



Sonuçlanmayan Olgular

Dr. H. Selçuk Özger

Gazi Üniversitesi Tıp Fakültesi

Enfeksiyon Hastalıkları ve Klinik Mikrobiyoloji Anabilim Dalı

55 yaş, Erkek, Yozgat'ta yaşıyor

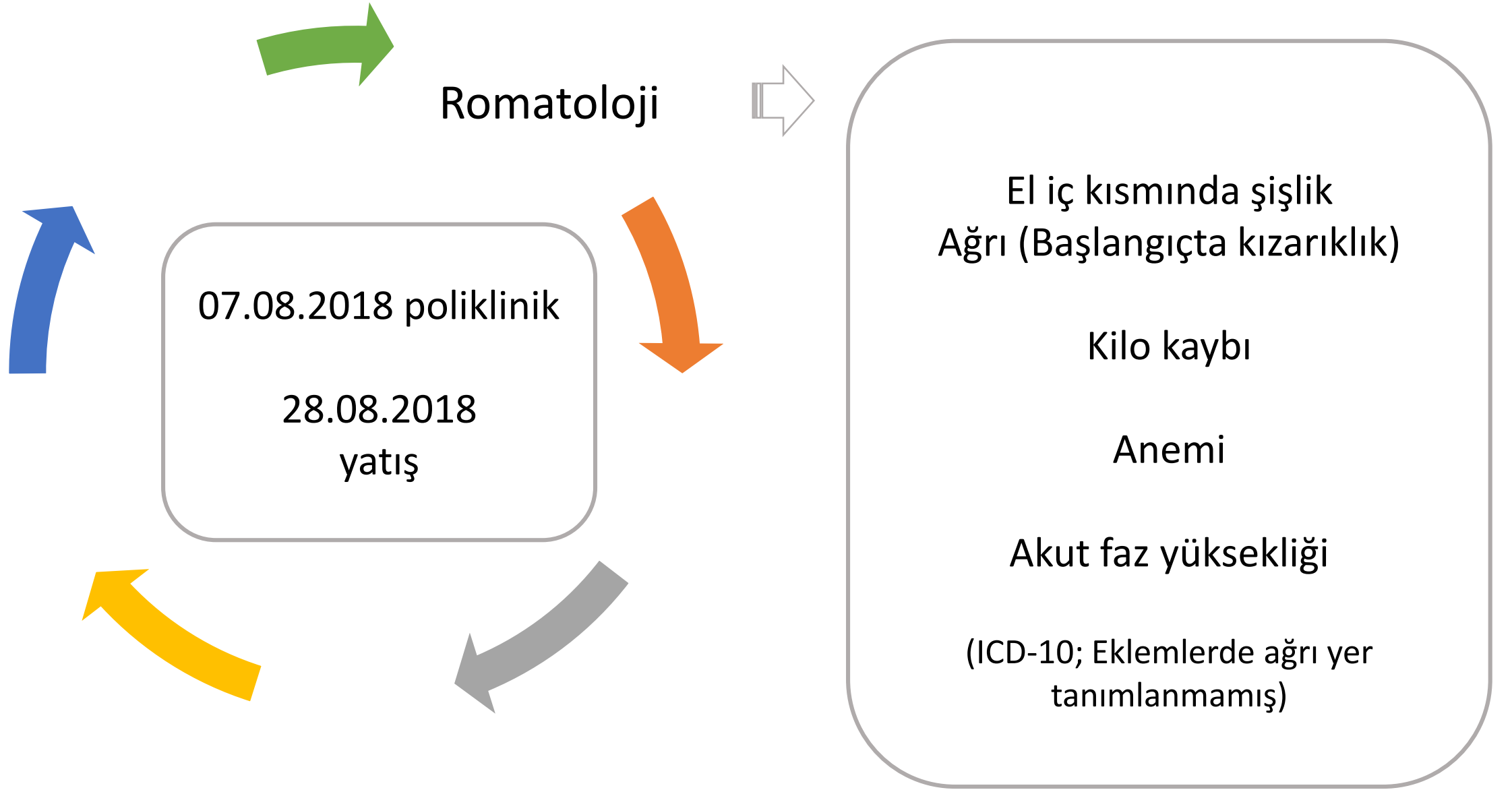
7 ay önce derin ven trombozu öyküsü

3 ay önce 2 kez karın ağrısı atağı

1 ay öce ayak bileklerinde şişlik

Köy sütü tüketimi, sınırlı tarımsal aktivite

Cerrahi girişim ve antibiyotik kullanım öyküsü yok



Sistem
Sorgusu

Kilo kaybı (7 ayda 12 kg)
Ateş ?
Aralıklı karın ağrısı

Fizik Muayene

Sol avuç içerisinde 1 cm'lik şişlik

Hasta Yatışındaki Laboratuvar Değerleri (28.08.2018)

Hemogram	WBC (Nötrofil)	16 000 (14300)(mm3)	
	Hgb	9,8 (g/dl)	<u>Periferik Yayma</u>
	PLT	305 000(mm3)	
Anemi			Hipokromi,
Parametreleri	Serum Demir	20.0 (µg/dl)	Anizositoz,Mikrositoz
	Demir Bağlama K.	205 (µg/dl)	
	Ferritin	560 (ng/ml)	Sola Kayma,
	Folik ait	6(ng/ml)	Atipik Hücre Yok
	Vit B12	196 (pg/ml)	
Biyokimya	AST / ALT	21 / 13 (U/L)	
	ALP / GGT	167 / 71(U/L)	
	T.bilurubin / D.bilurubin	0,4 / 0,1(mg/dl)	
	Üre / Kreatin	18 / 0,9 (mg/dl)	
	Ürik asit	4,5 (mg/dl)	
	Na / K / Cl / Ca	136 / 4,4 / 99 / 9,0(mmol/L-mg/dl)	
	Albumin / Total protein	3,3 / 7,7(g/dl)	
	LDH	511(U/L)	

Hasta Yatışındaki Laboratuvar Değerleri (28.08.2018)

Akut faz reaktanları	CRP	193 (mg/L)
	Sedimentasyon	68 (mm/saat)
	Prokalsitonin	0,11 (ng/ mL)
Tam İdrar Tetkiki	Lökosit; 5, Eritrosit;3, Protein +	
EKG	Normal sinüs ritmi	
PA grafi	Bilateral alt zonlarda bronkovasküler dansite artışı	
RF	24,3 (IU/MI)	
ANA-IFA	Negatif	
Anti-CCP	Negatif	
Gaita Gizli Kan	Negatif	
Hbs-Ag, Anti-HIV, Anti-HCV	Negatif	

Planlanan Tetkikler

TiT proteinüri

24 saatlik idrar

Anemi, sedimentasyon
yüksekliği

Torakal-Abdominal Tomografi, Endoskopi, Kolonoskopi,
PSA, Serum İmmunglobulin düzeyleri, Serum protein
elektroforezi, İdrar immunfiksasyon

Ateş

Romatoloji



Enfeksiyon

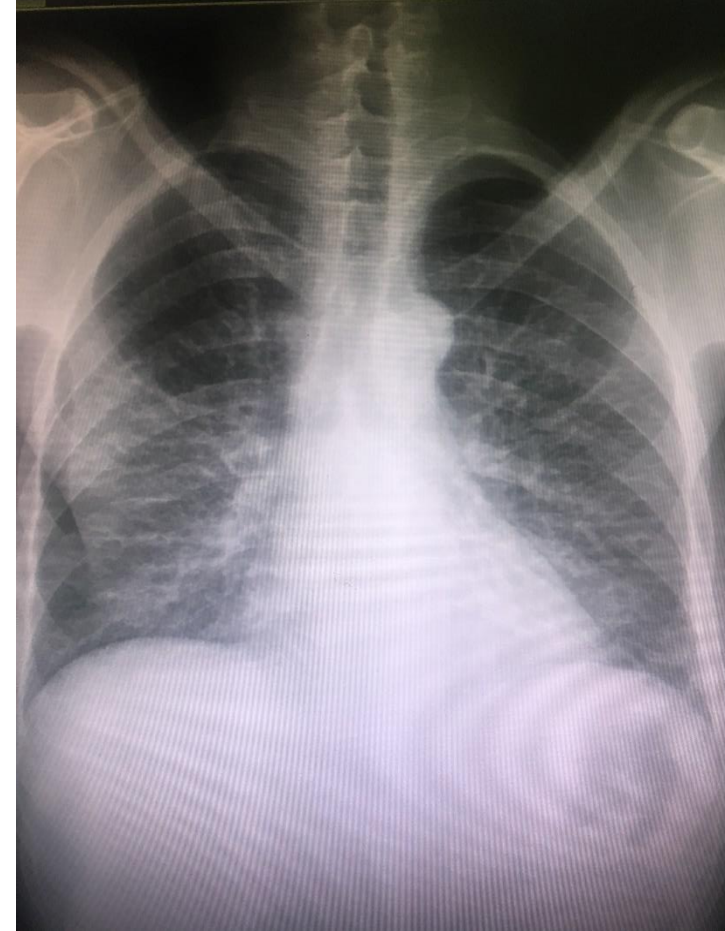
Enfeksiyon

Yatışının 1. gününde 1 kez, 2. gününde 3 kez tekrarlayan > 38.0
° C ateş
+
AFR yüksekliği
+
Pa grafi bulguları

