Bacterial Endocarditis

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Overview

• In pre-antibiotic era endocarditis was usually a fatal disease as a result of CHF
• Host defenses play minor role in disease
• Staphylococci and Streptococci usually responsible for ≥75% cases
  – S. aureus primary pathogen
• New Infective Endocarditis Guidelines
  – AHA Circulation 111:3167-3184, 2005
  – BSAC JAC 54:971-981, 2004
Definitions

• Acute Bacterial Endocarditis (ABE):
  – Fulminating infection
  – High fever
  – Systemic toxicity
  – Death in < 6 weeks
• Subacute Bacterial Endocarditis (SBE):
  – Indolent infection
  – Prior to valvular disease
  – Death in 6 weeks – 3 months
• “Left-sided” endocarditis
  – Mitral valve

Definitions

• “Right-sided” endocarditis
  – Involvement of the tricuspid valve
  – Related to IVDA and indwelling pacemakers
• “Native-valve” endocarditis
• “Prosthetic-valve” endocarditis
• “Culture-Negative” endocarditis
  – Bad isolation/identification technique
  – Fastidious isolate
  – Non-bacterial culprit
  – Antibiotics administration pre-culture
Pathogenesis

- Valve surface altered through trauma or blood turbulence eroding endothelial lining
  - Fibrin and platelets deposited at the damaged site forming nonthrombotic vegetative lesion
  - Transient bacteremia seeds vegetative lesion
  - Bacteria enter exponential growth protected from WBC in the confines of the vegetation
  - Bacteria can begin to damage valve and seed bloodstream with bacteria
Native Valve Endocarditis

• Right Sided
  – Tricuspid ≤ 6% (Most often IVDA)
  – Pulmonary < 1%

• Left Sided
  – Mitral 30 - 45%
  – Aortic 5 - 35%
  – Both valves ≤ 35%

Intravenous Drug Abuse (IVDA) Endocarditis

• Disease of the right side of the heart
• May present as pulmonary syndrome
  – Fever
  – Cough
  – Pleuretic chest pain
  – Hemoptysis
  – Pathogen a function of patient’s IV drug practices
    • Contaminated water, drugs, or equipment
Pathogenesis

• Conditions contributing to the development of endocarditis
  – Bacteremia (15-25%)
  – History of IV drug abuse
  – History of rheumatic heart disease
  – Congenital heart disease or malformations
  – Mitral valve prolapse or valvular insufficiency
  – Ventral septal defect
  – Valvular stenosis
  – Prosthetic valve
Endocarditis

- Common Bacterial Pathogens
  - S. aureus (MRSA or MSSA)
  - S. epidermidis (MRSE or MSSE)
  - S. viridans
  - Enterococci
  - S. pneumoniae
  - HACEK organisms
Endocarditis

• Bacterial Pathogens
  – HACEK Group
    • Haemophilus spp.
    • Actinobacillus actinomycetemcomitans
    • Cardiobacterium hominis
    • Eikenella corrodens
    • Kingella kingae
    Slow growing, fastidious Gram negatives likely cause of Culture Negative Endocarditis

Pathogens

• Staphylococci
  – S. aureus vs S. epidermidis (?contaminated B/C)
  – Methicillin sensitive vs resistant

• Enterococci
  – E. faecalis vs E. faecium vs other
  – Gentamicin &/or streptomycin sensitive
  – Ampicillin sensitive or resistant
  – Vancomycin sensitive or resistant
Enterococci

• Enterococci naturally tolerant to aminoglycosides
  – MIC < 500 mg/L = “sensitive” or synergy likely
  – MIC > 2000 mg/L = “resistant”
  – Gentamicin or Streptomycin aminoglycosides of choice
  – Resistance to gentamicin does not always mean resistance to streptomycin (reverse also true)
  – Tobramycin or amikacin not reliable choice

Culture Negative Endocarditis

• Misnomer as there may be a pathogen but organism recovery may not be possible with standard methods
  – Fungal
  – HACEK group
  – Rickettsiae
  – Chlamydiae
  – Anaerobes
  – Cysteine/Vitamin B6 dependent Streptococci
  – Brucella
  – Viral
  – Prior antibiotic therapy
  – Misdiagnosis
Diagnosis of Endocarditis

  – Definite Case of Endocarditis
    • Must have 2 major criteria or
      1 major criteria & 3 minor criteria or 5 minor criteria
  – Possible Case of Endocarditis
    • Patient appears to have endocarditis but does not have
      the necessary number of major and minor criteria
  – Rejected Possibility of Endocarditis
    • While possibility considered initially an alternative
diagnosis established or pathologic diagnosis not
  established
Duke - Major Criteria

