CASE REPORT

Community acquired staphylococcal pulmonary valve endocarditis in non-drug users: case report and review of the literature

J J Edmond, S J Eykyn, L D R Smith

Abstract
Right sided endocarditis usually involves the tricuspid valve, predominantly in intravenous drug users. It is also occasionally acquired in hospital as a result of contaminated intravascular devices. Isolated infection of the pulmonary valve is rarely seen. A case of community acquired Staphylococcus aureus pulmonary valve endocarditis that caused diagnostic confusion is reported. This infection occurred in a patient with no history of intravenous drug abuse and a previously structurally normal heart.

Keywords: Staphylococcus aureus; pulmonary valve; endocarditis

Right sided endocarditis usually involves the tricuspid valve, and occurs predominantly in intravenous drug users, although occasionally it is acquired in hospital from contaminated intravascular devices. Isolated infection of the pulmonary valve is rarely seen. We describe a patient with community acquired pulmonary valve endocarditis on a structurally normal valve caused by Staphylococcus aureus. The patient had no previous history of intravenous drug use and the infection caused diagnostic confusion. We review the previous reported cases of this rare condition.

Case report
A 40 year old previously healthy man was admitted to hospital with one week's history of general lethargy and myalgia with rigors, diarrhoea, and anorexia. His general practitioner had treated him with erythromycin, as he returned to hospital with rigors, fever, nausea, and vomiting. CRP was 63 mg/l and he was discharged home with oral antibiotics for a further week. Within 10 days of finishing the oral antibiotics he returned to hospital with rigors, fever, nausea, and vomiting. CRP was 63 mg/l and white blood cell count 8.7 × 10^9/l; blood cultures were taken and intravenous cefotaxime, flucloxacillin, and gentamicin were given. All bottles of three sets of blood cultures grew S aureus sensitive to flucloxacillin; therefore, cefotaxime and gentamicin were stopped. Four days after admission an early diastolic murmur was heard in the left parasternal region and a transthoracic echocardiogram showed large vegetations on the pulmonary valve (fig 1). Intravenous flucloxacillin and oral rifampicin were given for four weeks. The patient felt well and his CRP was normal; he went home only to be readmitted one week later very unwell, febrile, and tachycardic. Blood cultures were taken and he was immediately started on appropriate antibiotics, with systemic improvement. S aureus was isolated from all bottles of three sets of blood cultures and he was referred for valve replacement.

At operation the pulmonary valve cusps were found to be destroyed, one with a large vegetation. Gram stain of the excised valve showed a few pus cells and large numbers of Gram positive cocci. A heavy growth of S aureus was isolated on culture. He made an...
Right sided endocarditis presents not with the classical signs of endocarditis but with respiratory symptoms and signs. The patient is usually thought to have pneumonia. Our patient was no exception and was thought to have pneumonia on admission. In four of the five previously reported cases septic emboli were detected, although in one of these patients this was only recognised at a postmortem examination. Community acquired \textit{S. aureus} bacteraemia is very much more likely to be associated with endocarditis, or bone or joint infection, than with pneumonia.

Although many organisms have been shown to cause isolated pulmonary valve endocarditis, overall \textit{S. aureus} is most commonly involved particularly in cases associated with intravenous access infection and intravenous drug abuse. There are little published data on the need for valve replacement in pulmonary valve infections, but since the tricuspid valve seldom requires replacement in endocarditis by inference this may also be true of the pulmonary valve. In this case report and that of Calleja and colleagues, valve surgery was required as a result of persistent infection rather than haemodynamic instability. Indeed, in the patient reported by Calleja and colleagues the vegetation was removed from the “virtually destroyed” valve, but the valve was not replaced. In reports of other pathogens or \textit{S. aureus} infections in intravenous drug abusers, patients have survived with few problems despite seemingly very destructive infections of their pulmonary valves.

The most useful clinical message from this case is as a reminder that, although pulmonary valve endocarditis is itself rare, right sided endocarditis must be considered in a patient with community acquired \textit{S. aureus} bacteraemia presenting with respiratory symptoms and signs.

**Discussion**

In one year (1999), this and one other case of isolated pulmonary valve endocarditis were seen in the tertiary referral cardiothoracic centre. No other cases had been recognised in the preceding 30 years among 570 prospectively documented cases of endocarditis seen at this hospital. This serves to emphasise how unusual this infection is, particularly when it involves previously normal valves and is not associated with intravenous drug use or intravenous access infection. A review of the literature found only five previously reported cases of \textit{S. aureus} isolated pulmonary valve endocarditis in structurally normal hearts in the absence of a history of drug abuse or central venous access (table 1).

In community acquired \textit{S. aureus} endocarditis the source of the staphylococcus is seldom evident but the bacteria must be assumed to have entered the bloodstream through an epithelial breach. In this case, there was a facial sore that was not swabbed but that may have been an infective focus.

**Table 1 Previous reported cases of community acquired \textit{Staphylococcus aureus} pulmonary valve endocarditis in non-drug users**

<table>
<thead>
<tr>
<th>Case report</th>
<th>Year</th>
<th>Patient’s age, sex</th>
<th>Possible source</th>
<th>Pulmonary emboli seen</th>
<th>Treatment and clinical outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levin et al</td>
<td>1964</td>
<td>30, male</td>
<td>None</td>
<td>No</td>
<td>Conservative, survived</td>
</tr>
<tr>
<td>Cremieux et al</td>
<td>1985</td>
<td>31, male</td>
<td>Caruncous</td>
<td>Yes</td>
<td>Died</td>
</tr>
<tr>
<td>Fourieste et al</td>
<td>1986</td>
<td>21, female</td>
<td>None</td>
<td>Yes</td>
<td>Died</td>
</tr>
<tr>
<td>Calleja et al</td>
<td>1992</td>
<td>21, female</td>
<td>Puerperal sepsis</td>
<td>Yes</td>
<td>Surgery, survived</td>
</tr>
<tr>
<td>Kelly et al</td>
<td>2000</td>
<td>59, male</td>
<td>Unclear</td>
<td>Yes</td>
<td>Conservative, survived</td>
</tr>
</tbody>
</table>

F, female; M, male

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