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Next

Preventing infective endocarditis

Name: _____

NHS #: _____

Heart condition: _____

Valve type: _____

Implant date: _____

Dr: _____

Hospital: _____

Take antibiotic prophylaxis

Do not take antibiotic prophylaxis

Please carry this card with you and show it to your dentist or dentist before treatment is started.

Risk groups for endocarditis

Higher risk

Previously had infective endocarditis

Heart valve replacement or repair

Unrepaired cyanotic congenital heart disease or residual shunt

Subacute bacterial endocarditis

In operated heart valve disease

Leaking or narrowed heart valve

Ischaemic cardiomyopathy

Facing your risk

Brush your teeth (upper and lower) and have your teeth checked-up with your dentist

Avoid body piercing or tattooing

Avoid recreational drugs

Recognising endocarditis

Symptoms of endocarditis are often very vague.

You are at risk of getting endocarditis if you have a heart condition and have flu-like symptoms (fever, sweats or night sweats) that are severe or last more than a week.

If you have a heart condition, you should seek medical attention from your dentist and bring this card.

GP's: Always obtain blood cultures before starting antibiotics in patients with possible endocarditis.

Association Guidelines (2007) British Society for Antimicrobiology

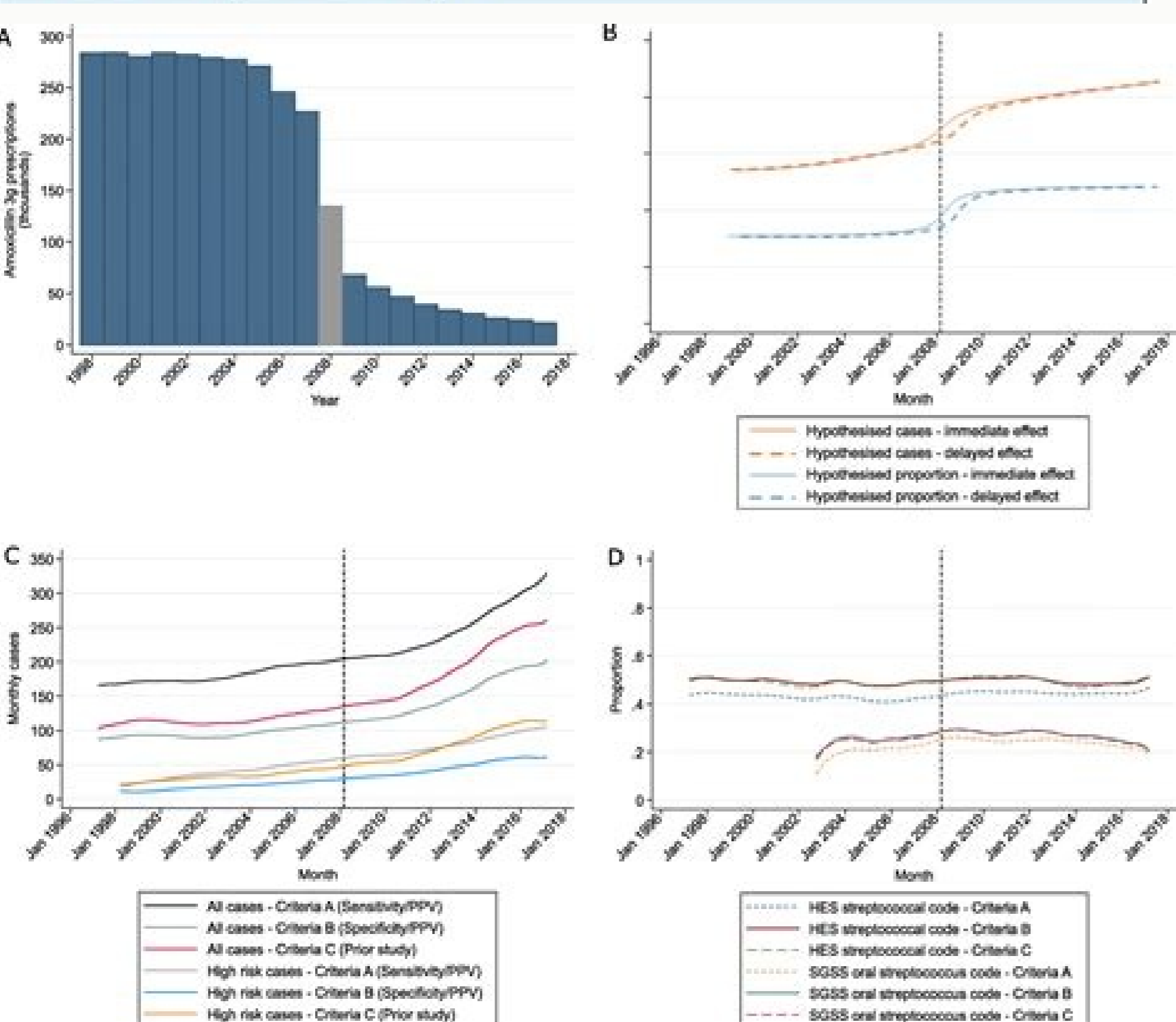
Regimen: single dose 30 to 60 min before procedure	Agent	
2 g	Amoxicillin	
2 g IM or IV		
1 g IM or IV	Amoxicillin	1 g
2 g		
600 mg	Clindamycin	600 mg
500 mg		
1 g IM or IV	Clindamycin	300 mg
600 mg IM or IV	Azithromycin	500 mg cann