- **Positive blood cultures**
  - Typical pathogen frequently associated with endocarditis
  - Multiple positive cultures (75-100% of cultures positive)
  - Positive cultures obtained throughout the day
  - Positive serology
- **Evidence of endocardial involvement**
  - New evidence of valve regurgitation
  - Echocardiogram positive
    - Vegetation present
    - Evidence of intra-cardiac abscess
    - Dehiscence of prosthetic valve

Duke - Minor Criteria

- **Fever ≥38 C (100.4 F)**
- **History of IVDA or predisposing heart disease**
- **Positive Blood culture but not typical pathogen**
- **Echo not meeting major criterion**
- **Immune**
  - +RF, Osler Node, Roth Spot, or Glomerulonephritis
- **Vascular**
  - PE, mycotic aneurysm, Janeway lesion, arterial emboli, intracranial hemorrhage, Flame hemorrhage
Janeway Lesion

Janeway lesions are seen in people with acute bacterial endocarditis. They appear as flat, painless, red to bluish-red spots on the palms and soles.

Janeway Lesion: Flat, painless, erythematous lesions seen on the palm of this patient's hand. While frequently associated with bacterial endocarditis, in this case, they are the result of an infected radial artery aneurysm (inflamed area proximal to thumb). Photo credit, Josh Fierer, M.D.
A white, round spot in the retina close to the optic disk, often surrounded by oval areas of haemorrhages. Seen in bacterial endocarditis, pernicious anaemia, and leukaemia.

Roth Spot

Osler Node

Painful, red, raised lesions on the finger pulps, indicative of the heart disease subacute bacterial endocarditis. They are caused by immune complex deposition.

10-25% of endocarditis patients will have Osler's nodes. It can also be seen on the soles of the feet.

They are named after Sir William Osler.
Diagnostic work-up

- CBC with differential, U/A, ESR
- ≥ 3 sets of blood cultures drawn at different sites and times
- EKG & Echo
- Antibiotic sensitivity studies if +B/C’s
- Peak / trough serum inhibitory titer (SIT) & serum bactericidal titer (SBT)
- Physical for classic findings of endocarditis
  - Neurologic (change in mental status or stroke)

Echocardiography

- Attempt to visualize vegetation's on heart valve
  - Lesions must be > 2mm in size
- Negative test does not necessarily exclude endocarditis
  - Transesophageal (TEE)
    - Provides the most information but most invasive
      (approx 90% accurate in diagnosis)
  - Transthoracic (TTE)
    - Less invasive but harder to visualize valves
Endocarditis Treatment

• For left sided endocarditis generally 4 to 6 weeks of antibiotic therapy recommended
• For right sided endocarditis shorter courses of antibiotics may be considered

Therapeutic Goals

• Identify, if possible, the primary site of infection
• Identify infecting pathogen so as to direct therapy
• Sterilize the blood now and following therapy
• Prevent or limit valvular damage and resulting CHF
• Use a bactericidal antibiotic regimen
• Maintain optimal nutritional status of patient
• Prevent embolic disease
• Advise patient &/or family regarding future need for antibiotic prophylaxis
Treatment Considerations

- Large bacterial inoculum
- Pathogens not in exponential growth phase compromising the effect of antibiotics
- Platelet fibrin network prevents WBC from confronting bacteria
- Antibiotics and surgery only real treatment options

Staphylococci

- Methicillin Resistant
  - Vancomycin, Linezolid, Daptomycin or Q/D
- Methicillin Sensitive
  - Nafcillin
  - ± Gentamicin
  - ± Rifampin
Daptomycin vs. Standard Therapy for S. aureus Bacteremia & Infective Endocarditis


- Daptomycin dosed at 6 mg/Kg/day vs semisynthetic penicillin or vancomycin with low dose gentamicin X 4 days
- TOC (42 days) 53/120 (44.2%) DAP vs. 48/115 (41.7%) COMP
- CPK elevation 25.0% DAP vs 12.5% COMP (p= 0.038)
  - Drug D/C’d due to CPK elevation in 3/120 (2.5%) DAP
- Worsening renal function 19.8% DAP vs. 46.8% COMP (p < 0.001)
  - Vancomycin troughs averaged just under 15 mg/L
- MIC elevations in 7 daptomycin patients (6/7 microbiologic failures)
- No difference between drugs in time to sterilize blood

