

Poster

Between the Liver, Lung, and Heart: A Web of Diagnoses

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Infective endocarditis (IE) is a serious disease that primarily affects patients with structural heart disease or intracardiac devices. Its clinical manifestations can be atypical, often delaying diagnosis and complicating treatment. We report the case of a 47-year-old male patient with a history of moderate alcohol use, long-standing systemic arterial hypertension, and dilated cardiomyopathy characterized by poor biventricular function and complete left bundle branch block (LBBB). He had a cardiac resynchronization therapy defibrillator (CRT-D) implanted in 2022 and a history of pulmonary thromboembolism in the same year, currently on chronic anticoagulation. He was followed in gastroenterology for chronic gastritis due to *Helicobacter pylori*, with symptoms of epigastric pain, nausea, vomiting, sialorrhea, flatulence, and general malaise for two years, worsening after discontinuation of cardiac therapy. He was evaluated, treatment was optimized, and he was referred for gastroenterological reassessment. Seven days later, he returned with severe abdominal pain, dark urine, jaundice, asthenia, and lower-limb edema. On examination, he was in poor general condition, jaundiced, tachypneic, with decreased breath sounds at both lung bases, subcrepitant crackles, pleural friction rub, and peripheral edema. Laboratory findings showed anemia, leukocytosis, elevated transaminases, mixed hyperbilirubinemia, hyponatremia, renal dysfunction, and elevated C-reactive protein and erythrocyte sedimentation rate. Chest X-ray revealed cardiomegaly and bilateral infiltrates, while CT imaging showed pulmonary consolidations and multiple peripheral infarctions suggestive of sepsis with pulmonary embolization. A previous transthoracic echocardiogram (TTE) had demonstrated a CRT-D lead in the right chambers, left atrial dilation, moderate tricuspid regurgitation, mild mitral regurgitation, and a severely dilated left ventricle (LV) with severe systolic dysfunction. He was admitted with a diagnosis of sepsis, likely of pulmonary origin. Within the first 24 hours, his clinical condition deteriorated, presenting with hemoptysis, dyspnea, and a new systolic murmur. He was transferred to the intensive care unit (ICU), where empirical antibiotic therapy was initiated after blood culture collection. A new TTE revealed biatrial dilation, LV segmental wall motion abnormalities with severe systolic dysfunction (ejection fraction 29%), and an image suggestive of vegetation attached to one of the CRT-D leads, along with moderate tricuspid and mitral regurgitation. Infective endocarditis associated with the intracardiac device was suspected. A transesophageal echocardiogram confirmed a vegetation of approximately 2 cm attached to the tip of the elec-

trode, along with multiple (>5) mobile masses consistent with thrombi. After seven days in the ICU, the patient showed clinical and laboratory improvement and was transferred to the ward, where he remained afebrile, eupneic, and breathing spontaneously. This case illustrates the atypical presentation and protracted course of IE in a patient with multiple comorbidities and an intracardiac device. The imperative indication for lead extraction conflicts with the patient's dependence on the device, underscoring the therapeutic complexity and challenges in managing such cases.

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