A healthy 29-year-old man presented with unexplained acute left tibial pain with a rapid and spontaneously favourable evolution. One year later, he experienced symptom relapse, with a 5-kg weight loss and night sweats for 2 months. His C-reactive protein was 14 mg/l. Radiological assessment revealed a centromedullary metaphyseal bone defect (3 × 3 × 4 cm) associated with tibial pandiaphysitis, but no cortical lysis (Figure 1A–C). A surgical bone biopsy was performed, which exhibited haemorrhagic and purulent fluid with no malignant cells. Microbiological cultures yielded *Salmonella saprophyticus*, leading to the final diagnosis of chronic tibial pandiaphysitis with metaphyseal Brodie abscess. No history of dysenteric syndrome was reported.

The patient underwent a surgical osteotomy for excision of the abscess cavity (Figure 1D) after a preoperative course of...
ceftriaxone (2 g/day, body weight 65 kg, minimum inhibitory concentration [MIC] ≤ 1 mg/l), followed by oral ofloxacin (200 mg twice daily, MIC ≤ 0.25 mg/l) for a total duration extended to 6 months due to a 3-month delay in surgical management and the large size of the abscess. The outcome was favourable after 2 years of follow-up.

Osteomyelitis is a rare but classic complication of Salmonella infection, typically affecting the long bones of patients with haemoglobinopathies or immunosuppression. The ability of most Salmonella isolates to form a biofilm reinforces the importance of surgical debridement in large Brodie abscesses (>3 cm), in addition to a prolonged antimicrobial course, if possible based on a fluoroquinolone.

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References


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