E-Poster Presentations

EP001 Adult Still's Disease Activation or COVID-19 Infection: A Case Report

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Background Adult Still's Disease (ASD) is a systemic inflammatory disease manifested by fever, arthritis, and salmon-colored maculopapular rash. It may accompany pharyngitis, splenomegaly, generalized lymphadenopathy, and serositis. In the COVID-19 pandemic, COVID-19 findings can be confused with the exacerbation of ASD. We aimed to present a patient with a diagnosis of ASD who applied to our outpatient clinic with fever and rash.

Material and Methods A 50-year-old female patient diagnosed with ASD in 2017 with complaints of common joint pain, fever, rash, and sore throat was being followed up with prednisolone 5 mg 1x1, anakinra 100 mg 1x1, hydroxychloroquine 200 mg 1x1. She applied to the polyclinic with complaints of widespread rash and fever.

Results The patient stated that she had a sore throat a week ago, thought that she had a cold, did not take anakinra treatment, and used other drugs irregularly. She had an ongoing sore throat complaint. On physical examination, the oropharynx was natural, and there were widespread maculopapular rashes, more prominent in the upper extremities. Her body temperature was 36.8 °C, blood pressure 120/80 mmHg, and pulse 80 bpm. In laboratory values; leukocyte: 12,690 K/mcl, neutrophil: 10,660 K/mcl, lymphocyte: 955 K/mcl, hemoglobin: 12.3 g/dL, platelet: 293,900 K/mcl, urea: 32 mg/dL, creatinine: 0.7 mg/dL, AST : 55 U/L, ALT: 79 U/L, CRP: 96 mg/L, sedimentation rate: 63 mm/h, ferritin: 1,181 mcg/L, D-dimer: 1.46 mg/L, fibrinogen: 597 mg/dL measured. Considering the exacerbation of ASD, 80 mg methylprednisolone was administered, prednisolone was increased to 15 mg/day, and a 2.5 mg reduction scheme was given once a week. Anakinra treatment was interrupted when the COVID-19 PCR was positive. As her complaints continued after four days, anakinra was restarted every other day. When the patient came to the outpatient clinic 3 weeks later, her sore throat and joint pain complaints had regressed, and her rashes continued, although they decreased. Leukocyte: 8,690 K/mcl, neutrophil: 5,468 K/mcl, lymphocyte: 1,224 K/mcl, hemoglobin: 12 g/dL, platelet: 259,000 K/mcl, AST: 92 U/L, ALT: 74 U/L, sedimentation rate: 28 mm/h, CRP: 23 mg/L. His treatment was continued with anakinra 1x1/d and prednisolone 10 mg/d.

Conclusions Symptoms of ASD exacerbation may be confused with or coexisting with signs of COVID-19 infection. In case of clinical suspicion, patients should be evaluated for COVID-19.

EP002 A Case of Autoimmune Polyglandular Syndrome Presenting with Latent Autoimmune Diabetes

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Background Autoimmune polyglandular syndrome (OPS) is a group of autoimmune diseases characterized by the failure of at least two endocrine glands in hormone production. OPS type 1 is seen in childhood and is diagnosed with hypoparathyroidism, Addison's disease, and candida infection involving the skin or mucous membranes. OPS type 2 (Type 1 diabetes with Addison's disease or autoimmune thyroid disease), OPS type 3 (Autoimmune thyroid disease with other autoimmune diseases other than Addison) and OPS Type 4 (Addison's disease with one or more organ-specific Type 1 and type 2 autoimmune diseases that do not include major components seen in OPS). When we look at the subgroups of OPS type 3; Autoimmune thyroiditis is accompanied by type 1 diabetes in type 3A, pernicious anemia in type 3B, vitiligo in type 3C, and collagen tissue diseases in type 3D. We wanted to share with you a case of OPS type 3A+3B with latent autoimmune diabetes and pernicious anemia accompanying autoimmune thyroiditis.

Material and Methods 38-year-old female patient applied to the external center for 1 month due to pain in the legs, drinking too much water, frequent toileting and weakness.

Results Fasting blood glucose was found 383 mg/dL, thereby metformin, vildagliptin, gliclazide and alpha lipoic acid treatments were initiated for diabetes and diabetic neuropathy. In her next control, hemoglobin A1c (HBa1c) was detected 16 mmol/mol and she was hospitalized immediately. Gliclazide treatment was discontinued, and insulin glargine and insulin aspartate was initiated. C-peptide was sent with the suspicion of adult's latent autoimmune diabetes (LADA) in a young patient with polyuria, polydipsia, and HbA1c 16 mmol/mol, c-peptide 0.8 µg/L and GAD 65 antibody was found as >250 IU/mL. The patient was diagnosed with LADA, and thereby vildagliptin and metformin treatment was discontinued. Pancytopenia was detected in whole blood count and very low vitamin B12 levels in laboratory. Subsequent peripheral smear confirmed pernicious anemia and intravenous B12 therapy was initiated. Subclinical hypothyroidism was observed with anti-thyroid peroxidase positivity. Thyroid ultrasonography showed that thyroid gland dimensions were normal, contours were smooth, parenchyma echogenicity was decreased and heterogeneous. The patient was diagnosed with Hashimoto's thyroiditis and started levothyroxine therapy. She was screened for other autoimmune diseases, including autoimmune hepatitis, myasthenia gravis, vitiligo, sarcoidosis and collagen tissue diseases. None of the further laboratory or clinical investigations suggest any other autoimmune disease, but only granular 1/100 anti-nuclear antibody and a basal cortisol le-

vel of 6.6 µg/dL was detected. Subsequent 1 µg ACTH stimulation test excluded the presence of adrenal insufficiency as well.
Conclusions In conclusion, the association of autoimmune diseases should be considered in young patients with diabetes and LADA must be suspected. In such cases, further investigation of autoimmune tiroiditis, adrenal insufficiency, myasthenia graves etc. should be performed to support the diagnosis.

EP003

Primary Membranous Glomerulonephritis in A Young Patient with Proteinuria

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Background Under physiological conditions, daily protein excretion with urine is below 150 mg. Detection of protein excretion above this value in repeated measurements should not be ignored and further evaluation should be made. Protein excretion above this level is an important indicator of kidney damage in general. The commonly used method to evaluate whether the protein excretion in urine is within normal limits is the measurement of protein in 24-hour urine.
Material and Methods A 31-year-old patient with a known illness and no regular medication was admitted to the outpatient clinic with proteinuria.
Results The patient did not have any complaints other than foaming in the urine and a new rash on the nasal wings. There was no previous history of upper respiratory tract infection and arthritis. No pathology was found on physical examination. The test results of the patient are given below: RF: negative, ANA: negative, PR3 ANCA: negative, MPO ANCA: negative, urea: 24 mg/dL, creatinine: 0.7 mg/dL, albumin: 2.9 g/dL, sodium: 141 mmol/L, potassium: 4.4 mmol/L, LDL: 259, HDL: 40 mg/dL, TSH: 2, PTH: 57, hemoglobin: 15.2 g/dL, MCV: 82, IgM: 31, IgG: 644, IgA: 205, C4: 28, C3: 129, HbsAg, anti-HIV and anti-HCV: negative, and protein excretion: 9 g in 24-hour urine. ACE inhibitor and acetylsalicylic acid treatment was started for the patient. The patient, who was found to have proteinuria at the nephrotic level, hyperlipidemia, and hypoalbuminemia, was referred to a kidney biopsy with a pre-diagnosis of glomerulonephritis to investigate the etiology of proteinuria. Pathology result was determined as IgG4 + membranous glomerulonephritis. Atorvastatin 1o mg was started in the low-risk patient whose protein was found to be 1.5 g in 24-hour urine during controls, and the patient, whose diet was regulated, was called for a control with 24-hour urine. Phospholipase A2 was checked in the follow-up of the patient and when it was positive, it was followed up as idiopathic membranous glomerulonephritis.
Conclusions Membranous nephropathy (MN) is the leading cause of nephrotic syndrome in the adult population. The disease is characterized by the deposition of immune complexes outside of the glomerular basement membrane. This buildup causes the glomerular filtration barrier to fail, resulting in proteinuria. It is generally classified as membranous nephropathy, primary or secondary membranous nephropathy. There is no known etiology in 70-80% of cases. If a secondary cause cannot be identified, this group is classified as "Primary membranous nephropathy." In 70% of adult patients, phospholipase A2 in podocytes has been shown to be the target antigen in primary membranous nephropathy. In conclusion, glomerulonephritis should be considered in every patient with proteinuria. Patients should be directed to biopsy before progressing to end-stage renal disease, and they should be followed up and treated.

EP004

A Case of Resistant Hypocalcemia Treated with Teriparatide

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Background Hypocalcemia is a common complication after thyroidectomy. Transient hypocalcemia is more common and calcium replacement alone may be sufficient. Permanent hypocalcemia is seen in 0.8-3% of the cases. Calcium (Ca) and vitamin D supplements are used in treatment of persistent hypocalcemia. Rarely, high-dose Ca and Vitamin D supplements may not be successful, in that case teriparatide (recombinant human parathyroid hormone) may be an alternative therapy.
Material and Methods A 52-year-old woman with Graves' disease underwent total thyroidectomy in 2000. She had persistent hypocalcemia after the surgery.
Results She was treated with levothyroxin Na, calcium and vitamin D supplements. She had cataract surgery 10 months ago. She had multiple emergency department admissions and hospitalization due to recurrent hypocalcemia symptoms and signs. When she was admitted to the endocrine clinic, The laboratory evaluation confirmed severe hypocalcemia due to postsurgical hypoparathyroidism: calcium (Ca) was 5 mg/dL, albumin was 4.1 g/dL, phosphorus (P) was 4.1 mg/dL, magnesium was 1.6 mg/dL, 25-OH vitamin D was 14.8 mcg/L and parathyroid hormone (PTH) was 9 ng/L. Celiac autoantibodies were undetectable. Bone mineral densitometry was normal. Teriparatide (recombinant human PTH) was begun with the approval of the Ministry of Health. There was no emergency department admission or hospitalization within 9 months after the initiation of teriparatide treatment. At the last control of the patient, the calcium level was increased to 7.4 mg/dL and phosphorus was decreased at 2.7 mg/dL. The 25-OH vitamin D level was

markedly inreased to 34.5 mcg/L. The treatment of the patient continues with calcium, magnesium, vitamin D supplements, and teriparatide 20 mg/month.
Conclusions It has been observed that the administration of multiple doses of teriparatide in the early postoperative periods prevented the development of hypocalcemia symptoms and reduced the duration of hospitalization due to hypocalcemia. In our case, it was observed that hospitalizations decreased and calcium levels increased after the administration of teriparatide every 28 days.

EP005

Acute Tubular Necrosis Associated with Autoimmune Hemolytic Anemia due to Acute Gastroenteritis

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Background Autoimmune hemolytic anemia (AIHA) is a rare disease with a rate of 1-3 in 100,000 in adults. AIHA is defined as primary (idiopathic) or secondary depending on the presence or absence of accompanying disease. Secondary causes include drugs, immunodeficiencies, infections, other autoimmune diseases, or malignancies. The coexistence of autoimmune hemolytic anemia and acute renal failure has been observed in studies. Generally, this association has developed due to various drugs. In our case, the association of AIHA due to acute gastroenteritis and acute tubular insufficiency was considered appropriate for the presentation since it was a rare case before.
Material and Methods 42-year-old female patient without chronic disease was applied to the emergency service with the complaints of diarrhea, nausea-vomiting, fever, chills, and jaundice for two days.
Results At admission, fever: 37.1 °C, blood pressure: 104/64 mmHg, pulse: 99/minute, conjunctivae were pale, sclera, and skin were icteric. Leukocyte: 31,000/mm3, hemoglobin: 11 g/dL, platelet count: 176,000/mm3, urea: 104 mg/dL, creatinine: 3.3 mg/dL, alanine aminotransferase: 48 IU/L, aspartate aminotransferase: 100 IU/L, lactate dehydrogenase: 1340 U/L, total bilirubin: 16 mg/dl, direct bilirubin: 3.2 mg/dL, reticulocyte: 3%, C-reactive protein: 197 mg/L, procalcitonin: >100 µg/L was detected. She was hospitalized with a pre-diagnosis of hemolyzed secondary acute renal failure. Hematology was consulted because it was directly Coombs (+). Methylprednisolone 40 mg/day was started considering autoimmune hemolytic anemia. In terms of the etiology of autoimmune hemolytic anemia, ANA was negative, and complements were normal. No pathology was found in the thorax, neck, and abdominal tomography performed for malignancy screening. There was no history of drug use or broad beans consumption. Klebsiella and E.coli grew in the stool culture of the patient sent in terms of infection focus. Brucella agglutination test, rotavirus, adenovirus test, and hepatitis markers were negative. The patient's pathology result, who underwent renal biopsy, was consistent with acute tubular necrosis due to an anuric course and progressive creatinine values. She was on hemodialysis every other day. Ceftriaxone treatment was terminated on the 14th day. LDH, bilirubin, and creatinine regressed to the normal range. Direct Coombs test became negative. She did not need hemodialysis any more. Methylprednisolone treatment was continued at 32 mg/day.
Conclusions Determining the etiology of AIHA is important in terms of treatment. The coexistence of AIHA and acute tubular necrosis is expected in the literature. However, infection-related AIHA cases are limited in the literature. AIHA cases secondary to Brucella or legionella infection are presented. As a result, this case shows us that, although rare, acute tubular necrosis can be seen with AIHA associated with acute gastroenteritis.

EP006

Osteoporosis in a Case of Multiple Epiphyseal Dysplasia

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Background Multiple epiphyseal dysplasias (MED) is a heterogeneous group of diseases characterized by different phenotypes such as short stature, joint deformities, abnormal gait, scoliosis, and brachydactyly. In this report, a patient admitted with bone pain and was diagnosed with osteoporosis, and diagnosed with multiple epiphyseal dysplasias is mentioned.
Material and Methods 21-year-old female patient presented with bone pain.
Results Her history learned that he had received alendronate, calcium, and vitamin D replacement with a diagnosis of osteoporosis for about 5 months. The patient who had a family history of his parents had short stature (height: 150 cm), shortness in arms and legs relative to the trunk, and brachydactyly. In the patient's medical history, he had a history of operation due to cocca plana, pectus excavatum, and scoliosis, the first of which was 7 years old. Similar orthopedic pathologies were found in the patient's brother, who did not have a history of fractures. There was no pathological finding in liver, kidney, and thyroid function tests in the laboratory evaluation. Serum parathyroid hormone, calcium, alkaline phosphatase levels, and 25 hydroxyvitamin D levels were normal. As a result of dual-energy X-ray absorptiometry (DEXA), the lumbar vertebra total Z score was -3.3. The fracture was not observed in the whole skeleton scan. The reasons that could cause osteoporosis in the patient were investigated with the available clinical and laboratory findings. Considering family history, genetic analysis was performed, and a homozygous mutation was found in the SLC26A2 gene monitored in MED cases. The cause of

premenopausal osteoporosis was MED in the patient whose tests for osteoporosis etiology were completed, and other reasons were ruled out.
Conclusions Premenopausal osteoporosis causes are endocrine causes such as Cushing's syndrome, hyperthyroidism, hyperparathyroidism, hypogonadism, type 1 diabetes mellitus, insufficient vitamin D and calcium intake; bone marrow diseases such as amyloidosis, lymphoma, multiple myeloma, malabsorption syndromes, osteogenesis imperfecta; collagen tissue diseases such as Marfan syndrome; organ transplantation; inflammatory diseases such as rheumatoid arthritis and ankylosing spondylitis; drugs such as glucocorticoids, immunosuppressants, chemotherapeutics; smoking and alcohol use. However, skeletal dysplasia is not clearly included among the differential diagnosis. Although skeletal dysplasias are rare, they should be one of the pre-diagnoses in people with early-onset osteopenia and osteoporosis. After excluding other causes of premenopausal osteoporosis in our case, MED was considered as the cause of osteoporosis.

EP007 Chronic Myeloid Leukemia Secondary to Radioactive Iodine Therapy

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Background The development of leukemia secondary to the treatment of thyroid carcinomas is rare. When the literature is examined, the cases mostly occur as acute leukemia and develop after exposure to cumulative doses higher than 800 mCi. Here, we reported a 75-year-old female patient who was diagnosed with chronic myeloid leukemia (CML) after a total of 1100 mCi radioactive iodine (RAI) treatment during an 8-year follow-up period for thyroid papillary carcinoma.
Material and Methods A 75-year-old female patient was being followed up with a papillary thyroid carcinoma diagnosis after surgery due to a multinodular goiter.
Results The patient, who was found to have extensive lung metastases and metastases in the sternum, was administered a total of 1100 mCi RAI treatment at intervals. The patient, who was found to have leukocytosis and thrombocytosis in the examinations performed for weakness and flu infection for the last 1 month, was evaluated by the hematology department. A bone marrow biopsy was performed with a pre-diagnosis of CML; bone marrow pathology was compatible with CML. Hydroxyurea treatment was started. Neutropenia and thrombocytopenia developed under hydroxyurea treatment. The hematology clinic planned imatinib treatment for the patient who was also found to have Philadelphia chromosome positivity. The patient with a thyroglobulin level of 43550 µg/L and multiple metastatic foci scattered in both lungs on thorax computed tomography was evaluated endocrinologically. Treatment with systemic agents for thyroid carcinoma was planned after the patient's follow-up in terms of CML, taking into account the cytopenias in the peripheral blood. The hematology clinic is still treating the patient in terms of CML.
Conclusions Secondary leukemia is extremely rare in thyroid carcinoma cases receiving RAI treatment. In the follow-up of these cases, abnormalities in the peripheral blood, especially leukocytosis, should be followed closely.

EP008 Intestinal Edema due to Hypoalbuminemia

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Background Hypoalbuminemia is defined by a serum albumin <3.5 g/dL, although clinically significant hypoalbuminemia is probably identified by levels <2.5 g/dL. Hypoalbuminemia is commonly observed in elderly patients, especially those who are institutionalized and/or hospitalized, and in patients with malnutrition or advanced-stage chronic diseases. Low serum albumin levels are risk factors and a predictor of morbidity/mortality regardless of the implicated disease. Hypoalbuminemia is frequently observed during acute disease states as albumin is a negative acute-phase protein. In pathological conditions such as sepsis, infection or trauma, or after major surgery, the level of serum albumin is reduced by about 1 g/dL within 1 week of the event.
Material and Methods An 86-year-old female patient with a diagnosis of chronic obstructive pulmonary disease, hyperthyroidism, and hypertension was admitted to the pandemic service due to shortness of breath and moderate involvement in thorax CT after 8 days of follow-up at home for coronavirus positive.
Results The patient, who received favipravir treatment at home for 5 days, was completed in 10 days and empirical antibiotic treatment was started. During the hospitalization of the patient, oral and rectal laxatives were started due to constipation. The patient did not complain of nausea and vomiting. Physical examination revealed no positive abdominal examination findings. However, the constipation complaint did not regress. No fecaloid was detected in the patient who was performed rectal examination with the prediagnosis of phecaloid. His current treatment was continued, since air-fluid level was not detected in the standing direct abdominal radiography. In the patient who had potassium replacement due to low potassium, there was no stool discharge, the patient was perfromed rectal examination again, and a direct abdominal radiograph was taken. However, no phecaloid or air-fluid level was detected in the patient. Ileus was not considered in the patient who was consulted with a general surgeon. Abdominal CT was performed to the patient. Contrast-enhanced abdominal CT was planned for the patient, since it was reported as a subileus prediagnosis

and without contrast. No pathology was found on repeated CT. In the laboratory values of the patient who had swelling in the abdomen, the albumin value was found to be 2.1 g/dL. Hypoalbuminemia found in the laboratory where he was examined in the previous days was evaluated as a negative acute phase reactant and treatment was given for the current infection. However, in line with the symptoms of the patient, albumin replacement was performed with a preliminary diagnosis of intestinal edema due to hypoalbuminemia so as to exceed 2.5 g/dL. The patient had stool discharge, his general condition improved. He did not have any additional complaints in his follow-up.

Conclusions Hypoalbuminemia is one of the main causes of common edema. Although the primary treatment is to eliminate the cause, as seen in our case, the serious effects of hypoalbuminemia on the organs should be done accordingly. Intestinal edema due to hypoalbuminemia has not been encountered much in the literature, and it is a preliminary diagnosis that should not be missed.

EP009

Marginal Zone Lymphoma in a Patient Presenting with Autoimmune Hemolytic Anemia: A Case Report

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Background Autoimmune hemolytic anemia (AIHA) is an anemia group characterized by the production of antibodies against autologous erythrocytes. It is divided into primary and secondary. Secondary AIHA can usually be seen in lymphoproliferative diseases, measles, EBV and CMV infection, leukemia, thymoma, and colon cancer. Among lymphoproliferative diseases, it is associated with B-cell chronic lymphocytic leukemia. Still, it has also been reported in other non-Hodgkin's lymphomas with a lower prevalence. One of them is marginal zone lymphoma (MZL). Here, we reported a case report of MZL presented with AIHA.

Material and Methods A sixty-year-old male patient was referred to our clinic with the complaint of fatigue for a month and macrocytic anemia.

