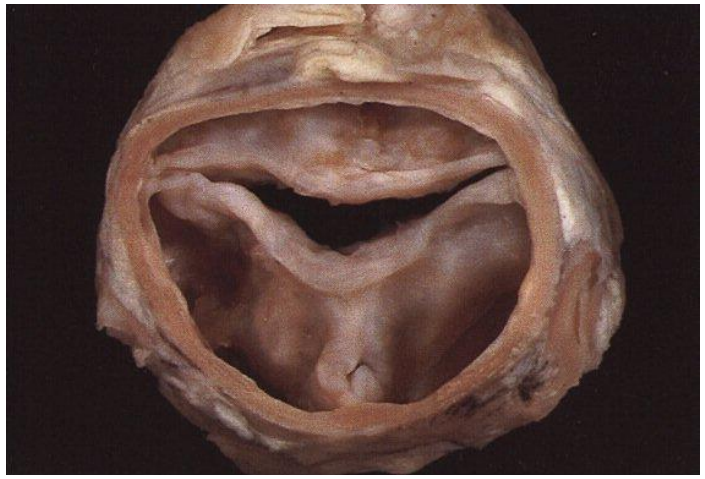

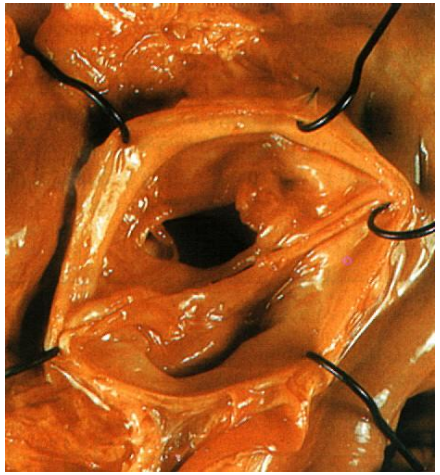

Bikuspidální aortální chlopeň – je indikovaná ATB profylaxe IE?

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25. Symposium pracovní skupiny Chlopenní a vrozené srdeční vady, Hradec Králové 29.2.-1.3.2024

Bikuspidální aortální chlopeň – je indikovaná profylaxe?

AHA Guideline

Prevention of Infective Endocarditis

Guidelines From the American Heart Association

A Guideline From the American Heart Association Rheumatic Fever, Endocarditis, and Kawasaki Disease Committee, Council on Cardiovascular Disease in the Young, and the Council on Clinical Cardiology, Council on Cardiovascular Surgery and Anesthesia, and the Quality of Care and Outcomes Research Interdisciplinary Working Group

Walter Wilson, MD, Chair; Kathryn A. Taubert, PhD, FAHA; Michael Gewitz, MD, FAHA; Peter B. Lockhart, DDS; Larry M. Baddour, MD; Matthew Levison, MD; Ann Bolger, MD, FAHA;

