CHRU HÔPITAUX DE TOURS

CENTRES DE RÉFÉRENCE POUR LES INFECTIONS OSTÉO-ARTICULAIRES COMPLEXES DU GRAND OUEST
CRIOGO

université de TOURS | Faculté de médecine

Best-of 2023 - Infectiologie

Journée annuelle du CRIOGO

Tours - 26/01/2024

Adrien Lemaignen

adrien.lemaignen@univ-tours.fr

SMIT

Recommandations

- Pied diabétique
- Infections disco-vertébrales
- Mise à jour arthrites septiques
- Antibioprophylaxie chirurgicale (SFAR)
- Ostéomyélites Wiki-guidelines

RECOMMANDATIONS : PIED DIABÉTIQUE

Contents lists available at ScienceDirect

Infectious Diseases Now

journal homepage: www.sciencedirect.com/journal/infectious-diseases-now

Guidelines

Clinical practice recommendations for infectious disease management of diabetic foot infection (DFI) – 2023 SPILF

E. Bonnet [a], L. Maulin [b], E. Senneville [c], B. Castan [d], C. Fourcade [e], P. Loubet [f], D. Poitrenaud [g], S. Schuldiner [h], A. Sotto [f], J.P. Lavigne [i], P. Lesprit [j], the individual members of the "Review group"

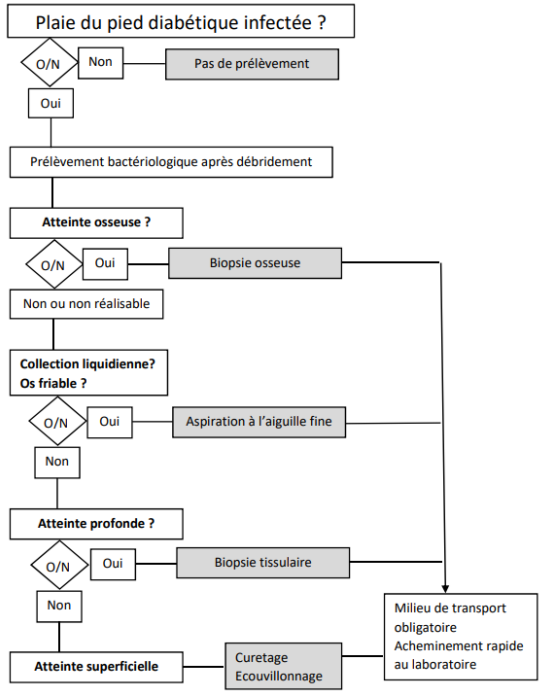
Clinical Infectious Diseases

IDSA GUIDELINES

IWGDF/IDSA Guidelines on the Diagnosis and Treatment of Diabetes-related Foot Infections (IWGDF/IDSA 2023)

Éric Senneville,[1,2] Zaina Albalawi,[3] Suzanne A. van Asten,[4] Zulfiqarali G. Abbas,[5] Geneve Allison,[6] Javier Aragón-Sánchez,[7] John M. Embil,[8] Lawrence A. Lavery,[9] Majdi Alhasan,[10] Orhan Oz,[11] Ilker Uçkay,[12] Vilma Urbančič-Rovan,[13] Zhang-Rong Xu,[14] and Edgar J. G. Peters[15,16,17]

- Précisions des définitions IPPPD et OPPD et des critères d'hospitalisation
- Classification IWGDF de gravité de 1 à 4 (1 non infecté, 4 infection sévère)
- Chir : en urgence si gravité, à discuter si G3/4 avec bilan vasculaire ou OPPD
- Antibio :
  - SAMS et strepto < 4 sem, + EB et anaérobies si > 4 semaines
  - Grade 2 récent : PO : cefalexine ou clinda
  - Grade 2 chronique ou 3/4 : AAC, C3G/MTZ si allergie, avis infectio si gravité
  - Grade 4 + gravité : Pip/Taz + anti-SARM +/- AMK si choc
- Durées :
  - 5 jours après amputation en l'absence d'infection tissus mous
  - 7 jours si infection des tissus mous (→ 14 j si persistance à J7)
  - 21 jours si débridement si débridement incomplet +/- cultures positives sur les berges (données contradictoires)
  - 42 jours si OPPD et pas de chir



https://www.infectiologie.com/UserFiles/File/spilf/recos/spilf-groupe-recos-idv-2023.pptx

RECOMMANDATIONS : INFECTIONS DISCO-VERTÉBRALES

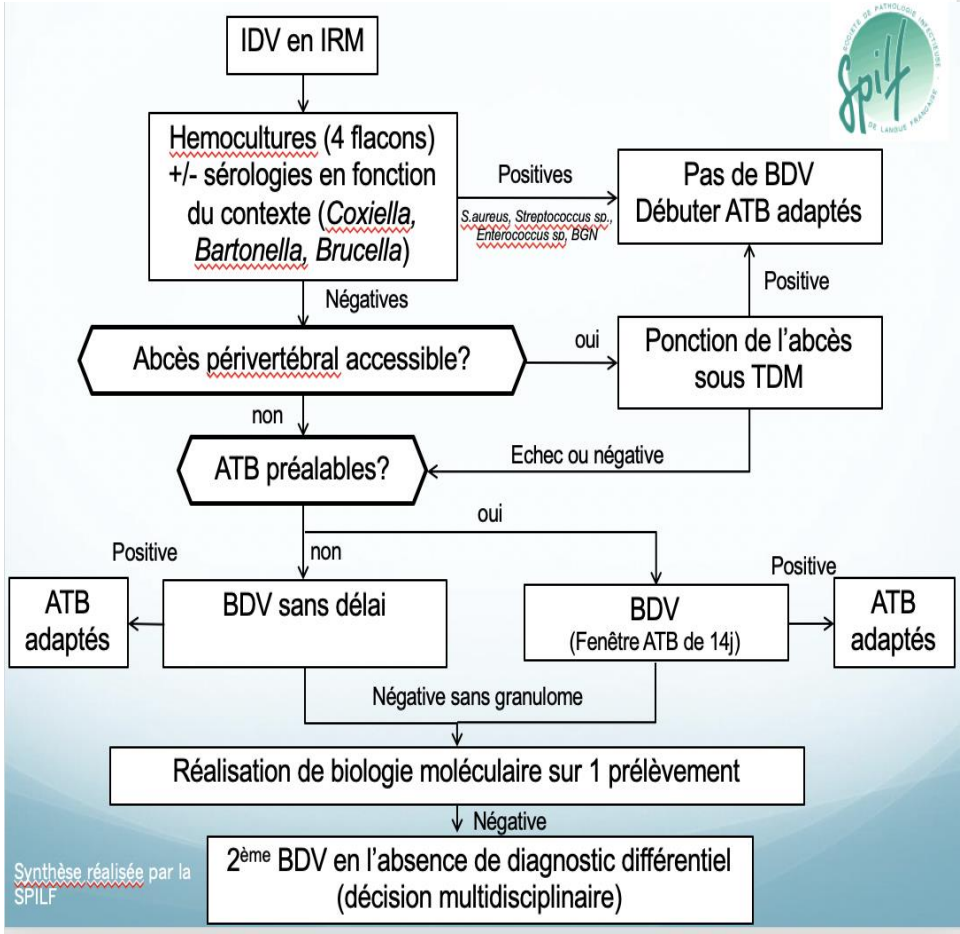
Available online at ScienceDirect www.sciencedirect.com
Elsevier Masson France EM|consulte www.em-consulte.com/en

