ABSTRACTS BOOK

V BALEARIC MEETING OF EUROPEAN RESIDENTS AND YOUNG GP´S 2017

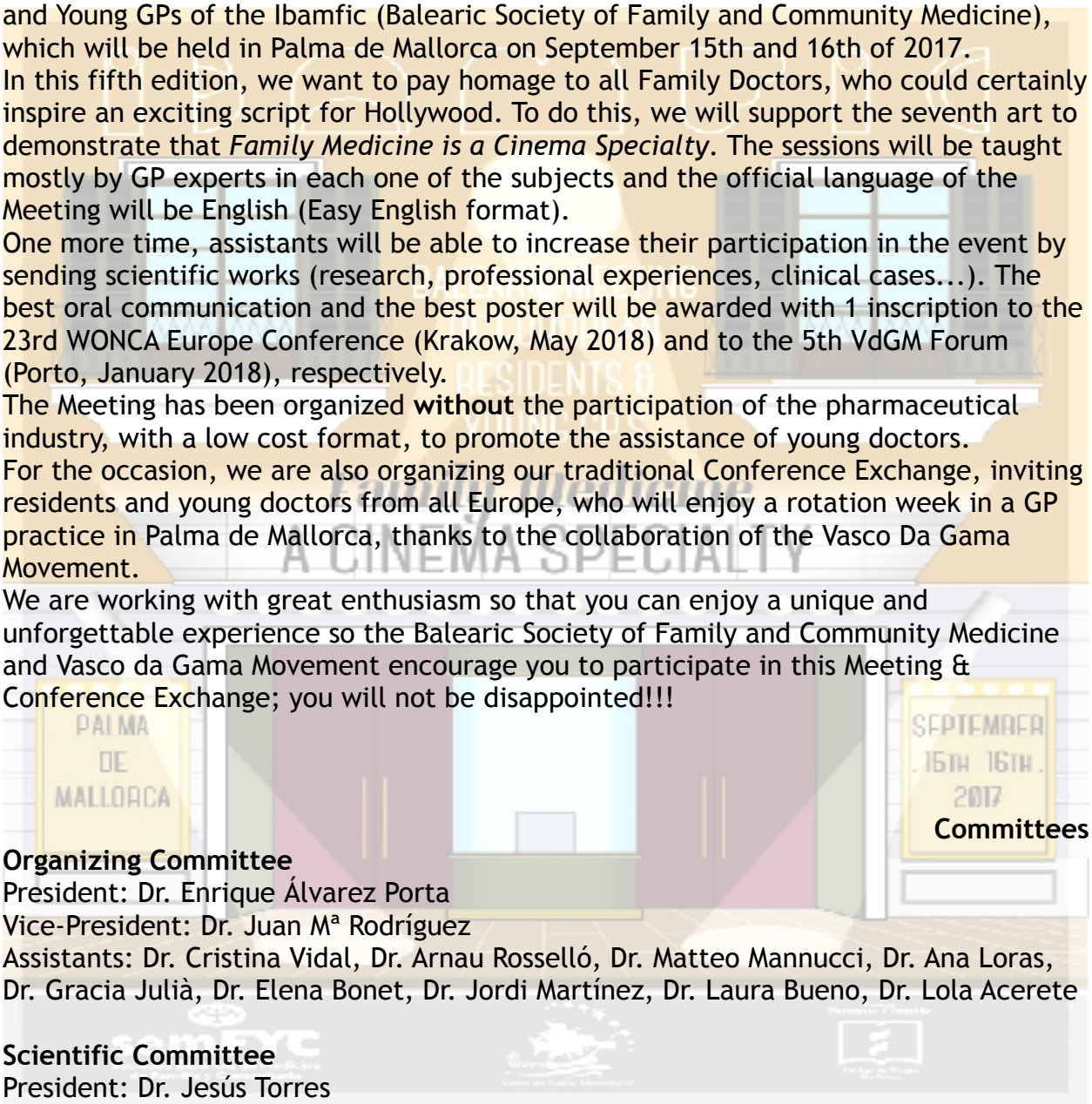
Index

WELCOME

V Balearic Meeting of European Residents & Young GP´s 2017

V Balearic Meeting of European Residents and Young GPs of Ibamfic
Family Medicine: A Cinema Specialty

It is a great honor for us to invite you to the V Balearic Meeting of European Residents and Young GPs of the Ibamfic (Balearic Society of Family and Community Medicine), which will be held in Palma de Mallorca on September 15th and 16th of 2017.
In this fifth edition, we want to pay homage to all Family Doctors, who could certainly inspire an exciting script for Hollywood. To do this, we will support the seventh art to demonstrate that *Family Medicine is a Cinema Specialty*. The sessions will be taught mostly by GP experts in each one of the subjects and the official language of the Meeting will be English (Easy English format).
One more time, assistants will be able to increase their participation in the event by sending scientific works (research, professional experiences, clinical cases...). The best oral communication and the best poster will be awarded with 1 inscription to the 23rd WONCA Europe Conference (Krakow, May 2018) and to the 5th VdGM Forum (Porto, January 2018), respectively.
The Meeting has been organized **without** the participation of the pharmaceutical industry, with a low cost format, to promote the assistance of young doctors.
For the occasion, we are also organizing our traditional Conference Exchange, inviting residents and young doctors from all Europe, who will enjoy a rotation week in a GP practice in Palma de Mallorca, thanks to the collaboration of the Vasco Da Gama Movement.
We are working with great enthusiasm so that you can enjoy a unique and unforgettable experience so the Balearic Society of Family and Community Medicine and Vasco da Gama Movement encourage you to participate in this Meeting & Conference Exchange; you will not be disappointed!!!



Committees

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V Balearic Meeting of European Residents & Young GP´s 2017

Scientific Programme

Friday 15th

8:30	**Registration**
9:30-10:30	**REQUIEM FROM A DREAM** Recreational Drugs Uptodate, Dr. Elena Klusova
10:30-11:15	**DANCES WITH WOLVES** Empathy, Assertiveness & Respect in primary Care Consultation, Dr. Natalia Pérez
11:15-11:45	**Coffee Break + Oral Posters Exposition**
11:45-12:30	**THE DOCTOR** Why humanism is important in 21st century Medicine?, Jonathan McFarland
12:30-13:15	**La VITA É BELLA** Reality & Fiction of smoking Cessation in Primary Care, Dr. Lucía Gorreto
13:15-14:45	**Lunch**
14:45	**Opening Act**
15:00	**Opening Conference,** Dr. Claire Marie Thomas (England)
16:00-18:00	**Workshops**

Saturday 16th

9:30-10:15	**BABEL** International Debate Session, Conference Exchange participants
10:15-11:00	**BIG FISH** *The Vasco da Gamma Movement*, Dr. Enrique Álvarez
11:00- 11:30	**Cofee Break + Oral Posters Exposition**
11:30-12:00	**Oral Exposition Posters**
12:00- 13:30	**Oral Exposition Scientific Works**
13:30-14:30	**Trivial of Medicine**
14:30	**Closing Ceremony & Award**

Oral communication. Saturday 16th

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Full-Text Oral Communications

OC1. Original Research. Percentage and characteristics of patients with suboptimal doses of antihypertensive drugs (3 or more) without reaching control in primary care.

Authors: Fabián Unda Villafuerte, Patricia Lorente Montalvo, Patricia Bassante Flores, Alfonso Leiva Rus, Joan Llobera Cànaves. ***Contact:*** fabianundav@gmail.com
***Filiations*:** Primary care centers (Camp Redó, Santa Ponça, La vileta, Son Rullan), Palma, Spain

Key words: Hypertension, dose, antihypertensive agent

Abstract: High blood pressure is the main modifiable factor of cardiovascular risk in the world. Increases the possibility of suffering: heart attack, stroke, kidney damage and death. Despite knowing the benefits of treatment, in Spain 58% of men and 61% of women are not controlled. The factors that perpetuate poor control are: therapeutic inertia: incorrect doses, inadequate associations; Lack of adherence and unhealthy lifestyles.

OBJETIVES

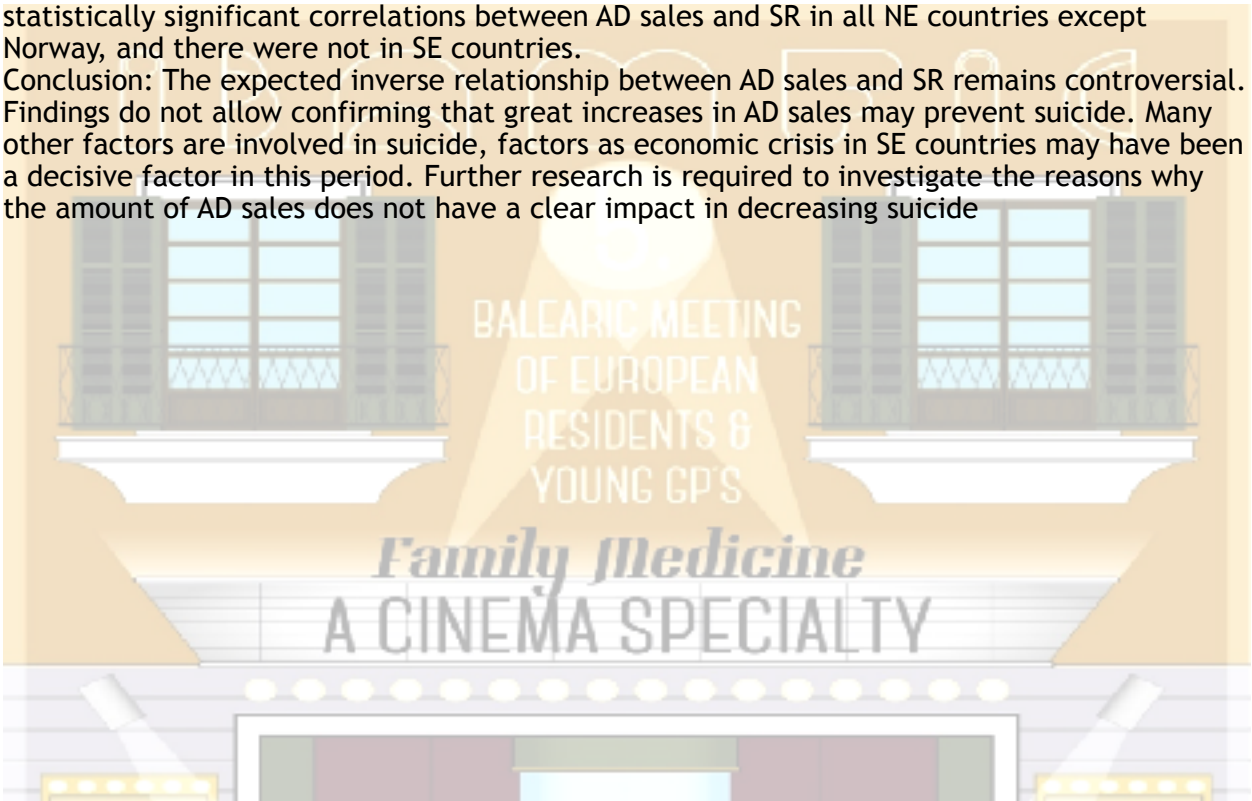
To estimate the prevalence of suboptimal doses in patients with 3 or more antihypertensive drugs in primary care and describe their characteristics.

METHODS Design: Descriptive transverse. Subjects: Patients under treatment for hypertension, not controlled with 3 or more drugs in four primary health care centers. Information: Patients with suboptimal doses receiving 3 or more antihypertensive. The optimal dose is defined by Calhoun et al as 50% or more of the maximum recommended dose by the FDA or the hypertension guidelines.
Personal variables, target organs, associated pathologies, tobacco, active principles, dose.
RESULTS: Of the 777 uncontrolled hypertensive patients with 3 or more drugs, 10.3% received suboptimal doses, the mean age was 68.4 ± 9.3; 45, 5% were women; 15.3% smokers; 22.1% had ischemic heart disease; 23.8% Heart failure; 20.8 hypertensive retinopathy; Cerebrovascular disease; 22.1% hypertensive nephropathy; 21.4% microalbuminuria; 49.9% diabetes. Subjects with suboptimal doses had an average age of 70.1 ± 8.1; 42.3% were women. The percentages of suboptimal doses among the different groups were: 18.8% in smokers;
14% in ischemic heart disease, 16.5% in heart failure; 13.3% retinopathy; 12.5% cerebrovascular disease; 18.1% hypertensive nephropathy; 12% microalbuminuria; 10.6% diabetes. 48.26% received three active principles, 40.67% four, 9.27% five and 1.80% six. The most commonly used drugs were: Hydrochlorothiazide, followed by Amlodipine and Enalapril
CONCLUSIONS - In our area in primary care, the percentage of suboptimal doses was 10.3%. - Doses representing 50% of the maximum dose may not be sufficient for blood pressure control. - Pharmacological treatment should be complemented by other non-pharmacological measures to achieve control of hypertension.

OC2. Original Research. Relation between antidepressant sales and suicide rate in North and South European countries.

Authors: F. Reus, C. Vicens. ***Contact:*** dr.reus@hotmail.com
***Filiations*:** Son Serra-La Vileta Health Center, Palma, Spain.
Key words: Antidepressants, Suicide, Europe
Abstract: Relation between antidepressant sales and suicide rate in North and South European countries
Background:
Most suicides occur in presence of depression; therefore, it is expected that a better treatment of depression may reduce suicide mortality. With this hypothesis, researchers of some North-European (NE) countries found inverse relation between sales of antidepressant (AD) and suicide rate (SR) in the last twenty years. In contrast, in South-European (SE) countries, the most affected by the economic crisis, the SR remains constant or with a slight tendency to increase in spite of the great increases in AD sales. Research question: To study whether there is an inverse relationship between sales of AD and SR in four Nordic countries and four South-European countries in the time period 2000-2015.
Methods: Ecological study: Aggregated suicide rate and antidepressant sales over the period 2000-2015 in four North- European countries (Sweden, Finland, Denmark and Norway) and four South-European countries (Spain, Portugal, Italy and Greece). Data were obtained from The Organisation for Co-operation and Development (OECD) who obtained data of SR from the

WHO Mortality Database and for AD sales from the wholesale register Medicine of the Health Departments of each Country. Relationship was examined using Spearman's Rank correlation.
Results: The range of total sales of AD increased 26,5 to 66,7% during the period 2000-2013 in all the
countries, 26,5 to 48,9% in the NE countries and 53.9 to 66,7% in the SE countries. The SR declined in NE
countries (-27,8 to 0,8%) and increased in SE countries (-1,19 to 131,4%). There were statistically significant correlations between AD sales and SR in all NE countries except Norway, and there were not in SE countries.
Conclusion: The expected inverse relationship between AD sales and SR remains controversial. Findings do not allow confirming that great increases in AD sales may prevent suicide. Many other factors are involved in suicide, factors as economic crisis in SE countries may have been a decisive factor in this period. Further research is required to investigate the reasons why the amount of AD sales does not have a clear impact in decreasing suicide



OC3. Research projects. Association of simultaneously measured inter-arm systolic blood pressure difference with peripheral arterial disease.

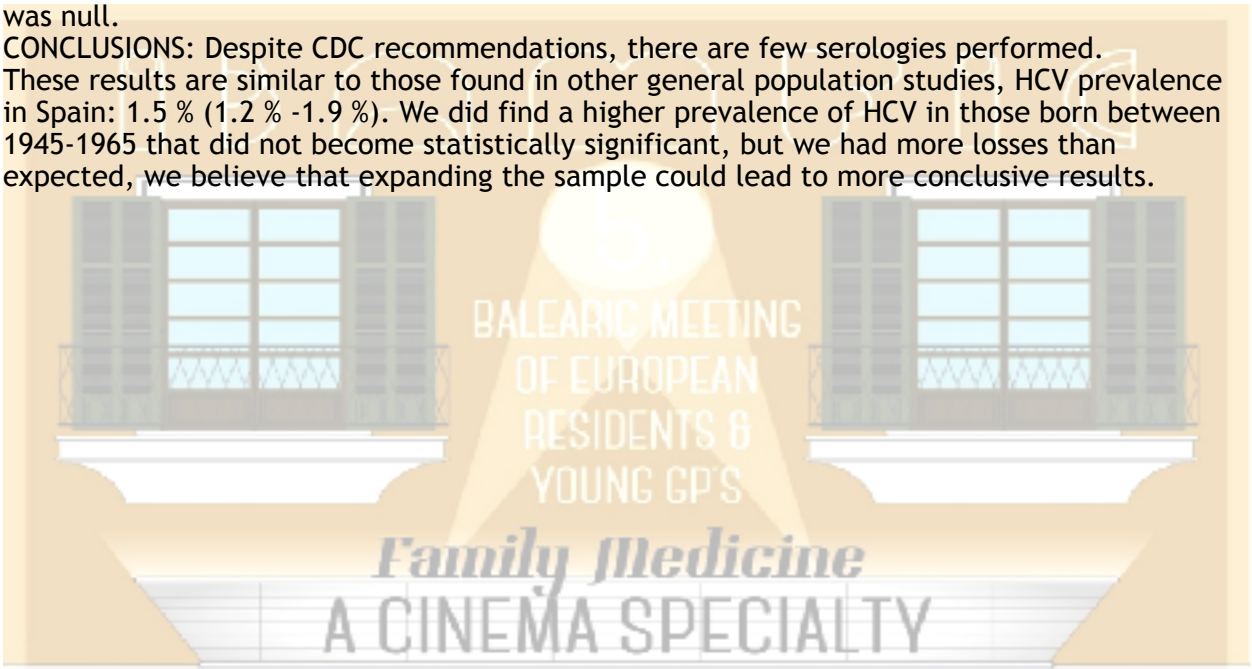
Authors: Pérez Fonseca, Carmen; Santana Oteiza, Miriela; Viñuales Palazón, Laura; García Regalado, Natividad; Rigo Catalá, Fernando; Sanchez Mate, María Isabel. ***Contact:*** carmenperezfonseca@gmail.com
Filiations**:** San Agustí Health Care Center, Génova Health Care Center, Trencadors Health Care Center, Palma de Mallorca, Spain.
Key words: inter-arm systolic blood pressure, peripheral arterial disease, cardio-ankle vascular index
Abstract: Summary:
Difference in simultaneously measured systolic blood pressure (SBP) in both arms has been associated with an increased risk of peripheral arterial disease (PAD).
Objectives: To estimate the prevalence of inter-arm systolic blood pressure difference > 10mmHg in patients aged 35-74 years attending at primary care consultation. In which differences are established and the proportion that has an ankle arm index or altered CAVI is established. Where differences are found and setting the proportion having an ankle-brachial index (ABI) or CAVI altered.
Methods:
A cross-sectional descriptive study of the population served at the San Agusti / Génova and Trencador's health center in Palma. In a first contact with the voluntary patient and signing the informed consent, it will proceed to perform double taking of SBP simultaneously. If there

is a difference of inter-arm SBP>10mmHg, the patient will be referred again to confirm de presence of the difference >10mmHg. When confirming in second consultation will proceed to the realization of the ABI or VASERA to assess if there is PAD. In case the ABI is pathological it will proceed according to the protocol of action of primary attention. Estimated sample of 325 patients for 95% confidence and accuracy of +/- 5%.
Main variable: Inter-arm systolic blood pressure differences. Other variables: personal, cardiovascular risk factors and comorbilities including diagnosed of hypertension and/or treatment with antihypertensives. The patients inter-arm blood pressure > 100mmHg we maked ABI and CAVI with Vasera to confirm PAD. Descriptive analysis and estimation of 95% confidence intervals. Consent signature will be reported and proceeded.
Conclusions: The inter-arm SBP has the potential to become an invasive screening method, identifying patients who could benefit from a peripheral arterial study by ABI testing or Vasera.

