Actualités Réso-Infectio-PACA-Est

Pierre-Marie Roger

46ème Réunion Thématique du Réso-Infectio-PACA-Est

Château St Martin, Vendredi 25 mai 2018

Vie du Réso: 11 ans depuis son initiation, 7 ans depuis son institution

- **> 150 adhérents; > 40 établissements**
- **réunions thématiques, journal, protocoles partagés, astreinte téléphonique…**
- **une « certaine » vivacité : *cf* travaux**
- **aide logistique privée**
- **résistance aux GHT ?**
- **penser à la relève**

26 Communications du RésO en 2016-2018

- **Sensibilisation au Bon Usage des carbapénèmes: audit régional des prescriptions dans sept établissements de santé**. VIARD D, BERTRAND B, AGULLO M, LOMBARDO AC, BOUSSETA J, FAFI F, LABAT C, FALCONI I, MONDAIN V, DEGAND N, RISSO K, FOSSE T, ROGER PM, RUIMY R, LIEUTIER-COLAS F et le RésO-InfectiO-PACA-Est. *XVIème Congrès* ***SFPC*** *(n°142), Montpellier, février 2016*
- **Appropriate use of carbapenems: a regional audit in seven hospitals**. VIARD D, LIEUTIER-COLAS F, BERTRAND B, AGULLO M, LOMBARDO AC, BOUSSETTA J, LABAT C, FALCONI I, RISSO K, ROGER PM, RUIMY R, and the RésO-InfectiO-PACA-Est. *26th European Congress of Clinical Microbiology and Infectious Diseases* ***(ECCMID)*** *(P-1298), Amsterdam, avril 2016*
- **New software to help optimize regional antimicrobial stewardship policy ? Results from a two year- survey of antibiotic consumption and antimicrobial resistance in five hospitals in south-esatern France**. WAREMBOURG M, LOMBARDO AC, BLANC V, BERTRAND B, LEOTARD S, LABAT C, AGULLO M, MONDAIN V, BOUSSAT S, ROGER PM, RUIMY R, LIEUTIER-COLAS F, and the Regional Network ResO-InfectiO-PACA-Est. *26th European Congress of Clinical Microbiology and Infectious Diseases* ***(ECCMID)*** *(EV-0707), Amsterdam, avril 2016*
- **Antibiotherapy of community-acquired urinary tract infection due to multi-susceptible *Escherichia coli*: also a challenge for infectious diseases referres ?** AMRANE H, ROGER PM, LOMBARDO AC, DENIS E, COMTE B, HOFFMANN P, JOUBERT S, BLANC V, and the ResO-InfectiO-PACA-Est Network. *26th European Congress of Clinical Microbiology and Infectious Diseases* ***(ECCMID)*** *(EV-0696),* ***Amsterdam, avril 2016***
- **Severe community-acquired penumonia in the elderly: impact of empirical antibiotic therapy without respiratory fluoroquinolones nor third generation cephalosporins.** AILLET C, COURJON J, DEMONCHY E, RISSO K, CUA E, ROGER PM**.** *26th European Congress of Clinical Microbiology and Infectious Diseases* ***(ECCMID)*** *(O-402),* ***Amsterdam, avril 2016***
- **Audit de ralisation des ECBU en SSR**. ETIENNE P, LEBRUN C, ESCOFFIER B, LEFLOCH P, BARDAGI L. *XXVIIème Congrès National de la Société Française d'Hygiène Hospitalière* ***(SF2H)****, Nantes, juin 2016*
- **Endocardites infectieuses : audit régional sur la qualité de prise en charge**. CHIRIO D, DEMONCHY E, MARTIS N, MOCERI P, MOTHES A, FOUCAULT C, DE LA CHAPELLE A, CHAILLOU S, PIETRI P, TIGER F, ROGER PM. *17èmes Journées Nationales d'Infectiologie* ***(JNI)*** *(ENDO-08), Lille, juin 2016*
- **Ratio ceftriaxone/cefotaxime : un indicateur de bon usage des antibiotiques ?** BERTRAND B, WARENBOURG M, LIEUTIER-COLAS F, LOMBARDO AC, AGULLO M, LABAT C, FARACO-BONNIER P, RAETZ S, ROGHI J, ROGER PM, pour le RésO-InfectiO-PACA-Est. *17èmes Journées Nationales d'Infectiologie* ***(JNI)*** *(BU-26), Lille, juin 2016*
- **Infectiologue Référent pour des Etablissements de Soins Privés: importance des infections associées aux soins**. ROGER PM, LEROUX E, ROGHI J, DELLA GUARDIA M, BOIVIN HJ, GIRARD D. *17èmes Journées Nationales d'Infectiologie* ***(JNI)*** *(BU-05), Lille, juin 2016*
- **Amélioration de la couverture vaccinale anti-pncumococcique d'une cohorte de patients vivants avec le VIH en Région PACA-Est.** ETIENNE C, MOTHES A, DIDES PY, VASSALLO M, ROGER PM, PUGLIESE P. *17èmes Journées Nationales d'Infectiologie* ***(JNI)*** *(VAC-06), Lille, juin 2016*
- **Bon usage antibiotiques et hygiène hosptialière : appropriation insuffisante des mesures (P108).** ROGER PM, MAGNANI J, CARRAT V et le RésO-InfectiO-PACA-Est**.** *36ème Réunion Interdisciplinaire de Chimiothérapie Anti-Infectieuse* ***(RICAI),*** *Paris, décembre 2016*
- **Audit des patients bactériémiques au SAU dans 3 hôpitaux de PACA-Est (P116).** AILLET C, KERKAOUI I, ETIENNE P, JAMES D, FRIBOURG A, PELLAT O, LEOTARD S, LAMECHE D, NERI D, ROGER PM et le RésO-InfectiO-PACA-Est**.** *36ème Réunion Interdisciplinaire de Chimiothérapie Anti-Infectieuse* ***(RICAI),*** *Paris, décembre 2016*

