

# Endocarditis Prophylaxis

## Prevention of Endocarditis

The guidelines for the prevention of infective endocarditis (IE) issued by the American Heart Association underwent a major revision in 2007. Key changes include the following:

- Dental procedures have been found to be associated with a small number of cases of IE. Prophylaxis, even if 100% effective, would thus prevent only an extremely small number of cases.
- The emphasis has shifted from antibiotic prophylaxis to good oral health and increased access to dental care.
- Prophylactic antibiotics based on a patient's lifetime risk for acquiring IE are no longer recommended. Instead, prophylaxis focuses on patients with the highest risk for adverse outcomes from endocarditis.

## Candidates for Prophylaxis

Only those patients with conditions associated with the highest risk for adverse outcomes from IE should receive prophylaxis. These high-risk conditions include:

- Prosthetic cardiac valves
- Previous IE
- Congenital heart disease (CHD) **only** for the following specific conditions:
  - Unrepaired cyanotic CHD, including palliative shunts and conduits
  - Completely repaired congenital heart defect with prosthetic material or a prosthetic device placed either during surgery or by catheter intervention, during the first 6 months after the procedure
  - CHD repair with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device
- Development of cardiac valvulopathy after cardiac transplantation

## Dental Procedures

Prophylaxis is directed against viridans-group streptococci.

- Procedures for which dental prophylaxis should be given to appropriate candidates include any procedures that involve manipulation of gingival tissue or the periapical region of the teeth or perforation of the oral mucosa.
- Procedures that do **not** require prophylaxis include routine anesthetic injections through noninfected tissues, dental radiographs, placement of removable prosthodontic or orthodontic appliances, adjustment of orthodontic appliances, and placement of orthodontic brackets. Prophylaxis is also not necessary after the shedding of deciduous teeth or for bleeding from trauma to the lips or oral mucosa.

## Prophylactic Regimens for Infective Endocarditis Before Dental Procedures

Clinical Situation	Adult prophylaxis
Oral regimen	amoxicillin 2 g oral

Unable to take oral medication	ampicillin 2 g IM or IM <b>OR</b> cefazolin 1 g IM or IV <b>OR</b> ceftriaxone 1 g IM or IV
Allergy to penicillin or ampicillin (oral regimen)	cephalexin 2 g oral <b>OR</b> clindamycin 600 mg oral <b>OR</b> azithromycin 500 mg oral <b>OR</b> clarithromycin 500 mg oral
Allergy to penicillin or ampicillin (unable to take oral regimen)	cefazolin 1 g IM or IV <b>OR</b> ceftriaxone 1 g IM or IV <b>OR</b> clindamycin 600 mg IM or IV

#### NOTES:

- Give single dose 30-60 minutes before procedure.
- If the antibiotic is inadvertently not administered before the procedure, it may be administered up to 2 hours after the procedure.
- Do not use cephalosporins in patients with a history of anaphylaxis, angioedema, or urticaria with penicillin.
- If a patient is already receiving long-term antibiotic therapy with an antibiotic that is also recommended for IE prophylaxis, an antibiotic from a different class should be used.

## Respiratory Procedures

For candidates for prophylaxis as listed above.

- It may be reasonable to give one of the above prophylactic regimens recommended for dental procedures before an invasive procedure (e.g., tonsillectomy) involving the respiratory tract that necessitates incision or biopsy of the respiratory mucosa.
- Prophylaxis is not recommended for bronchoscopy unless the procedure involves incision of the respiratory tract mucosa.

## Gastrointestinal or Genitourinary Procedures

For candidates for prophylaxis as listed above.

- Prophylaxis solely to prevent IE is no longer recommended.
- For patients scheduled for an elective urinary tract manipulation who also have an enterococcal urinary tract infection or colonization, it may be reasonable to administer antibiotic therapy to eradicate enterococci from the urine before the procedure.
- If the urinary tract procedure is not elective, it may be reasonable to administer an antimicrobial regimen to the patient that contains an agent active against enterococci.
- Amoxicillin or ampicillin is the preferred agent for enterococcal coverage; vancomycin may be administered to patients unable to tolerate ampicillin.

## **Procedures Involving Infected Skin or Soft Tissue**

For candidates for prophylaxis as listed above.

- It is reasonable that the regimen administered for treatment of the infection contain an agent active against staphylococci and beta-hemolytic streptococci.
- An antistaphylococcal penicillin or cephalosporin is preferable; vancomycin or clindamycin may be administered to patients unable to tolerate a beta-lactam or who are known or suspected to have an infection cause by MRSA.

## **Reference**

Wilson et al. Circulation. 2007 Apr 19;115.