A Case of Marantic Endocarditis

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CASE REPORT

A 78 year old woman presented with brief transient loss of consciousness, associated with subtle dyspnoea on exertion. There was no chest pain, haemoptysis, calf swelling or stigmata of left ventricular failure.

Respiratory examination revealed a clear chest with saturations of 94%. She had normal heart sounds with a normal JVP.

ECG revealed sinus tachycardia and the chest x-ray was unremarkable. Serum Troponin was elevated at 0.74 (Normal<0.04).

Urgent transthoracic echocardiography (Fig 1) revealed echogenic masses at the tricuspid valve, with impaired RV contractility and severe pulmonary hypertension. CT Pulmonary Angiogram (Fig 2) showed extensive bilateral pulmonary emboli with a saddle thrombus with right heart strain with a RV/LV ratio of 1.7 (Fig. 3).

She had initially been anticoagulated with LMWH and also given antibiotics but after the CTPA she was treated as Non-Bacterial Thrombotic Endocarditis, antibiotics discontinued, and commenced on lifelong anticoagulation. Pre-discharge ECHO showed full resolution.

DISCUSSION

NBTE commonly affects the left side of the heart², the mitral and aortic valves, making the above case rare. The diagnosis is usually made following systemic embolisation, and the mainstay of investigation is trans-thoracic echocardiography, with laboratory investigations utilised to distinguish between infective endocarditis.

The mainstay of treatment is lifelong anticoagulation³, with limited data suggesting LMWH to be more effective in reducing re-embolisation⁴.

This case highlights the importance of considering NBTE as an important differential diagnosis where endocarditis may have been diagnosed.

CONCLUSION

Patients with NBTE are usually asymptomatic, until systemic embolisation occurs, and is most often associated with malignancy.

Treatment is with lifelong anticoagulation, with suggestions that LMWH more effective in reducing rembolisation

REFERENCES