Epidemiological analysis of infective endocarditis at the Gold Coast area health service

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Abstract:

Aim: We aim to determine the risk factor profile, valve profile, complication rates, mortality, microorganisms involved and impact of antimicrobial resistance of patients with infective endocarditis at the Gold Coast area Health service

Design: We performed a retrospective single center analysis of 111 patients with echo-proven infective endocarditis

Place and duration of study: Department of cardiology, Gold coast area health service, January 2011 to December 2015

Inclusion criteria: Age > 18 years, Index admission with infective endocarditis, echocardiographic evidence of endocarditis

Results:

Median age**:** 59 years, median length of stay: 21 days, male predominance (68% males, 32% females), mitral valve was the most commonly involved valve, surgical intervention in 20%, mortality 16%

Risk factors: Intravenous drug use was the most common risk factor (28%).Presence of prosthetic heart valve (mechanical and bio prosthetic) was the second most common risk factor. Other risk factors-Healthcare related endocarditis (14%), previous episodes of endocarditis (15%), Rheumatic heart disease and intracardiac device (8%)

Staphylococcus was the most commonly involved organism (46%) followed by streptococcus(26%),enterococcus(11%).Methicillin resistant staphylococcus aureus was involved in 5% of the patients.

Septic emboli was the most common complication(42%).Heart failure which complicated endocarditis in 38% of patients had a relative risk of mortality of 2.83(p=0.018, 95%[CI] 1.1-6.7). Arrhythmias happened in 11% of patients which posed a relative risk of mortality, RR-2.71(p=0.037, 95% [CI] 1.0-6.9). The RR for mortality in the non-surgical group was 2.09(95%[CI] 0.5-8.4, P= 0.3) compared to the surgical group.

Conclusion: The key findings in our single center study were that intravenous drug use and health care related endocarditis were the most common reversible risk factors of endocarditis with complications of heart failure and arrhythmias posing a significant risk of mortality.

Keywords: *Infective endocarditis, complications, risk factors, mortality*

Abbreviations

Infective endocarditis IE

Methicillin sensitive staphylococcus aureus MSSA

Intravenous drug use IVDU

Heart Failure HF

Relative risk RR

1. Introduction

Infective endocarditis is known to be a condition associated with high mortality and morbidity (1). Some studies indicate an in hospital mortality of 16% with a one-year mortality of 37% with infective endocarditis (2). Despite advancements in diagnostic tools, antibiotics and surgical techniques, endocarditis has been associated with grave outcomes (3). The epidemiology of IE can vary depending on the demography and the risk factor profile of the patients. The rate and type of complications can vary significantly. Despite this, certain microorganisms are found to be associated with mortality. For example, staphylococcus aureus endocarditis on left sided native valve is associated with a high one-year mortality (4). The ICE-

PCS study was one of the few multicenter studies in IE. It showed that complications like heart failure and intra-cardiac abscess are associated with increased mortality (5). Mitral valve is the most commonly affected valve and infected prosthetic valves attributed to significant mortality risk (5).

There have been studies to develop prognostic scores which indicate that six month mortality of IE can be based on patient factors, culprit microorganisms and IE characteristics and complications (3). Some studies indicate early surgical interventions in patients with staphylococcus infections showed better survival (6).

There is lack of local epidemiological data for IE in Australia. Gold Coast is a coastal city in Queensland, Australia with a total population of 576,918 with a median age of 38 year. The total indigenous population is approximately 6000. We aim to assess epidemiological factors and key risk factors, complication rates, culprit micro-organisms and mortality rates in our study population. This is a pilot project with an aim to develop an endocarditis registry in future.

2. Methods and materials:

This is a retrospective analysis of all infective endocarditis with echocardiographic evidence of endocarditis admitted to Gold coast area health service from January 2011 to December 2015.

Inclusion criteria included patients with age above 18 years who had echocardiographically proven IE.

Patients with only echocardiographically proven endocarditis were included. Duke's criteria for diagnosis was not used due to lack of reliable reporting in the patient records. It also helps us make the data more reproducible and have diagnostic certainty. Only the index admission of a particular patient was taken into account.

