Acute osteomyelitis is a diagnostic and therapeutic emergency, whose early diagnosis and timely treatment improve prognosis and minimize the risk of progression to chronicity and complications. Knowledge about the use of bone grafts has demonstrated clinical success in musculoskeletal surgery. The clinical achievements and the ability to solve highly complex pathologies are directly related to the possibility of having allografts or bone autografts. The surgeon who faces a reconstructive and rescue problem must choose the graft to use that has the greatest integration potential, according to local conditions and minimize the risk of complications, especially in thumb injuries where the fist and clamp maneuver are of vital importance for activities of daily living.

CASE REPORT

The clinical case correspond a 63-years-old male, with no known morbid history or allergies. Smoker +. Two weeks of evolution of pain in the right thumb plus volume increase and erythema, secondary to a puncture wound in the kitchen area while on board.

Physical exam (image1), right thumb with erythema, increased phlegmonous volume, associated with functional impotence. Radiological studies (image2) were requested to complement the study, where an osteolytic lesion involving the entire distal phalanx is observed.

Patient is hospitalized for surgery and intravenous antibiotic treatment. Surgical cleanliness was performed with dorsal approach to proximal, with loss of almost the entire distal phalanx and almost complete infectious involvement of the extensor tendon. As well as commitment of the capsule and the joint.

3 cultures samples and 2 biopsies of perilesional and bony tissue are taken. It is left in treatment with intravenous Clindamycin, secondary to a puncture wound in the kitchen area while on board.

In medical control, it was decided to perform phalangisation by means of a structural bone graft technique of the anterior iliac crest, in addition to sample taking of secretion and tissue culture. Graft is carved (image 4) and fixed with transient axial Kirschner wire, and 28 mm TRIMED® compression screw step (image 5). He is immobilized with Jackson splint. It evolves favorably and it is decided released with ambulatory control. The following week, the last culture is rescued, being positive for negative coagulase staphylococcus, being evaluated by an infectious agent, for negative coagulase staphylococcus, being evaluated by an infectious agent, who suggests maintaining behavior without antimicrobials.

In 9 days, continuing with antibiotic treatment orally. Two weeks after structural bone grafting, the patient is referred to Occupational Therapy and Kinesiology (image 6). At 9 weeks postoperatively, he presented advanced signs of consolidation, with a well-tolerated grip and grip maneuver. It is decided to register as a patient together with a multidisciplinary team, reintegrating to differentiated tasks in his work.

Bibliography