Guidelines

2022 SPILF - Clinical Practice guidelines for the diagnosis and treatment of disco-vertebral infection in adults

M. Lacasse [a], S. Derolez [b], E. Bonnet [c,*], A. Amelot [d], B. Bouyer [e], R. Carlier [f], G. Coiffier [g], J.P. Cottier [h], A. Dinh [i], I. Maldonado [j], F. Paycha [k], J.M. Ziza [l], P. Bemer [m], L. Bernard [a], the Review group Géraldine Bart [aa], Pascal Coquerelle [ab], Stéphane Corvec [ac], Anne Cotten [ad], Marion Couderc [ae], E. Denes [af], Arnaud Dupeyron [ag], Sophie Godot [ah], Marion Grare [ai], A. Homs [aj], Brigitte Lam [ak], Jean Philippe Lavigne [al], V. Lemoing [am], Edouard Pertuiset [an], P. Ribinik [ao], France Roblot [ap], Eric Senneville [aq], Jean Philippe Talarmin [ar], I. Tavares Figueiredo [as], Marie Titeca [at], Valérie Zeller [au]

- Drapeaux rouges pour la suspicion diagnostique clinique
- Diagnostic :
  - IRM pan-rachidienne avec Gado avec plans orthogonaux (TEP si CI) + TDM (stabilité)
  - Hémoc ++ PBDV radioguidée (5 biopsies) si hémoc négatives (fenêtre 14 j)
- Evaluation stabilité rachidienne par un spécialiste du rachis (NC ou ortho) : score SINS
- Lever précoce à privilégier, DDS et corset non impératif (selon douleur et stabilité)
- Traitement uniquement sur documentation
  - Oral d'emblée si pas de bactériémie, 7j IV si SA et pas d'EI
  - 6 semaines
- Chir :
  - Débridement si IDV sur matériel < 1 mois, chgt matériel si > 1 mois
  - si signe neuro déficitaire dans les meilleurs délais +/- osteosynthèse
  - Corticothérapie envisagée si chir impossible et sepsis controlé après avis spécialisé



https://www.infectiologie.com/UserFiles/File/spilf/recos/spilf-groupe-recos-idv-2023.pptx

RECOMMANDATIONS : ARTHRITES SEPTIQUES

ELSEVIER

Available online at
ScienceDirect
www.sciencedirect.com

Elsevier Masson France
EM|consulte
www.em-consulte.com/en

Guidelines

SPILF update on bacterial arthritis in adults and children

J.P. Stahl [a,*], E. Canouï [b], P. Pavese [c], A. Bleibtreu [d], V. Dubée [e], T. Ferry [f], Y. Gillet [g], A. Lemaignen [h], M. Lorrot [i], J. Lourtet-Hascoët [j], R. Manaquin [k], V. Meyssonnier [l,m], T.-T. Pham [f,n], E. Varon [o], P. Lesprit [c], R. Gauzit [b], the reviewers [1]

Journal of the Pediatric Infectious Diseases Society

GUIDELINES

Clinical Practice Guideline by the Pediatric Infectious Diseases Society (PIDS) and the Infectious Diseases Society of America (IDSA): 2023 Guideline on Diagnosis and Management of Acute Bacterial Arthritis in Pediatrics

Charles R. Woods,[1] John S. Bradley,[2] Archana Chatterjee,[3] Matthew P. Kronman,[4] Sandra R. Arnold,[5] Joan Robinson,[6] Lawson A. Copley,[7] Antonio C. Arrieta,[8] Sandra L. Fowler,[9] Christopher Harrison,[10] Stephen C. Eppes,[11] C. Buddy Creech,[12] Laura P. Stadler,[13] Samir S. Shah,[14] Lynnette J. Mazur,[15] Maria A. Carrillo-Marquez,[5] Coburn H. Allen,[16] and Valéry Lavergne[17,18]

- Complément de la reco HAS/SFR/SPILF de 2020
- Précisions sur les modalités diagnostiques et le choix d'antibiothérapie
- Diagnostic
  - Hémocultures systématiques
  - 3 tubes sur pction articulaire dont 1 sec et 1 EDTA. Flacon hémoc si AB
  - Recherche systématique EI si CG+ (même hemoc neg)
- Traitement
  - Probabiliste : Cefazoline ou peni M IV +/- élargi en fonction orientation
  - Durées :
    - Gono : 7 j
    - Strepto : 4 sem
    - SA ou entérobactéries : 6 sem
    - Petites articulations après lavage : 14 jours

When should antibiotherapy begin?
- direct examination with positive results and/or synovial fluid culture and/or positive hemoculture (after having ruled out contamination)
→ antibiotic therapy adapted to Gram stain and/or bacterial culture
- sepsis with widespread repercussions, or septic shock
→ antibiotic therapy adapted to Gram stain and/or bacterial culture if infection is documented
→ cefazolin* or penicillin M (cloxacillin, oxacillin), + amikacin (24–48 h)
- purulent synovial fluid (with negative or unavailable direct examination results) + anamnesis compatible with the septic arthritis diagnosis + expert advice
→ cefazolin* or pencillin M (cloxacillin, oxacillin), +/- broadened spectrum if anamnesis suggests a specific bacterium.

*In case of beta-lactam allergy, daptomycin or, by default, a glycopeptide (vancomycin or teicoplanin) is used.

RECOMMANDATIONS : ANTIBIOPROPHYLAXIE

Antibioprophylaxie en chirurgie et médecine interventionnelle

Antibiotic prophylaxis in surgery and interventional medicine

2024

SFAR

SPILF

RECOMMANDATIONS FORMALISEES D'EXPERTS

De la **SOCIETE FRANÇAISE D'ANESTHESIE ET REANIMATION (SFAR)**

et de la **SOCIETE DE PATHOLOGIE INFECTIEUSE DE LANGUE FRANÇAISE (SPILF)**

- Points forts
  - Antibioprophylaxie ≠ BL = plus à risque de complication → enquête allergie ++
  - Readministration ½ dose si prolongation chir en fonction ½ vie antibio (sauf genta/teico)
  - Pas de prolongation au delà de la chirurgie
  - Pas de doublement de dose pour les BL chez patient.e obèse (sauf IMC >50)
    Adaptation conseillée pour autres classes
  - Adaptation ABP si EBLSE pour chir colo-rectale
  - Orthopédie : Cefazoline pour chirurgies avec mise en place de matériel