- High Risk Criteria to Receive Prophylactic Antibiotics For Individuals Undergoing Dental or Invasive Respiratory Procedures**
- Prosthetic cardiac valve or prosthetic material used for cardiac valve repair
 - Previous infective endocarditis
 - Congenital heart disease
 - Unrepaired cyanotic CHD, including palliative shunts and conduits
 - Completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first 6 months after the procedure
 - Repaired CHD with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device
 - Cardiac transplantation recipients who develop cardiac valvulopathy

Regimens for a dental procedure.

SITUATION	AGENT	REGIMEN: SINGLE DOSE 30-60 MINUTES BEFORE PROCEDURE	
		Adults	Children
Oral	Amoxicillin	2 grams	50 milligrams per kilogram
Unable to Take Oral Medication	Ampicillin OR Cefazolin or ceftriaxone	2 g IM* or IV† 1 g IM or IV	50 mg/kg IM or IV 50 mg/kg IM or IV
Allergic to Penicillins or Ampicillin Oral	Cephalexin§ OR Clindamycin OR Azithromycin or clarithromycin	2 g 600 mg 500 mg	50 mg/kg 20 mg/kg 15 mg/kg
Allergic to Penicillins or Ampicillin and Unable to Take Oral Medication	Cefazolin or ceftriaxone‡ OR Clindamycin	1 g IM or IV 600 mg IM or IV	50 mg/kg IM or IV 20 mg/kg IM or IV

* IM: Intramuscular.
 † IV: Intravenous.
 ‡ Or other first- or second-generation oral cephalosporin in equivalent adult or pediatric dosage.
 § Cephalosporins should not be used in a person with a history of anaphylaxis, angioedema or urticaria with penicillins or ampicillin.



Infective endocarditis (IE) is an infection of the endocardial surfaces of the heart, which includes one or more heart valves. The incidence of infective endocarditis in the United States is estimated to 12.7 for 100000 annually. Most patients (57.7%) are male, and more than a third are 70-year-old and older. Various risk factors predispose patients to IE, such as structural heart disease (valve disease or congenital heart disease), prosthetic heart valves, a cardiovascular device, an intravascular catheter, chronic haemodialysis, infection with human immunodeficiency virus, diabetes or history of infectious endocarditis. Other risk factors include males older than 60-year-olds, male sex, intravenous drug use (IV), poor teeth or dental infection. Infectious endocarditis may present as acute or subacute infection. Acute infections have a rapidly progressive disease with high fever, rigors and sepsis. On the other hand, the subacute diagnosis of bacterial endocarditis is often delayed and has non-specific symptoms such as weight loss, fatigue, having more weeks to months. There are different differences between subcutaneous bacterial endocarditis and acute bacterial endocarditis. Most cases of subacute bacterial endocarditis are caused by penicillin-sensitive Streptococcus viridans, while Staphylococcus aureus causes most cases of acute bacterial endocarditis. Bacterial subacute endocarditis occurs mostly in pre-existing heart diseases, while acute bacterial endocarditis occurs mostly in healthy hearts. After treatment, bacterial subacute endocarditis rarely causes serious cardiac damage; However, most patients who survive acute bacterial endocarditis often die of heart failure within weeks or months. This activity examines the prophylaxis of the subcutaneous endocarditis and puts in the role of the interprofessional approach. Describe the presentation of the patient of subacute bacterial endocarditis. Outline risk factors for subacute bacterial endocarditis. Explain the antibiotic prophylactic techniques used to minimise the risk of subacute bacterial endocarditis. Summarize the involvement of members of the interprofessional team in the prophylactic treatment of subacute bacterial endocarditis. Access free multiple choice questions on this topic. Infectious endocarditis (IE) is an infection of the endocardial surfaces of the heart, which includes one or more heart valves. The incidence of infective endocarditis in the United States is estimated at 12.7 per 100,000 annually. [1]194; 160; The majority of patients (57.7%) were male and more than one third were 70 years of age and older. [1]194; 160; Several risk factors predispose patients to IE, such as structural heart disease (valve disease or congenital heart disease), prosthetic heart valves, an intravascular catheter, chronic haemodialysis, infection with human immunodeficiency virus, diabetes or history of infectious endocarditis. Other risk factors include males older than 60 years, male gender, intravenous (IV) drug use, poor dentition or dental infection. Infectious endocarditis can present as an acute or subacute infection. [2]194; Acute infections present a rapidly progressive disease with high fever, rigors and sepsis. On the other hand, the subacute diagnosis of bacterial endocarditis is often delayed and presents 160; with non-specific symptoms such as weight loss, fatigue, dyspnoea over several weeks to months. There are several differences between subacute bacterial endocarditis and acute bacterial endocarditis. Most cases of subacute bacterial endocarditis are caused by penicillin-sensitive Streptococcus viridans. [1]194; 160; while Staphylococcus aureus causes most cases of acute bacterial endocarditis. [3]194; Subacute bacterial endocarditis occurs by more in pre-existing heart disease,

