ESC Guidelines

Guidelines on Prevention, Diagnosis and Treatment of Infective Endocarditis

Executive Summary

The Task Force on Infective Endocarditis of the European Society of Cardiology

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Table of contents

Preamble .................................................... 267
Introduction ................................................ 268
Definitions, terminology .................................. 268
Prevention of infective endocarditis ................. 268
  Cardiac conditions/patients at risk ............... 268
  Patient-related non-cardiac conditions .......... 268
  Predisposing diagnostic and therapeutic interventions ........................................ 268
Prophylactic antibiotic regimens .................... 269
Diagnosis .................................................. 269
  History, symptoms, signs and laboratory tests .. 269
  Echocardiography ..................................... 269
  Standard blood culture techniques .......... 270
  Culture-negative endocarditis (CNE) ............ 270
Treatment and management ............................ 271
  Antimicrobial therapy ............................... 271
  Drug level monitoring ............................... 271
Empirical therapy ...................................... 271
  Special subsets ...................................... 271
Management of complications ....................... 271
  Surgery for active NVE ............................. 272
  Surgery for active PVE ............................. 273
  Postoperative antibiotic treatment ............. 273
List of Abbreviations .................................... 273
Further Reading ............................................ 274

Preamble

Guidelines and Expert Consensus documents aim to present all the relevant evidence on a particular issue in order to help physicians to weigh the benefits and risks of a particular diagnostic or therapeutic procedure. They should be helpful in everyday clinical decision-making.

A great number of Guidelines and Expert Consensus Documents have been issued in recent years by different organizations, the European Society of Cardiology (ESC) and by other related societies. By means of links to web sites of National Societies several hundred guidelines are available. This profusion can put at stake the authority and validity of guidelines, which can only be guaranteed if they have been developed by an unquestionable
decision-making process. This is one of the reasons why the ESC and others have issued recommendations for formulating and issuing Guidelines and Expert Consensus Documents.

In spite of the fact that standards for issuing good quality Guidelines and Expert Consensus Documents are well defined, recent surveys of Guidelines and Expert Consensus Documents published in peer-reviewed journals between 1985 and 1998 have shown that methodological standards were not complied within the vast majority of cases. It is therefore of great importance that guidelines and recommendations are presented in formats that are easily interpreted. Subsequently, their implementation programmes must also be well conducted. Attempts have been made to determine whether guidelines improve the quality of clinical practice and the utilisation of health resources.

The ESC Committee for Practice Guidelines (CPG) supervises and coordinates the preparation of new Guidelines and Expert Consensus Documents produced by Task Forces, expert groups or consensus panels. The Committee is also responsible for the endorsement of these Guidelines and Expert Consensus Documents or statements.

Level of recommendations and evidence

<table>
<thead>
<tr>
<th>Strength of recommendation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Class I</td>
<td>Evidence and/or general agreement that a given treatment or a diagnostic approach is beneficial, useful and effective</td>
</tr>
<tr>
<td>Class II</td>
<td>Conflicting evidence and/or a divergence of opinions about the usefulness/efficacy of a treatment or a diagnostic measure</td>
</tr>
<tr>
<td>IIa</td>
<td>Weight of evidence/opinion is in favour of usefulness/efficacy</td>
</tr>
<tr>
<td>IIb</td>
<td>Usefulness/efficacy is less well established by evidence/opinion</td>
</tr>
<tr>
<td>Class III</td>
<td>Evidence or general agreement that the treatment/diagnostic measure is not useful/effective and in some cases may be harmful</td>
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Prevention of infective endocarditis

For prophylactic reasons, antibiotics should be given before a bacteraemia is expected. If antibiotic prophylaxis is not given prior to this event, antibiotics may help a late clearance if administered intravenously within 2–3 h.

Cardiac conditions/patients at risk

A previous history of IE, the presence of prosthetic heart valves or other foreign material, surgically created conduits, and complex cyanotic congenital abnormalities are considered high-risk situations. Only patients with high or moderate risk (Table 2) should receive prophylaxis. This is a class I recommendation based on level C evidence.

