

It describes a case of a 69-year-old woman with a history of smoking and alcoholism, who presented to the emergency department with intense left chest pain and expectoration of blood-stained sputum. The patient was admitted to the hospital with a diagnosis of left pleuritic pain and fever.

The patient was febrile and had a history of left sternoclavicular pain, fever, and expectoration of bloody sputum. The physical examination revealed a temperature of 39°C, a pulse rate of 120 beats per minute, and a respiratory rate of 24 breaths per minute. The patient was in mild respiratory distress and had a dry cough.

The patient was treated with empirical antibiotics, but the symptoms did not improve. A chest X-ray showed infiltrates in the left lower lobe and a left pleural effusion. A culture of the sputum grew S. aureus.

The patient was started on intravenous antibiotics and was admitted to the intensive care unit. The patient was also treated with analgesics and oxygen therapy.

The patient's condition improved over the course of the treatment, and she was discharged from the hospital after 7 days of hospitalization.

References

costal arch, and pulmonary consolidation with pleural effusion in the left lower lobe (Fig. 1). Findings were confirmed on both ultrasonography of the neck and bone scintigraphy. Ultrasound-guided fine needle aspiration and biopsy was performed, from which S. aureus was isolated. The strain was resistant to ampicillin, and susceptible to erythromycin, gentamicin, clindamycin, ciprofloxacin, levofloxacin, and cotrimoxazole. The same microorganism was isolated from the bronchoscopy samples. During admission, intravenous ciprofloxacin and amoxicillin–clavulanic acid were administered, in line with susceptibility results, and improvement was observed in clinical symptoms, radiological signs, and acute phase reactants. Drainage was not required. Treatment continued on an outpatient basis for another 40 days, with complete resolution of the syndrome.

SSA is exceptional and accounts for only 1%–9%2,4 of SA, and generally occurs in patients with debilitating risk factors and immunosuppression.1–6 It is also unusual to see the simultaneous development of SA in the acute period of an episode of pneumonia, as it tends to occur later.1,2 In our patient, the SSA was attributed to the bacteremic pneumonia, as the same microorganism was isolated. S. aureus pneumonia in a patient without risk factors is in itself exceptional. The clinical picture of SSA, in contrast to our case, is generally insidious, and presents with fever, pain in the shoulder, and edema and erythema in the sternoclavicular joint.1,2,4–6 The most widely used diagnostic test is ultrasound, although CT can identify the degree of bone destruction, and scintigraphy is used to delimit the inflammatory area and guide the biopsy and aspiration procedure. The definitive diagnosis depends on isolation of the microorganism. This will indicate the appropriate antibiotic therapy, which should continue for at least 4 weeks in the absence of complications.1–3,5,6 Surgical treatment is recommended in case of extensive osteomyelitis, abscesses, empyema, or mediastinitis.1,4,5

In conclusion, pneumonia can unusually cause SA, and exceptionally SSA, and these entities may go unnoticed in the clinical context. As this process is potentially disabling and possibly fatal, etiologic diagnosis should not be delayed.

References


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