1465. Pigmented Mold Endocarditis – Case Series and Review of the Literature

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Background. Pigmented mold endocarditis (PME) is an uncommon infection. Despite aggressive surgical and antifungal treatment, mortality remains high. A better understanding of the epidemiology and treatment of PME is needed.

Methods. We identified PME cases from the University of Alabama at Birmingham (UAB) mycology laboratory from 1994-2012 and queried MEDLINE from 1968-2012. Cases that met the Modified Duke Criteria for definite or possible IE were included. Cases in which PME was the result of disseminated infection in immunocompromised hosts were excluded. Demographics, clinical data, treatment and outcomes were extracted.

Results. A total of 44 cases (3 from UAB, and 41 from MEDLINE) were identified and included in the analysis. Mean age was 51.7 years; 30 (68%) were males. 24 (55%) were classified as PVE, 13 (30%) NVE and 5 (11%) as cardiac device infective endocarditis. The most common predisposing factor identified was a prior cardiac procedure (32/44); the median time from the procedure was 113 days. Other predisposing factors such as solid organ transplantation (31%), stem cell transplantation (15%), chronic intravenous access (23%), IVDA (15%) and HIV (8%) were prevalent in the NVE subgroup but otherwise uncommon. 30/44 had fever, and 21/44 had an audible murmur. An embolic event prior to diagnosis was common (28/44); mean events 1.6. The most common fungi were: *Scedosporium apiospermum* 13/44, *Phialemonium curvatum* 5/44 and *Exophiala dermatitidis* 4/44. Two of 7 and 1 of 4 isolates had high MIC's to amphotericin B and voriconazole, respectively. Echocardiography was performed in 31 of 44 patients; it identified vegetations in 23/31, valvular regurgitation in 7/31 and an intra-cardiac mass in 5/31. Blood cultures were positive in 20 (54%) of 37 cases. The crude survival was 32% (14/44); 25% (1/4) in the medical management and 41% (12/29) in the combined medical and surgical management subgroups. Recurrence was common (10/44).

Conclusion. PME is a rare disease, but it should be considered in the differential diagnosis of culture negative PVE and culture negative NVE in immunocompromised hosts, those with chronic venous access or IVDA. Lack of fever, multiple embolic events, large vegetations and positive blood cultures could be clues to the diagnosis. Mortality in PME is high and recurrence is common.

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