Simultaneously, inflammatory response, clinical arthritis, and septic arthritis were diagnosed. The patient was referred for further evaluation and treatment. The diagnosis was confirmed by extensive laboratory tests, including blood cultures, which yielded positive results for Staphylococcus aureus. The patient was treated with antibiotics and cultures showed resolution of the infection.

1. Simultaneous diagnosis of septic arthritis and sternoclavicular joint arthritis: a case report from Brazil.

2. The incidence of septic arthritis and sternoclavicular joint arthritis: a case report from Brazil.

3. The impact of early diagnosis and prompt treatment on the outcome of septic arthritis.

4. The role of antibiotics in the treatment of septic arthritis.

5. The importance of prompt diagnosis and treatment in septic arthritis.

6. The significance of early intervention in septic arthritis.

To the editor

The incidence of septic arthritis and sternoclavicular joint arthritis is a rare event in the literature. The present case highlights the importance of prompt diagnosis and treatment.

Suggested articles in this issue

- Simultaneous diagnosis of septic arthritis and sternoclavicular joint arthritis: a case report from Brazil.
- The incidence of septic arthritis and sternoclavicular joint arthritis: a case report from Brazil.
- The impact of early diagnosis and prompt treatment on the outcome of septic arthritis.
- The role of antibiotics in the treatment of septic arthritis.
- The importance of prompt diagnosis and treatment in septic arthritis.
- The significance of early intervention in septic arthritis.
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 SAA, 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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