

PS-01

Comparison Of Smoking, Alcohol Use And Demographic Characteristics Of Patients Applying To Our Polysomnography Laboratory

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ENTRANCE: Obstructive sleep apnea syndrome (OSAS) is a disease that manifests itself with interruptions in breathing due to repeated narrowings or blockages in the upper respiratory tract during sleep. Recurrent shortness of breath disrupts the continuity of sleep, prevents deep and restful sleep, and causes excessive sleepiness during the day. In our study, we aimed to examine the demographic characteristics, smoking and alcohol use, sleep-disordered breathing and treatment methods of the patients who applied to our sleep laboratory.

MATERIALS and METHODS: Anamnesis information, (PSG) data and treatments initiated on patients who were admitted to the AFSU Faculty of Medicine Hospital Polysomnography (PSG) Laboratory with a preliminary diagnosis of OSAS between January 2016 and December 2019 and whose body mass index was over 25 kg/m² were evaluated retrospectively.

FINDINGS: Between January 2016 and December 2019, PSG was the 178th accepted

A total of 494 cases, of which (36%) were female and 316 (64%) were male, were evaluated. The average age of all cases was found to be 53.21 ± 13.53 . Smoking, all cases 292 (59.1%) of them were smokers, 189 (64.72%) were men and 103 (35.27%) were women. Of the cases included in our study, 109 (22.1%) had regular alcohol use. and the majority of those who used alcohol regularly were patients with moderate and severe disease. There was regular use of antidepressants or sleeping pills in 51 of the cases (8.58%). 53 (10.7%) of the patients were diagnosed with simple snoring, 93 (18.1%) with mild snoring, 109 (22.1%) with moderate snoring, and 239 (48.4%) with OSA. Of the cases diagnosed with OSAS, general recommendations were given to 128, CPAP treatment to 311 (63%), BPAP treatment to 52 (10.5%), and BPAPST treatment to 1 (0.4%).

DISCUSSION: In our study, we found a significant relationship between OSAS and older age, male gender, alcohol use and smoking has been detected.

Key Words: Polysomnography laboratory, OSAS, smoking

PS-02

Anterior Chest Wall Mass in a Patient with Rheumatoid Arthritis and Asthma

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Case: The patient is a 62 year-old woman with a 25-years history of rheumatoid arthritis (RA) and asthma who presented with mass on the right side of the anterior chest wall. She noticed the mass six months before her admission to Manisa State Hospital, but that the mass enlarged over time. The mass was accompanied by night sweats and weight loss for three months. Past medical history was remarkable for asthma and osteoporosis. There was no personal history of trauma, malignancy or tuberculosis, and no family history of hematological malignancy. The patient was a non-smoker. She was taking deflazacort 30 mg daily, methotrexate (MTX) 10 mg weekly and folic acid 5 mg weekly, hydroxychloroquine 200 mg daily and, her other medications included an oral bisphosphonate, calcium and vitamin D supplements and salmeterol-flutikazon (50-250µg, 2x1 *daily*). She had seropositive (rheumatoid factor-positive) RA. Upon clinical examination, joint examination was remarkable for the following: Right shoulder limited abduction and external rotation with pain in all planes of motion, ulnar deviation in both hands and tenderness on small joints of hands. Respiratory system examination there was soft tissue mass 5x6 cm in size fixed on the 2nd and 3rd ribs was located in right parasternal location on the anterior chest wall. Breath sounds were normal on auscultation. Lymphadenopathy, hepatomegaly, and splenomegaly were not found.

The patient was initially investigated with blood tests and imaging in the form of radiographs and subsequent magnetic resonance imaging (MRI) and computed tomography (CT). The blood test results, including full blood count and renal and liver profiles, were unremarkable apart from elevated inflammatory markers (erythrocyte sedimentation rate: 67 mm/hour; C-reactive protein: 77 mg/dl) (Table 1).

The chest X-ray showed no abnormal findings. MRI revealed two masses (73x54 mm and 33x20 mm) on the right anterior chest wall fixed on the 3rd and 2nd ribs with high signal intensity on T2-weighted images and low signal intensity on T1-weighted images invading the ribs. Because of developing cough and dyspnea, thorax CT was performed. No lesions were found except the slightly ground glass opacities in the postero-basal sides of both lung on the lung window. The soft tissue mass on the anterior chest wall was seen on the mediastinal window (Figure 1).

The MRI of right shoulder was performed because of unresolved shoulder pain. STIR MR images showed multiple high signal intensity lesions in the head of humerus, acromion of scapula and clavicle which were consistent with metastatic deposits. Bone scan demonstrated increased radiotracer activity in axial and appendicular skeleton, and multiple ribs compatible with metastasis. Excisional biopsy of the chest wall mass was performed. The morphological and immunohistochemical findings supported a diagnosis of diffuse large B cell lymphoma (DLBCL). The biopsy showed infiltration by pleomorphic lymphocytes that were positive for CD20 and CD79a, which confirmed a B cell lineage (Figure 2). The atypical cells were also positive for PAX5, MUM1, BCL-2, and BCL-6.

A course of chemotherapy was initiated and the patient began a regimen of cyclophosphamide, doxorubicin, vincristine, prednisolone, and rituximab (R-CHOP); MTX was stopped at the time of chemotherapy.

Discussion: Malignant lymphoma cases presenting with an isolated mass in the chest wall are rare. The risk of developing lymphoproliferative malignancies, including Hodgkin and non-Hodgkin lymphoma (NHL), is increased in patients with RA [1-3]. Histologically, diffuse large B cell lymphoma (DLBCL) is the most frequent type of lymphoma in patients with RA [3]. All types of DLBCL are associated with RA disease activity. Physicians should be watchful for lymphoma development in patients with RA who have high cumulative disease activity, or a Disease Activity Score-28 for Rheumatoid Arthritis of >5.7 [4]. While immunosuppressive treatment itself may cause some lymphomas, better control of disease activity appears to negate this increased risk [5].