Tanı Toplum
Kökenli
Pnömoni

Seftriakson (IV), Klaritromisin (Oral)

Balgam gram-kültür, Kan kültür



Tetkik
sonuçları

Romatoloji



Enfeksiyon



Takipte İstenilen Tetkikler ve Sonuçları

Balgam İncelemesi

?

Patojen Bakteri
Üremedi

Kan kültürü

Sonuç Bekleniyor

Tedavinin 3.günü: Ateş yanıtı

Tedavi değişikliği yapılmıyor



Romatoloji



Takipte İstenilen Tetkikler ve Sonuçları

Brusella Tüp agg

Negatif

PSA-sPSA

0,30-0.29 (ng/ml)

ÜST GİS Endoskopi

Antral Gastrit

Kolonoskopi

İnternal Hemoroid

Total IGA, IGM, IGG

222 (82-453), 275 (46-304), 1300 (751-1561)

Göğüs hastalıkları konsültasyonu; FOB
planlanıyor



Hiler ve mediastinal **LAP** (En büyüğü 13 mm)

Her iki akciğer alt segment bronşlarda
bronşektaziler

Her iki akciğer alt loblarda parankimal bantlar
ve **atelektaziler**

Her iki akciğer alt loblarda interlobuler
septal, interstisyel kalınlık artışları

Enfeksiyon hastalıkları konsültasyonu;

-Tedavi devamı

-Ekokardiografi

Dinamik MR ve MR kolonjiografi

Hepatik kist.

Safra kesesi içerisinde milimetrik boyutlu taşlar. Sağ ana hepatik safra kanalı düzeyinde kalsifiye oluşum.

Sol sürrenal kalınlık artışı

Sağ böbrekte kama şekilli düzgün sınırlı hipodens alanlar

Dalakta 2,5 cm çaplı öncelikle yoğun içerikli kolleksiyon lehine değerlendirilen hipodens alan

AFR
yüksekliği

Romatoloji

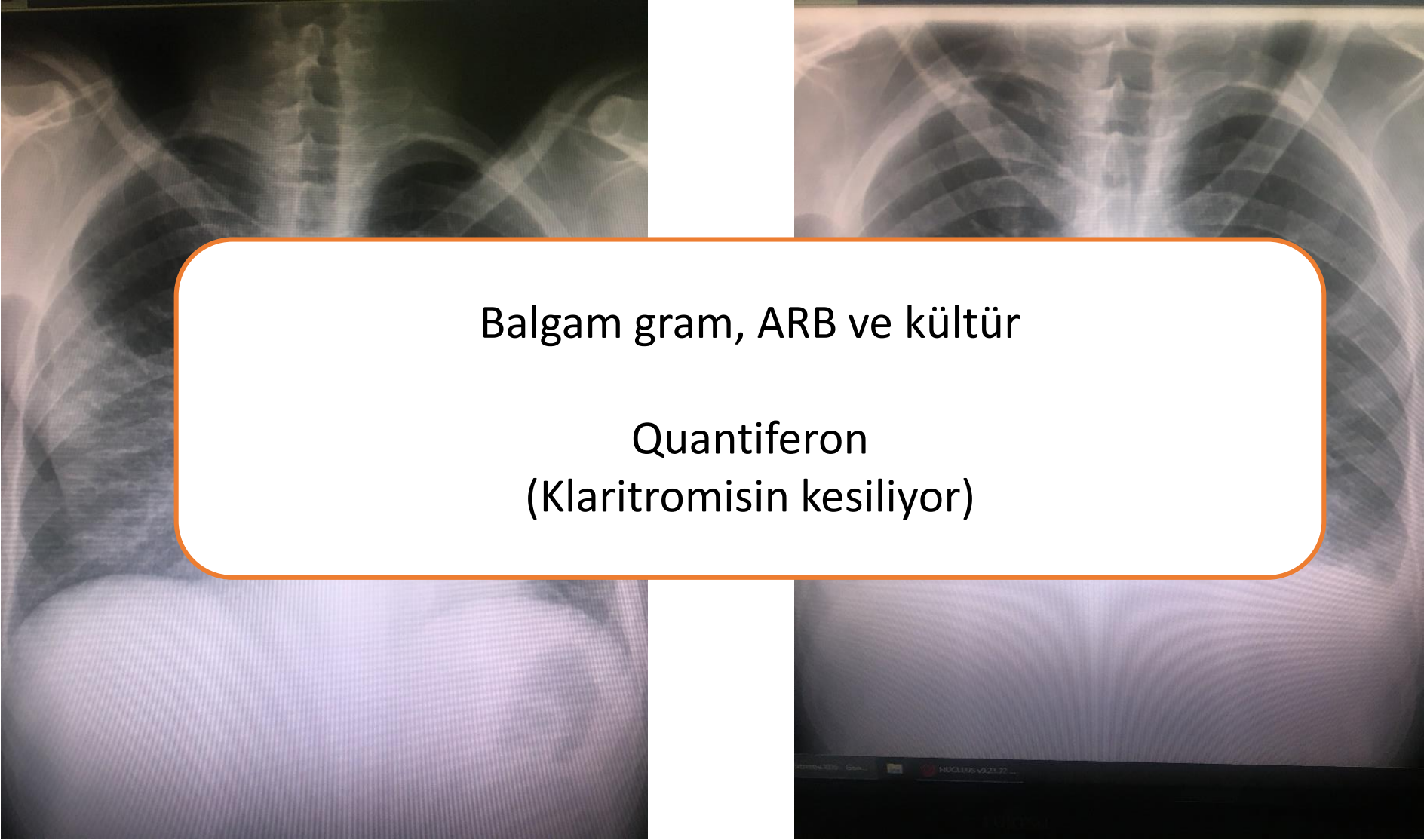
Enfeksiyon

Hasta seftriakson + klaritromisin tedavisi 8.gününde

5 gündür ateşsiz takip ediliyor

Hastanın öksürük ve balgam şikayeti

	28.08.2018	07.09.2018
CRP	193 mg/L	123 mg/L
Sedimentasyon	68 mm/saat	83 mm/saat
Prokalsitonin	0,11 ng/ml	0,065 ng/ml



Balgam gram, ARB ve kltr

Quantiferon
(Klaritromisin kesiliyor)

Kan kültür sonuçları

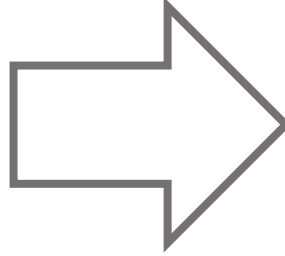
30.08.2018	Gram pozitif zincir yapmış kok	<u>Peptostreptokok</u> (Tanımlama devam ediyor)
31.08.2018		Bakteri üremedi

Aort kapakta uzunluğu 21 ve 12 mm olan her iki yaprakçıktan köken alan sol ventriküle girip çıkan vejetasyon. Ciddi aort yetmezliği, III.derece mitral yetmezlik

(Seftriakson tedavisinin 10.günü)

