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Автори: д.мед.н., професор Ковалевська Л.А., к.мед.н. доцент Врублевська С.В., Урсу О.Ю., Брайловський Б.Ю., Хаджинов О.В., Грицык В.П., Качурова І. М.

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CASE PEPORT

Vocabulary

Allergy – abnormal reactivity of organism

Anamnesis – history

Anuria – no urine

Apathy – indifference

Aphonia – loss of voice

Asphyxia – the condition in which a person is not able to get air into his lungs

Atrophy – a wasting or withering away or failure to develop normally, from lack of food or use

Consonant – sonorous

Diuresis – daily urine amount

Dyspnea:

Inspiratory – difficult and long breathing in
Expiratory – difficult and long breathing out
Combined – both phases are difficult
Dysuria – urination disorder, painful and frequent urination

Enophthalmos –recession of the eyeball

Exophthalmos – eyeball bulging

Gorner's syndrome – ptosis, miosis, enophthalmos

Hematuria – discharge of bloody urine

Hemorrhagic diathesis – bleeding sickness

Hernia – the protrusion of a bodily organ

Hypertrophia – abnormal increase in size

Irradiation – spreading

Kyphosis –backward curvature of spinal column

Lordosis – curvature of spinal column with forward convexity

Miosis – pupillary constriction

Midriosis – pupillary dilation

Nocturia – prevalence of night diuresis over day's one

Oliguria – low urine flow

Orthopnea – forced sitting position

Paroxysm – attack

Petechia – punctate bleeding

Pollakiuria – frequent urination

Polyuria – high urine flow

Purpura – macular hemorrhagic rash

Ptosis – falling of upper eyelid

Scoliosis – lateral curvature of spinal column

Tenesmus – false urge to defecate

Vicarious – substitutive

PLAN of case report

1. General information (passport data)
2. Patient's complaints
3. Systems review (Questions about organs and systems)
4. History of present disease (anamnesis morbi)
5. Past medical history (anamnesis vitae)
6. Patient’s objective examination
7. Tentative diagnosis
8. Additional investigations data
9. Final clinical diagnosis
10. Treatment
11. Observation diary
12. Epicrisis

I. GENERAL BIOGRAPHICAL PARTICULARS (PASSPORT DATA)

1. Surname, first, second name
2. Age, date of birth
3. Sex
4. Permanent Address
5. Place of work (job)
6. Occupation

7. Address of work
8. Date of admission to the hospital (day, month, year, hours with minutes)
9. Date of discharge from the hospital
10. The number of days spent

II. PATIENT'S COMPLAINTS

Detailed description of patient's complaints

III. SYSTEMS REVIEW (Questions about organs and systems)

a) **Questions about general condition (general symptoms)**

General weakness, rise in temperature, chills, edemas (localization, persistency, causes of appearance). General and local itch, hemorrhages, rashes, ulcers; changes in organs of locomotor system: joint pains, restriction of movement, joint deformity.

b) Respiratory Organs

Breathing through the nose (free, difficult). Nasal cold.

Nasal bleeding

State of olfactory function: distinguish smells

Nasopharynx: pain on swallowing

Larynx: change of voice, aphonia

Cough: dry, productive

Sputum: quantity, color, smell, consistency

Hemoptysis: frequency

Dyspnea: inspiratory, expiratory, mixed; dyspnea constant or from time to time; reasons of dyspnea (psycho-emotional stress, run or climb up stairs), patient's position during dyspnea (on the side, orthopnea)

Asthma – time of appearance, duration, arresting

Chest pain: localization, character (acute, dull etc.), connection with respiration, with cough

c) Cardiovascular system

Palpitation: while walking, at rest, when exited, like paroxysms; accompanied by vertigo, dropped heart beating, pains.

Pain in the heart: time of appearance, intensity, character (piercing, dull pressing etc.), duration, radiation. Suggested reasons of pain (psycho-emotional loads, exercise stress, food intake, arresting), relieving factors.

d) Digestive organs

Dry mouth. Sialorrhea. Abnormal taste (metal, bitter). Appetite. Swallowing: free, difficult.