The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

C. Corey Hardin, M.D., Ph.D., *Editor*

Periprosthetic Joint Infection

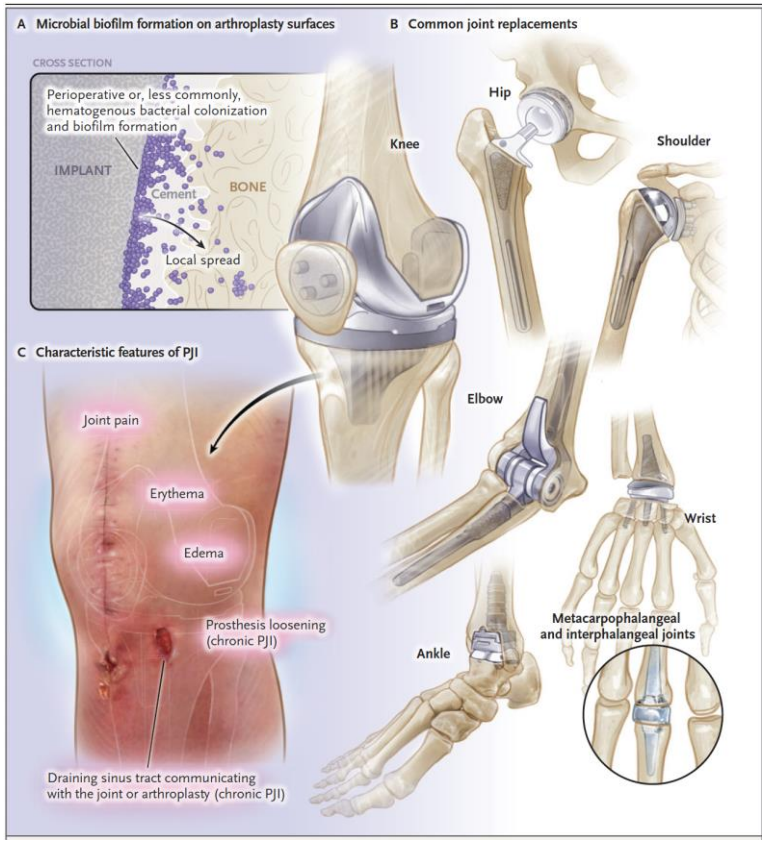
Robin Patel, M.D.

Table 3. Criteria for Diagnosis of Hip or Knee PJI.*

EBJIS "Confirmatory" Single Criteria[52]	2018 Parvizi et al. "Major" Single Criteria[51]
Two positive cultures (includes synovial fluid, tissue, and sonicate-fluid cultures) for the same microorganism	Two positive cultures (includes synovial fluid, tissue, and sonicate-fluid cultures) for the same microorganism
Sinus tract with communication to joint or prosthesis	Sinus tract with communication to joint or prosthesis
Synovial fluid leukocyte count, >3000/ml†	
Synovial fluid neutrophils, >80%†	
Synovial fluid alpha-defensin positive‡	
Sonicate-fluid culture, >50 CFU/ml for any organism (>200 CFU/ml if centrifuged)	
Histopathological assessment (high-power field, 400× magnification) showing ≥5 neutrophils in ≥5 high-power fields (or visible microorganisms)§	

Table 2. Risk Factors for PJI.

Potentially modifiable presurgical risk factors
Anemia
Injection-drug use
Malnutrition
Obesity
Receipt of intraarticular injection in prior 3 mo
Tobacco use
Nonmodifiable presurgical risk factors
Cardiovascular disease (arrhythmia, coronary artery disease, pulmonary hypertension, congestive heart failure, or peripheral vascular disease)
Diabetes (especially with poor glycemic control)*
Immunocompromised status (owing to cancer or receipt of a transplant)
Inflammatory arthritis
Kidney or liver disease (hepatitis or cirrhosis)
Male sex
Medicaid as primary payer
Mental health disorder (depression or alcohol use)
Relative with PJI
Patellar resurfacing and post-traumatic arthritis (knees)
Prior native joint infection
Prior PJI of same or different joint
Prior revision arthroplasty
Younger age
Operative risk factors
Allogeneic blood transfusion
Prolonged operative time
Simultaneous bilateral arthroplasty
Postoperative risk factors
Discharge to rehabilitation or convalescent care
Prolonged hospitalization
S. aureus bacteremia
Wound-healing complications (including superficial skin infection)



REVUES

Contents lists available at ScienceDirect

Clinical Microbiology and Infection

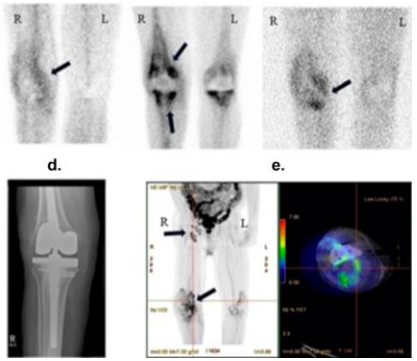
journal homepage: www.clinicalmicrobiologyandinfection.com

Narrative review

Imaging in osteoarticular infection in adults

Trisha N. Peel [1,*], Martin Cherk [2,3], Kenneth Yap [2,3]

	Benefits	Limitations	Considerations	Imaging modality of choice
Plain radiography (conventional radiography/X-ray)	• Readily available modality • Lower cost • Allows assessment of bony anatomy, including bony healing in setting of fracture • Assessment of device placement and alignment • Lower radiation exposure, compared with CT scan and gallium scans: plain x-ray extremities/spine <0.001–1.4 mSv (up to 6 mo background radiation) [2,3]	• May be falsely negative in early stages of infection • Low sensitivity and specificity [1] • Delay from infection onset until radiological evidence of infection, limiting utility in early infections	If typical changes of osteomyelitis present on plain radiography, further imaging investigations may not be needed in appropriate context. For example, in a patient with a diabetic foot infection, the diagnosis of osteomyelitis may be made based on clinical findings, such as probe-to-bone, raised inflammatory markers, and findings on plain radiography [15]	
CT	• More sensitive for assessing bony abnormalities, including visualization of sequestrum	• Decreased sensitivity for detecting soft tissue abnormalities [1] • Artefact from ferromagnetic metalware (e.g. chromium-cobalt implants) limits utility in device-associated infections [4] • Higher radiation exposure [12]. CT extremities/spine 0.1–8.8 mSv (up to 3 y background radiation) [2,3]	• Requires administration of contrast to improve visualisation of soft tissue structures • Reduced artefact issues with newer, non-ferromagnetic implants (e.g. titanium or ceramic devices) [4,5] • New techniques for artefact reduction available [5]	• Image-guided biopsy for vertebral osteomyelitis [30,31]
MRI	• Visualization of soft tissues, including abscesses and sinus tracts [1] • High sensitivity • High negative predictive value • Early detection of bone marrow oedema within days of infection • More timely diagnosis compared with some nuclear medicine approaches • No radiation exposure	• Bone marrow signal abnormalities seen with other conditions such as fracture • Artefact from ferromagnetic metalware may limit utility [6,12,23,24] • Contraindicated in patients with certain MRI incompatible pacemakers, intracranial devices, and other implants • Higher costs, availability may be limited	• A negative MRI is supportive of the absence of chronic osteomyelitis • Administration of gadolinium contrast may improve accuracy of detection and delineation of necrotic tissues, sinus tracts, and abscesses [19] • MRI may be falsely negative in early stages of vertebral osteomyelitis [36] • Reduced artefact issues with newer, non-ferromagnetic implants (e.g. titanium, ceramic) [6,23,24] • New techniques for artefact reduction available [24] • Avoidance of gadolinium in patients with end-stage kidney diseases	• Modality of choice for investigating vertebral osteomyelitis



