogenic cyst. Endobronchial ultrasound (EBUS-TBNA) guided aspiration resulted in partial drainage, cytological examination identified an cellular smear with positive microbiological cultures for Streptococcus pseudoporcinus. He was treated with antibiotics with benefit and he was discharged after improvement. We present a case of bronchogenic infected cyst , Endobronchial ultrasound (EBUS) can provide instant decompression of the cyst and can lead to a successful treatment.

A retired physician with diarrhea: a case report

M. Rinaldi[1], A. Maffettone[2], C. Peirce[2], O. Maiolica[2], M. Grimaldi[3], C. Tiberio[3], L. Atripaldi[3], S. Di Fraia[2]

[1]Ex UOD Metabolica, AO Specialistica dei Colli, Napoli; [2]UOC Medicina ad Indirizzo Cardiovascolare e Dismetabolico, AO Specialistica dei Colli, Napoli; [3]UOC Laboratorio di Biochimica Clinica, AO Specialistica dei Colli, Napoli, Italy

Introduction: The increasing population's aging of western countries leads to increasing prevalence of geriatric pts in hospitalization facilities. Our case report occurred in an orthopedic department of a rehab hospital (average pts' age >80yrs, length of stay (LOS) >30days).
Case report: A retired hospital internist accepts a job as hospitalist in a rehab orthopedic ward. He was previously diagnosed colon diverticulosis. After 3 months he suddenly presents, at home, spastic pain in lower abdomen with closed bowel for gas for a few hours; he starts ceftriaxone and metronidazole IV therapy for 2 days, resolving crisis in 4 days adding ciprofloxacin for os. After 6 days he presents aqueous diarrhea with vomiting and fever. He starts venous ceftriaxone and metronidazole with modest results. He is informed by phone that an elderly man in the rehab where he works was diagnosed with Clostridium difficile (Cd) infection. The "pt/doctor" performs a stool DNA test for Cd toxin research resulting positive. He begins oral vancomycin with rapid symptoms vanishing; after 2 wks the Cd stool test is negative. He returns to work, but after a few days diarrhea recurs and stool CD test is found positive. Therapy is started again with scaling i.v. antibiotics doses for 5 weeks. The test is negative twice at 2 and 4 wks after therapy withdrawal.
Conclusions: Cd's stool detection in long-term care facilities' elderly pts with prolonged diarrhea must always be investigated. Relapses at therapy's suspension are frequent. Diagnostic tests must be accurate and highly sensitive.

Disfunzione del sistema nervoso parasimpatico nell'ipertensione polmonare rilevata mediante il test da sforzo cardiopolmonare

A. Rodolico[1], G. Campi[1], A. Cuomo[1], E. De Rosa[1], F. Elia[1], R. Franco[1], D. Bonaduce[1], C.G. Tocchetti[1], M. Petretta[1], V. Mercurio[1]

[1]Dipartimento di Scienze Mediche Traslazionali. Università Federico II Napoli

Introduzione: La disfunzione autonomica nell'ipertensione polmonare potrebbe avere importanti risvolti prognostici. La riduzione dell'heart rate recovery (HRR) è considerata un marker di disfunzione parasimpatica ed in diversi setting clinici è stato messo in evidenza il suo potere predittivo in termini di mortalità. Scopo di questo studio è valutare l'attività del sistema parasimpatico attraverso l'HRR dopo un test da sforzo cardiopolmonare in pazienti con ipertensione arteriosa polmonare (IAP) e di valutarne una possibile correlazione con la riduzione della capacità di esercizio.
Metodi: Pazienti consecutivi con diagnosi di IAP sono stati sottoposti ad un test da sforzo cardiopolmonare massimale secondo protocollo a rampa. L'HRR è stata calcolata come la differenza tra la frequenza cardiaca massima al picco dell'esercizio e la frequenza dopo il primo minuto. I risultati sono stati confrontati con quelli di 15 controlli sani, compatibili per età e sesso, e con 15 pazienti con insufficienza cardiaca a ridotta frazione di eiezione (IC).
Risultati: Sono stati arruolati 25 pazienti con IAP (24 donne, età media 51.0±6.6 anni, 15 con forma idiopatica, 7 con IAP associata a malattie del tessuto connettivo, 2 con IAP associata a cardiopatie congenite). L'HRR è risultata essere significativamente ridotta nei pazienti con IAP rispetto ai controlli (11,83±8,0 *vs* 25,67±13,1, p <0,0001), e simile a quella dei pazienti con IC (10,53±2,7, p=0,549). Nel gruppo di pazienti con IAP l'HRR correlava positivamente con il picco di VO_2 (coefficiente di correlazione 0,607, p 0,004).
Conclusioni: Nella nostra coorte di pazienti con IAP è presente una significativa alterazione nella funzione del sistema parasimpatico, simile a quella osservata in pazienti con IC, che correla positivamente con la capacità di esercizio. L'alterata attività parasimpatica può contribuire alla riduzione della capacità di esercizio ed alla precoce insorgenza di dispnea.

Caso di emofilia A acquisita in paziente affetto da artrite reumatoide sieronegativa

B.A. Rosaia[1], N. Pulizzi[1], C. Pandolfo[1], F. Ponzanelli[1], A. Pampana[1]

[1]Ospedale Apuane, Massa, Italy

Introduzione: EAA è una rara malattia dovuta alla presenza di auto-anticorpi antiFVIII. Caratteristici della sindrome sono l'allungamento di aPTT e gravi manifestazioni emorragiche.
Caso clinico: Uomo di 61 anni si presentava alla nostra attenzione per astenia, mialgie e riscontro di voluminosi ematomi al livello delle cosce. In anamnesi era affetto da artrite reumatoide sieronegativa (AR) dall'età di 25 anni; negava storia personale e familiare per coagulopatie. Gli esami ematochimici documentavano aPTT di 146%, Hb 9.6 g/dl. Poiché il mixing test non si correggeva, si poneva diagnosi di emofilia acquisita. Successivamente il dosaggio del FVIII era del 0.7% e si documentava la presenza di antiFVIII con un titolo di 7.5 BU (metodo Bethesda). Si impostava la terapia immunosoppressiva con cortisone (1.5 mg/kg/die), ciclofosfamide (200 mg/die) e terapia bypassante con rFVIIa (Novoseven®, 90 μg/kg). Persistendo il fabbisogno trasfusionale con emazie concentrate, si rendeva necessario introdurre terapia con anti CD20 (rituximab: 375 mg/m^2/settimana per 6 somministrazioni). Dopo 74 giorni il paziente veniva dimesso in buon compenso clinico e in terapia con prednisone (50 mg/die) e ciclofosfamide (100 mg/die). L'attività del FVIII risultava 29.7% e antiFVIII risultava 1.6 BU.
Conclusioni: EAA si può associare a AR nel 4-8% dei casi e la prognosi è severa. La terapia eradicante con cortisone e ciclofosfamide risulta la più efficace. L'utilizzo di Rituximab può essere una valida alternativa nei casi di mancata risposta alla terapia standard.

Telestroke. Gestione dell'ictus iperacuto prima e dopo l'introduzione di un percorso diagnostico e terapeutico in area disagiata (Ospedale di Portoferraio, Isola d'Elba): la nostra esperienza (6 anni)

M. Rossi[1], E. Bollani[1], F. Stea[1], L. Sardo[1], A. Testa[1], L. De Toffoli[1], M. Irolla[3], M. Liberatori[3], F. Maggiorelli[3], U. Penney[3], G. Ramacciotti[3], A. Salzano[1], F. Stilo[1], G. Meucci[1], G. Criscione[1], F. Scazzeri[1], M. Baldereschi[1], F. Bellomo[1], G. Orlandi[1], R. Cecchetti[1]

[1]UOC Medicina interna, Ospedale di Portoferraio (LI); [2]UO Neurologia, Livorno-Portoferraio; [3]Area Emergenza-Urgenza, Pronto Soccorso Portoferraio (LI); [4]Radiodiagnostica Piombino-Elba; [5]Comitato Direttivo Rete Ictus Regione Toscana, Italy

Premesse e Scopo dello studio: La trombolisi endovenosa (IVT) e il trattamento endovascolare (ET) sono terapie tempo-dipendenti in grado di migliorare mortalità e qualità della vita in pazienti selezionati con ictus ischemico iperacuto. L'Isola d'Elba è la terza isola d'Italia: è un'area geograficamente disagiata per la gestione dell'ictus, perché mentre l'IVT può essere somministrata in loco, il centro di neuro-interventistica per l'ET è a Pisa. Questo trattamento richiede competenze cliniche e neuroradiologiche integrate nella selezione dei pazienti ma può avere ritardi a seconda della disponibilità dell'eliambulanza e delle condizioni meteorologiche.
Materiali e Metodi: Includiamo 37 casi consecutivi selezionati per IVT e ET quattro anni prima (2012-2016) e dopo (2017-2018) l'introduzione di un Percorso Diagnostico e Terapeutico (PDTA) integrato, basato su un programma Telestroke. I tempi "onset to door" (OTD), "door to needle "(DTN) e "door to groin" (DTG) sono stati valutati prima e dopo.
Risultati: Il tempo OTD complessivo mediano era 80 minuti prima dell'introduzione del PDTA e 67 minuti dopo. I pazienti selezionati per IVT erano 19 prima e 18 dopo; il tempo DTN mediano era rispettivamente 115 e 66 minuti. I pazienti selezionati per ET erano 1 prima e 3 dopo; i tempi di DTG mediano erano rispettivamente 310 e 290 minuti.
Conclusioni: In un'area periferica come l'isola d'Elba, l'introduzione di un percorso integrato che utilizza il programma Telestroke è associata ad un aumento del numero di IVT/ET e alla riduzione dei tempi OTD/DTN/DTG.

Severe anemia with esophageal candidiasis and *S. Haemolyticus* sepsis in black esophagus: a case report

V. Russo[1], M. Gobbi[2], A. Valoti[1]

[1]ASST Bergamo-Est, Ospedale F. Passi, Calcinate (BG); [2]Dipartimento di Ematologia, DiMI, Università degli Studi di Genova, Italy

Introduction: Acute esophageal necrosis (AEN) is commonly referred toas blackesophagus or necrotizing esophagitis. The etiology of AEN is unclear, but ischemia and gastric outlet obstruction may be the inciting events. Approximately 70% of patients with AEN present with hematemesis. We present a case of black esophagus with fever, melena and anemia.
Case report: A 92-year-old female with a past medical history significant for coronary artery disease, diabetes mellitus, and peripheral vascular disease presented to the hospital with temperature 38,8°C, blood pressure 114/55 mm Hg, heart rate 84 beats/min, respiratory rate 16/min, and oxygen saturation (SpO 2) 97% at room air. Hematologic examination and biochemistry demonstrated a platelet count 33 x 10^9/L, a C reactive proein of 24 mg/L, hematocrit 30%, blood glucose of 489 mg/dL, urinary ketones of 15 mg/dL, consistent with the diagnosis of DKA. Blood cultures detected the presence of *S.Haemolyticus* and *C. Albicans*. He developed coffee ground emesis, with a positive fecal occult blood test (FOBT) and melena. His hemoglobin dropped from 11.5 to 7.9 gm/dl and were need blood transfusions. Imaging studies including CT and chest X-ray were negative. An EGD showed remarkable improvement in the appearance of esophagus but demonstrated severe acute esophagitis. Endoscopic biopsies were deferred and showed an esophageal candidiasis with black patchy areas of residual necrosis without any bleeding, stricture, or stenosis. Empirical treatment with piperacillin/tazobactam,fluconazole,PPI and continuous insulin intravenous infusion was started.
Conclusions: Acute esophageal necrosis (AEN) is a rare clinical disorder and has never been recorded as a one symptom disorder.

Initial management consists of intravenous hydration, correcting anemia with packed red blood cell transfusion, NPO, and IV PPI.

A revealing back pain

F. Sartori[1], M. Pagani[1]

[1]ASST-Mantova, Borgo Mantovano (MN), Italy

Background: A 79-year-old man came to our Emergency Room for recurrent hyposthenia of the right upper limb and aphasia (2nd episode in a month). In anamnesis: arterial hypertension; ADR to iodinated contrast medium; onset of low back pain in the last month.
Description of the clinical case: A first brain CT scan was negative, so we decided to undergo the patient to a brain MRI that detected multiple cerebral lesions in the left hemispheric cortex, compatible with repetitive lesions. To identify a possible occult neoplasm, the patient underwent a PET-CT scan, resulted negative. In the following days the patient presented remitting fever, so we performed blood cultures that detected an infection by *Streptococcus gallolyticus*, treated with vancomycin with benefit. No cardiac vegetations were observed in a transesophageal echocardiogram. Two weeks later, a second brain and lumbar spine MRI showed the reduction of the previously described cerebral lesions and the presence of L3-L4 spondylodiscitis. The lumbar puncture was normal. On the basis of these findings we could diagnose a spondylodiscitis with cerebritis outbreaks in a sepsis from *S. Gallolyticus*. The patient was shifted to Amoxicillin/clavulanate and levofloxacin therapy (8 weeks), with complete regression of the symptoms.
Conclusions: *Streptococcus Gallolyticus* is known for its association with endocarditis and colorectal carcinoma; rare cases of meningitis are reported. This case shows an unusual presentation of an infection unusual itself.

A dangerous weight loss

M. Sbattella[1], E. Nicolini[2], A. Sironi[2], L. Tavecchia[1], M. Biancucci[1], A.M. Grandi[1], F. Ambrosini[2]

[1]Department of Clinical and Experimental Medicine, University of Insubria, Varese; [2]Department of Clinical and Experimental Medicine, Ospedale di Circolo, Varese, Italy

Background: Superior mesenteric artery (SMA) syndrome is an unusual cause of proximal intestinal obstruction due to loss of the intervening mesenteric fat pad that narrows the space between the superior mesenteric artery and aorta, resulting in the compression of the third portion of the duodenum.
Case report: A 75-year-old man with a personal history of atrial fibrillation and a reported weight loss of 5-6 kg in the last year, was admitted for nausea, vomiting and severe upper abdominal pain. Blood tests showed only mild leucocytosis and hyperkalemia. No signs of bowel obstruction were evident at the abdominal radiographs. We performed abdominal ultrasound that showed huge gastric distension and abdominal computer tomography (CT) that revealed duodenum critical stenosis due to compression by superior mesenteric artery. In order to explain the referred weight loss, we performed a complete screening for malignancy and malabsorption including colonscopy, bone scan, thoracic CT and total body positron emission tomography with no evidence of tumors. Malabsorption tests were negative as well. Diagnosis of SMA syndrome was done, the patient underwent gastrointestinal decompression with a nasogastric tube and received total parenteral nutrition. After three weeks of therapy, surgical approach was needed and the patient underwent gastrojejunostomy. At follow up visit one month later he was asymptomatic and fully able to feed.
Conclusions: Clinicians should think about SMA syndrome as an unusual cause of prossimal bowel obstruction in subjects with a recent history of weight loss.

A new algorithm-based approach to optimize outpatient waiting lists in health services

G. Scannapieco[1], V. Rosolen[1], L. Monasta[1], M. Bava[1], S. Vidmar[2]

[1]IRCCS Burlo Garofolo, Trieste; [2]CodaQ srl, Italy

Introduction: Long waiting times to access to health services are a crucial problem in health care systems and many countries have developed systems to guarantee priority access for patients with more urgent problems. We developed an algorithm to optimize the scheduling of the appointments and reduce waiting times.
Materials and Methods: We compared, in different situations of contact stress, the traditional outpatients' appointment system (fixed predefined number of slots available for each priority code), with a new one named "ERMES", (no predefined distinction by priority code and introduction of an algorithm assigning the slots according to the type of priority with the highest pressure on its queue).
Results: For each level of stress and for each priority code, means and medians of waiting time were lower in the ERMES system. In the situation based on real frequencies of contacts, no cases of non-compliance occurred in neither simulation system. In situations of moderate, medium and high levels of stress, no cases of non-compliance occurred in the ERMES system for all priority codes; in the traditional system, non-compliance occurred in the moderate situation of stress with priority code P, and in the medium and high situations of stress with all priority codes. The distributions of non-assigned appointments were very similar between the two simulation systems for all the levels of stress.
Conclusions: The ERMES system performed much better than the traditional one for each class of priority, allowing to optimize the scheduling of appointments and reduce waiting times.

La steatoepatite non alcolica: il ruolo del fibroscan e la correlazione con gli score predittivi di fibrosi

A.M. Schimizzi[1], F. Ridolfi[1], E. Brunelli[1], M. Candela[1]

[1]UOC Medicina Interna, Ospedale di Jesi, Area Vasta 2, Asur Marche; [2]UOC Gastroenterologia, Ospedale di Senigallia, Area Vasta 2, Asur Marche, Italy

Introduzione e Scopo dello studio: La crescente diffusione della NAFLD ha stimolato l'interesse allo sviluppo di procedure diagnostiche non invasive (il fibroscan) capaci di individuare, oltre alla presenza di steatosi, l'estensione alla fibrosi epatica, predittiva di evoluzione verso la cirrosi e l'HCC. Lo scopo dello studio è la correlazione tra il dato rilevato con il fibroscan e score predittivi di fibrosi, in particolare il NAFLD fibrosis score (NFS) estesamente validato nella NAFLD.
Materiali e Metodi: Tutti i pz osservati con il sospetto clinico di NAFLD o con una diagnosi ecografica di steatosi sono stati sottoposti ad esami di laboratorio, misurazioni antropometriche ed esame fibroscan con rilevazione del Controlled Attenuation Parameter (CAP) e dell'elasticità epatica. Il dato riguardante lo stadio della fibrosi è stato correlato con il NFS. Sono stati, inoltre, valutati le principali comorbidità correlati con la presenza di fibrosi avanzata.
Risultati: Sono stati valutati 55 pazienti (età media 57 aa, BMI medio 29,8). Il valore del CAP ha confermato il sospetto clinico o ecografico di NAFLD in 52 pz (94,5%). E' stata osservata una buona correlazione (P <0,05) tra il valore di elasticità epatica e il NFS. La presenza di diabete predice in maniera significativa una fibrosi avanzata (stadio F3/F4).
Conclusioni: Il fibroscan è una metodica non invasiva che permette di valutare l'estensione della fibrosi epatica nei pz affetti da NAFLD, ponendolo come un importante strumento di screening in pz ad elevato rischio di fibrosi quali i diabetici.

Implementing Transitional Care Unit to improve length of stay, appropriateness of hospitalization and decrease hospital readmission rates

A. Sciascera[1], N. Mumoli[1], W. Grimaldi[1], E. Bertani[1], M. Cei[2], A. Mazzone[3]

[1]Department of Internal Medicine, Magenta Hospital, Magenta (MI); [2]Department of Internal Medicine, Cecina Hospital, Cecina (LI), [3]Department of Internal Medicine, Legnano Hospital, Legnano (MI), Italy

Background and Aim of the study: The ASST Ovest-Milanese has developed an experimental model of management of chronic diseases with the creation of a Transitional Care Unit (TCU) run by the internist, taking into account the patient's clinical, welfare and social needs. Purpose of our study was to review the effectiveness of this new model of care.
Methods: We retrospectively compared the admissions into two

wards of Internal Medicine and in the TCU (Magenta hospital), before (2015) and after (2018) the full implementation of the new organization.
Results: Admissions were reduced from 2,282 to 1,853 (18,8%). Patients admitted to the TCU were more complex (medium weight of DRG rose from 1.0 to 1.5), whereas the mean length of stay in the Medicine Units was reduced by about two days.
Conclusions: The implementation of a TCD has achieved both a significant reduction in the average length of stay and greater appropriateness of hospitalization of patients with greater complexity outside the acute care wards.

Integrated gastroenterology and rheumatology ambulatory: an innovative approach for enteropathic spondyloarthritis diagnosis

P. Scolieri[1], R. Lorenzetti[2], A. Zullo[2], L. Ridola[2], C. Hassan[2], V. Bruzzese[1]

[1]Internal Medicine and Rheumatology, Nuovo Regina Margherita Hospital, Rome; [2]Gastroenterology, Nuovo Regina Margherita, Rome, Italy

Introduction: Patients with inflammatory bowel disease (IBD) may develop rheumatic diseases, particularly Entheropatic Spondyloarthritis (ESpA). Similarly, an IBD may develop in patients with SpA. Management of patients with these chronic diseases in a dedicated ambulatory could be advantageous.The aim of our study is to pioneer a novel integrated GastroRheumatology ambulatory.
Materials and Methods: We organized an integrated 'GastroRheumatology' ambulatory where a gastroenterologist and a rheumatologist with a long-lasting expertise in IBD and Spondyloarthritis, respectively, simultaneously visit those patients referred for a suspected ESpA.
Results: A total of 50 different patients with suspected IBD and a rheumatic disease were visited until now. A diagnosis of ESpA was eventually achieved in 6 (12%), and further 3 patients with an already known ESpA were referred for an appropriate simultaneous management. Of note, ESpA diagnosis was promptly performed in a patient who complained non-specific abdominal and articular symptoms for which she underwent a number of gastroenterology and rheumatology separate visits in other Hospitals during the last 3 years. No cases of IBD in those patients with an established rheumatic disease were until now observed.
Conclusions: Our preliminary data would suggest that an early diagnosis of ESpA is possible in a dedicated 'GastroRheumatology' ambulatory, so that a better prevention of disease-related disabilities is expected. Diffusion of such an integrated ambulatory could be implemented.

Lo strano caso della gamba gonfia

V. Scotti[1], L. Menicacci[1], F. Fabbrizzi[1], A. Torrigiani[1], A. Fanelli[1], S. Digregorio[1], G. Scocchera[1], S. Fruttuoso[1], L. Burberi[1], A. Morettini[1], S. Vecchiarino[1], F. Corradi[1]

[1]Medicina per la Complessità Assistenziale 2, Morettini, Careggi, Firenze, Italy

Uomo di 59 anni, affetto dall'età di 25 anni da malattia reumatologica inquadrata come artrite reumatoide sieronegativa/artrite psoriasica in terapia con corticosteroidi. Affetto inoltre da MGUS IgM-Kappa in follow-up. Il signore ha sviluppato gonfiore dell'arto inferiore sinistro per cui su indicazione del curante ha eseguito ecocolordoppler arti inferiori con riscontro di un tratto flebo-trombotico. Per tale reperto il curante ha prescritto EBPM a dosaggio terapeutico. Pochi giorni dopo il paziente ha sviluppato ematomi diffusi, mialgie ed artralgie per cui ha fatto accesso al pronto soccorso. Agli esami ematochimici è stata riscontrata anemia non nota in precedenza ed aPTT 146%. È stata dunque effettuata AngioTC degli arti inferiori con rilievo di estesi ematomi disomogenei nel contesto del muscolo retto del femore bilateralmente e del muscolo vasto intermedio di destra con dimostrazione di spandimento del MdC. Il paziente è stato trasfuso con GRC e PFC e nel sospetto di sindrome emorragica da inibitore sono stati dosati i fattori della coagulazione. Gli esami hanno mostrato Fattore VIII fortemente ridotto e presenza di inibitore del Fattore VIII, confermando l'ipotesi di emofilia acquisita. Il paziente è stato dunque trattato con infusioni di Fattore VIII attivato, steroidi ad alte dosi e ciclofosfamide ev. Tuttavia tale terapia non ha ottenuto la remissione della malattia, e si è assistito ad ulteriore riduzione del Fattore VIII e dell'Hb. È stata dunque iniziata terapia con rituximab con progressiva riduzione dell'inibitore ed aumento del Fattore VIII e dell'Hb. A completamento diagnostico è stata ricercata la presenza di una neoplasia, che tuttavia non è stata riscontrata. Si è dunque concluso che la causa della patologia possa essere stata verosimilmente di natura reumatologica vista la storia del paziente.

Progetto di antimicrobial stewardship nelle Cure Primarie

F.S. Serino[1], M. Scanferlato[1]

[1]UO Medicina Generale, Ospedale Portogruaro (VE), Italy

Premessa e Scopo dello studio: In ambito ospedaliero il problema della stewardship antimicrobica è sentito per il difficile controllo epidemiologico. Nelle Cure Primarie, la letteratura documenta per lo più progetti mirati al contenimento dell'uso di antibiotici, nonostante la quantità prescritta sia quattro volte superiore, anche se una certa quota è indotta dagli specialisti.
Materiali e Metodi: Verrà attivato un Board composto da rappresentanti delle Cure Primarie e delle UO di Medicina dove si analizzeranno i dati territoriali e l'appropriatezza prescrittiva *(la cosa giusta nel momento e nel modo giusto)* mediante la creazione di una scheda informatizzata condivisa tra i Sistemi Informatici Ospedaliero e Territoriale contenente dati clinici, sede e tipo d'infezione, dosi, tempi e modalità di somministrazione degli antibiotici.
Risultati: La terapia verrà decisa dal MMG attraverso algoritmi gestionali scaricabili dal Sistema Informatico condiviso. Al termine della visita la scheda sarà visibile allo specialista per un rapido consulto, specie per i casi complessi o per indicazioni al ricovero.
Conclusioni: L'analisi delle schede permetterà di monitorare l'appropriatezza mediante la correzione delle prescrizioni e delle abitudini errate (es. uso eccessivo dell'urocoltura); limitare l'uso di molecole ad elevato rischio di resistenza (cefalosporine e chinolonici); uniformare la terapia antibiotica alle infezioni ad elevato impatto epidemiologico; ridurre i costi diretti ed indiretti mediante l'aderenza agli algoritmi diagnostici senza necessità di politiche prescrittive restrittive.

Assumption of a large amount of the anticoagulant apixaban with self-injurer purpose without any clinical complication: a case report

C. Sgarlata[1], G. Buoni o Del Buono[2], P. Roveda[2], E. Peros[2], M. Carbone[3], M. Rollone[3], V. Perfetti[4], L. Magnani[2]

[1]Fondazione IRCCS San Matteo di Pavia, UOC Medicina Generale 3, Ecografia Interventistica, Pavia; [2]Azienda Socio-Sanitaria Territoriale di Pavia, UOC Medicina Interna, Ospedale Civile di Voghera, Voghera (PV); [3]Azienda di Servizi alla Persona of Pavia, Istituto di Cura Santa Margherita, Pavia; [4]Azienda Socio-Sanitaria Territoriale di Pavia, UOC Medicina Interna, Ospedale di Varzi, Varzi (PV), Italy

Background: A 76-year-old male patient was admitted to our Internal Medicine ward for clinical and laboratory surveillance due to assumption with self-injurer purpose of a whole package of the anticoagulant Apixaban (60 tablets of 5 mg each one for a total dosage of 300 mg).
Case report: The patient had a past medical history of atrial fibrillation and of bipolar disorder at young age (actually not taking any specific therapy). Gastric lavage and activated charcoal administration were performed at the ED however with doubtful benefit because self poisoning happened about 10 hours before the access to the ED. Plasma concentrations of apixaban at admission was 2788 ug l^{-1} (more then 10 times higher of the therapeutic range observed in the "Aristotle trial" in patients receiving a 5 mg bid dose. A daily monitoring of routine blood tests and Apixaban plasma concentrations dosage was performed until reaching plasma concentrations close to the normal therapeutic range. During the hospitalization no complications were observed and the patient remained asymptomatic for all the time. Routine laboratory tests showed no significant alterations.
Discussion and Conclusions: Apixaban is a highly selective direct inhibitor of free and clot-bound factor Xa anticoagulant used for

the treatment of venous thromboembolic events and the prevention of strokes in patients with atrial fibrillation; its clinical use usually involves the use of 5 mg bid or 2,5 mg bid doses. In the case described the patient has taken a very high dose of the drug without however developing complications.

Portal and splenic vein thrombosis secondary to antiphospholipid antibody syndrome: a case report

C. Sgroi[1], I. Timpanaro[1], S.A. Neri[1], D. Morana[1], L. Incorvaia[1], C. Virgillito[1], R.A. D'Amico[1], A. Tripiciano[1], I. Morana[1]

[1]Medicina Interna, Area Critica, ARNAS Garibaldi, Catania, Italy

Introduction: APS is a non-genetic thrombophilia's disorder caused by antiphospholipid antibodies. APS provokes arterial/vein thrombosis and pregnancy-related complications. APS can be primary (absence of any other related diseases) or secondary (presence of autoimmune diseases). We describe a case report of primary APS.
Case report: A 63-year-old-man was admitted to our department for dyspepsia and low grade of fever. On physical examination the abdomen was distended but not painful. The blood samples showed increased inflammatory markers and leukocytes. The abdominal CT documented a portal-splenic vein thrombosis. We completed the laboratory tests with autoantibodies, cancer markers, EBV, CMV and hepatitis markers (all negative). The thrombophilia's tests showed a high title of Anti-cardiolipin IgM antibodies. During the hospitalization the patient started antibiotic and LMWH associated with warfarin. When the INR reached the target of 2.5 the LMWH was stopped. After six month the abdominal CT showed the absence of thrombosis, actually the patient continue the warfarin.
Conclusions: Portal-splenic vein thrombosis usually is determined by myeloproliferative illness and thrombophilia's disorders. In some cases it can be determined by a local disease (abdominal trauma, pancreatitis, cirrhosis) or abdominal infectious diseases. In this case probably an abdominal infection caused, in a subject predisposed to thrombosis, a condition of hypercoagulability; this is due to the direct activation of thrombin and to a down regulation of the physiological mechanism of anticoagulation.

Challenges in early diagnosis and treatment of interstitial lung disease: a case of lung transplantation in a young woman

A. Soddu[1], F. Becciu[2], A.G. Fois[2], S. Piras[1]

[1]UO Medicina Interna Ospedale Civile, Alghero (SS); [2]UO Pneumologia, AOU Sassari, Italy

Introduction: Interstitial Lung Diseases (ILDs) are diffuse parenchymal lung disorders characterized by alveolar inflammation, fibrosis and other cellular changes. Among over 150 ILDs Idiopathic Pulmonary Fibrosis (IPF) is the most common and lethal. This case report intends to enlight the clinical problems concerning the differential diagnosis between ILDs.
Case report: 47-year-old female, dealer, smoker with increasing dyspnoea; no noteworthy pathologies and no therapy in use. CT scan showed heterogeneous distribution of cystic lesions and traction bronchiectasis without level predominance that suggested a non typical interstitial lung disease (Lymphangioleiomyomatosis, Lymphocytic interstitial pneumonia, Desquamative Interstitial Pneumonia, Idiopathic Pulmonary Fibrosis). Auto-antibodies were negative. The recurrence of severe respiratory infectious episodes requested the treatment with antibiotics and steroids in different care units (Pneumology, Internal Medicine, Intensive Care Unit). The rapid worsening of the respiratory condition did not allow the surgical lung biopsy needed for the diagnosis. After about one year from the onset of the symptoms the patient underwent lung transplantation and is actually in stable clinical conditions with normal pulmonary function test. The histologic examination showed a severe interstitial fibrosis with honeycombing aspects.
Conclusions: The diagnosis of interstitial lung disease can be challenging and needs a rapid multidisciplinary approach and in selected patients lung transplantation may be the only treatment option.

Anemia da stillicidio ematico nel paziente geriatrico: la ricerca dello pseudokidney ecografico

M. Spadaro[1], V. Sbolgi[1], C. Marone[1], L. Di Carlo[1], G. Fontana[1], R. Lo Sacco[1], S. Mandetta[1]

[1]Policlinico Umberto I, UOC Geriatria, Roma, Italy

Premesse e Scopo dello studio: Nel paziente geriatrico, con anemia da stillicidio ematico, le neoplasie gastrointestinali sono diagnosticate spesso tardivamente. In fase avanzata si evidenzia all'ecografia una "massa" caratterizzata da una regione iperecogena centrale (aria) circondata da una regione ipoecogena periferica (ispessimento segmentario parietale) dall'aspetto reniforme denominata "pseudokidney". Scopo del nostro studio è valutare se la ricerca sistematica dello pseudokidney possa modificare l'iter diagnostico.
Materiali e Metodi: Lo studio è stato condotto su 22 pazienti, ricoverati nella UOC di Geriatria, nel periodo compreso tra l'1/10/17 ed il 31/12/18. Sono stati sottoposti ad esame ecografico per la ricerca dello pseudokidney pazienti che presentavano all'ingresso quadri clinici non omogenei di anemia da perdita cronica. Tutti i casi, sottoposti ad ecografia bedside del tratto gastrointestinale, hanno effettuato indagine endoscopica per completare l'iter diagnostico.
Risultati: Lo studio ha messo in evidenza che in 7 pazienti (32%) l'ecografia bedside ha mostrato la presenza dello pseudokidney a livello del tratto colico. La colonscopia eseguita come prima indagine endoscopica rispetto all' EGDS, ha confermato nel 100% dei casi la sede e la diagnosi di neoplasia.
Conclusioni: Dai dati emersi dal nostro studio, si può ipotizzare che nel paziente geriatrico, con un quadro di anemia da stillicidio cronico, la ricerca sistematica dello pseudokidney ecografico possa determinare un migliore inquadramento clinico ed accelerare l'iter diagnostico.

A dangerous bite

S. Speroni[1], C. Marchesi[1], M.T. Lavazza[1], A. Mazzone[1]

[1]UO Medicina Interna, Ospedale di Legnano, ASST Ovest Milanese, Legnano (MI), Italy

West Nile Virus is a mosquito-born flavivirus that emerged in North America and Europe since 1999. WNV could be of significant morbidity and mortality for humans. In particular, neuro-invasive WNV meningo-encephalitis might be severe enough to require critical care and to be life threatening. An 80 years-old man with a history of hypertension, diabetes and previous hospital admission for brain haemorrhage, presented in August 2018 with a two-days history of fever, chills and progressive altered mental status, with disorientation, confusion and aggression. Physical examination was negative for neurological deficit, blood samples and chemistry were unremarkable, brain-CT excluded acute events. Blood and urine cultures were negative. EEG revealed mild to moderate encephalopathy without epileptic activities. Antibiotic therapy and fluid support were started. During hospital stay, progressive deterioration of mental status was observed with drowsiness and periodic breathing; lumbar puncture was thus performed. Cerebro-spinal-fluid analysis revealed clear liquor, pleocytosis with lymphocyte predominance, increased protein (96 mg/dl) and normal glucose level (60 mg/dl); initial bacterial and viral analysis was negative. PCR for WNV was also performed and revealed positive in CSF, blood and urine. Antibiotic treatment was stopped and steroid therapy was started with some improvement. The following clinical course was regular and patient was discharged after 30 days. The patient reported Culex mosquito bite four days before the onset of symptoms, while he was in his garden.

A strange case of lytic bone lesions

C.A. Stamerra[1], S. Ciasca[2], V. Cicconi[2], R. Cardi[2], M. Tozzi[2], F. Calcinaro[2]

[1]Department of Life, Health and Environmental Sciences, University of L'Aquila; [2]Ospedale "C. e G. Mazzoni", UO Medicina Interna, Ascoli Piceno, Italy

Introduction: Epithelioid Hemangioendothelioma (EHE) is a rare

endothelial tumor of intermediate grade of malignancy, which can occur in multiple locations.
Case report: Man, 71, former smoker. Anamnesis: bilateral polianeurismatic disease of the iliac-femoro-popliteal axis treated with multiple surgical, endovascular and bypass procedures subsequently thrombosed and disobstructed; type 2 diabetes mellitus; alcohol-related liver cirrhosis since 2004 in instrumental follow-up. He was admitted in the emergency department due to the onset of acute pain in his right knee. A lower limb echocolordoppler was performed which excluded vascular problems; RX /CT/ MRI of the lower limbs documented the presence of osteolytic lesions onthe right femur; a total body/bone scintigraphy described an active osteostructural remodeling at the right femoral-tibial region, in particular on the right femoral lateral condyle and on the medial side of the ipsilateral tibia. The blood tests excluded haematological proliferative and /or calcium metabolism disorders. In the suspicion of a septic embolism, an echocardiogram was performed, negative for endocarditic vegetations. No neoplasms were detected. We performed a bone biopsy, which was positive for epithelioid hemangioendothelioma.
Conclusions: The patient is awaiting specialist evaluations. Unfortunately there is currently no standard therapy for EHE.

An unusual pericardial mass: a case report

P. Sterpone[1], F. Ambrosini[2], E. Rancan[2], E. Romualdi[2], A.M. Grandi[1], E. Nicolini[2]

[1]Università degli Studi dell'Insubria Varese, Scuola di Medicina Interna; [2]Dipartimento di Medicina Interna, Ospedale di Circolo Fondazione Macchi, Varese, Italy

Background: Primary pericardial tumors account for 6.7–12.8% of all primary tumors of the heart. Lipomas are the second most common benign pericardial lesions; they usually grow insidiously and tend to be paucisymptomatic, therefore underestimated.
Case report: A 83 years old woman with a chronic known pericardial effusion and with recent evidence of a pericardial mass, was admitted to our ward for dyspnea and thoracic pain. In her medical history a breast cancer treated with surgery and radiotherapy. During hospitalization the patient underwent echocardiography which revealed increase of both pericardial effusion and mass dimensions. Given the oncological history we performed a total body computer tomography (CT) scan and a positron emission tomography that excluded a neoplastic relapse. Autoimmunity tests were negative. The cardiac magnetic resonance (MRI) demonstrated a mass adhese on visceral pericardium consistent with pericardial lipoma. No surgical approach was necessary and the patient was discharged on conservative therapy with colchicine and ibuprofene. At follow up visit she was asymptomatic and echocardiografic reduction of pericardial effusion was demonstrated.
Conclusions: Pericardial lipomas are rare; including ours only 25 cases have been reported. Compared to others our patient is older, with a smaller lesion but early symptomatic. Usually both CT and MRI are accurate to demonstrate extension and composition of the tumor. In our experience CT scan was not useful to straighten out the diagnosis and good clinical evolution was obtained with only medical therapy.

Sclerodermoid chronic graft-*versus*-host disease

A. Tamburello[1], L. Castelnovo[1], P.M. Faggioli[1], A.M. Lurati[2], A. Laria[2], A. Mazzone[1]

[1]UO di Medicina Interna, Ospedale di Legano, ASST Ovest Milanese, Legnano (MI); [2]UO di Reumatologia, Ospedale di Magenta, ASST Ovest Milanese, Legnano (MI), Italy

Background: Systemic sclerosis (SSc) is a connective tissue disease resulting in multiorgan fibrosis. GVHD is the major complication of hematopoietic stem cell transplantation; skin is one of the major organs affected. Chronic cutaneous GVHD is categorized by type of lesion into lichenoid and sclerodermoid variants (scl-GVDH).
Case report: 59-year-old woman. In 2014 she was hit by acute myeloid leukemia, treated with CHT and subsequent allogeneic bone marrow transplantation, complicated by GVHD. From 2016 she started complaining about Raynaud phenomenon in the winter period. 2017 capillaroscopy showed a picture of "scleroderma pattern active". No antibody positivity has been documented but the picture was therefore compatible with a scl-GVDH.Excluded any contraindications she started prostacyclin analogues with a marked improvement in the Raynaud phenomenon and the digital acroasfittic.
Conclusions: scl-GVDH represents a distinctive phenotype of chronic GVHD.It has some similarities with SSc but the pathogenic mechanisms of the diseases are different: systemic manifestations are rarely observed scl-GVHD. It's a complication of allogeneic hematopoietic stem cell transplantation that results from alloreactive processes leading to CD4 T-cells activation and consequent fibrosis of the skin. EGFR, a receptor involved in cell proliferation, differentiation, and motility has been implicated in autoimmune and fibrotic diseases so erlotinib, an EGFR-inhibitor was tested to prevent Scl-GVHD. In future erlotinib it could represent a valid therapeutic alternative to prostacyclin analogues

Different phenotypic clusters of comorbidities affect in-hospital death for acute heart failure

N. Tarquinio[1], L. Falsetti[2], A. Fioranelli[1], G. Viticchi[3], F. Picchio[1], A. Martini[1], L. Marconi[1], M. Mariottini[1], F. Pellegrini[4], M. Burattini[1]

[1]UOC Medicina Interna, Presidio Ospedaliero di Osimo "S.S. Benvenuto e Rocco", INRCA-IRCSS, Osimo (AN); [2]Medicina Interna Generale e Subintensiva, AOUR "Ospedali Riuniti", Ancona; [3]Clinica di Neurologia, AOU "Ospedali Riuniti" di Ancona; [4]Libero professionista, Osimo (AN), Italy

Introduction: Patients affected by acute heart failure (AHF) are often affected by comorbidities.
Aims: To evaluate how comorbidities associate and which cluster is more strongly associated to in-hospital death in AHF
Materials and Methods: All patients admitted for AHF (01/2015-01/2019) were retrospectively evaluated; we collected age, sex and all the comorbidities (18 different chronic pathologies); outcome was defined as in-hospital death; association between comorbidities was studied with Pearson's bivariate test: the association was significant for $p<0.10$, strongly significant for $p<0.05$. We tested each cluster against in-hospital death with logistic regression analysis, obtaining model significance and cluster's predictive value
Results: We obtained a sample of 460 patients (mean age 83.9±8.02 years; males 56.6%). While no single comorbidity was significantly associated to the outcome, 13 clusters of comorbities resulted associated with the outcome. Of these, two clusters showed a good predictive value: the first was represented by atrial fibrillation (AF), dementia, diabetes, coronary artery disease, haematologic diseases and prostatic hypertrophy (AUC: 0.70; $p=0.0005$). The second was represented by coronary artery disease, COPD, OSAS, dyslipidemia, chronic kidney disease, AF, peripheral arteriopathy, previous stroke, thyroid disease and chronic infectious diseases (AUC: 0.70; $p=0.03$).
Conclusions: In a cohort of elderly and comorbid patients, while no single chronic pathology predicred in-hospital death,we identified 13 clusters associated to this outcome.

Sepsis *versus* mixed connective tissue disease in HLH

I. Tartaglia[1], B. Farneti[2], M. Barletta[1], P. Di Giuseppe[1]

[1]Ospedale Perrino, Medicina Interna, Brindisi; [2]Ospedale Perrino, Malattie Infettive, Brindisi, Italy

Hemophagocytic lymphohistiocytosis (HLH) is a clinicopathological entity characterized by the activation of macrophages and/or histiocytes with prominent haemophagocytosis in bone marrow and other reticuloendothelial systems. HLH can be either primary, with a genetic aetiology, or secondary, associated with malignancies, autoimmune diseases, or infections. A distinctive trait of this pathology is the reactivation of a rheumatic disease, triggered by a bacterial infection. We present the case of an old woman with a history of inactive mixed connective tissue disease, suffering from severe fever, complicated by ARDS, sepsis due to *A. baumanii* and CID. This clinical picture is still just a

part of the manifestation of a more serious illness called HLH. Fever, lymphadenitis, hepatitis, leukopenia, anaemia, hyperferritinemia, hypertriglyceridemia, high level of auto-antibodies, decreased levels of C3 and C4, suggested a hemophagocytic lymphohistiocytosis syndrome. The biopsy of bone marrow and cytologic examination of BAL confirmed the diagnosis. Eventually, antibiotic therapy was successfull to stop severe sepsis and than the immunosuppressive therapy with prednisolone and mycophenolate improved significantly the clinical symptoms of HLH soon, and laboratory data results in a month.

An unusual abdominal pain: a case report of Dunbar's syndrome

L. Tavecchia[1], M. Donadini[2], S. Bozzato[2], L. Galli[2], A.M. Cremona[2], W. Ageno[1], A.M. Grandi[1], E. Nicolini[2]

[1]Università degli Studi dell'Insubria Varese, Scuola di Medicina Interna; [2]Dipartimento di Medicina Interna, Ospedale di Circolo Fondazione Macchi, Varese, Italy

Background: Dunbar's syndrome (DS) is a rare condition characterized by the stenosis of the celiac tripod by the medium arcuate ligament. An asymptomatic stenosis is present in 25-30% of the population, and becomes symptomatic in about 1%. The diagnosis is challenging, based on the combination of typical abdominal pain and typical radiologic findings. The treatment is usually surgical resection of the ligament. The symptomatology regresses quickly, otherwise an angioplasty and stenting of the tripod itself is possible.
Case report: A 19 year old healthy patient, amateur body builder, accesses the emergency department for intermittent abdominal pain prevalent on right quadrants and irradiated to the back. The physical examination was normal; blood tests revealed microcytic anemia in known thalassemic trait. Abdomen's echo was normal except for mild splenomegaly and increased systolic flow peak at the origin of the celiac tripod, therefore the patient underwent computed tomography that confirmed celiac tripod's stenosis by arcuate ligament with typical post-stenotic dilatation. Given the young age, the vascular surgeon imposed follow-up before laparoscopic treatment. At the follow up the patient was substantially symptomless not requiring surgical treatment.
Conclusions: DS is a rare and often underestimated condition, very difficult to be diagnosed and needs to be differentiated from other causes of abdominal pain, including biliary diseases and peptic ulcer. Therefore, these patients are often hospitalized in Internal Medicine ward where the diagnosis may be unknown.

Recurrent refractory pericarditis in Erdheim-Chester disease: response to recombinant IL-1 receptor antagonist anakinra

L. Tibullo[1], G. Di Monda[1], F. Gallucci[1], R. Muscherà[1], C. Romano[1], G. Uomo[1]

[1]UOC Medicina Interna 3, Dipartimento Medico Polispecialistico, AORN Cardarelli, Napoli, Italy

Introduction: Erdheim-Chester Disease (ECD) is a rare, multiorgan, non Langherans cell histiocytosis. Etiology is still unknown with skeletal and multiorgan extra-skeletal involvement. Adulthood age (40 -60 years) and male sex are preferred.
Case report: A 51-years-old patient with previous, well documented diagnosis of ECD, with exophthalmos, chronic renal failure, bilateral hydronephrosis (ureteral stents in situ), osteosclerosis, cerebellar ataxia, arterial hypertension, hypothyroidism and pericardic effusion. One year prior our observation he was hospitalized because of dyspnea with echocardiografic evidence of pericardial effusion that was unsuccessfully treated with cycles of interferon, cortisone, colchicine, non-steroidal anti-inflammatory drugs and pericardiocentesis. On admission to our department the patient present severe dyspnea and malaise; the patient underwent complete laboratory work-up, echocardiographic exams, cardiac MR, PET scan. Evaluation of patient showed worsening of pericardial effusion refractory to traditional drugs; then, a treatment with anakinra 100 md/day was started; within two weeks reduction of pericardial effusion (about 50%) with concomitant normalization of markers of inflammation (CRP and ESR) together with sharp decrease of the dyspnea were observed.
Discussion: In according with others few reports, our case-study has demonstrated that treatment with anakinra 100 mg is effective as anti-inflammatory action to improve clinical and morphological features of refractory recurrent pericarditis in ECD.

Cure intermedie, setting assistenziale infermieristico con sorveglianza medica: risultati a lungo termine e criticità

S. Toccoli[1], W. Spagnolli[1], S. Dorigoni[1], O. Gelasio[1], S. Viola[1], A. Nardelli[1], G. Gasperi[1], C. Mazzonelli[1], C. Sperandio[1], S. Sforzin[1]

[1]Servizio Territoriale, APSS del Trentino; [2]UO di Medicina Interna, Ospedale di Trento, APSS del Trentino, Italy

Premesse e Scopo dello studio: L'organizzazione della medicina interna per intensità di cura (MI) è in grado di identificare i pazienti post acuti che necessitano di un setting assistenziale a bassa intensità di cura (Cure intermedie, CI). Scopo del lavoro è quello di valutare a lungo termine l'efficacia di un nuovo setting di cura e rilevarne le criticità.
Materiali e Metodi: Sono stati studiati i dati di attività di 18 mesi (2017- 2018) di un setting di CI integrato con la MI dell'Ospedale di Trento: degenza di 20 posti letto ad assistenza infermieristica e con sorveglianza medica (criteri minimi di assistenza previsti 170 min/giorno a paziente) Criteri di accesso: pazienti (pz.) con percorso diagnostico terapeutico definito, con necessità di recupero clinico e ripersa della abilità funzionali e/o di organizzare assistenza domiciliare. Parametri valutati: numero pz. trattati, degenza media, tipologia di dimissione, rientri in ospedale, mortalità, adeguatezza dei tempi assistenza.
Risultati: Sono stati gestiti in CI 348 pz., età media 78 anni, 49% femmine: degenza media 16 giorni, dimessi a domicilio 92% (348), di cui 150 (43%) con piano di assistenza domiciliare, rientri in ospedale 5.3% (20), decessi 1.3% (5), altro 1% (4). Tempi medi di assistenza erogati 179 min /giorno.
Conclusioni: Il setting di CI ha dimostrato a lungo termine e di poter gestire in modo efficace e sicuro i pazienti post acuti inviati della MI. Si è rilevata tuttavia la necessità di espandere i minuti assistenziali medico – infermieristici previsti per garantire qualità e sicurezza delle cure.

So... is it there or not?

M. Tonon[1], M.T. Aldinio[1], P. Spagnolo[2]

[1]UO Medicina Generale, AO di Padova; [2]Respiratory Disease Unit, Department of Cardiac, Thoracic and Vascular Sciences, University of Padova, Italy

Background: Not infrequently occasional findings force to discriminate between pathologies with dramatically different prognoses.
Case report: A 79 years old woman was hospitalized because of acute cholecystitis. Routine chest x-rays showed thickening in the right hilus region. No lung diseases were recorded in her medical history and she was totally asymptomatic, except forprofuse fatigue started in the last month. A chest CT-scan described a 42 mm hilar expansive solid lesion, bronchial stenosis, multiple bilateral pulmonary nodularities, diffuse lymphadenopathy. Plasmatic neoplastic markers were negative. Histological examination of a sampling performed during bronchoscopy described a non-necrotizing chronic granulomatous pneumopathy. However, the specific plasmatic markers (ACE, calcemia, 24hr calciuria, CD4/CD8 ratio) werenegative. Therefore a second chest CT scan and a second bronchoscopy were performed. The new samplings described the presence of non-small cells lung carcinoma, with a neoplastic cellularity that was however less than 5%. A third CT scan was performed and a subsequent bronchoscopy, from which the definitive diagnosis of non-necrotizing, sarcoidosis-like granulomatosis was made. No therapy was started. The patient is currently under follow up, still asymptomatic.
Conclusions: Sarcoidosis is a pathology that can have an asymptomatic course, and a radiological appearance that in widespread forms can be confused with an advanced neoplastic disease.

Red yeast rice: alternative medicine is not always the best alternative, a case report

L. Trotta[1], E. Calabrò[2], A.L. Brucato[2]

[1]Medicina Interna D1, Ospedale Niguarda, Milano; [2]Medicina Interna, Fatebenefratelli, ASST Fatebenefratelli Sacco, Milano, Italy

Background: Myopathy is an adverse event associated with statin use, and food supplements containing red yeast rice (RYR) have been proposed as an alternative in statin-intolerant patients.
Case report: A 51-year-old male presented to emergency room complaining of generalized muscle weakness, intense pain of quadriceps and hyperchromic urine. Six months before he was prescribed RYR for mild hypercolesterolemia (245 mg/dl). Musculoskeletal exam revealed good muscle mass, normal strength, and no tenderness on palpation. Laboratory analyses revealed a marked increase in serum creatinekinase (CK), peaking at 67.558 U/L. Increase in transaminase (GOT/GPT respectively 1309/207 U/L) was also observed. Thyroid function, serum lactic acid and erythrocyte sedimentation rate were normal. Search for ANA, ENA, anti-DNA antibodies was negative. Alternative causes of muscle disorders, including alcohol abuse, illicit drug use, infections, metabolic, endocrine and inflammatory diseases were excluded. The patient was treated with endovenous hydratation and RYR pills were interrupted. CK levels dropped spontaneously (742 U/L) and the patient was discharged. After two months CK levels were completely normal.
Conclusions: RYR lowers cholesterol levels inhibiting HmG-CoA reductase thanks to its content of monacolin K that has a structural homology with lovastatin. It may cause similar side effects, including muscle disorders and liver damage. Patients receiving RYR supplements should undergo regular blood tests as it happens when they take statins.

Polyglandular Autoimmune Syndrome type 2: an unusual but predictable case

F. Vannoni[1], S. Barchiesi[1], C. Cappugi[1], F. Vannini[1], L. Fallai[1], L. Poggesi[1]

[1]AOU Careggi, Firenze, Italy

Background: Polyglandular autoimmune syndrome type 2 (PAS-2) is an autoimmune disease which leads to lymphocytic infiltration causing organ damage. PAS-2 is diagnosed with 2 out of 3 manifestations: Addison disease, autoimmune thyroid disease and type 1 diabetes. Specific antibodies like 21-hydroxylase antibody, thyrotropin receptor-TPO antibodies, and GAD65 antibody are assayed for diagnosis.
Case report: A 55 yo woman presented to the ED for syncope. She had history of hyperthyroidism (no longer in therapy), headache and previous episodes of loss of consciousness. Physical examination revealed cutaneous hyperpigmentation, fatigue, headache and orthostatic hypotension. Brain CT scan was normal. Blood samples revealed Hb 9 g/dL, severe hyponatremia (128 mEq/L), hyperkalemia (6.4 mEq/L), elevated TSH (12.47 mU/L) and ACTH (1170 ng/L). Antibody tests confirmed autoimmune hypothyroidism (anti-TPO 832.3 UI/mL) and adrenal insufficiency (serum cortisol 54.9 nmol/L, with high title of adrenal antibodies). Gastroscopy revealed chronic atrophic gastritis with elevated title of intrinsic factor and gastric parietal cells antibodies, confirming Pernicious Anemia. PAS-2 diagnosis was made and therapy with levothyroxine, hydrocortisone and fludrocortisone improved patient's symptoms.
Conclusions: Diagnosis of PAS-2 is often delayed because rarely patients present dysfunctions of all of 3 major endocrine organs, but there is usually a latent phase between the endocrinopathies. Delay in diagnosis can cause significant risk of severe hypothyroidism, adrenal crisis and diabetic ketoacidosis.

Chronic diarrhea with severe weight loss: a diagnostic challenge. A case report

A. Varriale[1], A. Mirijello[1], F. Molinaro[1], A. De Matthaeis[1], A. De Cata[1], L. Dimitri[2], P. Parente[2], S. De Cosmo[1]

[1]UOC Medicina Interna, IRCCS Casa Sollievo della Sofferena, San Giovanni Rotondo (FG); [2]Anatomia Patologica, IRCCS Casa Sollievo della Sofferenza, San Giovanni Rotondo (FG), Italy

Background: The diagnostic workup of chronic diarrhea can be quite frustrating for the Internist.
Case report: A 64-year-old men was admitted to our department with a 1- year history of watery non-bloody diarrhea and significant weight loss (>10%). He denied abdominal pain or fever. Past medical history was significant for hypertension on treatment with olmesartan 40 mg/day for the last four years. The patient did not experience any benefit from initial empiric therapy and gluten free diet. Lab tests revealed a slight increase of ESR, Tissue transglutaminase IgA antibody testing was negative. EGDS showed normal gastroduodenal mucosa, duodenal biopsies showed partial villous atrophy with intraepithelial lymphocytosis. Thus, Olmesartan-induced sprue-like enteropathy was suspected and the drug was withdrawn. A significant improvement of symptoms was achieved within 72 h, with resolution of diarrhea within 2 weeks . At six month follow-up the patient completely recovered of weight loss. Control endoscopy with duodenal biopsies showed complete recovery of mucosa. Celiac Disease (CD) is the most common cause of villous atrophy. A diagnostic dilemma is encountered when patients with villous atrophy have either negative celiac serology or nonresponse to a gluten-free diet. Diarrhea due to drug-induced enteropathy has been reported for medications as mycophenolate, metotrexathe and most recently olmesartan. Patients with OAE have often been misdiagnosed with CD. Clinicians should be aware that olmesartan can cause an enteropathy clinically and histopathologically similar to celiac disease. Failure to recognize this may result in patients continuing on a medication that is injurious to the gastronintestinal tract or embarking on an unnecessary and expensive medical evaluation.

Impact of antibiotic stewardship program in managing community-acquired pneumonia among Emergency Department

G.A. Vassallo[1]

[1]UO di Medicina Interna, Ospedale Barone Lombardo, Canicattì (AG), Italy

Introduction and Aim of the study: Antibiotic stewardship refers to a set of coordinated strategies to improve the use of antimicrobial medications with the goal of enhancing patient health outcomes, reducing resistance to antibiotics, and decreasing unnecessary costs. The aim of this study is to evaluate the impact of Antibiotic Stewardship Program in managing Community-Acquired Pneumonia among Emergency Department.
Methods: Medical records of patients with Community-Acquired Pneumonia admitted to Emergency Department of a Sicilian Hospital were retrospectively collected. Starting from this data, local microbiological reports and international clinical guidelines, a local Antibiotic Stewardship Program for the management of pneumonia has been drawn-up. Through a simulation model this Antibiotic Stewardship Program was applicated to collecting data to predict its performance in the real world.
Results: The application of this Antibiotic Stewardship Program reduce rate of hospitalization (-40%), length of stay in Emergence Department before hospitalization (from 8 to 1 day), prescription of corticosteroids (-10%) and antibiotics (-9.6%) in particularly carbapenems (-96%) and quinolone (-87,5%). Finally, cost for antibiotics therapy significantly decreases (-89,7%).
Conclusions: Based on these results, Antibiotic Stewardship Program should be implemented in Emergency Department in order to improve hospital performance, use of corticosteroids and antibiotics with consequent reduction of cost. Prospective and multicentric studies are needed to confirm these preliminary data.

30 day rehospitalization in Internal Medicine: the importance of a global approach

V. Verdiani[1], P. Marietti[1]

[1]Medicina Interna, Ospedale Grosseto, Italy

Introduction: Although there is extensive literature on early rehospitalization attributed to particular conditions (*e.g.* Heart Fail-

ure), there is very limited research addressing the broader issues involving the multitude of aspects that contribute to rehospitalization.
Aim and Methods: We enrolled 120 consecutively patients readmitted within 30 days after discharge from an Internal Medicine ward. To have a broader assessment, in the new hospitalization we considered for each patient many items, including those not necessarily related to the single disease determining admission.
Results: In this population (58 M 62F), the patients were old (mean age 83.3+9.5), with many comorbidities (86.6% ≥4 comorbidities). Cancer was present in 25 (20.8%). High level of disability (Barthel ≤30) was present in 68.3% and severe cognitive deficit (Pfeiffer ≤2) in 29.1%. Falls in the last 30 days occurred in 10.8%. Oxygen therapy at home needed in 10%. About one third of patients lived alone (someone with the help of a caregiver). Majority of patients (75.0%) had three hospitalizations and 40.8% four hospitalizations in the last 12 months. In only 42.5% of patients there was a correlation between diagnosis of admission index and previous hospitalization. In-hospital mortality was 22%.
Conclusions: The results of this study, thanks a more comprehensive assessment of patients with early rehospitalization in Internal Medicine, show that a lot of characteristics not single disease-related seem important. Probably the complex of these features contribute to determine a subgroup of "hospital-dependent patients".

A strange onset of Multiple Sclerosis

A. Vetrano[1], M. Esposito[2], R. Loffredo[3], A. Schiano[4], G. Balsamo[5]

[1]Alta Specializzazione Geriatria, ALS NA 2 Nord, PO Frattamaggiore (NA); [2]UOC Medicina, ALS NA 2 Nord, PO Frattamaggiore (NA); [3]UOC Medicina e Pronto Soccorso, ALS NA 2 Nord, PO Frattamaggiore (NA); [4]Responsabile Servizio Ecografia, ALS NA 2 Nord, PO Frattamaggiore (NA); [5]Responsabile UOC Medicina e Pronto Soccorso, ALS NA 2 Nord, PO Frattamaggiore (NA), Italy

Introduction: The most important feature of Multiple Sclerosis (MS) is represented by the intermittency and variability of clinical manifestations over a period of months or years, due to focal disorders affecting the optic nerve, spinal cord and brain. Yet it is very rare an acute, almost apoplectic, onset of neurological symptomatology.
Case report: We describe the case of a 53-year-old female who arrives at the Emergency Room for syncope and asthenia. She was lucid with absent neurological, febrile and nape-free deficits. No medical, notable diseases or psychotropic drugs were reported in the anamnesis. The B.P. was 170/100 mmHg, the heart rate was 100 rhythmic. Blood analysis showed an increase in troponin and renal failure (RF) with albuminuria. The renal echo showed the hyperechogenicity of the cortical as chronic RF. The head CT scan detected the hypodensities of the white substance on the basis of chronic hypoperfusion and streak with a right parietal site of clear hypodensities. Regarding the reason she subjected to magnetic resonance of the brain for suspected multiple sclerosis which confirmed the diagnosis.
Conclusions: Paroxysmal disorders are present in 25% of MS cases and have been erroneously impulsive nervous transmission (ephaptic conduction). They are in order of decreasing from instability, diplopia, dysarthria, pruritus, vertigo, vomiting, convulsions, sign of Lhermitte. The syncope is a very rare debut event in MS. This case report shows that the association between syncope, asthenia and streak of net brain hypodensities can lead to Multiple Sclerosis.

Utilizzo del Frailty Index in pazienti anziani con insufficienza renale cronica

C. Vezza[1], S. Vettoretti[1], L.C. Bergamaschini[1], M. Cesari[1]

[1]UOC Medicina Interna, PO di Gallarate (VA); [2]UOC Nefrologia Dialisi e Trapianto Renale Fondazione, IRCCS Ca' Granda, Ospedale Maggiore Policlinico di Milano; [3]Università degli Studi di Milano, Italy

Scopo del lavoro: La valutazione multidimensionale del paziente nefropatico permette di cogliere quegli aspetti geriatrici in grado di meglio personalizzare l'intervento (terapeutico, assistenziale e riabilitativo). Con il nostro studio abbiamo sviluppato un Frailty Index (FI) basandoci sul modello matematico di accumulo di deficit proposto da Rockwood al fine di identificare i soggetti che più possono beneficiare di percorsi di cure adattati.
Materiali e Metodi: Sono stati valutati 115 pazienti tra i 65 e i 94 anni, con un filtrato glomerulare stimato <45 ml/min afferenti ad un ambulatorio di Nefrologia. Un FI costruito su 38 items secondo gli standard descritti da Searle è stato sviluppato a partire dai dati raccolti nell'ambito della valutazione clinica (malattie, disabilità funzionali, misure di performance fisica e cognitiva, misure antropometriche e parametri biochimici ematici ed urinari). Nei 12 mesi successivi sono stati registrati eventi clinici quali decesso, ospedalizzazione ed inizio di trattamento dialitico.
Risultati: L'età media del campione (donne 30.3%) è 80.2 anni (deviazione standard, DS 6.3). Il FI medio è 0.29 (DS 0.10; per gli uomini 0.27, DS 0.09; per le donne 0.35, DS 0.10). Coerentemente con la letteratura, il FI aumenta con l'età (Spearman r=0.22), in entrambi i sessi. Il FI risulta significativamente associato agli eventi di ospedalizzazione (OR 1.06; 95%IC 1.01-1.11; p=0.02) e di decesso (OR 1.11; 95% IC 1.03-1.21; p=0.009) nei 12 mesi di follow-up. La decisione ad iniziare il trattamento dialitico è, invece, predetta dal valore di filtrazione glomerulare al baseline (OR 1.03; 95% IC 0.98-1.09; p=0.20), ma non dal FI. Queste associazioni si confermano anche dopo aver corretto le analisi per età e sesso.
Conclusioni: I nostri risultati confermano che questo strumento è fortemente predittivo di eventi avversi, indipendentemente da età e sesso. L'implementazione del FI può sostenere il clinico nelle sue scelte terapeutiche verso la persona biologicamente anziana.

"Percorso Rosa" per le situazioni di sospetta violenza alle donne. L'esperienza di un anno al Pronto Soccorso dell'Ospedale di Desio (Monza Brianza)

A. Villa[1], A. Romanò[1], M. Xocato[1], E. Svanetti[1]

[1]SC Pronto Soccorso, Ospedale di Desio (MB); [2]Direzione Medica, Servizi Sociali, Ospedale di Desio (MB), Italy

Introduzione: Il 30.01.18 sono state pubblicate le "Linee guida nazionali in tema di soccorso e assistenza socio-sanitaria alle donne vittime di violenza" (G.U. n. 24) che, nel territorio di Monza-Brianza, completavano un percorso già definito (rete ARTEMIDE). Riportiamo un'analisi retrospettiva di tale percorso di PS relativa all'anno 2018.
Metodi: Al triage e/o alla dimissione vengono evidenziati i casi di sospetta o accertata violenza con un "flag" rosa; sono stati analizzati i dati relativi all'evento e i percorsi all'interno del PS.
Risultati: Su 33.879 accessi di donne, 95 (0.3%) sono state inserite nel PR (range età 16-67). 33 erano straniere (35%). Al triage 50 pz sono state codificate con codice giallo. Il tipo di violenza subito è stato: fisico 72 (76%), psicologico (sempre associato a quello fisico) 15, stalking 4 e sessuale 4. La violenza era subita da: marito/partner 59 (62%), ex-marito/partner 14, padre 6, altri familiari 6, datore di lavoro 1, soggetto noto, ma non dichiarato in 9 casi. In 16 casi (17%) è stata sporta denuncia. In 40 pz (42%) è stata somministrata la scheda di rilevazione del rischio di revittimizzazione (Snider *et al.,* 2009): in 32 pz (80%) lo score era ≥3 (elevato rischio). Una pz è stata ricoverata, in 2 casi il ricovero è stato rifiutato, in 5 casi si è trattenuta la pz in OBI per consentire di attivare soluzioni sociali adeguate.
Conclusioni: Il fenomeno è rilevante, anche se si ritiene ancora sottostimato. A un anno dall'emissione delle linee guida il percorso necessita di ulteriore consolidamento e condivisone con gli operatori di PS.

Macrophage Activation Syndrome: a probable case in a Geriatric Department

F. Viola[1], C. Omiciuolo[2]

[1]Scuola di Formazione Specialistica in Geriatria, Università degli Studi di Trieste; [2]Struttura Complessa di Geriatria, ASUITS, Italy

An 81-year-old female patient was admitted to our Geriatric Department for a recurrent high fever over two weeks. A month earlier, she reported a viral infection with a fever. Clinical History was re-

markable with LES with a prevalent cutaneous, hematological, and articular involvement; splenomegaly; valvular cardiopathy, bioprosthetic atrial valve and first tract of aorta; atrial fibrillation. On the physical examination there were no signs of infection. She denied articular pain and did not experience other symptoms. Labs examination showed severe pancytopenia, a slight increase of inflammation markers, highly increased serum ferritin and triglycerides, importantly decreased fibrinogen. Chest x-rays did not show signs of pneumonia, the TT echocardiogram was negative for vegetations, the ultrasound of the abdomen reported the known splenomegaly of 20 cm. Repeated blood cultures were negative. She underwent a bone marrow biopsy, that showed mielodisplasia. High dose steroid IV therapy was started, followed by an immunotherapy with Ig; an empiric therapy with piperacillin/tazobactam was started. There was no clinical improvement: the patient was hypotensive, with a recurrent fever (39-40°C) and had signs of intestinal bleeding and liver abnormalities. The patient died after 3 weeks of stay. The anatomo-pathology reported DIC and MODS. The clinical presentation, the laboratory tests and the clinical history of the patient allowed us to hypothesize a macrophage activation syndrome in the setting of an autoimmune disorder, meeting 5 out of 8 criteria for diagnosis.

A rare case of imported typhoid fever in an Italian young man

G. Zaccagnini[1], E. Blasi[1], L. Corbo[1], O. Para[1], M.S. Rutili[1], T. Fintoni[1], L. Sammicheli[2], A. Mancini[2], F. Pieralli[2], C. Nozzoli[1]

[1]Medicina per la Complessità Assistenziale 1, AOU Careggi, Firenze; [2]Subintensiva di Medicina, AOU Careggi, Firenze, Italy

Introduction: Tiphoyd fever is most frequently found in developing countries, its incidence being linked to poor sanitation. Over the last 20 years, in Florence, this has been the only reported case of an Italian citizen with Tiphoyd fever.
Case report: An 18 years-old man was hospitalized for high fever and right gluteal pain begun three days earlier, unresponsive to Acetaminophen. His blood tests showed pancytopenia, increased PCR and PCT levels, decreased renal function, increased GOT and GTP levels and slight hyperbilirubinemia.; abdominal US showed hepatosplenomegaly. Blood cultures were drawn, and microbiological tests for TBC, hepatitis viruses, Brucellosi and Leptospirosis were negative; autoantibodies titers were normal and blood smear showed no schistocytes. Empirical antibiotic treatment was started (Coamoxiclav), with little improvement. Two days after admission the patient developed respiratory failure. Thus, we ordered urgent chest and abdomen CT scans, revealing ground glass lung opacities, diffuse colonic wall thickening and septic arthritis and osteomyelitis of the right hip. Blood cultures turned out positive for Gram negative bacilli, and subsequent microbiological tests were diagnostic for S. paratiphy. The source of infection was identified: the patient had been on holiday in Hungary a few weeks before, accidentally swallowing water while bathing in a thermal lake. Since quinolone-resistance was detected, Ceftriaxone was administered . The patient had to be treated daily for several weeks due to the osteo-articular localization of infection.
Conclusions: Tiphoyd fever is most frequently found in developing countries, its incidence being linked to poor sanitation. Over the last 20 years, in Florence, this has been the only reported case of an Italian citizen with Tiphoyd fever.

Efficacia del breath-test *Helicobacter pylori vs* gastroscopia nella diagnosi della dispepsia simil-ulcerosa. Studio real-life di 200 pazienti

G. Zaccardo[1], N. Buccianti[1], M. Licchelli[1], A. Carbonella[1], M. Lofrano[1], N. Mecca[1], M. Pace[1], V. Pascale[1]

[1]AO San Carlo, UOC Medicina Interna, Potenza; [2]Scuola di Specializzazione in Medicina Intarna, Salerno, Italy

Premesse e Scopo dello studio: La diagnosi di dispepsia simil-ulcerosa associata all'infezione Helicobacter pylori H.P. nella pratica clinica è realizzabile con la gastroscopia. Lo scopo del lavoro è valutare l'accuratezza diagnostica del breath-test (con urea) nella diagnosi di infezione gastrica da H.P. attraverso la comparazione con la gastroscopia.
Materiali e Metodi: Nel 2018 sono stati arruolati 200 pts di età compresa tra 18 e i 40 aa affetti da dispepsia simil-ulcerosa a cui non si associavano segni e sintomi di allarme (calo ponderale, disfagia, ematemesi, vomito). In tale coorte sono stati eseguiti in maniera sequenziale sia il breath-test (con urea) che la gastroscopia.
Risultati: Le infezioni gastriche da H.P. sono state rilevate nel 20% degli esami endoscopici e nel 19% dei breath-test. I due esami sono risultati sovrapponibili nella diagnosi di infezione H.P. correlata. La gastroscopia nei casi positivi ha mostrato la presenza di lesioni endoscopiche minori (erosioni) con note di flogosi subacuta sul piano istologico.
Conclusioni: Il breath-test per la diagnosi di infezione gastrica H.P. relata può rappresentare una valida ed efficace alternativa alla gastroscopia nel management diagnostico della dispepsia simil-ulcerosa in popolazione giovane (<40 aa) non associata a segni e sintomi di allarme. Tale approccio clinico comporta una significativa riduzione di esami endoscopici inappropriati e dei costi.