Yatış Fizik Muayane

S1-S2 ek ses üfürüm
yok



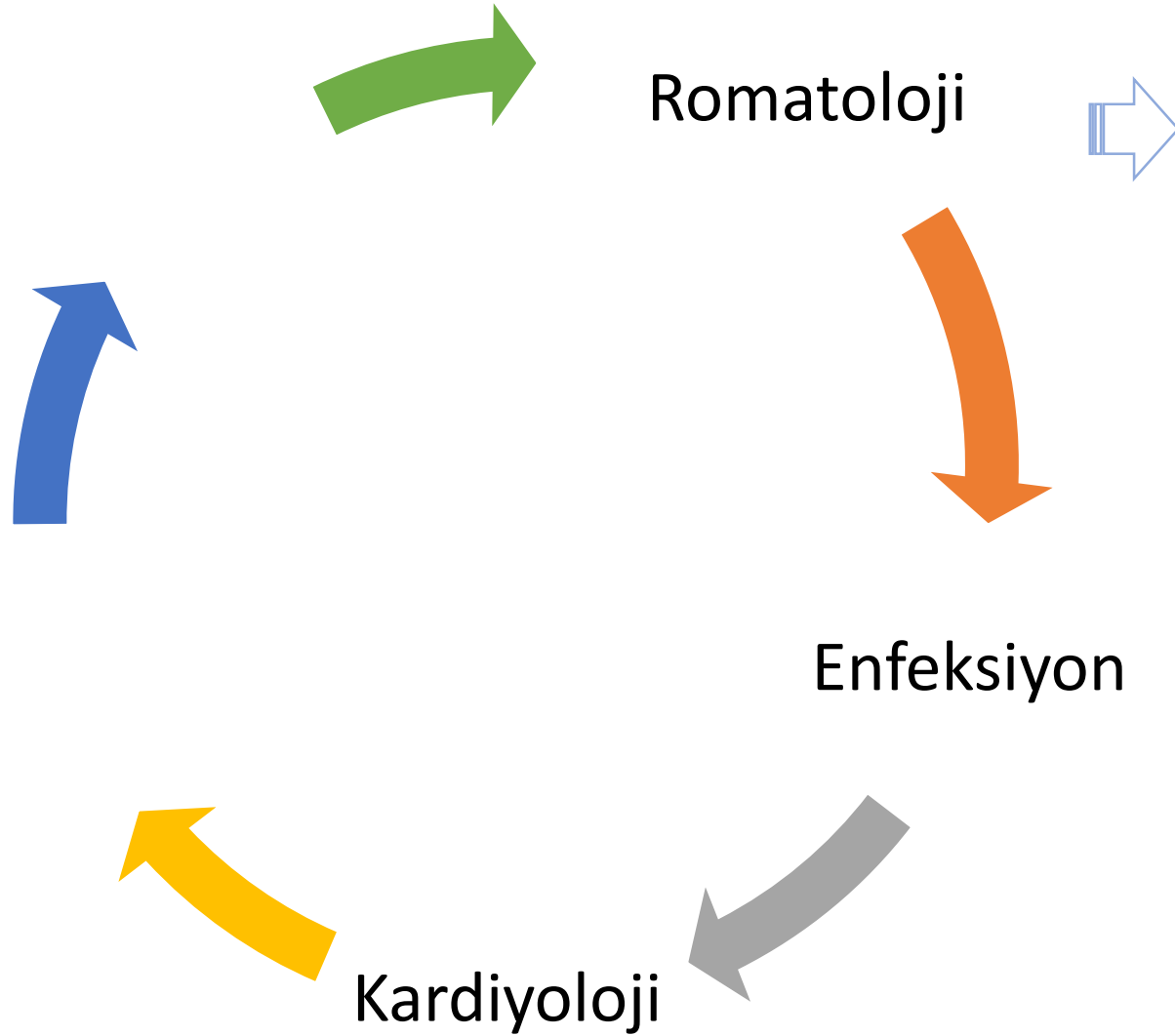
EKO ile eş zamanlı fizik
muayene

Aort ve mitral odakta
2/ 6 sitolik üfürüm

Hasta infektif endokardit tanı kriterlerini
karşılıyor mu?

Peptostreptokok infektif endokardit
etkeni mi?

Tedavi ampisilin - sulbaktam
olarak değiştiriliyor



Kardiyoloji devir
(11.09.2018)

Ampisilin-sulbaktam
tedavisine devam
ediliyor

Kardiyoloji

Akut kalp
yetmezliği

Kardiyoloji de yapılan fizik muayenede ateş yok, S3 (+), Mezokardiyak odakta 3/6 diyastolik üfürüm, 2/6 sitolik üfürüm, apekte 3/6 sistolik üfürüm

(Digoksin ve furosemid)



KVC konsültasyonu

Erken dönem operasyon

AFR yanıtıslık
(CRP 123->153)

Vankomisin ve rifampisin ekleniyor

Takipte İstenilen Tetkikler ve Sonuçları

Abdominal MR-MRCP
(05.09.2018)

Dalakta düşük intensite (hematokromatazis?) **Özellikle periferale yerleşimli kronik iskemi ile uyumlu enfarkt odakları. Abse lehine bulgu yok**
Sağ böbrek alt polde kortikal yerleşimli enfarkt alanları

Koronet BT anjiyografi
(12.09.2018)

RCA,LAD hafif-orta derecede darlık ve kalsifikasyon

En geniş yerinde 7 mm olarak ölçülen perikardiyal efüzyon, her iki akciğerde belirgin plevral efüzyon

Sağ paratrakeal en büyüğü 16 mm birkaç adet LAP ve mediastinal birkaç adet kalsifik LAP

Quantiferon
Balgam ARB

Pozitif
Negatif

Kardiyoloji

17.09.2019 (toplam 17 gün tedavi)

Seftriakson, ampisilin-sulbaktam, vankomisin ve rifampisin tedavisine rağmen **akut faz yanıtı alınamayan** ve **Quantiferon testi pozitif** olan hasta **tüberküloz endokarditi** olabilir mi?



Review

Tuberculous Endocarditis

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ARTICLE INFO

Article history:

Received 31 May 2012

Received in revised form 11 July 2012

Accepted 23 August 2012

Available online 26 September 2012

Keywords:

Mycobacterium tuberculosis

Tuberculosis

Endocarditis

ABSTRACT

Mycobacterium tuberculosis (TB) is a major cause of death globally. TB is capable of infecting every organ in the body, and the heart is no exception. Tuberculous endocarditis (TBE) was first reported in 1892 and subsequently many other cases have been described, highlighting the significant morbidity and mortality associated with this manifestation of TB. TBE usually presents with miliary tuberculosis and most early cases were diagnosed on autopsy. With increasing application of prosthetic valve replacements in the treatment of infective endocarditis (IE), TB infections have begun to affect these as well as native valves. With the introduction of TB culture methods and drug therapy, the prognosis has improved. HIV and drug resistance are likely to make the management of TBE more difficult in the future. Large scale studies, both prospective and retrospective, are required to ascertain the true incidence of TBE whilst development of novel anti-TB therapy is also required to combat resistance. We present the first extensive literature review on TBE in over 75 years.

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Clinical Infectious Diseases

IDSA GUIDELINE



Infectious Diseases Society of America



hiv medicine association



Official American Thoracic Society/Infectious Diseases Society of America/Centers for Disease Control and Prevention Clinical Practice Guidelines: Diagnosis of Tuberculosis in Adults and Children

David M. Lewinsohn,^{1,2} Michael K. Leonard,^{2a} Philip A. LoBue,^{3,4} David L. Cohn,⁴ Charles L. Daley,⁵ Ed Desmond,⁶ Joseph Keane,⁷ Deborah A. Lewinsohn,¹ Ann M. Loeffler,⁸ Gerald H. Mazurek,³ Richard J. O'Brien,⁹ Madhukar Pai,¹⁰ Luca Richeldi,¹¹ Max Salfinger,¹² Thomas M. Shinnick,³ Timothy R. Sterling,¹³ David M. Warshauer,¹⁴ and Gail L. Woods¹⁵

