Acinetobacter Baumannii Causing An Unusual Abscess Presentation

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INTRODUCTION:

Acinetobacter Baumannii (AB) is increasingly recognized as being a significant pathogen associated with nosocomial outbreaks, and its resistant to most antimicrobial agents is of great concern. AB has a characteristic protection from a wide class of anti-microbials and a phenomenal capacity to achieve resistance. This article aims to report how this organism presented as an infected olecranon bursitis, however with more investigations turned out to be a large intramuscular abscess in the posterior aspect of the arm communicating with the posterior chest wall.

REPORT:

A 66 year old Malay gentleman, with underlying metabolic syndrome presented with erythematous swelling and pus discharge of his left elbow after an alleged fall onto his elbow. His CRP was more than 156mg/L and his WCC was 31 x 10^9/L. He had a discharging wound over the left olecranon measuring approximately 0.5cm (Figure 1). Initial impression was discharging infected olecranon bursitis. He was taken to theatre for incision and drainage. Approximately 5cc of seropurulent discharge was drained. He continued to drain abscess. Therefore, he was taken to theatre for re-wound debridement and exploration of left elbow bursitis. Intraoperatively there was about 10cc of pus collection over the medial head of his left triceps muscle with sloughy tissue. His wound continued to discharge pus therefore a CT arm and chest was done (Figure 2). It showed large subfascial rim enhancing collection with air pockets tracking from the posterior arm, proximal humerus, axillary, and scapular regions with communications at the left posterolateral chest wall. This patient was then taken in for a third wound debridement of right posterior arm and posterolateral chest wall with the general surgical team. There was 150 mls of frank pus at the left posterolateral chest wall, with a cavity measuring 20x11cm with pus tracking from left scapula and axilla (Figure 3). His arm wound was extended proximally and there was 50 mls of frank pus (figure 4). His wounds were left open. Pus cultures grew AB. He was then treated with IV Ceftriaxone. Ten days later, he was taken to theatre for delay primary wound closure. He was then discharged with 2 weeks of oral antibiotics and his wounds healed at follow up and inflammatory markers normalized.

CONCLUSION:

To our knowledge, this is the first reported case of abscess communication between the arm and chest wall. A non-resolving abscess should warrant further investigation.

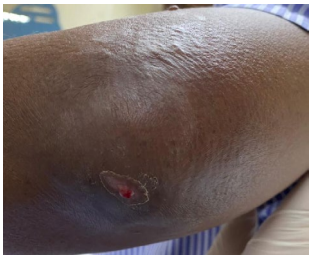

Figure 1

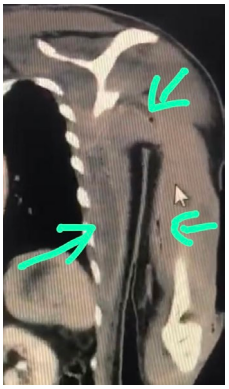

Figure 2

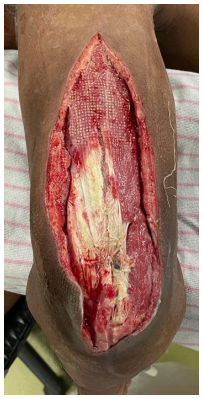

Figure 3

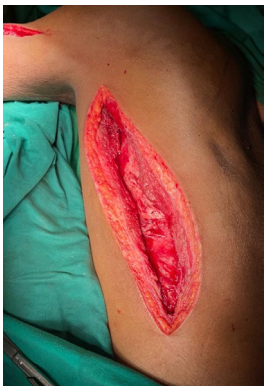

Figure 4