ABSTRACTS BOOK

IV BALEARIC MEETING OF EUROPEAN RESIDENTS AND YOUNG GP´S. 2016

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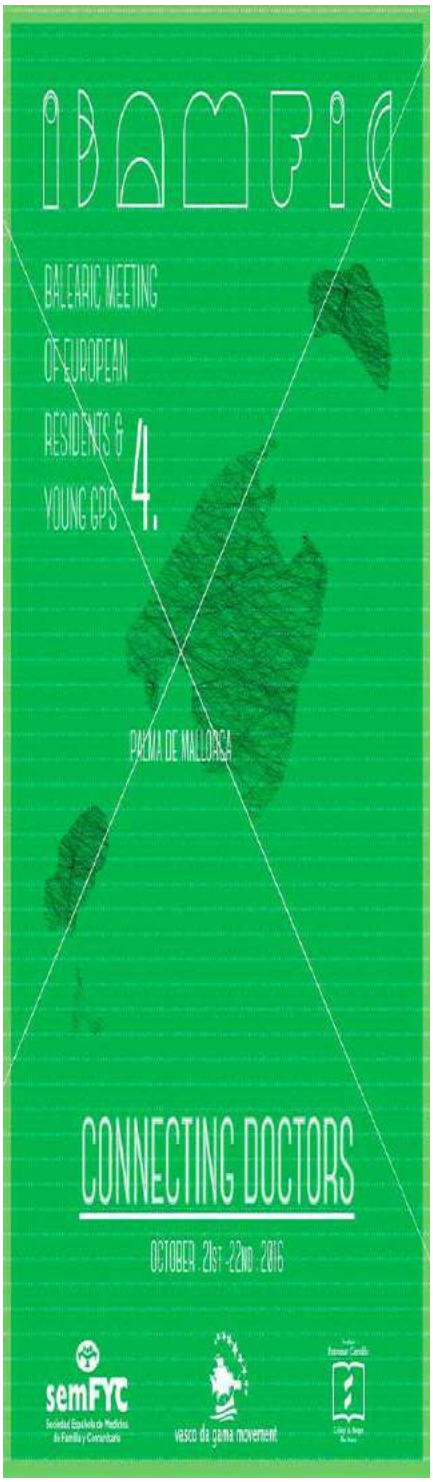

Welcome

It is a great honor for us to invite you to the IV 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 October 21st and 22nd of 2016.

In this fourth edition, we will try to connect residents and young GPs from all around the world, to share the Family and Community Medicine of the 5 continents and to exchange experiences of our clinical practices. 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 22nd Wonca Europe Conference (Prague, June 2017) and to the 4th VdGM Forum (Strasbourg, April 2017), 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 a "World Conference Exchange", inviting young doctors of the 5 contintents, 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!!!

Organizing Committee

Please do not forget that the oral poster exposition will be at the coffee time

Scientific Programe

Friday, 21st of October 2016

8:45-9:30. Registration

9:30.10:30. Session 1. Intoxications Management in Emergency, Dr. Christopher Yates

10:30-11:15. Session 2. Pediatric Emergency in Primary Care, Dr. Rosmary Argüelles.

11:15- 11:45. Coffe Break + **Oral Poster Exposition**

11:45-12:30. Session 3. Benzodiazepine Management in Primary Care, Dr. Caterin Vicens. Network.

12:30-13:15. Session 4. Ultrasonography uses in Emergency, Dr. Lorena Cuesta.

13:15:14:45. Lunch time

14:45-15:00. Opening Act Ms. Patricia Gómez, Health Minister of Balearic Islands.

15:00-16:00. Opening Conference Dr. Charilaos Lygidakis (Italy).

16:00-18:00. Workshop

Minor Surgical Procedures, Dr. Ignaci Ramírez.

Symptoms Management in Palliative Care, Dr. Enrique Ferrer.

Spirometry & Respiratory Therapies, Ibamfic Respiratory Network.

Cardiopulmonary Resuscitation, Dr. Germán Llopis.

Please do not forget that the oral poster exposition will be at the coffee time

Scientific Programe

Saturday, 22nd of October 2016

10:00-12:00. Connecting Doctors Session, Conference Exchange participants.

12:00-12:30. Coffe Break + **Oral Poster Exposition**

12:30-13:15. Sesion 5. Chest X-Ray Interpretation. Dra. Elena Klusova.

13:15-14:00. Session 6. Social Media uses in Primary Care, Ibamfic Tecnologies Network.

14:00-15:00. Lunch time.

15:00-16:00. Oral Exposition Scientific Works.

16:00-17:00. Trivial of Medicine

17:00. Closing Ceremony & Awards

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Full text- Posters

P1. Case report: The importance of a good medical history and physical examination in primary care.

Corresponding author: *Cruellas Garau, M.* ***Contact****: mcruellasgarau@gmail.com*

Filiations: Centre de Salut Santa Ponça. Illes Balears, Espanya.

Female, 53, comes for a shoulder-left pain. This pain has nocturnal prevalence, affects mobility and has been evolving during 3-4 weeks. She takes paracetamol but she doesn't improve. She hasn't come previously to consultation. She suffers hypothyroidism (treatment with eutirox 50mg) and allergic reactions against NSAIDs and ASA. In the physical exploration we observe that the skin has a normal colour and a lost of muscular mass of the left biceps without deviation of the axis. With the palpation, she complains about a selective pain at neck of the humerus and a contracture of the left triceps. The active and passive mobility are limited (specially internalexternal rotation and abduction which are painful and restricted).

With this painful shoulder clinical syndrome, three hypotheses are possible:

• Rotator cuff tendinitis: The most likely cause is the affectation of the supraspinatus tendon. In patients under 33 it is normally caused by joint instability due to laxity of the capsular structures; whereas between 40-50 years this affectation is related with overload mechanisms. In addition, the most common cause in patients below 55 years is sinewy degeneration with a partial or complete rupture.

• Retractable capsulitis: owing to a contracture of the capsule glenohumeral joint.

• Calcific tendinitis: which is produced by the deposition of calcium crystals within cuff tendons. This appears in people with degenerative tendons problems and enhances the rupture of them.

She told us that a month ago she felt down, forcing the abduction of her left hand. During this fall she heard a crack. Afterwards a hematoma appeared in the internal part of the arm.

Due to proximal humerus rupture suspicion, simple radiography 2P of the shoulder is ordered. On the anteroposterior projection an enclosed subcapital fracture affecting the neck of the humerus is observed.

With the diagnosis established, she is redirected to traumatology for treatment and monitoring.

Even though, few minutes are available per patient in primary health care, it is essential to make a proper clinical record. In most cases, a correct diagnosis can be achieved with an appropriate anamnesis and physical explorations, avoiding complementary tests and unnecessary derivations.

P2. Case Report: Complex Regional Pain Syndrome

Corresponding author: Esteves A; Correia, S**. *Contact*:** saraeacorreia@gmail.com

Filiations: Centro de Salud de Teis, Vigo, Spain.

Our patient is a 52-year-old male, smoker, with a long story of alcohol, hypertension and gout. In the past 2months, he consulted in two different occasions for pain in his left foot without suffering any associatedtraumatic lesion, except for maybe a walk with brand new boots. In the past examinations, we found no inflammation signs and no pain with passive and active movements, nevertheless, in a third consult, he complains of swelling and redness (see pictures). No signs of hyperesthesia. As such, we asked for a foot radiography that shows diffuse osteoporosis in tarsus. With the clinical suspicion of Complex Regional Pain Syndrome, we sent the patient to a secondary care attention level where a RMN and a ganmagraphy were ordered (see picture), both confirming our initial diagnosis: Complex Regional Pain Syndrome. We should also keep in mind other diseases such as infections, stress fractures, peripheral neuropathy or arthropathy, deep vein thrombosis, etc. The patient started treatment with bisphosphonates and rehabilitation follow-ups. Since then, the patient's condition has been progressing in a favorable way. Complex Regional Pain Syndrome, also known as Sudeck syndrome, is a complex chronic disease that affects the individuals' quality of life. It can be divided into two diseases entities: type I develops in the absence of identifiable nerve injury, while type II has nerve damage. It results from an individual's abnormal response to injury involving neural inflammation, vasomotor dysfunction and maladaptive neuroplasticity. It has 3 stages: acute, dystrophic and atrophic. The diagnosis is clinical and may be difficult, particularly in the early stages of the syndrome and there isn't definite treatment but it has been shown that early rehabilitation can improve the prognosis. This way we find that general practitioners should be aware of this medical condition in order to establish a prompt diagnosis and an early.

P3: Case Report: Small bowel obstruction caused by endometriosis

Correspondig author: Sorribas Morlan M**.** ***Contact:*** sorribasmonica@gmail.com

Filiations: Hospital Universitario Son Espases, Palma de Mallorca, Spain

Abdominal pain is one of the common reasons for emergency department visits and in young fertile women, endometriosis should be considered as a differential diagnosis.

Description:

A 35-years-old woman was referred to the emergency department by her family doctor, for five days of low abdominal pain with nauseas, vomits and diarrhea in the past 48 hours. She was asthmatic without treatment, nulliparous and her last period was 7 days before its visit. She was hemodynamically stable, and her abdominal physical examination showed pain and tenderness in the lower right and left quadrant with present intestinal peristalsis. The rest of examination was normal. A blood test was performed, revealing a C-reactive protein level of 9.87 mg/dl and a prothrombin time of 55%. Haemogram, renal and hepatic tests were normal and urinary pregnancy test was negative. Gastroenteritis was considered as initial diagnosis, but appendicitis, colitis, diverticulitis, inflammatory bowel disease, nephrolithiasis, pyelonephritis, ectopic pregnancy, ovarian mass o torsion or pelvic inflammatory disease were also included as differential diagnosis. Subsequent diagnostic testing included an abdominal ultrasound, that reported fluid-filled loops of small bowel, its diameter in the upper limit of normal and a hemorrhagic right ovary cyst was spotted. The patient was sent to the gynecology department and a transvaginal ultrasound was performed, that showed an ovarian endometrium. Contraceptive pills were given as treatment.

Back in the emergency department, the patient referred persisting pain despite analgesics and new vital signs showed tachycardia, hypotension and dysthermia. Intravenous fluids were administrated and a CT scan was realized, that reported distal small bowel obstruction. Emergency laparotomy was performed and ileocecal resection was needed, due to a distal small bowel loop that was adherent to the endometrium. During the postoperative course she presented severe abdominal sepsis, probably caused by bacterial translocation and she was discharged 7 days after the surgery. Histological examination confirmed severe endometriosis implants as the cause of obstruction.

Conclusion: Physicians must consider endometriosis as diagnosis when assessing acute abdominal pain and be aware of its ectopic implants as a rare cause of bowel obstruction.

P4: Case Report: A terrible headache

Corresponding author: Furquet, N. ***Contact:*** noelia@furquet.com

Filiations: CS Trencadors (Mallorca), Spain

Case Description: A 38 year-old woman with multiple consultations in Primary Care emergency for a discontinuous and oppressive headache ongoing for almost two months failure to respond to painkillers (acetaminophen, metamizole), NSAID medication (dexketeprofen, naproxen,diclofenac) and amitriptyline. The neurogical examination was always normal and the headache did not fulfill any warning sign. The patient finally decided to go to the emergency department of the hospital on her own.

Physical examination: Cervical contracture. The neurological examination was normal.

Blood analysis was normal. Hormonal analysis: cortisol, prolactine and gonadotropins level were alterated.

Cerebral CT scan: hydrocephalus caused by synchronous tumor (one located in the sellar region and the other in the pineal one) Cerebral MRI: confirms the two lesions observed in the CT scan

Results: Diagnosis: Choroid plexus carcinoma stage III. Prolactinoma.

Differential diagnosis: Supratentorial tumors (adenoma, meningioma).

Conclusions: Headache is a common cause of attendance for patients, which deserves particular attention concerning both the rapid and effective treatment and management. The role of the GP is crucial to detect the cases of headaches in which it is necessary to refer the patient to the hospital for neuroimaging tests. In this case the time of onset of pain, and the failure to respond to previous treatment were criteria to be taken into account for an earlier referral.

P5. Case Report: Smoking is bad even for hiding it´s own sympotoms

Correspondig author: García-Gutiérrez Gómez, R. ***Contact:*** rocio3g@gmail.com
Filiations: Centro de Salud Las Calesas, Madrid, Spain

30 year old woman, active smoker of 10 cigarettes per day (pack/year rate: 8) and no other medical history,went to the Health Center alluding pain in the left subcostal region that started while making an effort at work (physically active work in a supermarket). She denies any other symptoms.

Exploration and complementary tests: Body temperature: 36,8ºC; eupneic, oxygen saturation: 100%. CF: 79 beats per minute. Chest: left subcostal pain, that increases with movement. No crackles on palpation. No bruises or other superficial injuries. Cardiac auscultation: rhythmic heart sounds of low intensity, no murmurs. Pulmonary auscultation: generalized decreased breath sounds. A ribcage X-ray was performed where we could see a cavitating image in the left upper lobe. Costophrenic angles were clear. Ribs were intact. No fractures or cracks. The patient is sent to the Emergency Department, to get, this time, a chest x-ray done, which confirms the cavitating infiltrate in the left upper lobe.

Diagnosis: Pulmonary tuberculosis Mycobacterium tuberculosis COMPLEX, with cavitating pneumonia.

Differential Diagnosis:

- Lung mass: Primary Lung Cancer, Metastasis, Carcinoid tumors
- Infections: tuberculosis, aspergillosis ...
- Vascular Malformations
- Mediastinal mass: Thymoma, Lymphoma, Lymph tissue teratoma

Evolution and conclusions.

After knowing the diagnosis, we spoke again with the patient, who admitted that she had been presenting a yellowish sputum for several weeks. She denied strands of blood in the expectoration, fever or any other symptom. We asked her why she did not visit us before, but she said that she was not worried because she is an active smoker and attributed this fact to her normal expectoration, and therefore did not consult her family doctor. Another fact that we consider important is the systematic assessment used to interpret the X-rays: first, the structures displayed the worst (in this case, the x-ray was a ribcage one, and therefore the radiation has a higher kilovoltage peak which makes the pulmonary parenchyma look worse, but systematic reading allowed us to see the injury at this level), and then those structures better displayed.

P6. Is asymptomatic cholelithiasis more prevalent in Latin American women between 18 and 65 with respect to Non Latin American women of the same in our Health Area?

Corresponding author: García-Gutiérrez Gómez, R. ***Contact:*** rocio3g@gmail.com
Filiations: Centro de Salud Las Calesas, Madrid, Spain

Key words: Gallstones, Asymptomatic Diseases, Women

Background. Between 5% and 15% of the western population have gallstones (either symptomatic or asymptomatic). It is a chronic, multifactorial disease with serious medical, social and economic implications to its high prevalence and associated complications. This disease affects millions of people around the world, especially those in Western societies where it is diagnosed in 10 to 20% of that population, with 800,000 new cases each year. It occurs in 20% of women and 10% of men. In Spain studies have been published placing the prevalence of the disease at 9.7%. In Latin America between
5% and 15% of people have gallstones, and there are populations and ethnic groups with the highest prevalence, such as Caucasian, Hispanic or Native Americans. Chile and Bolivia are amongst the countries with the highest number of people affected by this disease. Currently, there are no studies about the prevalence of asymptomatic cholelithiasis in Spain, nor can we cannot find comparative studies regarding women in our health area.

Objectives

1. Determine the prevalence of asymptomatic gallstones in Latin American women between 18 and 65 years of age in our health area.
2. Determine the prevalence of asymptomatic gallstones in non Latin American women between 18 and 65 years of age in our health area.
3. Compare the two study groups.

Methods

- Material: ultrasound scan of our Health Center. The researchers (family doctors) are those who will do the ultrasound scan of the patients.
- Inclusion criteria: women between 18 and 65 years old
- Exclusion criteria: digestive symptoms and clinical history of cholecystectomy.
- Sample: for an accuracy of 0.05, a confidence level (1- alpha) of 0.95 and an expected rate of 12% we have to do 300 abdominal ultrasounds to 300 different women.

Conclusions

- There are few studies worldwide
- Total absence of studies in our health area
- We want to describe the characteristics of our target population and compare between populations
- Scope

Depending on the conclusions, we may have the ability to predict the complications or/and provide long term treatment for galltones.

P7. Case Report: Varicella Zoster Virus (VZV) a latent enemy.

Corresponding author: Osinaga Peredo **S. *Contact:*** susyosinaga@gmail.com
Filiations: Health Center Sarria-Lugo-Spain

The authors declare that the pacient has given permission to use clinical information

- CASE DESCRIPTION: A 34 year-old Dominican male resident in Spain for 18 years. According to the family life cycle, he has 3 children (nuclear family in stage).

He has been suffering from allergic rhinitis and asthma, medical treatment with inhalers steroids for years. Smoker. He attended General Pratitioner (GP) surgery for pruritic rash; maculas papulas and vesicles on the face, trunc, extremities and oral mucosa in different stages of development.

He didn't remember if he had been vaccinated, but he had a contact with chickenpox case in previous days. He was diagnosed with chickenpox and treated with valacyclovir, ibuprofen and cetirizine.

On 5 day he had 2 episodes of acute urinary retention, in addition to fever, constipation, intense asthenia and generalized weakness.

He was referred to emergency hospital with a suspected diagnosis of complications within varicella infection.

- PHYSICAL EXAMINATION

Postration, general rash with crusted papulas. Paraparesia on his legs 4/5, hypoesthesia T5-T10 dermatoma. He had some inestability that impressed sensory ataxia.

Complementary examination incluyed serology VZV IgG and IgM positive. Serology syphilis, human inmunodeficiency virus, hepatitis, brucella, borrelia were negative. Imaging test chest x-ray normal. Magnetic Resonance Imaging (MRI) revealead signs compatible with encephalomyeilitis.

- EVOLUTION: Antiviral therapy with valacyclovir up to 15 days was completed. The patient after 3 weeks at discharge get better, but persist hypoesthesia and he needs vesical catheterization.
- CONCLUSION: VZV infection is usually a clinical diagnosis based on the characteristic vesicular lesions. No futher diagnostic testing in necessary. Neurologic complications such as encephalitis, in the past Reye syndrome, aseptic meningitis, transverse myelitis are unlikely. All patients with varicella should be educated about potential complications. A notion that attenuad virus vaccine is the most effective prophylaxis, antiviral therapy to reduce the severity of symptoms and risk of complications.