Data was collected by the study investigators and stored in secured filing locations that was only accessible to the study investigators. Data was collected on from electronic and paper medical records, pathology and echocardiography database. Patients diagnosed by transthoracic and trans-esophageal echocardiograms were included. The follow up duration of these patients was one year.

The data collected included the age and sex of the patient, index hospital stay.

Risk factors like indigenous or aboriginal status, previous episodes of IE, history of intravenous drug abuse, history of rheumatic or congenital heart disease, prosthetic heart valves or intra-cardiac devices and recent invasive procedure were assessed.

We also looked at the frequency with which each cardiac valve was affected and reviewed the complications like heart failure, septic emboli, intracardiac or perivalvular abscess or arrhythmias.

As antibiotic resistance is a major issues in IE patients, we also examined the rates of antibiotic resistant organisms in our patient cohort. The treatment strategy (medical therapy versus surgical intervention) was noted and mortality rates were also calculated.

3. Results and discussion

We performed a retrospective analysis of 111 echocardiographically proven cases of infective endocarditis.

3.1. Patient characteristics

The median age of the patients was 59 years.Also the median length of inpatient stay was 21 days.

The sex distribution was male predominant with males affected in 68%of cases and females 32%

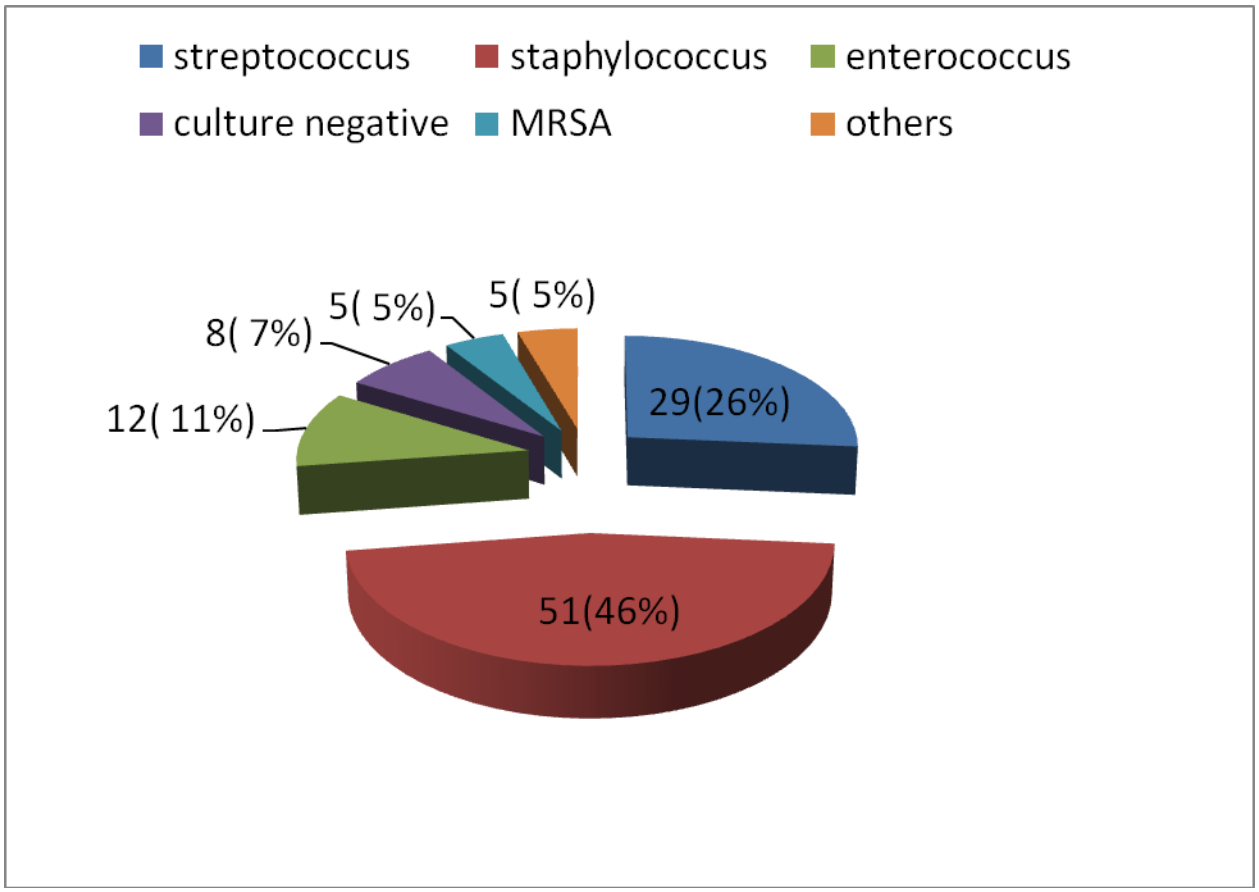
3.2. Micro-organisms (Fig 1)