- **Audit régional de prise en charge des endocardites infectieuses (P320).** CHIRIO D, DEMONCHY E, MONDAIN V, GIBELIN P, MOTHES A, FOUCAULT C, LOPEZ S, ZARQANE N, VILLAIN P, DENIS E, VASSALLO M, MAULIN L, ROGER PM et le RésO-InfectiO-PACA-Est**.** *36ème Réunion Interdisciplinaire de Chimiothérapie Anti-Infectieuse* ***(RICAI),*** *Paris, décembre 2016*
- **Bacteraemia in the emergency department: audit of antibiotic therapy and reassessment.** AILLET C, BERKAOUI I, ETIENNE P, JAMMES D, FRIBOURG A, PELLAT O, LEOTARD S, LAMECHE D, NERI D, ROGER PM**.** *27th European Congress of Clinical Microbiology and Infectious Diseases* ***(ECCMID****), Vienne, avril 2017*
- **Bactériémies aux Urgences: antibiothérapie probabiliste, réévaluation et pronostic.** AILLET C, BERKAOUI I, LAMECHE D, JAMMES D, FRIBOURG A, PELLAT O, LEOTARD S, ETIENNE P, ROGER PM**.** *Congrès de la Société Française de Médecine d'Urgence* ***(SFMU),*** *Paris, mai 2017*
- **Bactériémies aux Urgences : antibiothérapie probabiliste, réévaluation et pronostic.** AILLET C, PANTALONI O, TOURNOUD S, FRIBOURG A, LEOTARD S, SINDT A, ETIENNE P, ROGER PM**.** *18èmes Journées Nationales d'Infectiologie* ***(JNI)*** *(ENDO-04),* ***Saint-Malo, juin 2017***
- **Prélèvements bactériologiques aux urgences: organiser leur utilisation !** ETIENNE P, NERI D, LAMECHE D, ROGER PM**.** *18èmes Journées Nationales d'Infectiologie* ***(JNI)*** *(BU-38),* ***Saint-Malo, juin 2017***
- **Evolution de la confirmité de l'antibiothérapie des infections urinaires communautaires à *Escherichia coli* multi-sensible en ville: place de l'antibiogramme ciblé ?** WEISS N, AMRANE H, FRANCOIS A, ROGER PM, DENIS E, LIGUORI S, COMTE B, VASSALLO M, HOFFMANN P, BLANC V and the RésO-InfectiO-PACA-Est. *18èmes Journées Nationales d'Infectiologie* ***(JNI)*** *(BU-37), Saint-Malo, juin 201*
- **Pyélonéphrites aiguës de l'enfant à Entérobactéries productrices de bêtalactamases à spectre étendu dans le Sud-Est de la France.** BOUSKINE A, KHALFI A, HAAS H, ROGER PM, BLANC V, le RésO-InfectiO- PACA-Est**.** *18èmes Journées Nationales d'Infectiologie* ***(JNI)*** *(PED-03).* ***Saint-Malo, juin 2017***
- **Bactériémies à entérocoque et bon usage des antibiotiques.** ROGER PM, DEROUDIHLE G, NORMAND G, FERRET J, MALLICK S, GIMEL P. *37ème Réunion Interdisciplinaire de Chimiothérapie Anti-Infectieuse* ***(RICAI****) (CO-028). Paris, décembre 2017*
- **Infections urinaires communautaires et adéquation de l'antibiothérapie: étude prospective d'impact des antibiogrammes ciblés**. MICHELANGELI C, GIRARD-LAMOULERE D, ASSI AF, DELLA GUARDIA M, BOIVIN HJ, ROGER *PM.* 37ème Réunion Interdisciplinaire de Chimiothérapie Anti-Infectieuse **(RICAI)** (CO-002)**.** Paris, décembre 2017
- **A multicenter audit of the antibiotic therapy for *Enterococcus bacteraemia***. MANUELLO R, SOUHAIL B, LE MARECHAL M, CHRETIEN R, ASSI F, LEVENT T, SCHOENIG A, ROGER PM. *28th European Congress of Clinical Microbiology and Infectious Diseases* ***(ECCMID),*** *Madrid, avril 2018*
- **Syndromic approach for meningo-encephalitis care: e.ME panel, BioMérieuxd in a general hospital**. SINDT A, BLANC V, DUBUIS-GOURDANGE P, DORIN J, RIFFAUD K, WEISS N, ROGER PM. *28th European Congress of Clinical Microbiology and Infectious Diseases* ***(ECCMID),*** *Madrid, avril 2018*
- **Approche syndromique pour le diagnostic de gastro-entérite: évaluation du panel PCT Multiplex FilmArray® GE, BioMérieux dans un hôpital général.** DUBUIS-GOURDANGE P, SINDT A, BLANC V, DORIN J, RIFFAUD K, WEISS N, ROGER PM**.** *19èmes Journées Nationales d'Infectiologie* ***(JNI)*** *(DIAG-06),* ***Nantes, juin 2018***
- **Utilisation combinée des protocoles d'antibiothérapies et des antibiogrammes ciblés pour le bon usage des antibiotiques.** MICHELANGELI C , GIRARD-LAMOULERE D, ASSI A, DELLA GUARDIA M, BOIVIN HJ, ROGER PM. *19èmes Journées Nationales d'Infectiologie* ***(JNI)*** *(BU-05),* ***Nantes, juin 2018***
- **Profil épidémiologique et bactériologique des gonococcies isolées en milieu hospitalier.** DELAGES J, KEIRLE G, CUA E, DEGAND N, BLANC V, DEL GIUDICE P, ROUDIERE L, ROGER PM**.** *19èmes Journées Nationales d'Infectiologie* ***(JNI)*** *(IST-05),* ***Nantes, juin 2018***

