Author's response to reviews

Title: Vegetation on the run: a case report

Authors:

Vishal Luther Dr (vishal_luther@yahoo.co.uk)
Refai Showkathali Dr (refais@gmail.com)
Reto Gamma Dr (reto.gamma@btuh.nhs.uk)

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Author's response to reviews:

Many thanks for your review of our manuscript.
We hope to have addressed all the questions you have raised below.

1. When did the AVR happen?
   5 years before this presentation.

2. Why was this patient not eligible for PCI?
   Even though there are case reports showing successful reperfusion being achieved with primary PCI in the setting of septic coronary embolisation, there are still risks of distal embolisation, as well as localised mycotic aneurysm formation post balloon dilatation or stent deployment.

3. Can mycotic aneurysms be silent in the brain and how easily are they investigated to allow to move onto thrombolysis?
   Patients with left sided endocarditis do have a higher prevalence of silent cerebral microinfarction and mycotic aneurysms. Thus thrombolytic treatment in this setting has demonstrated an increased risk of cerebral vascular haemorrhage. We are unaware of how easily these can be investigated. One would likely need MRI/MR cerebral angiography facilities to operate fairly quickly in view of the short thrombolytic window seen in ST elevation MI.

4. What had been the time relationship for attempted DC cardioversion and the embolic event? Is it wise to do this in a patient with valvular adhesions?
   The embolic event occurred 3 days post DC Cardioversion. There must exist a risk of embolisation with DC cardioversion in this setting, though expectedly there is no data to quantify this risk. As there was initial delay in proceeding to definitive surgery on transfer to our unit, the decision to electrically cardiovert was made as the patient remained compromised in AF despite rate control.

5. Which bug was grown on pm?
   Unknown
6. You do not much help me in your argument with decision making were I to come across a similar case; I could not see how the patient was helped by the movement to a specialist centre.

The patient was moved to our cardiac centre as he met the criteria for surgical intervention of left sided endocarditis – i.e. entering in congestive cardiac failure. In addition, patients with prosthetic heart valves are often managed in cardiothoracic centres as surgical intervention is recommended in uncontrolled sepsis. It is also recommended that patients with septic emboli be transferred.

The patient was not helped in our centre with regard to his embolic event. For this unusual clinical scenario of coronary embolisation, there remains a lack of evidence supporting the most appropriate management strategy. We hope that as more experience of this scenario is gained by specialists, that better guidance will be available in the future.

We have valued all your questions and concerns and have edited the main manuscript to include these answers.