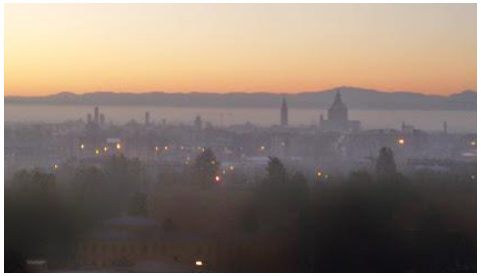


Il punto di vista del clinico

Stefano Perlini

Clinica Medica II, Internal Medicine Department
Center for the Diagnosis and Treatment of Systemic Amyloidoses,
IRCCS Policlinico San Matteo Foundation, University of Pavia

Roma, 5 dicembre 2018

Il signor A.F.

68 anni, falegname ancora in attività, iperteso e diabetico noto, poco “aderente” alla terapia (per sua stessa ammissione) con recente risconto di Hb glicata 10,2% e PA a domicilio spesso attorno a 160/95 mmHg

Ore 5.15:
arrivo in PS con emisindrome sinistra insorta da non più di 2 ore, agitato e sudato

PA 155/92 mmHg, FC 78R, Sat O_2 96% AA, TC 37,8°

Il signor A.F.

Riferisce nausea, vomito ed iperpiressia da qualche giorno, da lui attribuita a sindrome influenzale

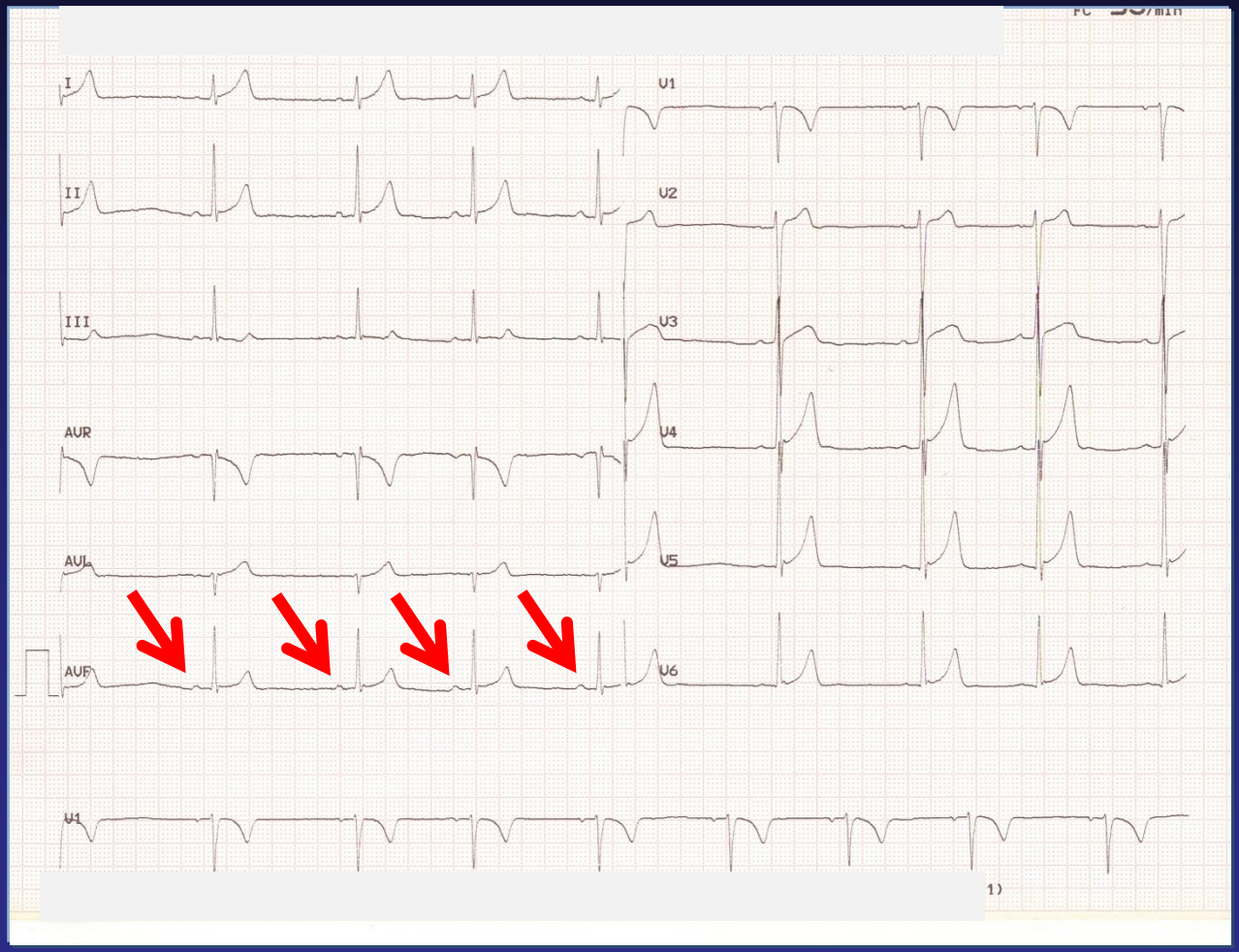
Dimesso in data 24 gennaio dalla Divisione di Cardiologia - *dopo ricovero di 6 settimane* - con diagnosi di:

- endocardite batterica su stenosi aortica lieve-moderata
- fibrillazione atriale permanente
- ipertrofia ventricolare sinistra
- funzione sistolica conservata
- esofagite da reflusso
- diabete mellito

Terapia dimissione: ASA, insulina, ramipril, propafenone.