4 Publications du RésO en 2016-2018, 3 en cours

- **Recommandations du bon usage des antibiotiques : améliorer les pratiques médicales et non assujettir les infectiologues.** ROGER PM, LEROY I, GARRAIT V, GUERY B**.** *Med Mal Infect 2016*; 46: 115-6
- **Pneumonies aiguës communautaires avec antigènes solubles urinaires positifs : facteurs associés à une antibiothérapie ciblée.** MOTHES A, LEOTARD S, NICOLLE I, SMETS A, CHIRIO D, ROTOMONDO C, TIGER F, DEL GIUDICE P, PERRIN C, NERI D, FOUCAULT C, DELLA GUARDIA M, HYVERNAT H, ROGER PM, RésO-InfectiO-PACA-Est**.** *Med Mal Infect 2016*; 46 : 365-71
- **Est-il possible de réduire la durée de l'antibiothérapie des exacerbations de BPCO chez les patients hospitalisés ?** VANDENBOS F, CAISSO C, HARB E, VIDAL R, NICOLLE I, RISSO K, ROGER PM**.** *Rev Mal Res 2017*, 34: 275-7
- ***Bacteraemia* in emergency departments: effective antibiotic reassessment is associated with a better outcome.** AILLET C, JAMMES D, FRIBOURG A, LEOTARD S, PELLAT O, NERI D, LAMECHE D, PANTALONI O, TOURNOUD S, ROGER PM. *Eur J Clin Microbiol Infect Dis 2018*; 37: 325-31

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« Les Infections Ostéo-Articulaires »

•10h30-10h50 : Morbi-mortalité liée aux infections ostéo-articulaires. **Pierre-Marie Roger, Faculté de Médecine de Nice**

•10h50-11h20 : Un temps versus deux temps, le point de vue des infectiologues. **Cédric Foucault, CH d'Hyères**

•11h20-12h00 Un temps versus deux temps, le point de vue des orthopédistes. ***Pro* : Baudouin Redréau - *Anti* : Pierre Leguilloux, Clinique St Michel, Toulon**

•12h00-12h30 : Daptomycine dans les infections ostéo-articulaires, où en est-on ? **Johan Courjon, CHU de Nice**

•14h00-14h30 : Risque infectieux en chirurgie du rachis. **Nicolas Bronsard, CHU de Nice**

•14h30-15h00 : Kit de prélèvement pour infection ostéo-articulaire au sein du Réseau. **Delphine Girard, Laboratoire Cerballiance, Toulon**

•15h00-15h30 : Utilisation de la CRP dans les IOA : données scientifiques. **Stéphane Liguori, CH d'Antibes**

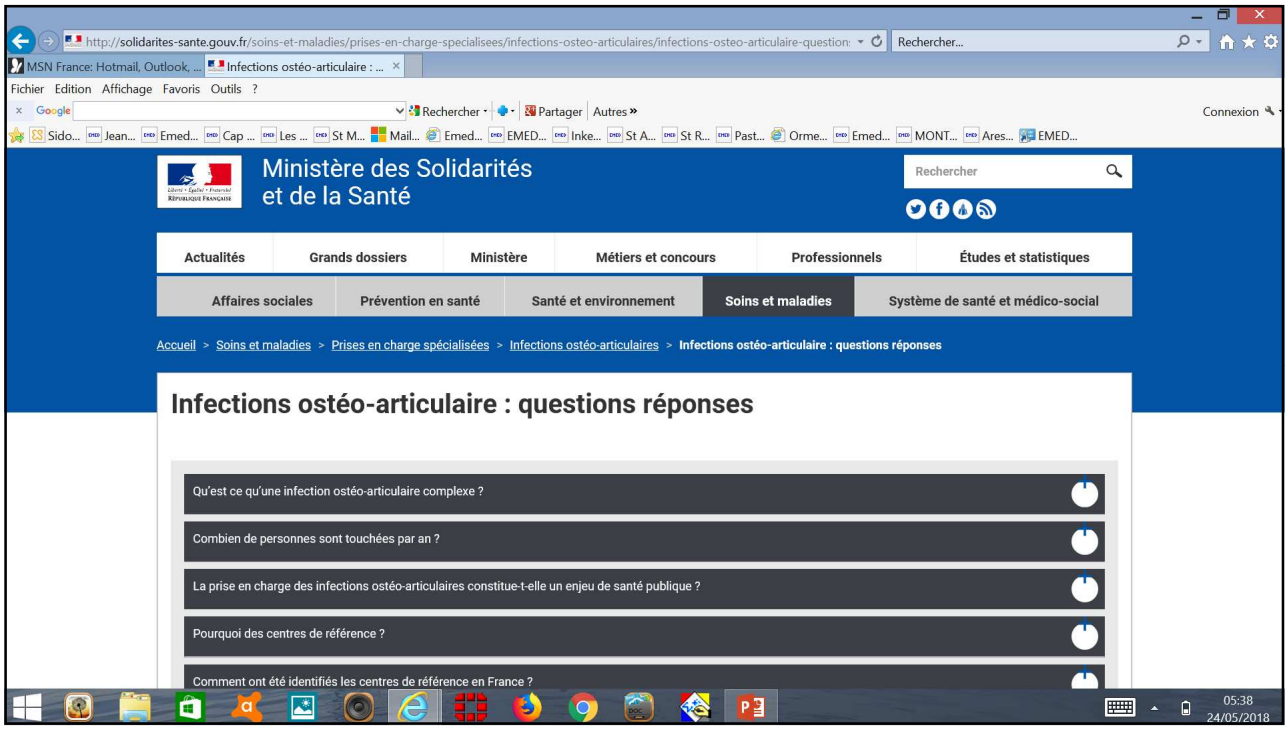
•15h30-16h00 : Le parfait dossier en expertise du fait d'une complication infectieuse. **Gérard Orst, Expert de Justice, Nice**