Post-sphincterotomy bleeding: can we use plastic stents?

M. Zippi[1], G. Traversa[1], I. De Felici[1], R. Pica[1], P. Crispino[2], C. Cassieri[3], G. Occhigrossi[1]

[1]Unit of Gastroenterology and Digestive Endoscopy, Sandro Pertini Hospital, Rome; [2]Unit of Medicine and Urgency, San Giovanni Hospital, Lagonegro (PZ); [3]Division of Internal Medicine and Gastroenterology, "Cristo Re" Hospital, Rome, Italy

Introduction: Post-sphincterotomy bleeding (PSB) may be observed in 1% to 48% of cases. Above the traditional hemostasis methods (injection of adrenaline, thermal methods, balloon tamponate,...), excellent results can be achieved with the placement of self-expandable partially or fully covered metal stents (SEMSs). Only in one study appears the use of multiple plastic stents in these situations.
Case report: We describe two cases concerning two patients who came to our observation for jaundice due to lithiasis of the common bile duct (CBD). Both presented PSB treated with the insertion of plastic stent in the CBD. The first was a man of 72 years-old, who presented immediate bleeding after endoscopic sphincterotomy of a major papilla located between 2 diverticula. The second was a woman of 78 years-old who had delayed bleeding the day after, found following an episode of melena with a reduction in her hemoglobin level (10 g/dL). In this case a second therapeutic procedure was performed. In both cases, we decide to use a single plastic stent (10 Fr 5 cm) (Cotton-Huibregtse® Biliary stent, Cook Ireland, Ltd.), placed across the biliary orifice, in order to compress mechanically the bleeding site. The stents were removed after two weeks in both.
Conclusions: The application of a stent in case of PSB is considered to avoid additional more aggressive interventional approaches such angiography or surgery, especially in elderly patients. We hypothesize that if the sphincterotomy is not too wide and the bleeding is not copious, you can place also a single plastic stent.

Early diagnosis of heart involvement in systemic sclerosis using speckle tracking derived global longitudinal strain

L. Zuliani[1], C. Fischetti[1], A. Ferrarini[1], F. Guerra[2], G. Stronati[2], G. Pomponio[1], A. Capucci[2], M.G. Danieli[1], A. Gabrielli[1]

[1]Clinical Medicine, Marche Polytechnic University, Ancona; [2]Cardiology and Arrhythmology Clinic, Marche Polytechnic University, Ancona, Italy

Background: Systemic sclerosis (SSc) is a rare connective tissue disease that involve different organ with progressive fibrosis. A subclinical heart involvement is difficult to detect through conventional imaging.
Design: We selected patients with systemic sclerosis and we evaluated whether speckle tracking-derived global longitudinal strain (GLS) could describe early subclinical systolic dysfunction.
Methods: A case-control, single-centre study on 52 SSc patients and 52 age and gender-matched controls. We excluded patients with pulmonary hypertension, heart failure, atrial fibrillation and structural heart disease. We collected for every patient a standard

echocardiographic and speckle tracking- derived for the systolic and diastolic function of both ventricles. Thereafter all patients underwent an echocardiographic follow-up one year later to compare if there is a correspondence between clinical and echocardiographic worsening.
Results: Traditional parameters of left and right systolic function did not differ between SSc patients and controls (p=NS). Left and right ventricular GLS were significantly impaired in patients with SSc when compared to controls (p=0.009 and p=0.012 respectively). Using -20% as a cut-off for GLS, SSc patients had a 2.5-fold and a 3.3-fold increased risk of subclinical LV and RV systolic impairment when compared to controls.
Conclusions: While common echocardiogram is ineffective in describing subclinical systolic impairment, reduced GLS is significant for both ventricles in SSc patients and it is useful for detecting early heart involvement.

ABSTRACTS SUBMITTED

Localized scleroderma and mixed connective tissue disease: the difficulty of diagnosis

D. Addesi[1], C. Pintaudi[1], M. Mitra[1], S. Mazzuca[2], M. Pintaudi[3], A. Tramontano[4], R. Cimino[1]

[1]AO Pugliese-Ciaccio, UOC di Medicina Generale, Catanzaro; [2]Casa di Cura "Villa del Sole", UO Medicina Generale, Catanzaro; [3]Facoltà di Medicina, Università degli Studi di Siena; [4]PO di Praia a Mare, ASP Cosenza, UO di Medicina Generale, Cosenza, Italy

Background: Mixed connective tissue disease is a systemic autoimmune disease that includes patients with overlapping clinical symptoms of systemic lupus erythematosus, systemic sclerosis, rheumatoid arthritis and polymyositis/dermatomyositis.
Localized scleroderma is an autoimmune disease that involves the skin causing hardening with loss of elasticity.
Case report: The patient was a 63 years old female admitted at our Hospital for a suspected deep venous thrombosis. She complained of a tickening of the skin of her arms (with saving hands) and legs associated with painful ulcerations. Clinical examination revealed the presence of a hardening skin of arms and legs, fissures, absence of skin appendages and violet-red complexion. The capillaroscopic examination excluded the presence of microangiopathy. We hypothesized a localized scleroderma. Laboratory evaluations showed: VES 13 mm/h, PCR 17.8 mg/l, weak positive ANA, anti-SSB, anti-RNP, anti-RNP68, anti RNP-A. Other autoantibodies (p-ANCA, c-ANCA, anti-native DNA) were in the normal range. These results were compatible with a mixed connective disease; we excluded the diagnosis of Systemic Sclerosis, considering the absence of Raynaud phenomenon and manifestations of organ damage. Patients started therapy with methotrexate and prednisone obtaining an improvement of skin lesions.
Conclusions: This case report raises many diagnostic doubts, as often happens in the management of autoimmune disease. We considered the patient as having a localized scleroderma, starting a close follow-up that we think can solve the diagnostic doubts.

Sindrome da iperinfezione da *Strongyloides stercoralis* per transitoria immunodepressione EBV correlata

A. Agostinelli[1], F. Falaschi[1], E. Cattaneo[2], A. Di Sabatino[3]

[1]Unità di Medicina Interna, Clinica Medica 2, Fondazione IRCCS Policlinico San Matteo, Pavia; [2]Unità di Malattie dell'Apparato Respiratorio, Fondazione IRCCS Policlinico San Matteo, Pavia; [3]Unità di Medicina Interna e Gastroenterologia, Clinica Medica I, Fondazione IRCCS Policlinico San Matteo, Pavia, Italy

Premesse: La Strongiloidosi è una malattia caratterizzata da sintomi sistemici aspecifici. Nella sua forma cronica può decorrere asintomatica ma, in caso di immunodepressione, può evolvere nella sindrome da iperinfezione, con migrazione della larva attraverso la mucosa enterica e sovrainfezione batterica. Descriviamo un caso di sindrome da iperinfezione manifestatasi con febbre in paziente con transitoria immunodepressione EBV-relata.
Caso clinico: Una donna di 82 anni giungeva in Pronto Soccorso per febbre resistente a terapia antibiotica. Agli ematochimici PCR 6.47 mg/dl, PCTI 0.52 ng/dl, eosinofilia, indici di colestasi e citolisi elevati. Non focolai broncopolmonari alla radiografia del torace, esami colturali negativi. In anamnesi ipereosinofilia presente da anni. La ricerca dei virus epatotropi evidenziava positività per IgM contro EBV, l'esame coproparassitologico infestazione endoluminale da Strongyloides Stercoralis. Non segni di larva currens cutanea. Inizia terapia con Ceftriaxone e Ciprofloxacina determinante defervescenza e normalizzazione degli indici di flogosi (cresciuti inizialmente con PCTI pari a 9,5 ng/mL); effettua poi terapia antiparassitaria con Ivermectina. Al domicilio nuovo episodio febbrile regredito con antibiotico orale (Coamoxiclav). Dopo tre mesi di terapia il coproparassitologico risulta negativo, gli eosinofili nella norma, non più episodi febbrili.
Conclusioni: Questo caso sottolinea l'importanza di sospettare la presenza di Strongyloides Stercoralis nei pazienti con sintomi sistemici influenzali, soprattutto in corso di immunodepressione ed eosinofilia. Spesso si presentano con disturbi gastrointestinali e febbrili per migrazione di enterobatteri attraverso la mucosa enterica. Una corretta terapia determina solitamente rapida normalizzazione dell'eosinofilia, negativizzazione dell'esame coproparassitologico e risoluzione del quadro clinico.

Febbre di origine sconosciuta: vecchie e nuove sfide per l'internista

M. Amitrano[1], S. Mangiacapra[1], F. Cannavacciuolo[1], M. Raimondo[1], M. Mastroianni[1], G. Antignani[1], S. Gioia[1], G. Ferraro[1], S. Vivolo[1], E. Allegorico[2]

[1]AORN "Moscati", UOC Medicina Interna, Avellino; [2]PO "Santa Maria delle Grazie", Pozzuoli (NA), Italy

Premesse: La febbre di origine sconosciuta (FUO) rappresenta, ancora oggi, una sfida per l'internista.
Caso clinico: Paziente di anni 82, giunta per febbre intermittente da un mese. In anamnesi: MGUS, Artrite reumatoide, pregresso intervento chirurgico per neoformazione mammaria destra. Riferiti recenti episodi ripetuti di fuoriuscita di materiale purulento dal cavo ascellare destro. La paziente presentava febbre quotidiana, con picchi di temperatura di 39°C, preceduti da brividi scuotenti. Gli esami di laboratorio mostravano un incremento degli indici di flogosi, in assenza di autoimmunità. Praticava ripetute emocolture (negative) e quantiferon. La TC torace risultava negativa. All'ecografia ascellare, presenza di tre raccolte fluide, unite da tramite fistoloso, comunicanti con il QSE della mammella destra. All'eco addome, lesioni ipoecogene epatiche. Si praticava una biopsia epatica e mammaria, con evidenza di processo necrotizzante granulomatoso con cellule giganti multinucleate tipo Langhans, con aree necrotiche simil-caseose, reperto specifico per Tubercolosi, confermata dal quantiferon.
Conclusioni: La particolarità di questo caso clinico risiede nella particolare localizzazione della malattia tubercolare (a livello della mammella), in assenza di coinvolgimento polmonare. Inoltre si mette in evidenza come la patologia tubercolare, per un periodo "dimenticata", costituisca, ad oggi, una delle cause di FUO da prendere in considerazione nell'iter diagnostico, anche in assenza del classico coinvolgimento polmonare.

La terapia dell'osteoporosi: tre farmaci antiosteoporotici a confronto (alendronato, zoledronato, teriparatide)

K. Ampatzidis[1], D. Ampatzidi[2], F. Finocchiaro[3], A.R. Bisicchia[4], S. Borzì[5]

[1]Università degli Studi di Catania, AO Cannizzaro, UOC Geriatria, Catania, Italy; [2]Social Worker (MSc), Society of Psychosocial Research and Intervention (S.P.R.I. – EPSEP in Greek), Ioannina, Greece; [3]Università degli Studi di Catania, AO Cannizzaro, Tecnico di Radiologia, Catania, Italy; [4]Infermiera Professionale, Centro Assistenziale per Anziani "Maria Regina", Sant'Agata Li Battiati (CT), Italy; [5]Direttore Sanitario, Centro Assistenziale per Anziani "Maria Regina", Sant'Agata Li Battiati (CT), Italy

Premesse e Scopo dello studio: Questo studio mette a confronto tre farmaci anti-osteoporotici. Due farmaci anti-riassorbitivi alendronato e zoledronato ed uno anabolico, la teriparatide; sia dal punto di vista dell'efficacia che come aderenza terapeutica.
Materiali e Metodi: Durata dello studio 24 mesi. Sono stati arruo-

lati 91 pazienti: aendronato 17 pz, Zoledronato 35 pz, teriparatide 39 pz. Sono stati esaminati con DXA i distretti lombare e femorale effettuati ad inizio trattamento (t0) ed a fine trattamento (t24). I criteri di inclusione allo studio sono stati dettati dalla NOTA 79.
Risultati: I soggetti in terapia con alendronato (aderenza 76,5%) hanno riportato un miglioramento della BMD a livello del collo del femore (p<0,0022). Non sono stati rilevati miglioramenti a livello degli altri segmenti ossei analizzati. I dati ottenuti nei soggetti in terapia con zoledronato (aderenza 82,9%), hanno rivelato un miglioramento a livello della colonna lombare (p<0,016) mentre non sono stati rilevati miglioramenti significativi dopo 24 mesi di terapia nei segmenti ossei femorali. Nei soggetti in terapia con Teriparatide (aderenza 46,2%), hanno ottenuto dei miglioramenti statisticamente significativi in tutti i segmenti femorali. Lo stesso, però, non è stato rilevato alla colonna.
Conclusioni: I tre farmaci hanno raggiunto gli obiettivi fissati; arresto della perdita di massa ossea e riduzione dell'insorgenza di nuove fratture sia cliniche che manifeste, tuttavia possiamo notare ancora una volta la scarsa aderenza terapeutica verso patologie croniche quale l'osteoporosi.

Atypical fractures with long-term bisphosphonate therapy. Case report

K. Bai[1], V. Galmarini[1], R. Capelli[1], T. Minora[2]

[1]ASST Fatebenefratelli Sacco, Milano,; [2]Farcologo Clinico, Milano, Italy

Introduction: Bisphosphonates are the most widely prescribed pharmacologic treatment for osteoporosis and reduce fracture risk in postmenopausal women by up to 50%. In the past decade long-term bisphosphonate treatment have been associated with atypical femoral fractures (AFFs), rare fractures about 3-10 cases/10,000/year patient in therapy. The site of "atypical" fractures is generally subtrochanteric and with a lower incidence in the femoral diaphysis.
Case report: A 52-year-old woman, competitive sports up to 30 years. A 20-year sub-ovarian ovariectomy for cysts and treated with HRT for 2 years. The patient has been, approximately 15 years, on indication of the treatment with alendronate, without calcium and vitamin D combination, in a densitometric picture of osteopenia. For over 15 months, he has reported anterior pain to both thighs, absent in the discharge o deambulation. No diagnostic tests were carried out have not been reported a pathology of rachid or neuropathic origin. Admitted in hospital for suddenly the lower limb sagging sin while he has walking. X-ray examinations, performed also on the contralateral femur, showed a transverse subtrochanteric fracture with a medial cortical beak, stabilized with blocked endo-medullary nail and right at the middle 1/3 after transverse interruption of the lateral cortex with intense periosteal reaction All bone turnover exams were normal, histological examination of reaming material and D-L morphometry were not significant.
Conclusions: Based on this experience, targeted scientific studies are needed in patients with atypical fractures to define gold standard therapy: optimal duration of bisphosphonate therapy, the need for therapeutic intervals, the usefulness and need for embryo with osteoformation drugs.

An unexpected, but eventually lucky pseudokidney sign

G. Bandini[1], E. Martinelli[1], P. Bernardi[1], C. Marchiani[1], M. Gagliano[1], E. Cioni[1], N. Palagano[1], G. Barbarisi[1], M. Zavagli[1], I. Bertoletti[1], P. Mercatelli[1], F. Crudele[1], A. Moggi Pignone[1]

[1]Medicina per la Complessità Assistenziale IV, AOU Careggi, Firenze, Italy

Introduction: The pseudokidney sign, seen through ultrasonography (US), is composed of a mass that has a reniform appearance with a central hyperechoic region surrounded by a hypoechoic region. Sometimes it can be found in asymptomatic patients as a "gastrointestinal incidentaloma".
Case report: A 80-year-old man was admitted to our Emercengy Department (ED) for abdominal upper quadrant pain associated with nausea and loss of appetite. His lipase and bilirubin were high; other blood tests, including hemoglobin levels, were normal. Abdominal US at the ED showed common and extrahepatic bile ducts dilation due to gallstones and increased pancreatic volume without any fluid collection or necrotic areas. They made diagnosis of acute non complicated pancreatitis and transferred the patient to our Internal Medicine Department. On the second day we decided to repeat abdominal ultrasound and a gastrointestinal incidentaloma was found: in the right lumbar region there was a mass with a reniform appearance which seemed to originate from the ascending colon. Computed tomography (CT) with intravenous contrast agent confirmed the presence of a right-sided colon cancer. After the resolution of acute pancreatitis the patient underwent a surgical operation of cholecistectomy and removal of the right colon adenocarcinoma.
Conclusions: Colorectal adenocarcinoma is a frequent disease and it is often asymptomatic, espacially in the early stages. Abdominal US with the pseudokidney sign can be a useful tool for the screening and diagnosis of large bowel tumors.

Interferometria-Cataract Syndrome

M. Barberio[1], L. Morini[2], N. Mumoli[1]

[1]Ospedale Fornaroli, Reparto Medicina Interna, Magenta, ASST Ovest Milanese; [2]Ospedale Magenta, Reparto Medicina Interna, Magenta ASST Ovest Milanese, Italy

Background: Hyperferritinemia-Cataract Syndrome is an autosomal dominant condition, described since 1995, characterized by an excess of an iron storage protein called ferritin in the blood (Hyperferritinemia). The Hyperferritinemia-cataract syndrome in this rare disorder does not usually cause any health problems other than cataracts, but if not timely surgically removed the cataract causes progressive and serious dimming and blurriness of vision.
Case report: AP is a 40-year-old Italian woman that was admitted to our Internal Medicine ambulatory due to hyperferritinemia incidental findings (1000 ng/ml during the routine examination). Hepatitis or cirrhosis familiar history was negative; her mother, maternal aunt and maternal grandmother were suffering from early cataract. Anamnesis was negative except for a cataract operation executed 5 years before. Physical examination: cardiovascular and respiratory systems were unremarkable. The liver function test, blood count, iron level and transferrin, virus hepatitis, autoantibodies, all resulted as normal.All causes of emocromatosis and emosiderosis were excluded. U.S. shows hepatic steatosis, without any structure's alteration. After exclusion of hereditary hemochromatosis and hemosiderosis, the patient has been screened with a further genetic test for Hyperferritinemia-cataract syndrome. The test was positive for a heterozygous substitution of nucleotide +40A>G, known as gene "Paris 1", an alteration of synthesis of L ferritin.
Comments: Individuals with Hyperferritinemia-Cataract Syndrome show elevated serum ferritin concentration but do not have an iron overload, inducing to potential wrong diagnosis.In fact, in absence of iron overload, the treatment with blood draws would reduce iron levels, leading to red blood cells number decrease (anemia).Correct diagnosis of hyperferritinemia-cataract syndrome is important to avoid unnecessary treatments or invasive test procedures such as liver biopsies.

Fat or muscular man?

M. Barletta[1], I. Tartaglia[1], B. Farneti[2], P. Di Giuseppe[1]

[1]Ospedale Perrino, Medicina Interna, Brindisi; [2]Ospedale Perrino, Malattie Infettive, Brindisi, Italy

Introduction: Madelung's disease is a rare acquired pathology characterised by multiple symmetrical lipomatosis most prominent in the head, neck, and upper torso, often associated with alcohol poisoning.
Case report: We present the case of an old man affected by cirrhosis HCV, with a history of alcohol abuse and suffering from osteoporosis and intestinal polyposis associated with diabetes, hospitalised for syncope. Clinical investigation was aimed at researching abnormalities in fatty tissues to explain metabolic, neurological and oncological disorders such as diabetes, osteoporosis, peripheral neuropathy and polyposis in gastro-intestinal tract. A biopsy of a massive fatty deposit and muscle on right shoulder of the patient was taken and the results were analysed using a scanning optical microscope. Some hypertrophic and some ipotrophic muscle fibres with splitting were discovered, besides high levels of activity in alkaline phosphatase and phosphorylase in endomysial

capillars. No lymphatic cells included were detected. Ultimately, no abnormalities were discovered in fat tissue.

Un intricato caso di LES all'esordio

C. Bassino[1], M. Frigerio[1], G. Alfieri[2], D. Sala[1], M. Casartelli[1], D. Tettamanzi[1], E. Limido[1]

[1]ASST-Lariana, Ospedale S. Antonio Abate, Cantù (CO); [2]ASST-Lariana, Ospedale S. Anna, S. Fermo della Battaglia (CO), Italy

Premesse: Il LES è una patologia infiammatoria cronica con alterazioni immunologiche e produzione di anticorpi, caratteristica importante della malattia che può avere anche complicanze non usuali.Di seguito descriviamo un caso di LES complicato all'esordio da TEP in assenza di anticorpi antifosfolipidi e sospetta MAS (Sindrome Attivazione Macrofagica).
Caso clinico: F, 22 aai, APR muta eccetto riscontro da 12 mesi di incremento ANA fino a 1/320 pattern speckled,artralgie diffuse, ENA assenti. Giungeva per peggioramento dei sintomi, limitazione funzionale e rush malare. All'ingresso dispnoica per sforzi minimi, sottoposta ad angio-TAC positiva per TEP. Agli ematici pancitopenia, Ab anti DNA in elisa positivi ad alto titolo, consumo di complemento Test di Coombs dir pos, ind neg, anticorpi antifosfolipidi negativi. Ecocardio ed ecocolordoppler venoso arti inferiori negativi. Completava accertamenti con positività CMV IgM con cattura positiva ma ricerca CMV DNA negativa. Valutazione oculistica con evidente quadro di vasculite retinica non compatibile con infezione da citomegalovirus. Per persistenza di febbre, pancitopenia, ferritina elevata e ipertrigliceridemia, possibile espressione di iniziale MAS, eseguita BOM negativa. Rivalutata TAC ed ecocardio per persistenza di dispnea, negativi. La sintomatologia è migliorata con l'inizio della terapia steroidea a cui è stata associata idrossiclorochina e warfarin.
Conclusioni: La MAS è una sindrome emofagocitica secondaria a malattie reumatiche nell'adulto più spesso associata a LES.

Tromboembolismo venoso recidivo sotto DOAC. Caso clinico

S. Beccaria[1], M. Vincenzi[1], S. Corbi[1], R. Caponetti[1], M. De Simone[1], R. Privitera[1], A. D'Uva[1]

[1]UOC Medicina Protetta, Ospedale Sandro Pertini, Roma, Italy

Descrizione: Paziente di 35 anni. Ad agosto '17 colecistectomia laparoscopica urgente complicata da sepsi. A 6 giorni dalla dimissione TVP AI sx e EP per cui inizia terapia con Dabigatran 150 mg x2/die. A maggio '18 riscontro di EP di piccolo ramo segmentario lobo sup dx. Doppler AAII negativo. Continua terapia in atto. Luglio '18 ricovero in cardiologia per sincope e trauma emitorace dx, impianta Loop Recorder. Agosto '18, in PS per dolore toracico improvviso e violento, esami ematochimici e strumentali negativi, dimesso senza modifiche terapia. A ottobre '18, in PS per dolore precordiale e dispnea, alla TC torace con mdc EP del ramo lobare per lobo sup sx. Dopo 48 h in PS viene ricoverato in Medicina Protetta ma a 24 h per recrudescenza sintomi ripete TC con riscontro di estensione dell'EP. Sospeso Dabigatran inizia Fondaparinux (per riferita allergia ad EBPM) embricandolo con Warfarin. Si effettua screening trombofilico con riscontro di positività AB anticardiolipina IgM, anti Beta2glicoproteina IgM ed iperomocisteinemia. Test genetici negativi. AI Doppler TVP AI dx. Si soprassiede a filtro cavale consigliato da angiologo, si sostituisce Warfarin con Acenocumarolo raggiungendo il range terapeutico dopo frantumazione farmaco e somministrazione a vista.
Conclusioni: Caso clinico che ha impegnato diverse equipe mediche dell'ospedale da cui emergono criticità nella tempistica di esami diagnostici, approcci terapeutici (es. mancata modifica terapeutica alla recidiva di TEV) e mancata verifica della compliance del paziente, espressione di frammentazione della presa in carico.

Antithrombotic therapy in a complex patient

A. Bellizzi[1], L. Moretti[1], P. Fenu[2], F. Lombardini[1], M. Cei[2]

[1]UO Medicina Interna, Ospedale "Villamarina", Piombino (LI); [2]UO Medicina Interna, Ospedale "Bassa Val di Cecina", Cecina (LI), Italy

Background: Atrial fibrillation (AF) is the most common type of cardiac arrhythmia worldwide. It increases the risk of stroke by 5 times and its magnitude is quantified by a score. The CHADS2 VASC2 is the most widely used. The patients with a score >2 are candidates for anticoagulant therapy. The Amyloid angiopathy is a pathology with a high risk of intracranial bleeding. Anti-coagulant drugs, after a lobar bleeding, are contraindicated. What to do when the two diseases coexist?
Case report: A seventy-two years man. Tabagism since he was fifteen. Hypertension. Access to the ER for general epileptic seizures. Neurological objectivity: stupor, a minimum deficit on left lower limb strenght. Brain CT: extensive right frontal intraparenchymal hemorrhage. ECG: atrial fibrillation. During his hospitalization, angioRMN excludes vascular malformations. Afterwards the improvement of his state of consciousness and his motor deficit. In the 7th day, CT brain: ischemic lesion in the right temporo-occipito-parietal site. TT Echocardiogram: no thrombotic images. TE Echocardiogram: left auricular thrombosis. Epiaortic ultrasound: not hemodynamic atheromasia. Brain T2 gradient RMN: Amyloid angiopathy. Discharged in 16th day in fair conditions, active mobilized, with enoxaparin therapy 4000 twice.
Conclusions: In case of atrial fibrillation, the risk of bleeding is particularly high in patients with an intracranial bleeding history. We might consider a closure of the left auricle. Therefore it involves periprocedural antithrombotic therapy with heparin IV (ACT 250-300s) and, thereafter, TAO followed by DAPT or DAPT for 3-6 months. This procedure can not therefore be carried out urgently. In these cases, further studies are needed to establish the best antithrombotic therapy.

Pleuropericardite emorragica con tamponamento cardiaco in paziente affetto da mielodisplasia trilineare e splenomegalia massiva

C. Bellotto[1], L. Landini[2], V. Annoni[1], D. Taccola[1], P. Nigro[1], L. Bertolucci[1], S. Ciaccio[1], L. Credidio[1], A. Cioppi[1], G. Galli[1], D. Carrara[1], S. Giubbolini[3], S. Fascetti[4], P. Fabiani[1]

[1]UOC Medicina Interna, ESTAV Nord Ovest, Ospedale Versilia, Lido di Camaiore (LU); [2]Medical Department Sanofi; [3]AOUP Medicina Interna, Pisa; [4]UOS Geriatria ESTAV Nord Ovest, Ospedale Versilia, Lido di Camaiore (LU), Italy

Premesse: Paziente di 78 anni affetto da malattia mieloproliferativa con mutazione Jack 2 positiva in terapia con bassa dose di Oncocarbide e comparsa di dolore toracico.
Caso clinico: Il paziente veniva ricoverato c/o il reparto di Cardiologia per pericardite acuta. Per l' ulteriore incremento del versamento pericardico con segni di tamponamento veniva sottoposto a pericardiocentesi. L'esame colturale del liquido pleurico risultava negativo. Veniva pertanto trasferito presso il reparto di Medicina per approfondimento diagnostico. Gli esami sierologici per ECHO virus, Coxackie e Clamidia, la batteria reumatologica (ANA, ENA, ANCA, crioglobuline, LAC e anticardiolipina) e i markers neoplastici risultavano negativi. A completamento diagnostico venivano effettuati accertamenti strumentali tra cui TC toraco-addominale, PET-TC total body, EGDS e colonscopia che non evidenziavano nulla di rilevante. Il paziente veniva quindi trattato con terapia antiinfiammatoria a base di Ibuprofene e Colchicina, quest'ultima, sospesa per comparsa di episodi diarroici e sottoposto a monitoraggio ecocardiografico con progressiva scomparsa del versamento pericardico e miglioramento della toracodinia.
Conclusioni: In un paziente ematologico in presenza di dolore toracico deve essere sempre sospettata la presenza di un'eventuale pericardite. Al fine di prevenire complicanze gravi, si rende naturalmente necessaria una scrupolosa diagnosi differenziale sull'eziologia di malattia e una tempestiva terapia adeguata.

Hospital Hurst

C. Benatti[1], M. Bertesi[1], F. Gilioli[2], C. Di Donato[1]

[1]UO Complessa, Medicona Iterna, Ospedale di Carpi (MO), [2]UO Medicina Interna, Ospedale di Mirandola (MO), Italy

Hypersensitivity pneumonitis (HP) or extrinsic allergic alveolitis, is

a complex pulmunary syndrome mediated by the immune system and caused by inalation of a wide variety of antigens to which the individual has been previously sensitized. We report a case of man with recurrent serotine fever with myalgia and dyspnea expecially during work shifts. The lab tests and chest radiograph were negative. He was treated with anthibiotic therapy without benefit. For worsening of clinical symptoms expecially during nighttime hours we repeated viral and autoimmune lab tests that were negative, so as a chest CT. Transbronchial biopsy showed a cellular interstitial infiltrate of lymphocytes and bronchoalveolar lavage demostrated lymphocytosis and preponderance of CD8+ cells. Serum precipitins against pigeon serum antigens were positive. Medical history, clinic and all investigations allowed us to make a diagnosis of Pigeon related Hypersensitivity Pneumonitis... in a DOCTOR. A few months before the symptoms appeared, the doctor's bedroom during hospital shifts had been moved to a new room just under the roof and the air conditioning system, allowing pigeon drops antigens to spread into the room, in spite of filters. HP is a complex pulmonary syndrome characterized by diffuse inflammation of lung and airways in response to the inhalation of antigens to which the individual has been previously sensitized. Corticosteroids may be useful in acute episodes for symptomatic relief or in chronic and progressive disease but the removal of the offending agents remains the cornerstone of treatment.

A prospective global registry on oral antithrombotic treatment in patients with atrial fibrillation: GLORIA-AF Phase III baseline characteristics

R. Benedetti[1], M. Huisman[2]

[1]Centro Emostasi e Trombosi, SC Medicina Interna, Ospedale G. da Saliceto, Piacenza, Italy; [2]Leiden University Medical Center, Leiden, Netherlands

Background: Following the introduction of non-vitamin K antagonist oral anticoagulants (NOACs), treatment patterns for stroke prevention in patients with atrial fibrillation (AF) are changing. GLORIA-AF is a prospective, threephase, global registry program, which assesses treatment patterns and outcomes in patients with AF. Phase III enrollment started 2 years after the first NOAC, dabigatran, was approved for stroke prevention in AF in the respective countries.
Methods: Newly diagnosed AF patients at risk of stroke were consecutively enrolled from January 2014–December 2016 at 935 clinical sites in 38 countries. Sites were eligible based on availability of both dabigatran and vitamin K antagonists (VKA).
Results: 21,248 eligible patients (median age 71; female44.9%) were enrolled. Stroke risks were high (CHA2DS2-VASc score ≥2) for 85.6% of patients and 9.3% had known high bleeding risk (HAS-BLED ≥3). Overall, oral anticoagulants (OACs) was prescribed in 82.2% of patients (NOACs:59.5%, VKAs: 22.7%), antiplatelet drugs alone in 11.2%, and 6.6% of patients received no antithrombotic therapy. Use of OACs was lower in Asia (61.5% vs other regions, 87.4%) where patients were less often at high stroke risk (78.7% vs 87.3%) and more often at high bleeding risk (11.8% vs 8.7%) than in other regions.
Conclusions: These global registry data show a continuing trend of high usage of OAC in AF patients at risk of stroke. NOACs are the most frequently prescribed treatment in this study period in all regions assessed, although this may vary within countries.
Study funded by Boehringer Ingelheim.

Caso complesso di linfoma non Hodgkin

V. Bernardis[1], S. Rondinella[1], M. Balbi[1]

[1]Medicina Interna, Ospedale San Vito al Tagliamento (PN), Italy

Premesse: Caso di LNH di difficile diagnosi.
Caso clinico: Un pz di 62 aa viene ricoverato per dolore addominale e ascite in pregresse pleuro pericarditi recidivanti con immunità negativa. TC toraco-addominale, EGDS, colonscopia, laparotomia con biopsie multiple, markers neoplastici, autoimmunità, portano alla diagnosi di dimissione di: mesenterite con infiltrazione eosinofila in corso di accertamenti; pregresse pleuropericarditi recidivanti in portatore sano HBV. Rapida recidiva del dolore e dell'ascite post dimissione, per cui si pongono in diagnosi differenziale le seguenti ipotesi: mesenterite/fibrosi retro peritoneale, mesotelioma mesenterico, patologia linfoproliferativa, amiloidosi, sarcoidosi, TBC peritoneale. Esegue TC-PET con evidenza di: patologici iperaccumuli focali del tracciante sospetti per localizzazioni di patologia neoproliferativa. Diffuso ispessimento del mesentere; iperaccumuli di FDG tra le anse intestinali non differenziabili tra uptake aspecifico e localizzazioni di malattia neoproliferativa. Modesto iperaccumulo di FDG in linfonodo inguinale destro. L'esame istologico sul linfonodo sottoposto ad exeresi chirurgica evidenzia: quadro compatibile con localizzazione di linfoma maligno non Hodgkin B-linfoide, follicolare, grado I sec. WHO 2018. In assenza di indicazioni a radioterapia, viene avviato solo trattamento steroideo.
Conclusioni: Al controllo TC-PET scomparsi foci addominali e mesenteriali. Persiste modesta attività intestinale aspecifica e diffuso modesto uptake lungo il decorso dei vasi arteriosi femoro-poplitei e sulla parete dell'arco aortico.

Trombosi portale primitiva

M. Bernetti[1], I. Bracali[1], P. Lotti[1], F. Risaliti[1], A. Foschini[1], A. Giani[1], L. Guarducci[1], S. Zanieri[1], R. Martini[1], T. Restuccia[1], M. Bertoni[1], A. Tammone[1], M.E. Di Natale[1]

[1]Nuovo Ospedale di Prato-Santo Stefano, Medicina II, Prato, Italy

Premessa: La trombosi portale in assenza di cirrosi epatica ha come causa più frequente (40-70%) una condizione di trombofilia ereditaria o acquisita.
Caso clinico: Uomo di 50 anni ricoverato per dolore epigastrico con rilievo di ipertransaminasemia ed elevati valori di D Dimero. All' AngioTAC evidenza di trombosi portale completa con estensione alle vene splenica e mesenterica superiore. Esclusa la cirrosi epatica, l'emoglobinuria parossistica notturna, le malattie neoplastiche tra cui malattie mieloproliferative, i test di trombofilia ereditaria hanno dimostrato mutazione eterozigote per il gene Wt/G20210A. Il paziente è stato trattato con terapia anticoagulante con parziale ricanalizzazione della vena porta al controllo a distanza di tre mesi.
Conclusioni: Tra le condizioni trombofiliche ereditarie, la mutazione del gene G20210 è quella che più frequentemente si associa con la trombosi delle vene sovra epatiche e della vena porta. Nel caso presentato la ricerca di una condizione trombofilica genetica è seguita all'esclusione delle non infrequenti patologie che possono determinare tali eventi trombotici anche senza che vi sia un substrato trombofilico genetico. L'altra difficoltà sarà quella di decidere quanto a lungo protrarre la terapia anticoagulante stante la giovane età del paziente.

Pseudocisti surrenalica emorragica ad esordio clinico acuto

G. Bertola[1], S. Giambona[1], R. Bianchi[1], S. Dassi[1], F. Di Nuovo[2], M. Onorati[2], M. Nicola[2], C. D'Urbano[3], A.A. Ianniello[4], A.E. Canì[4], G. Xhepa[4], S.A. Berra[1]

[1]UO Medicina I, ASST Rhodense, Garbagnate Milanese (MI); [2]UO di Anatomia Patologica e Citogenetica, ASST Rhodense, Garbagnate Milanese (MI); [3]UO Chirurgia Generale, ASST Rhodense Garbagnate Milanese (MI); [4]Servizio di Radiologia Interventistica, ASST Rhodense, Garbagnate Milanese (MI), Italy

Premesse: Le lesioni cistiche surrenaliche (LCS), suddivise in cisti parassitarie, epiteliali, endoteliali e pseudocisti, sono infrequenti; spesso asintomatiche, entrano in diagnosi differenziale con altri incidentalomi surrenalici. Sebbene raramente, le LCS possono giungere all'attenzione clinica in modo drammatico, per complicanze emorragiche, come si può osservare in altri espansi surrenalici (soprattutto feocromocitomi). La diagnosi differenziale, specie in presenza di emorragia, è ardua e necessita in genere del riscontro istologico da surrenectomia, che in alcuni casi, può essere differita, dopo il controllo del sanguinamento mediante embolizzazione endoarteriosa (EE).
Caso clinico: Donna di 47 anni, senza precedenti patologici, presentatasi in PS per dolore addominale ad insorgenza acuta. Alla TAC tumefazione surrenalica sinistra di 50 mm, disomogenea con aree a densità ematica e piccole calcificazioni. Per la presenza di blushes da rifornimento attivo, è stata effettuata in urgenza EE dell'arteria surrenalica sinistra, con decorso favorevole. Nella norma sono risultate le prove di funzionalità surrenalica. La paziente è stata sotto-

posta in seguito a surrenectomia laparoscopica, con diagnosi istologica di pseudocisti emorragica del surrene.
Conclusioni: Data la scarsa accuratezza dell'imaging nelle LCS, la chirurgia si rende spesso necessaria per una diagnosi istologica corretta. Sebbene non esistano attualmente linee guida specifiche in merito, anche nel caso delle LCS emorragiche l'EE può essere uno strumento efficace nel controllo della fase acuta.

Chilotorace come modalità di presentazione di linfoma linfoblastico

M. Bianchi[1], S. Vernocchi[1], A. Aceranti[2]

[1]ASST Lombardia Ovest Milanese; [2]Istituto Europeo di Scienze Forensi e Biomediche, Gallarate (VA), Italy

Premessa: La toracentesi è spesso vista come una manovra troppo invasiva e non viene quindi utilizzata su pz affetti da scompenso.
Caso clinico: Donna di 76 anni, ex forte fumatrice (30p/y). APR: tonsillectomia, appendicectomia, colecistectomia per colelitiasi, isterectomia per leiomioma, dislipidemia, ipertensione arteriosa, diabete mellito di tipo 2 in terapia. Da circa 6 mesi comparsa di edemi declivi, caviglia e gamba sn >dx e reperto bronchitico per cui si reca in località clinica per 3 mesi. In relazione alla non regressione degli edemi ed alla comparsa della dispnea si presenta prima dal MMG e poi in PS. Il quadro di dispnea per minimi sforzi, tosse stizzosa, edemi declivi e versamento massivo a destra e dubbio a sinistra, chiesto il ricovero nell'ipotesi di scompenso in ambito pneumologico ove dal drenaggio emerge liquido lattescente compatibile con chilotorace. L'EO rileva la presenza di almeno 3 stazioni linfonodali tumefatte compatibili con pacchetto linfonodale a livello: ascellare, nel triangolo di scarpa, ed in sede para-vulvare destra, tali tumefazioni presenti da almeno 6 mesi sono attribuiti inizialmente dalla paziente a lipomi. L'asportazione di un linfonodo di un pacchetto linfonodale ascellare dx mostra quadro di linfoma follicolare. Il drenaggio del versamento porta ad un miglioramento della funzione ventilatoria. Dopo 3 mesi il versamento torna ai livelli iniziali.
Conclusioni: Dall'analisi di questo caso si evince come la toracentesi diagnostica è un esame importante anche per i pazienti che presentano un quadro di scompenso.

Is there a role for magnetic resonance imaging of the spine in evaluating vitamin B12 deficiency? A case of subacute combined degeneration

E. Blasi[1], M. Finocchi[1], L. Corbo[1], G. Zaccagnini[1], M. Giampieri[1], C. Florenzi[1], S. Baroncelli[1], F. Rocchi[1], G. Degl'Innocenti[1], C. Nozzoli[1]

[1]Medicina per la Complessità Assistenziale 1, Firenze, Italy

A 62-year-old man underwent to repeated spine surgeries for disc disease, with residual hyposthenia of the right lower limb and paresthesia of the 4 limbs (recently worsening and extended till to submammary line), was admitted to the hospital because of constipation and urinary dysfunction. The blood tests showed reticulocytosis, macrocytic anemia, vitamin B12 deficiency, increased bilirubin and LDH levels. Abdominal imaging showed coprostasis, distended bladder with thickened walls. Upper and lower limbs MEP/SEP revealed altered sensory transmission. Spine CT scan showed thoracic bone spurs, disc herniation from L3 to S1. Cervicothoracic spine MR revealed T1-T2 hypointense marrow, hyperintensity in the posterior and anterolateral columns compatible with subacute combined degeneration (SCD). The gastric parietal cell antibodies were positive. Gastric biopsy showed atrophic gastritis with intestinal metaplasia. Patient was treated with cobalamin with clinical and instrumental improvement. Pernicious anemia is caused by autoantibodies directed against the intrinsic factor, gastric parietal cells or both, that interfere with cobalamin absorption, causing several manifestations. SCD is uncommon neurological complication, that involves posterior cervical and thoracic spine. Typical MR imagines are symmetric T2 hyperintensity in the posterior, posterolateral and occasionally anterior columns of the cervicodorsal spine, related to demyelination and intramyelin edema. Spine MR can help in early diagnosis and follow-up of SCD. The therapy is based on cobalamin administration.

Lasix e la macchia svanisce

V. Bonasia[1], M. Ponte[1]

[1]Medicina Interna 2, Udine, Italy

Premesse: Il cosiddetto *vanishing tumor* è un riscontro raro ed è causato da versamento pleurico localizzato in sede interlobare ed è indice di congestione venosa nel contesto dello scompenso cardiaco. E' importante conoscere questo tipo di versamento pleurico nella diagnosi differenziale di un'opacità polmonare alla radiografia.
Caso clinico: Pz di 87 anni, con storia di ipertensione arteriosa, accede in Pronto Soccorso per la comparsa di astenia e dispnea da sforzo, divenuta ingravescente, in assenza di tosse o febbre; i sintomi sono presenti da circa quindici giorni. All'esame obiettivo di segnalano: desaturazione in aria ambiente, MV ridotto alle basi, assenza di edemi declivi. All'elettrocardiogramma: tachicardia sinusale ed ipertrofia ventricolare sinistra. L'ecoscopia toracica evidenza versamento pleurico bilaterale, vena cava inferiore dilatata ed ipocollassante, frazione di eiezione ai limiti inferiori di norma. La radiografia del torace segnala la presenza di un'*opacità ovalare al campo medio destro compatibile in prima ipotesi con versamento saccato*, oltre alla presenza di velatura pleurica bilaterale. Alla luce dei reperti obiettivi e strumentali viene avviata la terapia per lo scompenso cardiaco e diuretica, che si dimostra efficace, risolvendo la dispnea, l'ipossiemia e migliorando la cenestesi del paziente. Alla radiografia di controllo eseguita dopo quattro giorni si dimostra la risoluzione dell' *opacità ovalare* su descritta.
Conclusioni: Il cosiddetto *vanishing tumor,* un reperto radiografico non a tutti famigliare e raramente riportato in letteratura, può innescare la richiesta di ulteriori costosi quanto inutili accertamenti. Dobbiamo invece considerarlo nella diagnosi differenziale nel paziente con un' opacità polmonare e scompenso cardiaco.

Find the end of the hank

R. Bonometti[1], M. Bellan[1], V. Spinoglio[1], M. Girino[2], V. Boccaccio[2], F. Massaro[2], M. Pirisi[1]

[1]Dipartimento Medicina Traslazionale, Novara; [2]Ospedale Santo Spirito, Casale Monferrato (AL), Italy

Introduction: Helicobacter Pylori (HP) is a bacterium found on the gastric epitelium. The infection is very common and it is associated to chronic gastritis and extragastric complications, such as: immune trombocytopenic purpura, metabolic syndrome, ischemic stroke, chronic spontaneus urticaria, asthma.
Case report: A 74 years old woman, in fair general condition, presents to the Internal Medicine outpatient clinic complaining chronic diarrhea started 8 months before. It was associated with nausea, vomit, loss of appetite and weight loss of 20 kg. The patient also referred saltuary itching rash on both arms in the last two months. In medical history she reported diabetes and hypertension. She carried in vision: fecal elastase, anti transglutaminases antibody, fecal calprotectine, coprocolture and colonoscopy. All of them resulted negative. Haematochemical demostrated normocytic normochromic anemia, acute renal failure with hypokalemia, hypoalbuminemia. During the hospitalization she performed: chest and abdomen CT negative, autoimmunity (ANA+1:640; ENA , Abanti dsDNA and ANCA were negative), EGDS showed the presence of gastritis with H.Pylori positivity. The patient underwent antibiotic treatment; HP eradication was paralleled by the resolution of diarrhea.
Conclusions: This clinical case suggests that HP infection might be responsible for unusual and multisystemic symptoms, such as diarrhea and skin rash. The treatment of the underlying infection, in our patient, was associated to the resolution of these atypical symptoms.

A strange case of hematemesis

F. Bonomi[1], G.P. Dognini[1], M.G. Manenti[1], V.C.G. Galimberti[1], M. Destro[1]

[1]Ospedale "Treviglio-Caravaggio", UOC Medicina Generale 1, Treviglio (BG), Italy

Anisakiasis is a zoonotic disease, caused in humans by accidental ingestion of larvae present in raw fish. The new popularity of raw fish in Western countries has led to an increase in the number of Anisakis cases. A 73-year-old Caucasian male was referred to our Unit with

a history of normocitc anemia. In September '17 he had been admitted to hospital for hemoptysis and was diagnosed with pulmonary carcinoma. He underwent surgical operation. In November '18 he was readmitted for anemia and black tarry stools. Esophagogastroduodenoscopy, colonoscopy, computer-tomography (CT), CT-colonography were normal. He was transfused and released. He had a readmission on December '18 with evidence of haematemesis and abdominal pain. Blood exams showed slightly increased white blood cells. Physical examination and abdominal X-ray were normal. EGDS was performed with evidence of angectasiae and a worm on it. The larva was extracted from the mucosa and the presence of Anisakis was confirmed by microscopical examination. The patient subsequently reported that he ate raw anchovies. During hospitalation he received a blood bag; new EGDS was negative for further nematodes presence. On the second hospital day, abdominal pain was relieved. He was discharged in good conditions, haemoglobin was 9.6 g/dl; he did not report any sign of bowel obstruction or any other manifestations suggestive of anisakiasis. In conclusion it is important, in the appropriate context, to consider anisakiasis as a differential diagnosis for patients presenting with suggestive history, abdominal symptoms and anemia.

Effects of DPP-IV inhibitors on mild cognitive impairment in type 2 diabetic patients at an older age

A.M. Borzì[1], E.S.D. Vicari[1], S. Luca[2], M. Vacante[2]

[1]Medicina Clinica e Sperimentale, Catania; [2]Chirurgia Generale e Specialità Medico-Chirurgiche, Catania, Italy

Background and Aim of the study: The association between diabetes and cognitive impairment is a common feature in the elderly. DPP-4 inhibitors are widely used in diabetes treatment and showed different beneficial effects on glycaemia, weight and cognitive impairment. This study aimed to investigate the effect of DPP-4 inhibitors, in particular vildagliptin, on the cognitive functioning of older patients with diabetes and mild cognitive impairment.
Materials and Methods: In this prospective study, 53 elderly people with type 2 diabetes were enrolled and divided in 2 groups in accordance with glycated hemoglobin (HbA1c) levels: Group A, (HbA1c ≤7.5%, n=24) treated with metformin, and Group B (HbA1c >7.5%, n=29) treated with metformin and vildagliptin. MMSE, fasting plasma glucose (FPG) and HbA1c were evaluated at baseline and after 24 weeks treatment.
Results: The 2 groups showed statistically significant differences as regards FPG (P <0.05) and HbA1c (P <0.01) at baseline, and MMSE (P <0.001) after 24 weeks. The intra-group comparison exhibited a statistically significant decrease of MMSE score in group A (P <0.05), and of HbA1c in group B (P =0.01).
Conclusions: The combination of vildagliptin and metformin seemed to result in the maintenance of MMSE score, with a protective effect on cognition compared to the metformin only group.

Una milza difficile

A. Bovero[1], M. Giovinale[1], M. Uccelli[1], I. Persico[1], R. Goretti[1]

[1]Ospedale Santa Corona, Pietra Ligure (SV), Italy

Premesse: Un uomo di 51 anni è stato ricoverato nel nostro reparto per febbricola, pancitopenia ingravescente (GB 1710/mm^3, Hb 10,9 g/dl, Piastrine 82000/mm^3) e splenomegalia. In anamnesi solo disturbo di personalità seguito presso il CSM.
Descrizione: Sono stati eseguiti esami colturali, sierologici per virus, leishmania per escludere patologie infettive. L'ecografia addome confermava voluminosa splenomegalia (18 cm); negativa la Tac body per lesioni occulte ed alla PET modesta captazione in sede splenica. La BOM eseguita evidenziava midollo trilineare lievemente ipercellulare senza patologia clonale e con modesta fibrosi. Si è deciso di eseguire biopsia Eco-guidata splenica: la manovra è stata però complicata da sanguinamento importante con necessità di embolizzazione e poi splenectomia in urgenza. Non dirimente la biopsia, né l'esame istologico sulla milza in toto (ampio danno ischemico ed emorragico). Il paziente ha successivamente sviluppato importante epatomegalia con plurime lesioni nodulari e massiva captazione alla PET. Una nuova BOM ha mostrato un midollo trilineare ipercellulare con atipie e fibrosi questa volta di grado importante.
Conclusioni: La biopsia splenica raramente si complica con sanguinamenti e ancor più raramente massivi; tale complicanza in letteratura è più frequente su patologia diffusa. La nostra diagnosi finale è di mielofibrosi idiopatica con emopoiesi extramidollare, la più rara tra le forme mieloproliferative croniche. La splenectomia non ha permesso di porre diagnosi, ma ha accelerato la proliferazione extramidollare a livello epatico.

Caso di aritmia ventricolare in un paziente cardiopatico: sindrome coronarica acuta e sue forme di presentazione atipica

A. Brazzi[1], P. Fortini[1], S. Mariano[1], V. Cancelloni[1], S. Gonnelli[1], C. Caffarelli[1], R. Nuti[1]

[1]Policlinico Santa Maria delle Scotte, Siena, Italy

Una diagnosi sicura di IMA è data dalla presenza di dolore precordiale irradiato all'arto superiore sinistro, associato generalmente a sopra o sottolivellamento del tratto ST e incremento della troponina. Tuttavia dato che ogni parte di miocardio e di tessuto specifico di conduzione può essere coinvolta nel processo infartuale, è possibile il verificarsi di qualsiasi tipo di aritmia. Giunge alla nostra osservazione un paziente maschio di 70 anni per dispnea. In anamnesi cardiopatia ischemica trattata con PTCA cinque anni fa, fumatore di 5 sigarette/die. All'ingresso nel nostro reparto il paziente presenta all'ECG bigeminismo ventricolare. Si pone indicazione alla coronarografia che mostra stenosi del 90% IVP di Cdx e occlusione totale 2° post-lat CDx con successivo PCI e duplice impianto di DES sulla coronaria destra distale. Ad un Holter ECG post-procedura si registra ritmo da fibrillazione atriale con frequente extrasistolia ventricolare polimorfa ed episodi di tachicardia ventricolare. Il paziente viene candidato all'impianto dell'ICD. Nei casi di aritmia di nuova insorgenza (disturbi della funzione del nodo del seno; disturbi della conduzione; aritmie ipercinetiche; combinazione di tutti i tipi di aritmie) è necessario prendere in considerazione la causa ischemica alla base di tale aritmia.

Madelung disease (multiple symmetric lipomatosis, MSL)

L. Brivio[1], C. Ferrari[1], E. Ricchiuti[1], C. Marchesi[1], M.T. Lavazza[1], S. Speroni[1], A. Mazzone[1]

[1]UO Medicina Interna, Ospedale di Legnano, ASST Ovest Milanese, Italy

Madelung disease (MSL) is a rare disease of fat metabolism and it is characterized by painless non-encapsulated and symmetric fatty deposits. The etiology of the disease is still unknown. Chronic alcohol consumption may play a role in adipocyte hyperplasia in genetically susceptible individuals. The natural history of the disease shows progressive growth of the fat masses. A 57-year-old man patient was hospitalized for macrocytic anemia in folic acid deficiency. He also had alcoholic liver cirrhosis and he is carrier of tracheostomy (previous surgery for carcinoma of the tongue). The physical evaluation revealed masses in the anterior cervical region, in the left pre-auricolar region and on the arms. The CT imaging study did not show sign of airway obstruction. The mediastinum was not involved by lipomatosis. The malignant transformation of MSL is rare. Complications are also rare and result from compression by the fatty deposits. CT is useful for the evaluation of tracheal compression, presence of blood vessel within the adipose mass and malignant transformation. Although alcohol withdrawal and weight loss are recommended, these measures are not effective to reverse or to stop the progression of disease. Currently surgery is the only treatment available. In our specific case the patient was not subjected to surgical treatment in consideration of his will, the CT report and the comorbidities, but he underwent to a regular follow up.

Due cuori e una pericardite. Pericardite in gravidanza: quale trattamento?

L. Brugioni[1], E. Mazzali[2], J. Petri[2], C. Catena[2], F. De Niederhousern[1], D. Vivoli[1], A. Borsatti[1]

[1]AOU di Modena; [2]Scuola di Specialità di Medicina d'Emergenza ed Urgenza, Università di Modena e Reggio Emilia, Italy

Premesse: La pericardite causa il 5% dei dolori toracici. Clinica

tipica: toracoalgia respirofasica alleviata dal clinostatismo, sfregamento pericardico, diffuso sovraslivellamento ST, versamento pericardico, flogosi sistemica. Indicazione al ricovero ospedaliero: pericardite ad alto rischio (include gravidanza). Trattamento: riposo, FANS+colchicina, steroide se controindicati. Prognosi: generalmente favorevole.
Caso clinico: KC, ghanese 28enne, anamnesi muta, gravida. VIII settimana dolore toracico respirofasico alleviato dal clinostatismo associato a febbre e vomito, ECG nella norma, cTnI picco 213 ng/L, ecocardiogramma TT con iper-rifrangenza del pericardio e minima diastasi dei foglietti pericardici: ibuprofene 600 mg BID per 15 giorni. XXV settimana recidiva: deltacortene 10 mg/die per 20 giorni. XXVI settimana recidiva: ibuprofene 600 mg TID+deltacortene 10 mg/die. XXXI settimana recidiva: deltacortene 27 mg/die. XXXVIII settimana parto cesareo con nascita di feto vivo e vitale. Post-partum alla RMN cardiaca con mdc esile versamento pericardico senza danno miocardico.
Conclusioni: Clinica e prognosi della pericardite in gravidanza non si discostano dallo standard. Fare attenzione alla terapia: i FANS sono raccomandati entro la XX settimana di gestazione, dopo la quale se ne consiglia la sostituzione con steroidi. In caso di mancata risposta allo steroide possono essere somministrati FANS fino alla XXVIII settimana, dopo la quale è invece elevato il rischio di danno fetale e vanno pertanto sospesi; controindicazione alla colchicina.

Efficacia e sicurezza della terapia immunomodulante nell'epatite autoimmune (studio real-life di 45 pazienti)

N. Buccianti[1], G. Zaccardo[1], M. Licchelli[1], A. Carbonella[1], M. Lofrano[1], N. Mecca[1], M. Pace[1], V. Pascale[2], D. Ferrante[3]

[1]AO San Carlo, UOC Medicina Interna, Potenza; [2]Scuola Specializzazione Medicina Interna, Salerno; [3]Medico di Continuità Assistenziale, Potenza, Italy

Premesse e Scopo dello studio: L'epatite autoimmune rappresenta, oggi, una sfida diagnostica e terapeutica per il medico internista. Lo scopo dello studio è dimostrare l'efficacia e la sicurezza della terapia di mantenimento immunomodulante dopo la fase di induzione corticosteroidea in una coorte di 45 pts.
Materiali e Metodi: L'arruolamento dei 45 pts è compreso tra il 2017 e il 2018. La diagnosi è formulata sulla base dei criteri dello Score Autoimmune Hepatitis e dell'esame istologico.La fase di induzione farmacologica (16 settimane) è realizzata con lo steroide (prednisone) mentre la fase di mantenimento con azatioprina o ciclosporina.
Risultati: La normalizzazione del valore delle transaminasi è del 100% nella fase di induzione; nella fase di mantenimento la normalizzazione del valore di transaminasi è raggiunta nel 70% dei casi con l'azatioprina; nel 30% dei casi è impiegata la ciclosporina per l'inefficacia e per gli eventi avversi dell'azatioprina.
Conclusioni: L'epatite autoimmune è una patologia che rientra tra le prerogative diagnostiche e terapeutiche dell'internista e si inserisce nel contesto di un disordine autoimmune a cui si possono associare manifestazioni sistemiche (cute, occhio, articolazioni, cuore) che alterano la qualità e la prospettiva di vita dei pazienti.

Se un deficit neurologico subacuto ha origine piramidale e la RM è negativa: il ruolo dell'anamnesi

L. Burberi[1], F. Fabbrizzi[1], L. Menicacci[1], V. Scotti[1], A. Fanelli[1], G. Scocchera[1], A. Torrigiani[1], S. Di Gregorio[1], S. Fruttuoso[1], M. Bernardini[1]

[1]Medicina Interna, ACA 2, AOU Careggi, Firenze, Italy

Premesse: La PML è una patologia rara dei pazienti immunodepressi, che può esordire con quadri clinici estremamente variabili.
Caso clinico: Maschio 54enne, ha fatto accesso al PS Careggi per la comparsa di ipostenia subacuta della mano sx. In anamnesi non significativi fattori di rischio cv; un anno prima diagnosi di linfoma follicolare, trattato con bendamustina e rituximab, con remissione della malattia, e successivo mantenimento con solo antiCD20. L'EO confermava l'ipostenia della mano in assenza di altri deficit. Nel sospetto di lesione nervosa periferica, eseguita EMG risultata negativa; eseguiti dunque PEM, identificativi di alterazioni della conduzione nervosa a sede centrale; la RM con mdc del cranio non ha tuttavia evidenziato reperti suggestivi per alterazioni ischemiche, o di altra natura, in grado di giustificare i sintomi. Eseguita dunque rachicentesi: l'immunofenotipo e l'esame citologico sul liquor non sono risultati compatibili con ripresa di malattia linfomatosa a sede centrale. Gli esami microbiologici tradizionali, comprensivi di PCR per la ricerca dei virus erpetici, sono risultati interamente negativi; alla luce dell'anamnesi del paziente (immunodepressione iatrogena) è stata richiesta PCR su liquor per la ricerca del virus JC, risultata positiva con riscontro di oltre 1000 copie virali/mL. E' stata dunque posta diagnosi di leucoencefalopatia multifocale progressiva; una settimana più tardi la RM con mdc del cranio evidenziava alterazioni compatibili con la patologia. Il paziente è stato trattato mediante sospensione del rituximab.

CTnT-hs dosing in early detection of IMA: rapid rule-out (0-1h)

M.A. Burgio[1], T.M. Attardo[2], G. Marino[3], G. Augello[2]

[1]UO Patologia Clinica, Ospedale Barone Lombardo, Canicattì (AG); [2]UO Medicina Interna, Ospedale Barone Lombardo, Canicattì (AG); [3]Laboratorio Analisi, Ospedale di Vergato, AUSL Bologna, Italy

Aim of the study: To compare the algorithm with 1 hour TnT-hs Roche validated by the TRAPID-AMI study, with the protocol currently in use, according to ESC 2012.
Materials and Methods: In order to introduce the 1-hour algorithm into daily practice, patients were ≥18 years old who arrived in the Emergency Area of our Hospital from 11 January to 11 March 2017 with new-onset chest pain (6-12 hours) or other symptoms of SCA, with or without ST-elevation. Patients on thrombolytic or revascularization therapy, with thoracic trauma, defibrillated, cardiac surgery within the previous month, dialysis, IMA within the last 3 weeks, pregnancy were excluded. Furthermore, a second sampling was performed after 1 hour (T1h). Patient observation was based on the recommended guidelines, using TnT-hs at T0 and T3-6 hours. Cut-off>14ng/L, with a of 50% for baseline values.
Results: 195 patients with chest pain. Rule-out: 76 patients (39%); NPV=100%; Sensitivity=100% Rule-in: 53 patients (27.2%); PPV=29%, Specificity=66%. Of which 38 non-IMA patients (mean increase of cTnT-hs equal to 1.2ng/L) and 15 patients IMA (average increase 51.30 ng/L).
Conclusions Rapid Rule-out could be applied in our population. As the data move away into the Roule-in and the gray area. The low number of the field and the need for longer observation times should be noted. This algorithm is limited by the definition of the "Time of onset of pain", ie the high accuracy even in early presenters (6-12 h), but not in very early presenters (<6h) so it is important that the patient describe his symptom and time well.

Atypical presentation of Churg Strauss syndrome or eosinophilic granulomatosis with poliangiitis

F. Caliari[1], L. Lenzi[1], F. Pugliese[1], E. Vettorato[1], S. Cozzio[1]

[1]APSS Trento, Ospedale di Rovereto (TN), Italy

Introduction: Care of the patient with chest pain (CP) is one of the most challenging issues in Internal Medicine. Physycal findings often overlap between the subtypes of CP, thus physical examination (PhEx) can be misleading.
Case report:: A 66-year-old woman affected by asthma and carrier of aorthic mechanical valve was admitted to our Internal Medicine Unit with 7-days history of CP and fever, unsuccessfully treated with cefixime. Her National Early Warning Score was 1. No pathological signs were found on PhEx. ECG showed suspected anterior ischemia, not confirmed on echocardiography. Chest X-ray and pulmonary CT-scan shown multiple bilateral infiltrates. 24 hour later a cutaneous erithematous rash spread all over her body. Laboratory tests revealed hypereosinophilia (9.5 x 10^9/L), and a progressive elevation of troponin T, consistent with a rapid deterioration of clinical conditions characterized by the abrupt onset of slowing in psychomotor performance and unstable march. The diagnostic hypothesis of Churg Strauss Syndrome (CSS) or eosinophilic granulomatosis with po-

liangiitis (EGPA) was made. Then she underwent cutaneous biopsy and bronchoalveolar lavage (BAL). The same day she underwent high-dose steroid therapy, tapered over 12 weeks, and combined with immunosuppressive therapy (cyclophosphamide, then azatioprine). Histological examination confirmed the presence of an eosinophilic vasculitis; eosinophil was 28% of total cells on BAL. 9 months after diagnosis she has recovered a good health status.
Conclusions: Atypical presentation of CSS/EGPA with chest pain and ECG sign of ischemia can be very challenging. The careful analysis of both anamnestic, physical, radiographic and laboratoristic findings, allowed us to formulate the correct diagnostic hypothesis, and consequently the winning therapeutic strategy.

A pulmonary carcinosarcoma in systemic sclerosis: a rare case report

S. Camarri[1], F. Carrella[1], C. Caffarelli[1], S. Gonnelli[1], R. Nuti[1]

[1]Dipartimento di Scienze Mediche, Chirurgiche e Neuroscienze, Siena, Italy

Introduction: The pulmonary carcinosarcoma is a rare, aggressive type of cancer with a peculiar hystology: a non small cell lung cancer to one side and sarcomatoid to the other one.
Case report: A woman, affected by systemic sclerosis, reached our attention complaining right chest pain and fever for more than one month. We performed a chest CT-scan which showed an area of flogosis of the medium lobe with involvement of the wall, compatible with pulmonary abscess. A bronchoscopy and an alveolar broncho-lavage were performed highlighting a bacterial alveolitis. An infectious evaluation suggested to set up a specific antibiotic therapy. One month later no clinical effect was highlighted and hospital admission was renewed: a new CT-scan showed an increase of both the flogosis area and the interest of the thoracic wall. A thoracentesis was performed founding no results for the microbiological and cytological investigations. An ultrasonography-guided biopsy was practiced but few material was collected, so we decided to perform a surgical biopsy which can let us to diagnose the pulmonary carcinosarcoma. A staging total body PET-CT scan was performed and the case was submitted to the attention of the thoracic surgeon and the oncologist: no surgical indication was given and a chemotherapeutic treatment was set up.
Conclusions: Two important points have to be underlined: the finding of an extremely rare neoplasia in an equally rare systemic disease and the fact that this kind of report seems to be the first case described in literature.

Black esophagus: acute esophageal necrosis syndrome: case report

T. Candiani[1], O. Grassi[1], G. Alessandro[1], M.G. Amadeo[1], C. Ternavasio[1], A. Valvano[1]

[1]General Medicine Geriatrics ASST West Milan, Italy

Acute Esophageal Necrosis, commonly known as black esophagus or acute necrotizing esophagitis, is a rare clinical entity characterized by black or dark brown endoscopic findings of the oesophageal mucosa in widespread or circumferential form, with variable extension that abruptly stops at the esophagogastric junction level. We report the case of a 76-years-old patient, known for moderately differentiated intestinal adenocarcinoma, ulcerated infiltrating the colic wall up to the subservient, undamaged margins, surgically treated in September 2018 with colostomy packaging and subsequent chemotherapy according to the De Gramont scheme, arterial hypertension, prostatic hypertrophy, multinartual encephalopathy. Three months later, blood tests with evidence of important neutropenia and fever. Performed tomography with evidence of severe ectasia with parietal thickening, dilatation of the descending aorta at the thoracic-abdominal passage with affixation of endoluminal thrombosis. Esophagogastroduodenoscopy and echoendoscopy were performed because of the appearance of persistent sobs, with evidence of severe reflux oesophagitis with mucosal thickening. Specific therapy was introduced, and parenteral feeding started. Subsequently appearance of coffee vomiting. A further Esophagogastroduodenoscopy was performed with evidence of Black esophagus. Therapy with parenteral feeding and proton pump inhibitors at high doses continued. During the endoscopic control, performed after seven days, it was completely resolved. The patient resumes hydration and oral nutrition.

Cardiac amyloidosis in a liver transplanted patient: a case report

R. Capra[1], L. Pavan[1], M. Barberio[1], N. Mumoli[2]

[1]Medicina Interna, Ospedale Magenta (MI); [2]Direttore Medicina Interna, Ospedale Magenta (MI), Italy

Introduction: In the majority of cases, cardiac amyloidosis is discovered during an episode of low EF cardiac failure, with poor prognostic features. We present a case of a 55-years-old man who developed the first episode of cardiac failure owing to acute viral illness of lower respiratory tract, with preserved ejection fraction.
Case report A liver transplanted 61-year-old man was admitted because of coughing, wheezing and dispnea for minimal efforts (NYHA III). He had been well until one week earlier when he began to experience respiratory unwilling when climbing 2 stairs or during expedite walking. In ED, the patient showed a type 1 respiratory failure; an ECG showed no sign of cardiac ischaemia. A chest X ray showed bilateral reinforcement, normal cardiac shape. The patient was started clarithromycine 500 bid and ceftriaxone 1 gr and was admitted with diagnosis of pneumonia during immunosuppression. We performed a lung and cardiac bedside ultrasound, that showed only moderate lung rockets bilaterally at lung bases, and a huge , symmetrical, hypertrofy of LV (SIV- EDVD-PW : 22 mm – 3 cm – 20 mm), with a prominent restrictive pattern on E/A and E'/E. PCT, PCR resulted negative, proBNP was positive, at high levels. The patient's condition improved markedly with 100 mg of furosemide and ramipril 2.5 twice daily, in the course of a week (NYHA I)
Conclusions: Cardiac amyloidosis is an insidious cause of cardiac failure. The diagnosis is rarely obtained, due to a workup that maybe difficult to organize . This case underscore the utility of integrated bedside ultrasonography to address proper treatment and clinical workup.

L'accoppiata "resistente"

M. Carafa[1], M. Di Palo[1], M. Sacco[1], P. Morella[1]

[1]Medicina DEA, AORN Antonio Cardarelli, Napoli, Italy

Premessa: Il TEV riconosce cause acquisite o congenite, che condizionano strategie diagnostiche e terapeutiche.
Caso clinico: Maschio (21aa) in PS per dolore e notevole incremento volumetrico dell'arto inferiore dx; all'ECD estesa trombosi venosa dell'asse iliaco-femoro-popliteo-gemellare. Si avvia EBPM, ma per la precoce comparsa di ipospigmia dei polsi tibiale e pedidio dx, si effettua procedura di tromboaspirazione. Inefficace (controllo a 72h), si esegue trombolisi loco-regionale con Streptokinasi seguita da infusione ev di ENF. In corso di parziale risoluzione dell'edema dell'a.i. dx, tumefazione dell'arto controlaterale, con conferma ECD di trombosi iliaco-femoro-poplitea sx e persistenza della trombosi a dx. AngioTC total body mostra mancata opacizzazione del tratto retroepatico della VCI con sbocco diretto delle vene sovraepatiche in Atrio Destro e circoli vicarianti sangue dal tratto sottorenale della vena cava inferiore in vene azygos ed emiazygos, attraverso plessi venosi paravertebrali. Gli esami di Laboratorio, ripetuti dopo alcune settimane, evidenziano positività per LAC, ACA e Ab anti 2GP1. Diagnosi "APS in paziente con agenesia della VCI". Si dimette in miglioramento clinico e strumentale in terapia con metilprednisolone (1mg/Kg p.c./die) e TAO.
Conclusioni: La rara agenesia della VCI è uno dei maggiori fattori di rischio per TVP recidivanti, resistenti alla terapia farmacologica ed alle procedure interventistiche. Nel caso descritto, la coesistenza di APS primitiva potrebbe aver rappresentato il fattore precipitante l'esordio della complicanza trombotica.

