ACUTE HEMATOGENOUS OSTEOMYELITIS AND PYOGENIC ARTHRITIS GUIDELINE

Definition:
Osteomyelitis is inflammation of the bone and bone marrow generally caused by a bacterial infection. The most common form in childhood is acute hematogenous osteomyelitis (AHO), which is infection of the bone of less than two weeks duration spread hematogenously. [1]

Incidence:
The incidence of acute hematogenous osteomyelitis is approximately 60/100,000 cases, accounting for one percent of pediatric hospitalizations. The risk is higher in younger children, with 50% of cases identified in children younger than five years of age. [7] Boys are affected about twice as often as girls. [2,3] The majority of cases are limited to a single anatomic site.

Etiology:
Acute hematogenous osteomyelitis typically arises in the metaphysis of long tubular bones, with approximately two-thirds of all cases involving the femur, tibia or humerus. While a variety of bacterial pathogens may be involved, Staphylococcus aureus is the pre-eminent pathogen and is responsible for 70–90% of acute hematogenous osteomyelitis infections in children. Other etiologic agents, in no particular order, include Streptococcus pyogenes, Streptococcus pneumoniae, Group B streptococci, coagulase-negative staphylococci, Kingella kingae, enteric Gram-negative bacilli and anaerobic bacteria. [1,4-5]

Diagnosis:
The diagnosis of osteomyelitis depends primarily on clinical findings. Patients most commonly complain of pain at the affected site that may be associated with noted erythema, warmth, or edema. Symptoms may be present for days to weeks and often are associated with fever. Diagnostic imaging and laboratory results can assist with the diagnosis. Plain radiographs of the affected region are most helpful in narrowing the differential as they may not show significant changes early in AHO. Magnetic resonance imaging (MRI) is the most accurate modality, with high sensitivity and specificity, even in early disease. Erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) are important non-specific inflammatory markers that can be followed during treatment to assess clinical response. Blood cultures are positive in approximately 50% of patients with AHO and should be drawn prior to initiating therapy. [7]

Clinical features suggestive of bone infection:
- Constitutional symptoms (irritability, decreased appetite or activity), with or without fever
- Focal symptoms and signs of inflammation (pain, erythema, swelling, and tenderness)
- Limitation of function (limp, limited use of an extremity)
- Elevation of ESR and/or CRP levels

Differential Diagnosis:
- Transient synovitis
- Reactive arthritis
- Legg-Calvé-Perthes disease
- Pyogenic arthritis
- Malignancy
- Chronic Osteomyelitis
- Trauma
- Fracture
- Sickle Cell Disease
- Juvenile idiopathic arthritis
- Slipped capital femoral epiphysis

Guideline Inclusion Criteria: [14-19]
- Physical exam and/or history suggestive of acute hematogenous osteomyelitis or septic joint.
- Less than 14 days of signs and symptoms
- Previously healthy children ages 6 months to 18 years of age

Last updated: 12/3/2018
Guideline Exclusion Criteria: ([8,14-15])

- Evidence of sepsis or hemodynamic instability
- Contiguous osteomyelitis: penetrating trauma or fracture
- Complicated or difficult to treat osteomyelitis
  - Multifocal
  - Chronic
  - Head, face, or orbital involvement
  - Presence of orthopedic device or prosthesis
  - Post-operative wound
  - Presence of an indwelling vascular catheter

History of the following disease states:
- Bone or cartilage disorder
- Congenital or acquired bone disease
- Congenital or acquired immunodeficiency
- Type I or II diabetes
- Sickle cell disease
- Chronic sinusitis
- Sacroiliitis
- Fasciitis
- Synovitis
- Arthropathy

Transition to Management off Pathway

- Culture is negative
- Culture is positive for bacterial etiology other than methicillin-sensitive *Staphylococcus aureus* (MSSA) or *Kingella kingae*
- Culture is positive for methicillin-resistant *Staphylococcus aureus* (MRSA)
- Culture was positive for MSSA or *Kingella kingae* and patient does not meet criteria for oral step-down therapy in <5 days of start of focused antibiotic therapy.

