Case Discussion: Chronic and Extensive Osteomyelitis of the Proximal Humerus

Cory Stewart

4/30/2021

First, I'm acting under the assumption that the inflammatory markers have normalized at this point. Second, there certainly are far better resources in this group than I, but I did see a similar patient in the recent past with an MSSA infection unrelated to prior surgery.

I would propose that you start with PT at this point. If he fractures I would treat him with an antibiotic spacer. If he can achieve reasonable function to shoulder height, that likely is one of the best case scenarios which remain.

Wouldn't add bone graft given concern for small pockets of residual infection.

Would only consider a reverse in the setting of no signs/symptoms/labs consistent with infection after several months off all antibiotics. Even then, the risk/benefit would seem to skew heavily toward avoiding any future surgery involving an implant barring a completely dysfunctional shoulder.

Cory

Florian Grubhofer

4/30/2021

Hello Dr. Warner,

We reviewed all our antibiotic loaded cement spacer cohort for periprosthetic infections and we achieved an infection control of 95% and best functional outcome if a RTSA was able to be implanted. If the cement spacer was left in place for more than 12 weeks there was a risk for bony erosion of the glenoid and no RTSA could be implanted anymore. The presented case is not a periprosthetic joint infection but nevertheless a two stage approach seems for me a reasonable option. Attached you find the publication that was published in CORR.

Best,

Florian

Felix Savoie

5/3/2021

Hi JP;

Unfortunately have had a few of these; I agree with multiple staging ; and certainly would agree with I and D and removal anchors and sutures and IV atb. However if that doesn't work I have only had success with placing a true preformed HHR prostalac. The anchors and their insertion tracks seem to be how the infection gets in , thus very difficult to eradicate without pretty extensive removal.

Once all labs (we do IL-6 at Tulane) normalize then a scope, culture and biopsy would be next step. If you can get IL 6 and it is normal you might just aspirate and skip this surgical step.

In the current situation I would agree with PT and see what happens, but most likely the shoulder is ankylosed and will not move.

I would probably do a HHR with complete release and make sure I have a stem I can easily convert to RSP but would not do it as next surgical step although he will likely end up there, as recurrent infection is likely and you would prefer not to seed the glenoid.

Buddy

Ed Yian

5/4/2021

Thanks for everyone's input for this case. Very helpful advice and I appreciate your time and thoughts! I'll let you know what outcomes occur. Currently his labs are normal and I will start therapy soon for him and talk to him about other treatment options.

- Ed