while acute bacterial endocarditis occurs mostly in healthy adults. At present, rarely bacterial endocarditis subacute subacute subacute However, patients who survive acute bacterial endocarditis often die of heart failure within weeks or months.[3] As the incidence of infectious endocarditis continues to rise in the United States, health care providers must make appropriate decisions about antibiotic prophylaxis to prevent further complications. Pre-procedural antibiotic prophylaxis, particularly dentistry, was widely used to prevent infectious endocarditis, despite the lack of documented evidence to support this practice. In guidelines published by the American Heart Association (AHA) in 2007, the recommended indications for the use of antibiotics for the prophylaxis of endocarditis were significantly limited.[4] There were several reasons for this change. First, infectious endocarditis was more likely to occur with daily activities such as brushing teeth and flossing than with a single medical or dental procedure. Second, antibiotic prophylaxis for dental procedures was considered to have prevented very few cases of EI. The cost of antibiotic therapy and the risk of adverse events, as well as the risk of promoting antibiotic resistance, greatly outweighed the benefits of such prophylaxis. Third, good oral hygiene is considered to be more advantageous in preventing EI than a single dose of antibiotics.[4]The logic of prophylactic antibiotic therapy for subacute bacterial endocarditis is as follows:Infectious endocarditis is a fatal disease, and prevention is preferable to treatment of EI. confirmed infections. Reduce the incidence of bacteremia associated with invasive dental, oral, gastrointestinal (GI), and genitourinary (GU) procedures.In animal studies, there is evidence that antimicrobial prophylaxis effectively prevents endocarditis Antimicrobial prophylaxis effectively prevents infectious endocarditis in high-risk teeth, Oral, GI or GU GU GU endocarditis is fatal if untreated or unrecognized. It causes significant morbidity and mortality, despite current advances in antimicrobial therapy and surgical treatment. Therefore, prevention of infectious endocarditis is necessary. Animal studies have shown that antibiotic prophylaxis can prevent infectious endocarditis, but data in humans are still lacking. Therefore, current guidelines in the United States still recommend the use of antimicrobial prophylaxis for patients undergoing various procedures at risk for infectious endocarditis.The American Heart Association currently recommends antibiotic prophylaxis only in patients with the following high-risk heart conditions:Patients with heart valve prosthesesPatients with previous endocardial prophylaxis Infectious heart diseaseReceptor heart transplant Patients with valve regurgitation due to a structurally abnormal valvePatients with congenital heart disease withUnrepaired congenital heart disease, including palliative shunts and ductsA congenital heart defect completely repaired with prosthetic material or device placed surgically or catheter in the first 6 months after surgery. Genital heart disease with residual defects at or adjacent to the site of a patch or prosthetic devicePatients with these high-risk conditions should receive antibiotics for the following procedures:Dental procedures involve manipulation of the gum tissue, manipulation of the periapical region of the teeth, or perforation of the oral mucosa. Routine injections of anaesthetic through uninfected tissue, dental x-rays, placement or adjustment of orthodontic devices, or trauma to the lips and teeth are excluded.[4][6]The 2007 AHA guidelines also recommended prophylaxis for invasive procedures of the respiratory tract involving incision or biopsy of the respiratory mucosa (e.g. adenoidectomy). Antibiotic prophylaxis has not been recommended forUnless the procedure provides for an engraving of the mucosa of the respiratory tract. [4] Procedures on the infected skin, on the skin structures or on musculoskeletal tissues. [4] Prophylaxis against the ie is not recommended in patients a IE risk for other non-dental procedures, such as transesophageal echocardiogram, esophagogastroduododscopy, colonoscopy, or cystoscopy, in the absence of active infection. [4] [7] [8] Currently, there is no indication for condensation for dental procedural, gastrointestinal or genitus -urinary for patients with implantable cardiovascular devices. However, the prophylaxis with an anti-security antibiotic is indicated at the time of the cardiovascular device system and of every subsequent manipulation of the device of the device created surgically. For patients who have undergone a coronary bypass intervention, the antibiotic prophylaxis is