Results He had dual antituberculosis drug use in his medical history due to pulmonary tuberculosis 18 years ago and mild hepatosplenomegaly and no lymphadenomegaly in his physical examination. Initial laboratory studies revealed, hemoglobin: 5.8 g/dL, MCV: 104 fl, leukocyte: 9.65x109/L, neutrophil: 5.85x109/L, lymphocyte: 3.19x109/L, platelets: 300x109/L, reticulocyte count (corrected): 8.39, sedimentation: 93 mm/h, LDH: 455 U/L, total to direct bilirubin: 1.91/0.7 mg/dL, direct coombs (IgG ve Cd3): 3+, anti-nuclear antibodies (ANA): negative. Spherocytes were seen in the erythrocytic series in the peripheral blood smear. With the diagnosis of AIHA, 1 mg/kg/day methylprednisolone treatment was initiated. The patient who had a history of tuberculosis was consulted with the pulmonology department, and active disease was not considered. Thorax and abdomen computed tomography (CT) was performed to evaluate lymphoproliferative and malignant disease. A few lymph nodes below 1 cm in the mediastinum were seen on thorax CT. Abdominal CT showed widespread lymph nodes around the celiac trunk, extending to the small intestinal mesentery and left paraaortic area, consistent with lymphoproliferative disease. In the patient's first-month follow-up examinations, it was found that his hemoglobin levels returned to normal, but the lymphocyte count increased. Peripheral blood flow cytometric analysis identified cells with CD5, CD19, CD20, CD22, CD45, HLA-DR, and FMC-7. PET-CT was performed with the pre-diagnosis of non-Hodgkin lymphoma. Pathological lymphadenomegaly was not detected in PET/CT. A diagnostic bone marrow biopsy was performed on the patient. Bone marrow pathology was reported as "low-grade B cell lymphoma (MZL) partially suppressed under steroid therapy." It was planned to taper then discontinue the patient's steroid treatment, whose hemoglobin level increased to 12.6 g/dL.

Conclusions The frequency of AIHA accompanying MZL has been reported as 10% and is thought to be associated with chronic antigen stimulation and autoantibody formation. Our patient is a rare case in terms of being an MZL presenting with AIHA and responding to steroids. Since AIHA can be seen together with lymphomas, patients who apply with AIHA should be examined in detail.

EP010

Focal Segmental Glomerulosclerosis with Sjogren Syndrome: A Case Report

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Background Sjoren's syndrome (SS) is a chronic, slow-progressing, autoimmune and lymphoproliferative disease. The syndrome's main symptoms are xerostomia and keratoconjunctivitis sicca as a result of chronic inflammatory infiltration of the salivary and lacrimal glands. Especially interstitial nephritis and tubular dysfunction are observed in primary SS. Although rare, glomerulonephritis may accompany membranoproliferative glomerulonephritis, membranous nephropathy, and focal mesangioproliferative glomerulonephritis. Here, we presented a case of focal segmental glomerulosclerosis (FSGS) developed in the follow-up of SS.

Material and Methods A 39-year-old female patient has been being followed up with a primary SS diagnosis since 2015 and is using 200 mg of hydroxychloroquine.

Results 478 mg proteinuria was detected in the 24-hour urine

of the patient and referred to nephrology outpatient clinic. Physical examination such as pulmonary, cardiovascular, and abdominal examinations was unremarkable. There was no bilateral trace pretibial edema. The complete urinalysis showed protein ++ without hematuria. 4.7 g of proteinuria was detected in 24-hour urine. In blood tests, albumin 2.6 g/L, LDL-cholesterol 214 mg/dL, ANA (1/3200), SS-A and SS-B positivity, IgG, A, M, complement levels, serum protein electrophoresis, complete blood count, and kidney function tests were normal. Hepatitis markers were negative. Histopathological findings in kidney biopsy were compatible with FSGS, and cyclosporine 200 mg/d, prednisolone 15 mg/d, vitamin D3, and proton pump inhibitor treatment was started.

Conclusions Typical renal complications associated with SS are tubulointerstitial nephritis and renal tubular acidosis. Glomerular diseases manifested by the nephrotic syndrome are rare in this population, with only 5 cases of severe or nephrotic proteinuria reported in 60 patients undergoing kidney biopsy in studies. However, more case reports should be added

EP011

Thyrotoxic Hepatitis in A Patient with Subacute Thyroiditis: A Case Report

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Background Subacute granulomatous thyroiditis (DeQuervain's disease) is a self-limiting inflammatory disease with a triphasic clinical course -hyperthyroidism, hypothyroidism and euthyroidism- frequently seen in young and middle-aged women during seasonal transition periods. Viral (Adenovirus/Coxsackievirus/Mumps/EBV/Influenza) infections and genetic predisposition (HLA-BW35) are blamed in the etiology; while autoimmune response is not. Weakness, fatigue, myalgia, mild/moderate fever and arthralgia are common features in patients with subacute thyroiditis. Severe neck pain in the thyroid gland region often radiating to the jaws/ears is observed. On physical examination, the thyroid gland is enlarged and sensitive. In laboratory tests ESR, CRP are elevated. The disease is often diagnosed in the early "temporary thyrotoxicosis period". In this phase, thyroid gland parenchyma destruction secondary to inflammation causes increase in blood T3 and T4 levels and suppression of TSH. Thyroid radioactive iodine131 uptake (RAIU) is low (<2/24 hours). After stored colloid in the follicles is completely discharged, hypothyroidism phase initiates. During the recovery period, parenchyma cells regain hormone producing capacity in several weeks and the euthyroid period is entered. The hypothyroidism rarely becomes permanent. Liver enzyme abnormalities can be seen in the course of thyrotoxicosis. The diagnosis of "thyrotoxic hepatitis" can be made after excluding other causes of liver pathology. In the pathogenesis of thyrotoxic hepatitis, the inability to compensate for the increase in hepatic oxygen demand (perivenular hypoxemia), autoimmunity, heart failure. etc. are held responsible. Thyrotoxic hepatitis clinical picture ranges from asymptomatic enzyme elevation to severe liver damage but is generally self-limiting. Here, we want to report a patient who had concurrent hepatitis in the thyrotoxic period of subacute thyroiditis and whose clinic improved with symptomatic treatment, to remind the importance of evaluating liver functions in the follow-up of subacute thyroiditis.

Material and Methods A 35-year-old female patient without known chronic disease was admitted to our clinic with complaints of generalized body pain, weakness, hair loss, palpitations, dyspnea on exertion, and sore throat for a month.

Results Physical examination showed the thyroid gland was enlarged and tender to palpation. Lab studies showed TSH 0.01 mU/L (0.34-5.60), fT4 41.29 ng/L (6.1-11.2), anti-TPO 0.3 kU/L (0-9), ALT 110 U/L (0-50), AST 118 U/L (<35), ALP 254 U/L (33-98), GGT 129 U/L (0-38), CRP 94.35 mg/L (<5). Ferritin, hemogram, vitamin B12, glucose and creatinine results were normal. Thyroid ultrasonography revealed thyroid parenchyma was hypoechoic-heterogeneous, and the gland was diffusely enlarged. The RAIU test was found to be 4% (8-15) at the 2nd hour and 1% (15-35) at the 24th hour. The patient was started on 1 mg single dose dexamethasone, propranolol 40 mg 2x1/2, (etodolac 400 mg 2x1, paracetamol 500 mg 2x1, when necessary). Tests performed 5 weeks post-treatment showed: TSH 13.2 mU/L (0.34-5.60), fT4 4.22 ng/L (6.1-11.2), ALT 21 U/L (0-50), AST 23 U/L (<35), ALP 83 U/L (33-98), GGT 30 U/L (0-38), CRP 1.12 mg/L (<5). The patient, who was treated with L-thyroxine during the hypothyroid period, was planned to be followed up with 4 week intervals.

Conclusions Since thyrotoxicosis occurs without hyperthyroidism in the course of subacute thyroiditis, there is no place for antithyroid drugs in the treatment. Beta blocker drugs are used to reduce the systemic effect of elevated thyroid hormones during the thyrotoxicosis phase while analgesics/NSAIDs and short-term steroid therapy can be used for fever and pain. Similar to the conditions in hyperthyroidism, the possibility of developing acute hepatitis during thyrotoxicosis of subacute thyroiditis should be kept in mind. The patients liver functions should be monitored regularly. Likewise, thyroid functions should definitely be evaluated in the etiology of patients presenting with acute hepatitis.

EP012

A Primary Amyloidosis Case Presented By Multiple Myeloma

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Background Amyloidosis is a rare heterogeneous disease group which biochemically unrelated, gives apple green double reflex in polarized light when it's painted with Kon-

go-Red, shows beta folded stratification in X-ray crystallography, characterized by extracellular accumulation of at least 31 different fibrillar proteins, systemic or localized, diagnosis based on histopathological evaluation. In systemic amyloidosis, amyloid deposits can occur in many organs, such as bone marrow, heart, gastrointestinal tract, liver, and kidney. The average survey is three years. Amyloidosis can be idiopathic, as well as it may be associated with multiple myeloma, lymphomas, and dyscrasia of monoclonal B cells, including macroglobulinemia. Multiple myeloma is a malignant proliferation of plasma cells, which usually secreting large amounts of monoclonal immunoglobulin. Amyloidosis is common in patients with multiple myeloma, and it causes cardiac, renal dysfunction, malabsorption syndromes, and peripheral neuropathies.

Material and Methods A 67-year-old female, diagnosed with chronic renal failure of unknown origin, receives hemodialysis 3 times a week for 3.5 years. The patient was referred to us with a pre-diagnosis of multiple myeloma upon complaint of diffuse bone pain and general condition disorder.

Results In her laboratory tests: leukocyte: 8,920 mm3, neutrophil: 6,040 mm3, hemoglobin: 8.9 g/dL platelet: 476,000 mm3, ESR: 62 mm/h, Direct Coombs: IgG +2 positive, iron: 29 µg/dL, total iron binding capacity: 245 µg/dL, ferritin: 295 µg/L, vitamin B12: 811 ng/L, folic acid: 9.1 µg/L, urea: 51 mg/dL, creatinine: 2.66 mg/dL, protein: 9.1 g/dL, albumin: 3.0 g/dL, calcium: 9.9 mg/dL, beta-2 microglobulin: 14.8 mg/L, IgG: 35.9 g/L, IgA: 8.5 g/L, IgM: 0.84 g/L, serum kappa light chain: 10.7 g/L, serum lambda light chain: 6.3 g/L, serum kappa/lambda ratio: 1.69 g/L. Serum immune electrophoresis was reported as "monoclonal IgG Lambda band formed." Urine immune electrophoresis, "monoclonal IgG Lambda band detected." There was a chronic compression fracture with grade 2 height loss on the L3 vertebral corpus anterior in the skeletal survey. There was a mosaic-like appearance in the bilateral lower limbs and proximal bone structures of the upper limb medullary bone. It was considered significant in terms of multiple myeloma involvement. In peripheral smear, 64 segmented, 5 rods, 11 monocytes, 14 eosinophils, 1 lymphocyte, 13 atypical lymphocytes, 1 basophil, 2 x cell was seen. No pathological finding was found in the morphological features of leukocytes, erythrocytes, and platelets. Roll formation was not observed. Bone marrow biopsy was performed in the patient who had chronic kidney disease of unknown primary origin. Bone marrow biopsy revealed polytypic plasma cell increase, extracellular amorphous material accumulation compatible with amyloid, and normocellular bone marrow with a focal hypercellular area containing lambda (+) plasma cells concentrated around amyloid. The patient, whose bone marrow biopsy resulted in AA amyloidosis, but had monoclonal bands on serum immune electrophoresis and had lytic lesions in the skeletal survey, was asked for a cardiology opinion, re-evaluated in terms of the tongue size, and re-evaluated in terms of pathology and amyloid type. On echocardiography, granular sparkling consistent with amyloidosis was observed in the left ventricular myocardium. In the interrogation of the patient, it was learned that he had difficulty speaking for the last 1-2 years, and it was observed that his language was larger than normal. Focal lymphocytic infiltration was detected in the salivary gland biopsy performed by rheumatology. The patient was accepted as primary amyloidosis because of the presence of chronic kidney disease, lytic lesions in the skeletal survey, detection of monoclonal IgG lambda band in serum immunization, amyloid accumulation in bone marrow biopsy, the reversal of total protein/albumin ratio, findings of amyloid involvement in cardiac echocardiography and macroglossia. VCD treatment was started.

Conclusions Multiple myeloma and primary amyloidosis occur as a result of clonal plasma cell proliferation. The presentation of these two diseases can be confused with each other. Typical hematological and biochemical laboratory findings specific to both diseases are guiding in the differential diagnosis. The presented case presented with myeloma, with anemia, high Beta-2 microglobulin and immunoglobulin, gamma-band height in serum protein electrophoresis, monoclonal band formation in serum urine immune electrophoresis, and involvement compatible with multiple myeloma in the skeletal survey. In the reported case report, hyperechogenic sparkling on echocardiography is a sign of cardiac amyloidosis. Similar to the case reported in the patient's echocardiography, granular sparkling compatible with amyloidosis was observed in the left ventricular myocardium. Macroglossia and tongue involvement is almost always seen in systemic amyloidosis. With these findings and staining with Congo red in the bone marrow, a primary diagnosis was made.

EP013

Pectoral Muscle Hematoma as A Complication of COVID-19 Treatment: A Case Report

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Background The new coronavirus, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV2), which emerged in the last months of 2019, spread worldwide in a short time and caused a pandemic-sized epidemic. The target organ for COVID-19, the disease caused by the virus, is the lung, and the disease can cause acute lung damage and progress to respiratory failure. It has been shown that one of the most important processes in the pathogenesis of the disease is increased activation in the coagulation system. For this reason, anticoagulant therapy is applied to COVID-19 patients at doses appropriate to the patient's clinical and laboratory values.

Material and Methods A 70-year-old male patient with a positive COVID-19 RT-PCR test 10 days ago was admitted

to our hospital with complaints of fatigue, fever, and increasing shortness of breath.

Results He had completed 5 days of favipiravir treatment. There was a known history of hypertension and by-pass. He did not smoke. He was using acetylsalicylic acid 150 mg. On physical examination, diffuse crepitant rales were heard in the lung. Heart sounds were natural. There was no rebound or defense in the abdominal examination; he had no edema. His weight was 78 kg. In vital signs, the temperature was 39.8 °C, blood pressure was 128/67 mmHg, pulse was 96/min, respiratory rate was 18/min. Oxygen saturation was 99% with 3 L/min oxygen support. In laboratory tests, D-dimer 4.22 mcg/mL, erythrocyte sedimentation rate 67 mm/h, C-reactive protein (CRP) 18.96 mg/dL, ferritin 1544 ng/mL, fibrinogen 713 mg/dL, LDH 498 IU/L, albumin 3.10 g/dL, AST 106 IU/L, creatinine 1.92 mg/dL, glomerular filtration rate (GFR) 34.5 mL/min/1.73 m2, proBNP 1158 pg/mL, troponin I 0.151 ng/mL. In the CT, there were extensive ground-glass consolidations in the lung consistent with COVID-19 infection. The patient was started on favipiravir 600 mg 2x1, levofloxacin 500 mg 1x1, enoxaparin 2x0.8 IU, dexamethasone 8 mg 1x1, and supportive treatment. On the 3rd day of his admission, the patient described pain in his left chest and limited movement in his left arm. ECG was normal. When the blood pressure was measured as 170/80 mmHg, 50 mg of captopril was given, but glyceryl trinitrate infusion was started when the blood pressure was 220/130 mmHg in his follow-up. In laboratory tests, hemoglobin 8.7 g/dL, D-dimer 1.78 ug/mL, ferritin 1109 ng/mL, fibrinogen 596 mg/dL, LDH 363 IU/L, CRP 4.47 mg/dL, AST 48 IU/L, creatinine 1.33 mg/dL, troponin-I decreased to 0.060 ng/mL, and GFR increased to 53.8 mL/min/1.73 m2. In the follow-up of the patient who had swelling in the left shoulder, an 11x7 cm hematoma was seen in the muscle plans in front of the left thorax wall in the thorax CT. Also, common ground glass densities and consolidated areas were evaluated as progressive. Enoxaparin was stopped on the 3rd day. 4x5 mL transexamic acid was started. 1 U erythrocyte suspension was given. Phenocodein was added 2x1 treatment because of hemoptysis. Two days later, ecchymosis appeared on the patient's axillary anterior face, who was applied ice and elastic bandages during follow-up. In the following days, the ecchymosis spread to the arm's inner surface, and stiffness was observed in this area. In the laboratory follow-up, hemoglobin remained at 8.0-9.0 g/dL. The patient's oxygen requirement decreased on the 5th day of his treatment, and his saturation at room air was 94%. The patient, whose treatment was completed for 9 days, was discharged to come to the polyclinic.

Conclusions As a known side effect of the anticoagulants we use in the treatment of COVID-19, we see bleeding in some patients. Therefore, patients who are given anticoagulants should be closely monitored in terms of bleeding. Anti-Xa levels should be controlled, especially in patients with risk factors such as low GFR levels. Kidney function tests have an important place in the algorithm in applying the correct dose. In conclusion, anticoagulant amounts should be adjusted according to anti-Xa and other coagulation markers in risky patients. In this way, the morbidity-mortality rate can be decreased by reducing the risk of bleeding in patients.

EP0014

Langerhans Cell Histiocytosis in Bone: A Case Report

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Background Langerhans cell histiocytosis (LCH) is a rare disease (most commonly seen in children aged 1-3) with histiocytic infiltrations in almost every organ. Incidence is 1-2/ per million, in adults, most common in Northern European men. Pulmonary LCH is associated with smoking, while extrapulmonary LCH is not. Two types of clinical presentations of LCH can be observed: 1-Single system involved; unifocal/multifocal involvement in bone, skin, lymph nodes, lungs, liver, CNS, spleen, pituitary or rarely thymus, thyroid without systemic symptoms (fever, weight loss), 2-Multi-system involvement; two or more organ infiltrations with systemic symptoms. LCH is accepted a reactive condition secondary to defects in the immuneregulatory system with no data on genetic, viral, neoplastic etiology. In histology, Langerhans cells do not contain phagocytic material in their cytoplasm; have the appearance of folded "coffee bean" nucleus; express CD1a, S100, C207, and contain Birbeck granules (intracytoplasmic tennis racket-shape, central streaking organels) seen in electron microscope. Here, we report a LCH case, diagnosed in a patient with suspected malignant neoplasm in his thoracic vertebra, which is seen very rarely in internal medicine practice.

Material and Methods 51-year-old male, presented to internal medicine outpatient clinic with complaints of localized back pain; ongoing for a year increasing the last 3 months.

Results The patient had no known chronic disease. System examinations were normal. LDH 281 (125-220); glucose, creatinine, AST, ALT, ALP, GGT, sodium, potassium, calcium, uric acid, total protein/albumin, hemogram, CRP were normal. Thoracic spinal CT and MRI revealed a 66x37 mm lytic, destructive mass infiltration on the right side of the vertebra corpus at the level of the 7th rib, compression on the spinal cord and a nodular lesion in the 6th rib. In PET-CT, there was increased FDG uptake in the lesions (SUVmax: 10.5). Additional involvement was not detected in bone scintigraphy. The patient was taken into an emergency operation due to risk of compression and collapse of the spinal cord. Extradural total tumor resection was performed by total laminectomy at the T6-T7 level, subtotal excision was performed on the 6-7th costa; vertebral stabilization was achieved by placing a transpedicular screw. Radiological regression was observed in the postoperative 2nd month imaging. Pathological examination revealed cells with oval vesicular structured notching nuclei infiltrating the bone trabeculae, spreading to soft tissue, containing, mixed-type inflammatory cells rich in eosinophils. In histology, findings were consistent with Langerhans cell histiocytosis: CD1a

(Thermo/Ab-5): positive, S100 (BioGenex/15E2E2): positive, CD68 (Biocare/KP1): positive. With the decision of the council, a total of 2000 cgy radiotherapy was applied to the patient with the IMRT technique in 10 sessions. The patient, who was in remission after the treatment, is still under follow-up for 4 years.
Conclusions Patients with LCH bone involvement may be asymptomatic or cause localized swelling/pain/tenderness. In the vertebral column, thoracic then lumbar regions are most frequently affected. Corpus of the vertebra is the most frequently affected area, collapse can occur with compression of the medulla. Patients with marrow, liver, spleen, lymph node involvement and cytopenias have poor prognosis. In treatment, if there is risk of collapse in spinal/femoral bone lesions, surgery/radiotherapy should be performed first for stabilization. Vinblastine (6 mg/m2/day) and prednisolone (40 mg/m2/day) can be given as induction to multisystem LCH patients. If the clinical response is good in the 6th week, the treatment is completed to 12 months; Mercaptopurine (50 mg/m2/day) may be added if risky organ involvement is present. Second induction or second line chemotherapy regimens (MACOP-B, cladribine, cytarabine, imatinib, chlorodeoxyadenosine, vemurafenib) can be tried in patients with poor response to treatment. Patients with diagnosed LCH should be referred to centers with study groups in order to give chemo-radiotherapy after evaluating for surgery and follow-up.

