Introduction: As of 2007, there have been only 72 cases of Candida parapsilosis endocarditis documented [1]. Infective endocarditis during pregnancy is also rare. We present a case of a parturient with C. parapsilosis endocarditis.

Case Presentation: A 23-year old female at 31 weeks gestation was transferred to our institution with endocarditis. She initially presented to an outside hospital with right thigh pain found to be a thrombus in the right femoral artery (RFA), for which she was started on enoxaparin. A TTE done as workup for the thrombus revealed a large vegetation on the aortic valve (AV). Preliminary blood cultures showed yeast and treatment was started with amphotericin. It was determined that the patient would need an aortic valve replacement (AVR) and delivery of the baby. She was transferred to our cardiothoracic ICU (CTICU) for further management.

On arrival, repeat blood cultures were drawn and amphotericin and micafungin continued. A Doppler showed complete thrombosis of the RFA, while TTE revealed vegetations on all 3 leaflets and a 1 cm mobile vegetation on the AV, and mild AI. Enoxaparin was discontinued and a heparin infusion started due to imminent surgery.

A multidisciplinary meeting involving the CTICU, obstetrics, cardiothoracic surgery, cardiology, and obstetric anesthesiology teams was arranged. The goal was to coordinate the patient’s care, determine timing of the AVR with regards to delivery as well as the mode of delivery itself, and further stratify the patient’s and fetus’ risk.

The patient had an uneventful Caesarean section under general endotracheal anesthesia (GETA). The baby’s Apgar scores were 8 and 9 at 1 and 5 minutes. The following day the patient underwent a bioprosthetic AVR and RFA thrombectomy. Blood cultures from the outside hospital speciated to reveal C. parapsilosis, as did cultures from our institution. She was discharged from the CTICU on postoperative day (POD) 3 and left the hospital on POD 17.

Discussion: This case highlights several issues concerning the parturient with cardiac disease. First, a decision was needed on whether or not to deliver the baby. At 31 weeks gestation a viable fetus was very likely. Second, the mode of delivery was discussed. The patient’s fungemia and systemic anticoagulation made neuraxial anesthesia less desirable, and labor would likely have increased risk of embolism and cardiac dysfunction in the setting of AI, so a Caesarian section was done under GETA. Lastly, the timing of the AVR in relation to the Caesarian section was discussed. Numerous authors [2] report Caesarian section in the operating room immediately prior to cardiac surgery. However, concern was raised about excessive uterine bleeding in this scenario due to anticoagulation. The decision was thus made to separate the surgeries by 24 hours. This case illustrates that cardiac disease in the parturient requires a multidisciplinary approach individualized for each patient.

References: