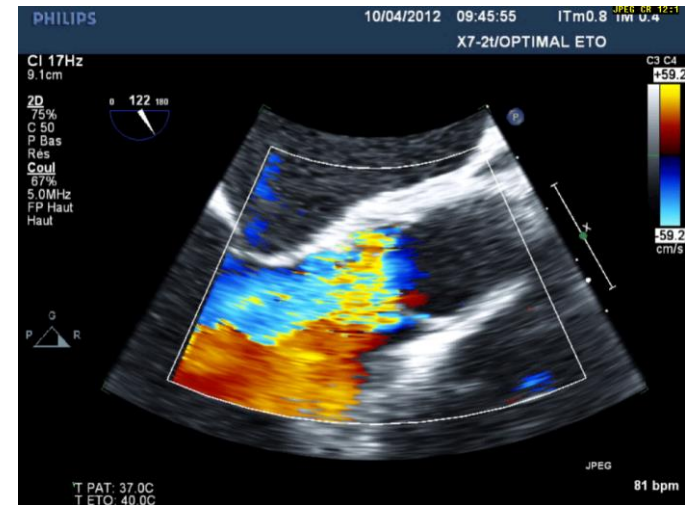
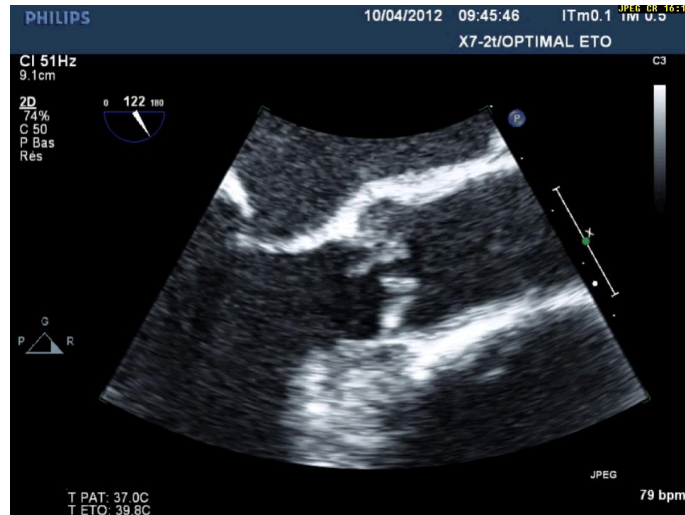


# Eurovalves

- Patient 40 years old, admitted for fever and cardiac murmur
- IV drug abuser
- Transesophageal echocardiography : aortic regurgitation, vegetation.
- Body CT scan: ischemic stroke, spleen infarction, kidney infarction
- WBC: 15000, blood culture: staphylococcus lugdunensis
- Normal renal function
- During in hospital course the patient had an acute chest pain
  - High level of CPK and the S-T elevation in leads D2, D3, AVF
  - EKG becomes normal in a few hours following the chest pain

