likely to developed statin induced ILD. The drug induced ILD should be considered in differential diagnosis after excluding common causes of chronic cough. Statin therapy should be discontinued at early stages to prevent progression to irreversible fibrosis.

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A case of primary amyloidosis presenting with massive proteinuria and localized gastrointestinal involvement

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Amyloidosis involving different parts of gastrointestinal system were reported in the literature and there has been only one case of ampullary involvement so far. We report on a case of a female patient diagnosed at advanced age presenting with massive proteinuria and bile duct dilatation.

Case presentation: A 82-year-old female presented with a 7-month history of edema in the lower extremities. Physical examination; minimal ascites, palpable liver 2 cm below the left costal margin and Murphy positivity were detected. The patient's biochemical parameters were as follows: hematocrit 32.7%, hemoglobin 10.5 mg/dL, creatinine 1.6 mg/dL, albumin 1.5g/dL, 24h total urinary protein 14g. IgG/lambda monoclonal band (Lambda 3510 mg/L, 900–2100) was detected in immunofixation electrophoresis. Primary AL amyloidosis was diagnosed by percutaneous renal biopsy. Mild dilatation of common bile duct and Wirsung canal and bulging of papilla were demonstrated by endoscopic USG and ERCP (Figure 1). Biopsies showed that amyloid deposition. Melphalan was not be able to given to the patient due to poor general condition, thus only 2 cycles of chemotherapy including dexamethasone (20 mg/m^2) were administered. Because of the progression of the condition and intervening infections it was unable to continue the treatment. The patient died six months after the initial diagnosis.

Conclusion: Our case becomes notable as being the case of a primary amyloidosis accompanied by nephrotic syndrome with ampullary involvement, which caused rapid progression of widespread ascites, hydropic gallbladder, bile duct dilatation, although the diagnosis is established shortly after admission. It also comes into prominence as being the only case reported from Turkey.

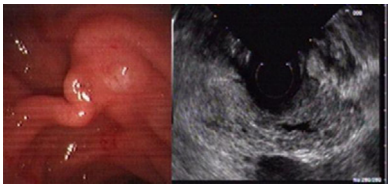


Figure 1. On the left, slightly bulging and fluffy appearance of ampulla Vateri is seen with ERCP, and on the right, irregularity of the papilla is seen.

P520

Recurrent stress-induced cardiomyopathy: a case report

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Stress-induced cardiomyopathy (SIC) is a syndrome of transient cardiac dysfunction precipitated by intense emotional/physical stress. We report a rare case of recurrence that provides more insight into the nature of this unique syndrome.

Case presentation: A 60-year-old female was admitted to the emergency department with chest pain after learning of her mother's death. Electrocardiography showed T-wave inversion on leads V1–V6 (Figure 1a). Laboratory findings showed a significantly elevated serum level of troponin I. Transthoracic echocardiography showed mid to distal diskinesis left ventricular chamber. On coronary angiography we did not find coronary stenosis and ventriculography was akinesis of anterolateral region, with ejection fraction of 30%. The patient was discharged with acetylsalicylic acid, angiotensin converting enzyme inhibitor (ACEI) and a beta-blocker. A follow-up echocardiography at 2 weeks showed left ventricular ejection fraction of 55% with no wall-motion abnormalities. Four months later, on learning about the sudden unexpected death of her sister, she developed left-side chest pain. The patient presented to the emergency department.

Electrocardiography showed T-wave inversion on leads V1–V6 (Figure 1b). Laboratory findings showed a significantly elevated serum level of troponin I. The coronary angiography was normal and similar to previous ventriculography finding. The patient was discharged in stable condition on ASA 100 mg, beta-blocker, and ACEI. A follow-up echocardiography at 4 weeks showed an ejection fraction of 58% with no wall-motion abnormalities.

Conclusion: Reports of a single episode of stress-induced cardiomyopathy are common in recent medical literature but recurrence of this syndrome is rare.

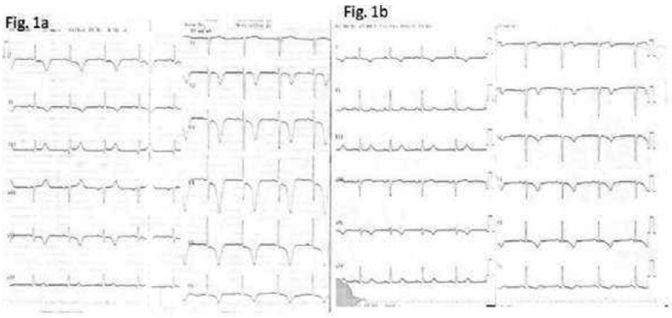


Figure 1. ECG: Sinus rhythm, significant for deep anterior T wave inversions.

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Ogilvie syndrome revealing hypothyroidism in an old patient

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Introduction: Ogilvie's Syndrome presents as massive colonic dilatation without mechanical cause. Its causes are either surgical or medical, which might be associated with intra-, retro-, extraperitoneal surgery, trauma, sepsis, malignancy, systemic diseases, fluid-electrolyte imbalances. The pathogenesis generally cannot be clarified. The most common mechanism is the sympathetic-parasympatheticneurostimulatory imbalance.

We report a case of Ogilvie syndrome revealing hypothyroidism in an elderly patient.

Case report: An 85-year-old man was admitted in our department for electrolytes imbalance. In his past history, he had a depression since a year treated with antidepressants. He was admitted since 3 months in surgical department for recurrent abdominal distention. Abdominal radiograph revealed gaz-filled loops of large intestine. On contrast-enhanced computed tomography abdomen, the colon appeared distended. Ogilvie Syndrome was considered. He was treated with neostigmine and colonoscopic decompression without resolution. In front of electrolytes imbalance, he was transferred in our department. Clinically at admission, the patient had a pulse