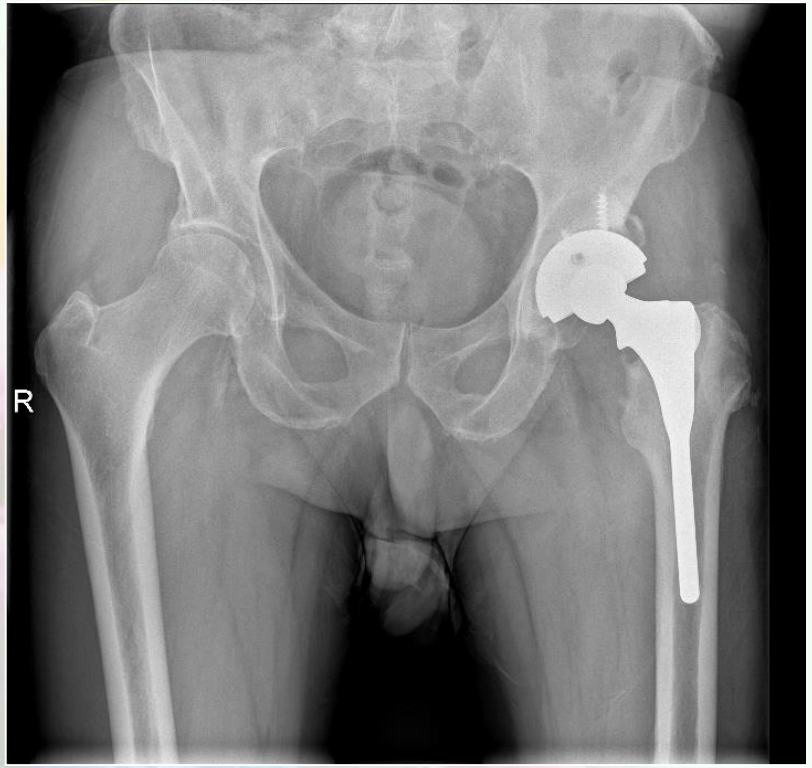
X REUNIÓN CIENTÍFICA
GEIO 2025

MIS CASOS CON INFECCIÓN PROTÉSICA CRÓNICA

José Mª Lamo de Espinosa
Hospital Biomédico ASCIRES (Valencia)
José Mª Barbero Allende
Hospital Príncipe de Asturias (Alcalá de Henares)

