

Enterococcal Endocarditis: The Eternal Return of the Same Bug

TO THE EDITOR—We read with great interest the article by Lecomte et al [1]. The authors are to be commended for their contribution in answering a highly relevant and for a long time unaddressed question, namely, what are the main outcomes and prognostic factors among patient with prosthetic valve endocarditis (PVE) that is not operated on? The 2 main findings of the study were that a relatively small proportion of patients who had indications for surgery but were not operated on died at 1 year (33.9%) and that enterococcal endocarditis was significantly associated with a higher likelihood of relapse than nonenterococcal endocarditis. Although not emphasized by the authors, another relevant finding was that enterococcal endocarditis was the second most common after that caused by viridans group streptococci [1].

Among the most relevant results of a recent study including 3824 cases of endocarditis from the Spanish Collaboration on Endocarditis (GAMES cohort), we found that enterococcal endocarditis (n = 516) was associated with significantly higher rates of PVE and relapse, compared with nonenterococcal endocarditis (35.8% vs 28.9%, respectively, for PVE [$P = .002$] and 3.5% vs 1.7% for relapse [$P = .04$], respectively) [2]. The only identified risk factor for relapse among enterococcal endocarditis was persistent bacteremia. However, when we compared only enterococcal and nonenterococcal PVE, the proportion of relapses increased in the former group while decreasing in the latter (5.4% vs 1%, respectively; $P = .01$) [2].

Although they specified that no case of enterococcal endocarditis was caused by vancomycin-resistant strains, Lecomte et al [1] did not provide the types of enterococcal species causing the 23 causes of

enterococcal endocarditis. In our study, we did not find significant differences in the rates of relapse between *Enterococcus faecalis* and non-*E. faecalis* endocarditis (3.4% vs 4.2%, respectively), yet PVE was more frequent among the former (37.2% vs 22.9%; $P = .03$) [2].

The lack of information on antibiotic treatment is also a gap in the study reported by Lecomte et al [1]. Three relevant aspects that might have a direct impact on relapse were omitted: the type of treatment (mainly β -lactams plus aminoglycosides vs double β -lactam combination), the use of suppressive oral antibiotic treatment in patients with surgical indications who were not operated on, and the length of treatment [3, 4]. Lecomte et al also assumed that the length of treatment was 6 weeks [1]; however, patients were included from 2013 to 2017, and the recommended length of double β -lactam therapy for PVE was at least 8 weeks in earlier published guidelines [5], before the current international guidelines from 2015.

In any case, the study by Lecomte et al [1] helps emphasize the importance of relapse as a main feature of enterococcal endocarditis. Besides the type of valve (native vs prosthetic) and of enterococcal species, there are other aspects potentially related to relapses of enterococcal infective endocarditis, for which further research is warranted; these include the type and length of antibiotic treatment (ie, antibiotic combination [6], use of suppressive treatment, whether oral or intravenous, such as dalbavancin), the presence of cardiovascular implantable electronic devices [7], the role of colonic lesions [8], the persistence of enterococcal DNA in valves [9], or the impact of specific deletions in the enterococcal genome [10].

Notes

Author contributions. All authors contributed to conception, drafting, revision, and approval of the final version of the manuscript.

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