Diagnostic Evaluation:

**History:** Assess for

- Bone pain for several days
- Restricted use of the involved limb
- Minor trauma coincident with bacteremia
- Fever

**Physical Examination:** Assess for

- Constitutional symptoms of infection that are consistent with osteomyelitis, with or without fever
- Signs of localized inflammation of bone, including redness, swelling, point tenderness, and/or loss of function.
- Warmth, swelling, and point tenderness of the involved site.

Critical Points of Evidence

**Evidence Supports**

Early transition to oral antimicrobial therapy (≤5 days) compared to prolonged intravenous antimicrobial therapy for duration of treatment. ([9, 14-17, 20-24])

Use of a combination of laboratory tests to confirm likelihood of diagnosis: blood culture, CRP, and ESR.

Use of MRI as the preferred imaging study for diagnosis. ([5-6,20])

Use of molecular diagnostics (i.e. polymerase chain reaction) to determine the etiology when obtained cultures are negative (specifically for *Kingella kingae*).

Empiric antimicrobial therapy that includes an agent directed against MRSA. ([7,11,25-26])

**Evidence Lacking/Inconclusive**

The quantitative CRP measurement to best measure clinical response and guide decisions regarding transition from intravenous to oral antimicrobial therapy.

Optimal duration of intravenous antimicrobial therapy prior to transition to oral antimicrobial therapy.

Optimal duration of combined intravenous and oral antimicrobial therapy for complete clinical cure/resolution.

**Evidence Against**

Routine use of MRI to assess for clinical cure/improvement

**Practice Recommendations**

**Laboratory Testing**

An initial diagnostic evaluation should be ordered prior to start of antibiotic therapy; CRP and ESR can be followed to track resolution of the illness. ([7])

*(Strong recommendation, Moderate quality evidence.)*

Cultures are critical to focus antimicrobial therapy, blood cultures and aspirate should be performed prior to the initiation of antimicrobial therapy if the patient is stable. ([11])

*(Strong recommendation, Moderate quality evidence.)*

Polymerase chain reaction (PCR) tests for *Staphylococcus aureus* and *Kingella kingae* should be ordered if culture is negative.

*(Strong recommendation, low quality evidence)*
Imaging
Plain film radiograph should be ordered for the affected region; critical for excluding differential diagnosis such as fracture or malignancy. [33] (Strong recommendation, Moderate quality evidence.)

MRI is the modality of choice when imaging other than plain radiography to establish the diagnosis of osteomyelitis or to delineate the location and extent of bone involvement. [5-6,20,33-36] (Strong recommendation, High quality evidence.)

Antibiotic Therapy
Empiric antimicrobial therapy that includes an agent directed against MRSA should be started early and after cultures have been obtained. (Strong recommendation, moderate quality evidence)

Following a short intravenous antimicrobial therapy (≤5 days) the patient should be transitioned to oral antibiotics. (Strong recommendation, Moderate quality evidence.)

Clinical Management
(for full recommendations see attached pathway and addendums)

Laboratory Assessment:
Diagnostic: (See Addendum 2 for Diagnostic Test algorithm)
Initial test prior to antibiotic therapy should include (8-12):
- Complete Blood Count (CBC) with differential
- Comprehensive Metabolic Panel (CMP)
- Erythrocyte Sedimentation Rate (ESR)
- C- reactive protein (CRP)
- Blood culture minimum of one set

CRP test should be repeated every 48 hours to evaluate response to antimicrobial therapy. Surgery may cause an increase in CRP level of patients and should be accounted for when evaluating patient response to antimicrobial therapy

Fluid/tissue sample should be collected for diagnostic if aspiration is indicated.

Antibiotics should be withheld until cultures are obtained unless patient condition warrants administration.

