Abstract: **P629**

An uncommon cause for a frequent problem

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Topic(s):
Echocardiography: Masses and Sources of Emboli

Citation:

Introduction
Libman-Sacks endocarditis is the most characteristic cardiac manifestation of the autoimmune disease systemic lupus erythematosus. Embolic phenomena, although uncommon, can also complicate valvular abnormalities and can cause neurologic and systemic complications.

Case Report

Man, 52 years old. Active smoker and with previous peptic ulcer history. Admitted to our emergency department due to sudden onset of confusion and incoherent speech. The physical examination showed only a Glasgow Coma Scale of 9 and the presence of expressive aphasia. Normal pulmonary and cardiac auscultation, without any other pathological findings on physical examination.

Investigations showed a normal EKG, chest X-Ray and arterial-blood gas test. Blood test showed only the presence of thrombocytopenia, leucocytosis and renal disfunction. Brain CT revealed left-sided thalamic lacunar lesion. We assumed an ischemic stroke and admitted the patient in our emergency department. Neurological deterioration in the first 24h. A new brain CT was performed and showed multiple lesions in the middle cerebral artery territory. The echocardiogram was performed and showed the presence of multiples vegetations in both mitral leaflets with moderate to severe mitral regurgitation associated. We assume an ischemic stroke in the context of possible infective endocarditis. Medical therapy was optimized and empirical antimicrobial therapy was started (ampicillin + gentamicin + flucoxacillin).

The patient never had fever during hospital stay. Duke criteria with only 1 major criteria. Persistent negative microbiological cultures with decreasing inflammatory parameters. Blood tests revealed a progressive increase level of INR (2-4) and renal function deterioration. Patient began with massive episodes of diarrhea and sudden decrease of haemoglobin level (sudden reduction of 3g/dl). Endoscopic studies were performed and multiple ischemic lesions of embolic etiology and small vessel disease had been described. Serology test revealed a positive IgG for Mycoplasma pneumoniae. Autoimmune lab tests showed positivity for lupus anticoagulant, antcardiolipin and anti–beta-2 glycoprotein I.

We discussed the clinical case with our autoimmune experts team and the diagnosis of Systemic Lupus Erythematosus + Antiphospholipid Syndrome + Libman-Sacks Endocarditis was assumed. The patient started immunosuppressive therapy (Azathioprine + Mycophenolate Mofetil + Prednisolone). Despite the used therapy the size of vegetation persisted and mitral regurgitation didn’t improve.

In this context, the patient was presented to our cardiac surgery team and underwent surgical intervention (vegetation removal + mitral valve repair). Evaluation one year after surgery revealed progressive functional and echocardiographic improvement.

Conclusion

The authors presented a didactic clinical case where valvular surgery was required thanks to a hemodynamically significant valvular dysfunction and embolic events.
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