which have a recognized anti-inflammatory and antithrombotic action).

Furthermore, South Asians in our series presented a significantly lower prevalence of hypertension, smoking, and cocaine abuse than the white Spanish population, with similar values of low-density lipoprotein cholesterol, but a lower prevalence of previous treatments with statins. Studies performed in Britain have reported contradictory results regarding the presence of these risk factors in South Asian patients, and this has been related to the heterogeneity of the subgroups analyzed, which makes extrapolation to our setting difficult. For its part, the risk profile observed among the young Spaniards in our series is in keeping with previous findings, in which early infarction has been associated with high rates of smoking and hypercholesterolemia, and glucose metabolism disorders have a smaller role. Our study highlights the specific features of cardiovascular risk in South Asians in our setting and the differences with respect to the young Spanish population.

There were no significant differences between the 2 groups in the clinical presentation of AMI (with or without ST elevation). Nonetheless, among patients with ST elevation AMI, there was a significantly higher percentage of anterior AMI in South Asian patients. In addition, coronary angiography showed more severe disease in these patients, and a larger number were considered to have nonrevascularizable lesions. AMI without coronary lesions was more common in the white Spanish population. These observations indicate that coronary disease in South Asians is related more to accelerated atherosclerosis than to predominantly thrombotic or vasospastic processes.

Despite the differences described, the 2 groups presented a similar in-hospital clinical course with low complication rates and mortality, which was likely due to the young age of the patients, low prevalence of comorbidities, absence of significant differences in the treatment received, and the improved in-hospital prognosis of AMI observed in our setting.

This series is the first in Spain to address ischemic heart disease in South Asian immigrant patients. Knowledge of the differential characteristics of this ethnic group can facilitate the development of primary and secondary prevention strategies adapted to their risk profile.

Miguel Cañizos-Achirica, Cosme García-García, Roberto Elosua, Neus Piulats, Lluis Recasens, and Jordi Bruguera-Cortada

Servicio de Cardiología, Hospital del Mar, Parc de Salut Mar, Barcelona, Spain
Grupo de Epidemiología y Genética Cardiovascular, IMIM (Institut Hospital del Mar d’Investigacions Mèdiques), Hospital del Mar, Parc de Salut Mar, Barcelona, Spain
CIBER de Epidemiología y Salud Pública, Barcelona, Spain
CAP Drassanes, Barcelona, Spain

Corresponding author:
E-mail address: cgarcia@parcdesalutmar.cat (C. García-García).
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Constrictive Infectious Pericarditis Caused by Propionibacterium acnes

Pericarditis constrictiva por Propionibacterium acnes

To the Editor,

Propionibacterium acnes is a slow-growing Gram-positive anaerobic bacillus, which is part of the bacterial flora of the skin and is also present in mucous membranes. Isolated cases of pericarditis caused by P. acnes have been reported but, even though this microorganism is a frequent cause of the disease, its characteristics have not been described. We report the characteristics of 5 patients with constrictive infectious pericarditis caused by P. acnes—initially manifesting as constrict in 3 and as effusive-constrictive syndrome in 2—characterized by a torpid clinical course, minimal signs of infection, much inflammatory activity and the need for surgery and prolonged treatment with antibiotics, antiinflammatory drugs, and corticosteroids.

The 5 patients were attended between 2006 and 2011. All underwent transthoracic echocardiography and 3 underwent magnetic resonance imaging studies. For diagnostic purposes, the microbiology results were combined with the echocardiogram results in 4 patients and with the magnetic resonance imaging results in 1. Pathologic analysis was performed in 4 patients.

The mean age was 44.4 years; 4 were men. Possible predisposing factors are shown in the Table. The predominant symptoms were asthenia, chest pain and symptoms of heart failure with elevated venous pressure, dyspnea and edema of the lower limbs; 3 patients had pulsus paradoxus. One patient had fever and another had chylous ascites with tension. The mean diagnostic delay was 30 weeks. One patient had hypogammaglobulinemia, adenopathy and pulmonary infiltration caused by lymphangectasia, which disappeared once pericardial constriction had been resolved. All electrocardiograms showed low voltage in precordial leads, with ST-segment depression and T wave inversion in 3 of them.