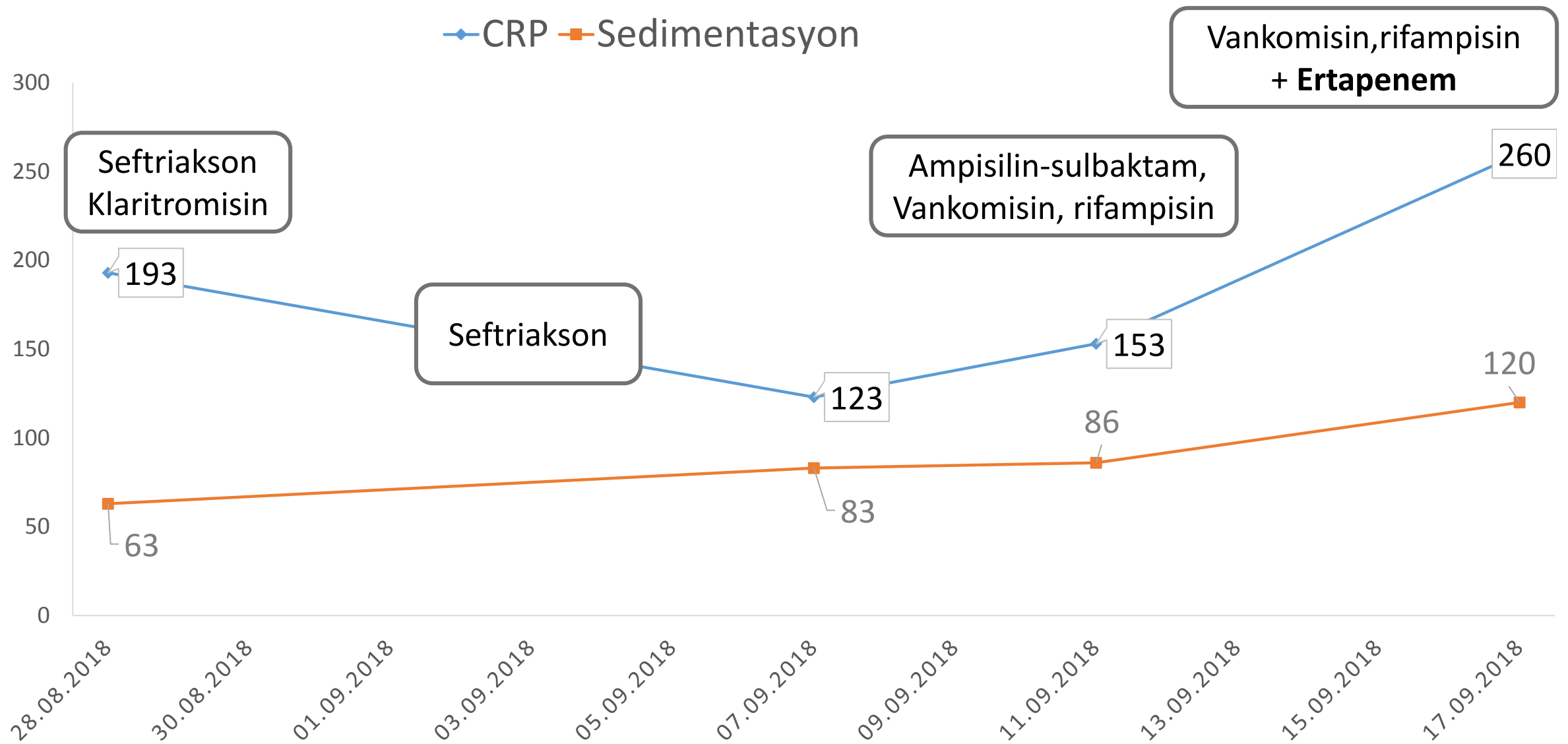
Miliyer Tüberküloz birlikteliği

ARB, PCR, Kültür, Histopatoloji

Enfeksiyon

17.09.2018 Tarihli değerlendirme

Tedavisi süreci	Seftriakson	11 gün
	Ampisilin-sulbaktam	7 gün
	Vankomisin	5 gün
	Rifampisin	5 gün
Mikrobiyolojik Sonuçlar	Toplam 6 kan kültürü	
	1.Kültür	5 üreme yok
	Peptostreptokok ?	



İnfektif endokardit Etken peptostreptokok

ANTIMICROBIAL AGENTS AND CHEMOTHERAPY, Mar. 2011, p. 1199–1203
0066-4804/11/\$12.00 doi:10.1128/AAC.01771-09
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Vol. 55, No. 3

Antimicrobial Susceptibility of Clinically Relevant Gram-Positive Anaerobic Cocci Collected over a Three-Year Period in the Netherlands^{∇†}

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Received 15 December 2009/Returned for modification 26 April 2010/Accepted 20 December 2010

Penisilin MIC 0,064-2 µg/ml

Clin Lab. 2018 Jul 1;64(7):1269-1277. doi: 10.7754/Clin.Lab.2018.180317.

A Retrospective Analysis of Anaerobic Bacteria Isolated in 236 Cases of Pleural Empyema and their Prevalance of Antimicrobial Resistance in Turkey.

Demirci M, Gemicioglu B, Saribas S, Taner Z, Mamal-Torun M, Karatoka B, Asik-Cagli L, Guven O, Demiryas S, Kocazeybek BS, Bahar-Tokman H.

Abstract

BACKGROUND: Parapneumonic effusions usually occur secondary to an infection and produce pus (empyema) that accumulates in the pleural space. We aimed to evaluate the prevalence of anerobes in patients with empyema and to assess their resistance patterns for seven antimicrobials.

METHODS: Pleural fluid specimens from 236 patients were inoculated on Schaedler agar. Anaerobic bacteria were identified via API 20 A. Susceptibility testing for penicillin, ampicillin + sulbactam, amoxicillin + clavulanate, cefoxitin, clindamycin, metronidazole, and imipenem were performed with the E-test.

RESULTS: There were 118 anaerobic bacterial strains detected in 66 (27.9%) of the 236 specimens. Gram-positive anaerobic cocci were detected in 54.23% and the predominant cocci were 41 Peptostreptococcus spp. (34.75%) followed by 17 P. acnes (14.41%) and 6 C. tertium (5.08%). The Gram-negative anaerobes were B. fragilis (28, 23.73%), P. melaninogenica (8, 6.78%), P. intermedia (4, 3.39%), F. nucleatum (6, 5.08%), F. mortiferum (5, 4.24%), and P. asaccharolytica (3, 2.54%). All anaerobic strains were susceptible to ampicillin + sulbactam, amoxicillin + clavulanate, and imipenem. The highest MIC was found to be > 256 µg/mL for penicillin in B. fragilis strains, 128 µg/mL for cefoxitin was detected in 10 (8.47%) of the 118 strains. CONCLUSION: The results of this study show that all anaerobic bacterial strains isolated from patients with empyema were susceptible to ampicillin-sulbactam. The resistance profiles of the isolated strains were similar to those reported in the literature.

Tüm izolatlar ampisilin-sulbaktam
duyarlı

Antibiyotik değişikliği gerekli mi?

Enfeksiyon

Kültür negatif endokardit etkenleri açısından deęerlendirelim (*Coxiella burnetii* ve *Bartonella* spp.serolojisi gönderiliyor)

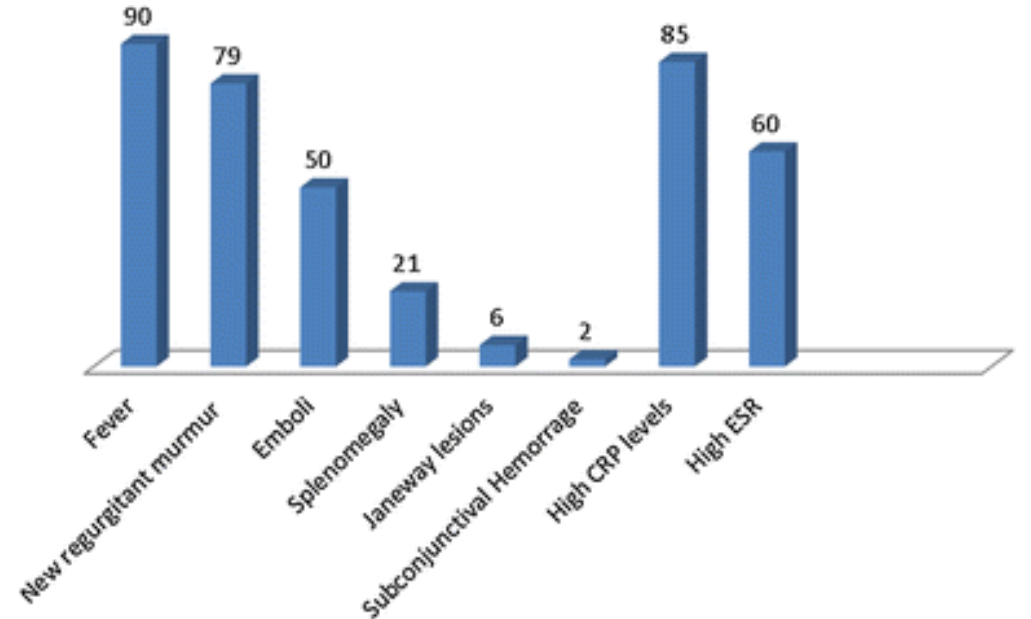
Infection (2016) 44:459–466
DOI 10.1007/s15010-015-0863-x