Interrotta terapia antibiotica dopo 6 settimane con ecocardiogramma refertato come negativo

Il signor A.F.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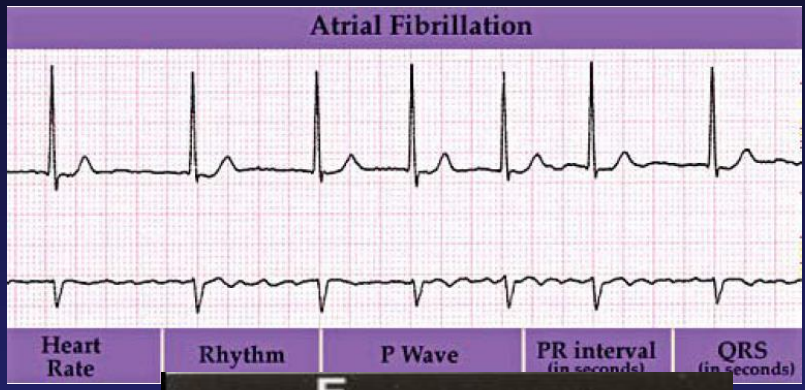
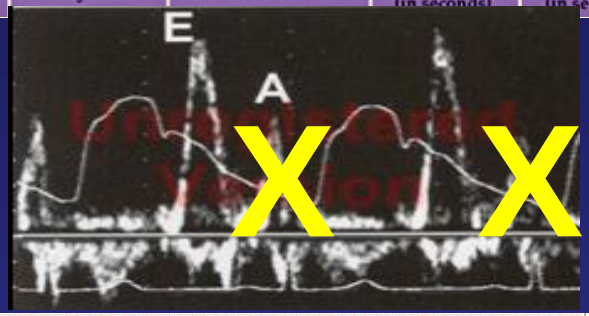
Con fibrillazione atriale si indica una sindrome clinica con varie modalità di presentazione,

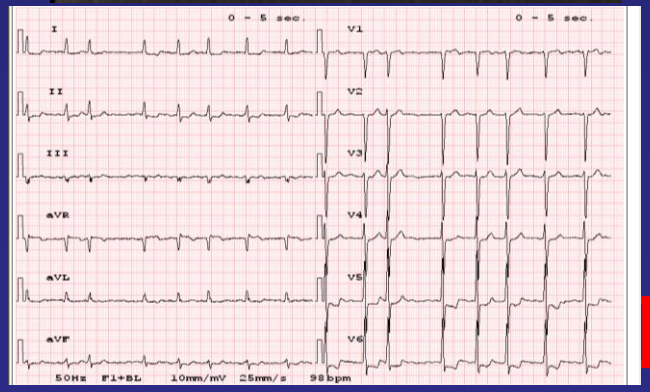
caratterizzata da attività atriale disorganizzata e assenza di onde P,

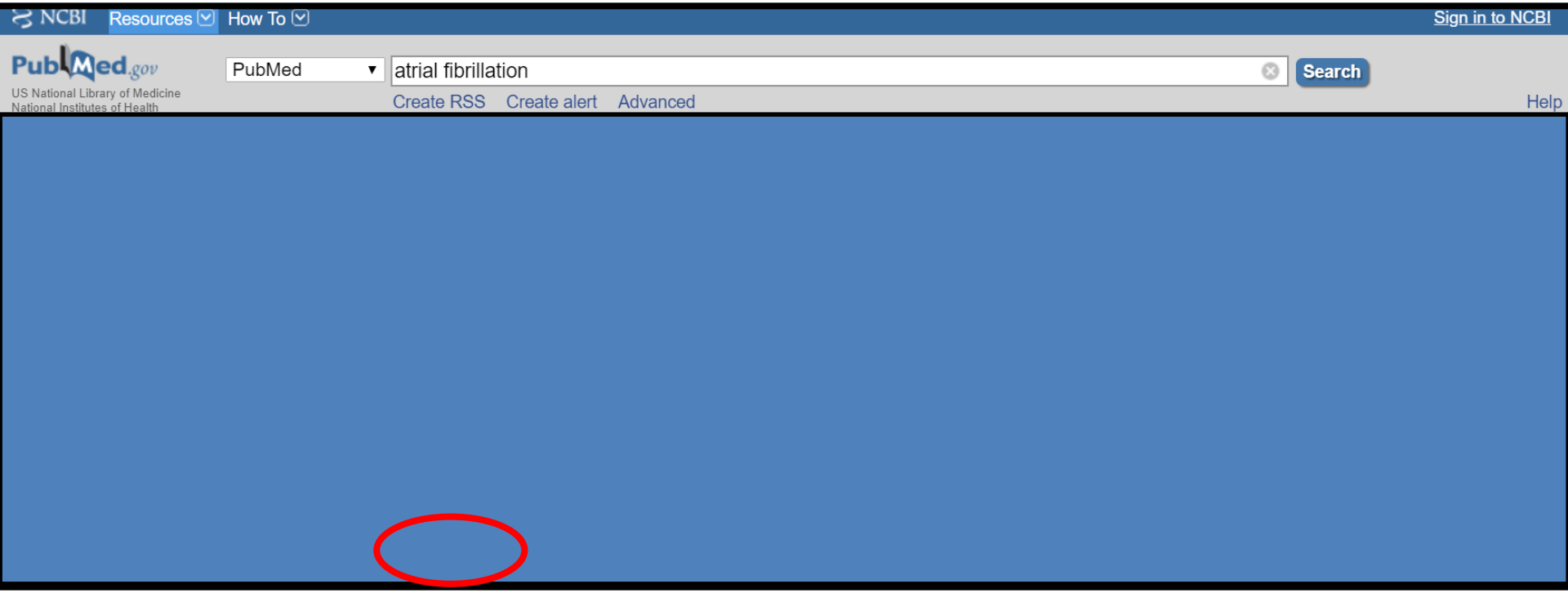
da cui derivano la perdita del contributo atriale al riempimento ventricolare

