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Letter to the Editor

Infective endocarditis after transvalvular aortic replacement: A call for a joined effort to improve its results☆

Endocarditis infecciosa sobre TAVI: la necesidad de trabajar en equipo para mejorar los resultados

Dear Editor,

We have carefully read the article by Rodríguez-Vidigal et al., "Infective endocarditis after TAVI: contributions of experience in a single centre on the incidence and associated factors".[1] The expansion of TAVI[2] indications will increase the frequency of this complication, and given its high morbidity and mortality, it is necessary to clarify certain aspects of the prevention and management thereof. For this reason, articles such as the one presented by Rodríguez-Vidigal et al. are highly useful. An aspect of particular relevance, which is already mentioned in the article, is knowledge of the incidence of this complication. In the publications cited in this article, as well as in other recently published ones, the disparity of these data is salient. As Rodríguez-Vidigal et al. point out, higher incidences are described in single-centre studies[3,4] compared to multi-centre registries.[5–8] The authors attribute these differences to the difficulty of diagnosing infective endocarditis in some patients, hypothesising that more exhaustive research would be carried out in single-centre studies in order to reliably diagnose this complication. However, this trend is not found in all cases, as shown in the study by Gallouche et al.,[8] who describe an incidence of 1.4% cases during the first year, very close to that of the multicentre registries.

Therefore, we consider it necessary to study the causes that justify this discrepancy in results, as well as the high incidence observed in some series. One issue that could be fundamental is the pre- and post-intervention antibiotic prophylaxis regimen. As of yet, there are no studies that have randomly evaluated different antibiotic prophylaxis regimens in the context of TAVI. Current recommendations for the management of endocarditis recommend that prophylaxis for TAVI should be started immediately before the procedure and repeated if it is prolonged, but the times are not specified. In addition, for patients who are going to undergo surgery, they recommend screening for nasal carriers of *S. aureus* to be treated with mupirocin and chlorhexidine. Taking into account these data, and that in 4/11 of patients in this series the probable source of bacteraemia was unknown, we could discuss the possibility of screening for carriers of nasal *S. aureus* in patients scheduled for TAVI, and of considering at least 2 doses of antibiotics after the procedure, as recommended by some guidelines.[9] In our centre, this has been the usual clinical practice for some years and the incidence of endocarditis on TAVI is under 1%.

Finally, the authors comment that "the progression of the work culture in a haemodynamic laboratory towards the equivalent of a more surgical environment involves a learning process"; however, they do not describe the time sequence of the incidence of endocarditis in this series, which would allow us to draw that conclusion.

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María Sánchez Ledesma[a,b], Ana Elvira Laffond[a,b], Borja Arias del Peso[a,b], David González Calle[a,b,*]

[a] *Servicio de Medicina Interna (Enfermedades Infecciosas), Hospital Clínico de Salamanca, Salamanca, Spain*
[b] *Servicio de Cardiología, Hospital Clínico de Salamanca, Salamanca, Spain*

* Corresponding author.
E-mail address: davidgonzalezcalle@gmail.com (D. González Calle).

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