	Benefits	Limitations	Considerations	Imaging modality of choice
Three-phase bone scintigraphy	• Changes appear within several days of infection • High negative predictive value, therefore, normal scan highly supportive of absence of osteomyelitis • Lower cost • Widely available • Lower radiation exposure ~6 mSv [3]	• Low specificity • Less sensitive in axial skeleton (some improvement with SPECT/CT) • Moderate radiation exposure • The test takes several hours to perform [8]	• False positives occur with recent fracture, inflammation, recent surgery, and malignancy • Commonly combined with CT (SPECT/CT) for better localization and differentiation between bone and soft tissue infections [12,13]	• Nonvertebral osteomyelitis considered unlikely if scan negative • Prosthetic joint infection considered unlikely in low probability context if scan negative [42]
Gallium scans	• May be used in setting of equivocal bone or white blood cell scintigraphy	• Requires imaging at multiple time-points, delaying time to diagnosis • Relatively high radiation exposure of ~18.5 mSv per scan compared with bone scintigraphy [3,7] • Gallium scans can be equivocal in up to 30% of scans, limiting its utility as a sole investigation [1]	• Should be interpreted in conjunction with bone scintigraphy where possible • Can be combined with CT (SPECT/CT) for better localisation and differentiation between bone and soft tissue infections [12,13]	• Assessing treatment response nonvertebral and vertebral osteomyelitis
White blood cell scintigraphy	• Accuracy may be less influenced by recent surgery • Frequently combined with Technetium-99m sulphur colloid marrow imaging to improve sensitivity and specificity, allowing discrimination between normal bone marrow accumulation of white blood cells compared with accumulation in infection [51] • Lower radiation exposure ~6.7 –8.1 mSv [3]	• Laborious process [1,25,27]. • Requires handling of blood products [1,25,37]. • Requires imaging at multiple time-points, delaying time to diagnosis • Less sensitive in axial skeleton • Less widely available • Expensive	• The test is influenced by the peripheral white blood cell count with decreased test performance noted with white blood cell counts less than 2000 cells/μL [1,8] • Not recommended for diagnosis of vertebral osteomyelitis [29,37] • Commonly combined with CT (SPECT/CT) for better localisation and differentiation between bone and soft tissue infections [12,13]	May be considered in: nonvertebral osteomyelitis including fracture-related infections and in prosthetic joint infections [42]

REVUES

Contents lists available at ScienceDirect

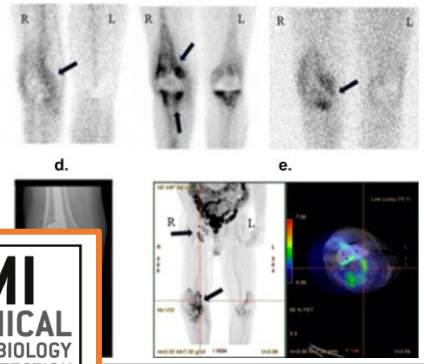
Clinical Microbiology and Infection

journal homepage: www.clinicalmicrobiologyandinfection.com

Narrative review

Imaging in os

Trisha N. Peel [1,*]



	Benefits				Considerations	Imaging modality of choice
Plain radiography (conventional radiography/X-ray)	• Readily availabl • Lower cost • Allows assessm anatomy, includi setting of fracture • Assessment of c and alignment • Lower radiation compared with C scans: plain x-ray <0.001–1.4 mSv background radia				• False positives occur with recent fracture, inflammation, recent surgery, and malignancy • Commonly combined with CT (SPECT/CT) for better localization and differentiation between bone and soft tissue infections [12,13]	• Nonvertebral osteomyelitis considered unlikely if scan negative • Prosthetic joint infection considered unlikely in low probability context if scan negative [42]
CT	• More sensitive abnormalities, inc visualization of s				• Should be interpreted in conjunction with bone scintigraphy where possible • Can be combined with CT (SPECT/CT) for better localisation and differentiation between bone and soft tissue infections [12,13]	• Assessing treatment response nonvertebral and vertebral osteomyelitis
MRI	• Visualization of including abscesses and sinus tracts [1] • High sensitivity • High negative predictive value • Early detection of bone marrow oedema within days of infection • More timely diagnosis compared with some nuclear medicine approaches • No radiation exposure	seen with other conditions such as fracture • Artefact from ferromagnetic metalware may limit utility [6,12,23,24] • Contraindicated in patients with certain MRI incompatible pacemakers, intracranial devices, and other implants • Higher costs, availability may be limited	absence of chronic osteomyelitis • Administration of gadolinium contrast may improve accuracy of detection and delineation of necrotic tissues, sinus tracts, and abscesses [19] • MRI may be falsely negative in early stages of vertebral osteomyelitis [36] • Reduced artefact issues with newer, non-ferromagnetic implants (e.g. titanium, ceramic) [6,23,24] • New techniques for artefact reduction available [24] • Avoidance of gadolinium in patients with end-stage kidney diseases	investigating vertebral osteomyelitis	• Frequently combined with Technetium-99m sulphur colloid marrow imaging to improve sensitivity and specificity, allowing discrimination between normal bone marrow accumulation of white blood cells compared with accumulation in infection [51] • Lower radiation exposure ~6.7 –8.1 mSv [3]	• The test is influenced by the peripheral white blood cell count with decreased test performance noted with white blood cell counts less than 2000 cells/μL [1,8] • Not recommended for diagnosis of vertebral osteomyelitis [29,37] • Commonly combined with CT (SPECT/CT) for better localisation and differentiation between bone and soft tissue infections [12,13]	May be considered in: nonvertebral osteomyelitis including fracture-related infections and in prosthetic joint infections [42]

Contents lists available at ScienceDirect

Clinical Microbiology and Infection

journal homepage: www.clinicalmicrobiologyandinfection.com

Review

Early switch from intravenous to oral antibiotic treatment in bone and joint infections

Parham Sendi [1,*], Jaime Lora-Tamayo [2,3], Nicolas W. Cortes-Penfield [4], Ilker Uçkay [5]

[1] *Institute for Infectious Diseases, University of Bern, Bern, Switzerland*
[2] *Department of Internal Medicine, Hospital Universitario 12 de Octubre, Instituto de Investigación Biomédica 'i+12' Hospital 12 de Octubre, Madrid, Spain*
[3] *CIBER Enfermedades Infecciosas, Instituto de Salud Carlos III, Madrid, Spain*
[4] *Division of Infectious Diseases, University of Nebraska Medical Center, Omaha, NE, USA*
[5] *Infectiology, Balgrist University Hospital, University of Zurich, Zurich, Switzerland*