e l'irregolarità di durata del ciclo cardiaco.









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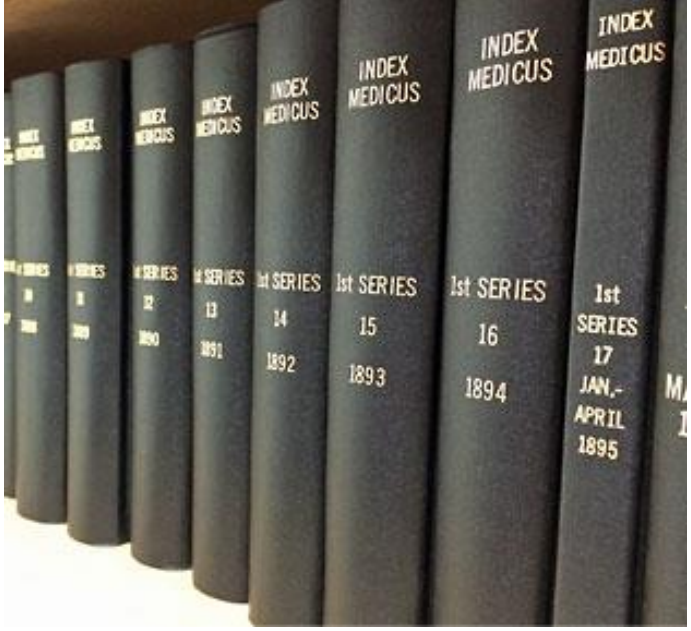
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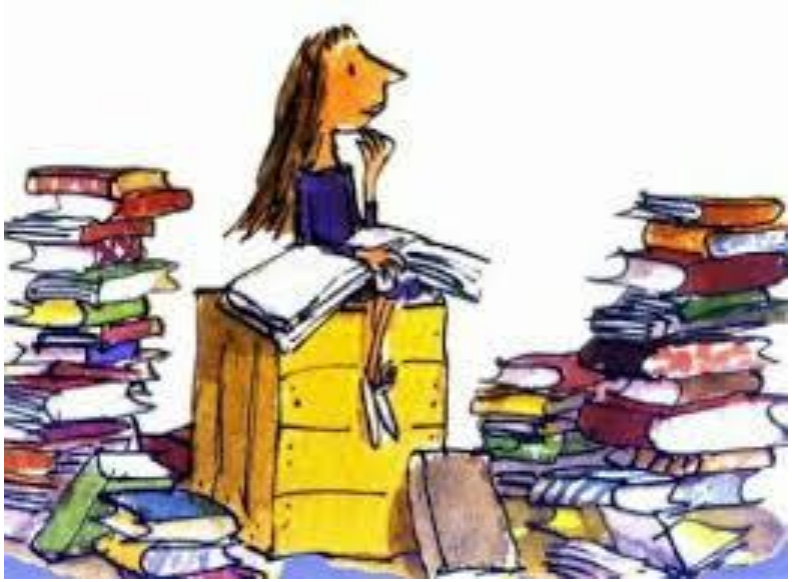

