

**Abstract # 388****Peripheral neuropathy revealing systemic Amyloidosis in elderly: case report**Derbal Samar<sup>1</sup>, Ben Dahmen Fatma<sup>1</sup>, Abdallah Maya<sup>1</sup><sup>1</sup>Regional hospital of Ben Arous

**Introduction:** Amyloid light chain (AL) amyloidosis due to deposition of monoclonal immunoglobulin light chains, is a rare and heterogeneous hematologic disease. We report a case of chronic polyradiculoneuropathy revealing AL amyloidosis in an old patient.

**Case report:** A 65-year-old man admitted for edema of the lower limbs, weight loss, and progressive motor slowdown affecting the 4 limbs evolving for 3 months. Physical examination showed a proximal and distal symmetrical sensory and motor deficiency with abolished ankle reflexes. The rest of the examination was normal apart from an infiltrated purpura of the 2 lower limbs. Viral serologies were negative. The bioassay eliminates a phosphocalcic disorder, a hemostasis disorder, diabetes and vitamin deficiency. Brain CT was normal. The first electromyography (EMG) demonstrated a severe sensory and motor neuropathy. Negative serology for hepatitis B, hepatitis C, rheumatoid factor, anti-CCP antibodies, and antinuclear, anti-dsDNA, anti-neuronal, and anti-neutrophil cytoplasmic antibodies confirmed the absence of underlying auto-immune diseases. Skin biopsy confirmed amyloidosis. The immunohistochemical investigation was positive for AL deposits. Serum protein electrophoresis did not show a monoclonal component. Immunofixation of serum proteins revealed normal kappa/lambda ratio. The bone marrow cytology showed 5% plasma cell infiltration with no other signs multiple myeloma. There were no bone lesions on radiographs of the complete skeleton. The patient was diagnosed with peripheral neuropathy revealing AL amyloidosis. There was also no evidence of cardiac or renal involvement. He was treated with high-dose corticosteroids with no improvement of the motor deficiency after 48 months.

**Conclusion:** Peripheral neuropathy is described in 15–20% of cases of AL amyloidosis. This involvement may mark the beginning of the disease and may present with progressive sensorimotor polyneuropathy, focal neuropathy, autonomic neuropathy, as well as other unusual clinical presentations. Diagnosis is often delayed. It is prudent that physicians consider the diagnosis of AL amyloidosis in patients with neuropathy, so that these patients may be treated earlier.

**Abstract # 389****Telephone support for complex chronic patients**Francisco Javier Balea Fernandez<sup>1</sup>, Cristina Cazorla Guillen<sup>1</sup>, Antonia Jesús Solano Benítez<sup>1</sup><sup>1</sup>Hospital Insular de Lanzarote, <sup>2</sup>Nutritionist in Centro Hebe

Medical activity in geriatric units extends beyond mere routine clinical practice and it is essential for a real, easy and direct healthcare continuity. However, in the XXI century access to medical specialists in hospitals remain a Penrose Stair for geriatric patients. The particularities of this population require that accessibility to medical resources become more fluid and direct. At this point, why something so basic and cheap as a phone consultation in the age of telecommunications is something so unusual? Perhaps by the overloading of clinicians, lack of time and support that allows registration or because it has been doing in an informal way for long without any registration. The benefits of continuity of care in this population are well documented today. Phone support reduce hospitalizations and emergency departments consultations 1, 3, 6, premature readmissions, improve the health status of chronic patients 2, 3, improves prognosis of patients with heart failure 5, and therapeutic adherence 7. It has also

been incorporated into the comprehensive management in palliative care services with improvements in quality of care perceived by patients 10. Within the framework of state programs chronicity justifies the need to develop and document this innate care activity in most geriatric units since its inception and is now extrapolating and incorporating other services. The aim of our study is to enhance the recording of telephone consultations in the geriatric unit which for years has been carrying out this activity and analyze the user profile to provide an efficient, actual non-contact continuous and specialist care and focused on the particularities of our population

**Abstract # 390****Cardio-metabolic risk in elderly patients in the context of the COVID-19 pandemic**Dragos Munteanu<sup>1</sup>, Leonard Iosif Pertea<sup>1</sup>, Alexandru Vlase<sup>1</sup>, Andrei Cernomaz<sup>1</sup><sup>1</sup>UMF Iasi

Pre-existing cardiovascular and metabolic diseases could be a predisposing factor in itself for COVID-19 induced cardiac impairment, as elderly patients with heart injuries frequently have a history of coronary heart disease and hypertension, and metabolic pathologies (diabetes mellitus). Thus, in the report published in JAMA (April 2020), 25% and respectively 58.3% of patients with critical COVID-19 had a history of cardiovascular and metabolic diseases. Although there is currently little evidence to establish a direct link between acute cardiopulmonary lesions associated with COVID-19 and cardio-metabolic comorbidities, it can be assumed that patients with chronic cardio-metabolic disorders are susceptible to acute cardiac injury. Once these patients are infected and develop severe SARS-COV-2 pneumonia, myocardial ischemia, cardiac dysfunction, or pulmonary thromboembolism are more likely to eventually lead to acute hemodynamic impairment.

**Material and results:** we further present the case of a 72-year-old woman patient, hospitalized in the Internal Medicine and Geriatrics-Gerontology Clinic Iasi, Romania, between May 21-31, 2020. The patient was transferred from the Infectious Diseases Hospital in the context of SARS-COV-2 (positive test April 2020) for continued treatment and monitoring of SARS-COV-2 infection. Hospitalization diagnosis: SARS-COV-2 infection (lung damage), SARS-COV-2 pneumonia, essential hypertension grade III additional high risk, type 2 diabetes. Among the reasons for hospitalization are dyspnea and moderate neurasthenia. The patient's evolution was stationary until May 30, when the general condition suddenly deteriorated, with loss of consciousness, decreased blood pressure, bradycardia, agonizing breathing, and generalized edema. Cardiopulmonary resuscitation maneuvers were instituted, without clinical symptoms, and the patient's death was finally declared.

**Discussions and conclusions:** Chronic cardiopulmonary pathology in an elderly patient with severe form SARS-COV-2 infection (viral pneumonia) represent an high risk factor in these conditions and can cause sudden hemodynamic and respiratory decompensation with irreversible cardiopulmonary arrest. Thus, severe lung damage, caused by pneumonia, can lead to severe respiratory distress syndrome (ARDS), evolving into septic shock, which cause the death of the patient.

**Keywords:** ELDERLY, SARS-COV-2, CARDIOMETABOLIC DISORDERS. All the authors are quality as first author