ARTICLES ORIGINAUX : DALBAVANCINE

Contents lists available at ScienceDirect

International Journal of Antimicrobial Agents

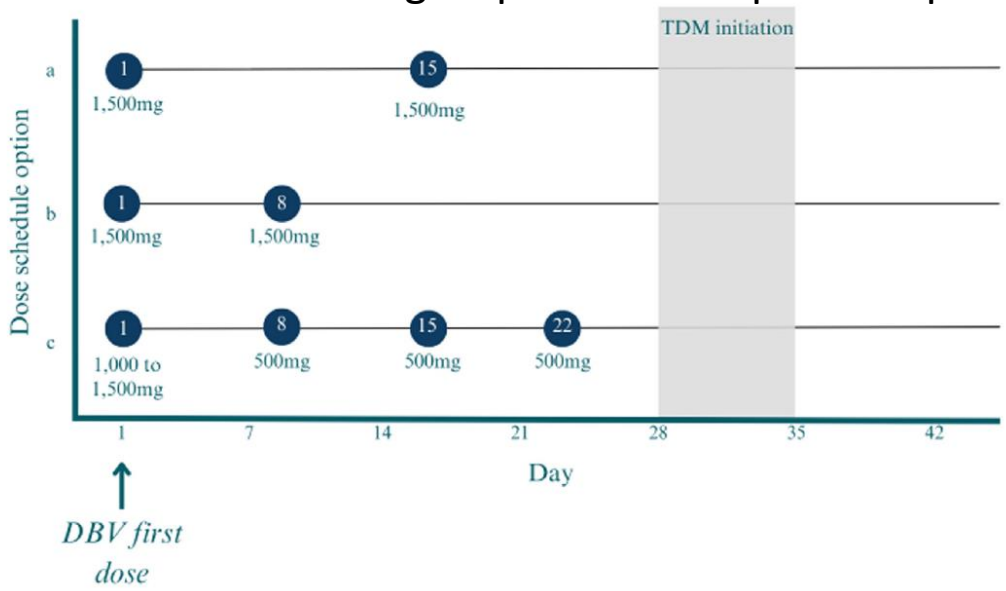
journal homepage: www.elsevier.com/locate/ijantimicag

Expert Opinion on Dose Regimen and Therapeutic Drug Monitoring for Long-Term Use of Dalbavancin: Expert Review Panel

Eric Senneville[a,*], Guillermo Cuervo[b], Matthieu Gregoire[c,d], Carmen Hidalgo-Tenorio[e,f], François Jehl[g], Jose M. Miro[b,h], Andrew Seaton[i], Bo Söderquist[j,k], Alex Soriano[l,h], Florian Thalhammer[m], Federico Pea[n,o]

→ 6 semaines : 3000 mg sur 4 semaines

> 6 semaines : dosage à partir de J28 pour adaptation



J Antimicrob Chemother 2023; **78**: 669–677
https://doi.org/10.1093/jac/dkac434 Advance Access publication 6 January 2023

Journal of Antimicrobial Chemotherapy

Emerging resistance in *Staphylococcus epidermidis* during dalbavancin exposure: a case report and *in vitro* analysis of isolates from prosthetic joint infections

Jasmina Al Janabi[1]†, Staffan Tevell[1,2]†, Raphael Niklaus Sieber[3], Marc Stegger[1,3] and Bo Söderquist[1,4]*

- Cas clinique d'IPOA à *S. epidermidis* avec émergence de R conduisant à un echec
- Mutation système de régulation WalKR (idem GISA)
- Confirmation *in vitro* sur souches cliniques : émergence en concentrations sub-inhibitrices
- Schémas J0-J7 ?

ARTICLES ORIGINAUX : TOUJOURS DE LA RIFAMPICINE ?

Contents lists available at ScienceDirect

International Journal of Antimicrobial Agents

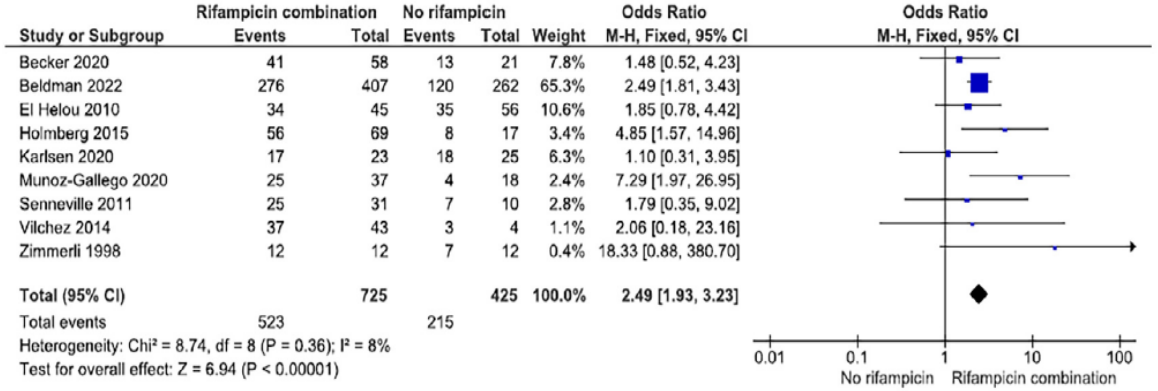
journal homepage: www.elsevier.com/locate/ijantimicag

Review

Clinical outcomes of rifampicin combination therapy in implant-associated infections due to staphylococci and streptococci: A systematic review and meta-analysis

Erlangga Yusuf[a], Wichor Bramer[b], Adam A. Anas[a,c,*]

- Méta-analyse de 14 études (obs++)
- SA et DAIR : OR 2,5 [1.93–3.23]



Study or Subgroup	Rifampicin combination Events	Total	No rifampicin Events	Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Becker 2020	41	58	13	21	7.8%	1.48 [0.52, 4.23]
Beldman 2022	276	407	120	262	65.3%	2.49 [1.81, 3.43]
El Helou 2010	34	45	35	56	10.6%	1.85 [0.78, 4.42]
Holmberg 2015	56	69	8	17	3.4%	4.85 [1.57, 14.96]
Karlsen 2020	17	23	18	25	6.3%	1.10 [0.31, 3.95]
Munoz-Gallego 2020	25	37	4	18	2.4%	7.29 [1.97, 26.95]
Senneville 2011	25	31	7	10	2.8%	1.79 [0.35, 9.02]
Vilchez 2014	37	43	3	4	1.1%	2.06 [0.18, 23.16]
Zimmerli 1998	12	12	7	12	0.4%	18.33 [0.88, 380.70]
Total (95% CI)		725		425	100.0%	2.49 [1.93, 3.23]
Total events	523		215			

Heterogeneity: Chi² = 8.74, df = 8 (P = 0.36); I² = 8%
Test for overall effect: Z = 6.94 (P < 0.00001)

Odds Ratio M-H, Fixed, 95% CI
0.01 0.1 1 10 100
No rifampicin Rifampicin combination

- Autres procédures :
  - 2 temps : faible niveau de preuve, intérêt limité
  - Strepto : faible niveau de preuve, intérêt limité