GEIO
GRUPO DE ESTUDIO DE LA INFECCIÓN OSTEOARTICULAR
seimc

seimc



H 69 a

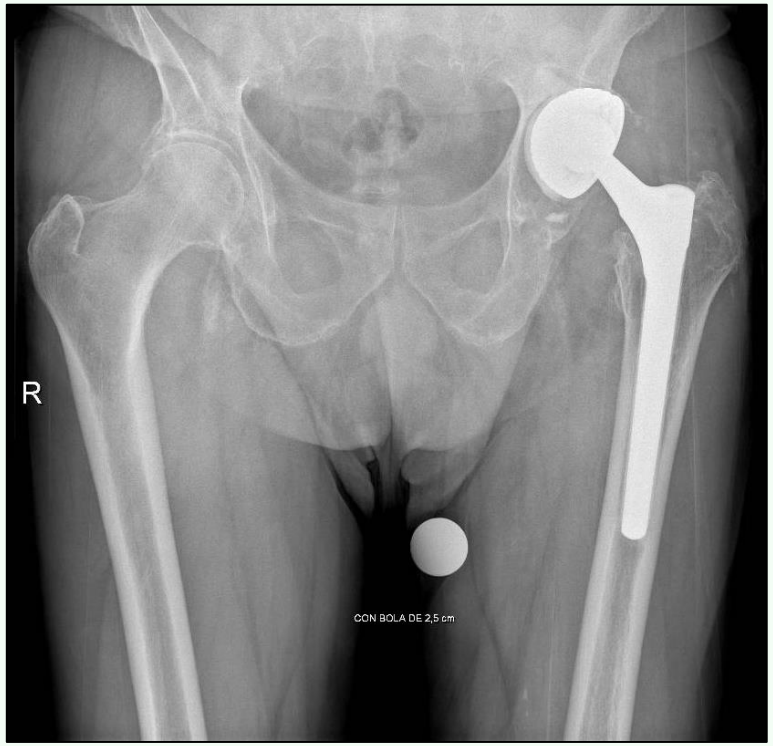
Implantes movilizados

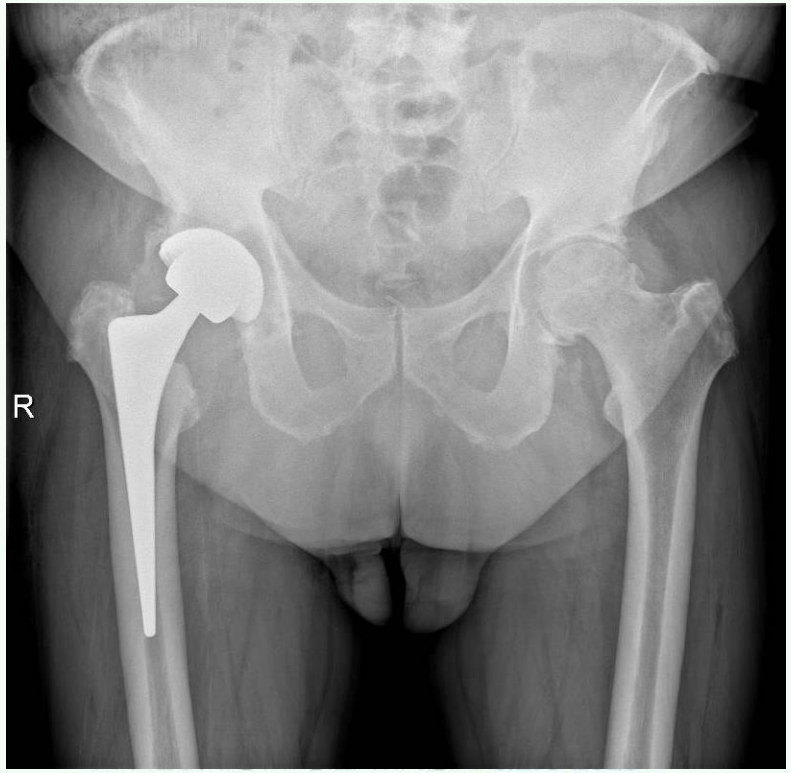
H 79 a

Antecedente Ca. Púlmón

Cardiópata

Recambio previo



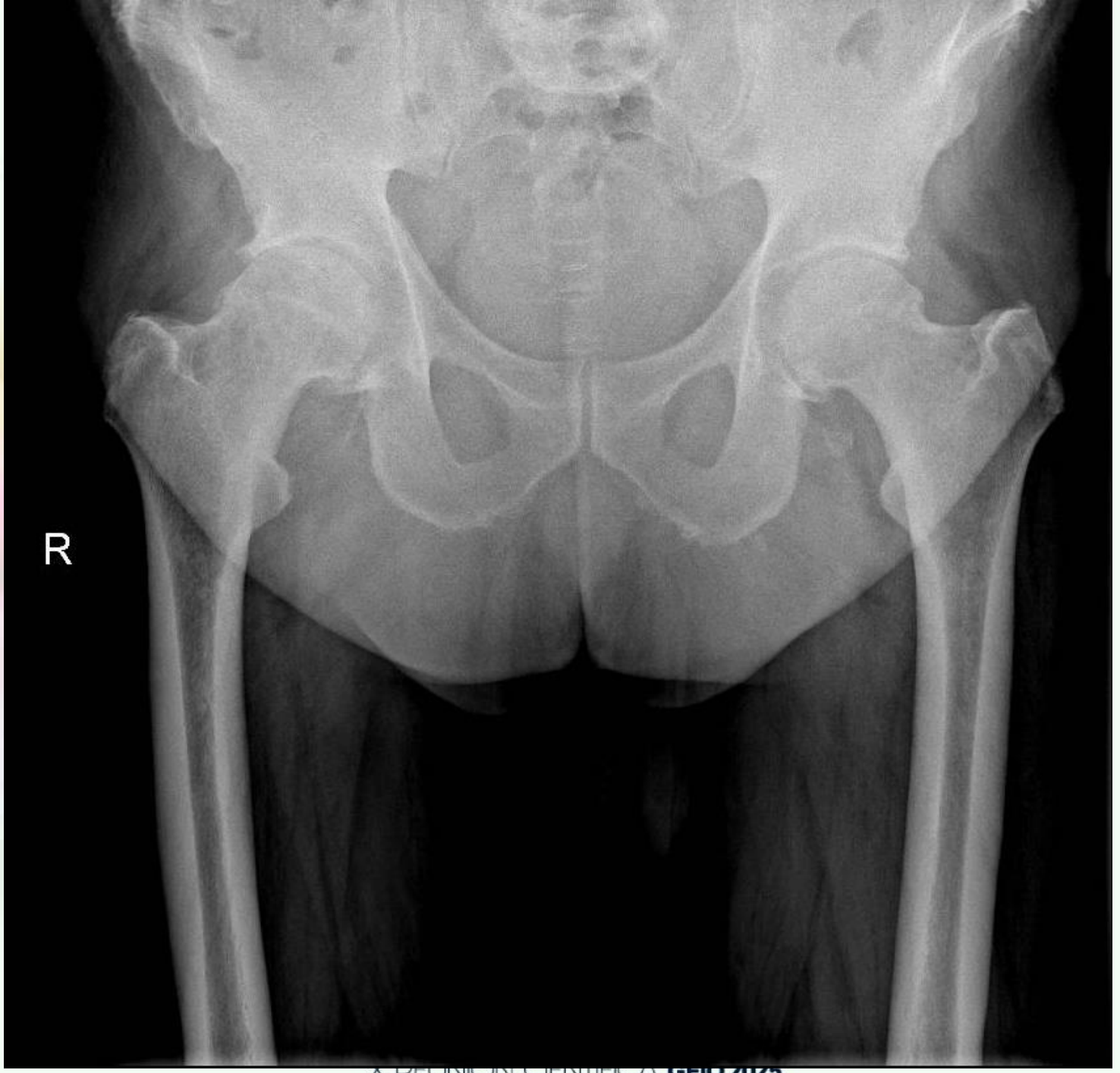


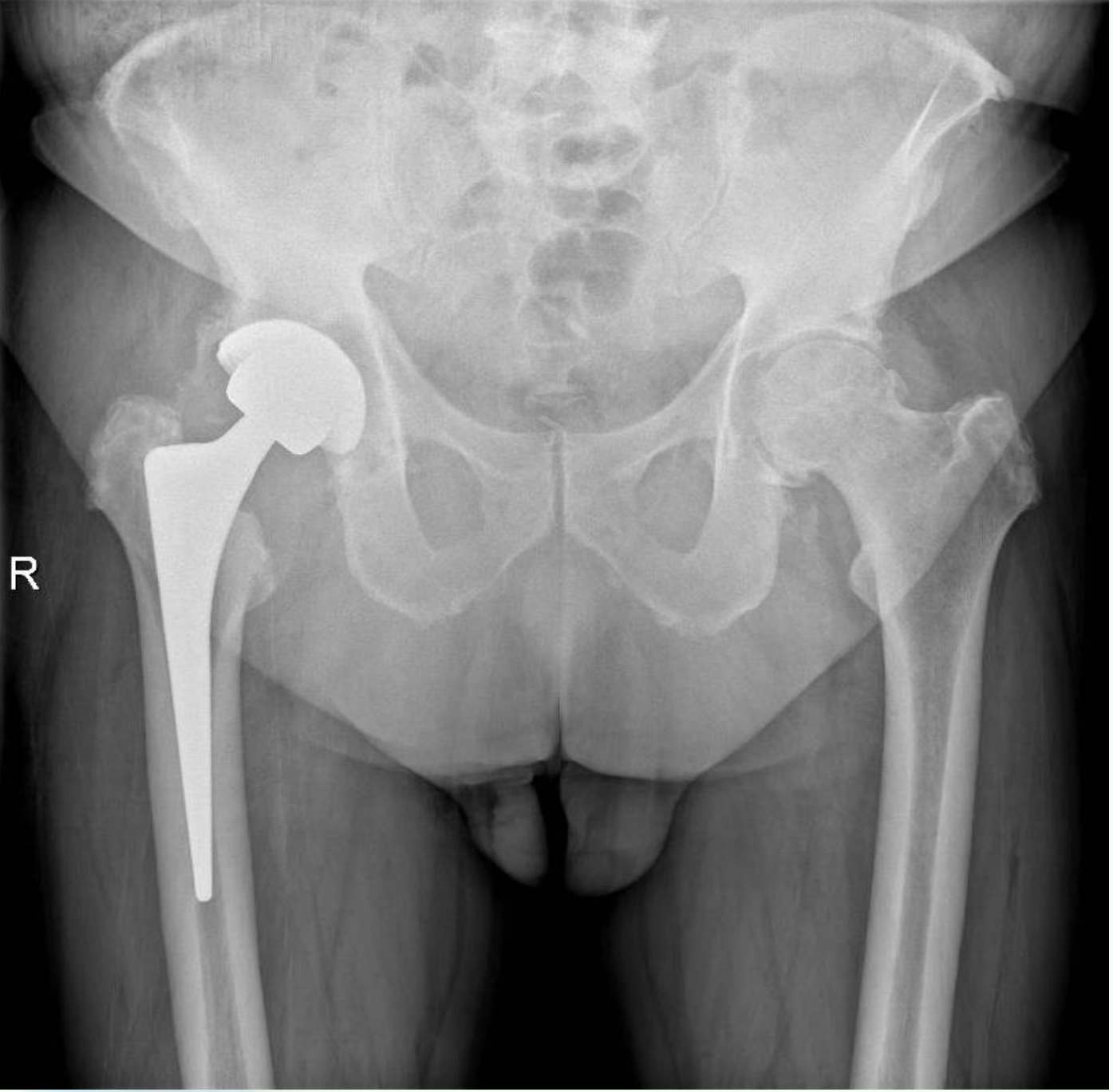
H 60 a

Implantes estables

V60a

379946
ABRIL 2014





379946

H 64 años

PTC dcha (Abril 2014)

Prostatectomía radical (Julio 2024)
Eritema, dolor inguinal.

