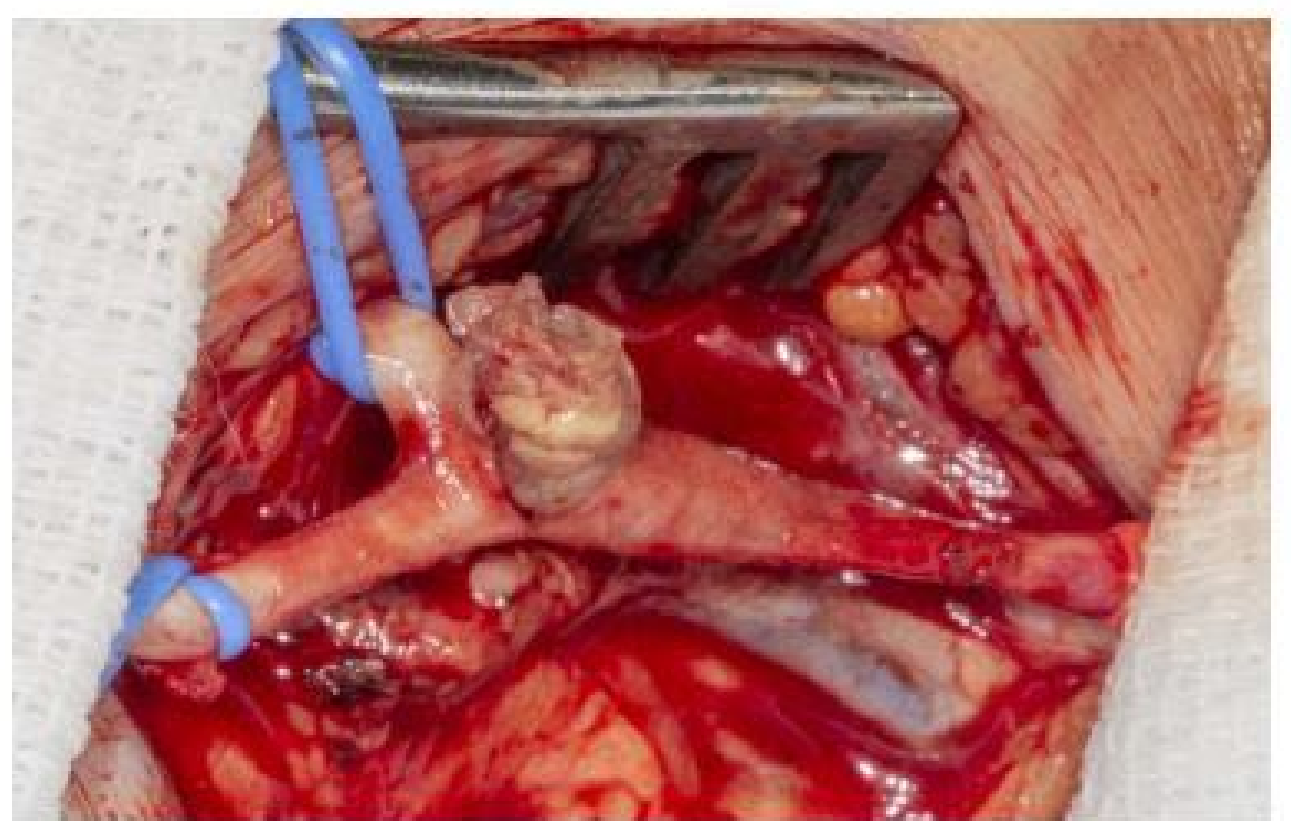
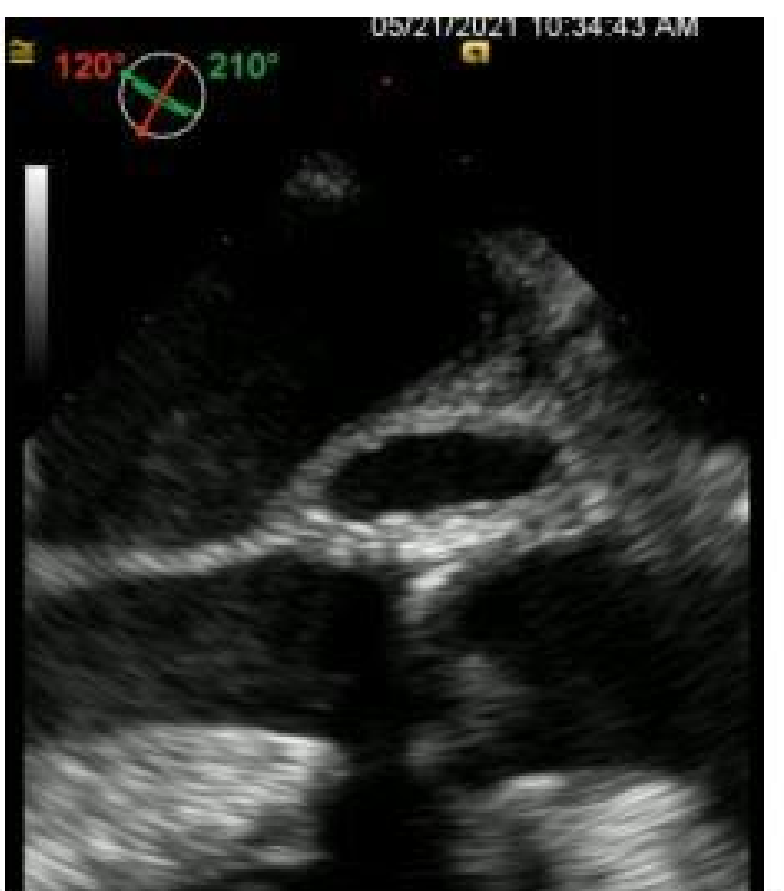


center for *Enterococcus faecalis* bacteremia first diagnosed six weeks prior and treated with long-term antibiotics. Past medical history was significant for aortic stenosis and coronary artery disease; the patient had undergone bioprosthetic porcine Aortic Valve Replacement and 3-vessel Coronary Artery Bypass Graft (CABG) five years prior to admission. A transesophageal echocardiogram (TEE) revealed diffuse thickening of the aortic valve leaflets with mobile vegetation and an echodensity in the aortic root suggestive of abscess vs pseudoaneurysm. While emerging from sedation for this initial diagnostic TEE, the patient complained of sudden pain, weakness and numbness with associated cold sensation in his right forearm; he underwent emergent embolectomy.



A. Septic Emboli from Endocarditis



B. Mid-Esophageal Aortic Valve Long Axis zoomed in on Aortic Valve



C. ME AV SAX showing abscess/pseudoaneurysm

- associated with a 20-30% mortality
- Risk factors include Ejection Fraction (EF) <35%, Age > 60, female sex, emergent surgery
- Morbidity following procedure (stroke, rebleed, pacemaker implantation) are attributed to long bypass and cross clamp time
- Can consider commando/hemi commando procedure when there is lack of surrounding tissue to support a new annulus
- In this case, there was development of new LVOT obstruction with associated severe mitral regurgitation (not previously seen), however this was not repairable without sacrificing the surgical fix of the valve

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