Imaging Assessment:
Magnetic Resonance Imaging:
(See MRI Block Time Algorithm)
MRI has been found to be extremely sensitive 97% and specific 92% in helping to diagnose hematogenous osteomyelitis infections. [36]

Orthopedic should be consulted prior to MRI to coordinate aspiration procedure if indicated.

MRI orders should include the following information:
- Priority: STAT
- Reason for exam: OSTEO-ORTHO PROTOCOL
- Call reporting to: MD name
- Phone number: MD telephone number

Antibiotics:
(See Addendum 1 for dose guidelines)
Empiric antibiotic therapy should be started prior to identification of specific etiologic agent: [6-7,14,18,20,27,33]
- patients less than 4 years of age should receive clindamycin and ceftriaxone
- patients 4 years of age or older should receive clindamycin and cefazolin
(Strong recommendation, moderate quality evidence)

Focused antibiotic therapy based on etiologic agent and Susceptibilities: [6-7,18,20,27,36]
- MSSA – Oxacillin
- Kingella kingae – Ceftriaxone
(Strong recommendation, moderate quality evidence)

Antibiotic oral therapy transition:
(See Addendum 1 for dose guidelines)
The following criteria must be met in less than 5 days to transition to oral antibiotics: [7,9,11,14,18,23]
- Confirmed diagnosis of uncomplicated osteomyelitis
- Clinical improvement of signs and symptoms
- Afebrile for at least 48 hrs
- CRP decreased from 50% of initial CRP
- Received at least 72 hrs of IV antibiotics
(Strong recommendation, Moderate quality evidence.)

Oral antibiotic therapy options based on etiologic agent: [6-7,14,18,20,27,31,36]
- MSSA – Cephalexin
- Kingella kingae – Amoxicillin/Clavulanate
(Strong recommendation, Moderate quality evidence.)

Additional antimicrobial therapy options: [6-7,20,27-29,36]
(REQUIRES INFECTIOUS DISEASES APPROVAL, See Addendum 1 for recommendations)

Discharge Criteria
- Patient is afebrile for 24 hours with clinical improvement in symptoms and physical exam
- Patient has tolerated one dose of oral antibiotics identical to the planned home regimen in the hospital
- Scheduled follow-up with the primary pediatrician, infectious disease, and orthopedics is arranged.
- Antibiotic prescription is filled and delivered prior to discharge or easily accessible by parents immediately after discharge to avoid missed dose
(Strong recommendation, low quality evidence)
Consults/Referrals:
- Orthopedic consultation early to evaluate need for additional imaging and if aspiration is necessary.
- Infectious Diseases consultation early for diagnostic and antibiotic guidance.
  - Certain antimicrobial therapy options require approval from Infectious Diseases.

Outcome Measures
See addendum 3.

Addendums
1. DCMC Acute Hematogenous Osteomyelitis Antibiotic Dosing and Recommendations
2. DCMC Acute Hematogenous Osteomyelitis Diagnostic Testing ordering form and information
3. DCMC Acute Hematogenous Osteomyelitis Scorecard
ACUTE HEMATOGENOUS OSTEOMYELITIS PATHWAY
EVIDENCE-BASED OUTCOME CENTER

INCLUSION CRITERIA
- Physical exam and/or history suggestive of acute hematogenous osteomyelitis or septic joint
- Less than 14 days of signs and symptoms
- Previously healthy children ages 6 months to 18 years of age

RECOMMENDED INITIAL DIAGNOSTIC EVALUATION
- Order CBC with differential x 1, CMP x 1, ESR x 1, CRP every 48 hours
- Order blood culture (minimum 1 set)
- Order plain film of affected region

Early Orthopedic consultation preferred to evaluate need for additional imaging and aspiration

Aspiration Indicated?
- YES
  - MRI Indicated?
    - YES
      - START EMPIRIC ANTIBIOTIC THERAPY (See Addendum 1 for antibiotic dosing)
        - Age < 4 years
          - Clindamycin and Ceftriaxone
        - Age ≥ 4 years
          - Clindamycin + Cefazolin