Staphylococcus aureus was the most common culprit organism as it affected 51 patients (46%).It was noted the 71% of patients with staphylococcus endocarditis had at least one or more major complication. These findings were consistent with the results of Fowler V et al in a study including 1779 patients (7).

Streptococcus was the culprit organism in 26% of the patients. Methicillin resistant staphylococcus aureus (MRSA) was a causative organism in 5% of the patients. The incidence of MRSA was looked at separately as it significantly changes the patient management as well as infection control precautions during their hospital stay.11% patients had enterococcus as a causative organism and 7% were culture

negative. 5% of the patients had other organisms like serratia, burkholderia, erysipelothrix and heamophilus .

Figure 1: Culprit micro-organisms



3.3. Risk factors (Fig 2)

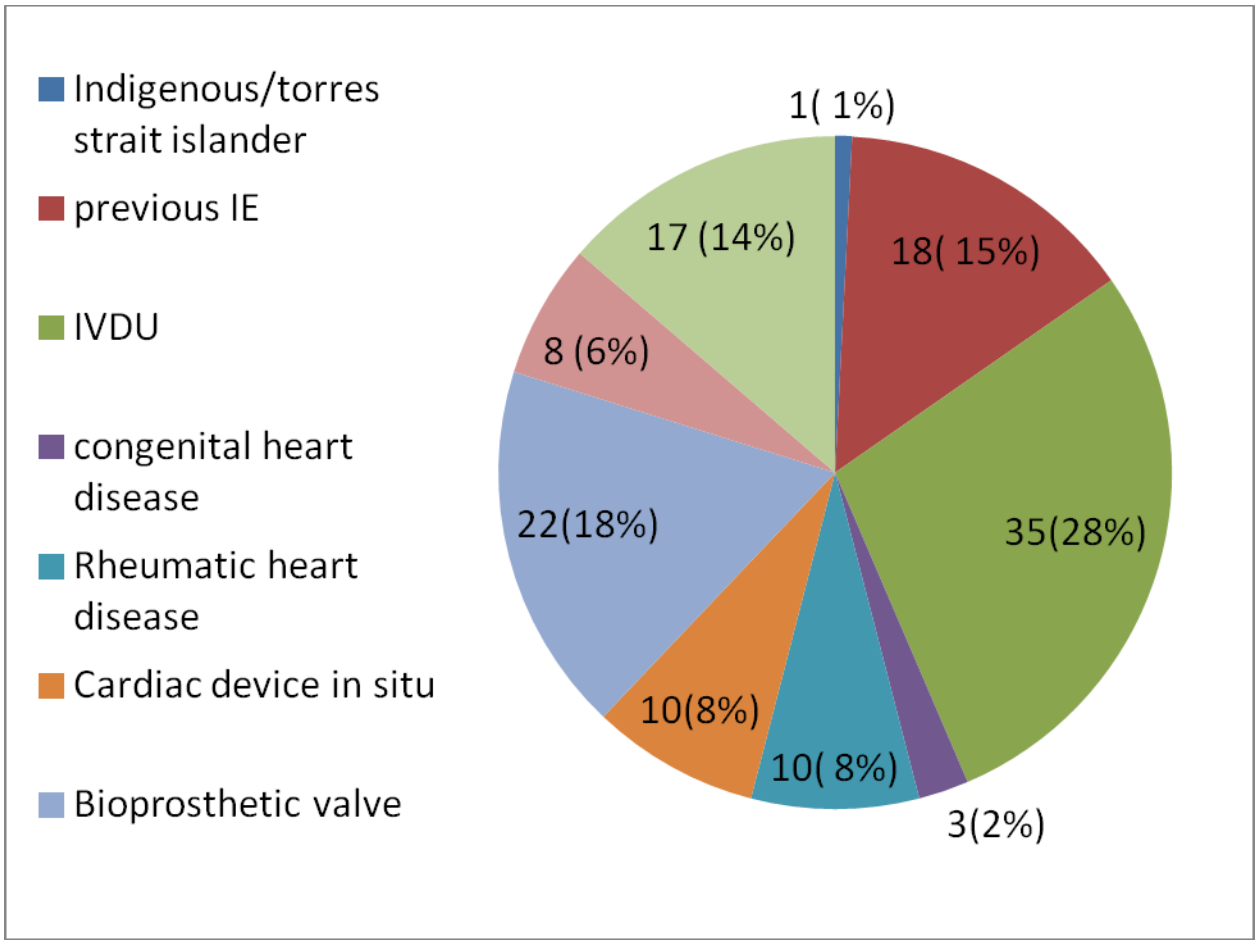
On assessment of risk factors, it was found that only one patient in the cohort was Indigenous Australian in origin.