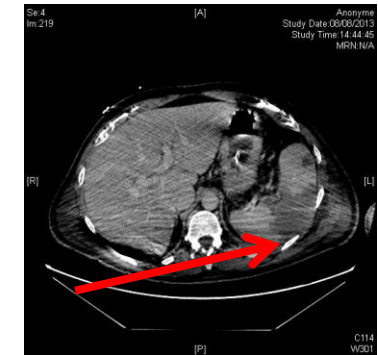
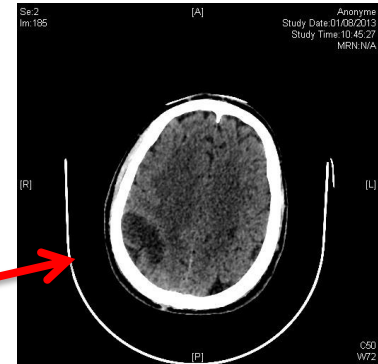
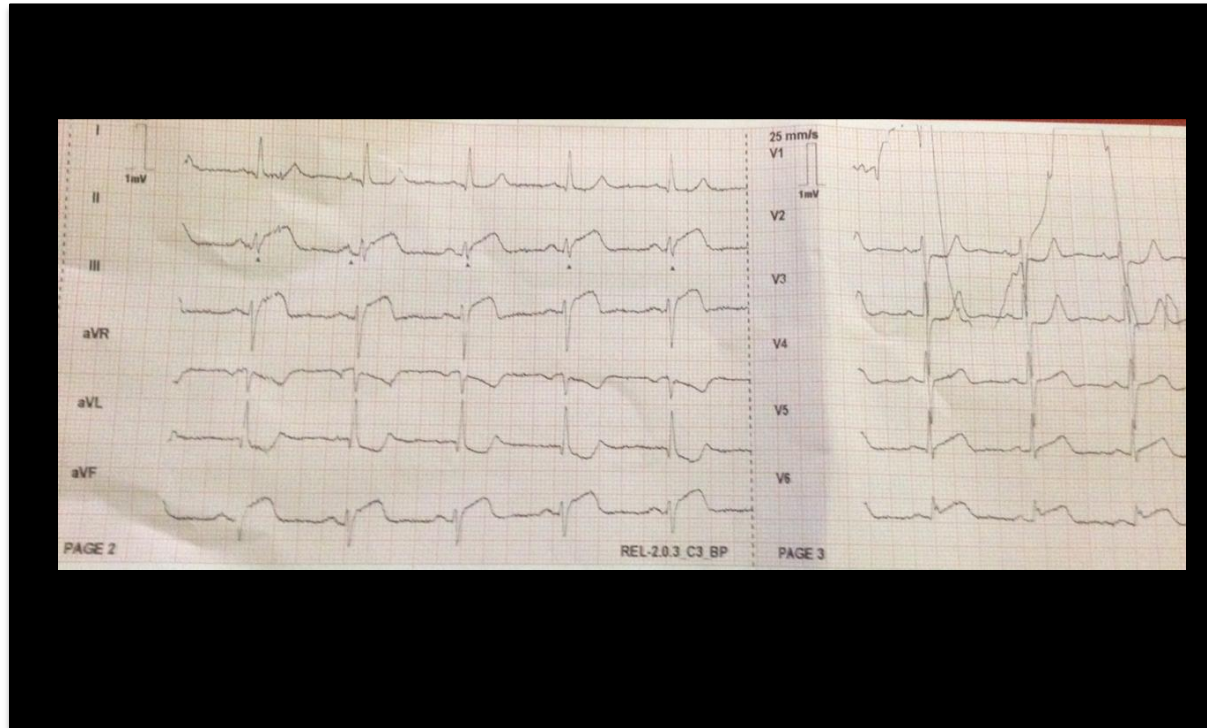
# Eurovalves



