What are the differences in outcomes between right-sided active infective endocarditis with and without left-sided infection?

Abderahman Kamaledeen, Christopher Young and Rizwan Q. Attia

Department of Cardiothoracic Surgery, St Thomas’ Hospital, London, UK

* Corresponding author. Department of Cardiothoracic Surgery, 6th Floor East Wing, St Thomas’ Hospital, Westminster Bridge Road, London SE1 7EH, UK.
Tel: +44-207-1880214; fax: +44-207-1881006; e-mail: rizwanattia@doctors.org.uk (R.Q. Attia).

Summary

A best evidence topic in cardiac surgery was written according to a structured protocol. The question addressed was: in patients with isolated right-sided infective endocarditis (RSE) is the outcome of surgical management the same as in patients with or without left-sided involvement? Altogether, 419 papers were found using the reported search, six of which represented the best evidence to answer the clinical question. Two studies point towards better outcomes with isolated RSE. In one paper, mortality was significantly lower in isolated RSE patients (\( P = 0.0093 \)) for the duration of the follow-up time (median 488 patient-years). Two studies reported early mortality (<30 days) for RSE patients at 3.6 and 3.8%, respectively. Combined right- and left-sided endocarditis (RLSE) patients were found to have a poorer pre-operative clinical presentation than isolated RSE patients with a greater requirement for inotropic support (\( P < 0.006 \)) and the likelihood of an emergency operation (\( P < 0.001 \)). They had a poorer intra-operative course with a higher incidence of cardiac abscess formation (\( P < 0.001 \)). One study suggested that there is no significant difference in in-hospital and long-term mortality between intravenous drug abuse (IVDA) patients and non-IVDA patients. Left-heart involvement in the IVDA group was 61.5%. This was in-line with the published literature, demonstrating a rise in RLSE in IVDA compared with non-IVDA patients. Three articles looking at isolated left-sided endocarditis (LSE) gave mortality rates in the surgical group to be 27.1, 27.8 and 38%, respectively. In one study, the LSE mortality was not different for native vs. prosthetic valve infection (OR 0.65, 95% CI 0.23–1.87). After propensity matching and adjusting for hazards, the complication rate in the LSE group was higher and this translated to a higher mortality rate. We conclude from the literature that outcomes are more favourable with lower early and late mortality for isolated RSE patients over pure LSE or combined RLSE.

Keywords: Infective endocarditis • Right-sided infective endocarditis • Left-sided infective endocarditis • Outcomes

INTRODUCTION

A best evidence topic in cardiac surgery was written according to a structured protocol. This is fully described in Interactive Cardiovascular and Thoracic Surgery (ICVTS) [1].

THREE-PART QUESTION

In patients with isolated [right-sided infective endocarditis (RSE)], is the [outcome of surgery] the same as in patients with [left-sided or combined right- and left-sided infective endocarditis (RLSE)]?

CLINICAL SCENARIO

The cardiologists ask you to see a 30-year old patient who has tricuspid valve infective endocarditis and has septic pulmonary emboli. They ask your surgical opinion and to counsel the patient for risks for surgery. You remember seeing a patient earlier on with native aortic valve infective endocarditis. You wonder if right- vs. left-sided infection has a difference in operative outcomes. You decide to look up the evidence on the topic.

SEARCH STRATEGY


SEARCH OUTCOME

Four hundred and nineteen papers were found using the reported search criteria. Six of which represented the best evidence to answer the clinical question (Table 1). Case reports and small series of <10 patients were discarded. Studies that did not declare a clear clinical outcome were also excluded. Primary outcomes of interest were in-hospital or early (<30 days) and overall mortality rates for cases with isolated RSE,
<table>
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<tr>
<th>Author, date and country, study type</th>
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<td>Zhang et al. [2], 2010, China; Retrospective cohort study (level IIb)</td>
<td>Single-centre study over 15 years $n = 28$; adult patients with isolated RSE</td>
<td>Primary outcome: (1) mortality</td>
<td>Mortality: 3.6% (one in-hospital death)</td>
<td>Good outcomes are observed with surgery in the setting of isolated RSE No recurrent infection found</td>
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<tr>
<td>Musci et al. [3], 2007, Germany; Retrospective cohort study (level IIb)</td>
<td>Single-centre study over 20 years $n = 79$; adult patients undergoing 84 operations for RSE ($n = 57$) and combined RLSE ($n = 27$)</td>
<td>Primary outcome: (1) mortality</td>
<td>Early mortality for isolated RSE at ($&lt;30$ days) and 1-year post-operation were 3.8 and 11.6%, respectively</td>
<td>Involvement of the left heart with RSE is statistically significant independent predictor of early and late mortality Combined RLSE showed worse pre-operative condition with complications and significantly poorer prognosis post-surgery</td>
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<tr>
<td>Tleyjeh et al. [4], 2007, USA; Prospective observational study (level IIa)</td>
<td>Single-centre prospective study over 18 years $n = 546$; adult patients with LSE</td>
<td>Primary outcome: (1) mortality</td>
<td>129 of 546 (23.6%) had surgery at $&lt;30$ days of diagnosis Mortality: 99 of 417 (23.7%) non-surgical group vs. 35 of 129 (27.1%) surgical group 86 cases (93 pairs of surgical vs. non-surgical cases) matched and propensity scored on diagnosis and follow-up time demonstrated no significant association existed between surgery and mortality (adjusted HR 1.13, 95% CI 0.5–3.1) Surgery was not associated with a survival benefit (adjusted HR 0.92, 95% CI 0.48–1.76)</td>
<td>Valve surgery in LSE found to be not associated with a survival benefit (vs. the non-surgical group) and could be associated with increased 6-month mortality</td>
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Continued
left-sided endocarditis (LSE) and RLSE. Secondary outcomes of interest were surgical complications.