ORIGINAL PAPER

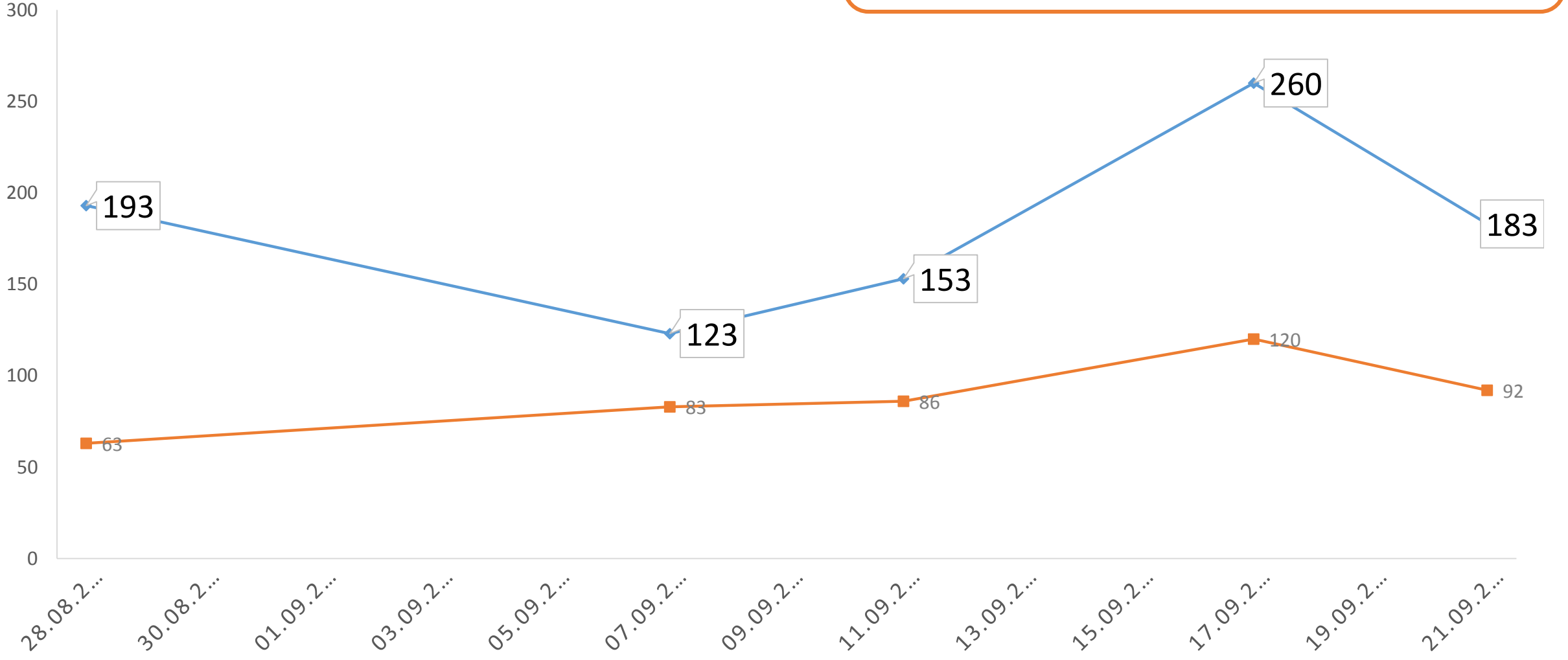
Diagnosis of blood culture-negative endocarditis and clinical comparison between blood culture-negative and blood culture-positive cases

Cristiane C. Lamas^{1,3} · Pierre-Edouard Fournier² · Monica Zappa¹ ·
Tatiana J. D. Brandão¹ · Carolina A. Januário-da-Silva³ · Marcelo G. Correia¹ ·
Giovanna Ianini F. Barbosa¹ · Wilma F. Golebiovski¹ · Clara Weksler¹ ·
Hubert Lepidi² · Didier Raoult¹



Ertapenem 3.gün
Vankomisin ve rifampisin 9.gün

CRP Sedimentasyon



Parametre	Metot	Sonuç
<i>Coxiella burnettii</i> (Q fever) Faz II IgM	IFA	1/48 Titrede pozitif
<i>Coxiella burnetii</i> (Q fever) Faz II IgG	IFA	1/256 Titrede pozitif
<i>Coxiella burnetii</i> (Q fever) Faz I IgG	IFA	Negatif
Sonuçlanma tarih; 19.09.2018		

Coxiella burnetii ilişkili akut endokardit olarak değerlendirir misiniz?

Saptanan test pozitiflik değerleri tanı için yeterli midir?



Original Investigation | Infectious Diseases

Clinical Features and Complications of *Coxiella burnetii* Infections From the French National Reference Center for Q Fever

Cl  a Melenotte, MD; Cam  lia Protopopescu, PhD; Matthieu Million, MD, PhD; Sophie Edouard, PharmD, PhD; M. Patrizia Carrieri, PhD;
Carole Eldin, MD, PhD; Emmanouil Angelakis, MD, PhD; F  lix Djossou, MD, PhD; Nathalie Bardin, PharmD, PhD;
Pierre-Edouard Fournier, MD, PhD; Jean-Louis M  ge, MD, PhD; Didier Raoult, MD, PhD

Coxiella burnetii enfeksiyonlarının % 2,1 Akut Endokardit

Hepatit (% 50) ve pn  moni (% 26) ile birliktelik

Acute Q fever endocarditis: a paradigm shift following the systematic use of transthoracic echocardiography during acute Q fever.

Melenotte C¹, Epelboin L², Million M¹, Hubert S³, Monsec T⁴, Djossou F², Mège JL¹, Habib G², Raoult D¹

Author information

Abstract

AIMS: As Q fever, caused by *Coxiella burnetii*, is a major health challenge due to its cardiovascular valvular injury to improve therapeutic management.

METHODS AND RESULTS: In the French national reference center for Q fever, we prospective fever and valvular injury. We identified a new clinical entity: acute Q fever endocarditis, defined

C. burnetii whether stenosis and 48 endocarditis fever $p < 0.001$ *C. burnetii*

CONCLUSION

the prevention of persistent endocarditis. Transoesophageal echocardiography should be proposed. 60 GPLU.

Major criteria within three months of the onset of symptoms

- Microbiological criteria
 - IgG levels ≥ 200 & IgM levels ≥ 50 for phase II

OR

Tanının kesinleştirilmesi veya ekartasyonu için ek test yada yöntem önerir misiniz?

Minor criteria echocardiographic criteria (TTE or TEE) within three months of the onset of symptoms

- Valve thickening
- Chorda tendinea thickening

C. burnetii acute endocarditis is definite

Two major criteria are fulfilled: one microbiological & one echocardiography criterion