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November 2013

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# Eurovalves



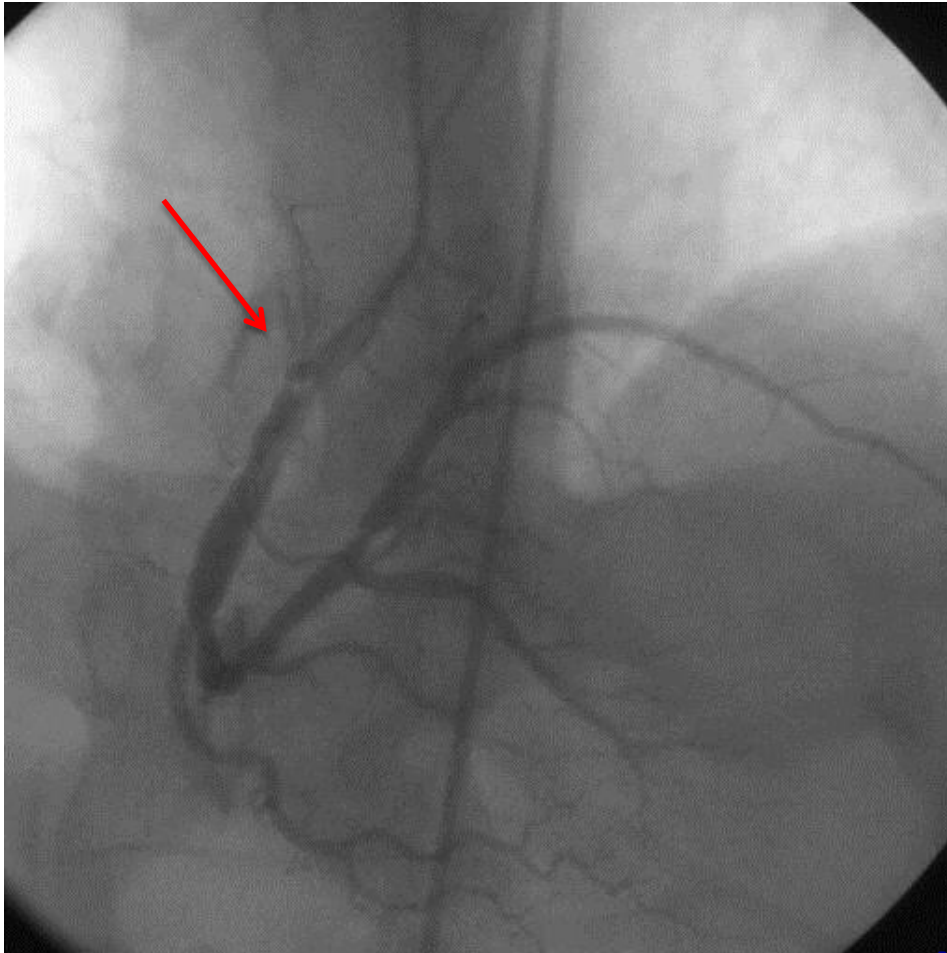
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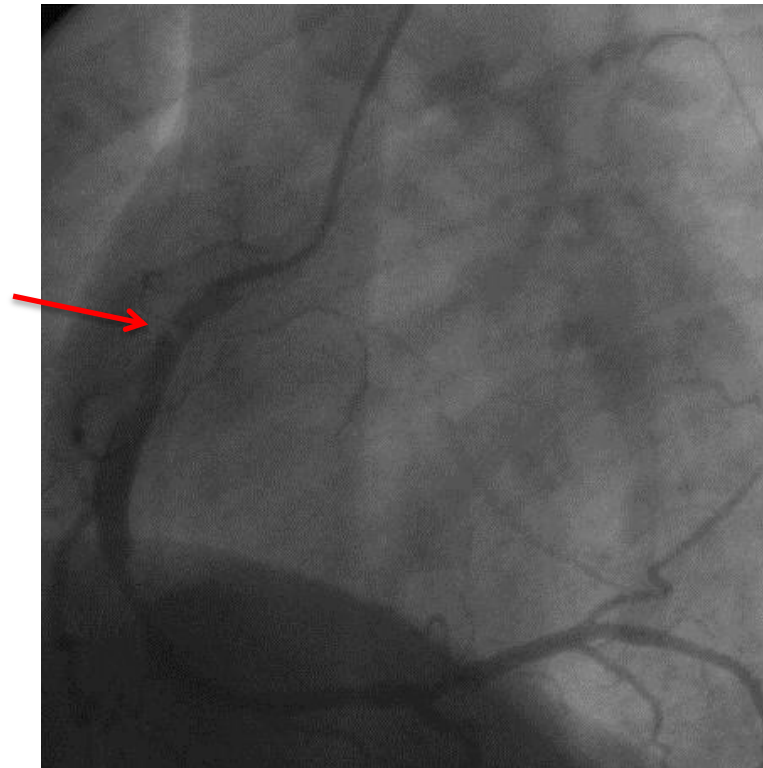
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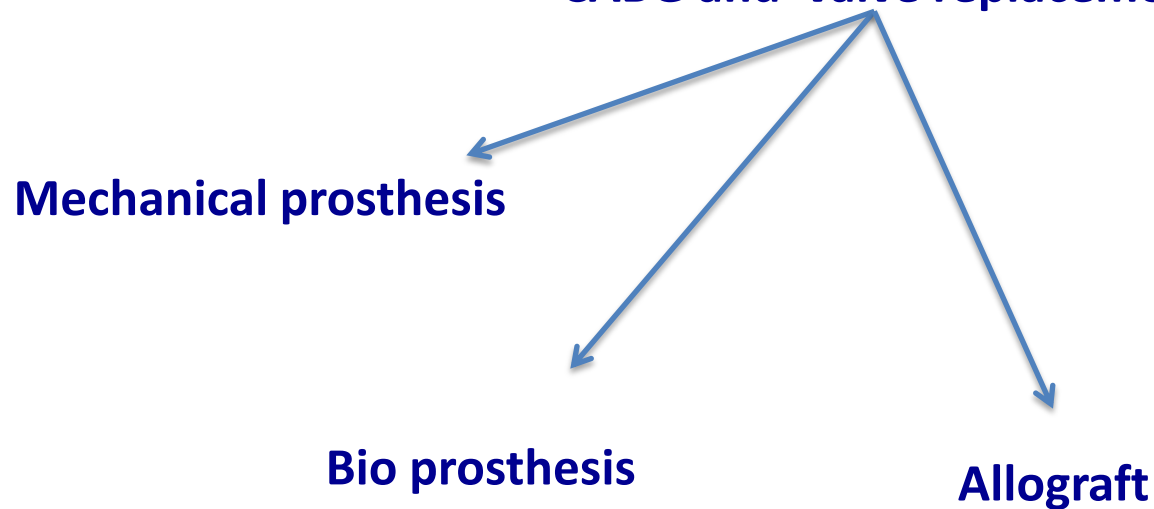
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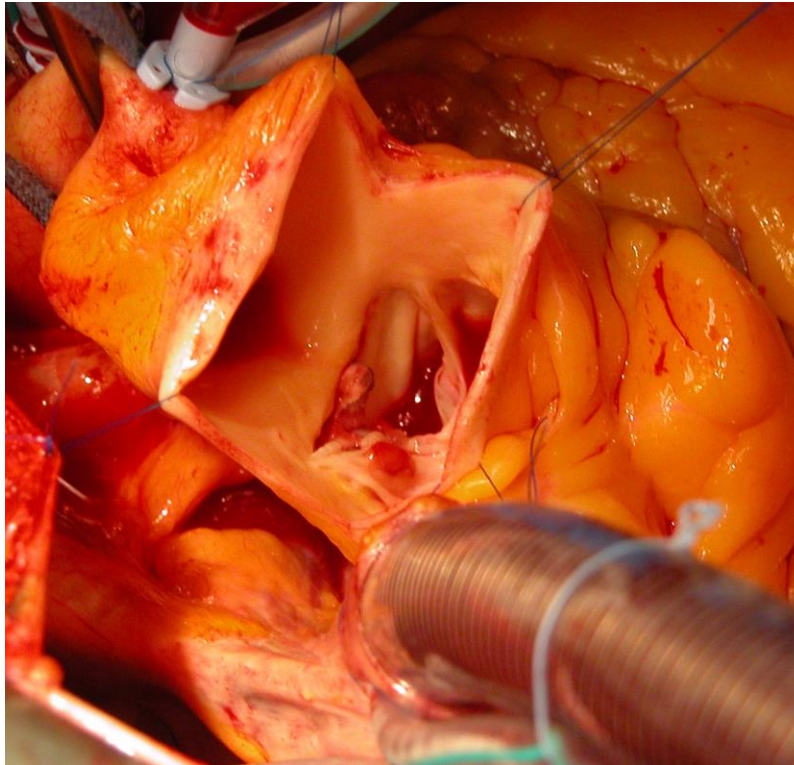
# Eurovalves

