

Chronic Osteomyelitis after Seven Years Neglected Bone Exposed in 12-Year-Old Boy: A Case Report

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Abstract

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BACKGROUND: Access to modern medicine is still limited in some rural areas in Indonesia. This is mostly due to lack of people's knowledge and concern for their health, especially in orthopaedic cases. Osteomyelitis is generally described as infection and inflammation of the bone, which results in local bone destruction, necrosis, and apposition of new bone. Chronic post-traumatic osteomyelitis (CPTO) is a complex condition and one of the most challenging problems in orthopaedic surgery that cause considerable morbidity.

CASE PRESENTATION: We present a case of chronic post-traumatic osteomyelitis with radial nerve injury, in which radical surgical debridement and broad-spectrum antibiotic administration were done. A 12-year-old boy with a history of falling from the three-meter-high tree had swollen, deformed, and neglected humerus bone exposed. After stabilisation in the emergency room, surgical limb amputation was scheduled, yet the family refused this medical care and chose debridement instead.

CONCLUSION: This case is an important addition to the literature about chronic post-traumatic osteomyelitis with neglected bone exposed and the lacking of society's concern in regards to orthopaedic cases.

Introduction

Although government health programs, known as BPJS (*Badan Penyelenggara Jaminan Sosial*), has given access to health care, by the subsidised hospital cost and has become a way out for a poor urban's financial problem, the number of neglected fractures has not dwindled in recent years. Thus, fractures are often first treated by traditional bone-setters and healers whose method is not adapted to the management of open fractures. Most patients come to the hospital after a certain delay presenting with severe injuries or sequela that are difficult to cure with the diagnostic and therapeutic means available in traditional local facilities.

Chronic osteomyelitis occurs either after sequelae of acute osteomyelitis in children or secondary osteomyelitis due to trauma involving open fracture. The last entity defines our case which is

post-traumatic osteomyelitis [1], [2], [3]. There are two most well-known classification systems for osteomyelitis, the Cierny-Mader, and the Waldvogel. Recently, new classification systems have been introduced and designed to be more specific to modern diagnostic and management approaches of osteomyelitis [3], [4]. Those important variables used in the new systems are bone involvement, antimicrobial resistance patterns of causative microorganisms, the need for soft tissue coverage, and host status [4], [5]. Tenderness, effusion, increased warmth, pain with motion, and drainage on the area of the affected bone are signs and symptoms of chronic osteomyelitis [6].

Trauma is one of the risk factor for osteomyelitis [7]. Open fractures are at high risk of transcutaneous contamination of bacteria [8]. The pathophysiology of traumatic osteomyelitis depends on bones involved, initial injury's characteristic, and host condition [9]. Radial nerve injury (particularly radial neuropraxia) as the main presentation of

fracture middle third humerus (diaphyseal fracture), is one of the most aetiology for peripheral nerve palsy associated with humerus bone fracture. The incidence ranges from 1,8% to 22% [10], [11], [12], [13].

Lesions, caused by traumatic injury, can occur anywhere along the radial nerve. Therefore, the anatomy of it is clinically significant. The structures along its course also play an important role in determining the sites at which lesion might occur and in localising the origins of pathological lesions during diagnostic examinations [13], [14], [15], [16]. They are classified as lesions in the axilla (very high lesions), lesions in the arm in the radial groove (high lesions), lesions at the elbow, and lesions of the superficial branch of the radial nerve (low lesions). In our case, it is the high lesions type. The deficit of high lesions type presents brachioradialis weakness, wrist drop, finger drop, thumb drop, and sensory loss [16]. Diagnosis of osteomyelitis can be confirmed by bone scan or MR scan, along with needle aspiration, bone biopsy, elevated erythrocyte sedimentation rate (ESR), elevated C-reactive protein (CRP), elevated WBC count, and culture [6], [7]. Treatment of osteomyelitis is multiple surgical procedures, including surgical debridement of all necrotic bones, soft tissue coverage, the combination of appropriate antibiotics, and long-term follow-up, which are all still a problematic clinical challenge for osteomyelitis [1], [2], [3], [4], [8].

Identification of the pathogen in the bone, through a bone biopsy, is a definitive diagnosis of osteomyelitis. In the selection of antibiotic administration, most studies reported *Staphylococcus aureus* is the aetiology and responsible for 80% to 90% of its cases [7], [8]. Eighty-five to ninety percent of radial nerve lesion can recover spontaneously within three months. Thus, if nerve function doesn't return within three to four months, nerve surgical exploration should be performed [10], [11], [13], [15], [17]. The prognosis of radial nerve injury is influenced by the severity of humeral shaft fracture according to AO/OTA Classification [12].

Hereby we present a case report of a 12-year-old boy with chronic post-traumatic osteomyelitis (CPTO) after seven years of neglected bone exposed. He was successfully treated with radical surgical debridement, broad-spectrum antibiotics, analgesics, neuroprotective agents, and physiotherapy.

