A previously healthy 37-year-old man was admitted to a nephrology clinic due to the left-sided abdominal pain, petechiae and recurring hematuria. Laboratory tests revealed high levels of C-reactive protein and Antineutrophil Cytoplasmic Antibodies (cANCA). On this basis, vasculitis was suspected and prednisone in high doses was administered. After 30 days of immunosuppressive treatment, due to persistence of symptoms, the patient was referred for an ambulatory echocardiographic study, and because of the abnormal result, he was admitted to our department.

On admission, the patient was clinically in good condition. However, the physical examination revealed a systolic-diastolic heart murmur. Transthoracic echocardiography demonstrated a vegetation attached to the non-coronary aortic leaflet and severe aortic insufficiency. Additionally, an abnormal, perforated, bulging of the anterior mitral leaflet was present, with severe mitral insufficiency (Figure 1). Three blood cultures were positive for Streptococcus sanguinis. Therefore, the patient was diagnosed with IE according to the modified Duke criteria. Subsequently, the treatment was adjusted to include intravenous antibiotic therapy with vancomycin and ceftriaxone. Afterwards, the patient was qualified for the replacement of the aortic and mitral valves with mechanical valve prostheses. The procedure was uneventful and the patient was discharged home in good condition.

The medical history of this patients is an outstanding example of how complex and misleading the IE diagnosis can be. A selected laboratory test, like cANCA is indeed an important
diagnostic marker for vasculitis [1,2]. However, several infectious diseases have been reported to stimulate positive cANCA tests and therefore to mimic vasculitis. One of them is infective endocarditis, which is known to initiate the immune complex disease in about 25% of patients [3,4]. One could speculate that an immunosuppressive treatment, in our patient might have led to a blunted antibacterial response, and potentially to the expansion of the endocardial infection with the bivalvular involvement, while reducing clinical symptoms. Our patient can be a reminder of the clinical rule, that before the definitive diagnosis and treatment of suspected vasculitis, an active infection, especially IE must be excluded [5].

**Declarations**

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