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Commentary: Collective responsibility in combating injection drug use-related endocarditis

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CENTRAL MESSAGE

Collective responsibility in combating injection drug use-related endocarditis supports difficult decision making.

All too often, an injection drug abuser with endocarditis undergoes successful surgery to the point that the endocarditis recurs, creating even worse medical challenges and personal disaster. Injection drug use-related endocarditis consists of a combination of medical, social, and ethical burdens.

The expert opinion by Mori and colleagues[1] describes the hurdles in treating injection drug use-related endocarditis. The disease incidence increases quasi-exponentially, and reflects the path of 3 distinctive opioid epidemics starting in the 1990s. Current guidelines offer a variety of recommendations for the often socioeconomically disadvantaged patient group with injection drug use-related endocarditis. Surgical options, such as valvectomy, aspiration via catheter, antibiotic treatment protocol, and the use of bioprosthesis versus mechanical prosthesis, are briefly discussed, but the emphasis is on ethical considerations in the management of these patients. The authors conclude that surgeons must work closely with a multidisciplinary team that comprises not only cardiology, internal medicine, and infectious disease but also addiction medicine. The medical task is to treat—simultaneously—2 diseases: the endocarditis and the addiction. In addition to treating the infection itself, including radical surgery, addiction medicine, psychiatry, the patient, the family, and legal representatives may all be involved to seek the best solution to address the drug abuse. Similar to many chronic diseases, addiction may be treatable with evidence-based therapies and longitudinal care.

Many patients with injection drug use-related endocarditis may not consent to cardiac surgery followed by a strict rehabilitation program. Although multidisciplinary decision making to seek efficient surgical protocols may not always include the most extensive technical approach, successful management of injection drug use-related endocarditis is always dependent on accepting the whole treatment packet, including rehabilitation.

Surgical patient care may be considered a collective endeavor, reflecting the functionality of the existing corporate social responsibility.[2-4] This includes responsibility toward the community, ethical responsibility to individual patients, and decision making that benefits the whole of society.[5] Although the patient with injection drug use-related endocarditis is the aim of the treatment protocol, the medical challenge affects the whole community. Treating effectively the injection drug abuser serves as an example to fellow patients; the patient is not left alone. Rehabilitation is not only an individual choice, but also a responsibility to the whole community. We are all responsible to each other in keeping society safe from infections, criminality, and fashion-driven misbehaviors. Restricting the treatment to surgery alone without planning for rehabilitation represents short-sighted medicine and leads to poor outcomes without hope for abstinence from injection drugs and recurrent infection. In this sense, injection drug abuse becomes like a contagious disease despite proper antibiotics.

Neither surgery nor teamwork alone is sufficient, as pointed out by Mori and colleagues.[1] Teamwork ought to be considered as an initial path to broader social

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Disclosures: The author reported no conflicts of interest.

The *Journal* policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

Received for publication May 26, 2021; revisions received May 26, 2021; accepted for publication May 26, 2021; available ahead of print June 9, 2021.

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JTCVS Open 2021;8:321-2

2666-2736

https://doi.org/10.1016/j.xjon.2021.05.016

responsibility,[3] which includes shared responsibility after surgery.[6] Surgeons are already deeply involved in selecting different health care options, expenditures, and resources to secure the welfare and economic growth of society.

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