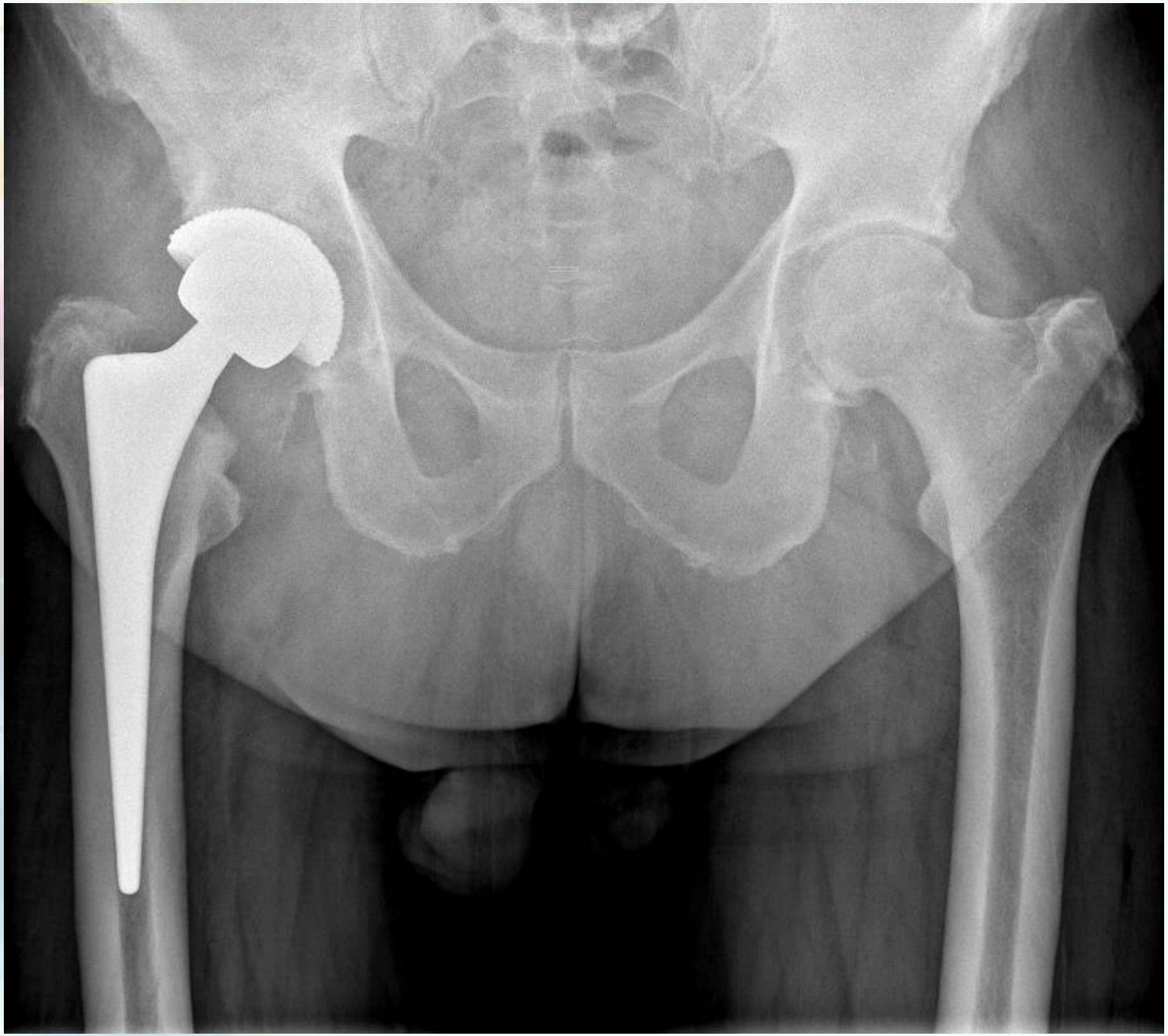
Signos inflamatorios →

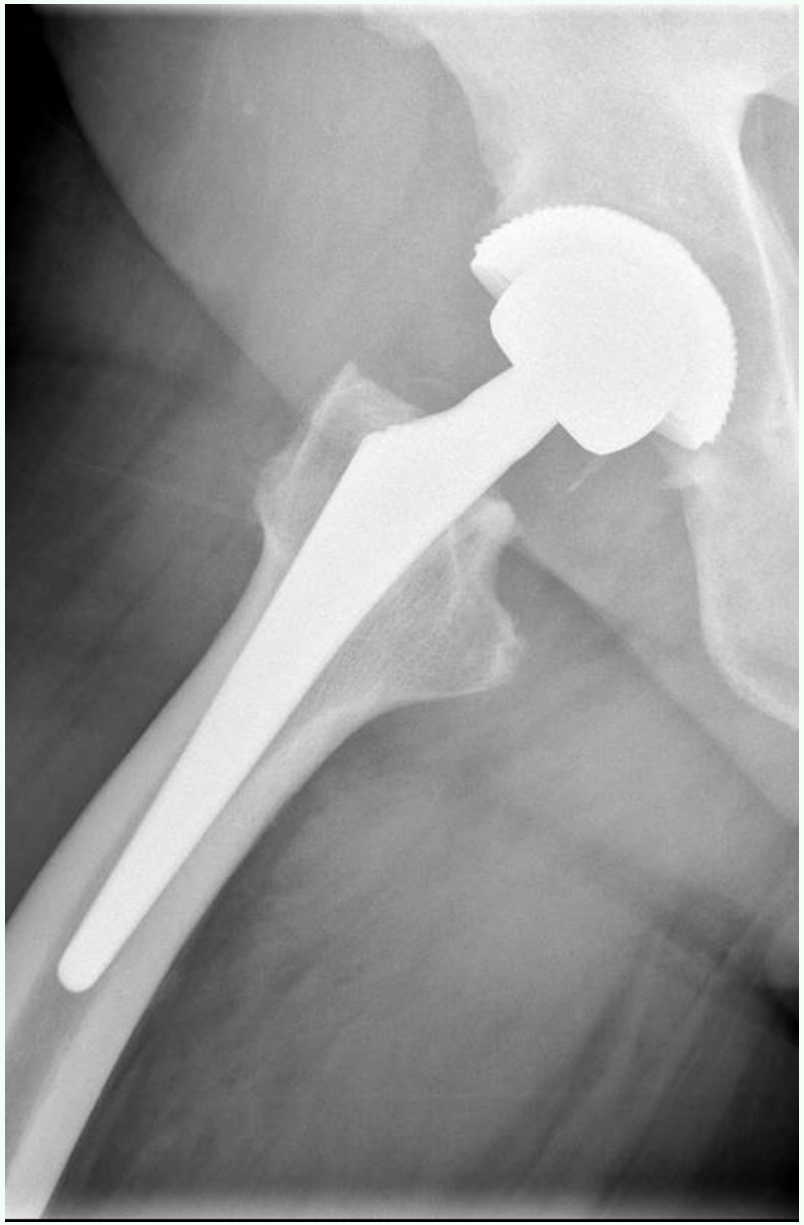
Cultivos Negativos → Levofloxacino

↓

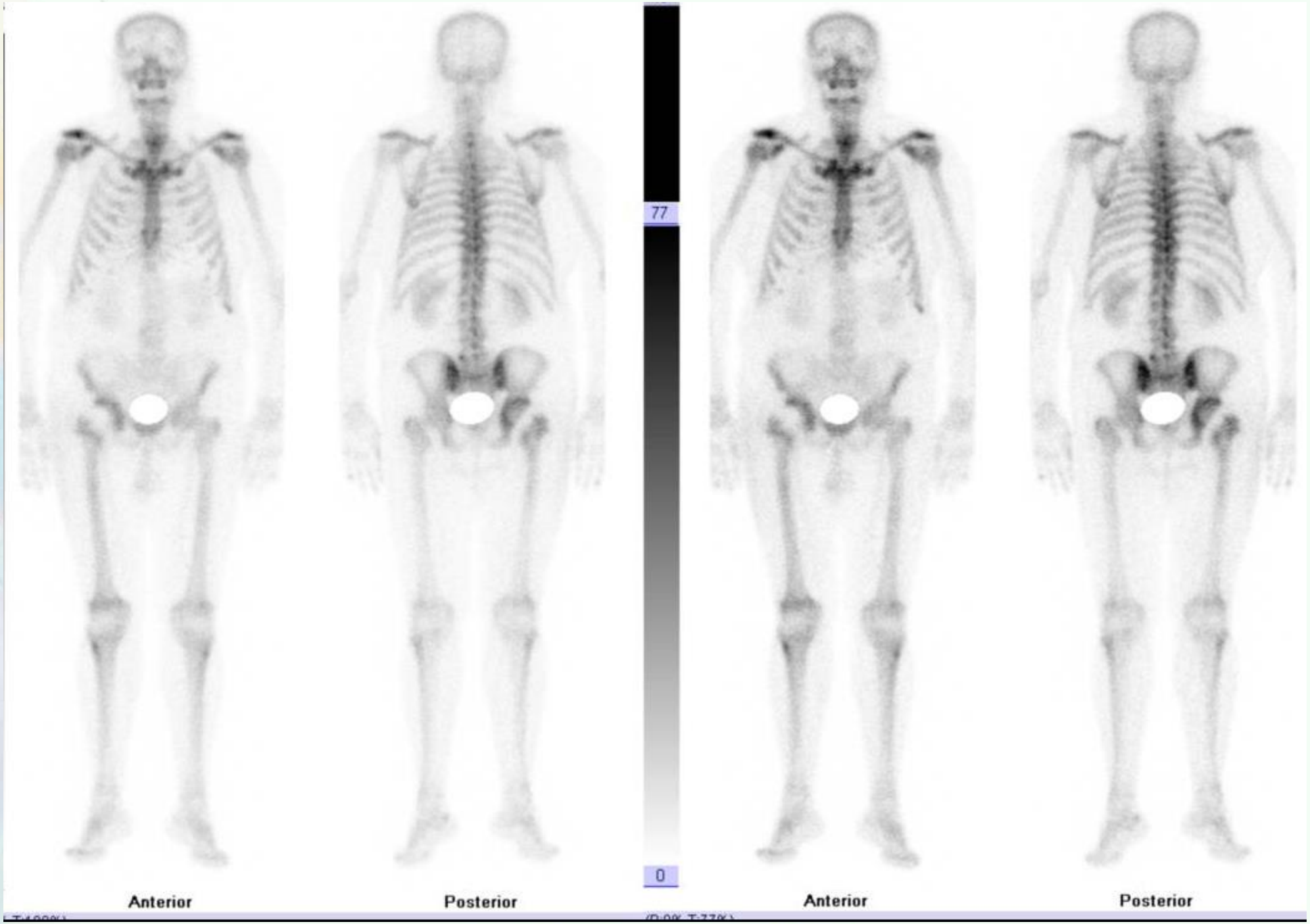
El mismo suspende
los antibióticos
por agotamiento