EP015

Vertebrobasilar Artery Dolicoectasia: A Case Report

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Background Dolichoectasia is a dilative arteriopathy characterized by the lengthening, widening and bending of an artery. Intracranial vertebral and basilar arteries are the most commonly affected vessels. The incidence of vertebrobasilar artery dolichoectasis (VBD) in the population has been reported 0.06%-5.8% range. Most cases are asymptomatic and diagnosed by cranial imaging performed for other reasons. Risk factors are hypertension-age (>40). Symptomatic patients show cerebral ischemia, bleeding, or compression of the brainstem/third ventricle/cranial nerve roots. VBD is a rare cause of trigeminal neuralgia. One of the theories for pathogenesis of VBD; loss of elastic tissue due to early fragmentation/degeneration of internal elastic lamina;accompanying smooth muscle atrophy. Another theory is, it occurs as a complication of atherosclerosis. The extension of the artery lateral to the clivus or dorsum sella, and its bifurcation on the suprasellar cistern is considered to be elongated (dolicho). If the basilar artery diameter is over 4.5 mm, it is considered to be enlarged (ectasic).In this case report, we aimed to present the detection of VBD in a hypertensive patient who presented with dizziness and balance disorder, since it is a rare condition.
Material and Methods A 67-year-old female patient with type 2 diabetes mellitus and hypertension presented with complaints of dizziness, tinnitus, and numbness in the hands and feet. Her medical treatments were metformin, clopidogrel, amlodipine, atorvastatin, and Ginkgo biloba.
Results Her physical examination was normal. HbA1c 6.4%, LDL 166 mg/dL (60-130), 25-OH Vitamin D 8.51 ng/mL (30-80), LDH 314 U/L (0-247). ESR, CRP, TSH, hemogram, vitamin B12, AST, ALT, GGT, urea, creatinine, sodium, potassium, calcium, urinalysis were normal. In bilateral carotid/vertebral artery doppler US, partially calcified echogenic plaque with a stenosis rate not exceeding 50% was observed in the posterior wall of the right bulbus. Local diffuse enlargement was noted at the top of the basilar artery in cranial MRI. Six months later, contrast-enhanced cervical MR angiography showed normal traction/contour/flow signal patterns of the bilateral internal and external carotid arteries, and mild contour irregularities were observed in the right bifurcation region due to plaques, without significant stenosis. In cranial arterial MR angiography, local enlargement of approximately 6 mm in size in the anterior contour of the artery, which could not be clearly identified on the top of the basilar artery on MIP images, was noted in the raw images, and the findings were primarily thought to be aneurysm; therefore, it was recommended to be evaluated with conventional angiography. After this stage, the patient was consulted with neuroradiology in another center to clarify the need for conventional angiography. In TOF cranial MR angiography; it has been shown that the vertebrobasilar system and both ICAs have an appearance compatible with dolichoectatic changes, it has been determined that there is no aneurysmatic condition and conventional angiography is not required. The patient will be followed clinically and angiographically.
Conclusions Dolichoectasis; describes pathological long, dilated, tortuous cerebral arteries. Traditionally, the diagnosis of VBD was made by catheter angiography. However, VBDE diagnosis can now be made by non-invasively with CT and MR angiography imaging. MR angiography is the most sensitive imaging method and high resolution and thin section T1 and T2 weighted spin echo sequences, three-dimensional time-of-flight (TOF) MRA, 3D CISS sequence are the most effective sequences in the evaluation of VBDE. In addition, differential diagnosis of VBDE from pathologies such as aneurysms and other vascular problems, demyelinating diseases, and space-occupying lesions can be easily made with MR imaging.

EP016

A Case of Hairy Cell Leukemia Diagnosed by Leukocyoclastic Vasculitis Symptoms

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Background Hairy cell leukemia (HCL) is a rare chronic lymphoproliferative disease characterized by pancytopenia and splenomegaly, with 'hairy' cells seen in peripheral blood and bone marrow. The average age at diagnosis is between 50 and 55 years. The male/female ratio is 4/1. Common findings of HCL includes massive splenomegaly, pancytopenia, and lymphadenopathy; fever is a rare symptom. The frequency of several autoimmune diseases is increased in HCL, but rare cases of leukocytoclastic vasculitis (LSV) have been rarely reported. LSV is characterized by inflammation of small vessels. The etiology of LSV includes drugs, infections, malignancies, and systemic inflammatory diseases. Palpable purpura is typical, especially in the lower extremities. Here, we aimed to present an HCL case with leukocytoclastic vasculitis symptoms.
Material and Methods A 70-year-old male patient was admitted to the emergency department with complaints of palpable purpuric lesions, fever, night sweats, and weakness, which started on his extremities for 6 months and were more intense on his abdomen and back for the last 2 weeks.
Results His general condition was normal on physical examination, and there were crusted, pustular lesions on the erythematous ground on his extremities and body (Figure 1). The patient did not report any history of medical disease, and his family history was normal. Complete blood count revealed: leukocyte: 1,470/mm³, neutrophil: 831/mm³, lymphocyte: 601/mm³, hemoglobin: 7.9 gr/dl, platelet: 150,200/mm³, C-reactive protein: 123 mg/L, erythrocyte sedimentation rate: 140 mm/h. The serological examination for Brucella, hepatitis was negative, parvovirus, cytomegalovirus, Epstein-Barr virus, measles, chickenpox, mycoplasma, Lyme, and rubella found to be negative. The anti-neutrophil cytoplasmic antibody, rheumatoid factor and anti-cyclic citrullinated peptide negative, C3 and C4 normal, antinuclear antibody (ANA) 1/100 endpoint positive, ANA profile negative. The patient was hospitalized, and piperacillin/tazobactam 3x4.5 gr was administered. Punch biopsy pathology of the lesion in the extremity was reported as leukocytoclastic vasculitis. The patient's constitutional symptoms also increased the probability of possible systemic disease. The patient's COVID-19 PCR test was negative, the absence of ARB in urine and sputum, normal level of immunoglobulins, no lymphadenomegaly in thoracic and abdominal computed tomography, spleen size at the border of 13 cm, and peripheral smear showed atypical lymphocytes. Bone marrow biopsy was performed to explain the cause of pancytopenia. In bone marrow aspiration and imprint examination, atypical lymphocytes were larger than normal, and chromatin structure was thin, cells with large cytoplasm and cytoplasmic protrusions (Figure 2). Bone marrow pathology; morphological features primarily suggest HCL. TRAP was poorly stained, and immunohistochemical negative results were reported as other B-cell lymphoid neoplasms could be excluded, and the diagnosis of HCL was confirmed. The patient was transferred to the pandemic service due to respiratory distress in the follow-up, and the received COVID-19 PCR test was positive. The treatment for COVID-19 was administered. In his follow-up, acute respiratory distress syndrome developed and died.
Conclusions HCL and LSV are rare diseases. Few cases are reported together in the literature, and the underlying mechanism is not clear. In its pathogenesis, infiltration into the vessel wall by hairy cells is thought to be responsible. Local cytokines causing inflammatory tissue damage, antibody cross reactivation with the vessel wall of hairy cells may be responsible for further propagation of the process. LSV can be seen at any stage of HCL. Cutaneous symptoms also regress when treating the underlying HCL with interferon or purine analogs. In conclusion, HCL can be seen in histological LSV etiology even though there is no clinical picture.

EP017

A Case Report of Euglycemic Ketoacidosis due to Dapagliflozin Treatment

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Background Recently, new drugs have been developed that reduce plasma glucose levels by inhibiting sodium-glucose co-transporter 2 (SGLT-2) transporters that allow glucose reabsorption in the ultrafiltrate. SGLT-2 inhibitors also called "glyphosins" or "glucoretics", reduce glucose reabsorption by causing SGLT2 inhibition in the kidneys' proximal tubules and increasing urinary glucose excretion. Dapagliflozin is the first SGLT-2 inhibitor that has been used in Europe in 2012 and the United States in 2014 and is used in the treatment of diabetes. Euglycemic ketoacidosis (EKA) is a rare form of diabetic ketoacidosis without a severe high blood sugar level. EKA has been reported as a side effect in the follow-up of some patients using SGLT-2 inhibitors. The mechanism by which SGLT-2 inhibitors cause the development of EKA has not been fully elucidated. It is thought that the decrease in insulin secretion from the pancreas due to urinary glucose excretion may increase the glucagon/insulin ratio, and this situation paves the way for increased gluconeogenesis, ketogenesis, and ketoacidosis. Here, we aimed to present a case of EKA that developed after dapagliflozin use.
Material and Methods A 57-year-old male patient with known diabetes for 20 years was admitted to our center with complaints of nausea, dizziness, and weakness.

Results There was no pathological finding in the patient's physical examination. In venous blood gas, ph: 7.3, lactate: 2.6 mmol/L, HCO3 was found to be 10 mmol/L. In biochemistry analysis, fasting plasma glucose was 167 mg/dL, creatinine level 0.83 mg/dL, and HbA1c level was 9.5%. Ketone ++ and glucose ++++ were found in urinalysis. It was learned that the patient used metformin 1000 mg 2x1, linagliptin 5 mg 1x1, and dapagliflozin 10 mg 1x1 for the treatment of diabetes. The patient was diagnosed with EKA. Dapagliflozin treatment was stopped, and insulin infusion was started in addition to fluid therapy. Ketone became negative with insulin infusion. Diabetes treatment of the patient whose acidosis improved and ketone became negative during the service follow-up was arranged as 14 U insulin glargine, 2x50 mg vildagliptin, and 2x1000 mg metformin. The patient was discharged by recommending outpatient follow-up.
Conclusions If there are no contraindications, SGLT-2 inhibitors are recommended as antidiabetic drugs in patients with a history of proven atherosclerotic cardiovascular disease, history of heart failure, or high risk of atherosclerotic cardiovascular disease. Before giving SGLT-2 inhibitors in treatment, a detailed history should be taken, and factors that may predispose the patient to ketoacidosis should be evaluated. SGLT-2 inhibitors should be used with caution in patients with low insulin reserve, restricted oral intake, patients susceptible to dehydration, and in cases where insulin need increases due to acute medical illness or surgery. EKA should be kept in mind in the differential diagnosis, especially in patients using SGLT-2 inhibitors and in whom acidosis is found even though blood glucose levels are not very high.

EP018

A Case of Normocomplementemic Urticarial Vasculitis Triggered by Urinary Tract Infection

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Background Here, we presented a case with a diagnosis of normocomplementemic urticarial vasculitis.
Material and Methods A 39-year-old woman, who had no history of any disease other than urticaria and who had been occasionally using antihistaminic medications for itching, presented to our outpatient clinic with a diffuse rash all over the body, itching, and difficulty breathing.
Results On physical examination, she had edema and redness of the entire face, which were more prominent on the eyelids and lips, as well as widespread urticarial plaques and purple lesions that faded in patches all over the body. She had no uvula edema or abnormal breath sounds. Her history was not notable for any medication except for an antihistaminic medication that she had taken in the last month; her complaints had started 5 days ago and not responded to the antihistaminic medications (rupatadine fumarate) that she had used. It was also learned that she had been admitted to the emergency service of an outside medical facility, where she had been treated with intravenous pheniramine, methylprednisolone, and dexamethasone; her complaints had regressed following the first three days of intravenous treatment but resumed thereafter. As she began to have a skin rash, itching, burning, and stinging sensation again on the fourth day, and as she remained unresponsive to intravenous treatment administered in the emergency service, she presented to our facility with resistant urticaria. Her laboratory tests revealed the following: urea 39 mg/dL, creatinine 0.81 mg/dL, total protein 76 g/L, albumin 45.5 g/L, uric acid 2.7 mg/dL, AST 13 IU/L, ALT 15 IU/L, LDH 258I U/L (N: 135-214), ALP 52I U/L, GGT 10 IU/L, total bilirubin 0.47 mg/dL, direct bilirubin 0.15 mg/dL, calcium 9.5 mg/dL, sodium 140 mmol/L, potassium 4 mmol/L, WBC 22.2x103 mcg/L, neutrophil 20.02x103 mcg/L, lymphocyte 0.95x103 mcg/L, monocyte 1.21x103 mcg/L, eosinophil 0.0x103 mcg/L, TSH 1.38 mlU/L, HBsAg, anti-HCV and anti-HIV were negative. Anti TPO and anti-thyroglobulin were negative. Sedimentation rate 10 mm/h, C3 1.15 g/L (N), C4 0.14 g/L (N), total IgE 296 mcg/L (N: 0-240), CRP 15 mg/L. In urinalysis, there were 7 erythrocytes and 7 leucocytes. The patient was admitted to a regular ward with the diagnoses of resistant urticaria and urinary tract infection. Urine culture was ordered. ANA and anti-dsDNA tests returned negative. There were no pulmonary infiltrates on PA chest X-Ray. The patient was begun on intravenous methylprednisolone at a dose of 1 mg/kg, pheniramine, and pantoprazole. Empirical intravenous ceftriaxone was also added for a possible urinary tract infection. As urticarial lesions persisted for more than 24 hours and they left pigmentation after fading and caused pain and tingling sensation in addition to itching, urticarial vasculitis was primarily considered, which prompted us to take a punch biopsy of 4 mm thick from the lesions. As the patient's rash and angioedema have gradually regressed, the steroid dose was down titrated. Urine culture produced no bacterial proliferation.
Conclusions The pathology report of the biopsied lesions was compatible with normocomplementemic urticarial vasculitis: mild orthokeratosis in the epidermis; edema and vascular proliferation in the upper dermis; swollen endothelium; perivascular infiltration by lymphocytes, histiocytes, neutrophils, and eosinophils; and the presence of neutrophils and interstitial eosinophils on some vascular walls.

EP019

Polycystic Renal Disease Presented by Anuria and Nephrolithiasis Associated Progressive Kidney Damage: A Case Report

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Background Autosomal Dominant Polycystic Kidney Disease (ADPKD) is the most common inherited kidney disease. Kidney stones develop in 20-30% of patients with ADPKD, and urinary stones are usually treated conservatively. When kidney dysfunction develops in patients with ADPKD, Glomerular filtration rate (GFR) loss reaches an average of 4.4 to 5.9 mL/min per year. In these patients, faster deterioration requires investigation of dehydration or stone-related postrenal factors that trigger acute kidney injury. Due to the frequent occurrence of kidney stones in ADPKD and difficulty detecting hydronephrosis with ultrasonography (USG) in these patients, despite negative ultrasound reports for hydronephrosis, the stone-related postrenal obstruction should be considered in rapid GFR losses. We presented a case of ADPKD whose renal functions rapidly deteriorated during chronic follow-up and renal function markers returned to basal levels with treatment of the underlying cause.
Material and Methods 73-year-old patient with basal creatine 1.6 mg/dL and GFR 62 mL/min, who was under outpatient follow-up with ADPKD, had a history of hypertension and occlusive cerebrovascular events.
Results The patient's creatinine level increased from 1.6 mg/dL to 3.6 mg/dL in the outpatient follow-up, and there was no new drug use or fluid loss, suggesting a prerenal event in the evaluation. The patient who had no signs of pain, bleeding, and urinary tract infection was considered the accelerated natural course of ADPKD, considering creatinine's elevation in the first place and comorbidities. One week later, the patient whose general condition deteriorated and creatinine value increased to 7.1 mg/dL (GFR 10 mL/min) was hospitalized for further examination and treatment. No postrenal pathology was detected in the USG, and the patient received emergency hemodialysis due to uremic symptoms. In the non-contrast computed tomography (CT) taken to explain the current findings, there was dilatation in the pelvicalyceal system of both kidneys and stones in the right and left ureters, the largest of which were 9.5x4.5 mm and 5.5x3 mm, respectively. Bilateral ureterorenoscopy was performed on the patient under emergency conditions. Stones causing complete obstruction were observed at the bilateral distal ureter level. Bilateral DJ stents were placed. After the procedure, urine output started, and the creatinine level decreased to the basal level of 1.7 mg/dL.
Conclusions It should be kept in mind that stones frequently found in unexplained accelerated progression in ADPKD may occlude ureters. Cysts in both kidneys can easily be confused with pelvic enlargement due to obstruction. Pelvicalyceal dilatation can quickly be evaluated as a cyst in USG, which is inexpensive, practical, and the first choice to evaluate postrenal pathologies without radiation exposure. Obstruction due to stones may result in irreversible renal failure when not diagnosed in the early period. The prevalence of stones in ADPKD ranges from 3% to 59%. Stone prevalence has been reported widely at different intervals in the literature. Although stone interventions' prevalence is between 1% and 8%, the prevalence of kidney stones and stone interventions remains uncertain. In ADPKD, stones can be confused with pain due to cyst rupture. Stones can usually cause acute renal failure due to infection/urosepsis, persistent pain, vomiting, and rarely bilateral obstruction in the ureteropelvic region. Besides, acute GFR losses should be considered in patients with a chronic course, as in our case. Imaging, especially USG, may be insufficient to diagnose with the presence of multiple renal cysts. Diagnostic uncertainty may arise. Therefore, the best imaging method is CT, which detects stones and calcifications. Studies suggest that unenhanced CT is the preferred imaging method for diagnosing suspected nephrolithiasis in ADPKD.

EP020

Blastic Plasmacytoid Dendritic Cell Neoplasia: A Rare Case Report

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Background Blastic plasmacytoid dendritic cell neoplasia is a rare hematological malignancy that is considered to be caused by plasmacytoid dendritic cells and was included in the acute myeloid leukemia-associated precursor neoplasm subgroup by the World Health Organization (WHO) in 2008. The patients frequently presented with common cutaneous lesions. Blastic cell infiltration can be seen in the peripheral smear. Lymphadenomegaly and pancytopenia can be detected in patients. Typically CD4, CD56, CD123 expression is observed in the bone marrow and skin biopsy by flow cytometry/immunohistochemistry (IHC). The patients are generally men and older adults. The median survival is 12-14 months from diagnosis. Advanced age and stage are thought to be associated with poor prognosis. Patients often respond to initial chemotherapy, but relapses are frequent. Multiagent chemotherapies such as CHOP, HyperCVAD are frequently used. Stem Cell Transplantation can be an option in young and well-performing patients.
Material and Methods The patient, 81 years old, known to have no comorbidities, was examined 5 months ago with newly developed swelling in the right arm and widespread rash on the whole body.

Results The patient didn't have B symptom. On physical examination, there were multiple lymphadenomegalies in bilateral cervical, axillary, and inguinal regions, the largest of which was 2.5x2 cm in size. He had hepatomegaly. Splenomegaly wasn't detected. In laboratory tests, WBC 3060/mm3, neutrophil 1270/mm3, lymphocyte 1.620/mm3, hemoglobin 11.1 g/dL, platelet 16,800/mm3, ESR 25 mm/h, LDH 170 U/L, beta-2 microglobulin 3.23 mg/dl. Platelet count in his peripheral smear was consistent with the hemogram. Aspiration and imprints were infiltrated with heterogeneous cells, some with lymphocyte morphology, some with narrow cytoplasm and large-small lymphoblasts without granules at bone marrow biopsy. Blast rate was evaluated as 51%. The immunophenotype was in Flow cytometry CD3 (+), CD4 (+), CD5 (+), CD7 (+), CD8 (+), HLA-DR (+), CD20 (-), CD34 (-), and CD103 (-). IHC staining as CD4 (+), CD8 (+), CD38 (+), CD138 (+), CD20 (-), TDT (-), CD5 (-), and LCA (+) bone marrow biopsy interpreted CD4 expression as supporting T-cell neoplasia. The skin biopsy has been reported as punch biopsy showing atypical lymphoid infiltration. It resulted as IHC as CD3 (-), CD4 (+), CD7 (+), CD8 (-), CD20 (-), LCA (+), and MPO (-). Ki-67 index was reported as 50%. BPDCN was considered primarily supported by skin findings, pancytopenia, and flow. On PET-CT, diffuse increased metabolic activity was observed in the neck, right lung, mediastinum, bilateral axillae, subcutaneous soft tissue in the right humerus, right nipple, spleen, and all bone structures entering the imaging field. Based on the available information, the patient was considered as BPDCN. With the CVP protocol, after 4 cycles of chemotherapy inter evaluation, the CVP protocol was planned to continue.

Conclusions In summary, BPDCN is a rare disease with poor prognosis. Response to initial chemotherapy is good, but relapse is common. More studies are necessary to have a better understanding of the disease for proper management.

EP021

Intravascular Large B Cell Lymphoma: A Rare Case Report

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Background Diffuse large B cell lymphoma (DLBCL) is a common hematological malignancy that usually presents with signs of peripheral lymphadenopathy, hepatosplenomegaly, and bone marrow suppression, and/or symptoms such as fever, night sweats, and weight loss. Intravascular Large B Cell Lymphoma is an aggressive and rare tumor characterized by neoplastic cells' tendency to remain in the vessel. Most of the patients are in the middle or advanced age group. The symptoms are related to the lesions caused by the tumor cells' occlusion in the small vessels. Findings related to the central nervous system (convulsions, neurological deficits, progressive dementia) or skin involvement (subcutaneous nodules, plaques) are frequently observed. In patients with skin lesions, the prognosis is better than those with only central nervous system involvement, as early diagnosis can be made by skin biopsy.

Material and Methods A 71-year-old female patient with known hypertension was examined with complaints of redness, warmth, swelling, and pain in the legs for about 3 months.

Results Systemic examination revealed redness, increased warmth, and edema in the lower extremities. Multiple lymph nodes, the largest of 2x1 cm, were palpated in the bilateral inguinal area. There was no organomegaly. Cellulite and deep vein thrombosis were excluded, skin punch biopsy was performed from the lower extremity. Its pathology resulted in "LCA positive Ki-67 blast lymphoid cell groups with high proliferative activity in subcutaneous vessel lumens" (Picture 1). WBC 6,500/mm^3, neutrophil 3,308/mm^3, hemoglobin 8.6 g/dL, platelet 181,000/mm^3, sedimentation rate 71 mm/h was detected. The peripheral blood smear was unremarkable. No infiltration was detected in the bone marrow biopsy. Intravascular Large B-Cell Lymphoma Stage 3B was evaluated. R-CHOP chemotherapy was planned for the patient. Since hypermetabolic lymph nodes in the mediastinum and hiluses persisted after 8 cycles of R-CHOP chemotherapy, R-BENDA was planned as a second-line treatment. Lenalidomide+Rituximab was chosen as the treatment plan for the patient who was evaluated as stable disease by PET-CT after 4 cycles of R-BENDA. The follow-up and treatment of the patient continue in Bursa Uludag University Faculty of Medicine Hematology Department.

Conclusions Although diffuse large B cell lymphoma is the most common subtype among non-hodgkin lymphomas, its variant, intravascular large B cell lymphoma, is a scarce form. The diagnosis can be easily missed due to nonspecific presentations, infective and vascular problems included in the differential diagnosis. The main diagnosis is based on pathology. Neoplastic cells are rarely seen in the bone marrow, and peripheral blood smears, so intravascular large B cell lymphoma diagnosis is difficult. Most of the reported cases have been confirmed by autopsy or cutaneous biopsies. In conclusion, we think it would be appropriate to evaluate the skin lesions that could not be diagnosed specifically in lymphoma infiltration.

