Orthopaedic Oncology and Infections

Contemporary treatment of chronic osteomyelitis: implementation in low- and middle-income countries

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Abstract

Aim: Chronic osteomyelitis is still a difficult problem to treat in the developed world, but even more so in low- and middle-income countries. Contemporary treatment options result in satisfying outcomes in a setting with abundant resources, but the question is whether these treatment options can be translated to other, less supported health care systems and if they obtain the same results.

Methods: Eighteen patients with established chronic osteomyelitis (eight type III, ten type IV) were prospectively enrolled and treated in a one-stage procedure with radical debridement and dead space management using bioactive glass S53P4 granules, together with adjuvant antibiotic therapy.

Results: Thirteen patients were assessed at 24 months. Infection control was achieved in five patients (38%). Eight patients (61.5%) had persistence or recurrence of infection. Loss to follow-up was substantial (five patients, 28%).

Conclusion: Due to specific challenges treating chronic osteomyelitis in low- and middle-income countries, contemporary treatment options cannot be ‘copy-pasted’ with the same results in these settings.

Level of evidence: Level 4

Key words: osteomyelitis, bio-active glass, biomaterial, low and middle-income countries


Editor: Dr LC Marais, University of KwaZulu-Natal

Received: July 2017 Accepted: November 2017 Published: May 2018

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Funding: The following benefits have been received from a commercial party: Bonalive® 1.0–2.0 mm granules, provided in kind by BonAlive Biomaterials Ltd, Turku, Finland.

Conflict of interest: None to report.
**Introduction**

Chronic osteomyelitis is still a difficult problem to treat in the developed world, but even more so in developing, low- and middle-income countries (LMICs). Musculoskeletal infections in general can be the reason for hospital admission in as much as 14.5% of cases in these countries. Contemporary treatment options, such as the use of bioactive glass in a one-stage setting, result in satisfying outcomes in a setting with abundant resources, but the question is whether these treatment options can be translated to other, less supported health care systems and if they obtain the same results. Specific challenges come particularly with the treatment of chronic osteomyelitis in the setting of low- and middle-income countries: lack of good diagnostic tools (imaging as well as microbiology), availability of proper antibiotics and the possibility of administering these intravenously and for the proper length of time, conditions of availability of proper antibiotics and the possibility of administering these intravenously and for the proper length of time, conditions of surgery and adequate follow-up possibilities. This often results in misdiagnosis and/or under-treatment. Treatment often requires long hospitalisation which can lead to financial problems for the affected patient and their families as well as the health care system of the country concerned. Recurrence rates in the most ideal conditions can still be around 30%, but are of unknown magnitude in LMICs. The aim of this study was to evaluate if a favourable outcome could be obtained using a treatment protocol from a European dedicated infection unit (Maastricht University Medical Centre, the Netherlands) in a setting with much fewer resources.

**Patients and methods**

A series of 18 consecutive patients with chronic osteomyelitis was treated in Ghana over a two-week period in March 2014. This occurred in a 150-bed district hospital which serves as a local referral centre for orthopaedic surgery. X-ray and ultrasound services are also provided. All patients were diagnosed with chronic osteomyelitis, half of which were post-traumatic in origin. The group included 15 men and three women. The average age was 26 years (range 10–70 years). Only patients with implant-associated osteomyelitis and spinal infections were excluded. Data was collected on demographics, comorbidities, clinical features and diagnostic tests, after consent by the individual patient and with the agreement of the hospital’s ethical committee. Grading according to Cierny-Mader, which describes the bone involvement as well as the host status, was done at the time of surgery. All patients had pre-operative X-rays of the affected limb. These were made with a classic X-ray machine (Philips, Eindhoven, the Netherlands), producing hard-copy images (Figure 1). At follow-up in 2016, the hospital had acquired a modern digital system (DigiMedX, Medex Loncin SA, Liège, Belgium).

All patients were operated by the two senior authors (JG & PM). Surgical debridement consisted of thorough bony debridement with removal of all known sequestrae, sauceration of the hypertrophic cortex until punctate bleeding was observed (paprika sign), lavage with at least 3 L of Ringers lactate, curettage of all fistula and removal of abscessed soft tissue. Finally, bony defects were filled with bioactive glass granules, was 48 cc on average (range 10–100 cc). Tissue cultures revealed S. aureus in six cases, Proteus species in six, S. epidermidis in two, Pseudomonas in one, Enterobacter in one, and no organism was cultured in two (Table I). Unfortunately, we were not able to get antibiotic sensitivities in all cases, but the majority in which we did, did not show multi-resistant patterns.

At one-year follow-up, only seven patients (38%) were able to be assessed in person at the outpatient clinic. Of the other 11, four were able to be contacted by mobile phone. All but one were infection-free at that time (55%). The other seven were lost to follow-up. Figure 2 shows a one-year post-operative image of a defect filled with bioactive glass granules. Extra effort was made to see all patients back at the two-year follow-up in March 2016 by reaching out to them in different ways (telephone, mail, community hospitals); we were able to get 13 patients (72%) back to the clinic and five were lost to follow-up (could not even be contacted by phone).

Recurrence (fistula at other than the operated site, but in the same bone) or persistence of infection occurred in eight of those 13 cases in these countries. Contemporary treatment options, such as the use of bioactive glass in a one-stage setting, result in satisfying outcomes in a setting with abundant resources, but the question is whether these treatment options can be translated to other, less supported health care systems and if they obtain the same results. Specific challenges come particularly with the treatment of chronic osteomyelitis in the setting of low- and middle-income countries: lack of good diagnostic tools (imaging as well as microbiology), availability of proper antibiotics and the possibility of administering these intravenously and for the proper length of time, conditions of surgery and adequate follow-up possibilities. This often results in misdiagnosis and/or under-treatment. Treatment often requires long hospitalisation which can lead to financial problems for the affected patient and their families as well as the health care system of the country concerned. Recurrence rates in the most ideal conditions can still be around 30%, but are of unknown magnitude in LMICs. The aim of this study was to evaluate if a favourable outcome could be obtained using a treatment protocol from a European dedicated infection unit (Maastricht University Medical Centre, the Netherlands) in a setting with much fewer resources.

