Published in final edited form as:

JAMA. 2018 November 13; 320(18): 1939. doi:10.1001/jama.2018.14071.

Injection Drug Use–Associated Infective Endocarditis

David Phillip Serota, MD

Division of Infectious Diseases, Emory University, Atlanta, Georgia

J. Deanna Wilson, MD, MPH and Jessica S. Merlin, MD, PhD, MBA

Division of General Internal Medicine, University of Pittsburgh, Pittsburgh, Pennsylvania

To the Editor

Dr Wang and colleagues comprehensively reviewed diagnostic and management considerations for infective endocarditis.¹ They appropriately raised awareness of the increasing incidence of injection drug use–associated infective endocarditis. However, we have concerns regarding statements made in reference to the surgical management of this syndrome.

They stated: “Because of concerns regarding drug use recidivism and relapsed infective endocarditis in this group, it is not clear that they should be routinely offered surgery.” Opioid use disorder (OUD) is a chronic disease that is responsive to medications with a good prognosis when patients are provided evidence-based interventions.² Few patients in the cited studies about surgical outcomes received evidence-based addiction treatment. Not surprisingly, they had poor outcomes, but denying surgery to patients with injection drug use–associated infective endocarditis is not the answer. We believe that OUD should be considered in surgical planning for injection drug use–associated infective endocarditis; but similar to any other chronic illness, addiction treatment should be optimized as much as possible in the acute care setting prior to or immediately following surgery and during discharge planning. Optimization of treatment could include initiation of medications for addiction treatment along with linkage to outpatient addiction care. More evidence as to the optimal way to implement evidence-based OUD treatment for these complex patients is needed.³

In addition, we advocate for avoiding stigmatizing language in discussing the care of persons with OUD, which contributes to patients with OUD being viewed and treated differently than persons with other chronic diseases. We agree with the recommendations of others who have recommended person-first language (“person who uses drugs” rather than “drug user”) and omitting words associated with criminality (“recidivism”).⁴

Corresponding Author: David Phillip Serota, MD, Division of Infectious Diseases, Department of Medicine, Emory University, 1518 Clifton Rd NE, GCR 420, Atlanta, GA 30322 (dserota@emory.edu).

Conflict of Interest Disclosures: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

References

1. Wang A, Gaca JG, Chu VH. Management considerations in infective endocarditis: a review. *JAMA* 2018;320(1):72–83. 10.1001/jama.2018.7596 [PubMed: 29971402]
2. Schuckit MA. Treatment of opioid-use disorders. *N Engl J Med* 2016;375(4): 357–368. 10.1056/NEJMr1604339 [PubMed: 27464203]
3. Springer SA, Korthuis PT, Del Rio C. Integrating treatment at the intersection of opioid use disorder and infectious disease epidemics in medical settings: a call for action after a National Academies of Sciences, Engineering, and Medicine workshop. *Ann Intern Med* 2018;169(5):335–336. 10.7326/M18-1203 [PubMed: 30007032]
4. Botticelli MP, Koh HK. Changing the language of addiction. *JAMA* 2016;316 (13):1361–1362. 10.1001/jama.2016.11874 [PubMed: 27701667]