EP022 A Case with Severe Hypocalcemia and Hypophosphatemia after A Single Dose Denosumab

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Background Mineral bone diseases are frequently encountered in patients with chronic renal failure and these patients are at risk of fracture. Denosumab is a monoclonal antibody that binds to the receptor activator of nuclear factor kappa B ligand and inhibits osteoclastic activity. Denosumab is preferred in patients with chronic renal failure and osteoporosis. Metabolic side effects of the drug include hypophosphatemia, hypocalcemia, hypokalemia, and hypomagnesemia. In the present case, we will present a patient with stage IV chronic renal failure who developed severe hypocalcemia after denosumab administration.
Material and Methods A 72 years old male patient with diabetes mellitus and stage 4 chronic renal failure was followed-up with hormonotherapy due to prostate adenocarcinoma and was hospitalized in the orthopedic service due to a right femur fracture.
Results In the hospitalization examinations of the patient consulted with us due to hypocalcemia, corrected calcium value was 4.8 mg/dL, potassium 2.6 mmol/L, sodium 134 mmol/L, creatinine 3.81 mg/dL, urea 86 mg/dL, parathormone 902 ng/L, phosphorus 0.8 mg/dL, 25-OH vitamin D 21.1, PSA <0.01. The patient who described muscle cramps had no tetany or seizures. Chvostek was negative. The patient had newly developed hypocalcemia without QT prolongation on the electrocardiogram, hypokalemia, hypophosphatemia, and hyperparathyroidism. When his anamnesis was deepened, it was learned that he had previously used bisphosphonate due to osteoporosis and switched to denosumab when creatinine clearance was thought. It was learned that the first dose was given 15 days ago. A total of 19 ampoules of calcium gluconate were replaced with the patient who had open diuresis and did not need hemodialysis. The patient's corrected calcium level increased to 9.6 mg/dL after three days. Potassium replacement was also performed, and the potassium value of the patient was 3.7 mmol/L and the phosphorus value was 1.5 mg/dL. The patient whose calcium level was 8 mg/dl during follow-up was discharged with oral calcium and calcitriol prescription. It was learned that the patient died one month later due to fat embolism.
Conclusions Denosumab is our first choice in patients with osteoporosis with stage 4 chronic renal failure. It should be kept in mind that denosumab, which we consider as a reliable choice, can cause deep hypocalcemia and hypokalemia in patients. Especially in patients with low creatinine clearance, the risk of hypocalcemia is increased. It should not be forgotten to perform close electrolyte monitoring in patients after drug administration.

EP023 HIV Related Primary Central Nervous System Lymphoma: Case Study

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Background Primary central nervous system (SSS) lymphoma is a rare variant of extranodal lymphoma that causes brain, leptomeninxes, eye or spinal cord involvement without any systemic involvement. The important risk factor in the development of the disease is the immuno deficiency. Immuno deficiency includes congenital insufficiency tables such as iatrogenic immunosuppression, X-dependent insufficiencies – Wiskott Aldrich, especially HIV.
Material and Methods A 28-year-old male patient was diagnosed with sudden speech impairment, urine and gaita incontinence.
Results Physical examination showed no clear, oriental, cooperative, apathetic, dysartric, pupils isococic, direct/induced light reflexes bilateral positive and no obvious side findings. There was a feeling defect that went up to L1-T12. Deep tendon reflexes were normoactive and pathological reflexes were not observed. In cranial MRI, bilateral caudal nucleus formed significant bass in frontal horns; on the right, mass lesions were monitored in the talamus, in the right middle cerebral paddynacle and in the posterior fossa, showing a pathogen of contrast scattered. The patient was performed a stereotactic biopsy by Brain and Neurosurgery. Biopsy results were found to be compatible with Non Hodgkin Diffuse Large B Cell Lymphoma - CNS involvement. In Pet-CT, multiple hypermetabolic involvements with, SUVmax: 15 were monitored in the 4th ventricle of the brain, caudate nucleus and right cerebellum. No other involvements was observed in body (Figure 1). Patient with negative hepatitis markers was detected as HIV Ag/Ab positive. Methamphetamine addiction of the patient in his anamnesis and anti-HIV positivity were detected in the examinations performed 5 years ago. Bictagravir-emtrisitabin-tenofovir alafenamide treatment was initiated. HIV RNA was positive in follow-up. High dose MTX was started in accordance with the patient's chemotherapy (CT) plan. On the 3rd day of the 2nd cure, approximately 6 cm mass at the level of basal ganglia in cranial CT of the patient who developed sudden low Glasgow Coma Scale (GCS) (GCS: 3) and hemorroragia findings were followed (Figure 2). Under mechanical ventilator support, the intubate began to be monitored. With the findings of intracranial bleeding and sepsis in their follow-up, the patient was died.
Conclusions Although primary CNS lymphomas are rare malignancy, their rates have increased as a result of frequent use of both diagnosis and immunosuppressive treatment methods. Its relationship with HIV is strong. Aphasia can show itself in different ways, such as hemiparesis,

seizures. HIV+ people can be diagnosed differentiators with lymphoma according to the number of CD4s. In HIV-related cases, initial treatment with high dose MTX is recommended instead of radiotherapy or anti-retroviral therapy (ART) alone. Diagnosis should be made by stereotactic biopsy. In addition to treatment for tumors, ART should also be given to patients. 2-years survival rates are higher in patients taking high dose MTX with or without radiation therapy. As a result, HIV is more prominent in the associated groups; in cases of primary CNS lymphoma, the prognosis is poor and the life is less than 1 year. With combined treatments, improvement in life can be observed.

EP024

Burried Bumper Syndrome

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Background Percutaneous endoscopic gastrostomy (PEG) is a frequently used method for maintaining enteral nutrition in patients who cannot use oral pathway for a long time. PEG related complications range from 0.4% to 22.5%, with the majority being minor. Burried Bumper syndrome (BBS) is one of the major complications. By definition, the inner fungus of the PEG tube migrates into the abdominal wall, inside the layers from mucosa to the submucosa, muscularis propria and skin, outwards. Its incidence is around 1%. Complications include gastrointestinal bleeding, perforation, peritonitis, intraabdominal and abdominal wall abscesses and phlegmon. In our case, our aim is to present BBS presenting with upper gastrointestinal bleeding.

Material and Methods A 94-year-old female patient with known cirrhosis due to non-alcoholic steatohepatitis, was hospitalised due to drowsiness and deterioration in her general condition.

Results She was intubated and taken to intesive care unit (ICU) following a respiratory failure development. Due to prolonged period of intubation in ICU, a tracheostomy was performed. She was transfered to the ward with tracheostomy canula and external breathing apparatus support. Enteral nutrition was contunued via nasogastric tube for more than two months. PEG tube insertion was performed. There were no early complications. While the patient did not have any problems in the follow-ups, on the 35th day, we were consulted due to spotting of fresh blood upon drainage of the PEG. Fresh blood was also seen in the tube and around its entrance hole. Endoscopy of the patient, whose vitals were stable, was performed. An area of approximately 2-3 cm diameter in the antrum of stomach was covered with a clot. The clot extended from the antrum to the pylorus (Figure 1). Fungus was not observed in the stomach. It was concluded that the clot source was the entrance hole of the PEG. The stomach wall was stiffened by insufflation of air into it and external pressure was applied to the PEG tube. Afterwards, the fungus in the inner side of PEG tube advanced to the stomach lumen. A hemorrhagic tissue defect, created by the PEG fungi, was detected *(Figure 1)*. Adrenaline was injected around bleeding points and then the bleeding stopped. The procedure was terminated by leaving the inner bumper in the stomach to move freely. In order to facilitate mucosal healing, enteral feeding was interrupted, proton pump inhibitor infusion was initiated. After hemoglobin and peristaltic movements returned to normal, feeding was resumed through the PEG tube.

Conclusions Enteral nutrition with PEG attachment is a frequently preferred method, especially in patients with prolonged oral intake problems in ICUs. Care should be taken during tube cleaning and patient's handling, so that the tension between the inner cork of the tube and the outer plastic stabilizer should not be increased. If tension increases, the internal fungus may migrate through the layers of the abdominal wall. BBS should be considered in cases of problems during infusion of the enteral food and leakage around the tube. In order to prevent mortal complications, a diagnosis should be made with endoscopy and treatment should be

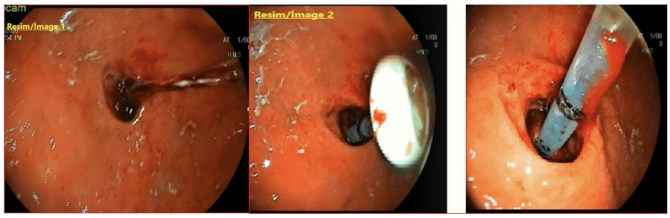

Figure 1. Endoscopic findings of the patient

EP025

Cardiac Tamponade: A Rare Cause of Liver Damage Which Should Not Be Missed

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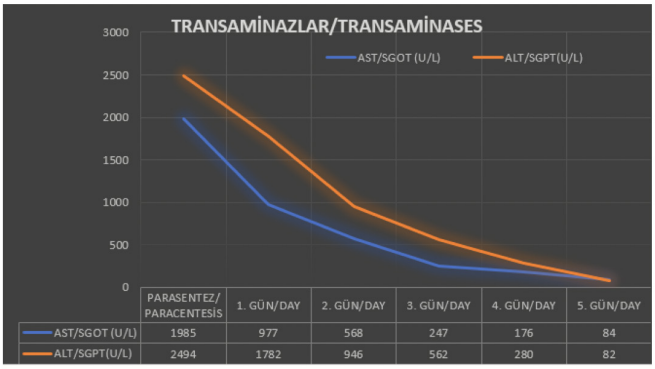
Background In patients without prior chronic liver disease, severe liver injury is defined by elevation of transaminasses (more than 2 to 3 times) and liver dysfunction characterized by jaundice and coagulopathy in patient. Viral hepatitis is major etiology in developing countries, while toxic hepatitis is most common cause in the USA and UK. Ischemic hepatitis is a condition that is seen due to different underlying diseases like acute cardiac failure, trauma, hemorrhage and respiratory failure. The main problem in ischemic hepatitis is restriction of liver perfusion and oxygen supply. Once the underlying condition is resolved, transaminases return to

normal dramatically. Our aim is to present a case of cardiac tamponade with severe acute liver injury.

Material and Methods 20 days ago, a 42-year-old male patient with a long history (21 years) of HBeAg-negative chronic hepatitis B infection was started on amoxicillin-clavulonate and then ceftriaxone treatment due to upper respiratory tract infection.

Results Due to ALT and AST values exceeding 1000 IU/mL during the follow-up, he was referred to our facility with the diagnoses of toxic hepatitis and hepatitis B reactivation. It was stated that the physical examination and imaging of the patient at the time of sending were unremarkable. In his history, he had used alcohol for 20 years. Laboratory findings were: ALT 1,411 IU/mL, AST 1,322 IU/mL, total bilirubin 0.6 mg/dL, ALP 86 mg/dL, GGT 61 mg/dL, LDH 1769, albumin 4 g/dL, PT 28.7 seconds, INR 2.54, leucocyte 18x103 U/L, CRP 12 mg/dL. There were no abnormalities on the ECG and chest radiography. Abdominal USG done in the emergency room showed a 17 cm microlobulated liver, normal spleen, perihepatic, perisplenic and minimal pelvic fluid. Due to its small quantity, the fluid could not be extracted, even with the guidance of ultrasonography. The patient was hospitalised. Further investigations showed HBsAg (+), HBV-DNA 3320 IU/mL, anti-HBcIgM (-), anti-HAV IgM (-), anti-CMV IgM (-), Delta antigen (-). On physical examination, his pulse rate was 110 beats/minute, blood pressure 130/70 mmHg. It was noticed that there was a distinct jugular venous distention. Detailed hepatobiliary ultrasonography was repeated by our team because of suspected cardiac etiology. It was found that the hepatic veins were dilated (>20 mm, normal <6.5 mm) and the inferior vena cava was significantly enlarged. Due to this finding, indicating congestive hepatopathy, the probe was placed on the apex of the heart. USG showed massive pericardial effusion. After urgent pericardiocentesis about 1.5 liters of hemorrhagic fluid was drained within a few hours. Following the drainage the ALT and AST values decreased dramatically within 48 to 72 hours and neared normal values on the fifth day *(Graphic 1).*

Conclusions Ischemic hepatitis is among the etiologies of acute liver injuries which show dramatic improvement when the underlying cause is treated. Hypotensive episode may not be seen in approximately fifty percent of patients. Cardiac tamponade is a condition that causes liver function disorder that can be mortal when the diagnosis is delayed or not established. Therefore, it should be considered in every case with signs of ischemic hepatitis. Additionally, detailed physical examination and hepatobiliary ultrasonography should



	PARASENTEZ/ PARACENTESİS	1. GÜN/DAY	2. GÜN/DAY	3. GÜN/DAY	4. GÜN/DAY	5. GÜN/DAY
AST/SGOT (U/L)	1985	977	568	247	176	84
ALT/SGPT(U/L)	2494	1782	946	562	280	82

ALT/SGPT: Alanin Aminotransferase/Serum Glutamic Pruvic Transaminaz AsT/SGoT: Aspartat Aminotransferase/Serum Glutamic Oxaloacetic Transaminaz

Graphic 1. ALT and AST values of the patient

EP026

Unexpected Cause That Leads to Failure in Inserting Nasogastric Tube: Zenker Diverticulum

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Background Nasogastric tube insertion is one of the most common interventions in intensive care unit(ICU). However, due to absence of swallowing reflex, flexibility of the tube and over inflated endotracheal cuff, problems may be encountered during its insertion. Tube usually remains coiled in the mouth. Serious complications can be seen due to its invasive nature such as pneumothorax, pneumomediastinum, hemothorax, mediastinitis and perforation. Zenker's diverticulum is a pouch formed due to pulsation in relatively weaker structure of hypopharyngeal wall, between the oblique fibers of the inferior pharyngeal constrictor muscle and the horizontal fibers of the cricopharyngeal muscle. It contains the mucosa and submucosa layers. It is usually seen in men in their seventh and eighth decade of life. The main symptom is dysphagia in about 80-90% of patients. The diagnostic method is usually pharyngoesophagography under fluoroscopy. We will try to present the detection of the Zenker diverticulum in a patient following unsuccessful and repeated attempts to insert a nasogastric tube.

Material and Methods A 80-year-old patient with known hypertension, chronic kidney disease and rheumatoid arthritis, presented to the emergency room with shortness of breath, coughing and swelling in the legs.

Results He was hospitalised in Chest Disease ward due to pneumonia and because of increased dyspnea, non-invasive mechanical ventilator support was initiated. Urgent hemodialysis was performed following acute kidney failure. Due to hypoxemia and reduced Glasgow Coma Scale the patient was transferred to the ICU and was intubated. Enteral nutrition support was planned via nasogastric tube which is essential in every patient. However, despite repeated attempts and with the aid of laryngoscope, the tube could not be advanced. We were therefore consulted based on this. In the systemic examination, the head and neck region, cardiovascular systems, abdomen were normal. Pulmonary bilateral basal crackles were heard. Laboratory results showed 10.3x103/uL leukocytosis, 10.3 g/dL hemoglobin, 51x103/uL thrombocytopenia, 22.3 mg/dL CRP, 89 mg/dL urea, and 1.66 mg/dL creatinine. Endoscopy showed that in the esophageal entrance the lumen was divided into two by insufflation. The left one was short and blind. The lumen on the right continued to the stomach – normal esophageal tract *(Figure 1).* The patient was diagnosed with Zenker diverticulum due to its location. Conclusion was that the diverticulum compressed real eosophageal lumen which caused the nasogastric catheter to go into the diverticulum every time. Using endoscope and guidewire the NGT was finally inserted (*Figure 1).* The procedure was fi-

nalized but unfortunately, the patient died 15 days later due to pneumosepsis and multiorgan dysfunction syndrome.
Conclusions Zenker diverticulum should be considered as a diagnosis in cases where there is failure of nasogastric tube insertion, especially in elderly patients who do not have history of esophageal stricture and alarm symptoms for malignancy. Because Zenker Diverticulum does not include the muscularis propria and adventitia layers, there is a risk of perforation during aggressive manipulations. In cases where the nasogastric catheter cannot be inserted, excessive force should be avoided. Although dynamic pharyngoesophagography is recommended for diagnosis, it is not possible to perform this procedure in ICU. Bedside endoscopy is an

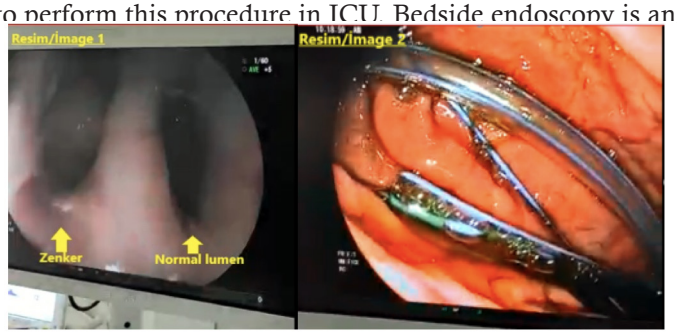

Figure 1. Endoscopic findings of the patient

Results This study showed that NLR and PLR levels are elevated in patients with SAT in comparison with other thyrotoxic patient groups and controls. The post hoc analysis of comparison of NLR and PLR in each study groups revealed that NLR and PLR were statistically different in the SAT group in comparison to the GD, TMNG, TA, and healthy controls. A significant decrease in the level of MPV was demonstrated in thyrotoxicosis patients (p<0.001) *(Table 1)*.
Conclusions NLR, PLR and MPV that is routinely and automatically calculated from complete blood count plays an important diagnostic role in thyrotoxicosis

Table 1. Demographic and laboratory characteristics of study participants

	TA patients (n =39)	TMNG patients (n =46)	GD patients (n =46)	SAT patients (n =45)	Control group (n =45)	P value*
Age, years	64.97±10.14	69.23±8.33	51.00±16.37	44.62±9.86	49.22±14.49	0.000
Gender (F/M)	24/15	34/12	31/15	42/3	27/18	0.003
Hgb (g/dl)	13.64±1.58	13.62±1.56	12.91±1.44	12.01±1.25	13.46±1.79	0.000
Plt (x10^9/L)	241.30±71.34	242.93±56.43	247.15±65.37	341.86±80.89	260.33±80.25	0.000
WBC (x10^9/L)	7.38±2.17	7.73±1.98	6.75±1.75	8.46±1.69	7.39±1.94	0.001
TSH (mIU/L)	0.09±0.24	0.12±0.24	0.03±0.05	0.07±0.11	2.20±0.98	0.000
Free T4 (ng/dL)	1.43±0.81	1.23±0.33	2.31±1.69	2.33±0.98	-	0.000
Free T3 (ng/dL)	5.24±2.93	4.73±2.35	7.87±6.94	5.20±1.54	-	0.001
Anti-TPO (+/-)	3/36	6/40	8/38	2/43	-	0.204
Anti-Tg (+/-)	2/37	6/40	8/38	4/41	-	0.312
CRP (mg/dl)	0.64±0.63	0.62±0.48	0.60±0.71	5.04±4.13	0.49±0.55	0.000
ESR (mm/h)	19.51±12.88	20.97±10.10	18.00±10.90	61.95±27.72	15.60±10.16	0.000
NLR	2.21±1.43	2.18±1.10	2.17±2.17	2.99±1.47	1.73±0.66	0.002
PLR	118.78±56.93	114.81±41.57	131.76±82.63	176.07±59.59	112.04±46.49	0.000
MPV	8.88±0.92	8.88±1.25	9.04±1.35	8.34±0.96	9.99±1.39	0.000

Values are presented as median (range) or mean±SD as appropriate. WBC: white blood cells, TSH: thyroid-stimulating hormone, Anti-TPO: thyroid peroxidase antibody, Anti-Tg: antithyroglobulin, CRP: C-Reactive protein, ESR: erythrocyte sedimentation rate, NLR: neutrophil-to-lymphocyte ratio, PLR: platelet-to-lymphocyte ratio, MPV: mean platelet volüme.
*p value, calculated by chi-square (for categorical variables), ANOVA (for parametric variables), and Kruskal–Wallis (for nonparametric variables), p<0.05 is significant.

EP027

Evaluation of The Hematologic Indices in Patients with Thyrotoxicosis with Distinct Etiologies: A Case-Control Study

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Background Thyrotoxicosis is a clinical state of inappropriately high levels of free T4 (thyroxine) and/or free T3 (tri-iodothyronine) in the body caused by distinct etiologies including Graves' disease (GD), subacute thyroiditis (SAT), toxic adenoma and toxic multinodular goiter (TMNG). Simple hematologic indices such as neutrophil/lymphocyte ratio (NLR), and platelet/lymphocyte ratio (PLR) and mean platelet volume (MPV) have increasingly been mentioned as measures of presence and severity of thyrotoxicosis. In this study, we aimed to analyze whether there is a link between these peripheral blood parameters and the presence of thyrotoxicosis.
Material and Methods A total of 46 GD, 46 TMNG, 39 TA and 45 SAT patients and 45 control subjects were studied. Laboratory parameters in all patients were recorded and NLR, PLR and MPV values were recorded from peripheral blood complete blood cell counts.

EP028

A Meta-analyses on The Role of IL-6 Associated JAK/STAT3 Signaling Pathway Modulation in The Inflammatory Bowel Disease Complicated Colonic Cancer Development

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Background The signalling pathway of Janus kinase (JAK)/signal transducer and activator of transcription 3 (STAT3) is suggested to be involved in various pathophysiological processes, including immune function, cell growth, differentiation, hematopoiesis and more importantly oncogenesis of distinct tumoral conditions. Interleukin (IL) 6 is a pro-inflammatory cytokine produced by antigen-presenting cells and non-hematopoietic cells in response to external stimuli and considered to be a key player in the development of the microenvironment of malignancy by promoting tumor growth and metastasis by acting as a bridge between chronic inflammation and cancerous tissue. In tumour cells, JAK/STAT3 hyperactivation can occur as a result of elevated

IL-6 levels in the serum and/or in the tumour microenvironment, owing to signals from other growth factors and/or their receptors, activation by non-receptor tyrosine kinases, or loss-of-function mutations affecting negative regulators of STAT3. Ulcerative colitis (UC) and Crohn's disease (CD) are subtypes of inflammatory bowel disease (IBD) in which abnormal reactions of the immune system cause inflammation and ulcers on the distinct segments of the gastrointestinal system with a significant risk of colorectal cancer development. Recent studies suggest that aberrant interleukin IL6/JAK/STAT3 signaling pathway exists in both IBD and inflammation-related gastrointestinal cancers. In the present meta-analysis we aimed to analyze the relationship between IL-6/JAK/STAT3 and IBD associated colorectal carcinogenesis and the effect of the inhibition of this system on disease follow-up and management.

