

## **B1**

### **Title: Septic Embolism**

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A 26-year-old Caucasian female who presented with a one-week history of pleuritic chest pain, malaise, chills and fatigue as well as a chronic forearm lesion from IV drug use. Medical history is significant for several years of IV heroin abuse and untreated hepatitis C. On presentation, the patient was febrile, hypotensive, tachycardic at a rate of 120b/m and tachypneic at a rate of 24c/m. Patient had multiple injection marks in both arms and a linear full thickness 13 by 4cm wound in the left forearm. Lab results showed leukocytosis with bandemia and lactic acidosis. Patient was diagnosed with septic shock, samples for blood culture were collected with initiation of aggressive IV hydration and broad-spectrum antibiotics via a central catheter. Chest x-ray and CT angiogram showed multiple consolidations and bilateral cavitated nodular opacities suspicious for active and chronic septic embolic process. Echocardiography revealed huge masses on both mitral and tricuspid valves confirming the presence of vegetations. She was then transferred to another facility for evaluation by cardiothoracic surgery where she later died from multiorgan failure.

Septic emboli are a complication of infective endocarditis that result in downstream vessel occlusion leading to pulmonary or systemic complications like pulmonary embolism, stroke, myocardial, renal or splenic infarction etc. Septic emboli may occur in both right sided and left sided infective endocarditis and IV drug abusers are at high risk. Urgent resuscitation measures and initiation of broad-spectrum antibiotics and possible surgical intervention are warranted.