OC4. Original Research. PREVALENCE OF HEPATITIS C VIRUS (HCV) TESTING IN COHORTS BETWEEN 1945-1975.

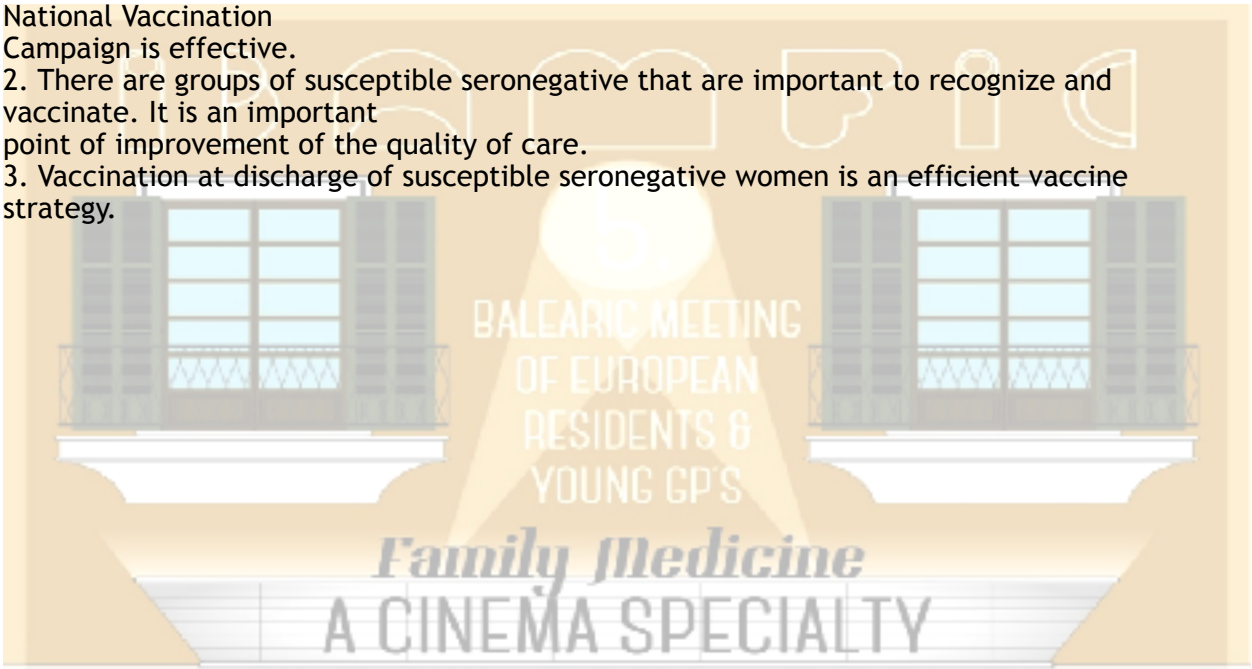
Authors: Guerra Feo, C.; Soler Galindo, L.; Munuera Arjona, S.; Piqué Sistac, T.; Esteva Cantó, M. ***Contact:*** cristinaguerrafeo@hotmail.com
Filiations**:** Son Pisà Medical Health Centre, Palma de Mallorca, Spain.
Key words: Hepatitis C, Prevalence, Aged
Abstract: BACKGROUND: CDC recently recommended that all adults born 1945-1965 should undergo one-time testing without prior ascertainment of HCV risk status. Higher prevalence in this United States age group is due to historical aspects. However in Spain prevalence peak could be considered in people born 1955-1975: there was no clear Baby-Boom after Spanish Civil War, and parenteral drug users increased later. We decided to analyze HCV prevalence in 1945-1975 birth cohort and to contrast whether the higher prevalence occurs in the CDC proposed age group or ten years later.
OBJECTIVES:
-To estimate HCV prevalence in 1945-1975 Birth Cohort.
-To compare prevalence between 1945-1965 and 1955-1975 cohorts.
-To identify unknown HCV cases by active screening.
METHODS: Descriptive Prevalence Study. Primary care urban population born between 1945-1975. Sample size: 429 subjects (95 % confidence +/-0.9% precision). 25 % replacement rate anticipated. Simple random sampling through electronic medical records. SPSS Statistics 14.0 for Windows. Variables: Previously known and newly diagnosed HCV infection.
RESULTS: Total HCV prevalence in the sample (1945-1975) was 1.62 %, being 2.11 % in 1945-65

cohort and 1.84 % in 1955-75 birth year, statistically non-significant difference (p=0.94). Final sample: 430 subjects, in whom clinical history was reviewed. 104 individuals (24.2 %) had already serology performed in whom 7 subjects were positive for HCV. Population susceptible to screening: 326 cases; 84/326 cases (25.7 %) were initially excluded. 242 individuals who did not have serology were contacted to be invited for the study. In the 120 subjects that could be contacted, 5 did not want to participate. Finally 115 (26.7 %) became HCV serology of which none was positive. Consequently, screening in those who did not have serology (326) was null.
CONCLUSIONS: Despite CDC recommendations, there are few serologies performed. These results are similar to those found in other general population studies, HCV prevalence in Spain: 1.5 % (1.2 % -1.9 %). We did find a higher prevalence of HCV in those born between 1945-1965 that did not become statistically significant, but we had more losses than expected, we believe that expanding the sample could lead to more conclusive results.



OC5. Research project: Screening of rubella during pregnancy; are we doing it correctly?
Authors: García-Gutiérrez Gómez, Rocío; Moreno Jiménez, Julia; Gómez Marco, José Javier; Klusova, Elena; Pizarro Sanz, Irene; Gutiérrez Gacía, Lucía. ***Contact:*** rocio3g@gmail.com.
Filiations**:** CS Las Calesas, Madrid, Spain.
Key words: Cross-Sectional Studies, rubella, Measles-Mumps-Rubella Vaccine
Abstract: Introduction: Pregnancy care protocols recommend systematic rubella screening to avoid congenital infection.
In addition, vaccination before the discharge in seronegative patients is an efficient preventive strategy.
Objectives:
1. To know the seroprevalence of rubella infection in term pregnant patients treated at the referral hospital
during the year 2015.
2. To determine the adequacy of the screening to the protocol established by the National Health System
(repeat serologies on a quarterly basis in negative cases).
3. To know the kind of performance in the moment of discharge in cases of negative serologies.
Material and methods:
Cross-sectional descriptive study. The obstetric medical records were evaluated at discharge during the year 2015. The requests and results of the rubella infection markers (anti-IgG antibodies) were analysed. Data about age, country of origin and test results were collected. Statistical analysis was based on means and percentages.
Results:
Data was analysed for 417 women, 89% (372 women) had positive rubella serology. 36 patients

were
seronegative (8.6%); (22), followed by Latin Americans (10) and those from Eastern Europe (3). Of the 36
women with negative serology, 25 were vaccinated at discharge with MMR (measles / mumps / rubella) giving relevant recommendations.
Conclusions:
1. Most of the women analysed were immunized against rubella, which means that the National Vaccination
Campaign is effective.
2. There are groups of susceptible seronegative that are important to recognize and vaccinate. It is an important
point of improvement of the quality of care.
3. Vaccination at discharge of susceptible seronegative women is an efficient vaccine strategy.



OC6. Case Report. MOBITZ I IN ATHLETIC PATIENT.

Authors: Figuerola Bucklitsch, Cristina; Aguiló LLobera, Maria Antònia; Vidal Solivelles, Maria del Carmen; Ramírez Arroyo, Violeta. ***Contact:*** crisfig971@hotmail.com
***Filiations*:** UBS El Molinar.
Key words: Atrioventricular block, Young adult, Exercise
Abstract: Medical history
A 32-year-old patient, undergoing orthostatic presyncope, frequent and lasting for minutes, which have been recurring for a month. He does not present any medical history of interest. He works as a lifeguard and does intense sport (20 km cycling and 30 minutes swimming daily and goes running 4 times a week along with triathlon training). It does not interfere with his daily routine nor symptoms are shown with exercise. Physical examination:
Normal. Blood pressure: 112/71 mmHg.
Diagnostic tests:
Electrocardiogram (same day of consultation): sinus rhythm at 43 beats per minute and Mobitz I second-degree atrioventricular block. Blood test: normal.
Diagnostic orientation: Mobitz I second degree AV block
Differential Diagnosis:
Orthostatic hypotension, presyncope of cardiological origin, rhythm disturbances.
Evolution: Mobitz I AV block in symptomatic patients with syncope or effort intolerance may be subject of urgent care.
Given the age and intense sport background, it was considered to be referred to hospital emergencies, but finally, we made telephone contact with Cardiology and sent them images of the electrocardiogram. After images being assessed, sports rest for 3 months was recommended together with preferential referring. The patient was seen in our clinic three days later. An ECG is carried out and we visualize normalization of the rhythm with a slight

increase of the heart rate. The importance of doing sports rest and / or decreasing intensity is explained to the patient. After following our advice, symptoms disappear. When in Cardiology Consultations, echocardiogram and Holter are performed and these are normal.
Conclusions: In Primary Health Care is crucial to have at our disposal a good interaction at a hospital level. In this case, we treated the patient multidisciplinarily, avoiding referring to Hospital Emergencies when not necessary. On the other hand, we obtained feed-back which enables us to learn for future cases.
Bibliography Bradiarritmias y bloqueos de la conducción. Julia Vogler a,, Günter Breithardt a, Lars Eckardt a a Abteilung für Rhythmologie, Department für Kardiologie und Angiologie, Universitätsklinikum Münster, Münster, Alemania http://en.ecgpedia.org/index.php?title=Main_Page

Full-Text Posters

P1. Case Report. Statins: Are they guilty of charge?

Authors*:** Esteves A. Correia, Sara; Castro Abalde, Maria Luz; de Sousa Valente, Liliana P.; Callejas Cabanillas, Pedro A. ***Contact: saraeacorreia@gmail.com
***Filiations*:** Teis public Health Clinic in Vigo, Spain
Key words: Statins, Myopathy, Intense exercise
Abstract:
It's about a patient that comes to our consult to know the results of an ordinary blood test. It's a 62-year-old male, asymptomatic, without relevant medical history apart from dyslipemia.
Diagnosed in late 2015, in April 2016, he starts treatment with 10 mg/day of Atorvastatin because he couldn't achieve good lipid control with lifestyle changes. A month after, there was an improvement in cholesterol levels and no changes in his liver function, so we decided to keep the treatment. A few months later, in a new analysis, there's a clear elevation of CPK. That's when we start to wonder if there was consumption of other drugs, toxics or the practice of intense physical exercise, but the patient denies it all. Results of blood tests:
• 10/2016: cholesterol 225 mg/dL, LDL 159 mg/dL. Normal liver, thyroid and renal function. CPK 1397 UI/L (21.0-200.0).
• 11/2016: cholesterol 255 mg/dL. CPK 1023 UI/L.
• 01/2017: cholesterol 202 mg/dL. CPK 102 UI/L.
Differential Diagnosis:
• Myopathy induced by toxics or drugs (Statins).
• Myopathy secondary to intense exercise.
• Others: inflammatory, infectious, metabolic causes.
Treatment plan: Firstly we suspended treatment with Atorvastatin but the CPK elevation persisted in posterior analytical controls. Therefore, we insisted in asking the patient for other possible causes and that was when he admitted that he was performing muscular electrostimulation exercises.
Final Diagnosis: Myopathy secondary to muscular electrostimulation.

Evolution: After putting an end to the muscular electrostimulation, the CPK levels normalized. This persisted unchanged despite the reintroduction of Atorvastatin.
Conclusions: Statin myopathy is a known and infrequent typical side effect of all drugs of this group. In this case, perhaps the clinical inertia led us to think in this diagnosis as one of the first possibilities, without researching thoroughly other possible causes that could also explain it. This being said, we shouldn't forget that new sport practices such as muscular may not be considered as
"intense exercise" by patients, but they do justify elevations of CPK, and so far, even cases of rhabdomyolysis have been described. In conclusion, GPs' should always do a precise anamnesis since it's our most useful tool in the quest for patients' wellbeing.

P2. Case Report. Fever...where does it come from?

Authors: Gandia Lopez, Sara; Vidal Ribas, Cristina; Torrens Darder, Maria del Mar; Mudrychova, Jitka; Pujol Girol, Helena. ***Contact:*** sra44_g@hotmail.com
Filiations: Calvià Health Center. Mallorca. Spain.
Key words: cystitis, spinal cord compression, lymphoproliferative disorders
Abstract: Reason for consultation: A 61-year-old female came to our consulting room for fever (38-38.5°C) for seven days, lumbar pain (bilateral) in the first days, which later changed to sensation of paresthesias in the left flank without another clinic.
Most relevant data from the medical history: Smoker, Renal lithiasis (right) with recurrent colic, with double J catheter inertion in April 2016 and retired in November.
Physical examination: Regular general state, Cardiopulmonary auscultation: normal, Abdomne: soft and
depressive, without masses or organomegaly, preserved peristalsis and without pain on palpation, although there was a decrease in sensitivity in the left flank area. Percusion in lumbar area was negative. Diagnosis tests: Combur test: hematuria, proteinuria. Doubtful piuria. Sediment and urine culture are collected and renal ultrasound is requested.
Differential diagnosis: acute cystitis, pyelonephritis, renal colic complicated.
Treatment: At the first moment, it is oriented as complicated acute cystitis and antibiotic treatment with
cefuroxime is initiated with previous collection of urine.
Evolution and conclusions: After 3 days of antibiotic therapy, the patient came back for persistent fever and abdominal paresthesias. The cultive of the urine was negative. Due to the persistence of fever and discarding the urinary focus, it was decided to perform an ultrasound at that moment in the health center, visualizing a mass in the spleen. For that reason, the patient was referred to the hospital emergency department. In the emergency room, they saw a lesion in the spleen (12cm of longitudinal diameter, homogeneous echogenicity). They decide to perform an abdominal CT scan to complete the study, where they saw solid focal lesions in both kidneys and in the spleen .
Blood analysis is normal. At that moment, the first diagnostic possibility was extranodal lymphoproliferative/ lymphoma disease as the first possibility (without being able to rule out metastatic disease as a second option). Finally, the patient is diagnosed with Lymphoproliferative Syndrome with complication of spinal cord compression, thus initiating chemotherapy.

P3. Experience. Family Medicine 360º in Japan, a WONCA Experience

Corresponding author: Matteo Mannucci . ***Contact:*** drmatteomannucci@gmail.com
***Filiations*:** Family Medicine Resident in Mallorca

Key words: Primary Care, Japan, Continuity of Care

Abstract: Background: This is a description of an international exchange for a last year resident of Family Medicine who spent 3 weeks in Japan.
Through the FM 360º programme of the WONCA I have been able to visit Japanese's Kaita and Iizuka Hospitals in the Fukuoka region, and Chiba University Hospital in the district of Chiba, near Tokyo.
Objectives: The main aim of my external rotation to Japan was to observe and experience the organisation, the similarities and differences, and the day-to-day running of family medicine. Those cultural differences enable one to learn new techniques and ways of communicating for the purpose of maintaining the patient as the “centre of the medical consultation”.
Materials & Methods: I was able to witness primary care consultations, home-based consultations, patients admitted to the Department of Internal Medicine, and chronically ill patients; to observe the functioning of the Emergency Department and the specialist Internal Medicine Department.
I conducted over 50 home visits, which is a rather new service in Japan, but every day it demonstrates its importance in a population which is ageing rapidly (it is thought that 38.8% of the population will be over the age
of 65 by the year 2050).
Results: Some aspects to highlight of the Japanese healthcare system: courtesy and mutual respect; thoroughness in the anamnesis; access to complementary tests and time dedicated to each patient.
Conclusions: These points represent an improvement in the clinical work, in the capacity to perform differencial diagnosis, and in the quality of care.

P4. Case Report. Early diagnosis of tuberculosis to avoid intracommunity dissemination.

Authors: Nuria Arencibia Hernández, Ana Sofía Mateo Acuña, Luz Bibiana Díaz González, Arrate Leibar Loiti, Olga Fernández Casares. ***Contact:*** arencinur@gmail.com
***Filiations*:** Laredo's Hospital, Laredo, Cantabria, Spain.

Key words: Tuberculosis, therapeutic compliance, intracommunitary dissemination

Abstract: Our patient is a 52-year-old woman who had consulted several times in the last month to her GP for cough with brownish expectoration, and had been treated with antibiotics and inhaled therapy with no improvement. The last three days she presented dysphonia , anorexia and more asthenia. No fever. A chest X-Ray was practiced at the health center, and showed an interstitial pattern, predominant in upper pulmonary lobes. She was an active smoker of 20 cigarettes per day (pack/year rate: 35), alcohol consumer of 20g/day, and 9 years ago she was diagnosed of pneumococcal pneumonia.
She was referred to de emergency department, and she arrived hemodynamically stable with no fever. Oxygen saturation 94%. There weren't more relevant findings on physical examination.
Blood tests didn't show relevant findings, except C-reactive protein 6.4mg/dl.
As differential diagnosis we thought about tuberculosis infection, interstitial pneumonia, pulmonary mycosis, interstitial pneumonitis, sarcoidosis in miliary stage. The patient was admitted to the hospital, and respiratory isolation was required. There, Ziehl- Nielssen stain in a sputum sample showed acid-fast bacilli.
Diagnosis: Pulmonary and laryngeal TB.
At this point, tuberculostatic treatment (Isoniazid + rifampicin + pyrazinamide) was started. There was an improvement of the dysphonia after 4 days of treatment. 20 days after discharge, at GP consultation, the patient refers clinical improvement, weight gain, good therapeutic compliance, and also she had kept respiratory isolation for s few days at home.
Conclusion: The presence of tuberculosis should be ruled out in the clinical setting suggestive of infectious pulmonary disease, as well as encouraging therapeutic compliance in order to avoid intracommunity dissemination.

P5. Case Report. Teenagers with diarrhea. Sometimes we need to take a second look.

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Filiations: Can Misses Health center, Ibiza, Spain.

Key words: Colitis, Ulcerative , Irritable Bowel Syndrome , fecal calprotectin

Abstract: Reason for consultation: one episode of bleeding with deposition.

Background: no smoking, history of chronic diarrhoea, irritable bowel syndrome. Studying abroad.

-Case Presentation: 20 year old man comes to our primary care consultation with one day of rectal bleeding, some episode of diarrhoea without pathological products, not abdominal pain or fever. After normal physical exploration, blood without alterations, dietary recommendations are made.

Two months later, we made physical exploration including rectal examination and complete blood tests with coproculture. Comes 10 days later for the results and reports daily diarrhea of 4-5 depositions per day, skin paleness, appetite loss and abdominal pain, reasons for a digestive doctor evaluation after inflammatory bowel disease is suspected

-Physical examination: No fever, diffuse abdominal pain. Rectal examination with hematic remains.

-Supplementary tests: blood test shows microcytic anemia, leukocytosis, elevation of RCP and GSV, negative coproculture, negative antitransglutaminase, calprotectin high levels, hemoglobin positive in feces. Abdominal normal radiology. Colonoscopy: Continuous affectation from rectal to blind bladder.

-Diagnosis: biopsy confirms inflammatory bowel disease favoring ulcerative colitis on Crohn's disease, no signs of viral infection.

Diagnosis: Ulcerous colitis

Differential diagnosis: Celiac disease, irritable bowel syndrome, Infectious or drugs diarrhea, malabsorption syndrome, diverticulitis, ischemic colitis.

Case evolution: after assessment by digestive doctor and patient's hospitalization for endoscopic study it’s treated with corticosteroids and mesalazine.

