Abstract: **P587**

**A rare cause of pericarditis complicated by tamponade**

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**Topic(s):**
Pericardial Effusion

**Citation:**
The Female Armenian patient 56 y.o. admitted to hospital with complaints of shortness of breath at rest. Previously considered herself to be absolutely healthy. Body temperature -37.9 C. SpO2 % 92%, on oxygen 98%. Respiratory rate-24 per minute. The heart sounds are deaf, the rhythm is correct. BP-90/45 mmHg, HR-110 beats per min. Determined pulsus paradoxus. No symptoms of peritoneal irritation. The ECG revealed sinus tachycardia and a slight decrease in voltage. According to transthoracic echocardiography; we have signs of hemodynamically significant amount of pericardial effusion. On the basis of clinical signs of the Beck’s triad (swollen neck veins +hypotension +deafness of heart tones) and ECHO data, the threat of cardiac tamponade was diagnosed, and the patient was urgently hospitalized in the intensive care unit. In the ICU, the patient underwent pericardiocentesis for emergency indications with and 200 ml of hemorrhagic effusion was obtained. In control ECHO in 2 hours after pericardiocentesis: right chambers in diastole not collaptated. In order to find the diagnostic causes of hydropericardium, the patient underwent additional studies. Hemogram: C-reactive protein 80 * mg / l Serological studies: antibodies to Tr.pallidum was not detected, were not detected HBs Ag, anti-HCV antibodies ted, HIV antibodies, the immunoblot is negative, sputum for acid-fast bacilli negative. Full laboratory tests for tuberculosis have not shown disease. Serological analysis for antibodies to Borellia Bavariensis, Brucella abortus, Coxsackie b viruses (types 1 — 3, 5), Coxsackie A (types 1, 4, 15) and ECHO (type 6) are negative. Laboratory examination of pericardial fluid: Rivalta Test: negative. In cytological study: a moderate amount of lymphoid elements, neutrophils in small quantities. No tumor cells were found. Specific causes of pericarditis: tuberculosis, cancer have not been confirmed. During therapy with ibuprofen 2400 mg per day, the condition has stabilized, temperature became normal, shortness of breath and chest pain didn't recommence, but marked increase of CRP up to 130 mg / l. The colchicines was added in dose 1 mg 2 R / day. On the 12th day, due to the lack of effect of colchicine (persistent increase in CRP, ESR and pericardial effusion in the same volume), prednisolone 30 mg per day was added to the therapy. On the 14th day, there are no complaints, body temperature within the norm, CRP 17 µmol/l, according to ECHO there was no separation of pericardial leaves. We have eliminated the most likely causes of pericarditis: infectious, neoplastic, metabolic, traumatic, drug - associated, acute aortic syndrome, pulmonary arterial hypertension, chronic heart failure. Given the Armenian nationality, Mediterranean fever (“periodic disease” FMF) was suspected. Genetic research – sequencing - homozygous mutation M694V/M694V was conducted. This confirmed only the presence of this mutation in this patient, i.e. predisposition to FMF development.
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