reperfusion. The phenomenon is even seen in patients without AMI. We found that a transient drop in blood pressure induced an aggravation of the ischaemia, and as such may be regarded as hazardous for the patient.

In studies analysing ECG-patterns during thrombolysis, similar observations, of an additional ST segment elevation during early reperfusion, have been made. In these studies, it has been demonstrated that the benefit of reperfusion is limited in patients with additional ST-segment elevations[5]. This early ST elevation is surely a counterpart to the transient peak we describe.

In our study we observed that patients with hypotension had a transient peak in the initial ST-VM trend curve. It occurred irrespective of signs of reperfusion or AMI, and seems to be a consequence of the hypotensive reaction. We therefore assume that the transient peak can be explained as streptokinase-induced hypotension.

As we are well aware, only part of the variability in the ST-VM trend curve is explained by drop of blood pressure. The variability could also be a consequence of unstable angina pectoris, or alteration in patency of the coronary arteries as previously described by Krucoff *et al.*[6]. It is important to note that we only studied the initial changes, and not the occlusion/reocclusion pattern described by Krucoff *et al.*

We conclude that VCG monitoring allows the effect of blood pressure drop during thrombolysis to be examined. We found that transient hypotension accentuates the ischaemic burden. A transient peak is interpreted as a sign of alteration in myocardial ischaemia, not as evidence of reperfusion.

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A case of infective endocarditis complicated with anterior mitral valve leaflet abscess

Infective endocarditis is a microbial infection of intact or degenerated cardiac values, the endothelium surrounding congenital or acquired cardiac defects and the endothelium of vascular malformations[1,2]. Although there are many complications of the disease, to our knowledge there are few reported cases complicated by an abscess of the cardiac valve leaflet[3].

We report a case of infective endocarditis very probably complicated by an abscess of the anterior mitral valve leaflet in addition to embolic complications.

A 19-year-old white male presented to the emergency room semiconscious with fever, abdominal pain, weight loss, motor aphasia and a possible diagnosis of infective endocarditis. His physical examination revealed a body temperature of 38·8 °C, an apical third heart sound, a grade 2/6 pansystolic murmur on the apex, a right hemiparesis, cutaneous embolic phenomenae and a sacral grade 2 decubital ulcer.

Circulating blood cells showed a haemoglobin of 9 gm . dl^{-1}, and a haematocrit of 28%. His white blood cells were 12 200 mm^{-3} with a left shift on the differential count. Erythrocyte sedimentation rate was 75 mm . h^{-1}. His ECG and chest X-ray were normal. A head computed tomography scan showed multiple infarctions. Blood cultures were drawn. His echocardiogram revealed a 1·3 × 0·7 cm mobile vegetation and a prolapse of the anterior mitral valve leaflet into the left atrium. Abdominal ultrasound showed a 12 × 7 cm splenic abscess which was drained and cultured. Three of four blood cultures grew methicillin resistant *Staphylococcus aureus* (MRSA) as did the splenic drainage specimen. On the 12th day of admission, there was no cessation of fever. A Doppler echocardiogram revealed a lesion compatible with an abscess on the anterior mitral valve leaflet (Fig. 1): grade 2–3/4 mitral insufficiency, and grade 1–2/4 tricuspid insufficiency. Surgery was ruled out because of the patient's poor clinical condition. Three weeks after admission his fever ceased and on the 42nd day of admission the patient left hospital, against medical advice. He was put on oral ciprofloxacine 500 mg four times a day and rifampicin 600 mg daily and was requested to return to the clinic one month later. The patient failed to return and died at home 3 months later; no autopsy could be performed.

There are many complications of infective endocarditis but an abscess

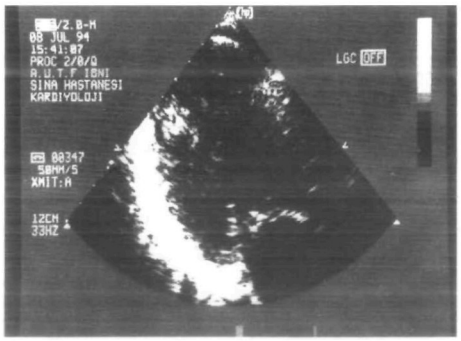


Figure 1 **Circular lesion, compatible with an abscess, on the anterior mitral valve leaflet.**

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of the cardiac valves is rare[3]. The diagnosis of infective endocarditis is based on the criteria described by many authors, but only the recently described Duke criteria, includes intravenous drug abuse and echocardiographic findings[4,5]. In the reported case, three major and two minor Duke criteria were fulfilled, although two major criteria were sufficient for the diagnosis of infective endocarditis. The sensitivity of the Duke criteria is higher than the other proposed criteria[4,5], but the specificity may be lower[5].

In the present case, MRSA was isolated but the disease was clinically resistant to treatment, possibly because of the abscess on the vessel free anterior mitral valve leaflet. Although no abscess was seen on the first echocardiogram, it is possible to overlook a small one. The prognosis of infective endocarditis complicated with a mitral valve leaflet abscess is poor[3] and because of this early surgical treatment should be advocated.

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