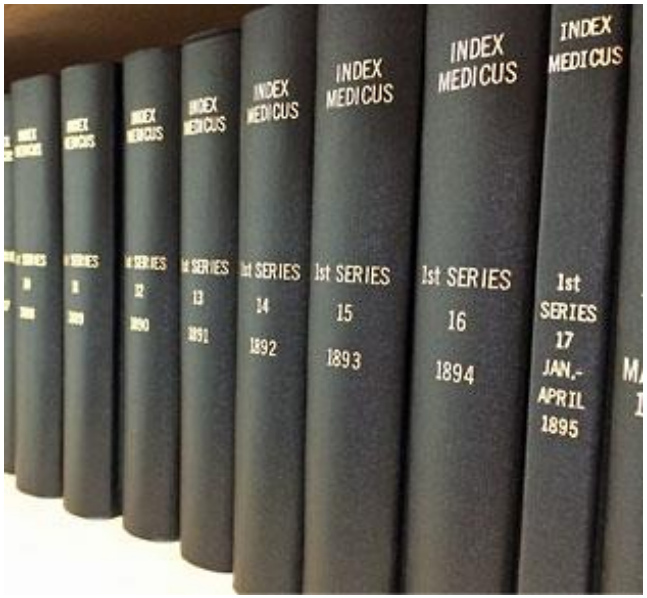
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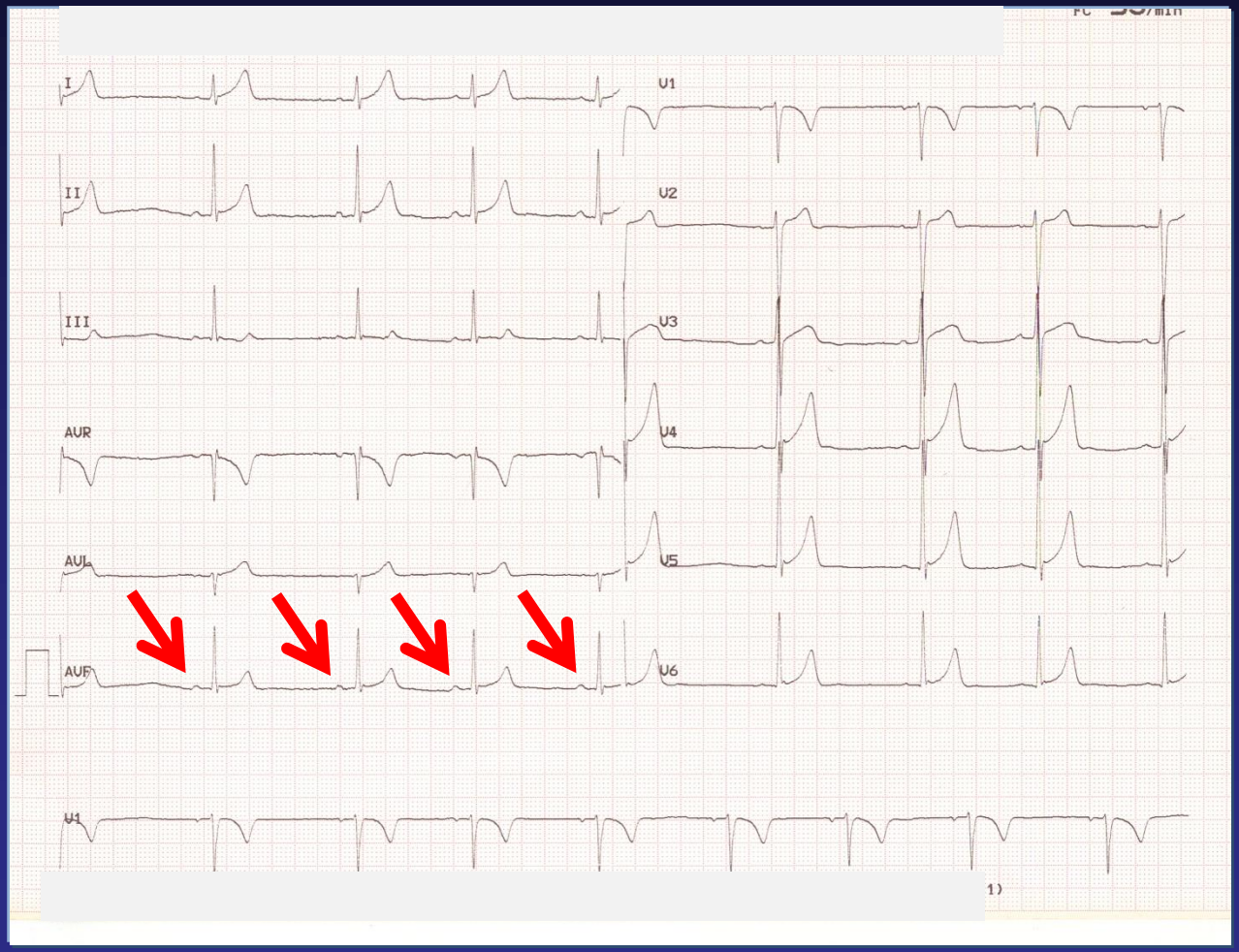
Il signor A.F.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Villines TC[1], Ahmad A[2], Petrini M[3], Tang W[3], Evans A[4], Rush T[4], Thompson D[5], Oh K[5], Schwartzman E[6].

Author information

Abstract

AIMS: We used the US Department of Defense Military Health System database to compare the safety and effectiveness of direct oral anticoagulants (

METHODS AND approval dates: (150 mg BID) or = 12 763 per tre up duration were rivaroxaban (2.0 (0.60% versus 0 major bleeding (P=0.489).

