80.7% had relatives with type 2 and 15.3% with type 1 diabetes. Furthermore, 51.4% reported a family history of hypertension or high cholesterol, but only five individuals indicated that family members had undergone genetic testing for diabetes.

Conclusion. In conclusion, a considerable proportion of students present multiple risk factors associated with diabetes. While the presence of these risk factors does not imply an inevitable progression to diabetes, it underscores the importance of increased awareness and proactive health management among the student population.

DECODING MULTIPLE MYELOMA: A RETROSPECTIVE CASE STUDY

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Introduction. Multiple myeloma (MM) is a malignancy of hematological origin characterized by the clonal proliferation of cancerous plasma cells in the bone marrow. It presents with a constellation of symptoms and laboratory abnormalities, including anemia, renal dysfunction, hypercalcemia, and bone lesions (CRAB criteria).

This case report highlights the diagnostic challenges and complexities in managing a 66-year-old female patient with multiple comorbidities including Chronic Kidney Disease (CKD) stage 2, Type 2 Diabetes Mellitus (DM) and Arterial hypertension, complicated by nephropathy, anemia, and elevated Erythrocyte Sedimentation Rate (ESR), ultimately diagnosed with MM.

Aim of the study. This study is unique due to the atypical presentation of MM in a patient with well-controlled diabetes mellitus and CKD, emphasizing the diagnostic dilemmas met in distinguishing MM-related kidney damage from diabetic nephropathy. Such cases showcasing the coexistence of MM and preexisting CKD are rare, underscoring the need for thorough investigation of symptoms in patients with overlapping chronic conditions.

Materials and methods. A 66-year-old woman with CKD stage 2 was admitted with complaints of lower extremity edema constant for about 1.5 months, fatigue, exertional dyspnea and significant fluctuations in her laboratory markers. These fluctuations started 1 year ago and were treated on an outpatient basis. The patient has a history of Type 2 Diabetes Mellitus, Arterial Hypertension. The patient has no relevant psychosocial or family history for oncological diseases.

After evaluating the patient, pitting edema of the shins was noted. The rest of the examination revealed no noteworthy findings. Fluctuated laboratory

markers included proteinuria, mild normocytic hypochromic anemia, increased ESR and decreased total protein.

The diagnosis upon admission was chronic tubulointerstitial nephritis due to the preexisting nephropathy of combined genesis (DM, Arterial Hypertension). The patient's hypertension was effectively managed and within normal limits. She also had good glycemic control (7%), but the level of proteinuria (2.1 g/l) was not consistent with this range of HbA1c, so alternative diagnoses were considered. After consultation with a hematologist, she was recommended to undergo sternal puncture, which revealed changes consistent with diffuse-focal form of Multiple Myeloma stage 2.

The patient was recommended Bortezomib 1.75mg and Cyclophosphamide 200mg, Dexamethasone 20mg, which is the standard treatment regimen for MM.

Results and discussion. Multiple myeloma and CKD are 2 diagnoses that have overlapping symptoms.

Mild anemia presenting in this patient projected many red flags that prompted the need for a hematological investigation. Firstly, the anemia is disproportionate to the stage of CKD; for a patient in CKD stage 2, normocytic hypochromic anemia would be atypical, as this often presents at much later stages of CKD due to erythropoietin deficiency.

Additionally, elevated ESR and as well as the aforementioned proteinuria point to a systemic process beyond diabetic nephropathy or heart failure. The triad of anemia, renal involvement and increased ESR justified the need to rule out hematological malignancies, hence a bone marrow biopsy was undertaken.

The majority of existing studies mostly focus on MM-induced kidney damage and don't address the fact that several symptoms are shared between the two diseases that could lead to a misdiagnosis. Further studies should be done examining the relationship between these two conditions. Recent guidelines (KDIGO, IMWG) encourage considering the possibility of MM in patients presenting with Acute Kidney Injury of unknown origin, but broader CKD populations are still not addressed. It's important to note that a lack of awareness about the possibility of MM in a CKD patient could potentially have a fatal outcome.

Conclusion. Overall, this case report emphasizes the difficulties in diagnosing MM in patients that present a history of multiple comorbidities which have similar symptoms, especially in patients suffering from CKD. When a patient presents with unexplained anemia, increased ESR and proteinuria, it's always important to consider a possible MM diagnosis, especially if the patient is over the age of 65. The rapid diagnosis of such patients allows healthcare providers to offer better treatment modalities leading to lower rates in mortality and better outcomes for the patient, as depicted in this case report. This report also serves to demonstrate the importance of thoroughly investigating patients with multiple comorbidities and complex medical histories.