Intravenous drug use (IVDU) was the most common risk factor. It was present in 28% of the patients contributing to 83% of IE amongst patients under the age of 50 years. This was significantly higher than the rates of IVDU in the ICE-PCS study, possibly related to the differences in patient demographics (5). Presence of prosthetic heart valves was the second most common risk factor (24%). This was comparable to the ICE-PCS study.

18 (15%) of these patients had a previous history of IE. 14% of IE patients had an invasive procedure in the preceding 3 months amounting to the nosocomial risk of endocarditis. This group has been shown to have worse prognosis in some studies (3).We define this group as patients with healthcare related endocarditis which is one of the potential reversible risk factors of endocarditis.

8% of the patients had an intra-cardiac device (permanent pacemaker or automated implantable cardiac defibrillator) and 8% had history of rheumatic heart disease.

Figure 2: Risk factors



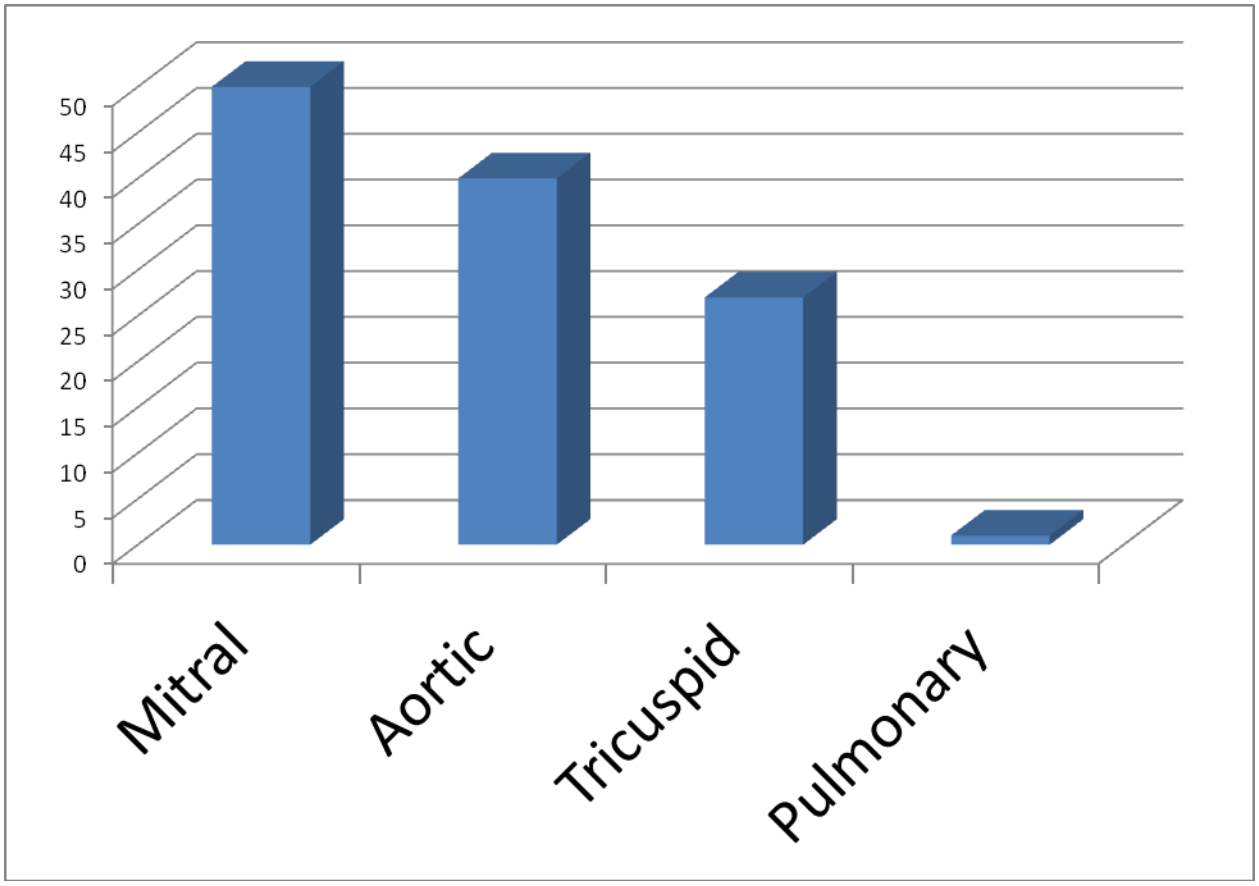
3.4. Valvular involvement

The frequency of valvular involvement was 45% for mitral, 36% for aortic, 24% for tricuspid and 1% for pulmonary valves (Fig 3). These rates are consistent with the findings of the ICE-PCS study where mitral valve involvement occurred in 41% and aortic valve in 38% (5).Hasbun R et al also noted 50% of their 513 patients had mitral valve endocarditis(8). There was a higher