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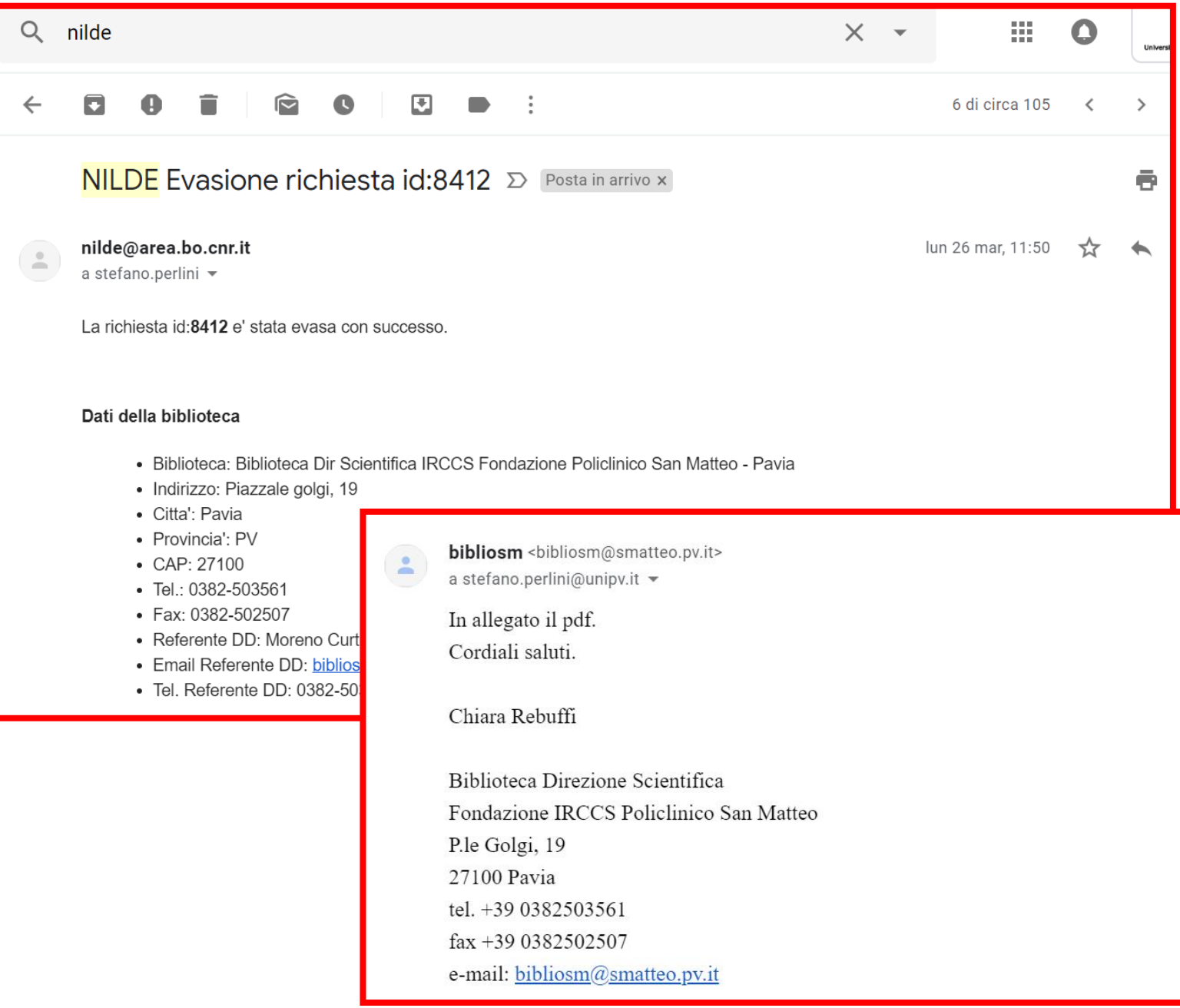
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Vincent Thijs

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Focused Updates in Cerebrovascular Disease

Section Editor: Karen L. Furie, MD
Atrial Fibrillation

Atrial Fibrillation Detection
Fishing for An Irregular Heartbeat Before and After Stroke

Vincent Thijs, MD, PhD

See related articles, pp 2653, 2654, 2660, 2665

Atrial fibrillation (AF) is present in ±3% of the general population above age 20, and its prevalence increases substantially in the ≥65-year-olds age group.[1] It is expected that AF prevalence will increase as populations get older. AF is asymptomatic in ≤40% of patients. Unfortunately, the absence of symptoms does not suggest a benign course.[2] The Framingham Heart Study found that stroke is the first manifestation of AF in at least 2% to 5% of AF patients.[3] In a hospital-based series, ≤20% of stroke patients had previously unidentified or unrecognized AF.[4] AF also increases the risk of cognitive impairment and dementia.[5] Identifying AF and reducing stroke risk in patients with AF before stroke occurs is, therefore, an important goal.

Should We Detect AF in the General Population Prior to Stroke?

Whether screening for AF in the general population is warranted is heavily debated. Opportunistic screening refers to screening offered to people as part of a routine medical checkup or when examined for another reason, whereas ethnicity and risk factor profile of the target population.[9] Only a minority of identified AF patients report symptoms. A significant proportion of patients with known AF who are undertreated are also identified.[10] The concerns with screenings are the optimal method, frequency and setting of screenings, the lack of randomized evidence of whether screening will lead to measurable reductions in stroke incidence, and the questionable cost-efficacy of screening approaches. One randomized trial found no clear evidence of benefit of mass screening, but found opportunistic screening with pulse palpation, and found confirmation with 12-lead ECG to be probably cost-effective and superior to both mass screening and targeted screening.[11] However, this trial was performed in the warfarin era before non-vitamin K antagonists with an improved safety profile and reduced patient burden were available. Only half of the patients identified through mass screening attended a follow-up confirmation ECG.

