

Predict Statin Non-Adherence Following Acute Coronary Syndrome

Claes Held*

Department of Cardiology, Middlemore Hospital, Auckland, New Zealand

Corresponding author: Claes Held, Department of Cardiology, Middlemore Hospital, Auckland, New Zealand, Japan, E-mail: Held_c@ucr.uu.nw

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Introduction

In endocarditis patients, an uncommon complication with a high mortality rate is Acute Coronary Syndrome (ACS). It requires quick and fitting administration to fix the patient. We present the case of a 52-year-old patient who was initially admitted for an acute non-ST-segment elevation coronary syndrome with very high ischemic risk. Despite the fact that coronary x-rays were negative, echocardiography revealed a mobile image of the aortic valve, pointing to infective endocarditis. Due to his size and embolic complications, the patient benefited from an aortic valve replacement with a favorable evolution. During infective endocarditis, an uncommon complication with a high mortality rate is acute coronary syndrome. A few systems are conceivable: the embolic system, coronary extraluminal pressure because of coronary mycotic aneurysm and impedance of the coronary ostium by huge vegetation. The endocarditis team is required to make the best therapeutic decision, and the treatment remains multidisciplinary and individualized based on the patient's characteristics. Infective endocarditis should be evoked in any understanding without normal cardiovascular gamble factors who gives an ACS that is joined by fever and raised fiery markers, and an exhaustive clinical assessment as well as the presentation of extra tests. Intense Coronary Disorder (ACS) is a phenomenal complexity related with high mortality in patients with endocarditis. For the patient to recover, prompt and appropriate treatment is required. An endocarditis team composed of specialists in interventional and non-interventional cardiology, cardiothoracic surgery, and infectious diseases is necessary for the treatment of a patient with Infective Endocarditis (IE) who presents with an Acute Coronary Syndrome (ACS).

Cardiopulmonary Auscultation

In the context of infectious aortic valve endocarditis, the patient in our case presented with coronary syndrome. We present the case of a 52-year-old smoker with active smoking as a cardiovascular risk factor who presented with acute infractoid chest pain five hours before being admitted to the emergency department. A fast patient with a heart rate of 153 beats per minute, normal blood pressure (123/76 mm Hg), respiratory and neurological stability, and a 38.9° fever were discovered during the admissions exam. Although the cardiopulmonary auscultation was normal and the clinical examination did not

reveal any signs of cardiac insufficiency, we did notice the presence of an inflammatory plaque in front of the right wrist joint, which was red and painful and limited both active and passive mobility. With a heart rate of 154 beats per minute, the electrocardiogram revealed an atrial fibrillation rhythm with an overshift in the anterior territory and a diffuse ST-segment undershift (more than 6 leads). The patient was immediately taken to the catheterization room after the diagnosis of an acute coronary syndrome without ST-segment elevation at very high ischemic risk was made based on the clinical presentation and electrical appearance. Angiographically, the coronary network was found to be normal on the coronary angiography, rendering our initial diagnostic hypothesis null and void. An elevated CRP level of 456mg/l (Nvalue 6–12mg/l), a hyperleukocytosis of 22376 elements/mm³ (Nvalue 4000–1000/mm³) with PNN predominance, severe renal insufficiency with a creatinine level of 24mg/l (Nvalue 6–12mg/l), and a clearance rate of 24ml/min (according to MDRD) were all observed during the biological An echocardiogram through the thorax. A tri-commissural aortic valve with two vegetations appended respectively to the left coronary and non-coronary cusps measuring 3*34 mm and 4*41 mm in large diameter was found to have normal segmental and global right and left ventricular function, with an estimated EF of 57% in SBP. There was also no evidence of significant leakage or stenosis. Brain MRI revealed signaling abnormalities of the left basi-frontal subcortical white matter in favor of microfoci of vascular accidents that may be related to septic microemboli. For this reason, we realized that three hemocultures were negative after one hour, that the rheumatoid factor was positive, and that the fractions of the complement C3 and C4 were normal. Additionally, an injected Cerebro-thoraco-abdomino-pelvic the patient was placed on antibiotics based on amoxicillin and Gentamycin (dose adapted to the renal function), and given the size of the vegetation and the embolic complications, the patient was referred to surgery. The diagnosis of infective endocarditis was made based on the modified Duke criteria (one major and three minor criteria), which included the presence of a fever, embolic syndrome, and inflammatory phenomena. The patient underwent a vegetectomy and mechanical SJM aortic valve replacement on day 4 of his admission, with straightforward postoperative care and prompt vasopressor withdrawal. The patient was prescribed Vancomycin acenocoumarol 2 mg/day and ceftriaxone 2 mg/day for six weeks after the results of the vegetation culture were inconclusive. At day 20 of his admission, the patient's biological balance had returned to normal.

Infective Endocarditis

The cytobacteriological examination of the urine revealed no evidence of drug abuse via intravenous injection. A bad oral condition was found during the stomatological examination. Oral care was beneficial to the patient. The infectious balance sheet, which included procalcitonin at day 20, was negative when the patient was discharged from the hospital on day 26 of his admission. An infection of the endocardial surface, such as the heart valves, the mural endocardium, or a septal defect, is known as infectious endocarditis, and it is a multisystemic disease that, if not treated, can result in death. Acute coronary syndrome during infective endocarditis is a rare complication

with a mortality rate of 64 percent and an incidence of 2.9%. It can be the first sign of the infection, reveal the infection, and recur a few days after the diagnosis of IE or after treatment has ended. Patients with endocarditis had higher levels of troponin T, which were linked to an increased risk of death and stroke. The treatment of ACS in infective endocarditis is still up for debate. Empirical antibiotic therapy should be considered while blood culture results are awaiting the diagnosis of endocarditis. Antithrombotic therapy should be used with caution because bacteremia alters hemostasis, which may increase the risk of intracerebral hemorrhage due to intracerebral mycotic aneurysms and cerebral infarcts (sequelae of IE).