Conclusions:

The incidence of IBD has increased in recent years and up to 30% has been diagnosed in adolescence, reason to be considered in the differential diagnosis of chronic diarrhea.

Fecal calprotectin may be useful in discriminating between inflammatory instead of irritable bowel disease and may be of great importance in primary care since up to 10-20% of the population may have irritable bowel syndrome and symptoms may be confused with those of the IBD. Several patients with IBD present higher fecal calprotectin levels with a sensitivity and specificity greater than 90% to identify inflammatory disease.

The IBD presents a great challenge for the GPs as the first contact with the patient, despite the limitation of tests to reach a diagnostic, does not justify that at least the differential diagnosis for subsequent referral is performed.

P6. Case Report. Sore lump in frontal bone. Imaging and differential diagnoses. An open case.

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Key words: Histiocytosis, Langerhans-Cell, Adult Bone

Abstract: Present Complaint: 22 year old lady with a past medical history of morbid obesity, smoking (5 cigs/day), no
contraceptives nor other drugs taken; complaining of a frontal lump, sore to touch for the last 3 weeks. No previous trauma nor skin infections. Complaints of frontal headache worsening during evenings radiated to occipital part, oppressive. No nausea nor vomiting, no high temperature, no photophobia nor sonophofia, resting is not interrumped.
Family history: Father and paternal grandfather history of thrombophilia, heterozigotic pattern for Factor V Leiden, Factor II G20210A Mutation, and MTHFR C667T mutation. Paternal great uncle lung cancer, no smoker, died at 30; cusin of paternal granfather: MTS unknown origin at 60.
Physical examination: Good condition, obesity, hirsutism. Frontal region: no clear lump, frontal suture too anterior. Phototype II-III, no malignant nevus are seen. Seborrheic kerathosis vs fibroma in right scapula. No focal neurologic signs.
Diagnostic tests: cranial Xray: well defined and limited radiotransparent lession 1.3 x 0.8 cm in right frontal bone, coincident with the sore place.
Cranial CT scan: osteolytic frontal lesion, right parasagital with irregular and well defined limits 0.9 cm, soft tissue density on the inside. Possible X Histiocytosis
Differential diagnosis: X hitiocytosis, osteofibroma, trombofilia, oncological, endocrinological predisposition.
Diagnosis is to be confirmed (Fine Needle Aspiration to be performed)
Conclusions:
- It is important to perform a correct anamnesis and fisical examination focused to the complaint
- As a GP it is important to know about genetics. In this case, because Langerhans Cell Histiocytosis
(Previously known as X Histiocytosis is related to a big ammount of deseases, from benign nevus to malignant
melanoma
- The age range is wide: from a posible viral origin in children to a smoke relation in adults, so as GP we can
contribute to its prevention. (inheritance is proved only in 1% of cases)

P7. Case Report. Recurrent Furunculosis.

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Key Words: furunculosis, recurrent, abscess

Abstract:

Reasons for consultation:
1 month and a half of medical consultation regarding the following injuries:
- 2 abscesses at the cervical region
- Dacryocystitis
- Furuncle in the nose
- Abscess in the gluteal area

Most relevant data from the medical history:
- 57-year-old man
- Ex-smoker
- Patological background: obesity, diabetes mellitus, dyslipidemia.
- In treatment with metformin and atorvastatin.

Physical examination:
Cardiopulmonary auscultation: Rhythmic tones without murmurs, preserved vesicular murmur without pathological noises.
Abdomen: Normal.Different abscesses in the course of a month and a half.

Diagnostic tests:
- General Analysis
- Culture of the lesions

Diagnostic orientation:Recurrent furunculosis

Differential diagnosis:
- Immunosuppresion
- Wrong controlled diabetes
- Hyperhidrosis

Treatment:
- Lesion draining
- Amoxicilin/Clavulanic Acid
- Topical Mupirocin

Evolution:
At the third medical consultation, the patient states that all the people who lives at his address are experiencing the same symptoms. He says that his wife has been in a trip to Paraguay and he believes that she has brought a virus since the symptoms after coming back from that trip. He also comments that his wife and his three children have had multiple skin infections in a small period of time.
Once applied lesion treatment, they improved but this evolution was slow.
The results of the general analysis were normal.The culture results were: S. Aureus Methicillin-resistant
A disinfection has been carried out with: showers with a solution of Chlorhexidine 4%, furniture disinfection, towel and bed linen cleaning.
The first choice of antibiotic treatment is clindamycin or cotrimoxazole.

Conclusions:
- The importance of carrying out an anamnesis in depth.
- Asking for recent trips.
- Importance of GP's general view.
- Importance of patient environment.

P8. Case Report. A patient with subclinical hyperthyroidism.

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Key words: breathlessness, TSH, subclinical hyperthyroidism
Abstract: A 37- years-old woman consults because of increased breathlessness and sore throat that began 2 weeks ago
and become more intense 2 days ago. The patient didn't have temperature, no dysuria, no diarrhea and neither chest pain.
As interesting personal background stand out smoking (15pack/year), surgery of nose septum in 07/2013 because of breathlessness, a Pulmonary emphysema diagnosed by High resolution TAC without pulmonary obstruction in 10/2013, SAHOS in treatment with CPAP and generalized anxiety disorder in treatment with Venlafaxina 150 mg and Alprazolam 0.5mg.
Examination:
Temperature 35.2ºC, blood pressure 110/57mmHg, pulse 107 hpm, oxygen saturation 96%.
She appeared well and the findings on general physical examination were normal.
Important laboratory test results:
No leukocytosis neither anemia
NTProBNP 45 pg/mL.
TSH 0,07 uUI/mL, FT4 1,31 ng/ml, FT32,51 pg/mL.
AntiTPO 15 UI/mL (positive >5.6), Antitiroglobulina 32.56UI/mL. (positive>4)
Images studies were obtained:
HRCT: upper lobe centrilobular pulmonary enphysema.
Thyroid scintigraphy Low thyroid radioiodine uptake.
At the beginning we thought that all symptoms were caused by her anxiety disorder because the examination was normal, but with the laboratory findings we first discuss thyroid problems. In developing a differential diagnosis, subclinical hyperthyroidism can be caused by different kinds of thyroiditis, including subacute thyroiditis, Hashimoto thyroiditis and painless thyroiditis. Image studies were obtained in a way to achieve the diagnosis.
According to the laboratory findings, scintigraphy result and symptoms the diagnosis of painless thyroiditis wasthe most consistent. In the treatment we included a beta-blocker (propranolol) and a Nonsteroidal anti-inflammatory (Ibuprofen) and the patient had a good clinical evolution during the next weeks. Also we did some more controls of the TSH that rose progressively and finally normalized after 8 weeks.
Conclusion:
With this clinical report we want to show the importance of a good physical exam and reflect about the
laboratory solicitation and image studies. Always the image studies have to be based on the physical exam and are very helpful to achieve the final diagnosis.

P9. Research Project. Analysis of referrals and waiting lists in a Majorcan Health Center.

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Key words: Referral, Waiting lists, Primary Health Care

Abstract: Background: One of the main problems of our health system is the waiting list of referrals from primary care to a second level of hospital care. In order to have an effective and good quality health system to meet the needs of the population, an improvement in the connection between primary and specialized care is required with a reduction in waiting lists. So the first step is to perform an evaluation of the data to be able to intervene properly.
Objectives: To know the specialties that generate the greatest number of referrals and its prioritization and to know the waiting times associated with the referrals made from the Escola Graduada Primary Health Center.
Methods: Referrals were collected in the Escola Graduada Primary Health Centre from the 17th November to 17th December 2016. The variables: Specialty to which the referral is requested, number of references and their prioritization and waiting list for different medical specialties were analysed.
Results: With a total number of referrals of 326, the 66% corresponded to medical-surgical specialties and 34% to radiology service. Most referrals to the radiology service are conventional X-ray (67%). Considering the medical-surgical specialties, Ophthalmology (23,25%) takes the first place of the referrals followed by Dermatology (15,81%) and Traumatology (10,23%). The highest percentage of preferential referrals correspond to Rehabilitation (50%), Urology (33,33%) and Traumatology (22,72%).
The longest waiting list is for Gastroenterology (192 days) followed by General Surgery (90 days) and
Cardiology (80 days) while the shorter one is for conventional radiography (6 days). Five months later some of the specialties had not offered an appointment being Ophthalmology, Neurology and Gastroenterology the specialties with the highest number of referrals without appointment.
Conclusions: Our results show waiting lists longer than data published on local newspapers. It is surprising that rehabilitation is the service with the highest number of preferential referrals. Knowing the hospital services with greater demand allows designing possible solutions. Reducing waiting lists is essential to improve the resolution of health problems and to make the health system more effective and resolutive.

P10. Case Report. Glucocorticoids: Daily use and continuous care.

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Key words: Immunosuppression, Glucocorticoids, Tuberculosis

Abstract: Our patient is an 83-year-old male, nonsmoker, with relevant medical history of leukopenia, lymphopenia and anemia in the past year, who consulted because since last month, his condition had seriously deteriorated, with loss of strength in both legs, asthenia and anorexia but without fever. In his previous blood analysis, there was an increase of the erythrocyte sedimentation rate, ferritin, PCR and polyclonal peak in the gamma zone. Suspecting polymyalgia rheumatica, treatment with Prednisone 30mg/24h was initiated. A couple of weeks later, his caretaker asked for a house visit since he presented decreased level of consciousness, fever and low pulse Ox. We referred him to the emergency room for possible infectious disease.
Complementary studies:
• Chest X-ray showed known apical granulomas;
• CT-scan: diffuse micronodulillar interstitial pattern with multiple micronodules in all pulmonary lobes of random
distribution
• Bronchoscopy: BAAR positive for Mycobacterium complex.
Diagnosis:
• Acute respiratory failure in a patient immunosuppressed by corticosteroids.
• Miliary tuberculosis.
Differential Diagnosis: infectious diseases; certain types of cancer.
Treatment and evolution:
The patient started empirical treatment with tuberculostatics (RIMSTAR). His follow-up consults will be made by his GP and the specialized tuberculosis unit.
Conclusions:
Tuberculosis (Tb) is one of the 10 leading causes of mortality in the world and about one-third of the world population is infected with M. tuberculosis. The risk of getting ill increases in immunosuppressed, malnourished, diabetic and smoker patients.
Chronic glucocorticoid therapy affects the immune system therefore increasing the risk of reactivating chronic infections. Several studies have observed that taking > 15mg of prednisone / 24h for ?1 month suppresses the reactivity of tuberculin; nevertheless, the threshold of the dose / duration of treatment that could increase the risk of tuberculosis, has not been demonstrated. It is estimated that there is a linear relationship, but so far, there isn't much research in this field to verify this.
To sum up, in our daily practice, when starting a chronic treatment with glucocorticoids, it's necessary to take into consideration the patient profile and his risk factors, to avoid a reactivation of latent Tb, like in this case, where, in addition the glucocorticoid dosage used was higher than recommended.

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P11. Case Report. When the sodium-potassium pump is extenuated.

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Key words: Hypokalemia, Graves Disease, Muscle Weakness

Abstract: - Reason for consultation: muscle weakness
- Medical History and physical examination: 26 year-old man with a history of a heavy consumption of toxicants
(marijuana, methamphetamines, tobacco and alcohol) was admitted into the Health Center presenting sudden clinical symptoms that consisted of weakness in the proximal muscles that prevented him from walking or getting up. When questioned, he acknowledged a similar episode two months previously when after excessive consumption of shabu
(methamphetamine) for a duration of 4 days and for which he did not seek medical attention. Two months after this episode he repeated the same pattern by consuming an excessive amount of shabu.
Detailed neurological assessment did not find weakness in any muscular group. No atrophy of muscle groups.
The rest of the examination was normal.
- Diagnostic tests: In the analytical done in the emergency room, there was a hypokalemia of 1.5 mEq/l as a
precautionary measure he was admitted into Intensive Care. Electrocardiography showed a sinusal tachycardia
at 118 bpm.
- Evolution: During the admission further diagnostic tests were completed and it was determined that the thyroid
hormones showed a suppressed TSH, so beta-blocker treatment was started. Once stabilised with the
correction of the hypokalemia the patient was transferred to the plant of Internal Medicine to complete the study.
The evolution was favourable, with a normalised level of potassium which did not require additional
supplements.
- Diagnosis Orientation: The study was completed, reaching the diagnosis of thyrotoxic periodic paralysis (TPP)
after a Graves' disease (palpable goiter, suppressed TSH, raised levels of T4 and T3, antithyroid antibody and
gamma-thyroid antibody positivity with diffuse hyperplastic gland).
- Treatment: In addition to maintaining the beta-blockers, treatment with antithyroid drugs (carbimazole)
commenced and the patient was transferred to Primary Care to continue treatment and long-term follow-up.
- Conclusions: Hypokalemia in TPP results from an intracellular shift of potassium induced by the thyroid
hormone sensitization of Na+/K+-ATPase rather than depletion of total body potassium. Excessive
consumption of methamphetamines and alcohol and the change to a largely carbohydrate diet may have been
the triggers of periodic hypokalemic crisis in this patient with Graves' disease, previously undiagnosed.

P12. Case Report. Not every fever is infection.

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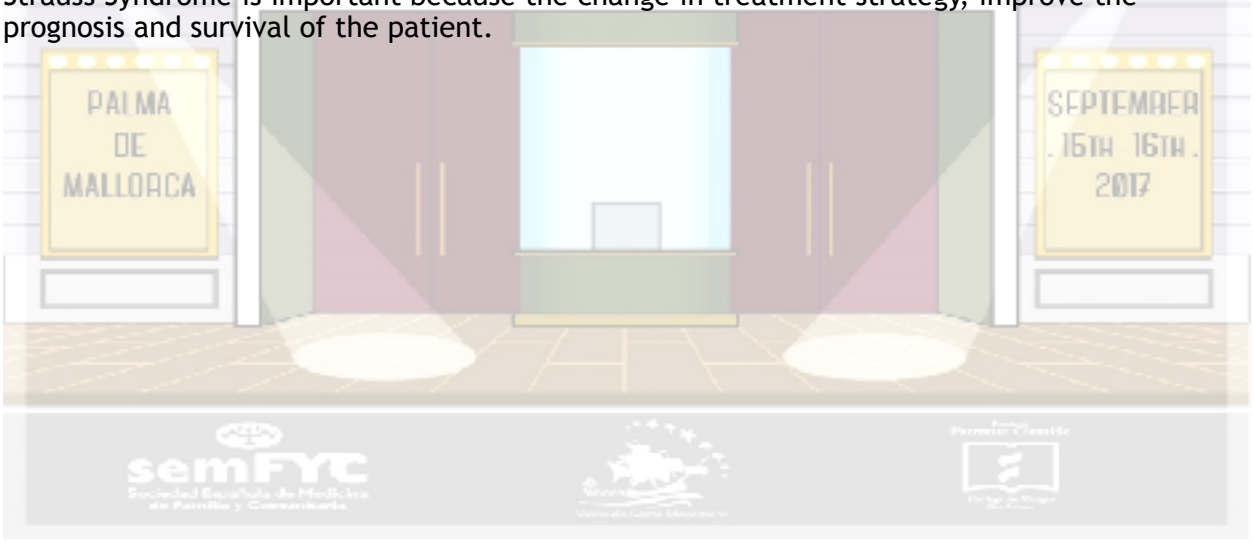
Key words: Vasculitis, Fever, Antimyeloperoxidase antibodies

Abstract: Male 68 years old, with episodes of profuse nocturnal sweating together with myalgias in lower limbs since 4
months ago, previous edema lower lip with habituating lesions in lower limbs and trunk that disappeared with
corticoid, and weight loss. Admitted with diagnostic of fever of origin unknown (FOU).
Personal history: HT in treatment, Dyslipemia, Bronchial asthma and chronic rhinitis in treatment Aneurysm
carotid, Previous admission: Probable Pneumonia. Surgical: Bilateral rhinosinusal polyposis.
Analytical: Leukocytosis with confirmed Eosinophilia, increased ESR, Proteinogram and tumor markers
negative, positive Antimyeloperoxidase antibodies, Muscle biopsy: Fibrinoid necrotizing vasculitis.
Electromyogram: Polyneuropathy.
Differential diagnosis: Lymphoma, Solid neoplasia, Infective endocarditis, Microscopic polyangiitis, Parasitosis, Autoimmune disease.
Diagnosis: Vasculitis Syndrome of Churg Strauss
Evolution: During the admission, complementary tests and evaluation by rheumatology for suspicion of
vasculitis were requested and corticoid treatment is initiated with resolution of fever, clinical and analytical improvement. Patient is given ambulatory treatment with Rituximab. Corticoid therapy with descendent pattern, antihypertensive treatment, Azatiprine, Adiro and Association of bisphosphonate and vitamin D3 (Adrovance).
Conclusion: In patients with asthma and high peripheral eosinophilia, considering Churg Strauss Syndrome is important because the change in treatment strategy, improve the prognosis and survival of the patient.



P13. Case Report. Thrombosis in the arm of a young patient, what was the cause?

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Key words: Venous Thrombosis, Pain, Edema

Abstract: 19 year old male patient, no known allergies to medications, with a history of shoulder subluxation right, tonsillectomy, left inguinal hernia repair, works as a bicycle mechanic and dominant right hand, smoking 7 cigarettes a day.
He comes to the emergency department sent from his primary care center to present edema of the upper right extremity of 24 hours of evolution. Deny overexertion, trauma or dyspnea. It refers to dysthermia the day before.Good general condition, normal color, well hydrated. Neurological: Sensory normal. Vascular exploration: upper right extremity: radial pulse present. Edema with respect to contralateral. Collateral venous circulation. Mild cyanosis. Laboratory data: 16500 leukocytes, D-dimer 237, PCR 3.31. Rest without significant alterations.
Imaging tests:
-Rx thorax: No cervical rib or megaapophysis, any obvious bony anatomic abnormality.
-Venous echo Doppler upper right extremity: Jugular, humeral distal, cephalic and basilic veins, compressible, without image of endoluminal occupation. Subclavian, axillary and proximal humeral veins not compressible, without flow, with endoluminal occupation image. Conclusion: Signs of axillary-subclavian venous thrombosis in the upper right extremity.
-Phlebography: Axillary vein occlusion with drainage through collaterals to the jugular system
Diagnosis:
Subclavian-axillary venous thrombosis of the upper right extremity - Paget-Schroetter's Syndrome
Differential diagnosis: lymphedema, thrombosis secondary to medications.
Treatment: fibrinolytic therapy is established and the reperfusion of the thrombosed segment is confirmed and the presence of a pre-existing stenosis is observed at this level, which is exacerbated by the abduction of the upper limb. Anticoagulation treatment with low molecular weight heparin and outpatient follow-up to assess the need for transaxillary first right rib resection.
In conclusion, Pager-Schroetter's Syndrome is an underdiagnosed disease, affecting young individuals in their dominant extremity. The most accepted management is fibrinolysis as soon as possible, decompressive surgery and anticoagulation, with the result that the sequelae decrease and more than 90% of the patients are reincorporated to their habitual activity, as it was practiced to this patient.

P14. Case Report. It was not just a depression.