Review della Panarterite Nodosa: descrizione di un caso clinico

A. Carbonella[1], N. Buccianti[1], G. Zaccardo[1], M. Licchelli[1], M. Lofrano[1], N. Mecca[1], M. Pace[1], V. Pascale[2]

[1]AO San Carlo, UOC Medicina Interna, Potenza; [2]Scuola di Specializzazione, Medicina Interna, Salerno, Italy

Premesse: La Panarterite Nodosa (PAN) è una vascuilte che nel 5% dei casi si associa all'infezione da virus B. Si differenzia dalla forma classica perchè si associa alla presenza di immunocomplessi**.** Il cardine della terapia è la somministrazione di antivirale, di corticosteroide e plasma echange. Tale condotta terapeutica comporta la remissione della flogosi e dei sintomi in un elevata percentuale di casi.
Descrizione: Uomo di 44 aa; *epicrisi:*febbre,astenia e parestesie aa.ii, artralgie diffuse, orchialgia, calo ponderale; *anamnesi:* non affezioni; *obiettività:* edema aa ii; *laboratorio:* hgb 10 gr/dl; wbc 14.000; pcr 172; ves 112; ast 110 UI/L; alt 150 UI/L; HBsAg pres.; HBV-DNA 164000000 UI/ml; *strumentale*: elettromiografia:polineuropatia sensitivo-motorio; test da sforzo al cicloergometro: minima ischemia miocardica in sede inf. sx e del siv; coronarografia*:* ndp; ect fegato:steatosi epatica; biopsia epatica:epatite attiva (grading 5 e staging 0); terapia: prednisone 60 mg/die; tenofovir 300 mg/die; *risultati*: remissione dei sintomi, del valore degli indici di flogosi e negativizzazione della viremia.
Conclusioni: La combinazione dello steroide e dell'antivirale (tenofovir) è il trattamento di scelta della panarterite nodosa associata all'inf. da virus B. La diagnosi precoce e la terapia adeguata si associano ad un beneficio clinico immediato e tardivo (complicanze). Il farmaco antivirale elettivo deve possedere un elevata barriera genetica (basso indice di resisetnza) e un efficacia massimale nel controllo della viremia.

Management of nosocomial pneumonia in Medical Wards: Less is more?

P. Carfagna[1], E. Pistella[2], D. Martolini[2], M. Galiè[2], C. Santini[2]

[1]Medicina Interna, AO San Giovanni Addolorata, Roma; [2]Medicina Interna, Ospedale Madre Giuseppina Vannini, Roma, Italy

Background: There is an increasing evidence that Hospital-acquired pneumonia (HAP) in Medical Wards is associated with higher morbidity, prolongation of hospital stay and mortality in comparison to ICU acquired pneumonia. Risk factors for increased mortality, in addition to the etiology of multi-drug resistant organisms, include age, underlying chronic medical conditions, inappropriate antimicrobial therapy. This study focuses on diagnostic and therapeutic strategies and outcome of HAP in non-ICU medical wards.
Methods: Retrospective, double center analysis of cases of HAP, from January 2017 to December 2018, in Rome. Data on epidemiology, comorbidity, diagnosis, antibiotic therapy and outcome were collected.
Results: 65 cases (40% male) of HAP in medical wards were collected (mean age 76ys). Microbiological diagnosis was obtained in 30,7% of HAP. Gram negative rods and *S. aureus* were isolated respectively in 75% and 50% of microbiological documented HAP. Piperacillin/tazobactam was the most used empiric therapy (67,7%); MRSA empiric coverage concerned 23% of cases. Targeted therapy, often delayed, was started in 20% of cases. In hospital mortality was 38,5%.
Conclusions: In medical HAP management, there is no effort for early microbiological diagnosis, which is crucial for reducing antibiotic pressure and probably mortality. Early coverage for MRSA and XDR bugs isn't commonly used.

It is not hemochromatosis, but...

E. Carmenini[1], S. Majore[2], M.B. Rondinelli[3], R. Villani[1], G. Pitucco[4], A. Pellicelli[1]

[1]Malattie del Fegato, AO San Camillo-Forlanini, Roma; [2]Genetica Medica, AO San Camillo-Forlanini, Roma; [3]Medicina Trasfusionale, AO San Camillo-Forlanini, Roma; [4]Medicina Interna, AO San Camillo-Forlanini, Roma, Italy

Introduction: It has not yet established if a heterozygous mutation of p.C282Y of the HFE gene may play a role in iron absorption and storage.
Case report: We describe the case of a 46 year old man, professional athlete, who came to our attention for fatigue lasting 3-4 months and the finding of elevated ferritin levels (7126 ng/ml) and high transferrin saturation percentage (110%) with elevation in transaminases values (AST/ALT=70/72 U/L).
The patient had been taken iron supplementation daily for the last 15 years for low levels of ferritin diagnosed in 2002 and since then he never stopped taking iron per os. A RMN of the abdomen showed 11.1 mg Fe/g dry weight (N.V.=200-2,400 mcg/g dry weight). A liver biopsy revealed a total iron score of 57/60 and a Searle grading=4/4. The genetic screening for hereditary hemochromatosis showed heterozygous mutation of p.C282Y of the HFE gene. The patient stopped iron intake and underwent phlebotomy and chelation therapy with initial decrease in ferritin levels (7126 → 2604 ng/ml). For poor compliance of the patient to the therapy, ferritin levels remained high and the patient continued his sport activity.
Conclusions: It is not well known the role played by heterozygous condition of the HFE gene in iron metabolism but a recent article has shown that HFE gene mutation was found in 80% of French elite athletes. This case may confirm a possible role of heterozygous condition of the HFE gene, not yet proven, with a genetic advantage in high level sport results.

Case report of Henoch-Schonlein purpura in adult

P. Carrai[1], C. Caffarelli[1], C. Pondrelli[1], S. Gonnelli[1]

[1]Dipartimento di Medicina e Neuroscienze, Università degli Studi di Siena, Policlinico Le Scotte, Siena, Italy

Henoch-Schonlein purpura (HSP) is an immune-mediated vasculitis that commonly affects small and medium sized vessel. HSP presents with purple spots on the skin (purpura), arthralgia, digestive problems, and kidney injury. The pathogenesis involves the deposition of immune complexes (IgA) in small to medium size blood vessels which leads to necrosis and inflammation. We report a 55-year-old male patient who presented with purpura, arthralgia, worsening abdominal pain, and diarrhea. Physical examination showed erythematous, palpable, purpuric rashes on thighs and lower legs. Abnormal blood test included anemia, elevated level of white cell count and C-reactive protein. Moreover we found moderate proteinuria. Contrast-enhanced computed tomography (CT) scan showed thickening of the digiuno and ileum wall, and EsophagoGastroDuodenoScopy (EGDS) and colonoscopy revealed mild erythema and diffuse purple spots on the mucosa. We have also performed renal biopsy, and the Immunohistochemistry revealed IgA deposits mainly in the mesangium, consistent with the diagnosis of HSP. PET-TC performed to search for secondary causes was negative *(*as well as the investigated tumor markers*)*. The patient was treated with high doses of corticosteroid with marked clinical improvement. Subsequently the therapy continued with corticosteroid and ciclofosfamide. HSP most commonly affects the pediatric population and rarely affects adults. We suspected HSP for the presence of palpable purple, abdominal pain, arthralgia and proteinuria. Moreover, we found characteristic endoscopic results of diffuse and hemorrhagic erythema in gastro intestinal tract. Mostly, the presence of IgA immune complexes in the mesangio reinforced the diagnosis of HSP.

Shock settico complicato da CR.I.MY.NE. e disfunzione ventricolare sinistra

D. Carrara[1], G. Galli[1], P. Nigro[1], A. Cioppi[1], S. Ciaccio[1], C. Bellotto[1], L. Credidio[1], L. Bertolucci[1], S. Fascetti[1], V. Annoni[1], D. Taccola[1], P. Fabiani[1]

[1]UOC Medicina Generale, Ospedale "Versilia", ATNO, Lido di Camaiore (LU), Italy

Premesse: La sepsi è caratterizzata da una risposta immune inappropriata verso un patogeno, che può rendersi responsabile di disfunzione d'organo come il danno renale acuto, l'insufficienza epatica e respiratoria. La cardiomiopatia settica è un'evenienza verosimilmente sottostimata, mentre lo sviluppo di polineuromiopatia è raramente descritto.
Caso clinico: Uomo 73, anamnesi patologia sostanzialmente muta, viene trasferito dalla terapia intensiva in medicina interna con un quadro di tetraplegia flaccida dopo un episodio di shock settico a sorgente ignota. Lo studio EMG ha mostrato quadro di neuropatia sensitivo motoria per cui è stato iniziato trattamento riabilitativo. L'ecocardiografia, che aveva escluso localizzazioni endocarditiche, mo-

strava una compromissione della funzione ventricolare sinistra. Nel corso della degenza il paziente ha sviluppato plurime recidive settiche polimicrobiche fra cui: setticemia CVC-relata da C. albicans e S. heamolyticus, infezioni urinarie e setticemie da germi MDR fra cui K. Pneumoniae KPC. La TC torace e addome non ha mostrato localizzazioni infettive e lo studio colonscopico non ha evidenziato lesioni. Dopo il trattamento antimicrobico mirato e la prosecuzione della riabilitazione, il paziente ha recuperato la funzione cardiaca e motoria periferica.
Conclusioni: Il paziente ha sviluppato una polineuromiopatia sensitivo motoria nota come CR.I.MY.NE. associato ad una cardiomiopatia settica e uno stato di immunoparalisi, che ha esposto il paziente a numerose recidive di infezioni correlate all'assistenza ospedaliera.

Analisi sull'esperienza di implementazione temporanea dei posti letto subacuti ASST-Lariana presidio di Cantù

S. Casati[1], E. Limido[1], M. Frigerio[1], C. Bassino[1], D. Tettamanzi[1]

[1]ASST-Lariana, Ospedale S. Antonio Abate, Cantù (CO), Italy

Premesse e Scopo dello studio: La delibera X/7406 della Regione Lombardia è incentrata in particolare sulla risoluzione dell'iperafflusso in Pronto Soccorso; in ottemperanza l'ASST Lariana ha attivato 20 nuovi letti di cure subacute bis per di 40 giorni (16 gennaio 2018- 23 febbraio 2018).
Materiali e Metodi: 10 letti sono stati ubicati presso il Sant'Anna a San Fermo e 10 presso il Presidio di Cantù. L'analisi è stata effettuata sui letti di di Cantù affidati all'UO di Medicina. Le conclusioni sono frutto di un'esperienza locale che vede la realizzazione dei letti aggiuntivi contestualizzata in una realtà specifica. L'obiettivo era un tasso di occupazione dei letti maggiore o uguale al 95% ed è stato del 98.29%, i pazienti ricoverati 35, le giornate di degenza 371. La comparazione al periodo di riferimento, senza i subacuti bis, ha mostrato: incremento delle giornate di degenza pari a 299 gg (4.94%), riduzione degenza media in Medicina di 0.48 gg, media dei ricoveri giornalieri da PS 3.07 rispetto a 3.1.
Risultati: C'è stato incremento delle giornate di degenza del 5% in Medicina, sono stati aboliti gli appoggi con maggior sicurezza sul paziente,soddisfacimento dei bisogni, miglioramento della qualità di assistenza e soddisfazione degli operatori.
Conclusioni: Criticità principali: mancato incremento dell'organico medico, riorganizzazione dei turni con rinuncia a riposi e ferie, affidamento continuità assistenziale a un singolo Medico con aumento di orario di servizio e carico di lavoro dell'intero organico. Dai dati non è possibile desumere un incremento dei posti disponibili per PS.

Direct oral anticoagulants in elderly patients: assessment of plasma levels

M. Caselli[1], R. Cappelli[1], D. Fineschi[2], E. Franceschini[2], P. Calzoni[2], F. Laghi Pasini[1]

[1]UOC Medicina Interna 2, AO Universitaria Senese, Siena; [2]UOC Patologia Clinica, AO Universitaria Senese, Siena, Italy

Background: Direct oral anticoagulants (DOAC) are increasingly prescribed in elderly patients with atrial fibrillation (AF) or venous thromboembolism (VTE). Aim of the present study is to evaluate the use of DOAC in people aged 75 or older, with special reference to frailty and renal function.
Materials and Methods: 74 consecutive AF and VTE patients were prospectively followed, 15 of which were frail in accordance with Fried's criteria. The median follow-up was 12 months. Blood for plasma levels was taken after the first month of treatment.
Results: More than 90% of patients were treated with low dose DOAC and about one third was under-dosed. Frail patients experienced a more rapid decline in renal function. However, only apixaban levels showed a significant correlation with creatinine clearance. Despite high thromboembolic risk and inappropriate use of low doses, just one patient with AF presented an ischemic event (1,5%). Bleeding complications were more frequent (major and overall hemorrhage rate was 2,7% and 13,5%, respectively). Finally, no relationship between frailty or plasma levels and complications was found in our study.
Conclusions: Most elderly, nephropathic and frail patients are treated with apixaban and prescription of inappropriately low doses is a frequent occurrence. Based on high inter-individual variability and poor association between plasma levels and events, laboratory tests are not useful in order to improve clinical outcomes. In addition, the efficacy and safety profile of DOAC appears preserved even in the presence of frailty.

Recurrent *Clostridium difficile* infection in a large teaching italian hospital: a 2-years retrospective study

L. Castellani[1], A. Battaglini[2], F. Butera[2], S. Schenone[2], G. Noberasco[2], A. Ferrazzin[3], M. Spadaro[1], M.G. D'Angelo[1], M. Morfino[1], E. Arboscello[1], A. Orsi[2]

[1]Dipartimento di Emergenza, Ospedale Policlinico San Martino, Genova; [2]Dipartimento di Scienze della Salute, Ospedale Policlinico San Martino, Genova; [3]Dipartimento di Medicina Specialistica, Ospedale Policlinico San Martino, Genova, Italy

Introduction: *Clostridium difficile* infection (CDI) is one of the most common cause of morbidity and mortality for hospitalized patients. There is a significant risk of recurrence with an important impact on cost and patients' life. We evaluated the total hospital number of CD toxins' positive stool tests and the Emergency Department (ED) burden of recurrent CDI over a 2-years period at San Martino Policlinic, Genoa.
Patients and Methods: Patients' CD toxins positivity from 1 January 2017 to 31 December 2018 were obtained from hospital laboratory database. CDI, recurrence and reinfection were defined according to European Centre for Disease Prevention and Control. Median age, 30-days mortality and emergency code distribution were evaluated among patients with more than one CD toxin positivity who accessed at the ED at the second episode.
Results: We identified 44 patients with more positive tests; we observed 5 reinfections (1,8%) and 10 recurrences (3,5%); 7 out of 10 recurrence (30d mortality=0%, Yellow-code=57%) and 4 out of 5 reinfection (30-mortality=50%,Yellow-code 75%) episodes returned through the ED. The median age was 89 years for recurrences and 86 years for reinfections. Between the hospitalizations we observed a median of 14 days for recurrence and 95 for reinfection. The median stay was 13 days (reinfection) and 11 days (recurrence).
Conclusions: Considering the burden of CDI recurrences and reinfections in old patients, availability of a rapid test and new drugs as fidaxomicin and human monoclonal antibody (e.g. Bezlotoxumab) represent a key fact for decreasing recurrence rates.

Churg-Strauss syndrome with cardiac involvement

L. Castelnovo[1], A. Tamburello[1], P.M. Faggioli[1], D. Bompane[1], A.G. Gilardi[1], M.G. Marrazza[2], A.M. Lurati[2], A. Mazzone[1]

[1]UO di Medicina Interna, Ospedale di Legano, ASST Ovest Milano; [2]UO di Reumatologia, Ospedale di Magenta, ASST Ovest Milano, Italy

Background: Eosinophilic granulomatosis with polyangiitis (or Churg-Strauss Syndrome – CSS) is a rare necrotizing small to medium-sized vessels vasculitis, usually associated with asthma and eosinophilia. Cardiac involvement is the most important predictor of mortality and it seems to be more frequent in ANCA-negative patients.It has been reported with a prevalence of 66%,however, post-mortem studies suggest a prevalence of up to 92%.
Case report: We present a case of this condition in a 76-year-old woman with a past medical history of nasal polyposis and asthma, that initially showed rhino-bronchial exacerbation than fever and worsening dyspnea with clinical and radiographic evidence of heart failure.Echocardiography showed slightly LV dilatation with severely depressed ejection fraction due to anterio-lateral wall achinesia and hypokinesia of the remaining segments as well as pericardial effusion.Haematochemical investigations showed elevated peripheral blood eosinophilia (more than 52%) but ANCA negative so the diagnosis of CSS with cardiac involvement was formulated and she started steroids and azathioprine with excellent clinical and laboratory response
Conclusions: CSS-related cardiac syndrome can present with many different forms, including coronary vessels, pericarditis, my-

ocarditis, endocarditis, myocardial infarction and subendocardial vasculitis that can contribute to reduced life expectancy and that are often underdiagnosed. Complementary cardiac investigation is mandatory because early detection and appropriate treatment are crucial due to the possible life-threatening manifestations.

Bilateral mastoiditis with facial nerve paralysis as initial symptom of Wegener's granulomatosis: an unusual case

L. Castelnovo[1], A. Tamburello[1], P.M. Faggioli[1], K.A. Re[2], A. Laria[2], D. Mazzocchi[2], A. Mazzone[1]

[1]UO di Medicina Interna, Ospedale di Legano, ASST Ovest Milano; [2]UO di Reumatologia, Ospedale di Magenta, ASST Ovest Milano, Italy

Background: Wegener's granulomatosis (WG) is an idiopathic, systemic inflammatory disease characterized by necrotizing granulomatous inflammation and small-vessel vasculitis of upper and lower respiratory tract and kidneys. The condition affects both genders equally, although some inconsistent gender differences have been observed. The aetiology remains unknown. Clinical characteristics of this disease are non-specific, making diagnosis challenging; locoregional disease may include otological manifestations. Facial nerve paralysis is possible but acute mastoiditis is extremely rare.
Case report: 49-years-old woman without medical history. In July 2017 was diagnosed first a right otitis than a bilateral mastoiditis, treated with multiple antibiotics then with steroids, with benefit. Two months later she developed severe right hypacusia and VII cranial nerve paralysis with MRI evidence of bilateral recurrence of mastoiditis. Infectious causes were excluded while the chest xRay showed multiple pulmonary cavitary nodules and the blood tests were positive for cANCA so she underwent myringotomy and then started steroid in combination with cyclophosphamide, with resolution of the paralysis and the mastoiditis and improvement of hearing loss.
Conclusions: The lack of symptoms in respiratory tract is unusual but not impossible in WG and the diagnosis should be considered possible in patients with recurrent ENT symptoms specially otitis media, facial paralysis, mastoiditis, or external otitis. Prompt therapy is essential to prevent permanent damage

A recurrent, fatal, DRESS syndrome, complicated by sepsis and severe systemic Cytomegalovirus reactivation at relapse: a case report

A. Castrovilli[1], T. Mastrofilippo[1], L. Di Fino[1], A. Perrone[1], C. Sabbà[1], F. Vella[1]

[1]Medicina Interna Universitaria "C. Frugoni", Bari, Italy

We report a case of recurrent, fatal, DRESS (drug reaction with eosinophilia and systemic symptoms) syndrome induced by allopurinol. A 57-year-old man was admitted to our clinic manifesting a severe skin rash and fever, after following a four-week- long allopurinol therapy. On the basis of clinical, laboratory and instrumental features, the patient was diagnosed with DRESS syndrome, following RegiSCAR and Japanese group's criteria. The clinical course of the disease was complicated by viral infection, methicillin-resistant *Staphylococcus aureus* endocarditis, bacterial pneumonia and severe recurrences. Despite allopurinol therapy was suspended and systemic steroids, targeted antibiotics, ganciclovir and immunoglobulins were administered, the clinical course had a fatal outcome. Herpes viruses have shown to have a crucial role in the pathogenesis of severe DRESS syndrome, suggesting that an early use of antiviral therapy, in addition to steroids, could improve the prognosis of DRESS syndrome.

A rare case of pneumonia in patients with ulcerative colitis treated with vedolizumab

R. Cattaneo[1], S. Colombo[1], S. Biagiotti[1], L. Marchionni[1], F. Capelli[1], M. Cimpanelli[1], E.E. Re[1], A. Mazzone[1]

[1]ASST Ovest Milanese, Medicina Interna, Ospedale di Legnano (MI), Italy

Background: Patients with inflammatory bowel disease are currently subjected to therapies with immunosuppressive agents, anti-TNF, monoclonal antibodies. Complications associated to these therapies may arise.
Case report: We describe the case of a 71-year-old male patient suffering from ulcerative colitis, treated with mesalazine, then adalimumab and finally vedolizumab due to disease recurrence. He came in the emergency room because of cough, fever, dyspnoea. Chest x-ray showed multiple pulmonary densities. Blood chemistry tests showed increased PCR and neutrophilic leukocytosis but normal procalcitonin. Respiratory failure was present. We started piperacillin/tazobactam and levofloxacin and high-flow oxygen. Urinary antigens for pneumococcus and legionella and serology for atypical and CMV were negative. Respiratory conditions worsened even with positive pressure ventilation and FiO2 up to 80%. The patient was transferred to intensive care unit. CT-scan demonstrated confluent pulmonary densities. BAL for bacteria, mycetes and mycobacteria was negative but lymphocytosis was present. Antibiotic therapy was changed without any benefit. We added methylprednisone 1 mg/Kg and conditions gradually improved, oxygen administration was dismissed. The patient was discharged with prednisone 25 mg therapy and diagnosis of vedolizumab pneumonia. Vedolizumab is a selective antibody against 4β7 integrin for the treatment of IBD. Vedolizumab induced pneumonia is a very rare but severe complication of this therapy of which physicians should be aware, considering the increasing use of this class of drugs.

A surprising surprise in a patient already complex

M. Caturano[1], V.M. Magro[2]

[1]UOC Medicina Interna, AORN San Giovanni di Dio e Ruggi D'Aragona, Salerno; [2]Dipartimento di Medicina Interna e Geriatria, Università della Campania "Luigi Vanvitelli", Napoli, Italy

Background: The population in chronic dialysis has increased both in number, but also in frequency of co-morbidity and the management of the complications of a patient already in dialysis therapy represents a continuous challenge for the clinician.
Case report: A 79-year-old patient with a history of HCV-related hepatopathy, hypertension and CKI in dialysis, MGUS, hyperemic duodenitis, was treated for marked asthenia. Vigilant, open alve with normochromic faeces. BP 140/90 mmm Hg, tachyarrhythmia at 120 bpm, SpO2 99%, TC 38.3 C°. Blood tests: Hb 7 g/dl, WBC $2.65x10^3$, RBC $2.88x10^6$, PLT $79x10^3$, INR 1.29, uricemia 9.6 mg/dl. At the EKG AF. We proceeded to a heart echo, which highlighted a concentric hypertrophy, normal EF and presence of voluminous image at the level of the tricuspid, suspected for endocarditis. Infusion of 2 pockets of red blood cells (Hb 7.9 g/dl), pantoprazole 20 mg, ranitidine 300 mg, amiodarone 200 mg (with decreased heart rate), cinacalcet 30 mg, allopurinol 300 mg, calcitriol 0.5 mcg, erythropoietin 4000 IU, iron 30 mg/vitamin C 70 mg. A TE echo confirmed vegetative formation and a smaller, mitral. Risk for any intervention ASA 4. Waiting for the cultures, antibiotic therapy with gentamicin 240 mg and ampicillin/sulbactam 3 g was started, with preparation for the dialysis session.
Conclusions: From our case it is clear the complexity of this type of patients. Only taking into account the clinical needs of the individual and defining, sometimes from dialysis to dialysis, the specifics of the treatment, we can think of obtaining clinical efficacy goals.

Is it possible to consider a fever of uknown origin in oncological patient?

C. Cefalogli[1], S. Feliciano[1], P. Assalone[1], F. Tomei[1], R. Iaciancio[1], E. Armenti[1], D. Traficante[1]

[1]UO Oncologia, PO Veneziale, Isernia, Italy

Background: The fever is often present in oncological patient, and it is the expression of a paraneoplastic syndrome in many case. But is it possible to consider a fever of uknown origin (FUO) in neoplastic patient?
Case report: A 62 year-old-man came to our observation for a refractory fever. In anamnesis he presented advanced non-small cell lung cancer and mediastinal lymph nodes metastasis(stage III a) treated with chemo and immunotherapy. Laboratory exams: Procalcitonin 8.97 ng/ml, white blood cells $8.99 x10^3$; lymphocyte typing was normal; Haemocoltures on peripheral vein and CVC were negative such as investigations for autoimmune viruses and

diseases, urinocolture, research for Koch's Bacillus, echocardiogram and total body CT. The patient performed two bronchoscopies that shown the presence of Enterococcus, Candida Brusei and Klebsiella and He started a medical treatment based on the antibiogramm. After initial defervescence of about two days, he presented new thermal increase that was not responsive to treatment with steroids. The CVC was been removed. The involved infectiologists did not find any cause of infectious nature. The patient continued to present fever even after a month.
Conclusions: In oncological patient, fever can be a symptom of a paraneoplastic syndrome. However, this case suggests to consider a fever of unknown origin in the differential diagnosis in all cases of a fever that is refractory to steroid treatment excluding infectious or autoimmune causes.

Trombosi venosa profonda e terapia con anticoagulante orale diretto: un caso limite

M. Celeste[1], M.C. Serafini[1], A. Scarsella[1], D. De Blasis[1]

[1]PO SS.F ilippo e Nicola, Avezzano (AQ), Italy

Premessa: I nuovi anticoagulanti orali diretti (DOACs) hanno dimostrato efficacia e sicurezza per il trattamento della trombosi venosa profonda (TVP)ma in presenza di comorbilità, politerapiaospecifici fattori di rischio emorragico, la scelta terapeutica deve essere attentamente valutata.
Caso clinico: Uomo di 62 anni giunge al ricovero con diagnosi di TVP spontanea delle vene femorale superficiale e comune e vena poplitea di sinistra. In anamnesiesiti di craniotomia temporo-frontale bilaterale e microclipping per aneurismi multipli, aneurisma residuo della arteria comunicante anteriore e terapia antiepilettica,oltre che ipertensione arteriosa sistemica in trattamento, dislipidemia ed insufficienza renale cronica. Inizia terapia anticoagulante con EBPM e quindi edoxaban 60 mg 1 cp/die, sotto stretto monitoraggio in considerazione dell'elevato rischio emorragico. L'esame ecocolor doppler venoso degli arti inferiori mostragià a 30 giorni una ricanalizzazione completa delle vene femorale comune e superficiale, con parziale ricanalizzazione della vena poplitea. Al controllo a sei mesi, con la completa risoluzione della patologia trombotica, viene sospesa la terapia intrapresa.Nessun evento emorragico avverso segnalato per tutta la durata del trattamento.
Conclusioni: E' fondamentale identificare la strategia terapeutica ottimale considerando le evidenze scientifiche,ma anche le caratteristiche farmacologiche delle singole molecole, attenzionando il rischio di interazioni farmacologiche e la maneggevolezza del trattamento.

Give me a G.A.V.E.

C. Cerasi[1], P. Vertolli[1], M. De Feo[1], E. Biferi[1], E.G. Onori[1], A. Viscido[1], C. Ferri[1]

[1]University of L'Aquila, Department of Life, Health and Environmental Sciences, Division of Internal Medicine and Nephrology, San Salvatore Hospital, L'Aquila, Italy

Introduction: Gastrointestinal (GI) bleeding is a common health problem. Occult GI bleeding usually presents as iron deficiency. The diagnosis is crucial for definitive treatment.
Case report: A post-menopausal woman 45 years old was admitted to our Division for several weeks of fatigue. No history of haematemesis or rectal bleeding. She did not drink alcohol. Laboratory finding showed a hemoglobin of 5.9 g/dl, hematocrit of 28% with low MCV, AST 152 UI/L, ALT 138 UI/L. The anemia was secondary to a severe iron deficiency. The serology of celiac disease resulted negative. Blood stool test was positive. An abdominal ultrasound showed hepatomegaly, with normal biliar tract. An EGDS revealed mild stripes of the antrum suggestive of angioectasias, defined as gastric antral vascular ectasia (GAVE), treated with argon plasma coagulation. AST/ALT continued to be increased. Viral hepatitis were excluded. Autoimmune serology showed antinuclear antibody (ANA) 1:640 omeogeneus pattern and smooth muscle antibody (ASMA) positive, suggestive of autoimmune liver disease. A liver biopsy was performed. GAVE is a rare but significant cause of acute or chronic GI bleeding. Endoscopically, GAVE is characterized by tipical stripes so it is also called Watermelon stomach. It is associated with chronic illness, such as connective tissue disease. GAVE affect most commonly females. Endoscopy is the goal for diagnosis and treatment.
Conclusions: Pathogenesis of GAVE is still unknow but patient with GAVE has to be investigated to systemic diseases such as autoimmune diseases.

La sindrome delle urine viola

L. Chiecchi[1], C. Checchetto[1], M.T. Lorenzi[1], P.L. Pujatti[3]

[1]UOC Medicina, Ospedale Arzignano (VI), ULSS8 Berica; [2]UOC Ospedale Arzignano (VI), ULSS8 Berica, Italy

Premessa: Una paziente di 87 anni veniva ricoverata in reparto internistico per scompenso cardiaco e fibrillazione atriale ad elevata frequenza ventricolare media. La paziente presentava numerose comorbidità: diabete mellito tipo II, dislipidemia, cardiopatia ischemica post infartuale e decadimento cognitivo- motorio con allettamento e stipsi cronica.
Caso clinico: All'arrivo in reparto veniva impostata terapia diuretica e posizionato caterere vescicale per il monitoraggio della diuresi; si assisteva a fuoriuscita di urine color viola. L'esame urine standard dimostrava leucocituria e proteinuria e l'urocoltura risultava positiva per Escherichia coli plurisensibile; su antibiogramma si introduceva nitrofurantoina con normalizzazione del colore dell'urina.
Conclusioni: La sindrome delle urine viola è costituita da una colorazione viola delle urine a causa della trasformazione dell'indossil solfato (prodotto del metabolismo del triptofano ed escreto in forma idrosolubile nelle urine) in due metaboliti (indigo e indirubina) a causa di batteri produttori di solfatasi/fosfatasi. L'indigo è causa della colorazione blu, l'indirubina di quella rossa, producendo insieme un colore delle urine viola. Tale sindrome è legata ad infezioni del tratto urinario; i patogeni più frequenti sono Pseudomonas aeruginosa, Proteus mirabilis, Morganella morganii, Escherichia coli, Klebsiella pneumoniae. I fattori di rischio sono il sesso femminile, l'età avanzata, la stipsi cronica, il caterere vescicale a permanenza, l'insufficienza renale cronica.

Dementia?

F. Ciaburri[1], B. Ferravante[1], G. Zampa[1], F. Capasso[1], S. Scarfiglieri[1], M. D'Avino[1]

[1]UOC Lungodegenza, AORN A. Cardarelli, Napoli, Italy

Background: Spongiform Transmissible Encephalopathies (TSE), known as Creutzfeldt-Jakob disease (CJD), are neurodegenerative diseases ,fatal, caused by the cerebral accumulation of the anomalous Prophc prion isoform,the Prionctic Scrapie protein (PrPSc), an anomalous infectious agent, without both RNA and DNA.
Case report: Male patient of 75 years,hypertensive,dyslipidemic and with anamnestic history of depressive state.Long-term hospitalization for "Sleep syndrome in recent TEP. Multinfarct encephalopathy". Family members report and point out a progressive deterioration of cognitive functions,in the last two months, with admission to another structure for "Multinfartual Encephalopathy in patients with arterial hypertension and dyslipidemia". In the ward, the patient showed a further and progressive decay of neurological functions. Practate MRI and EEG showed alterations that, associated with the clinical history and the symptomatology, in the suspicion of a prion disease led us to practice rachicentesi for research of the protein 14-3- 3. The liquor sent to the reference center for Prion Diseases confirmed the diagnosis.
Conclusions: Careful clinical observation of the evolution of symptoms and clinical signs, associated with a personal anamnesis strongly stigmatized by the family and the investigations carried out, have allowed the diagnosis of a rare, incurable and lethal disease like CJD, as happened at the our patient.

Correlation TR velocity-PEIndex. "Trend" Study: comparative analysis with student test In 30 patients with venous thromboembolism. Three-year experience (2016-2018)

M.M. Ciammaichella[1], R. Maida[1]

[1]Medicina d'Urgenza, AO S. Giovanni, Roma, Italy

Background and Aim of the study: The "TREND" study, acrostic deriving from "TRicuspidal regurgitation - pulmonary Embolisn iNDex", enrolled 30 patients with venous thromboembolism admitted in the three-year period January 2016-December 2018. In all patients, it was measured and post-lysis the PE Index tomographic score and the TR pre-lysis was measured. The "TREND" study proposes the following objectives: to verify possible relationships between the prearranged TR velocity and Pulmonary Embolism Index values in the 30 patients enrolled during the three-year period January 2016 - December 2018 and verify the statistical significance found applying the Student's parametric "t" test.
Materials and Methods: The test then calculates the relative value (VR) of the t index to be associated with the difference found according to the following formula: t=(M1-M2)/√DS12/N1+ DS22/N2.
Results: Student's "t" test applied to the 30 patients shows a highly significant correlation (p <0.001) of the two variables examined (TR velocity and PE Index pre-lysis values) and, therefore, not attributable to the case. In fact, the value of "t" obtained is 3.87 and the VC (critical value) of "t" for p=0.001 is 3.659 with GL=29.
Conclusions: The "TREND" study showed that in the group of 30 patients with venous thromboembolism (central pulmonary embolism) there is a highly significant correlation between the two variables considered: TR velocity pre-lysis and Pulmonary Embolism Index pre-lysis. This correlation shows an absolute positive concordance according to the Student's comparative analysis "t" test and is an expression not of a random association but of a close correlation between the pre-defined TR velocity values and the pre-lysis PE Index values.

Anticoagulation in jugular vein thrombosis: experience of an Internal Medicine clinic

S.A. Ciampi[1], A. Cirulli[1], S. Longo[1], S. Noviello[1], M. Guarascio[1], B.M. Forina[1], A. Vacca[1]

[1]Medicina Interna "G. Baccelli", Policlinico di Bari, Italy

Background: Less than 5% of deep vein thrombosis is due to thrombosis of the internal jugular vein. Genetic, malignant or inflammatory underlying diseases as well as insertion of venous catheters can be responsible for this pathology. Due to its rare occurrence, it is difficult to find systematic research and treatment about this condition.
Aim: To evaluate the use of direct oral anticoagulant (DOAC) in the management of anticoagulation therapy for internal jugular vein thrombosis (IJVT).
Materials and Methods: We observed 2 patients, 1 female and 1 male, 75 and 52 years old respectively, affected by IJVT demonstrated with color-doppler-ultrasound (CDU) and enhanced CT scan. The study for thrombophilia and research for malignancy were negative in all patients. One patient had jugular-brachiocephalic veins narrowing and the other permanent atrial fibrillation. All patients started anticoagulation therapy with low-molecular-weight-heparin and then they changed to DOAC (1 Rivaroxaban and 1 Apixaban).
Results: At the follow-up, CDU showed complete resolution of thrombosis after a period between 3 and 6 months. Therapy with DOAC was continued for presence of risk factor for thrombosis. Patient with jugular-brachiocephalic veins narrowing had a reduction of DOAC dosage (Apixaban 2,5 mg twice a day) after 6 months of therapy, with no relapse. No bleeding was observed.
Conclusions: According to our experience, DOAC could represent an alternative treatment in internal jugular vein thrombois. In consideration of their infrequence, more observational studies need to establish a new common approach for anticoagulation in these conditions, evaluating the real efficacy and safety of DOAC.

Malignant hypertension in a young woman

M. Ciannarella[1], A. Belfiore[1], V.O. Palmieri[1], P. Portincasa[1]

[1]Clinica Medica Universitaria "A. Murri" Policlinico, Bari, Italy

Background: Malignant hypertension is a condition characterized by severe hypertension and multi-organ ischemic complications with an activaction of the renin-angiotensin-aldosterone system (RAAS).
Case presentation: A 42-year-old woman presented with headache, nausea, neck pain and disorders of the visus. Severe Hypertension (220/150 mmHg), anemia, renal damage with proteinuria and retinopathy were found. In the anamnesis she presented multiple sclerosis. Suddenly the patient lost consciousness, presenting "grand mal" epileptic seizure. CT skull and head MRI revealed vasogenic edema affecting the posterior occipital and parietal lobes of the brain, suspecting "Posterior Reversible Encephalopathy Syndrome". Multiple antihypertensive therapy (5 drugs) was started . Initial evaluation demonstrated hyperreninemia with hyperaldosteronism. In order to remove causes of secondary hypertension were performed CT and MRi abdomen and renal duplex ultrasound for the analysis of blood flow velocity. All the exams were negative. After 30 days of therapy a second MRI revealed the resolution of the cerebral clinical picture; also anemia and renal damage had gradually improved. We obtained the normalization of pressure values. After 3 months we observed normalization of hormones associated with the activation of RAAS.
Conclusions: Malignant hypertension is an uncommon but life-threatening complication of hypertension. The correct diagnosis at the acute phase is critical to immediately start the antihypertensive treatment which can modify the evolution towards the permanent organ damage.

An unusual case of Bernard Horner's syndrome post local radiotherapy

E. Cioni[1], C. Marchiani[1], N. Palagano[1], G. Bandini[1], M. Gagliano[1], P. Bernardi[1], G. Barbarisi[1], M. Zavagli[1], I. Bertoletti[1], F. Crudele[1], P. Mercatelli[1], E. Martinelli[1], A. Moggi Pignone[1]

[1]Medicina per la Complessità Assistenziale IV, AOU Careggi, Firenze, Italy

A 48-year-old woman came to emergency department for the onset of left arm hypostenia, hypoaestesia and swelling in the previous days. Her medical history included breast cancer with lymph node involvement treated with radical mastectomy and adiuvant chemotherapy; she had a disease relapse after one year, treated with local radiotherapy involving left hemithorax and left armpit. On arrival miosis, enophthalmos and left superior eyelid ptosis were evident, suggesting Bernard Horner's syndrome. We performed a contrast-enhanced chest, neck and cranial CT which were negative; a brain MRI extended to cervical and dorsal spine showed a polyradiculopathy suspected for post actinic injury, with leptomeningeal involvement. EMG confirmed a motor injury of left brachial plexus. Since the patient showed a progressive neurological worsening with drowsiness and confusion, we suspected a paraneoplastic encephalitis, performing a lumbar puncture; onco neural antibodies and immunophenotype of cerebrospinal fluid resulted negative, as well as malignant cell presence. We treated the patient with IV dexamethasone with considerable clinical improvement, and we subsequently transferred her to a rehabilitation center.

Skin lesions as first sign of late stage prostate cancer... and normal PSA level

R. Cipriani[1], G. Mancini[2], M.G. Mastrullo[2], A. Nazzaro[3], C. Ocelli[2]

[1]Internal Medicine Department, Frosinone Hospital, Frosinone; [2]Internal Medicine Department, Palestrina Hospital, Palestrina (Roma); [3]Urology Department, Palestrina Hospital, Palestrina (Roma), Italy

Background: Prostate cancer (Pca) is the second most common urological malignancy to be associated with paraneoplastic syndromes (PS) after renal cell carcinoma. The literature features around 100 cases of PS associated with prostate cancer and these include mainly endocrine manifestations, neurological entities and dermatological conditions.
Case report: We describe a case of a 66-years-old male patient that came to our observation for fever and pruritic rush. The chest radiography performed in emergency room didn't show pathologic images, urine test was normal but blood count showed increased of WBC and anemia and the patient was hospitalized. In his history there was only a mild anemia treated for 1 month with folic acid. Urine and blood culture were negative, echocardiogram and endoscopic examinations too. The persistence of fever and the per-

sistent increase of white blood cells were suspected for myeloproliferative syndrome but phenotypic and molecular biology study have excluded that. A total body computerized tomography was performed and an invasive prostate cancer was evidenced. It was surprising find out that specific prostate antigen (PSA) was normal.
Conclusions: An internist must always remember that fever and dermatologic lesions, frequent among hospitalized patients, can be the first sign of late-stage and aggressive tumors with poor overall outcomes. Moreover, high-grade prostate cancer is not rare among men with PSA level of 4.0 ng per milliliter or less.

Role of endometriosis in defining cardiovascular risk in women: an interdisciplinary approach of gender medicine

M. Cirillo[1], M.E. Coccia[2], F. Rizzello[2], T. Ciarambino[3], C. Fatini[4]

[1]Department of Experimental and Clinical Medicine, University of Florence, Florence; [2]Center for Assisted Reproductive Technology, Division of Obstetrics and Gynecology, Careggi University Hospital, Florence; [3]Department of Internal Medicine, Hospital of Marcianise, ASL Caserta; [4]Department of Clinical and Experimental Biomedical Sciences, University of Florence, Florence, Italy

Background: The relationship between endometriosis and subclinical atherosclerosis represents an emergent topic in women's health. Women with endometriosis are at higher risk of cardiovascular (CV) disease later in life. We investigated metabolic and endothelial markers of atherosclerosis, and the association between atherosclerotic burden and clinical endometriosis degree.
Methods: The study population comprised 660 women framed for CV risk.
Results: 109 women (16.5%) had endometriosis, an altered lipid profile, and increased homocysteine values in comparison to women without endometriosis. By analysing CV profile according to degree of endometrial involvement, 92 women (84.4%) had stage III/IV, whereas 15.6% had stage I/II. We observed a significant difference of lipid profile in stage III/IV in comparison to stage I/II of endometriosis ($p<0.05$), as well as lower vitamin B6 and folate ($p=0.01$ and $p=0.03$, respectively) values, and higher hs-CRP concentrations ($p=0.04$). After adjustment for traditional CV risk factors (OR 5.24, $p=0.02$), the worsen lipid profile remained significantly associated with severity of endometriosis.
Conclusions: Our findings provide evidence of an unfavourable vascular profile related to accelerated atherosclerosis.
The clinical relevance of our study lies in identify women with stage III/IV of endometriosis at higher risk of atherosclerotic disease, who could have a greater benefit for an early CV screening for controlling future CV risk.

Hypertransaminasemia: etiological classification and orientation between public and private hepatic clinic

C. Clementi[1], G. Gimignani[2]

[1]Casa di Cura "Santo Volto" S. Marinella (Roma); [2]ASLRM4 AO S. Paolo, Civitavecchia (Roma), Italy

Introduction and Aim of the study: The finding of an increase in hepatic cytolysis in patients in apparent healthy conditions is a frequent occurrence since the demand for amino transferases and enzymes of the bile pole are often requested in outpatient examinations routine. The aim of this study was to investigate the possible etiological difference of hypertransaminasemia in patients attending the public and/or private hepatology clinic.
Patients and Methods: Over a period of one year, 431 patients (pts) were studied of both genders (Female 151, Man 280) patients average age (63,4 years, range 34-85 years) affected by various types of chronic liver disease attending the public hepatology clinic (283 pts) and/or private (148 pts). Patients with primary and secondary malignancies, patients with secondary forms, rare forms were excluse. The various hepatopathies have been grouped according to the etiology and not by the severity of the evolution.
Results: The recognized causes of chronic hepatopathy for the public surgery were: metabolic (54%), alcoholics (26%), viral [(B and C) (12%)], bile (2.1%), autoimmune (1%), heterozygous hemochromatosis (1.1%), drug abuse and/or herbal supplements (3.1%), excess of physical activity (0.4%). For the private clinic were: metabolic (75%), alcoholics (11%), viral (6.7%), bile (2.7%), autoimmune (2%), drug abuse and/or herbal supplements (1.3%), heterozygous hemochromatosis (0.6%), excess physical activity (0.6%). Metabolic forms $p=0.000001$, alcoholic forms $p=0.05$, other form p=ns.
Conclusions: The characteristics of the chronic hepatopathies observed in the hepatological clinics were the same. The differences arise from the prescription of antiviral therapies and the management of transplant patients generally charged to public clinics

An unusual complication in patient with inferior vena cava filter

S. Colombo[1], R. Cattaneo[1], L. Marchionni[1], F. Capelli[1], S. Biagiotti[1], M. Cimpanelli[1], E.E. Re[1], A. Mazzone[1]

[1]ASST Ovest Milanese, Medicina Interna, Ospedale di Legnano (MI), Italy

Background: Inferior vena cava filter is positioned during deep vein thrombosis when contraindications to anticoagulant therapy are present.
Case report: We present a case of a 72 years old man. Ten years ago right partial nephrectomy for cancer and vena cava filter positioned for venous thrombosis. Anticoagulant therapy for 6 months followed by antiplatelet therapy. Oncology follow up was negative during the years. Patient came in emergency room for syncope during micturition and lumbar pain, he was out of the hospital with the diagnosis of situational syncope. After two day the patient was admitted to hospital for lumbosacral pain with bilateral legs oedema, dysuria and erection post micturition. Blood chemistry tested showed thrombocytopenia. Abdominal CT angio revealed the presence of the inferior vena cava filter with down and up thrombosis extended to bilateral iliac, superficial and deep inferior veins. We started anticoagulant therapy with Fundaparinux but urological disorder, lumbosacral pain and impossibility to maintain standing position continued. The lumbosacral MRI demonstrated pathological contrast enhancer in anterior epidural between L5 and S2. We excluded hematologic and oncologic diseases with PET and blood chemistry test. The neurosurgeon concluded that MRI report was due to lumbar epidural vein dilatation secondary to vena cava thrombosis. Anticoagulant therapy was continued with Warfarin with the complete resolution of symptoms. Vena cava thrombosis can complicated the cava filter implantation and increased with time of implantation and the absence of anticoagulant therapy.

Palliative physiotherapy in the elderly patient: a challenge for the geriatrician between hospice and rehabilitation

C. Coppola[1], V.M. Magro[2], G. Scala[3]

[1]Casa di Cura Alma Mater S.p.A., Villa Camaldoli, Napoli; [2]Dipartimento di Medicina Interna e Geriatria, Università della Campania "Luigi Vanvitelli", Napoli; [3]Centro Assistenza Domiciliare (CAD), ASL RM2, Roma, Italy

Background: The role of the geriatrician in the oncological field is expanding of new knowledge and precise duties on choices that involve both the rehabilitation and the palliative sphere.
Materials and Methods: A 73-year-old patient with history of osteoporosis and colon cancer with pulmonary and hepatic repeats and previous thrombotic stroke was recruited. He was vigilant, lucid but suffering (VAS 8/10) and dysphagic. Humoral tone reduction (GDS 10/15). Reduction of tonotrophism and generalized hyposthenia, greater in the left limbs. Vital parameters and EKG within limits.
Results: After multi-disciplinary assessment the drugs considered to be not useful were suspended (atorvastatin, colecalciferol, calcium carbonate); therapy: esomeprazole 20 mg, irbesartan/hydrocolorothiazide 300 mg/12.5 mg, amlodipine 10 mg, escitalopram 10 mg, trazodone 150 mg, enoxaparin 4000 IU, fentanyl 50 mcg/hour. Neuromotor rehabilitation was practiced, as well as re-education to postural passages and to the erect posture, speech therapy sessions. Pain (VAS 4), dysarthria and dysphagia reduction, with improvement of communication disorders; reduction of spasticity with improvement of left-hemilate motility; Postural steps possible with help; sitting posture maintained for short periods. Increased mood tone.

Conclusions: Respecting the eubiosia the task of the geriatrician is in the combat of futility and to make the rehabilitation/functional side, now a pivotal role in oncology, in order to recover/acquire a new psycho-physical balance and quality of life, even when the prognosis remains poor.

Pseudomasses in the right atrium: role of echocardiographic artifacts

M.G. Coppola[1], P. Madonna[1], S. Damiano[2], P. Tirelli[1], G. Oliva[1], L. Aran[3], C. Bologna[1], M. Lugarà[1], C. De Luca[1], E. Grasso[1]

[1]UOC Medicina Generale, PO Ospedale del Mare, ASL Napoli 1 Centro, Napoli; [2]Dipartimento di Medicina Clinica e Sperimentale, Università degli Studi di Napoli Federico II, Napoli; [3]Scuola di Specializzazione Geriatria Università degli Studi di Napoli Federico II, Napoli, Italy

Case report: We report a case of a 74 years-old man admitted to our hospital for dyspnea, bilateral pleural effusion, lower limbs edema. History: chronic atrial fibrillation, hypertension, heart failure, anemia. Recently he had undergone colinic polypectomy. Warfarin was discontinued and fondaparinux 2.5 mg once daily was started. Transthoracic echocardiography also showed a mobile rounded hyperechoic structure and a polylobed mass with mobile components in right atrial in parasternal aortic short axis and 4 chamber view. Thrombus, vegetation, tumor, other? An echocardiographic subcostal view showed a redundant Eustachian valve at the junction of the inferior vena cava and right atrium, while confirmed the other polybobed structure of unknown origin in right atrium. Lung echography demonstrated atelectatic areas and bilateral large pleural fluid. We performed right evacuative thoracentesis for worsening dyspnea. The polylobed structure disappeared after evacuative thoracentesis. Our diagnosis was persistence of Eustachian valve in right atrium and presence of a mirror image, intracardiac artifact by lung atelectasis and pleural effusion.
Discussion: The case presented show that echocardiographic artifacts may present as intracardiac configurations resembling 'pseudomasses' that may be attributable to beam with artifact, generated by anomalies of the lung parenchyma. In a study of a total of 205 mechanically ventilated patients who presented with pulmonary atelectasis and/or pleural effusion, an intracardiac artifact was documented in 17 out of 205 patients(8.29%) using echocardiography.

Aortic stenosis is it always a simple diagnosis?

F. D'Agostino[1], A.G. Angeletti[1], M. Cassese[2], M. Braccio[2], R. Alemanni[2], G. Serviddio[3], A. Greco[4]

[1]Dipartimento di Scienze Mediche e Chirurgiche, Università degli Studi di Foggia; [2]Divisione di Cardiochirurgia, IRCCS "Casa Sollievo della Sofferenza", San Giovanni Rotondo (FG); [3]Dipartimento di Scienze Mediche e Chirurgiche, Università degli Studi di Foggia; [4]Unità Complessa di Geriatria, Dipartimento di Scienze Mediche, IRCCS "Casa Sollievo della Sofferenza" San Giovanni Rotondo (FG), Italy

Background: The aortic stenosis (AS) is the most common cardiac condition affecting elderly population and its frequency is age-correlated. It is characterized by a classical triad of symptoms which appear mostly on exertion such as dyspnea, syncope and angina. Although diagnosis and quantification of AS is very simple using a standard 2D echocardiography evaluation, sometimes there are several pitfalls in this approach requiring a more detailed evaluation.
Case report: A man of 88 years old presented with recurrent episodes of syncope within the last year and with no vomiting or sphincter incontinence. Physical examination revealed a systolic murmur on aortic focus radiated towards the apex and carotids with intensity of 3/6 on the Levine grading scale. On these evidences and after the exclusion of other syncope's causes, the suspicion of AS was posed. In this patient the transthoracic echocardiography (TTE) was not suggestive for severe aortic stenosis because there was discordance between diagnostic severity criteria. At this time, the negative echocardiography results were not consistent with the patient's symptoms for this, we have evaluated the area valve planimetry in 3D with transesophageal echocardiography (TEE). TEE showed a severe AS and the patient was successfully treated with a transcatheter aortic valve implantation (TAVI).
Conclusions: TEE should be a mandatory diagnostic option in unclear cases of severe AS when there is no accordance between clinical symptoms and TTE examination.

MRSA sepsis from unusual outbreak of infection

M.A. D'Agostino[1], D. D'Ambrosio[1], V. Vatiero[1], M.D. Concilio[1], G. Vargas[1], S. Giovine[2], F. Ievoli[1]

[1]UOC Medicina Generale, PO "G. Moscati" Aversa (CE), ASL CE; [2]UOC Radiologia, PO "G. Moscati" Aversa (CE), ASL CE, Italy

Case report: A 58-year-old female presented to our hospital due to fever, confusional state and left iliac fossa pain. The patient was in home treatment with intramuscular nonsteroidal anti-inflammatory drugs for a falling and she suffered pain and functional impairment of left leg. The biochemical analysis showed an elevation of inflammatory tests. The blood cultures were positive for MRSA and the patient was treated with teicoplanin at the dose of 12 mg/kg/day for 72 hours and subsequently at the dose of 6 mg/Kg/day. The transesophageal echocardiogram excluded endocarditic vegetations. Total body CT showed absence of the brain and parenchymal organs changes and no traumatic lesions. MRI of the pelvis depicted an inflammatory and colliquative infiltrate of coxofemoral joint and ileopsoas muscle. After two weeks of antibiotic therapy, the patient had normalization of biochemical tests, and a functional improvement of the leg. She is actually in close follow up with a MRI scheduled for 3 months.
Discussion: Pelvic articular and muscular MRSA infection through intramuscular injection is uncommon and it often requires surgical or arthroscopic debridement. Its involvement highlighted by MRI at early stage postponed an invasive treatment.
Conclusions: Use of MRI during MRSA sepsis showed an unusual outbreak of infection. The early diagnosis and the start of a prompt antibiotic therapy avoided abscess complications of the affected joint and the contiguous muscle.

Artrite psoriasica e leucemia mieloide cronica trattata con apremilast: descrizione di un caso clinico

T. D'Errico[1], M. Varriale[2], C. Ambrosca[3], G. Italiano[4], A. Maffettone[5], S. Tassinario[3]

[1]UOC di Medicina Interna, DH di Reumatologia, PO "S.M.d.P. degli Incurabili", ASL Napoli 1 Centro, Napoli; [2]UOC di Medicina, PO "S.M.d.P degli Incurabili", ASL Napoli 1 Centro, Napoli; [3]UOC di Medicina Interna, PO "S.M.d.P. degli Incurabili", ASL Napoli 1 Centro, Napoli; [3]UOC di Medicina Interna, AO "S. Anna e San Sebastiano", Caserta; [5]UOC di Medicina Interna, Ospedale "V. Monaldi", Azienda dei Colli, Napoli, Italy

Introduzione: L'Apremilast è un inibitore dell'enzima fosfodiesterasi 4,approvato per l'PsA in pz con controindicazioni ai f. biologici. Le neoplasie(comprese le leucemie e i linfomi) in atto o pregresse (remissione >5) controindicano l'utilizzo dei farmaci biologici in pz con concomitanti malattie croniche articolari, determinando un peggioramento della prognosi in questo subset di pz.
Caso clinico: Femmina di 58 anni affetta da psoriasi ai gomiti e alle ginocchia dall'età di 29°; nel maggio 2015 aveva presentato tenosinovite al polso e al 3° raggio della mano di dx; un reumatologo posta diagnosi di PsA aveva prescritto terapia con Methotressato (MTX) 15mg/sett. e prednisone 5mg/die con buona risposta clinica fino al gennaio 2016, successivamente incremento delle transaminasi fino a 6X e sospensione di MTX; ad aprile 2016 diagnosi di LMC trattata con Nilotinib. A settembre 2016 la pz giungeva alla nostra osservazione per riacutizzazione tenosinovitica nelle sedi già in precedenza impegnate e psoriasi severa (80% del corpo), LMC in remissione. In accordo con lo specialista ematologo abbiamo instaurato terapia con Apremilast; a 2 mesi si è realizzato un netto miglioramento della psoriasi e remissione quasi completa della tenosinovite, LMC in remissione.
Conclusioni: Nei pz affetti da neoplasie in atto o in remissione e con artrite, la scelta terapeutica risulta di difficile gestione, soprattutto per il possibile effetto dei DMARD sulle neoplasie. Il caso clinico descritto mostra l'efficacia e la sicurezza di Apremilast per il trattamento di questi pazienti, confermandosi una importante opzione terapeutica.

Steatosi epatica non alcolica e sindrome metabolica: potenzialità del Bagnacavallo Fatty Liver Score nel setting della medicina proattiva sul territorio

F. Dazzani[1], M.G. Barbieri[2], M. Domenicali[3], R. Romagnoli[1], F.G. Foschi[4], P. Giacomoni[1]

[1]UO Medicina Interna, Lugo (RA); [2]Continuità Assistenziale, Ravenna; [3]Alma Mater Studiorum, Bologna; [4]UO Medicina Interna, Faenza (RA), Italy

Premesse e scopo dello Studio: Il riscontro ecografico accidentale di steatosi epatica nei pazienti che afferiscono all'ambulatorio del medico di medicina generale è sempre più frequente, ponendo la necessità di un corretto inquadramento diagnostico al fine di prevenire severe complicanze e le conseguenti ospedalizzazioni. Scopo dello studio è quindi quello di valutare l'applicazione del Bagnacavallo Fatty Liver Score (BFLS) nell'inquadramento e nel follow up dei pazienti affetti da NAFLD (Non Alcoholic Fatty Liver Disease).
Materiali e Metodi: Applicazione del BFLS e valutazione della capacità di questo score nell'individuare i pazienti a maggior rischio di sindrome metabolica. Lo score, che valuta parametri quali sesso, body mass index, grado di steatosi ecografica e circonferenza addominale, è stato applicato ad una popolazione campione di pazienti con NAFLD di età compresa tra 30-65 anni, escludendo i pazienti già affetti da cirrosi
Risultati e Conclusioni: Il BFLS ha dimostrato di essere in grado di identificare nel campione di pazienti steatosici in oggetto quelli a maggior rischio di sviluppare sindrome metabolica. Lo score si è confermato di facile applicazione in un setting ambulatoriale, sottolineando la sua utilità sia per l'inquadramento che per il follow up. Si propone così uno strumento con cui poter costruire in modo proattivo e personale un percorso di assistenza specifico nei confronti di questi pazienti sempre più frequenti sul territorio, limitando l'accesso al setting specialistico ed ospedaliero ai casi con patologia evolutiva e/o complicata.

A rare cause of endocarditis

M.T. De Donato[1], R.M. De Vecchi[1], M. Marracino[1], L. Landolfi[1], M. Renis[2]

[1]UOC Medicina Interna, PO Ruggi, AOU Salerno;[2]UOC Medicina Interna, PO Cava de' Tirreni, AOU Salerno, Italy

Introduction: Corynebacterium is a Gram-positive bacillus, saprophyte of skin and mucous membranes. Non-diphtheria Corynebacterium is considered a contaminant when it is found in blood culture. However, C.striatum is one of the emerging nosocomial agents potentially implicated in endocarditis.
Case report: Man, 64, hemodialysis. Two previous hospitalizations for intermittent fever in the last month, concluded without diagnosis, because of voluntary hospital discharge. Further admission, again for fever, with evidence of mitral and tricuspid valvular endocarditis. In the second of the previous admissions, the blood culture had been positive, but the laboratory had not carried out the antibiogram, because the isolated germ, C. Striatum, had been considered as an occasional contaminant. The antibiotics targeted against the germ, at this point rightly considered responsible for endocarditis, has determined improvement of the patient, who is currently in f.u.
Discussion and Conclusions: C. striatum is a rare cause of infective endocarditis, mostly in patients with pacemakers and vascular access for hemodialysis. As Corynebacterium species are generally considered to be contaminants, C. striatum infection rates are probably underestimated. In unusual clinical scenarios, positive blood cultures for this germ should not be neglected as potential causes of various clinical conditions (sepsis, pneumonia, arthritis, COPD exacerbations). Therefore, dialogue and cooperation between the laboratory worker and the clinician are fundamental for the achievement of a correct diagnosis.

Diagnosi differenziale di paralisi in un giovane adulto

R. De Giovanni[1], L. Giampaolo[1], G. Eusebi[1], L. Ghattas[1], M.G. Finazzi[1], P. Montanari[1], L. Poli[1], A. Salemi[1], D. Tirotta[1]

[1]UO Medicina, Ospedale di Cattolica, Dipartimento Internistico Rimini, AUSL Romagna, Cattolica (RN), Italy

Premesse: La Paralisi Periodica è un raro disturbo neuromuscolare correlato ad un difetto dei canali ionici a muscolari, caratterizzato da paralisi non dolorosa che può essere precipitata da esercizio fisico pesante, digiuno o pasti ricchi di carboidrati. Paralisi Periodica Ipokaliemica è la più comune delle paralisi periodiche. Può essere famigliare (autosomica dominante) oppure acquisita (in coso di tireotossicosi).
Caso clinico: Un maschio di 25 anni dopo una partita di calcetto si è presentato in PS per paralisi degli AAII. Gli ematochimici evidenziavano marcata ipokaliemia: <1.5 Mmol/L; dopo esecuzione di supplementazione di potassio il pz veniva dimesso. Pochi giorni più tardi il pz si ripresentava in PS per una recidiva e veniva ricoverato. Veniva eseguito TSH con riscontro di tireotossicosi senza sintomi di ipertiroidismo: TSH <0.005 mUI/L, FT4 44.9 ng/L. Veniva impostata terapia tireostatica e somministrato K+ con risposta clinica. Sono stati effettuati RMN, rachicentesi e dosaggio enzimi muscolari per ricerca di diagnosi differenziali. E' stato proposto anche test genetico.
Conclusioni: Poiché la PPI in corso di tireotossicosi è rara 0.1/0.2% nei Pz non asiatici è necessario escludere altre forme di paresi come la crisi miastenica, la sd di Guillain-Barré, la mielopatia, la miopatia in corso di tireotossicosi, la puntura di zecca e il botulino.

Iperferritinemie: un caso di emosiderosi tipo IV

A. De Palma[1], C. Di Blasi Lo Cuccio[1], M. Alessandri[1]

[1]UOC Medicina Interna, Colline Metallifere, Massa Marittima (GR), Italy

Premessa: Il sovraccarico di Fe può essere primario o secondario: l'Emocromatosi tipo 4, quadro noto come malattia della ferroportina, è determinato da una mutazione di questa proteina con perdita di funzione. Clinicamente, nella forma classica, si osserva una spiccata iperferritinemia, una bassa TS, un accumulo di ferro nei macrofagi epatici. Nei quadri sintomatici la salassoterapia è il trattamento di scelta; previene lo sviluppo del danno d'organo, cirrosi epatica in primis, migliorando significativamente la sintomatologia. Nelle forme di grave sovraccarico può essere praticata l'eritrocitoferesi. Tra le forme secondarie ricordiamo quelle in corso di epotapatia, l'aceruloplasminemia, le anemie secondarie.
Caso clinico: Uomo di 52 anni, giungeva alla nostra osservazione per il riscontro casuale di ferritina 1638 ng/ml. Per la diagnosi differenziale delle iperferritinemie eseguiva Transferrina (221 mg/dl), TS (31%), Cu, Zn e ceruloplasmina nei limiti; una RMN addome documentava steatosi spiccata ed accumulo di Fe intraepatico ai limiti superiori; un'agobiopsia epatica concludeva per un quadro di steatoepatite 2° e siderosi kupfferiana (compatibile con emosiderosi HH tipo 4); la RMN encefalo e l'ecocardiogramma richiesti per valutare sedi di accumulo di ferro risultavano nella norma.
Conclusioni: Nel caso in questione siamo di fronte ad una Emocromatosi, la tipo 4, come confermato da riscontri strumentali e laboratoristici. Il paziente attualmente segue una dieta ipoglucidica ed ipolipidica e salassi periodici con riduzione Ferritina a 352 ng/ml e TS 29%.

Una "particolare" epigastralgia

K. Del Pin[1], S. Serdino[1], M. Manzocco[1]

[1]Istituto di Clinica Medica, Dipartimento Medico, AOU Sassari, Italy

Premessa: La trombosi venosa mesenterica è una forma non comune d'ischemia intestinale, molto rara nei pazienti non cirrotici che continua a presentare una prognosi infausta, con una mortalità ospedaliera del 59-93%. Varie condizioni patologiche possono presentarsi in associazione a questo quadro clinico, come l'ipertensione portale, le infezioni intestinali, i traumi, gli interventi chirurgici, gli stati d'ipercoagulabilità o i disordini trombofilici. Nel 50% dei casi rimane idiopatica.
Caso clinico: Un paziente di 49 anni, con storia di diabete mellito in terapia dietetica e in buon compenso metabolico, viene ricoverato per dolore epigastrico insorto dopo sforzo fisico in palestra, persistente da 3 gg, associato a piressia. Non alterazioni cardiologiche. Agli esami ematochimici aumento delle CPK e delle transaminasi. Viene sottoposto a TC addome con riscontro

di trombosi della vena porta e della mesenterica superiore con linfoadenopatia isolata all'ilo epatico. Viene escluso un quadro di epatopatia, alterazioni del profilo trombifilico e neoplasie occulte anche con l'esecuzione di PET-TC. Viene trattato con TAO (Coumadin), con ricanalizzazione parziale dopo 3 mesi di terapia e remissione della linfoadenopatia.L'eziologia rimane incerta, probabilmente polifattoriale: sforzo fisico associato a virosi intestinale.
Conclusioni: La gestione della trombosi venosa mesenterica è multidisciplinare. La sola terapia anticoagulante potrebbe essere utilizzata nel gruppo di pazienti con quadro clinico più sfumato; viceversa, l'approccio chirurgico immediato dovrebbe essere considerato solo se le condizioni cliniche si deteriorino rapidamente o allorquando si sviluppino i segni clinici di peritonismo.

Autoimmune hepatitis and dermatomyositis: an uncommon but possible association

P. Dellaca'[1], M.A. Marzilli[1], M.A. Maioli[2], C. Caria[1], N. Granata[1], C. Varsi[3], A. Caddori[1]

[1]SC Medicina Interna, PO SS Trinità, ASSL Cagliari, ATS Sardegna; [2]SS Neurofisiopatologia, Centro Sclerosi Multipla, ASSL Cagliari, ATS Sardegna; [3]UOC Anatomia Patologica, PO SS Trinità, ASSL Cagliari, ATS Sardegna, Italy

Background: In course of collagen disease is common to find liver enzyme abnormalities; however a primary liver disease is discovered rarely in patients affected by connective tissue diseases, especially in inflammatory miopaties like polymyositis (PM) and dermatomyositis (DM).
Case report: We reported a case of a 58-years-old female, who presented with dermatitis and elevation of liver enzymes. Cholestatic hepatitis and allergic dermatitis (allopurinol) was the first diagnosis. The patient started therapy with prednisone 0,5 mg/Kg. After she developed fatigue and proximal symmetrical weakness with elevation of creatin kinase (CK). The immunological tests revealed positive antinuclear antibodies (ANA=1:1280), with negative AMA, SMA and LKM type 1. Liver biopsy was suggestive for autoimmune hepatitis (AIH); electromyography showed mixed neurogenic and myopathic damage. We started prednisone 1 mg/Kg/die. On steroid tapering the patient had a CK flare; muscle biopsy was compatible with inflammatory myopathy. Our finally diagnosis was AIH associated to DM. She improved with this therapy; after a year she showed new CK flare without other liver enzyme abnormalities: therefore we started a DMARD therapy with Methotrexate 10 mg/weekly, under a close monitoring of liver function.
Conclusions: The association between AIH and inflammatory myopathy is uncommon and not extensively studied. In this suspicion hystologyc definition allow to stage liver damage and modulate therapy to delay the progression of liver disease.

Infezioni da germi MDR in reparti riabilitativi di alta complessità assistenziale (Centro svezzamento dalla ventilazione meccanica prolungata e Unità di riabilitazione gravi cerebrolesioni acquisite)

T. Deri[1,2], G. Vagheggini[1,2,3], E. Chiellini[1,2], D. Salamone[3], F. Dinelli[1,3]

[1]Centro Riabilitativo Multispecialistico Auxilium Vitae, Volterra, Italy; [2]Fondazione Volterra Ricerche Onlus; [3]Azienda USL Toscana Nordovest, Pisa, Italy

Premessa: I dati di prevalenza dei germi *multi-drug resistant* (MDR) nei reparti di riabilitazione intensiva e di svezzamento prolungato sono scarsi. Scopo dello studio è stato valutare l'incidenza di infezioni da MDR e l'utilizzo di antibiotici in due unità riabilitative di alta complessità assistenziale.
Metodi: Analisi retrospettiva degli isolati di MDR nelle unità cerebro lesioni (UGCA) e svezzamento prolungato (CS) del centro riabilitativo Auxilium Vitae Volterra in due periodi: Luglio-Dicembre 2014 (LD14) e Gennaio-Giugno 2018 (GG18). Gli isolati sono stati analizzati per tipologia e sede. Abbiamo analizzato inoltre il consumo di antibiotici, calcolati come dose unitaria, suddivisi nelle diverse classi ATC.
Risultati: Nel periodo LD14, nei 99 pazienti ricoverati (66 CS, 33 UGCA) sono stati isolati 247 MDR (121 CS, 132 UGCA); nei 114 pazienti del periodo GC18 (59 CS, 55 UGCA) sono stati isolati 389 MDR (211 CS, 195 UGCA). Si è osservato un aumento di MDR, sia Gram+ (58vs149; p<0.001) che Gram- (189 *vs* 240; p=0.003), non differenze di miceti (51 *vs* 72; p=0.656). Abbiamo osservato un maggiore utilizzo di betalattamici e fluorochinolonici, ed un decremento di carbapenemi e glicopeptidi nel periodo GG18 rispetto a LD14. Abbiamo osservato 29 infezioni da C. Difficilis nel periodo LD14, e 3 in GG18.
Conclusioni: Rispetto a LD14, nel periodo GG18 si è osservato un significativo incremento degli isolamenti di germi MDR. Si è osservata una variazione della tipologia dei germi isolati, ed una diversa distribuzione degli antibiotici utilizzati.

Uno strano dolore addominale: addome acuto o altro?

S. Di Carlo[1], C. Tana[2], M. Tana[3]

[1]AUSL Pescara, PO Pescara, UOC Geriatria, Pescara; [2]AOU Parma, PO Parma, UOC Medicina, Parma; [3]ASUR Marche, PO di Urbino, UOC Medicina, Urbino (PU), Italy

Premesse: La spondilodiscite (SD) è un processo flogistico dell'unità vertebro-discale che può interessare tutti i tratti della colonna vertebrale ed anche le strutture anatomiche contigue (meningi, midollo, nervi e muscoli).
Caso clinico: Paziente di aa 47, africano, non parla ne italiano ne inglese, ricoverato in Mal. Infettive. Da 3 mesi presenta febbre e dolori addominali e lombari trattati sistematicamente con paracetamolo e FANS. In terapia antibiotica con Piperacillina/Tazobactam e Levofloxacina. Es. laboratoristici: VES e PCR elevati con PCT negativa. Emocolture ed urinocoltura negative. Es. strumentali: RX rachide L-S, RX Addome e RX Torace negativi. Ecografia addome negativa. Durante il turno di guardia notturno interdivisionale venivo chiamato per la comparsa di intenso dolore in fossa iliaca sn e nel sospetto di un addome acuto richiedevo una TC addome urgente con mdc. La TC documentava una spondilodiscite con marcata osteolisi dei corpi vertebrali di L3 e L4 ed ascessi bilaterali a livello degli ileo-psoas. Mantoux e Quantiferon +, nuove emocolture+per BK. Posta dunque diagnosi di SD tubercolare ed avviata terapia specifica. Eseguita visita ortopedica con prescrizione di busto. Pz attualmente in follow-up infettivologico.
Conclusioni: La clinica della SD è varia e subdola e la diagnosi difficile e spesso tardiva. Nei paesi occidentali l'incidenza della SD tubercolare è in aumento per via dell'intensa immigrazione dai paesi in via di sviluppo. Diagnosi precoce e terapia mirata migliorano i risultati clinici e riducono la probabilità di complicanze neurologiche.