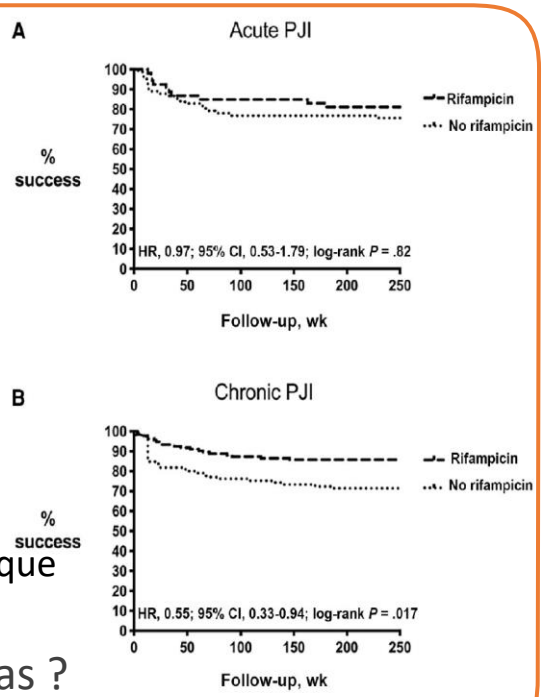
Open Forum Infectious Diseases

MAJOR ARTICLE

Should We Use Rifampicin in Periprosthetic Joint Infections Caused by Staphylococci When the Implant Has Been Exchanged? A Multicenter Observational Cohort Study

Tobias Siegfried Kramer,[1,2,3] Alex Soriano,[4] Sarah Tedeschi,[5,6] Antonia F. Chen,[7] Pierre Tattevin,[8] Eric Senneville,[9] Joan Gomez-Junyent,[10] Victoria Birlutiu,[11] Sabine Petersdorf,[12] Vicens Diaz de Brito,[13] Ignacio Sancho Gonzalez,[14] Katherine A. Belden,[15] and Marjan Wouthuyzen-Bakker[16]; on behalf of the ESCMID Study Group on Implant Associated Infections (ESGIAI)

- Etude obs multiC
  - IPOA à Staph
  - Chgt proth
- 375 patients
  - 124 C1T / 251 C2T
  - Chro 240 / aigu 135
  - 187 Rifam /188 non rifam
- Échecs
  - 42 rifam vs 59 non rifam (p .051)
  - Significatif si C2T et chronique
  - SA > SCN
- IPOA aigue ? Autres schémas ?



ARTICLES ORIGINAUX : TOUJOURS DE LA RIFAMPICINE ?

Contents lists available at ScienceDirect

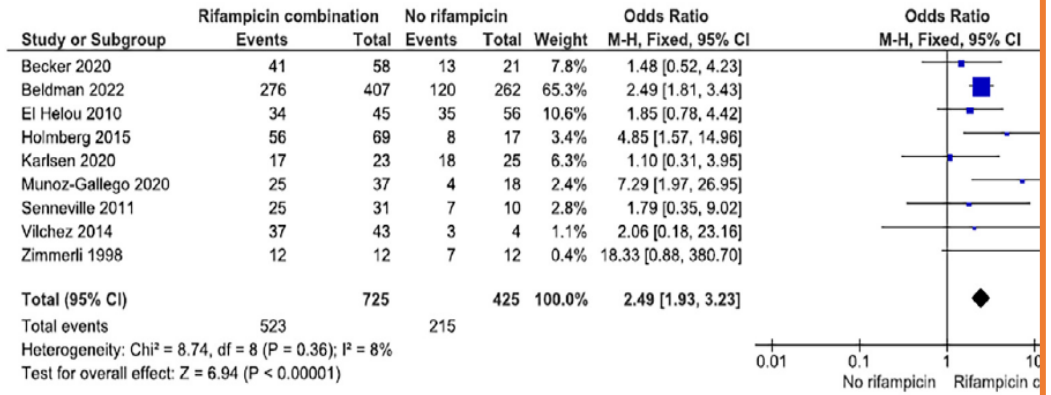
International Journal of Antimicrobial Agents

journal homepage: www.elsevier.com/locate/ijantimicag

Pharmacokinetic interaction between rifampicin and clindamycin in staphylococcal osteoarticular infections

T. Goulenok[a,*], J. Seurat[b,#], A. de La Selle[c,#], V. Jullien[d], V. Leflon-Guibout[e], N. Grall[b,f], F.X. Lescure[b,g], R. Lepeule[h,i], J. Bertrand[b], B. Fantin[b], C. Burdet[b,j,†], A. Lefort[c,b,†]

- SA et DAIR : OR 2,5 [1.93–3.23]



Study or Subgroup	Rifampicin combination Events	Total	No rifampicin Events	Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Becker 2020	41	58	13	21	7.8%	1.48 [0.52, 4.23]
Beldman 2022	276	407	120	262	65.3%	2.49 [1.81, 3.43]
El Helou 2010	34	45	35	56	10.6%	1.85 [0.78, 4.42]
Holmberg 2015	56	69	8	17	3.4%	4.85 [1.57, 14.96]
Karlsen 2020	17	23	18	25	6.3%	1.10 [0.31, 3.95]
Munoz-Gallego 2020	25	37	4	18	2.4%	7.29 [1.97, 26.95]
Senneville 2011	25	31	7	10	2.8%	1.79 [0.35, 9.02]
Vilchez 2014	37	43	3	4	1.1%	2.06 [0.18, 23.16]
Zimmerli 1998	12	12	7	12	0.4%	18.33 [0.88, 380.70]
Total (95% CI)		725		425	100.0%	2.49 [1.93, 3.23]
Total events	523		215			

Heterogeneity: Chi² = 8.74, df = 8 (P = 0.36); I² = 8%
Test for overall effect: Z = 6.94 (P < 0.00001)

Odds Ratio M-H, Fixed, 95% CI
0.01 0.1 1 10
No rifampicin Rifampicin

- Autres procédures :
  - 2 temps : faible niveau de preuve, intérêt limité
  - Strepto : faible niveau de preuve, intérêt limité

Hashimoto et al. Journal of Pharmaceutical Health Care and Sciences (2018) 4:27
https://doi.org/10.1186/s40780-018-0123-1

Journal of Pharmaceutical Health Care and Sciences

RESEARCH ARTICLE Open Access

Effect of coadministration of rifampicin on the pharmacokinetics of linezolid: clinical and animal studies

Satsuki Hashimoto[1,2*], Kyoko Honda[1], Kohei Fujita[1], Yuka Miyachi[1], Kazuya Isoda[1], Ko Misaka[1], Yukio Suga[3], Satoshi Kato[4], Hiroyuki Tsuchiya[4], Yukio Kato[3], Masaki Okajima[5], Takumi Taniguchi[5], Tsutomu Shimada[1,2] and Yoshimichi Sai[1,2]

Articles originaux : Monothérapie et IOA

Lombès *et al. BMC Infectious Diseases* (2024) 24:62
https://doi.org/10.1186/s12879-024-08977-y

RESEARCH BMC Open Access

Efficacy of single antibiotic therapy versus antibiotic combination in implant-free staphylococcal post-surgical spinal infections: a retrospective observational study

Amélie Lombès[1*], Marie-Paule Fernandez-Gerlinger[1], Marc Khalifé[2,5], Najiby Kassis-Chikhani[3], Amira Jomli[4], Jean-Luc Mainardi[1,4,5], David Lebeaux[1,5,6] and Marie Dubert[1,5]

- Etude observationnelle monocentrique
- 20 patients inclus avec IDV post-opératoire sans matériel à staphylocoque
- Traitement initial IV par cefazo (12) > amox (3) > peniM/vanco/dapto
- Relais
  - Combinaison (9): clinda/levoflo (4) > levoflo/rifam (3) > levo/amox ou doxy
  - Monothérapie (11) : clinda (5) > levoflo (3) > amox (2) > line (1)
- Pas de récidive, 4 reprises chir dont 3 groupe mono (avant relais …)
  1 décès tardif lié aux comorbidités
- Faisabilité monothérapie dans les IDV à staph après chir, y compris par FQ seule