  - NO
    - Early Infectious Diseases (ID) consultation preferred for diagnostic and antibiotic guidance

Aspiration Only

MRI Indicated?
- NO
  - Culture Negative?
    - YES
      - Send-out samples for the following PCR testing:
        - PCR for Staph aureus
        - PCR for Kingella Kingae
    - NO
      - DISCHARGE CRITERIA
        - Kingsella kingae
          - Amoxicillin/Clavulanate
        - MSSA
          - Cephalexin

EXCLUSION CRITERIA
- Evidence of sepsis or hemodynamic instability
- Contiguous osteomyelitis: penetrating trauma or fracture
- Complicated or difficult to treat osteomyelitis
  - Multifocal
  - Chronic
  - Head, face, or orbital involvement
  - Presence of orthopedic device or prosthesis
  - Post-operative wound
- History of the following disease states:
  - Bone or cartilage disorder
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  - Congenital or acquired immunodeficiency
  - Type 1 or II diabetes
  - Sickle cell disease
  - Chronic sinusitis
  - Sacroiliitis
  - Fasciitis
  - Synovitis
  - Arthropathy

Order a MRI with the following information:
- Priority: STAT
- Reason for exam: OSTEO-ORTHO PROTOCOL
- Call reporting to: MD name
- Phone number: MD telephone number
- Call Imaging: 86-498 Order has been placed.

Place NPO Orders
- See MRI Block Time Algorithm

Order diagnostic tests for fluid/tissue sample
- See Addendum 2 for recommendations
- Hold antibiotics until cultures obtained unless patient condition warrants administration

FOCUSED ANTIBIOTIC THERAPY based on culture(s) and susceptibilities (See addendum for antibiotic dosing)

- MSSA
  - Oxacillin
- Kingella kingae
  - Ceftriaxone
- Other organisms
- Culture positive for MSRA

Meets Criteria for oral step-down therapy?
- Confirmed diagnosis of uncomplicated osteomyelitis
- Clinical improvement of signs and symptoms
- Afebrile for at least 48 hrs
- CRP decreased 50% from initial CRP
- Received at least 72 hrs of IV antibiotics

Manage Off-Pathway
- Develop Plan of care for antibiotic selection, route, and duration of therapy

DISCHARGE CRITERIA
- Afebrile for 24 hours with clinical improvement in symptoms and physical exam.
- Tolerated one dose of oral antibiotics identical to the planned home regimen in the hospital.
- Scheduled follow-up with the primary pediatrician, infectious disease, and orthopedics.
- Antibiotic prescription is filled and delivered prior to discharge or easily accessible by parents immediately after discharge.

For questions concerning this pathway, Click Here
Last Updated December 13, 2018
ED Triage
Patient with Fever & Limp – Initiate NPO Status

Patient Presents to ED with Osteomyelitis and is Determined to Need a MRI

Urgent MRI

NPO >4 hours Optimal 8 hours

Maintain NPO For 8 hours

Admit to Appropriate Unit

Handoff Communication re: NPO Status and MRI Time

Patient to MRI

Order a MRI with the following information:
- Priority: STAT
- Reason for exam: OSTEO-ORTHO PROTOCOL
- Call reporting to: MD name
- Phone number: MD telephone number
(Call Report to Ortho PA at 897-3821)

Patient Scheduled for Next Available MRI Time by Imaging RN

Patient Scheduled for 7AM MRI block time
## ADDENDUM 1
**DCMC ACUTE HEMATOGENOUS OSTEOMYELITIS ANTIBIOTIC DOSING AND RECOMMENDATIONS**