Un raro caso di coma

S. Di Carlo[1], C. Tana[2], M. Tana[3]

[1]AUSL Pescara, PO Pescara, UOC Geriatria, Pescara; [2]AUSL Parma, PO Parma, UOC Medicina, Parma; [3]ASUR Marche, PO Urbino, UOC Medicina, Urbino (PU), Italy

Premesse: L'arteria di Percheron è una rara variante anatomica per cui entrambe le arterie talamiche originano da una sola arteria cerebrale posteriore. In caso di occlusione di tale arteria si verificano ischemie talamiche bilaterali. Questo rappresenta un raro caso di stroke (0,7% degli ictus ischemici).
Caso clinico: Paziente di 78 aa, trovata a casa in stato di coma e condotta in PS. In PS GCS=3, pz apiretica ed a ritmo sinusale, parametri vitali e glicemia nei limiti, assenza di segni meningei, ROT e riflessi plantari conservati. Esami ematici nei limiti. TC cranio urgente in PS negativa per lesioni emorragiche e/o ischemiche. Ricovero in Stroke Unit. Nel sospetto di ischemia tronco-encefalica acuta si eseguiva in urgenza RMN cerebrale con sequenze pesate in diffusione (DWI) col riscontro di aree a ridotta velocità di diffusione in sede talamica bilaterale suggestive per alterazioni ischemiche in fase acuta da occlusione dell'arteria di Percheron. Eseguita trombolisi sistemica ev con Actilyse. A circa 2 ore recupero graduale dello stato di coscienza sino a remissione completa. Pz dimessa a domicilio in quarta giornata.
Conclusioni: Sebbene rara l'occlusione dell'arteria di Percheron andrebbe sospettata in quei pz con alterazioni dello stato di coscienza e deficit neurologici tipici (paralisi verticale dello sguardo,

deficit mnesici, rallentamento ideo-motorio). Nelle Stroke Unit la RMN con DWI è l'esame di riferimento nel sospetto di ischemia cerebrale acuta. In caso di diagnosi precoce la trombolisi sistemica risulta rapidamente efficace.

Ipocalcemia acuta associata a somministrazione di bicarbonato

M. Di Giorgio[1], A. Antenucci[1], V. De Feo[1], F. Golosio[1], S. Martini[1], F. Tiratterra[1]

[1]UOC Medicina Interna, Ospedale G.B. Grassi, ASL Roma 3, Italy

Premesse: L'ipocalcemia è una comune anormalità biochimica che può manifestarsi con diversi gradi di severità clinica. Ha una prevalenza del 18% nei pazienti ospedalizzati. E' frequentemente causata da deficit di vitamina D o da ipoparatiroidismo, ma può essere dovuta ad altre cause, anche iatrogene.
Caso clinico: Donna di 66 anni in trattamento con ramipril ricoverata per Insufficienza renale acuta (creatinina 5,81 mg/dl) ed acidosi metabolica (ph 7,16, HCO3-: 7,4 mEq/l). La calcemia all'ingresso era normale (Ca: 8,6 mg/dl). La paziente è stata trattata con sospensione del ramipril, idratazione e sodio bicarbonato e.v. Nei giorni successivi progressivo miglioramento della funzionalità renale, normalizzata dopo otto giorni. La degenza, in quarta giornata, è stata complicata da crisi tetanica, associata ad un valore di calcemia di 5,4 mg/dl, che è stata trattata con calcio gluconato ottenendo un rapido miglioramento. Il PTH è risultato normale, il dosaggio della vitamina D ridotto, l'EGA dimostrava alcalosi metabolica. (ph:7,49, HCO3-: 41 mEq/l). La sospensione del sodio bicarbonato ha rapidamente normalizzato i valori di calcio ematici.
Conclusioni: Il trattamento della acidosi metabolica con bicarbonati può, se non monitorizzato con attenzione, provocare una ipocalcemia acuta per riduzione della quota di calcio ionizzato ed eventuale crisi di tetania. E' quindi necessario monitorizzare strettamente il ph e la concentrazione di HCO3- in corso di terapia con bicarbonati.

An unusual necrotizing myositis

P. Di Giuseppe[1], I. Tartaglia[1], B. Farneti[1], A. Amati[2], R. Rossi[3], M. Barletta[1]

[1]Department of Internal Medicine, Perrino Hospital, Brindisi; [2]Department of Neurobiology, University of Bari; [3]Department of Pathology and Electron Mycroscopy, University of Bari, Italy

A sixteen years old boy developed a syndrome characterized by faryngodinia, severe fever (39-40° C), asthenia and malaise; after four days of persisting symptoms despite amoxicilline and paracetamol 2 gr/day, laboratory tests revealed mild elevation of muscular enzymes and ESR & CRP. Parents conducted him to our division and CPK reached 5000 u/ml. An elevated titer of anti-mycoplasm antibodies IgM completed the picture. A muscular biopsy was performed and optic mycroscopy revealed necrotising myositis; electron mycroscopy confirmed the data revealing particles resembling mycoplasms. Treatment with hydratation, clarytromicin 1,5 gr/day and a mild dose of steroids rapidly reversed the symptoms and the laboratory tests. No similar cases were detected before in our research in scientific literature.

An overlooked cause of hyponatremia: Cerebral Salt-Wasting syndrome

M. Di Norcia[1], C. Ferri[1], S. Moscardelli[1], A. Viscido[1], L. Natali[1], I. Scopacasa[1], S. Dell'Anna[1], F. Tonello[1], M.F. Lapenna[1], P. Vertolli[1], S. Leone[1], E. Onori[1]

[1]Dipartimento MESVA, Università degli Studi dell'Aquila, Italy

Introduction: Sodium is the most important osmotically active solute in the extracellular fluid. Hyponatremia defined as serum sodium <135 mEq/L is commonly seen in patients with acute brain injury, as the central nervous system plays a major role in sodium regulation. In this subset of patients disturbances of sodium balance are usually either due to Syndrome of Inappropriate Antidiuretic Hormone secretion (SIADH) or Cerebral Salt Wasting Syndrome (CSWS). It is important to differentiate between these two syndromes as the treatment of the two is diametrically opposite.
Case report: A 77-year-old woman with Parkinson's disease was admitted to our hospital for consciousness disturbance and seizures after head concussion. Brain imaging revealed bilateral frontal subarachnoid hemorrhage and two subcortical hematomas. She showed persistent hyponatremia accompanied by polyuria, high urine osmolality (due to increased sodium loss), dehydration state and increased BNP. Diagnosis of CSWS was made. She recovered with proper fluid replacement, electrolyte management (3% saline) and Fludrocortisone administration.
Conclusions: The main clinical manifestations of CSWS are hyponatremia, increased urine output, natriuresis, hypovolemia. CSWS is frequently misdiagnosed, as SIADH is the most well-known cause of hyponatremia after acute brain injury. Therefore we should improve the understanding of this syndrome considering that early diagnosis and prompt treatment are very important in order to avoid the detrimental effects of hyponatremia as well as to limit increases in ICP.

A case report of solitary plasmacytoma presenting with ischemic colitis

R. Di Stefano[1], G. Garofalo[1], S. Sblano[1], C. Trotta[1], N. Barone[1]

[1]UOC Medicina Interna, Ospedale San Paolo, Bari, Italy

Background: Solitary Bone Plasmacytoma (SBP) is a localized plasma cell tumor accounting for 2–5% of plasma cell malignancies with no evidence of systemic proliferation and has a better prognosis than Multiple Myeloma (MM).
Case report: A 73 years old woman presented to the Emergency Department with a 3 weeks history of abdominal pains and obstinate constipation. His past medical history was significant for a β thalassemia minor and hypertension. The abdominal CT showed only fecal stasis and vertebral height loss of L1. To the entry in our Department of Internal Medicine the physical examination exhibited a tender abdomen and slightly distended. Laboratory investigations showed microcytic anemia according to thalassemia trait, increase of inflammatory indices and fecal occult blood furthermore, the colonscopy showed a vast ulcer to the crossbeam colon with histological report of ischemic colitis. A second abdominal angioCT did not underline occlusion of the main intestinal vessels and therefore no indication was given to the reperfusion but only medical therapy with mesalazine. The patient was submitted besides to laminoplasty of L1 vertebra with bone biopsy with histological report of bone infiltration of clonal plasmacells with light chain κ restriction. The diagnosis was SBP of L1 vertebra according to the International Myeloma Working Group criteria for the diagnosis of MM.
Conclusions: SBP is a rare disease that is difficult to make a diagnosis. Although in this case the ischemic colitis allowed a rapid diagnosis and treatment, the cause of intestinal ischemia, to date, remains to understand.

Un'intuizione rivelatrice

S. Digregorio[1], A. Torrigiani[1], F. Fabbrizzi[1], L. Burberi[1], S. Fruttuoso[1], M. Bernardini[1], G. Scocchera[1], A. Fanelli[1], L. Menicacci[1], V. Scotti[1], F. Corradi[1], A. Morettini[1]

[1]AOU Careggi, Firenze, Italy

Donna di anni 75, affetta da ipertensione arteriosa, ha presentato negli ultimi anni diversi episodi di perdita di coscienza. Accede nel nostro reparto dopo essere stata rinvenuta a terra, in stato confusionale, con perdita sfinteriale; riferiva perdita di coscienza improvvisa. Per rilievo di insufficienza respiratoria tipo 1 si eseguiva angio-TC del circolo polmonare, positiva per alterazione tromboembolica a carico del ramo segmentario anteriore e posteriore dell'arteria lobare polmonare superiore destra. Dopo esecuzione di monitoraggio ECG Holter ed EEG, risultati negativi, la sincope è stata attribuita all'ipossiema dovuta all'evento embolico. Durante la degenza la paziente ha presentato alcuni episodi di platipnea ed è stata rilevata importante ortodeossia, sproporzionata rispetto

al difetto embolico, che regrediva subito in posizione clinostatica e che richiedeva flussi elevati di ossigeno. E' stato richiesto ecocardiogramma transesofageo per ricercare la presenza di FOP; l'esame ha mostrato presenza di aneurisma del setto interatriale e, dopo una iniezione di ecocontrasto galenico, marcato e precoce shunt diretto dall'atrio destro in atrio sinistro già in condizioni di riposo. E' stata eseguita procedura angiografica di chiusura del FOP in assenza di complicanze, e dopo la procedura la paziente ha potuto ridurre la somministrazione di ossigeno a domicilio fino a risultare al controllo a distanza eupnoica in aria ambiente.

Chronic kidney disease and risk of mortality, cardiovascular events and severe hypoglycemia in type 2 diabetes: DEVOTE results

O. Disoteo[1], A. Amod[2], S.S. Emerson[3], S.P. Marso[4], D.K. Mcguire[5], T.R. Pieber[6], R. Pop-Busui[7], R.E. Pratley[8], B. Zinman[9], M.V. Hansen[10], T. Jia[10], T. Mark[10], L. Salvi[11], N.R. Poulter[12]

[1]Diabetology Department, Niguarda Hospital, Milan, Italy; [2]University of KwaZulu-Natal, Durban, South Africa; [3]University of Washington, Seattle, USA; [4]HCA Midwest, Kansas City, USA; [5]University of Texas Southwestern Medical Center, Dallas, USA; [6]Medical University of Graz, Graz, Austria; [7]University of Michigan, Ann Arbor, USA; [8]Florida Hospital, Orlando, USA; [9]Mount Sinai Hospital, University of Toronto, Toronto, Canada; [10]Novo Nordisk A/S, Søborg, Denmark; [11]Novo Nordisk, Rome, Italy; [12]Imperial College London, London, UK

Background and Aims: Type 2 diabetes (T2D) is associated with an increased risk of cardiovascular disease (CVD) and chronic kidney disease (CKD). CKD is a known risk factor for major adverse cardiovascular events (MACE), all-cause mortality and hypoglycaemia. This secondary, pooled analysis from DEVOTE examined whether baseline CKD stages were associated with an increased risk of MACE, all-cause mortality or severe hypoglycaemia in patients with T2D.
Materials and Methods: DEVOTE was a treat-to-target, randomised, double-blind trial in 7637 patients with T2D at high cardiovascular (CV) risk, treated once daily with insulin degludec or insulin glargine 100 units/mL. Based on eGFR levels (mL/min/1.73 m2), patients were divided into four CKD groups: normal+CKD stage 1 (n=1486), CKD stage 2 (n=3118), CKD stage 3 (n=2704) and CKD stage 4+5 (n=214). Severe hypoglycaemia was defined as an episode requiring the assistance of another person to actively administer carbohydrate or glucagon, or to take other corrective actions.
Results: According to baseline CKD stages (CKD stages 2–5), more patients had a history of CVD (CKD stages 3–5), were older and had lower HbA1c *versus* those with normal kidney function (normal+CKD stage 1). The risk of MACE and all-cause mortality was significantly higher ($p < 0.05$) in those with a higher baseline CKD stage. There was a significantly higher rate of severe hypoglycaemia for CKD stages 3 and 4+5 *versus* CKD stage 2 or normal+stage 1. There were no significant interactions between treatment and CKD stages. Comparisons between treatment groups by CKD stage mirrored those from the primary analyses.
Conclusions: Increasing severity of baseline CKD stages was associated with a higher risk of MACE, all-cause mortality and rates of severe hypoglycaemia in patients with T2D at high CV risk.

A reversible cardiomyopathy

F. Elia[1], A. Cuomo[1], A. Bianco[1], D. Bruno[1], A. Rodolico[1], R. Franco[1], E. De Rosa[1], G. Campi[1], C.G. Tocchetti[1], D. Bonaduce[1], V. Mercurio[1]

[1]Dipartimento di Scienze Mediche Traslazionali, Università Federico II, Napoli, Italy

Background: Pheochromocytoma is a rare catecholamine secreting tumor with heterogeneous clinical presentation. It may determine cardiac hypertrophy and dilation and finally left ventricular dysfunction, whose restoration depends on early detection and management of the tumor.
Methods and Results: A 45-year-old man was admitted to our Internal Medicine ward for dyspnea, fatigue in everyday activity, palpitations, headache, irritability, sweating, anxiety and mild weight loss. Blood pressure was high. His electrocardiogram showed left ventricular hypertrophy and secondary marked repolarization abnormalities. At transthoracic echocardiography, there was left ventricular dilatation and eccentric hypertrophy, with increased end-diastolic volume and moderate systolic dysfunction. Abdominal ultrasound, used for assessment of secondary causes of hypertension, revealed an incidental mass above the right adrenal gland; moreover, 24-hour urinary levels of total catecholamines and normetanephrine were high. The contrast-magnetic resonance confirmed the presence of a heterogeneously enhancing mass in the right adrenal gland. The histological analysis of the laparoscopic resection was compatible with pheochromocytoma. Six months after surgery, the patient reported a great improvement of his clinical conditions. Electrocardiogram showed a significant reduction in abnormalities. Transthoracic echocardiography proved a complete regression of the left ventricular hypertrophy and an improvement of left ventricular size and function with an estimated left ventricular ejection fraction (57% *versus* 40%).
Conclusions: Pheochromocytoma can induce left ventricular dysfunction, initially often misdiagnosed, but whose diagnosis should lead clinicians to a specific search for tumor secreting catecholamines, since the surgical treatment can lead to complete resolution.

Blocco sequenziale renale nello scompenso cardiaco congestizio

G. Eusebi[1], L. Giampaolo[1], M.G. Finazzi[1], L. Ghattas[1], P. Montanari[1], L. Poli[1], A. Salemi[1], D. Tirotta[1], R. De Giovanni[1]

[1]Medicina Cattolica, ASL Romagna, Italy

Introduzione: Nello scompenso cardiaco congestizio si osserva spesso una ridotta risposta alla furosemide, anche se a dosi che dovrebbero saturare i trasportatori dell'ansa di Henle, questo accade poiché i sistemi di compenso renale potenziano il riassorbimeno di sodio del Tubulo contorto distale e dotto collettore. Bersagliare questi ultimi con tiazidici e antialdosteronici è il presupposto del blocco sequenziale del nefrone.
Caso clinico: Un pz di 80 aa affetto da cardiopatia ipertensiva a evoluzione dilatativa con FE conservata e IRC grave è stato ricoverato per scompenso cardiaco congestizio (edemi declivi, dispnea con ortopnea, distensione giugulare). Agli esami ematici risultavano proBNP 12118 ng/L, creatinina 2.42 mg/dL, VFG 24 mL/min (CKG), kaliemia 5.2 mEq/L. Il pz era già in terapia con furosemide 100 mg/die, è stata inizialmente impostata terapia diuretica in pompa con 250 mg/die. Dopo una iniziale risposta diuretica (fino a 1900 cc/24h) si è osservata la comparsa di oliguria, per cui i dosaggi sono stati incrementati fino a 300 mg/die senza benefici. Sono stati introdotti Metolazone 5 mg e Canrenoato di potassio 25 mg per os, con restrizione idrica e monitoraggio di creatinina ed elettroliti. La diuresi nelle 48h successive ha presentato un incremento (fino a 2500 cc/die) che ha richiesto riduzione della terapia con furosemide e miglioramento clinico. Si è osservata alla dimissione una iponatremia di grado lieve.
Conclusioni: Il blocco sequenziale del nefrone può rivelarsi risolutivo in pazienti con ridotta risposta alla terapia diuretica.

Embolia polmonare in giovane età: un'insolita associazione con malattia infiammatoria intestinale

I. Evangelista[1], A. Incisore[1], A. Palazzuoli[1]

[1]UOS Malattie Cardiovascolari, Dipartimento di Scienze Mediche, Chirurgiche e Neuroscienze, AOUS Siena, Italy

In questo caso clinico abbiamo riportato un'insolita presentazione di rettocolite ulcerosa diagnosticata in occasione di un episodio di embolia polmonare acuta. Un uomo di 27 anni si presenta alla nostra attenzione per insorgenza improvvisa di dolore a livello dell'emitorace destro irradiato alla spalla. In anamnesi riferiti disturbi dell'alvo con feci poco formate e occasionale riscontro di muco e sangue da un anno. Agli esami ematochimici: incremento di PCR e VES, severa anemia microcitica ipocromica (Hb 6,5 g/dl), leucocitosi neutrofila, piastrinosi, aumento del D-dimero, ipoferritinemia. All'esame obiettivo del torace: MV ridotto al campo medio

di destra, praticamente abolito in sede basale bilateralmente; all'EGA alcalosi respiratoria; all'ECG tachicardia sinusale con blocco incompleto di branca destra. Veniva pertanto effettuata TC torace che mostrava quadro di embolia polmonare. Negativo il doppler artero-venoso degli arti inferiori. Ecocardiografia nei limiti. Per positività del sangue occulto fecale e della calprotectina fecale veniva praticata EGDS risultata negativa e colonscopia che diagnosticava rettocolite ulcerosa acuta estesa a tutto il colon. Uno screening per patologie trombofiliche risultava positivo per mutazione in eterozigosi del gene dell'enzima MTHFR e in omozigosi del polimorfismo 5G/4G del promotore del gene PAI. In relazione al riscontro di elevati valori di anticorpi anti-muscolo liscio, nel sospetto di colangite sclerosante primitiva, veniva inoltre effettuata Colangio-RM risultata negativa. Il paziente veniva sottoposto ad emotrasfusione, a terapia con warfarin, mesalazina e ferro. Le condizioni generali sono progressivamente migliorate con stabilizzazione dei valori di emoglobina ed il paziente è stato pertanto dimesso. Ad un mese dalla dimissione nella norma i valori di emoglobina con normalizzazione della piastrinosi. Continua tutt'ora la terapia con mesalazina e con warfarin.

Mesotelioma peritoneale e malattia diverticolare: l'importanza di un'attenta valutazione clinica

A. Evangelisti[1], G.B. Cappello[1], E. De Marte[1], A. Zogheri[1], M. Ongari[1]

[1]UOC di Medicina, Ospedale di Porretta Terme (BO), Italy

Premesse: Il mesotelioma peritoneale rappresenta una rara causa di ascite.
Caso clinico: Donna, caucasica, 71 anni, con storia di appendicectomia, colecistectomia per litiasi e safenectomia. Diverticolosi del colon. Comparsa da circa un mese di dolori addominali ad andamento altalenante con nausea e vomito. All'Eco e quindi alla TC addome presenza di versamento ascitico di discreta entità associato a diverticolosi in particolare del colon discendente, con marcato ispessimento parietale. Viene sospettata una diverticolite con possibile perforazione coperta responsabile del versamento ascitico. La colonscopia conferma severa diverticolosi del colon sn. in assenza di patologia proliferativa e la citologia del liquido peritoneale ottenuto dalla paracentesi esplorativa è negativa. Ma gli indici di flogosi sono spenti, è assente la febbre, la cenestesi è compromessa ed il versamento ascitico è in lieve incremento ad un controllo ecografico. Si effettua quindi laparoscopia esplorativa, che documenta un quadro di diffuso ispessimento peritoneale con nodulazioni e l'esame istologico evidenzia un mesotelioma peritoneale. La paziente viene quindi inviata a centro Oncologico di riferimento per citoriduzione chirurgica e HIPEC (chemioterapia ipertermica intraperitoneale).
Conclusioni: Il mesotelioma peritoneale rappresenta una rara patologia (10-15% di tutti i mesoteliomi) che deve sempre essere considerata in diagnosi differenziale, specialmente quando alcuni elementi clinici sono discordanti in presenza di patologie ben più frequenti come la malattia diverticolare.

Reduction in fatal events with extrafine inhaled corticosteroid (ICS)-containing medications: results of stratified safety pooled analysis of the TRILOGY, TRINITY and TRIBUTE studies

L. Fabbri[1], A. Papi[2], A. Piraino[3], G. Micarelli[3], S. Petruzzelli[3]

[1]Sahlgrenska University Hospital, Gothenburg, Sweden; [2]Università degli Studi di Ferrara; [3]Chiesi Farmaceutici s.p.a., Parma, Italy

Background: In recent years, the efficacy of ICS-containing medications in reducing mortality in COPD patients has been debated based on randomized trials and real-world data, leaving the question still unanswered.
Methods: This is a post-hoc analysis of three randomized clinical trials comparing extrafine BDP/FF/G vs other treatments containing or not ICS: TRILOGY, TRINITY and TRIBUTE. Time to death was analyzed using a Cox proportional hazards model including only the effect of treatment. Hazard ratios (HRs) were calculated.
Results: In TRILOGY, there were 2.2% fatal events in BDP/FF/G arm vs 2.4% in BDP/FF arm. In TRINITY, 1.9% in BDP/FF/G arm, 2.7% in Tiotropium arm and 1.5% in BDP/FF+Tiotropium arm. In TRIBUTE, 2.1% fatal events in BDP/FF/G arm vs 2.7% IND/GLY arm. Overall, 2.7% experienced a fatal event in ICS-free treatment, while 2% developed a fatal event in ICS-containing treatment. Time to death analysis showed a numerical reduction in the risk of developing a fatal event (Hazard Ratio [HR] (95% CI): 0.72 (0.50, 1.02); p=0.066) for all extrafine ICS-containing treatments *versus* ICS-free treatments. A similar effect was seen when comparing BDP/FF/G only vs ICS-free treatments (HR (95% CI): 0.72 (0.49, 1.06); p=0.096).
Conclusions: Results suggest that the extrafine ICS-containing medications compared to ICS-free treatments may be associated with a lower rate of mortality in symptomatic COPD patients at risk for exacerbations. Notably, these results are confirmed when referring specifically to the extrafine fixed triple combination BDP/FF/G.

Una "grande manifestazione" extra-intestinale dell'amebiasi

F. Fabbrizzi[1], L. Burberi[1], S. Fruttuoso[1], A. Torrigiani[1], S. Digregorio[1], A. Fanelli[1], G. Scocchera[1], V. Scotti[1], L. Menicacci[1], L. Ciambellotti[2], A. Morettini[1], F. Corradi[1]

[1]Medicina Interna 2, AOU Careggi, Firenze; [2]Pneumologia 2, AOU Careggi, Firenze, Italy

L'ascesso epatico amebico (AEA) è la manifestazione extra-intestinale più frequente dell'amebiasi, infezione a trasmissione orofecale causata dal protozoo *E. histolytica*. L.T. anni 69 viene ricoverato per febbre, dolore addominale e rilievo ecografico di ascesso epatico di 8 cm. Nell'ultimo anno viaggi in Africa e Asia. Agli esami ematici rialzo di indici di flogosi e di colestasi e di transaminasi. Alla TC addome mdc riscontro a livello del lobo epatico destro di lesione di 9 cm con sfumata impregnazione periferica cercinata. In relazione al reperto radiologico e ai soggiorni in paesi a rischio sospettata infezione da *E.histolytica*. Positiva la ricerca sierologica specifica. Antigene fecale negativo. Intrapresa antibiosi con metronidazolo. Al controllo radiologico rilievo di incremento dimensionale dell'ascesso nonostante la terapia specifica, per cui è stato effettuato drenaggio percutaneo ecoguidato dello stesso con abbondante fuoriuscita di materiale corpuscolato tipo *pasta d'acciughe* su cui è stata confermata la presenza di *E.histolytica* mediante PCR. Al controllo ecografico sostanziale risoluzione della raccolta per cui è stato possibile rimuovere il drenaggio epatico. Terminata la terapia antibiotica, intrapresa terapia con paromicina per eliminare eventuali cisti coliche. Il trattamento dell'AEA richiede un team multidisciplinare, infatti oltre all'antibiosi può rendersi necessario l'intervento del radiologo interventista soprattutto negli ascessi di dimensioni >5 cm che guariscono più difficilmente con la sola terapia medica e che sono a rischio di rottura.

Il dolore è di chi lo prova: risultati preliminari da un clinical trial del Pronto Soccorso del Policlinico San Matteo di Pavia

A.G. Falchi[1], C. Blatti[2], A. Spadoni[2], A. Bruno[3], W. Brambilla[3], L. Demitry[3], M. Mascolo[3], I. Melara[3], S. Pioli[3], G. Secco[3], S. Perlini[3]

[1]Pronto Soccorso Accettazione, Dipartimento di Medicina Intensiva, IRCCS Policlinco San Matteo, Pavia; [2]Università degli Studi di Pavia; [3]Scuola di Specializzazione in Emergenza e Urgenza, Università degli Studi di Pavia, Italy

Scopo dello studio: Identificare differenze significative nella comunicazione e quantificazione del grado di dolore, in sottopopolazioni di pazienti che hanno compilato la scala NRS nell'ambito di un Clinical Trial presso il PS di Pavia.
Materiali e Metodi: È stato confrontato il valore di NRS con il genere, la scolarità e l'età.
Risultati: Il valore medio di dolore riferito con scala NRS nelle femmine è 8.1±1.9; nei maschi 8.2±1.6, p=0.78. Il valore medio della scala NRS di chi ha come titolo di studio scuola elementare è 7.7±2.1, diploma di scuola media inferiore 8.5±2.3, diploma di scuola media superiore è 8.2±1.6, università 7.4±2.0. Confrontando il valore NRS con due gruppi costituiti da pazienti con titolo di studio inferiore e titolo di studio superiore non sono emerse differenze statisticamente significative: p=0.91. Età: <40

aa NRS 8.2±1.2; 40-49 aa NRS 8.2±1.9; 50-69 aa NRS 8.2±2; >70 NRS 7.9±1.9. Confrontando due gruppi di pazienti divisi in base all'età <70 aa e >70 aa è emerso un trend lievemente superiore per i pazienti <70 aa, p=0.36.
Conclusioni: Questi dati confermano che la tendenza alla sovrastima del proprio livello di dolore è un dato ricorrente in tutti i pazienti, in assenza di differenze statisticamente significative tra le varie popolazioni. In questi pazienti sono essenziali la precocità di trattamento nonchè gli aspetti comunicativi inerenti la presa in carico della patologia dolorosa.

Una strana endocardite

A. Fanelli[1], S. Digregorio[1], S. Fruttuoso[1], M. Bernardini[1], A. Torrigiani[1], F. Fabbrizzi[1], L. Burberi[1], G. Scocchera[1], V. Scotti[1], L. Menicacci[1], F. Ferrante[1], V. Ponticelli[1], F. Corradi[1], A. Morettini[1]

[1]Medicina Interna per la Complessità Assistenziale 2, AOU Careggi, Firenze, Italy

Sig.ra di 83 anni, giunge presso il nostro reparto inviata dal Cardiologo curante a seguito del rilievo di massa polilobata (2x1 cm) a livello di un lembo tricuspidale, con movimento sistolico verso il ventricolo. In anamnesi anche storia di astenia e affanno da circa 3 settimane, per cui aveva eseguito Rx torace (negativo); non altri segni o sintomi a domicilio. Una precedente ecocardiografia, eseguita circa 6 mesi prima, risultava nella norma. Agli esami ematici riscontro di anemia microcitica non associata a carenza marziale e insufficienza renale moderata, non note in precedenza. Riscontrata insufficienza respiratoria tipo I, dato il concomitante riscontro di edema dell'arto inferiore sinistro, è stata richiesta scintigrafia polmonare, che ha confermato il sospetto di embolia polmonare. Nel sospetto di endocardite infettiva sono stati prelevati indici di flogosi ed emocolture (risultati negativi) ed è stata eseguita ecocardiografia trans-esofagea, che ha rilevato estesa formazione a partenza dalla vena renale destra, estesa fino all'atrio. Una successiva TC total body ha confermato un completo sovvertimento del rene destro da parte di una voluminosa neoplasia (11x12 cm), estesa inferiormente fino all'origine delle vene femorali comuni. L'esame ha mostrato anche ripetizioni polmonari bilaterali.

Clostridium difficile infection without diarrhea: a case of toxic megacolon

A. Faraone[1], C. Angotti[2], F. Baccetti[1], C. Baruffi[1], A. Fortini[3]

[1]Medicina Interna, Ospedale San Giovanni di Dio, Firenze; [2]Medicina Interna, AOU Careggi, Firenze; [3]Medicina Interna, Ospedale San Jacopo, Pistoia, Italy

Background: Clostridium difficile infection (CDI) is the leading cause of hospital-associated diarrhea, and is increasingly reported in long-term care facilities (LTCF). Disease severity spectrum is wide, ranging from mild self-limiting diarrhea to life-threatening colitis.
Case report: A 90-year-old man was transferred to our institution from a LTCF with complaints of abdominal pain, vomiting, ileus. At presentation, he was febrile, tachypneic and tachycardic; the abdomen was distended and painful on palpation, bowel sounds were absent. No diarrhea was reported. Blood tests showed leukocytosis, hypokalemia, raised creatinine and procalciton. CT scan of the abdomen revealed a marked dilatation of colon and ascites. The patient was started on supportive treatment and broad-spectrum antibiotic therapy (piperacillin/tazobactam). Based on anamnestic data (LTCF residence), clinical and radiological findings, a CDI complicated by toxic megacolon was suspected, and IV metronidazole was added. C. difficile toxins assay yielded a positive result, and treatment with vancomycin via nasogastric tube and rectal instillation was added. The patient experienced a progressive recovery.
Conclusions: Toxic megacolon is a rare but potentially lethal complication of CDI. Diagnosis is based on a constellation of clinical, laboratory and imaging findings. Diarrhea, the hallmark of CDI, may be absent as a result of ileus. Supportive measures and antibiotics are the mainstay of treatment, with surgical intervention as a therapeutic chance for patients not improving with medical management.

A "tricky" dyspnoea: heart failure and viral pneumonia in suspected systemic amyloidosis

S. Feltrin[1], A. Bellodi[1], F. Rossi[1], A. Minetti[1], G. Scaglione[2], A. Ballestrero[1]

[1]Clinica di Medicina Interna ad Indirizzo Oncologico, Ospedale Policlinico San Martino, Genova; [2]Anatomia Patologica, Ospedale Policlinico San Martino, Genova, Italy

Introduction: Amyloidosis refers to localized or systemic heterogeneous diseases. In the systemic form, progressive organ damage is caused by protein misfolding and aggregation into amyloid fibrils in tissues. The most common form of acquired systemic amyloidosis is monoclonal immonoglobulin light chain amyloidosis (AL).
Case report: A 71-year-old woman affected by micromolecular multiple myeloma (del13q) treated with bortezomib and daratumumab, came to our attention for dyspnoea, fever and occasional hematochezia. At clinical examination, symptoms of lower respiratory tract infection, severe peripheral oedema and periorbital purpura. Blood chemistry showed inflammatory response (C reactive protein: 321 mg/L) and NTproBNP: 19.685 ng/L. Bronchoalveolar lavage demonstrated Respiratory Syncytial Virus B and Cytomegalovirus=62.207 copies/mL. Echocardiography corroborated severe left ventricle hyperthrophy (interventricualre septum=19 mm), restrictive diastolic dysfunction with preserved ejection fraction. Rectoscopy was performed showing frail and purpuric spotted mucosa, with biopsy positive for amyloid deposits (assessed with Rosso-Congo stain).
Conclusions: Only 10–15% of patients with myeloma have coexisting AL amyloidosis which leads to delay in diagnosis and heart damage is often irreversible. The therapeutic possibilities are chemotherapy in combination with peripheral blood autologous haematopoietic stem cell transplantation and immunotherapy, targeting the B cell clone, to stop amyloid light chain synthesis. Early markers of disease are not yet available.

Fever, splenomegaly and anemia: who is the lead?

C. Ferrante[1], A. Pizzuto[1], S. Sipari Merlo[1], A. Casella[1], E. Beggiato[2], D. Ferrero[2], G. Montrucchio[1]

[1]Medicina Interna 2 U, AOU Città della Salute e della Scienza, Università di Torino; [2]Ematologia, AOU Città della Salute e della Scienza, Università di Torino, Italy

Background: Fever, splenomegaly and anemia are common findings in clinical setting. It is important to establish a correct cause-effect relation.
Case report: A 36-years-old male presented with fever and left quadrant pain. Two previous hospitalizations for same reason with negative investigations (including bone marrow and peripheral blood smear). Negative family history for hematologic diseases. At admission: fever, hepatosplenomegaly (spleen size 20 cm); Hb 11.8 g/dL, WBC 3220/μL, PLT 150000/μL, PCR 128 mg/L, LDH 1075 U/L, normal bilirubin level and liver function. Infectious and onco-hematologic exams were negative. Although we observed a clinical improvement, hemoglobin remained low. After further investigation a non-autoimmune hemolytic anemia was found. Therefore we performed the osmotic fragility tests and a new blood smear, consistent with spherocytosis.
Conclusions: Fever and splenomegaly were the most striking signs, whilst the mild anemia has been interpreted at first as alongside laboratory finding. Moreover we deemed an hemolytic etiology unlikely due to absence of hyperbilirubinemia and negativity of previous hematologic tests. When the diagnosis of hemolytic anemia was made, spherocytosis seemed improbable due to the normal MCHC value. The osmotic fragility tests however, performed according to guidelines, proved the spherocytosis. Eventually, we established the correct cause-effect relation: fever (likely viral) as the trigger event for hemolysis, splenomegaly as secondary to spherocytosis and hepatomegaly caused by the increased splenic blood inflow.

Macro-AST in young patient

C. Ferrari[1], L. Brivio[1], E. Ricchiuti[1], C. Marchesi[1], M.T. Lavazza[1], S. Speroni[1], A. Mazzone[1]

[1]UO Medicina Interna, Ospedale di Legnano, ASST Ovest Milanese, Italy

Macroenzymes are high molecular mass complexes of enzymes with plasma components with reduced plasma clearance (for example Ig), resulting in elevated serum activities due to the "trapping" of the enzymes in serum. Macro-AST has rarely been reported as a benign cause for increased AST. We report the case of a 38 year old female patient with an isolated chronic asymptomatic elevation of AST (5x ULN, measured when she was 35 at routine blood tests). She has history of dyslipidemy. She has no family history of hepatopathies and autoimmune diseases. Our patient was not taking any medication and she denied taking any other potentially liver toxic substances. Occasional consumption of alcoholic beverages. The viral serologies for hepatitis (A, B and C) were unremarkable. ANA, ASMA, AMA, LKM, anti-transglutaminase antibodies are negative. Ig, TSH, ferritin, blood count, ALP, GGT, bilirubin, ceruloplasmine, CK, protein electrophoresis and glycemia are normal. At blood tests there was only slight increase in LDL-c. Abdominal sonographic imaging is unable to identify any liver disease. Increase in AST was also confirmed after a hypolipidic diet with weight loss and abstention from consumption of alcoholic beverages. At this point a macroenzyme was suspected and AST were measured by the precipitation method with PEG, with evidence of a significant reduction. Physicians should be aware of macro-AST as cause of AST elevation. The prevalence of macro-AST is not defined. Their presence doesn't appear to be pathological in itself but macro-AST have been associated in some case-reports with several pathological conditions, which should therefore excluded.

Cardiac amyloidosis

C. Ferrari[1], L. Brivio[1], E. Ricchiuti[1], C. Marchesi[1], M.T. Lavazza[1], S. Speroni[1], A. Mazzone[1]

[1]UO Medicina Interna, Ospedale di Legnano, ASST Ovest Milanese, Italy

Amyloidosis is a progressive disease characterized by deposition of amyloid fibrils in various organs and tissues of the body. We describe a case of a man 51 years old, admitted in Internal Medicine for anasarca (lower extremity, abdominal wall, bilateral pleural effusion and scrotal edema). He reported just about paranoid schizophrenia. Baseline laboratory tests showed macrocytosis, renal failure with electrolytes normal, deficiency of Ig A and IgM, serum immunoelectrophoresis showed a double monoclonal band, which was confirmed to be immunoglobulin IgG/ in gamma region and light chains in beta region at immunofixation, urine analysis revealed proteinuria, positive Bence Jones protein. Elevated natriuretic peptide type B was detected. Thyroid function was normal. Echocardiography confirmed concentric thickening of left ventricular walls and normal ejection fraction (69%). In the suspicion of amyloidosis bone marrow biopsy was performed, revealing plasma cells monotypical lambda CD 138+ (20%), the search for Congo red staining was negative. Test of respiratory function showed mild severe restrictive syndrome with reduction of DLCO. CT scan total body was normal. Amyloid was detected on Congo red staining of abdominal fat pad fine needle aspiration. We concluded for multiple myeloma Ig G lambda ISS I with secondary amyloidosis. Patient was sent to Haematological department for treatment (therapy with VMD protocol). Marrow transplantation was contraindicated for his psychiatric problems.

Blood pressure control and anticoagulant therapy in atrial fibrillation

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

[1]Dipartimento di Medicina Interna Polispecialistica, Grande Ospedale Metropolitano Niguarda, Milano, Italy

Background and Aim: Atrial fibrillation (AF) is a very common condition in hospitalized patients in an Internal Medicine Department. Anticoagulant therapy (AT) is mandatory in AF patients to prevent thromboembolic consequences. Direct anticoagulants (DOACs) are nowadays the first option when no specific controindications suggest the use of vitamin K antagonists (AVK). We evaluated if blood pressure (BP) control can influence AT strategy in an Internal Medicine Department.
Materials and Methods: In a retrospective study we evaluated all patients with non valvular AF diagnosis in the first 6 months of 2017. Following data were recorded in each subject: age, sex, hospitalization time, AC therapy before, during and after discharge. CHA2DS2vasc, HASBLED e ATRIA score were calculated along with BP control, hemoglobin and creatinine values. INR range was recorded in AVK treated subjects and any potentially interfering drugs were also taken into account.
Results: 297 patients were considered. 63% of the new AF diagnosis were discharged in DOACs, while only 36% in the pre existing AF group. 21% of all patients had BP values >140/90, while 53% <these values. Non significative differences were observed in AT strategy within the two BP groups.
Conclusions: BP control does not seem to interfere with AT choice. Even if DOACs have a better safety profile there is still a great inertia in switching AF patients from AVK to DOACs, while a greater propention towards DOACs is shown in newly diagnosed AF.

Clinical development of Acquired Hemophilia: a case report

A. Ferretti[1], V. Mazzi[1], S. Del Ghianda[1], A. Busoni[1], A. Camaiti[1]

[1]Medicina Generale, Livorno, Italy

In October 2017 a diabethic 77 year old man presented to our department because of diffuse subcutaneous ecchimoses and anemia (Hb 7,8 g/dl). After evaluation of a very low factor coagulant activity (0.8%) and no correction at Mixtest we suspected acquired hemophilia. The presence of an antifactor VIII inhibitor (3.25 Bethesda Unit) confirmed the diagnosis. Patient received initially Prednison and then associated with cyclophosphamide in addition to bypassing agents reaching an improvement of laboratory test and clinical stabilisation. After a month patient was readmitted to our department for sepsis with blood culture positive for Enterococcus faecalis and treated with Ceftriaxone. In February 2018 he was subjected to surgical drain because of a hip replacement infection with subsequent dislocation surgically reduced. After administration of Cefditoren patient developed a rash and an increase in corticosteroid therapy has become necessary. A month later patient noticed swelling of the left lower limb and color doppler ultrasound confirmed extended femoral thrombosis (the value of VIII factor was normal) that requested anticoagulation treatment with LMWH in following months.
Conclusions: Our case presentation is to remind that acquired hemophilia (and associated treatment) may cause severe complications (not only infectious), in remission too, with an high impact on burden of care.

The great pretender

M. Finocchi[1], M. Giampieri[1], M. Ronchetti[1], E. Blasi[1], G. Zaccagnini[1], L. Maddaluni[1], M.S. Rutili[2], T. Fintoni[2], L. Corbo[1], C. Nozzoli[2]

[1]Università degli Atudi di Firenze; [2]AO Universitaria Careggi, Firenze, Italy

Background: Spinal cord metastasis are a rare localisation of oncologic disease (0.9-2.1%).Among them Intramedullary spinal cord lesions without primary bone involvement are even more less described.We had to manage a case of small cell lung cancer whose first manifestation was an anterior medullary syndrome.
Case report: A 65 years old man was admitted to our ED complaining about right limb hypoesthesia, pain and inability to walk. One month before he remembered a pruritic vescicular rash on his right thigh.Physical examination showed sensory ataxia, lower limb dysmetria and dysesthesia with a possible segmental level to L1. Monolateral symptoms and no motorial involvement excluded acute transverse myelitis (infarction, varicella zoster and other infections).An EMG and a brain CT were performed and they excluded brain and SNP involvement.At the laboratory, no alterations were found, including normal respiratory exchange.After few days acute urinary retention appeare.Spinal MRI reveald an intramedullary neoformation at D11-D12 level without any evidence of vertebral alterations.Meantime a lung parenchima alteration was underlight so a thoracic CT was performed: at the pulmonary hilum multiple confluent lymphadenopathy were present and they invade both left superior lobar artery and bronchus.Diagnosis was challenging, since a lymphoma was likely, but histologic examination revealed SCLC.

Conclusions: SCLC is a great mime.This case has been challenging because of its rapid clinical evolution and its polymorphous presentations that suggested multiple differential diagnosis.

Un raro caso di ganglionopatia non paraneoplastica... e non solo

A. Fioranelli[1], N. Tarquinio[1], M.S. Del Prete[1], C. Palmieri[1], G. Filippi[1], M. Lucesole[1], M. Burattini[1]

[1]UOC Medicina Interna, PO di Osimo "S.S. Benvenuto e Rocco", INRCA-IRCSS, Osimo (AN), Italy

Introduzione: La ganglionopatia subacuta è una patologia di rara osservazione in Medicina Interna, considerata una sindrome paraneoplastica
Caso clinico: Donna, aa 55, ricoverata da PS per atassia ingravescente da 15 gg, parestesie mani da 3 gg. Fumatrice, assunzione moderata di alcool, mastectomia radicale sn+svuotamento ascellare nel 2003 (CHT+radioterapia). Familiarità per k mammario. E.O: marcata astenia, no deficit motori, ROT diffusamente ipoevocabili. TC encefalo negativa. EMG/ENG: compatibile con ganglionopatia diffusa. TC total body: no masse/linfoadenomegalie. Ispessimento parietale di alcune anse digiuno–ileali+digiunalizzazione ileo. RMN tenue: no ispessimenti. EGDS: esofagite da reflusso tipo A. Colonscopia+istologia: no lesioni; flogosi acuta/cronica, immagini di pericriptite/criptite neutrofila. Calprotectina++. Liquor-. Negativa ricerca HIV, HBV, HCV, sierologia autoimmune, anticorpi antineuronali. In corso di ricovero scompenso cardiaco acuto a FE intermedia+insuff. resp tipo 1 (FE vsx:41%, ipocinesia del SIV+apice); BNP: 964. Insufficienza mitralica moderata-severa. Buona risposta a diuretico. Ripetuta EMG, confermata la diagnosi, somministrate Ig ev 20g x 5 gg: miglioramento atassia. Dopo sospensione alcool/fumo, rivalutazione ambulatorio nostra UO scompenso cardiaco+eco: pz asintomatica, normalizzazione FE. Solo deficit di prensione dopo cicli di Ig ev,
Conclusioni: Caso esemplificativo di complessità: patologia rara (ganglionopatia), peraltro non associata a neoplasia attiva, associata a patologia "insidiosa" più frequente, non ad essa correlata (cardiomiopatia alcolica, reversibile con sospensione etanolo).

A case of Miliary pattern after intravesical *Bacillus Calmette-Guérin* immunotherapy for superficial bladder cancer

C. Fischetti[1], A.M. Schimizzi[1], G. Passarini[2], M. Cavina[1], N. Camppelli[1], A. Ali[1], M. Candela[1]

[1]UOC Medicina Interna, Ospedale Carlo Urbani-Jesi, Area Vasta 2, ASUR Marche; [2]UO Radiologia e Diagnostica per Immagini, Ospedale Carlo Urbani-Jesi, Area Vasta 2, ASUR Marche, Italy

Background: Intravesical instillation of BCG is widely used for treatment of superficial bladder tumors and carcinoma *in situ*. BCG has proved to be more effective in the prophylaxis and treatment than most chemotherapeutic agents. Considering that BCG is a living organism, systemic side effect such as pneumonitis, hepatitis and systemic BCG infection, may result.
Case report: A 79 years old man with a recent intravesical BCG therapy for a superficial bladder cancer presented to department of Internal Medicine for a fever. Despite the administration of intravenous antibiotics, fever continued. Serologic tests show lymphopenia and elevated C reactive protein. Due to recent BCG therapy the patient was treated by steroid therapy for the suspect of immune-mediation reaction with a clinical improvement. Mantoux test and QuantiFERON-TB Gold In-Tube test were negative. No mycobacteria were grown from fluid culture (blood, urine and bronchoalveolar lavage). A computerized tomography (CT) of the chest showed a miliary lung diffusion without relevant pathology for the abdomen and pelvis. The patient began therapy with rifampicin, isoniazid and pyrazinamide.
Conclusions: Disseminated Mycobacterium bovis is an uncommon side-effect of intravesical BCG immunotherapy witch creates a significant diagnostic problem inpatients that present with fever generalized symptoms. It support that clinical isolation of mycobacterium on tissue, fluid culture and computer tomography study in patients who have undergone intravesical BCG therapy must be included in their workup.

A case of mitral valve endocarditis in a patient with previous aortic valve replacement

C. Florenzi[1], M. Giampieri[1], M. Ronchetti[1], L. Maddaluni[1], G. Galante[1], E. Antonielli[2], S. Baroncelli[2], E. Blasi[1], F. Pieralli[3], C. Nozzoli[2]

[1]Medicina per la Complessità Assistenziale 1, AOU Careggi, Università degli Studi di Firenze; [2]Medicina per la Complessità Assistenziale 1, AOU Careggi, Firenze; [3]Subintensiva di Medicina, AOU Careggi, Università degli Studi di Firenze, Italy

A 79 year old woman, with arterial hypertension, aortic stenosis treated with aortic valve replacement with CABG, anxious depressive syndrome, previous cutaneous SSc and PMR, came to our ED for five-day fever (up to 39°C) with shiver, headache, nausea, dry cough and presyncope. She had started empirical antibiotic therapy with cefuroxim. Blood exams showed mild normocytic anaemia and thrombocytopenia, normal leukocyte count and PCT, elevated INR and CRP. Urinalysis revealed microhematuria. Chest X-ray didn't show acute lung consolidations. Multisensitive Enterococcus faecalis was isolated on multiple blood cultures. TTE and TEE documented an image suggestive of vegetation on native mitral valve. We started targeted antibiotic therapy with ampicillin and gentamicin, with early decrease in temperature. Blood exam revealed negativization of CRP. Echocardiographic follow-up showed persistence of a mobile vegetation after three weeks. PET confirmed the presence of pathological tissue with higher glucose metabolism on mitral valve. CCTA and coronary angiography documented high grade coronary artery calcification. Considering high operative risk, we continued conservative treatment. After one month of therapy, TEE revealed vegetation decrease. We discharged the patient when afebrile, with indication for ATB therapy with oral amoxicillin and day hospital iv gentamicin. One month after hospital discharge, the patient remained afebrile. TEE showed further vegetation decrease in absence of mobile components. ATB therapy was stopped and echocardiographic follow-up was planned.

Between Scilla and Cariddi: a case of recurrent pulmonary embolism in a patient with post-traumatic intracranial haemorrhage

M.C. Fontana[1], S. Ballestri[1], A. Marrazzo[1], G. Cioni[1]

[1]Medicina Interna, Pavullo nel Frignano, AUSL Modena, Italy

Background: Current guidelines do not help physicians in the management of life-threatening pulmonary embolism (PE) in patients with a recent major haemorrhage. Anticoagulants, theoretically contraindicated, might increase the risk of re-bleeding while no treatment might increase the risk of recurrent PE.
Case report: A 81 years-old female with cognitive impairment and history of PE on warfarin treatment, was admitted for head trauma after falling. Brain computed tomography (CT) showed subarachnoid haemorrhage (SAH) and intracerebral haemorrhage (ICH). Prothrombin complex concentrate was given for urgent anticoagulation reversal and pneumatic compression stockings were started. At day 7 she had sudden dyspnea with severe hypoxic respiratory failure due to acute bilateral PE detected by CT. PE risk was intermediate-high. Lower limbs compression ultrasound was normal. Unfractionated heparin (UFH) was started in order to control therapeutic range and have a reversal agent available. At day 12 she was shifted to intermedium-dose low-molecular weight heparin (LMWH) (enoxaparin 4000U b.i.d.). At day 14 she had recurrent PE, thus UFH was restarted. At day 17, once she was clinically stable, Dabigatran 110 mg b.i.d. was started. At day 24, after a normal brain CT scan, she was discharged fully recovered.
Conclusions: A treatment dilemma exists in patients with PE after a recent ICH. Given the lower incidence of ICH with direct oral anticoagulants, their use appears reasonable after a course of UFH. We deemed Dabigatran the safest choice because a specific reversal agent is available.

Un caso di sepsi a partenza biliare sostenuta da patogeni MDR: percorso diagnostico-terapeutico

P. Fortini[1], A. Brazzi[1], S. Mariano[1], V. Cancelloni[1], S. Gonnelli[1], C. Caffarelli[1], R. Nuti[1]

[1]Policlinico Santa Maria delle Scotte, Siena, Italy

Premesse: La sepsi è definita come una disfunzione d'organo causata da una risposta non regolata ad un evento infettivo. Le infezioni da patogeni MDR determinano un incremento della mortalità e della degenza.
Caso clinico: Uomo di 39 anni ricoverato per febbre presente da alcuni giorni e peggioramento delle condizioni generali. In anamnesi: tetraplegia post incidente stradale; colecistite trattata con colecistectomia e impianto di stent biliare, complicata da grave insufficienza respiratoria richiedente tracheostomia. L'esame obiettivo, gli elevati valori di globuli bianchi, di procalcitonina, degli indici di colestasi e di SOFA score, associati al riscontro strumentale di dilatazione delle vie biliari ed inginocchiamento dello stent, hanno fatto porre diagnosi di sepsi biliare. E' stata iniziata terapia antibiotica empirica con Piperacillina/ Tazobactam e Gentamicina. Il persistere di febbre ed elevati indici di flogosi ci ha indotto,dopo 36 ore di terapia, a sostituire Piperacillina/Tazobactam con Merrem;eseguita ERCP non efficace. Le emocolture sono risultate positive per Klebsiella oxytoca, resistente a Piperacillina/Tazobactam, e per C. parapsilosis trattata con echinocandina. Posizionato drenaggio biliare percutaneo, il paziente è progressivamente migliorato.
Conclusioni: La sepsi costituisce una delle principali cause di mortalità tra i pazienti ospedalizzati: un tempestivo e corretto percorso diagnostico-terapeutico rappresenta l' elemento fondamentale per migliorare l'outcome dei pazienti.

Tutto ciò che sembra una sepsi non è una sepsi

N. Franzolini[1], S. De Carli[1]

[1]SOC Medicina Interna, S. Daniele del Friuli (UD), AAS3 Alto Friuli-Collinare-Medio Friuli, Italy

Introduzione: La procalcitonina (PCT) è un marker in pazienti con sepsi. Elevate concentrazioni hanno una buona sensibilità e specificità per la diagnosi di infezioni batteriche in pazienti febbrili.
Caso clinico: Una giovane donna veniva accolta per febbre associata a riscontro di insufficienza renale acuta (IRA) e anemia. Nei giorni antecedenti veniva segnalato episodio di dolore addominale associato a vomito e diarrea autolimitatosi in 48 ore. La paziente presentava dall'età di 18 anni storia di episodi febbrili autolimitantesi. All'ingresso la paziente era apiretica, ipotesa, tachipnoica e tachicardica. L'obiettività addominale, articolare e neurologica erano negative. Gli esami di laboratorio eseguiti in ingresso evidenziavano leucocitosi, anemia, piastrinopenia, incremento di PCR (27 mg/dl) e PCT (38 ng/ml). Si associavano IRA con disionie. Non vi erano segni di emolisi. Veniva avviata terapia antibiotica nell'ipotesi di un quadro di sepsi severa a partenza non determinata, successivo trasferimento in Area di Emergenza per supporto aminico. Dopo 72 ore comparivano febbre, rash al decollete, artralgie polidistrettuali ed evidenza ecografica di versamento pleurico e pericardico. La ferritinemia era di 1016 ng/ml. Gli esami colturali, le sierologie, l'autoimmunità risultavano negativi. Nel sospetto di malattia di Still veniva avviata terapia steroidea con rapido miglioramento delle condizioni cliniche della paziente.
Conclusioni: Nei pazienti febbrili con malattia di Still la procalcitonina può essere aumentata anche in assenza di un evento infettivo intercorrente.

Non una banale otite...

S. Fruttuoso[1], F. Fabbrizzi[1], L. Menicacci[1], A. Torrigiani[1], A. Fanelli[1], S. Digregorio[1], G. Scocchera[1], V. Scotti[1], L. Burberi[1], A. Morettini[1]

[1]Medicina Interna, OACA 2, Firenze, Italy

L'otite esterna maligna è una rara infezione invasiva necrotizzante del CUE, dell'osso temporale e della base cranica causata da *P. aeruginosa*, specie in anziani, diabetici o immunodepressi, con prognosi non infrequentemente infausta (mortalità fino al 30%). .. anni; ipertensione arteriosa, DM tipo II, pregressa epatite B. Da Giugno 2018 otalgia sx con otorrea purulenta trattata con amoxicillina-a.clavulanico e medicazioni in ambulatorio ORL, necessitante un primo ricovero ad inizio Agosto con implementazione di antibiosi (ceftriaxone+cotrimossazolo); colturale da CUE negativo. A fine Agosto accesso in DEA e ricovero presso la nostra SOD per comparsa di deficit periferico del VII n.c. sx. Alla TC del massiccio facciale flogosi del CUE sx con rimaneggiamento erosivo delle pareti mastoidee esteso fino alla cavità glenoidea con sublussazione del condilo, associato a lesione necrotizzante di orecchio medio e interno. All'RM rocche petrose confermata la flogosi del CUE con interessamento fino alla mastoide ed impregnazione a livello del m. temporale e della III porzione del n. faciale. Al tampone auricolare profondo isolata *P. aeruginosa* toti-S; esame istologico inconcludente. Iniziata antibiosi a base di piperacillina-tazobactam+ceftazidima con progressivo miglioramento clinico, con diminuzione di dolore ed edema facciale e ricanalizzazione del CUE; residuata la paralisi del VII n.c. sx. Il trattamento prevede l'utilizzo di antibiosi antipseudomonas per almeno 6 settimane; nelle fasi avanzate può essere indicata la bonifica chirurgica. Il ruolo dell'O2 iperbarico è dibattuto.

Utilizzo dei DOACs nel real world della Medicina Interna

R. Furloni[1], D. Biondi[2], M. Miclini[1], G. Galbassini[1], M. Mendeni[1], M.L. Ghirardelli[1], S. Molinari[1], A. Patroni[1], D. Richini[1], M. Scarsi[1]

[1]UO Medicina Ospedale Valle Camonica, Esine (BS), ASST Valcamonica; [2]UO Medicina Ospedale Iseo (BS), ASST Franciacorta, Italy

Premesse e Scopo dello studio: La terapia anticoagulante costituisce il trattamento cardine per la cura e la prevenzione delle malattie trombo-emboliche e delle patologie vascolari in generale. L'introduzione degli anticoagulanti ad azione diretta (DOACs) nella pratica clinica, sta progressivamente mutando l'approccio al trattamento della Fibrillazione Atriale.
Materiali e Metodi: Abbiamo valutato 197 pazienti consecutivi con diagnosi di FA nel periodo gennaio 2015-gennaio 2018. Tutti i pazienti sono inseriti nel database AIFA per l'utilizzo dei farmaci anticoagulanti ad azione diretta (DOACs), con shift da TAO a DOACs, shift da aspirina a DOACs o introduzione *de novo* di DOACs. Rivalutazione clinica a 30 giorni, definizione dei parametri clinici ed ecocardiografici; i valori di CHA2DS2-VASc score e HAS-BLED hanno definito lo score di rischio.
Risultati: Età media 78.2±10.5; maschi (49.7%) femmine (50.2%); Hb:11.9±0.4 gr/dl, creatinina 1.1±0.4 mg/dl, Cr clearance: 52.2±12.0 ml/min, CHA2DS2-VASc score: 4.1±1.2, HAS-BLED: 2.4±0.6, volume atriale sin (LAV): 62.7 ml±15.2. I DOACs utilizzati: Rivaroxaban (66.4%) Edoxaban (5.0%), Apixaban (6.0%), Dabigatran (22.3%). FA parossistica (35%), FA permanente (59%), FA persistente (6%). Comorbilità: Ipertensione arteriosa (96.4%), Scompenso cardiaco (31.3%), Cardiopatia ischemica (32.5%), Diabete mellito (18.2%) Anemia (53.8%), IRC valutata con Cr clearance (94.4%); shift TAO/DOACs (39.5%), shift ASA/DOACs (29.3%), DOACs *de novo* (68.8%), DOACs in corso all'arruolamento (31.2%).
Conclusioni: Sono ancora numerosi i pazienti con fibrillazione atriale che assumono impropriamente ac. acetilsalicilico come prevenzione cardioembolica; i pazienti anziani e anche i grandi anziani hanno tollerato bene la terapia con DOACs, a sottolineare la sicurezza ed efficacia dei DOACs anche nel piano clinico reale.

Idiopathic retroperitoneal fibrosis: a case report

M. Gagliano[1], E. Cioni[1], G. Bandini[1], E. Martinelli[1], P. Mercatelli[1], M. Zavagli[1], I. Bertoletti[1], G. Barbarisi[1], C. Marchiani[1], F. Crudele[1], N. Palagano[1], P. Bernardi[1], A. Moggi Pignone[1]

[1]Medicina per la Complessità Assistenziale IV, AOU Careggi, Firenze, Italy

Introduction: Idiopathic retroperitoneal fibrosis (IRPF) is characterized by extensive fibrosis throughout the retroperitoneum, resulting in entrapment and obstruction of retroperitoneal structures, notably aorta and the ureters. It is associated with autoimmune diseases and its response to corticosteroids (CS) and immunosuppressants (IS) suggest that is probably immunologically mediated. The evaluation of IRPF includes ruling out secondary RPF

due to malignancy, infections, radiotherapy, surgery and drugs.
Case report: We admitted a 77 years old male with a recent history of back pain, oliguria and hypertension. ABG revealed metabolic acidosis and severe iperkaliemia, blood exams showed high serum creatinine and the patient had to be dialyzed urgently. An abdomen CT scan reveled a retroperitoneal fluid collection surrounding both ureters with an upstream dilatation of both urinary tracts. An abdomen MR confirmed the suspect of IRPF. Bilateral ureteral stenting and nephrostomy were required and the patient was dismissed with CS.
Conclusions: IRPF is a rare cause of acute renal failure (ARF). The diagnosis requires a high degree of suspicion because symptoms are non specific. Obstruction of the ureters, leading to varying degree of renal insufficiency, is the earliest and most common sign. The first goal of treatment is the relief of ureteral obstruction and ARF. CS are the first-line therapy and are rapidly effective. However, they can also fail to induce mass regression and IS have to be considered but it is still debated whether they actually potentiate CS efficacy.

Casual detection of hilar-mediastinal lymphoadenophaty and pulmonary fibrosis in a polytraumatized patient

G. Galante[1], L. Maddaluni[1], M. Giampieri[1], C. Florenzi[1], G. Zaccagnini[1], O. Para[1], G. Degl'Innocenti[1], M. Finocchi[1], F. Pieralli[2], C. Nozzoli[1]

[1]ACA, Careggi, Firenze; [2]Subintensiva Pieralli, AOU Careggi, Firenze, Italy

The diffuse interstitial lung diseases are a group of pathologies characterized by flogistic-fibrotic processes determining a compromission of pulmonar gas exchanges due, in most of cases, to aspecific symptoms such as dyspnea and asthenia thus diagnosis is often late and difficult. A 53 years old man was admitted to the emergency room after a car accident. The thoracic-CT, in addition to trauma related consequences, revealed some unexpected findings: a lung parenchymal fibrotic streak and multiple mediastinal swelling lymphnodes tending to confluence. Suspecting an interstitial disease serological tests, BAL with coltural and cytology research, a lymphnode biopsy were carried out. The biopsy showed an hystological pattern compatible with sarcoidosis, according to radiological findings. So, although the patient's hospitalization for emergency-traumatic reasons, the Internal Medicine inquire has lead to an unexpected diagnosis, moreover in a subclinical early phase, with prognostic and therapeutics benefits. This case underlines the importance of an holistic point of view and the necessity of hospitalist in all clinical setting.

Scompenso cardiaco congestizio e diabete insipido

G. Galli[1], S. Fascetti[2], V. Annoni[1], C. Bellotto[1], L. Bertolucci[1], D. Carrara[1], S. Ciaccio[1], A. Cioppi[1], L. Credidio[1], P. Nigro[1], D. Taccola[1], P. Fabiani[1]

[1]AUSL Toscana NO, Ospedale Versilia, UOC di Medicina Generale; [2]AUSL Toscana NO, Ospedale Versilia, UOS di Geriatria, Lido di Camaiore (LU), Italy

Introduzione: Lo scompenso cardiaco congestizio ed il diabete insipido comportano alterazioni del bilancio idro-elettrolitico. Data la rarità della patologia ipofisaria non vi sono indicazioni di gestione terapeutica combinata.
Caso clinico: Donna di 73 anni con storia di sella vuota e diabete insipido centrale isolato in terapia con desmopressina (D) 60 mcg e di cardiopatia ipertensivo-fibrillante in terapia con ramipril 5 mg, bisoprololo 2,5 mg e rivaroxaban 20 mg. Nelle ultime settimane contrazione della diuresi, aumento ponderale e comparsa di dispnea per sforzi moderati. Radiologicamente: versamento pleurico destro e congestione polmonare. All'ecocardiografia: normale FE, iniziale disfunzione diastolica ed ingrandimento atriale. A livello laboratoristico: NT-proBNP elevato, valori di sodiemia ed osmolarità plasmatica ai limiti bassi della norma.. Veniva introdotta terapia con furosemide (F), ridotta la D a 45 mcg, iniziata dieta a controllato intake di sodio e moderata restrizione idrica. E' stato osservato miglioramento clinico ed alla dimissione veniva mantenuta la ridotta dose di D e l'aggiunta di F a basso dosaggio. I successivi controlli clinici dimostavano buon compenso emodinamico e pressorio, stabile bilancio idrico, normale funzione renale ed elettroliti nella norma.
Conclusioni: A livello renale la terapia sostitutiva con D attiva il recupero osmotico di acqua libera, mentre la terapia diuretica con F porta a perdita urinaria di acqua, sodio e potassio. Nel paziente con entrambe le patologie è necessario modulare le terapie su entrambi i fronti per ottenere un adeguato bilancio idrico ed elettrolitico.

Genotype 5, 6 and mixed HCV infections in the interferon-free era: the neglected ones?

E. Garlatti Costa[1], A. Berto[2], A. Rosso[1], S. Grazioli[1], R. De Rosa[2], A. Camporese[2], M. Tonizzo[1]

[1]Department of Internal Medicine, Pordenone; [2]Department of Microbiology and Virology, Pordenone, Italy

Introduction and Aim: Clinical trials on efficacy of interferon free therapy for HCV infection included genotypes most prevalent in Europe but the data on genotype 5, 6 and mixed HCV infections are scarse. The aim is to assess the prevalence of these genotypes in our patients and to estimate the efficacy of Direct Antiviral Agents.
Materials and Methods: Between January 1, 2015 and May 31, 2018, patients with genotype 5, 6 and mixed HCV infections treated in our center, were identified.
Results: Of 540 patients, 4 Italian subjects (3 males and one female) had chronic hepatitis C sustained from genotype 5. Median age was 58 years old. One patient had blood transfusion while all others had dental cares in their past history as risk factor for HCV infection. Liver disease was mild and ALT were persistent normal (<40 U/L). In these patients, we did not registered comorbidities associated and they were all naive to previous therapy. Treatment with glecaprevir/pibrentasvir for 8 weeks was prescribed and sustained virological response was reached. We reported two cases of mixed infections (genotype 1+genotype 3 and genotype 1a+genotype 4) in two Italian males with liver cirrhosis (Child A) treated successfully with sofosbuvir/velpatasvir for 12 weeks. No genotype 6 infection was found.
Conclusions: In our cohort of patients, genotype 5, 6 and mixed HCV infections are uncommon. Pangenotypic treatment for the cure of these genotypes plays an important role. Larger studies in different countries are needed to define if epidemiological features combined with these infections exist.

A body shape index and body roundness index: relationship between new anthropometric adiposity indices and carotid atherosclerosis

G. Geraci[1], M.M. Zammuto[1], R. Gaetani[1], T. Attardo[2], G. Augello[2], S. Cottone[1], G. Mulè[1]

[1]Dipartimento Biomedico di Medicina Interna e Specialistica, Università di Palermo; [2]PO "Barone Lombardo", Canicattì (AG), Italy

Background: A Body Shape Index (ABSI) and Body Roundness Index (BRI) are new anthropometric adiposity indices recently proposed in order to overcome the limits of traditional obesity markers. They have shown to correlate with adipose abdominal tissue better than BMI and to predict the onset of diabetes and the risk of premature death. Little is known about the influence of ABSI and BRI on subclinical vascular damage, and in particular on carotid atherosclerosis.
Materials and Methods: 468 patients with hypertension were enrolled; adiposity indices were calculated (BMI, WC, ABSI, BRI) and carotid ultrasonographic examination was performed to detect atherosclerotic damage (IMT or atherosclerotic plaque). Population was divided in tertiles based on BMI (<25; 25-30; ≥30 kg/m2).
Results: Subjects with higher BMI showed a higher BRI and ABSI than subjects with lower BMI (p<0.001). BRI, but not ABSI, was higher in subjects with IMT >0.90 mm, whereas patients with carotid plaques showed higher values of ABSI (p=0.001) as well as of BRI (p=0.003). Linear regression analysis disclosed significant correlation of IMT with ABSI, BRI and BMI (all p<0.001). In the multivariate analysis BMI independently correlated with cIMT (p=0.011), and similar results were obtained

with BRI (p=0.015). ABSI did not show any independent association with cIMT. However, ABSI, neither BRI nor BMI, was strongly associated with carotid plaques in multiple logistic regression analysis.
Conclusions: ABSI may be proposed as a better correlate of carotid atherosclerosis than the traditional measures of adiposity.

Un caso di astenia da chinoloni

L. Giampaolo[1], G. Eusebi[1], M.G. Finazzi[1], L. Ghattas[1], P. Montanari[1], L. Poli[1], A. Salemi[1], D. Tirotta[1], R. De Giovanni[1]

[1]Medicina, Cattolica (RN), ASL Romagna, Italy

Introduzione: I chinoloni fluorurati hanno recentemente acquisito un "black box alert" del FDA per seri effetti su tendini, muscoli, nervi, SNC. In letteratura sono disponibili numerosi casi di miopatia indotta da chinoloni, con presenza di debolezza quale sintomo cardine. Occasionalmente i chinoloni possono evidenziare una miastenia gravis. In alcuni casi il disturbo non è reversibile, si possono associare depressione e neuropatia nel quadro della sindrome da disabilità associata a chinoloni (FQAD).
Caso clinico: Ad uomo di 35 anni sono state prescritte 4 settimane di Levofloxacina per una prostatite da E. Coli. Dopo 3 settimane di trattamento il paziente lamentava intensa astenia e facile faticabilità, prevalente ai cingoli. L'esame obbiettivo mostrava un punteggio di 2 al SUSS test (Sit Up Squat Stand), indicativo per debolezza. Erano presenti buon trofismo muscolare e stato nutrizionale, il restante EO era nei limiti. E' stata sospesa la levofloxacina. Agli esami biochimici gli enzimi muscolari risultavano ai limiti superiori della norma (nella norma flogosi, funzione renale, elettroliti, TSH, anti recettore AcH). E' stata effettuata anche RMN del rachide cervicale e dorsale (rifeirta rachialgia dopo incidente stradale 16 mesi prima) risulata nn. Dopo 4 settimane da sospensione di levofloxacina si è osservata una progressiva notevole riduzione dell'astenia. Era stata programmata EMG, annullata dal paziente per risoluzione del disturbo.
Conclusioni: Tra gli effetti avversi dei chinoloni deve essere sempre ricordata la possibile tossicità muscolo-scheletrica.