  We use oral therapy (valacyclovir or acyclovir) for individuals who present are at high risk for complication as well as inmunocompetent individuals.

  Salycilatos should be avoided has been associated with Reye syndrome as well as ibuprofen whith poor evolution.

P8: Critical Incident: Transmission of vaccine-associated measles: Is it possible?

Corresponding author: Ortega-Cutillas M. ***Contact:*** jesustorresp@gmail.com

Filiations: CS Es Trencadors. Llucmajor. Mallorca-España

Introduction: Measles is a viral infectious disease clinically characterized by fever, skin rash, cough, conjunctivitis and Koplik's sing (small white spots inside the cheek).

Facts: A 37 yeard-old man, with no relevant medical history, came to the emergency room complaining fever, itching and abdominal pain. The physic exploration revealed cutaneous rash and white lesions inside the cheek. Laboratory showed lymphocytosis as the case was initially oriented as a viral infection. Interestingly, the patient said that his daughter (1 year old) suffered fever after measles vaccination 2 weeks ago. He denied history of measles nor measles exposure.

We faced with the questions (objective):

Is the vaccine reaction of his daughter a vaccine-associated measles (VAM)? And more relevant: Is the viral infection of our patient a VAM transmitted from his daughter? But, is this last one possible?

To answer these questions we systematically consulted bibliography on PubMED.

Attenuated measles virus vaccine can leads to VAM in both healthy and immunocompromised children. VAM is clinically indistinguishable from wild-type measles. However, some febrile post vaccine reaction course without rash, conjunctivitis or cougth, corresponding to unrecognized sub-clinic measles.

There is only one report of measles transmitted from a VAM patient (Millson et al, Lancet 1989). However, the vaccine strain was not microbiologically confirmed by molecular techniques. On the other hand, Kaic and co-workers (2010) demonstrated that vaccine-induced rubella is contagious. Thus, as rubella vaccine is composed by attenuated virus, the transmission of VAM is, at least, theoretically possible. To support this hypothesis, attenuated virus most be detected in secretion or in oropharingeal mucosa. Thus, Kaik (2010) an others detected attenuated measles virus in secretion from patients with VAM during the febrile phase (without full clinic manifestations). Moreover, in the latest report of lethal VAM (Hau et al, BCM Public Health 2013) authors claim that "it has not been demonstrated that measles attenuated virus is un-transmissible" and suggest that immunocompromised contacts of a VAM must receive gamma-globulin treatment.

The serology of our patient showed anti-citomegalovirus IgM, as it was not a transmitted VAM. However, it let me think about this possibility, especially in immunocompromised patients

P9: Case report: I've always been "micro"

Correspondig author*:** Vercelli, G. ***Contact: gabrielaver78@hotmail.com

Filiations: CS Es Trencadors. Llucmajor. Mallorca-España

The patient is a 46-year-old male with bariatric surgery, decreased IQ and depression as personal/medical history. In primary care consultation the downsizing of external genitalia is accidentally observed. The rest of the physical examination reveals eunuchoid habit, gynecomastia, sparse body hair and long limbs. Once a pharmacological cause is excluded, a blood test with hormone profile is requested, which shows decreased testosterone and increased gonadotrophins. The patient is referred to endocrinology and a 47 XXY karyotype is confirmed by a genetic test. Moreover, the patient is diagnosed with osteopenia. Treatment with testosterone is initiated, which results in an improvement of hormone levels.

It is suspected that Klinefelter Syndrome's prevalence in Spain is 1 / 500-1000 men, but due to its low phenotypic expression only about 25% of them (10% before puberty) are diagnosed with the syndrome. One important task of the family doctor is to know, prevent and treat complications associated with this syndrome, as osteoporosis, obesity, dyslipidemia, insulin resistance, infertility, autoimmune thyroiditis, breast cancer and extragonadal cells cancer. We must not forget that these patients may present difficulties in social relationships and a lower IQ. With an early diagnosis and treatment they can achieve a normal life. That is why it is important for the general practitioner to have a high index of suspicion in these patients.

P.10: Case Report: A propos of a case ... Autoimmune thyroiditis and chronic urticarial

Corresponding author*:** Vargas-Osorio K. ***Contact: ksvo0321@hotmail.com

Filiations: Family and Community Medicine . Health Center Can Misses , Ibiza.

A 51 years old female with no past medical history of interest or drug allergy known to date, who had consulted at emergency services and primary care for generalized episodes of urticaria in the last 3 months . Some of them had associated angioedema (lips and tongue). On physical examination were found urticarial lesions on her face, scalp, trunk, arms and legs. Such injuries are partially mitigated with various treatments including H1 antihistamines and short courses of oral corticosteroids.

Diagnosed orientation was directed as a chronic urticaria (more than 6 weeks of evolution). The complementary studies we found: normal blood counts without eosinophilia, Phadiatop negative, negative prick test for inhaled and food allergens, TSH, T3-T4 normal; and remarkably increase of acute phase reactants, high positivity for Thyroglobulin antibodies 553UI / ml (115), Peroxidase antibodies 362 IU / ml (34), anti DNA 7.6 (Chronic urticaria is characterized by itchy erythematous swellings persisting for longer than six weeks. It represents approximately 30% of all types of urticaria, around 40% have associated angioedema, and most commonly affects middle aged women.

Many studies have suggested the autoimmune etiology due to the positive results for antibodies associated in some cases to other autoimmune diseases. In particular, the presence of anti-microsomial antibodies or antiperoxidase anti-TPO antibodies may be found in3% to 26% of cases, compared to general population. In few studies the treatment with thyroid hormones in euthyroid patients with positive anti-TPO led to a complete remission of the urticaria. So, an association between Chronic Idiopathic Urticaria and Autoinmune Thyroide Disease is theoretically possible. Many patients with chronic urticaria do not have a response to therapy with H1 antihistamines even at high doses. Those cases could be treated with Omalizumab.

P.11: Prevalence of hepatitis C virus (HCV) testing in cohorts between 1945.

Corresponding author: Guerra Feo, C. ***Contact:*** cristinaguerrafeo@hotmail.com
Filiations: Son Pisà Medical Health Centre, Palma de Mallorca, Spain.

Key words: Hepatitis C, Prevalence, Aged

Objetives:

- To estimate HCV Prevalence in the 1945-1975 Birth Cohort.
- To compare Prevalence between 1945-1965 and 1955-1975 cohorts.
- To identify unknown HCV cases, detected by active screening.

Material and methods:

- Design: Descriptive Prevalence Study
- Target population: Primary Care urban population. Born between 1945-1975: 1100 individuals
- Sample size: 429 subjects are needed to estimate with a 95% confidence and a precision +/-0.9%, considering a population prevalence of around 1.5%. Replacement rate of 25% has been anticipated. Simple random sampling selected automatically through electronic medical records.
- Data analysis: SPSS Statistics 14.0 for Windows. Sample characteristics by percentages, means and standard deviation; overall HCV prevalence and in the two age cohorts will be estimated. Characteristics of the prevalent cases will be described and they will be compared with healthy individuals. Chi-square test will be used for categorical variables, Student´s T-test for quantitative variables. Absolute and relative frequencies, odds ratios and confidence intervals at 95% will be calculated.
- Study variables: Primary variables: Previously known and newly diagnosed HCV infection. Secondary variables: gender, birth date, country of birth, risk factors for HCV transmission, alcohol consumption, RNA test result.
- Limitations: selection and information bias.

Study justification: The CDC recently recommended that all adults born between 1945-1965 should undergo one-time testing without prior ascertainment of HCV risk status. The higher prevalence in this US age group is due to different historical aspects. However in Spain prevalence peak should be considered in persons born between 1955- 1975 because there was no clear Baby-Boom after Spanish Civil War, and the rise in parenteral drug users occurs later than in the United States. Taking this into account, we decided to analyze the HCV prevalence in the 1945-1975 birth cohort and to contrast whether the higher prevalence occurs in the age group proposed by the CDC or ten years later, and if the CDC screening recommendations are applicable in our population.

Ethical and legal aspects: Accepted by the Clinical Research Ethical Committee. Voluntary participation and Informed Consent will be ensured.

P12. Case report: Acute B Hepatitis

Corresponding author: Puigserver Rosselló, JA. ***Contact:*** jtpuigserver@gmail.com
Filiations: Hospital de Manacor

75 years old male with no medical allergies, no alcohol or tobacco habit. 100 points in Barthel index. Presenting the following pathological history: Hypertension, treated with Enalapril 10mg/24h, dyslipidemia treated with Simvastatin 20mg/24h, prosthetic adenocarcinoma (pT2c) treated with radical prostatectomy 8 years ago and an umbilical herniorraphy. Now presenting an episode of one week evolution of asthenia, fever up to 39ºC , nausea with no vomits and leg pain.

Physical examination: conjunctival jaundice, with no cutaneous jaundice or any other cutaneous lesion.

Cardiopulmonary auscultation was normal. Neurological exploration was normal. Abdomen was painful only at the palpation in the right hypochondriac region, Murphy negative; the rest of the exploration was normal.

Blood test: normal hemogram. Coagulation: Quick 41% and INR 2,18. Biochemical: GPT 3545 UI/l, GOT 2800 UI/l and GGT 491 UI/l. Bilirubin 6,9 mg/dl (direct 5,1 mg/dl). PCR 7,83mg/dl.

Abdominal ultrasonography: chronicle hepatitis signs with no obstruction in biliary ducts. No other alterations in the exploration.

The case was oriented as an acute hepatitis and tested for hepatic viruses antigens and antibodies (HAV, HBV, HCV, EBV, HSV), antibodies for an autoimmune hepatitis and bacteria: R.conorii, C.burnetti, B. mellitensis and Leptospira. We thought of bacteria because in Mallorca is common the tick bite which can produce acute hepatitis. No toxics were found neither in urine nor blood.

The tests showed a positive result for acute B hepatitis with positive HbsAg, HbeAg and anti-HBc, Anti-HBc IgM and Anti-HBe. The viral charge for B hepatitis was 4.566.200 UI/ml.

95% of acute B hepatitis has spontaneous improvement, but 5% of them need treatment. Treatment is indicated when: INR>1,6 + jaundice + >4 weeks evolution; immunosuppression, HCV, previous hepatic affectation or age >65 years.

The patient was treated with Entecavir 0.5mg/24h for 48 weeks. After a 3 months follow-up, he presented seroconversion and complete remission after completing the treatment.

Despite of a complete anamnesis, the transmission path could not be found.

P13. Case report: How to get to the diagnosis of a rare disease?

Corresponding author: Vidal Ribas C. ***Contact:*** cris.3.v.r@gmail.com

Filiations: Primary Health Center in Santa Ponsa, Mallorca. Spain.

Clinical history: Male, 20 years old, comes for puffed injury in parietal area (he thought his cat might had scratched him). On subsequent visits, cervical, retroauricular and occipital lymphadenopathy. Dysthermia feeling without fever. In several visits he complains of headache.

- Personal history: Epicranial tumor resection when he was 5-year-old. Neither the patient nor his family know the diagnosis or provide reports
- Physical exploration:

Puffed injury with a diameter about 1 cm in the parietal (right) area, soft consistency. It appears superinfection.

In the subsequent visits: cervical, retroauricular and occipital lymphadenopathy. Neurological examination is always normal.

- Supplementary tests:

- Blood test and serology: normal.

His father explains that when the patient was younger, coinciding with tumor, he also had the puffed injury and lymphadenopathy like now. For this fact and severe headache, cranial radiography+ CT scan are requested.

- Cranial radiography: lytic lesion in the parietal area.

- Brain CT: extracranial swelling, malignant characteristics, extends intracranial compartment.

- Clinical judgment, differential diagnosis:

At first, it is oriented as cellulitis and lymphadenopathy. We prescribed antibiotic, but the lump and the lymphadenopathy persist. We think different diagnoses: neoplastic disease, benign tumor, viral infections (Epstein Barr virus, Rubeola, Parnovirus) and cat-scratch disease.

- Treatment:

When the patient comes to our consulting room for results, he is derived to the emergency room, where the lumpectomy was decided (craniotomy and partial resection of brain tumor) by the neurosurgery service . The histopathology reported findings consistent with Rosai-Dorfman disease (histiocytosis with massive lymphadenopathy). After surgery, steroid therapy is initiated and a CT for control is requested; it shows residual area; a PET-CT is done for a extension study, describing laterocervical minimally hypermetabolic lymph nodes. A second PET-CT reports that it is in remission (the hypermetabolic areas have disappeared).

Evolution: The patient has not resubmitted with related clinical diagnosis. He continues to controls in our consulting room and hematology service.Conclusions: Although the Rosai-Dorfman disease is rare, this case highlights the importance of studying the lymphadenopathy. Although at first it may be related to a local infection, we must always reevaluate the patient once solved the infectious episode.

P14. Case report: Always do an exhaustive study in patients with chest pain, taking into accunt the differential diagnosis.

Corresponding author: Vidal Ribas C. ***Contact:*** cris.3.v.r@gmail.com
Filiations: Primary Health Center in Santa Ponsa, Mallorca. Spain.

Reason for consultation: Woman, 49, came to our consulting room by oppressive chest pain that radiates to the ribs, back and both arms. This pain was initiated 3 days ago while she was swimming and when she came back at home she vomited. No breathlessness

The pain has been stable during all these days, in the morning it has been more intense, and it didn't worsen with efforts. She took alprazolam without improvement.

Medical history: Three paternal uncles had ischemic heart disease before age 60. Ex-smoker for 25 years

Physical examination: The pain is reproduced in the acupressure of sternum, rib cage and biceps muscle. She impresses affected although the rest of the exploration is normal.

Complementary tests: ECG with pain (no previous to compare): sinus rhythm, 75 beats per minute, axis 30º, PR 0,15 seconds, QRS narrow, T negative in III and isoelectric in aVF.

Diagnostic orientation and differential diagnosis: Atypical chest pain. Differential diagnosis:

- Ischemic heart disease.
- Acute aortic syndrome.
- Pericarditis.
- Musculoskeletal pain.
- Anxiety.

The patient is affected and for the importance of the entities included in the differential diagnosis, we refer thepatient to the emergency room in the hospital for study.

There the following tests are done:

- Aorta-CT: Normal.
- Blood test: troponins 18211'4 ng/l.
- Chest x-ray:normal
- ECG: ST rectified in V5-V6, I, aVL.

Suspecting acute myocardial infarction, a coronary angiography is performed, objectifying dissection of the left coronary trunk.

Treatment: The establishment of four stents was necessary. In addition treatment is initiated with Adiro, bisoprolol, atorvastatin and ticagrelor.

Evolution: While the patient was in the hospital, she again had chest pain. Coronary angiography was performed, seeing post-stent dissection, so she needed new implantation.

Conclusions: Although at first moment, a chest pain is not typical or no ECG changes, and it can be oriented as anxiety, other studies are needed to rule out more serious pathology.

In our room, we can give the patient treatment with anxiolytic and if the clinic doesn't improve, referral the patient to emergency services where other tests can be performed.

P15: Case report. The need to study visits as a whole

Corresponding author: Vidal Ribas C. ***Contact:*** cris.3.v.r@gmail.com

Filiations: Primary Health Center in Santa Ponsa, Mallorca. Spain.

Woman, 47 years, comes to our consulting room for bilateral rib pain, more in inspiration, cough and yellow expectoration. No fever. At the first moment, this is oriented as cold and muscle pain.

Later she explains left arm pain, with nocturnal predominance. After 4 weeks of onset of symptoms, she comes back for appearance of parasternal mass and dyspnoea.

Personal history: Smoker, total cumulative dose of 14 pack-years.

Physical exploration:

Left rib cage: Pain in the palpation. Cardiac-respiratory auscultation: normal. Subsequent inquiries: left parasternal mass, 3x3cm.

Supplementary tests:

- Spirometry: FEV1/ FVC: 65.56, post- bronchodilation: 67.72. FVC: 3.29ml. FEV1 pre: 2.16ml. FEV1 postbronchodilation: 2.23ml.
- Blood test: ANA+, erythrocyte sedimentation rate 82, c-reactive protein 1.5
- Electrocardiogram and chest X-ray: Normal.

Clinical judgment, differential diagnosis: First nonspecific symptoms, oriented as cold muscle pain. As the weeks and new symptoms, this is de differential diagnosis:

- Neoplasia
- Autoimmune disease
- Inflammatory disease (condritis).
- Benign tumor.
- Pulmonary embolism

She is derived internal medicine and while she is waiting this visit, the patient has three tumours to costal level, severe dyspnoea and facial-neck edema. It is derived emergency room: Blood test: lymphocytes low (13.70%), thrombocytosis (plaquette 473.000), c-reactive protein 1.59ng/ul, LDH 375U/l, CA125 176.5U/ml, AC anti-EBNA positive. Chest CT: invasive anterior mediastinal mass, compressed and stenotic superior vena cava, possible right pulmonary infarction. Biopsy: Bulky mass, stage IVB.

Treatment: First line chemotherapy treatment.

Evolution: The facial edema has improved and the patient has good tolerance to treatment. She is at home, she explains fatigue and mild chest discomfort with dry cough and anxious-depressive clinic. For this reason, she has started anxiolytic-antidepressant treatment, besides chemotherapy.

Conclusions: The applicability of this case is for seeing the need for monitoring, studying the different visits together. In this case, all the symptoms were for the same process, but if you studied separately w

P16. Case report: When you find a complete atrioventricular block...

Corresponding author: Vidal Ribas C. ***Contact***: cris.3.v.r@gmail.com

Filiations: Primary Health Center Santa Ponsa, Mallorca. Spain.

Male, 85, comes for dizziness (without turning objects) for years (worse last weeks), morning predominance, and seconds long. It happens several times a day. On one of the occasions he lost conscience for seconds without movement tonic-clonic or relaxation of sphincters, and complete recovery within seconds. Another time he seemed disconnected from the middle, but he encouraged when his wife answered him.