All chest X-rays showed cardiomegaly. Echocardiographic and magnetic resonance imaging studies are described in the Table. One patient had a calcific mass, with pericardial effusion and lateral myocardial hypokinesia. The Figure shows the surgical specimen, illustrating growth of P. acnes, together with a magnetic resonance imaging scan.

Medical treatment, microbiology and histology results are outlined in the Table. P. acnes grew in the samples between days 10 and 12. The results of blood cultures (3 patients) were negative. P. acnes was penicillin-sensitive in all patients. The 5 patients
received intravenous beta-lactam antibiotics, followed by oral antibiotics for a mean of 5.6 months. Four received corticosteroids and 3 received nonsteroidal antiinflammatory drugs (NSAIDs) plus colchicine. Surgical treatment and outcome are described in the Table.

Pericarditis caused by *P. acnes* is mainly found in men and is associated with cardiac surgery and immunosuppression.²,³ Ikei et al.¹ describe a patient with comorbidity and a calcified mass containing caseous material, as found in 1 of our patients (Figure). Fever has only been described in 1 other case.¹ Chest pain has also been described, as have signs of right heart failure and cardiac taponade.¹,³

Late growth has been described in other infections caused by *P. acnes*² and, in the context of compatible symptoms, it should not

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**Table** Characteristics of the 5 Patients With Constrictive Infectious Pericarditis Caused by *Propionibacterium acnes*.

<table>
<thead>
<tr>
<th>Predisposing factor</th>
<th>Symptoms and diagnostic delay</th>
<th>Echocardiogram</th>
<th>Magnetic Resonance Imaging</th>
<th>Pathology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory infection</td>
<td>Pleuritic pain, dyspnea, heart failure, 2 months</td>
<td>Constrictive infectious pericarditis, mild pericardial effusion, bilateral pleural effusion</td>
<td>Pericardial thickening, whistling colored nodule</td>
<td>Pericardial thickening, with associated effusion</td>
</tr>
<tr>
<td>Tonsillitis, dental caries</td>
<td>Chest pain, dyspnea, palpitations, syncope, 2 weeks</td>
<td>Constrictive infectious pericarditis with cardiac tapenade, moderate-to-severe effusion of up to 21 mm</td>
<td>Pericardial thickening, dilated inferior vena cava</td>
<td>Pericardial thickening with associated effusion</td>
</tr>
<tr>
<td>Dental infection</td>
<td>Dyspnea, chest pain, right heart failure, fever, 9 months</td>
<td>Increased intrapericardial space, solid/fluid material causing constriction</td>
<td>Pericardial thickening, with associated effusion</td>
<td>Pericardial thickening with associated effusion</td>
</tr>
<tr>
<td>Not reported</td>
<td>Asthenia, progressive dyspnea, right heart failure, 20 months</td>
<td>Performed at the onset of symptoms, without changes (1 year prior to surgery)</td>
<td>Pericardial thickening, dilated inferior vena cava</td>
<td>Pericardial thickening with associated effusion</td>
</tr>
<tr>
<td>2 week-long respiratory infection</td>
<td>Chest pain, asthenia, dry cough, dyspnea, right heart failure, 1 month</td>
<td>Pericardial thickening with mild effusion, effusive-constrictive syndrome</td>
<td>Pericardial thickening with associated effusion</td>
<td>Pericardial thickening with associated effusion</td>
</tr>
</tbody>
</table>

**Biologic samples**

- *P. acnes* + *Staphylococcus epidermidis* in pericardial tissue
- *P. acnes* in pericardial fluid and pericardial tissue
- *S. epidermidis* in fluid in first surgical intervention
- *P. acnes* in pericardial tissue in second intervention
- *P. acnes* in pericardial fluid

**Surgical treatment**

- Subtotal pericardiectomy with pericardial patching in right cavities
- Pleuropericardial pericardial window-type surgical drainage
- First subtotal pericardiectomy, second patched epicardiecotomy and residual pericardiectomy
- Total pericardiectomy with decortication
- Subxiphoid pericardial drainage without surgery