An unusual cause of fever of unknown origin

M. Giannetti[1], V. Iacopetti[1], M.C. Bertieri[1], C. Gigli[1], R.C. Gravili[1], Q. Lucchesi[1], C. Sterpi[1], G. Tintori[1]

[1]SC Medicina Interna, Valle del Serchio, PO Barga, AUSL Toscana Nordovest, Barga (LU), Italy

A 51-years old woman was admitted to our hospital for persistent fever for about one month, associated with asthenia, headache, hypophonia and pharyngodynia, initially treated with antibiotic therapy, without benefit. At the clinical examination we found a strong tenderness in the thyroid loggia, where an enlarged thyroid gland and a hard wood consistency was appreciated. The ultrasound study of the neck showed enlarged thyroid gland, with an inhomogeneous and hypoechoic echostructure and reduced vascularization. Blood tests showed lymphocytosis, elevated values of erythrocyte sedimentation rate at 119 mm/h and C-reactive protein 8.95 mg/dL. Thyroid function tests showed elevated levels of free thyroxine FT4 (2.48 ng/dL; normal range 0.9-1.7 ng/dL), suppressed thyroid stimulating hormone TSH (0.01 µUI/mL; normal range 0.27-4.20 µUI/mL), elevated thyroglobulin (385.20 ng/mL; normal range 3.5-77 ng/mL) and normal levels of antithyroglobulin antibodies. These blood tests, associated with patient's clinical history, symptoms and neck ultrasound results, confirmed the diagnosis of subacute thyroiditis, or DeQuerven thyroiditis, an inflammatory disease of the thyroid gland, caused by viral infection. Although viral infection indexes are often not found, sub-acute thyroiditis has a viral origin, since a) often manifests itself in conjunction with viral epidemics; b) is often preceded by an infection of the upper respiratory tract; c) patient complains prodromal symptoms such as asthenia, myalgia, fever. Is usually self-limiting with restitutio-ad-integrum. The therapy is based on the use of corticosteroids such as prednisone, at the initial dose of 0.5-1 mg/kg/day to decrease gradually; therapy must last at least 30 days. The thyrotoxicosis is transient and does not require therapy. Our patient was treated with prednisone, initial dose 25 mg/day, with remission of symptoms after 2 days of treatment and normalization of blood tests and ultrasound pattern after 30 days.

A rare complication of antithyroid drugs

C. Giannoni[1], A.M. Pizzini[1], S. Dapporto[1], S. Zaccaroni[1], C. Mancusi[1], C. Cavoli[1], M. Silingardi[1]

[1]Dipartimento Medico, Ospedale Maggiore, Bologna, Italy

Background: Antithyroid drugs (Methimazole and Propylthiouracil) have adverse hematological effects, ranging from mild leukopenia to agranulocytosis and aplastic anemia.
Case report: We present a 59-year-old woman receiving Methimazole for Grave's disease (30 mg/die). She was hospitalized for fever up to 39°C and headache. Chest X Ray was normal while leukocytes was 0.8 x 10^9/L, neutrophilis 1.2% (150 µL), RCP 14 mg/dl. Methimazole was then stopped and hyperthyroidism controlled with beta-bloker. After failed response to empiric antibiotics (Ceftriaxone and Levoxacin), antiviral and granulocyte colony-stimulationg factor, a positron emission tomography scan (PET) was taken with evidence of a voluminous hypercaptant mass between pectoral and axillary region in the left side. The collection was drained with a purulent discharge. Microbiological examination was negative while white blood cell count has gradually increased to 7.1 x 10^9/L.
Conclusions: Agranulocytosis, defined as a marked decrease in the number of granulocytes <500/µL, is a rare (0.1-0.5%) and life-threatening complication of antithyroid drug. The lungs are the most common organ to be infected, but also other organs can be involved. The subcutaneous tissue is rarely involved and the diagnosis of infection can be difficult. The PET can be a valid aid to discover the site of infection, as in our case. Alternative way to control hyperthyroidism is surgery or radioactive iodine.

Un raro caso di sindrome emolitico uremica dopo intervento di sostituzione di valvola mitralica con protesi meccanica

M.C. Giofrè[1], S.A. Pignata[2], N. Laganà[3], A. Mirto[1], G. Zerbi[1], G. Grippaldi[1], G. Mammi[1], G. Ielasi[1]

[1]Cardiologia, Casa di Cura Madonna della Consolazione, Reggio Calabria; [2]Dipartimento delle Scienze Biomediche Odontoiatriche e delle Immagini Morfofunzionali e Funzionali, Università degli Studi di Messina; [3]Dipartimento di Medicina Clinica e Sperimentale, Università di Messina, Italy

Premesse: La sindrome emolitico uremica (SEU) include anemia emolitica microangiopatica, trombocitopenia e insufficienza renale acuta. Si distingue una forma tipica, dovuta all'E.Coli, e una atipica per attivazione della via alternativa del complemento. Si riporta un caso di SEU dopo intervento di sostituzione di valvola mitralica stenotica con protesi meccanica.
Caso clinico: Dopo protesizzazione mitralica, una donna di 85aa veniva ricoverata presso la nostra Cardiologia. All'ingresso presentava ittero, astenia, ecchimosi al dorso, aritmia, mv medio basale abolito. Dal laboratorio emergeva: anemia, piastrinopenia, indici di citolisi aumentati, alterata funzionalità epatica e renale. La diagnosi differenziale era posta tra trombocitopenia da eparina, porpora trombotica trombocitopenica, anemia emolitica da rottura meccanica dei globuli rossi attraverso la protesi valvolare. Ai test di II livello: negatività di Coombs test, markers epatici e dell'autoimmunità. Attività ADAMS3 del 36%, livelli di C3 ridotti, microematuria, protenuria e presenza di schistociti su sangue periferico. L'imaging ecografico evidenziava buona funzionalità valvolare. Con diagnosi di SEU, la paziente veniva inviata alla UO di Nefrologia per plasmaferesi e somministrazione di Eculizumab, risolvendo la sintomatologia.
Conclusioni: La SEU entra in diagnosi differenziale con patologie, che hanno un comune denominatore: la trombocitopenia. Per una corretta diagnosi è necessario considerare il paziente nella sua globalità e correlare la semeiotica clinica, bioumorale e strumentale.

Allungamento del QTc: un ulteriore fattore di rischio cardiovascolare nel paziente iperteso e diabetico? I nostri dati

M.C. Giofrè[1], S.A. Pignata[2], R. Nava[1], N. Laganà[3], A. Fortiguerra[1], M. Fazio[1], G. Ielasi[1]

[1]Cardiologia, Casa di Cura Madonna della Consolazione, Reggio Calabria; [2]Dipartimento delle Scienze Biomediche Odontoiatriche e delle Immagini Morfofunzionali e Funzionali, Università degli Studi di Messina; [3]Dipartimento di Medicina Clinica e Sperimentale, Università di Messina, Italy

Premesse e Scopo dello studio: Il QTc lungo ha eziologia congenita o acquisita. Abbiamo studiato la probabilità di rischio di sviluppare QTc lungo in pazienti con ipertesione (IPA), fumatori e non, dislipidemici e non, e con diabete mellito di tipo 2 (DM II). E' stato inoltre valutato se la componente infiammatoria (PCR, conta piastrinica) potesse influenzare la durata del QTc.
Materiali e Metodi: Sono stati arruolati 195 pazienti con età media 57±1,76, affetti da IPA e non, con associato DM II e/o dislipidemia afferenti all'ambulatorio di cardiologia. I criteri di esclusione erano: malattie infiammatorie croniche, squilibri elettrolitici, cardiopatia ischemica, fibrillazione atriale, blocco di branca sn. È stata eseguita visita con ECG ed ecocardio, esami ematochimici con dosaggio della PCR e conta piastrinica. Il metodo statistico usato è stato quello di Pearson.
Risultati: Il QTc è risultato lungo nel 57% di pazienti con IPA, il 62% di questi era affetto da cardiopatia ipertensiva. L'allungamento era direttamente correlato all'età, alla PCR e al numero delle piastrine. proporzionale. I pazienti con IPA e DM avevano un rischio 4 volte superiore di QTc lungo rispetto ai soli ipertesi. Il rischio era 112 volte superiore quando vi era un incremento della PCR.
Conclusioni: lo studio dimostra come l'ECG di superficie sia capace di fornire elementi utili sulla conduzione elettrica, e sottolinea l'importanza del calcolo del QTc nella routine ambulatoriale al fine di valutare il rischio cardiovascolare nei pazienti con IPA e/o DM ed aumento degli indici di infiammazione.

La meningite da *Listeria monocytogenes* in un adulto immunocompetente: un caso clinico nel Dipartimento d'Emergenza

D. Giordani[1], M. Fanzutti[2], F. Pertoldi[2]

[1]Scuola di Specializzazione in Medicina d'Emergenza-Urgenza, Università degli Studi di Udine; [2]Pronto Soccorso e Medicina d'Urgenza, San Daniele del Friuli (UD), Italy

Premessa: Listeria monocytogenes è un batterio Gram+ trasmesso per ingestione di cibo contaminato. La meningite da Listeria si riscontra di solito in neonati e pazienti anziani immunocompromessi, raramente in adulti sani. In Italia l'incidenza di meningite è circa 34 casi/anno.
Descrizione del caso clinico: Una donna di 57 anni si presenta in PS per cefalea, febbre, vomito comparsi da 12 ore. In anamnesi, una tiroidectomia per neoplasia; non assunzione di cibi a rischio. L'obiettività è negativa. Per un lieve aumento dei globuli bianchi con PCR negativa, è trattenuta in osservazione. Al peggioramento dei sintomi, aumento degli indici di flogosi e comparsa di lieve rigidità nucale, con TC encefalo negativa, si esegue una rachicentesi: liquor torbido, rapporto glicorrachia/glicemia ridotto (27%), proteine aumentate (937 mg/L) e 600 leucociti/μL. Si avvia terapia antibiotica empirica per meningite batterica. La diagnostica su liquor e le emocolture mostrano un'infezione da Listeria monocytogenes. Si adegua la terapia antibiotica (ampicillina+gentamicina). Si assiste al progressivo miglioramento clinico e laboratoristico; dimessa dopo 23 giorni a completa risoluzione del quadro. Viene eseguita una RMN di follow-up, dopo 3 settimane, negativa.
Conclusioni: La listeriosi può determinare sequele neurologiche. In questo caso, nonostante l'atteggiamento attendista per la clinica inizialmente sfumata, si è avuta la guarigione completa. Si conferma l'importanza della terapia empirica per Listeria anche nel paziente adulto immunocompetente con meningite fino agli accertamenti colturali.

Candida infective endocarditis: risk factors and clinical management

P.G. Giuri[1], R. Ricceri[2], R. Cornacchia[2], G. Prampolini[2], E. Scalabrini[2], E. Carretto[3], G. Magnani[4]

[1]SOS Medicina Infettivologica, Dipartimento Internistico Interaziendale, Reggio Emilia;[2]UIM di Medicina Interna, Ospedale S. Anna, Castelnovo Ne' Monti (RE);[3]Microbiologia, Arcispedale Santa Maria Nuova, IRCCS, Reggio Emilia;[4]Malattie Infettive, Arcispedale Santa Maria Nuova, IRCCS, Reggio Emilia, Italy

Background: Infective endocarditis (IE) is a high-mortality disease (>50%) with severe complications. We may suspect a fungal etiology by Candida spp. in prosthetic valves IE or in native valves IE (NV-IE) associated to risk factors as intravenous drug abuse or immunodeficiency.
Case report: 75-year-old man with a history of hypertension, dyslipidemia and squamous cell carcinoma on the right side of the base of the tongue, in chemo-radiotherapy (until October 2018) with a midline intravenous catheter. In November 2018 he was admitted to Hospital for fever and diffuse pulmonary consolidation, then treated with Piperacillin/Tazobactam therapy after confimation of Escherichia Coli bacteremia. Since the persistent low-grade fever, he repeated blood coltures that were positive, after 48 hours, for Candida Albicans with multidrug sensitivity. So we started antifungal intravenous therapy with fluconazole 12 mg/Kg/day, as loading dose, then 6 mg/Kg/day as mainteinance dose. At the same time, we removed the midline. Then we performed a fundus oculi examination, Beta-D-glucan detection and transesophageal echocardiography, positive for native mitral valve vegetation of 9 mm. Then we changed fluconazole to micafungin 200 mg/day for ten weeks.
Conclusions: NV-IE by Candida often affects patients with venous catheters, with or without other risk factors. Echocardiography studies should be perfomed in patients with blood coltures positive for Candida spp.

Regressione di severa sindrome psicorganica dopo eradicazione di HCV

A. Grassi[1], S. Maccariello[1], N. Celli[1], G. Donati[1], A. Fabbri[1], G. Ballardini[1]

[1]Medicina Interna ed Epatologia, Ospedale Infermi, Rimini, Italy

Paziente maschio, 55 anni, ex tossicodipendente. Epatite cronica HCV correlata nota da circa 25 anni, genotipo 3. 1995: trattamento antivirale con interferone: sospeso dopo 3 settimane per l'insorgenza di diabete mellito. 2015: biopsia epatica: steatosi, G10, F2. 2017 seguito dal SerD per disassuefazione da alcol. 2018: comparsa di disturbi della marcia con frequenti cadute a terra e disturbi del comportamento. 2018: Ricovero per sincope. EEG: anomalie lente irritative prevalenti a sinistra. TC encefalo: modesta atrofia cerebrale. RM encefalo: sfumata alterazione di segnale iperintenso a livello della corteccia insulare compatibile con encefalite di verosimile natura erpetica. Rachicentesi: negativa per virus erpetici ed altre patologie infettive ed infiammatorie acute. Ecografia addominale: epatomegalia steatosica senza segni di malattia epatica evoluta. Esami di laboratorio: Emocromo, funzione epatica, funzione renale: nella norma. Criocrito positivo; HCV RNA positivo. CDT, etanolemia, dietilglucuronide urinario: negativi. In considerazione del possibile ruolo di HCV, nella genesi del danno neurologico viene prescritta terapia con glecaprevir+pibrentasvir 3 cps/die per 8 settimane. Dimesso con diagnosi: Sindrome psicorganica ad insorgenza acuta di n d d in epatopatia cronica HCV correlata. Dopo 4 settimane: HCV RNA negativo con progressivo miglioramento del quadro neurologico. Dopo 6 mesi: EEG, quadro neurologico e psichiatrico normali. HCV RNA e criocrito negativi.
Conclusioni: I disturbi neuropsichiatrici in corso di infezione cronica da HCV non sono affatto infrequenti. In questo paziente la sindrome psicorganica era difficilmente riconducibile alla semplice astinenza alcolica. L'eradicazione di HCV è risultata consensuale alla regressione del quadro neuropsichiatrico rafforzando l'ipotesi del ruolo patogenetico esercitato da HCV in tal senso.

Macrohematuria: two different diagnoses, one sign

O. Grassi[1], G. Alessandro[1], M.G. Amadeo[1], R. Padalino[1], C. Ternavasio[1], A. Valvano[1], T. Candiani[1]

[1]General Medicine Geriatric ASST WEST Milanese Italy

We describe two curious cases of patients arrived at the Emergency Department of our hospital in apparent health status with common evidence of recurrent macrohematuria. Both with negative objective examination and blood tests performed urgently in negative. No specific daily therapy. Asymptomatic. Case 1: 25-year-old young woman reports a trip to Tanganica 2 months earlier, with macrohematuria for about 2 weeks. The attending physician prescribed therapy with Amoxicillin and Clavulanate in the suspicion of cystitis, without benefit. Urine stick GR +++, GB ++, proteinuria ++. Urine and BK sediment were required as an outpatient procedure. Discharged without therapy. Case 2: 40-year-old man also with macrohematuria from about two years Negative urine stick. The urine, CTM, PSA and BK sediment is required to be performed as an outpatient procedure. The clinical revaluation occurred after a month as described in the minutes of the PS: - the woman presented schistosomiasis in the urinary sediment and was sent to the Infectious Diseases Clinic where she started treatment with Praziquantel, -the man presented negative required tests, he was sent to the Urological Outpatient department where, after performing angio abdominal tomography, he was diagnosed with S. Nutcracker.

An unusual cause of metabolic coma end electrolyte imbalance in helderly

O. Grassi[1], M.G. Amadeo[1], G. Alessandro[1], C. Ternavasio[1], R. Padalino[1], A. Valvano[1], T. Candiani[1]

[1]General Medicine Geriatric, ASST WEST Milanese, Italy

90 year old woman arrives at the emergency room of our hospital in a coma with relapsing myoclonias. APP: reported diarrhea with low-grade fever. APR: mute. On-site evidence of severe hypokalemia (K2.16 mmOl/l), hypomagnesemia (0.2 meq/l) and metabolic alkalosis. Negative instrumental examinations. He was admitted to medicine and after therapy aimed at correcting rhabdomyolysis the patient showed no clinical improvement. The diagnostic confirmation came with the verification of the electrolytes lost in the urine of 24h, hyperpotassiuria (190 meq); hypermagnesiuria (69.4 meq) hypocalciuria (13.8 mg) and hyperaldosteronism (...). Post diagnosis of Barter-Gitelman syndrome (unusual in old age). Infusion therapy was started with Mg ++, K +, and steroid. After 4 days the patient appeared vigilant, collaborating, with slow and progressive stabilization of the electrolyte. The patient's clinical history was reconstructed, describing recurrent feelings of fatigue, muscle cramps during fever and episodes of concomitant diarrhea and vomiting. The patient was discharged on the 18th day with electrolyte supplementation. At the outpatient check (one month), improvement of the general conditions and improvement of the quality of life was confirmed. It is a salt-losing tubulopathy of an autosomal recessive disorder caused by a mutation of the SLC12A3 gene and in a minority of the patients with the phenotype for GS a gene mutation has been identified CLCNKB. The prevalence is estimated at 25/million with about 1% of the Caucasian carrier population Heterozygous.

Un caso di tumore intraduttale papillare mucinoso del pancreas in un paziente anziano

W. Grimaldi[1], E. Bertani[1], F. Caccavale[1], N. Mumoli[1]

[1]UO Medicina-Geriatria, Ospedale di Magenta, ASST OVEST Milanese, Italy

Premessa: I tumori intraduttali papillari mucinosi del pancreas (IPMT) sono caratterizzati dalla proliferazione di cellule mucinose all'interno dei dotti pancreatici. Gli IPMT dal punto di vista prognostico si dividono in 3 forme: centrali, periferici e misti. Rappresentano le neoplasie cistiche pancreatiche più comuni, con prevalenza del 10% nella popolazione con età >di 65 anni.
Caso clinico: M di 78 aa ricoverato per comparsa di astenia agli arti inf. In APR: IPA e steatosi epatica All'EO vigile, orientato T/S, con itterosclero-cutaneo. Obiettività cardiorespiratoria nei limiti. Addome trattabile, non dolorabile alla palpazione. Blumberg -. Agli EE Hb 11,4 g/dl, elevati indici di colestasi (ALP 253 U/l, GGT 221 U/l), transaminasi (AST 223 U/l, ALT 473 U/l) e iperbilirubinemia totale (4,4 mg/dl, diretta 3,5 mg/dl). All'ECO addome colelitiasi con vie biliari indenni. Markers neoplastici negativi. All' ERCP riscontro di colelitiasi e lieve dilatazione del dotto di Wirsung, Alla colangio RMN formazioni cistiche pancreatiche di 2,4 cm in comunicazione con il dotto di Wirsung senza enhancement, compatibili con IPMT. L'ECOendoscopia bilio-pancreatica confermava presenza di lesione focale cistica (2,5 x 1,9 cm) tra testa e corpo pancreatico compatibile con IPMT del dotto principale pancreatico modestamente dilatato con coledoco e papilla di Vater regolari.
Conclusioni: Per la terapia le lesioni cistiche con segni ad alto rischio devono essere asportate chirurgicamente; per le lesioni cistiche con caratteristiche di allerta si consiglia un follow up stretto (trimestrale) mediante colangioRMN; mentre per le lesioni senza segni di allerta o di alto rischio è utile un follow up annuale mediante colangioRMN come indicato nel caso clinico del nostro paziente. Alcuni studi hanno dimostrato una correlazione tra presenza di IPMT e aumento dell'incidenza di neoplasie extrapancreatiche (es. colon-rettali) e di neoplasie pancreatiche di tipo duttale.

Heyde syndrome in Internal Medicine Unit

A. Grittini[1], E. Venegoni[1], L. Pavan[1], M. D'Urbano[2], N. Mumoli[1]

[1]Department of Internal Medicine, Magenta Hospital, Magenta (MI); [2]Department of Cardiology, Magenta Hospital, Magenta (MI), Italy

Introduction: The Heyde Syndrome is featured by association between calcific aortic stenosis and gastrointestinal bleeding from vascular latent malformations due to the consumption of Von Willebrand' factor. In our Operative Unit during last year we hospitalized 20 patients with calcific aortic stenosis; 4 (20%) out of those showed severe anemia from gastrointestinal bleeding therefore it was appropriate to proceed with endoscopic exams and blood transfusions but not with cardiac surgery of valvulopathy. Herewith we are presenting the first clinical case where we diagnosed the Heyde syndrome and suggested the surgical treatment that allowed to settle the anemia problems.
Clinical case: 77 years old, female, with severe calcific aortic stenosis (a mean aortic valve gradient of 44 mmHg and with aortic valve area of 0,7 cm2) waiting for TAVI any time postponed due to anemia persistence, with numerous hospitalizations for blood transfusions. She has been hospitalized due to a further anemia. Due to the presence of hidden blood in feces it was executed gastroscopy and colonoscopy without any evidence of bleeding sources; the endoscopic pill-cam was not performed due to sudden and transitory worsening clinical scenario. At that point the patient has been transfer to the Cardiac surgery Department in order to have aortic valvuloplasty surgery; the Von Villebrand's factor has not been investigated.
Comments: Due to the aging of the population and related increase of calcific aortic stenosis incidence in patients often having antiplatelet or anticoagulant therapy and with the presence of anemia, it is always necessary to speculate about the Heyde syndrome. An appropriate diagnosis together with an immediate surgery approach notwithstanding the anemia would suggest to postpone it could obtain a reduction in hospitalisation and decrease of endoscopic exams, saving in blood transfusions practice and especially the improvement of patients' prognosis quoad vitam et valetudinem.

Spunti di riflessione: gli ultranovantenni nell'ospedale per intensità di cura

L. Guarducci[1], A. Giani[1], S. Zanieri[1], T. Lazzarotto[2], V. Panetta[3], S. Tombelli[2], V. Vigna[2], M. Bernetti[1], M. Bertoni[1], I. Bracali[1], A. Foschini[1], P. Lotti[1], R. Martini[1], T. Restuccia[1], F. Risaliti[1], A. Tammone[1]

[1]Medicina Interna 2, Ospedale Santo Stefano, Prato; [2]Corso Post Laurea, Università di Firenze; [3]Scuola di Specializzazione Medicina d'Urgenza, Università di Firenze, Italy

Premesse e Scopo dello studio: L'invecchiamento della popolazione e le comorbidità costituiscono una grande sfida per la me-

dicina interna e della sanità pubblica. Le migliori condizioni di vita e di assistenza sanitaria hanno allungato la sopravvivenza delle persone affette da patologie croniche. L'organizzazione sanitaria è ancora prevalentemente strutturata per accogliere i bisogni del paziente acuto piuttosto che il cronico.
Materiali e Metodi: Dalle cartelle cliniche del 2018 degli ultranovantenni degenti presso la SOC Medicina 2, abbiamo estrapolato dati relativi a età media, sesso, grado di autonomia, n° dei caregiver, farmaci assunti al domicilio, procedure diagnostiche effettuate nel ricovero, provenienza (RSA o domicilio) e destinazione alla dimissione (rientro al domicilio, RSA o Hospice).
Risultati: Gli ultranovantenni rappresentavano il 13,9% (65% femmine); il 74% aveva perso l'autonomia funzionale, disponendo mediamente di 2,5 caregivers. Assumevano al domicilio in media 6,4 farmaci. L'87% proveniva dalla propria casa ma alla dimissione solo il 69% vi faceva ritorno (il 30,5 veniva istituzionalizzato e il 3,6% veniva inviato in Hospice). Nel corso della degenza venivano sottoposti mediamente a 2,5 esami strumentali.
Conclusioni: Una elevata percentuale di pazienti anziani, fragili e con disabilità accedono all'ospedale per acuti; in una elevata percentuale di casi al ricovero seguono la lungodegenza e le cure di fine vita. Ciò solleva interrogativi sull'appropriatezza della gestione delle risorse e sull'attuale necessità ri-organizzativa del sistema sanitario.

To be or not to be: a rare case of acute pancreatitis

L. Incorvaia[1], D. Morana[1], S.A. Neri[1], I. Timpanaro[1], C. Sgroi[1], C. Virgillito[1], C. Di Mauro[1], M. Callea[1], R. D'Amico[1], M. Crisci[1], F.R. Arcerito[2], I. Morana[1]

[1]UO Medicina Interna, Area Critica, ARNAS Garibaldi, Catania; [2]UOC Radiodiagnostica, AOE Cannizzaro, Catania, Italy

Introduction: Diagnosis of acute pancreatitis (AP) is made with two of three criteria (abdominal pain, increase of lipase or amylase, radiological signs), although AP with normal enzymes is rare. Radiological mesentery abnormality is described. Since several diseases affect mesentery, biopsy may be necessary. A rare complication of AP is vascular damage with portal venous system thrombosis and vessel erosion, pseudoaneurysm formation and rupture resulting in massive bleeding.
Clinical case: A 51 years old man came to our attention for abdominal pain with leukocytosis and CRP elevation. CTscan showed enlargement and dishomogeneity of the pancreas head, mesenteric vein thrombosis and thickened and irregular mesenteric tissue. Percutaneous mesenteric biopsy was performed and antibiotical and anticoagulant therapy started. Two day after, exacerbation of abdominal pain and hemorrhagic shock occurred. AngioCT showed pseudoaneurysm of pancreatic-duodenal artery branch, right paracolic hematoma and celiac tripod thrombosis. Arteriography confirmed pseudoaneurysm with active bleeding, which was embolized. Histology finally showed fibrin, rare granulocytes and some vessel. Then, the presence of abdominal pain and pancreas CT abnormality (two criteria for AP diagnosis), vascular impairment (thrombosis/bleeding) and mesenteric inflammation, led us to diagnosis of AP with vascular complications.
Conclusions: Although uncommon, AP can occur with normal enzymes. Vascular complications are rare. Early diagnosis and management is important, with increasing role of interventional radiology.

Phlegmasia cerulea dolens: un caso clinico

G. Italiano[1], A. Maffettone[2], T. D'Errico[3], A. Gargiulo[4]

[1]IPAS Immunopatologia, UO Medicina Interna, AOC Caserta; [2]IPAS Diabetologia, AOC dei Colli, Napoli; [3]DH Ambulatorio di Reumatologia, UO Medicina Interna, ASL Na1; [4]Direttore UO Medicina Interna, AOC Caserta, Italy

La Phlegmasia Cerulea Dolens (PCD) è una complicanza della trombosi venosa prossimale. Interessa entrambi i circoli venosi (profondo e superficiale) con aumento della pressione interstiziale compressione dei piccoli vasi arteriosi e conseguente ischemia.
Caso clinico: Maschio a. 53, anamnesi di artrite reumatoide, in PS per febbre con dolore e tumefazione dalla caviglia sinistra; ecodoppler arti inferiori nella norma;esami di laboratorio lieve aumento degli indici di flogosi e dell'aPTT: 52 sec (v.n 28-40 sec). Rapido instaurarsi di un progressivo edema dell'arto con cianosi, dolore. Un nuovo esame doppler evidenzia una estesa trombosi venosa profonda della vena femorale e della safena con trombosi delle comunicanti. Polsi pedidei flebili. Grave ipotensione. Acidosi metabolica. Eparina calcica EV, ciononostante si impone la necessita di amputazione dell'arto inferiore sinistro per occorrenza di gangrena venosa.
Conclusioni: PCD è una rara condizione che occorre in <1% delle trombosi venose profonde; più del 90% dei pazienti ha una sottostante neoplasia(50% occulta). Il 50% dei pz si complica con un quadro di gangrena venosa che richiede una amputazione dell'arto nel 30-50% dei casi con una mortalita' del 20-40% . Le trombosi determinano l'occlusione completa del drenaggio venoso (sistema profondo e superficiale) con aumento della pressione capillare conseguente essudazione del fluido nello spazio interstiziale e formazione di vesciche ematiche cutanee. L'arto assume una colorazione bluastra ("cianosi blu"); aspetto patognomonico oltre al dolore e la tumefazione. QUESTA È UNA EMERGENZA!! i pazienti devo essere trattati con eparina ev ed avviati rapidamente a trombectomia chirurgica. Diversamente se il dolore è lancinante, l'edema e' esteso, c'è stravaso di liquidi dalla cute e soprattutto se si instaura un deficit sensitivo-motorio dell'arto ci troviamo di fronte ad una condizione irreversibile il cui trattamento e' l'amputazione per gangrena venosa.

Fibrillazione atriale: causa misconosciuta di embolia polmonare?

N. Laganà[1], M.C. Giofrè[2], S. Pignata[3], M. Russo[4], D. La Rosa[1], A. Caruso[1], M.C. Tringali[1], M. Chiappalone[1], M. Gigliotti[1], A. De Gaetano[1], F. Napoli[1], A.G. Versace[1]

[1]Dipartimento di Medicina Clinica e Sperimentale, AOU G. Martino, Messina; [2]Reparto di Cardiologia, Casa di Cura Policlinico Madonna della Consolazione, Reggio Calabria; [3]Dipartimento di Scienze Biomediche Odontoiatriche e delle Immagini Morfologiche e Funzionali, Messina; [4]Reparto Medicina d'Urgenza, Ospedale Piemonte, Messina, Italy

Premesse e scopo dello studio: Si indaga la relazione tra la fibrillazione atriale non valvolare (FA)e l'embolia polmonare (EP) nei pazienti con dispnea al fine di confermare la relazione di causalità tra FA ed EP. E'stato indagato se PAP ed EGA correlano come variabili indipendenti con l'EP in presenza di fibrillazione atriale e se ci sono differenze significative tra EP massiva e microembolia.
Materiali e Metodi: Sono stati selezionati 15 pazienti con FA di nuova insorgenza non in terapia con anticoagulante, dimero positivo e senza fattori di rischio per tromboembolismo venoso. Sono statti eseguiti ECG, EGA, ecocardiogramma, scintigrafia polmonare perfusionale.
Risultati: 11 dei 15 pazienti avevano l'EP, di cui embolia polmonare massiva, 7 microembolia. L'assenza di tipiche alterazioni ECGrafiche, la mancata dilatazione delle camere destre, la normalità della frazione d'eiezione non esclude l'embolia polmonare. L'EGA (PCO2 e D(A-a)) si è confermato strumento valido nel sospetto diagnostico dell'EP nei soggetti affetti da FA.
Conclusioni: Si conferma il possibile ruolo causale della FA nell'EP. Nella FA il riscontro di tromboembolismo del piccolo circolo è frequente, soprattutto in forma microembolica. La microembolia ha importanza prognostica perchè è indice di stato protrombotico, dal quale possano esitare fenomeni tromboembolici responsabili di embolie massive. Quindi già il riscontro di trombi in atrio destro o di microembolia alla scintigrafia potrebbero costituire un'indicazione all'inizio di terapia specifica anticoagulante per la profilassi del rischio tromboembolico.

But how many antibodies! A complex case

A. Laria[1], A.M. Lurati[1], P. Faggioli[2], K.A. Re[1], M. Marrazza[1], D. Mazzocchi[1], A. Tamburello[2], L. Castelnovo[2], A. Mazzone[2]

[1]Fornaroli Hospital, Rheumatology Unit, Magenta (MI); [2]Internal Medicine Unit, Ospedale Civile Legnano (MI), Italy

Man affected by untreated Systemic lupus erythematosus (SLE) un-

derwent to our clinic for acute renal failure (ARF)/hypercalcemia (hyperCa). Were present lymphopenia, anemia, proteinuria and raised acute phase reactants. Chest X ray was normal. There were aspecific presence of alloantibody, anti-erythrocyte positivity; low complement; presence of Lupus anticoagulant, AntiDNA/AntiSSA/SSB/antiSm and antiRNP. Hemotransfusion and supportive therapy were performed. Fever with shaking chills and pulmonary inflammatory thickening appeared. A broad-spectrum antibiotic therapy was started. Because of atypical thoracoalgia ischemic disease/pulmonary thromboembolism were excluded. Thorax CT scan showed several thickening with cavitation/bilateral pleural effusion. Bronchoalveolar fluid was negative for bacteria, BK or malignant cells. QuantiFERON Test was undetermined, CMV-DNA and galactomannan were negative; atypical ANCA were positive. For anemia and thrombocytopenia steroid boli were started. A clinical worsening with hypotension, desaturation and hemoptysis appeared. Chest HRCT showed multiple areas of parenchymal confluent thickening. Patient was transferred to intensive care unit for mechanical ventilation. Disseminated intravascular coagulation was excluded; antiplatelet antibodies were positive, all serology and culture for respiratory patogens were negative. CD64 counts/ANCA/Anti-membrane antibodies were negative. Which the possible diagnosis?Hemorrhagic alveolitis in SLE?Goodpasture Syndrome?Microscopic Polyangiitis? We concluded for a probable hemorrhagic alveolitis in SLE with severe thrombocytopenia. Methylprednisolone 1 gr/day iv for 5 days associated with Cyclosporine were started; severe thrombocytopenia contraindicated plasma exchange. After steroid boluses Chest X-Ray showed radiological picture unchanged. Patient was transferred for Extracorporeal Membrane Oxygenation but an acute aortic valve rupture occurred with exitus.

A strange case of hypertension with high variability

M.T. Lavazza[1], C. Marchesi[1], S. Speroni[1], C. Ferrari[1], A. Mazzone[1]

[1]UO Medicina Interna, Ospedale di Legnano, ASST Ovestmi, Italy

Subclavian steal syndrome is a form of peripheral artery disease which may be a marker of underling diffuse atherosclerotic disease. It can manifest as symptomatic ischemia affecting the upper extremities, the brain and heart. We described a case of 78 year old man, with diabetes mellitus, hypertension, hypercolesterolemia, previous bladder cancer, presented to our Unit for fever, cough and pleural effusion. An antimicrobial treatment was started; due to persistence of fever and dyspnea, a pulmonary CT scan was performed with evidence of pleural empyema treated with surgical pleural drainage. During the 2 weeks hospital stay, he showed significant inter-operator variability in blood pressure values (in different day and by different operators), leading to continuous interruption and restoration of anti-hypertensive therapy. Thus, he was found to have significant difference in blood pressure between right and left arm (PA 150/100 mmHg on the right arm and PA 90/60 mmHg on the left arm, respectively). Doppler ultrasounds demonstrated steno-occlusion of the left subclavian artery with complete theft of the ipsilateral vertebral artery. When he was questioned about the symptoms, he described the presence of paresthesias at the left upper arm under strain, without any central neurologic disturbances. A CT scan of the brain was found negative for ischemic lesions. A treatment with ramipril, acetylsalicilic acid and simvastatin was started. At the discharge, the patient was advised to measure the pressure on the right arm.

A painful diagnosis delayed by the absence of pain

M. Lillu[1], G. Argiolas[1], W. Cordeddu[1], M.N. Mura[2], D. Firinu[1], F. Marongiu[1]

[1]Department of Medical Sciences and Public Health, University of Cagliari, Cagliari; [2]Internal Medicine, Allergology and Clinical Immunology, University Hospital "Duilio Casula", AOU Cagliari, Monserrato (CA), Italy

Introduction: A 71 years-old man affected by diabetes mellitus and paraparesis due to complete medullar injury was admitted to our Department for intermittent fever, dated from twenty days, treated by his physician with Amoxicillin, without results.
Case report: On physical examination the patient appeared feverish (CT 39°C), no alteration on chest and heart were found, the abdomen was apparently normal, besides the absence of tactile and painful sensitivity due to the medullar injury. Lower limbs muscles were hypotrophic, but the right one appeared slightly increased in volume. On admission a chest radiography and an abdominal ultrasound examination were performed, showing no alteration. Microbiological tests of blood and urines were negative. First blood tests showed a mild anaemia (Hb 10.7 g/dl), evidence of inflammation (WBC 10910/ul, CRP 350 mg/l, PCT 1.98 ng/ml), so an empirical antibiotic treatment (Piperacillin/Tazobactam) was started. Considering the right lower limb swelling and the possibility of an incomplete clinical picture due to the medullar injury an abdominal and lower limbs CT was obtained showing an abscess extended from the right ischium-rectal area to the thigh, involving fascial area and muscles, with evidence of several gaseous bubbles. The patient was urgently transferred to the Surgery Department where a complicated ischium-rectal abscess was drained.
Conclusions: The absence of pain has probably delayed the diagnosis of the abscess, so it could affect adjacent areas, making an urgent surgery necessary.

A rare case of hypogammaglobulinemia in elderly age

M. Lillu[1], G. Argiolas[1], W. Cordeddu[1], M. Torrazza[2], M.N. Mura[2], D. Firinu[1], F. Marongiu[1]

[1]Department of Medical Sciences and Public Health, University of Cagliari, Cagliari; [2]Internal Medicine, Allergology and Clinical Immunology, University Hospital "Duilio Casula", AOU Cagliari, Monserrato (CA), Italy

Introduction: A 87 years-old female, with an initial cognitive worsening was admitted to our Department for fever and cough started after anti-influenza vaccine.
Case report: On admission the patient was feverish, physical examination evidenced a mild bilateral pleural effusion, with crackles on the left lung, without significant alterations on abdomen and heart. A chest-radiography and a successive CT showed a bilateral pleural effusion and a left pneumonia. At laboratory tests, she had mild anaemia (Hb 9.4 g/dl), thrombocytopenia (PLT 100000/ul) and elevation of CRP, (121 mg/l). The serum proteins electrophoresis showed hypogammaglobulinemia, with IgG 310 mg/dl, B_2 microglobulin was increased (2 mg/dl, nv <0.24) and the patient had proteinuria (4600 mg/24 h; albuminuria: 288 mg/24h). We performed the serum free light chains determination with evidence of low lambda chains level (39 mg/dl, nv >90) and elevation of kappa/lambda ratio (4.95, nv <2.65), with absence of lambda chains in the urines; a successive serum/urine immunofixation showed a monoclonal kappa light chain component. The patient started an empirical antibiotic therapy for pneumonia and intravenous Immunoglobulin infusion. Considering the poor expectative of life and the general conditions of the patient we decided, according with family, to not perform a bone marrow biopsy; after pneumoniae resolution the patient returned home, where she died a month later.
Conclusions: The final diagnosis was probably "micromolecular myeloma", with secretion of k light chain only, a rare form of Multiple Myeloma.

A minor head injuries...but not too much

M. Lugarà[1], C. Bologna[1], M.G. Coppola[1], C. Deluca[1], L. Erario[1], F. Fasano[2], F. Granato Corigliano[1], P. Madonna[1], G. Oliva[1], P. Tirelli[1], E. Grasso[1]

[1]UOC Medicina Generale, Ospedale del Mare, ASL Napoli 1 Centro; [2]UOC Neuroradiologia, Ospedale del Mare, ASL Napoli 1 Centro, Italy

In July 2018, an 81 year old Italian man was admitted to our operative unit for a 6 day fever (T C° 39), confusion and disorientation, absence of neurological deficits. In anamnesis, prostate cancer in hormonal treatment and hypertension. The patient's son report 1 month ago, an accidental fall with head trauma in frontal region, assessed at home by the General Practictioner. At the Emergency Room was performed brain tomography that showed an hypodense area in the right parietal site. After 2 days was performed an MRI of the brain with contrast media administration that showed hypointense lesion in T1 and hyperintense in T2 with

central cavitation, in right frontoparietal region, compatible with abscess lesion. During hospitalization were performed Total Body CT scan, negative for neoplastic disease, Echocardiogram, negative for endocarditis, cancer and viral markers: negative, coltures of blood and urine: negative. Elevated phlogosis markers (PCR 15). We have administered empirical antibiotic therapy to the patient with ceftriaxone 2 gr once daily and metronidazole 500 mg three times a day. After 7 days there was resolution of clinical symptomatology and decrease of inflammatory markers (PCR 8). MRI of the brain with contrast media was performed to the patient after 15 days, 1 month and 2 months. After 8 weeks of antibiotic therapy, the radiological control showed resolution of abscess and PCR normalization. We concluded that the abscess development was secondary to the traumatic event.

Leishmaniasis in cirrhotic HBV/HDV coinfected: a smokey case gone to liver transplant

T. Lupia[1], S. Corcione[1], G. Cariti[1], F.G. De Rosa[1]

[1]Malattie Infettive, Università di Torino, Italy

Introduction: New onset pancytopenia opens a wide list of differential diagnosis in clinician mind. Complexity is deeper when the underlying comorbidities masking some peculiarity that can lead clearly to the right diagnosis.
Case report: A 48-years-old east-European woman was admitted to our hospital, for an infectious disease consult complaing about low-grade fever, loss of weight and new onset pancytopenia in a known Hepatitis B (HBV) and Delta Virus (HDV) related-cirrhosis. Her chronic liver disease had a stationary course for the last five years but in her recent past medical history were frequent episodes of clinical liver failure such as ascites, spontaneous bacterial peritonitis and porto-systemic encephalopathy requiring several hospitalizations in medical ward. Hematological and Internal Medicine consults were requested before infectious disease visit, with less lights and more shadows. Clinical, microbiological and anatomo-patological elements were pivotal to define the diagnosis of Visceral Leishmaniasis (VL) and started an appropriate anti-infective treatment. After successful Liposomial Amphotericin B regimen she had an Orthotopic liver transplant (OLT). For prevention of the risk of recurrent VL in recent liver transplantation, a prophylaxis was set for the first six months after transplantation. No signs of reactivation were reported after 12 months of follow-up.
Conclusions: VL is an endemic infection in different regions of Italy and Europe that can lead to a delayed diagnosis in some clinical scenarios. Reactivation after Solid Organ Transplantation was reported in literature and could be a risk of organ rejection.

Role in diagnosis and follow-up of colour duplex ultrasonography of temporal arteries in a case of giant cell arteritis

A.M. Lurati[1], A. Laria[1], P. Faggioli[2], K.A. Re[1], M. Marrazza[1], D. Mazzocchi[1], A. Tamburello[2], L. Castelnovo[2], A. Mazzone[2]

[1]Fornaroli Hospital, Rheumatology Unit, Magenta (MI); [2]Internal Medicine Unit, Ospedale Civile, Legnano (MI), Italy

On February 24 2017 a 79 year-old male was admitted to our Rheumatology Unit for appearance of frontal-temporal headache that it had not advantage of Non-steroidal Anti-inflammatory Drugs. He had not scalp tenderness or jaw claudication or systemic manifestations (fever, weight loss, anorexia, and malaise). Patient had not myalgia or ocular symptoms (such as monocular or binocular vision loss or diplopia or ocular pain). The temporal arteries were painful and thickened. The erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP)values were 71 mm/h (normal range 0-10) and 11.1 mg/dl (normal range 0-5). A B-mode ultrasound of shoulders didn't show subacromial/subdeltoid bursitis or long-head biceps tenosynovitis. The CDU assessment of temporal arteries was performed with a high-resolution linear probe set as defined in literature. Examination of the superficial temporal arteries (the common, frontal, and parietal branches) was performed in longitudinal and transverse planes. We found a hypo echogenic halo of the left temporal artery >0.5 mm in thickness. Moreover, left temporal artery Doppler signal showed the presence of turbulent flow. On the clinical, laboratory, ultrasound findings we formulated diagnosis of GTA and we immediately started therapy in order that avoid retinal damage with blindness. We administered oral prednisone 1 mg/kg and introduced low-dose aspirin The follow up CDU examination was performed 7 days later. The right temporal artery showed similar findings with a marked reduction of halo sign. Temporal Artery Biopsy (TAB) was not performed because of difficulties in reproducibility and because of the presence of bilateral halo sign that has a high specificity in diagnosis of TA suggesting that TAB can be spared by CDUS.

A rare case of hemolytic anemia

V. Maestripieri[1], G. Pinto[1], C. Bazzini[1], I. Fiordelli[1], M. Palazzi[1], T. Sansone[1], G. Panigada[1]

[1]Ospedale SS Cosma e Damiano, Pescia (PT), USL Toscana Centro, Italy

A 44-year-old man went to the ER for jaundice and abdominal pain. In his clinical history he reports alcohol abuse, Mediterranean anemia and previous episodes of jaundice and abdominal pain. Deny use of drugs, it does not take any medication. Blood tests performed in the ER: alcoholemia 3.28 mg/dL, Hb 6 g/dL (MCV 85 fL), platelets 355.000/mm3, creatinine 1 mg/dL, increase in LDH, hyperbilirubinamia (total 13 mg/dL, direct 2.2 mg/dL) and mild hyperkalaemia. The findings were suggestive of haemolytic anemia, confirmed by indosable haptoglobin. Direct and indirect Coombs test was negative and there were no schistocytes in the smear. The spleen was normal in size. Given the history of previous episodes of jaundice, we search for G6PDH deficiency (but it was normal) and we perform hemoglobin electrophoresis, which showed heterozygosity for beta thalassemia. The vitamin B12 dosage showed a marked deficit (70 pcg/ml), triglycerides and total cholesterol were increased. During the hospitalization there was a progressive increase in hemoglobin ad decrease of bilirubin within the normal limit. Due all the examination performed, that showed hemolytic anemia related to alcohol abuse, we diagnose Zieve syndrome, a rare form of haemolytic anemia associated with alcohol abuse and consists of a symptomatology characterized by anemia, jaundice and transient hyperlipidaemia. It is often under-diagnosed, but recognizing this syndrome is important because it saves unnecessary investigations and therapies (such as corticosteroids). The therapy of this syndrome is abstention from alcohol.

Imported fever: a case report

L. Magnani[1], C. Sgarlata[2], G. Buoni o Del Buono[1], M. Carbone[3], P. Cavallo[1], E. Peros[1], V. Perfetti[4], M. Rollone[3]

[1]Azienda Socio-Sanitaria Territoriale di Pavia, UOC Medicina Interna, Ospedale Civile di Voghera, Voghera (PV); [2]Fondazione IRCCS San Matteo di Pavia, UOC Medicina Generale 3, Ecografia Interventistica, Pavia; [3]Azienda di Servizi alla Persona of Pavia, Istituto di Cura Santa Margherita, Pavia; [4]Azienda Socio-Sanitaria Territoriale di Pavia, UOC Medicina Interna, Ospedale di Varzi, Varzi (PV), Italy

Case report: A 44-year-old woman presented to our attention complaining of general malaise, elevated fever (>39°C), head and eye pain, arthralgias and petechial rash on the lower limbs and the chest. Her past medical history was unremarkable. She reported to be recently returned from a trip to her native town in Indonesia. Phyical examination showed normal findings except for the presence of tachycardia (HR=110 pfm. Routine blood tests showed leukopenia (WBC 2300 per mm^3), thrombocytopenia (PLT 93000 per mm^3) and CRP value mild increas (16,3 mg/dl). A broad-spectrum antibiotic therapy (meropenem) was started. An abdominal US showed no pathological findings. Chest X ray was also normal. Blood and urine culture were negative. Autoantibodies were negative. Considering the clinical presentation and the history of a recent travel in a tropical country a clinical suspicion of imported fever was placed. The research of IgM against dengue virus was positive and the detection of dengue virus RNA confirmed a dengue serotype 2 infection. Antibiotic therapy was then sus-

pended; paracetamol was administered for the treatment of fever. Patient's clinical conditions improved rapidly with progressive complete resolution of the symptoms.
Discussion and Conclusions: Dengue infection is still a major health concern and is endemic in 110 countries infecting 50 to 100 million individuals each year in the world. In Italy, like it happened in our case, the infection is usually diagnosed in people returning from endemic areas.

Un indice per la valutazione del carico pressorio. Studio su 4605 report ABPM

G. Malgieri[1], G. Ranaldo[2], M. Di Resta[3], P. Di Santo[4], C. Pellegrino[5], R. Capasso[6], G. Di Santo[2]

[1]Centro Ipertensione, AO "San Pio", PO Sant'Agata de' Goti (BN); [2]UOC Medicina Interna, AO "San Pio", PO Sant'Agata de' Goti (BN); [3]Casa di Cura "Alma Mater-Villa Camaldoli", Napoli; [4]Policlinico Universitario Campus Bio-Medico, Roma,; [5]Università della Campania "Luigi Vanvitelli", Napoli; [6]PhD Department of Precision Medicine, School of Medicine & Surgery, University of Campania "Luigi Vanvitelli", Naples, Italy

Introduzione: Il Carico pressorio (CP) è la pressione che insiste sull'apparato cardiovascolare nell'unità di tempo. Un aumento del CP può comportare una modificazione strutturale delle pareti vascolari e successive complicanze cardio-vascolari. Non esiste allo stato una formula per definirlo, ma ci si riferisce ad aumenti percentuali di pressione arteriosa rispetto ai valori limite. Scopo dello studio è individuare un riferimento numerico che dia informazioni più complete del carico pressorio con ABPM.
Materiali e Metodi: Studio prospettico sui report ABPM di 4605 pazienti, divisi in 4 gruppi: gruppo A con PA <130/80 mmHg; gruppo B con PA >130/80 mmHg; gruppo C con PA sistolica (PAS) >140 mmHg; gruppo D con PA sistolica >150 mmHg. Sono stati calcolati: PAS, PAD, Pressione arteriosa media (PAM) e, indirettamente, la pressione differenziale; DS della PAM; la frequenza cardiaca media (FCM) e la sua DS. Calcolando il rapporto PAM/FCM, avendo la PAM per ogni battito cardiaco, si supera il problema della sindrome da camice bianco, che abbiamo chiamato Quoziente di Normalizzazione (QN). Il CP è stato così calcolato: QN+[0.2 x (DSPAM-DSFCM)/12]
Risultati: I valori dei carico pressorio sono statisticamente differenti tra loro per t di Student (p<.0001). Avendo un riferimento numerico preciso del CP possiamo caratterizzare la gravità della patologia con i dati forniti da un esame ABPM.
Conclusioni: Il QN definisce con maggiore precisione il carico pressorio superando la "sindrome da camice bianco". Tale fattore consente di caratterizzare con maggiore precisione la gravità della patologia cardiaca.

Ariadne's thread

G.F. Manfredi[1], M. Bellan[1], R. Rapetti[1], S. Fangazio[1], C. Smirne[1], M. Pirisi[1]

[1]SC Medicina Interna, AOU Maggiore della Carità, Novara, Italy

Introduction: As in the myth of Theseus and Princess Ariadne, who helped the hero defeat the Minotaur, also in this patient we had to retrace the thread to find the way out of the labyrinth.
Clinical case: A 75-year-old man was admitted to our hospital complaining persistent and widespread abdominal pain from 5 days; except for inappetence, no other symptoms were reported. He had a history of acute lithiasic pancreatitis, ischemic and valvular heart disease treated with CABG and mitral valve plastic, chemoembolization of pseudoaneurysm at the mesenteric artery, performed approximately 8 months earlier, with application of three metal spirals. Abdominal ultrasound revealed the presence of gallstones and biliary sludge, pancreas was not evaluable. A plain abdominal X-ray was normal except for signaling the presence of multiple metal wires in the abdomen. Despite the therapy, the abdominal pain remained unchanged. An EGDS was performed that was negative for ulcers or other injuries. The CT scan reported the presence of a radiopaque wire 2 mm-thicked that extends from the III portion of the duodenum to the hepatic flexure. This wire was referable to the slinking of one of the spirals previously used for the embolization procedure.
Conclusions: The slinking of spirals used in these procedures is a rare complication. In this case, the decubitus first occurred and then the foreign body entered the small intestine; gradually it has been extended by the intestinal peristalsis. A second extended EGDS confirmed the duodenal entry of the wire, with concomitant mucosal ulceration.

Attivazione in Pronto Soccorso di un percorso dedicato ai pazienti anziani fragili

E. Marcante[1], A. Rigo[2], L. Leone[3], P. Donegà[4], N. Annunziata[5], D. Spolaore[5], C. Bertoncello[1], D. Montemurro[6]

[1]Dipartimento di Scienze Cardio-Toraco-Vascolari e Sanità Pubblica, Padova; [2]Direttore DMO Ospedali Riuniti Padova Sud Madre Teresa di Calcutta; [3]Direttore UOC Medicina, Ospedali Riuniti Padova Sud Madre Teresa di Calcutta; [4]UOC Geriatria, Ospedali Riuniti Padova Sud Madre Teresa di Calcutta; [5]UOC Pronto Soccorso, Ospedali Riuniti Padova Sud Madre Teresa di Calcutta; [6]DMO Ospedali Riuniti Padova Sud Madre Teresa di Calcutta, Monselice (PD), Italy

Introduzione: Il DEA degli Ospedali Riuniti Padova Sud accoglie circa 53.000 pazienti/anno: il 30% è rappresentato da ultra 75enni in condizioni di fragilità. Il Coordinamento Regionale Emergenza Urgenza del Veneto ha chiesto di tracciare in via sperimentale un percorso di gestione agevolata di tali pazienti al fine di ridurre i ricoveri ed i rientri a 4 e 30 giorni dalla dimissione, anche tramite la collaborazione con il nucleo di continuità delle cure (NCC).
Materiali e Metodi: Il percorso clinico/assistenziale è rivolto ad utenti fragili con età ≥75 anni e determinate patologie internistiche e prevede specifiche modalità di presa in carico dell'infermiere di triage, del medico di PS, del geriatra e del NCC. Alla dimissione è garantito l'accesso agli ambulatori specialistici e la presa in cura dei medici del territorio. È stato creato uno spazio funzionale adeguato, l'Osservazione Breve Estensiva (OBE), per la gestione di pazienti dimissibili entro 48h.
Risultati: Nel periodo di osservazione giugno-dicembre 2018 sono stati reclutati 249 pz. Il percorso ha determinato una riduzione dei ricoveri del 38% rispetto agli stessi mesi del 2017, dovuta ad un maggiore utilizzo dell'OBE (44% vs 28%) e all'incremento del 28% del tempo medio di permanenza in OBE. Grazie al maggior numero di segnalazioni al NCC, i rientri in PS a 30 gg si sono ridotti del 50% e i rientri a 4 gg sono pari all'8%.
Conclusioni: L'obbiettivo riduzione dei tempi d'attesa non è stato raggiunto, in quanto i traumi, esclusi dal percorso, rappresentano una delle patologie di maggiore rilevanza nella casistica del PS.

Use of edoxaban in a cancer patient

C. Marchesi[1], S. Speroni[1], L. Brivio[1], M.T. Lavazza[1], A. Mazzone[1]

[1]UOC Medicina, ASST Ovest Milanese, Ospedale di Legnano (MI), Italy

A 87 year-old male was referred to our Emergency Department (ED) for worsening of general conditions, dyspnea, and persistent dry cough. He was known to have gastric carcinoma treated with total gastrectomy in the past month; no complications occurred soon after surgery and he was discharged in 10 days. After surgery he was admitted to a nursing home and he had lost physical autonomy. On admission to ED, he was afebrile, heart rate was 96 bpm, blood pressure 130/70 mmHg, respiratory rate 24 bpm and oxygen saturation was 88% on room air. There was neither jugular venous distention nor audible pulmonary murmurs, his left lower extremity was slightly swollen. Chest radiograph showed clear lung fields, Doppler ultrasound of heart and legs revealed normal right heart and intra-luminal filling defects from the left superficial femoral vein to the left popliteal vein. CT scan showed bilateral filling defects in pulmonary arteries, confirming the hypothesis of pulmonary embolism. Patient underwent oncologic evaluation, which excluded specific treatment. He was started on anticoagulation: 7 days of LMWH (enoxaparin 8000 UI sc BID), then switched to edoxaban 60 mg QD (82 kg, serum creatinine 0.88 mg/dL, CrCl 69 ml/min). After 3 months, the patient was doing well with significant improvement in quality of life, without bleeding events. Doppler ultrasound of legs revealed almost complete resolution of the left deep vein thrombosis. Thus, in light of the recent *Hokusai VTE Cancer* trial data, edoxaban may be considered a safe anticoagulation choice for oncologic patients.

Ambulatori Dipartimentali Area Medica: un nuovo modello gestionale per pazienti internistici complessi

M. Marchetti[1], L. Cecchetto[1], L. Sarolo[1], F. Confente[1], A. Biancardi[1], G. Rorato[1]

[1]Ospedale Asiago, ULSS 7 Pedemontana, Asiago (VI), Italy

Premesse e Scopo dello studio: Creazione dell'Ambulatorio Dipartimentale di Area Medica ADAM dove poter seguire in maniera più continua e regolare paziente affetti da patologie croniche gravi ed eliminare il problema della non congruità dei Day Hospital.
Materiali e Metodi: A tale ambulatorio si accede con visita specialistica o tramite valutazione di un medico del reparto. I pazienti vengono gestiti da personale infermieristico dedicato con prelievi, prenotazione esami e visite specialistiche, organizzazione di visite periodiche con lo specialista afferente e somministrazione di terapia. Alla fine del trattamento e del follow-up lo specialista provvederà con lettera di dimissione e consigli diagnostico-terapeutici.
Risultati: I pazienti seguiti dall'ADAM sono portatori di patologie croniche che necessitano di terapie complesse, ma non di ricovero come GHD, acromegalia, NET, AR o altre patologia reumatologiche, anemia con trasfusioni e somministrazioni di ferro, neoplasie tiroidee e osteoporosi complicate e antibiotico terapia a lungo termine. Attualmente presso il nostro ADAM sono in follow-up e terapia 3 pz con acromegalia, 8 pz con p-NET, 15 pz con anemia (trasfusioni e/o ferro), 4 pz patologie reumatiche e 3 pz con osteoporosi complicate e 4 pz in terapia antibiotica a lungo termine.
Conclusioni: Con l'ADAM possiamo quindi seguire in modo completo e facilitato pazienti complessi che, oltre al già gravoso peso della malattia stessa, dovrebbero gestirsi da soli sia le prenotazione di esami che la somministrazione dei farmaci.

Incidentaloma del pancreas (p-NET): un classico caso da team multidisciplinare

M. Marchetti[1], L. Cecchetto[1], L. Sarolo[1], F. Confente[1], A. Biancardi[1], G. Rorato[1]

[1]Ospedale Asiago, ULSS 7 Pedemontana, Asiago (VI), Italy

Premesse: Se fino a qualche anno fa si parlava si incidentaloma surrenalico ora si inizia a parlare di incidentaloma pancreatico in quanto le nuove metodiche radiologiche riescono ad individuare e tipizzare formazioni pancreatiche anche di pochi millimetri. Questo impegna quindi i reparti di Medicina Interna, ed il paziente stesso, in un tortuoso percorso tra valutazioni multidisciplinari, diagnosi ed eventuali terapie al fine di chiarire la natura di queste lesioni.
Caso clinico: Maschio 68 aa in follow-up per pluripatologie endocrine. Anamnesi: nel 2007 tiroidectomia totale per adenoma micro-macro follicolare; nel 2008 asportazione di adenoma ipofisario TSH secernente; ipertensione arteriosa; pregressa uretrotomia per stenosi uretrale. A Luglio 2018 per sospetta calcolosi renale esegue TC addome con riscontro incidentale di formazione nodulare della testa del pancreas di 1 cm. Esegue quindi ad Agosto 2018 RMN addome che la caratterizza come formazione neuro-endocrina del pancreas. Successivamente esegue PET Ga-DOTATOC che conferma trattarsi di NET pancreatico e PET FDG, che non mostra significativo aumento del metabolismo glucidico. Inviato in valutazione presso Chirurgia del Pancreas veniva consigliata ecoendoscopia con FNAC. Il paziente eseguiva valutazione per PRRT. Il viene valutato dal team multidisciplinare.
Conclusioni: Secondo le linee guida (p-NET <2 cm) tale paziente viene messo in follow-up. Resta da valutare se iniziare terapia con analoghi della somatostatina, come terapia adiuvante, anche se vi sono ancora forti evidenza in letteratura.

Gestione della terapia anticoagulante orale con edoxaban nella trombosi venosa distale isolata

P.G. Mariani[1], A. Fiorentini[1], C. Meschini[1]

[1]ASL Viterbo, Italy

Introduzione: La terminologia trombosi venosa distale (TVDI) indica le trombosi venose localizzate nel circolo sotto-popliteo. I dati presenti in letteratura circa l'epidemiologia e l'evoluzione clinica sono caratterizzati da grande eterogeneità. Concorde è il fatto che la TVDI è associata ad un minore rischio di recidiva rispetto alla TVP. L'incertezza circa la rilevanza clinica ed il rischio associato alla TVDI è alla base del disaccordo circa la diagnosi e il trattamento della stessa. Le linee guida dell'ACCP contemplano due opzioni terapeutiche in pazienti con TVDI: terapia anticoagulante o monitoraggio ecografico seriato.
Materiali e Metodi: Criteri di inclusione: diagnosi di trombosi venosa profonda distale diagnosticata da non più di 5 giorni. Braccio 1 → Edoxaban 60 mg per 3 mesi, dopo iniziale trattamento con EBPM per almeno 5 giorni. Braccio 2 → Edoxaban 60 mg per 1 mese, dopo iniziale trattamento con EBPM per almeno 5 giorni; seguito da Edoxaban 30 mg per 2 mesi. Braccio 3→ EBPM per 3 mesi.
Obiettivi: Obiettivo principale: frequenza di eventi trombo-embolici valutati a 1 e 2 anni; frequenza di sanguinamenti maggiori e/o minori valutati a 1 e 2 anni. Obiettivo secondario: percentuale di pazienti con veno-occlusione residua.
Conclusioni: In considerazione del minore rischio di recidiva e dell'evoluzione "benigna" della TVDI rispetto alla TVP ci attendiamo una non inferiorità in termini di frequenza di eventi trombo-embolici associato ad una maggiore sicurezza espressa in termini di sanguinamento nel braccio 2 rispetto al braccio 1 e 3.

A case of neuro-Beçhet

E. Martinelli[1], P. Mercatelli[1], G. Bandini[1], F. Crudele[1], M. Zavagli[1], I. Bertoletti[1], G. Barbarisi[1], N. Palagano[1], E. Cioni[1], C. Marchiani[1], M. Gagliano[1], P. Bernardi[1], A. Moggi Pignone[1]

[1]Medicina per la Complessità Assistenziale IV, AOU Careggi, Firenze, Italy

Background: Beçhet disease is an inflammatory disorder characterized by several systemic manifestations. Neurologic disease (neuro-Beçhet) occurs in less than 10% of patients and it is observed more frequently in men than in women. Although on average the neurologic symptoms of Beçhet syndrome appear 5 to 6 years after the onset of the disease, in about 7% of the cases they can appear concurrently or even precede non-neurologic features.
Case report: A 41-year-old male patient was admitted to our hospital presenting acute right hemisensory loss, slight deficit of right facial nerve, tinnitus, postural instability, headache and low fever. Blood tests showed lymphocytosis. Infectious, autoimmune and inflammation markers resulted negative. There were no relevant findings in EMG, PEM, PESS and CSF analysis. Brain MRI showed a small hyperintense area in T2-weighted images in the right cerebral peduncle. During the follow up the patient developed oral and genital aphtae, and resulted positive to tissue HLAB51 typing. On the basis of clinical presentation, neurological evaluation, MRI and test results the most plausible diagnosis is a neurological presentation of Beçhet disease.
Conlcusions: Neurological symptoms in a young male patient entail a careful differential diagnosis, since alternate diagnoses, such as multiple sclerosis, Lyme disease or neuro Beçhet are progressive, invalidating conditions that may benefit from early treatment. Thus correct interpretation of clinical and instrumental findings combined with a close follow up are paramount for the best possible outcome.

An atypical onset of chronic myelomonocytic leukemia

G.P. Martino[1], G. Bitti[1], M. Valentini[1], S. Marzan[1], S. Angelici[1]

[1]Medicina Interna, Fermo, Italy

Chronic myelomonocytic leukemia (CMML) is a hybrid disease with proliferation of the monocytic-myeloid series and dysplasia of the megakaryocyte-erythroid series. Although the clinical and morphological features of such disease are similar to those ones of chronic myeloid leukemia, it appeared with some particular clinical, therapeutic and prognostic aspects. In the case reported below CMML had a rather unusual onset, to the point of becoming a multidisciplinary case: hematological, infectious and surgical. Mr. JM (male, African, 77 years old; history of arthritis rheumatoid) came to our Dept. sent by the Emergency Dept. for a right axillary swelling associated with fever. Hepatosplenomegaly and the evident changes in blood chemistry (important leukocytosis with dysplastic notes and blast count at 10%, moderate-severe anemia, thrombocytopenia and increased ESR/RCP) led us to the hypothesis of a myeloid proliferative dis-

order. The patient was then subjected to a neck-thorax-abdomen CT scan with contrast, a bone marrow biopsy (CMML with blast count at 15%, in probable transformation), the research of JAK2 and BCR-ABL mutations (negative). The axillary swelling required surgical removal and it led to the following results: the microbiological culture was positive for staphylococcus aureus, and the histological examination showed extramedullary localization caused by a blast evolution of the CMML. Despite the bad prognosis, the diagnosis should be considered a success: the commitment of the entire medical team and the multidisciplinary approach were the keystones for a proper patient management.

Should a multidisciplinary medical team replace the internist? A case of eosinophilic granulomatosis with associated polyangioitis

G.P. Martino[1], F. Marconi[1], O. Burattini[1], M. Valentini[1], G. Bitti[1], S. Angelici[2]

[1]Medicina Interna, Fermo; [2]Medicina Interna, Fermo, Italy

A 54-year-old woman presented with low-grade fever, purpuric lesions and paraesthesia in the lower limbs for several months (history of allergic rhinosinusitis and asthmatic bronchitis with poor control of symptoms); For several years she had complained of migrant arthralgias, only partially responsive to brief steroid cycles prescribed orally by the rheumatologist. In the last few months, for increasing pain in the lower limbs, the patient consulted a neurologist who, after excluding Lyme disease, sent her to our Dept. of Internal Medicine. Hypereosinophilia and elevation of inflammatory markers were evident in blood chemistry tests. Low QRS voltage were present in the electrocardiogram. The echocardiogram showed a circumferential pericardial effusion of about 2 cm. The EMG/ENG was compatible with axonal type multineuropathy of the lower limbs and left ulnar neuropathy. The test for autoantibodies p-ANCA (anti MPO +++) was positive. According to the criteria of Lanham, ACR 1990 and Chapel Hill reviewed in 2012, the symptoms and clinical data suggested Eosinophilic Granulomatosis with associated Poliangioitis (EGPA ex Churg Strauss disease). High dose steroid therapy and an initial infusion of cyclophosphamide 750 mg/m2 were administered with progressive improvement of the clinical and laboratory data. EGPA is a vasculitis of small and medium-calibre vessels. By the time of diagnosis, there is frequently irreversible vascular organ damage, therefore it is useful to implement the knowledge of this group of pathologies early to avoid the diagnostic delay.

A rare case of multiple thrombosis: which treatment?

M.A. Marzilli[1], P. Pisano[1], M. Mantega[1], S. Marongiu[1], V. Moledda[1], A. Caddori[1]

[1]SC Medicina Interna, PO SS Trinità, ASSL Cagliari, ATS Sardegna, Italy

Background: Direct anticoagulants (DOACs) are the standard of care for acute venous thromboembolism treatment. Few data exist on their efficacy and safety in the treatment of venous thrombosis in atypical sites.
Case report: Female 25 years old patient hospitalized for edema in the right lower limb and dyspnea. She was on estroprogestinic treatment. At admission TC was 38.5°C; D-dimer 7.58 mg/l (vn <0.55). Colordoppler of lower limbs negative for deep venous thrombosis. AngioCT highlighted: 1) bilateral multifocal segmental PE, 2) ectasia of the azigos vein with his lumen fused with the inferior vena cava with thrombosis; 3) partial thrombosis of right renal vein and emiazygos; 4) massive thrombosis of ipogastric vein. Screening for thrombophilia, search for PNH clone and JAK2 mutation were negative. After counseling and an appropiate informed consent, the patient opted not to undergo to AVK treatment (poor compliance) and started dabigatran 150 mg bid off label. Two months later CT showed persistence of thrombosis of inferior vena cava up to the right common iliac vein but regression of all the other endoluminal hypodensity previously described. Five months later recanalization of cava vein was also obtained. During treatment the patient didn't experience any adverse events.
Conclusions: Although the current guidelines recommend the use of LMWH and AVK in the treatment of atypical thrombosis, dabigatran has been an efficient and safe option in this rare condition of polidistrictual thrombosis on a congenital malformative basis complicated by PE.

A case of multifactorial iron overload

M. Masotti[1], S. Accordino[1], P. Formagnana[1], S. Provini[1], A. De Matthaeis[1], C. Canetta[1]

[1]Medicina Generale e di Accettazione Urgenza, ASST Crema, Italy

Introduction: The term "iron overload" includes a range of acquired and congenital disorders. We present a case in which both genetic predisposition and acquired conditions led to liver damage.
Case report: A 73 years old woman came to attention for asthenia and abnormal liver function. Ten months before she was hospitalized for hemorrhagic shock during anticoagulation for deep vein thrombosis. The patient had multiple complications: infections, acute renal failure, intestinal ischemia and a wide abdominal wall hematoma treated with selective embolization and blood transfusions. Currently she presented elevation of transaminases (x 10) and cholestasis indexes (x 20). Abdominal ultrasound showed regular biliary tract and hepatic parenchyma. Serologies for hepatotropic viruses were negative. In the suspicion of iatrogenic etiology all drugs were stopped (sertraline, PPI, furosemide) without benefit. Ferritin values were very high at multiple controls (max 14388 ng/ml) and transferrin saturation was steadily higher than 50%. In suspicion of liver injury due to iron accumulation she underwent abdomen MRI, confirming iron overload. The search for mutations for hemochromatosis showed heterozygous state for C282Y.
Conclusions: Our patient developed liver injury caused by hemosiderosis due to several factors: inflammation, multiple transfusions and reabsorption of the abdominal hematoma. The evidence of iron overload on MRI in the absence of C282Y homozygosity or C282Y/H63D compound heterozygosity indicate non-HFE related hemochromatosis or secondary iron overload.

Trattamento e profilassi di trombo-embolismo venoso in paziente con trombofilia severa e cancro attivo

B. Matani[1], A.F. Arcoria[1]

[1]Università di Napoli, "Federico II", Centro di Riferimento Regionale per le Emocoagulopatie, Dipartimento di Clinica Medica e Chirurgia, Napoli, Italy

Il cancro è un fattore di rischio maggiore per tromboembolismo venoso (TEV). Una strategia terapeutica del TEV in corso di neoplasia è rappresentata dall'eparina a basso peso molecolare (EBPM); tuttavia trattamenti prolungati predispongono all'osteoporosi ed aumentano il rischio di frattura. Una femmina caucasica di 54 anni ha manifestato nel 2004 trombosi venosa profonda complicata da embolia polmonare (EP), trattate con warfarin per 24 mesi. La donna, portatrice di doppia eterozigosi per polimorfismo G20210A della Protrombina e del fattore V Leiden ed in menopausa chirurgica da 16 anni, ha poi sviluppato nel 2009 un carcinoma della mammella trattato con chirurgia e chemioterapia (CHT) adiuvante. Nel 2014 evidenza strumentale di metastasi linfonodali e recidiva di EP, con necessità di nuovo ciclo di CHT, temporanea ripresa di EBPM e successivo ritorno a warfarin. Per nuova recidiva oncologica nel 2015 ha praticato CHT ed EBPM ancora per 9 mesi. Una densitometria ossea di controllo evidenziava osteoporosi. All'esito di ulteriore recidiva nel 2018, passaggio ad edoxaban. All'attuale follow-up, assenza di complicanze tromboemboliche e di peggioramento dell'osteoporosi. L'EBPM è il trattamento di scelta nei casi di TEV e neoplasia attiva, ma la via di somministrazione parenterale e l'incremento di incidenza di osteoporosi creano problemi nella pratica clinica. Questo caso mostra la mancata progressione del riassorbimento osseo in una paziente affetta da trombofilia severa, pregresso TEV e cancro attivo, durante trattamento anticoagulante con edoxaban piuttosto che con EBPM.

