TREATMENT OF 'SALMONELLA PARATYPHI A' OSTEOMYELITIS WITH TRIMETHOPRIM-SULPHAMETHOXAZOLE

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There have been several reports of the use of trimethoprim-sulphamethoxazole in typhoid and paratyphoid A fevers (Akinkugbe et al., 1968; Farid et al., 1970; Kamat, 1970). Its successful use in the treatment of acute staphylococcal osteomyelitis is described by Craven et al. (1970). This paper describes, for the first time, the successful treatment of Salmonella paratyphi A osteomyelitis with this drug.
Salmonella paratyphi A
Osteomyelitis
Trimethoprim-Sulphamethoxazole
Therapy
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Case Report
A farmer aged 16 years was admitted to hospital complaining of severe pain on movement of the right shoulder joint, fever, weakness and dysuria. He gave a history of having been ill for at least one year with recurrent attacks of fever. These usually lasted one to two weeks. He had noted the shoulder pain and swelling approximately six months after the first febrile attack.

He was pale and febrile (38°C.), and had limitation of motion of the right shoulder. There was a fusiform tender swelling over the upper end of the right humerus. The haemoglobin was 10.5 g./100 ml., reticulocyte count was less than two per cent, and there was no evidence of haemolysis or sickling. There were live eggs of Schistosoma haematobium in the urine and of Schistosoma mansoni in the stools. Blood and urine cultures were repeatedly positive for S. paratyphi A. Radiography of the right humerus showed an area of bone destruction with new bone formation at the lateral border of the upper extremity, near the shoulder joint (Fig. 1). Material obtained by needle aspiration from the abscess was cultured and yielded S. paratyphi A. After one week of trimethoprim-sulphamethoxazole (Bactrim), two tablets twice daily, he became afebrile and blood and urine cultures were reported negative for S. paratyphi A. The swelling gradually diminished in size and movement of the shoulder joint became much easier. By the end of four weeks there was radiographic evidence of bone healing (Fig. 2). Treatment was continued for 10 weeks. Four months after ending therapy there was complete healing of the bone lesion (Fig. 3). Nitidazole was later given for treatment of schistosomiasis.

Comment

Osteomyelitis is a rare complication of typhoid and paratyphoid A fevers (Aegerter and Kirkpatrick, 1968); none were reported from this hospital during the past 20 years in studies including over 1,000 proven enteric fever patients (El Ramli 1950, 1953; Hathout et al., 1967; Omar and Wahab, 1967; Robertson et al., 1968; Wahab and Robertson, 1969). Others (Terregrosa et al., 1960) reported the occurrence of salmonella osteomyelitis but usually as a complication in patients with sickle-cell disease. There was no evidence of sickle-cell anaemia in our patient. He, however, demonstrated all the classic characteristics of salmonella osteomyelitis — prolonged recurrent phases of S. paratyphi A septicaemia with fever and the gradual development of pain and swelling at the upper extremity of the humerus (from which organisms were cultured), and radiographic evidence of bone destruction with periosteal new bone formation (Black et al., 1960).

Farid et al. (1970) and Scragg and Rubidge (1971) previously noted the remarkable rapidity with which trimethoprim-sulphamethoxazole alleviates toxicity in patients with typhoid and paratyphoid fevers. Craven et al. (1970) also reported prompt response in six patients severely ill with acute staphylococcal
osteomyelitis and treated with trimethoprim-sulphamethoxazole. In the present case, pain and fever rapidly subsided. The swelling gradually disappeared and the bone lesion showed evidence of healing after four weeks of treatment. Healing was complete after four months.

References