not It is necessary for dental procedures, as there is no increase in the risk of long-term infection. In particular, for patients with coronary stents, antibiotic prophylaxis is not necessary for dental procedures. [4] A, further studies to evaluate the effectiveness of antimicrobial prophylaxis in the prevention of infectious endocarditis are needed. [9] [10] [11] For dental procedures and respiratory, common bacteria common are the various species of Streptococcus Viridans. The recommended prophylactic antibiotic is amoxicillin 2 grams oral 1 hour before the procedure. If the patient needs intravenous drugs (IV), ampicillin or ceftriaxone can be used. Cefalexin or Azithromycin can be used in patients with penicillin allergy. [There is a new resistance to the penicillin of Streptococcus Viridian; Therefore, the prescriber doctor must consider the resistance in their area of practice when it prescribes the appropriate antibiotic. In cases where Staphylococcus is suspected It is recommended that anti-stafilococcic penicillin or vancomicin be used. I'm a little horrified.antibiotic regimen for patients undergoing dental procedures, given the most serious adverse reactions associated with this clindamycin.[5]The most commonly reported adverse drug reactions with amoxicillin are nausea, vomiting, and headache. The overall incidence of serious adverse drug reactions such as urticaria, angioedema, and anaphylaxis is low.[12] Similarly, the fatal anaphylaxis due to a single dose of a cephalosporin in patients with no history of allergy is estimated to be less than one in a million doses. Clindamycin may cause more frequent and severe reactions such as clostridium difficile-associated diarrhea, and recent American Heart Association guidelines do not recommend its use anymore.[5]Doxycycline is an alternative in patients who cannot tolerate penicillin, cephalosporin or macrolide. A severe reaction from a single dose of doxycycline is uncommon. There is a risk of serious cardiovascular events, particularly torsades de pointes with ventricular tachycardia, following the use of azithromycin in patients with a prolonged ECG QTc interval > 450 milliseconds. Therefore, azithromycin should be used with caution in patients known to have QTc prolongation.[13]Subacute infectious endocarditis is a lethal disease if left untreated. Healthcare professionals, including nurses, dentists, pharmacists, primary care providers, internists and cardiologists, should be familiar with the latest ACA and AHA guidelines on prophylaxis for patients at risk of EI. Prophylaxis against EI is not recommended in patients at risk of EI for other non-dental procedures, such as transesophageal disease, echocardiogram, esophagogastroduodenoscopy, colonoscopy or cystoscopy, in the absence of active infection. In addition, for patients who have undergone coronary bypass surgery, antibiotic prophylaxis is not necessary for dental procedures, as it does not It is an increase in the risk of long-term infection. Similarly, for patients with coronary artery prophylactic antibiotics[94, 160, is]94; 160, not necessary for dental procedures. [5]The subacute bacterium A 160; endocarditis (IE) is an infection that is a rare occurrence and a challenge to diagnose. If the diagnosis is done in advance, the results are improved. All members of the health team should be diligent in considering the possibility of IE in patients at risk, as early treatment will improve results. As mentioned above, the subacute prophylaxis of bacterial endocarditis requires close monitoring and communication, and follow-up monitoring requires coordination between clinicians, specialists, nurses, nurses, specialized nurses, dentists and pharmacists. In summary, an interprofessional group approach for patients will result in better patient results, maximizing effectiveness and minimizing adverse reactions to the drug. [Level 5]Revision 1. Bor DH, Woolhandler S, Nardin R, Brusck J, Himmelstein DU. Infectious endocarditis in the United States, 1998-2009: a national study. PLoS One. 2013; 8(3):e60033. [free article PMC: PMC343929] [PubMed: 23527296]2. Habib G, Lancellotti P, Antunes MJ, Bongioni MG, Casalta JP, Del Zotti F, Dullegheru R, El Khoury G, Erba PA, Iung B, Miro JM, Mulder BJ, Plonska-Gosciniak E, Price S, Roos-Hesse J, yg-Martin U, Thuny F, Tornos Mas 2015 Committee guidelines for managing infectious endocarditis: Task Force for the Management of Infective Endocardite of the European Society of Cardiology (ESC). Approved by: European Association for Cardio-Thoracica Surgery (EACTS), European Association of Nuclear Medicine (EANM). Eur Heart J. 2015 Nov 21; 36(44):3075-3128. [PubMed: 26320109]3. HAMBURGER M. 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