- **What must be done:**

- PTA and valve replacement
- CABG and valve replacement



# Eurovalves



**Aortic valve replacement  
With a bioprosthesis  
CABG right coronary artery**

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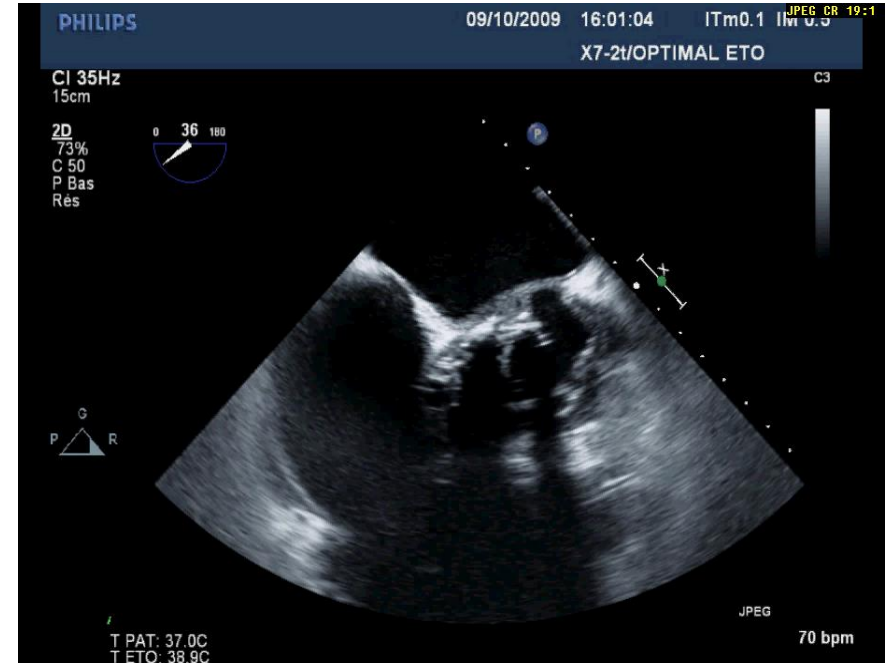
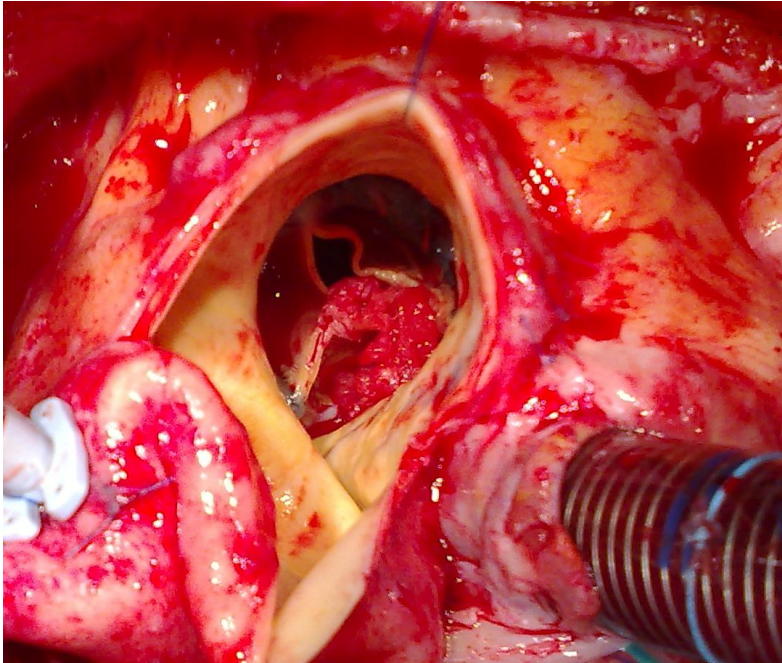
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# Eurovalves

