Iliac Osteomyelitis and Gluteal Abscess Following an Intramuscular Injection

Daas S1,2, Jlidi M1,2, Slama SB1,3, Chaabane I1,4*, Souissi M1,2 and Khorbi A1,2

1University Tunis El Manar, Faculty of Medicine of Tunis, 1007, Tunis, Tunisia
2Department of Orthopaedic Surgery, MT Maamouri Hospital, 8050 Nabeul, Tunisia
3Department of Pathology, M. Slim Hospital, 2046 Sidi Daoud, Tunis, Tunisia
4Department of Internal medicine, MT Maamouri Hospital, 8050 Nabeul, Tunisia

*Corresponding author: Chaabane Imen, Department of Internal medicine, MT Maamouri Hospital, 8050 Nabeul, Tunisia, Tel: +21655270739; E-mail: imen_chaabane@hotmail.fr

Received date: October 24, 2018; Accepted date: November 20, 2018; Published date: November 23, 2018


Copyright: ©2018 Daas S, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Abstract

Gluteal abscess following intramuscular injections are more common, often due to non-sterile injection techniques. We present a case of iliac osteomyelitis and gluteal abscess mimicking a tumor disease.

Keywords: Gluteal abscess; Staphylococcus aureus; Intramuscular injection

Introduction

Local infections are one of the most common infections among intramuscular (IM) injections. It can rarely result in serious infectious complications such as abscesses, osteoarticular infections which may progress to bacteraemia and generalized sepsis [1,2]. However their incidence is difficult to estimate. Staphylococcus aureus is the most common organism usually isolated in these complications [1,3]. We describe a case of iliac osteomyelitis and gluteal abscess due to Staphylococcus aureus following IM injection.

Case Observation

A 63-year-old female patient presented with a two months history of left hip pain with asthenia and weight loss without fever. She had no past medical history. Examination revealed a swelling in the iliac wing (Figure 1) and a hip flexion pain. Laboratory tests showed biological inflammatory syndrome. Standard X-rays were normal. Imaging studies were performed, including pelvic, abdominal and chest

Figure 1: Posterior swelling in the iliac wing.
Discussions

The administration of intramuscular injections is a common nursing intervention in clinical practice. It should be done with care to avoid complications. Today, the incidence of developing a complication from IM injections ranges from 0.4 percent to 19.3 percent of patients receiving the IM injection of a medication [4]. Gluteal abscess was the most common complication of IM injections, it has been reported by various authors [4,5]. While, in literature, there aren’t many cases of osteoarticular infections developed after intramuscular injections.

The mechanism of the infection is probably related to direct or drug-induced tissue trauma, tissue ischemia and inoculation of bacteria. In developing countries, abscesses are secondary to injection involving unsterile techniques including the use of contaminated needles and dirty clothes. These infections are most likely to occur in immunocompromised patients, but also have been described in immuno-competent people [4-6].

Given the rarity of the condition and its relatively non-descript clinical presentation, it is almost impossible to suspect the diagnosis at first encounter. This explains the high rate of initial mis-diagnosis, and hence delayed treatment [7].

Detailed history and a careful clinical examination are essential.

CT scan are needed to confirm the diagnosis or to exclude accompanying diseases [5]. The literature does not describe the imaging characteristics of gluteal abscesses. In our case, gluteal abscesses were observed after a two months of injections in the form of Soft tissue mass.

The main treatment of gluteal abscess is surgical associated with antibiotic therapy. There is no consensus regarding the management of these infections. In summary, gluteal abscess disease is still common despite improvements in antiseptic techniques. It poses a diagnostic challenge for the clinician and the radiologist because of its nonspecific and misleading symptoms. Furthermore, we want to underline the importance of correct anamnesis to make quickly the right diagnosis and provide the right treatment.

References


This article is available from: http://www.archivesofmedicine.com/