M Stegemann

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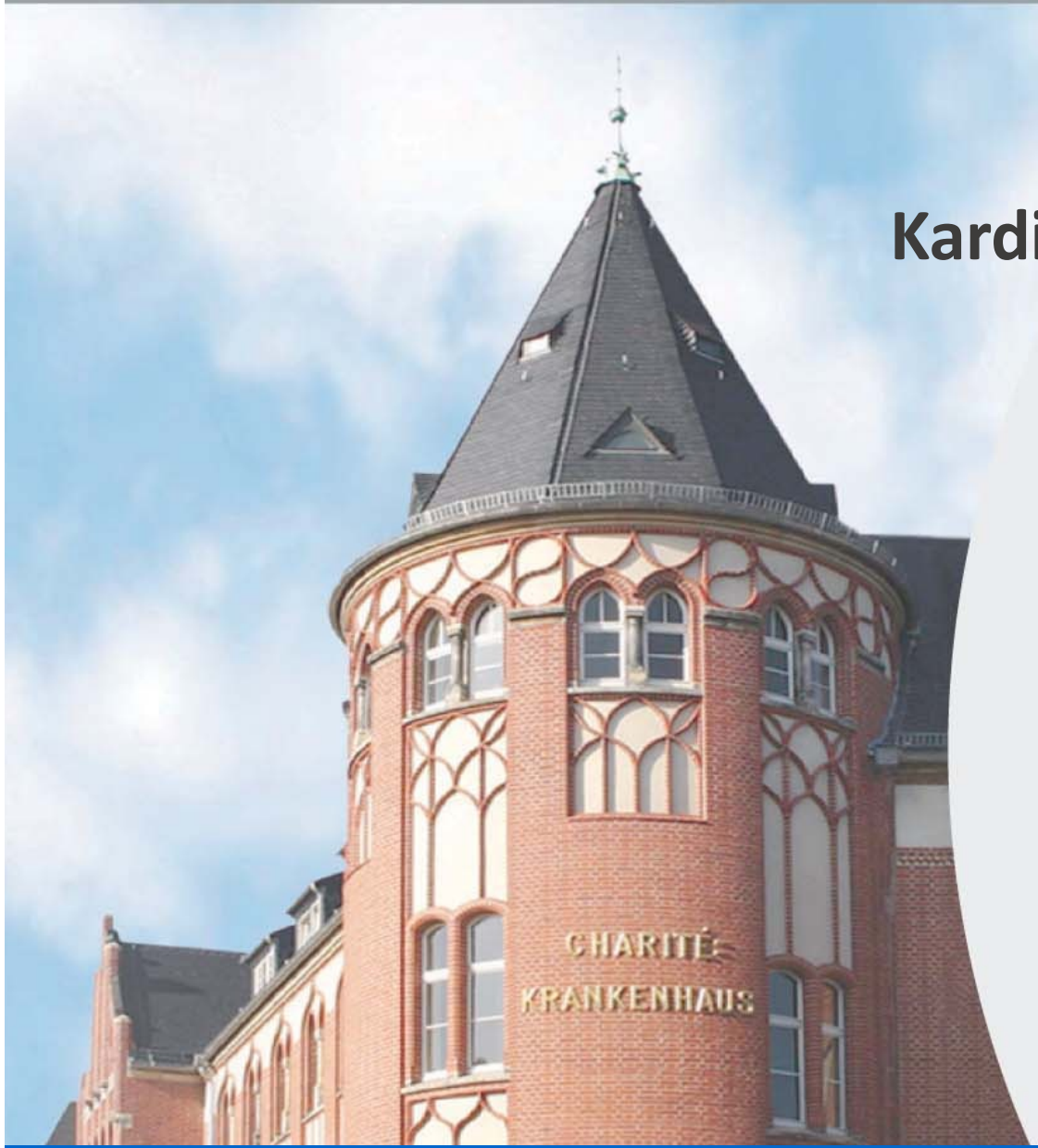

Kardiovaskuläre Infektionen
Aufgabe 1

Handout

Okt 2021

DGI ABS fellow 2.0
Berlin Online

Sie werden zu diesem Patienten um Rat gefragt…

Anamnese

- Patient, 40 Jahre, Einweisung von der Hausärztin über die Rettungsstelle
- Seit 5 Wochen Fieber bis 39,5°C, in den letzten 2 Wochen kontinuierlich über 37,5°C
- Leichte allgemeine Schwäche

Vorerkrankungen:

- Mittelgradige Aortenklappeninsuffizienz
- Allergisches Asthma seit Kindheit

Körperlicher Untersuchungsbefund:

- Temp. 36,8°C, HF 88/min, AF 12/min, RR 130/70; SpO2 96%
- 3/6 Diastolikum, p.m. über Aortenklappe
- Übriger Befund unauffällig, keine Auffälligkeiten der Haut.