Medical history: High blood pressure, treatment enalapril-hydrochlorothiazide. Peripheral vertigo. Smoking 8cigarettes/day.

Physical examination:

- 88 beats/minute,SatO2 98%.
- Cardiac-respiratory auscultation:normal. Neurologic :normal.

Complementary test: ECG: 85beats/minute, PR0.16msec, 0°axis, no signs of ischemia or early repolarization.

Diagnostic orientation and differential diagnosis: It is oriented as nonspecific dizziness and treatment is initiated with betahistine.

Differential diagnosis: Peripheral vertigo. Cardiologic origin. Central origin (neurological). Absence crisis. Vasovagal syncope. Hypoglycemia.

Treatment: It is oriented as nonspecific dizziness, betahistina is initiated.

Evolution: He returns after 4 days and explains that afternoon, while he was sitting, he suffered "an absence". Relatives stimulated him but he seemed disoriented the first few seconds, with complete recovery after a few minutes.

After a while, when getting up, he suffered dizziness and started walking backwards until he fell down. At the time of the visit he's asymptomatic.

Physical examination/complementary test:

- Cardiac auscultation:bradycardia.
- Respiratory auscultation:normal.
- Neurological:normal.
- ECG: 40 beats per minute, variable narrow QRS morphology.

It is oriented as complete atrioventricular block. ECG is done while the patient becomes dizzy. It was decided to place external pacemaker and the patient is referred to hospital (emergency room), where is visited by the cardiology department who decide to place permanent pacemaker.

Conclusions: Dizziness is a very nonspecific symptom that may be due to multiple causes. Although the patient is diagnosed with vertigo, we have to do a complete examination to rule out other posible causes. If the result is normal, explaining the patient the signs and symptoms of

P17.Patients without a prior appointment. Use or abuse of our health system?

Corresponding author: Amengual L. ***Contact***: lara.amengual.sastre@gmail.com
Filiations: CS Escola Graduada (Palma)

Key words: Health Services Accessibility, Appointment, Health education

Objectives:

To analyse whether the majority of visits of patients without a prior appointment (PWPA) are due to necessity orbecause of a lack of knowledge for a good use of our Health System.
To analyse the main reasons for those visits
To determine if there is a profile of the regular user.
To know the perception of justification on the part of the professionals.

Material and Methods:

Interviews, for a period of 14 days, in our Local Medical Centre, to the users who requested an emergency visit, and to the professionals who received them.

Results:

- There is a predominant profile of a PWAPA: Male or female alike, with a mean age of 45 (SD 21,1), Spanish nationality, and who has already been a PWAPA before.
- The leading reasons for consultation are medical (77,4%) and 87% of the patients perceive the necessity of a quick attention, which is why they do not book a prior appointment.
- 59,6% of the visits of PWAPA which take place, are not considered justified by the professionals who have received them.

Conclusions:

- Despite the fact that 89,4% of users admits to know how our Health System works, more than half of those visits (59,6%) could have been done following the usual protocol of the Prior Appointment.
- Even though the professionals say that they impart health education in their surgeries, the fact that the majority of the Patients Without a Prior Appointment that they receive are those who have done it previously, shows that this health education is not good enough. It also shows that the System of Booking a Prior

Appointment is not sufficiently adapted to the care necessities, or that from the population there is a demand for immediacy, which is hardly sustainable within our current system.

P18. Case report: Palmoplantar keratoderma in smoker patient

Corresponding author: Cerdó Ensenyat, M. ***Contact***: mariacensenyat@gmail.com
Filiations: CS Coll den Rabassa, UBS El Molinar

1) Reason for consultation: palmoplantar hyperkeratosis and fissures?

2) Hippocratic questions. Relevant medical history: Chef. Smoker, COPD.? Refer since 8 months ago palmoplantar hyperkeratosis associated with onychodystrophy that has progressed despite treatment with high potency topical corticosteroids, keratolytic and mitotic inhibitor treatment (oral and topical). Weight loss of about
7 kg in the last 15 days.?

3) At physical examination presents hyperkeratosis and fissures in palms and soles of the feet with nail pitting and subungual hyperkeratosis. Some hyperkeratotic and erythematous plaques on extensor areas and another one in occipital region. Cardiopulmonary auscultation: normal

4) Complementary tests: Analytical anodyne. Chest XR: parahiliar right mass (pulmonary VS mediastinal)?

5) Diagnosis orientation: Palmoplantar keratoderma (Psoriasis?) and parahiliar mass to be studied?

6) Differential diagnosis: Palmoplantar psoriasis, contact eczema, pityriasis rubra, palmoplantar keratoderma paraneoplastic. // Lymphoma, teratoma, Sarcoidosis, inflammatory pseudotumor, granuloma, pulmonary neoplasia or another cause with pulmonary metastases.?

7) Treatment: Oral retinoids // Treatment for the base disease.?

8) Study was completed by body CT and PET-CT confirmed the presence of lung mass with adenopathic conglomerate parahiliar without metastases. Bronchoscopy confirmed the presence of a small cell carcinoma.

Given these findings, cutaneous syndrome Bazex was oriented. This is a rare paraneoplastic phenomenon associated with squamous cell carcinoma of the upper aerodigestive tract, described as associated with other tumors though. It comes in the form of erythematous psoriasiform plaques mainly located in acral locations. It can be associated with onychodystrophy, palmoplantar keratoderma and alopecia.? In most patients, skin manifestations precede the diagnosis of neoplasia, but up to a third of cases it is diagnosed at the same time or before the Sde Bazex.?

Palmoplantar keratoderma is a frequent reason for consultation in primary care and most often has a genetic component and may be associated with external factors. In most cases it has a benign course and responds favorably to treatment with emollients and topical steroids. Should bad evolution occur, the differencial diagnosis must be extended and think of entities as Bazex Syndrome

P19. Cardiovascular risk factors in medical residents of the Hospital de Clinicas

Corresponding author: Gimenez B. ***Contact:*** belen_30187@hotmail.com

Filiations: Hospital de Clinicas, San Lorenzo, Paraguay

Key words: CARDIOVASCULAR RISK, RESIDENTS, BMC

Abstract: Introduction: Cardiovascular diseases are the leading cause of morbidity and mortality worldwide and its incidence is increasing, so we consider priority identifying and learning about cardiovascular risk to prevent them.

Objective: To determine the prevalence of cardiovascular risk factors in medical residents of the Hospital de Clinicas.

Materials and Methods: A prospective, descriptive study of crosscut. data from 107 medical residents of both sexes were included in the registry. Variables: age, sex, family history, toxic habits, knowledge of their cardiovascular risk factors, abdominal circumference, body mass index, blood pressure, laboratory control in the past year, and weekly working hours.

Results: 52.3% female, mean age was 28.4 ± 2.21 (24-38) years. As family history had hypertension in 20.5%,

4.6% DM, dyslipidemia 4.6%, two antecedents in 36.4%, all by 23.3% and 10.2% none. 14.02% smoke; use alcohol less than 3 times per week 74.7%. Eat fruits every day 27,1%. 55.1% are not physically active. The mean BMI was 25.7 ± 4.6. more women with normal weight (62.9% vs 27.5%) whereas men have more overweight (60.8% vs 27.7%) was found. The abdominal circumference was high risk in 37.3% of men and 15.6% women. Cicunferencia neck was 32.9 ± 2.7 (30-41) cm in females and males was 38.4 ± 3.1 (31-47).

Half of the residents had SBP and DBP less than 120 and 80 respectively. 14.9% had between 130-139 SBP and DBP 6.5% had between 85 and 89. The mean heart rate was 77.9 ± 11.4 (50-113), 12.2% in the FC is greater than 90 bpm. 2.8% have Impaired Fasting Glucose. Dyslipidemia 14.9%. Women have higher incidence of dyslipidemia (17.8% vs 11.7%), not significant. laboratorial control is performed 59.8%. They work more tan 60 hours per week 70.1%.

Conclusion: These results provide relevant information to develop internal health policies aimed at prevention and control of cardiovascular risk factors in residents.

P20. The risk of those who care risk. Findrisk in white staff.

Corresponding author: *Gimenez* B. ***Contact****:* belen_30187@hotmail.com

Filiations: Asunción***.***

Key words: FINDRISK, white staff, bmc

Abstract: Introduction: The DM is one of the biggest problems for health systems in Latin America.

Objective: To determine the likelihood of developing DM2 to 10 years in health personnel, taking into account the lifestyle and family burden.

Materials and Methods: A prospective, descriptive study of crosscut. the probability of developing DM 100 individuals, personal white Clinics Hospital was evaluated. Findrisk questionnaire was used to assess the probability of developing DM 10 years from September 1, 2015 to October 31, 2015. It is considered: 20 Very High Risk.

Results: female (77%); 73% less than 45 years; 57% do not have relatives with diabetes and 19% have parents and / or siblings with diabetes, with no significant differences between the sexes. 32% had normal weight; 27% overweight, obesity and obesity 24% GI GII 17%, finding greater obesity in men compared to women (52.1% vs 37.6%). Only perform physical activity 30.4%, mostly men compared to women (30.4% vs 14.3%). Half consume fruits and vegetables every day; more women (57.1% vs 30.4%). Only 6% had a history of hyperglycemia. 43% have very high risk of abdominal circumference. Only 16% regularly consume drugs for hypertension. Applying the questionnaire Findrisk the global average was 14.4 ± 4.4 (7-24); similar in both sexes (14.7 vs 14.3), with no statistically significant difference (p = 0.6 T test). In the risk assessment, presented a high risk Findrisk almost half the 47% (95% CI: 36.9 to 57.2%) of officials, followed by 31% slightly increased risk (95% CI: 22.1 % to 41.1%); moderate risk 11% (95% CI 5.6% to 18.8%) and very high risk 11% (95% CI 5.6% to 18.8%).

In the bivariate analysis using as a cutoff point of 15 Findrisk, we found that 38% of staff have high risk level.

Conclusion: The purpose of this work was timely detect the existence of risks in order to diminish the appearance of new cases or delay the onset of the disease.

Full text- Oral Communications

OC1. Pulmonary embolism and deep venous thrombosis

Corresponding author: Loza García I**. *Contact:*** irenelozagarcia@gmail.com

***Filiatons*:** Barrio del Pilar (Primary Care Center), Hospital la Paz

Abstract: Presenting complaint: Swelling of right arm.

Past medical history: No allergies. Tobacco: Smoker, 20 pack-year. No alcohol. No hypertension, no diabetes. No dyslipemia. No history of clotting disorder. No cardiac history. Hiatus hernia. Insomnia. No surgical history. Medication: Lorazepam 1mg.

History of presenting complaint: Patient, is a 46-year-old female , who presented to a Primary Care with one day history of swelling and pain of right arm associated to shortness of breath. She refers a trauma on the right arm three days before, without functional impairment. She refers right-sided pain located midway down below the axila. This pain is sharp, about 6/10 in severity and worsens with movement. Refers transient dyspnea the day before. No fever. No caugh. No palpitations. No other associated sintomatology.

Physical examination: BP: 128/64 Pulse: 110 Tº: 35.7ºc Sat O2: 97%. Alert, calm, no acute distress. Tachycardia : 110 rate. Normal lungs. Abdomen: Normoactive bowel sounds. Soft, flat, no-tender, and nondistended. No hepatoesplenomegaly. Right arm: swelling from the should to the hand. Skin with a dusky red discoloration and pitting oedema of the wirst and hand. Elevetaed temperature. Tenderness of palpation. Shoulder pain on dorsiflexion of the hand. Lower limbs: No signs of deep venous thrombosis. Rest normal. Diagnostic tests: Doppler venography upper limbs in Primary Center: Increase of diameter of axilar and braquial veins, no colour flow vascular image of these veins.

Diagnostic orientation: Probably deep venous thrombosis and pulmonary embolism.

Differential diagnosis: Cellulitis, DVT (deep venous thormbosis), ruptured cyst of a joint.

Treatment: We start oral anticoagulation with the aim of achieving an international normalised ratio (INR) OF 3 with subcutaneous low-molecular-weight heparin for the acute phase and send the patient urgently to Hospital Urgency. There the rest of test were completed. AngioCT: showed an acute pulmonary embolism.

Conclusion: Deep venous thrombosis and pulmonary embolism are acute medical emergency, and we are expected to know how to diagnose and manage it in Primary Care. Medical ultrasound in Primary Care Center allow the doctor to perform diagnosis and start therapeutic procedures. This technique has no known long-term side effects.

OC2. Peripheral Arterial Disease (PAD): Detection and Cardiovascular risk Re-Classification in a Primary Care Practice

Corresponding author: Cantallops Borras MA**.** ***Contact:*** juliof.fothy@gmail.com

Filiatons**:** CS Coll d'en Rabassa, Palma de Mallorca, Islas Baleares, Spain.

Key words: Hypertension, Peripheral Arterial Disease, Secondary Prevention

Objectives

- To estimate the proportion of undiagnosed PAD among hypertensive patients 50-69 years of age by Ankle Brachial Index (ABI)
- To reclassify the Cardiovascular Risk in patients with abnormal ABI by ReGiCor score
- To know the proportion of these patients with intermittent claudication (CI)

Methods and materials

- Design: Cross-sectional study
- Inclusion criteria: 50-69 years old men and women diagnosed with hypertension that consult in an urban health centre. Exclusion criteria: Previous cardiovascular event. Physical restrictions for the ABI realization. Patients assigned to other health centres, institutionalized or that do not sign consent form, advanced illness, ABI >1,4
- Sample: 154 patients that consult for any reason (Precision +/- 5%, predictable population to detect 9, 45%, Replacement 15%)
- Variables: Age, gender, BP, smoking, diabetes, hyperlipidaemia, sudden death, family backgrounds. Intermittent claudication symptoms (Edinburgh Claudication Questionnaire)
- ReGiCor will be calculated and notes will be taken about the anti-hypertension actual treatment.
- Cases: ABI. ABI will be measured with a Doppler probe.

Analysis: The relative frequency will be calculated (prevalence) and 95% confidence interval of PAD in hypertensive requesting population.

Limitations: The sample will reflect hypertensive patients attended at the health centre, over representing patients treated with drugs and/or other RCV factors.

- External validity: A training will be done to minimize the interobservers (Each GP trainee tutored by an experienced nurse will measure the ABI of 5 patients) The results will be collated by the GP resident and the ABI will be measured with the automatic treatment VaSera VS1500*, checking the concordance in the classification. Preliminary results (20 patients studied)
- 3 patients are smokers, 8 ex-smokers.
- 5 noninsulin-dependent diabetes patients and only 1 insulin-dependent diabetic patient.
- No patient with Intermittent Claudication symptoms (Edinburgh Claudication Questionnaire)
- No Family History of sudden death
- Only 1 patient had the ABI done before this study.
- So far, only 1 patient had an altered result (ABI)

OC3. Prevalence of overweight, obesity and metabolic syndrome in children of a Health Center in Mallorca

***Corresponding author*:** Argüelles Vazquez R. ***Contact*:** rosargu2210@gmail.com

***Filiatons*:** Centro de Salud Muntanya, CS Santa Ponsa, Mallorca, Islas Baleares

Key words: obesity, metabolic syndrome, overweight

Background: Childhood obesity is associated with hypertension, high triglycerides, low HDL cholesterol, central obesity and fasting glucose impaired, all parameters of metabolic síndrome. Metabolic syndrome (MS), multiplied by 2 the risk of cardiovascular disease. Therefore, it is very important to diagnose it early to make premature interventions. Unfortunately, there is no consensus on the components and cut-off values in children.

Objectives:

1.-To analyze the prevalence of overweight and obesity among children aged 8, 10, 12 and 14 years, attending the Healthy Child Program Consultation in our Health Center.

2.-To evaluate what percentage of these children with overweight or obesity, fullfil the criteria for MS in childhood, according to three different definitions.

3.-To assess whether the prevalence of MS in our overweight population changes depending on the definition used and also, depending on which tables of reference for blood pressure are used, national or american.

Methods: Descriptive cross-sectional study. To calculate prevalence of overweight and obesity, we included all children who came to checkup Healthy Child Program at our Health Center, between february and october 2014 (Total:108 children). Overweight was diagnosed with a body mass index (BMI) in 85th-90th percentiles. Obesity with a BMI ? 95th percentile. The prevalence of MS was made only in those children with overweight an obesity (total 37), after a blood test, using 3 different definitions for MS: Cook, De Ferranti and International Diabetes Federation (IDF), employed tables of reference for blood pressure based on national and american population.

Results: The prevalence of obesity was 19% and 15% of overweight. The prevalence of MS changes depending the diagnostic criteria used: Cook, De Ferranti or IDF. Also for same definition, the prevalence varies depending on which blood pressure reference table have been used, whether national or american.

Conclusion:

• The prevalence of overweight and obesity in our study was high

• Prevalence of MS varies depending on which of the three definitions are used.

• Prevalence also varies for definitions of Cook and De Ferranti, depending on blood pressure reference tables used.

• Between MS criteria, high waist circumference was the most frequently observed, followed by low HDL colesterol.

OC4. Ask for the pets. A review on the "cat's scratch disease" as a result of an adenopathy's study.

Corresponding author: Planells Serra A. ***Contact*****:** albaplanells@hotmail.com

Filiations**:** Consorci Sanitari Integral, Barcelona, Spain, SERVICIO DE URGENCIAS HOSPITAL UNIVERSITARIO CAN MISSES IBIZA

The main purpose for this article is to review a nowadays uncommon clinical entity in which family doctors don't usually think when diagnosing adenopaties; the “cat’s scratch disease”.

The following review is based on a real case of a fourteen year old patient without previous medical or toxic habits records.

The appointment’s cause was the appearance of a left-sided cervical adenopathy and high temperature. In the following appointments the temperature disappeared but there were asthenia, weightloss and general uneasiness. There wasn’t any evidence of night sweats, skin injuries,the patient hadn’t recently travelled to risk countries but manifests she has cats and sometimes they scratch her.

On the physical examination a painful left-sided cervical tumor between four and five centimeters size stands out. It’s hard and immobile when swallowing. No presence of pus patches in the throat, visceromegaly or tenderness during abdomen’s palpation.