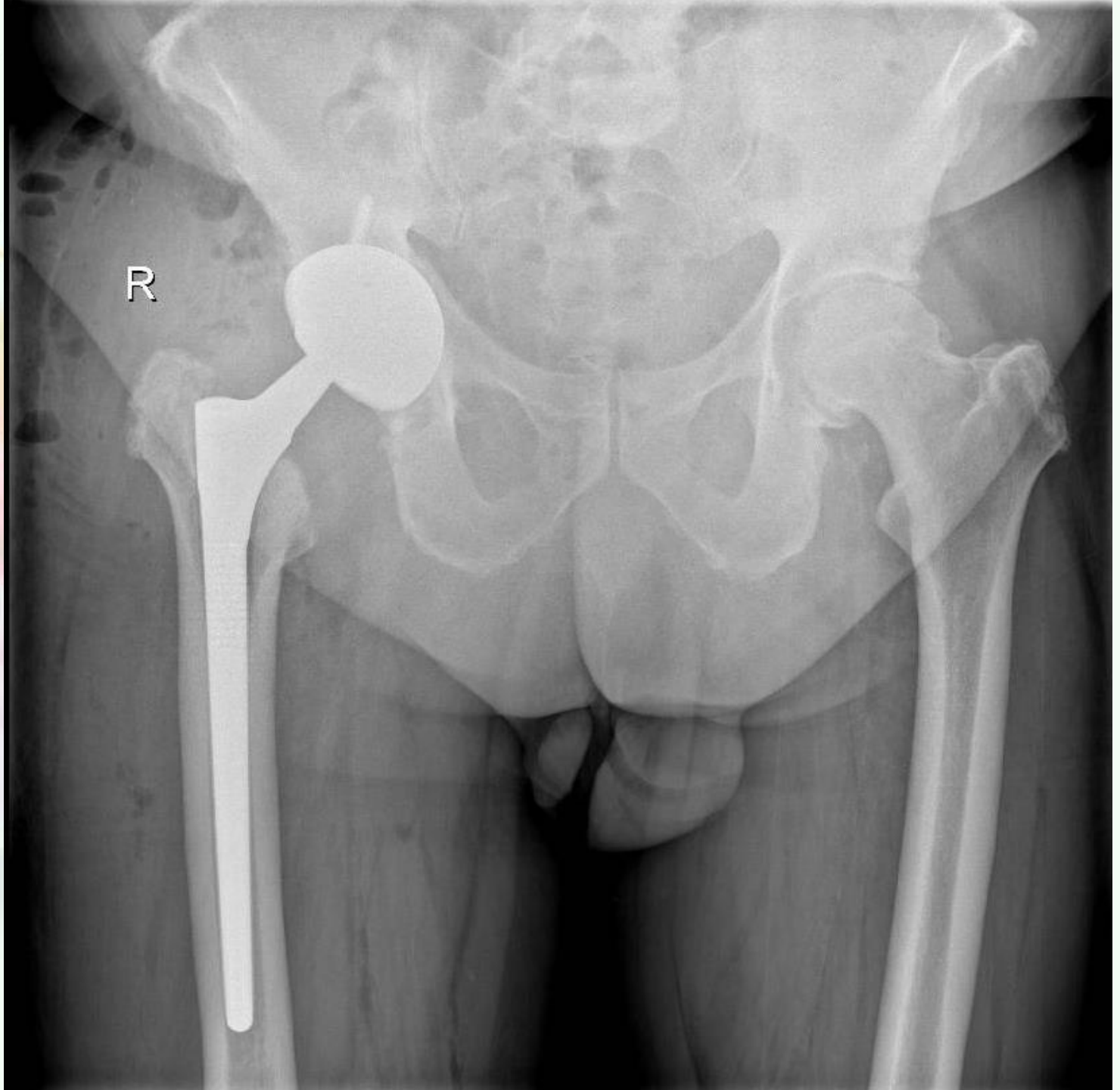
379946
JUNIO 2014





379946

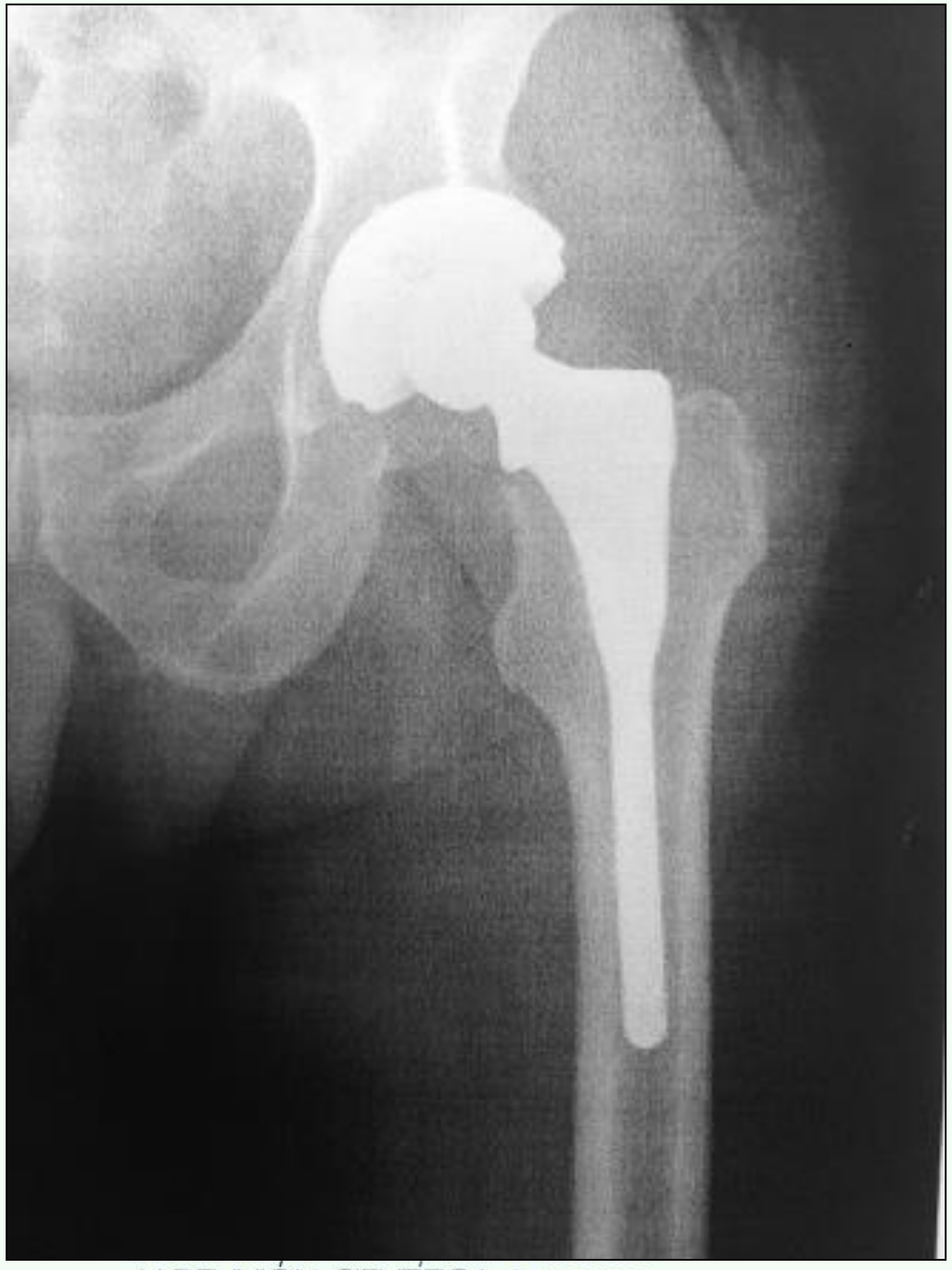


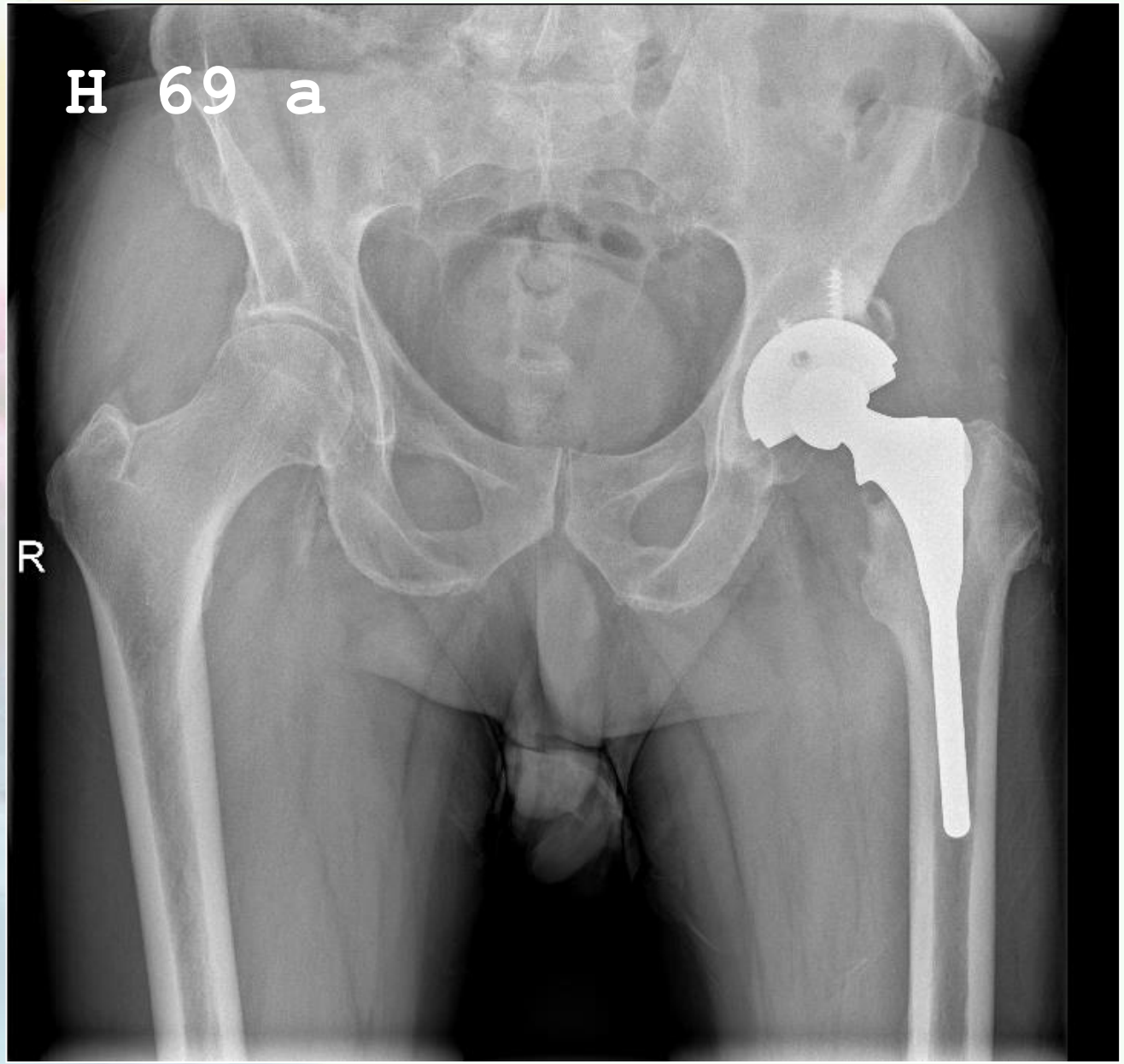


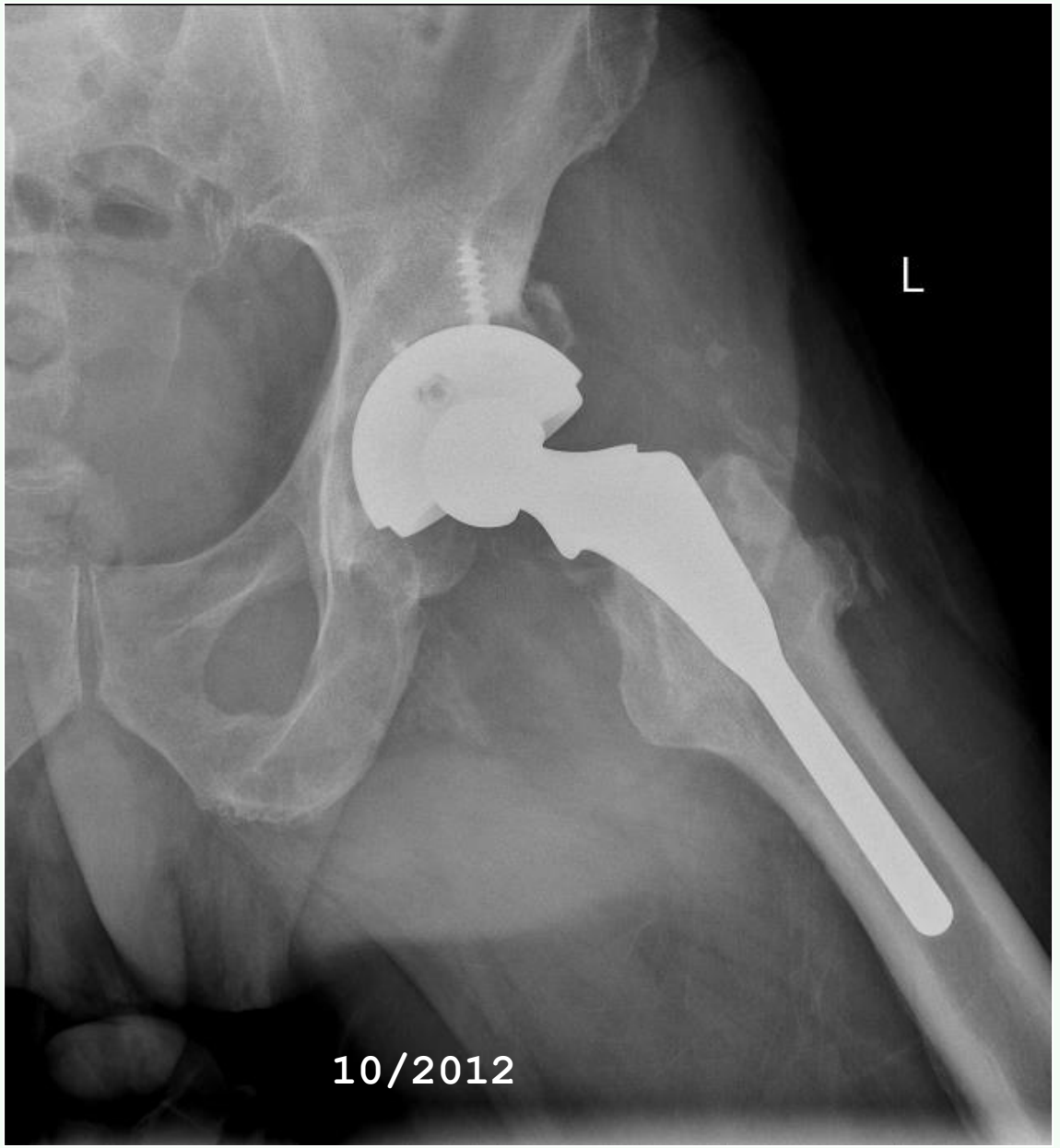
379946

H 69 a

2011

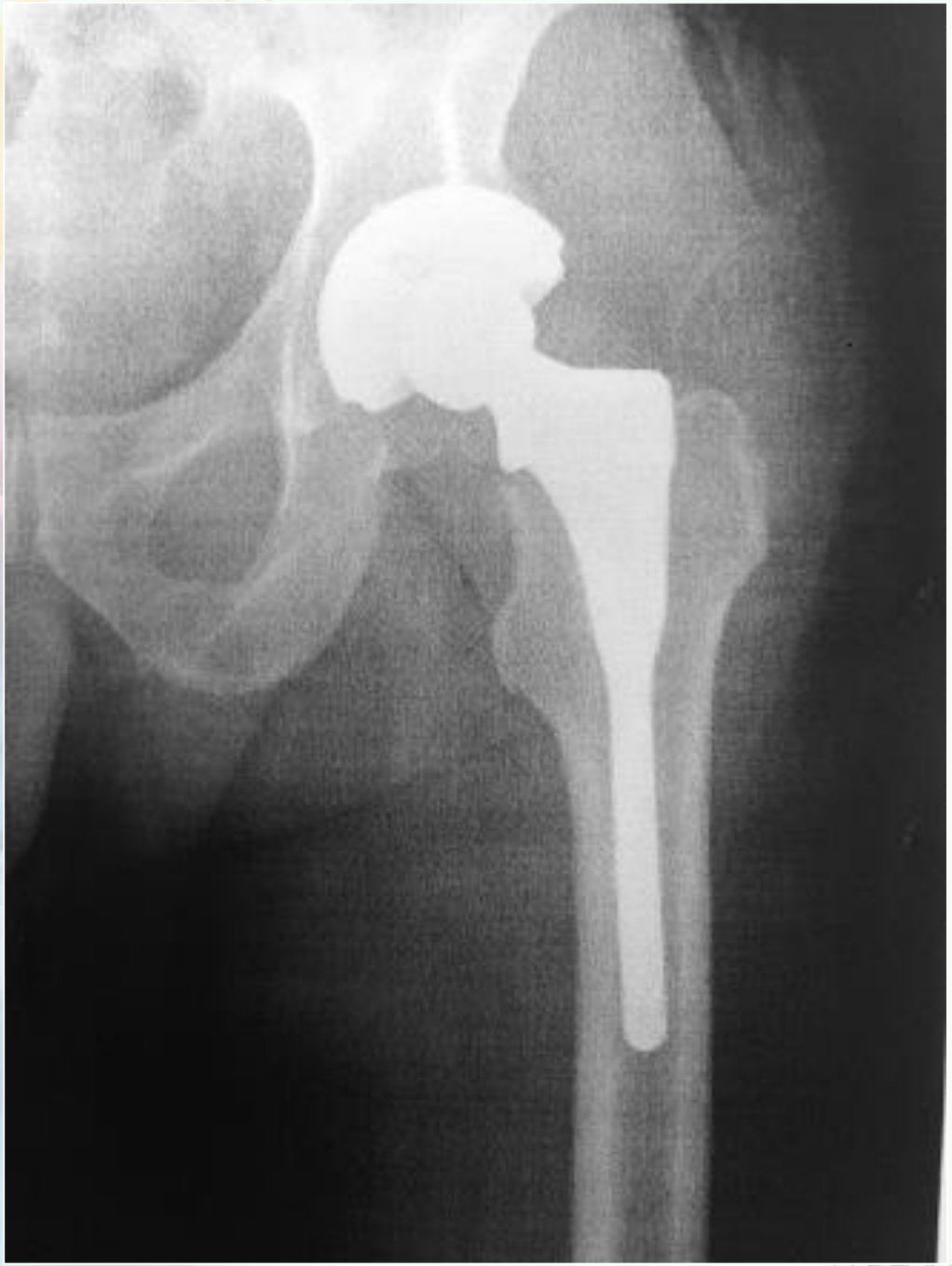


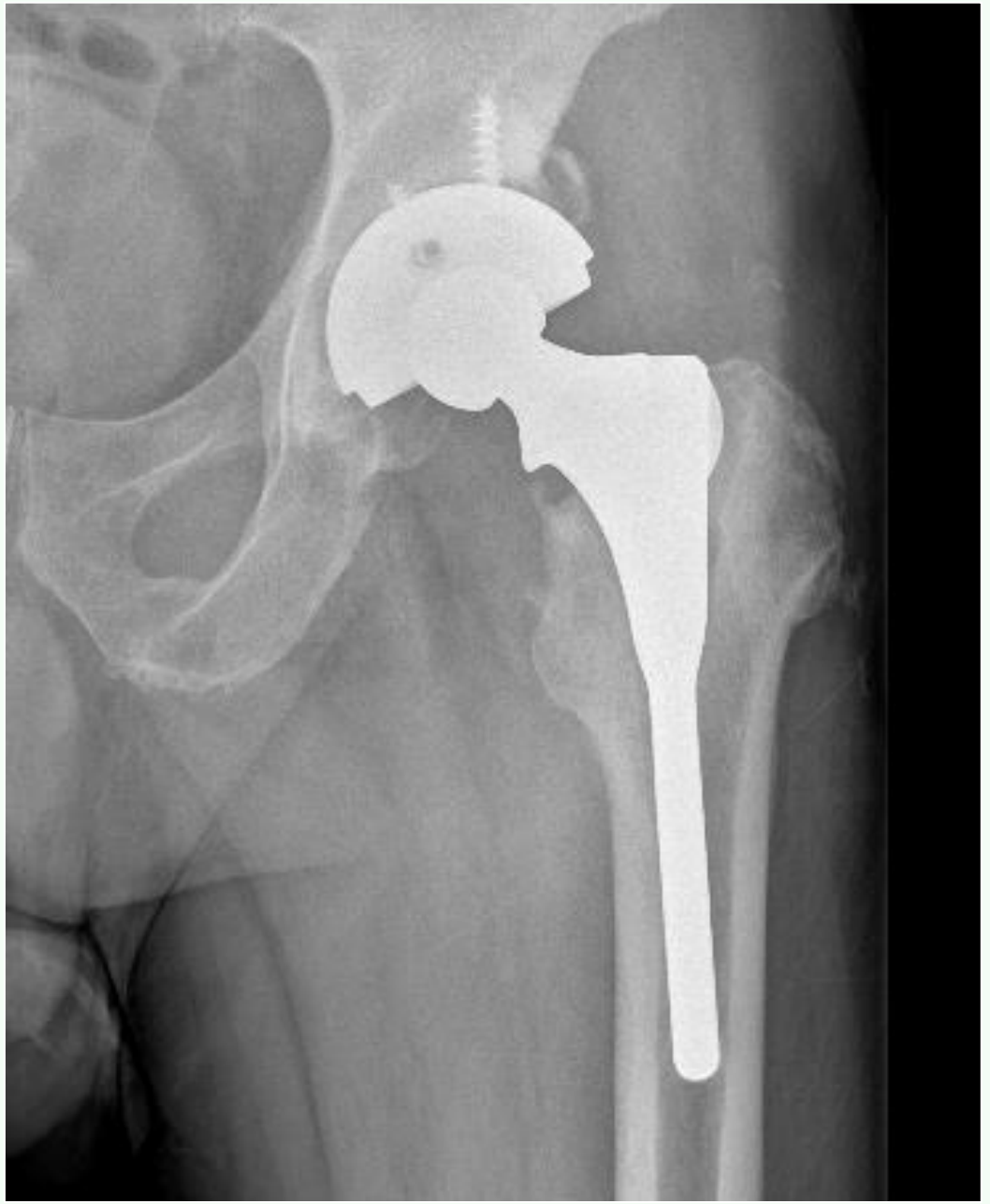




Cultivo: S. Epidermidis

248827





