reflux symptoms, the patient was prescribed PPIs and scheduled for gastroscopy. Surprisingly, the gastroscopy unveiled an ulcer in the mid-thoracic oesophagus as also a Barett-oesophagus. However, the mystery deepened when the patient returned to the ER one week later, complaining of worsening dyspnoea. Initially suspected pulmonary Embolism and a slightly elevated D-dimer level prompted a CT Thorax, revealing a 5 cm mediastinal tumour compressing the oesophageal wall at the site of the previously diagnosed ulcer.

Methods: The initial clinical hypothesis was that the patient's symptoms were related to reflux symptoms due to smoking. The discovery of the oesophageal ulcer during gastroscopy supported this hypothesis. However, the exacerbation of dyspnoea raised concerns of an underlying condition not explained by reflux alone.

Discussion: This case highlights the significance of elevated D-dimer levels as a potential marker for tumorigenesis and the need for a comprehensive diagnostic approach. The key takeaway is that seemingly subtle symptoms can indicate hidden malignancies, even in the absence of classic cancer-related symptoms.

Keywords: *D-dimer, tumorigenesis, tumour*

[Abstract:1849]

CASE OF PULMONARY EMBOLISM PROVOKED BY INSOLATION IN A 36-YEARS-OLD VACCINATED MAN WITH PRIMARY ANTIPHOSPHOLIPID SYNDROME

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The case of venous thromboembolism in young man 2 months after vaccination with the clinic of pulmonary embolism after insolation.

36-year-old man was admitted to ICU due to unmotivated dyspnoea, haemoptysis and chest pain. Anamnesis: 2 months ago he was vaccinated; probably reason of his condition was exposure to sunlight with developing fever and symptoms on the next day.

COVID-19 infection was excluded serologically.

Objective: Hemodynamically stable, blood pressure 110/80 mmHg, pulse 110 bpm, tachypnoea, saturation 80%, swelling of jugular veins. D-dimer – 7.1 ng/ml. CT-angiography – thrombotic masses in the segmental branches S9, 10 of both lungs (80% of the vessel lumen). Initial treatment - UFH (patient refused thrombolysis). On 6th day patient developed hemodynamic instability (BP 80/50 mmHg) and systemic thrombolysis with alteplase 100 mg, then LMWH in therapeutic doses, rivaroxaban according to the scheme was performed.

Further examination: we detected serological markers of antiphospholipid syndrome (APS) - IgG/M antibodies to β2-HP, lupus anticoagulant, antibodies to cardiolipins and phospholipids.

The patient had triple positivity for antiphospholipid antibodies (in dynamics up to 12 weeks). Based on the primary APS (Sydney diagnostic criteria), rivaroxaban was replaced by warfarin with a titrated dose up to 11.25 mg to maintain an INR of 2.0-3.0 (TTR 70%). The high dose of warfarin is apparently due to the presence of high titers of antiphospholipid antibodies.

Thus, the likely combined effect of several triggers (vaccination, insolation) that could simulate immunothrombosis with the development of PE on the background of APS can be traced.

Keywords: *pulmonary embolism, antiphospholipid syndrome, anti COVID-19 vaccination*

[Abstract:1937]

AORTO-ENTERIC FISTULA: A TICKING CLOCK WITH A TRICKY DIAGNOSIS

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Case Description: A 60-year-old man was rushed to our emergency room due to recurrence of massive gastrointestinal (GI) bleeding and haemorrhagic shock. He experienced two self-limiting episodes of melena during the first 14 days of hospitalization at a minor facility; no active bleeding spots were seen at endoscopic studies. Since a contrast-enhanced computed tomography (CT) performed earlier that day detected duodenal bleeding, the patient was referred to our angiography. Clinical conditions upon arrival were critical and the patients suffered from cardiac arrest shortly thereafter.

Diagnostic and therapeutic crossroads: After return of spontaneous circulation, it was collegially decided to proceed with endovascular treatment though a persisting state of hemodynamic instability on high-dose vasopressors. No active bleeding points were seen at angiography and patient was transferred to intensive care unit after prophylactic ligation of the gastroduodenal artery. After a new bleeding episode occurred few hours later, aorto-duodenal fistula (AEF) was confirmed and repaired in the operating room. Unfortunately, the patient died 10 days later due to complications of refractory coagulopathy.

Discussion and Learning Points: AEF is a rare yet highly lethal condition and timing for treatment is crucial to increase survival. Diagnosing AEF might be difficult especially in the emergency context, and clinicians should be particularly aware of this scenario when dealing with a massive GI bleeding preceded by less severe episodes called "herald bleedings". Endoscopy is usually uninformative in AEF, and angiography has a low sensitivity when performed on a hemodynamically unstable patient due to splanchnic vasoconstriction, especially when on vasopressors.

Keywords: *aortic fistula, haemorrhagic shock, angiography*

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