Culture negative endocarditis: data from the national survey in Slovakia

Millar et al in their interesting review discussed culture negative endocarditis. The majority of diagnosis of infective endo-carditis is still conventional blood culture; however, blood culture may be negative in 1%–79% of all cases. The incidence of culture negative endocarditis has been increasing. This could be for a number of reasons. Prosthetic heart valves are prone to infection and in many of these cases the culture is negative. Many aetiological agents causing infective endocarditis may be fastidious in nature, such as the HACEK group of organisms or unusual and require specialised microbiological techniques.

Within our national survey of 180 cases in Slovakia, culture negative endocarditis appeared in 35 cases (19.5%), which is higher than that reported in the Netherlands (1%), the USA (3%), Sweden (12%), the UK (15%), France (18%), but lower than in Russia (26%) and Spain (37%–43%) and much lower than in India (53%–79%).

In univariate analysis comparing all cases (180) to culture negative (35 cases), prior cardiac surgery within two weeks (p<0.045) to culture negative (35 cases), prior endocarditis (p<0.04) according to Duke’s criteria, probable endocarditis (p<0.04) among all cases of endocarditis (see table 1). In addition multivariate analysis (STAT ADV computerised package of the postgraduate medical school) was performed. The only significant risk factor for culture negative endocarditis in multivariate analysis was presence of complications. The odds ratio was 2.45 (confidence interval 0.95 to 2.35) in the group with culture negative endocarditis, which was 2.45 times higher than in culture positive endocarditis.

Interestingly mortality was lower in culture negative endocarditis than among all cases (24.5% v 44.4%, p<0.001). Millar et al in his excellent review analysed reasons for culture negative endocarditis. We found according to our experience one more risk factor—prior cardiac surgery. Probably, those undergoing cardiac surgery and receiving antibiotic prophylaxis (first generation cephalosporins/cefazolin in Slovakia) have lower death rates in endocarditis due to protective effect of antimicrobials for occurrence of infection.

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<table>
<thead>
<tr>
<th>Risk factors</th>
<th>CNE (n=180)</th>
<th>OR</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age less than 60</td>
<td>46 (25)</td>
<td>11 (31)</td>
<td>NS</td>
</tr>
<tr>
<td>Male gender</td>
<td>125 (69.4)</td>
<td>20 (57)</td>
<td>NS</td>
</tr>
<tr>
<td>Rheumatic fever</td>
<td>64 (35)</td>
<td>11 (31)</td>
<td>NS</td>
</tr>
<tr>
<td>Malignancy</td>
<td>12 (6.7)</td>
<td>24 (5.5)</td>
<td>NS</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>11 (6.1)</td>
<td>3 (9.8)</td>
<td>NS</td>
</tr>
<tr>
<td>Intravenous drug use</td>
<td>2 (1.1)</td>
<td>0</td>
<td>NS</td>
</tr>
<tr>
<td>Prior cardiac surgery</td>
<td>14 (7.8)</td>
<td>5 (14.3)</td>
<td>0.045</td>
</tr>
<tr>
<td>Prior endoscopy</td>
<td>8 (4.4)</td>
<td>1 (2.9)</td>
<td>NS</td>
</tr>
<tr>
<td>Dialysis</td>
<td>8 (4.4)</td>
<td>2 (5.7)</td>
<td>NS</td>
</tr>
<tr>
<td>Central venous catheter</td>
<td>6 (3.3)</td>
<td>3 (9.8)</td>
<td>NS</td>
</tr>
<tr>
<td>Dental surgery &lt;96</td>
<td>37 (20.5)</td>
<td>3 (9.8)</td>
<td>0.03</td>
</tr>
<tr>
<td>Tonsillitis or sinusitis &lt;96</td>
<td>15 (8.3)</td>
<td>2 (5.7)</td>
<td>NS</td>
</tr>
<tr>
<td>Duke’s criteria and localisation</td>
<td>169 (93.9)</td>
<td>27 (78)</td>
<td>0.045</td>
</tr>
</tbody>
</table>

Table 1: Comparison of all cases with those with culture negative endocarditis (CNE); values are number (%)

References


Ethical, professional, and legal obligations in clinical practice

We wish to applaud Mr Gore on conducting sessions and writing about ethical, professional, and legal obligations in clinical practice. It is an area in which most doctors fail to get training at an earlier stage, and there is a case for other specialties to take heed from Gore’s series and conduct such educational exercises in their hospitals.

