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Complicated aortic prosthetic valve endocarditis

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Introduction: Prosthetic valve endocarditis (PVE) occurs in 1 to 3% of cases at 1 year and 3 to 9% at 5 years postoperative (PO) with 40% mortality. Clinical complications, uncontrolled infection and agents such as staphylococci and fungi indicate the need for surgery. Recent trial with stable patients (26.7% PVE), oral antibiotic therapy (ATB) proved to be as effect as intravenous antibiotic. However, in complicated cases, prolonged clinical treatment still an exception.

Case Report: ANFJ, male, 45 years old, aortic valve replacement by mechanical prosthesis in 2015, was hospitalized in Jun/18 with right front-temporal-parietal cerebral hemorrhage and sub febrile for 1 week. Transthoracic echocardiogram (TTE) showed pseudoaneurysm of the mitral valve anterior leaflet with 4+ regurgitation and aortic metallic prosthesis without dysfunction, but transesophageal echocardiogram (TEE) disclosed periprosthetic abscess. Empirical ATB was started until blood cultures yielded *S. Agalactiae*. After 3 weeks with ceftriaxone, patient persisted sub febrile, high CRP, pulmonary congestion and a new TEE showed mobile aortic prosthesis, fistula and periaortic regurgitation 4+. Urgent surgery was carried out at the same day for abscess drainage and replacement of prosthetic valve by biological aortic prosthesis but without mitral valve approach. Immediate PO underwent with hemodynamic instability, prolonged mechanical ventilation, pleural empyema, acute renal failure requiring dialysis and persistence of fever. Two weeks after surgery, TTE demonstrated new periprosthetic abscess with multiple collections along the ascending aorta. Reassessed by heart team and reoperation was contraindicated due to poor clinical conditions. Patient received parenteral broad-spectrum antibiotic evolving with clinical stabilization, normalization of inflammatory tests becoming afebrile. Aortic angiogram in Aug/18 showed a periaortic collection of 3.0X2.0X1.9cm and contrast extravasation. New TEE in Aug/18 showed periprosthetic abscess and discrete aortic-right atrium fistula (2+). Maintained ATB until D42, persisting afebrile, negative blood cultures, normal leucogram and CRP. Considered inoperable, he was discharged on Sep/18. After 30 days, patient was stable, negative blood cultures however with worsening ESR (2 -> 99mm/h) and CRP (0.5 -> 15mg/dl). He performed ETT and 18F-FDG PET/CT on Nov/18 with persistence of abscess, fistula and high increase 18F-FDG uptake. Heart team again opted for prolonged oral ATB with amoxicillin 3.0gr/day. Re-evaluated on Dec/18 with laboratory normalization and good clinical evolution until last appointment on April/19 under oral antibiotic.

Conclusion: Reoperation of PVE improves prognosis, however in some cases where surgical risk is prohibitive, prolonged ATB may be the only option to control infection or as a bridge for eventual heart transplantation.

Abstract 1646 Figure.

