



CR29**HEART TRANSPLANTATION AS THERAPY FOR DOXORUBICIN INDUCED CARDIOMYOPATHY**Mihovil Santini^a, Nika Barbara Pravica^a, Mario Udovičić^{a,b}^a School of Medicine University of Zagreb^b Department of Cardiology, University Hospital DubravaDOI: <https://doi.org/10.26800/LV-144-supl2-CR29> Mihovil Santini 0000-0002-1428-4484, Nika Barbara Pravica 0000-0001-5478-2392, Mario Udovičić 0000-0001-9912-2179

Keywords: dilated cardiomyopathy; heart transplantation; R-CHOP chemotherapy

INTRODUCTION/OBJECTIVES: Cardiotoxic effects of the established therapy protocols can cause severe cardiomyopathy and advanced heart failure, which may require advanced heart failure treatment.**CASE PRESENTATION:** In November 2014, a 39-year old female patient was admitted to the cardiology department presenting with newly detected dilated cardiomyopathy and acute heart failure, NYHA 4,**INTERMACS 2.** Previously, she was diagnosed with follicular center cell lymphoma (FCC) and successfully treated with R-CHOP chemotherapy, first in 2008 and again in May 2014 due to a relapse. Despite therapy, her condition was worsening and she was put on venoarterial extracorporeal membrane oxygenation (VA-ECMO), followed by temporary Centrimag biventricular assist device (BiVAD) support. Due to the recent lymphoma relapse a heart transplantation was not a viable option at that time. After two weeks, the left ventricular assist device (LVAD) HeartWare was implanted, with satisfactory right ventricular function. In June 2018 she presented for the first time with manifest right-sided heart failure. Since its progression could not be otherwise managed, the patient was put on the high urgent waiting list of Eurotransplant for heart transplantation in November 2018. In January 2019, a heart transplant operation was successfully performed and three years later, the patient remains well, and without any signs of relapse of the FCC.**CONCLUSION:** Temporary circulatory support followed by LVAD implantation as a bridge to candidacy strategy, and finally, the heart transplantation proved to be an excellent decision even though less than 5 years have passed since the relapse of the malignant disease.**CR30****Hyperthyroidism as a secondary cause of worsening hypertension - a case report**Mia Edl^a, Lucija Čolaković^a, Lada Zibar^{a,b}^a Faculty of Medicine, Josip Juraj Strossmayer University of Osijek, Osijek, Croatia^b University Hospital Merkur, Department of Nephrology, Zagreb, CroatiaDOI: <https://doi.org/10.26800/LV-144-supl2-CR30> Mia Edl 0000-0002-7818-5741, Lucija Čolaković 0000-0002-0212-3843, Lada Zibar 0000-0002-5454-2353

Keywords: Blood pressure, Hypertension, Hyperthyroidism, Secondary hypertension

INTRODUCTION/OBJECTIVES: Hyperthyroidism increases systolic blood pressure (BP) by decreasing systemic vascular resistance, increasing heart rate, and raising cardiac output. Symptoms of hyperthyroidism may include palpitations, nervousness, sweating, weight loss, frequent bowel movements, heat intolerance, and insomnia. Treatment of hyperthyroidism alone lowers systolic BP in most patients.**CASE PRESENTATION:** A 75-year-old woman reported to a nephrologist for extremely high hypertension, with BP jump above 200/110 mmHg 2 - 3 times/month for the last 2 years, after many years of perfectly controlled hypertension. She complained of fatigue, weight loss, insomnia, and nervousness. A workup for secondary hypertension was suggested. Laboratory findings showed thyroid-stimulating hormone of 0.17 mU/L (ref. range 0.35-4.9 mU/L) and free thyroxine of 12.82 pmol/L (ref. range 9.00-19.00 pmol/L). Thyroid imaging revealed a toxic nodular goiter. Subclinical hyperthyroidism was diagnosed and thiamazole treatment was introduced. Upon the treatment, her BP was within normal values with amlodipine 5 mg. She felt well, has gained weight, while control findings indicated adequate suppression of the thyroid.**CONCLUSION:** Although hyperthyroidism is a well-known cause of secondary hypertension, it is still seldom to meet it as such in clinical practice. We presented a case of hyperthyroidism as the cause of secondary dysregulation of long-lasting essential hypertension. Secondary hypertension is generally infrequent and thus easy to miss. Deterioration of BP control in a patient with previously well-controlled hypertension for years should also raise suspicion for a secondary cause. By treating hyperthyroidism, BP was under control again, confirming the presented relationship.