950841719
HLGMC
0357073
57762/7oq7
07/01/1993 12:00:00 AM
ACUTE POLYMICROBIAL BACTERIAL ENDOCARDITIS .
Unsigned
DIS
Report Status :
Unsigned
ADMISSION DATE :
07-01-93
DISCHARGE DATE :
07-26-93
DISCHARGED TO SOUTHOBASSKING'S VILLEMARG HOSPITAL .
PRINCIPAL DIAGNOSIS :
Acute polymicrobial bacterial endocarditis .
ASSOCIATED DIAGNOSES :
Ascending aortic dissection , cutaneous drug eruption , diarrhea , congestive he art failure , pulmonary edema , anuric renal failure , stroke , postoperative bl eeding , mitral regurgitation , history of rheumatic fever .
PRINCIPAL PROCEDURE :
7/21/93 - mitral valve replacement and replacement of ascending aorta .
OTHER PROCEDURES :
06/29/93 - white cell scan ; 07/03/93 - cardiac ultrasound ; 07/05/93 - brain ma gnetic resonance imaging study ; 07/05/93 - abdominal computerized tomography sc an ; 07-08-93 - cardiac ultrasound ; 07/07/93 - pelvic ultrasound ; 07/09/93 - b arium enema ; 7/14/93 - cardiac catheterization and coronary angiography ; 7/15/ 93 - cardiac ultrasound ; 7/21/93 - reopening of sternum ; 07/22/93 - mediastina l exploration .
HISTORY OF PRESENT ILLNESS :
This extremely complex 75 year old woman was admitted from an outside hospital w ith fever .
She was in her usual state of health until 6/15/93 when she began to experience intermittent confusion , diarrhea , and fevers up to 104 , associated with chill s .
There were transient mental status changes but no convulsions or loss of conscio usness .
She was also noted to have some diarrhea at this time .
Because of increasing mental status changes , the patient was admitted to O Cent er in Sondibrid Ey on 6/20 , and she was found to have a gram-positive urinary t ract infection , high fever , and was started on Ciprofloxacin .
Blood cultures drawn on admission showed multiple organisms including Clostridiu m perfringens , coagulase negative Staph , and alpha hemolytic Streptococcus .
Her antibiotics were appropriately changed .
At the family 's request , the patient was transferred to Heaonboburg Linpa ck Grant Medical Center for further evaluation .
HOSPITAL COURSE :
Further evaluation at Heaonboburg Linpack Grant Medical Center , demonstrated th at the patient had mitral valve endocarditis with mitral regurgitation that was initially managed medically .
Her antibiotics were appropriately adjusted because of the polymicrobial nature .
Cardiac echo showed that she had moderate mitral regurgitation , an enlarged lef t atrium , and good ventricular function .
There was a suggestion of mitral valve vegetation .
She was placed on intravenous antibiotics with gradual decrease in her temperatu re , although some low grade temperatures initially persisted .
The patient had an extensive evaluation over the days that followed in order to find potential sources .

She was evaluated by the Gynecology Service including the performance of a pelvi
c ultrasound and also by the GI Service where she underwent a barium enema .
There was no evidence of GI or pelvic disease which would account for the bacter
ial source .
In addition , she was evaluated by the Sileyer Medical Center and there was no e
vidence of active dental infection .
She had a cerebral magnetic resonance imaging study performed and there was evid
ence of stroke .
Because of her complex picture , and because the source of her sepsis was not fo
und , the initial plan was to treat with antibiotics and hopefully obtain a comp
letely sterile surgical field for subsequent valve replacement , if indicated .
Her temperature became low grade and it was initially stable with her mitral reg
urgitation .
Towards the end of June , she had become afebrile and the initial plan was to co
mplete a full course of antibiotics to obtain a sterile surgical field .
A rash developed and antibiotics were appropriately changed and antibiotic level
s were optimized .
On 7/13 , she developed a sudden episode of pulmonary edema that resolved quickl
y and she was thought to have possible worsening of her mitral regurgitation .
She was moved to the Intensive Care Unit and underwent subsequent cardiac cathet
erization in preparation for possible surgery .
Her cardiac catheterization demonstrated minor coronary artery disease and sever
e mitral regurgitation with a suggestion of an annular abscess .
After considerable discussion among the physicians involved in the patient &apos
;s care , it had become apparent that the mitral regurgitation had worsened .
Also , no source for sepsis had been found .
Because of worsening mitral regurgitation , and the findings of severe mitral re
gurgitation at cardiac catheterization , as well as elevated filling pressures ,
 it was everyone 's opinion that the patient would not wait to complete a l
ong course of antibiotics .
Accordingly , she was taken to the operating room on 7/21/93 .
During her cardiac procedure , she sustained dissection of the ascending aorta .

She , therefore , underwent graft replacement of her ascending aorta and mitral
valve replacement .
Her valve was excised and any material that appeared infected was debrided .
It was possible to clean the area thoroughly and it also became apparent that th
ere was evidence of calcification in and around the annulus consistent with prio
r rheumatic fever .
Her valve was replaced with a St. Jude Medical mitral prosthesis and it was poss
ible to place the valve securely .
She weaned from cardiopulmonary bypass with hemodynamics consistent with extreme
 vasodilation , and she required enormous doses of vasoconstrictors to maintain
her blood pressure .
She was bleeding after operation with her picture also consistent with coagulopa
thy , and the overall picture suggested the effects of systemic sepsis .
In the early postoperative period , she had evidence of tamponade , possibly rel
ated to compression from her lungs , as the patient was noted to have elevated i
nspiratory pressures on the ventilator .
The sternum was reopened with improvement in her hemodynamics and additional sta
bility .
She was returned to the operating room on 07/22 and underwent mediastinal explor
ation , removal of some mediastinal clot , and by now , hemostasis had improved
.
Her sternum was left opened and the skin wound was left opened , using an elasti
c membrane to close the chest .
With clotting factor replacement , bleeding gradually abated and was no longer a
 problem .
She subsequently developed ongoing manifestations of sepsis with sustained vasod
ilation and developed anuric renal failure which required peritoneal dialysis .

She remained on full support in the Intensive Care Unit , on dialysis , with ong oing evidence of acidosis .
Despite full support on multiple , high dose inotropic and vasoconstrictor agent s , her clinical status continued to deteriorate and it became apparent that her prognosis was extremely poor .
After consultation with the family , it was decided to not resuscitate her and , with continued deterioration , she expired on 07/26/93 at 11:10 a.m.
Autopsy permission was granted .
RIEMUND C. GRAFT , M.D.
TR :
qt / bmot
DD :
07-26-93
TD :
07/27/93
CC :
Collea Douetscarv , M.D.
Gittetumn Darnnaman Graft , M.D.
Asha Vengloan , M.D.
Bulon Vitro , M.D.
Hypor Vikays , M.D.
Lanette Sc , M.D.
Lupevickette L. Ca , M.D.
[report_end]