Labor

		Referenzbereich
Leukozyten	12,2 /nl	4-11
Hämoglobin	11,6 g/dl	13,5-17
Thrombozyten	400/nl	150-370
CRP	47,7 mg/l	< 5
GOT	47 U/l	< 41

Röntgen Thorax, Sono Abdomen

- Milz 12,7 x 4,5 cm
- sonst unauffällig

Blutkulturen 24.08. und 25.08.

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Keim 1  Blutkulturfl. aerob und anaerob        Streptococcus salivarius
Bebrütungszeit aerob            14.00                                Std.
Bebrütungszeit anaerob          10.00                                Std.
ANTIBIOGRAMM:              Keim 1   Keim 2   Keim 3   Keim 4   Keim 5
Cefotaxim                  S <=0.12
Penicillin                 S <=0.06
Ampicillin                 S <=0.25
Ceftriaxon                 S <=0.12
Clindamycin                S <=0.25
Vancomycin                 S 0.5
```

TEE 24.08.

- Aortenklappe funktionell bikuspid (RCC und LCC verschmolzen), deutlich sklerosiert an der Raphe RCC/LCC mit exzentrischem Jet mit noch
- mittelgradiger Insuffizienz
- Keine Vegetationen

- **Welche Diagnose stellen Sie?**
- **Welche Kriterien treffen zur Diagnosesicherung zu?**
- **Welche Therapie leiten Sie ein?**
- **Dauer?**
- **Weiteres Procedere?**

Literatur

European Heart Journal
doi:10.1093/eurheartj/ehv319

ESC GUIDELINES

2015 ESC Guidelines for the management of infective endocarditis

The Task Force for the Management of Infective Endocarditis of the European Society of Cardiology (ESC)

Endorsed by: European Association for Cardio-Thoracic Surgery (EACTS), the European Association of Nuclear Medicine (EANM)

AHA Scientific Statement

Infective Endocarditis in Adults: Diagnosis, Antimicrobial Therapy, and Management of Complications

A Scientific Statement for Healthcare Professionals From the American Heart Association

Endorsed by the Infectious Diseases Society of America

Circulation. 2015;132:00-00. DOI: 10.1161/CIR.0000000000000296.

Literatur

Ceftriaxone Once Daily for Four Weeks Compared with Ceftriaxone Plus Gentamicin Once Daily for Two Weeks for Treatment of Endocarditis Due to Penicillin-Susceptible Streptococci

Daniel J. Sexton, Marvin J. Tenenbaum, Walter R. Wilson, James M. Steckelberg, Alan D. Tice, David Gilbert, William Dismukes, Richard H. Drew, David T. Durack, and the Endocarditis Treatment Consortium Group