C. burnetii acute endocarditis is possible

Faz II IGG ≥ 200

IGM ≥ 50

+

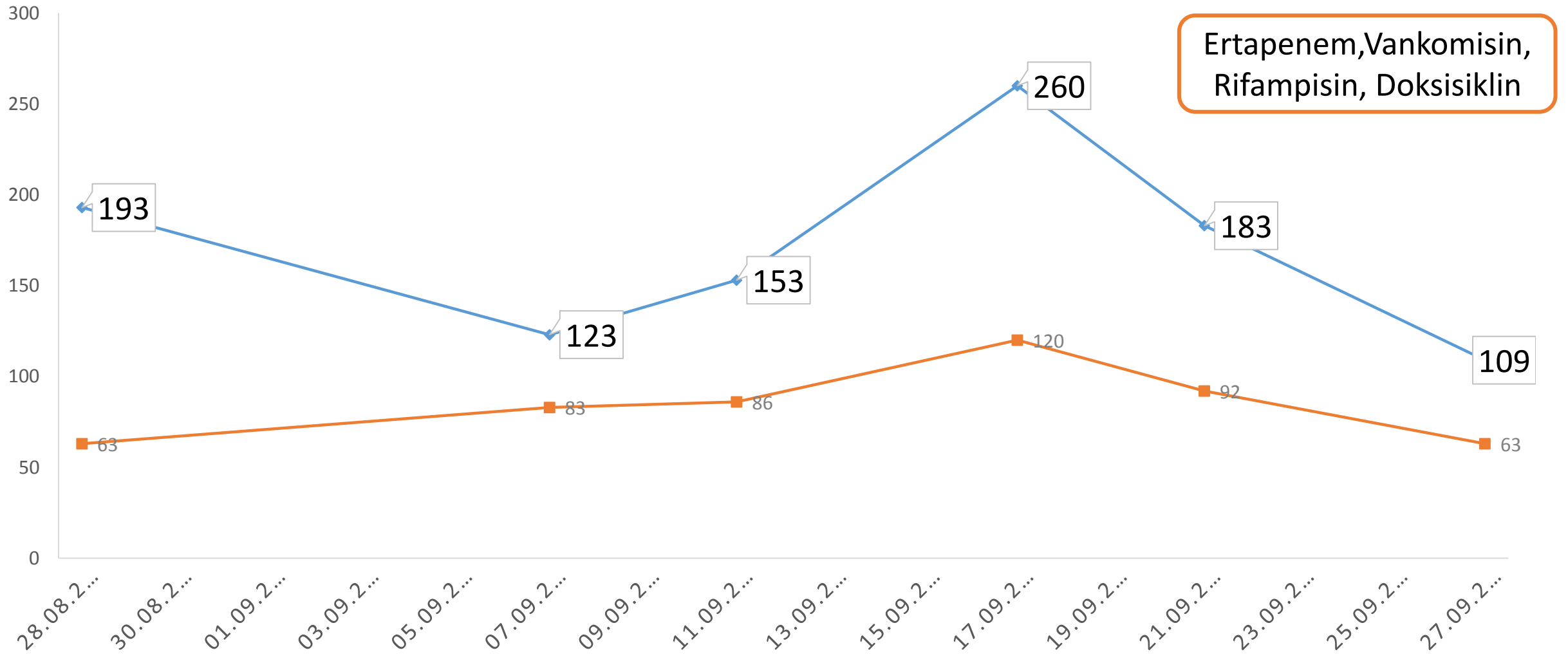
Ekokardiografik Bulgu

Akut *Coxiella*
burnetii
endokarditi

Seroloji tekrarı, kanda ve kardiyak kapaktan *Coxiella* PCR,
anti-fosfolipid antikorların gönderilmesi

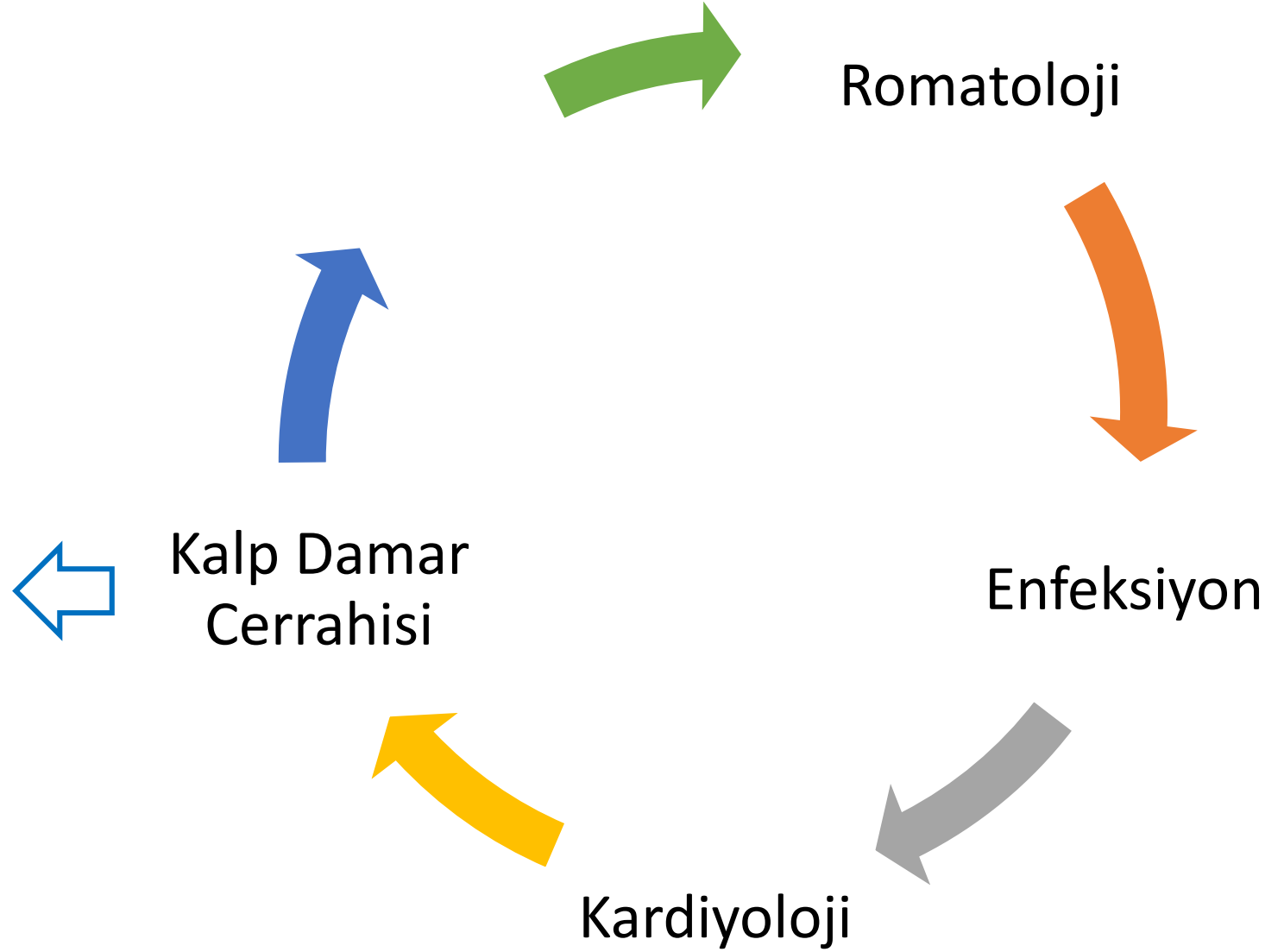
Hastanın tedavisine doksisisiklin 2x100 mg tedavi eklendi

—●— CRP —■— Sedimentasyon



Kalp Damar
Cerrahisine
operasyon
amacıyla devir

24.09.2018





	Metot	Sonuç
<i>Coxiella burnettii</i> PCR	Real Time PCR	Negatif
Örnek: Serum, Sonuçlanma tarih; 29.09.2018		
Anti-fosfolipid antikor IGM ve IGG	Negatif	

Hastalık semptomlarının yaklaşık 1.ayında

Bu sonuç *Coxiella* enfeksiyonunu ekarte ettirir mi?



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MINIREVIEW



Laboratory Diagnosis of Infective Endocarditis

Rachael M. Liesman,^a Bobbi S. Pritt,^{a,b,c} Joseph J. Maleszewski,^c Robin Patel^{a,b}

Division of Clinical Microbiology, Department of Laboratory Medicine and Pathology,^a Division of Infectious Diseases, Department of Medicine,^b and Division of Anatomic Pathology, Department of Laboratory Medicine and Pathology,^c Mayo Clinic, Rochester, Minnesota, USA

ABSTRACT Infective endocarditis is life-threatening; identification of the underlying etiology informs optimized individual patient management. Changing epidemiology, advances in blood culture techniques, and new diagnostics guide the application of laboratory testing for diagnosis of endocarditis. Blood cultures remain the standard test for microbial diagnosis, with directed serological testing (i.e., Q fever serology, *Bartonella* serology) in culture-negative cases. Histopathology and molecular diagnostics (e.g., 16S rRNA gene PCR/sequencing, *Tropheryma whippelii* PCR) may be applied to resected valves to aid in diagnosis. Herein, we summarize recent knowledge in this area and propose a microbiologic and pathological algorithm for endocarditis diagnosis.

KEYWORDS clinical microbiology, endocarditis

Serum PCR değerlendirmelerin duyarlılığı doku örnekleri ile karşılaştırıldığında düşük

Accepted manuscript posted online 28 June 2017

Citation Liesman RM, Pritt BS, Maleszewski JJ, Patel R. 2017. Laboratory diagnosis of infective endocarditis. *J Clin Microbiol* 55:2599–2608. <https://doi.org/10.1128/JCM.00635-17>.