Devices Used in Screening Programs

Technological advances have made screening without standard 12-lead ECG machines possible, removing at least

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Focused Updates in Cerebrovascular Disease

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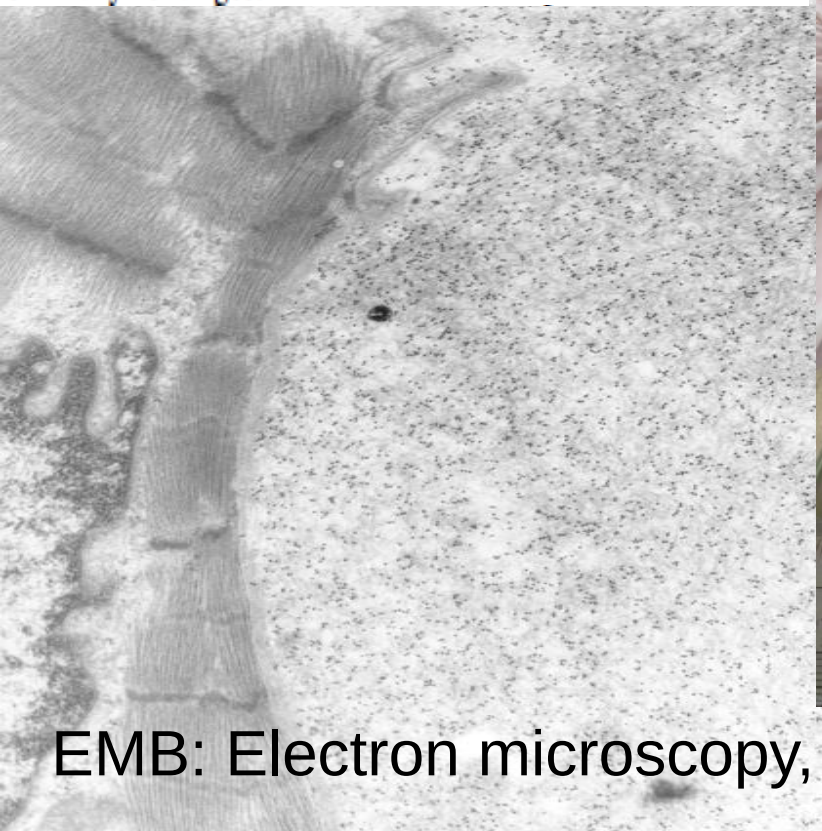
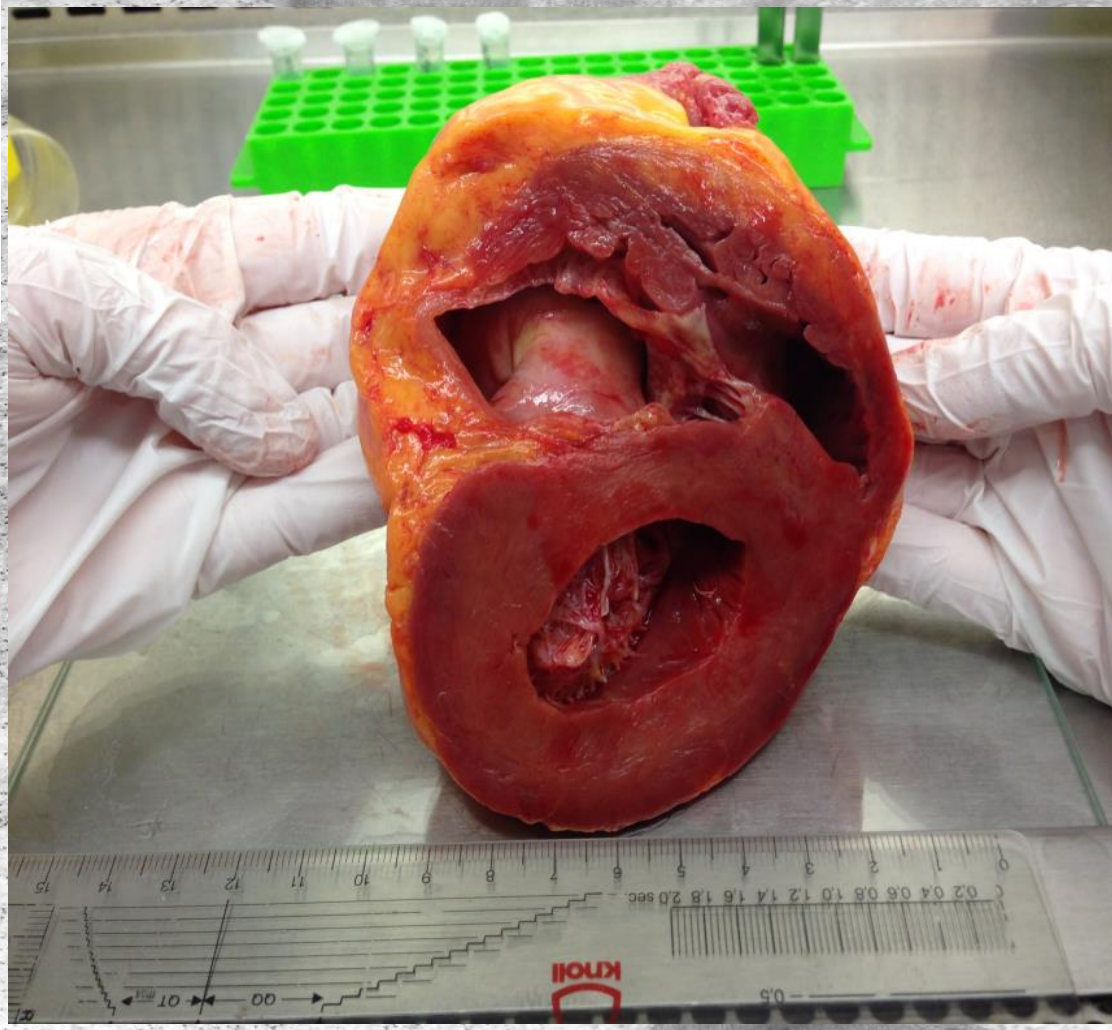
Rudolph Virchow, in 1854, used the term amyloid because of the peculiar reaction of the corpora amylacea of the nervous system with iodine. He was convinced that cerebral corpora amylacea could be considered identical to starch. He preferred amyloid to the commonly used terms 'lardaceous' or 'waxy' changes.