Patient-related non-cardiac conditions

Older age, conditions (a), promoting non-bacterial thrombotic vegetation; (b), compromising host defense; (c), compromising local non-immune defence mechanisms; and (d), increased risk/frequency/amount of bacteraemia are considered patient-related, non-cardiac risk conditions.

Predisposing diagnostic and therapeutic interventions

Procedures which may cause bacteraemia and for which antimicrobial prophylaxis is recommended are given in Table 3. Prophylaxis is not recommended for cardiac catheterization.

Dental hygiene is of major importance for the prevention of IE.
**Prophylactic antibiotic regimens**

Prophylaxis aims primarily at viridans streptococci and HACEK organisms before dental, oral, respiratory, and oesophageal procedures, and at enterococci and *Streptococcus bovis* before gastrointestinal and genitourinary procedures. Despite a lack of convincing evidence antibiotic prophylaxis (Table 4) is a class I recommendation (based on level C evidence).

**Diagnosis**

**History, symptoms, signs and laboratory tests**

The diagnosis of IE is established (definite IE) if during a systemic infection involvement of the endocardium is demonstrated. If, in addition, bacteraemia (positive blood cultures) or bacterial DNA are found, IE is definite and culture/microbiologically positive, otherwise IE is definite but culture/microbiologically negative (Table 5). Duke or modified Duke criteria may be used to make the diagnosis in otherwise unclear cases.

**Echocardiography**

Any patient suspected of having NVE by clinical criteria should be screened by transthoracic echocardiography (TTE). When images are of good quality and prove to be negative and there is only a low clinical suspicion of IE, endocarditis is unlikely and other diagnoses are to be considered. If suspicion of IE is high, transoesophageal echocardiography (TEE) should be performed in all TTE-negative cases, in suspected PVE, and if TTE is positive but complications are suspected or likely and before cardiac surgery during active IE. If TEE remains negative and there is still suspicion, it should be repeated within one week. A repeatedly negative study should virtually exclude the diagnosis (Fig. 1). These class I recommendations are based on level B evidence.

Three echocardiographic findings are considered to be major criteria in the diagnosis of IE: (a), a mobile,
echodense mass attached to the valvular or the mural endocardium or to implanted prosthetic material; (b), demonstration of abscesses or fistulas; (c), a new dehiscence of a valve prosthesis, especially when occurring late after implantation.

**Standard blood culture techniques**

Three or more blood cultures (BC) should be taken irrespective of body temperature at least 1 h apart. If the patient has been on short-term antibiotics, one should wait, if possible, at least for three days after discontinuing antibiotic treatment before new BCs are taken. Blood cultures after long-term antibiotic treatment may not become positive after treatment has been discontinued for 6–7 days.

One BC consists of one aerobic and one anaerobic bottle, each containing approx. 50 ml of medium (less in pediatric BC bottles). Venous blood, minimally 5 ml and better 10 ml in adults and 1–5 ml in children should be added to each bottle. Minimum inhibitory concentrations should be determined for the drugs of choice.

**Culture-negative endocarditis (CNE)**

The most frequent cause of CNE is previous antimicrobial treatment. If traditional (non-automatic) BC systems are used, longer incubation periods (>6 days) are required when organisms of the HACEK group, *Propionibacterium* spp., *Neisseria* spp., *Brucella*, *Abiotrophia* spp., or *Campylobacter* spp. are suspected. Especially in CNE all material excised during cardiac surgery for active IE should also be cultured and examined.

The value of serology has been proven for IE due to *Bartonella*, *Legionella*, *Chlamydia* (immunofluorescence) and *Coxiella burnetii*.

The use of broad-spectrum polymerase chain reaction (PCR) provides a significant improvement in the capability to detect difficult-to-culture organisms and even dead bacteria.
Treatment and management

Antimicrobial therapy

For treatment strategies refer to Tables 6–9.

All patients with streptococcal IE should be treated for at least 2 weeks in hospital and observed for cardiac and non-cardiac complications. Patients may then be candidates for outpatient and home parenteral antibiotic therapy. Treatment recommendations for streptococcal IE are based on consistent results of a large number of studies (class I recommendation based on level B evidence).

IE caused by methicillin-resistant S. aureus (MRSA) is a therapeutic challenge as most strains are also resistant to most aminoglycosides. If the clinical course is complicated, treatment should be as for PVE.

