

Huge Vegetation on Aortic Valve in a Young Patient with Infective Endocarditis Caused by *Enterococcus Faecalis*

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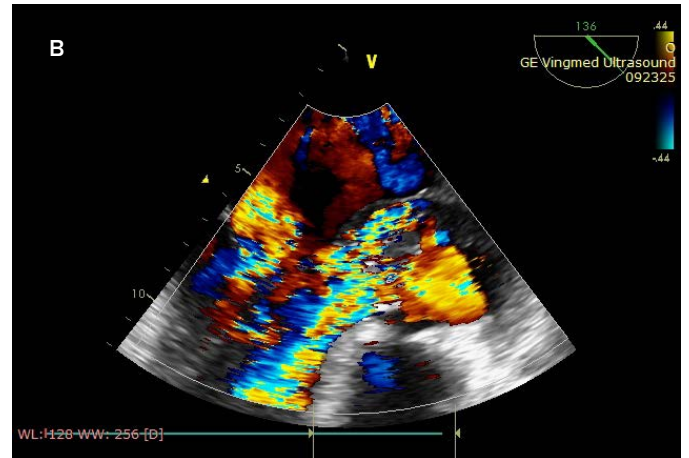
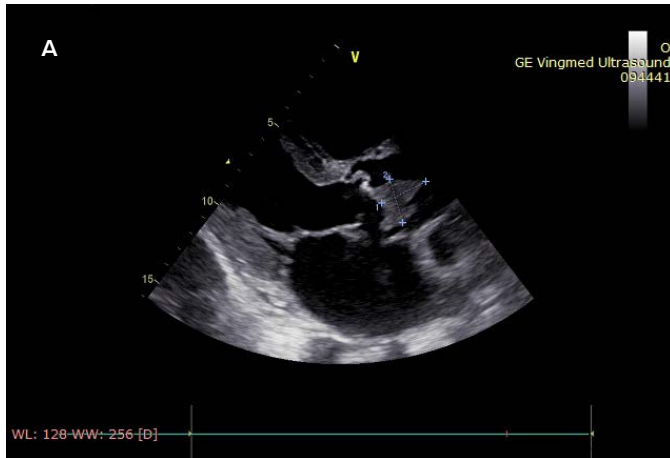
A 46-year-old male patient, without any previous history of cardiovascular events, was admitted to our emergency department presenting fever, dyspnoea, tachypnea, weakness, diaphoresis, chest pain, started 7 days before presentation. On physical examination, the patient presented fatigue, monocular blindness after a recent retinal embolic event, fever of 39° C, blood pressure 115/70 mmHg, heart rate 110/min and a respiratory rate of 20/min. Further examination revealed a pansystolic murmur over the cardiac area and pulmonary crackles. Laboratory tests revealed severely elevated white blood cells count (23,600/ml), anemia (hemoglobin 9.6 g/dl), C-reactive protein >30 mg/dl, renal dysfunction (blood urea 7.5 mmol/l, creatinine 175 µmol/l) and abnormal liver function (AST/ALT 136/218 IU).

Transthoracic echocardiography (Panel A) revealed a huge (27/17 mm) polycyclic mass attached to the aortic valve, an oscillating structure with extension in the ascending aorta, and also a moderate aortic regurgitation. Transesophageal echocardiography (Panel B) indicated severe aortic regurgitation associated with multiple microabscesses on the aortic valve and the ascending aorta.

Repeated blood culture indicated the presence of Vancomycin-sensitive *Enterococcus faecalis*, and high-dose antibiotic treatment was initiated. Following antibiotic treatment the patient experienced a favorable evolution, with fever remission and improvement of dyspnoea and fatigue. Unrecognized and untreated infective endocarditis is a severe disease, due to the different severe complications such as valve destruction, intracardiac abscesses, embolic events, acute heart failure.¹⁻³ The images revealed by transthoracic or transesophageal echocardiography are in line with major Duke diagnostic criteria. In the majority of cases, such as in our case, the definitive treatment is surgical intervention.⁴

CONFLICT OF INTEREST

Nothing to declare.



REFERENCES

1. Mouly S, Ruimy R, Launay O, et al. The changing clinical aspects of infective endocarditis: Descriptive review of 90 episodes in a French teaching hospital and risk factors for death. *J Infect.* 2002;45:246-256.
2. Paterick TE, Paterick TJ, Nishimura RA, Steckelberg JM. Complexity and subtlety of infective endocarditis. *Mayo Clin Proc.* 2007;82:615-621.
3. Sexton DJ, Spelman D. Current best practices and guidelines: Assessment and management of complications in infective endocarditis. *Cardiol Clin.* 2003;21(2):273-282.
4. Wolff M, Witchitz S, Chastang C, et al. Prosthetic valve endocarditis in the ICU. Prognostic factors of overall survival in a series of 122 cases and consequences for treatment decision. *Chest.* 1995;108:688-694.