Mitral valve : From Endocarditis to Pseudoaneurysm

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Case

62 years-old female, with complicated insulin-dependent diabetes mellitus, hypertension, hypercholesterolemia and penicillin allergy, was admitted for septic shock, presumed secondary to toe injury. Blood cultures grew *Staphylococcus aureus*. Vancomycin antibiotic therapy was initiated. The wound was debrided. **Transesophageal echocardiography** (TEE) revealed posterior mitral leaflet large vegetation (16mmx9mm), extensive posterior annular calcification. **Coronary angiography** showed bitroncular lesions. Patient underwent **emergency mitral valve repair and coronary artery bypass grafting**. Segments P2-P3 were reconstructed using bovine pericardial patch with nec ene.
Postoperative course was complicated by respiratory m aspiration) on postoperative day six. **Resuscitation** was successful but she required prolonged invasive v *coccus faecalis* and *S. aureus)*, and pulmonary aspergillosis were observed. TEE and positron emissi

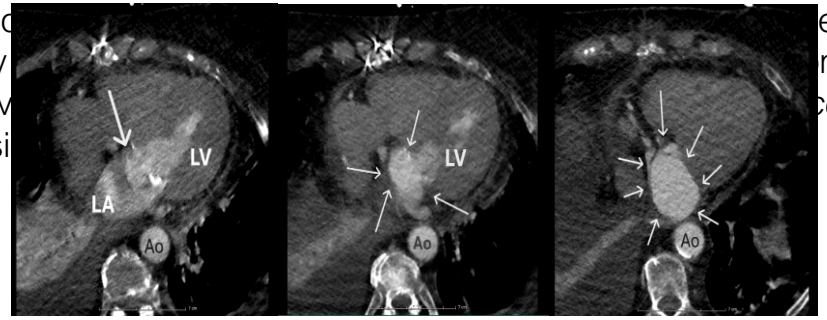

Figure 1: CT images of the lesion.

Serial echocardiography identified a **rapidly expanding pseudoaneurysm at left ventricular septal base** (neck: 11 mm, height: 42 mm). With informed consent, a second surgery was performed.

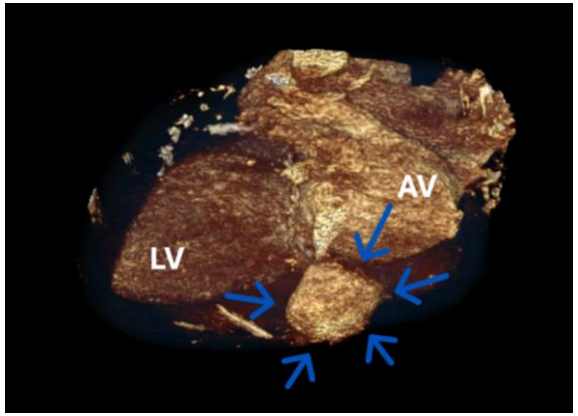

Figure 2 : 3D reconstruction of the lesion

It included **posterior annulus decalcification**, **pseudoaneurysm exclusion** and **posterior annular reconstruction using autologous pericardium**, followed by **mitral valve bioprosthesis implantation**. Extracorporeal membrane oxygenation was required for eight days. No pseudoaneurysm