### EMPIRIC ANTIBIOTIC THERAPY

<table>
<thead>
<tr>
<th>Age &lt; 4 years</th>
<th>Potential pathogens: S. aureus S. pyogenes S. pneumoniae Kingella kingae</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clindamycin 40 mg/kg/day IV divided every 6 hours</td>
</tr>
<tr>
<td></td>
<td>Ceftriaxone 100 mg/kg/day IV every 24 hours</td>
</tr>
<tr>
<td>Maximum dose:</td>
<td>600 mg/dose, 2400 mg/day</td>
</tr>
<tr>
<td>May consider</td>
<td>every 8 hour dosing for home therapy only</td>
</tr>
<tr>
<td>Recommended monitoring:</td>
<td>CBC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age ≥ 4 years</th>
<th>Potential pathogens: S. aureus S. pyogenes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clindamycin 40 mg/kg/day IV divided every 6 hours</td>
</tr>
<tr>
<td></td>
<td>Cefazolin 100-150 mg/kg/day divided every 8 hours</td>
</tr>
<tr>
<td>Maximum dose:</td>
<td>900 mg/dose, 2700 mg/day reserved for patients with severe disease and/or patients that are obese</td>
</tr>
<tr>
<td>May consider</td>
<td>150mg/kg/day dosing in cases with bacteremia</td>
</tr>
<tr>
<td>Recommended monitoring:</td>
<td>CBC +/- CMP</td>
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</tbody>
</table>

### FOCUSED ANTIBIOTIC THERAPY

**MSSA Intravenous Therapy**
- Oxacillin 200 mg/kg/day IV divided every 4 to 6 hours *(consider continuous infusion)*
- Maximum dose: 2000 mg/dose, 12 gram/day
- May consider continuous infusion for home therapy
- Recommended monitoring: CBC & CMP

**MSSA Oral Therapy**
- Cephalexin 150 mg/kg/day PO divided every 6 hours
- Renal dosage adjustment if CrCl < 10 mL/min
- May consider every 8 hour dosing for home therapy only
- Recommended monitoring: CBC +/- CMP

**Kingella kingae Intravenous Therapy**
- Ceftriaxone 100 mg/kg/day IV every 24 hours
- See above
### Kingella kingae

**Oral Therapy**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage</th>
<th>Maximum Dose</th>
<th>Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin/clavulanate</td>
<td>90 mg/kg/day PO divided every 12 hours</td>
<td>4000 mg amoxicillin component/day</td>
<td>CBC &amp; CMP</td>
</tr>
<tr>
<td>(dosed based on amoxicillin component)</td>
<td></td>
<td>Renal dosage adjustment if CrCl &lt; 30 mL/min</td>
<td></td>
</tr>
</tbody>
</table>

### Additional Antimicrobial Therapy Options which Require Infectious Diseases Approval for Use

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage</th>
<th>Maximum Dose</th>
<th>Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clindamycin</td>
<td>30 mg/kg/day PO divided every 6 hours</td>
<td>600 mg/dose, 1800 mg/day</td>
<td>CBC</td>
</tr>
<tr>
<td>Sulfamethoxazole-trimethoprim</td>
<td>15-20 mg/kg/day PO divided every 6 to 12 hours</td>
<td>960 mg trimethoprim component/day</td>
<td>CBC &amp; CMP</td>
</tr>
<tr>
<td>Linezolid (less than 12 years old)</td>
<td>30 mg/kg/day IV/PO divided every 8 hours</td>
<td>600 mg/dose, 1200 mg/day</td>
<td>CBC &amp; CMP</td>
</tr>
<tr>
<td>Linezolid (greater than or equal to 12 years old)</td>
<td>20 mg/kg/day IV/PO divided every 12 hours</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
OSTEO PROTOCOL LAB ORDERS
Hematology x 87037
Ordering Physician: __________________________
Collector's Username: _______________________
Date: ___________ Time: ________________

☐ Fluid Specimen or ☐ Tissue Specimen

Body site: __________________________________________

Send in Lavender 2ml or 0.5ml (bullet) tube, depending on volume of specimen

☐ Cell Count with Diff Body Fluid ----------- send STAT / ROUTINE with a callback to Surgery OR #_______ x __________

Prioritize Culture Request based on amount of fluid
Send remaining specimen in SYRINGE with sterile syringe cap to lab.

