

Splenic abscess associated with infective endocarditis; Case series



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Splenic abscess is a well-described but rare complication of infective endocarditis. Rapid diagnosis and treatment are essential as its course can be fatal. We present three case reports that describe the management of splenic abscesses in patients initially diagnosed with infective endocarditis. In all cases, the diagnosis was based on the findings of abdominal computed tomography (CT) scan or magnetic resonance imaging (MRI). In two of the cases, splenectomy was performed before valve surgery; while in the third case, the spleen was removed after cardiac surgery. All three patients recovered fully, with satisfactory follow-up as outpatients. Immediate splenectomy, combined with appropriate antibiotics and valve replacement surgery alongside multi-disciplinary team work could be the treatment of choice in this clinical scenario.

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Introduction

Splenic abscess is a well reported but rare complication in infective endocarditis. Splenic infarction is a more common and usually benign condition. It is estimated that approximately 5% of patients with splenic infarction will develop splenic abscesses [1–3].

We report the cases of three patients who presented with splenic abscesses secondary to infective endocarditis with evidence of sepsis, vegetation, and positive blood cultures. Those cases were referred to our center and operated on during the first half of 2014. The course of the disease in all three cases was variable but all were, at the very least, either very severe or critical.

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Case descriptions

Case 1

A 42-year-old female patient was transferred to our center after a diagnosis of infective endocarditis and septic embolization with multiple splenic abscesses for further workup. The patient presented initially with prolonged fever, shortness of breath, and debilitating symptoms. Her initial echocardiography revealed severe aortic regurgitation and vegetation attached to the left ventricular outflow tract just below the aortic valve. Her blood cultures were positive for enterococcus faecalis. She later developed septic embolization to the spleen, and was transferred to our center for further management.

Despite being septic, morbidly obese, and in heart failure, the patient maintained stable hemodynamics and normal oxygen saturation at room air. A clear, soft, early diastolic murmur on the aortic area and tender, left hypochondrium

were crucial findings by local examination. Other than being anemic with high Pro brain natriuretic peptides (Pro-BNP) indicating significant heart failure, her laboratory findings were unremarkable. Ultrasound and computed tomography (CT) scan of the abdomen confirmed the presence of three splenic lesions which could most likely be abscesses (Fig. 1A and B, respectively).

After evaluation and discussion by a multidisciplinary team comprising cardiac surgeons, cardiologists, general surgeons, and infectious disease specialists, the decision for a splenectomy was carried out, and the patient was returned to the coronary care unit (CCU) in a stable condition. Splenectomy specimen with pus was sent for pathology examination and culture and sensitivity tests.

After six weeks of antibiotics and medical optimization, we were able to perform coronary angiography on our patient. This revealed normal coronaries, and the patient subsequently

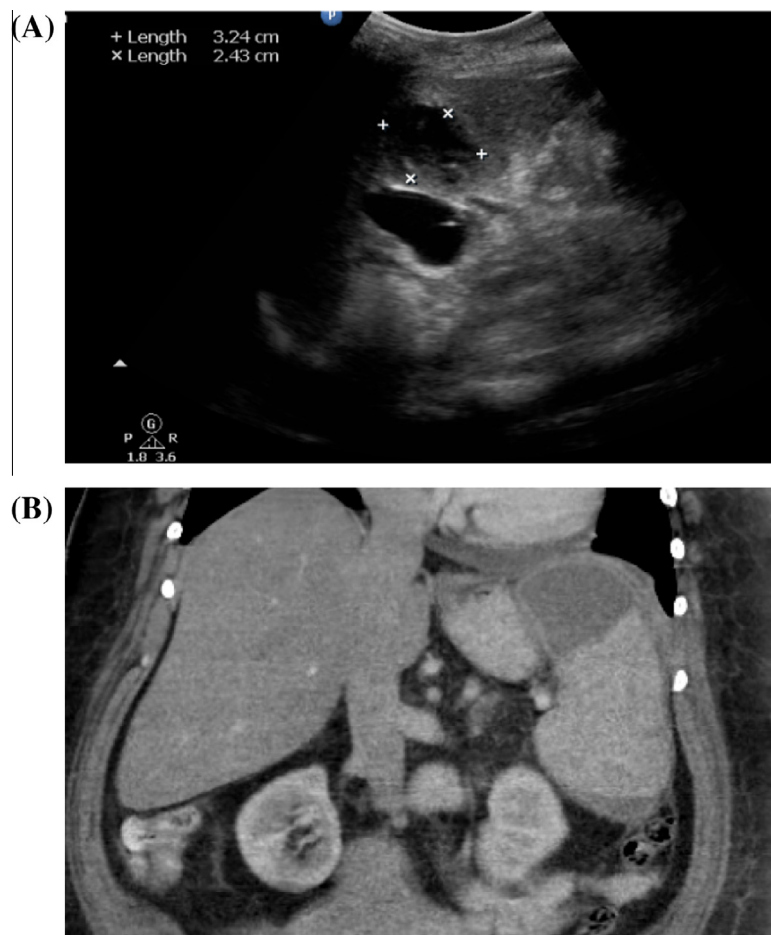


Figure 1. (A) Case 1: Ultrasound abdomen showing partially defined anechoic avascular cystic lesion in the spleen, measuring 3.2×2.4 cm, likely representing a splenic abscess. (B) Case 1: Computed tomography (CT) scan of the abdomen showing enlarged spleen with large splenic lesion, likely representing an abscess.

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