incidence of tricuspid valve endocarditis (24%) noted in this cohort. Tricuspid valve endocarditis has been linked with IVDU use in the community. Studies have shown that native tricuspid valve endocarditis, when associated with IVDU may have an improved prognosis (9).

We had 27 patients with tricuspid valve endocarditis (24%) out of which 18 had associated IVDU. There was only one mortality amongst these patients; in a 25 year old female with staphylococcus septicaemia

and complicating acute renal failure. Given the relatively small sample size of tricuspid valve endocarditis in our study, it is not possible to comment on improved prognosis in IVDU patients.

Figure 3: Frequency of valvular involvement



3.5. Complications

We reviewed the rates of four major complications amongst our patients which included heart failure, septic emboli, arrhythmias and para-valvular abscess (Fig 4).

Complications included heart failure in 40 patients (36%), septic emboli in 43 patients (42%), arrhythmias in 12 patients (11%) and para-valvular abscess in 9 patients (8%). Heart failure and septic emboli are documented to be some of the most common complications of IE in previous studies (5). Furthermore,

heart failure was associated with increased mortality. The relative risk (RR) of mortality with HF was 2.83(p=0.02, 95% [CI] 1.1-6.7).This was consistent with previous studies suggesting heart failure as a poor prognostic marker for death (10).

