

中文題目：隨脈搏窒息式地壓迫—心內膜炎致命性的併發症

英文題目：Pulsatile strangulating to the aorta---A fatal complication of infective endocarditis

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Case

A 76 year-old man presented to the emergency room exhibiting fever. He received a bioprosthetic aortic valve replacement for severe aortic regurgitation one year ago. After admission, the blood cultures yielded persistent *Corynebacterium striatum*. For his high risk of infective endocarditis, prompt transthoracic echocardiography was performed and revealed preserved function of the prosthetic valve with no vegetations. Though transesophageal echocardiography was recommended, the patients declined at that time. Post four weeks of adequate antibiotic therapy of Daptomycin, however, progressive dyspnea developed. Surprisingly, the subsequent transthoracic echocardiography indicated one newly developed false lumen surrounding the aortic valve (Panel A). It dynamically compressed the aortic root, resulting in a severe regurgitation. Furthermore, transesophageal echocardiography evidenced that the false lumen was directly connected to the left ventricle. The outward flow in systole caused pulsatile compressions to the aorta. Also, fluttering vegetations and septums were observed within (Panel B). The findings of a three dimensional echocardiography and computed tomography were compatible with the diagnosis of aortic pseudoaneurysm (Panel C, D). Unfortunately, even with prompt surgery, the patient did not survive.

Corynebacterium striatum has rarely been reported to be a pathogen and usually happened in immunocompromised or anatomically altered patients.¹⁻² According to previous literature, only few cases of *Corynebacterium striatum* endocarditis were reported.²⁻³ It presented in a subacute manner and the initially screening was usually

negative.²⁻³ Different from this patient developing to a pseudoaneurysm, most of this early endocarditis on a prosthetic aortic valve was successfully treated medically. This case emphasized the importance of persistent screening for endocarditis in the presence of prosthetic valves even though the pathogens were regarded to be atypical and minor. Through representing this case, we would like to shed light to the importance of persistent screening for endocarditis in the presence of prosthetic valves even though the pathogens were regarded to be atypical and minor.

Disclosure

Non

References

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Figure legend

Figure 1. (A) the transthoracic echocardiography representing pulsatile compressions of the false lumen (B) fluttering vegetations noted within the false lumen (white arrow) (C) three dimensional echocardiography indicating the false lumen surrounding the aortic root (black arrow) (D) the aortic pseudoaneurysm exhibited by computed tomography