- **Uneventful follow-up**
- **Discharged 30 days after the intervention**
- **Followed in the department of infectious disease and cardiology**
- **Fourteen month later re admitted for asthenia and fever**
- **Blood culture: staphylococcus aureus**
- **WBC: 17000**

# Eurovalves



**Replacement of the aortic root with an allograft**

**ICU stay 11 days**

**Discharged at 37 day**

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# Eurovalves

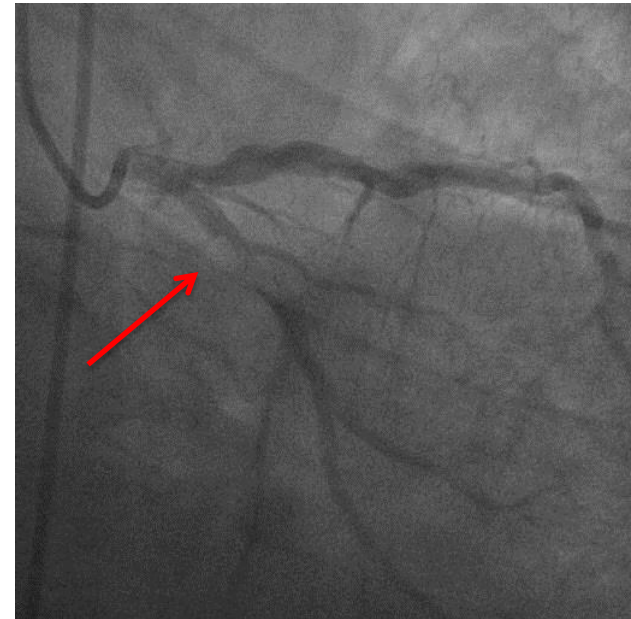
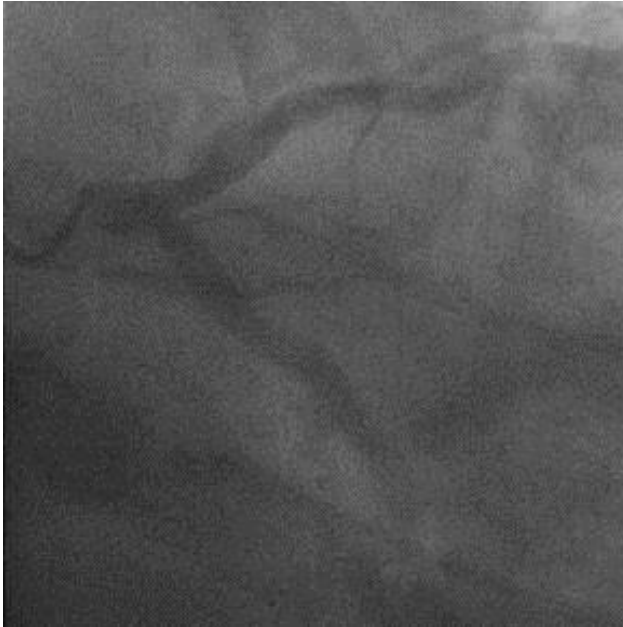