Dyspeptic phenomenon: Regurgitation (belching) - gaseous, sour, food, putrid odour. Heartburn. Nausea: on an empty stomach or after meals. Vomit: a) poor with mucus, b) abundant with pieces of food, c) coffee-grounds, d) artificially induced in order to relieve pain.

Feeling of heaviness and pain in epigastric area, intensity, character of pains, periodicity (night pains, season pains), appear before meals (after meals, during meals) and position of the body. Radiation of pain into spinal column, shoulder - blades, upper arms etc.

Enlarged abdomen, feeling of heaviness, abdominal murmur, pains (persistent, spasmodic). Stools – constipations, diarrheas, pains on defecation and tenesmus. Colour of feces (usual, too light, dark, tarry), admixture of mucus and blood in fecal masses. Discharge of parasites. Anal pruritus. Piles, anus bleeding.

Liver: pain on the right below the ribs, their character: as attacks, their intensity, irradiation, accompanied with jaundice, rise in temperature, chills, nausea, vomit. Influence of food on the beginning and intensity of pains. Pains on the left below the ribs.

e) Urogenital system

Low back pains (persistent or paroxysmal). Frequency and duration, radiation into femur and genitals. Low back pains accompanied with rise in temperature, chills, nausea, and vomit Diurnal urine excretion, polyuria, oliguria, anuria, nocturia, pollakiuria, hematuria, pyuria.

Sexual potency (men). Menstrual function (women). Urinary bladder – feeling of heaviness and pain over the pubis, painful and difficult urination. Pains and burning in urethra. Discharge from urethra.

f) Nervous system

Irritability, apathy. Ability to work, mood, memory, sleep. Headache: localization, duration, causes, character, intensity. Accompanying symptoms: nausea, vomiting, giddiness, flickering in front of eyes.

g) Organs of sense

Vision, hearing.

So, the **main complaints** (enumerate) **and complementary complaints** (enumerate in the order of revelation during questioning on systems).

IV. HISTORY OF PRESENT DISEASE (Anamnesis morbi)

When did the patient feel himself ill or when did he know about his disease and in what circumstances? What were the complaints? Did the disease begin in acute form or the symptoms developed gradually? Which painful phenomena began earlier and which joined later? What was the cause of the disease from the patient's point of view? Did he consult a doctor or not? When did he consult a doctor? What was the diagnosis? Was he treated at a hospital or in outpatient conditions?

What drugs have been used for treatment (enumerate if possible)? Administration of medicines: peroral or parenteral. What was the treatment response? Whether it was amelioration or changes for worse? What unpleasant feelings decreased? What complaints disappeared? What can the patient say about his working capacity?

What unpleasant feelings kept on after the patient had been discharged from the hospital? What were the results of treatment in the remission period? Did the patient feel himself better or his state gradually changed for worse?

What new complaints appeared?

When did the next exacerbation begin? What painful feelings became more intensive? What was the cause of this exacerbation from the patient's point of view? Where was he treated? What was the diagnosis? What medicines were used for treatment? What was the treatment response? What complaints disappeared or decreased?

What was the treatment in remission period?

Then the patient should be asked about the new acute condition using the same scheme of inquiry. If there were three of four exacerbations during the disease all of them should be described in details. If there were more acute conditions one should write that the exacerbations were annual or they took place twice a year. It should be mentioned in what period of the year they occurred. How many times a year the patient was treated. But in this brief description the time of new symptoms appearing must be indicated. Example: in _____there was the rheumatic polyarthritis in the period of new intensification of the rheumatism, in_____ the chronic insufficiency of blood circulation appeared (dyspnea, edemas, increased fatiguability) and etc.

When did the last impairment begin and what were the complaints? What was the reason of this impairment? Which complaints began earlier and which joined later? When did the patient consult a doctor? What was the diagnosis? What treatment was ordered?