In the differential diagnosis we consider a viric or bacterial infection, zoonosis, hematologic diseases like lymphoma or tuberculosis among other.

On the demanded tests the patient brings a blood test with average coagulation and haemogram. Slight rise on the hepatic enzymes and acute phase reactants with high pcr. Epstein-Barr antibodies were negative.

We extend the tests with a thorax x-ray several bacterial and viric serology, hepatitis, HIV, VSG, proteinogram and rheumatologic factors. The tests resulted normal except for the bartonella henselae antibodies IGG and IGM which showed recent infection.

In conclusion it’s a typical “cat’s scratch disease” case which manifests as a skin injury and near lymphatic glands inflamation.

Guided by multiple revisions in UpToDate we decided to treat the patient with 500mg Azitromicine every 24h during five days. As it is proven with a 2B level evidence it decreases faster the adenopathies’ size.

The patient recovered successfully and in posterior tests with ecographies and PAAF other problems were discarded.

This is an example on how sometimes the cause for the illness is more common to the daily life of the patient.

That’s why we should remember to include pets and other common aspects of our patient’s life among other inquiries such as travels or familiar records.

OC5. Chronic Obstructive Pulmonary Disease (COPD) in primary care: underdiagnosis or overdiagnosis.

Corresponding author: Valladares Fernández P. ***Contact****:* valladaresfernandez@hotmail.com
Filiations**:** Calvià Health Center. Santa Ponça. Majorca. Spain.

Key words: Chronic Obstructive Pulmonary Disease, Primary Health Care, Overdiagnosis

Background:

We could knew the prevalence of patients with COPD in our community, but we had a special interest in knowing which of them had spirometry, and those who had the typical spirometric pattern.

Objetives: Knowing the number of patients diagnosed with COPD in our area of work, and evaluate if they comply with spirometric criteria.

Methods: Cross-sectional descriptive study done by selecting all patients diagnosed with COPD in the electronic health record. They must be over 40 years old and belong to our work area.

Results:

In our working area, 911 patients older than 40 years were found with the diagnosis of COPD in the electronic health record.

519 of them had no registered spirometry (57%).

The remaining 402 patients had a total of 615 spirometry.

Among these 402 patients, there were 265 patients with spirometric pattern compatible with COPD (FEV1 /FVC There were 73 patients with FVC less than 80% (compared to the reference value), therefore restrictive spirometry pattern.

There were 15 patients with bronchodilator test positive (FEV1 bigger than 200ml and bigger of 12% baseline).

Finally 51 patients with normal spirometry (5.6% of the initially diagnosed with COPD, and 12% of COPD with spirometry done).

Conclusions:

- Low prevalence of COPD regarding expected in the population studied.
- Under spirometry done among this group of patients.
- Among patients diagnosed with COPD, a low number had a compatible spirometry.
- Possible mistakes in the classification.
- A relevant number of patients cataloged like COPD and with normal spirometry. They could represent overdiagnosis of this pathology.

OC6. The aplication of oral cancer early detection program

Corresponding author: Castanheira, J. ***Contact:*** scpmj.206bones@gmail.com

***Filiations*:** Family Health Unit of Fiães - ACES Entre Douro e Vouga I, Santa Maria da Feira, Portugal

Key words: oral cancer, prevention, pre malignant

Background:

In Portugal, oral cancer is the 5th cause of death from malignancy. After diagnosis only 40% of patients survive more than 5 years disease. The key to success is the diagnosis and timely treatment, so in 2014 it was implemented, in Portugal, a project named PIPCO - Early Intervention Program in Oral Cancer. The major focus of this program are the risk groups and early investigation of pre malignant lesions detected by the family doctor who, through problem coding, issues a dental check that allows a biopsy.

Objectives: Characterize the consultations at USF Fiães, from 2014 until 2016, where the problem "D20 - sign/symptom of mouth/tongue/lips" was codified in the diagnosis, with respect to(s) consultation motive(s), diagnosed problem(s) and procedure(s). Secondarily, characterize the situations in which a PIPCO dentalcheck was issued.

Methods: Descriptive retrospective observational study. Population: all individuals observed in medical consultations at USF Fiães, from March 2014 until August 2016, which were encoded with the "D20 -sign/symptom of mouth/tongue/lips (by the International Classification of Primary Care 2). Source: MIM@UF® and SClínico®. Variables: gender, age, smoking/drinking habits; recorded consultation motive(s), diagnosed problem(s) and procedure(s). Data Analysis:Microsoft Excel 2010®.

Results: During the analysis period, 131 consultations were encoded with the "D20" problem. The observed patients had an average age of 44,4 years [0,5-89 years] and 61,8% were women. About 13% were smokers and 15,3% had ethylic consumption habits. Regarding to the reasons for consultation, 81,7 % were complaints related to mouth/tongue/lip and the remaining were about teeth/gums, temporomandibular joint, throat and neck. The most frequent diagnosed problems were the "D20 Sign/symptom of mouth/tongue/lips" (100%), followed by the "D19 Sign/symptom teeth/gums" (8,4%). The PIPCO dental-check was emitted only in 20 consultations (15,3%). In 55 cases, patients were advised towards pharmacological therapy, namely: mouthwash, anti-infectious agents, vitaminic supplements and anti-inflammatory drugs. Nine patients were referenced to Stomatology specialist.

Conclusions: The PIPCO dental-check emission was lower than expected, also, some of these were wrongly prescribed in the absence of suspicious lesions. The analysis shows the evident need to improve the professionals knowledge about this program, that well used can lead to significant health gains.

Full text- Electronic Poster

E-Poster 1. Critical Incident: Dignified death, is posible? Reflections on a case on ALS

Correponding author: Sabalich, MA. ***Contact***: mangelesab@yahoo.com.ar
Filiations: Atención primaria, Mallorca. Spain

Abstract: A 75 year old female patient, diagnosed with a Bulbar Amyotrophic Lateral Sclerosis (ALS), with gastrostomy and VMNI (Non-invasive mechanical ventilation).

Admitted into Hospital because of uncontrolled dyspnoea despite of pharmacological treatment. The patient had expressed her wish to "finish it off now" and "I want to go now". She was aware of her diagnosis and prognosis.

Pharmacological treatment of the dyspnoea was considered as refractary, therefore palliative sedation was established. The patient died two days later.

Faced with this question:

Is the use of palliative sedation ethically correct?

What differences are between it and euthanasia, assisted suicide or limitation of therapeutic effort?

Learning targets

Assisted Suicide: To help somebody to carry out a suicide.

Euthanasia: To provoque death in a quick and painless way in a patient with incurable terminal illness.

It is necessary to distinguish between euthanasia and limitation of the therapeutic effort (LTE).

LTE is defined as a decision about the non-implementation or the withdrawal of medical therapies, when no significant benefit to the patient is expected.

The difference between euthanasia and palliative sedation is in the first case the intention, death, and in the second is diminish suffering. The LTE is considered at present by the science community as a solution ethically acceptable in those patients whose conditions warrant the irreversibility of their illness.

We highlight the fact that palliative care culture should permeate progressively, from primary care giving information, to hospital care, so when treatment is not going to improve the patient´s outcome, the aim should change from treating the disease to treat the patient and patient's family.

The decision has to be the result of a serious deliberation and a shared reflexion about the need to reduce the

patient´s level of consciousness as a therapeutic strategy. The use of palliative sedation does not seek to induce death; it´s aim is comfort and control of symptoms and suffering.

As a conclusion, according to the principles of autonomy and good doing, not wrong doing, we conclude that palliative sedation is ethically correct and we have a law that protect us.

E-Poster 2. Case Report: "Doctor, I´m scared of driving because I can´t see the rearviewmirror"

Corresponding author: Santiago Martínez Torre. ***Contact:*** santiagomtorre@gmail.com
Filiations: Ciudad de los Periodistas Healthcare Center, Madrid

Abstract: This 34 year old female presented for the treatment of recurrent headaches, vertigo and vision problems. She feels dizzy, unstable and has a lack of clear visión for the last 48 hours. She as headache that reliefs with Ibuprofen. The pain seems to be worse towards the end of the work day and is aggravated by stress. No vomits or nausea are reported. She denies earache or tinnitus. She describes recent difficulty to see the two rearwiew
mirrors of her car. The medical history refers hypothyroidism and asthma properly treated. This patient was initially misdiagnosed and treated as a peripheral vértigo without clinical improvement.

The General observation and Neurological Examination gave us essential information regarding the case: it reveled that the patient suffers alteration of the oculomotor muscles and cranial nerves involved in visión, such as left pupil anisocoria, internuclear ophthalmoplegia and spontaneous left-beating nystagmus with a positive Rombergs test.

Finally the patient was sent to hospital emergency department and diagnosed with multiple sclerosis. This case presents an atypical presentation of a first attack of Multiple Sclerosis that was quickly detected. It demostrates that a systematized Neurological Examination aplied to the most important aspects is a basic tool in our consultation all to optimize the valuable minutes in front of our patient.

E-Poster 3. Experience: Dealing with uncertainty in Family Medicine Medically Unexplained Symptoms

Corresponding authors: Carneiro, Joana. ***Contact***: medjoanacarneiro@gmail.com
Filiations: Family Medicine trainee USF Oporto, Portugal

Abstract: Background and aim: In Primary Health Care, 15 to 50% of the symptoms are not explained by a specific underlying known condition. Recent studies admit the existence of a distinct health issue – Medically Unexplained Symptoms (MUS). MUS has earned increasing interest due to the significant morbidity, frequent absenteeism from work and economic burden associated to it. It is also associated to higher risk of iatrogenesis due to increased "doctor shopping", investigation and hospitalization. Doctors and patients often experience frustration and helplessness in consultations around MUS.

We intend to raise awareness regarding this entity, it's epidemiology, characteristics and adequate management to ultimately improve health outcomes. Method: Bibliographic research using the MeSH terms "medically unexplained symptoms", "management" and "primary health care", including articles in english and portuguese. Results: The management of patients with MUS can be dvidided into – prevention and selfmanagement, identification of MUS, physical and psychological assessment, intervention (according to MUS intensity - low, moderate or high) and reassessment. Conclusion: When managing MUS it is essential to assess the patient in a holistic manner approaching both physical and psychological needs whilst motivating the patient in taking part of the decisions. Family doctors have an important role in optimizing the management of MUS, improving patient-doctor relationship, improving life quality and consequently diminishing health costs.

E-Poster 4. Case Report: Iatrogenic dyspnea

Corresponding author: Antonio Ciriaco López Díaz. ***Contact***: ciri_86@hotmail.com
Filiations: CS Coll d´en Rabassa and Son LLàtzer Hospital, Palma de Mallorca, Spain

Abstract:

1) Dyspnea.

2) Since one week refer progressive dyspnea without associated clinical infectious. As relevant medical history, he is a man of 79, hypertensive, transurethral resection in 2006, with ureteral postoperative sequela (urethral stenosis). Between 2013 and 2015, he consulted on multiple occasions by dysuria, with pathological sediment and urine culture positive for E. coli resistant to several antibiotics. Since August 2015 was initiated treatment with nitrofurantoin, with good control of urinary symptoms. In December 2015 came to our primare care consultation refering the symptoms described.

3) Good general condition, tachypneic with stable constant, saturating 91%. Anodyne cardiac auscultation. Respiratory auscultation presented roncus and hypophonesis widespread. Bibasal crackles. No maleolares edemas. Anodyne abdomen. It is referred to hospital emergency room for evaluation.

4) ECG sinus rythm. Analytical anodyne. GSA respiratory insufficiency. X-ray chest interstitial pattern in both lung.

5) Interstitial lung disease.

6) Idiopathic (rheumatoid arthritis, idiopathic pulmonary fibrosis, systemic lupus erythematosus, sarcoidosis, eosinophilia). Known (drugs such as nitrofurantoin), inorganic and organic dust inhalation, radiotherapy and chemotherapy, fungal and atypical pneumonias.

7) Broad-spectrum antibiotics and steroids.

8) After 3 weeks of treatment with broad-spectrum antibiotic and cortoides EV, great improvement of respiratory symptoms. Interstitial lung disease has multiples causes, including the medicines, and in this case, secondary to the use of nitrofurantoin for several months.

E-Poster 5. Critical Incident. Defining the role of the General Practitioner.

Corresponding autor: Viñuales Palazón, Laura. lauravinualespalazon@gmail.com
Filiations: Hospital Son Llàtzer, Palma de Mallorca, Spain

Abstract: At the moment I am training to become a General Practitioner.

He was probably one of the reasons why I am doing it. He was one of them, but not an ordinary one. He was one to admire, a humble, respectable idol among his devoted patients, a rural doctor: my grandfather.

Despite the tough moments that he had, for sure, he was always passionate when telling people about those hard working years, about his everyday life. I will never forget the sparkle in his eyes. And I'd better not, because we don't get to see many of those nowadays.

Why is that? What happened in between? Who or what stole that feeling from most of the 21st century General Practitioners?

In my very short experience as a doctor, I have had the chance to be part of comforting stories. But in my very short experience as a doctor, I have also had time for these thoughts: "is this profession really worth it?", "do I deserve to be referred to as the bad character?", "am I willing to put up with all the daily complaints about us?"

I am honestly beginning to get tired of that other side of the coin. And this has just begun!

Some of those complaints were about us not being strict enough with our patients, not telling them off louder, or not watching them more closely. As if acting as their parent was the crux of the matter.

This made me think about the real role of the modern General Practitioner.

I think our task is not just diagnosing and treating diseases. I think we should also take care of our patients, teach them how to take care of themselves, listen to their stories and even encourage them to make changes in their lifestyles that will most probably help them to improve their well-being.

But this will only bear fruit if we all keep in mind that there is a major role for patients to play: getting involved, taking responsibility for their lives, becoming pro-active. And sometimes this seems to have been forgotten.

E-Poster 6. Case Report. BLACK TONGUE

Corresponding author: Antonio Ciriaco López Díaz. ciri_86@hotmail.com
Filiations: CS Coll d´en Rabassa and Son LLàtzer Hospital, Palma de Mallorca, Spain

Abstract:
1) Black tongue.
2) Refer dark pigmentation across the tongue from about 7 days, with no other symptoms.
3) Female 45 years, smoker of 1 pack/day, and drinker 2-3 glasses of wine a day, as toxic habits. Did not mean other relevant medical history. Referred not taking any medication recently, nor related to any food or other causative agent.
4) At physical exploration, had dark pigmentation on the dorsum of the tongue without involvement of oral mucosa and floor of the mouth. No locoregional lymph nodes. Cardiological and respiratory exploration was normal. Soft and depressible abdomen without masses or organ enlargement. She didn´t have another skin disorders in the body.
5) Diagnosis: Black hairy tongue.
6) Etiology: Candida and chromogenic bacteria. Foods, such as tea, coffee, wine. Tobacco.
7) Differential diagnosis: oral thrush, hairy leukoplakia oral by EB virus.
8) Treatment: avoid causative agent (tobacco in this case). Hydration. Intense washing brush tongue after meal.
Mouthwashes. If extensive involvement, clotrimazole topical 1% or rinses with nystatin. If no improvement, refer
Dermatologist.
9) After 10 days of treatment with Nystatin was resolved.
10) The black hairy tongue is a benign process, characterized by the presence of papillary formations with dark coloration of varying intensity. Usually asymptomatic, although in severe forms can cause halitosis, altered taste or foreign body sensation. Most cases need to be diagnosed and treated in primary care.

E-Poster 7. Case Report: Patient with hip pain bilateral of months of evolution. About a case.

Corresponding author: Ruano, Patricia Andreu. patriciaruano_6@hotmail.com
Filiations: Altabix Health Center, Health Department Elche (Alicante), Spain.

Abstract: 50-year-old patient woman of age who comes to our consultation of Primary care, for low back pain and in both hips of 3 months of evolution. The patient says that the pain improves with the exercise and deteriorates with the rest. It recounts neither fever nor another symptomatology. Not previous traumatism. This one diagnosed of
Chronic Bronchitis and it recounts precedents of consumption of alcohol and of corticoesteroides of occasional form.
In the physical exploration objective limitation of the mobility, prevailing in the rotations.
Lumbar Rx is requested, Rx of pelvis completes and AP and axial of head femur, where changes are targeted in the contour of both femoral heads. Before the radiological findings and the great functional impotence of the patient, there is requested a magnetic Resonance of preferential form and analgesic treatment is ruled.
Our suspicion treats itself about the Avascular Necrosis Of Femoral Head, where the first symptom that appears is the pain of the hip, in the groin or zone glutea and it can be radiated to the thigh or knee. It is of sudden appearance, like stab that forces the patient to stop his activity immediately.
In the results of the magnetic Resonance a hypointense is targeted in both femoral heads, of left predominance, with marked bony edema related to necrosis to appraise sharp of both femoral heads. Spillage to articulate bilateral of left predominance.
There are sent the patient, to the external consultations of Orthopedic surgery to value surgical treatment.
Given the high prevalencia pictures of coxalgia in our consultations of Primary care, is very important his differential and precocious diagnosis, overcoat in case of factors of risk exist, since it can be due to a wide group of processes that must be known and rejected in the valuation of the patient. Avascular Necrosis Of
Femoral Head, though frequent little, it is one of them. The gravity of the sequels that can produce makes his study necessary.

E-Poster 8. Experience: Self Audit in type 2 diabetes patients

Corresponding autor: Gómez Hernández. Sahelys. sahegh@yahoo.es

Filiations: CSI Santa Pola. Elche. Alicante. España.

Abstract: OBJECTIVE: -Make Activity indicated by the type Teaching Unit Self Audit in type 2 DM.

DESCRIPCION: Teaching Unit as part of the training program orients R4 performing a Self Audit where proper enforcement of existing for the management of type 2 DM previously designed a study by the tutors of the UDA was measured made recommendations that was the selection of patients through systematic random sampling modified from list of type 2 diabetic patients we have in our quota attending medical consultation in the period between June / 15 and May / 16. We included only DM type 2, and excluded DM type 1, aged 80 years and / or lower life expectancy of 1 year or displaced. We measure different aspects as the control of HbA1c, BP, cholesterol, smoking, ECG, Micoralbuminuria, glomerular filtration rate and IC to Ophthalmology.