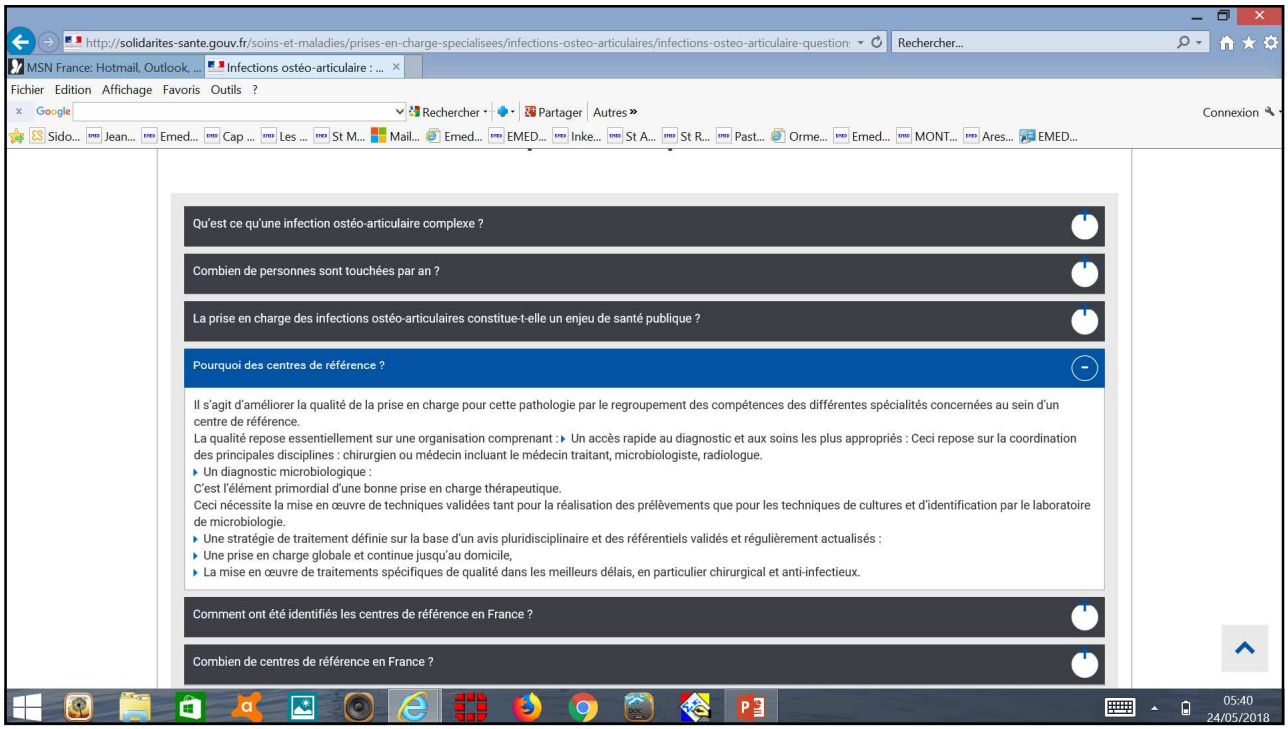
Morbi-mortalité des infections ostéo-articulaires

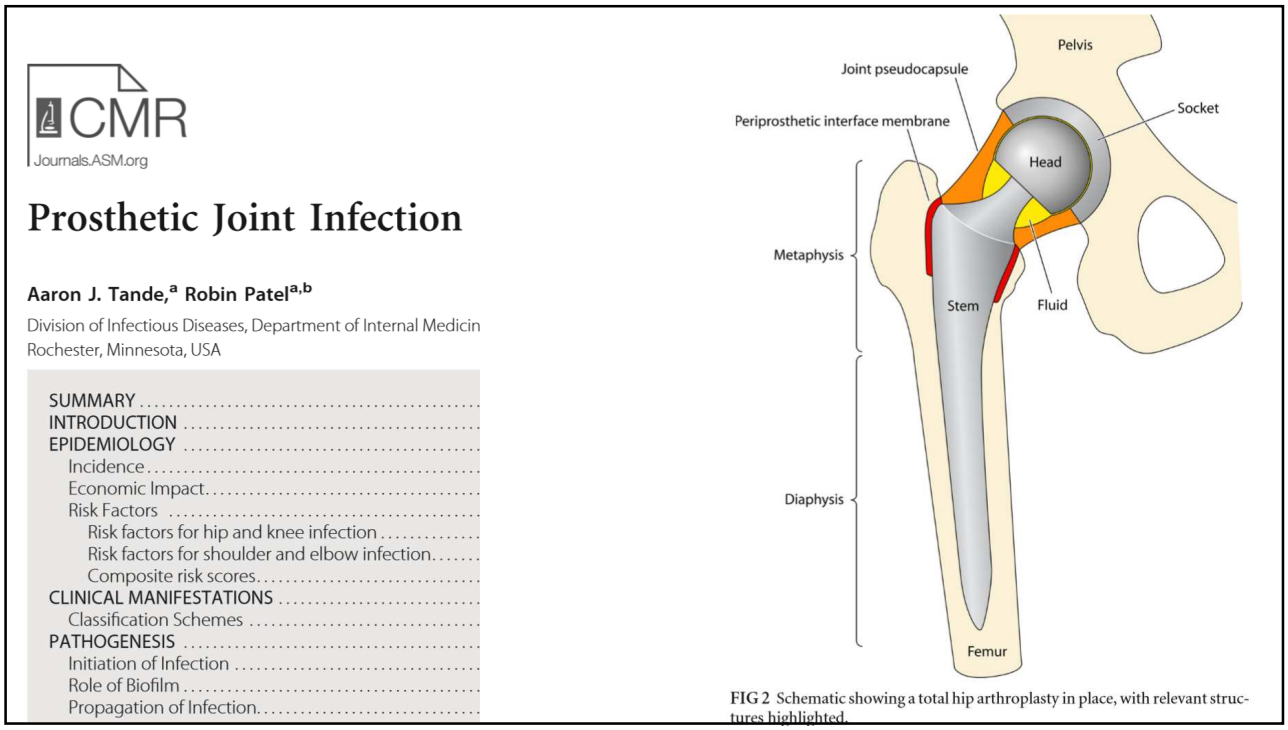
Pierre-Marie Roger

46ème Journée Thématique du Réso-Infectio-PACA-Est

Château St Martin, Vendredi 25 mai 2018







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Prosthetic Joint Infection

Aaron J. Tande,[a] Robin Patel[a,b]

Division of Infectious Diseases, Department of Internal Medicin
Rochester, Minnesota, USA

FIG 2 Schematic showing a total hip arthroplasty in place, with relevant structures highlighted.