**Patient followed in the department of  
cardiology  
(follow-up 8 years)**

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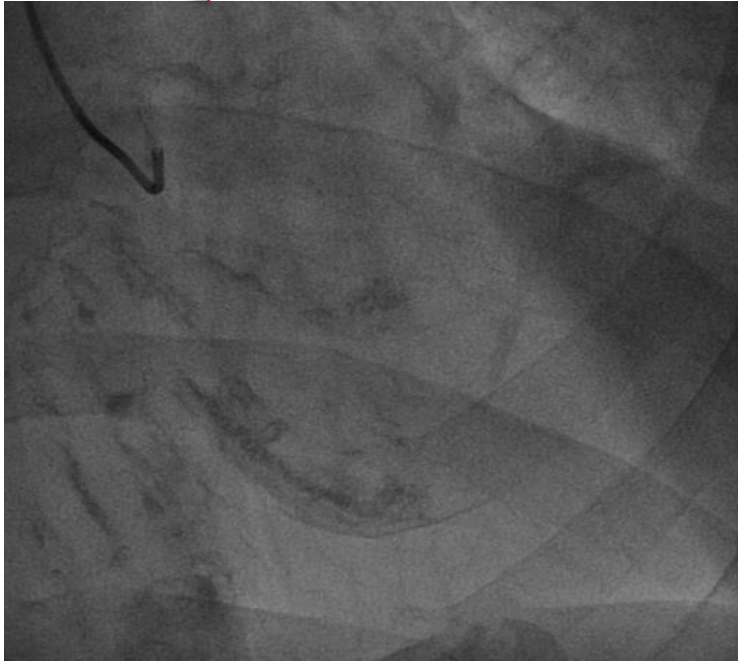
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# Eurovalves



**Among 1210 patients treated for endocarditis 26 had a coronary event (2.2%)  
23 due to embolism (88.4%)  
18/26 (69%) IE native aortic Valve  $p= 0.0001$   
4/26 (15%) PVE 15%  $p=< 0.01$**

