A Challenging Case of Acute Limb Ischemia Complicating an Endocarditis: Case Report in Mohamed VI University Hospital
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Abstract

Infective endocarditis (IE) occurs at a rate of approximately 25-50/1000000 people per year in patients with a preexisting cardiac pathology in 2/3 of the cases. Despite the therapeutic advances, and the development of new surgical approaches, the morbidity and mortality related to infectious endocarditis remains high. The epidemiological profile of infective endocarditis has changed considerably in recent decades in Morocco. Despite the efforts made to eradicate rheumatoid arthritis, rheumatic valve disease remains a public health problem in our context. Antibiotic therapy is the cornerstone of the treatment of endocarditis. However, some dreadful complications can occur, even with undergoing antibiotic therapy. Systemic embolism is one of them and occurs in 22%–50% of IE patients; emboli may involve major arteries, mostly affecting the central nervous system as well as other organs. However, peripheral arterial embolism that result from bacterial endocarditis may be silent or catastrophic. The present report presents an unusual case of infectious endocarditis complicated with peripheral arterial embolism of the common femoral artery and acute lower limb ischemia. The patient underwent urgent Fogarty embolectomy and a delayed surgical procedure for mitral valve replacement and tricuspid valve repair. Proper emergency management is discussed and conclusions are made regarding indications of conservative and invasive treatment.

Keywords: Infective endocarditis, acute limb ischemia, Fogarty embolectomy, mitral valve replacement.

INTRODUCTION

Infective endocarditis (IE) occurs at a rate of approximately 25-50/1000000 people per year in patients with a preexisting cardiac pathology in 2/3 of the cases. Despite the therapeutic advances, and the development of new surgical approaches, the morbidity and mortality related to infectious endocarditis remains high. The epidemiological profile of infective endocarditis has changed considerably in recent decades in Morocco. Despite the efforts made to eradicate rheumatoid arthritis, rheumatic valve disease remains a public health problem in our context. Antibiotic therapy is the cornerstone of the treatment of endocarditis. However, some dreadful complications can occur, even with undergoing antibiotic therapy. Systemic embolism is one of them and occurs in 22%–50% of IE patients; emboli may involve major arteries, mostly affecting the central nervous system as well as other organs. However, peripheral arterial embolism that result from bacterial endocarditis may be silent or catastrophic.

CASE REPORT

A 62-year-old patient was admitted to the cardiology department for the management of infectious endocarditis diagnosed by modified Duke criteria:

- 21 *12 mm vegetation on the atrial leaflet of the mitral valve with mitral stenosis (Fig-1).
- Positive blood cultures with staphylococcus aureus (Fig-2).
- Prolonged fever (39° during 1 month)
- Polyarthritis
- CRP at 160 mg/l, ESR= 110 mm, WC: 12000 cell/mm3

The patient fever subsided after treatment with antibiotics was initiated (2g of ceftriaxone and 160 mg of gentamycin); However, the patient presented on the 10th day of hospitalization an acute pain, coldness, paresis and pallor of the right lower limb. We immediately performed an arterial doppler ultrasound of the right iliofemoral artery that showed a thromboembolic occlusion of the right iliofemoral artery (Fig-3).
The patient immediately underwent a revascularization with 4F Fogarty catheter. A long thrombus molding the ilio femoral axis was removed (Fig-4).

We performed a doppler ultrasound after the revascularization that showed normal flow in both lower limbs arteries (Fig-5).

The patient underwent a mitral valve replacement with tricuspid plasty in his second week of hospitalization.
DISCUSSION

Acute Limb ischemia is a rare complication of infectious endocarditis [1]. This case report presents an infectious endocarditis caused by Staphylococcus aureus complicated with acute right lower limb ischemia.

After the management of acute lower limb ischemia with revascularization with Fogarty catheter, we opted for surgical treatment by performing a mitral valve replacement and tricuspid valve plasty.

Vascular complications of infectious endocarditis are frequent [2, 3]. Peripheric emboly, including cerebral strokes [4, 5], myocardial infarction [6] and pulmonary embolism [7] have been reported in case of infectious endocarditis. However, lower limbs thromboembolis are rare with incidence of 4%–5% in patients with native valve endocarditis [8, 9].

The general approach for an effective management of IE is initial clinical stabilization, early acquisition of blood cultures, an aggressive medical and/or surgical treatment [10]. Antibiotic treatment depends on whether the valve is native or prosthetic, as well as on the identified microorganism and its antibiotic sensitivity. After diagnosing endocarditis according to modified Duke criteria, an empirical antibiotic treatment was started (Ceftriaxon 2g and gentamycin 160 mg).

Valve replacement is suggested in patients with multiple or recurrent embolic events [11]. Early surgery may be recommended for patients with vegetations >15 mm with high mobility, important valve destruction, heart failure and non-response to antibiotic therapy [12].

CONCLUSION

Our case report shows an uncommon case of infectious endocarditis complicated with peripheral embolism of the common femoral artery and acute lower limb ischemia. Aggressive antibiotic therapy associated to Fogarty embolectomy and a delayed surgery for mitral valve replacement with tricuspid plasty have led to good clinical and biological outcomes.

REFERENCES