CONCLUSIONS:

The realization of the Self Audit is an interesting job because it offers a detailed overview of the DM of our quota. This will be detected irregularities in compliance with the treatment, and conducting analytical indication, assistance for nursing consultation and revision. Individual control of each patient is maintained by detecting time readjusting likely complications and treatments. With this activity we met the current situation of our quota type 2 DM and really felt satisfied to note that the management and control of these to have been correct. Daily in consultation we learn from our patients and the results help us improve the way to address their needs and try to control your habits and lifestyle, and encourage them to the proper conduct of dietary medical treatment, physical exercise and eradication of smoking habit.

E-Poster 9. Research Project: Linguistic barriers in primary care: the EU funded project KRISTINA

Corresponding author: Dr Carles Llor Vila. cbaudracco@semfyc.es
Filiations: semFYC, Barcelona - Spain

Abstract: Objectives: The European project KRISTINA aims to research technologies to ensure primary health care for migrants coming to Europe. Migrants often face a double challenge: they could not speak the language and they are not acquainted with the culture of the resident country. Many of them are unfamiliar with health administrations of the country. As a consequence, they are often reluctant to take an appointment with a doctor, a tendency that is often further aggravated by cultural matters. KRISTINA is going to be a knowledge-based information agent with social competence and human interaction capabilities able to interact from the linguistic, emotional and cultural perspective. This new technology will run on mobile communication devices ensuring the linguistic, cultural and emotional support and providing all the information the patient will need in primary care.

Material and methods:The agent will advance the state of the art in dialogue management, multimodal communication analysis and communication (vocal, facial and gestural). Use cases target patients and their families from North Africa and they have been validated around 9 selected topics: baby care, vaccinations, pregnancy, anxiety, depression, diabetes, high blood pressure, sexually-transmitted infections, and low back pain. The agent will be able to ensure assistance, providing the information related to each topic and acting as a mediator between the patient and the National Health System explaining how to get an appointment with the Family Doctor or Medical Specialist. Dialogue examples have been developed for each topic and they have been translated into Moroccan Arabic [dāriŷa]. Visits in Spanish and Arabic will be recorded in different primary care centres. The first prototype will be presented in October 2016: the virtual agent will be able to interact providing information on baby care and low back care in Spanish. Results, conclusions, scope: Many migrants from North Africa with a poor understanding of Spanish have a deficient communication with Spanish-speaking health professionals. KRISTINA, as an intercultural facilitator, ensures a valuable role among vulnerable migrants by both end-users and health professionals side.

E-Poster 10. Case Report: INR 1.1

Corresponding author: García-Gutiérrez Gómez, Rocío. rocio3g@gmail.com
Filiations: Centro de Salud Las Calesas, Madrid, Spain

Abstract: 70-year-old woman with atrial fibrillation (anticoagulated with acenocumarol), S protein deficiency, elevated factor VIII, fibromyalgia, osteoporosis, and polyarthrosis, was admitted in the hospital with pain in the right hip and groin area, and inability to walk or put weight or pressure on the affected hip and leg after falling in her house. The affected leg was shorter than the asymptomatic leg in the examination, and finally a hip x-ray diagnosed a broken right hip. Hip replacement surgery was done the same day and we recommended physical therapy to help recover faster. Two months later, the patient comes to our office with swelling of the right hip and increased local temperature. In the surgical wound, granulation tissue is observed with serous exudates.

With the clinical suspicion of surgical wound infection in the operated prosthetic right hip, the patient was admitted in the Orthopaedic Department, started intravenous antibiotic treatment and stopped taking acenocoumarol for two days, then a surgical exchange of the prothesis was done.

She is discharged from the hospital only with subcutaneous enoxaparine, and 6 month oral antibioteraphy with levofloxacin and rifamipcin.

In Primary Care we have been initiating the acenocoumarol with the objective of maintaining the international normalized ratio (INR) between 2.0 and 3.0. We started with a dose of 14 mg of acenocoumarol and checked one week later and her INR was 1.1. We modified the dose to 16 mg/week and checked again. Her INR was still 1.1. Some weeks passed though and we continued elevating the dose of acenocumarol, and when she was taking 29mg/week, the INR kept on 1.1.

Differential diagnosis

- Poor adherence to treatment
- Malabsorption syndrome
- Dietary interactions
- Pharmacological interactions

Treatment

We found that the treatment with rifampicin interacts with acenocoumarol. Since she needed to take this antibiotic for six months, we decided to stop the treatment with acenocoumarol during this period and continue only with heparin.

Conclusions: We always have to think about the pharmacological interactions when we treat our patients, and even more if prescribing a drug like acenocoumarol, with an hepatic metabolism and many dangerous interactions.

E-Poster 11. Case Report: Title: Just a simple cough?

Corresponding author: Rosalia Ferrando Sanchis. rosalia1308@gmail.com
Filiations: Can Misses Health center, Ibiza, Spain

Abstract: Background: no smoking or any other toxic habits; no previous medical history; administrative staff at the hospital. Case presentation: We report the case of a 61 year old immunocompetent woman presenting with dry cough predominantly in the evening lasting one month. Chest imaging was reported as normal by otolaryngology; they diagnosed laryngitis and treated with corticosteroids. Physical examination was unremarkable except for a slight pharyngeal hyperemia. Antitussive treatment showed no response. Fever appears a week later. The review of previous X-rays leads to diagnosis doubts. A new one reveals signs of bilobular pneumonia. Along with the neumonologist the patient was referred to the emergency room for further study.

Supplementary tests: Analytical test shows a nonspecific inflammatory syndrome, blood, sputum cultive and analytical test with serology were negative. It is diagnosed as pneumonia and treated with levofloxacin. No improvement is achieved and a pleuritic pain appears, thus, a chest CT is requested. This shows a possible pulmonary tuberculosis.

Diagnosis: though the bacilloscopy shows negative, two weeks later, the blood cultive for tuberculosis proves positive.

Differential diagnosis: ACE inhibitors, GERD, asthma, spostnasal drip symdrom and interstitial pulmonary diseases.

Presently the patient is being treated with rifampicin, pyrazinamide, ethambutol and isoniazid with good evolution and symptomatic remission.

Conclusions:

• In patients with two weeks lasting cough associated to a febrile syndrome, tuberculosis should be considered in the differential diagnosis, despite the incidence decrease in the last few decades.

• A chest x-ray must be performed, aswell as a review the previous ones.

• If immunosuppresion, organically or pharmacologically, a possible latent bacterial reactivation has to be foreseen.

• Primary care physicians discharge a main roll in the early diagnosis of TB, in the contribution to the notifiable diseases and in the study of the possible affected contacts.

• Due to the accesability and global attention we offer the patient, it is possible to contribute to a better treatment fulfillment and a surveillance of its side effects.

E-Poster 12. Case Report: The GP as an educator for travelers on chemoprophylaxis.

Corresponding author: Fóthy, Julio Francisco. juliof.fothy@gmail.com
Filiations: CS Coll d'en Rabassa, Palma de Mallorca, Balearic Islands, Spain.

Abstract: A 35-year-old man, native from Ghana, living in Europe for the last 7 years (no other relevant medical history) returns from his country. He made a Chloroquine chemoprophylaxis, finishing early 2 weeks before coming back. 2 weeks after arriving he starts with nausea (no vomiting), anorexia, headache and high temperature with shivering, so he consults at his General Practice.

Physical examination: Temp 38.2°C; HR 98 bpm, BP 126/77 mmHg; Overall preserved. Respiratory auscultation: NAD. Normal abdomen without hepatosplenomegaly. No lymphadenopathy.

Malaria is suspected. The patient is referred to the A&E department for study. Thick blood film with Giemsa founds 1.5% parasitized red blood cells. Antigen chromatography reveals Plasmodium falciparum vs. Mixed infection. Laboratory: Full Blood Count, coagulation, renal function, urinalysis and electrolytes were normal.

Glucose 120 mg/dl, CPR 38.80 mg/l. Lactate 0.92 mmol/L. Total Bilirubin 2.44 mg/dl; Direct Bilirubin 0.88 mg/dl,

ASAT 43; ALAT 61 U/L, alkaline phosphatase 50 U/L, GGT 80 U/L.

Due to our patient´s clinical stability, he is discharged the following day with home treatment: Quinine sulfate

650 mg TDS and Doxycycline 100 mg BD for 7 days.

Conclusions:

- It is important to know that, because of its high resistance rate, chemoprophylaxis of choice for some

Plasmodium falciparum endemic areas (such as the exposed case) is NOT chloroquine (Resochin ®) but atovaquone 250mg+proguanil 100 mg (Malarone ®) or artenimol 40mg+piperaquine 320mg (Eurartesim ®) among others.

- It is essential to explain the importance of chemoprophylaxis to travelers to endemic areas: A complete course of chemoprophylaxis must be assured (pre-, intra- and post-traveling), which should be stocked up before the trip starts. So the quality of the treatment is assured and the purchase of circulating false drugs in endemic areas is also avoided.

- If chemoprophylaxis is rejected or there are contraindications there is the exceptional possibility of selfadministered treatment, as rescue on clinical suspicion, until professional health assistance is reached, with

Malarone ® or Eurartesim ® among others, both available in Europe.

E-Poster 13. Case Report: ACEI IN HIGH BLOOD PRESSURE: FRIEND OR ENEMY?

Corresponding author: Pablo Sueiro. pableras_sugar@hotmail.com
Filiations: Health center of Sarria (Lugo) ESPAÑA

Abstract: ACEI IN HIGH BLOOD PRESSURE: FRIEND OR ENEMY?

Permission has been given by the patient to use her medical information.

CASE DESCRIPTION

Our patient is a 70 year-old spanish female. According to the family life cycle, she is on the survival (not working) stage. She has been suffering from multinodular goiter (currently euthyroid) and High blood pressure (diagnosed 15 years ago). Ex smoker. Since her husband´s death, she´s diagnosed with depressive disorder.

Until 2013, the patient has maintained good control of their blood pressure. However, since then she has been progressively worsening. In January 2015, creatinine reached a peak of 1.9 and a glomerular filtration rate

(GFR) of 41.Under suspect of renal stenosis because of adverse ACE reactions, antihypertensive therapy is amended (ACE is removed) and diet is adjusted by her primary care doctor. She will be reassesed by the nephrologist 5 months later.

PHYSICAL EXAMINATION

On June 23th , our patient had improved her GFR. The patient doesn´t refer dyspnea, angina, loss of visual acuity, hematuria or using topical steroids. Normal cardiopulmonary auscultation. Anyway, blood pressure is measured in the consultation that day and figures of 180/100 and 180/80 are obtained, so an echocardiogram,

EKG, MR angiography and background eye test are requested due to complete the studio and to rule out a renovascular etiology.

EVOLUTION

On July 24th, MR angiography shows significant bilateral stenosis in both renal arteries, which is criticial on the right side. Because of this situation, the clinical case is discussed in vascular radiology service. It was decided unanimously between specialists involved (vascular radiology and nefrologists) to perform angioplasty and to place and stent in right renal artery. Fortunately, the procedure had a satisfactory result(confirmed by angiography)

CONCLUSSIONS

There are several mechanisms by which ACE inhibitors produce an ARI, such as efferent arteriolar vasodilatation beacuse of blocking Angiotensin 2 effect or inmunoallergic mechanisms, or even different pathologies that could trigger it (congestive heart failure) Despite these isolated cases, we don´t must forget all the benefits showed in cardiology and other chronic diseases, where they have even increased our life expectancy.

E-Poster 14. Critical Incident: How to save two lifes.

Corresponding author: García-Gutiérrez Gómez, Rocío. rocio3g@gmail.com
Filiations: Centro de Salud Las Calesas, Madrid, Spain

Abstract: 36-year-old woman with no clinical history, came to the Health Center referring dysuria and urinary urgency in the last 2 days, with severe lower abdominal pain that radiated along the flank towards the back.

She denied any other symptoms. She had her last menstruation the previous month and she confirmed having regular menstruation every month.

She did not have a fever, and she was hemodynamically stable. We wanted to explore her, but she did not allow us exploring the abdomen because she was feeling too much pain. Anyway, we could objectify left costovertebral angle tenderness. A urine strip was performed with this result: leukocytes: 3+, 2+ blood.

We prescribed oral treatment with metamizol, and after given clinical improvement, the abdominal exploration could finally be carried out: we could identify a painless mass with soft consistency localized in the right abdomen. The patient reported that she always had it.

We decided to do an abdominal ultrasound in our Health Center, where ongoing pregnancy was observed. The patient was admitted the same day in the Gynecological Emergency Department, where a blood test was performed where acute phase reactants were elevated (C-reactive protein: 6.63; 13000 leukocytes) and the ultrasound was repeated, observing a female fetus aged of 36 weeks and with positive fetal cardiac motion observed. Urgent c-section was decided because of suspicion of non-progression and loss of fetal well-being.

During the procedure a meconium aspiration syndrome was produced, and after that clinical sepsis and shock.

The newborn had to be admitted to the ICU for a month, finally being discharged stable without long term complications.

Although the treatment had to be done in a hospital, we would like to highlight the work done in Primary Care, where, with the limited resources available, we were able to reach the final diagnosis thanks to a good use of them and meticulous work since we decided to finish the physical examination before sending the patient directly to the hospital.

E-Poster 15. Critical Incident. Differential diagnoses in abdominal pain

Corresonding author: Boyero Fernández, Leticia. leboyfe@yahoo.es
Filiations: Hospital Universitario Lucus Augusti, Lugo, Spain

Abstract: 21-year-old woman who consulted for epigastric pain with a 72-hour evolution, with no accompanying nausea, vomiting or fever. Normal physical examination and lab tests. A few hours later she consulted again for increasing pain, radiating to the iliac fossa, and nausea. Altered physical examination and lab findings:

Blumberg, Rovsing and possitive psoas signs; 15000 leukocytes mil/mc, neutrophils 84,1%. Normal urine dipsticks and negative pregnancy test. Suspecting acute appendicitis, abdominal ultrasound is performed, in which no alterations in the right iliac fossa, liver, pancreas, spleen or kidneys are observed. To complete the study and rule out other pathologies, gynaecological examination, which is normal, is requested. Finally, it is assessed by surgery and an operation is decided, being the postoperative diagnosis acute gangrenous appendicitis, retrocecal subserosal appendix. The patient was in hospital for 10 days, treated with intravenous antibiotic therapy. She started having fever on the second postoperative day and purulent exudate through the surgical wound on the fifth. Escherichia coli, Pseudomonas aeruginosa and Prevotella oralis are isolated. Seven day intravenous treatment was completed. She was discharged from hospital with oral antibiotics for 7 days.

Twenty-four hours after discharge from hospital she consulted again for fever and general unwellness. Nonpainful abdomen and clean wound; 24,600 leukocytes mil / mc, 87% neutrophils. TAC was performed: inflammatory changes in the cecum and, in its lower portion, abscess of 3.6 cm. Admission to hospital is decided for intravenous antibiotic treatment.

CONCLUSIONS:

1. The diagnosis of appendicitis is mainly clinical. The patient may report atypical symptoms (flatulence, diarrhea, indigestion, general unwellness …) and not present the typical clinical irradiated abdominal pain.

2. Differential diagnosis and other processes involving abdominal pain are essential: gastroenteritis, diverticulitis, ileitis, pancreatitis, pelvic inflammatory disease, ectopic pregnancy, ovarian torsion, renal colic ...

3. Imaging tests are used to support the clinical diagnosis. Ultrasound is a sensitive method and CT has high sensitivity and specificity, and it is useful in the differential diagnosis and in cases of unusual appendiceal anatomical location.

4. It is important to consider postoperative complications and their management: bleeding, infections, abscesses, adhesions ...

E-Poster 16. Case Report. Loin Pain: Not always colics.

Corresponding author: Fóthy, Julio Francisco. juliof.fothy@gmail.com

Filiations: Centro de salud Coll d´en Rabasa, carrer de Vicente Tofiño 34, 07007, Palma de Mallorca, Spain.

Abstract: PC: Sudden onset of severe bilateral (mainly left) loin pain, radiated to lower abdomen.

46 male, Hypertension (10 years since diagnosis, pharmacological treatment not regularly taken: Amlodipin),

No other Cardiovascular Risk Factors; History of bilateral renal colics. physical examination: Severe pain, restlessness. BP 186/111 Hg mm, HR 56 bpm, apyrexial, 99% Sat O2. No

Abnormalities detected in Cardiac and respiratory auscultation, ABD soft, tenderness in left quadrants, posible tenderness in left loin percussion. Blumberg neg, Murphy neg, slightly weak bilateral femoral pulses.

Diagnostic tests: Urinalysis: Normal

Referred to the A&E department for SEVERE LOWER BACK PAIN NOT CONSISTENT WITH RENAL COLIC,

SUEGGESTING VASCULAR DISEASE.

A&E:- FBC: 13.300 leucocytes (86%N), 2273000/mm3 platelets U&E: 14.1 gr/dL Hb, 78% TP, 0.77g/dL Creatinine.

No leucocites nor blood in urine- US: NAD, Abdominal- CAT: RENAL ACUTE/SUBACUTE INFARCT. Scars in cortical Right Kidney

- CT Angiography: Left Kidney: significant stenosis (>60%) caused by adhered thrombotic material in midd third

Upper Left Renal Artery, mild irregularity in lower Left Renal artery. Right Kidney: stenosis by thrombotic material in lower Right Renal Artery. Right left kidney arteria: aneurisma 5x10 mm, lower left Renal artery: stenosis, bifurcation. No Abdormalities Detected in Aorta.

Diagnostic orientation: Renal vascular disease (Fibromuscular Displasia). differential diagnosis: Calculi, aortic aneurisma, embolia, apendicytis, diverticulytis, irritable Bowel Syndrome, osteomuscular causes, abdominal tumors, etc.