Authors: López Cleries, Celia; Ferrado Sanchis, Rosalia; Covacho González, Marina; Vidal Ribas, Cristina; Pérez Cuadrado, Esther; Albaladejo Blanco, María. *Contact:* clcleries@hotmail.com
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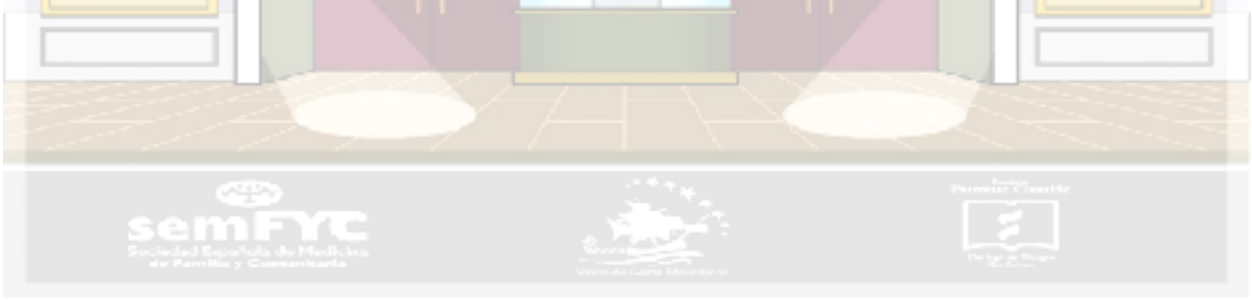
Key words: DEPRESSION, ANXIETY, CATATONIA

Abstract: Reason for consultation:
A 60-year-old woman, together with her husband, who asks for help against sadness, anxiety, selective mutism (that disappears when she is alone with him) and difficulties to move since 1 month, in relation with a diagnosis of lung cancer of her husband.
Medical history:
No toxics. No drug allergies.In April of 2014 she had anxiety and didn't react to Benzodiazepines. Good reaction to Paroxetine 20mg.
Physical examination: Afebril, heart ratio 98 beats/min, Blood pressure 130/78mmHg. Oxygen saturation 98%. Neurologic and traumatology examination were normal.
Diagnostic tests:
- CT scan: normal.
- Blood test, TSH, Vitamine B12, Folic acid, serologies: normal
Diagnostic orientation: Depression
Differential diagnosis: Adaptive disorder, anxiety, dementia…
Treatment: Paroxetine 20mg
Evolution:
After 1 week, the patient's symptoms had a rapid evolution to catatonia, for which she was forwarded to thehospital. After a neurological examination and diagnostical tests, they excluded catatonia causes as encephalitis and malignant neuroleptic syndrome. They made an electroencephalogram that showed periodic sharp wave complexes, a brain magnetic resonance with high signal abnormalities in caudate nucleus, putamen on diffusion-weighted imaging and fluid attenuated inversion recovery; typical findings of Creutzfeldt-Jakob disease. At this moment, 14-3-3 cerebrospinal fluid assay, another typical finding, is pending result.
Conclusions:
Creutzfelt-Jakob disease is a rare fatal brain disorder believed to be caused by a protein known as a prion. Specific Creutzfelt-Jakob disease symptoms can differ significantly between patients. The most common symptoms include myoclonus, visual or cerebellar signs, piramidal/extrapyramidal signs, akinetic mutism, depression, agitation, apathy, disorientation, and memory problems. Other frequently occurring features are paranoia, obsessive-compulsive symptoms and psychosis.



P15. Case Report. Doctor, take these hiccups off me!

Authors: AGUILÓ LLOBERA, MARIA ANTONIA; FIGUEROLA BUCKLITSCH, CRISTINA; VIDAL SOLIVELLAS, MARIA DEL CARMEN; RAMIREZ ARROYO, VIOLETA. *Contact:* mantoniauab@hotmail.com

Filiations: IBAMFiC.
Key words: Hiccups, drugs, lower back pain
Abstract: Doctor, take these hiccups off me!
CASE DESCRIPTION
A 79-year-old male patient who came to the clinic presenting hiccups with a duration of over 48 hours with an abrupt start. The pathological diseases described in the PMH (patient's medical history): ex-smoker for 30 years and hypertension treated with bisoprolol 2.5mg. Recent check-up by Cardiology without evidence of structural pathology. He denies abdominal pathology, bad digestions, infectious clinic in the last days, respiratory clinic nor weight loss. The only significant information is a visit a few days ago due to acute lower back pain which did not improve with oral analgesia and began intramuscular treatment (cyanocobalamin 250micrograms + dexamethasone 4mg + lidocaine 60mg + thiamine 50mg)
EXPLORATION AND COMPLEMENTARY TESTS
EF: TA 137/78, FC 61 bpm, afebrile. ABD: soft and depressible, no masses or megaleas are palpable. Not
painful, ACP normal. Othoscopy normal. Complementary tests: ECG: sinus rhythm at 61 lpm, without significant alterations. Chest X-ray: no mediastinal image, no image of condensation nor image suggestive of neoplasia. Since no pathology or alteration was found we decided to review the possible relationship with the recent start of treatment with lower back pain and we found in a Pharmacovigilance Centre Bulletin that hiccups could be related to the intramuscular drug described.
CLINICAL TRIAL
Hiccups as a drug side effect. It disappeared when intramuscular treatment was removed (cyanocobalamin + dexamethasone + lidocaine + thiamine)
DIFFERENTIAL DIAGNOSIS
Differential diagnosis should be made with: causes of irritation of the phrenic or vagal nerve (multiple digestive disorders, pregnancy, foreign body in external auditory canal, goiter, mediastinal lesions, respiratory and cardiac pathologies), central nervous system disease (inflammatory / infectious pathology, , Alcoholism), metabolic causes, drugs, psychogenic causes, etc ...
FINAL COMMENT
From primary health care we must make a complete anamnesis and exploration that guides us to the
complementary tests that we must request. Within the differential diagnosis, we must never forget to review the usual and recent treatment as a possible cause of the pathology we are studying.
Bibliografía Boletín informativo del Centro de Farmacovigilancia de la Comunidad de Madrid. Hipo por medicamentos. Octubre 2013.

P16. Case Report. Unexpected breast cancer.

Authors: Figuerola Bucklitsch, Cristina; Aguiló Llobera, Maria Antònia; Ramirez Arroyo,

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***Filiations*:** UBS El Molinar, Palma de Mallorca, Illes Balears.
Key words: Carpal tunnel syndrome, Lymphedema, Breast neoplasms
Abstract: Case Description:
A 40-year-old woman, who had a carpal tunnel syndrome (CTS) surgery of the left wrist a week ago, visits us to assess the condition of the suture, which is in good condition. The surgery had no complications but referred an oedema in the left upper limb and a lump in the left breast for 2 weeks.
Physical examination: Thorax: Asymmetry of the left breast with nipple retraction and significant hardening of the entire central area of the breast and a mass that suggests malignancy was detected with palpation. No local temperature increase or erythema but appearance of orange peel skin. Axillary lymphadenopathy were not palpable. The patient is referred to gynaecology hospital emergencies where preferential mammography and ultrasound were requested.
Complementary Tests: Mammography: shows a retroareolar mass of the left breast suspected of malignancy. In the upper inner quadrant of the right breast we can see a group of microcalcifications also suspicious. Ultrasound: suggests the same poorly delimited retroareolar mass of about 4 cm in the left breast and a 15 mm left axillary adenopathy suggesting metastasis. Subsequently, biopsies are performed using fine-needle aspiration that are positive for malignancy. The patient is referred to Oncology to complete the extension study and initiate treatment.
Diagnostic orientation:
Malignant neoplasm of the left breast.
Differential Diagnosis: Infectious pathology of the breast. Benign and malignant pathology of the breast.
Evolution and conclusions: The patient was again questioned and reported that she had had this mass in the breast for months along with mild oedema in the left arm especially in the wrist but had not wanted to be attended. She has no family history of breast cancer. The CTS diagnosed months ago was considered mild but when having symptoms, it was decided to treat with surgery. It is possible that symptoms, initially associated with CTS, were secondary to neoplasm. In Primary Health Care, apparently banal reasons for consultation may disguise important pathologies.

P17. Case Report. A rare disease ... pyoderma gangrenosum.
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Pedro Vidal. ***Contact:*** cris.3.v.r@gmail.com
***Filiations*:** Primary Health Center, Calvia, Spain.
Key words: pyoderma gangrenosum, ulcer, rare disease
Abstract: Reason for consultation:
Woman,26, came for having her right ankle swollen since that morning. She denied trauma, she thinks this is due to the bite of an insect. Most relevant data from the medical history: No interest Physical examination: Blistering lesion in the lateral region of the right ankle, with erythema of base and increase of temperature. No signs of deep venous thrombosis. After a few weeks, an ulcer lesion develops.
Diagnosis tests: At that time we think of insect bite+superinfection. Treatment with amoxicillin-calvulanic and nursing cures begins. The lesion does not improve and the patient complains of intense pain, so it was performed: - Lesion culture:negative - Analytical: Rickettsia conorii IgM+IgG 1/320 (title suggestive of infection), rest anodyne.
Treatment with doxycycline 100mg/12h*10 days is initiated. Despite the treatment the lesion is stagnant. A new lesion culture was made: mixed, aerobic with enterobacteria, pseudomonas and enterococos. It is treated with ciprofloxacin, without obvious improvement. Three months after the first consultation, and after several treatments with very slow evolution of the ulcerous lesion, with a necrotic background, she is referred to dermatology.
Diagnostic orientation (syndrome and/or etiology):
Rickettsial, fungal, mycobacterial or viral infection.
Lymphoproliferative process.
Metastasis
Treatment and evolution: Biopsy is performed: epidermal ulceration, non-specific reactive dermal changes. There is no evidence of microorganisms or signs of malignancy. compatible with pyoderma gangrenosum.
Treatment with betamethasone is initiated for 3 weeks and recited for control in dermatology service (pending at this time of new control)
Conclusions: Pyoderma gangrenosum (PG) is a cutaneous clinical-pathological entity that is part of the spectrum neutrophilic dermatoses". Although their actual incidence is unknown, there are estimates about 3 cases per million habitants per year, so it would be a rare disease. It is more frequent between the 3rd and 5th decades of life, with a slight feminine predominance. Its etiology is unknown and the clinical presentation can be very varied (ulcerative is the classic form but we can find blisters, pustules or other). The PG can compromise internal organs (lungs, liver and spleen) with sterile abscesses that can complicate the illness.

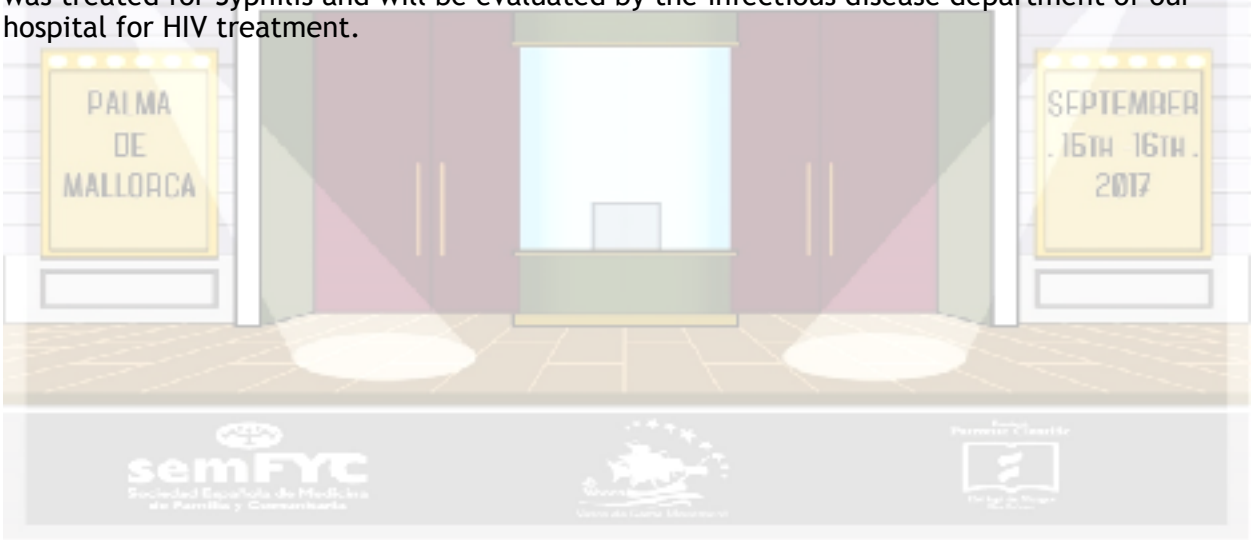
P18. Case Report. My abdomen swells after drinking coke.
Authors: Cristina Vidal, Bernardino Marcos, Celia Lopez, Cristina Mendoza, Ane Marie Pletea, Marina Covacho. ***Contact:*** cris.3.v.r@gmail.com
***Filiations*:** Primary Health Center, Calvia, Spain.

Key words: Abdominal pain, Colonic Neoplasms, metastasis
Abstract: Reason for consultation:
Woman, 31,comes to our consulting room because her abdomen swells after drinking coke, for 2 months.
The patient returns on several occasions for worsening of the abdominal swelling.
Most relevant data from the medical history: For 6 months she is trying to get pregnant, without success. She has a complete gynecological study done in private clinic a month before, it is normal.
Physical examination: Abdomen slightly distended, with generalized discomfort on palpation.
Diagnosis tests: Blood test: liver enzyme slightly increased (GGT 61).
For this reason the analysis is extended, requesting pancreatic profiles (normal), liver serologies (demonstrating correct vaccination virus hepatitis B), and autoimmunity study (negative).
The patients complained about more pain and abdomen distended, so we asked helicobacter pylory infection study (negative), allergic/intollerance study (negative) and abdominal ultrasound.
Diagnostic orientation (syndrome and/or etiology):
Abdominal swelling without associated pathology
Liver disease
Gynecological disease
Intestinal disease
Treatment and evolution: The patient suffers a bigger sensation of abdominal distension and in one of the visits, she refers intense pain of several days and a deposition with blood the last week. Pain does not calm with second-degree analgesia. The abdominal ultrasound has not yet been performed. She is referred to the emergency room in the hospital, where a blood test was done (it was normal, including liver enzymes). Due to the intense pain that the patient had, calming partially with morfina, an abdominal CTscan is done, evidencing lesions in the liver and descending colon.
Finally the patient is diagnosed of colon cancer with liver metastasis. At this time, in the second line of
chemotherapy.
Conclusions: The colon cancer is the most malignant tumor (of incidence) in Spain, if we consider men and women. About 41.441 new cases are diagnosed each year.
Although it is much more common after age 50, recently published studies have shown an increase in the incidence of colon cancer in young adults. Therefore, even if the patient does not present risk factors, it is a pathology that we must always take into account when we make the differential diagnosis of abdominal pain.

P19. Case Report. A 39-year-old male with fever, oral and pharyngeal lesions and macular exanthema on hands and soles.

Authors: Herranz Roig, Elisa; Landin Basterra, Julen; Caballero Segura, Gabriel Jesús; Angelini, Gastón Leonel. ***Contact:*** gaston.angelini@asef.es
***Filiations*:** Àrea de Salut Eivissa i Formentera - Spain.

Key words: Exanthema, Fever, Retropharyngeal ulcer
Abstract: A 39 year old male with no relevant medical history except for psoriasis, presented initially to the ER with a three-day history of sore throat, oral ulcers and fever; it was interpreted as oral candidiasis, for which he took two weeks of nistatine; after no improvement, he came back with the same symptoms plus a non pruriginous macular exanthema exclusive to the palms and soles, which was interpreted as Hand-foot-mouth disease and changed the antimycotic for Fluconazole. He persisted with the same symptoms, for which he came to our consult. Previous serologies (March 2017), were negative. On examination: Temperature of 38,9 ºC, HR 89 bpm, BP: 116/76 mmHg, O2 sat: 99%. Oral cavity with ulcers of the tongue and inner lip mucouse, throat with exudative lesions on the tonsils, and a white-coated retophrayngeal ulcer, laterocervical, tender lymphadenopathies. We suspended the Fluconazole and started Augmentine. Chest X-ray: normal. Throat culture: normal flora. First blood test:
RBC: 4,57 cells*10^6/uL ERS: 9 mm WBC: 4,42*10^3/uL Lymphocytes: 25% - 1,1*10^3/uL Neutrophyles: 65% - 2,88*10^3/uL Ferritine: 883 ng/dL HBsAg: negative Anti-HBc: negative HepC: negative RPR: negative IgG CMV: negative IgM CMV: doubtful EBV: negative. HIV: positive.
Four days after we initiated antibiotic treatment, the patient came back having improved in the oral lesions and the sore throat; the exanthema was practically gone and his overall status was good, although the retropharyngeal ulcer still persisted.
Serology confirmation:HIV P24Ag: positive.HIV serology: positive.RPR: Positive 1/32Treponema pallidum IgG: Positive.TPHA: Pending.Western Blot: pending.Diagnosis: HIV primary infection/ Syphilis.
Treatment: Penicillin + patient will be attending our hospital Infectious Disease department for evaluation ofantiretroviral treatment.
Conclusions:This is the case of a 39 year-old male, who presented with a two-week history of sore throat, oral lesions, fever,a single retropharyngeal ulcer and macular exanthema of the palms and soles, which was originally interpreted as oral candidiasis and then Hand-Mouth-Foot disease; later on we confirmed with serologies an HIV primary infection/Syphilis. Patient was treated for Syphilis and will be evaluated by the infectious disease department of our hospital for HIV treatment.



P20. Case Report. The importance of diagnostic tools in Family Medicine.
Authors: Herranz Roig, Elisa; Landin Basterra, Julen; Caballero Segura, Gabriel Jesús; Angelini, Gastón Leonel. ***Contact:*** gaston.angelini@hotmail.com
Filiations: Àrea de Salut Eivissa i Formentera.

Key words: Family Medicine, Tools, Ultrasound

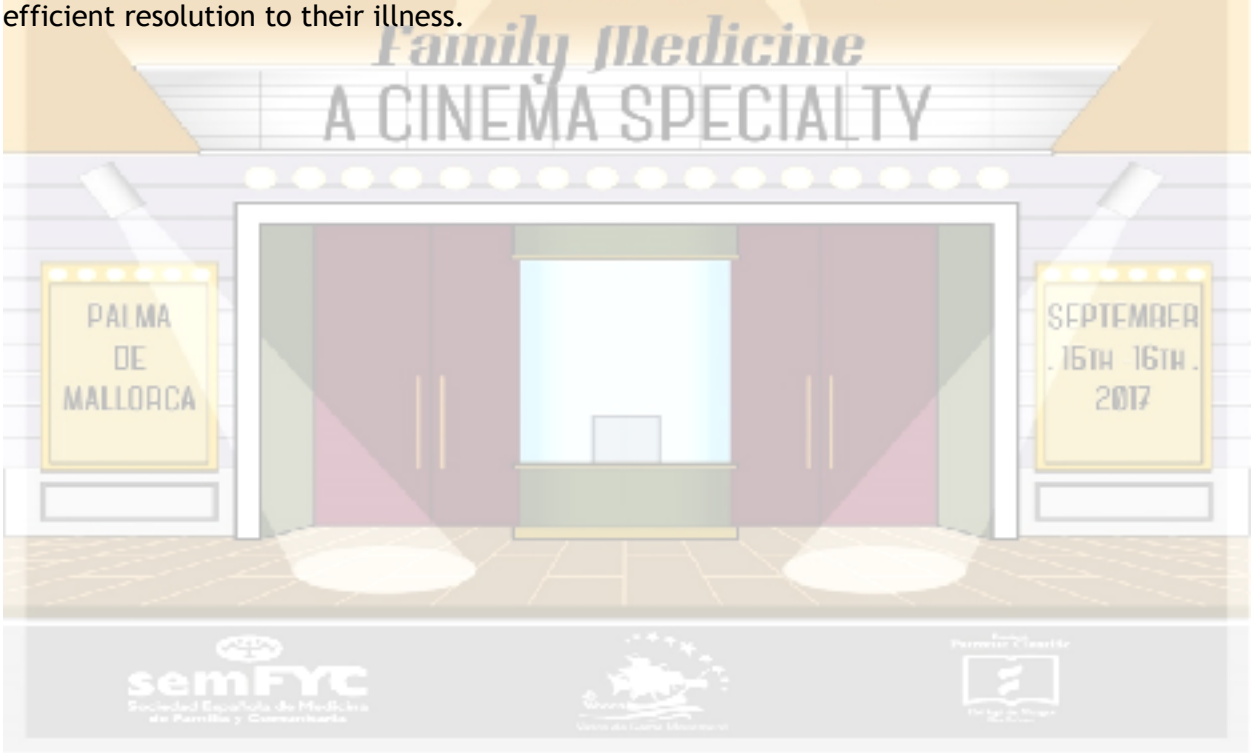
Abstract: A 79 year-ol male with previous history of high blood pressure, type 2 diabetes, chronic atrial fibrilation treated with acenocumarol, chronic renal disease, cataracts surgery, chronic bronchitis and triple-bypass due to coronary heart disease in 2007, came in to our consult refering pain on both calfs while walking, which made him stop every10-12 steps. He was previously studied in 2008 for Intermitent Claudication with no pathological findings at that moment.