Eculizumab therapy in a patient with paroxysmal nocturnal haemoglobinuria treated with steroids for 15 years

E. Mauro[1]

[1]UOC di Ematologia, Dipartimento di Medicina Interna, Ospedale Ca' Foncello, Treviso, Italy

Background: PNH pathogenesis is due to acquired lack of glycosylphosphatidylinositol-anchored protein complement regulatory proteins (CD55 and CD59) and intra-extravascular haemolysis. Eculizumab is a monoclonal antibody binding complement protein 5 (C5 receptor CD59), blocking complement upstream and reducing haemolysis.
Case report: November 1999: in a male 54 year-old, diagnosis of PNH has been done in our Institute. Therapy with prednisone and blood transfusions started. Disease's course was featured by multiple severe haemolytic crises, thrombosis of portal and splenic veins, infectious episodes and sepsis. After 13 years (2012) of continuative steroid (72845 mg of administered prednisone), we started eculizumab every 14 days. Clinical and laboratory improvement has been reported, the prednisone therapy has been tapered; no further haemolytic crises reappeared. However still in 2015 flow-cytometry showed a PNH-clone size 94%, mild anemia, high reticulocytes count, high LDH serum levels. Actually, despite to suboptimal response, the patient shows a good quality of life.
Conclusions: This is the third know case report of PNH with a fully documented medical history of long-term steroid therapy confirming efficacy and safety of eculizumab. However "C3 tick over" effect may induce suboptimal clinical results with residual haemolytic activity also on heavy steroid treated patients. Recently antibody-based anti-C3 strategies are emerging. However efficacy and safety (risk of severe infection, autoimmune diseases) has to be assessed.

A case of "not only" essential hypertension

A. Mazzieri[1]

[1]Dipartimento di Endocrinologia, Ospedale S. Maria della Misericordia, Università di Perugia, Italy

Introduction: Secondary hypertension is caused by disorders of kidneys, heart or endocrine system. This type differs from the essential form that is linked to genetic factors, improper diet and lack of exercise.
Case report: A 45 year old-man was admitted to hospital for headache and hypertension. He is an obese smoker trucker, alcohol drinker with an unregulated diet and an hypertensive brother. A chest-abdomen CT revealed a mass on left adrenal gland and at Lab tests there were values of hypercortisolism. A CRH test was diagnostic for Cushing's Disease; a brain MRI explained that the origin of his hypertension was a pituitary adenoma, while the adrenal mass was only an hyperplasia due to pituitary stimulation. After the discharge, waiting for surgery, he began a regular life; he had so partially reduced the drugs undertaken, remaining in good blood pressure control. Behind of his hypertension, there were both factors of primary type and a secondary cause.
Conclusions: The treatment of secondary hypertension is cause-dependent and this cause must be removed so that the blood pressure can return in a normal range. It should always be considered that it's possible that a secondary hypertension overlaps with an essential type, a circumstance which surely complicates its course.

Un caso di ipertensione polmonare combinata

L. Menicacci[1], V. Scotti[1], G. Scocchera[2], A. Fanelli[1], F. Fabbrizzi[1], L. Burberi[1], S. Digregorio[1], A. Torrigiani[1], M. Bernardini[1], S. Fruttuoso[1], F. Corradi[1], R. Innocenti[1], A. Morettini[1]

[1]AO Universitaria Careggi, Medicina per la Complessità Assistenziale 2, Firenze; [2]AO Universitaria Careggi, Medicina 2, Firenze, Italy

Premesse: Per PH si intende una condizione emodinamica caratterizzata da una mPAP≥25mmHg a riposo, determinata mediante CCD. La forma precapillare è caratterizzata da una mPAP>25mmHg con una PAWP<15mmHg mentre la forma post-capillare è caratterizzata da una mPAP>25mmHg con una PAWP >15mmHg a sua volta suddivisibili in post-capillare isolata (DPG<7WU e/o PVR≤3WU) e combinata post/pre-capillare (DPG≥7mmHg e/o PVR>3WU).
Caso clinico: Donna, 83aa, ex pellettiera, ipertesa, diabetica, ricoverata per dispnea e dolore epigastrico che regredisce a riposo, lieve rialzo delle troponina, in DEA ecg nei limiti, angio-TC negativa per PE. Viene eseguita TC-coronarica nei limiti, l'ecocardiogramma evidenzia un marcata dilatazione del VD,VS di piccole dimensioni e spessori parietali ai limiti superiori, FE conservata, TRV>3m/s, PAPs 90mmhg. Nel sospetto di una HP pre-capillare, vista l'anamnesi lavorativa, è stata richiesta un TC HDR che non ha evidenziato segni di interstiziopatia. Per dirimere l'eziologia dell'HP è stato eseguito un cateterismo destro che ha evidenziato una PAWP 18mmhg, mPAP 41mmhg, RAP 6mmhg,CI 1,87 l/min/m2, DPG 7mmHg, PVR 7.6WU. Un quadro di HP combinata per cui al momento non vi sono dati per utilizzo di farmaci specifici per il circolo polmonare se non una maggiore ottimizzazione della terapia anti-scompenso.
Conclusioni: Il caso ha evidenziato come ribadito dalle ultime linee guida ESC l'importanza di stratificare il rischio di HP tramite clinica ed esame ecocardiografico e di poter accedere a centri in grado di eseguire la procedura di CCD che rimane l'esame dirimente.

Appropriatezza dell'accesso venoso in base alle caratteristiche del patrimonio venoso e della tipologia di infusione: valutazione prospettica monocentrica

M.P. Modica[1], N. Gori[1], G. Astuto[2], A. Ghiglietti[3], C. Cattabiani[4], A. Luccini[1], M. Giorgi Pierfranceschi[5]

[1]Università di Brescia; [2]UO Chirurgia Generale, Ospedale Maggiore ASST Cremona; [3]Azienda Livanova, Milano; [4]UO di Medicina Interna, Ospedale Maggiore, ASST Cremona; [5]UO Medicina Interna, Ospedale Maggiore, ASST Cremona, Italy

Premesse e scopo: La scelta tra accesso venoso (AV) centrale o periferico può essere fatta con l'uso di scale di valutazione del patrimonio venoso (PV) e della terapia infusionale, ma il loro tasso di applicazione nei reparti di medicina interna non è noto. Scopo dello studio è stato valutare l'appropriatezza degli AV nel reparto di Medicina dell'Ospedale di Cremona.
Materiali e Metodi: In questo studio osservazionale sono stati raccolti prospetticamente i dati relativi ai ricoverati dal 1/10 al 20/12/2018, registrando le caratteristiche dei pz (età, sesso, patologia di ingresso) e le variabili relative alla terapia endovenosa (TE) quali pH (<5;5-9;>9), osmolarità (Osm) (≤600; >600 mOsm/L), durata (≤6gg; >6gg). Il PV è stato valutato sul numero di vene visibili e palpabili (0;1-2;2-3;4-5 vene). Criteri di inappropriatezza per l'uso di un AV periferico erano PV=0; pH <5 o >9; Osm>600.
Risultati: Di 436 pz ricoverati, sono stati analizzati 400 pz in TE. 84,7% era >65 anni. Tra le patologie 25% aveva malattie gastroenteriche, 22% cardio-respiratorie; 14% infettive, 13% anemia, 24% altro. Riguardo ai criteri di appropriatezza il 32% dei pz aveva AV non compatibile con TE (Osm>600, pH <5 o >9); 8% dei pz aveva AV non compatibile con PV (0 vene), tra questi si registravano rispettivamente il 78 e il 91% di complicanze.
Conclusioni: I risultati dello studio evidenziano che circa 4 pz su 10 non hanno AV appropriato. L'uso di scale di valutazione del PV, del pH e della Osm della terapia infusiva (Proactive Vascular Planning) dovrebbe guidare la scelta dell'AV per ogni pz.

A case report of Peutz-Jeghers syndrome onset with melena

E.G.M. Mondati[1], G.A. Piccillo[2], G. Gasbarrini[3]

[1]Department of Internal Medicine and Systemic Pathologies, University of Catania; [2]Emergency Department, Cannizzaro Hospital, Catania; [3]Professor Emeritus of Internal Medicine, Catholic University of Rome, Italy

Introduction: Peutz-Jeghers Syndrome (PJS or periorificial lentiginosis) is an autosomally dominant inherited rare condition determined by a gene mutation responsible for mucocutaneous pigmentation and gastrointestinal polyps and increased risk of carcinoma.
Case report: A 27 aged woman was admitted to our Department due to nausea, non-bloody vomiting and periumbilical abdominal pain. She had complained blackening of stool for five days. Physical examination revealed multiple, pigmented lesions on her face, lower lip, and buccal mucosa; which she had since childhood. On abdominal examination, epigastric and periumbilical tenderness, diminished bowel sounds, and a possible epigastric mass were observed. Laboratory data showed anaemia, leukocitosis, PCR rise. Stool ex-

amination revealed positive benzidine test for occult blood. Abdominal ultrasonography (US) showed a large heterogeneous mass in the upper abdomen consistent with mesenteric fat within an intussusception confirmed by abdomen-CT. We suspected a PJS and the patient underwent to laparotomy and small bowel segmental resection with histological evidence of hamartomatous polyp with epithelial misplacement as in PJS. Actually our patient is healthy in quite good clinical conditions observing the periodic checks for PJS.
Discussion: PJS is associated with significant morbidity, variable clinical course and considerable predisposition to gastrointestinal and non-gastrointestinal malignancies. Early detection and proper surveillance in these unlucky patients are vital to minimize the risk of carcinoma.

Study, prevention and treatment of frailty in the elderly. The experience of SC Geriatria ASL Città di Torino

S. Mondino[1], F. Ghiggia[1], R. Carlucci[1], E. Maina[1], M. Brandino[1], A.M. Cotroneo[1]

[1]SC Geriatria, ASL Città di Torino, Italy

Introduction and Aim:: The Italian National Health System is focused on hospital cares, with negative clinical consequences on older patients, hospital overcrowding and socio-economical burden. Our group created a frailty outpatients clinic for the follow-up of older people with cronic and degenerative diseases at high risck of acute failure.
Materials and Methods: We referred to our clinic all the inpatients discharged at home from our Geriatric department with social or clinical features of frailty (age >75, diagnosis of cronic diseses, comorbility, high risk of re-hospitalization, politerapy, low compliance). At each visit we provided a multidimensional assessment using validated tools, focused on signs and syntoms of riacutizations, cognitive and functional assessment compliance to therapies, social aspects, quality of life and caregiver burden.
Results: After one year we assisted to a better compliance to therapies, reduction of riacutizations, satisfaction of patients and caregivers, a smaller functional loss with a consequent reduction of the access to emergency cares.
Conclusions: Our experience revealed that a personalized and multidimensional out-hospital assitance to frail older patients is the best answer to their chronic needs with clinical and social advantages.

Sézary syndrome

D.G. Morana[1], M. Crisci[1], S. Neri[1], I. Timpanaro[1], C. Sgroi[1], L. Incorvaia[1], R. D'Amico[1], C. Di Mauro[1], C. Virgillito[1], I. Morana[1]

[1]Medicina Interna Area Critica, Arnas "Garibaldi", Catania, Italy

Sezary syndrome (SS) is an aggressive form of cutaneous T-cell lymphoma which is a group of disorders that occur when T-cells become cancerous and affect the skin characterized by a widespread red rash that may cover most of the body, the presence of cancerous T cells abnormally enlarged lymph nodes intense itchiness, scaling and peeling of the skin. SS has an annual incidence rate of 1/10.000.000 and represents 3% of all cutaneous lymphomas. We describe the case of a patient (Male-Age 88) with dilated cardiomyopathy and hearth failure, atrial fibrillation, kidney failure, intense itchiness and widespread red rash. CAT Thorax-Abdomen: abnormally enlarged lymph nodes above-under diaphragm. We diced to make the Lymphocytes typing T with result: 39.48/mmc CD3+75%, CD3+/CD4+38.7, CD3+/CD8+ 36.7 CD19+2.3. We made diagnosis of Sezary Syndrome. Treatment: Photodynamic therapy- Methotrexate.

Coca-Cola cancer

D.G. Morana[1], M. Callea[1], I. Timpanaro[1], C. Sgroi[1], L. Incorvaia[1], R. D'Amico[1], S. Neri[1], C. Di Mauro[1], C. Virgillito[1], I. Morana[1]

[1]Medicina Interna Area Critica, Arnas "Garibaldi", Catania, Italy

We report the case of a young male patient (35 years old), overweight, with a medical history changed due to pathologies, reaching our attention for severe postprandial epigastric pain resistant to the usual therapy. During the hospitalization he manifests copious hematemesis. In urgent gastroscopy is shown an antral gastric bleeding lesion, that was treated with clip-metal and noradrenaline. The patient was stabilized. After a few days it has been done a gastroscopy of control with evidence of hyperemic gastric mucosa with ulcerated areas and single roundish smooth antral ulceration of 3.5 cm. Biopsy diagnosis of gastric adenocarcinoma. The particularity of the case is represented by the absence of the usual risk factors for gastric CA (cigarette smoking, coffee, tea, alcoholic beverages, substances of abuse, Helicobacter Pylori, familiarity with tumors, previous gastric lesions). It reported exclusively high consumption (more than 2 liters) of Coca-Cola associated with the intake (of over 2L) of other carbonated drinks based on syrups and lemon juice. Therefore the cancer could be referred to the abuse of these drinks. The patient has been entrusted to the surgeon and the oncologist for the therapy.

Ipertensione portale idiopatica non cirrotica in paziente con sclerosi multipla

F. Mori Ubaldini[1], C. Fabio[2], A. Pedroni[3], L. Cugia[3], F. Pintus[2], S. Zaru[3]

[1]AOU Sassari, Malattie Infettive; [2]AOU Sassari, Radiologia; [3]AOU Sassari, Gastroenterologia, Sassari, Italy

Premesse: La causa più frequente di ipertensione portale è la cirrosi epatica ma esistono numerose altre eziologie. Più raramente questa può essere idiopatica. Presentiamo un caso di ipertensione portale non cirrotica idiopatica esordita con sanguinamento da rottura di varici esofagee.
Caso clinico: Paziente di 58 anni, ricoverato a Maggio 2017 per sanguinamento da rottura di varici esofagee con legatura. In anamnesi Sclerosi Multipla per cui ha effettuato terapia con Copaxone e Diabete Mellito di tipo II. Esami di citolisi e di funzionalità epatica nella norma in controlli ripetuti. Alla biopsia del fegato epatite reattiva non specifica e steatosi focale. Fibroscan nella norma. Alla TC escluse trombosi venosa portale o cavale e presenza di lesioni eteroplasiche. Presente notevole versamento periepatico, perisplenico, nelle docce parietocoliche e in sede pelvica; fegato lievemente ridotto di volume, modesta splenomegalia. Conservata la funzionalità cardiaca, negativo il profilo trombofilico. Recidiva del sanguinamento e posizionamento TIPS (Shunt Portosistemico Intraepatico Transgiugulare) in Giugno 2017. A due anni dal ricovero eseguita per comparsa di linfopenia biopsia osteomidollare per escludere la presenza di malattia linfoproliferativa: aspetto compatibile con fase iniziale di mielodisplasia.
Conclusioni: Dal posizionamento della TIPS non si sono verificati episodi di sanguinamento. Non è comparsa encefalopatia, mantenuta la buona funzionalità epatica. Tutti gli accertamenti eseguiti hanno dato esito negativo: la causa dell'ipertensione portale rimane sconosciuta.

Un caso di encefalite e pancreatite da EBV

G.R. Mozzillo[1], G. Rossi[1], T. Raffa[1], M. Monti[1], B. Bellini[1], A. Ostinelli[1], D. Pellegrino[1]

[1]UOC Geriatria, Ospedale S. Anna, Como, ASST Lariana, Italy

Premesse: L'infezione da EBV è rara nell'adulto immunocompetente per questo può essere causa di mancata diagnosi.
Caso clinico: Si ricovera una donna di 86 anni per febbre, cefalea, vomito ed impossibilità alla stazione eretta. L'obiettività risultava nei limiti, tranne per evidenza di tremori non intenzionali agli arti superiori. Non erano obiettivabili rigor né deficit focali. La paziente era ben orientata, ma mostrava fasi di sopore. Gli esami di laboratorio risultavano nella norma (comprese PCR e procalcitonina) tranne che per iperamilasemia (325 UI/L) e iperlipasemia (1304 U/L). La TAC, la RMN encefalo e l'EEG non mostravano alterazioni specifiche. Alla luce dei dati laboratoristici si era proceduto a terapia medica della pancreatite con Piperacillina/Tazobactam e Metronidazolo, ma la TAC addome e la Colangio-RMN non mostravano alterazioni specifiche a livello pancreatico. Eseguito screening anticorpale che risultava compatibile con pregresse infezioni da EBV, CMV ed HSV. Il peggioramento della sintomatologia neurologica ha portato ad esecuzione di rachicentesi. Il chimico-fisico su liquor orientava

per un quadro di meningoencefalite virale, per cui è stata impostata terapia con acyclovir. Dopo pochi giorni la paziente è deceduta. Post-mortem è pervenuto l'esito delle indagini su liquor che hanno mostrato positività della PCR per DNA di EBV.
Conclusioni: Questo caso in cui si associano encefalite e pancreatite mostra come le manifestazioni cliniche di infezione da EBV siano polimorfe e possano renderne difficoltosa la diagnosi.

Superior vena cava syndrome

N. Mumoli[1], L. Pavan[1], G. Rotiroti[1], R. Capra[1], M. Barberio[1]

[1]UO Medicina Interna, Ospedale Magenta (MI), Italy

Introduction: Superior Vein Cava (SVC) syndrome is an extremely rare but serious complication after pacemaker lead implantation; most patients are asymptomatic due to the development of an adequate venous collateral circulation; symptoms include headache, upper limb edema, cyanosis and facial swelling. We present a case of a 75-years-old woman who developed SVC syndrome after transvenous pacemaker implantation.
Case report: A 75-year-old woman was admitted because of headache and progressive cyanosis and swelling of the face, neck, and bilateral upper extremities and these symptoms worsened gradually. Clinical examination revealed prominent engorged vasculature in the neck and anterior chest wall. Thoracic CT angiography and superior cavography showed the SVC obstruction around indwelling leads with increased flow through the collateral circulation. The mechanism may had been mechanical stress caused by the transvenous leads, causing inflammation of the blood vessel wall and fibrosis, eventually leading to venous thrombosis and occlusion. Balloon angioplasty was considered but the patient refused and a treatment with Edoxaban 60 md die was started; gradually a complete resolution of the symptoms was obtained. The patient was discharged in a stable condition.
Comments: SVC syndrome results from the obstruction of blood flow through the SVC into the right atrium. Generally, malignancy is considered to be the most common etiology of SVC syndrome, but benign iatrogenic causes, mainly intravascular devices (catheters, cardiac defibrillators and pacemaker wires), are becoming increasingly common. Obstruction can be caused by invasion or external compression of the SVC by adjacent pathologic processes involving the lung, lymph nodes, and other mediastinal structures or by thrombosis of blood within the SVC. Procedures performed on venous vasculature, causing a possible intimal injury or vein stenosis provoked by transvenous leads seems to be the most reasonable explanation for the observed complication.

Vitamin D status in diabetic patients with or without diabetic foot

R. Muscariello[1], G. Accarino[1], F. Carcarino[1], F. Coretti[1], R. Di Donato[1], R. Giannettino[1], A. Iavarone[1], S. Ippolito[1], A. Lombardi[1], O. Romano[1], C. Sepe[1], V. Nuzzo[1]

[1]UOSD Malattie Endocrine, del Ricambio e della Nutrizione, Ospedale del Mare, Napoli, Italy

Background and Aim of the study: Diabetes is a condition associated with great morbidity and mortality; diabetic foot is one of the major diabetes complication. It can involve bone tissue, in whom metabolism is implicated vitamin D. The aim of our study is to assess vitamin D levels in diabetic patients with or without diabetic foot.
Materials and Methods: It has been enrolled diabetic patients of Endocrinology department, in "Ospedale del Mare", Naples, in the period May 2017-October 2018. Inclusion criteria are the presence of at least one 25-OH-D_3 evaluation and the absence of supplementation with cholecalciferol or analogues. We evaluated a control population hospitalized in the same period.
Results: We enrolled 111 subjects, 72 diabetics e 39 controls; among diabetic patients, 27 had diabetic foot. 30 controls (69%) and 60 diabetics (83%) had vitamin D insufficiency, (25-OH-D_3 <20 ng/ml, p=0.026); this difference was greater considering vitamin D deficiency (25-OH-D_3 <10 ng/ml, 44% vs 93%, p<0.0000001). Diabetic patients had lower 25-OH-D_3 levels compared to not diabetic (15,4118 vs 19,5714 ng/ml; p=0.0021); among diabetic patients, those with diabetic foot had vitamin D levels lower compared to whom without this complication (13,1786 vs 16,975 ng/ml, p=0.0302).
Conclusions: Diabetic patients had vitamin D insufficiency, particularly among diabetic patients with diabetic foot. Other studies are necessary to demonstrate a causality link between these two conditions.

Pomfi.. pomfi.. pomfi.. po'!

M. Naddeo[1], A. Sica[2], S. Di Sirio[1], R. Fittipaldi[1], G. De Felice[1], R. Luongo[1]

[1]UOC Medicina Interna, Oliveto Citra (SA); [2]Medicina e Chirurgia d'Accettazione e d'Urgenza, Oliveto Citra (SA), Italy

The 33-year-old patient has been in our emergency department for a few weeks' urticaria-angioedema. It had already been treated with corticosteroid therapy and antihistamines. He had an important angioedema of the left eye that prevented him from opening the eye and a frontal non-itchy urticarial erythema. By carefully examining the patient, we notice a slight discrepancy between the left and right cheek. Blood tests were within the normal range: mild leukopenia, mild thrombocytopenia. We decide to hospitalize the patient who was subjected to further second level investigations in particular: ANA and ENA that were very high; the ultrasound of the salivary glands showed a non-homogeneous picture compatible with a chronic autoimmune inflammatory process. Sjogren syndrome without typical disorders such as ocular xerosis and xerostomia, also in a man. Confirmed by the biopsy of the minor salivary glands.

Why is lactic acid so high on this patient? The answer is often in a careful medical history

O. Nannola[1], P. Amorelli[2], M. Arcopinto[1], L. Guadagno[1], E. Itto[1], V. Massari[1], B. Russo[1], P. Morella[1]

[1]UOC Medicina DEA, AORN A. Cardarelli Napoli; [2]Scuola di Specializzazione in Medicina Interna, Università degli Studi di Napoli Federico II, Napoli, Italy

Introduction: Metformin-associated lactic acidosis (MALA) is a diagnosis increasingly recognized, in parallel to the increase of the use of this drug for type 2 diabetes; in our experience, blood lactate increase may also be due to other associated factors, as in this clinical case.
Case report: A 63 years old woman with history of obesity, arterial hypertension, type 2 diabetes (on therapy with metformin) was admitted to hospital for persistent low-grade fever, asthenia and fatigue. Laboratory test showed neutrophil leucocytosis, red cell macrocitosis (mean corpuscular volume: 109 fl), mild renal impairment (creatinine clearance 57 ml/min). Arterial blood gas showed a lactic acidosis (pH 7.31, lactate 13.7 mmol/lt). With a more accurate patient's interview, two further data emerged: alcohol abuse (about 1 liter and a half of wine per day), non-steroidal anti-infiammatory drugs (NSAIDs) abuse for leg pain (consistent with diabetic and alcoholic neuropathy). Moreover, the patient continued to take metformin, while not taking meals regularly. However, the sequences of events leading to lactic acidosis emerged: NSAIDs abuse renal impairment metformin accumulation; alcohol abuse and poor diet quality anaerobiosis lactate accumulation. The patient received medical treatment (hydration, insulin, thiamine) obtaining a quick correction of metabolic abnormalities with a complete resolution of symptoms.
Conclusions: This report shows how important is to deepen the patient history in cases of hyerlactatemia, in which the etiology can be multifactorial.

Fever and intense asthenia in chronic lymphatic leukemia in apparent remission

S.A. Neri[1], I. Timpanaro[1], C. Sgroi[1], D. Morana[2], L. Incorvaia[1], C. Virgillito[1], M. Bonaccorso[1], M. Callea[1], I. Morana[1]

[1]UO di Medicina Interna in Area Critica, ARNAS Garibaldi, Catania; [2]Trainer, UO di Medicina Interna in Area Critica, ARNAS Garibaldi, Catania, Italy

Introduction: CLL is characterized by slow evolution with more or

less long periods of remission. We describe the case of an 82-year-old woman.
Case report: History of essential arterial hypertension and CLL in remission (last haematological follow-up 45 days before). The patient comes to our observation for a fever associated with intense asthenia and slimming. Objectivity is detected by an intensely painful elastic hard mass in the epigastrium. Blood tests showed creatinine 1.5 mg%, urea 82 mg%, albumin 2.2 g%, CRP 190 mg/l, WBC 2100 x mmc with lymphocytes 300 x mmc, Hb 9.8 g, PLT 32.000 x mmc and INR 1.4. CEA 11370 ng/ml, CA125 178 IU/ml, CA15.3 76 IU/ml, CA19.9 71 IU/ml, AFP 0.71 ng/ml. EGD and colonoscopy are negative. At CT: marked reticular thickening of the pulmonary interstitium due to lymphangitis and multiple lymphadenopathy - max 3x2.5 cm - in the thorax and abdomen with hepatic subversion due to the presence of voluminous nodules. The patient died on the 7th day.
Conclusions: The fulminating evolution did not allow us the liver biopsy that would have been useful in differentiating between other neoplasia, transformed lymphoma or LLC even if the CT and endoscopy did not show anything else. The peculiarity consists in the centrality of the hepatic commitment that appeared marked and with macronodular aspects.

An atypical case of relapsing ischemic cerebral stroke. Follow-up after 15 years

S.A. Neri[1], I. Timpanaro[1], C. Sgroi[1], D. Morana[2], L. Incorvaia[1], C. Virgillito[1], M. Bonaccorso[1], M. Callea[1], I. Morana[1]

[1]UO di Medicina Interna in Area Critica, ARNAS Garibaldi, Catania; [2]Trainer, UO di Medicina Interna in Area Critica, ARNAS Garibaldi, Catania, Italy

Introduction: Cryptogenic stroke still represents an important challenge for the clinician. We describe the case of a 50-year-old man.
Case report: In one year, the patient presented 3 episodes of ischemic cerebral stroke on the territory of the left middle cerebral artery in the absence of cardiovascular risk factors. In anamnesis paroxysmal abdominal pain sometimes with mucosanguinolent diarrhea. Blood tests were normal except for the elongated PTT. Colonoscopy with biopsy showed atypical localization of Crohn disease (transverse-rectum). Genetic thrombophilia and LAC were negative, while antiphospholipids (IgG-IgM anticardiolipin, antiphosphatidylserine, and antibeta2glycoprotein1) were present. At the Angio-MRI of cerebral vessels modest hypoplasia of the left middle cerebral. Treated with medical therapy (prednisone-azathioprine, clopidogrel and mesalazine), to date, no other ischemic episodes.
Conclusions: Antiphospholipid syndrome secondary to autoimmune diseases, especially SLE, is well known.
In the Crohn disease the different studies failed to correlate the various antibody patterns with a well-determined clinical phenotype, with the course of the disease or at the risk of thrombotic events. In our patient, the Crohn's therapy associated with clopidogrel (since it is not possible to treat it with warfarin) has zeroed the onset of ischemic events without reducing the titration of circulating antibodies.

Vasculite crioglobulinemica necrotizzante e carcinoma mammario

V. Nesticò[1], S. Giancotti[1], E. Maiorana[1], M. Mitra[1], D. Frontera[1], M. Lucia[1], R. Cimino[1]

[1]Struttura Complessa di Medicina Generale, AO Pugliese Ciaccio, Catanzaro, Italy

Nel dicembre 2018 è giunta alla nostra osservazione una donna di 72 anni a motivo di porpora e ulcere alle estremità dei quattro arti con necrosi digitale, comparse da alcuni giorni. In anamnesi tabagismo, fenomeno di Raynaud, poliartralgie. All'ingresso in Ospedale riscontro di ipertensione arteriosa, iperglicemia, deterioramento della funzione renale, leucocitosi e piastrinosi. La diagnosi di Vasculite crioglobulinemica è stata posta per la presenza dei seguenti criteri laboratoristici: 1) crioglobulinemia; 2) fattore reumatoide ad alto titolo; 3) ipocomplementemia; 4) componente monoclonale sierica; concomitava proteinuria al di sotto del range nefrosico, negativa è risultata la ricerca di HCV, nella norma l'ecocolorDoppler arterioso gli arti. Abbiamo somministrato terapia con *glucocorticoidi, Iloprost, Insulina, antiaggreganti, antipertensivi,* e praticato cinque sedute di *Plasmaferesi*, osservando graduale miglioramento clinico. Il concomitante riscontro di un nodulo alla mammella sinistra, rivelatosi all'esame istologico da agobiopsia un carcinoma duttale invasivo, ci ha indotti a soprassedere dal trattamento con immunosoppressori. Il chirurgo senologo ha consigliato terapia antiestrogenica neoadiuvante, in attesa di rivalutare la paziente prima dell'intervento.

Un'ipereosinofilia di difficile gestione: caso clinico

S. Noviello[1], S. Longo[1], E. Bozzolo[2], L. Dagna[2], A. Vacca[1]

[1]Medicina Interna "G. Baccelli" Policlinico Bari; [2]UNIRAR, IRCCS San Raffaele, Milano, Italy

Donna di 46 anni con storia di ipereosinofilia, pomfi orticarioidi, asma bronchiale. Ad Aprile 2018 comparsa di parestesie periferiche steroido- sensibili. Giungo '18: peggioramento dei sintomi neurologici. Agli esami: WBC: 17800 con EO%: 9.8%, PCR: 118 mg/l, VES: 25 mm/1h, MPO-ANCA: 596 UA. RX torace negativo. TC cranio: sfumate ipodensità sottocorticali parietali bilaterali confermate all'angioRMN encefalo come di significato infiammatorio- microischemico (verosimile vasculite), sinusopatia cronica. EMG: polineuropatia sensitivo- motoria assonale da vasculite. Si eseguiva biopsia nasale conclusiva per flogosi cronica ed erosiva, eosinofilia, danno vascolare. Posta diagnosi di Granulomatosi Eosinofila con Poliangioite (EGPA). Si impostata terapia con metilprednisolone 1 gr ev per 5 gg proseguendo con prednisone 1.5 mg/kg/die per os e successivo tapering con beneficio clinico, riduzione degli EO ma riscontro di tropo T: 6.2 ng/L e NT-proBNP: 363 pg/mL. Si eseguiva angioRMN cardiaca conclusiva per miocardite subacuta. Avviata terapia con ciclofosfamide 15 mg/kg in boli prima ogni 2 e poi ogni 3 settimane (5 boli totali) con parziale miglioramento e quindi praticate 3 sedute di Plasma Exchange (PE). Alla riduzione dello steroide spiccata eosinofilia (EO: 1700). Si impostava terapia con Mepolizumab (MPZ) 100 mg, 3 fl/mese. Dopo un mese di terapia con MPZ, VES: 20 mm/1h, PCR: 9.4 mg/L tropo T e NT- proBNP: negativi, EO%: 0, anti-MPO: 11.3. Ridotto progressivamente lo steroide quindi sospeso in 3 mesi. Paziente in attuale remissione clinica.
Conclusioni: MPZ è un anticorpo monoclonale umanizzato anti IL-5 approvato nel trattamento dell'asma cronico e della EGPA. La sua efficacia terapeutica prevale sul controllo dei sintomi respiratori e sulla riduzione degli eosinofili. Abbiamo descritto un caso di EGPA a prevalente interessamento cardiaco e neurologico. MPZ ha permesso stabilizzazione del quadro clinico, rapida sospensione della terapia steroidea senza successivi flare.

The use of provertinum, a non-activated plasma-derived factor VII to treat a case of severe gastric haemorragia of unknown origin

G. Oliva[1], P. Madonna[1], P. Tirelli[1], M.G. Coppola[1], C. Bologna[1], M. Lugarà[1], G. Vespere[2], E. Grasso[1]

[1]UOC Medicina Generale, Ospedale del Mare, Napoli; [2]UOC Gastroenterologia, Ospedale del Mare, Napoli, Italy

Introduction: The haemorrhagic shock in elderly with comorbidities represents a challenge for the physician. Is indicated the use of blood products to control the bleeding and to avoid the CID mechanism can be triggered. If the bleeding is not controllable with transfusion of both blood cell or fresh plasma, the use of coagulation factors allows to reach the patient's clinical stabilization and to reduce the consumption of blood products
Case report: A 87-year-old woman, admitted to Internal Medicine for dyspnea, oedema of lower limbs, is affected by colon cancer cryptogenic cirrhosis, atrial fibrillation, previous thyroid adenocarcinoma, renal failure, macrocytic anaemia. She had an hemorrhagic shock with severe anemia. The patient is transfused with 4 units of concentrated red blood cells, 4 units of fresh plasma. After transfusions the Hbg continues to drop to 4.7 g/dl. We performed EGDS, colonscopia, angioTC and arteriography without indentify the cause of bleeding. For this reason, in order to try stopping the haemorrhage, the patient is treated with 1800 U.I. of Provertinum,

a non-activated Plasma-derived factor VII, (posology 30 U.I./kg) and a further unit of concentrated red blood cells
Conclusions: The use of activated Plasma-derived factor VII in this case has effectively determined the recovery of the described clinical situation, allowing the complete stabilization and safe discharge of the patient. Further scientific investigations are needed, but we believe we can propose the use of Plasma-derived factor VII to control the bleeding in this type of patients.

Gestione della polifarmacoterapia nel paziente anziano pluripatologico. Il Progetto dell'ASUI di Trieste

T. Oliverio[1], C. Rotelli[1], L. Cocchia[2], D. Bianchini[3], G. Benedetti[4]

[1]SC Adulti Anziani, Distretto 2, ASUITS, Trieste; [2]Divisione di Medicina Interna, ASUITS, Trieste; [3]Direttore Divisione di Medicina, ASUITS; [4]Direttore Distretto 2, ASUITS, Trieste, Italy

Introduzione: L'assunzione di 5 o più principi attivi per un periodo di 60-90 giorni consecutivi è correlata a un incremento di mortalità e morbilità, attribuibile a interazioni farmacologiche sfavorevoli.La polifarmacoterapia può essere considerata un indice di severità clinica, di particolare rilievo nella popolazione anziana,dove è più frequente il ricorso a un elevato numero di principi attivi per la gestione delle principali malattie cronico-degenerative.
Materiali e Metodi: Le strutture ospedaliere e territoriali ASUITS hanno proposto valutazione multidimensionale di cittadini ≥75 anni che assumono almeno 8 farmaci.Le azioni prevedono rivalutazione del paziente per l'eliminazione dei principi attivi non indispensabili o con un rapporto rischi/benefici non favorevole alla condizione, con revisione del rapporto rischi(costi/benefici)sulla base delle caratteristiche individuali dell'assistito.Il protocollo prevede la segnalazione del paziente al momento della dimissione ospedaliera o segnalazione dal MMG al Distretto. Ogni Distretto quindi convoca, entro 30 giorni, un'equipe multiprofessionale composta dal MMG,Medico di Distretto e da uno specialista ambulatoriale o ospedaliero.
Risultati: Il progetto si prefigge di ridurre il numero di assistiti ASUITS sottoposti a polifarmacoterapia, per ridurre i ricoveri ospedalieri e migliorare il livello di salute della cittadinanza, mediante risk management degli eventi acuti,accidentali,iatrogeni, riduzione della spesa farmaceutica (mediante eliminazione di prescrizioni inutili e/o potenzialmente dannose), incremento dei livelli di integrazione tra professionisti.
Conclusioni: E' fondamentale parlare di Chronic Care Model nella gestione delle malattie cronico-degenerative con la creazione di un'equipe multiprofessionale e multidisciplinare per definire i bisogni clinici dell'assistito in funzione della sue comorbidità e fragilità, adeguando di conseguenza l'appropriatezza prescrittiva.

An unexplained case of hypoxemia

F. Olmati[1], M.E. Cardini[2], E. Frollano[2], S. Salvati[2], A. Sanna[2], P. Palange[1]

[1]Department of Translational Medicine and Precision, "Sapienza" University of Rome; [2]Department of Cardiovascular, Respiratory, Nephrology, Anesthesiology and Geriatric Sciences, "Sapienza" University of Rome, Italy

Introduction: Major causes of hypoxemia consist in hypoventilation, altered diffusing capacity, ventilation/perfusion (V/Q) mismatch, and shunt.
Case report: A 77 yrs old man came to our Department for the incidental finding of peripheral capillary oxygen saturation (SpO_2) less than 90%; arterial blood gases (ABG) confirmed normocapnic hypoxemia (PaO_2 48 mmHg; $PaCO_2$ 34 mmHg; pH 7.48; (A-a)O_2 59 mmHg; P/F Ratio 229; FiO_2 0.21). Physical examination was unremarkable, heart rate was 78 bpm, respiratory rate was 18/min and lungs were clear at auscultation. Hypoxemia was refractory to increasing oxygen supplementation. A new ABG under FiO_2 0.6 showed PaO_2 50 mmHg, $PaCO_2$ 35 mmHg, pH 7.52, P/F ratio 83. A Computed Tomography (CT) angiography excluded pulmonary embolism. Lung function testing including diffusing capacity for carbon monoxide (DLCO) was normal, ruling out chronic respiratory diseases [*e.g.*, Chronic Obstructive Pulmonary Disease (COPD)]. High resolution CT of thorax also excluded interstitial or other lung disorders. Echocardiogram with bubble contrast study was performed that showed atrial septal aneurysm with patent foramen ovale (PFO). The patient underwent percutaneous closure of PFO with no procedural complications and had complete resolution of hypoxemia.
Conclusions: In case of a un unexplained hypoxemia, it is important to think about a PFO, especially if hypoxemia is refractory to oxygen supplementation. Indication of percutaneous closure is still object of debate; the final decision is usually based on patient's comorbidities and severity of hypoxemia.

Bleeding *vs* thrombosis. Who has the best?

E.G. Onori[1], P. Vertolli[1], F. Tonello[1], C. Cerasi[1], M. De Feo[1], S. Cinotti[1], A. Viscido[1], C. Ferri[1]

[1]Dipartimento MESVA, Università degli studi de L'Aquila, Italy

Introduction: Gastrointestinal bleeding is increasingly common, particularly among the elderly,as they are related to the consumption of FANS and antiplatelet drugs.
Case report: An 86-year-old female, with medical history of paroxysmal atrial fibrillation in therapy with clopidogrel,hypertension and with a history for hemorrhage from acute diverticulitis,was admitted to hospital complaining severe hypochromic normocytic anemia,along with presence of hematochezia and melena for 3 weeks. An EGDS was negative. An colonoscopy,extended till right flexure, revealed diverticulitis on sigma tract without inflammatory signs. During recovery, onset of rectorrhagia. The patient underwent to transfusion of blood unit,ferrocarbossimaltosio infusion and tranexamic acid therapy, without benefit. An Angio-TC revealed a"slight focal area of hypervascularization on the cecum wall"of no certain meaning. Therefore, a second colonoscopy,extended till cecum,showed, on cecum, a continue hematic flow and after washing a source of bleeding was found. This lesion was compatible whit Dieulafoy Disease (DD). The patient was discharged home without antithrombotic therapy for atrial fibrillation because the CHA2DS2-VASc score was less than Has Bleeding Score. After 10days she was admitted to Emergency Department for chest pain and hemiparesis upper right limb. ECG revealed ST segment elevation like acute myocardial infarction by right coronary artery occlusion. The Head CT showed extended area of hypodensity compatible with acute ischemia.
Conclusions: DD is a rare case of gastrointestinal bleeding that can affect any tract of the gastro-enteric system.In the presence of major hemorrhagic events occurring in patients with atrial fibrillation the dilemma is whether and when to start oral anticoagulant therapy. The guidelines recommend the assessment of hemorrhagic and thrombotic risk by clinical scores,but,not always,the decision made on the basis of these scores is the correct one.

Una disfunzione sensitivo motoria risolta con immunoglobuline endovena

A. Ostinelli[1], B. Bellini[1], M. Monti[1], G.R. Mozzillo[1], G. Rossi[1], T. Raffa[1], D. Pellegrino[1]

[1]UOC Geriatria, Ospedale S. Anna, Como, ASST Lariana, Italy

Introduzione: La poliradicoloneuroparia infiammatoria cronica demielinizzante (CIDP) è una sindrome autoimmune caratterizzata da disordine sensitivo motorio cronico, progressivo e simmetrico con riscontro liquorale di dissociazione citoalbuminica, pleiocitosi linfocitaria e aumento di gamma globuline e perifericamente, infiltrazione perineuronale linfocitico-macrofagica con demielinizzazione.
Caso clinico: Uomo di 77 anni, ricoverato per approfondimento in polineuropatia demielinizzante periferica, precedentemente diagnosticata con EMG. Presentava ipostenia bilaterale agli arti inferiori, con deambulazione impacciata e alterata sensibilità. Alla visita: nervi cranici indenni, assenza di ROT, alterazione della sensibilità agli arti inferiori. In anamnesi: cardiopatia ischemica, aneurisma del VS con ICD, doppia componente monoclonale IgM K, adenocarcinoma della prostata. Ematici nei limiti, negativi ANCA, IgM per EBV e VZV, CMV IgM dubbio con CMV DNA negativo. Negativa la TC encefalo. Riscontro liquorale di elementi di tipo linfocitario, anticorpi

anti glicoproteina associata alla mielina 25000 U.A. (vn <1000), con negatività dell'indice di Link ed assenza di bande oligoclonali. Impostate Ig ev, con miglioramento sensitivo motorio, dei ROT, con ripresa della deambulazione autonoma.
Conclusioni: La CIDP si presenta in modo insidioso. I sintomi motori sono predominanti, secondari i sensitivi. Il principale approccio terapeutico sono Ig EV, eventualmente corticosteroidi o immunomodulanti. La remittente risponde meglio della cronico progressiva.

Trattamento osteopatico e stimolazione del sistema simpatico in soggetti sani

A. Palazzolo[1], S. Vernocchi[1], M. Tuvinelli[2], A. Aceranti[1]

[1]Istituto Europeo di Scienze Forensi e Biomediche, Gallarate (VA); [2]Accademia Osteopatia, Bergamo, Italy

Premesse e Scopo dello studio: Valutare se il trattamento osteopatico, con tecniche dirette HVLA (High Velocity Low Amplitude) a livello costo-vertebrale, stimoli il sistema simpatico in soggetti sani.
Materiali e Metodi: 50 soggetti maschi, dai 20 ai 30 anni, sani, non fumatori, reclutati consecutivamente eseguendo per ciascuno una valutazione basale (TC, FR, SpO2, PA omerale dx e sn e FC, almeno 3 rilevazioni). Il soggetto esaminato è seduto e a riposo da almeno 20 minuti. Nessuno presenta malattie genetiche, cifoscoliosi, alterazioni della meccanica respiratoria né assume farmaci. Le tecniche applicate HVLA "DOG" a livello osteo-articolare costo-vertebrale sui 3 progressivi livelli, da T3 a T5, da T6 a T8 e da T9 a T12 a dx o sn a seconda della disfunzione presente. I soggetti senza disfunzione, dieci, sono stati parametrati comunque, non trattati e considerati gruppo di controllo. Tutti sono stati rivalutati a 5 e 10 minuti, ed ad 1 ora dal termine del trattamento.
Risultati: I risultati mostrano una significatività statistica a 5,10 e 1 ora per la frequenza respiratoria p 0,0462 e per la pressione diastolica p 0,0325.
Conclusioni: Il trattamento osteopatico a livello costo-vertebrale, tramite tecniche dirette HVLA stimola il sistema nervoso autonomo simpatico prima e parasimpatico poi. Si tratta di valutare se il vantaggio apportato in termini di ipotensione e bradipnea possa mantenersi nel tempo.

Valutazione e trattamento non chirurgico della anchiloglossia

A. Palazzolo[1], D. Antonioli[2], E. Cassia[2], E. Gamba[2], M. Tuvinelli[2], S. Vernocchi[1], A. Aceranti[1]

[1]Istituto Europeo di Scienze Forensi e Biomediche, Gallarate (VA); [2]Accademia Osteopatia, Bergamo, Italy

Premessa e Scopo dello studio: La anchiloglossia è una anomalia congenita del frenulo linguale, la cui incidenza è del 5% nei neonati. Questa problematica interferisce con: deglutizione, fonetica e sviluppo dello splancnocranio. Non tutti i soggetti risultano idonei all'operazione, anche se presentano una lieve difficoltà inerente alla problematica in questione. Lo scopo dello studio è ricercare un trattamento non invasivo per migliorare la funzionalità della lingua, in soggetti con un frenulo corto e/o deglutizione atipica.
Materiali e Metodi: Lo studio valuta un soggetto sano e 2 soggetti con anchiloglossia di grado lieve trattati osteopaticamente. La misurazione è stata effettuata con calibro millimetrico ed esecuzione di vari test non presenti nei parametri valutativi di altri studi.
Risultati: In seguito al trattamento si è riscontrata una variazione di atteggiamento del capo, un miglioramento dell'apertura massima della articolazione temporo-mandibolare fino al 10% e un allungamento della catena linguale di 7 mm. I soggetti hanno riferito miglioramento nella deglutizione.
Conclusioni: Confrontando i dati raccolti, pre e post trattamento, si riscontra un miglioramento nella funzionalità nei parametri esaminati, sottolineando che l'anchiloglossia è un fattore che reca alterazioni al complesso stomatognatico. Si ipotizza che, il trattamento della lingua, possa essere una terapia di mantenimento per evitare possibili regressioni della funzionalità e favorire un miglioramento dei parametri qualitativi della lingua e della deglutizione, anche senza una variazione del frenulo.

Single inhaler extrafine triple therapy improves clinical outcomes in GOLD B COPD patients: Post-hoc analysis of the TRIBUTE Study

A. Papi[1], L. Fabbri[2], G. Micarelli[3], A. Piraino[3], S. Petruzzelli[3]

[1]Università degli Studi di Ferrara, Ferrara, Italy; [2]Sahlgrenska University Hospital, Gothenburg, Sweden; [3]Chiesi Farmaceutici, Parma, Italy

Background: TRIBUTE study demonstrated that extrafine beclometasone dipropionate/ formoterol fumarate/glycopyrronium (BDP/FF/G 87/5/9 µg per actuation) via pressurized metered dose inhaler (pMDI) significantly reduced exacerbations, improved lung function and quality of life compared to indacaterol/glycopyrronium (IND/GLY 85/43 µg per actuation) via dry powder inhaler (DPI) in symptomatic and exacerbators COPD patients. We re-categorised the study population into GOLD groups according to current guidelines to assess the effect of triple therapy in the subgroup of B patients.
Methods: TRIBUTE was a randomised, parallel-group, double-blind, double-dummy study. Patients received either BDP/FF/G or IND/GLY. Patients were ≥40 years, FEV_1<50% of predicted, ≥1 moderate/severe exacerbation in the previous year, CAT score ≥10. Out of 1532 patients, 969 (63.3%) were classified as B, according to GOLD 2018 classification. COPD exacerbation was defined as a sustained worsening of respiratory symptoms that required treatment with systemic corticosteroids, antibiotics, and/or hospital admission. EXACT-PRO questionnaire were used to better recognize potential exacerbations.
Results: In GOLD B patients, BDP/FF/G significantly reduced moderate/severe exacerbations by 23%, reduces SGRQ score by -2.16 points and improved FEV_1 by 28 ml over 52 weeks of treatment compared to IND/GLY.
Conclusions: Results confirm the superiority of extrafine BDP/FF/G compared to IND/GLY indicating that such beneficial effects can be extended to GOLD B patients with one moderate exacerbation in the previous year.

Prediction of fluid responsiveness in spontaneously breathing patients by using ultrasound measures: an update

N. Parenti[1], C. Palazzi[2], M. Silingardi[1]

[1]Department of Internal Medicine, AUSL Bologna, Bologna; [2]University of Modena e Reggio Emilia, Modena, Italy

Background and Aim: Several US measures are proposed to predict the fluid responsiveness (FRs) but there are divergent opinions on their efficacy and few reports on spontaneously breathing (SB) patients. We checked the reliability and validity in predicting FRs of the main US methods in SB patients.
Methods: This Systematic review was based on the PRISMA guidelines. We conducted a search of the literature from 1966/01/01 to 2018/12/31 on PubMed, Cochrane Library, Web of Science, and Scopus database. Inclusion criteria were: review and meta-analysis in English on reliability and accuracy of the ultrasound measures in predicting fluid responsiveness in adult SB patients.
Results: We considered for final analysis 5 studies (3772 patients): one review and four meta-analysis. The change of Cardiac Output after a Passive leg raising (PLR) maneuvers seems to have the best accuracy in predicting fluid responsiveness: positive Likehood ratio=4-7 and Diagnostic Odds Ratio=54; the Collapsibility index of Inferior Vena Cava and the Inferior Vena Cava diameter showed a fair-moderate and fair accuracy respectively: positive Likehood ratio=2.3-9 and Diagnostic Odds Ratio=6-13 for IVCc; AUC=0.62 (95%CI 0.5-0.8) for Inferior Vena Cava. There are not reviews on the reliability of US measures tested.
Conclusions: According to literature, there is evidence that dynamic change, after the PLR, of the Cardiac Output, tested by using the Echocardiography, could be the best tool to predict the fluid responsiveness in spontaneously breathing patients .

Gestione del paziente oncologico terminale ricoverato. Audit clinico

M.C. Pasquini[1], M. Manzoni[1], C. Bianchessi[1], S. Incardona[1], M. Moroni[2], S. Piloni[1], N. Rossi[1], I. Fugazza[1], M. Guerini[2], S. Defendi[2], M. Grassi[1]

[1]UO Oncologia, ASST-Crema; [2]UO Cure Palliative, ASST-Crema, Italy

Premesse e Scopo: La Direzione Medica ha evidenziato criticità nel setting di cura dei pazienti oncologici deceduti in ospedale. Abbiamo deciso di strutturare un'analisi rigorosa seguendo le regole dell'audit clinico con lo scopo di analizzare adeguatezza e appropriatezza del percorso diagnostico, terapeutico e gestionale del paziente oncologico terminale ricoverato.
Metodo: Audit clinico dei ricoveri esitati in decesso dal 01/01 al 30/06/2017. Partecipanti: oncologi, ematologi, palliativisti, psicooncologa e infermieri UO di Oncologia e Cure Palliative(CP).Fase preliminare di ricerca e analisi bibliografica, 6 incontri di 3 ore per analisi e discussione dei casi.
Risultati: 20 pazienti, 70% noto alla nostra UO, 85% ricoverato dal PS per sintomi non controllati. 40% nuova diagnosi, 10% ricovero e decesso per complicanze acute in malattia in risposta, 50% malattia in progressione. 20% effettuata chemioterapia nei 7 giorni precedenti, 80% nei 30 giorni precedenti. Nessuno noto all'unità di CP, in 12 attivazione durante il ricovero ma non dimissione per motivi organizzativi e rapida evolutività. Dall'analisi era indicata attivazione precoce delle CP nel 35%.
Conclusioni: L'audit è stato occasione di confronto multidisciplinare efficace tra personale con competenze specifiche diverse sul paziente oncologico. Il paziente oncologico che muore in ospedale è una realtà presente nelle nostre realtà ospedaliere. Il timing adeguato di integrazione con i colleghi di CP nel percorso di cura può essere di aiuto nel permetterne il trattamento in un setting più idoneo.

Nuovi approcci nella mastocitosi sistemica

V. Patella[1]

[1]GOI di Allergologia, Dipartimento di Medicina, PO di Battipaglia, ASL Salerno, Italy

Introduzione: Nuove acquisizioni nella mastocitosi sistemica (SM) sia in fisiopatologia che per nuovi farmaci permettono prognosi migliori rispetto al passato.
Metodi: Ricerca in letteratura di diagnosi e terapia in SM, neoplasia clonale dei mastociti (MC).
Risultati: Il criterio diagnostico maggiore è la presenza di cluster multifocali di MC anormali nel midollo osseo, i minori sono: livelli elevati di triptasi sierica, espressione anormale di MC CD25 e mutazione KITD816V. Una stratificazione del rischio è avvenuto stabilendo che tutti i pazienti con SM sono suddivisi in sottotipi: SM indolente; Mastocitosi isolata del Midollo osseo; Mastocitosi Smouldering; SM associate altra neoplasia ematologica; SM aggressiva; Leucemia Mastcellulare; Sarcoma Mastcellulare. L'identificazione di mutazioni povere di rischio (es. ASXL1, RUNX1, SRSF2, NRAS) raffina la stratificazione del rischio. Nuovi modelli clinici di rischio clinico-molecolare servono per una maggiore precisione della prognosi. I pazienti con SM indolente hanno un'aspettativa di vita normale e il trattamento è limitato alla prevenzione di anafilassi, controllo dei sintomi, trattamento dell'osteoporosi. I pazienti con SM avanzato necessitano di una terapia con midostaurina o con avapritinib (sperimentale), che hanno come bersaglio il recettore mutato del proto-oncogene tirosin-chinasi (KIT). Promettenti studi clinici includono DCC-2618 associato con avapritinib per indurre remissioni complete.
Conclusioni: Le terapie per la mastocitosi sistemica sono in uno stadio di evoluzione molto promettente, con un'ulteriore scoperte di ulteriori mutazioni associate all'oncogenesi, oltre al KIT più comunemente descritta, gli studi clinici in corso potrebbero potenzialmente portare a breve ed ulteriori terapie mirate e aumentare le risposte complete con remissioni durature.

A serious complication of an influenza syndrome

L. Pavan[1], B. Cattaneo[1], A. Grittini[1], E. Venegoni[1], P. Mantegazza[2], G. Patruno[1], A. Romorini[2], M. Mena[3], P. Viganò[3], N. Mumoli[1]

[1]Medicina, Magenta (MI); [2]Neurologia, Magenta (MI); [3]Malattie Infettive, Legnano (MI), Italy

Background: Guillain Barrè syndrome is an acute/subacute-onset polyradiculoneuropathy typically presenting with sensory symptoms and weakness over several days, often leading to quadriparesis. Approximately 70% of patients report a recent preceding upper or lower respiratory tract infection or gastrointestinal illness. Nerve conduction studies show multifocal demyelinating process, including conduction block or temporal dispersion in motor nerves.
Clinical case: A 44-year-old woman suffering from headache, presented intense pain in lower limbs and spinal cord during influenzal fever for 10 days. In a neurological examination the hypothesis of sensitive Guillain Barrè syndrome was formulated so the patient was admitted in Hospital to start immunoglobulin therapy. Blood tests, abdomen ecography,rachiocentesis and cerebrospinal fluid tests were performed. The situation worsened so she was transferred in Intensive Care Unit and treated by invasive mechanical ventilation. Immunoglobulin therapy went on with good results then the patient returned in Medicine Unit. The patient presented a 7th cranial nerve paresis, too. When CMV infection was diagnosed, ganciclovir was administered till virus DNA was set at zero. Spinal cord MR confirmed inflammation of roots. Then the patient was transferred in Rehabilitation where she improved very much.
Conclusions: In this case the consequence (Guillain Barrè syndrome) was treated before the real cause (CMV infection) because of its seriousness and the time necessary for laboratory results. Risk factors for a fast worsening were not found.

A case of late onset combined immunodeficiency

V. Pedini[1], C. Mezzanotte[1], C. Gelardi[1], D. Menghini[1], A. Gabrielli[1], M.G. Danieli[1]

[1]Clinica Medica, Università Politecnica delle Marche e Ospedali Riuniti, Ancona, Italy

Background: Common variable immunodeficiency (CVID) is the most common symptomatic primary immunodeficiency of the adulthood. Immunological and genetic heterogeneity reflects a wide spectrum of disease manifestations, which include not only recurrent infections but also autoimmunity, lymphoproliferation, entheropathy and cancer. Late onset combined immunodeficiency (LOCID) is a recently defined CVID subset.
Case report: We report the case of a 47 year-old Caucasian man with a history of severe sepsis from opportunistic agent (Candida spp) and encephalitis (Herpes simplex), complicated by an ischemic stroke. He referred a 10-year history of recurrent respiratory tract infections with persistent hypogammaglobulinemia. At the observation, he reported profound weakness and asthenia. Lab analysis revealed severe immunoglobulin deficiency of all classes associated with a low T lymphocyte CD4+ and switched memory B cells count. According to clinical and lab data, diagnosis of LOCID was performed and patient started treatment with replacement intravenous immunoglobulin, with no recurrent infections during the follow-up period.
Conclusions: LOCID represents a subgroup of CVID patients, characterized by hypogammaglobulinemia and associated severe T cells deficiency with opportunistic infections. These patients may present higher prevalence of complications related to CVID, so they require specific attention in the daily care.

Fournier gangrene: a real challenge for the Emergency Department overcome only with a collective effort!

G.A. Piccillo[1], E.G.M. Mondati[2], G. Gasbarrini[3]

[1]Emergency Department, Cannizzaro Hospital, Catania; [2]Department of Internal Medicine and Systemic Pathologies, University of Catania; [3]Professor Emeritus of Internal Medicine, Catholic University of Rome, Italy

Background: Fournier's gangrene (FG), is a very rare but serious emergency seen all over the world. Risk factors are diabetes, old age, alcoholism, obesity, paraplegia, renal insufficiency. Early diagnosis with prompt treatment are imperative for a good outcome.
Case report: A 72 aged man presented to our Emergency Dept for a rapidly fulminating scrotum and penis painful infection with smelling discharge. He presented pale, tachycardic, tachypnoic, hypotese, dehydrated, confused with mild icterus. The scrotum was grossly edematous, tender with palpable crepitations and multiple discharging gangrenous patches. Broad-spectrum antibiotics were started and an indwelling Foley's catheterization was done. At laboratory: anaemia and leukocytosis with neutrophils; renal parameters altered; rise of bilirubin and AST/ALT. He underwent to

surgical debridement and pus culture with presence of *E. coli* and *S. aureus* sensitive to antibiotics already administered. Within 7 days all the laboratory parameters normalized his jaundice subsided. He required daily wet dressing, many sittings of debridement, hyperbaric chamber sessions and wound reconstruction by secondary suturing before the discharge.
Discussion: FG is a serious disease with high mortality and morbidity. In the last years new diagnostic tools, surgical technique, potent antibiotics, and critical care, hyperbaric treatment have reduced the morbidity and mortality of the disease. But it is mandatory and recommended to adopt a prompt and multidisciplinary approach in FG management in order to save these unlucky patients!

The technological challenge of continuous wireless monitoring in Internal Medicine unit to improve management of complex patients: the green line from hospital to territory (Green Line H-T Study)

F. Pietrantonio[1], M. Ronchetti[2], A. Valerio[3], M.E. De Caris[4], G. Gussoni[3]

[1]UOC Medicina Interna, Ospedale dei Castelli, ASL Roma 6; [2]Direzione Sanitaria Aziendale, ASL Roma 6; [3]Fondazione Fadoi; [4]Direzione Sanitaria Aziendale, ASL Roma 6, Italy

Background: In Internal Medicine unit (IMU) the patients with serious illness, under acute exacerbation of chronic diseases needing high intensity care and evaluation of clinical deterioration risks, are progressively increasing. To implement a stratification of optimal treatments and intensity of care model would allow to contain costs, during hospital stay and when patients are discharged.
Materials and Methods: Prospective, randomized, controlled, open-label, monocentric study for the evaluation of critically ill patients admitted to IMU and subsequently sent to subacute care unit or to earlier discharge, in order to evaluate the effectiveness on outcomes (critical adverse events, clinical exacerbations) of a wireless *vs* a traditional monitoring of clinical conditions. Continuous wireless vital parameters and blood glucose monitoring are assured by WIN@Hospital and Dexcom G6 devices.
Pilot phase results: On September 2018 the Telemedicine service of the ASL Roma 6 was activated with local assistance 24h/24, and 8 patients with very high complexity were early discharged from the IMU wearing wireless monitoring and followed by Districts health personnel of the ASL Roma 6. 163 professionals were trained (146 nurses/17 physicians). The program was approved and granted by the Lazio Region (for more than 1 million €) and supported by FADOI Foundation as well.
Conclusions: Integrating hospital and territory is a new challenge of Telemedicine, and the aim of the Green-Light H-T study is to make it possible in the area covered by ASL Roma 6 health services.

Gemcitabine-associated Hemolytic Uremic Syndrome: a case report

C.C. Pircher[1]

[1]Istituto dei Tumori, Milano, Italy

Background: Atypical haemolytic uremic syndrome (aHUS) is characterized by haemolytic anaemia, thrombocytopenia, and renal impairment. It can be rarely caused by drugs. We present a case of aHUS secondary to anti-cancer agent gemcitabine.
Clinical history: In August 2017, a 64-year-old male started weekly gemcitabine for a recurrent soft tissue sarcoma. After the 11th cycle, he was admitted for a transient ischemic attack. A brain CT scan showed an oedematous left occipital lesion, presumably microangiopathic. The clinical examination showed generalized oedema, weight gain (5 Kg), hypertension. Blood tests showed anoemia (HGB 7 gr/dL), thrombocytopenia (PLT 89 x 10^3/mcL), acute kidney failure (GFR 26 ml/min). The diagnosis of gemcitabine-induced aHUS was performed upon the following, progressive, clinical deterioration and evidence of haemolysis (LDH 1000 U/L, undetectable haptoglobin and schistocytes on peripheral blood smear). Gemcitabine was discontinued and the patient treated with plasma infusion, steroids, loop diuretics, and eculizumab, without any amelioration. After 30 days, the patient being in terminal uremia, hemodialysis was started, achieving progressive normalization of hematologic parameters and clinical improvement. The patient is currently well, in periodic hemodialysis. No other anti-cancer treatments were needed.
Conclusions: Although rare, aHUS is a serious complication. Quick recognition of its signs leads to a prompt diagnosis and, eventually, early treatment. Options include plasma infusion or exchange, eculizumab, hemodialysis.

Diabetes, obesity, BPCO and cardiovascular disease management: a case report

R. Piro[1]

[1]Ambulatorio di Diabetologia ed Ecocolordoppler, Ospedale S. Francesco di Paola, Paola (CS), Italy

Background: Type 2 diabetes mellitus therapy should aim at reducing glycaemia, to lower micro and macrovascular complications, and other risk factors such as body weight, lipid profile and hypoglycaemia events. Personal targets should be defined considering lifestyle, cultural and socio-economic context.
Case report: I visited a 56 years old woman, diabetic since she was 36, BMI 55,88 Kg/m^2, fasting glycaemia 295 mg/dl, HbA1c11,5%, PA 145/100, total cholesterol 267 mg/dl, LDL 132 mg/dl, triglycerides 342 mg/dl, creatinine 1,1 mg/dl, creatinine/albumin ratio 206 mg/g of creatinine, ECG: signs of asymptomatic ischemic cardiopathy. Baseline therapy: sulfonylurea 60 mg and metformin 1000 mg both 3 times/die, basal insulin 30 U/die, ACE inhibitor 10 mg/die and calcium antagonist. During a hospitalization, because of respiratory/heart failures, she was treated with cortisone and basal bolus insulin therapy, after discharge she earned 6 Kg and HbA1c reduced to 9,5%. She came back to my clinic refusing to maintain basal bolus, so I decided to choose a therapy with high effectiveness and compliance, with the aim to reduce more body weight and improve lipid profile: I prescribed metformin 1000 mg, Liraglutide 1,2 mg and Insulin Degludec 12 U. 90 days after: HbA1c 9%, BMI 46,84 Kg/m^2, total cholesterol 180 mg/dl, LDL 90 mg/dl and triglycerides 70 mg/dl, so I intensified liraglutide to 1,8 mg and 90 days after BMI was 34,52 Kg/m^2, consequently insulin therapy was stopped.
Conclusions: Liraglutide confirms its efficacy in whole diabetes management, weight included, even in a long time disease and high cardiovascular risk patient.

Central nervous system lesions, not only metastasis

M. Piscaglia[1], G. Resta[1], F. Dazzani[1], P. Giacomoni[1]

[1]Ospedale Umberto I, Lugo (RA), Italy

Background: Toxoplasmosis is the most common central nervous system infection in patients with AIDS who are not receiving appropriate prophylaxis.This infection has a worldwide distribution and is caused by the intracellular protozoan parasite *Toxoplasma gondii*.
Case report: Patient female 42 years old, ukrainian, hospitalized because of fever, severe decay of general condition and imbalance. First hematologic tests (blood count, inflammatory markers, coagulation, renal and liver function) are normal. Brain CT: three lesions suggestive for metastases. Because of quickly worsening symptoms (confusion, lethargy), we submit patient to brain RM finding three ring-enhancing lesions (two localized in the parietal and one in the frontal lobes) suggestive for cerebral toxoplasmosis. Other possible diagnosis: lymphoma, mycobacterial infection, cryptococcosis, bacterial abscess. Meanwhile laboratory tests reveal: anti HIV antibody, IgG anti-toxoplasma, CD4 <100 cells/microL. Analisis of cerebrospinal fluid reveals a mild mononuclear pleocytosis and an elevated protein, and detection of *T. gondii*.
Conclusions: The probability of developing reactivated toxoplasmosis is as high as 30 percent among AIDS patients with a CD4 count<100 cells/microL who are toxoplasma seropositive and are not receiving effective prophylaxis or antiretroviral therapy.

Recurrent splenic infarcts despite antiplatelet-anticoagulant therapy in polycythemia vera

A.M. Pizzini[1], E. Accogli[2], S. Zaccaroni[1], S. Dapporto[1], C. Giannoni[1], C. Mancusi[1], C. Cavoli[1], M. Silingardi[1]

[1]Dipartimento Medico, Ospedale Maggiore, Bologna; [2]Dipartimento

Medico, Centro Ecografico, Ospedale Maggiore, Bologna, Italy

Background: Polycythemia Vera (PV) is a condition at high risk of arterial/venous thrombosis. Aspirin is recommended in primary prevention of cardiovascular events, but this treatment is sometimes not protective.
Case report: We present a 77-year-old woman with PV (JAK2+) on hydroxyurea treatment. She was on treatment with warfarin for recurrent venous thrombosis and Aspirin (75 mg/od) for a previous stroke. Past medical hystory was remarkable for recurrent splenic infarctions (at least four episodes since 2016), despite therapeutic INR range and regular aspirin intake. In January 2019 the patient was admitted for recurrence of abdominal pain. The platelet count was 394 000/mmc, LDH 770 U/L and INR 2.3. Contrast Enhancement Ultrasound Sonography (CEUS) showed a triangular area diagnostic for a recent infarction at the lower splenic pole. A second CEUS finally confirmed the diagnosis a week later. Warfarin was continued at the same INR target (2.5). We decided for a twice daily dose of ASA 75 mg. Follow-up is actually negative for events and bleeding.
Conclusions: The case suggests that antiplatelet treatment may not have the expected protective effects probably due to an accelerated platelet turnover in PV with reappearance of new platelets with intact-COX-1 activity . A recent report suggests that twice-daily aspirin may work better than once daily dose in patients with Essential Thrombocytemia. The case is also interesting for CEUS use instead of CT scan (more expensive and radiation exposing).

Evaluation of advanced nursing skills in oncology

M. Pizzuto[1]

[1]UOC Oncologia, ASL 4 Veneto Orientale, Portogruaro (VE), Italy

Background: To evaluate the nursing skills improves the quality and safety of care, although there is still no universal instrument, applicable to different realities, which measure levels. The specialization in oncology improves outcomes, determined in whole or in part direct nursing.
Materials and Methods: The aim of the research was to assess the fallout of advanced nursing skills in terms of outcomes. We conducted a retrospective study by analyzing a dataset examining clinical outcomes, organizational and professional.
Results: 264 patients with cancer were analyzed with PICC (peripherally inserted central catheter) in different stages of disease. The indication was chemotherapy in 94.7% with a mean of 133.2 days/catheter of 34,634 days of observation. The global rate of complications was 1.06 per 1000 days/catheter. In 3% of cases the device has been removed for complications. The analysis of the questionnaire showed a supportive environment, organizational and professional empowerment flexibility with full expression of the role.
Conclusions: The literature review highlighted the need for standardized tools in the evaluation of nursing skills. In oncology there is a need of qualified nursing staff and trained and an environment that permits the involvement, fundamental in terms of quality of care. The context of health practice has been linked with patient outcomes. Support the development of skills with well-defined areas of responsibility are indispensable for the development of highly professional operators.

Una rara infezione nel paziente cirrotico

G. Poggi[1], B. Montagna[1], I. Palumbo[1], C. Picchi[1]

[1]UO Medicina Generale, Istituto Clinico Città di Pavia, Gruppo San Donato, Pavia, Italy

Premesse: La manifestazioni clinica più comune dell'infezione da *Campylobacter jejuni* è la gastroenterite acuta che si manifesta con dolore addominale, diarrea e febbre. La batteriemia da Campylobacter è considerata un evento raro che colpisce i pazienti immunocompromessi.
Caso clinico: Un uomo di 70 anni con cirrosi epatica HCV-relata ed esiti di splenectomia e by-pass spleno-cavale per ematemesi recidivanti è stato ricoverato per febbre, ascite, edemi declivi subittero e marcato innalzamento degli indici di flogosi (PCR 18 md/dl; PCT 1,58 ng/ml). Non dispnea, tosse, nè catarro, non diarrea ma diffusa dolenzia addominale. L'addome era piano, trattabile ma dolente alla palpazione senza segni di peritonismo. Per il persistere di episodi febbrili T >38,3° C sono state eseguite emocolture seriate ed è stato somministrato antibiotico empirico (imipenem 1 gr x 3/die ev). In 3° giornata due set di emocolture sono risultati positivi per C. jejuni con antibiogramma che ha mostrato una spiccata sensibilità per Imipenem con sensibilità anche per ciprofloxacina. Dopo una settimana di antibiotico il paziente è stato dimesso, apiretico e in netto miglioramento clinico e laboratoristico con indicazione a proseguire ciprofloxacina orale.
Conclusioni: *C. jejuni* è principalmente isolato nelle feci e causa diarrea acuta, mentre la batteriemia si verifica in <1% dei casi. La maggior parte dei casi di batteriemia da Campylobacter ha coinvolto pazienti con condizioni sottostanti in particolare cirrosi epatica, neoplasie maligne, stati immunosoppressi e alcolismo.

