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Valvular emergency due to infective endocarditis: a case report

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Introduction: Acute valvular emergencies account for approximately 8% of coronary care unit admissions[1]. Because of its high mortality rate and potential complications, endocarditis is a complex, life-threatening condition if not recognized promptly.

Case report: 48-year-old patient was admitted on 29 May 2026 to the Department of Cardiovascular Diseases with suspected prosthetic aortic valve endocarditis after an arranged transfer from another institution. Four days earlier, the patient had been hospitalized in the Department of Neurology at that institution because of fever accompanied by weakness of the right extremities. Brain CT showed intracerebral hemorrhages with edema of the left cerebral hemisphere, along with supratherapeutic warfarin anticoagulation. *Streptococcus viridans* was isolated from blood cultures. Immediately after admission to our department, urgent transthoracic and transesophageal echocardiography were performed. Echocardiography showed a dilated left ventricle with thickened walls, a hypokinetic interventricular septum, and mildly reduced global systolic function (LVEF 45%), with moderate-to-severe mitral and tricuspid regurgitation. The prosthetic aortic valve was properly positioned, but three rounded cavities that could correspond to abscess cavities were described between the prosthesis and the mitral valve, and a 6-mm rod-shaped mass was visualized on the valve itself. The tip of the anterior mitral leaflet was thickened and hypermobile, resulting in severe mitral regurgitation. Two weeks later, the patient was transferred again to the Department of Cardiovascular Diseases at UHC Osijek for re-evaluation. Repeat TEE and follow-up brain MRI were performed, after which the patient was transferred to the Department of Cardiac Surgery for surgical treatment of aortic and mitral valve endocarditis. On the third day of hospitalization in the Department of Cardiac Surgery, he underwent surgery and was extubated 24 hours later in a hemodynamically stable condition. On postoperative day 5, the patient was transferred from the ICU to the ward, without cardiac symptoms and performed breathing exercises with the help of medical staff. He was discharged home on day 10 with oral and written instructions regarding his further care.

Conclusion: Postoperative care included antimicrobial therapy, and he was advised to continue antibiotic prophylaxis for at-risk dental and invasive procedures, in accordance with current guideline recommendations. This underscores the need for ongoing monitoring and adherence to long-term management strategies to reduce risk of reinfection. The successful outcome in this case shows the importance of a coordinated multidisciplinary approach to treating complex cardiovascular conditions and ensuring appropriate recovery.

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LITERATURE

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