On physical examination: Bilateral absence of femoral, popliteal, posterior tibial and dorsalis pedis pulses by palpation (two explorers). Heart auscultation was unremarkable, except for arrythmic beats according to his atrial fibrilation. Rest of the physical examination: without findings.

We proceeded to use a portable doppler device (Minidop) on both inferior limbs, with which we were unable to find the beating pulses from the waist down, bilaterally; we have an ultrasound device available in our center, so we ourselves performed an eco-doppler of both of the femoral and popliteal regions. We found that the arterial pulse was diminished in all of the areas explored.

We refered him to the vascular surgery service for confirmation and further study and evaluation of specialized treatment of intermitent claudication.

Conslusions: We have a 79 year-old male with clinical findings compatible with severe peripheral arteriopathy which causes intermitent claudication. We were able to diagnose him in one consult due to the fact that we had the tools available to us at the moment; we want to highlight the importance of diagnostic tools in the Family Medicine consults, to reduce timeframes in diagnosis and treatment, thus providing patients with a faster and more efficient resolution to their illness.



Full-Text e-Posters

eP1. Research Project. Health Network: "Saja"

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***Filiations*:** Resident of third year of family medicine. Health center: Saja. Cabezón de la Sal. Cantabria

Key words: community, health, network

Abstract:
Background: The degree of social cohesion, the existence or not of certain resources, how they are used and how they are connected to each other, are factors that influence the well-being of a population. The protagonism of citizenship and their participation in the community are decisive elements for their health and well-being.
Objectives: Maintain and improve well-being in a community, coordinating and working together with different sectors: education, transport, equality, public works, urban planning, health system, social services, environment ...
Methods: In our health center began the first meeting.
1) Health professionals meet and reflect on why and how to work in community health at the local level.
2) It is decided to invite all community associations, to form a group composed of different sectors, with common objectives and clear leadership from the community itself.
3) Know the assets for health that exist in the community and the situation of problems and needs. Identify resources that the community recognizes as riches that strengthen the ability of individuals or groups to maintain or improve health.
4) Prioritize the needs of the population according to the order in which we consider them to be addressed. We decide to expose needs and help each other with the resources we have each member to solve problems.
5) One meeting each month, to communicate progress and successes. Establish evaluation mechanisms that allow for improvement measures throughout the process.
Results: The results are currently very positive. We have been able to help seniors to improve their skills with the computer. The bibliotherapy project for people who are living important changes in their lives, has had a great reception in the community. Donations of toys and children's books for the neediest, has been a success. And best of all, it is that the network grows every day more and more.
Conclusions: Today, we need to design associative strategies, promote health, increase the quality of life and social welfare, enhance the capacity of individuals and groups to address their own problems, demands and needs. That is why today more than ever we need to develop into community activities.

eP2. Case Report. The consequences of bullying.

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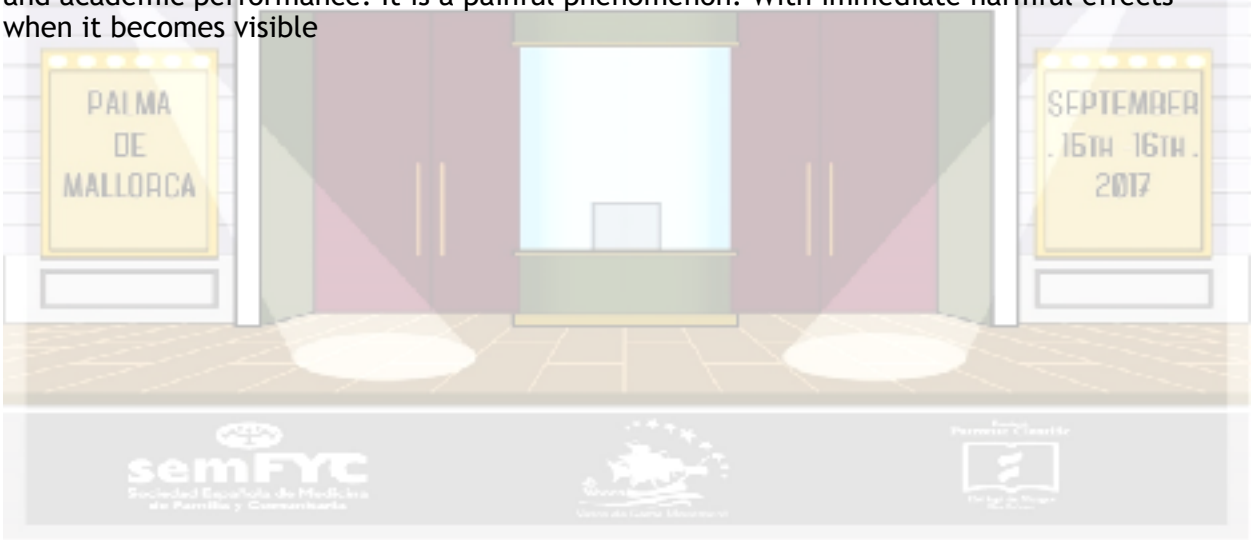
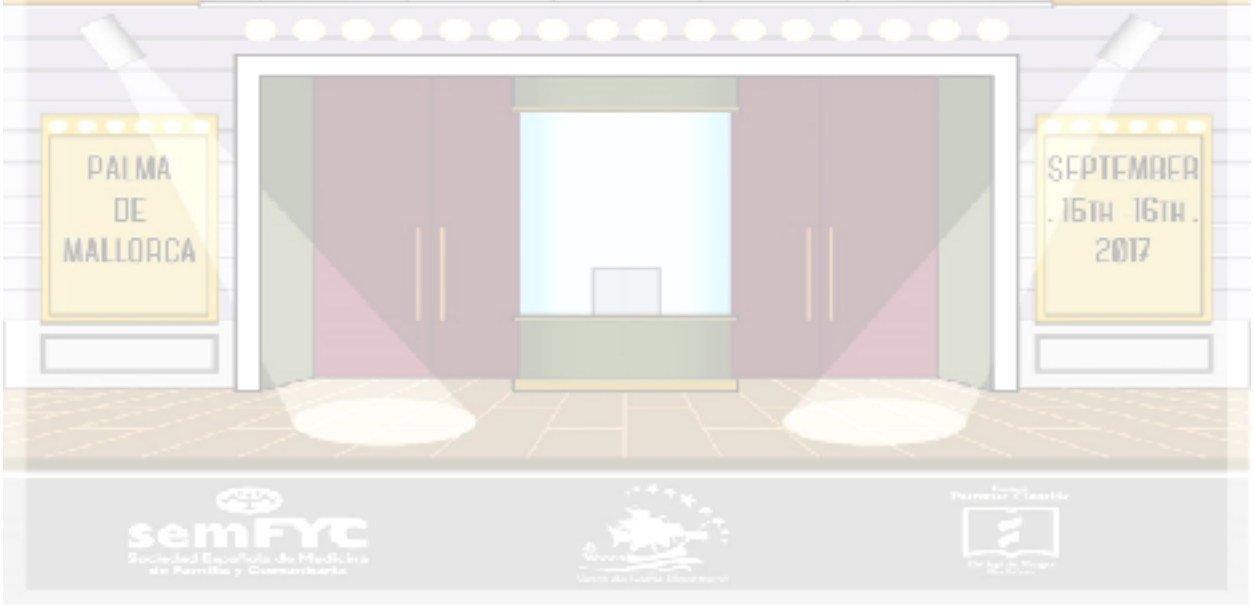
***Filiations*:** Resident of third year of family medicine. Health center: Saja. Cabezón de la Sal. Cantabria

Key words: Psychotic, Depression, Obsessive
Abstract: Reason for consultation: A 20-year-old man who attends the ER brought by 061 for the intake of crystals with autolytic purpose. The patient does not cooperate, and the family tells him that they had found him in the bathroom, swallowing the glass in the bathroom mirror, which he had broken, intending to hurt himself. Associates cough and respiratory distress.
Physical examination: Vital constants: TA 117/85; FC 87; FR 36; SatO2 98%; Tª 36.5º
- ORL: Normal pharynx, as well as rest of the oral cavity. - Cardiac auscultation: Rhythmic, without blows at the moment. - Pulmonary auscultation: Good bilateral ventilation with no added noise.
Diagnostic tests: Hemogram and biochemistry: No findings of pathological significance. - Cervical Rx: A foreign body is sensed at the centro-thoracic level, without being able to clearly specify the location. - Laryngoscopy: No findings of pathological significance. - CAT: Hyperdense foreign body located in the distal trachea, immediately cranial to the bifurcation, presenting a cylindrical morphology of vertical arrangement, and measures of 3.2 x 0.5 cm.
Diagnostic orientation: Psychotic disorder
Differential diagnosis: Schizophrenia, schizoaffective disorder, bipolar disorder, obsessive compulsive disorder, delusional disorder and major depression
Treatment and evolution: The patient was operated on Urgency by the thoracic surgery department, then entered the Psychiatry facility. There it was learned that two years before he moved to Madrid to work on making known his religion (Mormon). He lives there for one year, sharing his apartment and suffering psychological harassment from a partner. The family loses contact with the patient during that year, being the only contact e-mail in which he replied with few words that he was well. One day he wanted to return because he suffered from depression and, on his return, he found himself strange (he did not speak, he answered with monosyllables, obsessive behavior ...). After 15 days of admission, he was discharged voluntarily and is followed in the mental health unit, being treated with antipsychotic and with good control.
Conclusions: Bullying has negative effects on children's physical health, emotional well-being, and academic performance. It is a painful phenomenon. With immediate harmful effects when it becomes visible



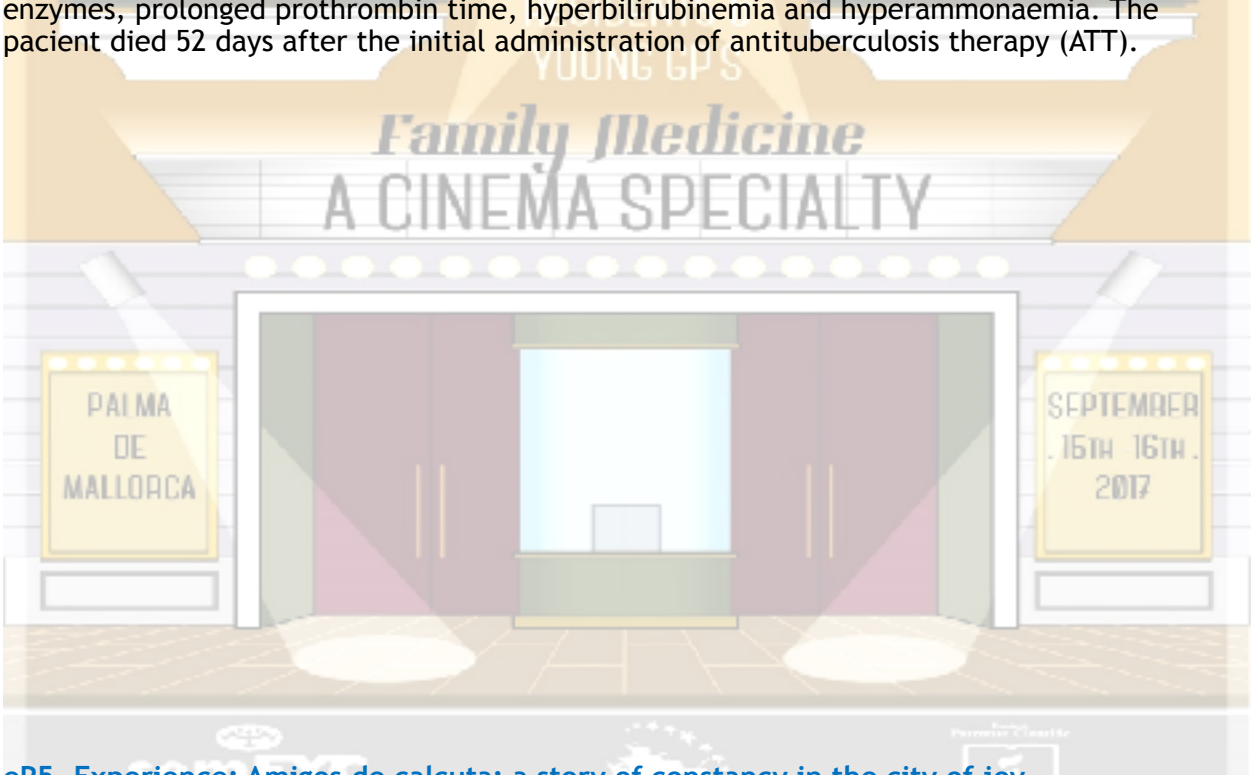
eP3. Case Report. Abdominal Mass diagnostic in Primary Care.
Authors: Lucía Alberdi Martín, Andrea Fernández Pérez, Sara Conde-Valvís Fraga (Corresponding Author). ***Contact:*** saracvf@gmail.com
***Filiations*:** Centro de Salud de Pola de Siero, Asturias, SPAIN.
Key words: Ovarian neoplasm, ultrasonography, early diagnosis

Abstract: 71 year old lady diagnosed of lower back arthritis as the only previous medical history diagnosis.
Complaint: crumpy lower abdominal disconfort, worsening lying back, long term diarrhoea without blood or mucus. No urinary symptoms, no vaginal bleeding, no loss of appetite nor weight.
On Examination: BP: 160/80 Hg mm, no lymph nodes enlarged, on auscultation: rythmic, no murmurs.
Abdomen: soft, not tender, normal peristalsis, possible mass in lower right quadrant. No groin lymph nodes, No edemae nor thrombotic signs in lower limbs.
Diagnostic tests: FBC and U&E normal, US: 2.5 cm cortical cyst in right kidney, sinusal cysts in left kidney, low amount of liquid in lower left abdomen.
Follow up: One month later, the patient complaits of a worsening abdominal pain, flatulence, increased
diarrhoea (2-3 liquid stools). US is repeated: Renal Cysts are still visualiced, but also a round tumor in lower right quadrant (hypoecoic lesion without posterior reinforcement), possible intraperitoneous liquid and possible pleural effusion. Our patient is reffered to the Gastroenterology Department, but 2 months of waiting list is needed, so we decide to reffer our patient to the A&E, from where she is discharged with symptomatic treatment. We talk to the Radiology Department and an abdominal CT scan is done: pleural effusion is confirmed. Mass next to right colon, ascites. Probable peritoneal carcinomatosis with an ovaric origin. The patient is reffered urgently to G&O where chemotherapy and surgery are prescribed. Palliative
chemotherapy is administered for 3 years before the patient passes away.
Conclusion: The importance of an US accessibility in our practice made possible an early diagnostic. Otherwise,
a wrong gastrointestinal refferal would have been done.



eP4. Case Report. An unfortunate case of fulminant hepatitis with tuberculous therapy.
Authors: Cantarero Duron Jennifer Paola, Rosello Galmes Joan Arnau, Jaramillo Ana Belen, Vega Ortiz Juan Francisco, Barona Valladolid Maria. ***Contact:*** jencantarero@yahoo.com.
***Filiations*:** Menorca, Spain.
Key words: Fulminant , hepatitis, antituberculous
Abstract: A 60 years old indian man developed fulminat hepatic failure followed by renal and

multiorganic fail. Past medical history of the patient was remarkable the smoking habit and moderate alcohol consumption. He was evaluated for his family doctor for experienced short of breath, cough, and fever. The chest X- ray provide an image of pleural effusion. The patient was translate at the hospital and was admitted to study. He was diagnosed of tuberculous pleuritis and received treatment with an antituberculosis therapy (ATT) of four drugs (Isoniazid, Rifampicin, Pyrazinamide, Ethambutol) and was scheduled every two weeks to visit for clinical assessment and monitoring for signs and symptoms of possible adverse effects.
The patient missed his second scheduled clinic appointment. On day 38 of treatment, his family observed yellowish discoloration of his sclera and he presented malaise general and asthenia. He came to the hospital, and his clinical condition worsened more and more. On examination, he was confused, jaundiced, but there was no flapping tremor. Abdominal examination showed ascitis. Liver function test, blood chemistry were performed and the results were high, Alanine aminotransferase (ALT) was 943 U/L, aspartate aminotransferase (AST) 2,052 U/L, total bilirubin 24.4 mg/dL and alteration of coagulation. The patient was given Vitamin K and fresh frozen plasma to correct the prolonged INR, and lactulose. Also, an evacuation paracentesis. Despite all these measurements, liver failure progressed and the patient was referred to another hospital for liver-transplant evaluation. After a couple of days, he developed hepatic encephalopaty and was traslate to the medical intensive care unit as a case of fulminant hepatic failure evidenced by marked elevation of hepatocellular enzymes, prolonged prothrombin time, hyperbilirubinemia and hyperammonaemia. The pacient died 52 days after the initial administration of antituberculosis therapy (ATT).



eP5. Experience: Amigos de calcuta: a story of constancy in the city of joy.
Authors: García-Gutiérrez Gómez, Rocío; Tentor Viñas, Ana; Pizarro Sanz, Irene; Martínez Torre, Santiago; Orbis Calleja, Alba; Rodríguez Nieto, Mercedes. ***Contact:*** rocio3g@gmail.com.
***Filiations*:** Nalanda Vidya Peeth, Kobardanga, Kolkata, India.
Key words: Social Conditions, Mass Vaccination, International Cooperation
Abstract: WHO ARE WE?
We are a group of diverse people that have had the opportunity to see first hand the project of Xavier Raj in Kolkata. This experience did not leave us indifferent, and in 2007 we began to organize (in a personal capacity) a group of volunteers to go to Kolkata every year to

collaborate.
Our purpose is to promote charitable activities, social assistance, cooperation for development, protection and promotion of women and children, economic/welfare aide to the development projects, and support for the children promoted by Xavier Raj in Kolkata.
THE SCHOOL AND SUNDERBANS In time, we got to know this project in Kobardanga (Kolkata), which has currently helped nearly 300 children in 5 home-schools receive accommodation and meals. Here they are provided with basic education in approved schools, receive medical attention and, above all, have the opportunity to discover and develop their talents and values. Additionally, Xavier Raj works in the Ganges Delta, a hundred kilometres away from Kolkata, in a region called Sunderbans. This region is composed of many islets where people live with almost no development. The cyclones regularly hit; as well as tuberculosis, cholera, malaria, and all types of deficiency diseases. Natural tragedies are not the only thing that affects the region; the increasing contamination of the water in the area is also a huge problem. It is one of the regions with the most contaminated water in the world.
THE SANITARY PROJECT:
The objectives of the Sanitation Project are:
- To do a medical examination of all the children in the Kobardanga Orphanage and Sunderbans.
- To perform the treatment and operations of some children.
- To sustain the pharmaceutical expenditure and diagnostic tests.
- To offer a salary to the pediatrician who will perform periodic check on the children in the orphanage.
- Reviewing the vaccination schedule for all children and the doses that remain.
- To train and ensure awareness amongst nurses in Kobardanga.
We have been going every year twice a year and tried to help all this children in Kobardanga and Sunderbans with different and important problems: HIV, leprosies, Turner Syndrome with aorta coartation, GH deficiency, mandibular hypoplasia, cleft palate, etc.

eP6. Case Report. Pay attention to the personal history of your patients.
Authors: García-Gutiérrez Gómez, Rocío; Gutiérrez García, Lucía; Pizarro Sanz, Irene; Klusova, Elena; Sánchez- Tembleque Sánchez, Jorge; Martínez Torre, Santiago; Bernaldo de Quirós Acebo, Carlos. ***Contact:*** rocio3g@gmail.com
***Filiations*:** Centro de Salud Las Calesas, Madrid, Spain; Centro de Salud Guayaba, Madrid, Spain; Centro de Salud Orcasitas, Madrid, Spain; Centro de Salud Barrio del Pilar, Madrid, Spain.
Key words: Low Back Pain, Muscle Strength, Glucocorticoids
Abstract: REASON FOR CONSULTATION
62 year-old woman presented for acute back pain and bilateral irradiation after an effort. Negative for direct trauma, sphincter incontinence, saddle anaesthesia, loss of strength or thermoalgesic sensitivity.

