



Disseminated Emboli caused by a Large Vegetation in *Staphylococcus aureus* Endocarditis

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Clinical Image

A 59-year-old woman with no prior medical history presented with acute fever and generalized weakness. Physical examination on admission was normal. Three sets of blood cultures drawn hours apart were positive for methicillin-sensitive *Staphylococcus aureus*, prompting therapy with flucloxacillin. Transesophageal echocardiogram revealed a bicuspid aortic valve bearing a 35 mm echogenic filamentous mass, swinging between the aorta during systole and the left ventricular outflow tract during diastole (Figure 1A and Figure 1B), confirming infective endocarditis. Within 24 hours, Janeway lesions became apparent (Figure 1C). Computed tomography scan revealed splenic and liver infarcts and intracranial subarachnoid hemorrhage. Cerebral angiography ruled-out significant vascular lesions and the patient underwent uncomplicated aortic valve replacement (Figure 1D). As a reminder, the 2015 European Society of Cardiology guidelines recommend surgery for left-sided vegetations larger than 10 mm with embolic events despite antibiotic therapy, and advise surgery for those larger than 15 cm, notably when over 30 mm [1].

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Figure 1: Echocardiogram revealing a 35 mm filamentous mass (*) on the aortic valve during systole (A) and diastole (B), Janeway lesions (C), resection of the bicuspid valve bearing the large vegetation (D).

Reference

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