Coagulase-negative species (CONS) causing PVE within the first year after valve replacement are usually methicillin-resistant. Therapy of choice is a combination of vancomycin and rifampicin for at least 6 weeks with the addition of gentamicin for the initial 2 weeks.

Despite lacking randomized studies and thus level A evidence, the scientific material available is convincing and allows for a class I recommendation.

Enterococci are generally resistant to a wide range of antimicrobial agents including aminoglycosides (MIC for gentamicin 4–64 mg/l). (Table 7)

Duration of treatment should be at least 4 weeks for the combination and at least 6 weeks in complicated cases, in patients having symptoms for more than 3 months, and in patients with PVE. These class Ila recommendations are based on level B evidence.

Drug level monitoring

Gentamicin trough levels should be less than 0.1 mg/l to avoid renal or ototoxic effects.

Optimum vancomycin effects are achieved if serum concentrations are continuously kept at least 2–4 times above the MIC of the causative organism. Trough levels should be at least 10–15 mg/l. In patients with normal renal function, drug levels should be controlled once, but 2–3 times weekly if combined with aminoglycosides.

Empirical therapy

In cases complicated by sepsis, severe valvular dysfunction, conduction disturbances, or embolic events, empirical antimicrobial therapy should be started after three blood cultures have been taken (see standard blood culture techniques section).

Recommendations for empirical antibiotic treatment (before microbiologic test results are available) and CNE are given in Table 9.

Special subsets

Antimicrobial therapy for infections of permanently implanted pacemakers or ICD leads are based on culture and susceptibility results. Duration of therapy should be 4–6 weeks in most cases. Removal of the entire system is generally recommended.

In intravenous drug abusers (IVDAs), a methicillin-susceptible S. aureus (MSSA) is the causative organism in about 60–70% of cases. The tricuspid valve is affected in more than 70%. The most common organism (S. aureus) must always be covered by the antibiotic regimen. Treatment will include either penicillinase-resistant penicillins or vancomycin, depending on the local prevalence of MRSA. If the patient is a pentazocine addict, an antipseudomonas agent should be added. In IVDAs use brown heroine dissolved in lemon juice, Candida should be considered and antifungal treatment added. In IVDAs with underlying valve lesions and/or left-sided involvement, antibiotic treatment against streptococci and enterococci must be added.

Management of Complications

Rapid and effective antimicrobial treatment may help to prevent embolism. If the patient is on long-term oral anticoagulation, coumarin therapy should be discontinued and replaced by heparin immediately after the diagnosis of IE has been established.

After an embolic complication, the risk for recurrent episodes is high. After manifestation of a cerebral embolism, cardiac surgery to prevent a recurrent episode is not contraindicated if performed early (best within 72 h) and cerebral haemorrhage has been excluded by cranial-computed tomography immediately before the operation. If surgery is not performed early it is advisable to be postponed for 3–4 weeks.

Surgery for active NVE

The following indications for urgent valve surgery are accepted:
Heart failure due to acute aortic regurgitation;
Heart failure due to acute mitral regurgitation;
Persistent fever and demonstration of bacteremia for more than 8 days despite adequate antimicrobial therapy;
Demonstration of abscesses, pseudoaneurysms, abnormal communications like fistulas or rupture of one or more valves, conduction disturbances, myocarditis or other findings indicating local spread (locally uncontrolled infection);
Involvement of microorganisms which are frequently not cured by antimicrobial therapy (e.g. fungi; *Brucella* and *Coxiella*) or microorganisms which have a high potential for rapid destruction of cardiac structures (e.g. *S. lugdunensis*).

If vegetations are larger than 10 mm on the mitral valve or if they are increasing in size despite antibiotic therapy or if they represent mitral kissing vegetations, early surgery should also be considered.

The prognosis of right-sided IE is favourable. Surgery is necessary if tricuspid vegetations are larger than 20 mm after recurrent pulmonary emboli.