Note: Gram Stain (smear) included with Aerobic/Anaerobic Culture.
Bare minimal for both Aerobic/Anaerobic total of 0.5ml

☐ Aerobic Culture (0.5ml)
☐ Anaerobic Culture (0.5ml)
☐ Misc lab Testing --- Hold fluid/tissue in lab for possible PCR testing. Store frozen with no additives. Each organism for PCR requires (0.5ml)

Optional Tests:
☐ Fungal Culture (0.5ml)
☐ AFB Culture (1.0ml)

10/2018
## ADDENDUM 3
### DCMC ACUTE HEMATOGONOUS OSTEOMYELITIS SCORECARD

<table>
<thead>
<tr>
<th>Type of Measure</th>
<th>Domain</th>
<th>Measure Definition</th>
<th>Donabedian Classification</th>
<th>IOM Domain(s)</th>
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</thead>
<tbody>
<tr>
<td>Care Process Team</td>
<td>Efficiency in Diagnosis</td>
<td>Utilization of MRI block schedule with Ortho Procedures</td>
<td>Process</td>
<td>Effective, Efficient, Equitable, Safe</td>
</tr>
<tr>
<td>Care Process Team</td>
<td>Efficiency in Diagnosis</td>
<td>Utilization of laboratory tests: Kingella kingae PCR, S. aureus PCR, CRP, Cell count w/ differential, WBC, &amp; ESR</td>
<td>Process</td>
<td>Effective, Efficient, Equitable, Safe</td>
</tr>
<tr>
<td>Care Process Team</td>
<td>Efficiency in Diagnosis</td>
<td>Time to culture</td>
<td>Process</td>
<td>Effective, Efficient, Equitable, Safe, Timely</td>
</tr>
<tr>
<td>Care Process Team</td>
<td>Efficiency in Diagnosis</td>
<td>Site of positive culture</td>
<td>Process</td>
<td>Effective, Efficient, Equitable, Safe</td>
</tr>
<tr>
<td>Medications</td>
<td>Efficieny in Diagnosis</td>
<td>Length of IV antimicrobial therapy</td>
<td>Outcome</td>
<td>Effective, Efficient, Equitable, Safe</td>
</tr>
<tr>
<td>Medications</td>
<td>Efficieny in Diagnosis</td>
<td>Length of PO antimicrobial therapy</td>
<td>Outcome</td>
<td>Effective, Efficient, Equitable, Safe</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Efficieny in Diagnosis</td>
<td>Number of times under sedation/received sedation.</td>
<td>Process</td>
<td>Effective, Efficient, Equitable, Safe</td>
</tr>
<tr>
<td>Avoidable Events</td>
<td>Hospitalizations</td>
<td>Rate of readmission to hospital within 30 days</td>
<td>Outcome</td>
<td>Effective, Efficient, Safe</td>
</tr>
<tr>
<td>Avoidable Events</td>
<td>Infection</td>
<td>Rate of PICC line complications</td>
<td>Outcome</td>
<td>Effective, Efficient, Safe</td>
</tr>
<tr>
<td>Throughput</td>
<td></td>
<td>Average Length of Stay</td>
<td>Outcome</td>
<td>Care Coordination, Effective, Efficient, Safe, Timely</td>
</tr>
<tr>
<td>Financial</td>
<td></td>
<td>Average Total Cost of Care</td>
<td>Outcome</td>
<td>Effective, Efficient</td>
</tr>
</tbody>
</table>
References

Background and Incidence

Labortory Diagnostic Testing

Antibiotic Therapy

Imaging
EBOC Project Owner: Sarmistha Hauger, MD

Approved by the Acute Hematogenous Osteomyelitis Evidence-Based Outcomes Center Team

Revision History
Date Approved: August 7, 2014
Date Revised: December 2018
Next Review Date: December 2021

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