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Conflicts of interest: none

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IMAGES IN CARDIOLOGY

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Infective endarteritis on an aortic dissection flap

A 59 year old man presented to the emergency department with sudden weakness of his lower limbs associated with altered sensation. His history included coronary artery bypass grafting and St Jude aortic valve replacement, hypertension, and atrial fibrillation.

On admission the patient had resistant hypertension despite treatment with multiple intravenous agents, bilateral lower limb weakness, and decreased pin prick sensation with absent proprioception and reflexes. The lower limbs were cool and pale with absent distal pulses consistent with bilateral ischaemia.

A computed tomographic scan revealed type 1 aortic dissection arising distal to the prosthetic aortic valve extending to the common iliac arteries and the patient underwent successful surgery with implantation of a Dacron aorto-bifemoral graft.

His postoperative course was complicated by acute renal failure, coagulopathy, and sepsis. Blood cultures grew sensitive enterococcus. Transoesophageal echocardiogram (TOE) demonstrated aortic dissection and a normal prosthetic aortic valve. In addition there was an echogenic mass (see panels) at the entry tear of the ascending aortic dissection consistent with a vegetation.

After four weeks of intravenous antibiotics a repeat TOE showed resolution of the vegetation. He was discharged after a further two weeks of treatment.

Three months later he successfully underwent elective aortic root replacement using a 24 mm human allograft. Reimplantation of the previous vein graft to the allograft was also performed as well as an additional aortocoronary grafting.

Four months after cardiothoracic surgery the patient leads a moderately independent life.

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Transoesophageal echocardiography (TOE) showing an echogenic mass (solid arrow) consistent with a vegetation at the aortic dissection entry site (open arrow).

TOE showing the same echogenic mass (solid arrow) at the aortic dissection flap (open arrow).