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Bilateral clavicle osteomyelitis: A case report

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ABSTRACT

INTRODUCTION: Osteomyelitis of the clavicle is rare. Infection occurs from hematogenous spread or trauma. In adults infection is usually secondary due to an exogenous cause such as open fractures, surgery (iatrogenic) or spread from local tissue with infection.

PRESENTATION OF CASE: The case is presented here of a 50-year old female with bilateral clavicular fractures, who was operated on with open reduction and internal fixation. At the 6-month follow-up, she had complaints of bilateral osteomyelitis which was successfully treated with resection of the infected segment of the bone, and antibiotic impregnated collagen.

DISCUSSION: Predisposing factors include diabetes, intravenous drug abuse, tuberculosis or immune suppression. Management involves the removal of bone fixation, debridement of the bone and if there is a defect, coverage with a muscle flap is applied.

CONCLUSION: In cases of clavicular osteomyelitis where infection continues despite debridement and antibiotic therapy, excision of the sequestered clavicular section is a successful treatment approach and has been seen to improve quality of life without any functional loss.

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1. Introduction

It is estimated that fractures of the clavicle represent 4% of extremity fractures.¹ These fractures are usually treated conservatively with a broad arm sling and have a good functional outcome.² Another treatment of clavicular fractures is surgery, there have started to be reports of complications such as non-union, injury to the subclavian vessels and hemopneumothorax after surgical treatment.^{3,4} Another rare complication is osteomyelitis. Although laboratory findings are useful in diagnosis, changes in bone structure in early stage osteomyelitis may not be seen on direct radiographs.⁵ Magnetic resonance imaging (MRI) is more useful as sensitivity and specificity are higher.^{3,5}

Despite modern surgical techniques and advanced antimicrobial therapy, osteomyelitis remains a difficult and challenging problem.^{6,7} In the treatment of clavicular osteomyelitis which occurs following surgery, the fixation material is removed and following aggressive debridement and a long period of antibiotic therapy, if there is defective soft tissue, a muscle flap can be applied.^{3,4}

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2. Case report

Following a traffic accident as a vehicle passenger, a 50-year old female patient with a 10-year history of diabetes mellitus was monitored for 10 days in the Intensive Care Unit (ICU) with a diagnosis of multiple rib fractures, minimal pleural fluid, bilateral clavicular, right sacrum and left superior pubis arm fractures and haemorrhagic contusion in the left temporal area. According to AO classification the clavicular fractures were type 15-B2.3 on the right side and type 15-B1.3 on the left side (Fig. 1). With a diagnosis of fragmented fracture in the mid third section of both clavicles, open reduction under general anaesthesia and fixation with anatomic locking clavicular plate (TST, Kurtkoy, İstanbul) (Fig. 2a and b) was applied to the patient on the 13th day after post-trauma. 30 min preoperatively, 1 gr cefazolin iv was administered to the patient. Postoperatively, cefazol 1 gr 3 × 1 iv was continued for 2 days. On postoperative Day 3 the patient was discharged with the recommendation of bedrest.

After discharge, the patient was followed up in the polyclinic and sutures were removed 3 weeks postoperatively. The patient did not attend further follow-ups and at the 6th month postoperatively she presented at the polyclinic with complaints, which had started first in the left and 2 days later in the right clavicle, of swelling, redness, skin heat and high temperature. Physical examination determined a temperature of 38 °C, sensitivity, increased heat and limited shoulder movement in both clavicles. Serological test results showed sedimentation 95, CRP 147, WBC 18,000,

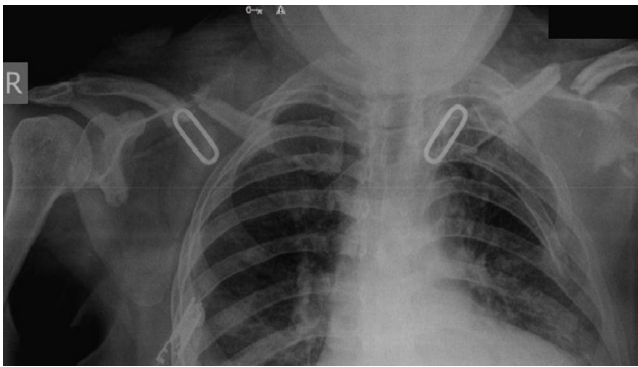


Fig. 1. 50-year old female with a 10-year history of diabetes mellitus with mid-third section fragmented bilateral clavicular fractures following a traffic accident within the vehicle. According to AO classification, right side fracture was 15-B2.3 and left-side was 15-B1.3.

nitrite positivity in the urine test, and abundant leukocytes. In the urine culture taken from the patient, 100,000 colonies *Escherichia coli* reproduction was seen. On the MRI taken of both shoulders, abscess formation and appearance compatible with osteomyelitis were seen (Fig. 3). During the operation, cultures were taken from soft tissue and the clavicles and the clavicular plates were removed. 2.7 mm drilling was made with forage on the osteomyelitis skip foci determined on the preoperative MRI, and cleaning was made with curettes and plentiful saline solution. Postoperatively, cefazol 1 gr 3 × 1 and genta 160 mg 1 × 1 iv were started. As *E. coli* and *Pseudomonas* reproduction was determined in the cultures taken intraoperatively, Targocid 400 mg 1 × 1 and Meronem 1 gr 3 × 1 iv were started from the 5th day conforming with the Infectious Diseases Dept. antibiogram. On the 20th day of antibiotherapy, the patient was again admitted for surgery due to discharge in the wound areas, which was more pronounced on the left side.