PERSONAL HISTORY
- Not known cardiovascular risk factors
- Monoclonal gammopathy of uncertain significance (stable IgG-Kappa in the context of Connectivopathy)
- Systemic erythematosus lupus
PHYSICAL EXPLORATION
Intense tenderness to palpation over the spinous process from lower to lumbar-thoracic vertebras. Pain at paravertebral musculature palpation. Osteotendinous reflexes were preserved. Negative lasegue test.
DIFFERENTIAL DIAGNOSIS
- Nonspecific lumbar pain (85%): functional.
- Secondary lumbar pain: inflammatory, infectious, tumoral, metabolic diseases.
- Referred lumbar pain: joint pathology, visceral diseases (renal colic), others (herpes zoster)
- Lumbar root pain: herniated disc.
DIAGNOSIS TESTS
Spine X-ray: vertebral crush at L12 level of
EVOLUTION. FINAL DIAGNOSIS
The patient was discharged after prescription of analgesic. The symptomatology progressively worsened and five months later she presented total functional limitation, incapacity to maintain the standing position and loss of strength in both low extremities. Blood test: Hypercalcemia (Ca 11.27 mg/dl) The physical examination showed loss of strength (1/5) in low extremities. Areflexia. Unexplored march. Rest was normal.
Lumbosacral spine CT scan is performed urgently, which shows a lytic lesion in L3 with invasion of the
medullary canal. A mass of soft tissue of dimensions 70x65mm that encompasses the sacrum and the left hip bone is also found.
DISCUSSION
Low back pain is one of the main reasons for consultation in Primary Care. 85% of them are for non-specific benign pain. The warning signs should always be taken into account: age greater than 50 years, fever, weight loss, severe trauma, history of neoplasia, use of parenteral drugs, immunodeficiencies, use of glucocorticoids, severe low back pain that does not improve or worsens with rest, neurological deficit in lower extremities and horsetail syndrome. The patient in this report presented several signs of alarm that should have made us think of a malignant etiology, which was later shown. It is important closely monitor of patients with treatmentresistant lumbago and long-term evolution in order to diagnose severe cases and put an early form of treatment. Probably, over-saturation of health systems was one of the reasons.

eP7. Case Report. Knowing our patients, one more tool to reach the diagnosis.

Authors: Cruellas Garau, Maria; Ramirez Manent, José Ignacio; Vidal Ribas, Cristina; Mendoza Cubero, Cristina; Llobera Gost, Miquel; Pujol Girol, Helena. ***Contact:*** mcruellasgarau@gmail.com
Filiations: Centre de Salut Santa Ponça (Calvià), Mallorca, Espanya.
Key words: pneumonia, dyspnea , Physicians, Primary Care
Abstract: Female, 59, come to her primary care doctor for a check from a cold. She has cough with white sputum
production for 5 days. She explains an isolated peak of fever at 37.5ºC 2 days ago. She denies dyspnea or
chest pain. She initially consulted the emergency department. Since then she has been treated with

paracetamol and expectorant. She explains symptomatic improvement and reports good general condition. She
works in greengrocer's shop with air-conditioned. She is a smoker 10 cigarettes a day since adolescence. There aren't any pathology in the patient's medical history.
Physical examination: patient with superficial respiration and with cachectic appearance, although she denies
weight loss. Constants: O2 saturation 92%, afebrile, tachycardic. Chest examination reveals vesicular murmur
preserved with audible crackles on the right pulmonary base.
With a diagnostic orientation of pneumonia versus lung cancer, the patient is referred to the hospital for
evaluation.
In a patient with dyspnea and the signs and symptoms described above, we must think of the following
diagnoses, in addition to others:
- Pneumonia: fever, cough, expectoration.
- Pulmonary thromboembolism: tachycardia, tachypnea, chest pain.
- Pneumothorax: pleuritic chest pain, tachypnea.
- Pulmonary neoplasia: constitutional syndrome, hemoptysis.
The following tests are performed at the hospital:
-Electrocardiogram: sinus tachycardia at 140 bpm.
-Arterial blood gas: pH 7.49, pO2 70.6mmHg, pCO2 25.8mmHg, HCO3- 19.8.
-Analytical: leukocytosis of 21,000 with neutrophilia 89%, PCR 293mg/L, procalcitonin 1.57 ng/mL.
-Chest x-ray: increase of bibasal density, especially in right base.
-Hemocultures, culture of sputum: negative.
-Urine antigens of L. pneumophila, and S. pneumoniae and HIV: negative determination.
With a diagnosis of acquired bibasal pneumonia in the community with sepsis criteria, empirical antibiotic
therapy with Levofloxacin 500mg intravenous every 12 hours initiates. She is admitted in pneumology.
In every patient, it is important to recognize if there are any symptoms or signs of alarm. In this patient, who
presented clinical-radiological and analytical dissociation, the role of her primary care physician was the key to
detect changes with respect to her baseline state and thus to reach the diagnosis.

eP8. Case Report. Heart failure in a young patient.

Authors: Martín Delgado, S. , Cerdó Ensenyat, M. ***Contact:*** mariacensenyat@gmail.com
Filiations: Centre de Salut Coll den Rabassa, Palma, Balearic Islands, Spain.
Key words: Dyspnea, Cardiomegaly, Amyloidosis
Abstract: 1) Reason for consultation: asthenia and dyspnea of 3 months of evolution, intermittent dysphonia, unquantified
weight loss. Severe muscle pain in both quadriceps.
2) Relevant medical history: 49 years, smoker, bilateral CTS (Carpal Tunnel Syndrome), pharyngitis repetition.
3) Physical examination: General condition affected. Rest of examination: anodyne.
4) Complementary tests to be performed: ECG: no alterations. Thorax Rx: Cardiomegaly,

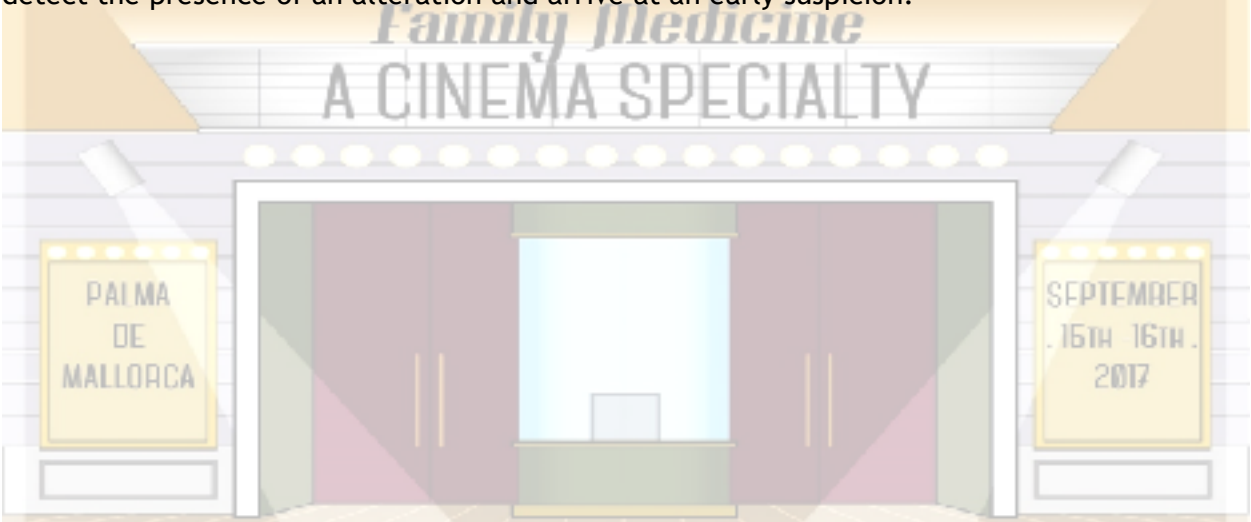
bilateral perihiliary
infiltrates and Kerley B lines. Blood test: Anodyne. Urine sediment: 20mg / dL proteins, without other findings.
5) Diagnostic guidance: Toxic Syndrome and dyspnea on study.
6) Differential Diagnosis: 1. Cardiac: ischemic heart disease, infiltrative cardiomyopathies - amyloidosis,
hemochromatosis, sarcoidosis-, stress cardiomyopathy, cardiomyopathy tachycardia. 2. Pulmonary: embolism
or interstitial disease. 3. Metabolic: diabetes, acidosis, impaired adrenals 4. Infectious: HIV, chagas 5.
Connective tissue disease: lupus, scleroderma. 6. Paraneoplastic syndrome or tumor. 7. Toxic liver cirrhosis.
8.Toxics
7) Treatment: symptomatic (diuretics)
8) Evolution and conclusions: The patient is admitted to Cardiology for a full study, with the following results:
- Echocardiographic study: severe left ventricular hypertrophy, suggesting a diagnosis of nonobstructive
hypertrophic cardiomyopathy.
- Cardiac MRI: patches compatible with amyloidosis.
- Skin biopsy with red congo staining: compatible with amyloidosis.
There was also involvement of the bone marrow in the form of multiple myeloma (MM).
These findings lead to a diagnosis of AL amyloidosis with multiorgan involvement (renal, cardiac, peripheral
nervous system).
Amyloidosis are a heterogeneous group of diseases that have in common the extracellular deposition of
insoluble fibrillar aggregates (amilode), altering the normal structure of tissues. They are classified according to
the type of protein that forms the deposit and to its location. The diagnosis requires high clinical suspicion, the
confirmation and identification of the type of deposit by biopsy, and an evaluation of the extension by means of
imaging tests. The treatment consists of support, chemotherapy and immunomodulators, although new
methods of immunotherapy are being researched.
In this case, the patient presented the worst prognosis variant, with an average survival of about 6 months due
to multiorgan involvement. This patient died after the first bout of chemotherapy, one month after diagnosis, due to complications secondary to hollow viscera perforation.

eP9. Critical Incident. The importance of anamnesis and physical examination in primary care.

Authors: Julià Noguera, Gràcia. Hernández Silva, Rafael E. Bueno López, Laura. López Velasco, Laura. Guerra Feo, Cristina. ***Contact:*** gracia.julia92@gmail.com
***Filiations*:** Centro de Salud Son Pisà.

Key words: Anamnesis, Clinical exploration, Primary care
Abstract: A 68 year old female patient who came to the consultation for constipation since a month ago. The constipation
increased progressively, until there were few bowel movements in the last week. The patient reported severe

abdominal pain was accompanied by intermittent vasovagal symptomatology.
On physical examination, we observed painful abdomen, distended abdomen it appeared with signs of
peritoneal irritation. By presenting this symptomatology, it was decided to refer the patient to the emergency
department of the Hospital for complete the evaluation. In the emergency they administered an enema, which
was not effective, the patient was discharged at home with symptomatic treatment, although the abdominal XRay
showed abscence air at the end of the descending colon, sigma and rectum.
A few days later, the patient returned to the medical center. She had rectal pain and the abdominal pain had
increased since the last day. The female hadn´t improved with the laxative treatment. Rectal examination
showed absence of stools in the rectum, the doctor palpated a probable mass through the anterior wall of the
rectum. After the signs found in the exploration, she was derived to the Hospital again orienting the clinical as a
subacute constipation for a possible pelvic mass. Nevertheless, to make complementary tests the patient was
diagnosed from ovarian cancer stage III unresectable with peritoneal carcinomatosis.
The realization of detailed anamnesis and a rigorous physical examination is a "key diagnostic element" to
detect the presence of an alteration and arrive at an early suspicion.



eP10. Experience. Healthy walking in Valdaracete.
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Key words: Healthy People Program, Walking, Rural Health
Abstract: Improving diet and challenging physical activity in population represents an opportunity to develop and enforce an effective strategy that substantially decreases global mortality and morbidity.
World Health Organization went in for The Global Strategy on Diet, Physical Activity and Health in May 2004. Primary Care takes over prevention, promotion and management of a good health in general population. “Healthy Walking in Valdaracete” is a health-promoting and disease-preventing activity developed in a rural center in Madrid. Valdaracete is a village with almost 700 inhabitants, many of them dedicated to farming, the main economic activity, but most of them working in the capital or bigger villages or towns. It is provided with a

medical center with a general practitioner, a nurse and an administrative assistant. The kind of patients we usually attend in the mornings is elderly people with chronic diseases and age-related pathology. Children are also assisted almost every day even though there are not too many of them. We also have a lot of patients with any type of disability and there is a group of young people with many risk factors for chronic diseases and little awareness of it.
We try to encourage healthy habits that improve health in the village. We also pretend to raise awareness of the importance of practicing regular physical exercise and involve the population in their own health care. The activity consists of going for a 1-hour-walk every Tuesday morning. Sometimes we also take advantage of training machines located in the park. We previously meet in the center and check blood-pressure, glucose levels or pulse oximetry depending on participants´ pathologies, if they have them, and talk about exercise benefits, healthy habits and disease prevention. It has been enrolled a 15 people group with different ages (most of them older than 65), with or without chronic pathology and some of them with physical or mental disability. The initiative has also been welcomed by local authorities and social services. Actually, the Social Assistant is going to collaborate in future activities dedicated to disabled people attention and cognitive stimulation in elderly patients.

eP11. Case Report. The continuity of the Family Medicine Resident.

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Key words: family medicine, continuity , resident

Abstract: Women, 66 years old. Arterial hypertension and appendectomy as medical history. No allergies. During my Emergency Service rotation, she consulted because she presented with progressive abdominal pain for about five months associating sickness, asthenia, anorexia and weight loss. The pain was localized in epigastrium, irradiated to both sides, continue, and increased with intake. Her primary care doctor prescribed esomeprazole and metamizole without improvement. Besides, the lab test founded hypertransaminasemia, so he referred her to Digestive Department. The appointment was scheduled for months later, so he decided to send her to the Emergency Service. Examining the patient, she presented normal vital signs, mucocutaneous pallor without icteric dye. No other significant findings. The lab

test evidence dissociated cholestasis, normal bilirubin, normocytic normochromic anemia, thrombocytosis and elevated ferritin. Abdominal echography suggested pancreatic neoplasm. We decided to admit her in Gastroenterology ward to get her studied so I proceed in my Internal Medicine 24h shift. After complementary studies regarding the advanced stadium and the general bad
state of the patient, we agreed that the patient follow- up should be done by Home hospitalization for palliative treatment. I followed the patient during my rotation in Home Hospitalization. She had strong family support and established good relationship with the whole medical team. During our visits she needed quick analgesic climb with morphs and finally sedation was decided due to the impossibility of the control of agitation and pain. The patient died shortly after that, surrounded by her family and friends. As family medicine residents, we perform one of the most complete formative itineraries, with the largest number of rotations. What can represent a detriment for the patient longitudinality at the primary care clinic, due to the difficulty of combining our hospital and family care activity. Nevertheless, sometimes is an opportunity for offering continuity to other patients, as we are in several locations and finally, participants in the integral health and the good dying.

eP12. Case Report. Primary care follow up, our best tool..

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***Filiations*:** Laredo's Hospital, Laredo, Cantabria, Spain.
Key words: superior vena cava syndrome, lung cancer, follow up
Abstract: Our patient is a 56-year-old woman, heavy smoker of 40 cigarettes per day (pack/ year rate:60) and dislipedimia, who is referred by her GP to the emergency department with history of facial and neck edema in the last week that worsens in decubitus.
At the beginning her GP thought that these symptoms were due to anti-inflammatory treatment that she took for paravertebral pain, but when these drugs were discontinued, symptoms did not relieve, and even there was a sudden appearance of spiders between both breasts and vessel engorgement in upper limbs. She arrived to the emergency department hemodynamically stable, oxygen saturation 100%, she had facial edema up to eyelids and on her neck and supraclavicular area, and bilateral jugular engorgement. The rest of the physical examination was normal. Chest X-Ray with no significant findings.
She was admitted to the hospital, with suspect diagnosis of superior vena cava syndrome. Other differential diagnoses proposed were angioedema, facial lymphedema, autoimmune

syndromes, parasitic infections, idiopathic edema, right heart failure, cardiac tamponade, nephrotic syndrome.
After completing other complementary tests that included chest CT that showed a tumor mass in the right upper lobe, and high tumor markers levels, a transbronchial biopsy was performed, and finally she was diagnosed with small cell lung cancer. From this case we have concluded that the primary care follow up is the main and also de best tool we have to assess the evolution of symptoms, allowing modification of causative agents, and if necessary, as in this case, hospital referral for completion of more advanced complementary tests that rule out or confirm the existence of potentially deadly pathologies.