V. PFST MEDICAL HISTORY (Anamnesis vitae)

In this section there is information, which reflects the course of patient's life from the birth to the moment he consulted a doctor.

Special attention should be given to the beginning of his labour activity, its character and occupational hazards (petrol, paints, antibiotics handling).

Life conditions (dwelling, nutrition, clothing).

Past medical history, residual signs, complications after them. Special attention may be paid to venereal diseases, tuberculosis, repeated anginas, "catarrhal diseases".

Women: time of the first menstruation, pregnancy, number of labors, labor complications, postnatal complications. Abortions: spontaneous or artificial. Harmful habits: smoking (how long is the period of smoking and number of cigarettes a day), usage of alcohol (amount, frequency), narcotics.

Family diseases: syphilis, tuberculosis, nervous diseases and mental diseases. Constitutional diseases of parents and the very near relatives (obesity, gout, diabetes). Diseases of parents and the cause of their death. Allergy

anamnesis.

VI. OBJECTIVE EXAMINATION OF A PATIENT

(Status praesens)

General state of the patient: good, satisfactory, grave, extremely grave.

Consciousness: clear, dull, lost.

Patient's posture: active, passive, forced.

Expression of the face: impartial, restless, frightened, dull, exhausted, face of

Hyppocrat, distressed, sardonic smile.

Eyes: eye-slit state, exophtalmos, enophtalmos, eyelid ptosis, pupillary constriction (miosis) or pupillary dilation (mydriasis), pupillary irregularity disproportion (anisocoria). Horner's syndrome.

Height, weight, body constitution: strong or weak. Constitutional type: normosthenic, asthenic, hypersthenic. Nutritional state: moderate, reduced and excessive. Cachexia. Obesity of the I – IV degree.

Skin and visible mucosal membranes: dry, moist (sweating); colour – normal, pale, bile-tinged (icteric, subicteric), cyanotic (acrocyanosis, diffusive cyanosis). Pigmentation disturbance (depigmentation, hyperpigmentation). Rashes, hemorrhages, scars. Bedsores. Skin elasticity (turgor), hair, nails.

Subcutaneous fat: **the degree of its development.**

Edemas: spreading, localization, level of intensity, subcutaneous edema (anasarka).

Lymphatic system: submandibular, cervical, occipital, supra- and subclavian, axillary, inguinal, femoral lymph nodes. Size, consistency, cohesion with subjacent tissues, painfulness, skin colour over lymphatic nodes.

Muscular system: muscular system state (good, moderate, weak), muscular tonus (increased, normal and lowered), induration, hypertrophies, atrophies, muscular

pain (independent, painful movements, pain on palpation).

Bone system: thickening of periosteum and bones, changes in value and form of bones, pain in bones.

Backbone: lordosis, kyphosis, skoliosis, kyphoskoliosis. “Drum-stick” fingers.

Joints: size, form (fusiform, nodular), mobility (active, passive). Joints immobility (ankylosis). Painful palpation and painful movements. Crunching. Compositional fluctuation (shaking). Colour of skin and temperature round joints.

RESPIRATORY SYSTEM

Shape of chest: cylindrical, funnel, paralytic, emphysematous (barrel) etc.; symmetry of half-chests; state of supra- and subclavicular fossae; state of intercostal spaces (intercostal retraction, transdural herniation); intercostal spaces width; scapulas position. Girth of chest (cm) on normal breathing, on inhalation and exhalation. Respiratory movements symmetry, respiration rate, type of

respiration (thoracic, abdominal, mixed, Cheyne-Stokes, Biot's, Kussmaul's, Grocco's).

Chest palpation: painful ribs, painful intercostal spaces, vocal fremitus palpation (normal, intensified, weakened, isolation of its changes).

Percussion of lungs:

Comparative percussion of lungs: determination of percussion sound quality (clear pulmonary, dull sound, tympanic). Localization of percussion sound changes.