As the mid-third of the left clavicle was seen to be sclerotic and infected, a piece approximately 20 mm in size was excised as far as bleeding bone (paprika sign) from the left clavicle and washed with plentiful saline (Fig. 4). The wounds were closed by placing collagen with gentamycin wrapped around both clavicles. Reproduction of *E. coli* and *Pseudomonas* was seen in the cultures of the material taken intraoperatively. After consultation with the Infectious Diseases Department, the patient was admitted to the relevant clinic for planned treatment. A 45-day period of Tazocin 4.5 2 × 1 iv was started. Antibiotherapy was terminated when the wound sites were clinically problem-free and laboratory findings returned to normal values after the par-enteral antibiotherapy. The patient was discharged with follow-up appointments at the polyclinic. At the follow-up 26 weeks after the trauma, there were no findings of infection. The movements of both shoulders were normal and the DASH score was measured at 40 (Fig. 5a–c).

3. Discussion

Although clavicular osteomyelitis is seen very rarely, it has been reported as a complication following subclavian vein catheterization and head and neck surgery.^{8–11} Systemic causes which create a predisposition to osteomyelitis include the use of corticosteroids, dependence on iv drugs, tuberculosis, mitral cover prosthesis, diabetes and lung cancer.^{12,13,14} There are both medical and surgical treatment approaches. There are studies reporting very successful results from long-term (6–8 weeks) iv antibiotic therapy in the treatment of haematogenously spread clavicular osteomyelitis.¹⁵ No benefit is seen from antibiotic therapy in extensive surgical

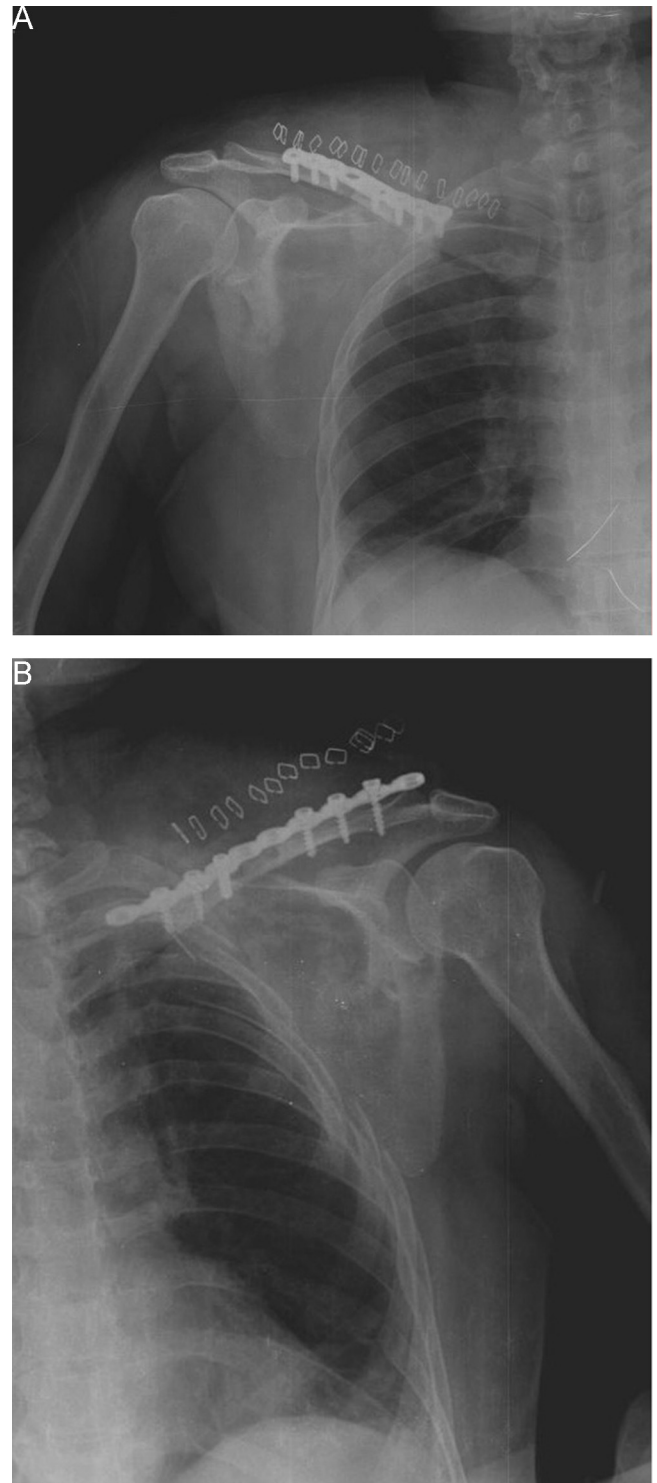


Fig. 2. (a) With a diagnosis of fragmented fracture in the mid third section of the right clavicle, open reduction under general anaesthesia and fixation with anatomic locking clavicular plate (TST, Kurtkoy, Istanbul) was applied to the patient on the 13th day post-trauma. (b) With a diagnosis of fragmented fracture in the mid third section of the left clavicle, open reduction under general anaesthesia and fixation with anatomic locking clavicular plate (TST, Kurtkoy, Istanbul) was applied to the patient on the 13th day post-trauma.

debridement but it is useful in the treatment of chronic osteomyelitis. In chronic osteomyelitis patients with a drain, if soft tissue defects have developed in the wound site, a muscle flap may be applied in these areas.

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