Treatment: Catheterization with stent Low right kidney artery. 13 days in hospital. Home Rx with amlodipin 5 mg BD, aas 100 mg OD, Clortalidona 25 mg OD, omeprazol 20 OD

Conclusions:

- It is very likely that our patient´s previous “renal colics” were actually infarcts.
- It is so important to make a good medical history and a detailed physical examination.
- Loin Pain is NOT ALWAYS a stone. Always consider secondary causes of hypertension in young patients. Shurely our patient would have had benefit on a Doppler US of his kidney arteries 10 years before.
- It is compulsory for every GP to know the red flags for a lower back pain.
- A check up must be done 48 h of the beginning of an antihypertensive treatment.

E-Poster 17. Case Report. STRONGYLOIDIASIS – NEGLECTED OR UNKNOWN DISEASE?

Corresponding author: Diogo, Figueiredo Gonçalves. diogo.figu@gmail.com

Filiations: Department of Tropical Medicine, National Reference Center for Tropical Diseases, Hospital La Paz-Carlos III (Madrid, Spain). Unitat Docent – Hospital Can Misses, Ibiza (Illes Balears, España)

Abstract: More than 1.5 billion people, 24% of the world's population, are infected with soil-transmitted helmintiasis (STH) worldwide. STH of the genus Strongyloides is currently believed to infect an estimated 30-100 million people around the globe and is one of the major neglected tropical diseases. The health consequences of S. stercoralis infections range from asymptomatic light infections to uncontrolled multiplication of the parasite (hyperinfection) and potentially life-threatening dissemination of larvae to all internal organs. This clinical spectrum is found more frequently among individuals with compromised immune system.

We describe two cases of strongyloidiasis infection which remained both undiagnosed until their final consult in a tropical medicine unit. Both patients consulted several medical services (primary care, ER, dermatology…) where different erroneous diagnosis where given. The first one, is a case of a 50 years-old caucasian male with onset of progressive abdominal pain, a skin rash on the right flank, diarrhea and fatigability, 3 days after arriving from Cameroon. The second patient, is a 29 years-old caucasian female with a history of several trips to different tropical regions in the last 9 years (Indonesia, Thailand and Mexico), who presented slight fever sensation and intense generalized pruritus, 9 days after arriving in Java during her last trip to Indonesia, as well as many excoriated skin lesions in periarticular and flexural areas. This patient related these skin lesions to her long evolution atopic dermatitis. Both patients showed significant eosinophilia in peripheral blood, which decreased to normal values after proper treatment was concluded.

We want to focus the importance of an adequate clinical assessment with any patient that presents a history of recent travels to tropical regions as well as when there is an eosinophilia of undetermined cause, since there may be an infection by Strongyloides. Although initially asymptomatic, strongyloidiasis can result in a serious and potentially fatal disease in case of subsequent immunosuppression, either by pathological condition or drug induced origin. This recommendation is addressed to all levels of medical assistance and mainly to primary care, given the high prevalence of asymptomatic cases worldwide.

E-Poster 18. Case Report. I'M GETTING WITHOUT NAILS DOCTOR!

Corresponding author: David Ruiz. darupadu@gmail.com
Filiations: Consorci Sanitaria Integral, Barcelona, Spain

Key words: communication skills, licheniform, primary health care

Abstract: Man of 70 years old that came to the consultation referring problems with all his nails from 6 months ago. He told that began to treat with antifungal liquid and watching not getting better he decide to ask for help to his family medicine doctor. Methods: Interrogation: Started in his nails of his hands which changed of colour and breaking down or falling. He asked in farmacy a treatment which suggested to start with antifungal liquid. No relation with errosive liquids or special products in his work. No traumatism before. A month after he discovered that was occuring the same with his foot nails and started to have a erruption in his back. No good results with antifungal treatment and ichy back with licheniform eruption was the reason to go ask to the doctor. Results:

Many months with treatment without any changed and getting more skin lesions extension, like small violet plaques, we decide it to get in touch by sending photographs to our dermatology service thinking about a skin disease. They recommended to discard other patologies process as psoriasis or lichen planus. Conclusion:

Dermatology in a month could visit him thinking the lesions were of lichen planus but to confirm they did a biopsy. Results: skin punch histological changes observed support as dermatitis lichenoides and such changes and if the accompanying medical history are compatible with lichen planus. Actually he is with cortison cream for skin lesions and nails which is now in his slow progressive recuperation.

E-Poster 19. Experience: Spanish Primary Healthcare in a glance – reflexions from Portuguese residents on their Vasco da Gama Movement experiences.

Corresponding author: Cerdeira, Eduarda. m.eduardacerdeira@gmail.com
Filiations: USF São João do Porto; USF Lethes; USF Vale do Vez

Abstract: Background: The Vasco da Gama Movement (VdGM) is an European working group for young and future
General Practitioners. It aims to improve the quality of general practice, by holding Conference Exchanges and other programs. Objective: To report the experience of a medical conference exchange in Spain.
Methods: Descriptive report and critical analysis. Pre-conference exchange promoted by VdGM, lasting for one week. One resident attended the Palma de Mallorca exchange (III Balearic Meeting of European Residents an
Young GPs - September 7-12th, 2015) and the other three participated in the Madrid exchange (XVIII
Conference of Family and Community Medicine Residents - March 14-20th, 2016). The programs included: attending a Spanish Family Doctor practice, discovering the Spanish health system from within, visiting an hospital emergency department, attending the medical conference, and giving a presentation about “What you must know and do to practice in my country”. Several cultural activities were optional.
Conclusions: This experience was a great opportunity for young family doctors to overview different approaches on primary healthcare and to interact with foreign colleagues and with local people. The authors believe that participating in these exchange programs has increased their social and intercultural competencies, which eventually could enhance the doctor-patient relationship. The authors hope to encourage other colleagues to participate in similar programs in the future.

E-Poster 20. Critical Incident. Back pain, are you sure?

Corresponding author: Rafael Emilio Hernández Silva. rafaelmedico@hotmail.com
Filiations: Hospital universitario Son Espases / Primary Care Cente Son Pisà.

Abstract: The case is about a patient 75 years old, man, with multiple illnesses. DM, Arterial hypertension, hypercholesterolemia, peripheral vascular insufficiency, history of thrombosis in lower limbs with a prosthesis in

Iliac arteries. The patient was transferred from the Primary care emergency, where has been for a period of 4 hours approximately with acute, severe pain in lumbar area, he was referred to the hospital by persistence of pain.

At the time of doing the triage decide to move the patient to the basic consultation with low back pain, diagnostic orientation. In assessing the patient still had pain, I decided place the analgesic treatment, extracted blood for analytic and a new examination of the patient was realized.

I found absence of distal pulses in both legs and uncertain palpation of femoral pulses with alteration of sensitivity and reflexes on left leg. Due to the history of the patient, the acute and intense symptoms, discussing the case with medical specialists and passed for monitoring and follow-up.

Initially with the loss of sensitivity was suspect that there might be a radicular problem, so it was asked of lumbar column X-rays, we continue with analgesia and it took 3 hours to take the decision to vascular surgery.

The case was discussed with vascular surgery, that apply for CT and doppler in which was confirm the presence of a thrombus at the level of the iliac prosthesis that obstructed the flow, and they were decided to urgently operate.

QUESTIONS: Is it correct to attend in the basic attention, patients who they are referred by another medical centre being treated for pain, without relief of symptoms?

Should have we warned the Vascular Surgeons earlier about this case?

CONCLUSIONS: Keep in mind that to care for patients with a history of thrombosis, which goes with the clinic of pain, absence of pulses or sensory disturbances, we must think within the differential diagnosis in a new vascular obstruction or an alteration of the function of the prosthesis; without forgetting that we must always try to relieve pain.

E-Poster 21. Experience. A young doctor in Germany

Corresponding author: Zárate Oñate, Carmen. carmen_zarate@hotmail.com
Filiations: Oldenburg, Germany

Abstract: Hippocrates is the European Exchange Program Residents of Family Medicine WONCA Europe (the European Society of Family Medicine) which is supervised by a working group dedicated to teaching: EURACT (European Academy of Teachers and Tutors in Family Medicine).

The program's goal is to promote the exchange and mobility of medical residents in family medicine and provide a broader concepts of Family Medicine both professionally and on a personal perspective. So through this program Hippocrates I requested a rotation in northern Germany and the program coordinators put me in touch with Dr. Marc Falkestein in Oldenburg, which is a small town of about 160,000 inhabitants in the north of

Germany. For two weeks I had the opportunity to learn about family medicine in primary care in this country. Thanks to Dr. Marc Falkestein, his team and family I could enjoy a fantastic experience. This experience, with the consequent acquisition of knowledge, has served to bring me an enriching international experience in a teaching health, improving professional skills and familiarity with the methods of continuing professional development, improved language skills in German language, in addition to enriching personal side in the field of creating new friendships in that country. Specifically, it was during the first half of April 2016 when I made the rotation and had the opportunity to see firsthand the operation of a Primary Care in Oldenburg. It is a city organized around a pleasant historic, pedestrianized center which makes it very comfortable for family life given the large amount of green areas and abundant bike lanes. It is very common to use the bike in this area of Germany, so as same as the rest of the health center team , I used this means of transport to commute daily to the query. It was a consultation in which they worked, other than Marc, resident family medicine physician, two nurses assistants and an assistant trainee. While rotating in Marc´s consultation and the rest of consultations, I could observe the functioning of these and get an idea of the organization and the characteristics of the German health system.

E-Poster 22. Case Report: When high blood pressure needs to be investigated?

Corresponding author: Cristina Vidal Ribas. cris.3.v.r@gmail.com
Filiations: Primary Health Center in Santa Ponsa, Mallorca. Spain.

Abstract: Clinical history: Male, 28, no history (no personal history of interest), comes to our consulting room for headache for 3 hours. It has appeared while he was doing exercise and it worsens with Valsalva. It's holocraneal, more intense in neck. One week before he felt down when biking.

Physical exploration:

- Blood pressure: 190/120. Neurological and cardiological/circulatory exploration:normal.

The treatment with metamizol is started, the pain didn't improve. He was derived to the emergency room.

Supplementary tests:

- CranialCT:discarding intracranial pathology.

The patient comes to our consulting room, persisting blood pressure 175/110. Enalapril 5mg/day was iniciated, and the following is requested:

- Blood test: creatinine 1.72mg/dl, urea 79mg/dl, glomerular filtering 47.
- Urine test: creatinine 96,1mg/ dl, micro-albuminuria 1691mg/L, microalb/creat1760.
- Electrocardiogram: 72beats per minute, sinus rhythm, PR 0'14, QRS narrow, not sharp repolarization, no signs of hypertrophy.

Clinical judgment and treatment:

With the results, we emphasize history. The patient explains that kidney disease was diagnosed several years ago in his country (Bulgaria), he has not more information and also no report. Sometimes the urine is brown.

His father suffers from kidney disease.

Differential diagnosis: 1. Hypertension secondary to acute glomerulonephritis/ chronic kidney disease/ polycystic kidney disease. 2. Hypertension secondary to neurological disease (secondary to bleeding). 3. Hypertension secondary to toxic substances (alcohol, cocaine).

Based on history, physic exploration and complementary tests, we think it's a hypertension secondary to kidney disease. We had started treatment with enalapril (antihypertensive effect and renal protector) and with this information we derive the patient to the nephrology department, where some complementary tests were done: Ultrasonography: normal. Biopsy: chronic proliferative glomerulonephritis-IgA.

Evolution: The patient had blood pressure levels of 140/67. Creatinine values had improved but remained proteinuria in the nephrotic range. For this reason, dacortin 30mg/24h and cellcept 500mg/12h were added. In the control after 3months, the proteinuria had decreased to 1g/L.

Conclusions: When we study a patient with high levels of blood pressure, although only on a determination or it can be justified for other reasons (pain at the time of measurement, anxiety, drug consumption, etc.) we must recite for monitoring and discard organic pathology.

E-Poster 23. Case Report: What is behind an ulcer?

Corresponding author: Cristina Vidal Ribas. cris.3.v.r@gmail.com
Filiations: Primary Health Center in Santa Ponsa, Mallorca. Spain.

Abstract: Clinical history: Male, 16 years old, came to our consulting room for labial edema. In subsequent consultations buccal ulcers and weight loss were added. Later, he explained the increase in the number of depositions and anal itching.
Personal history: asthma, in treatment with salbutamol.
Physical exploration: Paleness skin/mucosa. Edema lower left lip + left buccal ulcer.
Supplementary tests:
Blood test: hemoglobin 13.6mg/dl, VCM 75fL, ferritin 9ng/ml, Fe 22ug/dl, plaquette 522. Immunology test, with celiac disease:negative. Serology teste:negative. Proteinogram:normal.
We refer the patient to dermatology department.
- Biopsy: liquenoide chronic inflammatory injury.
After these results, the patient returns to our consulting room. In that moment he complained of increasing in the number of depositions and anal itching. In the exploration, we can see base penis and scrotum erythematosus, anal fissure.
Taking the information from the biopsy, the changes in bowel and anal fissures, the case is oriented as Crohn's disease, and the patient is referred to digestive service:
- Ileocolonoscopy: anal fissures, edematous, hyperemic valve.
- Pathological anatomy: non-specific granulation tissue inflammation.
- EnteroTAC: 7cm inflammatory involvement of the terminal ileum.
Clinical judgment, differential diagnosis, identification of the problem:
The differential diagnosis is quite wide, from autoimmune disease to blood disease (essential thrombocytosis + iron deficiency). As we added results and symptoms, we think of Crohn's disease.
Treatment: Oral iron for iron deficiency, being resistant. With the final diagnosis, oral budesonide is started, without improvement. Currently, he is using azathioprine.
Evolution: Incomplete improvement, 1-2 stools/day, pasty, with mucus and blood. It is possible that he needs TNFa.
Conclusions: In Europe there is more than one million affected by Crohn's disease, affecting more white and young people. In this case we focus on the involvement of the buccal mucosa. The patient explained gastrointestinal involvement after numerous consultations. This allowed for a differential diagnosis, including Chron's disease.
Is very common that in addition to diarrhea and abdominal discomfort, the patient has mouth ulcers and laboratory abnormalities typical of inflammatory processes
We must think about it in similar cases, decreasing anxiety that uncertainty of diagnosis can cause to the patient and their relatives.

E-Poster 24. Case Report: Sometimes additional tests cheat

Corresponding author: Cristina Vidal Ribas. cris.3.v.r@gmail.com
Filiations: Primary Health Center in Santa Ponsa, Mallorca. Spain.

Abstract: Clinical history: Female, 55, comes by dyspnoea, cough and yellow-green expectoration, without fever, and intense astenia for two weeks. She explains weight loss (1 month of evolution).

Personal history: - Diabetes-II, treatment with metformin. - High blood pressure, treatment with enalapril. - Traumatic injury in 2010 on left shoulder, she needed three interventions; she has functional limitations. The patient has not provided any reports or X-rays.

Physical exploration: Pale skin and mucous colour. Respiratory auscultation: hypophonesis, crackly right base. Cardiac auscultation: 2/6 systolic murmur in all foci. An antibiotic treatment is started, urgent radiography and general analysis is requested.

Supplementary tests:

- Chest X-ray(requested in consultation and viewed the next day): infiltrated in right lower lobe, cardiomegaly. In the humeral head, lytic image is observed.
- Analytical Hb8.16mg/dl, leukocytes 12,000 (neutrophils94,60%, lymphocytes4.69%, platelets237,000).

She explained that last month she had seen blood in stool. We refer the patient to the emergency room, the anaemia is confirmed and various tests are requested:

- ThoracicabdominalCT: discrete bilateral pleural effusion. Doubtful solid endoluminal and polypoid lesion of 13 mm in first to second duodenal portion.
- Gastroscopy: duodenal deformity, pathological anatomy is negative for malignancy.

Clinical judgment and differential diagnosis:

At first, we think of respiratory infection. With the results of additional tests, we do the following differential diagnosis: 1. Anemia. 2. Neoplasia bone (lytic image on left humeral head). 3. Heart failure and valvular disease. 4. Pulmonary embolism

It was decided to hospitalize the patient. During the admission, the specialist in radiology reports that the image has no signs of malignancy, he believes the image is a result of traumatic antecedent and subsequent surgical intervention.

Treatment: Red blood cells were transfused and iron was also necessary. With this, the haemoglobin increases to 12,5mg/dl.

The antibiotic and deplector treatment were dispensed, with improved X-ray. Cardiology confirms valvular disease and advises nonsurgical measures.

Evolution: The patient has not returned to be anaemic.

Conclusions (and applicability for family medicine):

The applicability of this case concerns the importance of monitoring our patients, requesting the necessary complementary test and given the importance it deserves and each sign/symptom.

E-Poster 25. Case Report: How do the detoxification of toxic from primary care.

Corresponding author: Cristina Vidal Ribas. cris.3.v.r@gmail.com
Filiations: Primary Health Center in Santa Ponsa, Mallorca. Spain.

Abstract: Clinical history: Male, 37, comes to our consulting room for elevated liver enzymes, found in work study.

The patient understands that it is due to alcohol but he has no intention of abandoning it.

Some months later, he came with symptoms of gastritis and intention of abandoning consumption. We initiated the decreased consumption in a controlled manner and treatment with diazepam to avoid abstinence syndrome.

Nevertheless, the patient returns to consume alcohol within one month

Two months after, he came to the consulting room with hematemesis, abdominal pain, and black stools.

Personal history: Hypercholesterolemia. Atorvastatina was prescribed, but the patient does not collect the medication. Alcoholism, 1l of whiskey and 3l of beer per day. Father and paternal grandfather were alcoholic. His father had cirrhosis

Physical exploration: Rhinophyma. Epigastric pain. hepatomegaly. Supplementary tests:

We request the following additional tests:

- Bood testl: Hb 15.50mg/dl, VCM 104fL, GPT 321U/l, GOT 758U/l, GGT 362U/l, amylase 61U/l, LDL 175U/l, negative serology.
- Fecal occult blood: positive.
- Gastroscopy: antral erosive gastropathy, small yuxtapiloric ulcer.
- Electrocardiogram: normal

Clinical judgment and differential diagnosis:

It is oriented as severe alcohol dependence and problems arising from it, such as gastropathy, gastrointestinal bleeding and anxiety.

