

Surgical treatment of multi-valve heart disease of infective endocarditis

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Abstract

Objective: The aim of the study was to analyse our own experience of diagnosis, choice of tactics and execution of multi-valve surgical correction of heart defects in infective endocarditis (IE).

Methods: We retrospectively analysed data and clinical results 156 patients with infective endocarditis underwent the cardiac surgery in our clinic. Among them, 85 were men (56.5%), and women - 71 (45.5%). Age Our patients ranged from 12 to 68 (mean 32.76 (1.6)) years. The patients were divided into 2 groups: group 1, 89 (57.4%) patients who underwent a complex of developed by the authors antibiotic therapy, treatment, surgical treatment and preventive measures and 2-group 67 (42.6%) patients who underwent the traditional surgical treatment scheme. We analysed electrocardiography, chest X-Ray, transthoracic echocardiography, transesophageal echocardiography, cardiac catheterization and coronary angiography and blood culture study in 38.6% of patients, with light electron microscopy (LEM) - in 47.5% of patients.

Results: Intraoperative treatment - preventive measures (TPM) were as follows; mechanical and chemical sanitation of the infected area of the heart; implantation of valves with antibacterial properties; hyperthermic perfusion; antimicrobial therapy, including anti-fungal agents. Application of the above measures could reduce mortality in the study group to 5.1%, in the control group - 9.3%. In dynamics, mortality declined to 3.9% in the study group.

Conclusion: Our results of surgical treatment of multi-valve heart defects with infective endocarditis showed the efficacy of developed complex preoperative and intraoperative measures in surgical treatment of IE. This new treatment approach is associated with significant improvement of left ventricular function and low mortality rate.

Key words: multivalve acquired heart diseases, complications of infectious endocarditis

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Introduction

Infective endocarditis (IE), being quite common etiological factor in the development of multi-valve heart defects, has a number of features in the diagnosis, definition of surgical tactics and surgery itself (1-4).

The valvular IE is a septic disease caused by pathogens or conditionally pathogenic microflora, which is the morphological substrate of polypous-destructive ulcerative endocarditis, affecting heart valve and manifesting as acute valvular insufficiency

and systemic embolic events. Vegetations on heart valves are the source for embolic complications. Vegetation is composed of fibrin overlay, blood clots, blood cells, damaged heart tissue and microorganisms. The incidence of IE in Russia varies between 2 - 6.5 cases per 100,000 of population (1). Incidence of IE varies between 2% - 18% affecting population of 20 to 50 years old, the employed adult population (3).

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There is a practice in cardiology to attempt of conservative treatment of infective endocarditis. However, according to some authors, the mortality rate in the conservative treatment is 50 - 90% (5). The effectiveness of surgical treatment over medical treatment is obviously clear. However, optimal early and late results of surgical treatment of multi-valve infective endocarditis are largely dependent on the correct definition of surgical tactics and with reduction of mortality to 8.3-11.2% (4-10). Thus, apparent urgency of the chosen topic on development the most efficient strategy in reduction of mortality the message is not in doubt.

In this article, we decided to discuss our own experience of diagnosis, choice of tactics and execution of multi-valve surgical correction of heart defects in infective endocarditis.

Methods

Study design and population

The population of this retrospective analysis included 156 patients with multi-valve heart disease and infective endocarditis operated in our hospital, of whom 85 were men (54.5%), and women - 71 (45.5%). The age of our patients ranged from 12 to 68 (mean 32.76(1.6)) years. Diagnosis was based on the classification criteria of Durack et al. (9).

The patients were divided into 2 groups: group 1 included 89 (57.4%) patients who underwent a comprehensive anti-bacterial treatment, surgery and preventive measures according to the complex of IE treatment measures developed by our group; group 2 – consisted of 67 (42.6%) patients who underwent the traditional scheme of prevention and surgical treatment.

The IE treatment protocol:

Taking in account the following features valve infective endocarditis (IE): high frequency of systemic embolism; high mortality in the treatment of IE; the dilemma of the optimal operation period; imperfect system of prevention; aspects of the antimicrobial therapy - we developed in our department comprehensive measures for the prevention and treatment of IE in these patients. They have the following objectives:

- 1.The elimination of infectious focus
- 2.Hemodynamic wrinkle correction
- 3.Reliable fixation of the prosthesis
- 4.Prevention of relapse of IE

Intraoperative treatment and preventive measures (LSM) were as follows:

1. Mechanical and chemical sanitation of infected heart area
2. Implantation of valves with antibacterial properties
3. Hyperthermic Perfusion
4. The antimicrobial therapy, including anti-fungal agents.

Clinical examinations

All patients underwent clinical examinations, electrocardiography (ECG), chest X-ray, transthoracic echocardiography (TTE) and blood culture analysis. Transesophageal echocardiography (TEE) was performed in 40.5% of patients, coronary angiography and heart catheterization in 12.65% of patients, histology analysis with light electron microscopy (SEM) in 47.5% of the operated patients.

