Infective Endocarditis in a Patient with Incomplete Shone’s Anomaly

Zhuang Tian¹, Ligang Fang² and Ruiyi Xu³

Key words: congenital heart defects, infective endocarditis, mitral valve stenosis, aortic coarctation

(Abst Med 51: 2835-2836, 2012)

Received for publication June 27, 2012; Accepted for publication July 9, 2012
Correspondence to Dr. Zhuang Tian, tianzhuangcn@sina.com

A 27-year-old woman presented to our hospital with fever of one month’s duration. Transthoracic echocardiogram (TTE) showed only one postero-lateral papillary muscle toward which chordae were converging from both leaflets. This resulted in the formation of a parachute-like mitral valve with mild stenosis (Picture 2, arrow). TTE also established the presence of a bicuspid aortic valve and an increased flow velocity of 3.7 m/s in the descending aorta. Computed tomographic angiography confirmed the tight coarctation of the aorta (Picture 3, arrow).
Vegetation was found on the anterior mitral valve leaflet on transesophageal echocardiography (Picture 4, arrow), and infective endocarditis was thus diagnosed.

Shone’s anomaly is defined by the presence of several left-sided cardiovascular defects: supravalvular mitral membranes, parachute mitral valves, subaortic stenosis, aortic coarctation and bicuspid aortic valves (1). Any three features are considered to comprise incomplete Shone’s anomaly. Parachute mitral valves are associated with transvalvular turbulence, which accounts for the onset of infective endocarditis.

The authors state that they have no Conflict of Interest (COI).

Reference