was taken which showed that the aneurysm had increased in size (Figure 1D). Faced with a risk of complications (thrombosis, embolism, rupture) we decided to perform another surgical procedure involving aneurysm resection and derivation of the internal mammary artery to the anterior descending artery (Figure 2). The microbiology culture was sterile and the histological study showed non-specific fibrosis. The patient underwent the operation with no complications and was discharged after 4 months of hospitalisation. One year later, he remains asymptomatic.

The natural history and treatment steps are not well defined for arteriosclerotic coronary aneurysms, but they are related to the size and symptoms. Some authors consider that a size >1 cm or 3-4 times the size of the native vessel is an indication for surgery4 or for percutaneous closure by implanting a stent graft. Other authors believe that if the aneurysm is small and does not present severe lesions or complications, the long-term prognosis is good and it can be handled with medical treatment.5

Mycotic aneurysms account for 2% of all coronary aneurysms. In most cases, they are a complication of bacterial endocarditis affecting the aortic and/or mitral valve. The most frequently isolated microorganisms are Staphylococcus aureus and Streptococcus viridans. Small aneurysms may respond favourably to early antibiotic treatment, but surgery is normally necessary to repair them. To date, the publications we reviewed contain no reported cases of mycotic coronary aneurysms caused by S pneumoniae.

In our case, we cannot confirm that this is a case of a superinfected aneurysm since the histological study of the cultured sample was negative (after antibiotic treatment), but its rapid growth and the association with purulent pericarditis make infection the most probable diagnosis.

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Redundant Eustachian Valve Endocarditis: Neonatal Diagnosis

To the Editor:

We present the case of a pre-term newborn at 33 weeks gestational age with a birth weight of 1730 g, who suffered respiratory difficulty and required non-invasive ventilation without supplementary oxygen and umbilical vein cannulation. On the third day he presented a clinical profile of sepsis with abnormal infectious parameters, and vancomycin and cefotaxime treatment was administered. Evolution was poor, with signs of right heart failure and audible regurgitating systolic murmur 2-3/6 in the tricuspid; the echocardiograph showed a large pediculated vegetation in the right atrium and two small vegetations in the septal tricuspid valve. There was a 5 mm permeable oval foramen with a left to right short circuit. *Staphylococcus aureus* was isolated in the blood culture.

The patient was referred to our centre, where we diagnosed endocarditis of a redundant Eustachian valve with peripheral echo refringencies (Figures 1 and 2) that were compatible with thrombotic vegetation. Antibiotic treatment was maintained during 6 weeks with the addition of low molecular weight heparin, and the patient’s evolution was
good. The echocardiography before the patient was discharged showed that the vegetation on the Eustachian valve had been somewhat reduced, and that the 2 small vegetations on the tricuspid valve had disappeared.

At 6 months of age, the patient underwent extracorporeal surgery involving total resection through right atriotomy with no post-operatory incidents. Anatomical pathology showed a redundant Eustachian valve with vegetation remnants and thrombosed areas. No microorganisms were isolated in the culture.

The Eustachian valve is an embryological remnant which serves in the foetus to direct the blood flow toward the left atrium through the oval foramen; it can be identified in the ostium of the inferior vena cava and seen on the inside of the right atrium. Its presence is infrequent in adults, but echocardiography identifies it in all infants younger than 1 month and in 2/3 of older children; only occasionally is it large and mobile.

In the literature review, we found a total of 17 cases of infectious Eustachian valve endocarditis, all of which were adult patients. Intravenous drug addiction is the main risk factor for Eustachian valve endocarditis. We have found no other recorded case during the neonatal period. The fundamental source of infection in these patients is central catheters, added to the state of physiological immunodeficiency presented by newborns, which is heightened in the case of premature birth.

Of the 17 adult cases we reviewed, 11 required study with transoesophageal echocardiography to make the correct diagnosis. Both techniques offer similar information in paediatric patients, but due to the limitations of transoesophageal echocardiography at this age, and the fact that the acoustic window offers much better quality than in adult patients, transthoracic ultrasound is always the method of choice; the transoesophageal technique is reserved for specific cases.

With respect to the treatment, we should make special mention of the persistence of the vegetation with signs of peripheral thrombosis (requiring antiaggregant and anticoagulant treatment to date) on a redundant Eustachian valve; after a good initial response to medical treatment, it was managed on an outpatient basis. We opted for a surgical procedure at six months fundamentally because the patient showed no initial response, and was a premature newborn with a very low birth weight. This was done considering the risks involved in extracorporeal surgery, the persistence and large size of the vegetation (which according to later
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echocardiographic images affected the function of the tricuspid valve) and the risk of embolism.

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