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PERSISTENT FEVER- IN SEARCH OF A CAUSE

Pulmonary Medicine

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ABSTRACT

Infective endocardities caused by Acinetobacter is rare but severe complications that affects seriously ill hospitalised patients. Infective endocardities has a high mortality rate, even with appropriate antibiotic therapy and surgical intervention. This is a case of elderly male who was presented with chronic left foot ulcer and was diagnosed as tricuspid valve infective endocardities due to Acinetobacter.

KEYWORDS

INTRODUCTION:

Infective endocardities is a multisystem disease that results from infection, usually bacterial, of the endocardial surface o the heart[1].

Infective endocardities are affected >50 years and two third cases occurs in males[2].

Mitral valve was the most common site involved.[3] Rheumatic heart disease, remains the most common predisposing cardiac condition for infective endocardities.[4]

Prosthetic valves and cardiac devices are significant factors for infective endocardities[5].

Case Discription:

A 55 male non smoker, non alcoholic, mason worker , admitted in local hospital with history of left foot ulcer with pus discharge and edema of both lower limb since 2 months. Treated with IV antibiotics and supportive measures. patient referred to MCHK in view of thrombocytopenia and deranged RFT and LFT.

Patient initially extensively evaluated in medicine department. Treated with IV antibiotics and supportive measures. Platelet and FFP transfusion done. RFT and LFT resolved. patient generally condition improved. after 1 week, patient developed intermittent high grade fever, dyspnoea, right sided chest pain.cxr taken –wedge shaped right lower lobe consolidation. patient referred to respiratory medicine. Differential diagnosis as-hospitalacquired pneumonia, pulmonary embolism.investigations:hb-10.3,tc- 18000, dc- p92,l6, platelet-1.7lac, ur/cr-32/1.3, ot/pt-42/21, alp-120, CRP-24, RT PCR-negative, URE-normal, URINE C&S-negative, sputum gram stain, AFB,C&S –negative, pus culture from wound – klebsiella, sensitive to : CEF+SB. Treated with iv antibiotics and supportive measures. D DIMER is high. lower limb venous doppler –no evidence of DVT. CTPA taken –s/o bilateral cavitating lesion suggestive of septic emboli. Left sided pleural effusion. echo done – 22*8 cm mobile mass attached to septal tricuspid leaflet s/o tricuspid valve infective endocardities. Started on in vancomycin and inj. Amikacin. Patient had fever, mean while blood culture was reported as ACINETOBACTER. sensitive to MEROPENAM. Started with inj. Meropenam and other supportive measures..fever subsided patient general condition improved. follow up cxr shows no new changes.

DISCUSSION:

Persistent fever with new cavitating lesion first we should suspect Infective Endocardities.

Most common microbe associated was staphylococuss aures. I Increasing incidence due to indwelling venous catheters and iv drug use. radiology characterised by unilateral or bilateral migratory shadows and sub pleural nodular infilterations with varying stages of cavitation with a basal predominance.

Can be missed in routine screening and routine echo. Can be diagnosed with blood culture and detailed echo.

Tricuspid valve infective endocardities was rare .this 55 year male admitted with left foot ulcer with pus discharge. CTPA shows bilateral cavitating lesion s/o septic emboli. echo shows tricuspid valve infective endocardities. Blood culture shows Acinetobacter.

Acinetobacter causing Tricuspid Valve Infective Endocardities is rare.

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