**RESULTS**

Zhang et al. [2] retrospectively analysed data on 28 patients with isolated RSE. Eighteen patients were females (64.3%) and 10 males (35.7%). Early mortality (<30 days) was 3.6% (1 of 28). The remaining patients were discharged and followed up for at least 6 months. New York Heart Association (NYHA) class decreased in all patients. There was no recurrence of infection during the follow-up. The authors declare favourable outcomes with surgical management of isolated RSE.

Musci et al. [3] compared the outcome of isolated RSE with combined RLSE in a retrospective analysis of 79 patients undergoing 84 operations (median age 43.5 years). Fifty-seven (67.9%) operations were for isolated RSE and 27 (32.1%) for RLSE. Follow-up ranged from 6 months to 19.27 years (median 3.59 years), totalling 448 patient years. There was a significant difference in the survival at 30 days and 1, 5, 10 and 20 years following surgery between the two groups (RSE 96.2, 88.4, 73.5, 70.4 and 57.7% and RLSE 72.0, 50.8, 35.6 and 35.6%; P=0.0093). For combined RLSE, early mortality was significantly higher (18%) compared with isolated RSE (3.8%). The RLSE group had a high
incidence of abscesses found during operation and the RSE group had none ($P < 0.001$). They also required high-dose catecholamines pre-operatively (22.2 vs. 3.85%, $P < 0.006$). Thirty-three per cent of patients ($n = 26$) were intravenous drug abuse (IVDA) with 73% ($n = 19$) having isolated RSE and 27% having RLSE ($n = 7$). However, IVDA was not associated with a significant increase in mortality. The study demonstrated that combined RLSE had a significantly poorer clinical outcome. The authors conclude that the surgical treatment of RSE with or without involvement of the left heart can be performed with favourable results. They acknowledged the limitations of a single-centre retrospective cohort study.

Tleyjeh et al. [4] conducted a prospective matched cohort study of 546 infective endocarditis patients diagnosed between 1980 and 1998. Ninety-three pairs were matched between the surgical group ($n = 129$) and the non-surgical group ($n = 417$). Propensity matching resulted in no significant differences between the two groups. Ninety-nine of 417 patients (23.7%) in the non-surgical group died compared with 35 (27.1%) of the surgical group. In the propensity-matched subset, 18 of 93 (19.4%) in the non-surgical group died vs. 27 of 93 (29%) in the surgical group. Surgery was associated with a hazard risk (HR) of 1.3 ($P = 0.56$). Valve surgery was associated with increased 6-month mortality (HR 1.9, $P = 0.11$) when it was treated as a time-dependent covariate. In subgroup analyses, LSE with the involvement of the mitral valve and abscess formation had a statistically significant association with mortality ($P = 0.03$ and 0.003, respectively). Post hoc subgroup results demonstrated worse outcomes for LSE.

Carozza et al. [5] looked at the outcomes of valve surgery in IVDA. A series of 39 IVDA patients were compared with 85 non-IVDA patients for total follow-up of 717.6 years. RSE involving the tricuspid valve was significantly higher in IVDA cases ($P = 0.001$). This is concordant with other published evidence that IVDA have a higher incidence of RSE than non-IVDA ($P = 0.001$). Although the authors found higher than the expected left-heart involvement in IVDA (61.5%), early and long-term survival were not significantly different between the two groups with no effect on the post-operative mortality.

Fernández Guerrero et al. [6] conducted a retrospective review of 133 cases. Patients were divided into RSE ($n = 64$) and LSE ($n = 69$). Overall, 74% of patients with LSE and 23.4% of RSE patients developed at least one complication. Mortality was 17 and 38% for RSE and LSE patients, respectively.

Sy et al. [7] reviewed 223 patients admitted with LSE between 1996 and 2006 to assess the potential effects of the survivor treatment selection bias and reduction in mortality post-operatively after adjustment. Although surgical patients ($n = 62$) had lower mortality (32 vs. 51%; $P = 0.02$) during a median follow-up of 5.2 years compared with medical patients ($n = 161$) with an unadjusted HR of 0.54 ($P = 0.01$), time-dependent analysis (HR, 0.50; $P = 0.02$) showed no significant effect on mortality with surgery. The survivor bias effect was confirmed with the conditional Kaplan–Meier analyses. Excess mortality in the medical group before access to surgery created a false apparent benefit of surgery. The authors conclude that evidence for surgical management is inconclusive, although it could be beneficial in high-risk patients, and when it is expedited in this group of patients within the first 2 weeks in hospital.

**CLINICAL BOTTOM LINE**

The literature suggests a much better outcome in patients with isolated RSE vs. patients with left-sided or combined RLSE. This is reflected in lower early and late mortality along with fewer post-operative complications.

**Conflict of interest:** none declared.

**REFERENCES**