248827

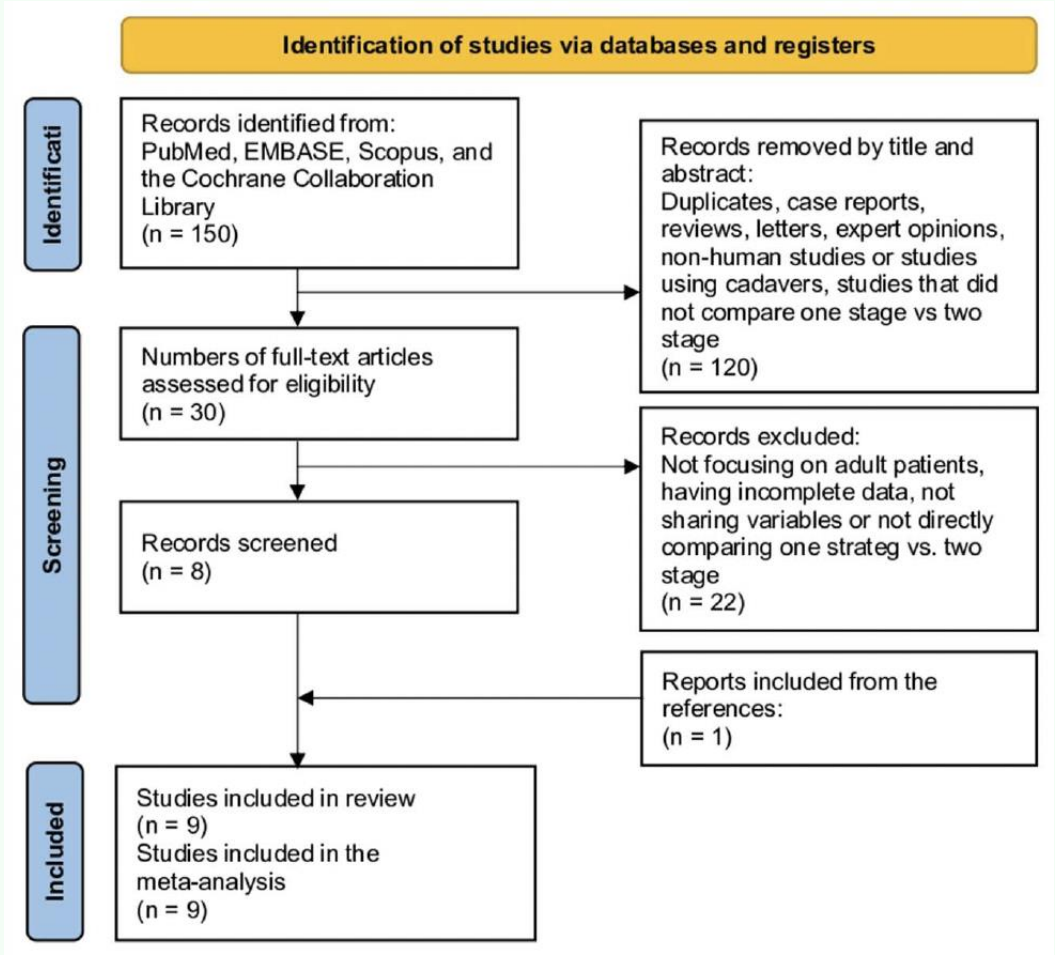

Axial
Sagital
Coronal
Spect Óseo [- Corrected Recon], 19/10/2012
AC Osteo 5.0 B80s, 18/10/2012
%
90
5
A
Der
Izq
P
H
F
AC Osteo 5.0 B80s, 18/10/2012
HU
D

248827

Journal of the AAOS
AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

