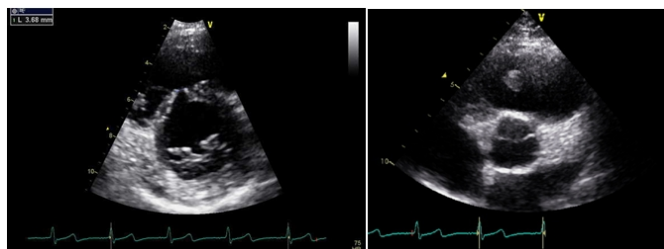


Infective endocarditis with RVOT vegetation associated with muscular ventricular septal defect

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Vegetation due to Bacterial endocarditis, secondary to jet lesions from congenital heart disease such as ventricular septal defect (VSD) has been reported not uncommonly. Usually, the vegetation is located on the septum near the cardiac valve or involves it on type 1 to 3 VSDs. Importantly, our patient had the muscular type VSD which is very rare congenital heart disease. In the situation of suspicious bacterial endocarditis due to previous dental procedure, we observed isolated right ventricle outflow tract (RVOT) vegetation complicating VSD. We report this because it is the first case of the RVOT vegetation with the muscular VSD. The patient's presentation was predominantly that of fever and lethargy for about 3 weeks, since he had dental caries treatment at local dental clinic without prophylactic antibiotics intake. He had a diagnosis of VSD in childhood. On his blood culture, an alpha hemolytic streptococcus viridians with intermediate level resistance (MIC: 0.125 mcg/mL) was grown. The lesions, RVOT vegetation, VSD and patent foramen ovale (PFO), were detailed on echocardiography and transesophageal echocardiography. At non-active phase, after the intravenous use of penicillin and gentamicin for 3 weeks, the patch closure of VSD with resection of vegetation, resection of anomalous muscle bundles on the right ventricle outlet tract and direct closure of PFO were performed. there was no residual shunt flow on interventricular septum, and no evidence of previous low echogenic mass on transthoracic echocardiogram.



Early Intervention in Octogenarians with Non-ST-Elevation Myocardial Infarction

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Background and Objectives: Octogenarians with coronary artery disease constitute a high risk group. Most studies documented that octogenarians with non-ST-elevation myocardial infarction (NSTEMI) may derive a greater benefit from an invasive strategy than younger patients, but the optimal timing of such intervention is not well established. We hypothesized that octogenarians with NSTEMI who underwent earlier intervention in the invasive arm would have improved outcomes. **Methods:** We retrospectively analyzed 567 octogenarians who underwent percutaneous coronary intervention (PCI) and who were enrolled in the Korean Acute Myocardial Infarction Registry. They were divided into 2 groups, an early intervention (PCI done within 24 hours after onset of symptoms; n=228) and deferred intervention (24 to 72 hours; n=339). The primary outcome was the incidence of in hospital death and major bleeding. Secondary clinical endpoints were the 12-month all-cause death and 12-month major adverse cardiac events (MACE), where MACE included all-cause death, recurrent myocardial infarction, target lesion revascularization (TLR), and coronary artery bypass grafting (CABG). **Results:** There were no significant differences in the incidence of in hospital death (6.4 vs. 5.9%; $p=0.808$) and major bleeding (0.0 vs. 3.0%; $p=0.110$) between groups. The secondary clinical endpoints were similar between two groups during 12-month follow-up: all-cause death (8.0 vs. 11.5%; $p=0.936$), MACE (11.3 vs. 16.9%; $p=0.897$), recurrent myocardial infarction (0.9 vs. 0.5%; $p=0.484$), TLR (1.8 vs. 1.6%; $p=0.693$) and CABG (0.0 vs. 0.5%; $p=0.678$). **Conclusions:** In octogenarians with NSTEMI, an early intervention approach does not offer an advantage over a deferred intervention.