We agree with Gore that doctors tend to underestimate how willing people are to talk about their own death and, in fact, their resuscitation status. As doctors we tend to assume that this discussion will not be involved in their “not for resuscitation” (NFR) decision. The group had equal number of male and female patients and equal number of patients below and above the age of 70 years. The results were very interesting and showed that majority (~71%) of the hospital inpatients wished to get involved in the discussion related to their NFR decision. This view was similar among young and old patients. This sends a strong message that ethically we ought to involve mentally competent patients in their NFR decisions if the latter so wish.

We disagree with Gore that resuscitation be offered if it is specifically requested by a patient even if a successful resuscitation is unlikely. In patients in whom cardiopulmonary arrest clearly represents a terminal event in their illness, attempted resuscitation might be considered inappropriate. Neither patients nor their relatives can demand treatment that the health care team judges to be inappropriate. There are situations where medical reality and patient’s expectations in relation to their illness and NFR decisions do not match. In situations like these the healthcare team has the moral and legal responsibility to help their patients reach a decision in their best interest.

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References

I welcome the comments of Dr Jain and his colleagues. The apposite study which they conducted at Wrexham Maelor Hospital demonstrates the desire among patients, young and old, for involvement in NFR decisions. As doctors we must confront our own unease at discussing matters of resuscitation and death with patients.

I accept the authors’ reservations about my endorsement of compliance with a patient’s wish for cardiopulmonary resuscitation in all cases. In many such cases cardiopulmonary resuscitation would be medically inappropriate, and it is indeed the responsibility of the healthcare team to counsel the patient accordingly. Nevertheless the series of discussion articles was geared towards education for junior medical staff, and I chose to keep the guidelines straightforward with an emphasis on patient autonomy. Certainly in any such situation one would expect a more senior member of the healthcare team to identify and address that mismatch between medical reality and patient/relative expectation. Counselling might then be offered in the hope of reaching consensus on the suitability of a NFR decision.

Intraoperative glove perforation

We read with interest the paper by Thomas et al concerning single versus double gloving in protection against intraoperative skin contamination from glove perforation. We note that one of the methods used to detect glove perforation was the water leak method. Although we accept that the water leak test is an acceptable method we believe that it is not as sensitive as the electrical conductance test as demonstrated by Sohn et al.2

Interim results from an ongoing study yielded 211 sterile and non-sterile gloves used during venepuncture or wound closure in our emergency department. We identified nine glove perforations with the water leak test and 22 with the electrical conductance test. All water leak positives were also electrical conductance test positive. This study supports the work by Sohn et al. We believe that Thomas, Agarwal, and Metha may have underestimated the incidence of glove perforation in their study group.

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References

Authors’ reply

The water load test, as per the criteria established by the American Society for Testing and Materials, is one of the methods approved by law for testing integrity of latex gloves. Recent studies have shown that the electrical conductance test has a higher sensitivity than the water load test in detecting smaller glove perforations. The study by Sohn et al cited by McLaughlin and colleagues shows similar findings, although the number of patients testing false negative with the electrical conductance test has not been mentioned.

Both these tests, however, have an inherent disadvantage as they overstress the gloves, thus negating the viscoelastic, self sealing properties of latex and aggravating the potential permeability to fluid/electrical impulses. It may be more appropriate if these tests are conducted with the gloves distended with liquid only up to the appropriate size; the significance of the glove perforation can then be assessed by the number of bacteria/quantity of water that can pass through the perforation in a fixed period of time.

In the ongoing study described by McLaughlin et al, there were 22 perforations in 211 gloves used in minor surgical procedures, indicating that one in five minor surgical procedures will result in perforated gloves (one pair of gloves for each procedure). This emphasises the point made by our article that even in minor surgical procedures, single gloving alone will not provide adequate protection.

Reference

Cor pulmonale: variation on a theme

We regret that an error occurred in the above paper by Jolobe, Schlayer, and Yates (Postgrad Med J 2001; 77:665, 675–7). The final diagnosis should have read “Cor pulmonale resulting from pulmonary tumour embolism.”
Clinical practice

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