**Medical treatment and outcome**

- 1 month ceftriaxone + amoxicillin-clavulanic acid 1 month + amoxicillin 6 months more
- 1 relapse, resolved in 1 year
- Amoxicillin-clavulan acid 6 months + doxycycline 3 months
- 1 relapse requiring ASA + colchicine, resolved in 21 months
- Post-second surgery, penicillin G sodium, amoxicillin 10 months + moxifloxacin 8 months, corticosteroids + colchicine + NSAID 10 months
- Resolved at 3 years
- Ceftriaxone 2 weeks + minocycline 2 months
- Without relapse
- Ceftriaxone 2 weeks + daptomycin 2 weeks, doxycycline 6 months
- 2 relapses, current treatment with corticosteroids + colchicine + NSAID 12 months

ASA, acetylsalicylic acid; NSAID, nonsteroid antiinflammatory drugs; *P. acnes*, *Propionibacterium acnes*; *S. epidermidis*, *Staphylococcus epidermidis*.

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**Figure** Cardiac magnetic resonance image of a patient with constrictive infectious pericarditis. A: cine echo image of short-axis plane gradient; pericardial effusion (*), pericardial thickening (**), and 1.5 cm diameter hypointense nodule image (arrow), corresponding to mass full of material, in which *Propionibacterium acnes* was cultivated (B). LP, left posterior; MRN, magnetic resonance nuclear; RA, right anterior.
CoreValve® Aortic Bioprosthesis Implantation in a Patient With Situs Inversus Totalis With Dextrocardia

Implante de bioprótesis aórtica CoreValve® en un paciente con situs inversus totalis con dextrocardia

To the Editor,

Dextrocardia occurs in 1/12,000 pregnancies, of which approximately a third are associated with inversion (mirror imaging) of the other visceral organs (situs inversus totals).1 In these cases, inversion of the normal anatomy can hamper the performance of fluoroscopy-guided interventional procedures.

We describe a 78-year-old man with situs inversus totalis and symptomatic severe aortic stenosis who was referred to our hospital for transcatheter implantation of an aortic valve. The patient had previously been considered ineligible for conventional aortic valve replacement due to high surgical risk (EuroSCORE logistic, 21%); porcelain aorta). The procedure was performed using a right femoral approach but was complex due to inversion of the cardiac anatomy. Classic ventriculography with 5 segments was performed using a 30° left oblique projection (the usual view is a 30° right oblique projection); a 10° caudal and a 10° right oblique projection were used to align the 3 Valsalva sinususes. Following aortic valvuloplasty with ventricular overdrive pacing, a 29-mm CoreValve® self-expanding aortic valve prosthesis (Medtronic, Irvine, California, United States) was successfully implanted. The patient was stable and asymptomatic when returned to the coronary unit. However, 24 h later he experienced cardiac tamponade secondary to right ventricular free wall perforation by the temporary pacemaker lead and required surgery. Three days later the patient experienced high-grade atrioventricular block and consequently a permanent dual-chamber pacemaker was implanted. The patient was discharged 10 days later, with no further incidents (Figure).

Dextrocardia is a rare abnormality of the heart position.2 Most cases with situs solitus are associated with other cardiac or noncardiac malformations. However, patients with situs inversus totalis (as in our patient) rarely have other associated malformations3-5 and, therefore, it is not unusual them to reach older ages in which degenerative aortic stenosis is common.

Inversion of cardiovascular structures is an added procedural difficulty for percutaneous aortic valve implantation.4 The most important difficulties are related to stable positioning of the temporary pacemaker when crossing the aortic valve with the straight guidewire or attempting to align the 3 Valsalva sinususes to assess correct positioning of the prosthesis. In fact, our patient experienced late perforation by the pacemaker leads, possibly related to malpositioning. In cases such ours, in which the abnormal cardiac anatomy can affect the operator’s spatial orientation, we recommend careful catheter handling and conscientious selection of the angiographic projections (usually opposite to those seen in a patient with levocardia5).

To our knowledge, this is the first case of the implantation of a CoreValve aortic valve prosthesis in a patient with situs inversus totalis.