### Surgery for active PVE

The following indications are accepted:

- Early PVE (less than 12 months after surgery)

<table>
<thead>
<tr>
<th>Table 6</th>
<th>Decision making for antibiotic treatment of native (NVE) and prosthetic valve endocarditis (PVE) due to streptococci</th>
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<tbody>
<tr>
<td><strong>Regimen A</strong> NVE; full susceptibility to penicillin (MIC ≤0.1 mg/l)</td>
<td></td>
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<tr>
<td>— patients ≤65 years, normal serum creatinine levels</td>
<td>penicillin G 12–20 million units/24 h IV, divided into 4–6 doses for 4 weeks plus gentamicin 3 mg/kg/24 h IV (maximum 240 mg/day), divided into 2–3 doses for 2 weeks</td>
</tr>
<tr>
<td>— same conditions as above with uncomplicated courses and rapid clinical response to therapy</td>
<td>penicillin G 12–20 million units/24 h IV, divided into 4–6 doses for 2 or 4 weeks with ambulatory treatment after 7 days treatment in hospital*</td>
</tr>
<tr>
<td>— patients ≥65 years and/or serum creatinine levels elevated or allergy to penicillin</td>
<td>penicillin G adapted to renal function for 4 weeks or ceftriaxone 2 g/24 h IV as single dose for 4 weeks</td>
</tr>
<tr>
<td>— patients allergic to penicillin and cephalosporins</td>
<td>vancomycin 30 mg/kg/24 h IV divided into two doses for 4 weeks</td>
</tr>
</tbody>
</table>

| **Regimen B** susceptibility to penicillin (MIC 0.1 mg/l–0.5 mg/l) or PVE |  |
| — penicillin G 20–24 million units/24 h IV divided into 4–6 doses or ceftriaxone 2 g/24 h IV as single dose both for 4 weeks plus gentamicin 3 mg/kg/24 h IV, divided into 2–3 doses for 2 weeks*, followed by ceftriaxone 2 g/24 h IV for additional 2 weeks | vancomycin as single drug treatment for 4 weeks (dosage see above) |

| **Regimen C** resistance to penicillin; MIC >0.5 mg/l* |  |
| — penicillin adapted to renal function for 4 weeks or ceftriaxone 2 g/24 h IV as single dose both for 4 weeks plus gentamicin 3 mg/kg/24 h IV, divided into 2–3 doses for 2 weeks, followed by ceftriaxone 2 g/24 h IV for additional 2 weeks | vancomycin as single drug treatment for 4 weeks (dosage see above) |

<table>
<thead>
<tr>
<th>Table 7</th>
<th>Decision-making for antibiotic treatment of IE due to enterococci and penicillin-resistant streptococci</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penicillin MIC ≤8 mg/l and for gentamicin MIC &lt;500 mg/l</td>
<td>Penicillin G, 16–20 million units in 4–6 divided doses plus gentamicin 3 mg/kg, IV, divided in two doses for 4 weeks Vancomycin 30 mg/kg/day IV in two divided doses plus gentamicin (dosage as above) for 6 weeks Vancomycin plus gentamicin (dosage as above) for 6 weeks Assistance of an experienced microbiologist is mandatory. If antimicrobial therapy fails, valve replacement should be considered early</td>
</tr>
<tr>
<td>Penicillin-allergic patients with penicillin/gentamicin susceptible enterococcal isolates</td>
<td>Penicillin G, 16–20 million units in 4–6 divided doses plus gentamicin 3 mg/kg, IV, divided in two doses for 4 weeks Vancomycin 30 mg/kg/day IV in two divided doses plus gentamicin (dosage as above) for 6 weeks Vancomycin plus gentamicin (dosage as above) for 6 weeks Assistance of an experienced microbiologist is mandatory. If antimicrobial therapy fails, valve replacement should be considered early</td>
</tr>
<tr>
<td>Penicillin-resistant strains, MIC &gt;8 mg/l*</td>
<td>Penicillin G, 16–20 million units in 4–6 divided doses plus gentamicin 3 mg/kg, IV, divided in two doses for 4 weeks Vancomycin 30 mg/kg/day IV in two divided doses plus gentamicin (dosage as above) for 6 weeks Vancomycin plus gentamicin (dosage as above) for 6 weeks Assistance of an experienced microbiologist is mandatory. If antimicrobial therapy fails, valve replacement should be considered early</td>
</tr>
<tr>
<td>Vancomycin-resistant strains including strains with low resistance to vancomycin (MIC 4–16 mg/l) or high resistance to gentamicin*</td>
<td>Penicillin G, 16–20 million units in 4–6 divided doses plus gentamicin 3 mg/kg, IV, divided in two doses for 4 weeks Vancomycin 30 mg/kg/day IV in two divided doses plus gentamicin (dosage as above) for 6 weeks Vancomycin plus gentamicin (dosage as above) for 6 weeks Assistance of an experienced microbiologist is mandatory. If antimicrobial therapy fails, valve replacement should be considered early</td>
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</tbody>
</table>