Circulation 2006, 2007, 2008

2.3.1. Endocarditis Prophylaxis

Table 2. Updates to Section 2.3.1. Endocarditis Prophylaxis

2006 VHD Guideline Recommendations	2008 VHD Focused Update Recommendations
Class I	**Class IIa**

1. Prophylaxis against infective endocarditis is recommended for the following patients:
• Patients with prosthetic heart valves and patients with a history of infective endocarditis. *(Level of Evidence: C)*
• Patients who have complex cyanotic congenital heart disease (e.g., single-ventricle states, transposition of the great arteries, tetralogy of Fallot). *(Level of Evidence: C)*
• Patients with surgically constructed systemic pulmonary shunts or conduits. *(Level of Evidence: C)*
• Patients with congenital cardiac valve malformations, particularly those with bicuspid aortic valves, and patients with acquired valvular dysfunction (e.g., rheumatic heart disease). *(Level of Evidence: C)*
• Patients who have undergone valve repair. *(Level of Evidence: C)*
• Patients who have hypertrophic cardiomyopathy when there is latent or resting obstruction. *(Level of Evidence: C)*
• Patients with MVP and auscultatory evidence of valvular regurgitation and/or thickened leaflets on echocardiography.* *(Level of Evidence: C)*
	1. Prophylaxis against infective endocarditis is reasonable for the following patients at highest risk for adverse outcomes from infective endocarditis who undergo dental procedures that involve manipulation of either gingival tissue or the periapical region of teeth or perforation of the oral mucosa (4):
	• Patients with prosthetic cardiac valves or prosthetic material used for cardiac valve repair. *(Level of Evidence: B)*
	• Patients with previous infective endocarditis. *(Level of Evidence: B)*
	• Patients with CHD. *(Level of Evidence: B)*
	  • Unrepaired cyanotic CHD, including palliative shunts and conduits. *(Level of Evidence: B)*
	  • Completely repaired congenital heart defect repaired with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first 6 months after the procedure. *(Level of Evidence: B)*
	  • Repaired CHD with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device (both of which inhibit endothelialization). *(Level of Evidence: B)*
	• Cardiac transplant recipients with valve regurgitation due to a structurally abnormal valve. *(Level of Evidence: C)*

Bikuspidální aortální chlopeň – je indikovaná profylaxe?

European Heart Journal (2015) **36**, 3075–3123
doi:10.1093/eurheartj/ehv319

ESC GUIDELINES

2015 ESC Guidelines for the management of infective endocarditis

The Task Force for the Management of Infective Endocarditis of the European Society of Cardiology (ESC)

Endorsed by: European Association for Cardio-Thoracic Surgery (EACTS), the European Association of Nuclear Medicine (EANM)

Authors/Task Force Members: Gilbert Habib* (Chairperson) (France), Patrizio Lancellotti* (co-Chairperson) (Belgium), Manuel J. Antunes (Portugal),

Eur Heart J, 2015

Prophylaxis is not recommended for any other form of native valve disease (including the most commonly identified conditions, bicuspid aortic valve, mitral valve prolapse, and calcific aortic stenosis).

Table 3 Cardiac conditions at highest risk of infective endocarditis for which prophylaxis should be considered when a high-risk procedure is performed

Recommendations	Class[a]	Level[b]
Antibiotic prophylaxis should be considered for patients at highest risk for IE: (1) Patients with any prosthetic valve, including a transcatheter valve, or those in whom any prosthetic material was used for cardiac valve repair. (2) Patients with a previous episode of IE. (3) Patients with CHD: (a) Any type of cyanotic CHD. (b) Any type of CHD repaired with a prosthetic material, whether placed surgically or by percutaneous techniques, up to 6 months after the procedure or lifelong if residual shunt or valvular regurgitation remains.	IIa	C
Antibiotic prophylaxis is not recommended in other forms of valvular or CHD.	III	C

Bikuspidální aortální chlopeň – je indikovaná profylaxe?

Co říkají nová guidelines ESC 2023 ???

ESC European Society of Cardiology
European Heart Journal (2023) 00, 1–95
https://doi.org/10.1093/eurheartj/ehad193
ESC GUIDELINES

2023 ESC Guidelines for the management of endocarditis

Developed by the task force on the management of endocarditis of the European Society of Cardiology (ESC)

Endorsed by the European Association for Cardio-Thoracic Surgery (EACTS) and the European Association of Nuclear Medicine (EANM)

Vysoké riziko IE:

3.2. Populations at risk of infective endocarditis

The groups of individuals at high risk of IE in whom antibiotic prophylaxis is recommended or should be considered include the following:

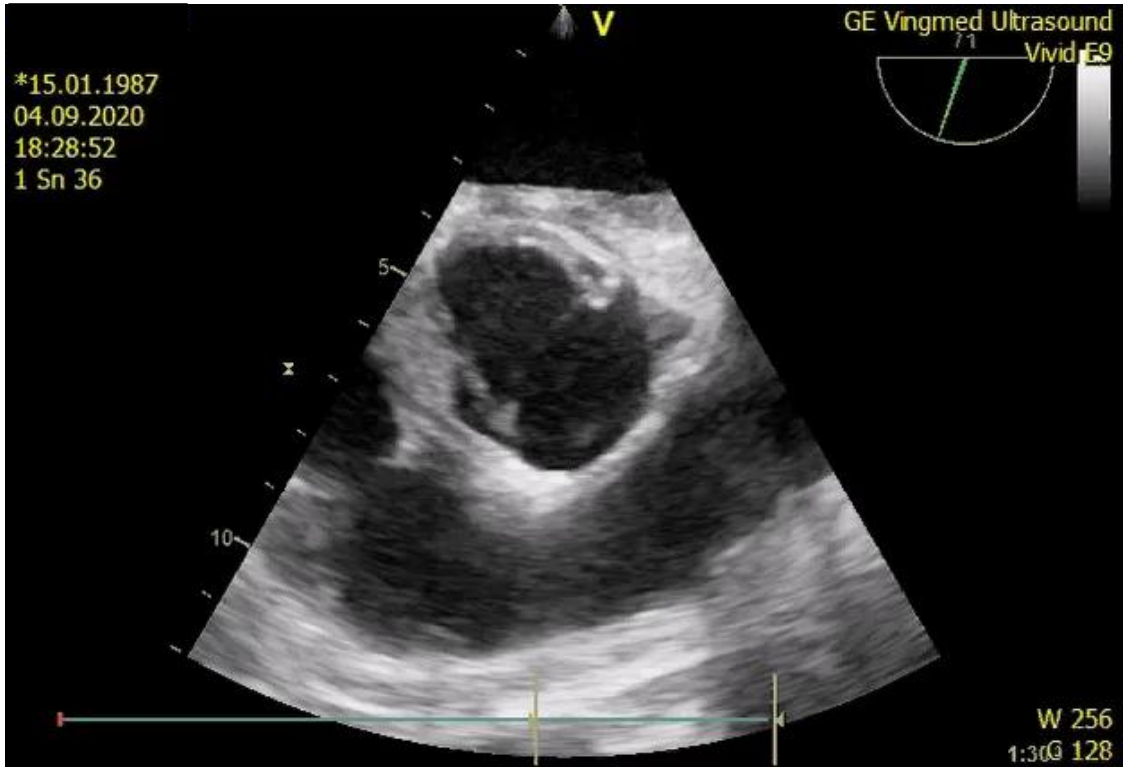
(i) Patients with previous IE: the highest risk of IE is observed in patients with previous history of IE who have an ominous prognosis during IE-related hospitalization. Patients with recurrent IE more frequently have prosthetic valves or prosthetic material, are more commonly PWID, or have staphylococcal IE.[47,84–86]

