Abdominal angina as the presenting symptom in bacterial endocarditis.
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Case
This is a 61 year old male who presented with 50 pound weight loss over five months, abdominal pain, poor oral intake, general fatigue and malaise. Abdominal pain was described as intermittent cramping pain, it was worse with eating, which lead to his poor appetite and weight loss.

Prior work-up for this complaint by Gastroenterology included EGD and HIDA scan. These tests showed Barrett’s esophagus and biliary dyskinesia. He was sent to a surgeon and underwent cholecystectomy. Pathology showed chronic cholecystitis, but surgeon and underwent cholecystectomy.

2. The patient was admitted and found to suffer from acute renal failure, acute anemia, and hemoccult positive stools. A colonoscopy was performed and showed evidence of ischemic colitis. Blood cultures returned positive for alpha streptococcus. Echocardiogram showed an aortic valve vegetation, and TEE confirmed an intravalvular abscess between the aortic and mitral valves. The size of the vegetation was estimated at 3x3 cm. He was treated with IV Rocephin and Vancomycin. The cardiac surgeons at our center were uncomfortable with the complexity of the surgery he would need, and recommended transfer to a tertiary center. He was transferred to Cleveland Clinic, where he underwent debridement and replacement of the aortic valve, mitral valve and intervalvular fibrosa. This surgery in itself is relatively rare, and has only been performed since 1997. In the end, he did well, and was able to be discharged to home.

Discussion
While the symptoms the patient was experiencing are common to subacute endocarditis, this diagnosis was not considered for many months. He exhibited several of the Duke’s minor criteria, including fever, renal failure suspected to be secondary to glomerulonephritis, and evidence of major arterial emboli. Of course, the diagnosis of endocarditis was definitive after the positive blood cultures and obvious vegetation on TEE.

Literature Cited:

Conclusion
Endocarditis is a relatively uncommon cause of febrile illness, but blood cultures should be sampled in any febrile illness, particularly once it becomes protracted. Abdominal pain, mesenteric ischemia, and renal failure are all possible presenting symptoms of embolic endocarditis, though less common than neurologic changes or pulmonary emboli.

A good, thoughtful, osteopathic internist, following the osteopathic tenets, should consider the patient as a whole in a case like this to make the appropriate diagnosis. We often fall into the trap of containing the work up to one organ or system, which did occur in this case for some time. For example, this patient had even underwent a cholecystectomy for these abdominal symptoms, before the true etiology was discovered. This also illustrates the role of the internist as the informational hub, which is essential to the coordination of patient care.

This was an interesting and challenging case that illustrates the importance of a thorough history and physical and the need to consider the patient as a whole.