Material and Methods A systematic literature review was carried up to January 2021 to identify all primary studies examining the role of IL-6 associated JAK/STAT3 system in IBD associated colorectal carcinogenesis. Studies related with the rest of other interleukins other than IL-6 was excluded. All articles were critically appraised with regard to methodological quality and risk of bias. 12 clinical trials that fulfilled the inclusion criteria were further pooled into a meta-analysis.

Results 22 studies met initial selection criteria but only 12 were eligible for inclusion in the meta-analysis. The majority of studies demonstrated a significant role of IL6 associated JAK/STAT3 in the pathophysiology of UC related carcinogenesis.

Conclusions In light of the small number of studies able to be included in the meta-analysis evidence strongly proposed that JAK/STAT3 signaling, especially via the IL-6/STAT3 axis is involved in the transition of inflammatory lesions to tumoral diseases and leading to ulcerative colitis associated colorectal cancer. For this reason, based on the evidence presented in this meta-analysis it is reasonable to suggest that targeting components of the IL-6/JAK/STAT3 signalling pathway can inhibit tumour cell growth and relieve immunosuppression in the UC associated colonic tumoral microenvironment.

EP029

A Case of Osteoporosis Secondary to Carbamazepine Complicated with Bilateral Femoral Head Fracture

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Background Carbamazepine is a major antiepileptic used in the treatment of epilepsy, especially partial epileptic seizures. Significant reduction in bone mineral density with classical (phenobarbital, carbamazepine, VPA, etc.) and some new antiepileptic drugs (oxcarbazepine, gabapentin) has been shown in many studies. Here, we presented a case of osteoporosis secondary to carbamazepine complicated by bilateral femoral head fracture.

Material and Methods An 18-year-old male patient with known asthma and epilepsy was admitted to the emergency room with sudden onset of chills, bilateral lower extremity allodynia, and proximal muscle weakness 1 month ago.

Results He continued to use carbamazepine therapy, which was initiated after focal epileptic seizures when he was 7 months old. The patient, who had diarrhea for 4 days, was confused. On his physical examination, muscle strength was 4/5 in the proximal bilateral lower extremities and complete in the distal. His body temperature was 37.3 °C, pulse 100 bpm, and blood pressure 150/80 mmHg. In laboratory tests, ESR was 4 mm/h, CRP 90 mg/L, leukocyte 14,930/mm3, and neutrophil 13,240/mm3. Stool microscopy and complete urine analysis were unremarkable. Moxifloxacin treatment was started because of pneumonic infiltration in thorax CT. COVID-19 PCR test was found negative for 2 times. Guillain-Barré syndrome (GBS) was not considered because the patient did not have distal muscle weakness. However, the patient's muscle weakness and allodynia complaints decreased. There were mild signs of myogenic involvement in the EMG. The patient had no oral aphthae, genital aphthae, joint pain, morning stiffness, and no family history of rheumatologic disease. CK values were within normal limits. ANA, ANCA profile, ANA profile, RF, and anti-CCP were negative. On examination, he had bilateral lower extremity flexion difficulty, extreme sensitivity, and allodynia. Fractures were detected in both femoral heads (Figure 1). DEXA was osteoporotic.

Conclusions Carbamazepine is one of the rare causes of osteoporosis. Spontaneous fractures after drug-related secondary osteoporosis should also be considered in the differential diagnosis in patients with the sudden loss of strength, immobility, severe pain specific to certain joints, and allodynia if there is no obvious rheumatologic

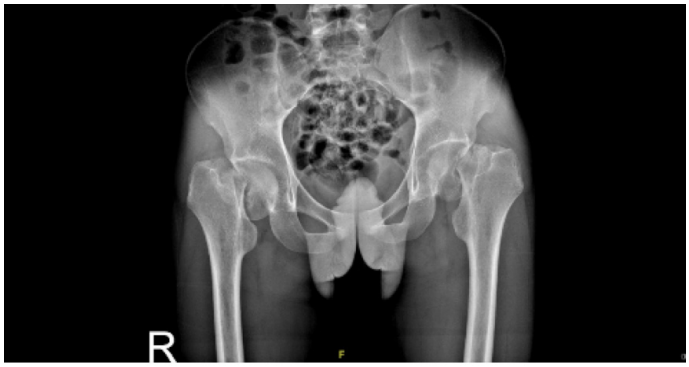

Figure 1. Fractures in both femoral heads

EP030

Coexistence of Systemic Lupus Erythematosis and C3 Glomerulopathy: Case Report

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Background Systemic lupus erythematosis (SLE) is a chronic, autoimmune, connective tissue disease of unknown etiology with immunological disorders, involving many organs and systems. It is known that kidney involvement occurs in about 60% of SLE patients and 10% to 20% of them progress to end-stage renal disease. Renal biopsy is recommended to subtype lupus nephritis in cases with suspected SLE renal involvement and to determine the treatment modality. It should be considered that the nephrological problem may also be due to kidney diseases other than SLE, and it should be considered that kidney biopsy will also be beneficial in terms of not missing other diagnoses. We present a case of C3 Glomerulopathy accompanying a patient with SLE.
Material and Methods Twenty-three year old male presented with discoid lupus three years ago. The patient was diagnosed with SLE because of ANA and RNP positivity, low complement, and skin findings.
Results Our patient had normal sedimentation and acute phase reactants at diagnosis, no anemia, and lymphopenia. Renal function tests were normal, and there was no proteinuria. He used hydroxychloroquine 400 mg/day and prednisolone 5 mg/day. One year later, methotrexate (MTX) was added to his treatment because of arthralgia. MTX was discontinued in the patient who developed proteinuria under the current treatment, considering lupus activation, and mycophenolate mofetil treatment was started. A kidney biopsy was performed in June 2020 due to the increase in creatinine and proteinuria. The biopsy was reported as non-diagnostic. Cyclophosphamide (CYC) treatment protocol was started due to the progressed disease. Due to severe nausea and vomiting, treatment was revised after CYC, and 2 doses of rituximab were administered. Because of the increase in creatinine and massive proteinuria in the follow-up, our patient resistant to treatment was re-biopsy. When renal biopsy pathology was evaluated together with C3c accumulation, it was reported as supporting c3 glomerulopathies (C3 GP). Alternative complement genetic screening was performed after the patient was consulted with nephrology.
Conclusions C3 GP is a glomerular disease with a high risk of progression to end-stage renal disease, defined in 2007. In many patients, acquired or genetic defect in alternative complement pathway control mechanisms causes continuous abnormal activation of the alternative pathway. C3 GP and other glomerulopathies should be considered in the differential diagnosis in patients with resistant proteinuria. As in our case, rebiopsy should be performed if necessary.

EP031

A Case of Severe Hypertriglyceridemia During Pregnancy

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Background Triglyceride and total cholesterol levels increase physiologically with the effect of estrogen during pregnancy. Acute pancreatitis and fetal losses can be observed concerning severe triglyceride levels during pregnancy.
Material and Methods A 28-year-old female patient was referred to the endocrinology outpatient clinic due to hypertriglyceridemia detected during routine obstetrics outpatient clinic control at the 18th week of her pregnancy.
Results The patient had a history of acute pancreatitis 2 years ago when she was 27 weeks pregnant with hypertriglyceridemia [triglyceride (TG): 3180 mg/dL]. The patient, who was treated with lipid apheresis and was discharged at that time, had a baby loss due to corpus callosum agenesis just after birth. The patient, who has not applied to an outpatient clinic for 2 years, was admitted to the endocrinology clinic to arrange the treatment of hypertrichosis. He had no active complaints. Her body temperature was 36.4 °C, blood pressure was 120/70 mmHg, and pulse was 98/min. No abnormal finding was found on physical examination. Total cholesterol: 337 mg/dL, TG: 3,117 mg/dL, HDL: 35 mg/dL, amylase: 44 mg/dL. The patient, whose oral feeding continued due to pregnancy, was administered insulin infusion (0.05-0.1 U h) for 24-48 hours and 5% dextrose infusion simultaneously to avoid hypoglycemia. Control TG: 669 mg/dL, total cholesterol: 227 mg/dL, HDL: 43 mg/dL and serum glucose: 90 mg/dL, omega-3 fish oil concentrate was started and discharged.
Conclusions The most common cause of patients diagnosed with acute pancreatitis after gallstones and alcohol is hypertriglyceridemia, and it is seen in 1-14% of cases. During pregnancy, the rate of pancreatitis due to hypertriglyceridemia is around 56%. A serious increase in TG levels increases the risk of preeclampsia, pancreatitis, hyperviscosity syndrome, preterm birth, and fetal death during pregnancy. Therefore, treatment should be started quickly. Besides diet regulation and lifestyle changes, intravenous buffered insulin, omega-3 support, plasmapheresis, and other medical treatments are used in the treatment. A timely multidisciplinary treatment approach will be reduced the risk of developing complications.

EP032

Bone Marrow Metastasis of Rhabdomyosarcoma Mimicking Acute Leukemia: A Case Report

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Background Bone marrow aspiration/biopsy examinations, which are referred to differentiate clinical entities such as anemia, leukopenia, or thrombocytopenia, play an essential role in diagnosing, staging, and managing the treatment of hematological malignancies and bone marrow metastasized solid tumors. In our case, considering the age and clinical findings of the patient, acute leukemia was initially thought. However, with further examinations, we have reached the diagnosis of metastasizing primary malignancy.
Material and Methods In December 2018, a 24-year-old female patient, who had not been diagnosed with a chronic disease before, applied to our institution's emergency service with syncope, epistaxis, and hypermenorrhea complaints.
Results Lymphadenomegaly and organomegaly were not found on physical examination, but ecchymoses with different maturities were found to spread on her body. The admission hemogram resulted with leukocyte: 5,460 K/µl, neutrophil: 1,520 K/µl, hemoglobin: 10.6 g/dL, and platelet: 13,540 K/µl.The patient's peripheral smear test resulted in slightly leukoerythroblastosis, blastic characterized non-fully differentiated cells, and absolute thrombocytopenia. Bone marrow examination and flow cytometric study were decided to be performed with prediagnosis of acute leukemia. Flow cytometric study of bone marrow resulted in blast rate within normal range and non-hematopoietic cell infiltration. At gate CD45, blast rate was 0.4%. Within 87% of the cell group, CD56 expression was strongly positive, and CD45 expression was weak. Cranial and thoracoabdominopelvic tomography were performed on patient with suspected bone marrow infiltration, but no pathology was found. In bone marrow biopsy, neoplastic cells replacing hematopoietic cells in the intertrabecular space contained cells with narrow cytoplasm and mild pleomorphism. Positive staining with desmin, myoglobulin, and MSA were observed. Widespread membranous staining with CD56 was observed. Based on these findings, metastatic rhabdomyosarcoma was considered. In the clinical follow-up of the patient, whose primary focus was investigated, a mass was detected in the nasal root due to rhinoscopic evaluation, which was performed due to the presence of anosmia, gradually increasing nasal obstruction, and intermittent epistaxis. The patient was diagnosed with rhabdomyosarcoma, the primary focus of which was accepted as nasal root and had diffused bone marrow metastases, which were shown on PET imaging. Then, the patient was referred to oncology department for treatment plan and follow-up procedures.
Conclusions In the initial evaluation, we have considered presence of a hematological malignancy in the foreground. However, flow cytometric study provided us the first differential diagnosis. In our case, rhabdomyosarcoma metastasis was detected by bone marrow biopsy performed on the patient, who came with thrombocytopenia initially. We aim to emphasize the fact rhabdomyosarcoma presents with bone marrow involvement and mimics lymphoma and leukemias. Still, it is mostly diagnosed by the absence of specific hematopoietic markers.

EP033

Pituitary Stalk Interruption Syndrome: A Case Report

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Background Panhypopituitarism is the name given to the clinical picture that occurs due to the insufficiency of all hormones produced in the anterior pituitary gland. Pituitary stalk interruption syndrome (HSIS) is a rare congenital syndrome usually presenting with a hypoplasic pituitary gland, an undemonstrated pituitary stalk, and an ectopic neurohypophysis. HSIS is an intrinsic pituitary cause of panhypopituitarism.
Material and Methods A 22-year-old female patient, who was followed up with the diagnosis of panhipopituitarism, was admitted to the endocrinology outpatient clinic with complaints of anorexia, weakness, nausea, and vomiting.
Results In the last 2 months, she had an involuntary weight loss of approximately 5%, did not comply with levothyroxine sodium and fludrocortisone treatments, and was amenorrheic. On the physical examination, her blood pressure was 100/60 mmHg, pulse 130 beat/min, and fever 36.4 °C. No pathological finding was found in system examinations. Creatinine was 0.75 mg/dL, sodium (Na) 136 mmol/L, potassium (K) 3.8 mmol/L, AST 21 U/L, ALT 9 U/L in the tests performed during admission. As a result of the clinical evaluation, the patient, who was suspected of having adrenal insufficiency, was administered hydrocortisone and hospitalized in the endocrinology clinic, and her follow-up and treatment were initiated. In the examinations performed during hospitalization, ACTH 5 ng/L, TSH 0.07 mU/L, free T3 1.73 ng/L, free T4 1.10 ng/dL, FSH 0.24 IU/L, GH <0.05 ug/L, somatomedin C (IGF-1) <15, cortisol 0.8 ug/dL. Sella (pituitary) magnetic resonance (MR) imaging showed an appearance compatible with ectopic neurohypophysis, empty sella syndrome, and PSIS. Oral hydrocortisone and oral contraceptive treatment were initiated at the appropriate

dose for the patient, and another hormonal treatment was re-arranged. Clinical improvement was observed in the follow-up.
Conclusions Hypopituitarism picture may occur with various clinical findings. The anterior pituitary panel should definitely be examined in patients who present with growth-developmental retardation and have GH insufficiency. After the diagnosis is made, MR imaging of the pituitary gland should be performed for etiology. Although HSIS is a rare cause of hypopituitarism, treatment is in the form of GH, thyroxine, and hydrocortisone replacement and replacing postpubertal gonadotropins. The prognosis of the disease is good with regular follow-up and treatment.

EP034

Endogenous Obesity Associated with Cushing's Disease: A Case Report

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Background Cushing syndrome (CS) is a rare disease accompanied by hypercortisolemia. Adrenocorticotropic hormone (ACTH) is divided into two as dependent and independent. ACTH-dependent causes constitute the majority of CS cases. Although it is more common in women, studies have shown that the incidence is increased in obese individuals. While investigating obesity etiology, evaluation of endogenous causes is important in revealing rare diseases.
Material and Methods A 36-year-old female patient with pituitary microadenoma and hypercortisolism findings investigated for obesity in our clinic.
Results The patient had a plethoric appearance, abdominal striae, and central obesity on the face. No suppression was observed in the 1 mg dexamethasone suppression test (DST) and 2 mg DST for 2 days. Inferior petrosal sinus sampling (IPSS) was performed to differentiate pituitary or non-pituitary CS in the patient. The left-sided central/peripheral ACTH ratio after corticotropin-releasing hormone (CRH) was 13.4, and was considered significant. The surgical operation was decided with the diagnosis of pituitary Cushing's disease (CD).
Conclusions CD results from excessive secretion of ACTH from the pituitary gland and endogenous hypercortisolism. It is sporadic and is more common in women. Central obesity, facial plethora, central obesity, purple colored wide striae, and proximal muscle weakness are among CD's main findings. The screening tests are 24-hour urinary cortisol level measurement at least 2 times at different times, 1 mg DST, night cortisol, and salivary cortisol measurement. More than 50% of CD cases have a pituitary microadenoma smaller than 5 mm in diameter on CT and/or MR imaging. Our case, who had a microadenoma of 2x2 mm in the left part of the pituitary, had hypercortisolism signs, and there was no suppression in screening tests. In the presence of ACTH-dependent endogenous hypercortisolism, IPSS is used to evaluate whether ACTH release is due to pituitary or ectopic causes. The ratio of ACTH level in the blood taken from the inferior petrosal sinus with IPSS to the peripheral blood level is often above 2 in CD, while it is below 1.7 in ectopic ACTH syndrome. After increasing the test's specificity with CRH stimulation, the central/peripheral ACTH ratio is expected to be above 3 in CD. In our case, after CRH stimulation, left-sided central/peripheral ACTH ratio was measured as 13.44. This patient was referred to the neurosurgery clinic for definitive treatment, who was diagnosed with pituitary CD after IPSS.

EP035

Burnout in Intensive Care Nurses

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Burnout is a process that expresses emotional, mental, and physical fatigue and develops insidiously over time. The concept of burnout, first defined by Freudenberger in 1974, has many definitions from past to present, but Maclach made the most widely accepted definition. In his description in 1981, Maclach said, "Burnout is a syndrome caused by the reflection of negative attitudes towards work, life, and other people on physical exhaustion, long-term fatigue, helplessness and feelings of hopelessness seen in people who are exposed to intense emotional demands due to their job and who have to work face to face with other people.". Burnout is seen mostly among healthcare workers. Studies show that intensive care nurses, who are an important member of the healthcare team, are the riskiest group in burnout. Intensive care units are clinics where a lot of technological equipment is used, critical patients are intensely treated and cared for, and the workload and stress are high. Patients' critical condition in the intensive care unit and the increased risk of death place a serious emotional and physical burden on nurses and other healthcare professionals. This increases the risk of burnout. Besides, many factors such as witnessing the continuous suffering of patients, making ethical decisions, not being useful to patients, frequent emergency intervention to patients, the complexity of technological devices, communication problems, insufficient equipment, and material problems, the need for advanced technical knowledge and skills, working in a closed area, and working in the night shift working increase the risk of burnout in nurses. Studies have shown that the level of burnout in intensive care nurses is moderate or high. As a result of burnout, problems such as reduced nurses' quality of life and job satisfaction, depres-

sion, deterioration in the family process, anger, restlessness, weakness, insomnia, decreased interest in work, absenteeism, headache, fatigue, alcohol intake, gastrointestinal system problems, difficulty concentrating, and social isolation can be seen frequently. Also, burnout in nurses can cause a decrease in patient care/service quality, a decrease in work efficiency, and financial and moral losses in the health institution. Thus, it is essential to carry out studies to prevent and reduce burnout in intensive care nurses and implement actions to develop coping strategies.

EP036 Psychological Effects of the COVID-19 Pandemic Process on Nurses

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The COVID-19 virus emerged in Wuhan, China, in 2019 and was declared a pandemic by the World Health Organization in 2020. The COVID-19 epidemic, which affects the whole world, can affect human health both physically and psychologically. During the pandemic process, it was observed that these effects were mostly on healthcare workers who were in close contact with sick individuals. The leading causes of mental health problems related to the pandemic in healthcare workers are the newness of the process, uncertainty, social isolation, working in high-risk positions, contact with infected people, lack of organizational support, responsibility for patient care, lack of personnel, and lack of personal protective equipment. Nurses are healthcare professionals who are in close contact with the patient diagnosed with COVID-19 in the pandemic. During the COVID-19 pandemic, nurses experienced a high level of physical and psychological exposure due to being a member of society and being a health professional caring for sick individuals. In addition to the losses in their social environment, emotional stress factors such as witnessing the patients' death near caused them to worry for their families and experience fear of death and despair. Nurses working in pandemic hospitals have been exposed to stigmatization as virus carriers and risky people in society. In this process, nurses also faced a decrease in their social support resources due to being separated from their families, leaving their jobs, and burnout. Another issue that negatively affects nurses' psychology is that society ignores the measures taken. Despite the seriousness of the illness, people do not obey the restrictions and ignore the warnings, causing nurses to consider themselves and their work worthless and a decrease in job satisfaction. In the compilation study of Wizheh et al., it is stated that disorders such as anxiety, post-traumatic stress disorder, depression, fear of death, insomnia, and decreased self-efficacy are seen more in nurses during the pandemic. According to a study conducted in our country, it has been shown that nurses working during the pandemic process have high levels of stress, depression, and anxiety. A study conducted on 261 nurses in the Philippines found that the fear caused by the COVID-19 disease caused nurses to leave their jobs, burnout, and decreased job satisfaction. In some studies, it is stated that during the pandemic, problems such as anxiety, stress, insomnia, depression, burnout, and decreased self-efficacy are seen a lot in nurses. The results of these studies show that nurses performing their duties in the front line during the pandemic went through physically and psychologically difficult processes. To minimize these psychological problems experienced by nurses, working hours and conditions should be improved, and support should be provided in stress management and early recognition of psychological problems. With on-site interventions and appropriate strategies, it can be made possible for nurses to overcome this process with the least damage. Safe and fast information and continuous training, such as the latest developments in the literature for the prevention and management of the pandemic, evidence-based guidelines and procedures, and ongoing training should be provided to all healthcare workers. Besides, it is recommended that healthcare professionals' mental health monitoring programs be established.