ARTICLES ORIGINAUX : OSTEOMYELITES SUR ULCÈRES

THERAPEUTIC ADVANCES in
Infectious Disease

Original Research

Retrospective analysis of the management of pelvic decubitus ulcers and their outcomes

Ther Adv Infect Dis
2023, Vol. 10: 1–9
DOI: 10.1177/
20499361231196664

Laura Damioli, Zachary Shepard, Melissa P. Wilson and Kristine M. Erlandson

- Ostéomyélite sur escarre
  - Meilleure option = débridement chir + lambeau de couverture
- Inclusion autres cas : 89 patients
  - 40% : debridement + AB > 6 sem
  - 60% : débridement + AB < 6 sem ou AB seule
  - 63% de réadmission à 1 an dont 70% pour complication OM
  - 17% de mortalité
  - Aucune différence selon les schémas
- Pas de bénéfice AB prolongée

Open Forum Infectious Diseases

MAJOR ARTICLE

Short Antibiotic Treatment Duration for Osteomyelitis Complicating Pressure Ulcers: A Quasi-experimental Study

Aurélien Dinh,[1] Emma D'anglejan,[1] Helene Leliepvre,[2] Frédérique Bouchand,[3] Damien Marmouset,[4] Nathalie Dournon,[1] Hélène Mascitti,[1] François Genet,[2] Jean-Louis Herrmann,[5] Haude Chaussard,[4] Clara Duran,[1] and Latifa Noussair[5]

- Etude avant/après OM sur escarre traitée par lambeau de couverture
  - Avant 2020 : 10 jours post-op
  - Après : 5-7 jours post-op
- Inclusion 415 patients
- Outcome favorable à 1 an
  - 117/179 pour 10 j (63%)
  - 169/287 pour 5-7j (72%)
- Pas de bénéfice AB prolongée

THÉRAPEUTIQUES INNOVANTES : PHAGOTHÉRAPIE

Clinical Infectious Diseases

SUPPLEMENT ARTICLE

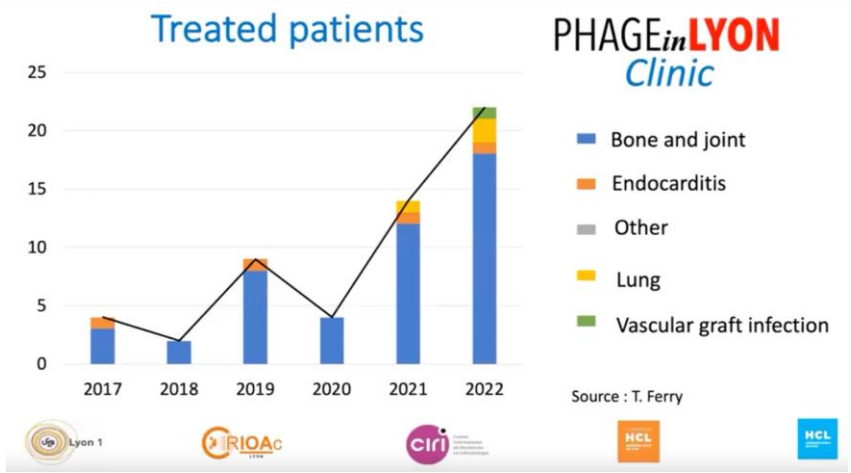
IDSA Infectious Diseases Society of America · hivma hiv medicine association · OXFORD

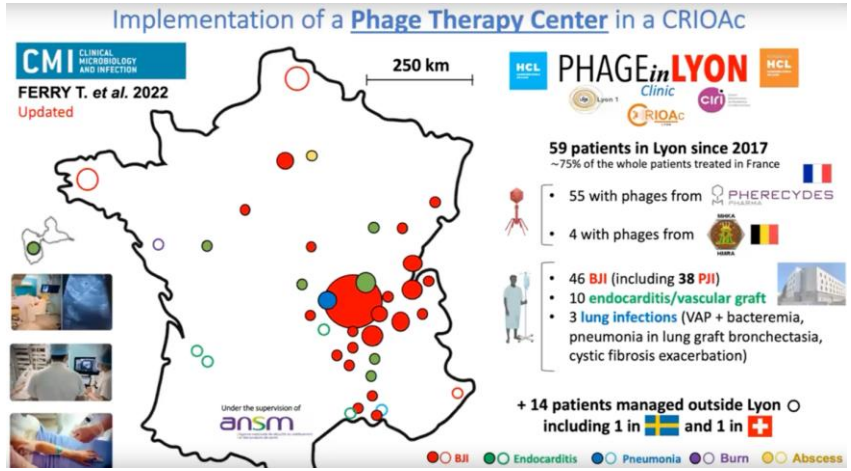
Phage Therapy as a Novel Therapeutic for the Treatment of Bone and Joint Infections

Gina A. Suh,[1] Tristan Ferry,[2] and Matthew P. Abdel[3]

Clinical experience with bacteriophage therapy in BJIs/PJIs: the Lyon perspective

tristan.ferry@univ-lyon1.fr
@FerryLyon





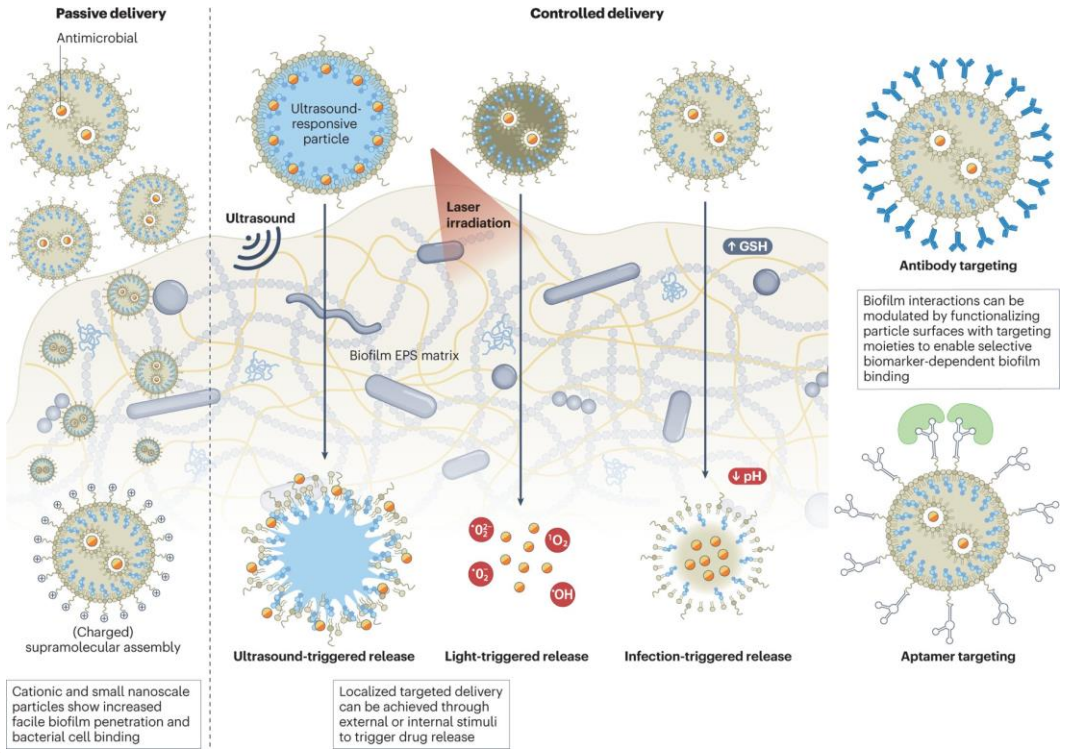
THÉRAPEUTIQUES INNOVANTES : LE FUTUR ?