Topographic percussion of lungs: determination of the upper borders of the lungs anteriorly and posterioly, Kroening's area areas (width of the lungs apices), lower borders of lungs along all vertical lines. Determination of respiratory mobility of lungs lower edge (excursion of lungs).

Auscultation of lungs: types of respiration (vesicular - normal, puerile, diminished, strengthened, harsh respiration, interrupted; bronchial - amphoric, metallic; mixed or undefined). Rales: dry (sibilant,sonorous), moist (fine bubbling, medium bubbling, coarse bubbling, consonating and unconsonating), crepitation. Pleural friction rub, splashing sound by Hippocrates, falling drop sound. Point out the localization of revealed changes. Bronchophony.

CARDIOVASCULAR SYSTEM.

Examination of heart region and big vessels: protrusion of the heart region (cardiac humpback). Apex beat (location, height, strength, resistence), cardiac beat. Systolic chest retraction. Epigastric pulsation. Pulsation in the second intercostal space, pulsation in the jugular fossa, pulsation of carotids and other arteries (temporal, brachial). Capillary pulse. Swelling of veins (jugular)

and their pulsation, positive venous pulse. Cat's purr symptom (systolic, diastolic, location).

Percussion: determination of relative and absolute heart dullness borders. Determination borders of the vascular bundle.

Auscultation: heart rhythm (regular, irregular), respiratory arrhythmia, extrasystolic arrhythmia, fibrillation), heart rate.

Heart sounds: loudness, timbre of I and II heart sounds, flapping of the I heart sound, 'pistol-shot' sound accoding Strazhesko, accentuated of the II sound, splitting and reduplication of the heart sounds ("gallop" rhythm - presystolic, systolic or protodiastolic). Cardiac murmurs (systolic, diastolic and their variants - presystolic, protodiastolic, mesodiastolic). Places of the best listening of cardiac murmurs, murmur conducting. Friction rub. Pleuropericardial murmur. Cardiopulmonary murmur.

Auscultation of carotids, femoral arteries, phenomenon of Traube – Vinogradov – Durozye. Auscultation of cervical veins (whipping - top sound).

Pulse: symmetry, rhythm, rate, tension, volume, size, speed, form. Absence of pulse (Takayasus disease), pulse deficit.

Determination of arterial pressure in the brachial artery from the left and from the right.

DIGESTIVE SYSTEM

Examination of oral cavity: bad smell from the mouth, colour of lips and visible mucous membranes, fissures in the mouth angles, inflammatory erythema, cyanosis, pigmentation, gingivae edge (when poisoning with bismuth, lead etc.).

State of teeth: carious teeth, absence of teeth, artificial teeth.

Tongue: humid, dry, furred, pale, brightly red, cyanotic. Lingual papilla atrophy (Addison – Biermer disease). Tongue aphthae.

Fauces and throat: paleness, hyperemia, dryness, pathologic spots. Tonsils: enlarged, presence of scars, purulent corks in crypts, spots on the tonsils, their colour, easiness of tearing away.

Examination of abdomen: form, symmetry, participation in breathing, abdominal swelling in hypogastric area and retraction in epigastrial area at the same time. Varicose cutaneous veins. Visible stomach and intestinal peristalsis. State of umbilicus: inverted, thrown out, smoothed. Postoperative scars on the abdominal wall.

Hernias (omphalocele, incisional, inguinal, femoral).

Palpation of abdomen:

Surface preliminary palpation: determination of abdominal wall resistance, painfulness (defuse, local), Shchetkin – Blumberg's peritoneal syndrome.

Determination of abdominal dropsy by the fluctuation method.

Deep, sliding, methodical, systematic, topographic palpation according to the V. P. Obraztov-N. D. Strazhesko begins with sigmoid palpation (determination of its thickness, mobility, consistency, painfulness), then caecum is palpated with determination of its state, then the bottom of stomach and transverse colon are palpated.