From the Division of Infectious Diseases, Department of Medicine, Duke University Medical Center, Durham, North Carolina; the North Shore University Hospital, Manhasset, New York; the Mayo Clinic, Saint Marys Hospital, Rochester, Minnesota; Infections Limited, Tacoma, Washington; the Providence Medical Center, Portland, Oregon; the University of Alabama, Birmingham, Alabama; and Becton Dickinson, Sparks, Maryland

Clinical Infectious Diseases 1998;27:1470–4

Table 3. Clinical outcome for 51 evaluable patients with endocarditis due to penicillin-susceptible streptococci who were treated with monotherapy with ceftriaxone for 4 weeks or combination therapy with ceftriaxone plus gentamicin for 2 weeks.

	No. (%) of patients	
Clinical outcome	Monotherapy recipients (n = 26)	Combination therapy recipients (n = 25)
Cure without surgery	21 (80.8)	15 (60)
Cure with surgery	4 (15.4)	9 (36)
Treatment failure	1 (3.8)	1 (4)

Literatur

Journal of Antimicrobial Chemotherapy (2006) **57**, 639–647
doi:10.1093/jac/dkl044
Advance Access publication 24 February 2006

JAC

The role of aminoglycosides in combination with a β-lactam for the treatment of bacterial endocarditis: a meta-analysis of comparative trials

Matthew E. Falagas[1,2]*, Dimitrios K. Matthaiou[1] and Ioannis A. Bliziotis[1]

[1]*Alfa Institute of Biomedical Sciences (AIBS), Athens, Greece;*
[2]*Department of Medicine, Tufts University School of Medicine, Boston, MA, USA*

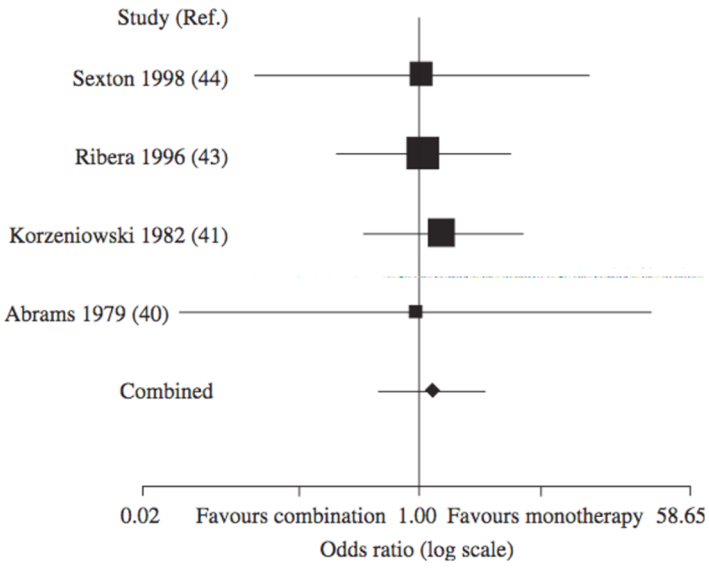

Figure 2. Odds ratios of clinical cure (treatment success) between patients who received β-lactam monotherapy and those who received β-lactam/aminoglycoside combination therapy. Vertical line = 'no difference' point in treatment success between the two regimens. Horizontal lines = 95% CI. Square = odds ratio; the size of each square denotes the proportion of information given by each trial. Diamond = pooled odds ratio for all studies.

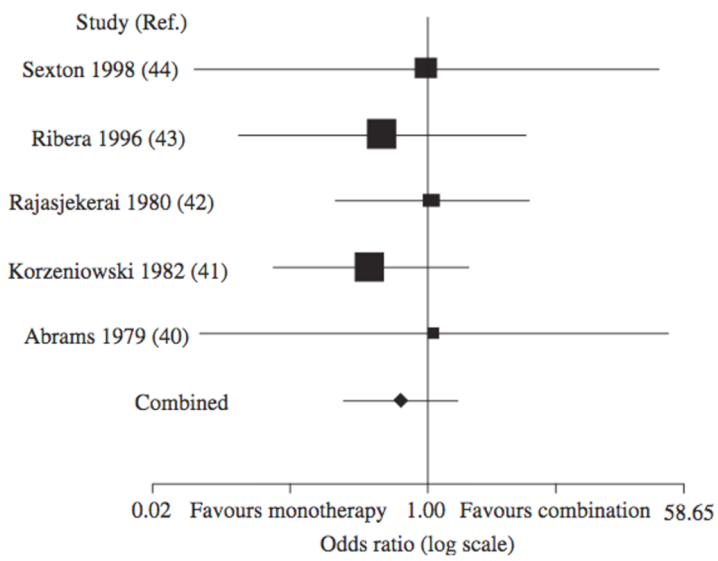

Figure 3. Odds ratios of all-cause mortality between patients who received β-lactam monotherapy and those who received β-lactam/aminoglycoside combination therapy. Vertical line = 'no difference' point in all-cause mortality between the two regimens. Horizontal lines = 95% CI. Square = odds ratio; the size of each square denotes the proportion of information given by each trial. Diamond = pooled odds ratio for all studies.

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