eP13. Research project. Participatory evaluation of Consulta Jove program.
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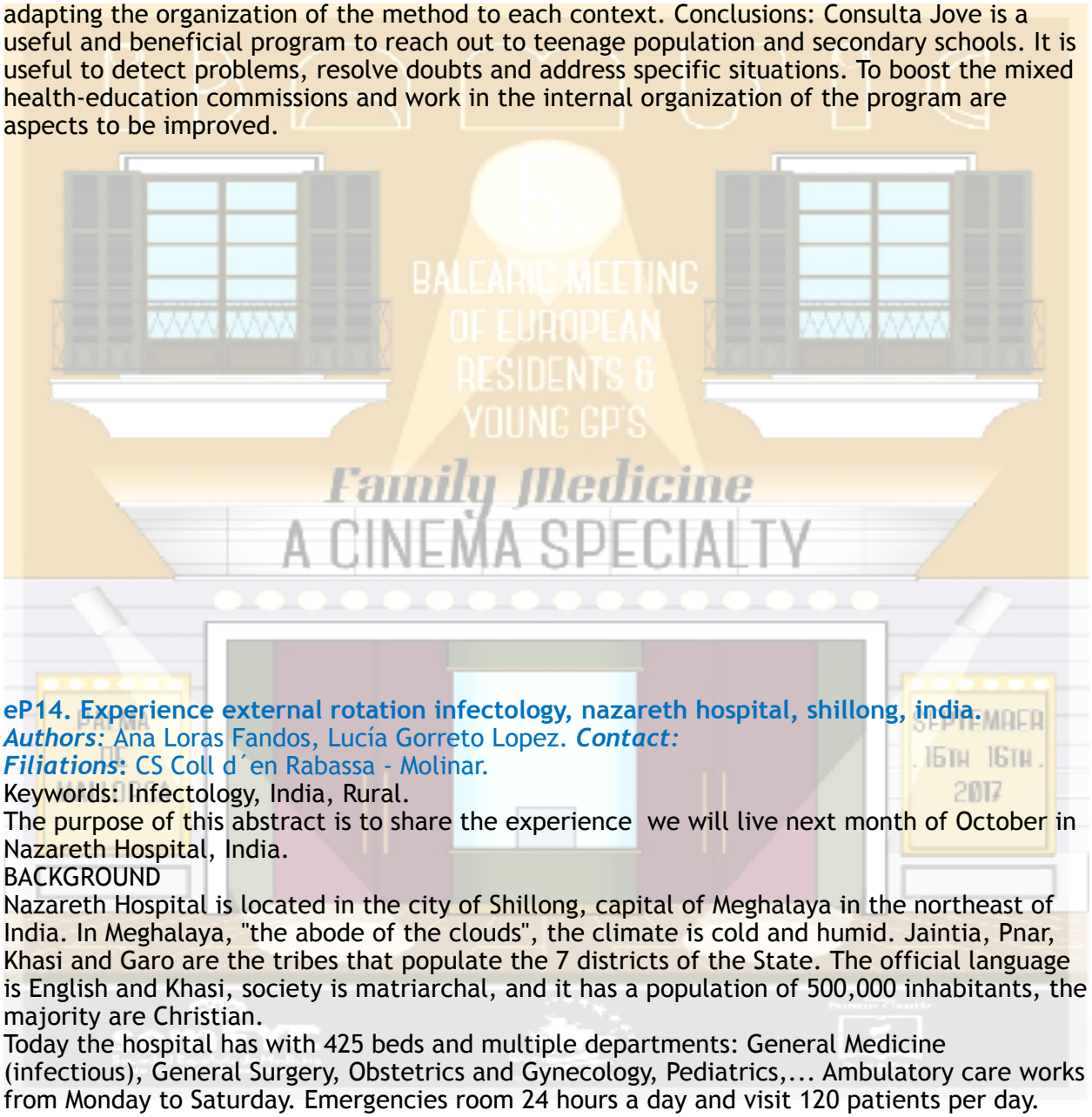
Key words: adolescent, health promotion, community medicine
Abstract: Objective: to assess the strengths and weaknesses of the Consulta Jove program. Material and methods: Participatory evaluation with a qualitative methodology of the intersectorial Consulta Jove program, which creates health-education commissions, offers health related workshops and allows sanitary consultations in the secondary school, conducted by health workers.
There were 3 focus groups with 20 participants: doctors (4), nurses (10) and teachers (6). Focal groups are group interviews, moderated by resident doctors and lasting approximately one hour.
It started from a previous script agreed by the research team. Later, an analysis of the content of the interviews was carried out. Results: Consulta Jove program is beneficial to the population and is satisfactory for those who take part in it. It is useful for problem detection, resolution of doubts and to improve the accessibility of teenagers to health resources. It built confidence among teens / teachers to be able to consult with health workers. It also boosted interest in health issues at the secondary schools. Nurses play a fundamental role in the program and they consider that health promotion tasks enrich their profession. There are

different ways of organizing the visits: weekly / fortnightly / monthly; open / by appointment. The main difficulties of the program relate to the organization of the secondary schools: promoting the program, attendance and lack of information. Others are: lack of support from the health team participating in the program, emotional burden; uncertainty about certain approaches, such as legal implications. As aspects of improvement: the need to find solutions to the control of attendance, maintaining the confidentiality; involve teachers in interventions, spread the program, promote mixed commissions healtheducation and adapting the organization of the method to each context. Conclusions: Consulta Jove is a useful and beneficial program to reach out to teenage population and secondary schools. It is useful to detect problems, resolve doubts and address specific situations. To boost the mixed health-education commissions and work in the internal organization of the program are aspects to be improved.



eP14. Experience external rotation infectology, nazareth hospital, shillong, india.
Authors: Ana Loras Fandos, Lucía Gorreto Lopez. ***Contact:***
***Filiations*:** CS Coll d´en Rabassa - Molinar.
Keywords: Infectology, India, Rural.
The purpose of this abstract is to share the experience we will live next month of October in Nazareth Hospital, India.
BACKGROUND
Nazareth Hospital is located in the city of Shillong, capital of Meghalaya in the northeast of India. In Meghalaya, "the abode of the clouds", the climate is cold and humid. Jaintia, Pnar, Khasi and Garo are the tribes that populate the 7 districts of the State. The official language is English and Khasi, society is matriarchal, and it has a population of 500,000 inhabitants, the majority are Christian.
Today the hospital has with 425 beds and multiple departments: General Medicine (infectious), General Surgery, Obstetrics and Gynecology, Pediatrics,... Ambulatory care works from Monday to Saturday. Emergencies room 24 hours a day and visit 120 patients per day.
The population of the Hospital is all the people who need medical care, regardless of caste or financial status. Giving to the poor special considerations, it means very low rates.
Nazareth Hospital is one of 450 accredited institutions throughout India to impart training in Post Graduate in the broad specialties of Pediatrics, General Medicine and General Surgery.

MAIN OBJECTIVE:

Form us as with basic notions of infectology, able to explain and treat major infectious problems.

SECONDARY
Develop the professional skills necessary for the proper exercise of the profession and specialty.
Be able to make the best diagnostic proposals based on appropriate clinical history and correct physical examination in accordance with available resources.
Directing a program of prevention and control of infections disease.

PLAN
Rotation by General Medicine service is the heart. We are every day of the week, except Sundays, involucrated in service activities: visit to inpatient, outpatient, discussion of clinical cases,... In addition we will make a medical guard in emergencies. The weekends will be able to go to different clinics in the province of Meghalaya: Tura, Maweit, Mendal,...

PERSONAL ASSESSMENT
From the professional point of view, it will bring large amount of new knowledge, generals, and above all about infectious diseases, thereby reinforcing the already acquired during the residency. From the personal point of view, it will represent an experience, allowing us to develop a different language, know a different culture and rediscover or reconnect with the motivation to be doctors.

eP15. Case Report. AGRANULOCYTOSIS BY DRUGS.
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Andaluz de Salud Urgencias Hospital Santa Ana Motril Granada, 061 área de Salud Ibiza y Formentera.
Key words: Metamizole, Agranulocytosis, Abscess
Abstract: Male, Age 28. No medical history of interest except migraines.
Usual treatment: Metamizole
Current disease: Consultation for odynophagia with fever up to 40ºC. It is diagnosed of tonsillitis and it is begun
a treatment with Amoxiciline7 Clavulanic acid 875/125 mg.
After 4 days he returned to consult because of worsening of his general condition and persistence of the fever.
On physical examination: Good general condition, axillary temperature of 38ºC. Hypertrophic tonsils with
presence of exudates and bulging of the left anterior pillar.
After the physical findings, it is referred to hospital emergencies due to suspicion of periamigdaline phlegmon.
Complementary studies:
Analytical: Leukocytes 0.98, Hb: 12.8, Platelets: 374,000, PCR: 31.01

Chest x-ray: no apparent abnormalities of the pulmonary parenchyma
AMO: Hypocellular bone marrow, with megakaryocyte enlargement, almost absolute granulocytic aplasia and
mature aspect plasma-cell-lymphocytic reaction.
Admission to Hematology with reverse isolation.
Evolution:
With the diagnosis of drug agranulocytosis, treatment with Filgrastin 48 MU / 24 was started, and after 3 doses,
elevation of leukocytes and neutrophils was observed. Treatment with piperacillin-tazobactan is instituted,
which, after normalization of neutrophils, is replaced by oral Clarithromycin
During admission, the patient has remained afebrile, with progressive improvement in odynophagia
At high physical examination is with persistent fibrinoid lesions and moderate hyperthermia, with no involvement
of the upper airway
Main diagnosis: Agranulocytosis
Secondary diagnosis: Peritonsillar abscess drained.
Conclusions: Agranulocytosis is an adverse reaction produced by a wide variety of drugs, including metamizole
that is widely used in our environment. It is uncommon, although very serious because of the risk of infections.
It is an independent reaction of pharmacological action that cannot be predicted, and immunological and/or
toxic mechanisms seem to be involved.

eP16. Case Report. Approach to tumor in face in immunosuppressed patient.
Authors: Arenas Puga María Jesús, Rodríguez Martínez Juan María, Ayllón Toro Ana María, Klusova Noguná Elena. ***Contact:*** juanmariarodriguez@hotmail.com
***Filiations*:** Servicio Andaluz de salud Urgencias Hospital Santa Ana Motril Granada, Atención primaria Área de salud Mallorca, Atención primaria Área de salud Ibiza y formentera, 061 área de salud Ibiza y Formentera.
Key words: tumor, face, Immunosuppression
Abstract: A 48-year-old woman with a history of rheumatoid arthritis treated with a methotrexate. Came to our clinic for 1
month presented a tumor in the left parotid region of progressive and painful growth, accompanied by
occasional fever, without any other accompanying symptoms.
Exploration and complementary tests:
Good general condition. Blood pressure 125/70; Heart rate 95, Saturation Oxygen 97%. T 37.5
A rounded lesion with a fluctuating, elastic, painful palpation, not inflammatory signs, could be seen on the inspection, extending over the left external auditory canal
Heart auscultation: non-murmur rhythmic tones. Pulmonary auscultation: preserved vesicular murmur.
Abdomen: soft, not painful without organomegaly. Neurological examination: normal
Analytical and X-ray thorax: no remarkable findings and mantoux induration test 7 millimiters considered positive for being an immunosuppressed patient.
Was referred to the hospital for evaluation by ENT/Internal Medicine requesting ultrasound and cervical CT scan and with well delimited hypodense 5x 3.5 centimeters, located in the left chewing space, affecting laterally the masseter muscle and producing mass effect on parapharyngeal space. Fine needle puncture was perfermed, which is a quick and cost-

effective test obtaining thick caseous material not conclusive, pending pathological anatomy compatible with chronic necrotizing granulomatous inflammatory process. Zhiel stain for bacillus resistant alcohol positive
After a week of admission to internal medicine to obtain results and initiation of tuberculous treatment, the patient is referred back to primary care to continue treatment over-treatment, to see progression and to monitor side effects. The response was satisfactory but required referrals to ENT for emergencies for local evacuations.
Clinical judgment: Tuberculous cervical lymphadenitis.
Final Comment:
Cervical tumors are a frequent reason for consultation in PA. Data from the medical history and physical
examination are critical to establishing the diagnosis.
Tuberculosis (TB) is an emerging infectious disease, more frequent in patients with human immunodeficiency virus, but also transplant patients, cirrhotics, nephropathies, ... in treatment with immunosuppressants.
Tuberculosis is a disease that can be found in any location. In extrapulmonary TB, the cervical ganglion is the most frequent, and there are in the paranasal area and salivary glands cases in which the diagnosis has been late in the low suspicion of this disease.

eP17. Case Report. Hemolytic anemia in a patient who ate beans.
Authors: Rodríguez Martínez juan María, Ayllón Toro Ana María, Arenas Puga María jesús, Klusova Noguiná Elena. ***Contact:*** juanmariarodriguez@hotmail.com
***Filiations*:** Atención primaria Área de salud Mallorca, Atención Primaria área de salud Ibiza y Formentera, Servicio
Andaluz de salud urgencias Hospital Santa Ana Motril granada, 061 área de salud Ibiza y Formentera, Santa Ponça, La vileta, Son Rullan), Palma, Spain.
Key words: Hemolytic, Anemia, Beans
Abstract: 44 male who came to the practice in Ibiza, with general discomfort, asthenia, weakness and hematuria, fever of 3 days duration.
Physical examination: heat rate 136bpm, BP 130/90mmHg, Tª 37.7ºC, O2 Sat 90%
Jaundice
Cardiac and pulmonary auscultation normal
Abdomen normal
Blood and urine tests were performed. And paracetamol prescribed.
He came the following day and the nurse was impressed by the color of the urine sample.
He was immediately referred to Hospital emergencies.
Blood and urine tests results:
-red cells 3.06 cells 106 Hb 9.6 gr/dl, Hto 30.10%, leucocytes 22.6 103/uL urea 60 mg/dl creatinine 0.70 mg/dl,
Total bilirubin 7.2 mg/dl, C-reactive protein 14.76, 1219.
-urine: proteins 250, red cells 300, leucocytes 2590.53.
After Emergency admission and blood and urine tests were checked, he was referred to Hematology and he commented that he had taken beans when he started with the symptoms.
He spent 2 days at the service and was treated with liquids, 2 red cells concentrate and heparin. It was

observed improvement of the condition of the patient, resolution of jaundice, normalization of bilirubin and improvement in LDH. He was thought to suffer from glucose 6-phosphate dehydrogenase deficiency and test to check that condition where performed.
After that he was referred to the health center to do the following.
Finally The glucose 6-phosphate dehydrogenase deficiency was confirmed with the tests.
Final comments:
Glucose 6-phosphate dehydrogenase deficiency is the most common human enzyme defect, being present in more than 400 million people worldwide. About 140 mutations have been described: most are single base changes, leading to aminoacid substitutions. The most frequent clinical manifestations of G6PD deficiency are neonatal jaundice, and acute haemolytic anaemia, which is usually triggered by an exogenous agent. Some G6PD variants cause chronic haemolysis, leading to congenital non-spherocytic haemolytic anaemia. The most effective management of G6PD deficiency is to prevent haemolysis by avoiding oxidative stress. Screening programmes for the disorder are undertaken, depending on the prevalence of G6PD deficiency in a particular community.

eP18. Case Report. A 76 years old female with increasing dyspnea.

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***Filiations*:** Camp Redó health center, Palma, Balearic Islands.
Key words: Dyspnea, Heart failure, Pulmonary Embolism
Abstract: A 76 yo female with past history of Hypertension, Heart failure (NYHA II) and spondylolisthesis D12-L1
presented to her family doctor emergency consultation with a worsening shortness of breath since 5 days. She had no chest pain, no fever or cough. She had paroxysmal nocturnal dyspnea and no orthopnea. She also refered increasing of her both legs´pitting edemas.
Prior to that she was with moderate dyspnea due to ordinary activity (Hearth failure) and 15 days ago she was discharged from the hospital where she was treated for Acute Gastrointestinal infection during 7 days. Her daily medication was: Enalapril 10mg and Furosemide 40mg
At admission her vital signs were: HR 95 bpm, BP 124/88, oxygen Saturation via pulse oxymeter 92% on room air, Temperature 36.2º
Examination revealed no neurological abnormalities, JVP was not raised, Cardiac auscultation shows regular heart rate with a systolic murmur (II/VI) while pulmonary was normal without wheezes, crackles or rales.
Oxygen therapy was started and ECG realized: Regular Heart rhythm, 90 bpm, axis -15º, PR interval 140ms, narrow QRS with qR' in V1, Q wave in III, inverted T in V3-4-5-6
Well's criteria was calculated with low risk group.
The patient was transferred to Emergency Department by ambulance with suspicion of PE vs decompensated heart failure.
In the emergency department complementary tests were realized, Chest X-ray that was normal, Arterial blood gas test that showed Respiratory alkalosis, hypoxemia with low pCO2, Blood test showed D Dimer 2750 ng/ml. raised troponin T of 203.5 ng/L and CRP of 7.85 mg/L
Angiography CT scan was realized that showed: Acute Central Pulmonary embolism with right heart

dysfunction. Treatment with Low molecular weight heparin was started and the patient was transferred to the Intensive
Respiratory Care Unit.
Echocardiogram and ECO - Doppler of Legs were realized (no signs of deep vein thrombosis). After two days she presented improvement and was transferred from the ICRU to a room with control ABG of pH 7.39, pO2 67 mmHg, pCO2 42 mmHg. She was discharged 6 days later and the treatment was switched from LMWH to Aceonocumarol.

eP19. Case Report. Acute myocarditis onset in a young male with synchronic streptococcal tonsillitis: A case study.

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Key words: myocarditis, streptococcal, tonsillitis

Abstract: Introduction: Streptococcal tonsillitis is a very common affectation in the GP practice which is usually selflimited.
Aside from reducing symptom duration, correct antibiotic treatment reduces the risk of complications,
both non-suppurative and suppurative. Special attention needs to be given to the differential diagnosis of cases which don't progress favourably in order to detect any such complications.
Case presentation: A 16 year-old male was admitted to the ED due to high fever, vomiting, and general
weakness 3 days after being diagnosed of streptococcal tonsillitis while undergoing treatment with oral
Penicillin. There were no previous symptoms to the onset of the tonsillitis indicating a viral infection. The ECG revealed tachyarrithmia with ST depressions in V2-V6. The laboratory results showed signs of inflammation, elevated liver enzymes and very elevated myocardium enzymes (CK 3763 U/L and TnI 131.391 ng/L). The patient rapidly developed hypotension, peripheral hypoperfusion and respiratory insufficiency. An echocardiogram revealed severe left ventricle dysfunction (VF 19%) portraying cardiogenic shock, without signs of endocarditis.

Management and Outcome: The patient required intubation, sedation and inotropic agonists. A cardiac
catheterisation ruled out coronary affectation and an MRI confirmed the diagnostic hypothesis of myocarditis. A CT-Scan ruled out pharyngeal abscess yet showed mediastinits. Blood cultures were negative. No endomyocardial biopsy was performed. The patient was treated with broad spectrum antibiotics (meropenem and linezolide) and progressed favourably within a week.

Discussion: There are a number of options to consider when doing the differential diagnosis of

complicated streptococcal tonsillitis among which myocarditis is extremely rare and therefore never taken into account.Myocarditis is a potentially fatal inflammation of the myocardium with a wide range of clinical presentations and
aetiologies. Despite diagnostic limitations in determining the causality of myocarditis, most cases are attributed to viral infections. However, there are a number of case studies and small-scale clinical studies reporting on a possible correlation between acute myocarditis and streptococcal tonsillitis. It mainly presents in young males with streptococcal tonsillitis and chest pain. Despite the rarity of said complication we believe it may be something for GPs to keep in mind when such cases arise.

eP20. Case Report. Iatrogeny in pluryphatologic patient.
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***Filiations*:** Laredo`s Hospital (Cantabria-Spain)
Key words: Drug Intoxication, Drug side effect, Iatrogeny
Abstract: Woman 87 years old, until two months ago she was living alone completely autonomous, with active social life,
she started abruptly with pain in both lower limbs, type neuroptic of difficult control, for that reason management was initiated with Pregabalin and Oxycodone / Naloxone, requiring dose adjustment which relief the pain, however it was progressive deterioration of the general state, greater difficulty for walking and eating, asthenia, realizing bed-couch life, impossibility to go to the bathroom, later sacrum ulcer and on the heel, last day diarrhea and fever.
Personal history: Arterial hypertension in treatment, Advanced dorsolumbar spondylarthrosis with severe L3L4 stenosis and bilateral foraminal stenosis in treatment, Chronic gastritis, exudative AMD.
Physical examination: Lower limbs: Decreased strength, Right heel ulcer with necrosis, Sacrum: erythematous plaque with central necrosis, rest anodyne.
Complementary exams: Hemogram: Anemia, altered iron profile, normal tumor markers, normal Proteinogram,
Abdominal ultrasound: no significant echographic alterations.
Differential Diagnosis: Soft Tissue Infection, Hydroelectrolytic Imbalance, radicular syndrome, Cerebral
Vascular Disease, General Neoplastic Syndrome.
Diagnosis: Drug intoxication
Evolution: Upon admission analgesia is withdrawn with progressive improvement and absence of pain for which initiates rehabilitation.
Conclusion: Pain is a common and incapacitating symptom which should be treated properly being cautious with the therapy combination because the adverse effects that can be caused.

eP21. Case Report. Swelling Painful Limb: Is it always DVT?

