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Pulmonary valve infective endocarditis with atrial septal defect and pulmonary valve disease – too coincidental to be true?

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In this case we describe a 68-year-old male patient who presented with malaise after being treated for a urinary tract infection caused by *enterococcus faecalis*. The electrocardiogram showed atrial fibrillation and subsequent transthoracic echocardiography revealed a mobile structure on the pulmonary valve with an increased transpulmonary valve gradient (Fig. 1). Blood cultures were positive for *enterococcus faecalis* and PET-CT revealed F-18-fluorodeoxyglucose (FDG) uptake in the right ventricular outflow tract and lungs.

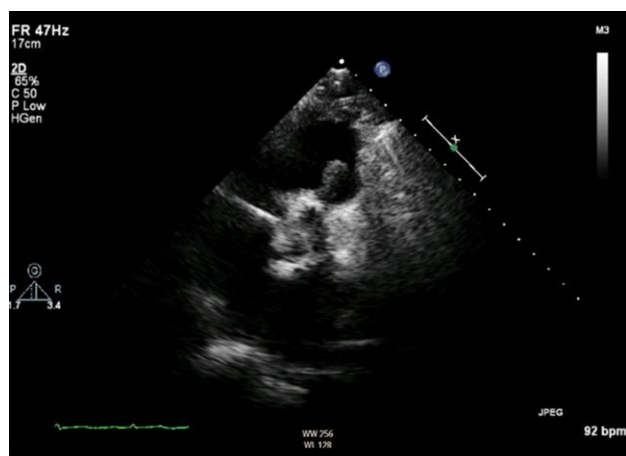


Fig. 1 TTE showing a mobile structure on the pulmonary valve. *TT* transthoracic echocardiography

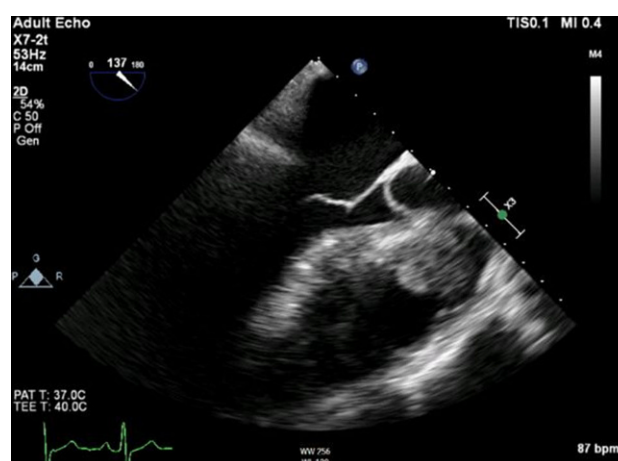


Fig. 2 TEE showing thickened pulmonary valve and atrial septal defect. *TEE* transoesophageal echocardiography

Transoesophageal echocardiography revealed a previously unknown small atrial septal defect type 2 with left-to-right shunt as well as a moderate pulmonary valve stenosis and severe regurgitation (Fig. 2).

In the majority of cases, right-sided infective endocarditis involves the tricuspid valve and is associated with intravenous drug use or the presence of pacemakers [1–3]. In this case, a type 2 atrial septal defect and a dysplastic pulmonary valve were observed. This case underscores the importance of thorough investigation of coexistent congenital heart defects in cases of right-sided infective endocarditis [4].

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References

1. Vereckei A, Vándor L, Halász J, et al. Infective endocarditis resulting in rupture of sinus of Valsalva with a rupture site communicating with both the right atrium and right ventricle. *J Am Soc Echocardiogr*. 2004;17(9):995–7.
2. Moss R, Munt B. Injection drug use and right sided endocarditis. *Heart*. 2003;89(5):577–81.
3. Yuan SM. Right-sided infective endocarditis: recent epidemiologic changes. *Int J Clin Exp Med*. 2014;7(1):199–218.
4. Das CK, Ete T, Dorjee R, et al. Atrial septal defect with pulmonary valve endocarditis—an unusual friendship. *MOJ Clin Med Case Rep*. 2017;6(2):42–3.

