

Session: P088 News about endocarditis

**Category: 2b. Severe sepsis, bacteraemia & endocarditis**

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## Oral treatment of infective endocarditis

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**Background:** Information on oral treatment of infective endocarditis (IE), mainly left-sided, is scarce. Oral drugs with excellent bioavailability are now available, which, theoretically, could allow an early discharge of selected IE patients. Our goals were to analyse the frequency and the outcome of IE patients who completed their therapy as outpatients with oral drugs.

**Material/methods:** The 435 patients in the HGUGM GAME cohort of IE (2008-2016) were included. Information was prospectively recorded in a pre-established clinical form.

**Results:** Overall 10% of the IE episodes were treated out of the hospital with oral therapy (44 episodes). Etiology was: *S. aureus* (15; 34%), *S. viridans/Granulicatella* spp. (7; 16%), Gram negative rods (5; 11.4%) *S. epidermidis* (4; 9%), *C. burnettii* (3; 6.8%), anaerobes (3; 6.8%), fungi (2; 4.6%), *E. faecalis*, *S. pneumoniae* and *Ureaplasma* spp. (1 case each). Two patients had unknown etiology. Mean age was 59 years old (SD 21) and 30 patients (68%) were male. Infection was mainly community-acquired (27; 61.4%). Infected sites were: native valves (54%), prosthetic valves (13; 29.5%) and intra-cardiac material (9; 20.5%). Most episodes affected the left heart (aortic 15; 34.1%/mitral 17; 38.6%). Distant septic metastasis were detected in 12 patients (4 spleen, 4 lung, 3 CNS, 2 spondylodiscitis). Heart surgery was performed in 29 patients (66%). Most common oral drugs were quinolones (29; 66%), mainly levofloxacin (22), followed by cotrimoxazole (4), linezolid (3), chloroquine-doxycycline (3), azoles (2), cephalosporins (2) and rifampin (6). Median duration of oral outpatient therapy was 19.5 days (IQR 14-41). Readmission (after a median of 41 days; IQR 19-83) was needed in 15 patients (34%) due to: pacemaker implantation (2), BSI of other origin, spondylodiscitis, respiratory insufficiency, Leishmaniasis, pneumonia, bleeding, anticoagulation adjustment, tachycardia, neoplasia and heart transplantation (1 each). There were two early relapses (1 *Aspergillus* and 1 *S. viridans* that had left hospital against medical advice). One-year mortality was 4.5%, but none of the patient died because of the endocarditis.

**Conclusions:** Our series suggest that it is safe and feasible to complete the treatment of complex endocarditis with outpatient oral regimens. However, these patients should be followed very closely, since the rate of hospital readmissions is high.