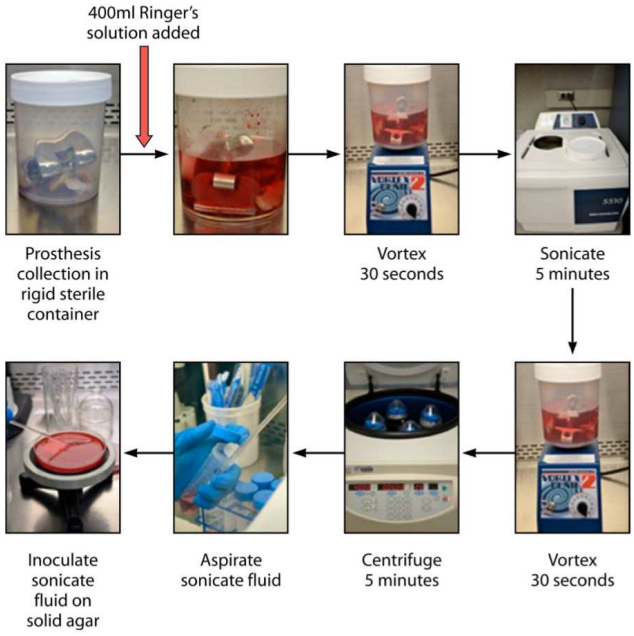

FIG 3 Prosthesis sonication protocol used in the Mayo Clinic Clinical Microbiology Laboratory. (Courtesy of David Lynch, reproduced with permission.)

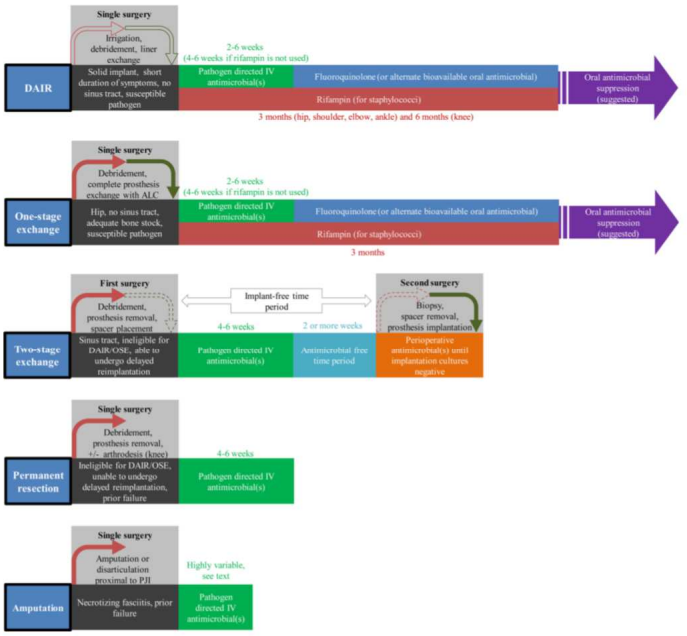

FIG 4 Medical and surgical strategies for management of prosthetic joint infection. Outlined arrows indicate exchange of polyethylene components only, solid arrows indicate exchange of all arthroplasty components, and dotted arrows indicate exchange of cement spacer. The use of suppressive antimicrobials after DAIR or one-stage arthroplasty exchange is controversial. Management of PJI without surgery is not generally recommended. Abbreviations: DAIR, debridement, antibiotics, and implant retention; OSE, one-stage exchange; ALC, antimicrobial-loaded cement; PJI, prosthetic joint infection; IV, intravenous.

Infections Ostéo-articulaires chez 28 453 Patients Hospitalisés en France en 2008

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CHRU HÔPITAUX DE TOURS

Caractéristiques des séjours pour IOA en France, 2008

	Native BJI		Device-associated BJI		p value
	N	%	N	%	
Public sector	20,514	83,2	7,919	69,2	NS
Surgical stay	11,334	46,0	8,513	74,4	0,001
Intensive care unit	1,552	6,3	689	6,0	NS
Transfer/ outstay					
home	17,447	70,8	6,711	58,6	0,001
died	931	3,8	391	3,4	NS
long term stay	216	0,9	111	1,0	NS
rehabilitation centres	3,485	14,1	3,004	26,2	0,001
length of stay [days (95% CI)]	16.8 d (16.6-17.1)		18.9 d (18.5-19.3)		0,001
Total	24,643	100,0	11,448	100,0	

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BIAM British Infection Association

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Infected hip hemiarthroplasties and total hip arthroplasties: Differential findings and prognosis

Jaime Lora-Tamayo [a,*], Gorane Euba [a], Alba
Oscar Murillo [a], Salvador Pedrero [b], Dolors
Miquel Pujol [a], Xavier Cabo [b], J. Ariza [a]

Summary *Objectives:* Infected hip hemiarthroplasties (HHA) are classically analyzed along with infected total hip arthroplasties (THA), but patients with either one or other device are different. We describe the clinical presentation, etiology and prognosis of infected HHA compared with infected THA.
Methods: Comparative study of patients with infected HHA and THA from a prospective database of prosthetic joint infection (PJI) cases in our hospital (2003–2011), focusing on patients managed with debridement, antibiotics and implant retention (DAIR).
Results: 210 episodes of hip-PJI (age 74 years, 63% women): 62 (39%) HHA and 148 (61%) THA. HHA-patients were older and had more comorbidities. Late-chronic and hematogenous infections were more frequent in THA. 123 (59%) patients were managed with DAIR: 72 THA and 51 HHA. *Staphylococcus aureus* was more frequent in THA (44% vs 26%, $p = 0.032$), while Gram-negative bacilli were more prevalent in HHA (73% vs 51%, $p = 0.018$), with a higher prevalence of fluoroquinolone-resistance in cemented-HHA. Overall failure was 37%, with no significant differences among groups. A higher mortality was observed in HHA cases (21% vs 4%, $p = 0.005$), particularly in cemented-HHA.