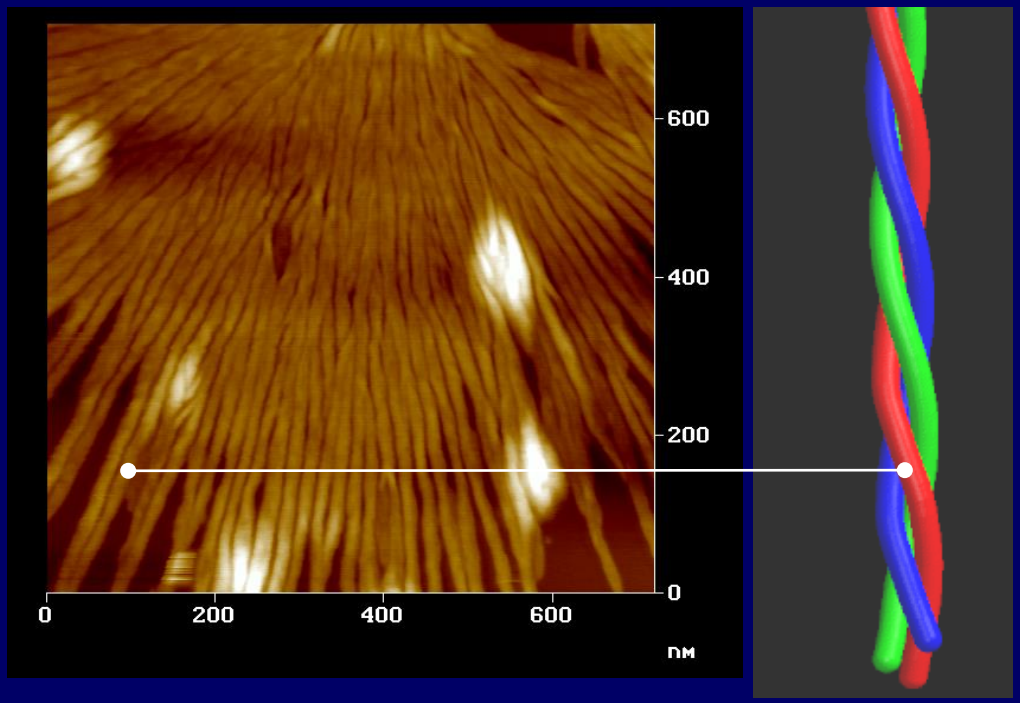


EMB: Electron microscopy, immunogold anti-λ

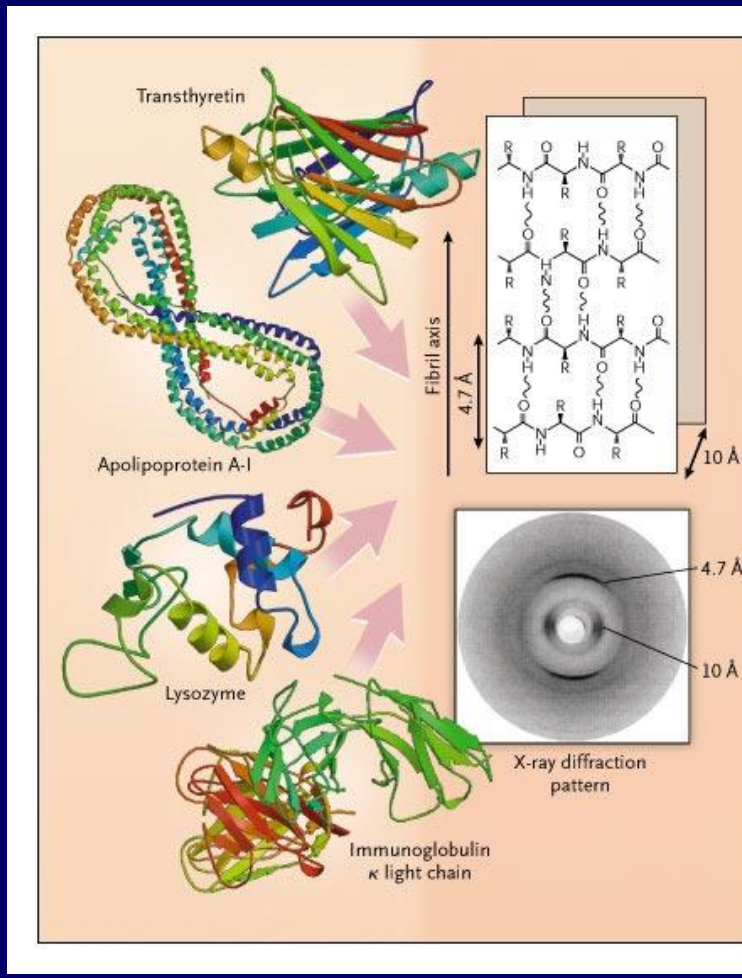
E Arbustini

Amyloidosis

Conversion of normally soluble proteins in cytotoxic aggregates that are organized in fibrils with a typical β-sheet structure, forming deposits in the extracellular space of target organ/tissues