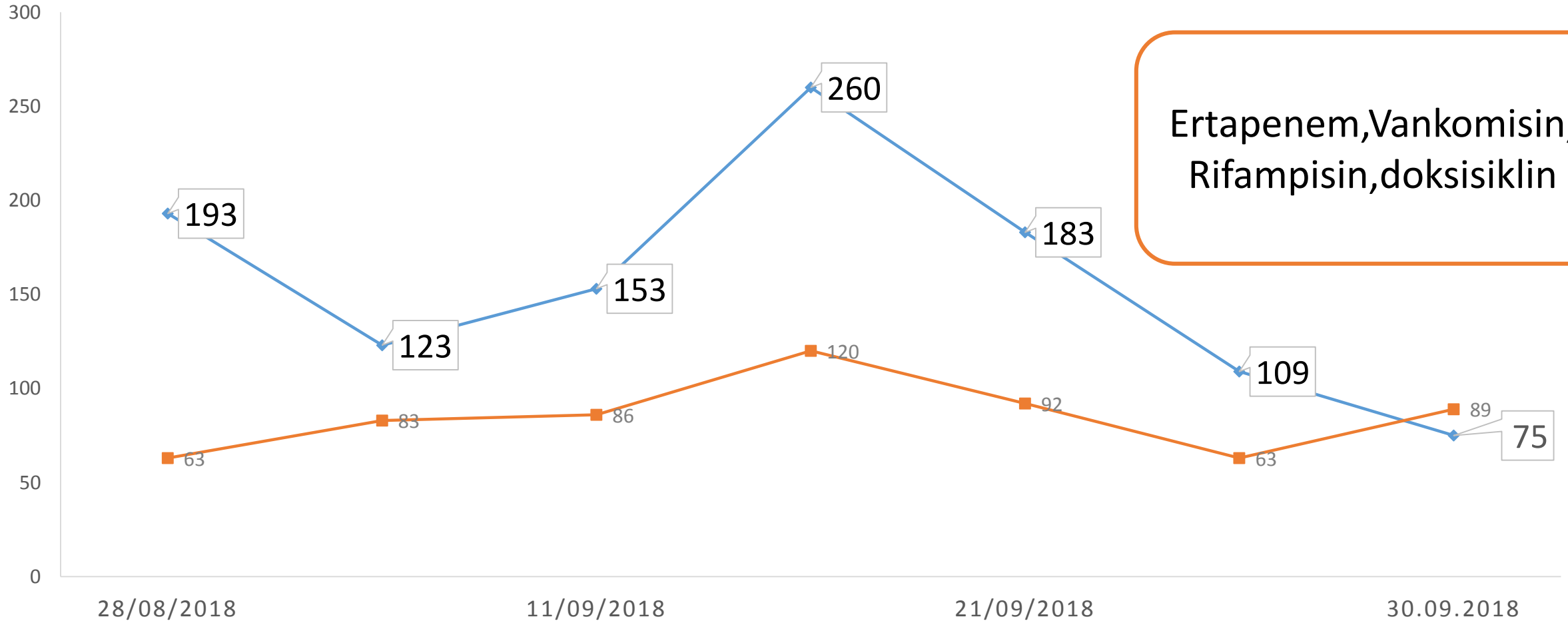
Editor Colleen Suzanne Kraft, Emory University

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Address correspondence to Robin Patel, patel.robin@mayo.edu.

Tedavi değişikliği yapılmıyor

—●— CRP —■— Sedimentasyon



01.10.2018

Tarihinde opere
ediliyor

Ertapenem: 13

Vankomisin :19

Rifampsin : 19

Doksisiklin:10

Operasyon notu:

İleri derecede kalsifiye ve sklerotik olan aort kapak rezeke edildi. Patoloji ve mikrobiyoloji laboratuvarına gönderildi.



Operasyon materyalinin değerlendirilmesi

Patolojik Değerlendirme **Kronik inflamasyon** ve fibrozis ile karakterli aort kapak
eksizyon materyali

Histopatolojik değerlendirmeye ek olarak mikrobiyolojik tetkik ister
misiniz?

Bu sonuçlar ile Coxiella endokarditi dışlanabilir mi?

Operasyon materyalinin değerlendirilmesi

Mikrobiyolojik
Değerlendirme

Doku Kültür

Tuberküloz Kültür (ARB)

DNA dizi analizi

Kandida PCR

Tüberküloz PCR

Coxiella burnetii PCR

Brucella PCR

Bakteri Üremedi

Üreme Olmadı (Negatif)

Mikroorganizma saptanmadı

Negatif

Negatif

Negatif (Doksisisiklin 9.gün)

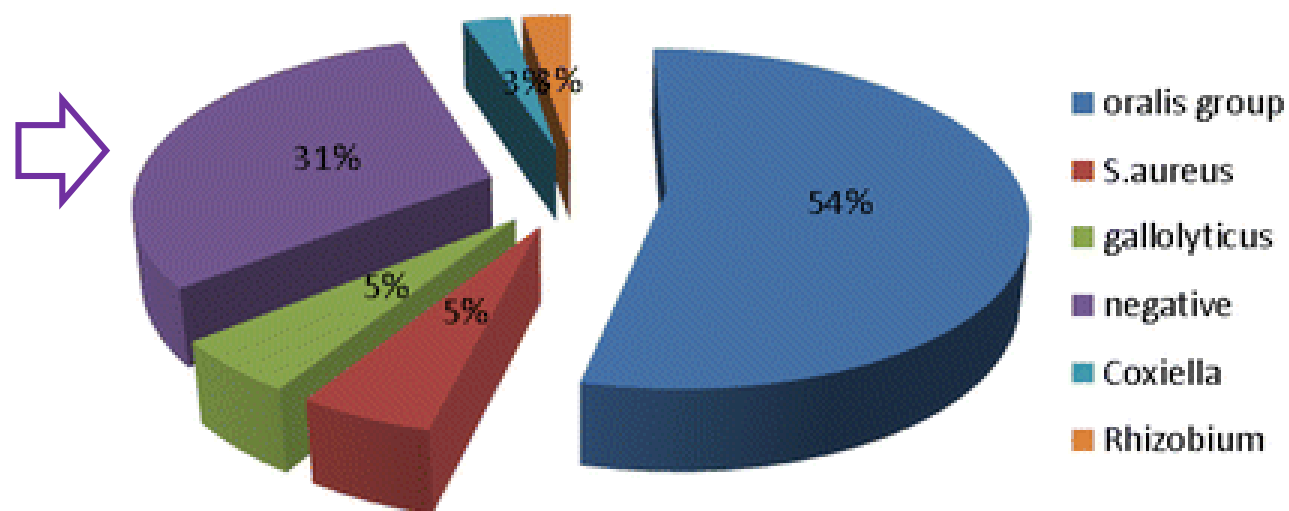
Negatif



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Hubert Lepidi² · Didier Raoult¹

PCR results in 39 valves of BCNE in
INC, 2006-2014





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MINIREVIEW



Laboratory Diagnosis of Infective Endocarditis

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Division of Clinical Microbiology, Department of Laboratory Medicine and Pathology;^a Division of Infectious Diseases, Department of Medicine;^b and Division of Anatomic Pathology, Department of Laboratory Medicine and Pathology;^c Mayo Clinic, Rochester, Minnesota, USA

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Editor Colleen Suzanne Kraft, Emory University

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Bakteriyel DNA'nın histopatolojik olarak İE ile uyumlu kapakta uzun süre (antibiyotik tedavisi altında ve sonrasında) saptanmaktadır

Yalancı negatiflik (PCR inhibitörleri, Nükleik asit miktarının sınır değerin altında kalması vb.)

Parametre	Metot	Sonuç 19.09.2018	Sonuç 09.10.2018
<i>Coxiella burnettii</i> (Q fever) Faz II IgM	IFA	1/48 Titrede pozitif	1/96 Titrede pozitif
<i>Coxiella burnetii</i> (Q fever) Faz II IgG	IFA	1/256 Titrede pozitif	1/64 Titrede pozitif
<i>Coxiella burnetii</i> (Q fever) Faz I IgG	IFA	Negatif	Negatif



Kan kültür sonuçları

30.08.2018

Gram pozitif zincir
yapmış kok

Peptostreptokok ?
(tanımlama devam ediyor)

31.08.2018

Bakteri üremedi

İnfektif endokardit etken nedir ?