EP037 A Case Report: Newly Diagnosed Granulomatosis Polyangitis

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Background Granulomatosis Polyangiitis (GPA) is a systemic necrotizing vasculitis affecting small and medium vessels. It's frequently seen at the age of 45-60, it affects both sexes. It progresses with upper and lower respiratory system and kidney involvement. In this case, we aimed to present a newly diagnosed GPA case who presented with lung involvement and whose kidney values were impaired during follow-up.
Material and Methods Forty-seven-year-old male patient without known additional disease was admitted to our center with the complaints of recurrent lung infection, nasal bleeding, bloody cough, night sweats for the last 2 months, and intermittent fever.
Results He was receiving multiple antibiotic therapy for recurrent cough and productive sputum. It was learned that his complaints had been for 5 months, he had repeated antibiotic use, but he did not benefit from it. He described pain in the knee and elbow joints in his rheumatological examination. There was no history of arthritis. In the last 5 months, there was a loss of 15 kg, hemoptysis, and nasal root dep-

ression. Small vessel vasculitis (GPA), COVID-19 pneumonia, tuberculosis, lung infection/abscess, malignancies were considered in the patient. There was no history of contact with the COVID-19 carrier, his COVID-19 test was negative. The ARB test was negative in the sputum. In thoracic computed tomography (CT); there were 2 thick-walled cavitary lessions in the right lung. The nasal septum biopsy resulted as granulation tissue. At admission, CRP was 107 mg/L, sedimentation was 78 mm/hour. Hemoglobin: 9.7, thrombocyte: 60,5000, anti-CCP <0.5 U/ml, RF: 86 IU/ml, ANA: negative, c-ANCA: 1/320 EP positive, PR3: 1/10 positive. Urea: 25.9 mg/dL and creatinine: 0.79 mg/dL. In complete urinalysis, erythrocytes: 6, leukocytes: 16, bacteria and proteins were negative. The patient was admitted to the clinic with a diagnosis of GPA. 80 mg methylprednisolone was administered. 500 mg/day methylprednisolone was given for 3 days and 750 mg cyclophosphamide was given. 40 mg/day methylprednisolone was continued for maintenance. On the 7th day of his admission urinalysis performed due to the increase in creatine and urea values. In complete urinalysis, erythrocyte: 197, leukocyte: 5. 1,184 mg/day proteinuria was detected in 24-hour urine. Methylprednisolone was started 500 mg/day for another 5 days and continued with a dose of 40 mg/day. In renal doppler ultrasound, bilateral kidneys' size and parenchymal echogenicity were increased. Renal artery and vein were normal. Renal biopsy was performed for diagnostic purposes. Plasmapheresis was applied to the patient whose creatine elevation continued despite the treatment. The patient whose general condition recovered was discharged with prednisolone treatment of 25 mg/day. He was followed up in the outpatient clinic. Biopsy was reported as "necrotizing cresenteric glomerulonephritis". It was planned to complete the cyclophosphamide to 6 doses and to continue with the methylpredisolone reduction scheme.

Conclusions GPA is a disease with high morbidity and mortality if organ involvement occurs. Early recognition is important. Recurrent upper respiratory tract symptoms should be considered as GPA in patients presenting with a lung mass. It's important to follow patients for renal involvement.

EP038

Evaluation of Fever of Unknown Origin under The COVID-19 Pandemic Condition

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Background The increased diagnosis and treatment methods developed in the last 30 years improved the detection of HIV (Human Immunodeficiency Virus) infected individuals at an earlier stage which increased the life expectancy and decreased the transmission rate of these patients. Although patients diagnosed with HIV mostly present with infectious mononucleosis-like symptoms, some patients may present with unusual clinical presentations. In this case, we aimed to present a 23-year-old diabetic patient (Type 1 diabetes mellitus: T1DM) admitted to hospital with generalized tonic clonic seizure and fever of unknown origin who finally diagnose with HIV infection and recovered after receiving anti-retroviral therapy.

Material and Methods A 23-year-old male, who had been followed up with intensive insulin therapy for 12 years with the diagnosis of T1DM, admitted to the emergency department with complaints of high fever, nausea-vomiting and headache.

Results Under the pandemic condition, the patient was evaluated for COVID-19 and admitted to the intensive care unit after the observation of a generalized tonic clonic seizure in the emergency room. Although, he had his first generalized tonic clonic seizure six months ago he did not admit neurologist for accurate diagnosis and treatment. On physical examination, he had a fever (38.6 °C), tachycardia (pulse 110 beats/min). Chest auscultation showed decreased respiratory sounds at lower zones. Neurological examination revealed retrograde amnesia and a positive Babinski reflex on the left. In laboratory examinations, plasma glucose level was 420 mg/dL, +3 ketone in the urine, arterial pH: 7.18, ferritin >2.000, CRP: 109 mg/dL, procalcitonin >50 pg/mL. Minimal pleural effusion in both hemithoraces, and a light ground glass density with unclear borders in the right lung middle lobe lateral segment posterior peripheral area was observed in chest computed tomography (CT). In cranial magnetic resonance imaging (MRI), high signal areas and mild edema signals observed in the ventral's of both temporal lobes and temporoparietal lobes, subcortical areas in T2 and Flair were noted, and it was reported that those findings may be associated with metabolic events or encephalomyelitis. Diabetic ketoacidosis treatment protocol was initiated. Meropenem and teicoplanin antibiotherapy was started empirically due to increased acute phase reactants including procalcitonin and fever. Favipiravir was started with the pre-diagnosis of COVID-19 pneumonia due to the ground-glass densities in chest CT. The patient, whose fever did not respond to treatment during the follow-up, was evaluated as pericarditis, and colchicine and ibuprofen treatment was initiated. Since the patient's headache complaint did not resolve and retrograde amnesia was observed in the repeated mini mental test the treatment was changed with the pre-diagnosis of encephalitis. The anti-HIV test requested from the patient, whose fever and neurological findings continued despite the treatment changes, was reported as positive. HIV-RNA was detected as 115,200 copies/mL, and the CD4/CD8 ratio of the patient was measured as 0.23. Lumbar puncture was performed on the patient to evaluate in terms of opportunistic infections. No cells were observed in the cell count of the sent cerebrospinal fluid (CSF) samples, glucose, protein and LDH levels were observed as 113 mg/dL (simultaneous blood glucose 139 mg/dL), 50 mg/dL, 22 U/L, respectively. Bacteriological, mycological and mycobacteriological growth was not detected in CSF cultures. ARB and VDRL tests were negative in CSF, meningitis-encephalitis panel (CMV-DNA, VZV-DNA, HSV1-DNA, HSV2-DNA, HHV6-DNA, Enterovi-

rus-RNA, H. influenzae, N. meningitidis, S. pneumoniae, C. neoformans) resulted as negative. Rose-Bengal test performed for brucellosis was also negative. After the initiation of trimethoprim-sulfamethoxazole and dolutegravir, tenofovir disoproxil plus emtricitabine for opportunistic infection prophylaxis and anti-retroviral therapy, the patient's fever decreased. No pathology was observed in the control cranial MRI taken 1 week after the patient's neurological examination showed improvement.

Conclusions Despite the multiple antibiotic treatments given for high fever, it was observed that the high fever and neurological findings of the patient continued. Patient's fevers decrease just after the initiation of anti-retroviral treatment. Although there is no response to broad spectrum antibiotic treatments given for the fever symptom, which is often associated with opportunistic infections during the course of AIDS, it can be speculated that HIV itself may cause high fever, based on the regression of fever just after the initiation of antiretroviral treatment.

EP039

Hypertriglyceridemia Induced Recurrent Pancreatitis Case

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Background Hypertriglyceridemia is the third most common cause of acute pancreatitis at the rate of 1-4% following cholelithiasis and alcohol use. Hypertriglyceridemia caused by defects in lipoprotein mechanism can be primary (genetic) or secondary (alcohol use, diabetes mellitus, obesity, hypothyroidism, nephrotic syndrome or drug use). Primary and secondary causes may coexist in patients. The presence of metabolic syndrome is also an important factor contributing to the development of hypertriglyceridemia. In this case, a pancreatitis case with type 2 diabetes, obesity and dyslipidemia is presented.

Material and Methods A 31 year old male patient admitted to emergency room due to acute onset epigastric pain radiating to the back.

Results His medical history included type 2 diabetes mellitus diagnosed 1 year ago and hospitalization due to acute pancreatitis seven months ago. He was using his insulin glargin, insulin aspart and fenofibrate medications irregularly. He had no alcohol use and 14 pack-years of smoking in his history. His height was 180 centimeters and weight was 122 kilograms and body mass index calculated 37 kg/m², body temperature was 36.7°C, blood pressure was 110/70 mmHg and pulse rate was 78 beat/minute on admission. On PE, had epigastric tenderness. Total cholesterol 340 mgdL, triglyceride 3,117 mg/dL, LDL 211 mg/dL, amylase 131 mg/dL, serum glucose 249 mg/dL, HbA1c 10% in his laboratory tests. There was no acidosis in ABG measurement. His abdominal CT revealaed concordance with acute pancreatitis. Ranson criteria: 1 points. In treatment; 4-6 liters/day intravenous fluid, 0.1 IU/kg/h insulin infusion and 5% dextrose infusion (to avoid hypoglycemia) was given intravenously at the same time. 3th day after admission, his oral nutrition and diabetes mellitus treatment was regulated. 8th day after admission, triglyceride was 642 mg/dL, total cholesterol was 227 mg/dL and serum glucose was 201 mg/dL in laboratory tests. Fenofibrate and omega-3 prescribed, a diet program was scheduled for obesity and he discharged 8 days after admission.

Conclusions The relationship between hypertriglyceridemia and pancreatitis -which is an acute life-threatening complication- is poorly understood. In HTGP, a decrease in triglyceride concentration is a management priority. Rapid triglyceride lowering can be provided by insulin or plasmapheresis. Therapeutic plasma exchange (TPE) and double-filtration (DF) provides a direct option for the removal of pathogenic substances. However, both of these therapies are expensive and not widely available, and have risks for infection and allergic reactions. Analgesia, prophylactic anticoagulation, lipid lowering agents (fibrates as first choice) and supportive therapies like oxygen, fluid replacement and antibiotics if necessary are used for treatment additionally depending on the severity of acute pancreatitis. Adjuvantly, middle chain fatty acids, niacin, microsomal transport protein inhibitors and also gene therapy can be used. It is also important that avoiding triglyceride increasing agents. As HTGP often presents in patient with uncontrolled diabetes, insulin is frequently used as treatment to lower both blood glucose and triglycerides. Weight control also contributes to the control of hypertriglyceridemia. In this case, clinical improvement and rapid triglyceride reduction was observed in the patient with insulin infusion therapy without the need for plasmapheresis.

EP040

Premenopausal Osteoporosis in a Patient with Autoimmune Polyglandular Syndrome: A Case Report

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Background Osteoporosis is a skeletal disease characterized by low bone mass associated with decreased bone strength and increased fracture risk. Low bone mass may be associated with insufficient peak bone mass acquisition and/or ongoing bone loss. The peak bone mass, which reaches 90% by the age of

eighteen, is reached around 30. Family history, gender, and race account for the bulk of peak bone mass, while nutrition and exercise are responsible for 25%. Osteoporosis is most common in postmenopausal women. Low bone mass is less common in premenopausal women. Bone loss in the premenopausal period may be due to secondary causes such as estrogen deficiency, glucocorticoid exposure, malabsorption, hypothyroidism, and hyperparathyroidism, as well as idiopathic. Bone mineral densitometry (BMD) measurements alone should not be used to define premenopausal osteoporosis. A young woman with low BMD for age (Z score -2.0) and risk factors for fracture or secondary osteoporosis (such as glucocorticoid therapy, secondary to hypogonadism, hyperparathyroidism, or vitamin D deficiency) can be defined as pre-menopausal osteoporosis.

Material and Methods A 21-year-old female patient with type 1 diabetes mellitus, autoimmune thyroiditis, adrenal insufficiency, Sjögren syndrome, fibromyalgia, primary biliary cholangitis, autoimmune hepatitis diagnosed as an autoimmune polyglandular syndrome was admitted to an external center with the complaint of widespread bone pain after long-term steroid use.

Results The patient was diagnosed with osteoporosis due to BMD and clinical evaluation, and intravenous zoledronic acid treatment was initiated. The patient applied to the endocrinology outpatient clinic with complaints of recurrent bone pain and amenorrhea. In current BMD measurement, femur total Z score -3.1, BMD 0.620 g/cm2, L1-L4 Z score -2.2, BMD 0.892 g/cm2, calcium 8.2 mg/dL, phosphorus 2.9 mg/dL, 25-OH vitamin D 13.3 mg/L, ALP 88 U/L, parathyroid hormone level 186 mg/L, FSH 0.73 IU/L, AST 14 U/L, ALT 17 U/L, creatinine 0.67 mg/dL. Vitamin D, calcium, and combined estrogen-progesterone were started in the amenorrheic patient, whom we evaluated as premenopausal osteoporosis, and a lifestyle change was recommended. Her steroid dosage was reviewed. Bisphosphonate treatment was not planned because of her reproductive age.

Conclusions The relationship between BMD and fracture risk is not correlated in premenopausal women, and the fracture prevalence is much lower than in postmenopausal women. As the relationship between bone mass and fracture risk in premenopausal women is not the same as in postmenopausal women, guidelines for the diagnosis of osteoporosis and the treatment of bone mass-based osteoporosis in postmenopausal women do not generally apply to premenopausal women. In women diagnosed with premenopausal osteoporosis, treatment should be directed to the underlying cause. The pharmacological [calcium (1000 mg/day), cholecalciferol (800-1500 IU/day)] and non-pharmacological approaches (lifestyle changes) are recommended for women with premenopausal osteoporosis. Lifestyle advice is regular exercise (such as walking), avoiding smoking and alcohol consumption, and limiting caffeine consumption. Estrogen replacement has beneficial effects on bone mass in women with premenopausal osteoporosis secondary to hypogonadism. Publications are showing that bisphosphonates are useful in women diagnosed with premenopausal osteoporosis secondary to glucocorticoid. As in our case, the treatment plan for premenopausal osteoporosis should be tailored to the patient. If there is an underlying secondary cause, the treatment should be directed to this cause.

EP041

Large Ganglioneuroma Case Mimicking as An Adrenal Adenoma

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Background Ganglioneuroma (GN) is a rare tumor with benign behavior mainly originating from the neural crest's common primitive cells. Histologically, it consists of Schwann and ganglion cells. The tumor is mostly located along the length of the sympathetic chain. It is most commonly seen in the posterior mediastinum and then in the retroperitoneum. It is often difficult to diagnose. It is most common in children and women. The tumor is not associated with hormonal activity and is usually clinically non-functional. Here, we presented a 49-year-old female patient diagnosed with GN after adrenalectomy with a mass in the right adrenal gland.

Material and Methods A 49-year-old female patient, who was examined for abdominal pain, was admitted to our center after the abdomen's magnetic resonance imaging revealed a lesion of 81x48x92 mm in the right adrenal gland together with a stone in the gallbladder (Figure 1).

Results No pathological finding was detected in the physical examination. There was no comorbid disease other than hypertension in the patient's history, and her blood pressure was under control with the use of 10 mg amlodipine. The hormonal activity was not detected in the patient's examinations for adrenal lesion, and it was considered non-functional. Right adrenalectomy was performed on the patient due to the size of the lesion. In the pathological study of the operation material, no pathology was found in the right adrenal gland. The mass adjacent to the adrenal gland was stained positively with S100, NSE, and synaptophysin, and ganglion cells were seen in the material, and the report was compatible with GN.

Conclusions GN are generally rare benign lesions. It is seen equally in men and women. Two-thirds of the cases are under the age of 20. It may occur spontaneously or as maturation or metastasis of neuroblastoma after chemotherapy or radiotherapy. They are mostly asymptomatic and are discovered incidentally during imaging. However, some large GN can cause compression symptoms. Most GN do not secrete catecholamines or steroid hormones. Rarely, diarrhea, hypokalemia, and hypertension can be seen due to the vasoactive intestinal polypeptide secreted. The treatment of adrenal incidentalomas varies according to the lesion's functional status and whether it is malignant. Hormonally active lesions should be surgically removed regardless of their size. Hormonally inactive lesions smaller than 4 cm should be followed up, and surgery should be planned in case of progression. A transparent approach has not been determined for asymptomatic adrenal lesions between 4-6 cm. However, surgery should be recommended for adrenal lesions larger than 6 cm. In the treatment of adrenal GN, the first choice is surgical resection. Right adrenalectomy was performed in our patient because the size of the lesion was greater than 6 cm. Today, detection of adrenal lesions has become easier thanks to the ease of access to imaging examinations. Because GNs are radiologically similar to other tumors, they

are difficult to diagnose preoperatively. It should be kept in mind in the differential diagnosis, especially in asymptomatic masses that are not hormonally active.

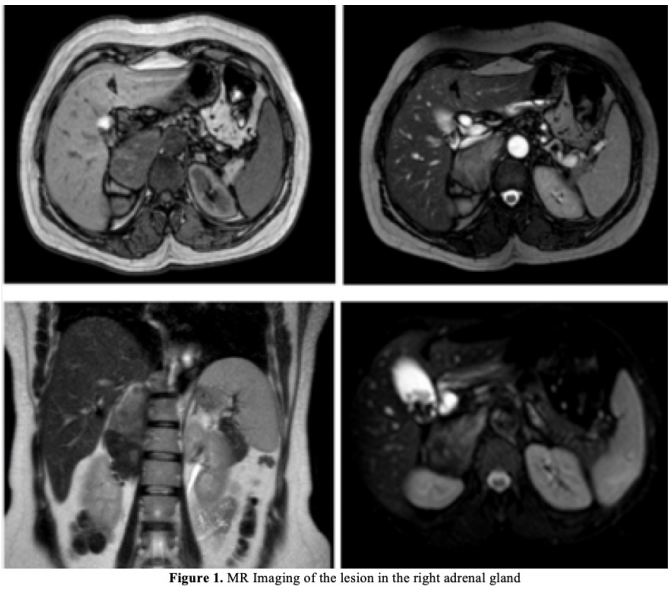

Figure 1. MR Imaging of the lesion in the right adrenal gland

EP042

A Case of Infective Endocarditis Diagnosed by PET-CT

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Background Infective endocarditis (IE) is a microbial endovascular infection of intra-cardiac structures that come into contact with blood, including intrathoracic vessels and intra-cardiac foreign bodies. Despite all recent developments in the diagnosis and treatment of IE, it is still a fatal and morbid disease, and there are difficulties in its diagnosis and differential diagnosis. We will present an IE case with a history of aortic valve replacement (AVR) + Benthall operation, in whom vegetation could not be demonstrated in transthoracic echocardiography (TTE) and transesophageal echocardiography (TEE) imaging, who did not meet Duke's exact diagnosis criteria and was diagnosed with PET-CT.

Matherial and Methods A 54 years old male patient with known hypertension, who had a Benthall+AVR operation due to an aortic aneurysm in April 2019 and a history of hemorrhagic cerebrovascular accident in July 2020, was admitted to the emergency room with a fever of up to 39 ° C and palpitations.

Results With a pre-diagnosis of infective endocarditis, he was interned at the Cardiology Clinic. It was learned that the patient had an intensive care unit hospitalization for 1 week and a clinic for 4 weeks due to sepsis in the external center, and no apparent fever focus was detected during this time. Still, he received teicoplanin, meropenem, and gentamicin iv antibiotics. These treatments were completed and discharged. In the patient's physical examination, there were no additional findings except a 2/6 systolic murmur in all foci, especially in the aortic valve. Osler nodules, Janeway lesions, Splinter hemorrhage, were not detected. Vital signs: blood pressure: 110/70 mmHg, fever: 38.1 °C, pulse: 130 bpm. ECG: 130 bpm, sinus tachycardia. Laboratory tests: CRP: 172 mg/L, ESR: 63 mm/h, RF: 38 IU/mL, leukocyte: 11,160 K/μL, neutrophil: 9,849 K/μL. Ceftriaxone + vancomycin iv treatment was initiated upon Infectious Diseases' recommendation by taking 6 blood cultures from the patient. Q fever CF, anti-HIV, VDRL, Syphilis IHA, Rose bengal, and Brucella agglutination was negative. The urine culture was sterile. No intraabdominal abscess or collection was detected in the abdominal USG. E.coli growth (sensitive to ceftriaxone) was detected in the first two blood cultures. No vegetation was observed in the TTE. Ejection fraction detected as 60%. Minimally mitral regurgitation, a max. 26 mmHg and average 12 mmHg systolic gradient was observed in the mechanical prosthetic valve in the aortic position minimal degree aortic insufficiency, 1st-degree tricuspid, systolic pulmonary artery pressure according to the tricuspid regurgitation method: 36. 1.1 cm pericardial fluid was detected in the posterior wall. Verrucous vegetation was not observed in TEE. Tumor markers were within normal limits, and there was no finding in favor of malignancy in the patient. The patient with a Benthall operation history was investigated in terms of graft infection. The thorax CT scan of the patient revealed a 6 mm defect in the anterior aortic wall just below the aortic replace valve and contrast material filling from this level towards the superior adjacent to the aorta. The pseudoaneurysm was considered in the patient whose appearance was limited in this area. Thereupon, PET-CT was planned for the patient in light of current guidelines. In PET-CT, an increase in focal metabolic activity was observed in the posterior neighborhood of the graft. SUVmax: was 6.4. Cardiology-Cardiovascular Surgery council decided to operate with the diagnosis of IE.

Conclusions In the 2015 IE Guideline of the European Society of Cardiology (ESC), it is recommended to use 18F-FDG PET/CT or SPECT/CT to show cardiac involvement, especially in patients with possible or rejected IE diagnosis with echocardiographic examination results, in case of continuing suspicion of IE. In this case, we wanted to emphasize that PET-CT was diagnostic in cases where vegetation was not detected in TTE, did not meet Duke definitive diagnostic criteria, and the suspected IE persists.

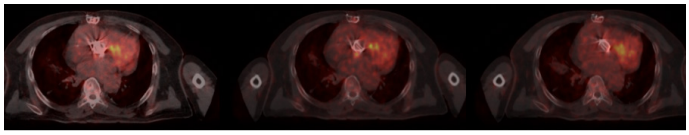

Figure 1. PET and CT images of the case with IE

EP043

Spinal Cord Compression due to Extramedullary Hematopoiesis in a Patient with-Thalassemia Intermedia: Case Report

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Background β-Thalassemia is a genetic disorder characterized by chronic anemia caused by ineffective erythropoiesis due to mutations in the β-globin gene. Thalassemia is classified as major, intermedia, and minor according to the severity of anemia. Beta thalassemia intermedia is not anemic enough to require transfusion. Extramedullary hematopoiesis (EMH) refers to hematopoiesis outside of bone marrow. EMH tends to occur in areas where active hematopoiesis is observed in fetal life as a physiological response to ineffective erythropoiesis in patients with thalassemia intermedia. Spleen, liver, pleura, lungs, gastrointestinal system, breast, skin, kidney and adrenal glands, dura mater of brain and spinal cord may contain primitive hematopoietic tissue from fetal life. These patients may be complicated by leg ulcers, gallstones, thrombosis, pulmonary hypertension, splenomegaly, and iron overload, apart from EMH. Rarely, as mentioned in the presented case, EMH in the epidural space can compress the spinal cord. Many treatment options are available, including transfusion therapy for complications, iron chelation therapy, modulation of fetal hemoglobin production, surgery, radiotherapy, and hematopoietic stem cell transplantation.

