CAPE HEART

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Dr Carissa van Aarde
Cancer Care

Dear Colleague

RE: Mr Jan Marten Daling - CP 15887
DOB: 14-05-1983

Thank you for the referral of this 42-year-old man for evaluation of possible infective endocarditis. The patient is a single man with no children. He is employed as an IT program.

In March of this year, he was diagnosed with a thymic carcinoma. He had presented with an anterior mediastinal mass associated with pleural effusion, pleural disease, pulmonary nodules and chest wall invasion. He subsequently developed a pericardial effusion and required a pericardial window. He has been treated with chemotherapy.

Following his 1st cycle of chemotherapy, he developed neutropenia with oral gingivitis and blood cultures grew Streptococcus mitis. He is currently on day 4 of the Piperacillin/Tazobactam. Inflammatory markers are low, and he is apyrexial. A recent echocardiogram was performed, and an echo bright structure was appreciated on the anterior mitral leaflet. The possibility of a vegetation was raised.

On further questioning, the patient documents recent symptoms of headache and tender gums prior to admission. He had a mild pyrexia. Since he has been treated, his symptoms have improved. His effort tolerance is NYHA Class II without symptoms of heart failure. There are no complaints of dizziness, palpitations or syncope.

There are no known pharmacological ALLERGIES.

Previous surgical history: Pericardial window-April 2025.

On physical examination, he had had a low BMI. There no peripheral features of infective endocarditis. All of the peripheral pulses are easily palpated, and no aneurysms are noted. His blood pressure is 90/60 and pulse rate 67 bpm and regular. He is not clinically clubbed. Heart sounds are soft auscultation with a normal S1 and S2 are noted. There is normal inspiratory splitting of the 2nd heart sound. No murmurs are detected. There no gallops rubs or clicks. The JVP is not elevated, and he does not have peripheral pedal oedema. There is no ascites or hepato-splenomegaly.

The electrocardiogram confirms normal sinus rhythm 67 BPM. The QRS axis is 45°. There is inferolateral T-wave flattening.

Echocardiography confirms a non-dilated, well contracting left ventricle with preserved systolic function. LVEF 63 percent. No regional wall motion abnormality noted. The mitral valve appears morphologically normal with trivial mitral regurgitation. The differential of the anterior mitral leaflet is thickened but there is no obvious/discrete vegetation. There is no mitral stenosis. No aortic stenosis or regurgitation. No overt valvular vegetations noted. The right side of the heart is normal with no tricuspid regurgitation or pulmonary hypertension. No pericardial effusion is noted.

On clinical and echocardiographic evaluation, there is no overt evidence of infective endocarditis. I note that he was mildly anaemic at the time of admission. Also, inflammatory markers were marginally elevated, and this seems to be responding to therapy. Based on the current clinical assessment, I do not believe that the patient has infective endocarditis. However, given the culture of Streptococcus mitis, a high index of suspicion needs to be held. If there is any concern, I was suggesting that we consider performing a transoesophageal echocardiogram.

I hope that this is of assistance.

Thank you for the kind referral.

Yours sincerely

Dr T Pillay.