Abstract

We have used a medical database to analyze our activity since 2005. We observed a frequent association between bone and joint infection (BI) and bacteremia. Our aim was to characterize patients with BI and bacteremia, and focus on the outcome.

Patients and method. – Our database includes the prospective recording of 28 characteristics of all hospitalized patients, including diagnosis, comorbid conditions, microbiological data, therapy, and outcome. We selected patients presenting with BI in this database, from July 2005 to December 2012. Fever before blood culture was retrospectively documented from the patient's chart. Chronic BI was defined as a disease lasting more than 1 month. An unfavorable outcome was defined by the need for intensive care or death.

Results. – Six hundred and thirty-two patients presented with BI and 125 with bacteremia (19.8%). We used a stepwise logistic regression analysis and determined that bacteremia was associated with vertebral osteomyelitis, OR, 3.97, $P<0.001$; alcohol abuse, OR, 2.51, $P=0.010$; fever, OR, 2.43, $P<0.001$; neurological and/or psychiatric diseases, OR, 2.41, $P\leq0.001$; and *Staphylococcus aureus* infection, OR, 2.32, $P<0.001$. The outcome was unfavorable in 23 cases (3.6%), associated with bacteremia, OR, 8.00, $P<0.001$, age >60 years, OR, 4.78, $P=0.018$, and *S. aureus* infection, OR, 3.96, $P=0.010$. No single comorbid condition was significantly associated with an unfavorable outcome.

Conclusion. – Bacteremia occurred in nearly 20% of the patients presenting with BI, and was associated with identifiable comorbid conditions; it was the main risk factor for an unfavorable outcome.

Ferrand et al. BMC Infectious Diseases (2016) 16:239
DOI 10.1186/s12879-016-1540-0

BMC Infectious Diseases

RESEARCH ARTICLE Open Access

Morbimo
arthritis: a

Julien Ferrand[1], Yous
Alice Séjourne[1], Jean-

Abstract

Background: The ol
patients with confirr

Methods: All adult p
with confirmed SA v
analysis was perform

Table 5 Univariate analysis of factors possibly associated with mortality attributable directly to septic arthritis

	Yes (*N* = 6)	No (*N* = 101)	p-value	Odds ratio [95 % CI]	Univariate analysis *p-value*
Age (years)	**82.5 [59–96]**	**62.0 [16–95]**	**0.017**	**1.09 [1.02–1.19]**	**0.023**
Gender (Female)	3 (50 %)	31 (31 %)	0.380	2.26 [0.40–12.80]	0.335
Knee involvement	3 (50 %)	22 (22 %)	0.138	3.59 [0.63–20.61]	0.133
Hip involvement	0 (<1 %)	12 (12 %)	1	not defined	0.993
Multiple joint involvement	2 (33 %)	8 (8 %)	0.097	5.81 [0.73–35.11]	0.062
Cardiovascular disease	3 (50 %)	42 (42 %)	0.694	1.40 [0.25–7.91]	0.686
Skin involvement	**4 (67 %)**	**12 (12 %)**	**0.004**	**14.83 [2.62–115.71]**	**0.003**
Rheumatoid arthritis and related conditions	**2 (33 %)**	**5 (5 %)**	**0.049**	**9.60 [1.14–64.04]**	**0.021**
Previous cancer	3 (50 %)	19 (19 %)	0.100	4.32 [0.75–24.95]	0.087
Diabetes mellitus	**4 (67 %)**	**22 (22 %)**	**0.030**	**7.18 [1.31–54.31]**	**0.028**
Time to presentation (days)	11 [4–24]	7 [0–120]	0.695	0.98 [0.92–1.02]	0.507
Confusion on admission	**3 (50 %)**	**10 (10 %)**	**0.023**	**9.10 [1.51–55.39]**	**0.012**
Creatinine clearance (MDRD, ml/min)	**32 [23–66]**	**81 [5–150]**	**0.003**	**0.96 [0.92–0.99]**	**0.009**
C-reactive protein (mg/l)	**375 [88–640]**	**120 [3–465]**	**0.003**	**1.01 [1.006–1.02]**	**0.002**
Staphylococcus aureus	4 (67 %)	53 (58 %)	1	1.47 [0.27–11]	0.665
Joint surgery	1 (17 %)	57 (56 %)	0.091	0.15 [0.01–1.002]	0.093
Bacteraemia	**5 (83 %)**	**25 (25 %)**	**0.006**	**15.20 [2.31–298.70]**	**0.015**
Small joint involvement	0 (<1 %)	32 (32 %)	0.175	*not defined*	0.993

MDRD Modification of Diet in Renal Disease
Statistically significant results are indicated in bold type

ORIGINAL ARTICLE

Surgical Site Infection After Primary Hip and Knee Arthroplasty: A Cohort Study Using a Hospital Database

Leslie Grammatico-Guillon, MD, PhD;[1] Sabine Baron, MD;[2] Philippe Rosset, MD, PhD;[3] Christophe Gaborit, Statistical Engineer;[2] Louis Bernard, MD, PhD;[4] Emmanuel Rusch, MD, PhD;[1] Pascal Astagneau, MD, PhD[5]

BACKGROUND. Hip or knee arthroplasty infection (HKAI) leads to heavy medical consequences even if rare.

OBJECTIVE. To assess the routine use of a hospital discharge detection algorithm of prosthetic joint infection as a novel additional tool for surveillance.

