

Infective endocarditis caused by *Alcaligenes faecalis* complicated with skin lesions

A 40-year-old man presented with a 10-day history of fever ($>38.5^{\circ}\text{C}$) and skin lesions. He had been referred for acute type A aortic dissection and had undergone a Bentall procedure with aortic valve replacement using a mechanical prosthetic valve six months ago. Transthoracic and transesophageal echocardiogram showed aortic valve vegetations. Additionally abnormal activity around the site of prosthetic valve implantation was detected by ^{18}F -fluorodeoxyglucose positron emission tomography/computed tomography. Repeated peripheral blood cultures showed the presence of *Alcaligenes faecalis*. The diagnosis of prosthetic valve endocarditis (PVE) was established (1).

Splinter hemorrhages [Fig. 1- (arrow)] that are defined as tiny bleeding points in the nails are not a specific sign for the diagnosis of infective endocarditis (IE). Conversely, vascular phenomena such as Janeway lesions (Fig. 2-4), and immunological phenomena, such as Osler's nodes [Fig. 3, 4 (arrows)], although



Figure 1. Splinter hemorrhages



Figure 2. Janeway lesions



Figure 3. Janeway' lesions and Osler's nodes



Figure 4. Janeway' lesions and Osler's nodes

minor criteria for the diagnosis of IE, are important clinical features and can help to establish the diagnosis, particularly for PVE, which is still associated with difficulties in diagnosis.

Reference

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Amiodarone-related blue-gray skin discoloration

A 55-year-old male patient had experienced an anterior wall myocardial infarction 7 years ago. Amiodarone was initiated in



Figure 1. Blue-gray discoloration appeared on the face, particularly on the nose, forehead, and cheeks



Figure 2. The blue-gray discoloration disappeared

order to prevent monomorphic ventricular tachycardia; since then, the patient was using amiodarone. The patient noticed gradually increasing blue-gray discoloration on the skin for 5 months, particularly on the nose, forehead, and cheeks (Fig. 1). A cardiologist, a dermatologist, and an internal medicine physician examined the patient for skin discoloration. Besides the skin discoloration, physical examination and laboratory results were normal. We noticed that the blue-gray discoloration increased under sunlight. Holter-electrocardiography was performed for 72 hours to check for cardiac arrhythmia, but no arrhythmia was observed. We stopped the use of amiodarone and optimized the dosage of metoprolol. The patient used sun protection (sunscreens, clothing, and hats) to decrease skin discoloration on his face. The blue-gray discoloration disappeared at the last examination after 8 months of appearance (Fig. 2).

Amiodarone is used for both ventricular and atrial arrhythmia. Amiodarone is known to cause cutaneous and systemic side effects. The most common cutaneous side effect is photosensitivity. Blue-gray discoloration occurs on body areas when exposed to sunlight. The disappearance of amiodarone-related skin discoloration may occur within months or years. Hyperpigmentation might be permanent despite the cessation of treatment with amiodarone. Apart from the cessation of treatment, avoiding exposure to sunlight and using a sunscreen cream