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Ralstonia pickettii: a rare cause of infective endocarditis

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Ralstonia pickettii (RP), is a non-fermenting gram-negative bacillus. Infections due to RP are very rare in healthy individuals. However, RP hospital outbreaks have been reported and associated with extrinsic contamination of disinfectants... and other solutions used for patient care. To our knowledge this is the first case report of Ralstonia species causing infective endocarditis.

We report here a case of infective endocarditis due to RP in a 55-year old female patient, with a past medical history of gastritis treated by gastric pump inhibitor, presented after several days of worsening dyspnoea, low-grade fevers. Several weeks prior to presentation patient has had a coloscopy. The evaluation in hospital, the patient was tachycardia with a pulse of 120 bpm, with a blood pressure of 106/54mmHg, and febrile to 39°C. ECG findings a atrial tachycardia (120 bpm), a transthoracic (TTE) and transeophageal echocardiogram (TEE confirmed presence of vegetation on the left coronary cusp and associated severe aortic regurgitation, with normal left ventricular systolic function. Blood cultures were obtained, and patient was initiated on empiric coverage for infective endocarditis. With installing maltolerance signs of tachycardia, patient was shocked by EEC. Repeat blood cultures on consecutive days were negatives (30 days). The patient was referred for emergent cardiothoracic surgery with replacement of the aortic valve. Surgical specimens from the aortic valve had heavy growth of RP. It was sensitive to ceftazidime, quinolones and imipenem. Her postoperative course was uneventful. Patients with health care-associated infections or who have had recent hospitalization or medical intervention are a new risk group that requires careful diagnostic attention in the presence of fever to evaluate infective endocarditis. RP should be considered an important potential etiology of nosocomial infections.

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0059

Infective endocarditis: clinical features and prognosis between 2004 and 2014 in a non-teaching hospital

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Infective endocarditis (IE) despite diagnostic and therapeutic progress remains a severe disease. We describe clinical features and prognosis of patients with Duke-Li definite infective endocarditis between 2004 and 2014 in a non-teaching hospital and compare them with a similar study conducted 10 years earlier. Results are consistent with current French data, including in-hospital death rate of 16%. In accordance with the literature, we report on an increase in Staphylococcus IE, health care associated IE and endocarditis on pace maker leads, but without significant difference compared to our previous study. In univariate analysis, renal failure, age over 70 years and Staphylococcus aureus were associated with in-hospital mortality. In multivariate analysis, predictors of in-hospital death were renal failure and lack of surgery. There was a non-significant trend of excess mortality in Staphylococcus IE or in patient with heart failure. IE remains a severe disease and Staphylococcus aureus is more often involved. IE can be safely managed in a peripheral hospital provided that there is a partnership with a reference center.

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Impaired glucose tolerance and impaired fasting glucose in patients with essential hypertension

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Objective The aim of the study was to assess of frequency and overlap of impaired glucose tolerance (IGT) and impaired fasting glucose (IFG) in hypertensive patients.

Methods 81 patients with essential hypertension (47 females and 34 males), from 36 to 75 years old were enrolled in the study. IGT was diagnosed then plasma glucose level after oral intake of 75g of glucose was in the range 7.8-11.1mmol/l, IFG was established then fasting plasma glucose was in the range 6.1-6.9mmol/l.

Results IFG was found in 18 (22%), IGT – in 40 (49%) of patients. The total number of patients with prediabetes (IFG and/or IGT) was 42 (51%). In 16 cases there was combination of IFG and IGT, in 2 cases – IFG was isolated, in 24 cases – IGT was isolated. Body mass index (BMI) was higher in prediabetic compare to normoglycemic patients (31.3±5.7 versus 28.4±5.1kg/m², p=0.017). In this study obesity and overweight were diagnosed in 61 (75%) patients.

Conclusions Prediabetes was found in half of patients with essential hypertension and predominantly associated with obesity and overweight. IGT is twice more sensitive marker of prediabetes than IFG.

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Aortic valve calcium score evaluated with CT scan predicts outcome after TAVI

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Background The clinical risk scores usually used for surgical valve replacement failed to accurately predict outcomes after TAVI and alternative risk parameters are lacking. We proposed to determine the prognostic value of aortic valve calcifications evaluated with CT-scan on outcome after TAVI.

Methods This prospective monocentric study included 118 patients referred for TAVI for severe symptomatic aortic stenosis. The procedure was performed via transfemoral route using a balloon expandable (n=61) or a self expandable (n=57) valve. Pre-intervention non enhanced, ECG-gated, multislice CT-scan was done in all patients. Aortic valve calcifications were evaluated using the Agatston calcium score (CS). Procedure-related complications were evaluated and clinical outcome was analysed using a composite criteria (mortality, stroke, myocardial infarction, heart failure) at 30-day follow-up.

Results Mean CS was 4092±2176. At 30-day follow-up, mortality was 6.8% (n=8) and 28 patients (23%) have presented the composite criteria. On univariate analysis (table), CS appears to be the best predictor of adverse outcome after TAVI, significantly higher in patients who have presented the composite criteria (5785 vs 3565, p<0.001). A CS threshold of 6000 allowed to define patients at risk of adverse outcome with a sensitivity of 90% and a specificity of 97%. On multivariate analysis, the only predictors of adverse outcome were dislipidemia (OR 12; IC95 2,7–54,7), BMI (OR 0,8; IC95 0,7–0,9) and CS>6000 (OR 106; IC95 15,5-727,6).

Conclusion High degree of calcification of aortic valve, easily quantifiable on the pre-operative CT-scan appears to be an important prognostic parameter which should be considered by the Heart Team in the decision making.

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