Material and Methods A 34-year-old male patient, with a known medical history of beta-thalassemia intermedia, had not received blood transfusions, was followed up with 50 mg/day hydroxyurea treatment, presented with complaints of severe pain spreading to the leg, difficulty in moving the toes, burning in the toes and soles, numbness, tingling and foot sole collapse. His complaints had progressed within the last month.

Results He could be mobilized independently in a short distance. There was neuropathic pain in both soles and toes on physical examination, and there was no urinary and stool incontinence. Hypoesthesia in L4-L5 dermatomes and dysesthesia in S1 and distal sacral dermatomes were detected. On motor examination, the right and left toe first finger's plantar flexion muscle strength was 1/5. Bilateral Achilles tendon reflex and plantar reflexes were not detected in deep tendon reflex examination. Sacrum MRI revealed massive solid lesions with hypointense T1W images, hyperintense in T2W images, and intense contrast feature in T1W images, which obliterate the presacral fat planes in the sacrum and sacrococcyx region compatible with extramedullary hematopoiesis, showing the epidural distance along the sacral foramina and filling the spinal canal. An extremely hypointense appearance was observed in the sacrum and all of the lower lumbar vertebra's bone structures, consistent with increased hematopoietic activation in T2W images. PET-CT was performed to exclude other malignancies and to confirm the diagnosis. In PET-CT, soft tissue density showing SUVmax: 3.3 metabolic activity at a level equal to the liver average activity with presacral extension filling the sacral foramina in the sacrum was determined. From the T11 vertebra level upward, around the bilateral thoracic vertebrae, the lesions showing metabolic activity at a level equal to the liver's average metabolic activity measured as 29x46 mm in the vicinity of the T11 vertebra were detected. Findings were consistent with EMH. The patient was evaluated by neurosurgery because of the compression findings. The patient, whose operation was not recommended, was taken to the 20 fx radiotherapy program. In the current physical examination of the patient whose fraction seven was completed, it was found that neuropathic pain completely regressed, hypoesthesia in L4-L5 dermatomes decreased, and the plantarflexion muscle strength of the right and left foot first finger was 5/5. The patient's radiotherapy continues, and a dramatic response was achieved on the 7th day of the treatment.

Conclusions There is no evidence-based guideline for the treatment of spinal or paraspinal pseudotumors caused by EMH. Treatment options include corticosteroids, blood transfusion, hydroxyurea, radiotherapy, surgical decompression, or a combination of these modalities. Therapy generally depends on the severity of the symptoms, the mass's size, the patient's clinical condition, and previous treatment.

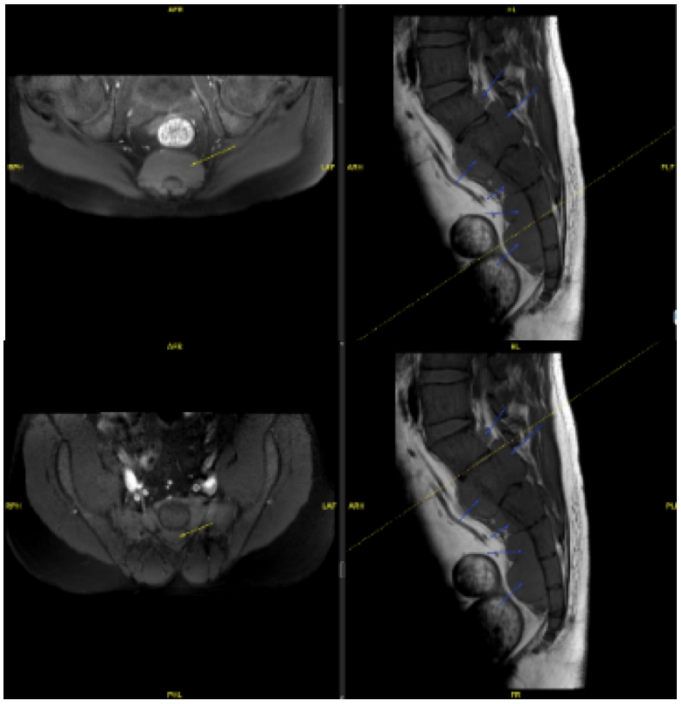

Figure 1. Spinal cord compression due to extramedullary hematopoiesis in MR imaging

EP044

Enteric Adenocarcinoma Arising from Mediastinal Teratoma in A Man: A Case Report

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Background Teratomas are a type of germ cell tumor that may be gonadal or extragonadal localized and show the malignant transformation. Adenocarcinoma is the most common histological subtype in malignant transformation. Here, we presented a patient with enteric adenocarcinoma based on teratoma presenting with a sternum-invasive mediastinal mass.
Material and Methods 54-year-old male patient presented with chest wall swelling under the right neck that started 9 months ago and progressed.
Results In the patient's thoracic computed tomography, a 68x57 mm lobulated contoured mass in the right half of the mediastinum and extending to the manubrium sternum in the anterior was detected. Pathological evaluation of the trucut biopsy from the mass was reported as adenocarcinoma (cytokeratin 20 and CDX2 positive, cytokeratin 7, PSAP, TTF1, Napsin A, chromogranin, and synaptophysin negative). However, histomorphological and immunohistochemical features of the tumor were not compatible with conventional type pulmonary adenocarcinoma, and it was recommended to exclude the possibility of metastatic carcinoma. The patient's esophagogastric endoscopy and colonoscopy were unremarkable. However, the patient did not continue with the examination and treatment. A 12x12 cm mass in the sternum and 2 x 3 cm masses in the scalp were detected in the patient's physical inspection admitted to the hospital one month ago with oral intake disorder and shortness of breath. The patient who was tachypnea had severe dyspnea at rest and exertion, and oral intake was low. In PET CT of the patient, in the lymph nodes with a diameter of 28x31 mm in the right supraclavicular area, the central mass that destructs the sternum by filling the mediastinum almost completely, showing prominent expansion in the anterior and protruding under the skin by deviating the trachea to the left is a heterogeneous lesion with an increased mass of 84x124x151 mm -18 FDG uptake was observed (Suv-max 8.22). The biopsy was repeated from the patient from the lesion on the manubrium sterni. Pathology result reported that adenocarcinoma infiltration/metastasis was consistent with enteric adenocarcinoma developed on a teratoma background (there was no staining with TTF 1, Napsin A, PSA, cytokeratin 7, chromogranin, synaptophysin, MUC 5AC, but diffuse strong staining with cytokeratin 20, EMA, CEA, CDX2, MUC 1). Pathological examination of the 2x3 cm lesion on the patient's scalp was evaluated to be consistent with adenocarcinoma metastasis. Upon developing VCSS in the patient, 20 Gy in 5 fractions of 9400 cGy/day (in sitting position because the patient could not lie down) was given palliative. The first step, palliative chemotherapy, was planned for the patient. In the follow-up after the first cycle, it was observed that the patient's clinical findings started to regress. Follow-up and treatment of the patient continue.
Conclusions Mediastinal teratomas show different clinical behaviors, but they are associated with rapid progression and poor prognosis when malignant transformation develops. In cases where surgery is possible, survival is similar to patients without malignant transformation, although it is incurable in metastatic patients.

EP045

Approaches to Dyslipidemia Treatments of Doctors of Family Medicine Discipline in Different Steps

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Background Cardiovascular diseases are the leading causes of death in our country and in the world. In our study, we aimed to show the approach of physicians at different academic stages in family medicine discipline to the treatment of dyslipidemia, which is one of the most important risk factors of cardiovascular diseases.
Material and Methods Our study was conducted between 01.01.2019 - 01.03.2019 in 189 (73%) of 259 family physicians actively working in the city of Kadıköy and its district, with face-to-face interviews and online survey filling. Opinions of the physicians participating in the study about their dyslipidemia and statin treatment were obtained with a questionnaire consisting of 32 questions about the demographic data, diagnosis and follow-up of dyslipidemic patients, their knowledge and experience about statin treatment.
Results It was observed that resident family physicians followed more chronic diseases than both specialist and general practitioners ($p<0.001$). Specialist family physicians think that they have more information about the diagnosis and treatment of dyslipidemia than general practitioner family physicians and general practitioner family physicians ($p=0.001$). It has been observed that assistant and specialist family physicians follow drug efficacy, duration of treatment and side effects more than general practitioners ($p=0.001$). 29.8% (n=25) of practitioner family physicians, 50.8% of assistant family physicians (n=31) and 68.3% (n=28) of specialist family physicians stated that they follow the latest guidelines. It has been observed that specialist family physicians follow more guidelines than assistant family physicians and assistant family physicians follow general practitioners ($p<0.001$).
Conclusions The fact that family physicians perform diagnosis, treatment and follow-up with cardiovascular diseases along with current guidelines will increase the quality of life of the

patient in the first step and decrease the accumulation in the 2nd and 3rd step health facilities. However, the rapid change of these guidelines requires physicians to renew themselves quickly.

EP046

Approaches to Dyslipidemia Treatments of Doctors of Family Medicine Discipline in Different Steps

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Background Fluid collections that occur as local complications in the late period after acute pancreatitis consist two categories: pancreatic pseudocyst and walled-off necrosis (WON). WON is encapsulated pancreatic/peripancreatic necrosis surrounded by a well-defined inflammatory wall. Radiological findings such as septations, intra-cyst debris, and thick cyst wall. WON may be asymptomatic or may cause symptoms as fever, pain, nausea, vomiting. It may become infected, cause sepsis, or manifest itself as a result of pressure on adjacent organs or may cause pancreatic fistula/perforation. In this case; a WON as a pancreatitis complication compresses the main portal vein through the mass effect.The patient also complicated by splenic vein thrombosis and portal hypertension occured due to these reasons.
Material and Methods A 43-year-old female was admitted to the emergency with epigastric pain radiating to the back, and was diagnosed with acute pancreatitis and ileus.
Results She had a history of pancreatitis 4 years ago and had familial hyperlipidemia. She was using fenofibrate and pancreatic enzymes irregularly. Glucose was 286 mg/dL, amylase was 662 U/L, and triglyceride was 2,039 mg/dL. No acidosis in ABG. CRP was 100 mg/L. Leukocytosis was seen in the CBC. Fever was 36.4 °C, pulse was 103 beat/min. Widespread abdominal tenderness and defense was observed on her physical examination. Rebound and skin rash wasn't observed. CT report revealed that significant loss of calibration is observed at the main portal vein level secondary to the necrosis compression. It is compatible with necrotizing pancreatitis. Splenic vein appears to be thrombosed. BISAP was 1, Marshall was 0, Ranson was 48th hour 4 (mortality 15%). IV hydration, oxygen, anticoagulant, nasogastric tube, antibiotherapy (high APR and fever) and insulin infusion was given to the patient. Subcutaneous insulin, fenofibrate and omega-3 were added as oral feeding started on 3rd day. She was discharged with anticoagulant and nutritional recommendations as amylase and triglyceride levels returned to the normal on 18th day. At the follow-up 1 month after discharge, she had mild epigastric pain. Current CT: "Significant loss of calibration at the main portal vein that considered secondary to the WON compression. An encapsulated WON is observed at the pancreatic head, trunk and it's covering the duodenum 360°, extending up to the splenic flexure, 3x7cm at its widest part. It affects the parenchyma more than 50%. "Varicose veins in the fundus and corpus were observed in the patient's gastroscopy. There were signs of portal hypertension in the portal doppler ultrasonography.
Conclusions Although portal hypertension is common after pancreatitis, one of the most common causes is thrombosis due to inflammation and hypercoagulability caused by pancreatitis. It is frequently seen in the literature that pancreatic cysts and tumors can cause portal hypertension indirectly. In some cases, it has been observed that the mass directly compresses the portal vein. However, it has not been observed –as far as accessed- in the literature that pancreatic walled-off necrosis directly compresses the portal vein with the effect of a mass. In this respect, this case can be considered as a rare case. The first treatment option in symptomatic or infected WON is endoscopic cyst drainage and endoscopic necrosectomy. In cases where endoscopic treatment cannot be applied, surgical treatment may also be considered.

EP047

A Rare Cause of Hypokalemia in Pregnancy: Thyrotoxic Hypokalemic Periodic Paralysis

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Background Thyrotoxic hypokalemic periodic paralysis is a rare complication of hyperthyroidism, and its prevalence varies between 0.1% and 2% in patients with hyperthyroidism. Thyrotoxic hypokalemic periodic paralysis in pregnant women is much less common, and only a few case reports have been reported in the literature. During attacks, hyperthyroidism, hypokalemia, and generalized weakness affecting mostly proximal muscles are observed. Attacks are often triggered by heavy physical activity, stress, or excessive carbohydrate intake. Here we presented a 12-week-old pregnant patient who was admitted with generalized muscle weakness and was diagnosed with thyrotoxic hypokalemic periodic paralysis.
Material and Methods 39-year-old female patient with 12 weeks of pregnancy presented with complaints of intermittent fatigue, generalized muscle weakness, and nausea for 3 months.
Results There was no pathology in the vital signs except tachycardia (pulse: 110/min). On her neck examination, a grade 1 palpable thyroid gland was found. Neurological examination revealed 3/5 proximal muscle weakness and 4/5 distal muscle weakness in the upper and lower extremities. In laboratory examination, K: 1.59 mEq/L (3.5-5.5), free T3: 5.86 pg/mL (2.3-4.2), free T4: 3.22 ng/dL (0.89-1.76), TSH: 0.008 mIU/mL (0.55-4.78) was detected. With these findings, thyrotoxic hypokalemic periodic paralysis was considered in the patient. Clinically, a dramatic improvement was observed with potassium replacement. Graves' disease was diagnosed in the patient

who was positive for thyroid receptor antibodies and had grade 1 blood flow on thyroid doppler USG. Propylthiouracil was started considering the pregnancy status of the patient. It was observed that the fT3-fT4 level was found to be normal 1 week after the antithyroid medication was initiated and that there was no need for potassium replacement.

Conclusions Thyrotoxic hypokalemic periodic paralysis during pregnancy is a rare cause of hypokalemia. Similar to the cases reported in the literature, with antithyroid treatment, free T3-free T4 level was maintained normal and improvement in hypokalemia. Potassium level should definitely be evaluated in patients presenting with muscle weakness. Thyroid function tests should also be requested in patients with hypokalemia, keeping in mind thyrotoxic hypokalemic period paralysis in the differential diagnosis, even if pregnant.

EP048

Primary Rectum Malign Melanoma Case Report

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Background Melanoma is a tumor that develops as a result of malignant transformation of melanocytes. Melanoma whose primary localization is often the skin is one of the most common cancers that metastasize to the gastrointestinal tract. However primary rectal malignant melanoma is rare. We aimed to present a primary rectum malignant melanoma case.

Material and Methods A 74-year-old female patient was admitted to the emergency department with complaints of abdominal pain, fresh bleeding and constipation.

Results There is not a systemic disease in her family history. She had abdominal tenderness in the left lower quadrant on physical examination and she had fresh-colored blood on the rectal examination. Blood count revealed: hemoglobin 7.9 g/dL, platelet: 320,000/µL. Emergency surgery was not considered by general surgery. Colonoscopy was planned for the patient whose hemodynamics was stable. The biopsy was taken from the fragile mass that caused stenosis in the lumen at the 6th cm from the anal canal in the rectum. Immunohistochemical staining S100 (+), EMA (+), HMB45 (+), MART-1 (+), CD117 (-), DOG-1 (-), SMA (-), desmin (-),synaptophysin (-) Detected, PanCK (-), CDX2 (-), calretinin (-), CK5/6 (-), WT-1 (-), CD99 (-). Histopathological diagnosis was reported as rectal malignant melanoma. Skin and ocular examination showed no lesions in terms of melanoma. In terms of systemic staging, PET CT showed the mass lesion in the rectum, lymph nodes in pararectal fat areas, nodular implants in mesenteric fat areas, the nodular lesion in the right adrenal gland, the hypodense lesion in the right lobe posterior of the liver, metastatic nodules in both lung parenchyma, left parapharyngeal, posterior cervical and inferior jugular lymph nodes, metastatic focus like osteolytic lesion in C2 and T10 vertebrae (Figure 1). No metastasis was observed in cranial magnetic resonance imaging. BRAF V600E mutation was detected negative. Cisplatin and temozolomide chemotherapy was started treatment in the patient due to metastatic rectal malignant melanoma. Palliative radiotherapy and bisphosphonate therapy was initiated for painful bone lesions. The patient was hospitalized due to febrile neutropenia and acute renal failure in the follow-up. Ipilimumab was initiated due to poor tolerance of cytotoxic chemotherapy and disease progression. After 4 cycles of ipilumab, regression in the mass of the primary rectum, newly formed inguinal lymph nodes, new metastatic lesions in the liver, multiple metastatic nodular lesions scattered in both lung parenchyma, metastatic lesions in C1, C2, C7 vertebrae and left mandible were observed in PET CT (Figure 2). The patient's general condition was poor so she did not want to continue the treatment. The patient was implemented palliative support therapy. She died after 2 months in her follow-up.

Conclusions For the diagnosis of primary intestinal melanoma, a solitary lesion, no previous resection of skin or ocular lesions, morphology compatible with the primary tumor, no synchronized melanoma during surgery can be used as criteria. HMB 45, MART-1 and S100 are positive in histopathological staining. Depth of infiltration, disease stage, lymph node status, patient age and performance are the most important determinants of prognosis. Poor prognosis is often positive lymph nodes,unresectable tumors and advanced-stage patients. Cases are generally resistant to chemotherapy. According to immunotherapy responses, primary rectum malignant melanoma is lower than primary skin malignant melanoma.

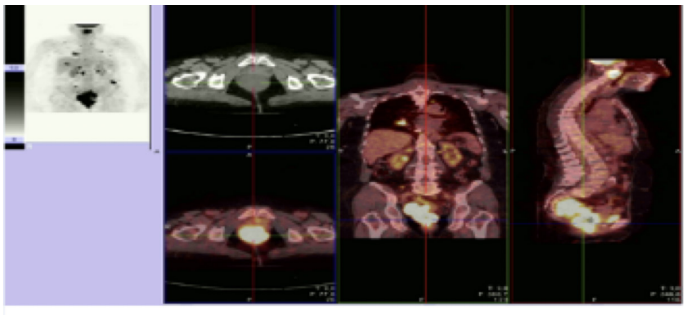

Figure 1. At the time of diagnosis PET CT images

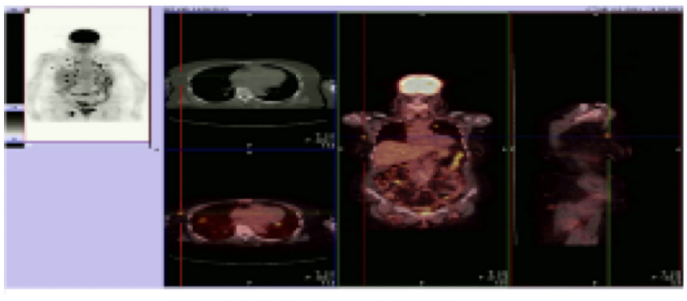

Figure 2. At the time of progression PET CT images

EP049

Recognizing The Sarcoidosis Behind The Window of Infection

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Background Sarcoidosis is a chronic multisystemic inflammatory disease of unknown etiology, often associated with pulmonary involvement and characterized histopathologically by noncaseating granulomatous lesions. The most common clinic features are respiratory symptoms (cough, dyspnea, bronchial hyperreactivity), fatigue, night sweat, weight loss, and erythema nodosum. Fifty percent of the sarcoidosis patients are asymptomatic, and their diagnosis are usually made with the detection of the bilateral and/or unilateral, hilar and/or paratracheal fullness, seen in the chest X-ray taken for other reasons. Cellulitis is a suddenly starting and rapidly spreading infection that affects the skin and subcutaneous adipose tissue. The responsible pathogen is usually Staphylococcus aureus and Streptococcus pyogenes. They are generally unilateral lesions in the lower extremities that do not have a sharp boundary with intact skin. It may present with local symptoms such as erythema, swelling, warmth, pain and tenderness or systemic symptoms such as fever, chill, shivering and malaise. These signs of cellulitis sometimes can be confused with erythema nodosum seen in the course of sarcoidosis. In this report, we aimed to present a 32-year-old patient who was hospitalized with a pre-diagnosis of cellulite, diagnosed with sarcoidosis based on skin lesions, and whose symptoms completely regressed with sarcoidosis treatment.
Material and Methods A 32-year-old patient who have repetitive admission to several hospitals with the complaints of chills, shivering, fever, and redness of the legs in the last month. Various oral and parenteral antibiotics was prescribed with a pre-diagnosis of cellulitis.
Results During the follow-up the patient's complaints did not relieve and the lesion which was initiated from the right tibial region spreaded to both lower and upper extremities. The lower extremity superficial tissue ultrasonography was reported as cellulitis. He was hospitalized with the pre-diagnosis of multiple cellulitis for further examination. The history of the patient related to the lesions reveals that the lesion was first appeared three weeks ago and progressed despite the treatments given in the outpatient clinic. Clinical and laboratory findings did not improve despite antibiotic treatment. Erythema nodosum was considered as a differential diagnosis. Chest X-ray reveals bilateral hilar lymphadenopathy. Steroid and indomethacin treatment was initiated with the pre-diagnosis of sarcoidosis, and antibiotherapy was stopped. During follow-up, the skin lesions were completely resolved within 3 days.Further evaluation for the other organ involvement of sarcoidosis was performed. No uveitis, cardiac arrythmia, hepatomegaly and splenomegaly were observed. The patient was discharged after the complete clinical and laboratory remission.
Conclusions Keeping the differential diagnoses on a large scale and making the true diagnosis among these differential diagnoses is the key to reach an effective treatment promptly. Although radiological and laboratory tests are powerful guides in diagnosis, the role of history taking and physical examination is undeniable. Early diagnosis of the patient with detailed history, physical examination and accurate laboratory and imaging tests are important for starting an effective treatment as soon as possible. The early diagnosis of a systemic, chronic disease affects the prognosis of the disease positively. Early initiation of necessary treatments by early recognition of multiple organ involvement and chronic injuries plays an active role in preventing complications related to disease-related chronicity. The most difficult patients are the patient who come with a pre-diagnosis. For this reason, we should approach each patient with an objective perspective and consider possible differential diagnoses, even if they come with a prediagnosis.