METHODS. A historic 5-year cohort study was built using a hospital database of people undergoing a first hip or knee arthroplasty in 1 French region (2.5 million inhabitants, 39 private and public hospitals): 32,678 patients with arthroplasty code plus corresponding prosthetic material code were tagged. HKAI occurrence was then tracked in the follow-up on the basis of a previously validated algorithm using *International Statistical Classification of Disease, Tenth Revision*, codes as well as the surgical procedures coded. HKAI density incidence was estimated during the follow-up (up to 4 years after surgery); risk factors were analyzed using Cox regression.

RESULTS. A total of 604 HKAI patients were identified: 1-year HKAI incidence was1.31%, and density incidence was 2.2/100 person-years in hip and 2.5/100 person-years in knee. HKAI occurred within the first 30 days after surgery for 30% but more than 1 year after replacement for 29%. Patients aged 75 years or older, male, or having liver diseases, alcohol abuse, or ulcer sore had higher risk of infection. The inpatient case fatality in HKAI patients was 11.4%.

CONCLUSIONS. The hospital database method used to measure occurrence and risk factors of prosthetic joint infection helped to survey HKAI and could optimize healthcare delivery.

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ELSEVIER
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Prosth

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[a] *Infection*

Abstract

Background. – Care to patients with prosthetic joint infections (PJI) is provided after pluridisciplinary collaboration, in particular for complex presentations. Therefore, to carry out an audit in PJI justifies using pluridisciplinary criteria. We report an audit for hip or knee PJI, with emphasis on care homogeneity, length of hospital stay (LOS) and mortality.

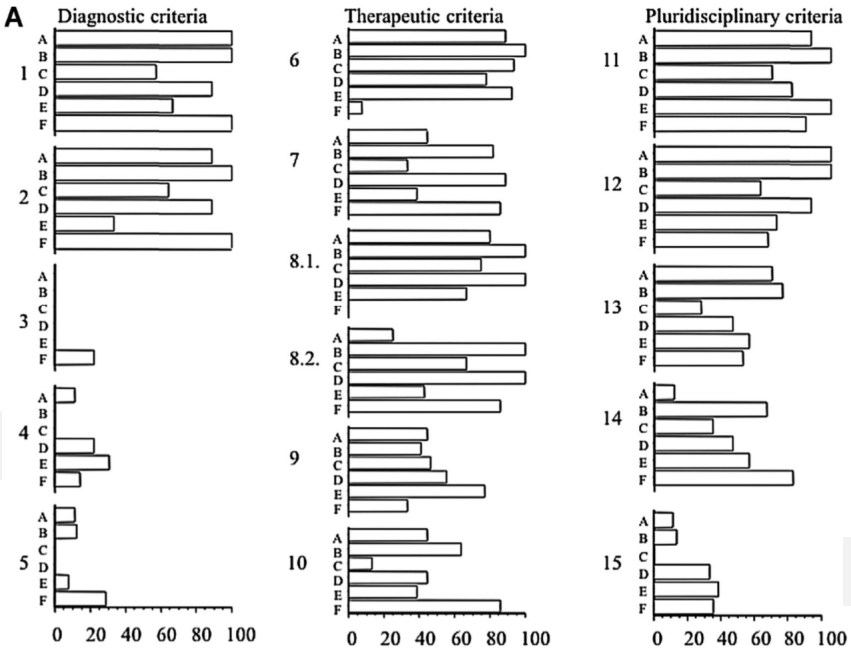
Patients and methods. – Fifteen criteria were chosen for quality of care: 5 diagnostic tools, 5 therapeutic aspects, and 5 pluridisciplinary criteria. Among these, 6 were chosen: surgical bacterial samples, surgical strategy, pluridisciplinary discussion, antibiotic treatment, monitoring of antibiotic toxicity, and prevention of thrombosis. They were scored on a scale to 20 points. We included PJI diagnosed between 2010 and 2012 from 6 different hospitals. PJI were defined as complex in case of severe comorbid conditions or multi-drug resistant bacteria, or the need for more than 1 surgery.

Results. – Eighty-two PJI were included, 70 of which were complex (85%); the median score was 15, with a significant difference among hospitals: from 9 to 17.5 points, $P<0.001$. The median LOS was 17 days, and not related to the criterion score; 16% of the patients required intensive care and 13% died. The cure rate was 41%, lost to follow-up 33%, and therapeutic failure 13%. Cure was associated with a higher score than an unfavorable outcome in the univariate analysis (median [range]): 16 [9–18] vs 13 [4–18], $P=0.002$.

Conclusions. – Care to patients with PJI was heterogeneous, our quality criteria being correlated to the outcome.