Surgery

Surgical treatment consisted of an "open" correction of affected valves, with carrying out complex measures to eliminate intracardiac foci of infection and prevention of postoperative septic complications. All patients underwent surgery with cardiopulmonary bypass (CPB) and cardioplegia (CP) with conventional protocol of operation in group 2 of patients and protocol of surgical correction developed in our department in group 1 patients (see above).

Statistical analysis

Statistical analysis of the result was carried out using Microsoft Office Excel 2007 with Statistical Version 6.0 package. Continuous variables are presented as mean and standard error, and categorical data as percentages. Comparison of continuous variables between groups was performed using parametric Student's (t) test and Chi-square test was used for comparison of categorical variables. The degree of accuracy was determined at the level of significance $p < 0.05$.

Results and Discussion

The surgical treatment of multivalvular heart disease with infective endocarditis is a challenging issue. Application of developed by our department complex of medical, surgical and preventive measures aimed at improving significantly the immediate and long-term results of our operations on affected heart valves. The etiology of infective endocarditis accompanying valvular heart disease in our patients included rheumatic heart valve disease in 62% of patients, infective endocarditis – 16%, degenerative valvular disease – 13%, and congenital heart disease in 9% of

patients. In our series, there were no patients with infective endocarditis developed due addiction to substance use.

Types of operations performed in our patients are provided in Table 1. The most commonly performed surgery was mitral valve replacement (MVR) plus aortic valve replacement (AVR) with tricuspid valve (TV) repair. Other types of operations included: mitral valve (MV) repair, aortic valve replacement (AVR), tricuspid valve open commissurotomy (OTC), tricuspid valve replacement (TVR) and mitral valve replacement (MVR). We also used left atrial thrombectomy of in combination with other types of surgery.

Table 1. The types of surgery performed in patients with multi-valve heart defects with infective endocarditis

Type of surgery	n	%
MVR+AVR with TV repair	78	50
TV repair, MV repair, and AV repair	26	16.7
MVR with TV repair and AV repair	21	13.4
AVR with TV repair and MV repair	7	4.5
MVR with TV repair	6	3.8
MVR+AVR with OTC	4	2.5
MVR, TVR, AVR	2	1.3
MVR, TVR	2	1.3
Other operations	10	6.4

AV - aortic valve, AVR –aortic valve replacement, MV – mitral valve, MVR - mitral valve replacement, OTC - open tricuspid commissurotomy, TV – tricuspid valve, TVR - tricuspid valve replacement

Use of specially produced artificial mechanical heart valves can prevent further development or activation of the infection. Antibiotic cuff impregnated in artificial prosthesis retains its activity for 2 weeks, which reduces the recurrence of IE (8). In addition, we used hyperthermic perfusion in these patients, targeting micro and macro-organism, as following: keeping temperature within 38.5-39° C for 15-20 min after removal of aortic clamp. This, results in "impact on the macro-organism": restoring the patient immunobiological properties (7); and "the impact on the micro-organism" - intensifying pathogen metabolism and enhancing effectiveness of antibiotics (6).

Laboratory and microbiological test are of particular importance to guide antibioticotherapy. Table 2 shows the results of microbiological tests, where in contrast to literature data: in 5% of all patients, we identified fungal lesions of the heart valves - *Candida* spp. The blood culture was positive in 39.1% of patients, in 8.8% of the cases we detected multidrug-resistant Gram-negative flora, in 7% - *Staphylococcus aureus*, and in 6.3% of cases - *Pseudomonas aeruginosa*. In remaining 60.1% of patients the blood culture was negative due to wide-spectrum antibiotic therapy used on pre-hospital state. According to above-mentioned results we used antifungal therapy in addition to antibiotics.

Table 2. Microbiological examination

Microorganisms	Frequency allocation,%
Gram (-) negative bacillus	8.8
Gram (+) positive bacillus	2.5
Staphylococcus aureus	7
Pseudomonas aeruginosa	6.3
Streptococcus epidermidis	5
Candida spp.	5
Klebsiella pneumoniae	4
Other	0.5
Total	39.1
No identified	60.9

Echocardiography had a particular importance in adequate definition and choice of surgical tactics for our patients. Transthoracic 2-dimensional and Doppler echocardiography data in addition to the clinical criteria were the basis of indications for surgical correction of multi-valvular defects with IE. An examination of our patients the following results were obtained data echocardiography preoperatively (Table 3). The peculiarities of defect anatomy of this disease complications, presence of comorbidities surgical tactics of the operation has been identified. At intraoperative preparation was carried even further TEE, which refined the tactics adopted by the performance of surgical correction and evaluation of the adequacy of the operation.