EP050

Dyslexia and Health

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Background Dyslexia is a very common learning disability. In the field of health, health education for patients and healthy individuals is very important in terms of protecting and improving health. It is thought that the knowledge and awareness of healthcare professionals about dyslexia will contribute to both increasing the effectiveness of health education and preventing health problems that patients with dyslexia may encounter. This review has been prepared to increase the awareness of healthcare professionals about dyslexia.
Results Dyslexia is a learning-reading difficulty that is claimed to be of neurological origin and can be seen in every individual, regardless of culture, race, gender and society. Dyslexia has been commonly associated with mental retardation in society and its development has been linked to family dynamics. Although dyslexia is generally associated with obesity problems and low socioeconomic status, neurobiological causes are involved in the main pathology of dyslexia. In studies conducted to date, it has been observed that the right or left hemispheres of the brain do not develop or are underdeveloped, and the brain structure is thin and narrow in individuals diagnosed with dyslexia. In other studies on

the etiology of dyslexia, it is assumed that low weight births, prenatal and postnatal problems, attention deficit disorders, eating habits, some types of allergies, visual/auditory/perceptual and similar problems are associated with specific learning difficulties. Dyslexia is a multidimensional learning disability. Therefore, dyslexia is classified into four groups according to the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders): Reading disorder (Dyslexia), Arithmetic disorder (Dyscalculia), Written expression disorder (Dysgraphia) and Learning disorders that cannot be named otherwise. After the diagnosis of dyslexia, each individual should be considered separately, it should be determined in which dyslexia class the individual is in and in which areas they have difficulties, the presence of different pathologies in addition to dyslexia (psychiatric, etc.) must be done. Dyslexia is noticed late due to the low level of knowledge and awareness of the society on this issue. However, early diagnosis of this diagnosis of neurological and cognitive origin is extremely important in terms of protecting and improving health. If dyslexia is diagnosed at an early stage, individuals diagnosed with dyslexia with correct guidance can lead a healthy life, their quality of life increases and can be very successful. However, studies show that the knowledge and awareness of the society on dyslexia is not sufficient.

Conclusions Healthcare professionals have an important role in informing the society and increasing the level of awareness. The responsibilities of healthcare professionals in this regard are as follows:

• Explaining the concept of dyslexia to parents, educators, children or adults in settings such as schools and hospitals, providing information about the symptoms and types of dyslexia,

• Conducting projects and studies to increase the awareness of the society, ensuring that the society is aware of these activities

• Planning and implementing diagnostic initiatives at regular intervals for children at schools and for adults in workplaces and public places.

• Finding solutions for children and adults with learning difficulties to cope with the difficulties.

EP051 **Skin Findings in Diabetic Patients**

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Background Background Diabetes mellitus is a disease that develops due to partial or complete lack of insulin and progresses with chronic hyperglycemia and impaired carbohydrate-fat metabolism. The prevalence of diabetes is increasing in the world and in our country. Diabetes is a chronic disease that affects all organs and organ systems in the body directly or indirectly and can cause serious complications. This review was conducted to review the skin problems seen in diabetic patients.

Results Although many skin problems are seen in individuals with diabetes, dermotopathy and infections have generally come to the fore in studies. In individuals with diabetes, skin findings vary and vary according to factors such as the treatment process, the severity and course of the disease, the follow-up of the treatment, the age of the patient, and the care of the patient. Skin findings seen in diabetes can be classified into 4 groups:

1-) Skin findings associated with acute metabolic disorders of diabetes,

A.) Infections: Candida Infections, Dermotophyte Infections, Bacterial Infections

B.) Eruptive Xanthomatosis: Yellow Color Change in the Skin (Carotenosis)

2) Skin findings associated with chronic degenerative complications of diabetes: Diabetic Dermopathy, Bullosis Diabeticorum, Diabetic Thick Skin, Pigmented Purpuric Dermatosis, Diabetic Foot Syndrome

3) Skin findings that are common in diabetes but not associated with acute metabolic disorders or chronic degenerative complications: Necrobiosis Lipoidica Diabeticorum (NLD), Disseminated Granuloma Anulare, Acanthosis Nigricans, Vitiligo, Perforating dermatoses

4) Skin findings related to treatment complications: Lipoatrophy, Lipohypertrophy

Skin findings seen in diabetic individuals may affect the physical appearance of the individual and cause psychological problems in the individual, resulting in difficulties in the regulation of blood sugar. These findings, which negatively affect the course of the disease, should be considered together with the diagnosis of diabetes, preventive interventions should be made, regularly evaluated, followed up with physical examination and necessary laboratory tests. In order to prevent skin findings such as lipoatrophy and lipohypertrophy due to insulin use, the patient and their relatives should be given practical training about the use of insulin and the patient should be evaluated regularly in terms of skin findings that may develop due to treatment.

Conclusions In diabetic patients, both disease and treatment related skin findings can be seen. Evaluation of diabetic patients in terms of possible skin findings is extremely important for the success and effectiveness of the treatment.

EP052 **Nursing Education and Stress**

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Background It is necessary to provide a nursing education that includes sufficient theoretical and practical education in order to respond to the health problems and

needs of the society and to train nurses who are open to learning and are aware of their social responsibility. Students experience different levels of anxiety and stress during their nursing education. Curriculum and theoretical knowledge play an important role in reducing the stress experienced during clinical practice. This review was conducted to draw attention to the stress experienced by students during their nursing education.

Results During their nursing education, students may face various interpersonal and environmental stressors that affect their learning and performance. When the literature is examined, the factors that cause stress in students can be listed as physical, psychological, social, mental, clinical environment and situational. Clinical practice is an education in which students develop their problem-solving skills, learn about the multidisciplinary team approach, the principles associated with being in the clinic, the holistic approach and the roles of their colleagues. However, although clinical practice areas are an indispensable part of students' professional knowledge and skills development, they are also an important source of anxiety and stress for students. Students can give physiological, emotional and behavioral reactions due to the stress they experience. Fear of nursing students to fail exams and problems caused by the professor, team conflicts in the clinical environment, difficulties experienced during patient care, pain and suffering of patients, lack of knowledge, inability to cope in emergency situations, the attitude of clinical staff to the student, theoretical training in the clinic Problems such as incompatibility are cited as a source of stress. Stress in the nursing education process can negatively affect students' learning and performance. Individuals use different methods of coping with stress, depending on their individual characteristics. Effective use of methods of coping with stress contributes to the successful coping of stressful situations that individuals encounter in their life. However, in the event of intense stress, the students' correct thinking and decision-making process is disrupted and the student's motivation is negatively affected, thus his academic success may decrease. For this, the desired stress is the low stress level that has a motivating effect on students, that can be controlled and where appropriate coping methods are used. As a result, students may face high stress levels during their nursing education. For this reason, it is recommended to teach students methods of coping with stress, to implement interventions to reduce stress in students and to take measures.

Conclusions As a result, students may face high stress levels during their nursing education. For this reason, it is recommended to teach students methods of coping with stress, to implement interventions to reduce stress in students and to take measures.

EP053 **Chemotherapy-induced Taste Change**

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Background Taste change is one of the symptoms associated with chemotherapy. Depending on the chemotherapy protocol and different variables, the taste changes and the severity of the taste changes may differ between patients. This review draws attention to the development of taste changes in patients receiving chemotherapy and contributes to the maintenance of nutrition in chemotherapy patients.

Results Taste is generally distinguished by tongue, cheek mucosa, lips, and cheeks. The tongue is the most sensitive to salty and sweet sensations, and the palate is the most sensitive to sour and bitter feelings. Taste is generally the sweet, salty, sour and bitter perception felt when food is taken in the mouth. The sweet taste implies the presence of simple carbohydrates, while the salty taste indicates the presence of sodium and sometimes other ions. The bitter taste indicates the presence of potential toxins such as various plant alkaloids. The sour taste is stimulated by acids, and the sour taste is thought to be due to protons. Taste change is defined as the changes in taste perception experienced by the individual. It develops due to changes in taste, physiological changes, disease state, infections, neural injury, drugs, malnutrition and exposure to toxic agents and normal aging. Taste changes due to chemotherapy; It includes hypogeusia, mouthpiece, paragousia, calabash, phantogeus and hypergonia. However, cancer patients often complain that the food is "tasteless". This situation negatively affects the nutritional status of cancer patients and thus the treatment process.

Conclusions Evaluating the type and severity of taste changes in patients receiving chemotherapy is extremely important in terms of maintaining nutrition and success of the treatment. It is recommended that cancer patients be evaluated at regular intervals in terms of taste changes.

EP054 **Mushroom Poisons**

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Background Background Mushrooms are plants that are quite common in nature. It has been consumed by being collected from nature since ancient times and has become a food source with important commercial value today. Health problems that occur with the consumption of mushrooms are a common health problem in our country, which can even lead to death. This review has been prepared to draw attention to poisoning caused by mushroom consumption.

Results Although there are more than 5,000 mushroom species known in the world, the number of poisonous ones is around 100, and 15-20 species have potentially lethal characteristics when consumed. Amatoxins are cyclic octapeptides. Amanita phalloides is responsible for approximately 95% of deaths due to mushroom poisoning. In poisoning cases, the survival probability of the individual, age, time of admission to the hospital, type and amount of toxic substance, prioritization of the triage of intoxication cases in the emergency department, intensive care and monitoring facilities are important. Liver transplantation is life-saving in severe liver failure due to mushroom poisoning. The urgent transfer of patients with severe hepatic insufficiency to a specialized center for transplantation is one of the most important points in treatment and follow-up. Fungal poisoning occurs as a result of the consumption of unconsciously collected mushrooms in rural areas, gardens and open areas, with the onset of rainfall in spring and autumn. Severe poisoning usually results from the misidentification of the mushroom species by the mushroom picker. The people in rural areas are at risk in mushroom poisoning. Trainings should be given to them. Especially in rural areas, training on the consumption of mushroom species and wild mushrooms in that region contributes to the prevention of mushroom poisoning.
Conclusions Mushroom poisoning causes serious health problems that can extend to death. It is recommended to plan and implement education and awareness studies for the society in order to prevent mushroom poisoning.

EP055 Health Literacy and Nutrition

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Background The concept of health literacy and nutrition have become even more important today in terms of protection and improvement of health with economic, social and political changes. Inadequate and wrong nutritional habits that occur with the effect of these changes cause serious health problems in individuals. The development of health literacy enables the patient to access the right knowledge from the right source in all matters related to health. This review was conducted to review the effect of health literacy on nutrition.
Results The number of people who prefer a healthy lifestyle is increasing in the world and in our country, but they have difficulty in accelerating this process due to the complexity in health and environmental systems. Among the reasons for this complexity; Marketing of unhealthy lifestyles in modernized societies, even the best educated people have difficulties in making progress within the health system and have a dilemma in decision-making on health issues, education systems are mostly aimed at individuals' accessing, understanding, evaluating and using the information needed to improve their health. The concept of health literacy was defined for the first time in 1974 as "the ability of individuals who receive education in the field of health to read and understand health-related information and to follow medical instructions". According to the World Health Organization, "health literacy is defined as the level of cognitive, social skills and motivation in accessing information, understanding information and using this information for the protection and development of individuals' health".It is an essential need for nutrition, growth, development and maintenance of vital functions. It is widely accepted today that there is a strong relationship between health and nutrition. Unhealthy diet, obesity, cardiovascular diseases, cancer, arthritis etc. causes health problems. This situation creates a serious problem in the economies of the countries by causing both the loss of manpower and the increase in the cost of diagnosis, treatment and care of chronic diseases. In order to determine the lifestyle behaviors and knowledge of individuals and to provide them with healthy lifestyle behaviors, it is necessary to provide nutrition training in line with their needs and to ensure the continuity of these trainings. Today, busy and long working hours, transportation and economic problems make it difficult for individuals to benefit from these trainings and the continuity of education. Therefore, it becomes more important to gain nutritional health literacy to individuals. Nutritional literacy of individuals needs to be developed with the widespread and effective trainings planned. Nutritional literacy, access to basic nutritional information (food, nutrients, portions, food groups, etc.) and services for the improvement and development of the individual's health, basic nutritional principles, preparation and cooking of food, what should be consumed when and how. knowledge of the subjects, the ability of individuals to read labels for calorie calculation, to understand and interpret this information.
Conclusions It is a serious public health problem with an increasing prevalence of health problems related to nutrition in the world and in our country. The most effective method to eliminate this problem is education.

EP056 Chronic Kidney Failure and Quality of Life

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Background Today, the increase in life expectancy and life expectancy has led to an increase in the prevalence of chronic diseases. This situation has led to the focus on the effects of diseases on the quality of life and the emergence of the concept of "health-related quality of life". Studies have focused on the relationship between chronic diseases and quality of life and the factors affecting this relationship. One of these diseases is chronic kidney failure. This review has been prepared to draw attention to the quality of life and the factors

affecting it in patients with chronic renal failure.
Results Like all chronic diseases, chronic kidney failure affects the individual's life physically, mentally, socially and economically, and this situation is reflected in the quality of life of the individual. In patients with chronic renal failure, chronic renal failure and its treatment characteristics (glomerular filtration rate, hematocrit level, referral time to nephrology, treatment types such as hemodialysis, peritoneal dialysis, renal transplantation, duration of hospitalization, present symptoms and severity of symptoms, disease stage disease duration, treatment method applied, compliance with the disease and treatment, presence of complications), individual characteristics (age, hypertension, diseases such as diabetes, depression, nutrition, gender etc.), social factors (income level, job status, education level), Physiological, psychological, social and economic problems experienced during illness and treatment, education given to the patient and accompanying comorbid diseases affect the quality of life. Malnutrition and anemia are the most important factors that can affect the quality of life in patients diagnosed with end-stage renal disease. In studies conducted to date, it has been determined that the prevention or control of diabetes and hypertension, providing healthy lifestyle behaviors to patients, increasing compliance with diet and treatment, application of renal replacement therapies and kidney transplantation are effective in increasing the quality of life.
Conclusions Increasing the quality of life is one of the most important goals in the treatment of patients with chronic renal failure. Chronic kidney failure is a disease that requires long-term treatment and many complications can be seen when adequate treatment and care is not provided. For this reason, it is important to evaluate the quality of life of the patients at regular intervals and to make the necessary interventions in the early period to improve the quality of life.

EP057

Fatigue and Sleep Problems in Patients Receiving Dialysis Treatment

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Background Chronic renal failure (CRF) is one of the important chronic diseases that cause chronic and progressive deterioration in metabolic and endocrine functions of the kidneys. Hemodialysis and peritoneal dialysis are a form of treatment applied until transplantation is performed in the treatment of chronic renal failure. HD works on the basis of dialysis of the blood taken from the patient through a membrane and rearrangement of the liquid and solid content. Natural peritoneal membranes are used as membranes in CAPD, and the dialysate fluid that fills the peritoneal cavity is replaced with a new one after a few hours of equilibration. Dialysis patients have many symptoms related to the disease, the effect of the disease on other organ systems and treatment. This review has been prepared to draw attention to the common symptoms of dialysis patients, such as fatigue and sleep problems.
Results As with many chronic diseases, fatigue is an important symptom in individuals who undergo hemodialysis due to chronic kidney failure. In the picture of chronic renal failure, individuals feel significantly tired due to the effects of cardiovascular, hematopoietic, metabolic and endocrine system functions, as a result, working life, leisure time, eating habits, sexual activities, enjoyment of life, family and friends relations are negatively affected and the quality of life. It seems to have also significantly affected. In order to prevent the fatigue symptom from limiting the daily life activities of the individual, it is necessary to effectively deal with this symptom with the evaluation of fatigue and appropriate activity planning. One of the most important problems affecting the quality of life in hemodialysis patients is sleep problems. In studies conducted with dialysis patients, it was reported that the deep sleep times of the patients were shortened, the total sleep time was decreased, various sleep problems were observed and the sleep quality was poor. Sleep problems can negatively affect the self-care ability and quality of life of hemodialysis patients. Restrictions in life, metabolic changes due to the disease, pain, dietary restrictions, dyspnea, fatigue, cramp, advanced age, hypocapnea with chronic metabolic acidosis, use of acetate dialysis, presence of peripheral neuropathy affecting upper respiratory tract nerves and emotional problems can cause sleep problems in hemodialysis patients. may cause. Identifying and effectively managing fatigue and sleep problems in dialysis patients contributes to increasing the quality of care, reducing additional health problems that may occur in the individual, and increasing the quality of life of the individual.
Conclusions Fatigue and sleep problems are common in dialysis patients. Nurses' level of knowledge and awareness on this issue should be increased in order to identify these symptoms at an early stage and to manage them effectively. It is recommended to plan and implement trainings on the management of fatigue and sleep problems for nurses working in dialysis units.

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Nursing Care in Diabetic Patient with COVID-19

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Background Pathophysiological changes occurring in diabetic patients are more susceptible to infections and related complications. On the other hand, any infection that occurs in diabetic patients also causes hyperglycemia. The effects of COVID-19 on diabetic patients depend on acute and chronic inflammation. The course of COVID-19 disease and diabetic control can be poor in diabetic patients. This indicates that

nursing care in diabetic patients should also be closely monitored in terms of diabetes control. This review has been prepared to draw attention to the importance of nursing care in diabetic patients diagnosed with COVID-19.

Results Due to the worsening of diabetes control due to COVID-19 disease, serious problems such as diabetic ketoacidosis, hyperglycemic shock, cardiovascular problems, pneumonia, sepsis, heart and kidney diseases, and death can be seen. For this reason, it is extremely important to monitor the patient in terms of symptoms (fever, shortness of breath, diarrhea, vomiting, etc.) and symptoms (blood sugar, ketone level, etc.) is important. It is necessary to evaluate the patient's compliance with the treatment recommended by the physician, to be educated about the use of insulin to the patient who is switched to insulin treatment because his diabetic control is poor or his general condition is not stable, and they must be informed that they should have at least two disease treatment doses. In diabetic patients diagnosed with COVID-19, the general condition can deteriorate rapidly and the prognosis worsens. The illness process can also cause psychosocial problems in the patient and his family. In particular, patients should be closely monitored for diabetic ketoacidosis and hyperglycemia and cardiovascular symptoms that may be associated with glucocorticoid use. Diabetic patients with COVID-19 disease require careful, effective and comprehensive nursing care. Nursing diagnoses that can be made on patients; Risk of fluctuation in blood glucose, Respiratory pattern disturbance/risk, ineffective airway cleaning/risk, impaired/risk of gas exchange, reduced tissue perfusion, activity intolerance, fatigue, risk of infection, acute pain/risk, activity intolerance, ineffective coping, self risk of lack of care, risk of under nutrition, risk of trauma, risk of bleeding, risk of decreased self-esteem, lack of knowledge, anxiety, risk of imbalance in body temperature, fluid-electrolyte imbalance, risk of infection, change in family roles, disruption in communication.

Conclusions Nursing care and follow-up are extremely important in preventing complications in diabetic patients diagnosed with COVID-19. Comprehensive evaluation of the patient and making patient-specific nursing diagnoses will contribute to increasing the quality of nursing care.

EP059

Nursing Care in Patient with COVID-19

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Background The incidence of COVID-19 disease is increasing worldwide. The first symptoms described in COVID-19 patients are fever, cough, and shortness of breath. The emergence of new symptoms (headache, taste change, inability to smell) together with the mutation of the microorganism that causes COVID-19 disease increases the concerns of individuals and healthcare professionals. Because, in patients diagnosed with COVID-19, pneumonia, ARDS, kidney failure and death may develop. The quality of the nursing care given to the patient is extremely important in preventing COVID-19 disease complications. This review has been prepared to draw attention to the importance of nursing care and nursing follow-up in patients with COVID-19 diagnosis.

Results It is known that the symptoms of the disease vary from patient to patient, the reliability level of the tests used in diagnosis is at a medium level, and antibodies provide 3-6 months protection in individuals who have had the disease. Studies on the effectiveness of treatment methods such as antiviral drugs and plasma treatments used in the treatment of the disease are ongoing. On the other hand, anticoagulant drugs are used to prevent cardiovascular complications. Again, in addition to compliance with distance, mask and hygiene rules for protection, vaccination studies are also continuing. The illness process can also cause psychosocial problems in the patient and his family. COVID-19 disease requires careful, effective and comprehensive nursing care. Nursing diagnoses that can be given to patients receiving treatment in pandemic wards Disruption/risk in breathing pattern, ineffective airway cleaning/risk, impaired gas exchange/risk, tissue perfusion risk, activity intolerance, fatigue, risk of infection transmission, acute pain/risk, activity intolerance, ineffective head risk of lack of self-care, risk of undernutrition, risk of trauma, risk of bleeding, risk of decreased self-esteem, lack of knowledge, anxiety, risk of imbalance in body temperature, fluid-electrolyte imbalance, risk of infection, change in family roles, impaired communication. With the patients being connected to the mechanical ventilator and becoming bedridden, new ones are added to these nursing diagnoses.

Conclusions It is known that the prognosis can deteriorate rapidly with the addition of respiratory and cardiovascular problems in patients with a diagnosis of COVID-19. This situation makes the intensive care needs of the patients and the application of patient care in the mechanical ventilator necessary. In particular, it is thought that providing effective and quality care by nurses working in the pandemic ward will be effective in reducing this need.