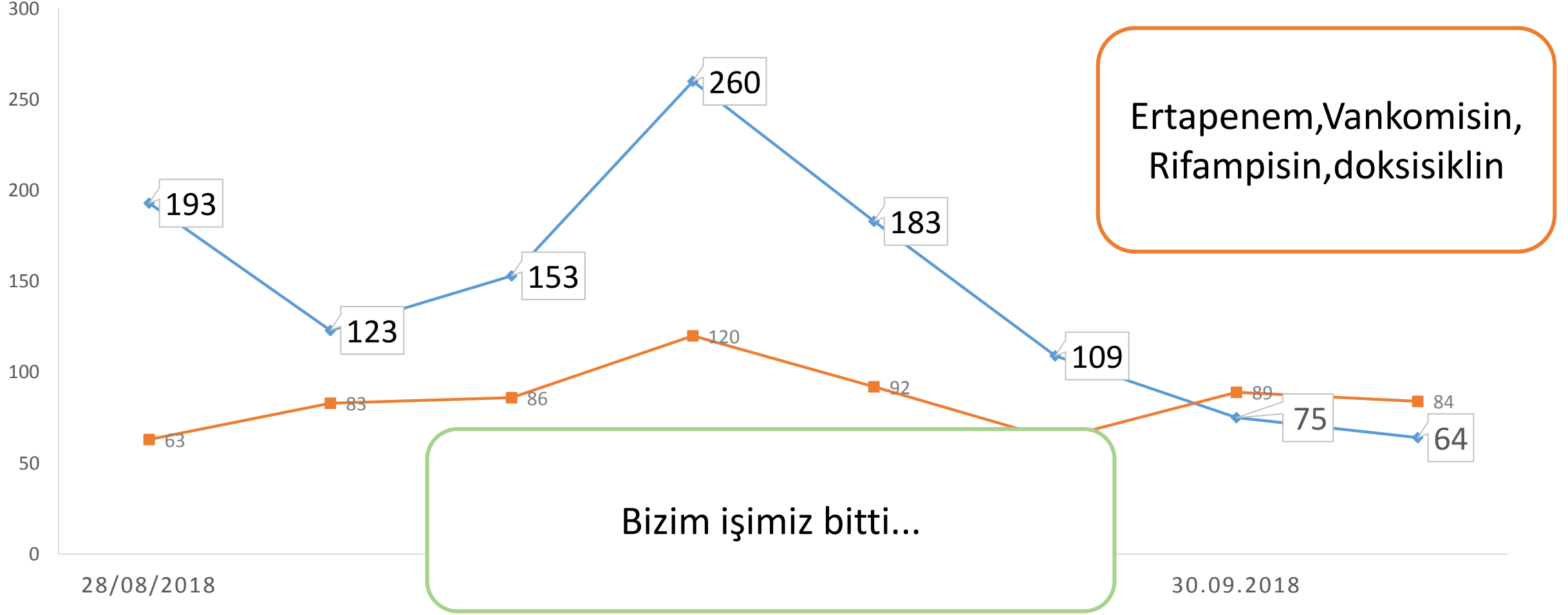
30.08.2018

Peptostreptokok ?



S.salivarius

—●— CRP —■— Sedimentasyon



S.salivarius etken olduđu
endokardit ?

4 haftalık tedavi



European Heart Journal (2015) **36**, 3075–3123
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 Ca
(EACTS), the European Association of Nu**

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

Akut Coxiella Endokarditi ?

[Clin Infect Dis](#). 2019 Feb 11. pii: ciz120. doi: 10.1093/cid/ciz120. [Epub ahead of print]

Acute Q fever endocarditis: a paradigm shift following the systematic use of transthoracic echocardiography during acute Q fever.

Melenotte C¹, Epelboin L², Million M¹, Hubert S³, Monsec T⁴, Djossou F², Mège JL¹, Habib G², Raoult D¹.

⊕ Author information

Abstract

AIMS: As Q fever, caused by *Coxiella burnetii*, is a zoonotic disease, the aim of this study was to evaluate the impact of echocardiography during acute Q fever valvular injury to improve therapeutic management.

METHODS AND RESULTS: In the French national cohort, we identified a new pattern of acute Q fever endocarditis: vegetation, valvular nodular thickening, and valvular regurgitation. Whether or not the disease was superimposed on pre-existing valvular disease, stenosis and insufficiency were considered as acute. In 35 patients, 25 had acute Q fever endocarditis and 48 had acute Q fever endocarditis. In 35 patients, 25 had acute Q fever endocarditis without underlying valvulopathy. Persistent endocarditis (OR=2.7; 95 confidence interval [1.3-5.5]; p=0.004). Acute Q fever endocarditis (OR=5.2; 95 confidence interval [2.6-10.5]; p<0.001) and age (OR=1.7; 95 confidence interval [1.1-1.9]; p=0.02) were independent predictors of progression towards persistent *C. burnetii* endocarditis.

CONCLUSION: Systematic TTE in acute Q fever patients offers a unique opportunity for early diagnosis of acute Q fever endocarditis and for the prevention of persistent endocarditis. Transoesophageal echocardiography should be proposed in men, aged over 40 years, with aCL > 60 GPLU.

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Akut *Coxiella burnetii* endokarditi persistan (endokardit, vasküler enfeksiyon, osteoartiküler tutulum) enfeksiyon riskini artırır

Carole Eldin, MD, PhD; Emmanouil Angelakis, MD, PhD; Félix Djossou, MD, PhD; Nathalie Bardin, PharmD, PhD; Pierre-Edouard Fournier, MD, PhD; Jean-Louis Mège, MD, PhD; Didier Raoult, MD, PhD

Coxiella burnetii Endokarditi ?

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⊕ Author information

Abstract

AIMS: As Q fever, caused by *Coxiella burnetii*, can cause fever and valvular injury to improve therapeutic management.

METHODS AND RESULTS: In the French Q fever cohort, we studied 100 patients with acute Q fever and valvular injury. We identified 48 patients with *C. burnetii*: vegetation, valvular nodular thickening, chorda tendinea rupture, valve thickness, chorda tendinea thickness, whether or not the disease was superimposed on pre-existing stenosis and insufficiency were considered. In 35 cases (72%), transthoracic echocardiography identified a valvular lesion of acute Q fever endocarditis without underlying valvulopathy. Positive anticardiolipin antibodies (>22 GPLU) were independently associated with acute Q fever endocarditis (OR=2.7; 95 confidence interval [1.3-5.5]; p=0.004). Acute Q fever endocarditis (OR=5.2; 95 confidence interval [2.6-10.5]; p<0.001) and age (OR=1.7; 95 confidence interval [1.1-1.9]; p=0.02) were independent predictors of progression towards persistent *C. burnetii* endocarditis.

CONCLUSION: Systematic TTE in acute Q fever patients offers a unique opportunity for early diagnosis of acute Q fever endocarditis and for the prevention of persistent endocarditis. Transoesophageal echocardiography should be proposed in men, aged over 40 years, with aCL > 60 GPLU.

Acute Q fever

Test for TTE and aCL

TTE with an acquired valvular lesion

Vegetation, valvular nodular thickening, chorda tendinea rupture, valve thickness, chorda tendinea thickness

TTE negative or inconclusive
aCL>60GPLU
Men

18 ay kombine tedavi

Klinik, serolojik ve EKO takibi

TTE with an acquired valvular lesion

Vegetation, valvular nodular thickening, chorda tendinea rupture, Valve thickness, chorda tendinea thickness

Acute Q fever endocarditis

18 months treatment with hydroxyplaquenil and doxycycline
Clinical, serological and TTE every 3 months
Blood antibiotic dosage every month

Hastanın antibakteriyel tedavi planı ne olmalıdır?

Post - operatif takip planı ne olmalıdır?

Enfeksiyon

Hasta oral sefiksim ve doksisiklin tedavisi ile taburcu edilmiştir

08.10.18 - 30.10.18 arasında oral tedavi almıştır (3 hafta)

Romatoloji

Enfeksiyon

Kardiyoloji

KVC

Son enfeksiyon hastalıkları poliklinik başvurusu: 22.10.2018

Klinik stabil, ateş yok, ek şikayet yok
Tedavi devamı, 14 gün sonra kontrol

Son kontrol (KVC): 22.02.2019

Klinik stabil, ateş yok, kapak fonksiyonları iyi, ek şikayet yok