Amyloid natural fibrils visualised by an atomic force microscope



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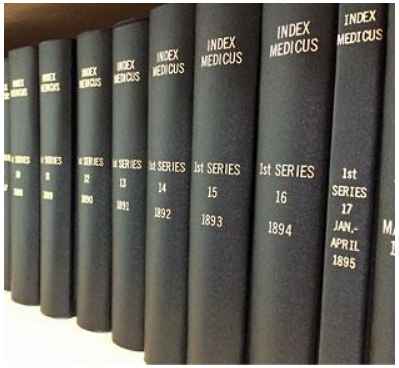

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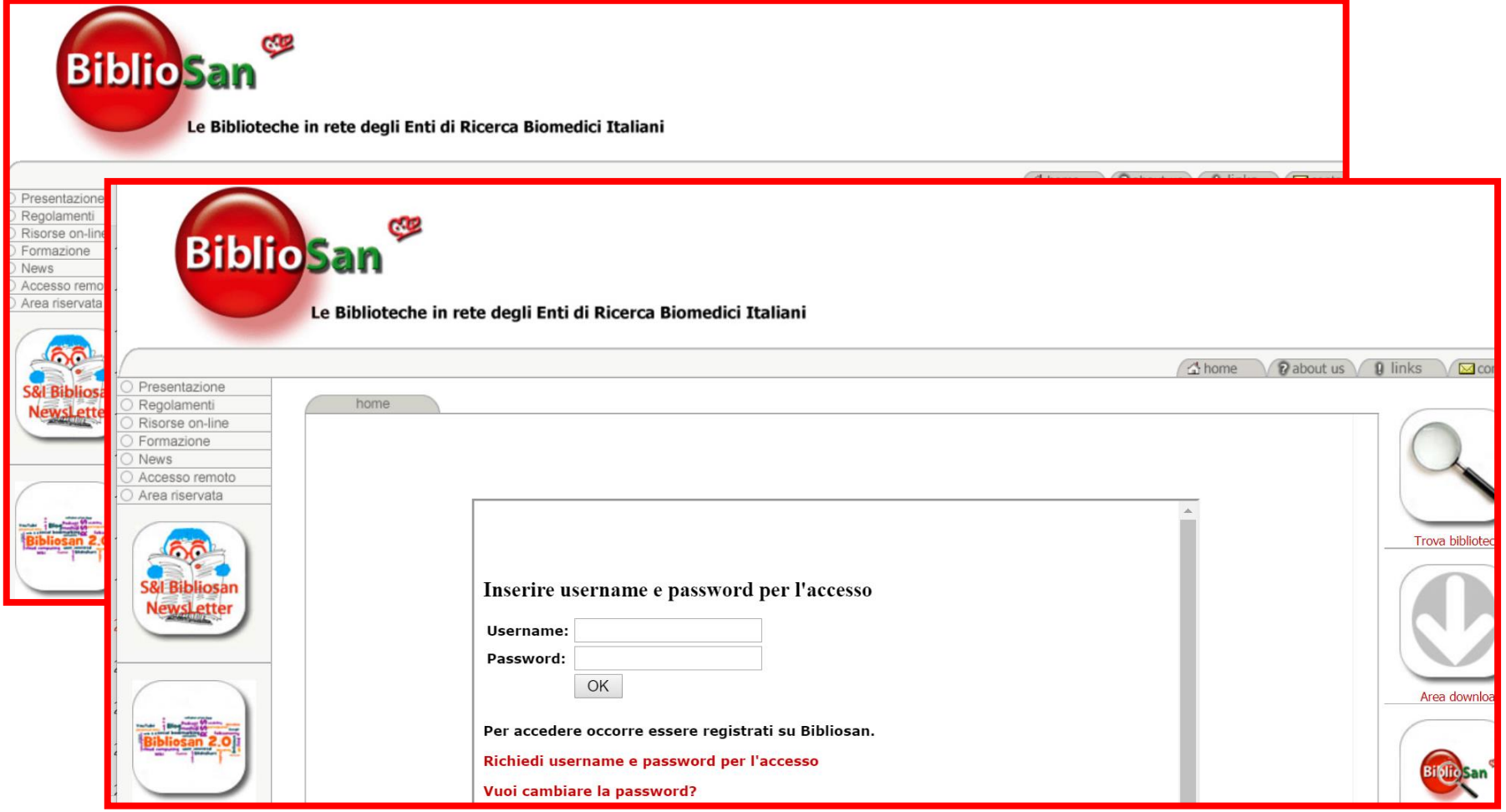

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