

# A Patient who was Diabetic Presented with Symptoms of Endocarditis

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## Abstract

The patient presented with the full clinical spectrum of infective endocarditis, including Roth spots, splenomegaly, changing cardiac murmurs, and splinter hemorrhages. Based on these classical features, an initial diagnosis of acute or subacute bacterial endocarditis was considered. However, subsequent fungal cultures revealed *Torulopsis glabrata* as the causative organism, establishing a diagnosis of fungal endocarditis. Although *Candida albicans* remains the most frequently isolated fungal pathogen associated with valvular vegetations, infections due to *Torulopsis (Candida) glabrata* have also been reported, albeit less commonly.

**Keywords:** patient; diabetic; symptoms; endocarditis; HIV/AIDS

## Short Letter

The patient presented with the full clinical spectrum of infective endocarditis, including Roth spots, splenomegaly, changing cardiac murmurs, and splinter hemorrhages. Based on these classical features, an initial diagnosis of acute or subacute bacterial endocarditis was considered. However, subsequent fungal cultures revealed *Torulopsis glabrata* as the causative organism, establishing a diagnosis of fungal endocarditis. Although *Candida albicans* remains the most frequently isolated fungal pathogen associated with valvular vegetations, infections due to *Torulopsis (Candida) glabrata* have also been reported, albeit less commonly. In this case, the patient responded favorably to a combination of antiretroviral therapy, intravenous amphotericin B, and intravenous fluconazole. Transesophageal echocardiography demonstrated valvular vegetations, which in fungal endocarditis are typically larger and more friable than those observed in acute or subacute bacterial endocarditis [1].

In recent decades, the incidence of fungal endocarditis has increased, largely attributable to the growing population of immunocompromised individuals. The widespread prevalence of HIV/AIDS, increasing numbers of patients with diabetes mellitus, and the expanded use of immunosuppressive therapies following organ transplantation have collectively contributed to this trend. These conditions predispose patients to opportunistic fungal infections, including invasive cardiac involvement, which is often associated with high morbidity and mortality.

In South Africa, rheumatic heart disease remains highly prevalent, resulting in a substantial number of individuals with chronically damaged cardiac valves, particularly the mitral valve. Such structural abnormalities provide a favorable substrate for microbial adherence and vegetation formation. When combined with immunosuppression, these pre-existing valvular lesions significantly increase the risk of fungal endocarditis.

This case represents an unusual presentation of *Torulopsis glabrata* endocarditis in an HIV-positive patient with underlying risk factors. It highlights the importance of maintaining a high index of suspicion for fungal etiologies in patients with endocarditis who are immunocompromised or who fail to respond to conventional antibacterial therapy. Early diagnosis through appropriate cultures and echocardiographic evaluation, coupled with prompt initiation of antifungal therapy, is crucial for improving clinical outcomes in this challenging and often life-threatening condition.

## References

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