Differential diagnosis: 1. Severe alcohol dependence. 2. Alcoholic liver disease. 3. Neoplasia gastrointestinal (stomach, small intestine / thickness). 4. Chronic pancreatitis. 5. Cardiac disease (epigastric pain in diabetic patients).

Treatment: The treatment is based on two pillars, cognitive behavioural therapy and drug therapy, which will vary depending on the phase in which the patient is.

Evolution: The patient continues to consume, has declined to fermented 200g per day and he has morning withdrawal with difficulty controlling consumption.

Conclusions: Alcohol is one of the main risk factors in terms of illness and premature death. Primary care.

E-Poster 26. Case Report: IS IT POSSIBLE THAT THYROID POINTS TO ZERO?

Corresponding author: Elena Klusova. ele.k@hotmail.es

Filiations: AP área de salud de Ibiza y Formentera. AP área de salud de Ibiza y Formentera. AP SaludMadrid.

SESPA área IV Oviedo

Abstract: Multidisciplinary diagnosis, monitoring and treatment by primary care and external consultations of

Endocrinology. When primary care monitoring of the patient treated with Iodine 131 in relation with Graves' disease, drastically reduced figures of thyroid hormone were found, as well as TSH in 138 and CK 1124.

Medical history: - Graves' disease treated with I-131 in August of last year, in follow-up by Endocrinology, treated with Neotomizol until September. - Chronic Lymphocytic thyroiditis. Toxic habits: - ex-smoker for 5 years.

Anamnesis: Weakness, drowsiness and decay since December of last year until this february. Numbness in hands and upper members, bipalpebral oedema and slight weight gain. Denies compressive symptoms. Not vomiting or diarrhoea.

Physical examination: goiter. Not cervical adenopathies. Rest strictly normal.

Complementary tests: alteration of thyroid function (TSH 138, FT4 0.07 ng/l). ECG without alterations.

Ultrasound: right thyroid nodule

Differential diagnosis and problem identification:

This is a 49-year-old woman with a history of Graves disease, treated with I-131 with analytical finding of TSH in

138. The patient referred to 1-month evolution of clinic of hormonal dysfunction and for 3 days in treatment with

Eutirox 75 mcg. Exploration and ECG without pathological findings. In analytical highlights CK 1124 (in probable context of hypothyroidism) and slight alteration of hepatic profile.

Problem identification: Thyroid Benign Compensatory Hyperplasia after fibrous transformation of the gland treated with radioactive Iodine.

Valued by area endocrinologist. In view of the good general state of the patient, decides to adjust doses of treatment (Eutirox 125 mg) and outpatient follow-up.

Diagnosis: Hypothyroidism IN RELATION with post-I-131-treatment of LYMPHOCYTIC chronic THYROIDITIS.

Increase in CPK in likely relationship with the prior.

Evolution: In progressive improvement

Conclusions: The extreme importance of knowledge and deep understanding of the disease and complications of its treatment with strict monitoring of these patients.

E-Poster 27. Case Report. This drug rules!

Corresponding author: Burillo Santamaría Alicia. alicia.mca@gmail.com
Filiations: Atención Primaria, CS Es Trencadors, Llucmajor, Mallorca.

Abstract: The patient is a 28-year-old male with drug addiction since the age of 12 to benzodiazepines, cocaine, cannabis and opioids. He is in medically-controlled detoxification therapy in a drug addiction and psychiatric care center, being treated with buprenorphine, buprenorphine/naloxone, lamotrigine, olanzapine and clometiazol.

He has had numerous relapses and hospitalizations, one of which required endotracheal intubation due to coma and cardiorespiratory arrest. The patient has had multiple consultations in the emergency room of our medical center for anxiety and drug overdose, and he appeals for new prescriptions. It is necessary to bear in mind that he is in detoxification from benzodiazepines, which is difficult to manage in an emergency room since several alternative treatments of addiction to benzodiazepines have been tried without satisfactory results. He came into the emergency room one night with anxiety, insomnia, emotional lability and tremors. He was neither agitated, delirious, nor did he display other psychotic symptoms. He was prescribed a 100mg sulpiride injection. The next morning, when examined by his general practitioner, the patient was calm, cooperative and satisfied with the drug prescribed the night before, and he described the remission of symptoms and a good night's rest, without any immediate, apparent side effects. In the patient information leaflet for sulpiride, we find psychopathological diseases (neurosis, depressions, neurotic somatizations), psychological functional disorders and psychosomatic syndromes. After reviewing the literature, we have learnt that this drug is not commonly used as an anxiolytic in the emergency room. We want to underline that sulpiride 100mg may be a valid option, contributing clear benefits in the treatment of patients like the one of this clinical report in which the therapeutic arsenal is limited.

E-Poster 28. Research projects: Spanish health care professionals and non-Spanish speaker patients. ¿Do we communicate?

Corresponding uthor: Sanz C. cristinasanzplaza@gmail.com

Filiations: 13 Primary health care centers of Puente de Vallecas and Villa de Vallecas districts in the southeastern medical area of Madrid, Spain

Abstract: Introduction: The doctor-patient relationship is central for a high-quality health care and essential for the diagnosis and treatment of disease. The present study aims to asses the impact of language and cultural barriers in districts with high rates of immigration, 10,57% and 14,77% , reaching 30% in some health centers, composed mainly by Romanian migrants.

Main Goal: Describing the communication difficulties health professionals encounters with non-Spanish

speaking patients.

Secondary goals:

1. Measuring the impact in the perceived quality by the health care professionals

2. Describing the professionals' awareness on the available resources to improve doctor-patient communication and which are used.

Type of study: descriptive observational study

Materials and Methods: Anonymous 15 questions survey which will be distributed using online forms to the health professionals (Primary care physicians, nurses, pediatricians, odontologists, and physiotherapists) working at the centers of the targeted districts. Survey will collect epidemiological data as well as questions to asses which difficulties professionals encounter, which resources they are aware of to overcome communication impairments, and which of them they use.

Analysis: A descriptive analysis of all study variables will be performed. Qualitative variables will be described with absolute frequencies and percentages for each category. In parallel, quantitative variables will be analyzed with the average, standard deviation (SD), maximum and minimum and with median and range interquartile when necessary. The corresponding confidence intervals (CI) at 95% will be calculated.

The statistical analysis will be performed with SPPSS 22.0 program.

Relevance: Study results could be extrapolated to other territories with similar demographic characteristics.

The obtained data will allow to describe the perception health professionals have about the doctors-patient relationships with non-Spanish speaking patients which will raise awareness.

It will also allow to identify if it exists an underutilization or unawareness of the resources available to improve the communication as well as establishing possible ways of amelioration.

Ethical and legal aspects: It presents a favorable report from the Investigation Local Committee. The survey is anonymous and voluntary. No personal data are gathered.

E-Poster 29. Critical Incident: Clinical eye!

Corresponding author: Ana Loras. ana.loras.fandos@gmail.com

Abstract: Description: 59 year- old women, allergic to penicillin and AAS

* 1st appointment at Health Center: General disconfort, odinofagia, cough with white phlegms. Normal physical examination. Diagnose: Pharyngitis. Treatment: Paracetamol

* 2nd appointment at Health Center: Peristent odinofagia +retroesternal burning. Normal physical examination.

Diagnose: Pharyngitis. Treatment: Ibuprofen.

* 3rd appointment Emergency room at Health Center: Peristency of the above explained symptons + thoracic pain that increase with respiratory movements. Normal physical examination. Complementary tests: Normal.

Diagnose: Acute tracheitis. Treatment: Azitromicine for three days.

* 4rd appointment Emergency room at hospital Urgencies Hospital: Persistency of retroesternal pain, feeling

“out of breath”, odinofagia and general disconfort. Blood test: leucocytoses with left derivation, elevated CRP.

Thoracic X-ray: Normal. Diagnose: Acute tracheitis. Treatment: Azitromicine for five days.

* 5th appointment at Health Center (same day as discharged from ER at Hospital). Physical examination: pansistolic breath vs pericardic fret that doesn´t vary with patients movements. Patient sent back to he Hospital:

PERICARDITIS

Framing the questions:

- Was pericarditis properly studied from primary care or Emergencyroom in the hospital?
- Did we do everything that was in our hands to diagnose the pericarditis?
- Do we know the atypical ways a pericarditis can appear?
- Do we know how to make a correct differential diagnose between types of thoracic pain?

Learning objectives: The importance of clinic in the diagnose. The importance of pruebas complementarias.

Review chest pain. Check perichardítis. Check the differential diagnosis of pericarditis in primary care.

E-Poster 30. Critical Incident: THINKING ABOUT WILSON DISEASE

Corresponding authors: Ainhoa Panzano Asensio. ainhoapanzano@gmail.com
Filiations: Trencador Health Center (Palma de Mallorca)-Spain.

Abstract: 26 years-old woman come for behavior problems. She explains that, sometimes, she has furious attacks and she can't control herself. She has been seeing in psychiatry before for a possible limit dissorder or bipolar disease. She doesn't have hepatic, neurologic or other organic troubles. We ask ceruloplasmin levels to reject a Wilson disease? Is it justified to think of a Wilson disease?

Wilson disease is a disorder of copper metabolism that can present with hepatic, neurologic, or psychiatric disturbances, or a combination of these.

Liver disease includes recurrent jaundice, simple acute self-limited hepatitis-like illness, elevated aminotransferase levels, autoimmune-type hepatitis, fulminant hepatic failure, or chronic liver disease.

Neurologic presentations include movement disorders (tremors, poor coordination, loss of fine-motor control, chorea, choreoathetosis) or rigid dystonia (mask-like facies, rigidity, gait disturbance, pseudobulbar involvement). Psychiatric disturbance includes depression, neurotic behaviors, disorganization of personality, and, occasionally, intellectual deterioration? What is the probability of Wilson disease?

It's an autosomal recessive disease with a prevalence of approximately 1 case in 30,000 live births and more frequently between 15 and 50 years old.

The majority of the people start with hepatic problems but since a 15-20% we can find psychiatric troubles without hepatic or neurologics alterations.

When we have neurologic problems, in 95% we find the Kayser-Fleischer corneal ring ? Should we discard it?

The diagnosis is established in most instances by a combination of biochemical findings (low serum copper and ceruloplasminconcentrations -In our health center we can ask for ceruloplasmin levels in a blood test.

Is not justified to ask for ceruloplasmin levels in all the psychiatric alterations but if we have elevated aminotransferase levels or not classified psychiatric problems, we can ask for them.

In addition, is easy to make the diagnosis because, in the majority of cases, only we need a blood test and it's fast and cheap.

In conclusion, is justified to think in a Wilson disease when we have doubts about the psychiatric diagnosis and we want to reject organic troubles.

E-Poster 31. Case Report: Autolytic attempt with "Abrus precatorius"

Corresponding author: Ana Loras Fandos. ana.loras.fandos@gmail.com
Filiations: Hospital de Manacor

Introduction: The frequency of autolytic attempts in young population is increasing. The methods are becoming more exotic day after day. This has not only medical significations, also social and psychological for the patient and the physician. The easy access to information with the new technologies, allow the population to find out, new ways of selfhurting. It implies a big challange for the physician during the patient management.

Case evolution: A 21-year-old woman required primary health attention after the intake of lethal seeds bought on Internet. The patient revealed having ingested intentionally five seeds of Abrus precatorius approximately one hour before the arrival to the health center in a suicide attempt. After going through a breakup, the patient searched on Internet: “exotic ways of suicide” due to own religious considerations. The patient bought the seeds of American Licorice (Abrus precatorius) through Ebay. When the patient came to the admission of the GP-Health Center carried with her the pillbox with the rest of the seeds, being awake, alert, and oriented.

Cardiac monitoring showed normal rythme. On physical examination his head, neck, heart, lung, and neurological exams were normal. Abdominal exam revealed normal bowel sounds with no pain during pal pation. The patient was transferred to the Hospital Manacor in order to be evaluated by the Psychiatry

Service. At the emergency room the patient started to feel abdominal pain and sickness with no other findings. After contacting with the toxicology service in Madrid, recommended continuous monitoring of the patient, NPO and intravenous fluids, supportive care will lead to good outcome of the patient. Additionally stool examination, laboratory tests did not reveal any disorder. Liver function tests and CBC were also normal. Salicylate, acetaminophen, and ethanol levels were within normal limits, and urine test was also normal.

National toxicology service never had a similar case so they did not know how will the case progress. After a research of the emergency service staff, it is found a possible severe stomach flu leading to dehydration and shock. Ingested seeds can affect the gastrointestinal tract, the liver, spleen, kidney, and the lymphatic system due to a lethal toxin named “abrin” within the seeds.

(More than 350 words)

E-Poster 32. Case Report: Ureteral colic complicated with acute deterioration of renal function in patients with unilateral renal hypoplasia.

Corresponding author: Rodríguez Martínez Juan María. juanmariarodriguez@hotmail.com
Filiations: Atención Primaria SESPA Asturias; Atención Primaria Área de salud Ibiza y Formentera IB-Salut; Urgencias Hospital Can Misses IB Salut

Abstract: Case Summary: It is exposed a case of ureteral colic complicated with acute renal failure in a single kidney patient. Due to the atypical clinical different hypothesis were considered, different diagnostic tests were used and finally the abdominopelvic CT confirmed the cause of obstructive hydronephrosis.

Introduction: UC is one of the most common diseases in emergency departments and diagnosis usually presents no complications. However, ultrasound the gold standard, faster and less expensive test, does not always ensure the correct answer.

Background: Hypertension treated with ACE inhibitors.

Development Case / Explorations

Reason for consultation: Male 49 years old presents pain in the right abdomen of 6 hours of evolution, insidious onset and progressive increase, bilious vomiting and irradiation to the Right Renal Zone. No fever in the days before, very productive cough since one week, no dysuria or rhythm disturbances and micturition volume.

Clinical symptoms: Constants: BP 143/85; HR 63; Tª 37º; O2S 99% Good general condition despite involvement by pain. Normal colour and hydration of skin and mucous membranes. CPA unchanged. Depressible abdomen with peristalsis preserved, hepatomegaly 4 cm, painful on palpation in epigastric, right upper quadrant and especially right flank. Negative bilateral renal fist percussion. Legs: without edema or fovea.

Lab: Creatinine 1.37 331 LDH (Serum hemolysate), PCR: 0.17, Leukocytes: 19700, Neutrophils 16800 (85.4%). Proteinuria 30 mg without alterations in sediment.

Radiology: Simple Rx thorax and abdomen without alterations.

Ultrasound: hypoplasia left kidney of 8,4cm. Low dilation of the right pyelocalyceal system in relation to grade I hydronephrosis without identifying obstructive cause.

Case development: During the telephone conversation with the Urologist thinks that the focus of the case isn't urinary, suggest possible cause right basal pneumonia. The patient is entered in charge of Internal Medicine to study leukocytosis with left shift among others, pain control and monitoring of clinical evolution.

Analytical control: 3.29 Creatinine 3.29, LDH 359 (hemolysis I. 59), PCR 2.78, regular gas analysis, leukocytosis 16500 (72% N). Abdominal CT: Obstructive urolithiasis 3.5 mm in the right ureteral meatus, with grade I hydronephrosis and discreet periureteral and perirenal secondary to obstructive uropathy. Clinical trial: Renoureteral Colic complicated right with acute deterioration of renal function in patient with hypoplastic left kidney.

Treatment / Monitoring: Treatment: Surgery and satisfactory resolution of the postoperative course.

E-Poster 33. Type: Case Report. Dermatosis induced by dental implants

Corresponding author: Castanheira, Joana. scpmj.206bones@gmail.com

Filiations: Family Health Unit of Fiães – ACES Entre Douro e Vouga I, Santa Maria da Feira, Portugal

Abstract: Background: In Portugal, oral health treatments are increasingly common, using dental implants consisting, mainly, of titanium and a small percentage of a metal alloy. The Lichen Planus (LP) is a rare inflammatory dermatosis of unknown cause that can affect the skin, oral cavity, esophagus or nails. This can be associated with infections or taking drugs, which includes contact metal, as present in the dental implants. A complete medical history is crucial for the diagnosis, for establishing a temporal relationship between the stimulus and the appearance of these lesions.

Case report: Female, 54 years, Portuguese, single, supermarket clerk. Background of osteoporosis, allergic rhinitis, chronic sinusitis, oral pathology and depressive disorder. Smoking 5 cigarettes/day, without drinking habits, with no known allergies. Updated vaccination plan. Treated with sertraline, montelukast, desloratadine and fluticasone furoate. At 10.08.2016, acute consultation is needed due to the appearance of skin lesions, maculopapular, flat, erythematous, scaly, slightly pruritic, scattered through the limbs and back, with four months of evolution. It was treated with acitretin and methylprednisolone and betamethasone topical, assuming it is LP. By 25.08.2016 she returns maintaining the clinical and referring appearance of vesicles in the oral cavity. At 06.09.2016 the clinical history was reviewed and a temporal relation to the application of orthodontic implants in April and the appearance of a first reddish lesion in the left leg, a month later, was found. In May she made a trip, as usual, to South Africa without registration of behaviors/risk exposures. The LP etiological relationship with hepatitis B and C and HIV, was excluded, as well as drug origin, leaving the association hypothesis of the alloys of oral implants.

Discussion: There are numerous clinical variants of LP, mainly of unknown etiology. Clinical history analysis led to this diagnosis because of the type of injury, it's characteristical location and temporal relationship with implant placement. We believe it to be an hypersensitivity reaction that was manifest in the form of LP, that may require multidisciplinary management.

E-Poset 34. Case Report: Back to med basics: physical examination came first

Corresponding author: J. Andreu Méndez. julia.andreu@hotmail.com
Filiations: El Raval Primary Care Center/, Elche, Spain

Abstract: Our pacient is a 49 years old man that consults in our primary care center for stomachache and constipation during the past 15 days. Allergic to penicillin. He does not suffer from high blood pressure, diabetes or hypercholesterolemia. He is an active smoker with cumulative consumption of 60 pack-years. Severe alcoholic habit.

Lymphoma (unkown type) diagnosed in 1984, treated with chemotherapy and radiotherapy. Rheumatic fever with secundary mitral and aortic stenosis. Carrier of pacemaker since 2015 due to Atrial Fibrillation and

Bradycardia- Tachycardia síndrome. Several episodes of recurrent pericardial effusion.

Surgical history includes appendectomy, tibia and fibula fracture.

Among his treatment, we would highline Amiodarone, beta-blockers and blood thinners.

Vital signs: Temperature 36'6ºC; Heart rate: 87 bpm; Blood pressure: 121/76 mmHg.

Our sistematic physical examination was totally normal, except for the palpation of an indurated mass located in epigastrium and right hipocondrium, painful with movilization, suitable with hepatomegaly.

Giving the findings exposed, we ran blood tests including hepatic enzymes, that proved an altered hepatic function, blood count and coagulation that was normal, and chest and abdomen X-Ray, that showed signs of cardiomegalia with right pleural efflussion.

With all this information our first differential diagnose will include: 1. Hepatitis. 2. Infectious (viral, bacterial, parasitic). 3. Alcoholic steatohepatitis 4. Autoinmune hepatitis. 5. Liver infiltratio. 6. Malignancy liver tumor. 7. Benign liver tumors. 8. Outflow venous hepatic disorder 8. Right heart failure

The study was extended with analysis of hepatic viruses without pathological findings, tumoral markers and Full

Body CT. In this last proof, there was detected a neoplasia in liver and lungs.

The pacient was admitted to hospitalization in oncology service, where, after doing histological analyses of hepatic biopsy and inmunohistochemical, he was diagnosed of neuroendocrine tumor poorly differentiated, stage IV due to pulmonary, ganglionar, bilateral adrenal, liver metastases and bone metastases; starting first chemotherapy cycle.

At the present time, the patient is at home, being followed by his doctor of primary care and the oncologists.

With this case there is revealed the importance of a correct anamnesis and physical exploration in our consultation of primary care, being able to detect vital pathology.

E-Poster 35. Case Report. Thoracic pain on my wedding day?

Corresponding author: J. Andreu Méndez. julia.andreu@hotmail.com
Filiations: El Raval Primary Care Center/, Elche, Spain

Abstract: Our pacient is a 33 years old woman, that comes to our primary care center for anxiety and atypical thoracic pain. The first thing she told us is that she is going to marry soon, and it's a little bit nervous this days. She feels very tired too, because of all the preparatives. Besides the anxiety, she refers the pain like punctures that start in the middle of the chest, without irradiation, and with improvement when she goes sedestation and leans forward. Last night, the pain has waken her up, being associated this time with light sweating. She is not allergic to any medication. She does not suffer from high blood pressure, diabetes or hypercholesterolemia. Is an active smoker with cumulative consumption of 4 pack-years. She denied alcoholic habit, surgical history, treatment or any other relevant medical data. Vital signs: Temperature 36'8 ºC; Heart rate: 80 bpm; Blood pressure: 110/56 mmHg, Oxygen saturation 99%.

Our physical examination was followed by sistematic check of the different systems, including cardiovascular, respiratory, neurological and abdominal, without finding any pathologic sign. With all this evidence we decided to make an electrocardiogram, that is totally normal. At this point, we can not make any other tests in our local primary care center, so we inform the pacient that she should go to the hospital to ran a more exhaustive study. She insist that everything may be just because of the wedding, but reluctantly she agrees to go to the hospital.

With all this information our first differential diagnose will include:

- Pericarditis
- Atypical pneumonia
- Pleural effusion
- Tietze syndrome
- Anxiety

At the hospital, blood tests including cardiac enzymes are ran (that proved an increasement of them), as well as chest X-ray and echocardiography that were normal. The patient was admitted to hospitalization in intensive care after being diagnosed of myopericarditis, starting treatment with ibuprofen showing a good clinical evolution. After a week she was out of the hospital. This clinical case reminds us how important is to make a good anamnesis, to helps us to discern the real pathology that the patient suffers from beliefs or hunches.

E-Poster 36. Case Report: Challenge of the diagnosis of Systemic Lupus Erythematosus (SLE) in a young woman

Corresponding author: Luz Amelia Tezen Valderrama. amelia25_05@hotmail.com
Filiations: ABS Sant Josep, L´Hospitalet. Barcelona-España

Abstract: Background: Systemic lupus erythematosus (SLE) is a chronic inflammatory disease of unknown cause that can affect virtually any organ of the body . Inmunologic abnormalities, are a prominent feature of the disease. Patiens present with variable clinical features (skin, renal , hematologic o central nervous renal system) . The clinical heterogeneity and the lack of phognomonic features or test pose a diagnostic challenge for the clinic. A consensus group experts on SLE , the SLICC (2012) has proposed revised criteria for SLE, requires either that a patient satisfy at least 4 of 17 criteria, incluiding at least 1 of the 11 clinical criteria and one of the six inmunologic criteria or that the patient has biopsy- proven neprhitis compatible with SLE in the presence of antinuclear antibodies or anti-double stranded DNA (dsDNA) antibodies. The SLICC revised criteria had greater sensitivity but lower specificity than the 1997 ACR classification criteria. The SLICC criteria might delay the diagnosis of SLE in a significant number of patients might not be classified at all.

Clinical Case:

A 18-years-old woman, no history of diseases. She reported to consultation complaining of poliarthritis, headache, palpebral edema. Her general physician started the study of that young woman. One day, increase of the perimeter of her leg, with pain and tenderness, no history of trauma, no signs of infection or sting; so he was derivated by his primary care physician to the hospital. Upon arrival at the emergency room, she had fever, tachycardic and blood pressure was normal. Physical examination revealed malar rash and increase of the perimeter of her leg. Laboratory assessment revealed anemia normochromic and normocytic, thrombocytopenia and neutropenia unknown origin. One month later, thrombocytopenia with immunologic disorder: high levels of antibodies to double stranded DNA. She was admitted to the hospital for the study of unknown disease. She was followed by hemathology and reumathology, also they found high levels of dimero D. The immunologic study showed antiphospholipid antibodies positives and the renal biopsy was compatible with nephritis. The patient was diagnosed of lupus, following the clinical and immunologic criterias.

Conclusions: The diagnosis of SLE is very complex; since it requires a thorough medical history, physical examination, and laboratory testing.

E-Poster 37. Experience. Do we know how lucky we are?

Corresponding author: Isabel Arenas Berenguer. isabelarbe@gmail.com
Filiations: Buitrago del Lozoya, Madrid, Spain

Abstract: One of the advantages of our unit is that we can carry out the rotation of rural medicine in the early years of residence. This consists of moving to a health care center far from the big city, there by car we move through small villages in the mountains, without appointment, without a strict schedule and almost with no medical equipment. In summer times it can even become a pleasant walk through the mountains, but in winter villages are cut off by weather conditions and doctors can't arrive there. At first I thought it would look like the rotation in my health center, but it was totally different as I imagined. There the most valuable weapon with the stethoscope is the word and the comfort of the doctor. Before referring a patient to another specialist we have to think it very well because this places are over 100 kilometers far away of the city.

These are areas where the nearest pharmacy is about 30 kilometers and there is only one person responsable for taking them the medicines twice a week. We have to talk to the pharmacist to ask for the medication people don't have and manage with them the days of delivery.

Clinical practice is different there. They are the same patient with the same pathology that we use to see in the big city but with a different management especially in the social context

Most of the doctors who work in big cities are not aware of the work in these areas. There the purest and simplest medicine is practiced, and also the most grateful. You get involved completely with patients, their lifes and their families. We don't know how lucky we are to live in a place where we have all the resources at our fingertips. It has been a very enriching experience where I have learned medicine and above all human values.

E-Poster 38. Research projects: Does the fact that smoking causes peripheral arterial involvement detectable with Cardio-Ankle Vascular Index?

Corresponding author: Jitka Mudrychová. mudr.mudr@live.com
Filiations: Health center San Agustin/Génova; Palma de Mallorca; Spain

Key words: Peripheral arterial disease, Cardio-ankle vascular index, cardiovascular disease

Abstract: Proyect of investigation: Peripheral arterial disease (PAD) refers to the atherosclerotic involvement of noncoronary and extracranial arteries, including visceral arteries, the aorta and its branches and the arteries of the limbs. Age, male sex, smoking and diabetes, as well as hypertension and dyslipidemia, are the most relevant risk factors for the development of PAD. Patients with PAD have increased risk of developing cardiovascular complications (coronary disease, stroke) and total and cardiovascular mortality, even after adjustment by conventional risk factor. Despite this PAD exhibit a worse control of risk factors. This opens up an important opportunity to optimize their control, which can result in an improvement of the prognosis of patients with PAD.

Goals: Trying to prove, that the fact of smoking causes alteration in the walls of peripheral arteries, which would be detectable with a new diagnostic method CAVI (cardio - ankle vasclar index), which aims to analyze arterial stiffness, which is a good marker of PAD. For this reason it is starting CAVI use as an intermediate method

(indicator) of cardiovascular involvement in clinical trials to measure the effectiveness of preventive interventions for cardiovascular risk factors. Design: This is a descriptive cross-sectional study of population, treated in primary care San Agusti / UB Genova. A random sample of 116 individuals is sufficient to estimate, with a confidence level of 95 % and an accuracy of +/- 0.2 units, the population mean of values that is expected to have a standard deviation of about 1.1 units. Participants in the study are those with low/intermediate risk according to REGICOR/SCORE with no history of atherosclerotic disease and 45-75 years of age and present active smoking or are former smokers. Analysis plan: Describe CAVI values globally and separated by group of smokers / ex-smokers and calculate averages of standard deviation according to age groups for decades.

Calculate the values adjusted for age and sex using multiple linear regression. Establish the proportion of altered and normal ABI (ankle-brachial index) and CAVI. Establish the proportion of patients detected with pathological CAVI and confirmed them with ABI altered.

E-Poster 39. Original researchs: NEW BRIEFCASE OF URGENCY

Corresponding author: Pérez Fonseca, Carmen. carmenperezfonseca@gmail.com
Filiations: Resident of Primary Care, CS Sant Agusti, Palma de Mallorca. Primary Care Doctor, CS Sant Agustí, Palma de Mallorca.

Abstract: Introduction: At the primary care physician will be required to deal with emergencies on public roads or addresses to which the emergency can not attend at that time. As to clinical, diagnostic and therapeutic complete equipment is needed, and at the same time easily transportable and manageable.

Objectives: Raise awareness among all health workers at the health center San Agustin the content and distribution of the new briefcase. Evaluate the acceptability, compliance and degree of knowledge of the new emergency case.

Methods:

To publicize the new emergency case all center staff two joint clinical sessions were held.

To achieve the second objective, a survey via online (www.typeform.com) anonymous, addressed to medical and nursing center is designed.

Results:

In the survey 19 people (13 doctors and 6 nurses) participated. Of which 79% (15 people) were aware of the new case of emergency. As for the safety assessment of new briefcase 63% do not feel safe in use, taking into account only the cohort of physicians are 77% who do not feel safe and the most frequent reason not feel safe is need for training and / or recycling. Instead nursing assessment 67% feel safe, the most common reason is knowledge of the content of the material. An overall assessment of the new case was performed using a scale from 1 to 10 where the average score was 5.65 and the old briefcase was punctuated with an average of 5.71.

Conclusions:

The medical team feels insecure when to intervene with the new briefcase in emergencies compared to the nursing team, analyzing these reasons we conclude that nursing work is imminently practical and should follow the instructions and orders of medical equipment which has the greater responsibility in decision-making.

Making proposals to improve the safety and quality of care can be with the completion of protocols algorithms performance of the most common diseases, conduct clinical sessions in the type megatons center simulating situations that can be found in a home or in the street urgently.

E-Poster 40. Case Report: Superior Vena Cava Syndrome

Corresponsing author: Covacho González Marina. covacha2@hotmail.com

Filiations: Centro de Salud Santa Ponça, Calviá. Mallorca. Centro de salud Santa Ponça, Calviá, Mallorca. Centro de salud Escola Graduada,Palma de Mallorca.

Abstract: Reason for consultation. A 50-Year-old Woman with neck swelling since 10 days and history of progressive dyspnea. Medical history smoker of 30 pack- year, no drug allergies, no DM, no DLP.

Physical examination: Afebril,heart rate 103 beats/min, BP 176/98mmHg, oxygen saturation 95%.

Neck and facial edema. Violaceous plaques on the upper chest. Colateral circulation. No lymph nodes. She had no other notable physical findings. Heart and chest examinations were normal without murmurs.

Neurologic examination: she was aware of person, place and time. Motor function , sensory exam, reflexes, cranial nerves and coordination exam were normal Abdominal examination was normal without abdominal distensión-ascites, large masses. Diagnóstic tests

+Blood test: Leucoc. 10100/ ul (N 80.61%),Hb 11.8 g/dl, Hto 37%, VCM 93fl, HCM 29.7pg, Plaq. 308000, INR

1.02, TP 97%, Glu. 126, Urea 32mg/dl, Cr 0.77, Na 141,k+ 4.1

+EKG: Sinus rythm. 100 beats/min, PR interval 120 ms ,QRS complex 80 ms, normal ventricular repolarization.

+Chest X-ray: Superior mediastinal widening and right hiliar prominence that may indicate the presence of mediastinal mass. Nodule in apical segment of superior lobe of right lung

Emergency Department: +CT scan: Nodule in apical segment of sup. Lobe of right lung 18x17mm. Mediastinal mass.Probable lung Cancer.

Internal Medicine department +Bronchoscopy(biopsy): Small cele lung cancer stage lV.

Diagnostic orientation

Lung cancer

Differencial diagnosis

Benign(15-40%)

+Thrombosis superior vena cava+Fibrosing mediastinitis+Benign tumor+Bocio, Sarcoidosis...Malign

+Lung cancer(75%)+LNH(10-12%)+Metastatic lesión

Treatment: QT(Paltino+Etopósido) .

Evolution: The symptoms of SVCS decreasing in 5 -10 days with QT. The survival statistics of small cell lung cancer is around 6 montas

Conclusions: We must remember that a SVCS 75% is because of a lung cancer.The importance of the X-ray in this type of cases.Bibliography 1. Navarro F, López J.L, Molina R, Lamarca A. Protocolo diagnóstico y terapeútico del síndrome de Vena Cava superior. Medicine. 2013; 11(24):1500-3.

E-Poster 41. Type: Case Report: Decisions on management of skin abscesses- antibiotic therapy versus drainage.

Corresponding autor: Isadora Silveira Camargos. isafogo@hotmail.com
Filiations: Hopital Universitário La Paz, Madrid, Spain

Abstract: Reason for consultation: Pain and swelling of knee. Past medical history: No allergies. Non- smoker. No alcohol. No hypertension, no diabetes, no dyslipemia. Surgical history: Apendicectomy.

Medication: none. Medical history: Patient, is a 26-year-old male, who presented to a Primary Care with four days evolution of pain in left knee and bordered redness with suppurative residual in foreside of left thigh, developed out of three small furuncles on same knee and one located above on thigh. The patient refers a motorcycle accident 1 month ago during a Thailand trip on affected knee with an open wound that healed completely without medical intervention. No fever. Functional impairment caused by pain in left leg resulting in difficulties to walk. The pain intensity is about 7/10. No other associated sintomatology. Physical examination: BP: 116/84 Pulse: 65 Tº: 37.2ºC

Alert, conscious. Cardiopulmonary examination normal. Abdomen: Soft, flat, no-tender, and non-distended. No organomegaly. Left leg: Knee with three erythematous furuncles on lower patella border, subcutaneous edema, joint movement complete, pain at palpation. 2cmx1cm erythematous well bordered, tender, painful, and fluctuative lesion with hyperthermia, surmounted by a pustule at thigh foreside 10cm above the knee. Homans sign negative. Rest normal.

Diagnostic tests: After 24 hours antibiotic treatment and appearance of fever:

- Blood test with determination of inflammation parameters
- Drained material send for culture

Diagnostic orientation: Skin abscess and cellulitis.

Differential diagnosis: Cellulitis, Folliculitis.

Treatment: We start oral antibiotic therapy with Amoxicillin-Clavulanate. NSAIDs for pain control.

Evolution: After 24 hours the patient returns to primary care with no notable relief and appearance of fever.

We proceed to incision and drainage of the thigh abscess. Drained material is send for culture. Blood test results show minimal alteration of inflammation parameters.

Besides, Clyndamicin is added to include activity against MRSA.

24 hours after intervention the patient refers absence of fever, no suppuration and pain relief.

Conclusion: Initial management of patients with skin abscesses is a frequent problem in Primary Care. The consideration of antibiotic therapy versus drainage of the abscesses depends on individual clinical presentation and should be tailored to present clinical improvement.

E-Poster 42. Research projects: Perception of body image as Body Mass Index in Resident Doctors Hospital of Clinicas

Authors: Gimenez. belen_30187@hotmail.com
Filiations: Asuncion

Abstract: Introduction. One of the determinants of body weight is the perception that the person has of his own body image. Residents of the Hospital de Clinicas more than being in the process of learning, eating behaviors and physical activity are not outlets and followed in this period, the aim of this study was to determine the perception that medical residents have of their body weight. Materials and methods Descriptive, observational study of transverse cut was used. Through a questionnaire the variables age, sex, waist circumference, weight, height, BMI, body weight perception were explored.

Results: 107 medical residents participated, 52.3% were female. Mean age was 28.4 ± 2.21 years.

The abdominal circumference was high risk in 37.3% of men and 15.6% of women; very high risk in 12.5% ??of men and 28.6% women.As for the average BMI was 25.7 ± 4.6; 42.9% being overweight. By sex more women with normal weight (62.9% vs 27.5%) whereas men have more overweight (60.8% vs 27.7%) it was found. As for the perception of body weight they are perceived obesity 23.4%; 46.7% overweight and normal weight 28,1%. Crossing data with real BMI, 37% have no real perception according to their BMI. Being higher in women (23% vs 11%) than in men and 13 (12.1%) are perceived as not being obese obese, 4 (3.8%) are perceived not having overweight overweight and conversely 17 (15.8%) who are normal weight, are not perceived as normal weight. The agreement regarding actual BMI and perception is 63 /% (67 residents)

Discussion: The perception is higher in women than in men according to their actual BMI. It requires more research in reference to the subject applied to the entire hospital population and not just residents.