

Antibiotics should be withheld until sterile tissue cultures are obtained, unless the patient is septic or there is a concomitant soft tissue infection. Identification of the causative organism is very important in order to treat appropriately.

## EVALUATION

- ✦ Obtain sterile tissue cultures by percutaneous aspirate or surgical deep culture (ideally before starting antibiotics)
- ✦ Wound swabs tend to reflect colonization, and often do not indicate the infecting organism at the site of osteomyelitis
- ✦ If septic, draw blood cultures

## EMPIRIC CHOICE

- ✦ For diabetic foot infections, refer to the 1-page document on that topic
- ✦ Acutely Unwell or Septic:
  - ceftriaxone 2 g iv q24h +/- metronidazole 500 mg p.o./iv q12h (add metronidazole for sacral osteomyelitis) +/- vancomycin (if known to be colonized/previous infection with MRSA)
  - if known to be ESBL colonized/previous infection: Meropenem 1 g iv q8h +/- vancomycin if known to be colonized/previous infection with MRSA
- ✦ Not septic:
  - Await sterile culture results to guide treatment

## DURATION

- ✦ 4-6 weeks
- ✦ Shorter courses could be considered if the infected bone has been appropriately debrided

## ALTERNATIVES FOR ALLERGIES

- ✦ If septic: meropenem 1 g iv q8h (penicillin cross-reactivity is ~ 1%) +/- vancomycin
- ✦ Not septic: await sterile culture results to guide treatment

## TOP ORGANISMS

- ✦ *Staphylococcus aureus*
- ✦ Streptococci
- ✦ Gram negative bacilli
- ✦ Anaerobes

## IMMUNOCOMPROMISED HOST CONSIDERATION

- ✦ Same as for immunocompetent host

## ADDITIONAL DIAGNOSTIC AND THERAPEUTIC COMMENTS

- ✦ X-ray be normal for the first 2 weeks of osteomyelitis; use CT or MRI for diagnosis if suspicion is high but x-ray is negative