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Pneumococcal polyarticular septic arthritis: A diagnostic challenge

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Introduction: Polyarticular septic arthritis accounts for only 15% of all cases of septic arthritis and strep pneumonia contributes only 5% of all cases of septic arthritis. The fact that septic arthritis can be polyarticular in presentation is insufficiently recognized and can present as diagnostic challenge for internists.

Case Description: A 90-year-old African-American female presented with chief complaint of bilateral knee and wrist pain for past 1 week. Vitals were within normal limit except for BP of 96/72 mmHg. Patient looked dehydrated with dry mouth; her knees and wrist (bilaterally) were swollen, warm tender to touch with marked decreased range of motion. Initial Labs: significant for mild leukocytosis 12.09 TH/ul, creatinine 3.8 mg/Dl, CRP 270 mg/dL. X-ray knee significant for bilateral joint effusion without acute fracture or dislocation. In Emergency Department patient was given fluids along with IV Solu-Medrol for presumed inflammatory arthritis. Overnight patient experienced worsening mental status with spike in temperature. Stat CT head and chest x-ray were unremarkable. Urgent bilateral bedside knee aspiration was performed which revealed grossly purulent material and decision was made to take patient to the OR for irrigation with debridement of bilateral knees and wrist. Patient started on broad-spectrum antibiotic with subsequent transfer to ICU. Blood cultures and cultures from multiple joints next day grew strep pneumonia. Echocardiogram did not show any evidence of vegetation. CT chest was negative for pneumonia. Infectious Disease was consulted and decision was made to transition patient on ceftriaxone. In ICU Patient complained of neck stiffness and meningitis was suspected as source of bacteremia but lumber puncture was not done as patient remained on meningitis doses of ceftriaxone. Over the course of admission patient continued to improve clinically.

Conclusion: The mortality for polyarticular septic arthritis is higher (30%) than inpatient mortality for myocardial infarction (10%). The possibility or polyarticular septic arthritis should always be in the differential diagnosis even if the patient is afebrile, have a normal white count or have several joints involved. Delayed/inadequate treatment or premature administration of steroids can lead to irreversible joint destruction with subsequent disability.

Biography

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