![Figure 1](image1.png)

**Figure 1.** Radiograph of a diffuse tibial osteomyelitis. Note the suboptimal quality, making the identification of sequestra very difficult.

<table>
<thead>
<tr>
<th>Micro-organism</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staphylococcus aureus</td>
<td>6 (33%)</td>
</tr>
<tr>
<td>Proteus mirabilis</td>
<td>6 (33%)</td>
</tr>
<tr>
<td>Staphylococcus epidermidis</td>
<td>2 (11%)</td>
</tr>
<tr>
<td>Pseudomonas aeruginosa</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Enterobacter</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>No growth</td>
<td>2 (11%)</td>
</tr>
</tbody>
</table>
factors are diabetes, sickle cell anaemia and vascular disease. Often it is the continuation of an acute osteomyelitis in childhood, or the result of open trauma. Predisposing factors are diabetes, sickle cell anaemia and vascular disease.4,12

**Discussion**

Low- and middle-income countries have a high burden of chronic osteomyelitis patients.9-11 Often it is the continuation of an acute osteomyelitis in childhood, or the result of open trauma. Predisposing factors are diabetes, sickle cell anaemia and vascular disease.4,12

As the affected population is young, hospitalisation is long and lower limbs are the preferred location, chronic osteomyelitis has an important socio-economic impact on the patient and their family. Depending on the state of the health system in these countries, patients often have to pay for the surgery and the medication themselves. This puts an enormous strain on the patient and his or her family and often results in suboptimal treatment (for instance, antibiotic treatment that is not prolonged beyond a couple of days).13,14 It is also an important reason why many patients don’t seek appropriate medical attention.

Standard surgical treatment includes thorough debridement of all devitalised bone and soft tissue, removal of sequestra, saucerisation and dead space management. If structural integrity is compromised, the affected limb must be stabilised either externally (external fixation or traction) or with plaster of Paris splinting.

Plain radiographs are of no value in the acute stage of osteomyelitis, but do give information about the extent and presence of sequestra in later stages. CT scans are superior for identifying sequestra and MRI for soft tissue involvement, bone marrow abnormalities and evaluation of the extent of the disease.15,16 The latter two are more often than not unavailable in the majority of rural and community hospitals in LMICs, thereby complicating work-up before surgery.

Although we attempted to treat these patients in a similar way to how we would in developed countries (by following our own institutional protocol for surgery, microbiology and adjuvant antibiotic therapy), we had significantly more relapses or unsuccessful

**Figure 2.** Post-operative (1 y) image showing tibial defect filled with bioactive glass granules. Granules in the soft tissues dissolve over time. Also note improved quality of the PACS image.

**Other contemporary methods of treating chronic osteomyelitis in a one-stage setting have been described, such as resorbable calcium sulphate pellets loaded with tobramycin (Osteoset®-T, Wright Medical Technology, Memphis, Tennessee, USA). Humm et al. report one recurrence (5%) of infection in a series of 21 patients with an average follow up of 1.3 years.29 Ferguson et al. describe a larger series of 193 patients, followed up for a mean of 3.7 years, with 18 patients suffering from recurrence (9%).20 Most authors describe wound leakage issues with this biomaterial. Unfortunately, no such studies performed in the setting of low- and middle-income countries could be identified. The same applies for the gentamicin-loaded calcium-sulphate/hydroxyapatite bio-composite known as Cerament G (Bone Support AB, Lund, Sweden). Very good results were reported by McNally et al., with a recurrence rate of only 4% at a mean follow-
up of 19.5 months, in a setting of one of the top referral centres for osteomyelitis in Europe.\textsuperscript{31} The manufacturer reported on a series of patients treated in the Butare University Teaching Hospital in Rwanda in 2013 with this biomaterial in a press release, but no publication on the follow-up was ever published. Finally, Herrafl G, gentamicin-loaded calcium sulphate pellets (Heraeus Medical, Werheim, Germany) have been reported to be used in a one-stage setting in Nigeria by Bafor et al.\textsuperscript{32} In their study, 15 patients were treated (46.7% type III, 13.3% type IV) resulting in infection eradication in 66.7% with a mean follow-up of 14.7 months (8–26 months). In this study, no microbiology was performed and no adjuvant antibiotic treatment administered.

Limitations of this study are the high number of patients lost to follow-up, limited and often suboptimal adjuvant antibiotic treatment, and the absence of a control group. We aim to repeat this study in the future as a randomised control trial with adequate follow-up.

Conclusion

In this paper we conclude that it is currently very difficult to implement state-of-the-art strategies for treating chronic osteomyelitis with modern biomaterials in a setting with often insufficient resources and expect the same outcome. There are a lot of conditions that have to be met, like proper imaging, access to microbiology, availability of adequate antibiotics and follow-up. The concept of treating osteomyelitis in a one-stage setting with modern biomaterials is, however, very attractive in these settings and further research should focus on optimising the implementation thereof, decreasing the need for antibiotic administration and reducing costs in order to offer these treatments to many more patients.

Ethics statement

Before the commencement of this study, consent was obtained from the individual patients, and with the agreement of the hospital’s ethical committee.

References