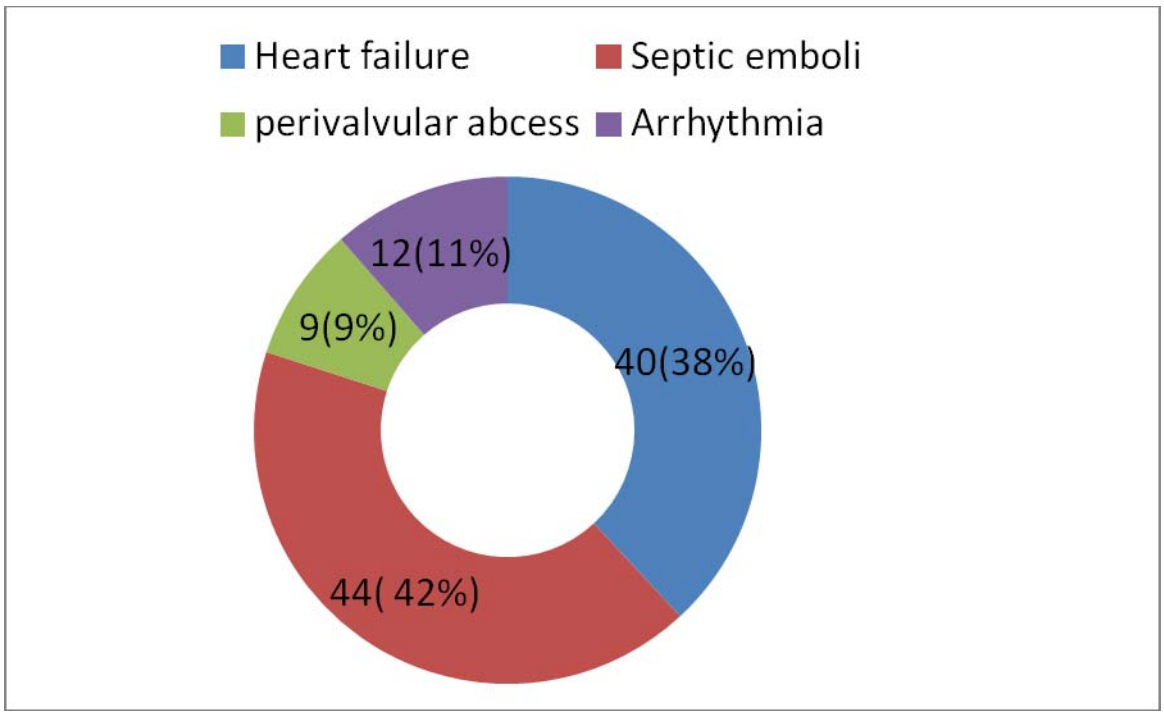
RR of mortality with arrhythmia: RR=2.71(95% [CI].1-7.0, P=0.04)

Para-valvular abscess RR=1.4(95% [CI] 0.4-5.2, P=0.59) and septic emboli RR=0.98(95% [CI] 0.4-2.3, P =0.97ere not statistically significant for mortality.

Twenty three (20%) patients underwent surgical intervention. The surgical rates were lower compared to previous studies (3).

Overall mortality was 16% in this cohort. This was lower than the predicted mortality rates with IE in spite of lower surgical rates (5).The RR for mortality in the non-surgical group was 2.09(95%[CI] 0.5-8.4, P= 0.3) compared to the surgical group.

Figure 4: complication rates



4. Study Limitations

This was a single center retrospective study hence the findings cannot be extrapolated to the entire population in Australia. Despite being a single center analysis, some of the findings were comparable to multicenter study indicating certain salient characteristics of the disease process.

The follow up period was approximately one year which meant that long term mortality and morbidity associated with IE could not be assessed.

Also only patients with echocardiographic evidence of endocarditis were included to make the findings more reproducible. This meant that patients with IE who met Dukes criteria for definite or probable endocarditis but did not have echocardiographic evidence could have been missed. It could have possibly included a sicker cohort of patients in the study as most of them would either have a significant vegetation, valvular pathology or paravalvular abscess.

5. Conclusion

Infective endocarditis is an infrequent pathology associated with high mortality and morbidity. There are definite risk factors which predispose patients to endocarditis and the risk factor profile changes with the population demographics. Staphylococcus is the most common causative organism and is associated with higher complications rates.

Heart failure is a common complication and is associated with grave prognosis.

Rates of surgical interventions vary significantly amongst the previous studies and so do their outcomes.

Intravenous drug use and healthcare associated infections are increasing associated with IE while rheumatic heart disease is a less common risk factor. More multicenter studies are needed to assess the dynamic nature of the risk factor profile of the varied demographic populations. Further studies will also enable development of prognostication scores and guide us towards better selection of patients needing early surgical intervention.

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