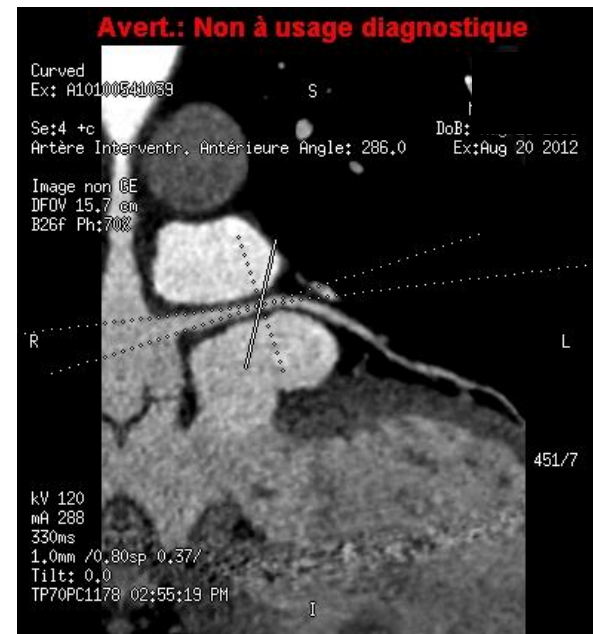
# Eurovalves



**3/26 (11.6%) due to a compression of the  
Coronary arteries**

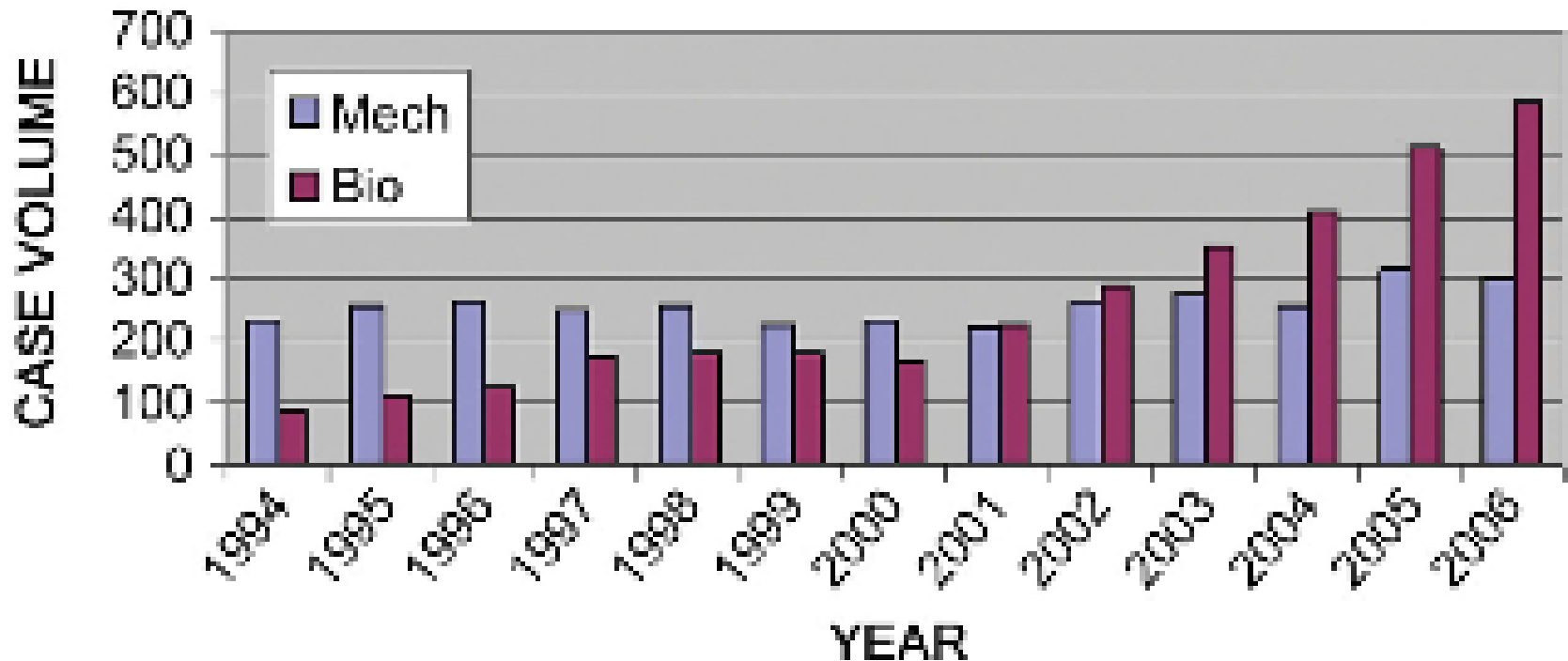
**Mortality endocarditis 11%**

**Mortality endocarditis with coronary event 27%**



# Eurovalves

- Mechanical valves (blue bars) biological valves (purple bars) for aortic endocarditis STS national data base 2007



# Eurovalves

## **Surgical Management of Endocarditis: The Society of Thoracic Surgeons Clinical Practice Guideline**

John G. Byrne, MD, Katayoun Rezai, MD, Juan A. Sanchez, MD, MPA,  
Richard A. Bernstein, MD, PhD, Eric Okum, MD, Marzia Leacche, MD,  
Jorge M. Balaguer, MD, Shyam Prabhakaran, MD, MS, Charles R. Bridges, MD, ScD,  
and Robert S. D. Higgins, MD, MSHA