Vancomycin vs. Nafcillin vs. S. aureus Endocarditis

<table>
<thead>
<tr>
<th>Investigator</th>
<th>Antibiotic</th>
<th>+BC</th>
<th>Cure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Korzeniowski</td>
<td>N</td>
<td>Mean 3.4d</td>
<td>22/35 (63%)</td>
</tr>
<tr>
<td>(1982)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chambers (1988)</td>
<td>N+T</td>
<td>19/20 sterile 48hrs</td>
<td>47/50(94%)</td>
</tr>
<tr>
<td></td>
<td>V+T</td>
<td>1 pt (+BC 12&amp;14d)</td>
<td>1/3 (33%)</td>
</tr>
<tr>
<td>Small (1990)</td>
<td>V</td>
<td>2Pt(+BC 7-16d)</td>
<td>8/13(62%)</td>
</tr>
<tr>
<td>Levine (1991)</td>
<td>V</td>
<td>Median 7d</td>
<td>18/22(82%)</td>
</tr>
<tr>
<td></td>
<td>V+R</td>
<td>Median 9d</td>
<td>18/20(90%)</td>
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Karchmer Ann Intern Med 1991
Adjunct use of gentamicin for staphylococcus

- Data almost exclusively with right sided endocarditis, nafcillin, and S. aureus
- Data has been extrapolated to:
  - Left sided endocarditis
  - Bacteremia
  - S. epidermidis
  - Vancomycin
  - Other beta-lactam antibiotics

Adjunct Therapy of S. aureus with Gentamicin

- Questionable practice
  - No difference in morbidity (other than duration of fever) or mortality
  - Addition of gentamicin reduces duration of bacteremia by approximately 1/2 day
  - Greatly increases risk of nephrotoxicity (NEJM 335:653-665, 2006)

- If decision is made to use gentamicin
  - Duration of therapy ≤ 5 days
  - Maintain Cpmax 3-5 mg/L & Cpmin < 1 mg/L
  - Present data would not support SDD
Adjunct Use of Rifampin

- Rifampin added for “synergy”
  - In-vitro data suggests possible synergy, antagonism, or indifference
- Levine suggests that the addition of rifampin to vancomycin offers no therapeutic advantage
- Drug might be useful in patients unable to lyse *S. aureus* inside WBC

Enterococci

- Beta-lactam sensitive
  - Ampicillin or Penicillin G (+ aminoglycoside if sensitive)
- Vancomycin Resistant
  - Daptomycin (6 mg/Kg/day)
  - Linezolid
  - Quinupristin/dalfopristin (*E. faecium* only)
  - Doxycycline/Minocycline
  - Chloramphenicol
- Aminoglycosides
  - Gentamicin or streptomycin if sensitive (+ cell wall agent)
  - Maintain gentamicin Cmax 3-5 mg/L & Cmin < 1 mg/L
  - Maintain streptomycin Cmax approximately 20 mg/L
**S. pyogenes & S. bovis**

- Can use any of the following
  - Penicillin G for 4 weeks
  - Penicillin G and gentamicin for 2 weeks
  - Penicillin G for 4 weeks and gentamicin for 2 weeks
    - MIC must be between 0.1-0.5 mg/L
  - Ceftriaxone daily for 4 weeks
- Outcomes are essentially equal

**Aminoglycosides and Endocarditis**

- Aminoglycosides are ototoxic and nephrotoxic
- Want to limit therapy to as short a period of time as possible to avoid toxicity
  - Staphylococci ≤ 5 days
  - Enterococci will require 4-6 weeks
  - Control peak and trough concentrations
- Elderly and/or renally impaired patients treated for extended periods of time are at greatest risk
Role of Anticoagulants in Endocarditis

- No anticoagulation if patient in NSR with uncomplicated endocarditis (native or bioprosthetic valve)
- Recommended long term in patients with PVE (mechanical) unless there are contraindications
- Embolism during therapy for native or bioprosthetic valve endocarditis uncertain & depend on circumstances

Surgical Indications in Endocarditis

- Hemodynamically unstable
  - New or worsening CHF
  - Valvular dysfunction
- Uncontrolled infection
  - + Blood cultures > 3 days
  - Fungal endocarditis
  - Perivavular or myocardial abscess
- Eliminate primary site of infection
Relative Indications for Surgery

- Vegetation >10mm
- Recurrent systemic emboli (≥ 2)
- Mitral valve preclosure
- Ruptured chordae tendineae, papillary muscle, ventricular septum
- Heart block
- Infection relapse

Endocarditis - Cause of Death

- CHF
- Embolic phenomena
- Mycotic aneurysm rupture
- Complications from cardiovascular surgery
- PVE
- Inadequate response to antibiotics
Antibiotic Prophylaxis
American Heart Assoc. JAMA 277:1794,1997

• One hour prior to procedure:
  – 2 Gm Amoxicillin orally or
  – 600 mg Clindamycin orally or
  – 2 Gm Cephalexin orally or
  – 500 mg Clarithromycin orally or
  – 2 Gm Ampicillin intramuscularly

Conclusions

• Despite changing pathogen picture for endocarditis, >75% still caused by staphylococci & streptococci
• Increasing use of prosthetic devices increasing the prevalence of MRSE
• Changing patterns of IVDA may alter the spectrum of bacterial pathogens
• Resistance with Gram positive pathogens may make us more dependent on new drugs