Pleuroparenchymal fibroelastosis with an UIP pattern: considerations on a group of patients

G.E. Polistina[1], G. Rea[2], A.S. Zamparelli[1], M. Bocchino[1]

[1]Department of Clinical Medicine and Surgery, Section of Diseases of the Respiratory System, University Federico II, Naples; [2]Department of Radiology, Ospedale Monaldi, Naples, Italy

Pleuro-parenchymal fibroelastosis (PPFE) is a rare entity whose etiology is often unknown. As such, it is included in the latest classification document for idiopathic interstitial pneumonitis. Often characterized by an aggressive clinical course, it is an orphan disease. We describe three different cases come to our observation in the last year (2F and 1M, mean age 65 years), all with radiological evidence of apical alterations suggestive of PPFE in association with definite UIP patterns/probable UIP pattern at lower lobes. Symptoms of onset were dyspnea due to mild efforts and dry cough. A moderate restrictive ventilatory pattern was present in all cases, with associated impairment of diffusing capacity of the lung for carbon monoxide (DLCO). A condition of latent respiratory failure was present at diagnosis in all three cases. We decided to start an anti-fibrotic drug, in an off-label regimen, in two patients as a bridge therapy awaiting lung transplantation. During the monitoring phase, anti-fibrotic therapy was suspended in one of 2 patients, due to severe loss of appetite and weight, together with a significant functional deterioration and a radiological progression of the disease. In the other case, the treatment is still well tolerated with stability of clinical-functional parameters. In the third patient (over eighty years old), more recently observed, we decided not to proceed with an anti-fibrotic therapy. The debate on the association of PPFE with radiological pattern suggestive of usual interstitial pneumonia as a nosological entity distinct from idiopathic pulmonary fibrosis, or rather as a different phenotype of IPF with characteristics of more severe aggressiveness, is still open. Despite a severe prognosis, PPFE is not an indication for treatment with anti-fibrotic drugs. Promising results are expected from clinical trials currently underway on different phenotypes of clinical-radiological presentation of pulmonary fibrosis.

Sometimes the clinical history is enough: tetanus

M. Ponte[1], V. Bonasia[2], D. Pecori[3]

[1]Medicina interna, PO S. Maria della Misericordia, Udine; [2]Medicina Interna, PO S. Maria della Misericordia, Udine; [3]Malattie Infettive, PO S. Maria della Misericordia, Udine, Italy

Background: Tetanus is an acute disease caused by an exotoxin produced by the bacterium *Clostridium tetani*. It enters the body through a wound. It is characterized by generalized rigidity and convulsive spasms of skeletal muscles. The incubation period ranges from 3 to 21 days.The first sign is trismus or lockjaw, followed by stiffness of the neck, difficulty in swallowing, and rigidity of abdominal muscles.Spasms may occur frequently and last for several minutes, can continue for 3–4 weeks. No laboratory findings are characteristic of tetanus. Tetanus immune globulin (TIG) is recommended for persons with tetanus.
Case report: 72-year-old patient reaches the hospital for irradiated neck pain in the back. The clinical history begins on 16/11 with a drop to domicile and access to emergency service where antitetanic vaccination was administered. After 10 days headache and pain in

the mandibular temporo region. 1/12 admits in our service. Steroid therapy is initiated in the suspicion of Horton. The 3/12 appearance of photophobia, stiffness in the lower limbs, limitations in the opening of the mouth gives the diagnosis of tetanus:500 IU of antitetan immunoglobulins are administered, antibiotic therapy is started and is transferred to intensive care where it is intubated for airway protection. He is discharged with complete recovery.
Conclusions: In literature finding cases of tetanus diagnosis in an Internal Medicine department is rare. Even in an Internal Medicine department not forget to check vaccinations.

Quel prurito insostenibile

L. Postacchini[1], E. Fabbri[1], L. Gardelli[1], P. Valentini[1], F. Girelli[1], V. Mazzeo[1], G. Bondi[1], M. Nizzoli[1]

[1]UOC Medicina Interna, Ospedale Morgagni-Pierantoni, Forlì, Italy

Premesse: Il prurito può essere espressione di manifestazioni allergiche, reazioni da farmaci o semplice xerosi ma spesso è la spia di patologie sistemiche quali malattia renale cronica, epatopatia colestatica,tumori maligni solidi o ematologici e parassitosi.
Caso clinico: Uomo di 86 anni ricoverato per prurito persistente con reazione eritematosa diffusa da oltre 6 mesi. In anamnesi: colecistectomia, BPCO ed ipertensione arteriosa in terapia con ACE-inibitore. Per tale sintomatologia assumeva steroidi con transitorio beneficio. All'obiettività nulla di rilevante ad eccezione di un lieve arrossamento cutaneo e lesioni da grattamento. Agli esami ematici riscontro di eosinofilia(18%) e rialzo della PCR(10 mg/L). Test allergologici per acari, alimenti, agenti inalanti negativi. All'ecografia addominale segnalata splenomegalia(16 cm). La TC total-body risultava negativa per patologia neoplastica. La biopsia cutanea documentava un quadro compatibile con reazione allergica da farmaci o parassiti ma l'esame parassitologico delle feci risultava negativo. Eseguite ricerca triptasi sierica e BOM che escludevano mastocitosi. La sierologia per Strongyloides Stercoralis risultava positiva per cui iniziava terapia con albendazolo con beneficio.
Conclusioni: La Strongiloidiasi è un'infezione parassitaria causata dallo Strongyloides Stercoralis trasmesso dal contatto della cute con il terreno contaminato. I sintomi principali coinvolgono cute,apparato gastroenterico e respiratorio. La diagnosi si basa su esame diretto delle feci e ricerca anticorpale.Terapia utilizzata ivermectina o albendazolo.

From COPD to chronic systemic inflammatory syndrome?

F. Provenzano[1], L. Spano[1], V. Aiello[1], D. Brancato[1], A. Di Noto[1], M. Fleres[1], G. Saura[1], A. Scorsone[1], V. Provenzano[1]

[1]UOC Diabetologia, PO Civico di Partinico, ASP Palermo, Italy

Background: COPD is a subdiagnosed and under-treated pathology associated with co-morbidities such as diabetes, cardiovascular disease and hypertension; so that COPD seems to be included in a chronic systemic inflammatory syndrome in which cytokines released at the visceral adipose tissue activate a systemic inflammatory response responsible of bronchial hyperreactivity, atopy, altered immune response.
Materials and Methods: The population of patients with T2DM related to the Integrated Management Clinic was analyzed. Patients underwent a visit, mMRC questionnaire, spirometric examination using Air Smart Spirometer. Between September and November 2018, 135 patients were evaluated and 82 spirometries were performed correctly (41% women, 59% men, mean data: age 64 years, weight 83 kg, BMI 30.4).
Results: 32% of diabetic patients with bronchial obstruction were unknown and deserving of pharmacological treatment. Statistical analysis revealed a linear correlation between BMI and FEV1 ($p<0.0365$). The statistical analysis also showed a significant correlation between the abdominal circumference and the degree of bronchial obstruction expressed as FVC/FEV1 <0.7 ($p<0.05$).
Conclusions: The obtained results denote the correlation between COPD and the metabolic syndrome in particular with the visceral obesity and the secondary systemic inflammatory. A diagnostic - therapeutic path has been created that allows the emergence of obstructive diseases, take appropriate therapeutic choices and contain the secondary costs to the high rate of hospitalizations.

How do sex and BMI affect glucocorticoid treatment in adrenal insufficiency?

S. Puglisi[1], I. Tabaro[1], S. Cannavò[2], G. Borretta[3], P. Micaela[3], F. Chiappo[1], A. Pia[1], M. Terzolo[1], G. Reimondo[1]

[1]Department of Clinical and Biological Sciences, University of Turin; [2]Department of Human Pathology 'G. Barresi', University of Messina; [3]AO S. Croce e Carle, Cuneo, Italy

Background and Objectives: Optimization of glucocorticoid (GC) replacement therapy in adrenal insufficiency (AI) is crucial to avoid under- or overtreatment. The aim of the study is to assess the influence of sex (M/F) and BMI on dosing GC in patients with AI of different etiology.
Patients and Methods: We retrospectively analysed 203 patients (104 primary AI [pAI], and 99 secondary AI [sAI]) followed-up for ≥12 months over the last 2 decades treated with hydrocortisone (HC), HC modified release (HCMR) or cortisone acetate (CA). We evaluated the total daily dose (TDD) and per-Kg-daily dose (KDD) of GC either at baseline or at the last visit.
Results: In patients with pAI at baseline, KDD was higher in F than in M ($p=0.016$). At last visit, KDD and TDD were significantly lower than at baseline ($p=0.014$ and $p=0.048$, respectively) only in F. KDD and TDD were not significant different between F and M at last visit. In patients with sAI both at baseline and at last visit, KDD was not significant different between F and M. At last visit, TDD was significantly lower in F than in M ($p=0.001$). At baseline, the use of HC was preferred in pAI, while the use of CA in sAI. At last visit, the rate of patients in HCMR was higher in pAI than in sAI.
Conclusions: Our real life study demonstrates that in pAI GC replacement is likely overdosed in F when treatment is initiated, but optimization of therapy and a more extensive use of HCMR lead to a marked GC dose reduction in these patients. In sAI patients, lower GC starting doses are used with minimal dose adjustment during follow-up.

Streptococcus gallolyticus subspecies *Pasteurianus* bacteraemia following adjuvant chemotherapy after distal pancreatectomy with splenectomy

N. Pulizzi[1], B.A. Rosaia[1], C. Pandolfo[1], L. Tomisti[1], A. Pampana[1]

[1]Ospedale Apuane, Massa, Italy

Background: *S. gallolyticus subsp. Pasteurianus* is part of normal intestinal flora and bacteraemia has been associated with heterogeneous hepatobiliary diseases.
Case report: A 60-years-old man presented to the emergency department (ED) with vomit and fever (38.1°C) and a history of cecal polypectomy and splenomegaly due to indolent non-Hodgkin (NH) lymphoma. Five months before he underwent distal pancreatectomy and splenectomy (G2 adenocarcinoma pT3N2; splenic NH lymphoplasmacytic lymphoma) and four months later he started adjuvant FOLFIRINOX, the first cycle followed by diarrhoea, the second cycle administered six days before the ED presentation. On admission the clinical exam was normal. Blood tests showed pancytopenia, compatible with chemotherapy toxicity. He started empirical treatment with piperacillin-tazobactam. On day 3 blood cultures showed *Streptococcus Pasteurianus* bacteraemia: the transesophageal echocardiogram ruled out endocarditis; colonoscopy was refused. The patient was discharged afebrile after nine days with the prescription of oral amoxicillin/clavulanate and was referred to the oncologist for further follow-up.
Conclusions: In this case *Streptococcus Pasteurianus* bacteraemia might be the result of iatrogenic mucositis and subsequent bacterial translocation in a patient immunedepressed after splenectomy and two cycles of chemotherapy. The impact of intestinal microbioma before chemotherapy on the risk of subsequent bloodstream infection remains unclear.

Uno strano caso di disartria

E. Reali[1], A. Sarno[1], S. Stefanini[1], R. Rondinelli[1], E. Amato[1], D. Tonietti[1], M. Cacciafesta[1], C.A.M. Lo Iacono[1]

[1]AO Universitaria, Policlinico Umberto I, Dipartimento di Medicina Interna e Specialità Mediche, UOC Geriatria e Gerontologia, Roma, Italy

Premesse: La SLA è una malattia neurodegenerativa dell'età adulta a decorso progressivo ed insidioso con debolezza focale e successivo coinvolgimento della maggior parte dei muscoli, incluso il diaframma.La morte per paralisi respiratoria sopraggiunge in 3-5 anni.
Case report: Paziente, di anni 79, presentava da 3mesi disartria con deficit di forza all'arto superiore dx e da 1mese disfagia.In anamnesi: ipertensione arteriosa, dislipidemia e aneurisma dell'arteria cerebrale media dx.All'esame obiettivo: condizioni generali discrete, vigile, orientato nel tempo e nello spazio, collaborante. Si rilevava disartria con eloquio lento, impastato e voce nasale. Alla prova di Mingazzini lieve sottoslivellamento dell'arto superiore dx con deficit di forza alla prensione alla mano dx. I ROT apparivano ipereccitabili. Non deficit di sensibilità.Le prove di deglutizione mostravano un'iniziale difficoltà nella gestione dei boli liquidi.La RMN dell'encefalo e del rachide confermava l'aneurisma noto in anamnesi senza evidenza di sanguinamenti, lesioni ischemiche né fenomeni compressivi a livello del rachide cervicale. L'elettroneuromiografia rilevava danno neurogeno con denervazione in più distretti non contigui. L'evidenza clinica ed elettrofisiologica della degenerazione dei motoneuroni sia centrali che periferici e la progressiva diffusione dei segni e dei sintomi ha supportato la diagnosi di sclerosi laterale amiotrofica bulbare.Il paziente iniziava terapia con Riluzolo, Levoacetilcarnitina e Palmitoiletanolamide.
Conclusioni: La presenza di atrofia e debolezza muscolare soprattutto alle mani e agli avambracci, le fascicolazioni, la lieve spasticità agli arti superiori e/o inferiori e l'iperreflessia generalizzata, in assenza di disturbi sensitivi, sono fortemente suggestivi per SLA. La conferma della diagnosi si basa sul quadro clinico, sui risultati dell'elettromiografia e sull'esclusione delle patologie che possono simulare la malattia.

Cardiac amyloidosis: a complex diagnosis

M. Renis[1], M.T. De Donato[2]

[1]UOC Medicina Interna, PO Cava de' Tirreni, AOU Salerno; [2]UOC Medicina Interna, PO Ruggi, AOU Salerno, Italy

Introduction: The etiopathogenesis of heart failure (HF) is not always obvious. There are some very infrequent causes.
Case report: Male, 70. Non smoker. Anamnesis: fibromyalgia; MGUS in follow up. For some months: dyspnoea for habitual activity and hypotension. He practiced: Blood tests: increased BNP; Echocardiogram: septal hypertrophy, normal systolic function, diastolic dysfunction; Chest X-ray and CT: bilateral basal fibrosis; Spirometry, Blood Gas and walking test: within limits. He gradually improved through the treatment of HF. After a few months: significant dyspnea with onset of atrial fibrillation; DOAC therapy was undertaken. Due to persisting symptomatology, the patient was hospitalized. During the hospitalization, after electrical cardioversion: severe bradyarrhythmias and subsequent implantation of pacemaker (diagnosys: arrhythmic disease of the atrium). A coronary angiography excluded ischemic pathology. He was then sent to another Clinic Center where the dignostic iter was completed with myocardial and osteomidullary biopsy, with a final diagnosis of cardiac amiliodosis.
Discussion and Conclusions: Two are the main observations: MGUS are not always "benign", but a reasoned follow-up must always be performed in order to exclude forms of micromolecular myeloma. (diffuse infiltration of the bone marrow, with only light chains in the circulation). In the presence of micromolecular myeloma, we must also think about of amyloidosis, and in particular, in a subject suffering by MGUS with heart failure of unclear eziopaogenesis, we must suspect cardiac amiliodosis

An original method for testing *in vivo* nutritional knowledge during a scientific meeting

M. Rinaldi[1], A. Campanile[2], A. Maffettone[2], E. Fiorillo[2], S. Bellafesta[2], G. Piccolo[2], F. Sabbatino[2], C. Peirce[2], O. Maiolica[2], S. Di Fraia[2]

[1]UOD Metabolica, UOC Medicina Cardiovascolare e Dismetabolica, AO Specialistica dei Colli, Napoli; [2]UOC Medicina Cardiovascolare e Dismetabolica, AO Specialistica dei Colli, Napoli, Italy

Background and Aim: During the FADOI "Nutrition and Internal Medicine: False Myths and Reality in the Third Millennium" meeting held on December 18, 2018 we chose to offer a Mediterranean diet menu with a limited caloric content, in pre-established portions, supplying the guests with the composition of the dishes as well as the quantities of the food principles per serving. Based on a distributed questionnaire, we performed an assessment of the nutritional skills of the at the meeting.
Materials and Methods: At the conference attended doctors, nurses, pharmacists, dietitians and nutritionists. In the buffet we chose 5 courses: 1) Minirustici 2) Vegetable couscous 3) Spelt with pesto 4) Ricotta sheep 5) Chickpea soup with croutons 6) Slice of pastiera. Dishes' composition and relative recipe were exposed on the table and on the walls of the hall. The questionnaire (5 questions) was distributed at the beginning and collected at the end of the meal and processed in real time (52 valid questionnaires; results were discussed in plenary.
Results: The greatest approval (52.3%) went to spelt with pesto, the most caloric food. Cocerning the other 4 items, the majority of the participants indicated 2 correct answers (higher in fat and easier preparation) and 2 wrong answers (more caloric food, more suitable food for diabetics).
Conclusions: The unusual evaluation test, outside the classic schemes with practical content, has be considered valid in the method (the most appreciated dish was also the most caloric) and extremely useful to arouse interest in discussion. The Mediterranean buffet showed how in real life it is possible to eat correctly, easy to prepare, with right caloric content, and macronutrients (correct amount in carbohydrates and fats).

Caso di eosinofilia

D. Riva[1]

[1]Reparto di Medicina, Ospedale A. Manzoni, Lecco, Italy

Descriviamo un caso di dispnea con eosinofilia ematica. Questo caso ha attirato la nostra attenzione non tanto sul valore degli eosinofili, ma sul resto delle manifestazioni cliniche ed in particolare sul polmone in base a cui poi siamo riusciti a fare diagnosi. Sig. V.D. anni 76: diagnosi di ingresso dal Pronto Soccorso: Dispnea. In anamnesi storia di asma in passato ed ultimamente di BPCO: Il paziente presenta eosinofilia marcata agli esami ematici (5840/mm3), poliposi nasale alla visita otorino, eosinofilia 40% nel BAL, alla tac del torace tenui aree di graund glass ai lobi inferiori, oltre alla presenza di fine ispessimento reticolare ai lobi inferiori e presenza di enfisema parastatale prevalente ai lobi superiori. La diagnosi di BPCO ci avrebbe sicuramente fuorviato, il fatto di trovare gli elementi di cui sopra unito alla presenza alla di EMG di mononeuropatia del nervo perineo comune dx ci ha ricondotti a far giusta diagnosi di sindrome di CHURG STRAUSS. Perché come dice un personaggio anonimo famoso: "il futuro del trascurare è perdere". Quindi diciamo che abbiamo avuto due casi di eosinofilia diversi, due diagnosi completamente diverse: una infausta, l'altra a prognosi favorevole con le attuali cure.

With the combined use of innovative drugs can diabetes type 2 go into remission?

E. Rocchelli[1], A. Martinelli[1]

[1]ASP S. Margherita, Università degli Studi di Pavia, Italy

Background: The use of innovative antidiabetic drugs in combination can determine, not only the rapid achievement of the ideal glycemic target but also the protection against organ damage without inducing hypoglycemia.
Case report: Man, 51 years old, DMT2 since 2015, first diabetological examination in 09/2016: HbA1c 13.5%, FPG 362 mg /dl, normal EGFR, Tryglicerides 205 mg /dl, LDL 166 mg/dl. Previous therapy with Metformin 1000 mg TID, for refusal of insulin therapy, we started Dulaglutide 1.5 mg/week (without Therapeutic plan)+Dapagliflozin/metformin 5/1000 mg BID and simvastatin 20 mg. With echo abdomen we excluded pancreatic lesions. Two-month control 11/2016: HbA1c 9%, FPG 89 mg/dl, TG 52 mg/dl,

LDL 43 mg/dl. Ab anti IA2 and anti GAD65 negative, good reserve pancreatic C-peptide 2.53 ng/ml, we confirmed therapy in place. Control at 4 months 01/2017: HbA1c 5.5%, FPG 78 mg /dl, we suspended gliflozine+metformin and we confirmed Dulaglutide 1.5 mg/week. Control at one year and 4 months 01/2018: HbA1c 5.5%, FPG 92 mg /dl, reduced Dulaglutide at 0.75mg/week. Control at one year and 10 months 07/2018: HbA1c 5.3%, FPG 99 mg/dl, we suspended GLP1-RA and started empagliflozin/metformin 5/850 mg.
Conclusions: Thanks to the use of hypoglycemic drugs with complementary effect, this patient has always shown glycated levels of non-diabetic despite the reduction of poly-drug therapy. The existence of a metabolic memory suggests that an aggressive and early approach is necessary in order to reduce the occurrence of future complications.

Un caso di sospetta sierosite farmaco-indotta

E. Romagnoli[1], C. Ognibene[1], M.C. Rosa[1], D. Arioli[2], L. Brugioni[1]

[1]AOU di Modena; [2]Arcispedale Santa Maria Nuova, Reggio Emilia, Italy

Premessa: Il versamento pleuro-pericardico necessita di precisa definizione eziologica al fine di impostare la terapia.
Caso clinico: Donna, 85 anni, ricovero per astenia e dispnea; cardiopatia ischemico-ipertensiva con FA, terapia con Dabigatran da 2 mesi. EE con rialzo della PCR, restanti parametri nella norma. Alla radiografia torace opacamento pleurogeno bilaterale, all'ecografia versamento pleurico bibasale, al cuore reperto nella norma ma versamento pericardico non emodinamico, non ascite. Eseguiti numerosi accertamenti: TSH-PCT-FR/C3/C4-oncomarcatori nella norma, Quantiferon con assente risposta immunitaria, numerose Sierologie negative per infezione acuta, HCV/HBV/HIV negativo, ANA-ANCA-Ab tTG negativi, proteinuria nella norma; TC addome torace versamento pleurico bilaterale, aspetto mammellonato della grande scissura a destra, non reperti patologici addominali. Eseguite 2 toracentesi con drenaggio liquido ematico: essudato ad elevata cellularità; al citologico flogosi a carattere linfogranulocitario con cellule mesoteliali attive, non cellule atipiche, colturale negativo. Il chirurgo toracico e il reumatologo non ponevano indicazioni specifiche: intrapreso steroide ex adiuvantibus a scalare e sospeso Dabigatran nel sospetto di patologia farmaco-indotta con ottima risposta bioumorale e strumentale al follow up, iniziato Edoxaban.
Conclusioni: A nostra conoscenza questo è il primo caso descritto di sospetta sierosite linfo-granulocitaria da dabigatran: bisogna effettuare esteso work-up di tutte le cause senza però dimenticare le forme più rare tra cui la farmaco-indotta.

Utility of nasal swab in diabetic patients with infected ulcers of lower limbs

O. Romano[1], R. Giannettino[1], S. Ippolito[1], R. Muscariello[1], V.D. Iula[2], F. Carcarino[1], A. Farinello[1], C. Camorino[1], A. Reale[1], F. Ingala[2], V. Nuzzo[1]

[1]UOSD Malattie Endocrine, del Ricambio e della Nutrizione, Ospedale del Mare, ASL Na 1 Centro, Napoli; [2]UOC di Patologia Clinica, Ospedale del Mare, ASL Na 1 Centro, Napoli, Italy

Introduction: An ulcer affecting the lower limbs is the most difficult complication for the diabetic patient: infections of these lesions can complicate the clinical picture, being able to vary from superficial infections to deeper interesting soft tissues and bone. The bacterium most often involved is the S. Aureus, which in 15-30% of cases is a MRSA, with worse prognosis.
Objectives: The aim of the study was to evaluate the association between S. Aureus infections and nasal colonization as a possible risk factor.
Materials and Methods: 33 patients were enrolled in the period July-August 2018, followed at the Diabetic Foot Clinic of the Endocrinology of Ospedale del Mare, Napoli. All patients performed a nasal swab, and 13 out of 33 also an ulcer swab, all examined to determine sensitivity or resistance to antibiotics.
Results: The S. Aureus was isolated from 7/13 ulcers and 6/13 nasal swabs. From patients with a positive ulcer 4/7 also had positive nasal swab, compared to 2/6 with a negative ulcer. The MRSA was isolated from 2 ulcers and 1 nasal swab. From 2 patients with a positive MRSA ulcer, 1 patient also had a positive nasal swab for MRSA.
Conclusions: The study has just begun and the data collected are still small: it seems, however, that the nasal colonization by S. aureus MSSA in diabetic patients represents an important risk factor for the appearance of ulcer infected in the lower limbs. For colonization by MRSA, the collected data are not yet sufficient to delineate a correlation. Further studies are needed.

Cryptogenic organizing pneumonia: a rare syndrome masquerading as common infective disease

M. Ronchetti[1], L. Maddaluni[2], C. Florenzi[2], L. Corbo[2], G. Galante[2], F. Bacci[2], M. Giampieri[2], G. Zaccagnini[2], M. Finocchi[2], C. Nozzoli[2]

[1]AOU Careggi, Firenze; [2]AOU Careggi, Firenze, Italy

Introduction: The cryptogenic organizing pneumonia is a rare syndrome nosologically belonging to diffuse interstitial lung diseases. Diagnosing this syndrome represents a difficult task since it is usually characterized by non-specific signs and symptoms.
Clinical case: An 86 years-old woman was transferred to our department complaining of dyspnoea and fever. In her clinical history she was admitted to hospital two times during the last three months because of the same symptoms: she was considered to be affected by infective pneumonia, however the prescribed antibiotic therapy turned out to be ineffective. During the clinical examination, she was alert and dyspnoeic. Oxygen saturation was 95% in FiO2 28% and temperature was 38°C. The auscultation of thorax revealed diffuse crackles and chest x-ray revealed wide multiple opacities. Therefore high resolution CT was performed and it showed areas of consolidation suggestive for cryptogenic organized pneumonia. Finally bronchoalveolar lavage excluded eventually neoplasm or infective process. Thus oral corticosteroids were prescribed with clinical improvement of dyspnoea.
Conclusions: This clinical case underlines the importance of taking in consideration the cryptogenic organized pneumonia among the possible diagnosis, when the patients seems to be affected by multifocal pneumonia which does not improve despite correct antibiotic therapy.

Disturbi neurocognitivi associati all'HIV in pazienti anziani

R. Rondinelli[1], D. Tonietti[1], E. Amato[1], E. Reali[1], A. Sarno[1], M. Cacciafesta[1], C.A.M. Lo Iacono[1]

[1]AOU Policlinico Umberto I, Dipartimento di Medicina Interna e delle Specialità Mediche, UOC Geriatria, Roma, Italy

Premesse: L'infezione da HIV può comportare neuro-patologie (HIV-associated neurocognitive disorders o HAND) da danno neuronale, causato da proteine virali, citochine e forse da auto-anticorpi specifici. L'esordio è graduale e aspecifico con instabilità dell'umore, calo ponderale, apatia. Seguono appiattimento emotivo, perdita delle capacità decisionali, esecutive e della fluenza verbale, fino a sindrome frontale e iperreflessia negli stadi più tardivi. L'atrofia cerebrale interessa gangli basali, sostanza bianca e regioni corticali. L'aderenza alla terapia antiretrovirale è essenziale nel trattamento degli HAND e consente il miglioramento cognitivo anche in pazienti con deficit severi.
Caso clinico: Uomo di 74 aa giunge presso i nostri ambulatori per comparsa improvvisa e ingravescente di amnesia, rallentamento ideo-motorio, astenia. Riferisce dimagramento intenso e tosse poco produttiva da 2 mesi. In anamnesi: ipertensione, BPCO, recente Herpes Zoster. Reca in visione Rx torace con "ipodiafania parailare". MMSE: 22.3. Alla RMN encefalo iperintensità periventricolare e della sostanza bianca, atrofia diffusa medio-lieve. Alla HRTC iperdensità a vetro smerigliato ilo-parailare e cisti apicali. Nel sospetto di immunodepressione si richiede ricerca HIV-Ab e HIV-RNA plasmatico, con diagnosi di AIDS e Demenza Associata ad HIV.
Conclusioni: Dato l'allungamento dell'aspettativa di vita e la comparsa di quadri clinici non usuali, la diagnosi differenziale delle demenze non deve sottovalutare forme secondarie anche nel paziente anziano.

Enterococcus avium: a rare and unknown germ

A. Rosso[1], B. Reginato[1], M. Avolio[2], S. Grazioli[1], A. Grembiale[1], E. Garlatti Costa[1], A. Camporese[2], M. Tonizzo[1]

[1]Department of Internal Medicine, Pordenone; [2]Department of Microbiology and Virology, Pordenone, Italy

Introduction: Enterococcus avium is a Gram positive organism belonging to Enterococcus species and it is present in the normal intestinal flora of humans. Human infections due to Enterococcus avium are emerging but data on the characteristics of these infections are limited.
Case report: A 89-year-old woman was admitted to our hospital with a 10-day history of fever and abdominal pain. Her past medical history included: hypertension, atrial fibrillation and senile dementia with immobilization. On examination, the patient had a blood pressure of 80/60 mmHg, a pulse rate of 120/min and a temperature of 38.4°C. We performed blood culture and we started empiric antibiotic. Laboratory studies revealed an elevated leukocyte count of 18500/mm^3 and elevated procalcitonin level of 14 microg/L. Liver function tests were normal. Thorax X ray and urine test were negative. The patient underwent an abdomen ultrasound (US) scan and then an abdominal computerized tomography (CT) scan with intravenous contrast administration that showed a single liver abscess (4x3 cm) in the right lobe of liver. Culture of blood was positive for Enterococcus avium, susceptible to beta-lactams. We excluded endocarditis and brain abscess. Because of comorbidities, the patient was treated only with prolonged antibiotic treatment. The following abdomen ultrasound scan proved a slow resolution of liver abscess.
Conclusions: Bacteriemia due to Enterococcus avium is usually associated with gastrointestinal disease. Selection of antimicrobial agents is necessary to obtain the successful management of infection.

Further insights into the use of edoxaban with LMWH bridge therapy for elective knee arthroplasty in a patient with NVAF

G. Rotiroti[1], A. Orlando[1], N. Mumoli[1]

[1]ASST Ovest Milanese, UO Medicina, Ospedale "G. Fornaroli", Magenta (MI), Italy

Background: The number of patients receiving DOACs is increasing, but often the perioperative management of DOACs in elective situations is difficult as it should take into account the half-life of the drug, the bleeding risk of the invasive procedure and the patient's thromboembolic risk.
Case report: A 76 y/o woman, obese (80kg, 1.58m, BMI 32kg/m^2), treated with 60mg QD edoxaban for NVAF, levothyroxine 100mcg QD for hypothyroidism, cholecalciferol 25.000 IU per month for osteoporosis, arrived to our clinic to perform an elective arthroplasty of the right knee. Her clinical history was substantially negative, on physical examination she was normal. Blood tests showed good renal function (serum creatinine 0.71mg/dL, ClCr 85ml/min). The patient took edoxaban until day -3. On days -2 and -1 she did not take anticoagulant therapy. On the day of surgery (day 0) she was given enoxaparin 4000 IU injection as prophylaxis of VTE until day +3. From day +4 she resumed edoxaban 60mg, she was then admitted to rehabilitation.
Conclusions: The patient did not take edoxaban between days -2 and -1 as there is a predictable waning of the anticoagulation effect that allowed short-term cessation of the therapy. From day 0 onwards bridge therapy with LMWH was necessary as prophylaxis of VTE. Furthermore, the orthopedic surgery had medium to high risk of bleeding and the DOAC therapy could not be resumed immediately but from day +4 onwards. In this tailored anticoagulation approach there were no bleeding complications or thrombotic events concomitant to the surgery nor in the 9 months follow-up.

Un incrocio pericoloso

M. Sacco[1], M. Di Palo[1], E. Cavaglià[2], M. Silvestre[2], F. Corvino[2], P. Morella[2]

[1]Medicina DEA AORN Antonio Cardarelli, Napoli; [2]Radiologia Vascolare, AORN Antonio Cardarelli, Napoli, Italy

Premesse: I dati sul rischio di recidiva e l'approccio terapeutico delle TVP/EP appaiono controversi.
Caso clinico: Maschio (28aa), in PS per improvvisa ed intenso dolore arto inferiore sx (volume raddoppiato rispetto al dx, cute tesa, pallida, calda). In anamnesi recente chirurgia addominale, profilassata con EBPM per soli tre giorni. EO: polsi periferici ipossfigmici. ECD: occlusione trombotica dell'intero asse femoro-popliteo-gemellare arto inferiore sx. In Medicina DEA: rapido peggioramento di sintomi ed obiettività clinica, inapprezzabili i polsi periferici, come da phlegmasia caerulea dolens. Avviata EBPM, eseguita fasciotomia decompressiva, parziale risoluzione del quadro clinico. Al follow-up (90gg) ambulatoriale: ricomparsa di dolore ed edema in ortostatismo. All'ECD venoso, stenosi 80-90% dell'asse iliaco-femorale sx, sino alla biforcazione. Ricoverato, flebografia e AngioTac addome descrivono compressione v. iliaca comune sx da parte dell'arteria ipsilaterale, come da sindrome di May-Thurner. Eseguita PTA venosa, applicato duplice stent. ECD a 48h: completa risoluzione della stenosi con iniziale regressione dei sintomi.
Conclusioni: La sindrome di May-Thurner (20-50% dei pz con TVP), identifica una variabile anatomica del decorso dei vasi iliaci di sx con intrappolamento della v. iliaca, causa TVP/TEP recidivanti e complicanze a lungo termine (PTS – IPTT). La terapia prevede approccio multidisciplinare: posizionamento di stent venoso, trattamento anticoagulante (durata variabile in relazione ad ulteriori ed individuali fattori di rischio trombotico/emorragico).

Enterite lupica, una enterite atipica

E. Sagrini[1], M.G. Sama[1], P. Cataleta[2], A. Buscaroli[3], M.E. Bellio[1], S. Bernardini[1], L. Montanari[1]

[1]UO di Medicina Interna, Ospedale Santa Maria delle Croci, Ravenna; [2]UO di Medicina Interna, Divisione di Reumatologia, Ospedale Santa Maria delle Croci, Ravenna; [3]UO di Nefrologia, Ospedale Santa Maria delle Croci, Ravenna, Italy

Premesse: I pazienti con lupus eritematoso sistemico (LES) soffrono spesso di sintomi dispeptici lievi; l'enterite lupica è una manifestazione rara e invalidante di esordio o di ricaduta di malattia.
Caso clinico: Donna di 60 anni giungeva alla nostra osservazione per calo ponderale, nausea, disfagia, addominalgie migranti e diarrea recidivanti da mesi. Trenta anni prima diagnosi di LES con nefrite lupica in remissione (proteinuria negativa), non più in terapia immunosoppressiva. Agli esami ematici all'ingresso piastrinopenia (61000/L), antiDNA positivi (47 KIU/L), proteinuria (1690 mg/die). Alla EGDS gastrite acuta con biopsia aspecifica. La TC mostrava ispessimento diffuso parietale gastrico e del piccolo intestino con edema di parete ("target sign"), versamento ascitico e adenopatie mesenteriali. Dimessa dopo nutrizione parenterale e riposo intestinale, procinetici e blanda terapia steroidea. Dopo un mese recidiva di dispepsia severa, piastrinopenia (4000/L), incremento proteinuria (4000 mg/die) e antiDNA (97 KIU/L). La biopsia renale documentava glomerulonefrite lupica diffusa IV stadio. Seguiva terapia con boli steroidei ad alte dosi con beneficio clinico, normalizzazione del quadro TC e risalita della conta piastrinica. In seguito si associava micofenolato a steroidi, con scomparsa persistente dei sintomi gastroenterici e di proteinuria.
Conclusioni: L'enterite lupica può essere una manifestazione misconosciuta e invalidante di recidive lupiche e l'imaging TC può fornire elementi diagnostici essenziali ai fini di una tempestiva terapia immunosoppressiva.

Sindrome di Roemheld: i dialoghi tra stomaco e cuore

L. Sanesi[1], G. Fabrizio[1], R. Sgariglia[1], A. Cerasari[1], I. Dominioni[1], S. Alessio[1], A. Faleburle[1], C. Mattioli[1], G. Pucci[1], M. Giuliani[1], A. Russo[2], L. Filippucci[2], G. Vaudo[1]

[1]Struttura Complessa di Medicina Interna, AOU Santa Maria, Terni; [2]Cardiologia Riabilitativa e Prevenzione Patologie Cardiovascolari, USL Umbria 1, Perugia, Italy

Introduzione: La sindrome di Roemheld rappresenta un complesso di disturbi cardiaci scatenati da un aumento delle dimensioni dello stomaco: un eccesso di aria nello stomaco provoca il

sollevamento diaframmatico con compressione del cuore ed attivazione di risposte riflesse. I sintomi comprendono precordialgia, dispnea, nausea, sudorazione algida, cardiopalmo dopo i pasti. La terapia prevede misure dietetico-comportamentali quali la riduzione del peso corporeo, l'eliminazione di fumo, alcolici, e cibo speziato, il consumo di pasti piccoli e frequenti.
Caso clinico: Paziente di anni 67 obeso affetto da diabete mellito di tipo 2 in trattamento con exenatide e gonartrosi recentemente sottoposta intervento di atroprotesi, giunge per due episodi lipotimici; non angor né cardiopalmo. All'obiettività riscontro di ipotensione ortostatica ed addome ipertimpanico. Non altri segni obiettivi di rilievo. D-Dimero 5310 ng/ml, indici di miocardionecrosi negativi. Veniva eseguito ECG (negativo per ischemia), ecocardiografia (VDx ipocinetico e dilatato). Nel sospetto di TEP, veniva effettuata angio-TC del circolo polmonare che escludeva tromboembolismo ma segnalava marcata gastrectasia con ingesti. Veniva posizionato SNG e modificata terapia anti-diabetica con miglioramento della sintomatologia.
Conclusioni: La sindrome di Roemheld può mimare numerose patologie di natura cardiologica e gastroenterologica. La diagnosi va posta dunque solo in seguito ad esclusione di condizioni acute che richiedono un intervento immediato, attraverso il dosaggio degli indici di miocardionecrosi, ECG, ecocardiografia, RX diretta addome ed eventuali accertamenti specifici sulla base delle caratteristiche cliniche. Nel nostro caso l'angio-TC ha messo in evidenza una iperdistensione gastrica; la recente introduzione dell'exenatide che determina un rallentamento dello svuotamento gastrico ha permesso una diagnosi precoce e la sua sospensione una rapida risoluzione del quadro clinico.

Un caso di granulomatosi eosinofila con poliangioite complicato da vasculite ipofisaria trattato con rituximab

G. Santoboni[1], A. Fiorentini[1], C. Di Nitto[1], G. Alessandrini[1], M. Alberti[1], G. Valeri[1], C. Sun[1], G. Marciani[1], L. Fontana[1], P.G. Mariani[1], C. Meschini[1]

[1]UOC Medicina Generale, Polo Ospedale Belcolle, ASL Viterbo, Italy

Un uomo di anni 45 giungeva alla nostra attenzione nell'Agosto del 2017 per un quadro caratterizzato da dolori addominali, febbricola persistente, diarrea, anamnesi positiva per asma ad insorgenza tardiva e poliposi nasale, infiltrati polmonari multipli alla radiografia del torace, recente comparsa di porpora agli arti inferiori, parestesie distali ai 4 arti ed ipostenia alle mani. Dopo aver escluso diagnosi alternative, sulla base dei dati clinici e laboratoristici veniva posta diagnosi di granulomatosi eosinofila con poliangioite con impegno multi-organo di grado severo (FFS 2). Durante il ricovero di fine ottobre, per il riscontro di dati compatibili con ipotiroidismo centrale (FT3, FT4, TSH ridotti), veniva eseguita una RM encefalo che mostrava esiti vascolari a livello ipofisario ed in sede nucleo basale destra. In considerazione delle frequenti recidive nonostante terapia steroidea ad alto dosaggio e terapia immunosoppressiva con ciclofosfamide (4 infusioni totali), nel novembre 2017 veniva intrapresa terapia di induzione con Rituximab 1 gr X 2 somministrazioni e successiva terapia di mantenimento con Rituximab 500 mg ogni 6 mesi con stabile remissione di malattia, negativizzazione degli ANCA, normalizzazione del complemento e degli indici di flogosi e conseguente progressiva riduzione della dose di steroide in assenza di nuove riacutizzazioni vasculitiche.
Conclusioni: Il caso clinico conferma l'efficacia del Rituximab in fase di induzione e di mantenimento nel trattamento di una forma severa di granulomatosi eosinofila con poliangioite con impegno multi-organo refrattario a terapia convenzionale con ciclofosfamide. Dopo analisi della letteratura, inoltre, il nostro *case-report* allo stato attuale risulta essere il primo caso descritto di granulomatosi eosinofila con poliangioite con impegno vasculitico a livello ipofisario.

Devo vendere le caprette?

M. Schiavon[1], I. Zanella[2], E. Zola[2], B. Girolami[2]

[1]UOC Clinica Geriatrica, AO Padova; [2]UOC Medicina Generale, AO Padova, Italy

Premessa: La presentazione clinica della pneumopatia interstiziale rende difficile la diagnosi tempestiva. Comprende più di 300 malattie diverse, divisibili in due gruppi anatomopatologici: con pattern granulomatoso e con prevalenza di infiammazione-fibrosi. Patogenesi non chiara, solo il 35% ad eziologia nota: polveri organiche e inorganiche, asbesto, fumi, gas, farmaci, radiazioni, post-infettive.
Caso clinico: Maschio 70enne accede al PS per dispnea ingravescente, tosse persistente e febbricola, presenti da 3 mesi e trattati con cicli di antibiotici e steroidi con parziale beneficio; un analogo episodio risale a 2 anni prima. Mai eseguita TC. In anamnesi: cardiopatia ipertensiva, fibrillazione atriale in amiodarone, asportazione di k retto-sigma *in situ*. Ex meccanico ed ex fumatore, lavora nei campi e alleva capre nel tempo libero. La TC con mdc del torace evidenzia un quadro parenchimale a vetro smerigliato, la broncoscopia con biopsia un pattern infiammatorio. La valutazione collegiale pone diagnosi di pneumopatia infiammatoria cronica da ipersensibilità con noxa patogena esogena come l'esposizione ad allergeni ambientali (attività contadina) o a farmaci (amiodarone): si sospende l'esposizione e si inizia terapia steroidea con beneficio clinico-radiologico.
Conclusioni: Per evitare ritardi nella diagnosi di pneumopatie interstiziali la TC è essenziale. Una valutazione multidisciplinare è necessaria per definire la patogenesi. Bisogna ponderare bene l'inizio della terapia steroidea prima della conclusione dell'iter diagnostico perché può ritardare la diagnosi.

Not all arthritis are rheumatoid

M.G. Schiesaro[1], E. Pigatto[1], V. Bettini[1], M. Sanna[1], F. Mazzaro[1], A. Vallenari[1], P. Zanlungo[1]

[1]UO Medicina, Ospedale Classificato Villa Salus, Mestre (VE), Italy

Background: Genetic haemochromatosis (GH) is a hereditary disease characterised by tissue iron overload. In Caucasians it is most often due to homozygous C282Y HFE gene mutation, but other genes may be involved. It results in progressive and massive iron deposition leading to fibrosis and organ malfunction.
Case report: A 68-year-old man was referred to our outpatient clinic for the evaluation of progressive polyarthralgia during the night for two months. He is affected by GH from the age of 30 with negative follow-up for the last 15 years. In the past he was treated with periodic phlebotomy therapy. Polyarthritis (wrists, II and III MPJ, right knee and sacroiliac joint) was found at the moment of the evaluation. Rheumatoid factor, anti-CCP and markers of inflammation were negative. Transferrin saturation was 50% and ferritin was 380 mg. X-rays revealed subchondral cysts, MPJ space narrowing and osteophytosis. He started therapy with colchicine with partial benefit. He is waiting to start DMARDs.
Conclusions: Arthritis secondary to GH is rare in males over 50 years old. The pathogenetic mechanism of joint damage is still unknown. Maybe iron could result in damage to the articular cartilage by promoting a series of pathological events. These events may have effects in production of free radicals and in precipitation of calcium crystals through the inhibition of pyrophosphatase (cartilage damage, production of immune complexes and inflammation). Colchicine therapy seems to slow down the frequency of attacks.

Progetto "Emersione" BPCO in Medicina Interna

A.M. Schimizzi[1], S. Gambini[1], M. Cavina[1], C. Fischetti[1], V. Ramazzotti[1], M. Candela[1]

[1]UOC Medicina Interna, Ospedale di Jesi, Area Vasta 2, ASUR Marche, Italy

Premesse e Scopo dello studio: Lo studio è rivolto a intercettare, nei pz ricoverati per dispnea, forme misconosciute di BPCO e valutare, attraverso semplici parametri l'impatto che tale patologia ha sulla vita del pz.
Materiali e Metodi: Presso l'UOC Med Int, Osp. di Jesi, da ott. 2018 a gen. 2019, pz consecutivi ospedalizzati per dispnea senza compromissione dello stato cognitivo, sono stati sottoposti a anamnesi lavorativa e abitudine tabagica, es. di laboratorio e strumentali (eosinofili, proBNP, PAPs), valutazione della dispnea con mMRC. Nei pz con diagnosi di BPCO, è stata valutata l'aderenza alla tp broncodilatatrice, il n. riacutizzazioni, la qualità di vita (que-

stionario CAT), mentre i pz senza una diagnosi nota sono stati sottoposti a GOLD test ed eventuale spirometria+DLCO
Risultati: Sono stati analizzati 44 pz (50% M, 50% F), età' media 85 aa, n° medio 4 comorbidità. I pz presentavano una media di eosinofili 200/mmc, pro-BNP 6651 pg/ml, PAPs 41,4 mmHg, mMRC 3. Il 36,3% (16/44) aveva una BPCO, presentava un n. di riacutizzazioni di 2,6/anno e CAT 25,9. Di questi solo il 31,3% (5/16) era aderente alla terapia. Il 35,7% (10/28) dei pz senza BPCO presentava FR e GOLD ≥3, per cui veniva sottoposto a spirometria+DLCO con riscontro di ostruzione bronchiale nel 50% dei casi.
Conclusioni: Una precoce identificazione dei pz, permette un'adeguata gestione diagnostico terapeutica al fine di prevenire le riacutizzazioni, migliorare lo stato di salute e ridurre la mortalità. E' fondamentale intervenire con adeguati programmi di counselling sull'aderenza alla terapia.

Not only stroke

R. Schirripa[1], V. Schirripa[2]

[1]UOS Medicina d'Urgenza, Ospedale Pertini, Roma; [2]UOC Cardiologia, Ospedale G.B. Grassi, Ostia, Roma, Italy

Background: The diagnosis of cardiac amyloidosis is often conditioned by difficult and confusing paths because the onset is sneaky and silent
Case report: A 65-year-old teacher with arterial hypertension and monoclonal gammapathy (MGUS) on sartan amlodipine and beta-blocker therapy followed by over 10 years at the hematology clinic. Following the high value of Pro/BNP, salivary gland biopsy was submitted for suspected negative amyloidosis. In August 2018 episode of Stroke with subsequent thrombolysis and thromboaspiration and resolution of the hemiplegia sn appearance. A subsequently performed transesophageal echocard showed a smook effect with a hypertrophic ventricle with PAPS of about 60mmHg, an MRI showed a suspected pathology of ventricular accumulation, while a total body scintigraphy did not show signs of uptake.
Conclusions: Ventricular wall biopsy appears as the gold standard procedure for diagnosing cardiac amyloidosis. the patient was then subjected to bone marrow sampling with initiation of cortisone and immunosuppressive monoclonal antibody

Una pancitopenia sospetta

G. Scocchera[1], S. Fruttuoso[1], A. Torrigiani[1], S. Digregorio[1], L. Burberi[1], F. Fabbrizzi[1], A. Fanelli[1], L. Menicacci[1], V. Scotti[1], A. Morettini[1], S. Vecchiarino[1], V. Ponticelli[1], F. Corradi[1]

[1]AOU Careggi, Firenze, Italy

F.B. giunge in pronto soccorso per malessere generalizzato e astenia associati a dolori articolari per cui ha effettuato terapia antidolorifica senza beneficio; alcuni giorni prima un episodio di epistassi autorisolto. In pronto soccorso rilievo di grave pancitopenia richiedente trasfusione sia di emazie che di piastrine e viene effettuata valutazione microscopica su striscio di sangue periferico con rilievo di monociti atipici (assenza di blasti o schistociti). In reparto la paziente si sottopone quindi a TC torace e addome con mdc nel sospetto di patologia ematologica: non sono evidenti, tuttavia, stazioni linfonodali con caratteristiche patologiche. Viene eseguito, inoltre, immunofenotipo su sangue periferico che rileva una depressione dei linfociti T totali e delle cellule NK, un incremento dei linfociti B con espressione policlonale delle catene leggere di superficie e popolazione monocitaria (18% della cellularita' totale) con fenotipo maturo senza alterazioni qualitative. Data la persistente sintomatologia dolorosa poliarticolare, associata a deficit funzionale e resistente alla terapia antalgica con paracetamolo e FANS, e considerato il riscontro di elevati valori di VES abbiamo inoltre intrapreso una ricerca autoanticorpale, nel sospetto di patologia immunologica, che ha portato al rilievo di positività per alti titoli di anticorpi anti-nucleosomi e anti-nucleo compatibili con quadro di LES: è stata perciò intrapresa terapia corticosteroidea ad alte dosi e la paziente ha mostrato un repentino miglioramento sia sul quadro clinico che laboratoristico.

Un caso di RCU dopo terapia con inibitori dei check-point immunitari

P. Scolieri[1], R. Polillo[2], G. Zampa[3], C. Marrese[4], V. Bruzzese[1]

[1]Medicina e Reumatologia, Ospedale Nuovo Regina Margherita, Roma; [2]Medicina e Allergologia, Ospedale Nuovo Regina Margherita, Roma; [3]Oncologia, Ospedale Nuovo Regina Margherita, Roma; [4]Reumatologia, Ospedale Nuovo Regina Margherita, Roma, Italy

Premesse: L'immunoterapia ha rivoluzionato il trattamento delle neoplasie. L'espandersi di una nuova famiglia di agenti terapeutici conosciuti come inibitori dei check-point immunitari (CPI) è stato però associato ad un nuovo gruppo di eventi avversi , dovuti ad una iperattivazione del sistema immune, esitanti in un ampio spettro di malattie autoimmuni, note come IRAEs (immune-related adverse events). Gli IRAEs coinvolgono cute , sistemi endocrino, gastrointestinale, nonché muscoloscheletrico.
Caso clinico:: Descriviamo il caso clinico di una donna affetta da neoplasia metastatica del polmone trattata con ottimi risultati clinici con nivolumab. A distanza di circa un anno e mezzo dall'inizio del trattamento la pz sviluppava dolori colici ingravescenti con perdita di sangue e muco con le feci. La colonscopia evidenziava mucosa iperemica, edematosa con microulcerazioni e presenza di muco e fibrina e l'istologia deponeva per una proctosigmoidite ulcerosa (RCU), per cui veniva intrapresa terapia ad hoc, con momentanea sospensione di nivolumab e iniziale risposta al trattamento intrapreso.
Conclusioni: Le IRAEs sembrano presentarsi tipicamente entro 3-6 mesi dall'inizio del trattamento con CPI, sebbene reazioni ritardate siano state descritte anche dopo un anno dall'inizio della terapia. Nel caso di nivolumab, farmaco anti-PD1, a differenza dei farmaci anti-CTL-4,peraltro, sono stati anche raramente descritti eventi avversi quali colite ulcerosa. Anche nel nostro caso clinico l'insorgenza di RCU potrebbe essere stata innescata da tale terapia.

Ambulatorio internistico integrato

F.S. Serino[1], M. Scanferlato[1]

[1]UO Medicina Generale, Ospedale Portogruaro (VE), Italy

Premessa e scopo dello studio: L'attività della UO viene suddivisa in due fasi in successione temporale. La prima prevede la diagnosi di quelle patologie complesse dove non è intuibile immediatamente l'indirizzo specialistico, che richiedono il ricovero ordinario in modo da coordinare gli interventi specialistici *(fase di degenza ospedaliera)*. La seconda è caratterizzata dalla gestione post-acuta stabilendo programmi terapeutici protratti nel tempo a livello ambulatoriale *(fase ambulatoriale integrata)*.
Materiali e Metodi: L'attività è rivolta alle patologie che necessitano di trattamenti non gestibili al domicilio (terapia biologica, immunoglobuline, terapie marziali, terapie antibiotiche anche con pompe infusionali) e a procedure diagnostico/terapeutiche (toracentesi, paracentesi) in un contesto ospedaliero idoneo mediante l'utilizzo di un posto letto in regime diurno con assistenza medico-infermieristica dedicata. Viene attivata su richiesta dello specialista o del MMG ed erogata dal lunedì al venerdì, tramite prenotazione su agenda informatizzata.
Risultati: Nell'anno di attivazione (2018), queste prestazioni hanno contribuito a ridurre i ricoveri e i tempi di degenza di circa il 30%, se confrontati con l'anno precedente.
Conclusioni: Tutto ciò, nell'ambito del processo di integrazione Ospedale-Territorio, al fine di ottimizzare la continuità assistenziale, l'efficienza, l'efficacia e la qualità delle prestazioni. L'incremento graduale del numero di prestazioni svolte ha permesso di rispondere adeguatamente ai bisogni dell'utenza, nonché di ridurre il tempo e il numero di ricoveri.

Severe cholestatic jaundice in a patient treated with methimazole: a case report

C. Sgarlata[1], G. Buoni o Del Buono[2], E. Peros[2], M. Rollone[3], M. Carbone[3], V. Perfetti[4], S. Bagnoli[5], L. Magnani[2]

[1]Fondazione IRCCS San Matteo di Pavia, UOC Medicina Generale 3, Ecografia Interventistica, Pavia (PV); [2]Azienda Socio-Sanitaria Territoriale di Pavia, UOC Medicina Interna, Ospedale Civile di Voghera, Voghera (PV);

[3]Azienda di Servizi alla Persona of Pavia, Istituto di Cura Santa Margherita, Pavia; [4]Azienda Socio-Sanitaria Territoriale di Pavia, UOC Medicina Interna, Ospedale di Varzi, Varzi (PV); [5]Azienda Socio-Sanitaria Territoriale di Pavia, UOC Medicina Interna, Ospedale di Mede, Mede (PV), Italy

Background: A 59-year-old man was admitted at our ward complaining of malaise, vomit and severe jaundice. He had a past history of ischemic cardiomyopathy and atrial fibrillation.
Case report: From the collection of the medical history the home daily patient drug therapy was as following: furosemide 25 mg , bisoprolol 5 mg, atorvastatin 20 mg and methimazolo 20 mg. Methimazole was recently prescribed following an endocrinological evaluation due to the finding of amiodarone-induced thyrotoxicosis (the antiarrhythmic was suspended at the same time). Physical examination was normal except for the finding of jaundice. Blood tests revealed a total bilirubin of 18,54 mg/dl (15,05 mg/dl direct, 3,49 mg/dl indirect), ALT 84 mU/ml, AST 100 mU/ml, ALP 244 U/l. Blood cell count as well as renal function and electrolytes were normal. Viral markers as well as an autoantibodies were negative. An US and a CT scan of the abdomen showed normal findings. Methimazole was suspended and methylprednisolone, 5% glucose solution and glutathione were administrated. During the hospitalization bilirubin values showed a slow but progressive reduction until to a complete normalization after about 4 weeks.
Discussion and Conclusions: Methimazole is an antithyroid medication and is known that it can cause liver injury that is typically cholestatic and probably caused by an immunological response to some metabolites of the drug. We observed an almost pure cholestatic liver injury and a good response to steroid administration compatibly with the hypothesis of an immunological pathogenetic mechanism.

Respiratory and gastrointestinal bleeding in Internal Medicine: the tip of the iceberg

O.F. Simone[1], M. Talia[1], A.P. Termite[2], P. Campanella[3], M.P. Ganimede[4], V. Gisone[4], N. Burdi[4], F. Sogari[5]

[1]UO Medicina Interna, Ospedale San Pio, Castellaneta (TA); [2]UO Medicina Interna, Ospedale San Pio, Castellaneta (TA); [3]UO Chirurgia Generale, Ospedale SS Annunziata, Taranto; [4]UO Neuroradiologia, Ospedale SS Annunziata, Taranto; [5]UO Medicina Interna, Ospedale SS Annunziata, Taranto, Italy

Background: Hemoptysis and melena are frequent admission diagnosis to Internal Medicine ward but unusual causes can be involved and should be evaluated.
Case report: At the same time were admitted to our division a 65 years old men and a 55 year old men, affected both by acute hemorrhagic diseases. The first presented a sudden bleeding of the upper respiratory tract; in emergency room underwent toracic CT scan: severe enphisema in brochiolitis with tree in bud pattern and bronchiectasies. EBUS was negative; angio CT-scan revealed as well an hypertrophic bronchial right artery therefore was put indication to endovascular embolization: after selective arteriografic procedure, embolization with PVA particles of bleeding bronchial artery was obtained with complete and enduring resolution of hemoptysis. The second underwent a rapid anemization due to melena, EGDS was performed and showed duodenal ulcer. Despite hemostasis, bleeding continued. The man, suffering from alcoholism and recurrent pancreatitis episodes, underwent abdomen angio CT scan that disclosed a fistula between duodenum and a pancreaticoduodenal artery pseudoaneurysm associated to celiac trunk stenosis. This patient underwent a not easy endovascular embolization procedure with rapid improvement of clinical features and no complications.
Conclusions: Both clinical cases focused on the importance of considering differential diagnosis, often underestimated, in sudden hemorrhagic presentation symptoms and the main therapeutic role of endovascular embolization treatment, the first choice with successful and safe exit.

Management of sepsis in an Emergengy Department in Italy in the era of new diagnostic criteria

E. Sozio[1], G. Bertolino[2], C. Pallotto[3], F. Sbrana[4], A. Ripoli[4], A. Bertini[1], L. Ghiadoni[5], C. Tascini[6]

[1]Emergency Department , North-West District, Tuscany Health Care, Spedali Riuniti Livorno; [2]Department of Public Health, Clinical and Molecular Medicine, Università degli Studi di Cagliari; [3]Infectious Diseases Section, Department of Medicine, University of Perugia, Perugia; [4]Fondazione Toscana Gabriele Monasterio, Pisa, Italy; [5]Emergency Medicine Unit, Nuovo Santa Chiara University Hospital, AO Universitaria Pisana, Pisa; [6]First Division of Infectious Diseases, Cotugno Hospital, AO dei Colli, Naples, Italy

Background and Aim: Early recognition is a key point of the entire management of sepsis. After Sepsis-3 new definitions, were performed many studies and the role of qSOFA was strongly reduced considering the non-conclusive results.
Aim of this study was to identify which clinical signs allow to identify in a few minutes patients who are at risk of death due to sepsis, so that necessary diagnostic and therapeutic measures can be promptly taken in Emergency Department.
Methods: In this real-life prospective study were enrolled 349 patients admitted to the ED of Pisa Hospital with diagnosis of infection with or without clinical criteria of sepsis or septic shock. Data shown are preliminary data from a series of cases still ongoing.
Results: We have chosen to test only those variables and clinical indicators that can be used in a few minutes during triage phase, such as qSOFA, lactate value, MEWS, Shock Index and hypotension: most performing result (AUROC values of 0.70 and higher) was that of lactate values (Sensitivity 81%, Specificity 59.5%, PPV 34.4%, NPV 92.7%), followed by MEWS (Sensitivity 72.4%, Specificity 56.6%, PPV 32.9%, NPV 89.2%) and shock index (Sensitivity 81%, Specificity 50.2%, PPV 30.5%, NPV 88%).
Conclusions: Lactates value and the use of clinical tools such as MEWS, or more simply the shock index, could be used already in the triage phase to identify patients at risk of poor prognosis due to sepsis.

A 23-year old woman with polyserositis

M. Spadaro[1], L. Castellani[1], M. Casu[2], N. Travaglio[3], G. Tini[3], M. Sarocchi[3], L. De Mattei[1], G. Sacchi[1], E. Arboscello[1], M. Ghinatti[2]

[1]Dipartimento di Emergenza, Policlinico San Martino, Genova; [2]Dipartimento di Medicina Interna, Policlinico San Martino, Genova; [3]Dipartimento Cardio-Toraco-Vascolare, Policlinico San Martino, Genova, Italy

Background: Pericarditis is the most common disease of the pericardium encountered in clinical practice and is responsible for 0.1% of all hospitalization. In some case it may present with cardiac tamponade without chest pain.
Case report: A 23 year-old woman was admitted to the emergency room for dyspnea, nausea, vomiting, hyporexia. At physical examination, the temperature was 36.5°C, the heart rate 150 beats per minute, the blood pressure 90/60 mmHg and the oxygen saturation 94% in ambient air. She presented slight edema in both limbs. The heart sounds were muffled.The abdomen was soft, slightly distended, with a possible fluid wave. The blood tests only affected a neutrophilic leukocytosis and elevated tumor serum marker CA125. An electrocardiogram showed sinus tachycardia with low QRS voltage in the precordial leads. An urgent echocardiogram ultrasound showed a large pericardial effusion, right atrial collapse and right ventricular collapse in diastole with sign of tamponade. A CT thorax and abdomen showed a large pericardial effusion, pleural effusion, ascites and a cysts on right ovary. She was transferred to the coronary care unit for an emergency pericardiocentesis. A pericardial fluid sample were negative for bacteria, fungus, virus, or malignancy. For suspected of neoplastic aetiology the patient executed pelvic RM, Pet and laparoscopy which resulted negative. At last, a cardiac RMN and a pericardium biopsy made a diagnosis of constrictive pericarditis.
Conclusions: Effusive-constrictive pericarditis in un uncommon pericardial syndrome that be missed in some patient who present with tamponade. Although evolution to persistent constriction is frequent, idiopathic cases may resolve spontaneously.

Un accumulo non gradito: caso di tossicità midollare da vancomicina

V. Spinoglio[1], M. Girino[1], V. Boccaccio[1], R. Bonometti[2]

[1]Ospedale Santo Spirito, Casale Monferrato (AL); [2]Università degli Studi del Piemonte Orientale, Novara (NO), italy

La vancomicina è un complesso glicopeptidico utilizzato per il trattamento di infezioni da batteri Gram positivi, ed è spesso prescritta in caso di infezioni da MRSA. La concentrazione plasmatica per una buona efficacia battericida è circa di 15 mcg/dl. La Vancomicina porta con sé un largo spettro di effetti collaterali, tra i quali i più conosciuti sono tachicardia, flebite, nefrotossicità e ototossicità. E' altresì riportato in letteratura come un utilizzo prolungato possa raramente esitare in tossicità midollare. Donna di anni 53 affetta da diabete mellito scompensato e complicato da ulcera plantare veniva ricoverata in Medicina per sovrainfezione dell'ulcera per cui era in trattamento con Vancomicina da circa 30 gg. Si evidenziava un quadro di leucopenia e anemia microcitica, con vancomicinemia in range terapeutico. Durante la degenza venivano eseguite ulteriori indagini: TC addome: versamento pleurico bilaterale, adenopatie diffuse, anasarca, epatosplenomegalia; FRI 2,1%, non deficit marziali, lieve carenza vitamina B12; WBC 0.94 x 10^3 UI, neutrofili 9,6%, linfociti 67%; Agoaspirato linfonodale: quadro reattivo. Data la neutrofilia ingravescente si decideva per sospensione di Vancomicina e avvio di Filgrastim, con successivo rapido incremento dei livelli leucocitari e della frazione neutrofila. L'ipotesi di agranulocitosi iatrogena è confermata dalla pronta risalita dei livelli di neutrofili alla sospensione di Vancomicina, ed è compatibile con l'utilizzo prolungato esitato in tossicità da accumulo, nonostante vancomicinemia inferiore alla dose tossica.

Relationship between vitamin D and cardiovascular risk: an observational study

V. Spuntarelli[1], G. Salerno[2], O. Barbetti[1], C. Iannone[1], M. Rocchietti March[1], P. Martelletti[1]

[1]Dipartimento Medicina Interna, AO Sant'Andrea, Roma; [2]Dipartimento Diagnosi di Laboratorio, AO Sant'Andrea, Roma, Italy

Background: Many articles describe a clear correlation between hypovitaminosis D and increase in cardiovascular (CV) diseases. Primary endpoint of this study is to understand if there is a correlation between low levels of vitamin D and hypertension. Secondary endopoint is to understand if population with high CV risk presents worse glyco-metabolic profile compared to that with low CV risk.
Methods: 40 non diabetic Pts (18 male, 22 female) older than 65 were divided into 2 groups according to their CV profile: the high CV risk group (H), composed by 22 Pts with hypertension and CV complications, and the low CV risk group (L), made up by 18 Pts without CV diseases. Calcium–phosphorus profile, vitamin D and homocysteine serum dosages, and serial fasting glycemia were assayed. R cran software, Poearson normality test and Anova test were used for statistical analysis. The significance level of statistical tests was $p<0.05$.
Results: Group H had serum vitamin D equal to 24±10ng/ml, while group L 35±7ng/ml. Statistically significant difference was found for phosphorus (3.15±0.1mg/dl for group H, 3.70±0.5mg/dl for group L). Serial fasting glycemia were higher for group H (110±15mg/dl) than for group L (91±10mg/dl). Group H showed high level of serum homocysteine (15±5µmol/L), data not found in group L (5.16±1.3µmol/L).
Conclusions: Our data showed a strong relationship between low vitamin D levels and CV risk. Glyco – metabolic profile of group H was worse than that of group L. Further studies in the long-term and a larger amount of subjects are needed to better elucidate this association.

Severe anemia due to digestive haemorrhage in patient with angiodysplasia of the gastric antrum and myelodysplasia

E. Stellitano[1], V. Aronne[1], B. Carerj[1], C. Caserta[1], A. Fulgido[1], P. Lipari[1], G. Meduri[1], A. Monopoli[1], A. Scordo[1], I. Tarzia[1], A. Stellitano[2]

[1]UOC Medicina Interna, PO Melito Porto Salvo (RC), ASP Reggio Calabria; [2]UOC Geriatria, PO Ospedale S. Anna, San Fermo della Battaglia, ASST Lariana, Como, Italy

The patient is hospitalized for severe anemia with melena as reported. She suffers from myelodysplasia with pancytopenia, hypertensive heart disease, a previous Mammary K, surgical exeresis and hormonal treatment. Recently she has shown marked asthenia, cutaneous pallor and black tarry stools. At her entrance: BP 100/70, EKG sinus rhythm 90b/m BBDX incomplete, cytometric blood count HB 6.4 HT 23 with pancytopenia. Hemotransfusion. Coagulative action within the range. Thorax XR: outcomes of right pleural effusion. EGDS " regular shape and caliber of esophagus, elastic walls and mucosal lining that presents linear erosion at the level of the squamous columnar junction that is 7 cm upward and incontinent for voluminous hiatal hernia. Stomach: regular shape and volume with a voluminous clot at the level of the gastric antrum along the large curve; the clot is removed and there is slight continuous bleeding from angiodysplastic lesion". EGDS of control: "healing of the previously treated angiodysplastic lesion, duodenum without lesions. The patient is discharged with the diagnosis of "Severe anemia for high digestive bleeding. Angiodysplasia with gastric antrum bleeding endoscopically treated with mixed hemostasis (placement of clips and injective haemostasis with adrenaline). Melena. Severe pancytopenia from myelodysplasia. Voluminous hiatal hernia. Hypertensive cardiopathy. Mitral insufficiency and mild tricuspidus insufficiency. Dilatation of the ascending aorta. Ateromasia of the SATs. Osteoarthritis. Previous right K mammary. Right pleural effusion outcomes".

Barrett's esophagus in patient with hiatal hernia and acute pulmonary edema

E. Stellitano[1], V. Aronne[1], B. Carerj[1], C. Caserta[1], A. Fulgido[1], P. Lipari[1], G. Meduri[1], A. Monopoli[1], A. Cordo[1], I. Tarzia[1], A. Stellitano[2]

[1]UOC Medicina Interna, PO Melito Porto Salvo (RC), ASP Reggio Calabria; [2]UOC Geriatria, PO Ospedale S. Anna, San Fermo della Battaglia, ASST Lariana, Como, Italy

The patient is hospitalized for intense dyspnea, has brought an ICD pacemaker for 6 years for severe left ventricular dysfunction from post-ischemic dilated cardiomyopathy. At the entrance his BP is 120/80 ECG sinus rhythm with BBSx and extra-systolic arrhythmia,HR 90/bm. PE:thoracic gasps in small and medium-sized bubbles.Echocardiogram:dilated left ventricle (60 mm) EF 35% with global hypokinesia. Presence of pacing lead in the right cavities. Ascending aorta ectasia (38 mm), mild mitral and tricuspid insufficiency. Haematochemical tests: BNP 827 (pg /ml), troponin increase (37.70 pg /m l-184.70 pg /m l-113.90 pg /ml -29.90), not anemia, not renal failure, electrolytes, D-dimer, thyroid hormones: within the range. Thorax XR: "presence of MP, accentuation of the bronchovascular plot, atheromatous ectasia of the aortic arch, enlarged ili, congesti, enlarged heart shadow." Negative occult blood. Abdomen echography:renal cysts, dysmorphic gallbladder. EGDS: shaped esophagus, regular calibre ,elastic and mucosal-coated walls presenting tongues of gastric metaplasia (Barrett) that rise for 4 cm the squamous column junction, the cardias is ascending and incontinent. Multiple biopsies on the metaplasic mucosa. Histological report: minute fragments of esophageal mucosa with cardial metaplasia,leukocyte infiltration and angiectasia in the lamina propria.Diagnosis at his discharge: APE. Post-ischemic dilated adromiomyopathy. Pacemaker-wearer.Ectasia of the ascending aorta.Mitral and mild tricuspid insufficiency. Axial hiatal hernia.B arrett's Esophagus. Discinesia of the gallbladder. Renal cysts.