2 prélèvements bactério

Anatomo-pathologie dispo



Patient informé risque rechute

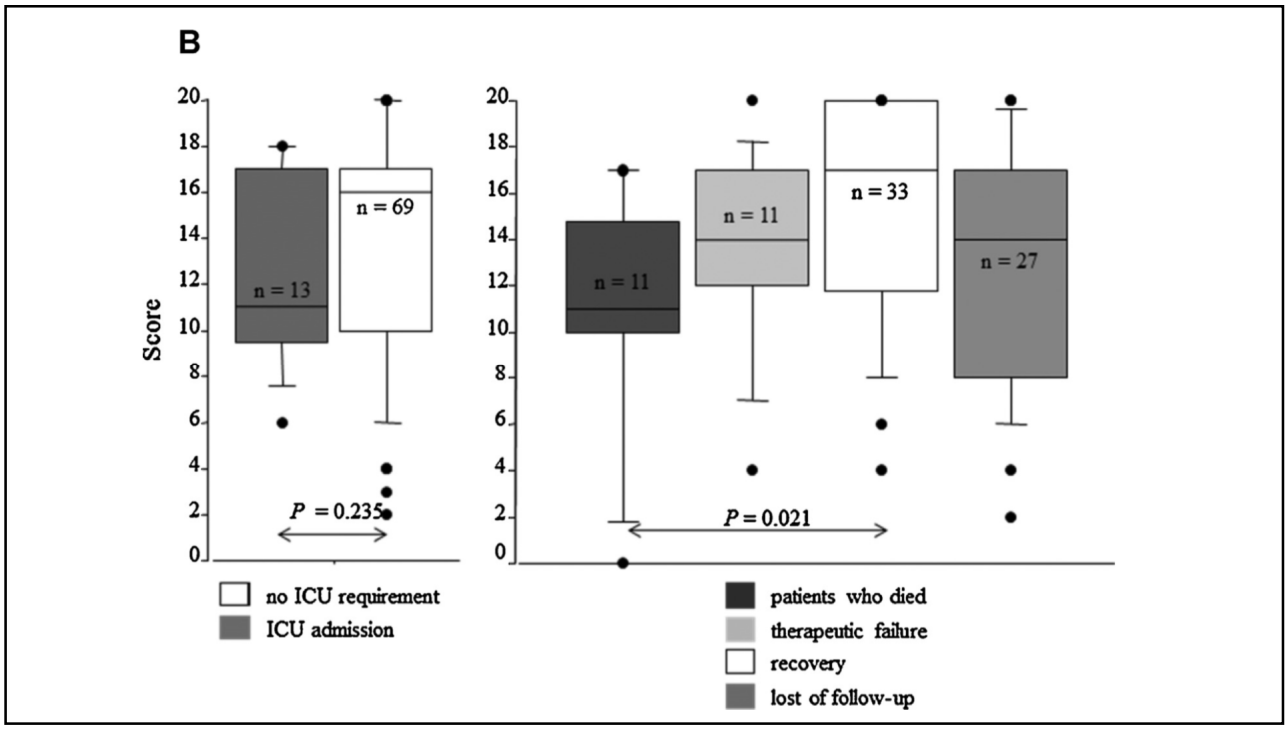


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Table 2
Adverse event (AE) rate of the different antibiotic associations used for staphylococcal bone and joint infections.

	RF+FQ[a]	RF+CD[b]	FQ+CD[c]	Others[d]
Hospitalization	89 (37%)	33 (14%)	23 (10%)	93 (39%)
Prescriptions *n* (%)	20	3	1	17
AE (*n*)	22%	9%	4%	18%
Rate	89 (37%)	33 (14%)	23 (10%)	93 (39%)
Ambulatory care				
Prescriptions *n* (%)	68 (29%)	32 (13%)	27 (11%)	111 (47%)
AE (*n*)	4	3	2	12
Rate	6%	9%	7%	11%
Overall rate	15%	9%	6%	14%
System organ class affected by the AE				
Gastrointestinal disorders	9	4	0	12
Hepatobiliary disorders	5	0	0	6
Skin disorders	3	0	2	3
Musculoskeletal disorders	3	0	0	2
Renal disorders	1	1	1	1
Hematological	0	0	0	4
Nervous system disorders	1	0	0	0
General disorder[e]	1	0	0	0
Others	1	1	0	1

[a] Rifampin and fluoroquinolones.
[b] Rifampin and clindamycin.
[c] Fluoroquinolones and clindamycin.
[d] Others antibiotics association.
[e] General disorder refers to fever. Classification of adverse events was the Common Terminology Criteria for Adverse Events version 4.0.

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Complex prosthetic joint infections due to carbapenemase-producing *Klebsiella pneumoniae*: a unique challenge in the era of untreatable infections☆

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Table 1

Characteristics and clinical outcomes of cases of prosthetic joint infection caused by carbapenem-resistant *Klebsiella pneumoniae*

Variable	Case 1	Case 2	Case 3
Age (years), sex	58, male	72, male	70, female
Comorbidities	Osteoarthritis, diabetes	Osteoarthritis, coronary artery disease, congestive heart failure	RA on immunosuppression with methotrexate and hydroxychloroquine
Onset of first PJI (months from index surgery)	60	36	1
Primary organism PJI	MSSA	VSE, VRE, *Proteus mirabilis*	*Corynebacterium sp* and VSE
Onset of CRKP PJI (months from first PJI)	2	2	5
Number of procedures (*n*)	10	12	57
Antibiotics	Oxacillin; piperacillin–tazobactam; daptomycin and oral doxycycline; tigecycline and fluconazole; colistin, amikacin, and tigecycline	Ciprofloxacin, linezolid, and rifampin; daptomycin and ciprofloxacin; vancomycin and tigecycline → doxycycline; oxacillin, oxacillin and tigecycline → doxycycline	Vancomycin; tigecycline; colistin; tigecycline; tigecycline; tigecycline and vancomycin → oral ciprofloxacin and clindamycin; tigecycline; colistin; tigecycline, and amikacin; ciprofloxacin
WBC $\times 10^9$/l (median (IQR))	9.07 (0.63, 12.49)	8.45 (7.73, 9.75)	8.92 (7.40, 11.68)
Hospital LOS (days)	51	101	225
Hospitalization costs ($)	N/A	N/A	850 000
Functional status	Above-the-knee amputation	Full	Disarticulated
Outcomes	Died	Died	Alive with major disability

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Prevention of Periprosthetic Joint Infection

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ABSTRACT

Periprosthetic joint infection (PJI) has moved into the first place as the cause of failure following total knee arthroplasty (TKA). Recent studies have shown that PJI results in higher mortality in patients than many cancers. The economic burden of treating PJI is likely to exceed $1 billion this year in the US. Thus, it is paramount that all efforts are invested to prevent this dreaded complication after total joint arthroplasty (TJA). This article summarizes some of the most effective and proven strategies for prevention of PJI. It is hoped that the article will be of benefit to the readers of the journal.

Discussion

- Morbi-mortalité des IOA: peu de données, hétérogènes
- Mortalité globale ~ 10%
- Morbidité imprécise, qualité de vie altérée
- Au sein du Réso moyens partagés d'amélioration des pratiques cliniques: prélèvements microbiologiques, protocoles d'antibiothérapies, expériences RCP

Nouvel audit pour objectiver une amélioration du pronostic ?