One-Stage Versus Two-Stage Revision Surgery for Periprosthetic Hip Infection: An Updated Systematic Review and Meta-Analysis of Clinical Outcomes

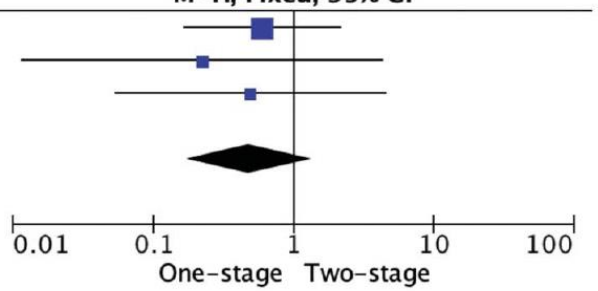
José María Lamo-Espinosa, PhD
Gonzalo Mariscal, PhD
Jorge Gómez-Álvarez, MD
Lluís Font-Vizcarra, PhD
Jose Luis del Pozo, PhD
Mikel San-Julián, PhD



a) MRSA

Study or Subgroup	One-stage Events	One-stage Total	Two-stage Events	Two-stage Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Choi et al. 2013	4	17	15	44	53.8%	0.59 [0.17, 2.14]
Oussedik et al. 2010	0	11	6	39	24.2%	0.22 [0.01, 4.30]
Sotiriou et al. 2020	1	46	4	92	22.0%	0.49 [0.05, 4.50]
Total (95% CI)		**74**		**175**	**100.0%**	**0.48 [0.17, 1.34]**
Total events	5		25			