An echocardiographic case report of complications of portopulmonary hypertension in alcohol related cirrhosis

S. Strada[1], E. Avitabile[1], L. La Mura[2], M. Pisaniello[3], C. De Benedittis[1], E. Zecca[1], M. Bellan[1], M. Pirisi[1]

[1]Università del Piemonte Orientale, Novara; [2]Università Federico II, Napoli; [3]Università degli Studi di Milano, Italy

Introduction: Portopulmonary hypertension (PPHTN) refers to a clinical entity, characterized by pulmonary arterial hypertension (PAH) associated with portal hypertension; it is a recognized complication of chronic liver disease, which can lead to annular dilatation and functional tricuspid regurgitation. A representative echocardiographic case is the focus of this case report.
Case report: A 62 years-old man from Georgia was admitted to the emergency department because of a worsening chronic lym-

phoedema. His past medical history included hypertension, coronary artery disease, atrial fibrillation and 20 years of alcohol abuse (30 g/day). At the admission he presented clinical signs of portal hypertension, lymphoedema and dyspnoea. An abdominal ultrasound showed a cirrhotic liver, ascites, splenomegaly and a dilated portal vein. An echocardiogram showed a severely distended right atrium (489 mL/m^2), a dilated right ventricle (basal and mid-ventricular diameter 76 mm and 60 mm respectively) with reduction of systolic function (TAPSE 15 mm, S' 5 cm/s) and a massive tricuspid regurgitation due to a severe annular dilatation which didn't allow estimating PAPs.
Conclusions: This case shows a paradigmatic example of heart disease belonging to PPHT and how this condition can impact on patient's quality of life. An echocardiogram should be performed in every cirrhotic patient, if the clinical suspicion of PPHTN arises to detect signs of PAH. This might allow to choose the best treatment strategy, to prevent complications and, consequently, to improve the patient's prognosis.

Face off: two sides of a killer

M. Talia[1], O.F. Simone[1], A.P. Termite[1]

[1]Medicina Interna, Ospedale San Pio, Castellaneta (TA), Italy

Background: Hepatic injury in thalassemic patient may be secondary to iron accumulation and/or parenteral transmission viral hepatitis; extramedullary erythropoiesis (EEM) can lead to hepatomegaly but doesn't usually compromise liver function.
Case report: 49-year-old man with intermediate thalassemia and long history of transfusion, iron metabolism disorder and SVR HCV infection, was referred to our institution with ascites and jaundice. His medical history included: radiological evidence of liver and adrenal focal lesions (referring to EEM) since 18 months, and mild hypertransaminasemia since 6 months. Ultrasound liver examination showed: numerous solid and not-well-circumscribed masses of low echo amplitude ranging side from 1 to 14 cm in diameter, suspicious for hepatocellular carcinoma (HCC). Biochemical tests showed significant increase in alphafetoprotein. HCC diagnosis was confirmed by CT scan.
Conclusions: EEM is a reactive mechanism in chronic anemia and is usually related to chronic transfusion, as well as HCV infection, that is a known risk factor for the development of HCC.
The differential radiological diagnosis between EEM and HCC can be very difficult due to hepatic iron accumulation, multiple morphological aspects of carcinoma and the absence of a pathognomonic pattern of erythropoietic foci. Therefore the integrated laboratory and radiological approach and the carfuel follow-up becomes essential.

Syncope in elderly

M. Tana[1], S. Di Carlo[2], L. Di Pizio[1], S. La Barba[1], C. Tana[3]

[1]Università G. D'Annunzio, Chieti; [2]UOC Geriatria, PO Pescara, AUSL Pescara; [3]UO Medicina Interna e Lungodegenza Critica, AOU di Parma, Italy

Case report: A 88 years old man was admitted to the Emergency Department (ED) after a trauma of the head secondary to syncope. During the night, lost of counsciousness occured during the postural passages. He had history of arterial hypertension, chronic heart failure treated with diuretics and Parkinson's disease. Cardiac examination revealed sinus bradycardia then confirmed by the electrocardiogram. Head CT was negative for ischemic/hemorragic disease and echocardiogram and troponins were within normal limits. The active lying-to-standing test, neurologic and respiratory examination were all normal. Holter monitoring of cardiac rhythm revealed the presence of severe bradycardia with long pauses and second-degree AV block. The cardiologist gave indication for permanent pacing.
Conclusions: Syncope in the elderly is a complex multifactorial disease that may involve many factors: most frequent cause is represented by orthostatic hypotension [1] which can be exacerbated by diuretics, antihypertensive drugs and deconditioning or neurological diseases. However, several life-threatening causes should be excluded, such as second- or third-degree AV block, severe bradycardia, pulmonary embolism, acute myocardial infarction, severe aortic stenosis, aortic dissection or other structural cardiac causes.
Reference: Ungar A, Mussi C, Ceccofiglio A, Bellelli G, Nicosia F, Bo M, Riccio D, Martone AM, Guadagno L, Noro G, Ghidoni G, Rafanelli M, Marchionni N, Abete P. Etiology of Syncope and Unexplained Falls in Elderly Adults with Dementia: Syncope and Dementia (SYD) Study. J Am Geriatr Soc. 2016 Aug;64(8).

An unusual case of hyperamylasemia

M. Tana[1], S. Di Carlo[2], C. Tana[3]

[1]Università G. D'Annunzio, Chieti; [2]UO Geriatria, PO Pescara, AUSL Pescara; [3]UO Medicina Interna e Lungodegenza Critica, AOU di Parma, Italy

Case report: A 79 years old man was admitted to the Emergency Department (ED) for acute abdominal pain, mainly located in the epigastrium and irradiated to the hips and back. Pain started after a large meal and it was associated to nausea and vomiting. He had history of arterial hypertension, obesity and cholelitiasis. Exams revealed increase of C-reactive protein (CPR), mild neutrophilic leukocitosis and moderate hyperamylasemia. Abdomen ultrasound was difficult due to gut air interference and abundant adipose tissue. Cardiac and the remaining objective examination were within normal limits. Acute biliary pancreatitis was hypothesized, so patient was submitted to fasting and intravenous hydrosaline solutions. After few days, clinical conditions worsened with increase of abdominal pain and stupor of new onset. Blood gas analysis revealed metabolic acidosis with elevation in glicemic levels. Hyperglicemia, glycosuria and metabolic acidosis with elevation of ketones in urine leaded to diagnosis of diabetic ketoacidosis.
Conclusions: Diabetic ketoacidosis represents an insidious disease. Hyperamylasemia may be a confounding element, especially in presence of abdominal pain and every effort are needed to exclude other causes of abdominal pain, such as acute pancreatitis; physicians must be always aware of these two conditions, especially in high risk patients such as obese and dyslipidemic subjects. However these two diseases may overlap and leading increased diagostic difficulties [1].
Reference: Qang Y *et al.* Concurrent Diabetic Ketoacidosis in Hypertriglyceridemia-Induced Pancreatitis: How Does It Affect the Clinical Course and Severity Scores? Pancreas. 2017 Nov/Dec.

Echocardiographic markers of ventricular interdependency in patients affected by heart failure

N. Tarquinio[1], L. Falsetti[2], A. Fioranelli[1], G. Viticchi[3], M. Mariottini[1], L. Marconi[1], A. Martini[1], F. Picchio[1], M. Burattini[1]

[1]UOC Medicina Interna, PO di Osimo "S.S. Benvenuto e Rocco", INRCA-IRCSS, Osimo (AN); [2]Medicina Interna Generale e Subintensiva, AOU "Ospedali Riuniti", Ancona, [3]Clinica di Neurologia, AOU Ospedali Riuniti", Ancona, Italy

Background: Left ventricle(LV) and right ventricle(RV) contraction efficiency varies according preload, afterload and ejection fraction(EF). Arterial elastance(EA) and TAPSE/PASP have been related to RV and LV ventricle-arterial coupling
Aims: To evaluate RV and LV ventricle-arterial coupling in a retrospective cohort of patients with acute heart failure(AHF)
Materials and Methods: Patients admitted to our department for AHF evaluated with echocardiography at the admission were enrolled. Age, sex, HF type according EF(HFpEF, HFmrEF, HFrEF), systolic(SBP) and diastolic blood pressure(DBP), LV volumes, stroke volume(SV), TAPSE and PASP. EA was calculated as (SBP×0.9)/SV. TAPSE/PASP was defined as pathologic if ≤0.36 mm/mmHg. Continuous values were compared with ANOVA, dichotomous variables with chi-squared test
Results: We obtained a final sample of 80 patients: 31 HFrEF, 23 HFmrEF and 26 HFpEF. 67.7% of HFrEF, 39.1% of HFmrEF and 38.5% of HFpEF had a reduced TAPSE/PASP (p=0.041). EA had a mean of 2.47±1.12 (HFpEF), 2.87±1.85 (HFmrEF), 4.48±3.56 (HFrEF), with significant linear trend across categories (p=0.017). EA difference between HFpEF and HFrEF resulted statistically significant (p=0.02). Patients with normal TAPSE/PASP had a significantly lower EA than reduced TAPSE/PASP (2.48±1.35 *versus* 4.15±3.99, p=0.016).

Discussion: HFrEF have higher EA and lower TAPSE/PASP than HFmrEF and HFpEF. Lower TAPSE/PASPs correlates with higher EA. This study underlines alterations of ventricular-arterial coupling and underlines ventricular interdependency in AHF

A novel lactofermented functional food from Annurca apple is effective on plasma levels of cholesterol and trimethylamine-N-oxide

G.C. Tenore[1], M. D'Avino[2], G. Caruso[3], D. Caruso[2], G. Buonomo[4], B. Bocchino[4], E. Novellino[1]

[1]Deartment of Pharmacy, University of Naples Federico II, Naples; [2]Department of Internal Medicine, AORN A. Cardarelli, Naples; [3]Department of Emergency, AORN A. Cardarelli, Naples; [4]Coop. Samnium Medica, Benevento, Italy

Background: Epidemiological studies show that consumption of foods containing polyphenols can result a decreased risk of chronic cardiovascular disease and colorectal cancer.Interactions between polyphenols and fiber are likely to affect intestinal bioaccessibility of these compounds thus affecting their ability to reach systemic circulation and exert protective effects at c.v level.Fermented foods have interest in Western countries. It is reported that lactic fermentation can enhance the intestinal bioaccessibility of polyphenols in fruits and vegetables through hydrolysis of esters with fiber polymeric constituents.
Materials and Methods: The study was a single centre randomised double blind placebo controlled 16 weeks trial to test a novel lactofermented functional food (lfAAP), with high levels of bioaccessible polyphenols and trimethylamine-N-oxide (TMAO) levels. At 26 people were administered daily for 8 weeks, with 125 g of lfAAP, (lactofermented Annurca apple puree).Endpoints measured were plasma variations of TC, HDL-C, LDL-C, glucose, TG, and TMAO. Key secondary outcomes were microbial composition of fecal swabs, parameters collected during clinic visits (B.P., H. rate, BMI).
Results: Data showed most significant serum changes:HDLCHL +61.8% *P*=0.0095;TMAO -63.1% *P*=0.0042. lfAAP revealed a significant increase in intestinal *Bifidobacterium* and *Lactobacillus* strains (3.5 and 2 times), respect to placebo.
Conclusions: This study suggest lfAAP is an effective functional food for a healthy control of HDL-C, TMAO levels, with clinical relevance in the primary c.v. prevention.

Paralisi periodica tireotossica ipocaliemica in caucasico

D. Tettamanzi[1], G. Scollo[1], S. Casati[1], C. Bassino[1], D. Sala[1], E. Limido[1]

[1]ASST-Lariana, Ospedale S. Antonio Abate, Cantù (CO), Italy

Premesse: La paralisi periodica (PP) tireotossica ipocaliemica appartiene alle patologie canalari, è più frequente nei maschi asiatici,va posta in DD con la forma famigliare. La clinica è scatenata da stress fisico, pasti ricchi di carboidrati, digiuno, alcol, infezioni, steroidi e broncodilatatori beta2 adrenergici. L'ormone tiroideo aumenta la sensibilità tissutale alla stimolazione adrenergica e insulinica della pompa sodio/potassio di membrana favorendo la concentrazione del potassio intracellulare.
Caso clinico: Maschio caucasico 31aa giunge alla nostra osservazione per comparsa di astenia profonda, dolori arti inferiori e impossibilità alla deambulazione. Gli esami ematici evidenziano ipopotassiemia, ipomagnesemia,cannabinoidi positivi e CPK elevate. Trattato in PS con infusione di potassio e magnesio ed eseguita visita neurologica con riscontro di ipostenia agli arti segmenti prossimali ROT presenti. Ricovero in Medicina dove si è evidenziato grave ipertiroidismo (TSH non numerico) e iniziata terapia con Tapazole, potassio e propanololo. Dimesso con diagnosi di PP tireotossica ipokaliemica. Dopo una settimana nuovo ricovero per analoga sintomatologia: il giorno precedente ha dimenticato la terapia, aumenatato attività fisica e assunto cannabinoidi. Anche in questo caso riscontro di ipocaliemia e ipomagnesemia, trattato con infusioni ev di potassio e magnesio con regressione della sintomatologia.
Conclusioni: La PP tireotossica ipocaliemica pur essendo a prevalente incidenza fra gli asiatici deve essere considerata anche nei caucasici.

Una rara localizzazione di tubercolosi

D. Tettamanzi[1], M. Casartelli[1], D. Sala[1], C. Bassino[1], S. Casati[1], E. Limido[1]

[1]ASST-Lariana, Ospedale S. Antonio Abate, Cantù (CO), Italy

Premesse: Nella malattia tubercolare la localizzazione esofagea è eccezionale (<0,1% dei casi) e può complicarsi con fistola esofago-mediastinica e mediastinite . Un'altra rara localizzazione della malattia tubercolare è l'ascesso del muscolo ileopsoas, per il quale un'eziologia specifica deve essere sempre considerata, se compatibile con il contesto clinico-epidemiologico.
Caso clinico: Donna di 64 anni, di nazionalità filippina, giunta presso il nostro PS per astenia, iporessia e calo ponderale progressivo, sintomi a lungo attribuiti a depressione reattiva. Non febbre né tosse. Grave stato di malnutrizione con BMI 15. Gli accertamenti eseguiti (TAC toraco-addominale, EGDS, broncoscopia) hanno permesso di porre diagnosi di tubercolosi polmonare con localizzazione ossea (vertebrale con aree litiche L1-L2) e muscolare (m. ileopsoas dx) e di fistola esofago-mediastinica verosimilmente secondaria ad adenite mediastinica tubercolare. Esame microscopico positivo per BK su broncoaspirato e su succo gastrico. Posizionato SNG a scopo nutrizionale e intrapresa terapia antitubercolare e antibiotica ad ampio spettro. La paziente è stata trasferita in Malattie Infettive dove è deceduta due settimane dopo per peggioramento del quadro settico e dell'insufficienza respiratoria.
Conclusioni: Condizioni di isolamento sociale e la presenza di barriere culturali e linguistiche possono ostacolare una diagnosi precoce di infezione tubercolare e far sì che essa giunga all'attenzione medica solo in stadio avanzato, con quadri di malattia disseminata tipici dell'era preantibiotica.

Sacubitril/valsartan improves functional dependence and quality of life in patients with heart failure and reduced ejection fraction

M.G. Tinti[1], M.P. Dagostino[2], S. Curci[3], D. Sancarlo[2], G. Vendemiale[1], A. Greco[2]

[1]Dipartimento di Scienze Mediche e Chirurgiche, Università degli Studi di Foggia; [2]Unità Operativa Complessa di Geriatria, Dipartimento di Scienze Mediche, IRCCS "Casa Sollievo della Sofferenza", San Giovanni Rotondo (FG); [3]Dipartimento di Scienze Mediche, IRCCS "Casa Sollievo della Sofferenza", San Giovanni Rotondo (FG), Italy

Introduction: Quality of life (QoL) in patients with chronic heart failure with reduced ejection fraction (HFrEF), is severely compromised by the symptoms of the disease. The development of physical disability and loss of independence is reflected by the alteration of the Barthel Index (BI). Besides patient-reported outcomes, little is known about the effects of recently introduced therapies on functional dependence in patients with HFrEF. We investigated the effects of the sacubitril/valsartan on BI in a sample of multiple morbidity patients with advanced heart failure.
Patients and Methods: We prospectively enrolled 9 patients, between January 2018 and January 2019, with chronic HFrEF (NYHA class III-IV). Charlson comorbidity index (CCI) was evaluated at baseline to test the level of comorbidity. In these patients, the BI and the echocardiography were assessed both at baseline and after six months of treatment with sacubitril/valsartan. BI values and their treatment-induced changes were faced to those of echocardiography parameters.
Results: The mean age was 69.0±13.2 (±SD). The mean CCI was high 7.5±2.2 (± SD). The mean baseline LVEF values were 28,2±4,7%, whereas after six-months therapy were 31.66±3.84% (p=0,001). BI changed from 41.7±15.4 to 53.9±8.9 (p=<0.001). BI was high correlated to LVEF at baseline (R^2=0.9 p<0.01) and after six months (R^2=0.88 p<0001)
Conclusions:: The treatment with Sacubitril–valsartan in HFrEF besides the effects on heart function, improve functional dependence and the perception of QoL in adults with co-morbidities.

Thrombocytopenia: don't forget to think about rare diseases!

P. Tirelli[1], L. Perna[2], M.G. Coppola[1], C. Bologna[1], P. Madonna[1], M. Lugarà[1], G. Oliva[1], V. Pergola[2], A. Barbato[2], P. Strazzullo[2]

[1]Department of Internal Medicine, Ospedale del Mare, Naples; [2]Department

of Clinical Medicine and Surgery, Federico II University Medical School, Naples, Italy

Background: Gaucher disease (GD) is the most common lysosomal storage disease with an incidence ranging from 0.39 to 5.80 per 100 000 newborn.
GD is an autosomal recessive disorder caused by a defective function of the lysosomal glucocerebrosidase enzyme. These defects leads to accumulation of glucosylceramide within lysosomes, especially in tissue macrophages. GD has been classically divided into 3 clinical types: the most common type 1 , a visceral disease (hepatosplenomegaly, bone marrow expansion, bone disorders, anemia, thrombocytopenia, lung involvement), mediated mainly by macrophage/inflammatory cell; types 2 and 3, with neurological involvement, but the disease is actually a phenotypic continuum.
Case report: MC, a 19 yrs old female, was admitted to our Internal Medicine department for a newly diagnosed thrombocytopenia. Blood chemistry revealed a platelet count of 65.000/ mm^3, in absence of anemia or leukocytopenia, and increased ferritin levels (600 ng/ml). Moreover, the patient had been complaining for years about widespread bone pain. Abdominal ultrasound showed a moderate splenomegaly (bipolar splenic diameter was 15 cm) and no hepatomegaly. Hematological evaluation was not able to identify a specific diagnosis. Suspecting Gaucher disease, we performed a dosage of β-glucocerebrosidase activity in leukocytes, and it resulted almost absent (0.3 nmol 4 MU/mg proteins/h, reference values 4.5-18.3), and a serum chitotriosidase measurement, which resulted increased (8970 nmol 4 MU/ml/h, reference values 3.2-97.2), which confirmed the diagnosis. An MRI study of abdomen and bone was performed, and confirmed splenic enlargement. In addition, there was diffusive bone marrow infiltration of both femoral diaphysis. The patient started the ERT at high dose (60 UI/kg every other week). At follow up examination, after 6 months of treatment, we detected a significant increase of platelet counts (PLT: 98.000/mm^3), and a huge reduction in serum chitotriosidase (1600 nmol 4 MU/ml/h), with a considerable relief of symptoms.

Problem solving in complex clinical cases: an instrument to reduce diagnostic inappropriateness. Case series

D. Tirotta[1], L. Poli[1], A. Salemi[1], L. Giampaolo[1], P. Montanari[1], L. Ghattas[1], M.G. Finazzi[1], G. Eusebi[1], R. De Giovanni[1]

[1]Medicina Interna, Ospedale Cervesi di Cattolica (RN), Italy

Background: The literature shows that 30-45% of patients do not receive appropriate interventions according to scientific evidence and 30-35% of the healthcare interventions are inappropriate and harmful. The consequences are not measurable (as consumption of economic resources, clinical and organizational inadequacy).
Case series: A 54 year old man was hospitalized for abdominal pain, vomiting, cytotoxicity /hepatic cholestasis, mild elevations of lipase. The patient was undergo abdominal US (gallbladder lithiasis) and surgical evaluation (cholecystectomy scheduled in election after ERCP). ERCP showed caliber reduction of the choledochus and the common hepatic duct). A sclerosing cholangitis was hypothesized, so the specialist planned a MRI. Anamnesis was positive for chronic hepatitis B in antiviral therapy. We hypothesized cirrhosis in association with lithiasis. The US confirmed cirrhosis, but also multiple abdominal lymphadenomegalies, and CEUS showed multiple liver metastases. TC confirmed this finding. Liver biopsy showed undifferentiated carcinoma. The patient worsened in few days, until his death. A 50 year old man with DM I, is hospitalized after consulting several specialists for abdominal pain, the last of which, in the suspicion of autoimmune pancreatitis, prescribed abdomen CT, MRI and echoendoscopy. However, these tests were negative and also IgG4 were normal. In view of the asthenia, mild hyponatraemia, the autoimmune disease (DM I) we hypothesized Addison disease. We diagnosed an autoimmune polyendocrine syndrome 2 (chronic thyroiditis was present), Clinical symptomatology improved after therapy.
Discussion: We report 2 complex cases in which the diagnosis was made late after an excess of examinations. These cases show the role of internist in the decision making of complex disease, through problem solving. We think that occasional audits in the Departments and pragmatic studies on the role of the problem solving in diagnostic pathway could be useful

Shock settico senza aumento della lattacidemia: case report

D. Tonietti[1], R. Rondinelli[1], E. Amato[1], A. Sarno[1], E. Reali[1], M. Cacciafesta[1], C.A.M. Lo Iacono[1]

[1]AO Universitaria Policlinico Umberto I, Dipartimento di Medicina Interna e delle Specialità Mediche, UOC Geriatria, Roma, Italy

Premesse: Nei criteri Sepsis-3 lo shock settico richiede la compresenza di elevati livelli di lattato (>2 mmol/L) e necessità di vasopressori per mantenere MAP>65 mmHg. Tuttavia in letteratura sono descritti casi di shock settico senza significativo aumento di lattati sierici.
Caso clinico: Donna di 92 anni giungeva in PS per stato soporoso, tremori, astenia e contrazione della diuresi. In anamnesi FA, ipertensione arteriosa, IRC con IVU ricorrenti. Gli esami ematochimici all'ingresso mostravano aumento degli indici di flogosi e creatinina 4.2 mg/dL; Rx torace e Tc cerebrale negativi per eventi acuti. All'ingresso presso la nostra UO l'ECOfast rilevava rene sn dilatato con assottigliamento corticale; la TAC addome confermava idroureteronefrosi; il successivo isolamento di Escherichia Coli dalle emo- e urinocolture ci permetteva di porre diagnosi di urosepsi. Clinicamente venivano soddisfatti i criteri qSOFA e SOFA score, pertanto si impostava antibiotico-terapia mirata e si procedeva a infusione di cristalloidi e ionotropi. Gli EGA seriati mostravano un quadro di acidosi metabolica a GAP anionico aumentato senza aumento dei livelli di lattato (valore max 1.3 mmol/L).
Conclusioni: Studi sperimentali mostrano shock settici con lattacidemia non elevata, nei quali la spettrometria mostra l'accumulo di altri metabolici intermedi del ciclo di Krebs non misurabili nella pratica clinica. Ciò conferma che la diagnosi di sepsi e shock settico è prevalentemente clinica e l'eterogeneità dei quadri clinici rende inadeguati rigidi protocolli diagnostici.

Un esordio atipico del morbo di Graves

G. Torin[1], V. Paon[2], A. Dalbeni[1], A.P. Sacco[3], A. Mazza[3]

[1]Dipartimento di Medicina Interna, AOUI Verona; [2]Dipartimento di Medicina Interna, AOUI Verona; [3]UOC Medicina Interna, Rovigo, Italy

Premesse: L'ittero è una condizione frequente in Medicina Interna e, quando evidenziato, è raccomandato valutarne le caratteristiche per poter eseguire una corretta diagnosi differenziale.
Caso clinico: Donna di nazionalità rumena, 50 anni, si presentava presso l'ambulatorio di Medicina Interna per ittero, dolore addominale e calo ponderale (13 kg in 6 mesi). L'anamnesi patologica remota era negativa; la paziente negava l'assunzione di farmaci e di preparati erboristici. Agli esami ematochimici si rilevava: bilirubina 24 mg/dl, prevalentemente diretta (20 mg/dL) rialzo degli enzimi epatici e di colestasi (ALT 70 U/L, AST 100 U/L, GGT 250 U/L, PT INR 1.7, albumina 25 gr/L TSH <0.001 mUI/L, fT4 102.1 pmol/L, TRab 345 Ui/mL, negativa la ricerca di autoanticorpi specifici per epatite autoimmune ed i markers virali). L'ecografia addominale e la Colangio- RMN non rilevavano calcoli nelle vie biliari e l'ecografia tiroidea mostrava una ghiandola aumentata di volume ed ipervascolarizzata. La biopsia epatica, escludendo cause autoimmunitarie, metaboliche, neoplastiche e tossiche dell'epatopatia, orientava per un quadro di tireotossicosi. Essendo controindicati la terapia con tionamidi e l'intervento chirurgico di tiroidectomia, la paziente è stata sottoposta a terapia inizialmente con perclorato di potassio e successivamente radiometabolica con I-131, con risoluzione della tireotossicosi e dell'ittero (bilirubina 1 mg/dL, TSH 0.4 mUI/L, fT4 15 pmol/L).
Conclusioni: Il caso rappresenta un esordio atipico del morbo di Graves, in cui prevalgono i sintomi gastrointestinali.

Il ruolo dei vasopressori nella sindrome cardiorenale di tipo II

M.C. Tringali[1], D. La Rosa[1], M. Gigliotti De Fazio[1], A. Caruso[1], M. Chiappalone[1], N. Laganà[1], F. Mamone[1], V. Natale[1], A.G. Versace[1], F. Napoli[1]

[1]AOU Policlinico, Dipartimento Medicina Clinica e Sperimentale, Messina, Italy

Premessa: Pz uomo di 69 anni affetto da cardiopatia ischemico-

ipertensiva, fibrillazione atriale, BPCO, pneumonectomia sinistra per pregresso carcinoma squamoso, cirrosi cardiogena, ipertiroidismo, diabete mellito di tipo 2, dislipidemia, ectasia dell'aorta addominale sottorenale e ipoplasia del rene di sinistra.
Caso clinico: Pz con scompenso cardiaco acuto (NT- proBNP di 3450 pg/ml) IV classe NYHA, versamento pleurico basale bilaterale, ascite di grado moderato, edemi periferici improntabili. Ecocardiogramma: camere destre dilatate con TAPSE 14 mm, severa insufficienza tricuspidalica con PAPs 70 mmHg. Insufficienza renale cronica III stadio (clearance della creatinina 55.7 ml/min). Terapia domiciliare: bisoprololo, Metimazolo, Furosemide, anti-aldosteronico, idroclorotiazide, atorvastatina, clopidogrel. 48 ore dopo si assisteva ad un peggioramento delle condizioni cliniche (alterato stato di coscienza, ipotensione, tachicardia, oligoanuria) e della clearance della creatinina (23 ml/min). Si sospendevano i farmaci nefrotossici, compresi i diuretici, e si praticava mantenimento del circolo con noradrenalina e colloidi/cristalloidi. Dopo 2 ore si assisteva ad una ripresa della diuresi (100 ml/h) e, dopo 7 giorni, al ripristino del baseline renale.
Conclusioni: Il caso clinico mostra una sindrome cardiorenale acuta I tipo in paziente affetto da cuore polmonare cronico. Lo shock cardiogeno ha determinato l'insorgenza di insufficienza renale acuta. Il miglioramento della performance cardiaca ha permesso il ripristino dei valori basali di funzione renale.

Severe hypomagnesaemia due to proton pump inhibitor use

L. Trotta[1], A.L. Brucato[2]

[1]Medicina Interna D1, Ospedale Niguarda, Milano; [2]Medicina Interna, Ospedale Fatebenefratelli, ASST Fatebenefratelli Sacco, Milano, Italy

Introduction: Hypomagnesemia can result from different causes including gastrointestinal and kidney diseases and as a side effect of drugs, *e.g.* the widely used proton pump inhibitors (PPI).
Case report: A 75-year old female who had been using omeprazole 40 mg for two years presented with weakness, cramps, nausea, tetany (positive Chvostek sign), tremor and muscle fasciculations that had been attributed to severe hypomagnesemia and hypocalcemia. She also took dabigatran 150 mg twice daily for atrial fibrillation and torasemide 10 mg for chronic heart failure. Her laboratory tests revealed severe hypomagnesemia 0,64 mg/dL (1,7-2.2), hypocalcemia 5.2 mg/dL, and hypokalemia 3.1 mmol/L. Very low urinary calcium, magnesium and potassium excretion was detected. Parathyroid hormone, vitamin D and sieric albumin were normal. ECG disclosed prolonged QT-interval and ST depression. After discontinuation of the PPI, intravenous treatment with magnesium sulphate and calcium gluconate, she recovered fully and was discharged.
Conclusions: This report emphasizes that even if long term-PPI users appear largely asyntomatic, numerous side effects such as hyomagnesemia can present. PPI impair the intestinal magnesium absorption through molecular mechanism of magnesium transporters, probably influenced by a complicated interplay of molecular, biology, pharmacology and genetic predisposition. Magnesium levels should be monitored in chronic PPI-users with any neuromuscular, cardiovascular symptoms, especially in the presence of malnutrition or concomitant use of diuretics.

Lithium toxicity occurring with a sodium-restricted diet

M. Uccelli[1], A. Bovero[1], M. Giovinale[1], R. Goretti[1]

[1]SC Medicina Interna, Ospedale Santa Corona, Pietra Ligure (SV), Italy

Lithium is a drug with narrow therapeutic range, widely usµed for the treatment of mood and behavior disorders. The only normal route of elimination is via the kidney; In addition to its therapeutic role in psychiatric disease it has diverse effects on endocrine function. These include thyroid enlargement, increase in PTH secretion, altered carbohydrate metabolism and nephrogenic diabetes insipidus. We observed a 54-year-old female patient with bipolar depression treated for years with lithium, without clinical evidence of diabetes insipidus (absence of polyuria or polydipsia, urinary specific weight 1.015) and with values of lithium serum levels in the therapeutic range (0.92 mEq/L). The patient had normal BP, BMI 24.5, creatinine 0,9 mg/dL, Na+140 mEq/ L, K^+3,9 mEq/L, Mg^{++} 1,98 mEq/L; normal thyroid function (TSH 2,28 µIU/L, fT4 0,86 ng/dL) and secondary hyperaldosteronism (renin 56 pg/mL, aldosterone 1331 pg/mL), were present. There was no other concomitant therapy. Informed of the outcome of the exams, following the advice of a friend, the patient followed a diet with a very low sodium content. After three weeks she developed the onset of confusion, tremor, ataxia , with need for hospitalization and subsequent diagnosis of lithium intoxication (lithium blood level 2.8 mEq/L). It is always important to remind patients taking lithium both to take an adequate daily amount of fluids and not to suddenly reduce the salt intake, to keep the drug blood level stable and avoid lithium intoxication.

Chetoacidosi diabetica euglicemica in paziente trattata con canaglifozin: case report

L. Venditti[1], N. Fortunato[1], I. Lelo[1], R. Gervasi[1], D. De Nardo[1], P. Sbraccia[1], M.A. Marini[1]

[1]Dipartimento di Medicina dei Sistemi, Università di Roma Tor Vergata, Roma, Italy

Premessa: Tra gli innovativi farmaci antiglicemici approvati vi sono gli inibitori del cotrasportatore 2 sodio-glucosio (SGLT2) che aumentano l'escrezione urinaria di glucosio.
Caso clinico: Donna, 66 anni, si presentava in Pronto Soccorso per nausea e vomito da 3 giorni. In anamnesi diabete mellito di tipo 2 (DM2), in terapia con canaglifozin/metformina 150/850 mg, 2 volte/die. All'ingresso si rilevavano: PA 140/80 mmHg, FC 125 bpm, SpO2 99%, GCS 15, HGT 197 mg/dl. All'EGAA riscontro di severa acidosi metabolica ad AG aumentato, presenza di chetonuria >100 mg/dl. Dopo 2 giorni veniva ricoverata nel reparto di Medicina Interna dove si sospendeva la terapia ipoglicemizzante orale, si iniziavano idratazione ev e insulina rapida a basse dosi (6 UI/die). Durante la degenza, si riscontravano valori di glicemia persistentemente <100 mg/dl a digiuno, marcata glicosuria durata oltre 15 giorni dalla sospensione del farmaco e chetonuria risoltasi al quindicesimo giorno. Considerato il quadro clinico, è stato effettuato il dosaggio degli autoAb che confermava il sospetto di Late Onset Diabetes of Adult anziché di DM 2.
Conclusioni: In letteratura sono descritti casi di chetoacidosi diabetica euglicemica in pazienti trattati con canaglifozin. In questo caso, in particolare, abbiamo documentato prolungata chetonuria e glicosuria euglicemica. Ulteriori studi e sorveglianza post-marketing sono necessari per valutare la frequenza di questa prolungata reazione avversa e comprenderne i meccanismi genetici, endocrino-metabolici e renali che possano determinarla.

A disease that has become rare

E. Venegoni[1], B. Cattaneo[1], A. Grittini[1], P. Marini[1], L. Pavan[1], C. Porta[1], G. Rotiroti[1], P. Mantegazza[2], G. Patruno[2], A. Romorini[2], N. Mumoli[1]

[1]Medicina, Magenta (MI); [2]Neurologia, Magenta (MI), Italy

Introduction: Paraparesis results from inflammation or tumours of medulla spinalis, meninges and nerves, from lesions of vertebrae and traumas.
Case report: A 69-year-old man, suffering from ischemic heart disease, arterial hypertension, diabetes mellitus, knee arthrosis, presented lower limb weakness which was worsening during the preceding 5 months. A spinal cord MR was performed (T3-T10 myelitis) and EMG (severe sensitive polineuropathy of upper and lower limbs and moderate motor one of lower limbs). Brain tests were normal. Rachiocentesis was not done because of suspect of infection site. A severe deficit of vitamin B12 resulted from blood tests and gastroscopy showed atrophic gastritis. After these data MR was reinterpreted as dorsal tabes. High doses of vitamin B12 were administered with immunoglobulins. The patient improved slowly by rehabilitation till he could stand up and walk a few steps.
Conclusions: The cause of paraparesis was very rare in fact one does not expect to find vitaminic deficit in Western European Countries nowadays. It resulted associated with atrophic gastritis and APCA antibodies, These elements were more frequent many years ago.

A very strange cause of fever of unknown origin

E. Venegoni[1], B. Cattaneo[1], A. Grittini[1], P. Marini[1], L. Pavan[1], C. Porta[1], G. Rotiroti[1], M. Mena[2], C. Magnani[2], P. Viganò[2], I. Lazzarini[3], G. Di Credico[3], N. Mumoli[1]

[1]Medicina, Magenta (MI); [2]Malattie Infettive, Legnano (MI); [3]Cardiochirurgia, Legnano (MI), Italy

Introduction: FUOs (fever of unknown origin) are caused by infections (30-40%), neoplasms (20-30%), collagen vascular diseases (10-20%) and numerous miscellaneous diseases (15-20%). The literature also reveals that between 5 and 15% of FUO cases defy diagnosis, despite exhaustive studies.
Case report: A 77-year-old man, suffering from diabetes mellitus, ischemic heart disease, arterial hypertension, was admitted in Hospital because of a facial trauma with anaemia and fever. A brain and cervical spine CT, rib, sternum, cranium and right hand X-rays (nasal bone fracture), otorhinolaryngologist examination, blood tests were performed. A gastroscopy, a colonscopy, colon CT and an enteroscopy by videocapsule were negative. Fever was treated by amoxicillin then levofloxacin. When S. aureus was detected in blood samples linezolid was administered with defervescence. After 4 days fever started again for a S aureus, this time treated by teicoplanin. Echocardiogram, cervical spine MR, facial CT resulted negative but chest CT showed a left pneumonia so vancomycin was prescribed. Whole body PET detected a sternum lesion with a probable abscess. The patient was transferred in Infectious Disease Unit and treated by linezolid and rifampin. He improved very much. Then in Cardiac Surgery Unit sternum was resected and replaced by a prosthesis.
Comments: This case was difficult because many infectious diseases were searched in connection with the trauma or it was suspected an endocarditis as result of colonization but tests were negative. PET was very helpful thanks to its overall vision.

A challenging case of an acute gastrointestinal bleeding: combined radiologic and endoscopic approach

F. Ventura[1], F. Piani[1], C. Borghi[1]

[1]Dipartimento di Scienze Mediche e Chirurgiche, Alma Mater Studiorum, Bologna, Italy

Introduction: Acute gastrointestinal bleeding is most frequently characterized and treated with endoscopic techniques. However, in case of failure of first line endoscopy, it's uncertain how to proceed. Alternative procedures could be angioCT, angiography, tagged RBC scintigraphy or surgical approach, depending on each specific case.
Case report: A 70 y/o woman presented with recurrent melena's episodes over the last month. 2 years earlier she started double antiplatelet therapy for ACS, then reduced to clopidogrel only. Despite reduction, the patient has been hospitalised 3 times for melena, the last one 1 week before. Endoscopic procedures were all negative, nevertheless transfusions of 5-5-8 RBC units respectively have been needed. At admission Hb was 8.6 g/dL. AngioCT showed thickening of a short segment around the 1st jejunal loop, suggesting angiodysplasia with minor bleeding. However, first line endoscopy and angiography didn't mark any lesion. Since recurrent bleedings (Hb down to 6.5 mg/dL) that needed blood support (14 RBC units during hospitalization) occurred, new angiography was performed: even after selective catheterization and infusion of vasodilating agents, no significant bleeding was noted. We have therefore done RBC scintigraphy: 24 hours later, an accumulation of tagged erythrocytes in right colon was revealed. Finally, we performed single-balloon operative enteroscopy which exposed a distal jejunum loop with abundant non-focal bleeding successfully treated with argon-plasma.
Conclusions: In our case, a non-endoscopic approach has helped identifying the source of bleeding whereas the enteroscopy has demonstrated useful in stopping the bleeding. Differences in the rate and amount of bleeding with discontinuation of antiplatelet therapy have not been noticed, suggesting that in high CV risk's patients antiaggregant therapy could not be discontinued.

Correct use of blood resource in orthopedic surgery

D. Venuti[1], B. Besmir[1], S. Porcile[1], P. Lazzoni[1]

[1]Ospedale Evangelico Internazionale, Genova, Italy

Aim of the study: We created a protocol for the appropriate use of blood in our Orthopedic Department. We want to reduce the blood consumption e to improve a correct use of transfusion in traumatic surgery and in elective surgery.
Materials and Methods: We checked each patient in the first day of delivery in traumatic surgery and before the delivery in elective surgery. Each patient received a complete iron assessment , coagulation assessment and a complete evaluation of anticoagulant /anti thrombotic therapy. We fixed the level of Hb using the parameters of Patient Blood Management document.
We use coded parameters to correct anemia and we use carboxy maltose iron, folic acid , B12 and erythropoietin.
Results: We treated since August 2017 278 patients : 113 in elective surgery and 165 in traumatic surgery. In elective surgery we observed a 30% of anemic patient and we treated these group before surgery. We used bood transfusion only in the 5% of this group of patients. We treated with iron, folic acid and B12 the 92% of the traumatic patientsin the first day of the delivery and we added erythropoietin in the 50% of the cases. We used blood transfusion in the 10% of the patients.
Conclusions: We reduced the blood transfusions in our Department with the introduction of a protocol where we fixed the level of Hb , we prevent the anemia using fixed dose of iron , vit B12 , folic acid and erythropoietin and with a correct use of anticoagulant and antithrombotic therapy.

Trattamento osteopatico sulla funzionalità respiratoria su un soggetto asmatico asintomatico

S. Vernocchi[1], A. Leggieri[2], S. Riva[2], G. Castronovo[2], A. Aceranti[1], M. Tuvinelli[2], A. Palazzolo[2]

[1]Istituto Europeo di Scienze Forensi e Biomediche, Gallarate (VA); [2]Accademia Osteopatia, Bergamo, Italy

Premessa: L'asma è una delle malattie respiratorie croniche più diffuse, colpisce ad oggi circa 300 milioni di persone nel mondo. Si tratta di una patologia complessa che si manifesta attraverso un'infiammazione cronica delle vie aeree. La flogosi genera un aumento della responsività bronchiale che, a sua volta, causa episodi ricorrenti di crisi respiratorie, respiro sibilante, senso di costrizione toracica e tosse. Lo studio mira a indagare se il trattamento osteopatico risulti efficace se affiancato alla medicina tradizionale, andando ad agire sul recupero dell'attività respiratoria tramite tecniche HVLA e trattamento fasciale della muscolatura accessoria e non della respirazione.
Caso clinico: Uomo, 23 anni, caucasico con diagnosi di asma asintomatica. Presenta difficoltà all'atto respiratorio in seguito a sforzo. Il paziente è stato sottoposto ad esame spirometrico prima (FEV1 79%; FVC 69%; FEV1/FVC 95%; PEF 75% FEF25-75% 98) e dopo (FEV1 119%; FVC 103%; FEV1/FVC 97%; PEF 122%; FEV25-75% 142) il trattamento per valutarne le percentuali di miglioramento.
Conclusioni: I risultati mostrano un notevole miglioramento dei volumi polmonari, in modo particolare delle piccole vie aeree. Inoltre risulta evidente il miglioramento sulla curva flusso-volume in espirazione. Utile sarebbe approfondire questo studio su un numero più ampio di pazienti, indagando anche l'effetto nel lungo periodo e non solo nell'immediato.

It's still here!

P. Vertolli[1], C. Cerasi[1], E. Onori[1], M. De Feo[1], F. Tonello[1], S. Cinotti[1], D. Grassi[1], C. Ferri[1]

[1]Dipartimento MESVA, Università degli Studi de L'Aquila, Italy

Introduction: Hyperferritinemia is associated with a multitude of clinical conditions and with worse prognosis in critically patients. It can be a result of inflammation, infection, chronic iron overload and autoinflammatory disease.
Case report: 71 years old woman,affected by hypertension, presented to our department with high-grade fever, sore throat and

drycough, widespread nonpruritic pink salmon skin rash, arthralgia of large joints, myalgia and night sweat. In the past,a similar episode had occurred. She had inflamed throat without any exudates and had bilateral laterocervical lymphadenomegaly. Abdomen exam showed only mild hepatomegaly. Laboratory test revealed elevated acute phase reactants, liver function tests,normocytic anemia with normal white cell with neutrophilic predominance and thrombocytopenia. The serum ferritin level was markedly increased at 132654ng/ml. A screening for infectious and autoimmunity diseases was negative. Chest radiograph was normal.Echocardiogram was performed ruled out endocarditis. Fever did not respond to antibiotic therapy and to paracetamol. To rule out malignancies a CT total body was done and it was normal except for jugular lymphadenomegaly and renal cysts. After ruling out malignancies, autoimmune disease and infectious causes, a diagnosis of Adult Onset Still's Disease(AOSD) was made based on the Yamaguchi criteria. Subsequently, the patient was started initially on high dose corticosteroids. Since then, the patient improved and the fever, skin rash and articular pain came down significantly. The patient was discharged home in a stable condition.
Conclusions: AOSD is a rare systemic inflammatory disease of unknow etiology e pathogenesis that present in 5th% of patients as fever of unknow origin accompanied by systemic manifestations. The diagnosis is of exclusion which should be considered only after excluding several other differential diagnosis.

Acute respiratory failure in subject with idiopathic pulmonary fibrosis: doctor's approach

A. Vetrano[1], G. Aruta[2], L. Errico[3], G. Balsamo[4], A. Caputo[5]

[1]Alta Specializzazione Geriatria, ASL NA 2 Nord, PO Frattamaggiore (NA); [2]UOC Medicina, ASL NA2 Nord, PO Frattamaggiore (NA); [3]DH Medicina ASL NA2 Nord, PO Frattamaggiore (NA); [4]Responsabile UOC Medicina e Pronto Soccorso, ASL NA2 Nord, PO Frattamaggiore (NA); [5]UOC Medicina e Pronto Soccorso, ASL NA2 Nord, PO Frattamaggiore (NA), Italy

Introduction: The guidelines in medicine are able to shed light and resolve issues on many diseases while ensuring doctors and patients. But there are other diseases such as the Idiopathic Pulmonary Fibrosis (FPI) the same lines refer to areas of shade and leave to clinical judgment clinical decisions that have important economic and also ethical consequences.
Case report: We describe the case of a 64-year-old female who came for dyspnoea. The medical history reported FPI and was awaiting lung transplantation. She was confused and asthenic. B.P. it was 100 mmHg, afebrile and heart rate is 130 rhythmic. Widespread crackles appeared in the chest. Blood tests showed an increase in neutrophils, cardiac enzymes, PCR, D-Dimer, LDH. The blood gas had a pH of 7.42; pCO2 46.8; pO2 48.8. Chest X-ray observed a diffuse micro nodular thickening. She underwent therapy based on antibiotics, cortisones, heparin, diuretics and bronchodilators and C-PAP cycles. Finally she was sent to UTIR at another hospital and submitted to NIV. The patient died after 18 hours.
Conclusions: FPI is the most frequent rare respiratory disease in Italy. The complexity of this disease implies clinical, management, ethical and economic decisions on the usefulness of intensive treatment also with NIV, considering that severe respiratory failure is a cause of death in such patients. However, it is also necessary to consider that the current evolution of the therapeutic schemes, including ECMO, allows today to offer a treatment capable of influencing the prognosis of the patient awaiting transplantation.

That strange dyspnoea

M. Vincenzo[1]

[1]Pronto Soccorso, Medicina d'Urgenza, Ospedale Parini, Aosta, Italy

Background: 76-year-old woman with a phaeochromocytoma.
Case report: Hypertesion, fa permanent, ischemic stroke in 2005, carrier of PM .Dispnea cough from 4 days takes home coumadin tenormin aldactone trittico. At the entrance to DEA dyspnoea, pa 150/70 FC 150/m, sao2 95% with 6lt/O2, eot: widespread moans and ronchi, tachycardic cardiac tones, hydrated mucosa, treatable abdomen not painful, not edemas declivities, the rest normal. Hematochemical values: gb 11000; Na 125; troponin 96; probnp 5799; pcr 59.6 ega arterial ph 7.49 co 32, 6 po2 76.9 hco3 24.6 lactates 5. INR 1.3 .Ecg fa at 160/m. At rx of thorax bilateral bilateral pleural veiling,at Tac chest and abdomen mdc bilateral pleural effusion ectasias of suprahepatic cardiac cavities dx megalic hyperthrensity of mesentery for mesenteric panniculitis, formation of 25 mm at the level of the body of the hypertonal right adrenal gland in the arterial phase suggestive for pheochromocytoma. Pheochromocytoma is a neuroendocrine neoplasm that derives from chromaffin cells of the adrenal medulla.Secerne catecholamines causing serious cardiovascular complications often and evolution towards a dilated cardiomyopathy.There are limited data on the presentation and outcomes of the various forms of cardiomyopathies induced by phaeochromocytoma.
Conclusions: We performed a literature review to evaluate the association of pheochromocytoma and cardiomyopathy: 163 cases from 150 articles published between 1991 and November 2016 (PubMed research) (63 dilated cardiomyopathy, 38 Takotsubo cardiomyopathy, 30 inverted Takotsubo cardiomyopathy, 10 HOCM, 8 myocarditis and 14 unspecified cardiomyopathy). Many patients showed no classic signs or symptoms of phaeochromocytoma. Phaeochromocytoma resection led to an improvement in cardiomyopathy in 96% while lack of resection was associated with death or heart transplantation in 44%

La terapia biologica (top-down) nella gestione delle malattie infiammatorie croniche intestinali. Studio real-life di 75 pazienti

G. Zaccardo[1], N. Buccianti[1], M. Licchelli[1], A. Carbonella[1], M. Lofrano[1], N. Mecca[1], M. Pace[2], V. Pascale[3]

[1]AO San Carlo, UOC Medicina Interna, Potenza; [2]AO San Carlo, UOC Medicina Interna, Potenza, [3]Scuola di Specializzazione in Medicina Interna, Salerno, Italy

Premesse e Scopo dello studio: Le MICI,spesso, si associano a complicanze intestinali (fistole, ascessi, steno-occlusione, magacolon tossico) e a complicanze extraintestinali. Lo scopo del lavoro è valutare l'efficacia e la sicurezza della terapia biologica (Ac-TNFa) con l'approccio top-down nella gestione delle MICI.
Materiali e Metodi: Tra il 2016 e il 2018 sono stati arruolati 75 pts con malattia di crohn e rettocolite ulcerosa. E' stato preferito l'approccio top-down (infliximab-adalimumab) alla step-up terapia (tradizionale) sulla base dei fattori prognostici (età,esordio,gravità) e del comportamento della malattia infiammatoria cronica intestinale.
Risultati: La terapia biologica ha comportato un ottimo controllo della malattia sia sul piano clinico (remissione della sintomatologia e complicanze), biologico (normalizzazione di ves e cpr) che endoscopico (healing mucosal). La safety ai farmaci biologici è stata ottima; in alcuni casi sono state eseguite la switch e la swap therapy per inadeguato controllo della flogosi.
Conclusioni: La terapia biologica con ac-TNFa si associa ad una valido ed efficace controllo delle MICI con associata riduzione delle complicanze intestinali ed extraintestinali. La guarigione mucosale è l'end-point ideale per il controllo della storia naturale delle MICI ed è la prerogativa della sola terapia biologica.

Iperbilirubinemia diretta: unico segno di epatite virale

M.C. Zaccaria[1], S. Beccaria[2], R. Satira[1], G. Vairo[1], M.C. Zappa[3]

[1]UOC Medicina, Ospedale Sandro Pertini, Roma; [2]UOC Medicina Protetta, Ospedale Sandro Pertini, Roma; [3]Direttore UOC Pneumologia e Direttore ad Interim UOC Medicina, Ospedale Sandro Pertini, Roma, Italy

Pz di anni 72 giunto in PS per ittero franco e vomito, senza febbre. In anamnesi Ipertensione Arteriosa e Diabete Mellito. Gli esami ematici mostravano bilirubina totale pari a 21,9 mg/dl con diretta 19,2 mg/dl, ipertransaminasemia (GOT 138 U/L, GPT 276 U/L), riduzione dei valori di pseudocolinesterasi (2274 U/l), elevati gli indici di flogosi (PCR 4,3 mg/dl, VES 78); nella norma emocromo, funzionalità renale e sintesi epatica. Le sierologie per epatite A, B, e C erano negative, così come quelle per Leptospirosi, Cytomegalovirus, Epstein Barr, i markers tumorali nella norma eccetto alfa-

fetoproteina 12,5 ng/ml. Negativi anche gli autoanticorpi (ANA, ASMA, AMA, c-ANCA). L'ecografia, la TC addome e la colangio RMN documentavano epatomegalia con disomogeneità parenchimale come per steatosi senza alterazioni di colecisti, vie biliari e pancreas. L'ecoendoscopia confermava iperecogenicità epatica come per steatosi di grado severo senza dilatazioni del Wirsung lungo tutto il suo decorso e con regolarità per calibro e decorso della via biliare. Durante il ricovero in Medicina Interna si è osservato un iniziale modesto aumento delle transaminasi (mai superiori a 300 U/l), associato ad una lenta e graduale riduzione della bilirubina e delle stesse transaminasi in assenza di terapia specifica a parte idratazione, digiuno e successiva dieta ipolipidica. Approfondendo l'anamnesi si è appresa l'assunzione di frutta (Caki) non ben lavata circa 15 giorni prima della comparsa dell'ittero. È stata quindi eseguita sierologia per virus dell'epatite E che ha mostrato positività di IgG e IgM.

The diagnostic flow of a hematological patient admitted with neurological synthoms

M. Zavagli[1], G. Barbarisi[1], C. Marchiani[1], G. Bandini[1], P. Bernardi[1], M. Gagliano[1], E. Cioni[1], N. Palagano[1], I. Bertoletti[1], P. Mercatelli[1], E. Martinelli[1], F. Crudele[1], A. Moggi Pignone[1]

[1]Medicina per la Complessità Assistenziale IV, AOU Careggi, Firenze, Italy

Introduction: The central nervous system (CNS) is an important site of involvement by acute lymphoblastic leukemia (ALL) in adults. A lumbar puncture should be routinely performed in all newly diagnosed patients.

Case report: A 73-year-old woman was admitted to our hospital for altered mental status and dysarthria. She was affected by paroxystic atrial fibrillation without anticoagulant therapy; she assumed cardioaspirin as primary prevention for peripheral artery disease. The history was also positive for dyslipidemia and arterial hypertension. 10 years ago she was diagnosed with ALL and assumed third line therapy with ponatinib. Because of the clinical presentation she underwent a CT and angio-CT scan that resulted to be negative for stroke. She soon developed recurrent episodes of limbs myoclonus and absence seizures: the EEG tests showed wide slow spike–waves in the frontal derivations. We submitted antiepileptic therapy with levetiracetam and performed lumbar puncture that confirmed our diagnostic suspect of CNS involvement. We immediately started intratecal chemiotherapy (IT-CHT) with methotrexate, aracitabina and methylpredinsolone. After the hospital discharge she continued CHT in the hematologycal out patient clinic. Despite the initial rapid clinical improvement, she died after few weeks.

Conclusions: The numerous cardiovascular risk factors made us firstly think of a neurovascular genesis of the synthoms. However, the fluctuating neurological state were better explained by a CNS ALL localization. Adults with CNS involvement have a poor prognosis despite effective IT chemotherapy.

ABSTRACT BOOK - Index of authors

ABSTRACT BOOK - Index of authors

ABSTRACT BOOK - Index of authors

ABSTRACT BOOK - Index of authors

ABSTRACT BOOK - Index of authors

ABSTRACT BOOK - Index of authors

ABSTRACT BOOK - Index of authors

ABSTRACT BOOK - Index of authors

ABSTRACT BOOK - Index of authors

ABSTRACT BOOK - Index of authors

ABSTRACT BOOK - Index of authors

ABSTRACT BOOK - Index of authors

ABSTRACT BOOK - Index of authors

ABSTRACT BOOK - Index of authors

pagepress

Italian Journal of Medicine

GUIDELINES FOR AUTHORS

http://www.italjmed.org/ijm/about/submissions

Manuscripts have to be *double-spaced* with *one-inch margins*. Headings must be used to designate the major divisions of the paper. To facilitate the review process, manuscripts should contain page and line numbering.

Manuscripts must be written in English. Authors whose native language is not English are strongly advised to have their manuscript checked by a language editing service, or by an English mother-tongue colleague prior to submission. As an option, PAGEPress offers its own professional copyediting service. Professional copyediting can help authors improve the presentation of their work and increase its chances of being taken on by a publisher. In case you feel that your manuscript needs a professional English language copyediting checking language grammar and style, PAGEPress offers a chargeable revision service in a few days. This service is available as well to authors who do not submit their manuscript to our journals. Please contact us to get more detailed information on this service.

The first page must contain: i) title (lowercase), without acronyms; ii) first name and family name of each author, separated by commas; iii) affiliation(s) of each author; iv) acknowledgments; v) full name and full postal address of the corresponding author. Phone, fax number and e-mail address for the correspondence should also be included; vi) three to five key words. The second page should contain: i) authors' contributions, e.g., information about the contributions of each person named as having participated in the study; ii) disclosures about potential conflict of interests; iii) further information (e.g., funding, conference presentation ...).

If *tables* are used, they should be double-spaced on separate pages. They should be numbered and cited in the text of the manuscript.

If *figures* are used, they must be submitted as .tiff or .jpg files, with the following digital resolution:

i) color (saved as CMYK): minimum 300 dpi;
ii) black and white/grays: minimum 600 dpi;
iii) one column width (7.5 cm) or 2 column widths (16 cm).

A different caption for each figure must be provided at the end of the manuscript, not included in the figure file.

Authors must obtain **written permission** for the reproduction and adaptation of material which has already been published. A copy of the written permission has to be provided before publication (otherwise the paper cannot be published) and appropriately cited in the figure caption. The procedure for requesting the permission is the responsibility of the Authors; PAGEPress will not refund any costs incurred in obtaining permission. Alternatively, it is advisable to use materials from other (free) sources.

If *abbreviations* are used in the text, authors are required to write full name+abbreviation in brackets [e.g. Multiple Myeloma (MM)] the first time they are used, then only abbreviations can be written (apart from titles; in this case authors have to write always the full name).

Original Articles (3500 words max, abstract 180 words max, 30 references max, 3/5 tables and/or figures): In general, this kind of publication should be divided into an Abstract, Introduction, Materials and Methods, Results, Discussion, Conclusions and References. A maximum of 10 authors is permitted and additional authors should be listed in an ad hoc Appendix.

Reviews (4000 words max, abstract 250 words max, minimum 40 references, 3/5 tables and/or figures): They should be introduced by a general summary of content in the form of an Abstract. Following a short introduction, putting the study into context and defining the aim, reviews will concentrate on the most recent developments in the field. A review should clearly describe the search strategy followed (key words, inclusion, exclusion criteria, search engines, ...). No particular format is required; headings should be used to designate the major divisions of the paper.

Brief Reports (about 2000 words, abstract 150 words max, 20 references max, 3 tables and/or figures): Short reports of results from original researches. They should be introduced by a general summary of content in the form of an Abstract. They must provide conclusive findings: preliminary observations or incomplete findings cannot be considered for publication.

Case Reports (about 1800 words, abstract 150 words max, 15 references max, 1-2 tables and/or 3 figures max): A case report is a detailed narrative of symptoms, signs, diagnosis, treatments and follow-up of one or several patients. Cases that present a diagnostic, ethical or management challenge or highlight aspects of mechanisms of injury, pharmacology and histopathology or are accompanied by a literature review of the topic presented are deemed of particular educational value. The narrative should include a discussion of the rationale for any conclusion and any take-home message. Information on the patient should be presented in the chronological order it has emerged in clinical practice. The evaluation will take into account the following aspects: Originality; Quality of the presentation; Correctness; Sustainability; Usefulness/relevance. They should be divided into: Abstract, Introduction, Case report(s), Discussion, Conclusions and References. For details please read the following Technical Note: http://www.italjmed.org/ijm/article/viewFile/itjm.2014.535/498

Letters to the Editor (800 words max): These are written on invitation, short essays that express the authors' viewpoint, may respond to published manuscripts in our journals, or deliver information or news regarding an issue related to the Journal scope. If the letter relates to a published manuscript, the authors of the original manuscript will be given the opportunity to provide a respond. Authors of Letters to the Editor should provide a short title.

Book Reviews (no abstract, no references needed): They should be a short critical analysis and evaluation of the quality, meaning, and significance of a short book which addressed at least one of main topics of the Journal (the authors should contact the Editor-in-Chief of the journal for his/her approval before submitting a Book review).

FADOI Position Statement: Position statements are developed in response to issues relevant to and/or directly impacting on Internal Medicine practice, such as clinical, structural, organizational, management, legislative and ethical issues.

Imaging in Internal Medicine: Reports describing clinical cases that can be educational, including adverse effects of drugs or outcomes of a specific treatment, with particular emphasis on imaging important for Internal Medicine, such as: echocardiography, traditional and advanced radiology, nuclear medicine, ultrasound and bed-side sonography, etc.). They should be divided into: Abstract, Introduction (optional), Case report(s), Discussion, Conclusions, and References.

Health Organization and Clinical Governance: This section should contribute to develop a multidisciplinary debate involving policy-makers, health organizations, consumers' organizations and profit and no-profit societies, operating in the field of public health. The contents of this section must be centred on scientific argumentations even if policy, economical and ethics issue can be addressed. A box with a clear description of the organization will be included in the manuscript. Papers highly polemic, written by an author addressing his own opinion and not an organization position or with a theme of local interest will not be published. These papers are not peer reviewed and are published at the discretion of the Editor. Conclusions and opinions expressed by the authors do not necessarily reflect the policies of the Italian Journal of Medicine.

REFERENCES

References should be prepared strictly according to the Vancouver style. References must be numbered consecutively in the order in which they are first cited in the text (not alphabetical order), and they must be identified in the text by Arabic numerals in *superscript*. References in the main text must always be cited after dots and commas. References to personal communications and unpublished data should be incorporated in the text and not placed under the numbered references [Example: (Wright 2011, unpublished data) or (Wright 2011, personal communication)]. Where available, URLs for the references should be provided directly within the MS-Word document. References in the References section must be prepared as follows:

i) more than three authors, cite 3 authors, et al. If the paper has only 4 authors, cite all authors;
ii) title style: sentence case; please use a capital letter only for the first word of the title;

iii) journal titles mentioned in the References list should be abbreviated according to the following websites:
   a. ISI Journal Abbreviations Index (http://library.caltech.edu/reference/abbreviations/);
   b. Biological Journals and Abbreviations (http://home.ncifcrf.gov/research/bja/);
   c. Medline List of Journal Titles (ftp://ftp.ncbi.nih.gov/pubmed/J_Medline.txt);
iv) put year after the journal name;
v) never put month and day in the last part of the references;
vi) cite only the volume (not the issue in brackets);
vii) pages have to be abbreviated, e.g., 351-8.

To ensure the correct citation format, please check your references in the PubMed database (http://www.ncbi.nlm.nih.gov/pubmed). Examples:

Standard journal article

Halpern SD, Ubel PA, Caplan AL. Solid-organ transplantation in HIV-infected patients. N Engl J Med 2002;347:284-7.

Proceedings

Christensen S, Oppacher F. An analysis of Koza's computational effort statistic for genetic programming. In: Foster JA, Lutton E, Miller J, Ryan C, Tettamanzi AG, eds. Genetic programming. EuroGP 2002: Proceedings of the 5th European Conference on Genetic Programming, 2002 Apr 3-5, Kinsdale, Ireland. Berlin: Springer; 2002. pp 182-91.

Article with organization as author

Diabetes Prevention Program Research Group. Hypertension, insulin, and proinsulin in participants with impaired glucose tolerance. Hypertension 2002;40:679-86.

Books

Murray PR, Rosenthal KS, Kobayashi GS, Pfaller MA. Medical microbiology. 4th ed. St. Louis, MO: Mosby; 2002.

Bjørn Lomborg, ed. RethinkHIV - Smarter ways to invest in ending HIV in Sub-Saharan Africa. Cambridge: Cambridge University Press; 2012.

Meltzer PS, Kallioniemi A, Trent JM. Chromosome alterations in human solid tumors. In: Vogelstein B, Kinzler KW, eds. The genetic basis of human cancer. New York, NY: McGraw-Hill; 2002. pp 93-113.

PEER REVIEW POLICY

All manuscripts submitted to our journal are critically assessed by external and/or in-house experts in accordance with the principles of peer review, which is fundamental to the scientific publication process and the dissemination of sound science. Each paper is first assigned by the Editors to an appropriate Associate Editor who has knowledge of the field discussed in the manuscript. The first step of manuscript selection takes place entirely in-house and has two major objectives: i) to establish the article's appropriateness for our journals' readership; ii) to define the manuscript's priority ranking relative to other manuscripts under consideration, since the number of papers that the journal receives is much greater than it can publish. If a manuscript does not receive a sufficiently high priority score to warrant publication, the editors will proceed to a quick rejection. The remaining articles are reviewed by at least two different external referees (second step or classical peer review). Manuscripts should be prepared according to the Uniform Requirements established by the International Committee of Medical Journal Editors (ICMJE).

Authorship: all persons designated as authors should qualify for authorship according to the ICMJE criteria. Each author should have participated sufficiently in the work to take public responsibility for the content. Authorship credit should only be based on substantial contributions to i) conception and design, or analysis and interpretation of data; and to ii) drafting the article or revising it critically for important intellectual content; and on iii) final approval of the version to be published. These three conditions must all be met. Participation solely in the acquisition of funding or the collection of data does not justify authorship. General supervision of the research group is not sufficient for authorship. Any part of an article critical to its main conclusions must be the responsibility of at least one author. Authors should provide a brief description of their individual contributions.

Obligation to Register Clinical Trials: the ICMJE believes that it is important to foster a comprehensive, publicly available database of clinical trials. The ICMJE defines a clinical trial as any research project that prospectively assigns human subjects to intervention or concurrent comparison or control groups to study the cause-and-effect relationship between a medical intervention and a health outcome. Medical interventions include drugs, surgical procedures, devices, behavioral treatments, process-of-care changes, etc. Our journals require, as a condition of consideration for publication, registration in a public trials registry. The journal considers a trial for publication only if it has been registered before the enrollment of the first patient. The journal does not advocate one particular registry, but requires authors to register their trial in a registry that meets several criteria. The registry must be accessible to the public at no charge. It must be open to all prospective registrants and managed by a non-profit organization. There must be a mechanism to ensure the validity of the registration data, and the registry should be electronically searchable. An acceptable registry must include a minimum of data elements. For example, ClinicalTrials.gov (http:// www.clinicaltrials.gov), sponsored by the United States National Library of Medicine, meets these requirements.

Protection of Human Subjects and Animals in Research: when reporting experiments on human subjects, authors should indicate whether the procedures followed were in accordance with the ethical standards of the committee responsible for human experimentation (institutional and national) and with the Helsinki Declaration of 1975 (as revised in 2008). In particular, PAGEPress adopts the WAME policy on Ethics in Research (http://www.wame.org). Documented review and approval from a formally constituted review board (Institutional Review Board - IRB - or Ethics committee) is required for all studies (prospective or retrospective) involving people, medical records, and human tissues. When reporting experiments on animals, authors will be asked to indicate whether the institutional and national guide for the care and use of laboratory animals was followed.

SUBMISSION PREPARATION CHECKLIST

As part of the submission process, authors are required to check off their submission's compliance with all of the following items, and submissions may be returned to authors that do not adhere to these guidelines.

1. The submission has not been previously published, nor is it before another journal for consideration (or an explanation has been provided in Comments to the Editor).
2. The submission file is in Microsoft Word, or PDF document file format.
3. We fight plagiarism: please understand that your article will be checked with available tools for discovering plagiarism.
4. The text is double-spaced; uses a 12-point font; employs italics, rather than underlining (except with URL addresses); and all illustrations, figures, and tables are placed within the text at the appropriate points, rather than at the end.
5. The text adheres to the stylistic and bibliographic requirements outlined in the Author Guidelines, which is found in About the Journal.
6. Please read this advice and download associated files. The International Committee of Medical Journal Editors has recently published in all ICMJE journals an editorial introducing a new "Disclosure Form for Potential Conflict of Interest", with the aim to establish uniform reporting system, which can go over the existing differences in current formats or editors' requests. We at PAGEPress Publications welcome this initiative as a possible uniforming, standardizing way to have this important disclosure authorizing the publications of manuscripts. We are therefore asking you to duly fill in the "Uniform Format for Disclosure of Competing Interests in ICMJE Journals" and upload it on the Web site of the PAGEPress journal your work is involved with or email it back to us, in mind to allow PAGEPress to peer-reviewing your work. The document is in Adobe format, it includes instructions to help authors provide the requested information and the completion procedure is user-friendly. Kindly note that the format have to be completed and signed by each author of the work. We

remain waiting for the completed form to proceed with publication. Please be informed that if this Disclosure Form is missing, we will not be able to publish your work.

COPYRIGHT NOTICE

PRIVACY STATEMENT

Privacy is an important concern for users of our site and is something that PAGEPress takes very seriously. Below you will find our policy for protecting users' personal information. Registration on our website is optional and voluntary. Browsing and viewing articles on our website does not require any personal information to be submitted from users. Nor do these functions require the user's browser to be set to accept cookies. Some other services published on our website do require the use of cookies and information such as name, e-mail, etc. This is necessary for security reasons and to enable us to be able to assure standards of scientific integrity. Users may submit further personal information (e.g. details of research areas of interest) in order to take advantage of present and future personalization facilities on our website. In accordance with European Union guidelines, registrants may decline to provide the information requested. They should be advised, however, that PAGEPress may be unable to deliver its services unless at least the information necessary for security and identification purposes is provided. In order to offer the best possible service to users, PAGE Press tracks the patterns of usage of pages on the site. This enables us to identify the most popular articles and services. Where users have provided details of their research areas of interest, this information can be linked to them, helping PAGEPress to offer scientists, the most relevant information based on their areas of interest. User information will only be shared with third parties with the explicit consent of the user. Publishing a scientific manuscript is inherently a public (as opposed to anonymous) process. The name and e-mail address of all authors of a PAGEPress manuscript will be available to users of PAGEPress. These details are made available in this way purely to facilitate scientific communication. Collecting these e-mail addresses for commercial use is not allowed, nor will PAGEPress itself send unsolicited e-mails to authors, unless it directly concerns the paper they have published on PAGEPress journals. PAGEPress reserves the right to disclose members' personal information if required to do so by law, or in the good faith and belief that such action is reasonably necessary to comply with a legal process, respond to claims, or protect the rights, property or safety of PAGEPress, employees or members.

EDITORIAL STAFF

Paola Granata, Journal Manager
paola.granata@pagepress.org

Claudia Castellano, Production Editor

Tiziano Taccini, Technical Support

SUBSCRIPTIONS

Annual subscription:
€ 100,00 (Italy);
€ 180,00 (abroad);
€ 50,00 (students).
One number: € 25,00 + shipping costs

Send requests to *subscriptions@pagepress.org* specifying the name of the journal and the type of subscriptions.

PUBLISHED BY

PAGEPress Publications
via A. Cavagna Sangiuliani, 5
27100 Pavia, Italy
T. +39.0382 464340
F: +39.0382 34872

pagepress

www.pagepress.org
info@pagepress.org

pISSN 1877-9344
eISSN 1877-9352

ITALIAN JOURNAL OF MEDICINE

Tutti gli articoli pubblicati su *Italian Journal of Medicine* sono redatti sotto la responsabilità degli Autori. La pubblicazione o la ristampa degli articoli della rivista deve essere autorizzata per iscritto dall'editore. Ai sensi dell'art. 13 del D.Lgs 196/03, i dati di tutti i lettori saranno trattati sia manualmente, sia con strumenti informatici e saranno utilizzati per l'invio di questa e di altre pubblicazioni e di materiale informativo e promozionale. Le modalità di trattamento saranno conformi a quanto previsto dall'art. 11 del D.Lgs 196/03. I dati potranno essere comunicati a soggetti con i quali PAGEPress intrattiene rapporti contrattuali necessari per l'invio delle copie della rivista. Il titolare del trattamento dei dati è PAGEPress Srl, via A. Cavagna Sangiuliani 5 - 27100 Pavia, al quale il lettore si potrà rivolgere per chiedere l'aggiornamento, l'integrazione, la cancellazione e ogni altra operazione di cui all'art. 7 del D.Lgs 196/03.

Stampato: April 2019.

PAGEPress - Scientific Publications
Via A. Cavagna Sangiuliani, 5 - 27100 Pavia - Italy
Phone +39 0382 464340 - Fax +39 0382 34872
www.pagepress.org