A 52-year-old man patient was admitted to our clinic with the presumptive diagnosis of infective endocarditis. He had a history of bioprosthetic aortic root and valve replacement 5 years previously. On admission, he had continuous fever of 5 weeks. On examination, he had a 3/6 diastolic murmur on the left sternal border. Laboratory studies revealed leukocytosis (23,500/mm$^3$), and accelerated erythrocyte sedimentation rate, 65 mm/h, and increased C-RP level, 104 mg/dl, normal: 0–5. Echocardiography showed vegetation measuring 1.6 cm on the aortic valve and a small one on the mitral valve. Blood cultures yielded ampicillin and gentamicin sensitive *Enterococcus faecalis*. On the 4th day of the treatment (ampicillin+gentamicin), a selective superior mesenteric arteriography (Fig. 1) was performed because of an emerged abdominal pain, and showed complete proximal superior mesenteric artery occlusion (arrow).

The vegetation on the aortic valve vanished on the repeated echocardiography. On day 15, an abdominal computerized tomography (Fig. 2) was performed for continuing fever and a wide, wedge-shaped hypodense area measuring 12×7 cm in the postero-inferior part of the spleen (arrow) compatible with infarction was noted. Surgical interventions to the infective bioprosthesis and mesenteric embolism could not be done since his general condition was found to be poor and not suitable for such an operation. He responded to medical therapy and is doing well.

**Key words:** endocarditis, mesenteric embolism, splenic infarction