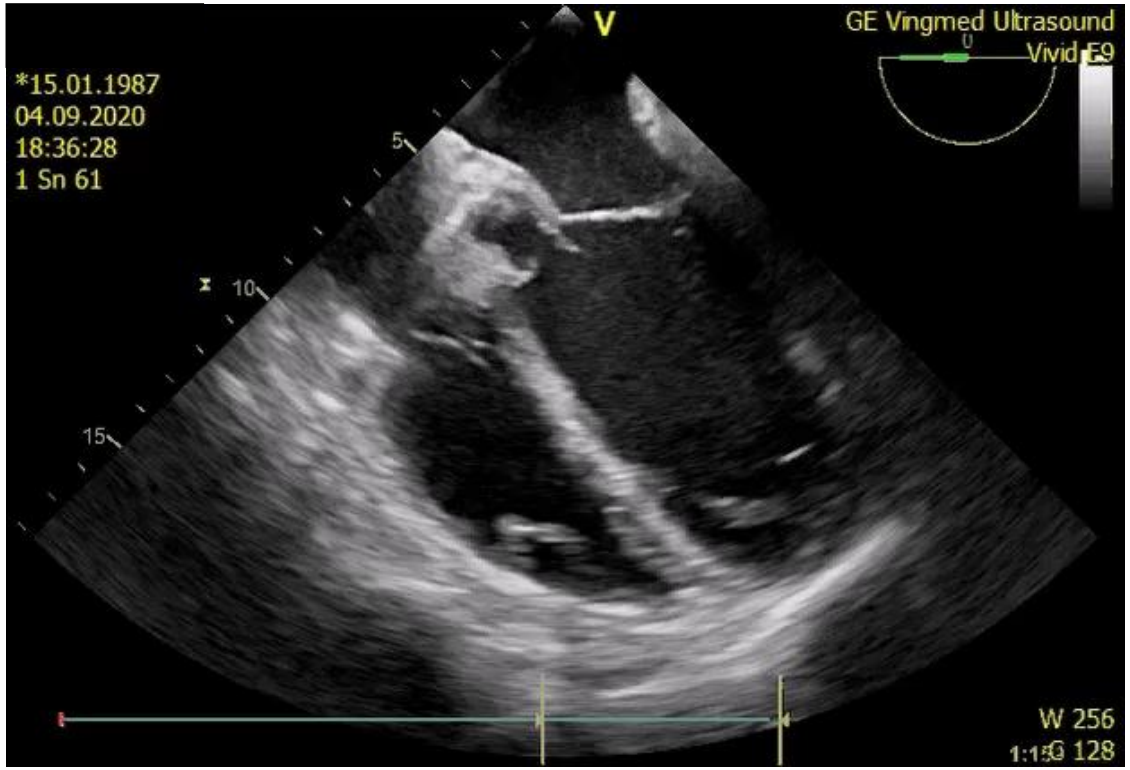
(ii) Patients with surgically implanted prosthetic valves, with transcatheter implanted prosthetic valves, and with any material used for cardiac valve repair: the increased risk of IE in these patients, combined with the ominous outcomes as compared with patients with native IE (NVE), make antibiotic prophylaxis advisable in this patient group. Patients with prosthetic valve endocarditis (PVE) have an in-hospital mortality rate that is twice as high with more complications (e.g. heart failure [HF], conduction disturbances) as compared with patients with NVE, regardless of the

Střední riziko IE:

Patients at intermediate risk of IE include those with: (i) rheumatic heart disease (RHD); (ii) non-rheumatic degenerative valve disease; (iii) congenital valve abnormalities including bicuspid aortic valve disease; (iv) cardiovascular implanted electronic devices (CIEDs); and (v) hypertrophic cardiomyopathy.[47,103,104] Some epidemiological data suggest that certain conditions stratified as intermediate risk are associated with a higher risk of IE compared with the background population,[47,90,103] but further studies are required. In patients at intermediate risk of IE, antibiotic prophylaxis is not routinely recommended and may be considered on an individual basis. However, prevention measures (*Table 5*) are strongly encouraged in these patients.

Bikuspidální aortální chlopeň – je indikovaná profylaxe?