*For resistant enterococci treatment with oxazolidinone may be an option but should be initiated only after advice from a reference centre has been taken.
Late PVE complicated by prosthesis dysfunction including significant perivalvular leaks or obstruction, persistent positive blood cultures, abscess formation, conduction abnormalities, and large vegetations, particularly if staphylococci are the infecting agents.

### Postoperative antibiotic treatment

A full course of antimicrobial treatment should be completed regardless of the duration of treatment prior to surgery, but at least 7–15 days postoperatively.

### Table 8  Decision-making for antibiotic treatment of IE due to staphylococci

<table>
<thead>
<tr>
<th>Regimen</th>
<th>A Native valve endocarditis</th>
<th>B Endocarditis involving prosthetic material/cardiac valve prostheses</th>
</tr>
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<tbody>
<tr>
<td><strong>MSSA</strong>&lt;sup&gt;a&lt;/sup&gt; no allergy to penicillin</td>
<td>Oxacillin&lt;sup&gt;b&lt;/sup&gt; 8–12 g/24 h IV, divided into 3–4 doses for at least 4 weeks&lt;sup&gt;c&lt;/sup&gt; plus gentamicin 3 mg/kg/24 h IV (maximum 240 mg/day), divided into 2–3 doses for the first 3–5 days of treatment</td>
<td>Oxacillin&lt;sup&gt;b&lt;/sup&gt; 8–12 g/24 h IV, divided into 3–4 doses plus rifampicin 900 mg/24 h IV divided into three doses, both for 6–8 weeks, plus gentamicin 3 mg/kg/24 h IV (maximum 240 mg/day) divided into 2–3 doses for the first 2 weeks of treatment</td>
</tr>
<tr>
<td><strong>MSSA</strong>&lt;sup&gt;a&lt;/sup&gt; allergy&lt;sup&gt;d&lt;/sup&gt; to penicillin&lt;sup&gt;e&lt;/sup&gt;</td>
<td>Vancomycin 30 mg/kg/24 h IV divided into two doses&lt;sup&gt;f&lt;/sup&gt; for 4–6 weeks&lt;sup&gt;g&lt;/sup&gt;, plus gentamicin 3 mg/kg/24 h IV (maximum 240 mg/day) divided into 2–3 doses for the first 3–5 days of treatment</td>
<td>Vancomycin 30 mg/kg/24 h IV divided into two doses&lt;sup&gt;f&lt;/sup&gt; for 6 weeks</td>
</tr>
<tr>
<td><strong>MRSA</strong>&lt;sup&gt;h&lt;/sup&gt;</td>
<td>Vancomycin 30 mg/kg/24 h IV divided into two doses&lt;sup&gt;f&lt;/sup&gt; for 6 weeks</td>
<td>Vancomycin 30 mg/kg/24 h IV divided into two doses&lt;sup&gt;f&lt;/sup&gt; for 6 weeks, plus rifampicin 900 mg/24 h IV divided into three doses, plus gentamicin&lt;sup&gt;i&lt;/sup&gt; 3 mg/kg/24 h IV (maximum 240 mg/day) divided into 2–3 doses, all for 6–8 weeks</td>
</tr>
<tr>
<td><strong>ASD</strong></td>
<td>Atrial septal defect</td>
<td><strong>BC</strong></td>
</tr>
<tr>
<td><strong>CNE</strong></td>
<td>Culture-negative endocarditis</td>
<td><strong>CONS</strong></td>
</tr>
<tr>
<td><strong>HACEK</strong></td>
<td>Group of bacteria consistent of Haemophilus spp., Actinobacillus actinomycetemcomitans, Cardiobacterium hominis, Eikenella corrodens, Kingella kingae</td>
<td><strong>HLR</strong></td>
</tr>
<tr>
<td><strong>ICD</strong></td>
<td>Implantable cardioverter defibrillator</td>
<td><strong>IE</strong></td>
</tr>
<tr>
<td><strong>IVDA</strong></td>
<td>Intravenous drug abuser</td>
<td><strong>MIC</strong></td>
</tr>
<tr>
<td><strong>MRSA</strong>&lt;sup&gt;k&lt;/sup&gt;</td>
<td>Methicillin-resistant <em>Staphylococcus aureus</em></td>
<td><strong>MSSA</strong>&lt;sup&gt;l&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>NVE</strong></td>
<td>Native valve endocarditis</td>
<td><strong>PCR</strong></td>
</tr>
<tr>
<td><strong>PVE</strong></td>
<td>Prosthetic valve endocarditis</td>
<td><strong>PVE</strong></td>
</tr>
<tr>
<td><strong>spp</strong></td>
<td>Plural of <em>species</em></td>
<td><strong>TTE</strong></td>
</tr>
<tr>
<td><strong>TEE</strong></td>
<td>Transthoracic echocardiography</td>
<td></td>
</tr>
</tbody>
</table>