nature reviews microbiology

Drug delivery strategies for antibiofilm therapy

Victor Choi, Jennifer L. Rohn, Paul Stoodley, Dario Carugo & Eleanor Stride

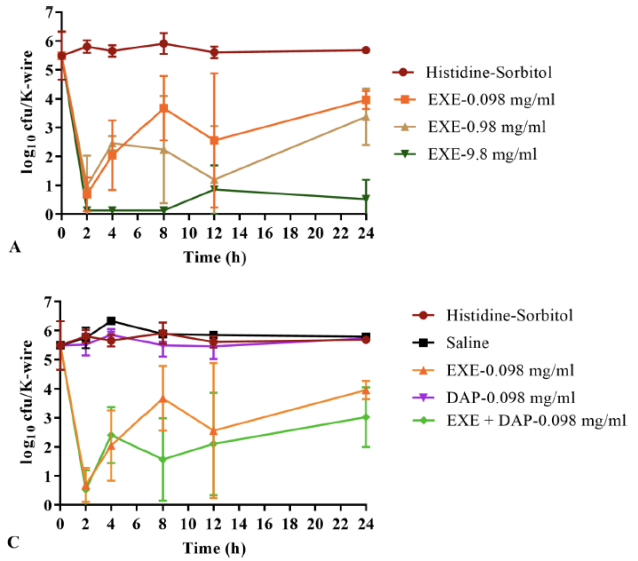
Nature Reviews Microbiology **21**, 555–572 (2023) | Cite this article



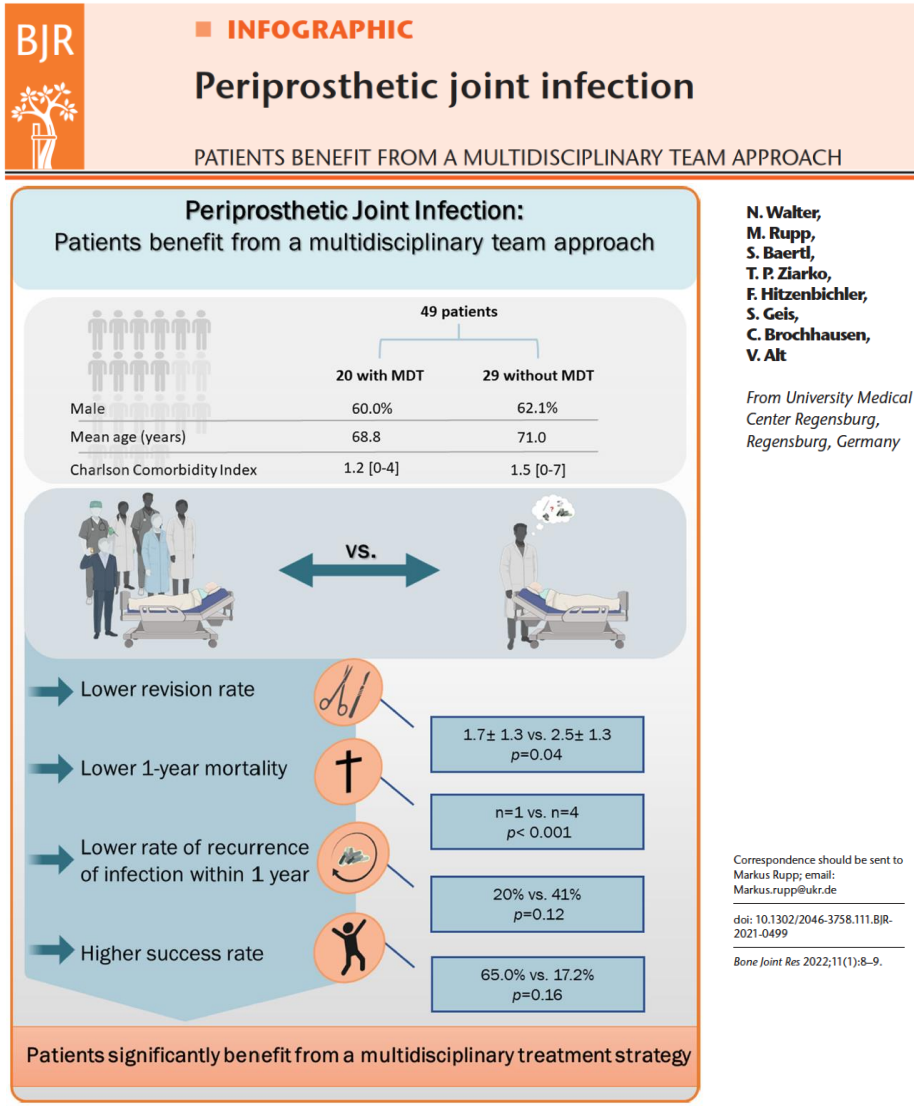
RESEARCH NOTE Open Access

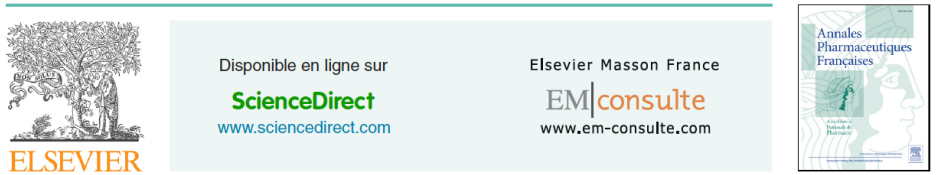
In vitro activity of exebacase against methicillin-resistant *Staphylococcus aureus* biofilms on orthopedic Kirschner wires

Melissa J. Karau[1], Jay Mandrekar[2], Dario Lehoux[3], Raymond Schuch[3], Cara Cassino[4] and Robin Patel[1,5*]



POUR CONCLURE





ORIGINAL ARTICLE

Impact of clinical pharmacist interventions in a bone and joint infection orthoseptic surgery unit

Impact des interventions pharmaceutiques dans une unité de chirurgie orthopédique spécialisée dans les infections ostéoarticulaires

Julie Coiffard[a,*], Alexandra Aubry[b], Alexandre Bleibtreu[c], Eric Fourniols[d], Helga Junot[a]

Etude PHARMADIAB

PHARMacist-led Antibiotics Drug Interactions and Advices in BJI treatment

AE ROYERE[1], V. TULOUP [2],LR LE NAIL [3], MF LARTIGUE [4], A. LEMAIGNEN [5], M. LACASSE[6]

CRIOGO

CHRU Tours
CRIOAC TOURS

Merci pour votre attention