Also, Weiss and coworkers dismiss the observed association between the estimated dietary intake of iron and AMI risk, which could not possibly have been caused by covariation with inflammatory states, unless iron intake is affected by inflammatory diseases. There was no evidence of that in our data. We think that our findings warrant further studies concerning the role of both dietary iron intake and serum ferritin concentration as risk factors for CHD. When there is a more comprehensive picture about both the strength and the impact of these associations in other populations, recommendations concerning the dietary intake of iron will have to be discussed.

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References

Infective Endocarditis After Transesophageal Echocardiography

Transthoracic echocardiography (TOE) generally is indicated in patients with significant valvular lesions, and therefore the question of antimicrobial prophylaxis for prevention of infective endocarditis associated with this procedure is an important one. In their article in Circulation, Steckelberg et al1 suggested that many patients may not require prophylaxis. They described their study in which 30 mL venous blood was cultured from 47 patients at 5, 10, and 20 minutes after the start of TOE. Significant bacteremia did not occur. Our recent experience with a patient undergoing TOE demonstrates that bacteremia and infective endocarditis can complicate this procedure and emphasizes that the decision regarding prophylaxis should be individualized to each patient, as Steckelberg et al indicated.

The case concerned a 25-year-old man with complex congenital heart disease who presented in 1989 with gradually worsening dyspnea and cyanosis. Cardiac catheterization in 1991 showed a double-outlet right ventricle, severe infundibular pulmonary stenosis, atrial septal defect, subtricuspid ventricular septal defect, a normally functioning Glenn anastomosis to the right pulmonary artery (performed in 1967), and a patent Blalock shunt (performed in 1981). As part of the assessment for radical repair, because there was concern about atroventricular valve morphology and attachments, the patient had TOE in January 1992. He was distressed by the procedure and tugged out the probe. Transthoracic echocardiography did not resolve the problem. A second TOE also was unsuccessful. Antibiotic prophylaxis was not given on either occasion. Between the first and second attempted TOE, he developed episodic sweating and shivering. On examination 3 weeks later, there were splinter hemorrhages and microscopic hematuria. Streptococcus sanguis was isolated from two sets of blood cultures, and appropriate antibiotic therapy was started. Three weeks later, transthoracic echocardiography demonstrated a vegetation on the wall of the ventricular septal defect. To date, the patient has made a satisfactory recovery. His teeth were examined radiologically and showed no abscess.

The history and timing of this patient’s symptoms suggest a causal relation to the endoscopy. The incidence of bacteremia after various forms of instrumentation will vary with the endoscopist, the institution, the procedure, and the state of the patient's teeth.2 It is possible that the encouraging data from Steckelberg et al simply reflected the skill of the operator. In another study, Gorge et al3 prospectively examined 24 patients with two blood cultures obtained simultaneously 6–12 minutes after the start of the TOE; 17% had positive blood cultures (albeit with organisms insensitive to standard prophylaxis). This rate is higher than those generally reported for upper gastrointestinal fiberoptic endoscopy.2 We emphasize that the risk of infective endocarditis after TOE will vary with individual cases and institutions. At this stage, it is difficult to generalize about the need for antibiotic prophylaxis for TOE, and further experience is necessary. For the time being, we plan to use antibiotic prophylaxis for this procedure. The issue of whether it is helpful at all in preventing native valve disease is another matter.4

References

Transesophageal Echocardiography and Bacterial Endocarditis

Read and colleagues1 raise an important point about chemoprophylaxis before transesophageal echocardiography. However, this represents only the second case that is about to be reported in the literature showing a temporal relation between the procedure of transesophageal echocardiography and bacterial endocarditis. More details about the present case would have been helpful, such as the actual time between the first transesophageal echocardiography and the reported episode of sweating, whether the patient had fever along with the sweating, and history of previous sweating, fever, or chills. These points would have served to document more fully the temporal association of the onset of symptoms with transesophageal echocardiography. It would have been useful to have information about the gingival and periodontal status at the time of the introduction of the probe in addition to the information about the absence of dental abscess on radiography. The patients in our study did not have any overt dental, periodontal, or
Infective endocarditis after transesophageal echocardiography.
R C Read, R G Finch, F E Donald, G K Morris and J Somerville

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