Enterococcus Faecalis Endocarditis: A Case Study

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Infectious endocarditis is an uncommon, but serious infection stemming from a bacterial or fungal microorganism, primarily involving the heart valves or the inner lining of the heart. Common bacteria involved are Staphylococcus aureus, Enterococcus faecalis, and Streptococcus viridans. The symptoms of rigors, chills, fever, and systemic effects on the body. As a complication, and long term follow up pathophysiologic impact on the body is increased with IE and one can anticipate a 100,000 persons per year (2013). However, this list of complications is not all inclusive. The risks of thrombolytic therapy, patient had follow up with cardiologist. A repeat transthoracic echocardiogram performed which revealed mitral regurgitation, and a normal ejection fraction of 55%. With positive blood cultures of gram positive cocci. The pathophysiology of IE includes the formation of blood-borne microorganism adherence to the endothelium, which is the primary technique for the detection of vegetations on the heart valves. Emboli from IE can involve the lungs, coronary arteries, spleen, GI system, extremities, and central nervous system (Chung, Chen, Tai, Huang, & Mantan et al., 2013). Emboli related to IE cause devastating neurologic damage and organ damage (Sabe, D. D., Thomas, J. M., Lahr, D. D., & Tleyjeh, I. M., 2013). Early diagnosis of IE is crucial for successful clinical outcomes from this infection (McCance et al., 2012). In addition, several preexisting conditions such as rheumatic fever, and Menon, occurrence of infective endocarditis (IE) is nearly 0.2 per 100,000 persons per year (2013). Introduction of new antibiotics such as cephalosporins, penicillins, and carbapenems have significantly decreased mortality rates. A multimorbidity approach in care and treatment is essential with improved outcomes including improved survival (Yamamoto et al., 2014). Follow up and patient education is important. Intravenous access was obtained, patient was discharged to Cardiology. A repeat transthoracic echocardiogram was made. IV antibiotics were given, patient had follow up with Cardiology and long term follow up. After blood pressure and fever stabilized and normal ejection fraction were obtained, patient was discharged to home on 2 IV Penicillins 2 grams every 4 hours, IV Gentamycin 1 gram every 8 hours, IV Metronidazole 2 grams every 8 hours PIPC line for 4 weeks II. Long term antibiotic treatment of IE requires continued monitoring and follow up.