Skull osteomyelitis

• Novel application of chelator-based bone debridement for refractory skull osteonecrosis complicated by Pseudomonas aeruginosa osteomyelitis

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- Calvarial Syphilitic Osteomyelitis as a Rare Manifestation of Secondary Syphilis in an Immunocompetent Patient: A Rare Diagnostic Challenge
- An Intriguing Case Report of Tuberculous Osteomyelitis of the Skull Base with Perineural Spread: Masquerading as Nasopharyngeal Carcinoma
- Metronidazole's hidden impact: decoding cerebellar clues on MRI through a case report
- Skull Base Osteomyelitis- Microbiological Profile and Management Implications
- Current Evidence in the Management of Central Skull Base Osteomyelitis: A Systematic Review
- Refining necrotising otitis externa management: A follow-up study on a departmental algorithm and the role of nuclear medicine imaging
- Clival Osteomyelitis Secondary to Isolated Sphenoid Sinusitis Caused by Nocardia veterana in an Immunocompetent Patient: A Case Report

see also Skull base osteomyelitis

In 1775, cranial osteomyelitis was first explained by surgeon Percival Pott as a collection of pus under the pericranium. Dr. Pott reported cranial osteomyelitis as a consequence of forehead trauma (bone contusion) and extradural hemorrhage $^{1)}$

General information

The skull is normally very resistant to osteomyelitis, and hematogenous infection is rare.

Etiology

Most infections are due to contiguous spread (usually from an infected air sinus, occasionally from scalp abscess) or to penetrating trauma (including surgery and fetal scalp monitors). With longstanding infection, edema and swelling in the area may become visible (usually over the forehead, but also may occur over the mastoids), and is called "Pott puffy tumor" (after Percivall Pott).

Osteomyelitis in pin sites: risk is reduced with good pin care.

Skull osteomyelitis from a infected pilar cyst

Pathogens

Staphylococcus is the most common organism, with Staphylococcus aureus predominating, followed by Staphylococcus epidermidis. In neonates, Escherichia coli may be the infecting organism.

Subgaleal abscesses and skull osteomyelitis are very uncommon since the introduction of antibiotics.

Skull-based osteomyelitis, which is a true bone infection, originates from a chronic infection, which has been inadequately treated. Because of the bony-based architecture and associated aesthetic concerns, osteomyelitis of the craniofacial skeleton must be managed differently than osteomyelitis of other bones of the body. This makes craniofacial infections more challenging to treat ²⁾.

Diagnosis

Skull osteomyelitis diagnosis.

Treatment

Skull osteomyelitis treatment

Books

Cranial Osteomyelitis: Diagnosis and Treatment By Ali Akhaddar.

This book is the first reference book covering exclusively all aspects of this challenging disease. It is designed to serve as a succinct appropriate resource for neurosurgeons, otorhinolaryngologists, neuroradiologists, researchers and infectious disease specialists with an interest in cranial infection. Cranial Osteomyelitis provides an in-depth review of knowledge of the management of skull osteomyelitis, with an emphasis on risk factors, causative pathogens, pathophysiology of dissemination, clinical presentations, neuroradiological findings and treatment modalities, medical and surgical. Sections on the prognosis and prevention of this illness are also included. The book will help the reader in choosing the most appropriate way to manage this challenging bone infection. In addition, it supplies clinicians and investigators with both basic and more sophisticated information and procedures relating to the complications associated with skull osteomyelitis. It also considers future areas of investigation and innovative therapeutic philosophies. The book is richly illustrated to provide readers with unparalleled access to a comprehensive collection of cranial osteomyelitis images (biological, clinical, neuroradiological, and surgical) taken directly from the author's collection and experience in the field.

Case series

A retrospective study includes 18 patients who underwent 28 admissions for treatment of osteomyelitis of the skull. Each admission was reviewed separately. Systemic symptoms were rare and signalled the presence of an associated collection of pus. Films of the skull, polytomography and bone scans were all useful in establishing the diagnosis, whereas white blood cell count, erythrocyte sedimentation rate and brain scans were of little value. Complete surgical debridement was found to be of significantly greater value than limited surgical debridement. The surgical results appeared to be improved when surgery was followed by long courses of antibiotics. Each patient who received complete surgical debridement followed by at least six weeks of antibiotic therapy was cured ³.

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Case reports

Skull osteomyelitis case reports.

Case reports from the HGUA

Early Conjunctival Membranous Reaction Suggestive of Stevens-Johnson Syndrome in a Patient Treated with Vancomycin for Skull Osteomyelitis

1)

Pott P. London: L Hawes, W Clarke, R Collins; 1768. Observations on the Nature and Consequences of Those Injuries to Which the Head Is Liable from External Violence.

Prasad K C, Prasad S C, Mouli N, Agarwal S. Osteomyelitis in the head and neck. Acta Otolaryngol. 2007;127:194–205

Bullitt E, Lehman RA. Osteomyelitis of the skull. Surg Neurol. 1979 Mar;11(3):163-6. PubMed PMID: 473006.

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