中文題目：一個以左上腹痛表現的心內膜炎病例報告

英文題目：Infective endocarditis presented with left upper quadrant abdominal pain：a case report

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Introduction: Infective endocarditis defines the infection of the inner tissue of the heart. The diagnosis of infective endocarditis is established with the Duke criteria, however, the clinical manifestation of it is variable and nonspecific. All physicians should be cautious and recognize the disease rapidly. To start the patients on proper empirical antibiotic immediately remains cardinal and this is the only way to avoid fatal conditions caused by fulminant inflammation of heart. Here we report a healthy young man presented with the left upper quadrant abdominal pain related to spleen infarction. Viridans Streptococci infective endocarditis was diagnosed based on two sets of positive blood culture together with a thickening aortic valve implied a perivavular abscess. The patient received Penicillin for infection control and the further surgical intervention was considered.

Case report: A 25-year-old man with two-day subacute left upper quadrant abdominal pain presented to our hospital. The patient stated his sharp abdominal pain was persisting and there was no aggravating or reliving factor. He also reported one-month fatigue and weight loss of 6 kg. One month prior to this admission, the patient had felt his right little finger tip painful, swelling and *erthymatous*. He then had been treated with 5-day Amoxillin with the impression of cellulitis. On examination, the patient's temperature was 35.9℃; pulse rate 92/ min; and blood pressure 111/73 mmHg. Systemic examination revealed a mid-systolic ejection murmurs Grade 3/6 and the left upper quadrant tenderness without peritoneal sign. His abdominal echo and esophagogastroduodenoscopy came back negative. Laboratory investigation disclosed leukocytosis (20930/uL) and microcytic anemia (Hb: 10.9g/dL; MCV77.9fL). Due to his constant abdominal discomfort, the patient underwent contrast-enhanced abdomen computed tomography and there was a wedge-shaped hypodense area in spleen.(Figure 1) W*ith the suspicion of* infective endocarditis, we started the patient on Penicillin and did a transthoracic echocardiography. The image disclosed a non-calcified bicuspid aortic valve with a thickening, which implied a perivalvular abscess.(Figure 2) Viridans Streptococci infective endocarditis was diagnosed based on two sets of positive blood culture. The patient then noticed a tender nodule on the pad of his left middle finger and it was compatible with Osler's nodes.(Figure 3) The patient was treated with 4-week Penicillin and the further surgical