

**Results.** Fever 39°C, chills, motor aphasia, paresis on the right side. Objective(s): pale skin, petechiae, Janeway lesions. Rhythmic heart murmurs, HR 90 b/min, systolic murmur at the apex and diastolic at the aorta, BP 90/50 mmHg. Paraclinically: BC beta-hemolytic streptococcus. ECGG: mobile vegetations on MV 10 mm and AoV 12 mm; regurgitation on MV, VAo and VTs of grade III, EF 56%; Radiologically – bilateral septic pneumonia; Hb 89 g/l, erythrocytes  $2.8 \times 10^{12}$ , leukocytes  $11 \times 10^9$ , ESR 66 mm/h; ASLO-1:400; FR 48 U/l. Treatment with 2 antimicrobial regimens in maximum doses, antifungals, diuretics, fractionated direct anticoagulants, nootropic medication.

**Conclusion(s).** Infective endocarditis can often occur with polyorganic embolic complications, more frequently with stroke and pulmonary thromboembolism, which negatively influence the evolution and prognosis of the disease, causing disability. The treatment of these patients is complex and individualized.

**Keywords:** stroke, infective endocarditis, individualized therapy.

### INFECTIVE ENDOCARDITIS WITH EMBOLIC SYNDROME. CLINICAL CASE

**Alina Istrati<sup>1</sup>, Xenia Spatari<sup>1</sup>, Livi Grib<sup>1</sup>, Elena Samohvalov<sup>1,2</sup>, Elena Jacotă<sup>1</sup>, Valeria Gaina<sup>1</sup>, Alexandra Grejdieru<sup>1</sup>**

<sup>1</sup>Discipline of Cardiology, SMPHU "Nicolae Testemițanu"

<sup>2</sup>Municipal Clinical Hospital "Holy Trinity", Cardiology Department

**Introduction.** Infective endocarditis (IE) presents with systemic embolic complications in 10-57% of cases: cerebral (26.3%), splenic (6.8%), and pulmonary (6.1-32%), leading to a malignant course with disabilities (172,359 cases/year). Early diagnosis and targeted treatment facilitate a favorable prognosis.

**Objective(s).** Description of the clinical case of a patient with infectious endocarditis and emboli in three organs. Importance of early diagnosis and personalized treatment in the management of IE.

**Materials and methods.** Female, 63 years old, with streptococcal infective endocarditis, involving the aortic valve (AV), with systemic and pulmonary emboli, admitted to the cardiology department of the CMH "Holy Trinity". Onset with fever, sweating, severe abdominal pain. Clinically and paraclinically investigated through echocardiography, blood cultures, biomarkers.

**Results.** Fever of 40.6°C, chills, dyspnea, palpitations. Physical examination: pale skin, Osler nodes. Heart rate 120 bpm, diastolic murmur at the aortic area, blood pressure 130/90 mmHg. Investigations: blood cultures (3 sets) *Streptococcus β-haemolyticus*. ECHO: 20 mm vegetations on the aortic valve, grade II aortic regurgitation, ejection fraction 55%. ESR 50 mm/h; rheumatoid factor negative; CRP 96 U/L; D-dimers 500 ng/mL. Abdominal ultrasound: splenic and renal emboli. Chest X-ray: small-branch pulmonary embolism (PE). Treatment included antimicrobial, antifungal, anticoagulant agents, and β-blockers, with an unfavorable prognosis.

**Conclusion(s).** Infective endocarditis, when diagnosed late, is complicated by severe valvular regurgitation and large vegetations, the fragmentation of which leads to multiple embolic syndrome, worsening the disease progression, hindering timely treatment, and often progressing toward an unfavorable outcome.

**Keywords:** infective endocarditis, embolic syndrome, large vegetations.