that the higher mean age, male sex, presence of hypertension and UI were risk factors of FI significantly. Although concomitant diseases such as diabetes mellitus, depression, chronic diarrhea, dementia, Parkinson's disease and the previous abdominal operations were higher risk factors for FI; it was not statistically significant.
Conclusions: Urinary incontinence, male gender, age and hypertension increases the risk of FI in the elderly patients. FI should be evaluated by FISI in the elderly outpatient clinics.

P516
The association between the number of teeth and appendicular skeletal muscle mass loss in elderly Koreans

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Objectives: The purpose of this study was to examine whether the number of natural teeth in Korean elderly was associated with appendicular skeletal muscle (ASM) mass after adjusting for potential confounding variables.
Design: This study was based on data from the 2008–2010 Korea National Health and Nutritional Examination Surveys. The subjects included 1,058 males and 1,582 females ≥65 years of age. ASMs were measured by dual energy X-ray absorptiometry.
Results: The frequency of functional dentition increased with the quartile value of ASM mass in both males and females (males, $P < 0.0001$; females, $P = 0.0001$) and a positive correlation was observed between the number of teeth and ASM mass. In particular, the positive correlation was significant in males ($P = 0.0044$) even after adjusting for age, body mass index, accompanying disease, protein intake, smoking status, drinking status, physical activity, periodontitis, and dental prosthesis use.
Conclusion: ASM mass correlated with the level of natural dentition in Korean males ≥65 years. In addition to the number of teeth, muscle mass was also correlated with dental-related behavior.

P517
Vitamin D deficiency and frailty criteria

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Introduction: The frailty in the elderly is often a purely clinical entity. The purpose of this work is to establish a relationship between vitamin D levels and frailty in the elderly.
Patients and Methods: A retrospective study including 35 patients aged over 65 in which the parameters of fragility were noted. The frailty syndrome is retained if at least three criteria were present. We studied levels of vitamin D: NL >20 ng/ml, insufficient if 10–20 ng/ml deficit if <10 ng/ml.
Results: The sex ratio M/F was 1.9. The average age was 75 years. The parameters of fragility were: poly-pathology (94%), 95% of men versus 91% of women; poly-medication (91%); depression (28%), 17% versus 50%; dementia (20%), 17% versus 25%; social isolation (17%), 13% versus 25%; concept fall (14%), 13% versus 16%; Static disorder (38%), 35% versus 42%; gait disturbances (29%), 22% versus 42%. The average circumference of the calf in our study was 32 cm; it was pathologic in 52% versus 8%. The majority of the patients was completely autonomous, 14% was dependent on environment: 4% versus 33%. 85% of patients had frailty: 82% versus 91%. 37% had Vitamin D insufficiency: 52% versus 8%. 57% had a vitamin D deficiency (39% versus 84%). In patients with a syndrome of frailty, 96% had insufficient or deficient in vitamin D.
Conclusion: Vitamin D deficiency is common in the elderly and may be regarded as predictive factor of onset of frailty.

Organ- and system-linked dysfunction

P518
A case of statin induced cough

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Introduction: Asthma and chronic obstructive lung disease are known as the most common etiological agents of chronic coughing. Meanwhile statins have begun to participate in this classification causing interstitial lung disease (ILD).
Case: A 85 year-old female patient was admitted with the complain of dry cough. She has been followed with the diagnoses of hypertension, hyperlipidemia, rheumatoid arthritis (RA). Pretibial oedema and two sided rales on the lower part of the lungs were detected. Hemogram and biochemical findings were normal. Two sided pleural effusion and pattern of interstitial oedema with an heart dilatation were detected (Figure 1). Global hypokinesis of left ventricle with an ejection fraction (EF) of 35% on echocardiography were seen. RA associated with interstitial lung disease and pulmonary toxicity of methotrexate were ruled out.
We detected minimal bilateral pleural effusion and an increase from 35% to 50% in EF with normal physical signs except dry cough after three months. The statin usage was stopped. The patient relieved more significantly. The complete cure of the cough occurred. She had not used any antitussives. She had not used any antitussives. After the one year follow up pleural effusion was disappeared (Figure 2).



Figure 1. Pleural effusion when using statin medication.



Figure 2. Normal chest radiography after statin medication stopped.

Discussion: Fernandez et al. reported that 1–40/10,000 of the biopsy proven. The patients with ischemic heart disease seem more

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.

P519

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.

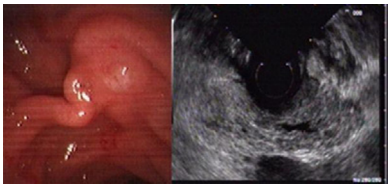


Figure 1. On the left, slightly bulging and fluffy appearance of ampulla Vateri is seen with ERCP, and on the right, irregularity of the papilla is seen.

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.

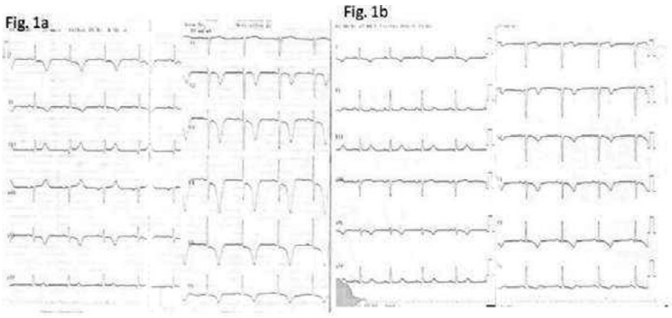


Figure 1. ECG: Sinus rhythm, significant for deep anterior T wave inversions.

P521

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