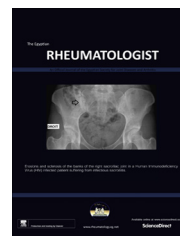




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SHORT COMMUNICATION

Profile of infectious sacroiliitis among rheumatology inpatients in Lomé (Togo): A single center experience



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KEYWORDS

Infectious arthritis;
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Abstract *Aim of the work:* To determine the epidemiological, clinical, bacteriological, and radiological characteristics of infectious sacroiliitis in patients admitted to the Rheumatology Department in Lomé (Togo).

Patients and methods: A retrospective study was conducted over 21 years on files of hospital patients admitted for infectious sacroiliitis.

Results: Of the 2995 patients admitted, 359 suffered from infectious arthritis, and 18 cases suffered from infectious sacroiliitis (5%). The mean age at admission of those 18 patients (seven men, eleven women) was 34.22 ± 13.5 years while the mean disease duration was 22.05 ± 41.9 days. The onset was sudden in 14 patients. The sacroiliitis was essentially unilateral (17 patients). The pain which was essentially inflammatory (16 patients), had irradiated in 14 patients. Fever was observed in 16 patients while weight loss was seen in 11. The infectious gate has been found in 15 patients (88.3%) with a post-partum period in five patients (27.8%). Limpness has occurred in 12 patients. Erythrocyte sedimentation rate was high in 13 patients with a mean of 78.83 ± 15.21 mm/1st hour. Of the 18 patients, pathogenic agents were isolated in 8 (Staphylococcus aureus: 7 cases, Mycobacterium tuberculosis: 1) and probable infection by Mycobacterium tuberculosis in another. Pathogenic agents were detected by cyto-bacteriological examination of vaginal sample in 5, urine in 2, sputum in 1 and psoas puncture in another. The mean antibiotic therapy duration was 3.25 ± 3.1 months. Followed up 6-months later the patients improved well.

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Conclusion: Our series confirmed that infectious sacroiliitis is rare and there is no clinical, bacteriological, and radiological particularity.

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1. Introduction

Infectious sacroiliitis is rare, involving between 1% and 2% of septic arthritis cases, which is probably due to the poor vascularization of this joint resulting in a low risk of infection via the haematogenous route [1,2]. Most observations are based on single case reports and review of the literature [3–8], small case series [9,10] or multicentre studies [11].

The diagnosis of osteoarticular infection is difficult in these anatomical sites and may be delayed due to the poor specificity of clinical signs and symptoms [1,12–14]. Delay in diagnosis may lead to several complications, such as abscess or sequestration formation, prolonged period of sepsis, and long-term joint deformity [15]. Studies of rheumatic diseases in Africa showed the paramount place of infectious pathology despite the progress of antibiotic therapy [16–20].

Despite the frequency of osteoarticular infections in Africa, infection of the sacroiliac, which is a disorder with sometimes misleading clinical signs, seems relatively rare [15,16,21,22].

The aim of this study was to determine the epidemiological, clinical, bacteriological, and radiological characteristics of infectious sacroiliitis in patients admitted to the Rheumatology Department, University Hospital Sylvanus Olympio of Lomé (Togo).

2. Patients and methods

This is a retrospective study that has been conducted over 21 years on the files of patients admitted in the Department of Rheumatology, University Hospital Sylvanus Olympio of Lomé; the capital city of Togo (West Africa). The study was approved by the ethics committee. The demographic, clinical, bacteriological and radiological data of the patients have been collected from their files.

The positive diagnosis of the osteo-articular infection has been essentially radiological and clinical while the etiological diagnosis was based on the isolation of the germ, and/or the underlining of the characteristic histopathological lesions, or a strong clinical suspicion (existence of another infectious location, namely a pulmonary or spine tuberculosis, response to antibiotic treatment). The infection was considered *certain* if a causal microorganism was isolated or if a specific histopathological lesion was observed in the infectious site. On the contrary, the infection has been considered *probable* in case of a strong clinical suspicion (existence of another infectious location, namely a pulmonary or spine tuberculosis, response to antibiotic treatment).

Sacroiliitis as a clinical feature of spondyloarthritis was excluded from this study. The combination of fatigue, anorexia, weight loss and pallor or the presence of at least three of these symptoms was considered as an alteration of the general condition. Each patient has been submitted to pelvis radiography, a complete blood count, measurement of the erythrocyte sedimentation rate, a retroviral serology. Fever was defined as a

temperature above 37.5 °C and leukocytosis defined as a leukocytic count >11,000/ml. Erythrocyte sedimentation rate (ESR) greater than 20 mm in the first hour was considered to be high. No patient has been subjected to bone scan or magnetic resonance imaging (MRI) due to the absence of scintigraphy and MRI in Togo at the time of the study. In case of underlining of a given infectious entrance, a swab has been done in view of a cytological and bacteriological test. Data analysis was performed by using SPSS software for Windows (Version 17.0).

3. Results

Of the 2995 patients admitted over the last 21 years, 359 suffered from infectious arthritis, and 18 cases suffered from infectious sacroiliitis (5%). The mean age at admission of those 18 patients (seven men, eleven women) was 34.22 ± 13.5 years while the mean disease duration of 22.05 ± 41.9 days. The onset of the symptoms was essentially sudden in 14 patients (77.8%) and insidious in the remaining four (22.2%).

The involvement of the sacroiliac joint was essentially unilateral ($n = 17$), with the left side involvement in 57.9% of cases. The site of the pain was varied; the buttock was the most common site of the pain ($n = 14$), although psoriasis groin pain ($n = 2$), low back pain ($n = 1$) and hip pain ($n = 1$) were also observed. The pain was essentially inflammatory in 16 patients (88.9%) and irradiated to the thigh in 14 (77.8%). Fever was observed in 16 patients (88.9%) with the highest temperature reaching 38.5° in eight patients (Table 1). A loss of weight has been identified in 11 patients (61.1%). The infectious gate has been found in 15 patients (88.3%) with a urinary route in 7 patients (38.9%). Five patients (27.8%) were in the post-partum period. The infectious sacroiliitis was associated with an infectious spondylodiscitis in three patients (16.7%). Fifteen patients (83.3%) had concurrent infectious diseases.

The pain increased subsequently to a monopodal pressure and usually provoked limpness in 12 patients (66.6%). The direct pressure of sacroiliac joint was painful in 14 patients (77.8%). The ESR was high in 13 patients (72.2%) ranging from 15 to 115 mm/1st hour and a mean of 78.83 ± 15.21 mm/1st hour. Leukocytosis was observed in 12 patients (66.7%) ranging from 11,400 to 17,000/ml.

Of the 18 patients, infection was certain and the pathogenic agents were isolated in eight cases; *Staphylococcus aureus* in 7 and *Mycobacterium tuberculosis* observed in one patient. Infection was probable (*M. tuberculosis*) in other patients. Pathogenic agents were isolated from other sites by means of cytobacteriological examination of vaginal sample ($n = 5$), urine ($n = 2$), sputum ($n = 1$) or puncture of the Psoas muscle ($n = 1$). Of the 12 patients submitted to retroviral serology, four were infected with human immunodeficiency virus (HIV), while the other eight were healthy. Those four

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