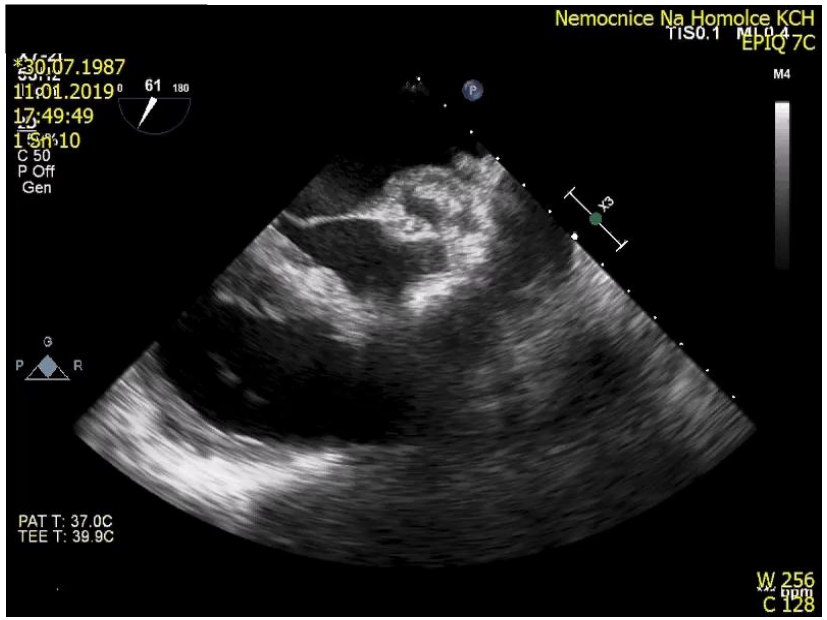


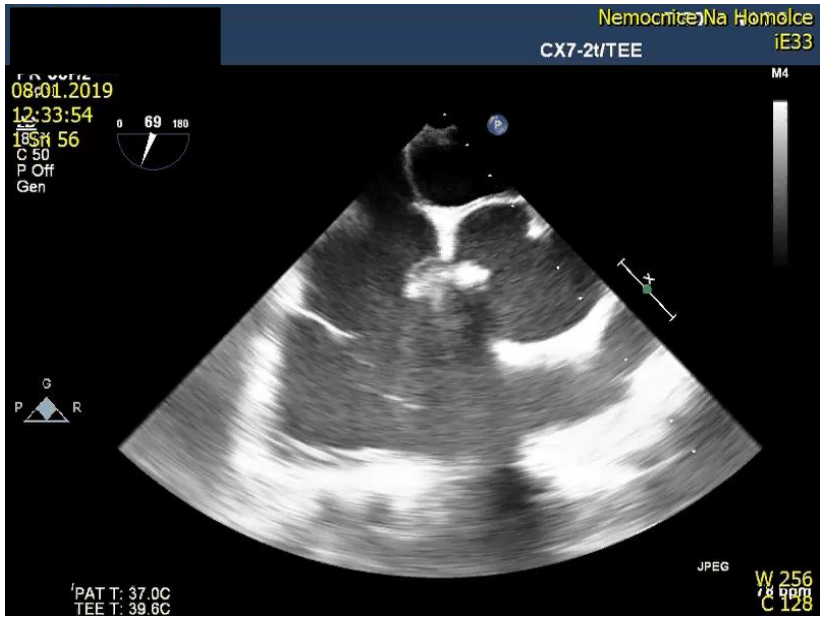


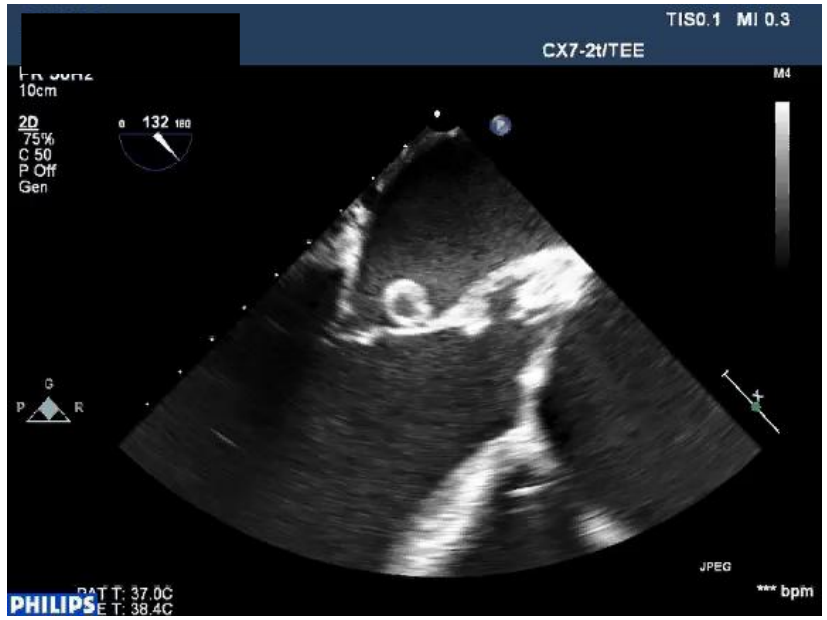
Naše data: databáze 3883 dospělých s VSV

- **IE u 5 % VSV (197)**
- **IE u 10,4 % BAO (66 z 635 BAO) sledovaných v průměru 8 let**

Bikuspidální aortální chlopeň – je indikovaná profylaxe?







ATB profylaxe u bikuspidální chlopně aorty

před rizikovým dentálním výkonem ?

- **1 – A je indikovaná, doporučuji ji**
- **2 – B není indikovaná, nedoporučuji ji**