Authors: Ana Sofía Mateo Acuña, Luz Bibiana Díaz Gonzalez, Nuria Arencibia Hernández, Begoña Alonso Alfayate, Olga Fernández Casares, Florencia Valentina Balduvino Gallo.
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Key words: Erythema nodosum, Sarcoidosis, Painful nodules

Abstract: -Clinical history:
39 year-old female patient refers 2 weeks of swelling lower limbs with elevated erythematous painful lesions associated with arthralgias. Previously asymptomatic. and no fever associated. It was initially treated with clexane and NSAIDs without clinical improvement of the lesions and no onset of new symptoms, which was the referral motive to our Emergency Room.
-Personal history
Postpartum left lower limb deep venous thrombosis (distal intern saphenous) – 07/2016
Medication: Before current episode: Desogestrel® (cerazet 75mcg). Which was suspended by its Primary Care.
For acute episode: Daflon every 12 hours, Clexane 40mg sc once a day and Ibuprofen 600mg every 8 hours.
-Pathologic Family History: Maternal grandmother ”Rheumatic disease”
-Physical exploration: Afebrile.
Lower limbs: multiple erythematous pretibial nodules of 5 cm of diameter
No arthritis. No deep venous thrombosis signs.
-Supplementary tests:
Chest X-ray: Hiliar enlargement without apparent parenchymal disease.
CRP: 4,9 (normal limits After discharge, in following visits to Rheumatologic External Consult: Normal
Serological markers. Tuberculin skin test: negative
-Clinical judgment: Erythema nodosum
Differential diagnosis: Nodular Vasculitis, Subcutaneous Infection, and Pancreatic panniculitis
-Treatment: NSAIDs and the treatment of the identified associated disease.
-Conclusions: Even though erythema nodosum is a disease that is not frequently seen in Primary Care, its characteristic lesions should be easily identified. In cases with involvement of sites other than lower limbs or in persistence of symptoms for more than eight weeks, or

secondary ulceration, alternative diagnosis should be considered. In this clinical case as seen in a simple complementary test as a Chest X-ray should always make us suspect of pulmonary sarcoidosis with radiographic stage I.

eP22. Case Report. Chagas, a forgotten disease?

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Key words: Chagas disease, Chagas Cardiomyopathy, Trypanosomiasis

Abstract: The reason for consultation: Palpitations.
Most relevant data from the medical history: A 57-year-old male patient with a history of hypertension treated with enalapril 2.5 mg daily, HCV positive, diagnosed in his country of origin (Ecuador) in 2003 of Chagas disease and history of multiple drug-addiction in treatment for drug dependency with methadone (occasional consumption of heroin). He came to our consult for the first time because he has been suffering with occasional palpitations for years, which in the last 2-3 months have become more frequent. We decided to ran EKG and blood tests and ask he to come back after a week. After two days, the patient returns from the emergency room to present an intense sweating episode, intense general discomfort and high heart rate, followed by oppression in the anterior chest region. EKG is performed where a regular QRS tachycardia at 190 bpm is observed with hypotension, proceeding to transfer to the emergency.
Physical examination: Blood pressure: 89/50mmHg, heart rate 50 lpm, afebrile, satO2 98%. Good general condition, conscious and oriented. Heart auscultation: rhythmic tones with low tones, no clear murmurs. Pulmonary auscultation: Consistent vesicular murmur, with no added noise. Lower extremities without edema. Symmetrical conserved peripheral pulses.
Diagnostics tests: Taking constant, blood test and urine tests and electrocardiogram.
Diagnostic orientation: Dilated cardiomyopathy due to chagas disease, with episodes of sustained
monomorphic ventricular tachycardia (SMVT) with hemodynamic repercussions.
Differential diagnostic: Iidiopathic dilated cardiomyopathy, alcoholic cardiomyopathy, acute viral
cardiomyopathy, among others.
Treatment: Stop smoking and others drugs. Amiodarone 200mg daily. Implantable cardioverter-defibrillator (ICD) is indicated.
Evolution: In the emergency department, 450mg Amiodarone is administered, the tachycardia stops after an electric shock. Mild renal failure, elevated Troponins plus and prolonged QTc are detected. The patient enters
Cardiology.
Conclusions: In front of a reason for consultation as frequent as palpitations we believe that

we must take into account not only the clinical context of the patient but also take into account their antecedents and habits of life.

eP23. Case Report. A bump in the head.

Authors: López-Velasco Laura , Hernández-Silva Rafael E., Bueno-López Laura A., Julia Noguera Gracia. ***Contact:*** laulovelas@gmail.com
***Filiations*:** Centro de Salud Son Pisà (Palma de Mallorca, SPAIN).
Key words: meningioma, brain mass, tumour
Abstract: Introduction: Meningiomas constitute the most often primary intracranial tumour (15-20%). Although they are
generally benign, these tumours have the ability to progress to a higher histologic grade with a more aggressivebiological behavior, which leads to multiple recurrences, extracranial metastasis, and decreased survival.
Case presentation: We have a 70-year-old female patient, with high blood pressure, moderate aortic
insufficiency and liver cirrhosis caused by hepatitis c virus, under treatment with spironolactone, beta-blockersand lidocaine patches. She had consulted 2 weeks before for cervicobrachialgia being discharged withsymptomatic treatment. Due to the persistence of symptoms, she was admitted to the emergency department,referring headache, associating an intense pain located in the temporo-occipital region, and both trapeze andcervical paravertebral muscles.
Management: She was hemodynamically stable, and her physical examination showed epigastrium pain and apainful, elastic tumour on the palpation of the temporal bone, with no inflammatory signs. While proceeding, thepatient went into a comatose state, with arreactive media mydriasis and hypotonia. Her Glasgow score was 6 out of 15, developing signs of intracranial hypertension. A blood test was performed, revealing a low number of platelets (31.000 / µL) and elevated levels of liver transaminases (Ast: 116 U/L, GGT: 79 U/L). The rest of the results, including urinalysis, were normal. An ECG was run, showing no alterations. A cranial CT scan was performed, that reported an extra-axial mass, of 110x50x55 mm, destroying the adjacent parietal bone, and a second one, causing a mass effect in the parenchyma and left ventricle herniation.
The differential diagnosis included an atypical meningioma as the first option, a hemangiopericytoma (causes bone destruction, although it’s more frequently in younger patients) or a metastasis.Mannitol and dexamethasone were given as treatment. Subsequently, supporting measures were withdrawn after ruling out surgery. The patient passed away 2 days later.
Conclusion: This type of tumor is clinically shown by several symptoms such as epileptic seizures, progressive neurological deficit, headache in the area where the tumor is implanted and intracranial hypertension. Although the deformity of the skull that presented our patient is truly exceptional, it has also been described and should have been paid attention to.

eP24. Case Report. A case of low back pain.

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Key words: back pain, osteomyelitis, discitis

Abstract:
A 60-year-old female patient who goes to a doctor's office for low back pain.
Personal history: possible allergy to Zaldiar, ex-smoker since August 2016. Dyslipemia, overweight.
Hypothyroidism. Other: recurrent nephritic colic. Back pain in 2007-2008 studied with MRI (various disc protrusions). Recently operated on Reinke's edema of both vocal cords and mass biopsy in cavum 03/21/17 (no signs of malignancy). One week after leaving the hospital, the patient begins with low back pain radiated to the abdomen and left leg, dysthermia and shivering.
We refer the patient to the emergency room and enter the urology plant with nephritic colic. The next day is seen by urology and when presenting a crippling lumbar pain advise to the service of traumatology that realizes a Magnetic Resonance with result compatible with L1 metastasis. Before this result is spoken with the service of internal medicine that after several weeks of tests of image and interventionists in the end is diagnosed ofspondilodiscitis. The most important in physical examination is palpation pain in lumbar spinal processes in L1-L2.
Diagnostic test: First blood test White cells 13.100 Fibringen 729 GGT 39 Urea 50 Creatinine 0.74 PCR 11.78. Successive; White cells 14.200 VSG 86 PCR 23.8 Normal tumor markers. Negative blood cultures after 72 hours without antibiotic treatment. Mantoux 13mm. Thoracic and abdominal cervical CT scan is normal. Magnetic resonance alteration of signal in body of L1 with enhancement after contrast that orient towards M1 like first possibility.
Gammagraphy showed contrast uptake in L1 body without other pathological uptake.
Negative CT guided aspiration for malignant cells with negative microbiology. PET-TC hypermetabolism in L1- L2 with highly suggestive distribution and intensity of infectious spondylitis.
Diagnostiic orientation infectious spondylitis.
Differential diagnosis osteoarthritis, herniated disc, spinal fractures, epidural abscess, metastatic carcinoma.
Treatment Empiric antimicrobial treatment with vancomycin and intravenous meropenem for 8 weeks.
Satisfactory evolution to recovery of bone destruction caused by the infection objectified in successive magnetic resonances.
Conclusions Osteomyelitis is an important disease that should be ruled out in a patient with low back pain and whose delay in diagnosis may have important morbidity and mortality.

eP25. Case Report. Fever and Cough but open your mind.

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Key words: Hematuria, Epistaxis, Nodule

Abstract: - Reason for Consultation: 15 day fever and cough with hemoptotic expectoration started 48 hours postpartum, in treatment with amoxicillin-clavulanic 500/125 mg for 2 days.
- Anamnesis: Female, 32 years old, without drug allergies and without pathological antecedents of interest in treatment with supplements of Fe, I and Mg after eutocic delivery.
- Physical examination: Tachycardia. Rest of normal constants. Good general condition. ACR: Anodine.
Bimalleolar edema with fovea.
- Diagnostic tests:
Venous gasometry: No alterations.
ECG: Sinus tachycardia at 100lpm. Axle 60º. Normal PR. Narrow QRS. No alterations in repolarization.
Analytical: Left-sided leukocytosis with eosinophilia. Normocytic anemia with thrombocytosis. Elevation of acute phase reactants (PLATELETS 1.077,00 10 ^ 9 / L, FIBRINOGEN 1,197.00 mg / dL, PCR 283.30 mg / L). Dissociated cholestasis pattern. Microscopic hematuria. Proteinuria.
Chest Rx: Bilateral dispersed pulmonary infiltrates possibly cavitated.
Ag Streptococcus pneumoniae: Negative. Ag of Legionella pneumophila: Negative. PCR virus influenza A and B: Negative. BK sputum culture: Negative.
- Diagnostic Orientation : Sepsis of respiratory origin.
- Differential Diagnosis: Tuberculosis. Atypical pneumonia. Acute interstitial pneumonia. BOOP. Influenza.
- Treatment: Amoxicillin-clavulanic 2gr every 8 hours and azithromycin 500mg orally per sepsis protocol.
- Evolution and conclusions: It enters S of Pneumology with diagnosis of respiratory origin sepsis in the context of biliary pneumonia, where it also discusses migratory arthralgia and an episode of self-limited epistaxis, which along with cough with hemoptocytic expectoration, anemia, high acute phase reactants, eosinophilia,
proteinuria, hematuria and radiological findings suggest autoimmune systemic disease. They initiate prednisone mg / kg and enlarge study with autoimmune profile + CT chest + bronchoscopy + consultation to otolaryngologist.
Relevant results of such tests: Immunology: positive ANCA antibodies. Chest CT: nodules Endoscopy ORL:Injuries in nasal and jugal mucosa compatible with systemic disease or rhinitis. Therefore, there is a high suspicion of Wegener's Disease.

Despite treatment with corticosteroids and rituximab suffer worsening of clinical and radiological condition,with severe ARDS and massive alveolar hemorrhage that requires transfer to the ICU where it remained several weeks due to secondary complications until clinical improvement.

eP26. Case Report. Clinical case.

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Abstract:
BACKGROUND
A 63-year-old male patient with a history of hypertension without affectation of target organ, dyslipidemia, severe SAOS, depression, and former smoker since 30 years. Under treatment with Valsartan/diuretic 160/12,5mg, and Paroxetine 20 mg.
CLINICAL CASE EVOLUTION
Patient goes to the health center with previous appointment for a loss of sensitivity and lack of coordination of the left hemibody with occasional falls for the last 10 days. Patient reports left-hand motor deficit and ataxia. His wife also refers having observed a deviation of the facial commissure toward the right. Patient reports he has not go before to Emergency Services because he feels well in general and paid no attention to it.
SCREENING
TA: 128/ 91. FC: 92. Glycaemia after breakfast: 117.
ECG: Sinus rhythm at 70 lpm, PR 0,14, QRS narrow, axis at 0º. No modification of repolarization.
Neurological Examination: Disturbance in the III PC affecting the left eyelid lift muscle. Deviation of the oral commissure toward the right (VII PC affected). No motion disturbance. Negative Romberg. Decreased strength (4/5). Altered sensitivity (4/5). No dysmetries. Normal ROTs.
Patient is referred that same day to HSLL by the 061 with the suspicion of sub-acute cerebral ischemia. Once at the hospital, a TAC was performed, which was informed as: multiple poorly defined injuries which get enhanced in the perifery using a contrast and which are accompanied by perilesional edema localized in the cortical and White substance of all cerebral lobules in the right hemisphere, lateral ventricles, with mass effect resulting In a displacement of the mean line, suggesting metastatic lesions.
Rx Torax: without alterations
CONCLUSIONS: Patient with initial suspicion of sub-acute ischemic stroke related with a 10-day evolution of left hemiparesis and ataxia, after TAC performance, is diagnosed with brain metastases of unknown primary tumor.

eP27. Case Report. When we have to split hairs to achieve a diagnosis.

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Key words: Alopecia, Neurodermatitis, Trichotillomania

Abstract: 86 year old woman with diagnosis of diabetes mellitus type 2, arterial hypertension, dyslipidemia, atrial fibrillation anticoagulated, ischemic stroke and mild non-affiliated cognitive impairment.

She consulted for pruritus at the right frontoparietal area with the need to scratch continuously.

The physical examination revealed an alopecia plaque, erythematous, with mild scaling without any other signs of inflammation. The initial diagnosis was neurodermatitis. Treatment with betamethasone and salicylic acid cream 1 application every 24 hours for 1 week was offered. Two months later, the same lesion persisted despite treatment. We prescribed clobetasol 0.05% 1 application every 24 hours for 2 weeks and we requested completed blood test without anemia or thyroid dysfunction and

negative serology for syphilis to discard other causes. After that, pruritus persisted and the alopecic plaque had increased compared to the previous visit, with lichenified skin and tonsured hair at different levels. At that moment our diagnostic orientation was tinea capitis and we prescribed an empirical treatment with terbinafine 250mg every 24h for 1 month, ketoconazole cream 2% every 24h for 3 weeks and we added antihistamine treatment for pruritus control. Given the poor improvement and rapid evolution of the lesion the patient was derived to the dermatologist. The patient was evaluated by dermatologist one month later who made a differential diagnosis with: alopecia mucinosa / trichotillomania / lichen simplex chronicus. Biopsy was performed in which it was suggested a trichotillomania or at least traumatic origin in relation to manipulation. The dermatologist recommended a pharmaceutical formulation (menthol + camphor + fitalite) for pruritus and Mirtazapine 15mgrs/nights, in addition to emollients. Later, in the primary care consultation, the patient and her family members reported that she was more anxious and agitated in relation to the progression of cognitive impairment.

Conclusions: This case shows us that although we must always look for an organic cause that justifies

symptomatology, in some cases the patients are themselves responsible for the disease.

eP28. Case Report. The priority is not the speed.

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Key words: Exhantema, Pharyngitis, Infectious Mononucleosis

Abstract: Reason for consultation: Generalized pruritic rash which started 5 days ago. Personal history: Female, 17 years old, without drug allergies and without pathological antecedents of interest. Anamnesis: The patient came to our health center without an appointment for persistence of generalized pruritic erythema already assessed 5 days ago at primary care emergency service, diagnosticated as food allergy without respiratory symptoms and treated with methylprednisolone 80mg im and adrenaline 0.5mg im; they recommended treatment at home with prednisone 30mg every 24 hours for 5 days and oral antihistamines. Then, I interrogated her again and review previous visits: 10 days before, she was also evaluated at primary care emergency service for fever (38.5ºC) and odynophagia, without coryza or cough. According to the doctor's note who attended her, the physical exploration revealed hyperemic oropharynx and cervical lymph node enlargement and painful. So that, the doctor recommended her taking amoxicillin 500mg 1 tablet every 8 hours for 10 days.
- Physical exploration: Afebrile. Normal constants. A generalized maculopapular and morbilliform rash (palms and foot's sole weren't affected). No other relevant findings in physical exploration.
- Diagnostic tests: Blood test with complete blood count, biochemical analysis and serologies of Epstein Barr virus and Cytomegalovirus.
- Diagnostic orientation: Mononucleosis rash following the administration of amoxicillin.
- Differential diagnosis: Urticaria, Allergic reaction to beta-lactams, Viral exanthems, Bacterial exanthems,
Pityriasis rosea.
- Treatment: Oral antihistamines and prednisone descent rate.
- Evolution and conclusions: The cutaneous lesions were progressively disappeared. The important laboratory findings were lymphocytosis (an absolute count >4500/microL) and abnormal liver function tests. Results of serology confirmed infectious mononucleosis with positive IgM antibodies directed against the Epstein-Barr.
- Conclusions: The lesson learnt from this case is the importance of a good anamnesis and physical
examination to perform a right differential diagnosis in primary care. In addition, the patient met Centor criteria (3/4), no rapid antigen detection test was performed but started amoxicillin. If this test had been done, the rash wouldn't have appeared.

eP29.

We present a strange clinical case of a 37-year old man, non smoker for 7 years, who went to Emergencies service with severe lumbar and inguinal pain from 2 months. This pain alleviated while he was idle and increased with posture changes. He was also bothered about weight loss non quantified and big efforts dyspnoea. He related the presence of three mass on the right tight, back and right forearm he had noticed that day.

The physical examination was normal except for right hemitorax hypophonesis and muscle lumbar contraction.

We palpated three muscle mass on the right tight (9 x5 cm), back (4x3 cm) and forearm (3x3 cm). All of them had hard consistency and were attached to deep tissues.

X-ray of them showed calcium deposits with cortical respected. After that we realized a torax X ray with pleural effusion that completely covered right lung. We realized an ultrasound guided thoracocentesis; a 50 ml serohematic liquid sample analysis showed abundant erythrocytes and lack of leukocytes with microorganism absence. Blood test showed normal haemogram, coagulation and biochemistry with PCR and tumor markers elevated

The differential diagnosis we proposed was rhabdomyosarcoma vs metastatic adenocarcinoma.

An extension study with head-neck-abdomen TC and forearm mass biopsy was realized. TC showed a right medium lobe pulmonary mass (3.5 cm) and multiples lytic/blastic metastasis on neck, both legs, torax, abdomen, right arm and cerebellum. The biopsy results were metastatic adenocarcinoma with K-ras mutation and EGFR positive.

The patient received a large-volume toracocentesis and followed pleurodesis and holocraneal radiotherapy. Actually he is receiving endovenous therapy cycles.

We must always do a good clinical history and physical examination, and most important, take special care on communication and relation with our patients so they can feel confortable and tell us why they are really worried about. Otherwise we can miss many important information that could guide us to cancer or other important diagnosis.

List of Authors

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