### Further Reading

Refer to full guidelines for complete reference list at www.escardio.org

50. Kim WJ, Weinstein RA, Hayden MK. The changing molecular epide-
meiology and establishment of endemicy of vancomycin resistance in enterococci at one hospital over a 6-year period. J Infect Dis 1999;
51. Working Party of the British Society for Antimicrobial Chemotherapy. Antibiotic treatment of streptococcal, enterococ-
52. Sharon DC. New guidelines for the antibiotic treatment of strept-
ococcal, enterococcal and staphylococcal endocarditis. J Antimicrob
53. The Endocarditis Working Group of the International Society for Chemotherapy. Wilson WR. Antibiotic treatment of infective endo-
54. Bugnon D, Potel G, Xiong YQ et al. In vivo antibacterial effects of
simulated human serum profiles of once-daily versus thrice-daily
dosing of amikacin in a Serratia marcescens endocarditis experimen-
daily for four weeks compared with ceftriaxone plus gentamicin once
daily for two weeks for treatment of endocarditis due to penicillin-
56. Hessen MT, Pitsakis PG, Levinson ME. Postantibiotic effect of penicil-
59. On behalf of the OHPAT UK Workshop. Nathwani D, Conlon C. Out-
67. Gutschik E. New developments in the treatment of infective endo-
71. Smart FW, Naftel DC, Constance MR et al. Risk factors for early cumulative and fatal infections after heart transplantation: A mul-
73. Fischer SA, Trenholme GW, Costanzo MR et al. Infectious compli-
74. McCarthy PA, Schmitt SK, Vargo RL et al. Implantable LVAD infec-
78. Ribera E, Gomez-Jimenez J, Cortes E et al. Effectiveness of cloxa-
cillin with or without gentamicin in short-term therapy for right-
82. Shtotan A, Widerhorn J, Hurst A et al. Risks of angiotensin-converting enzyme inhibition during pregnancy: Experimental and clinical evi-
87. Tischler MD, Vaitkus PT. The ability of vegetation size on echocar-
88. De Castro S, Magni G, Beni S et al. Role of transthoracic and tran-
89. Kuperwasser LI, Yeaman MR, Shapiro SM et al. Acetylsalicylic acid reduces vegetation bacterial density, hematogenous bacterial dissemination and frequency of embolic events in experimental Staphylococcus aureus endocarditis through antiplatelet and anti-
92. Horstottek D, Schulte HD, Niehues R et al. Diagnostic and therapeu-
tic considerations in acute, severe mitral regurgitation: experience in 42 consecutive patients entering the intensive care unit with pulmonary edema. J Heart Valve Dis 1993;2:512–22.
93. Arbulu A, Asfaw I. Tricuspid valvulectomy without prosthetic re-