Liver: determination of sizes by percussion according Kurlov, determination of the liver edge character (sharp, rounded), painfulness of liver, character of the surface, consistency (dense, soft). Special examination of gallbladder, its tenderness, enlargement. Courvoisier's symptom, phrenicus – symptom.

Spleen: location, consistency, painfulness.

Kidneys and urinary bladder: bimanual palpation of kidneys (nephroptosis, painfulness, tuberosity). Pasternatsky's symptom. Painfulness along ureter.

Examination of suprapubic area (painfulness, swelling).

VII. TENTATIVE (PROVISIONAL) DIAGNOSIS

(Scheme of substantiation of a diagnosis)

The patient complains of … (name the complaints, which confirm the diagnosis).

Anamnesis of the present disease. The patient considers himself to be ill since….. when…(briefly state the main stages of the disease, which confirm the diagnosis: beginning, symptoms, the course of the disease, the cause of the disease

etc.).

Anamnesis of life (anamnesis vitae). Describe only those diseases and unfavourable factors, which might contribute to the development of the present

disease. For example, old anginas provoke the development of kidney diseases, rheumatism; alcohol and tobacco abuse provoke ulcerous disease.

Objective data: the results of examination, palpation, percussion, auscultation, which confirm the diagnosis.

On the basis of the above-stated it may be considered that the patient has … (formulate the diagnosis in full)

The example of tentative diagnosis substantiation.

On the basis of patient's complaints of pain near the heart, heartbeating, short of breath while walking, shin edemata in the evening, subfebrile temperature in the evenings, asthenia, undue fatiguability.

On the basis of the anamnesis of disease**:**

The patient fell ill 6 years ago after he had had the angina. The patient had subfebrile temperature during a month, heartbeating, especially at night, pain in the area of heart, dyspnea on exertion (DOE), hyperhidrosis, undue fatiguability. Until then the patient had suffered anginas 2-3 times a year. There are new exacerbations of the disease in autumn and spring almost every year. These exacerbations are nasopharyngeal infections-dependant (focal streptococcal infections). The last impairment appeared after acute pharyngitis.

On the basis of clinical presentation of the disease (paleness of skin, acrocyanosis, leg edemata, specific (sour) smell of the patient's sweat, swelling of cervical veins, the apex beat displacement to the left and downwards, dilation of relative heart dullness borders to the left and upwards, minor dilation of

absolute heart dullness borders to all sides, weakening of the first apical heart sound, accent of the second sound over the pulmonary artery, systolic apical cardiac murmur which is conducted to the left axillary area, tachycardia up to 100 beats per minute, enlarged liver which is 3 cm protruded from hypochondrium) we may formulate tentative diagnosis:

Rheumatism. It is based on the beginning of the disease and the exacerbations after focal streptococcal nasopharyngeal infections. Paleness of skin, specific (sour) smell of the patient's sweat, night heartbeating, lingering subfebrile temperature, clinical signs of chronic carditis, heart failure;

Active phase, the second degree of activity. It is characterized by subfebrile state after clinical signs of previous streptococcal disease have disappeared, hyperhidrosis. Clinical picture of carditis – pain near the heart, heartbeating, dyspnea, tachycardia, development of cardiac insufficiency exacerbation against a background of the exacerbation of the process;

Recurrent carditis. Exacerbation of carditis against a background of the formed heart defect;

Mitral valve incompetence. Signs of the left ventricle hypertrophy and deviation of apical beat to the left and downwards, dilated apical beat (extended area, height, strength), dilation of relative heart dullness borders to the left, dilation of left auricle and raise of pressure in the pulmonary artery (expansion of pulmonary cone) – dilation of relative heart dullness borders upwards; minor hypertrophy and dilation of right ventricle as a result of carditis exacerbation,

hypertension of lesser circulation and cardiac decompensation development, which is revealed in some dilation of absolute heart dullness borders to all sides;

Circulatory insufficiency of the III functional class (classification NYHO**).**

Complaints: dyspnea on walking, heartbeating, undue fatiguability, leg edemata appearance in the evening, swelling of cervical veins, enlarged liver, which is 3 cm protruded from hypochondrium.