Case Report

A 12-year-old boy presented to the emergency department with a chief complaint of bone exposed and bleeding of the upper left arm every time he got minor trauma. It was caused by a past traumatic injury resulting from the impact of falling

from a three-meter-high tree which happened seven years ago. He fell forward with left arm outstretched, struck the ground with shoulder flexed, elbow flexed, forearm pronated, wrist dorsiflexed, resulting in the bone of the upper left arm exposed. His mother admitted due to the fear of having surgery, the exposed bone was never consulted to medical care and was only treated by traditional medicine for seven years.

On clinical examination, of which consists of look, feel, move, the upper left arm was swollen with shortening deformity, contraction, angulation, exposed humerus bone with the size approximately 2,5 cm in diameter, and full thickness tissue loss, which was covered by dry, black eschar on the base of the ulcer on anterior and posterior aspect of the upper left arm. The eschar extended from the middle shaft into the proximal of the upper left arm. There is no slough and yellow-coloured pus seen on the wound base. Bleeding, tenderness and crepitus were presented on the middle shaft upper left arm (Figure 1). Sensation on first dorsal web space of his left hand was weakened. Extension of the left wrist and left fingers including the thumb was also impossible (wrist drop, finger drop, and thumb drop). Yet, radial artery pulsation was still poorly palpated. The left elbow's range of movement (ROM) including flexion and extension was moderately restricted because of deformity and pain. While the ROM of left wrist, particularly on extension movement, was severely restricted.



Figure 1: Open fracture of the middle one-third neglected upper left arm in a 12-year-old boy; a) lateral aspect; b) anterior aspect

Blood investigations showed severe anaemia (Hb: 7.3 mg/dL) and leukocytosis (20.200/ μ L). ESR and CRP values weren't investigated due to lack of facilities. Anteroposterior and lateral radiographs of the upper left arm showed both open, complete, transverse fracture on proximal one-third to middle humerus bone with osteomyelitis and a gap between

proximal and distal humerus. There was the irregular contour of the glenoid on the shoulder joint (Figure 2). The patient was managed and stabilised with the administration of normal intravenous saline, one unit of packed red cells (PRC), broad-spectrum antibiotics, analgesics, neuroprotective agents, and surgical debridement, as his family refused to be amputated. He then was followed up for seven days after debridement had been performed.



Figure 2: Anteroposterior and lateral X-ray films of the upper left arm. They showed a complete, transverse fragment fracture from proximal one-third to middle humerus bone which is displaced into anteroinferior with the lytic lesion and sclerotic on distal one-third humerus bone

Discussion

The incidence of post-traumatic osteomyelitis is rising recently because of the increased frequency of trauma, whereas the incidence of chronic and neglected cases has not dwindled due to lacking knowledge and concern of our society in regards to orthopaedic cases [10]. Physical examinations of osteomyelitis found on the patient were quite similar to the literature, such as tenderness, effusion, increased warmth, pain with motion, and drainage of the affected area [6].

Based on several classifications, our patient is type IIIB of Gustilo & Anderson's open fracture classification, contiguous type of Waldvogel's osteomyelitis classification, type IV class B host classification with unstable, segmental diaphyseal type of diffuse osteomyelitis defect on Cierny-Mader's osteomyelitis classification, and high lesions type of radial nerve injury's classification [1], [4], [18].

The patient has been diagnosed osteomyelitis based on history taking, physical examination, and has been confirmed by the elevated WBC count on laboratory findings and the appearance of the sclerotic and lytic lesion on proximal one-third humerus in x-ray [5].

His Mangled Extremity Severity Score (MESS) for limb salvage is more than seven, referring to score 4 for the massive energy of injury, score 2 for tready pulses, score 2 for a prolonged shock. His fracture meets the Apley's criteria for amputation, such as dangerous and damned nuisance criteria. We, therefore, suggest amputation to be performed, but his family refused it [3], [5], [8], [19], [20]. Consequently, we performed radical debridement and excision of all avascular scarred and infected granulation tissue, followed by debridement of the infected endosteum, reaming, and the insertion of closed suction drainage system [3], [20], [21].

Determining the appropriate antibiotics has been an issue due to the paucity of instruments (specimen culture). Therefore, we use a broad-spectrum antibiotic to prevent the increase of bacterial resistance cases [5]. Besides, early exploration of the radial nerve is not performed as well due to the lack of instruments and resources.

Although the infection control and satisfactory functional outcome of our patient can finally be achieved, this case proves knowledge and concern of our society in regards to orthopaedic cases is ironically superficial. Most of them are still taboo and afraid to have surgery, particularly amputation. Once the patient's fracture meets the MESS and Apley's criteria, amputation is essential to give the good prognosis to the patient.

In conclusion, this case is an important addition to the literature about chronic post-traumatic osteomyelitis with neglected bone exposed and the lacking of society's concern in regards to orthopaedic cases.

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