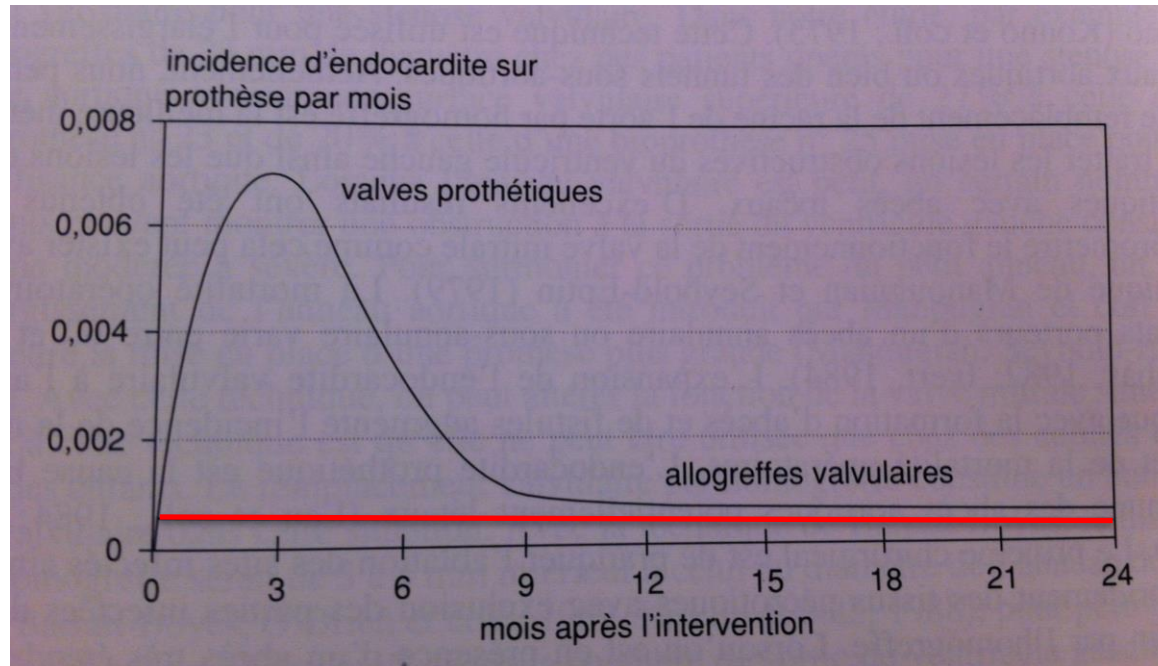
*Ann Thorac Surg*  
2011;91:2012-9

### **II) Aortic Valve Endocarditis**

#### **A) Native aortic valve endocarditis**

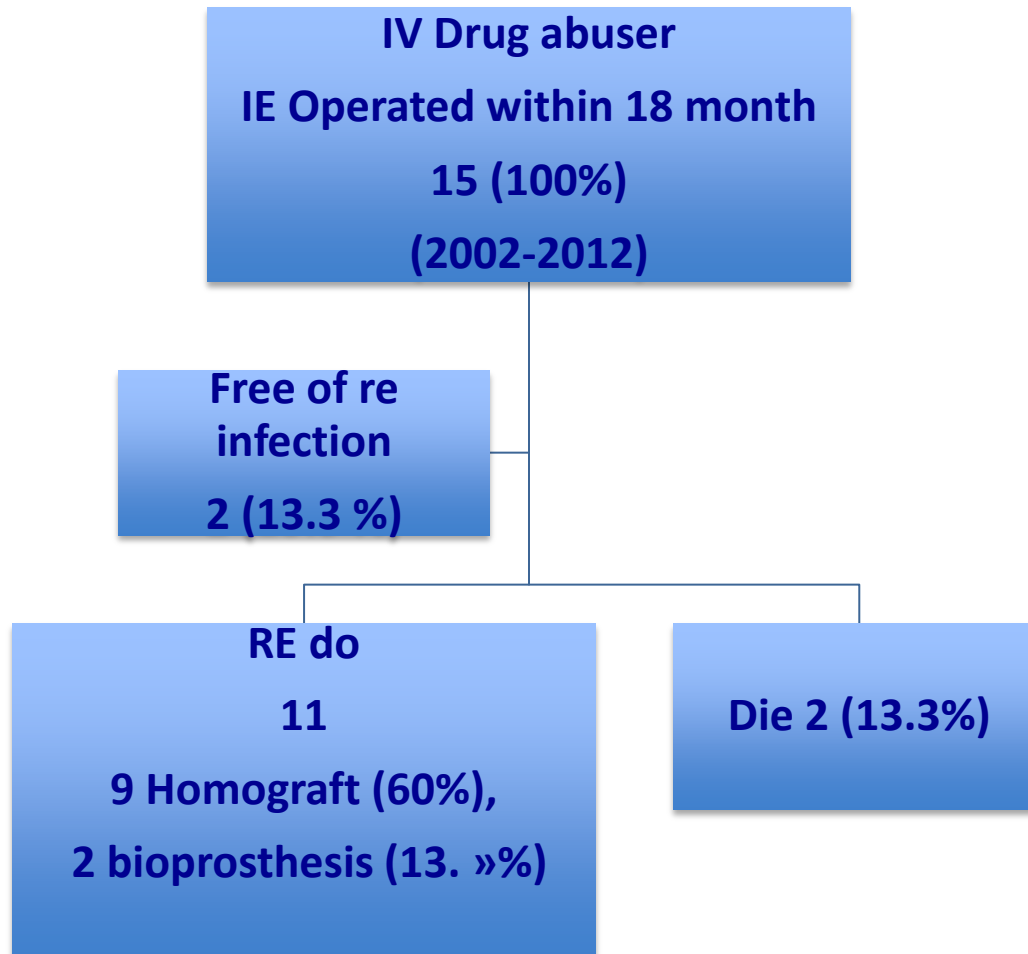
1. When surgery is indicated, a mechanical or stented tissue valve is reasonable in native aortic valve endocarditis if the infection is limited to the native aortic valve or to the aortic annulus. Valve choice should be based on age, life expectancy, comorbidities, and compliance with anticoagulation. (Class IIa, Level of evidence B)
2. A homograft may be considered in native aortic valve endocarditis when the infection is limited to the native aortic valve or to the aortic annulus. (Class IIb, Level of evidence B)

# Eurovalves





# Eurovalves



# **Eurovalves**

## **Conclusion 1:**

**Coronary embolism is a rare and life threatening complication**

**Approach for diagnosis and treatment have to be adapted in each case**

**More studies are necessary to standardize diagnosis and treatment**

## **Conclusion 2**

**The aortic valve replacement is a safe treatment in aortic endocarditis without perivalvular extension, when surgery is necessary**

**Homoggraf may be considered in patient with high risk of re infection**