Table 3. Preoperative echocardiography data

LV parameters	Group 1	Group 2	Overall	p
	M(m)	M(m)	M(m)	
EDD, ml	5.88 (0.15)	6.16 (0.18)	6.01 (0.12)	>0.05
EDV, ml	181.8 (9.81)	194.55 (13.4)	187.3 (8.01)	>0.05
ESD, ml	3.88 (0.12)	7.05 (1.65)	5.3 (0.76)	<0.05
ESV, ml	83.64 (12.1)	81.86 (6.82)	82.8 (7.44)	>0.05
SV, ml	111.24 (5.9)	116.45 (7.5)	113.5 (4.69)	>0.05
EF, %	63.21 (1.96)	60.3 (1.19)	61.83 (1.23)	<0.05

EDD – end-diastolic dimension, EDV – end-diastolic volume, EF-ejection fraction, ESD – end –systolic dimension, ESV – end –systolic volume, LV–left ventricle, SV-stroke volume

Indication for surgical treatment in our patients, in most cases, was progressive heart failure. As can be seen from the Table 4 among life-threatening complications of infective endocarditis, the main was progressive heart failure, which prevailed by the overwhelming number of cases, among indications for the implementation of urgent (sometimes urgent) for "health reasons" for surgical treatment of severe

patients (Table 4). At the same time, we are sure that lower inflammatory activity may be achieved using a complex of medical and antibiotic therapy. The combination of the preoperative preparation, using the developed therapeutic and preventive measures, subsequently, was the basis to decrease in mortality in the short and long periods of observation.

Indications for surgery	Number	%
Progressive heart failure	96	61.4
The ineffectiveness of antibiotic therapy	20	12.9
Floating vegetation	14	8.9
Embolism	17	10.9
Abscess	9	5.9
Total operated	156	100

Analysis of the nearest results of our operations in the two groups showed mortality rate of 5.1% in the first group, and in the second group - 9.3%. Thus, the overall hospital mortality was 6.9%. With the development of diagnostic criteria for multi-valve defect with infective endocarditis, choosing the right surgical technique and the use of therapeutic and preventive measures developed in the department,

we managed to reduce the rate of hospital mortality and improve cardiac function. We observed in 3-year follow-up period reduction of cardiac chamber and volume size (Table 5) and significant reduction of hospital mortality, as compared with previous years (from 33% in 2000-2001 to 3.9% in 2011-2015 periods) (Fig. 1).

Echocardiographic data	The periods of observation		
	Before surgery	At discharge	3 years later
Group 1			
EDD, ml	5.88 (0.15)	5.03 (0.13)	4.65 (0.16)
EDV, ml	181.8 (9.81)	133.63 (8.12)	105.4 (7.43)
ESD, ml	3.88 (0.12)	3.67 (0.11)	3.3 (0.21)
ESV, ml	83.64 (12.12)	67.58 (6.56)	45.4 (5.76)
SV, ml	111.24 (5.97)	65.8 (2.97)	60.01 (3.32)
EF, %	63.21 (1.96)	51.05 (1.48)	61.45 (2.5)
p	<0.03		
Group 2			
EDD, ml	6.16 (0.18)	5.34 (0.17)	5.14 (0.15)
EDV, ml	194.5 (13.39)	147.13 (11.21)	125.71 (8.07)
ESD, ml	5.25 (1.01)	5.1 (1.22)	3.3 (0.21)
ESV, ml	81.86 (6.82)	73.16 (7.05)	47.93 (5.91)
SV, ml	116.45 (7.55)	73.63 (4.95)	77.6 (6.06)
EF, %	60.0 (1.19)	52.34 (1.57)	58.36 (3.16)
p	<0.05		

EDD – end-diastolic dimension, EDV – end-diastolic volume, EF-ejection fraction, ESD – end –systolic dimension, ESV – end –systolic volume, LV–left ventricle, SV-stroke volume

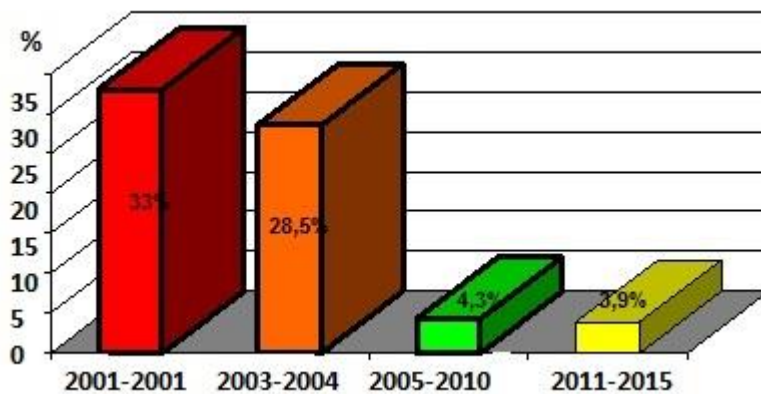


Figure 1. Dynamics of hospital mortality

Conclusion

Our results of surgical treatment of multi-valve heart defects with infective endocarditis showed the efficacy of developed complex preoperative and intraoperative measures in surgical treatment of IE. This new treatment approach is associated with significant improvement of left ventricular function and low mortality rate.

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