So, **tentative diagnosis** can be formulated like this: rheumatism in active phase, second degree of activity, recurrent carditis, mitral valve incompetence, circulatory insufficiency of III functional class (NYHA).

VIII. ADDITIONAL INVESTIGATIONS DATA

Blood, urine, and feces bulk analyses. Biochemical blood investigation data (acute phase reactants: fibrinogen, C–reactive protein, DPA, albuminous blood fractions, antistreptolysin-0, antistreptohyaluronidase, antistreptokinase etc., liver functional tests: thymol, sublimate, blood bilirubin etc., blood ferments).

Instrumental methods of the investigation: ECG, phonocardiogram, ultrasonic investigation of the heart, organs of the abdominal cavity, X-ray investigation and etc.

Professional advice.

IX. FINAL CLINICAL DIAGNOSIS. (The example of substantiation).

On the basis of patient's complaints of pains near the heart, heartbeating, short of breath while walking, shin edemata in the evening, subfebrile temperature in the evenings, asthenia, undue fatiguability.

On the basis of anamnesis: The patient fell ill 6 years ago after he had had the angina. The patient had subfebrile temperature during a month, heartbeating especially at night, pain in the area of heart, dyspnea on exertion (DOE), hyperhidrosis, undue fatiguability. Almost annual exacerbations of the disease in autumn and spring. These exacerbations are nasopharyngeal infections-dependant. The last impairment appeared after acute pharyngitis. Frequent anginas in anamnesis.

On the basis of physical examination data: paleness of skin, acrocyanosis, leg edemata, sour smell of the patient's sweat, swelling of cervical veins, the apex beat displacement to the left and downwards, minor dilation of absolute heart dullness borders to all sides, weakening of the first apical heart sound, accent of the second sound over the pulmonary artery, systolic apical cardiac murmur which is conducted to the left axillary area, tachycardia up to 100 beats per minute, enlarged liver which is 3 cm protruded from hypochondrium.

On the basis of additional investigations data: in blood bulk analysis – leukocytosis, increase of ESR up to 24 mm/hour, positive rheumatism activity immunebiochemical test (antistreptococcal antibodies and acute stage indices (DPA, sialic acids, seromucoid, C-reactive protein, hyperfibrinogenemia,

dysproteinemia with protein coefficient decrease up to 1,1); chest X-ray – mitral configurated heart; ECG – intra-auricular block, signs of the left ventricle and left atrium overload and hyperthrophia, non-defined signs of the right ventricle hyperthrophia; PCG – decrease of the first apical heart sound amplitude, increase of amplitude of the second sound over the pulmonary artery, the systolic noise of different frequencies and different amplitudes on the apex and in "O" point beginning with the I sound, the third sound is registered with some increase of amplitude.

Final clinical diagnosis can be formulated: rheumatism, active phase, the second degree of activity, recurrent carditis, mitral valve incompetence, the of blood circulatory insufficiency of the III functional class (by NYHA).

The second degree of the rheumatism activity is confirmed by the increase ESR up tol 24 mm/hour and positive rheumatism activity immune-biochemical test such (high titer of antistreptococcal antibodies and all positive unspecific indices of inflammatory process activity).

Mitral valve incompetence is confirmed by the additional examination data:

1. mitral configurated heart - on the chest X-ray ;
2. left ventricle and left atrium hyperthrophia - on ECG;
3. the decrease of the first apical heart sound amplitude, increase of amplitude of the second sound over the pulmonary artery, the systolic noise of different frequencies and different amplitudes on the apex and in "O" point beginning with the I sound - on the PEG.

Taking into consideration the beginning of this one and all previous exacerbations, clear clinical picture of exacerbations, subfebrile temperature

with rise to the febrile indices during exacerbations we can draw a conclusion that the exacerbations of the disease have a subacute course.

X. TREATMENT.

The prescribed treatment: the regime, the diet, drugs and other applied methods of treatment.

XI. OBSERVATION DIARY.

The diary reflects the patient's state in dynamics taking into consideration the effectiveness of the applied treatment.

XII. EPICRISIS.

Epicrisis includes short summary of anamnesis, objective examination data, clinical diagnosis of the disease with its substantiation and the most important additional methods of the investigation, which confirm the diagnosis. The applied treatment and its effectiveness (the improvement, impairment, without any changes) should be indicated.

Epicrisis is concluded with recommendations to the patient (regime, diet, treatment, including a sanitary – resort one and etc.).

The example of an epicrisis.

A 31-year-old teacher was treated in the cardiological department of 6-th city clinical hospital from 01.01.2001 till 21.01.2001 with the diagnosis: rheumatism, the active phase, the II degree of activity, recurrent carditis, mitral valve incompetence,

(subacute course), circulatory insufficiency of the III functional class (classification

NYHO).

When admitting the patient complained of pains near the heart, heartbeating, short of breath while walking, shin edemata in the evening, subfebrile temperature in the evenings, asthenia, undue fatiguability. As we know from the anamnesis the patient fell ill 6 years ago, after he had had the angina. The patient had subfebrile temperature during a month, heartbeating, especially at night, pains in the area of heart, dyspnea on exertion (DOE), hyperhidrosis, undue fatiguability. Almost annual nasopharyngeal infections-dependant exacerbations of the disease. The last impairment appeared after acute pharyngitis. Frequent anginas in anamnesis.

Objective signs when admitting: paleness of skin, acrocyanosis, leg edemata, sour smell of the patient's sweat, swelling of cervical veins, the apex beat displacement to the left and downwards, minor dilation of absolute heart dullness borders to all sides, weakening of the first apical heart sound, accent of the second sound over the pulmonary artery, systolic apical cardiac murmur which is conducted to the left axillary area, enlarged liver.

According to the additional investigation data: Blood bulk analysis - minor leukocytosis ($8{,}4 \cdot 10^9$), in blood bulk analysis - leukocytosis, increase of ESR up to 24 mm/hour, positive rheumatism activity immune-biochemical test (antistreptolysin – 0, antistreptokinase, antistreptohyalurokinase, C-reactive

protein, DPA, sialic acids seromucoid, dysproteinemia with protein coefficient 1.1, hyperfibrinogenemia. Chest X-ray – mitral configurated heart; ECG – intra-auricular block, signs of the left ventricle and left atrium overload and hyperthrophia, non-defined signs of the right ventricle hyperthrophia; PCG – decrease of the first apical heart sound amplitude, increase of amplitude of the second sound over the pulmonary artery, the trid sound is registered, the systolic noise of different frequencies and different amplitudes on the apex and in "O" point beginning with the I sound.

The applied treatment: bed regime, diet No.10, penicillin for 10 days, bicillin-3 - once a week, aspirin - 1,0 g × 3 times a day, ascorutinum - 1 tab × 3 times a day, prednisolone - 1 tab × 4 times a day reducing the day dose by 1 tab weekly, cordarone -

O,2 g according to the chart, courses of furosemide –1 tab ×a day during 3 days, then a 3-days' break.

After this course of treatment the patient showed much improvement. He doesn't suffer from dyspnea, heartbeating, pains near the heart, undue fatiguability. The temperature is normal. Tachycardia and edemata disappeared. The first sound became more pure. Liver is normal. Acrocyanosis decreased. ESR is normal. The patient was discharged from hospital with great improvement.

Out-patients should take Bicillin-5 intramuscularly once in 4 weeks during 3 years. Besides he should be administered aspirin - 1g × 3 times a day for 2 weeks and ascorutinum - 1 tab × 3 times a day for 2 weeks.

Every spring and autumn the patient is to have the drug therapy prophylaxis of rheumatism.

If there are no any clinical signs of the disease exacerbation in half a year the patient is recommended sanatorium-and-spa treatment in the local sanitarium of cardiological profile. The patient is able to work.