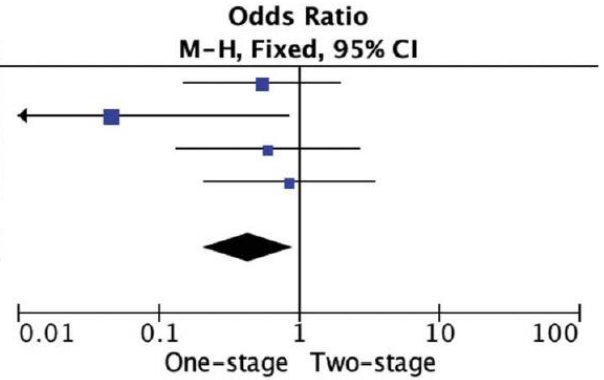
Heterogeneity: $Chi^2 = 0.36$, df = 2 (P = 0.83); $I^2 = 0\%$
Test for overall effect: Z = 1.39 (P = 0.16)



b) Coagulase-negative Staphylococcus

Study or Subgroup	One-stage Events	One-stage Total	Two-stage Events	Two-stage Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Choi et al. 2013	4	17	16	44	28.0%	0.54 [0.15, 1.93]
Oussedik et al. 2010	0	11	19	39	35.4%	0.05 [0.00, 0.83]
Sotiriou et al. 2020	3	9	21	46	18.8%	0.60 [0.13, 2.67]
Tirumala et al. 2021	3	46	7	92	17.9%	0.85 [0.21, 3.44]
Total (95% CI)		**83**		**221**	**100.0%**	**0.43 [0.21, 0.89]**
Total events	10		63			

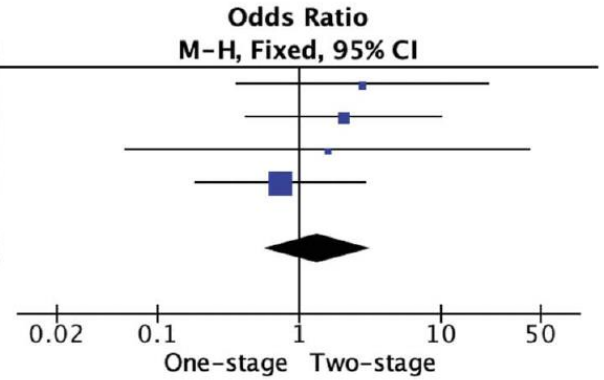
Heterogeneity: $Chi^2 = 3.50$, df = 3 (P = 0.32); $I^2 = 14\%$
Test for overall effect: Z = 2.26 (P = 0.02)



c) Gram-negative

Study or Subgroup	One-stage Events	One-stage Total	Two-stage Events	Two-stage Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Choi et al. 2013	2	17	2	44	11.8%	2.80 [0.36, 21.68]
Oussedik et al. 2010	3	11	6	39	23.0%	2.06 [0.42, 10.08]
Sotiriou et al. 2020	0	9	1	46	6.0%	1.60 [0.06, 42.26]
Tirumala et al. 2021	3	46	8	93	59.3%	0.74 [0.19, 2.94]
Total (95% CI)		**83**		**222**	**100.0%**	**1.34 [0.56, 3.20]**
Total events	8		17			

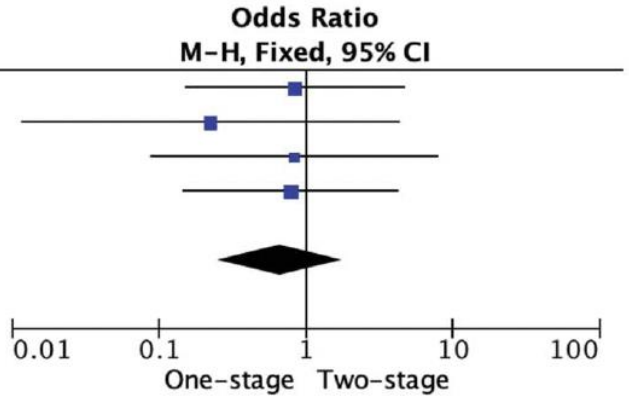
Heterogeneity: $Chi^2 = 1.50$, df = 3 (P = 0.68); $I^2 = 0\%$
Test for overall effect: Z = 0.66 (P = 0.51)



a) Mixed growth

Study or Subgroup	One-stage Events	Total	Two-stage Events	Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Choi et al. 2013	2	17	6	44	27.4%	0.84 [0.15, 4.66]
Oussedik et al. 2010	0	11	6	39	26.7%	0.22 [0.01, 4.30]
Sotiriou et al. 2020	1	9	6	46	16.2%	0.83 [0.09, 7.90]
Tirumala et al. 2021	2	46	5	92	29.6%	0.79 [0.15, 4.24]
Total (95% CI)		**83**		**221**	**100.0%**	**0.66 [0.25, 1.76]**
Total events	5		23			

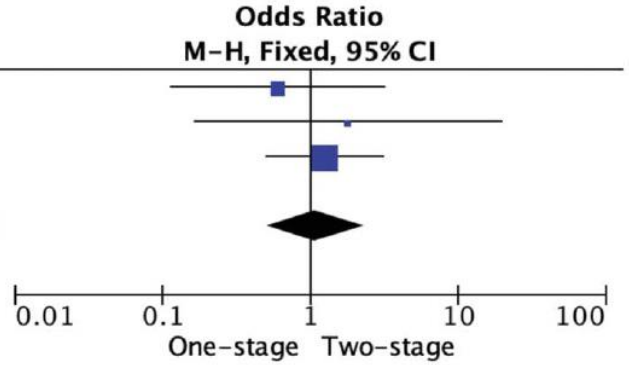
Heterogeneity: $Chi^2 = 0.68$, df = 3 (P = 0.88); $I^2 = 0\%$
Test for overall effect: Z = 0.83 (P = 0.41)



b) Negative culture

Study or Subgroup	One-stage Events	Total	Two-stage Events	Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Choi et al. 2013	2	17	8	44	30.6%	0.60 [0.11, 3.16]
Sotiriou et al. 2020	1	9	3	46	6.8%	1.79 [0.16, 19.47]
Tirumala et al. 2021	9	46	15	92	62.6%	1.25 [0.50, 3.12]
Total (95% CI)		**72**		**182**	**100.0%**	**1.09 [0.51, 2.31]**
Total events	12		26			

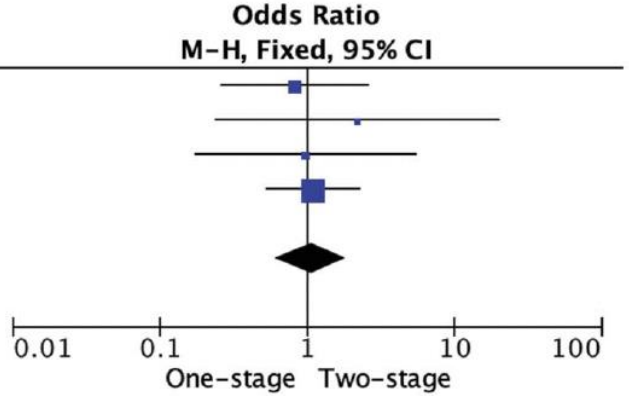
Heterogeneity: $Chi^2 = 0.75$, df = 2 (P = 0.69); $I^2 = 0\%$
Test for overall effect: Z = 0.22 (P = 0.83)

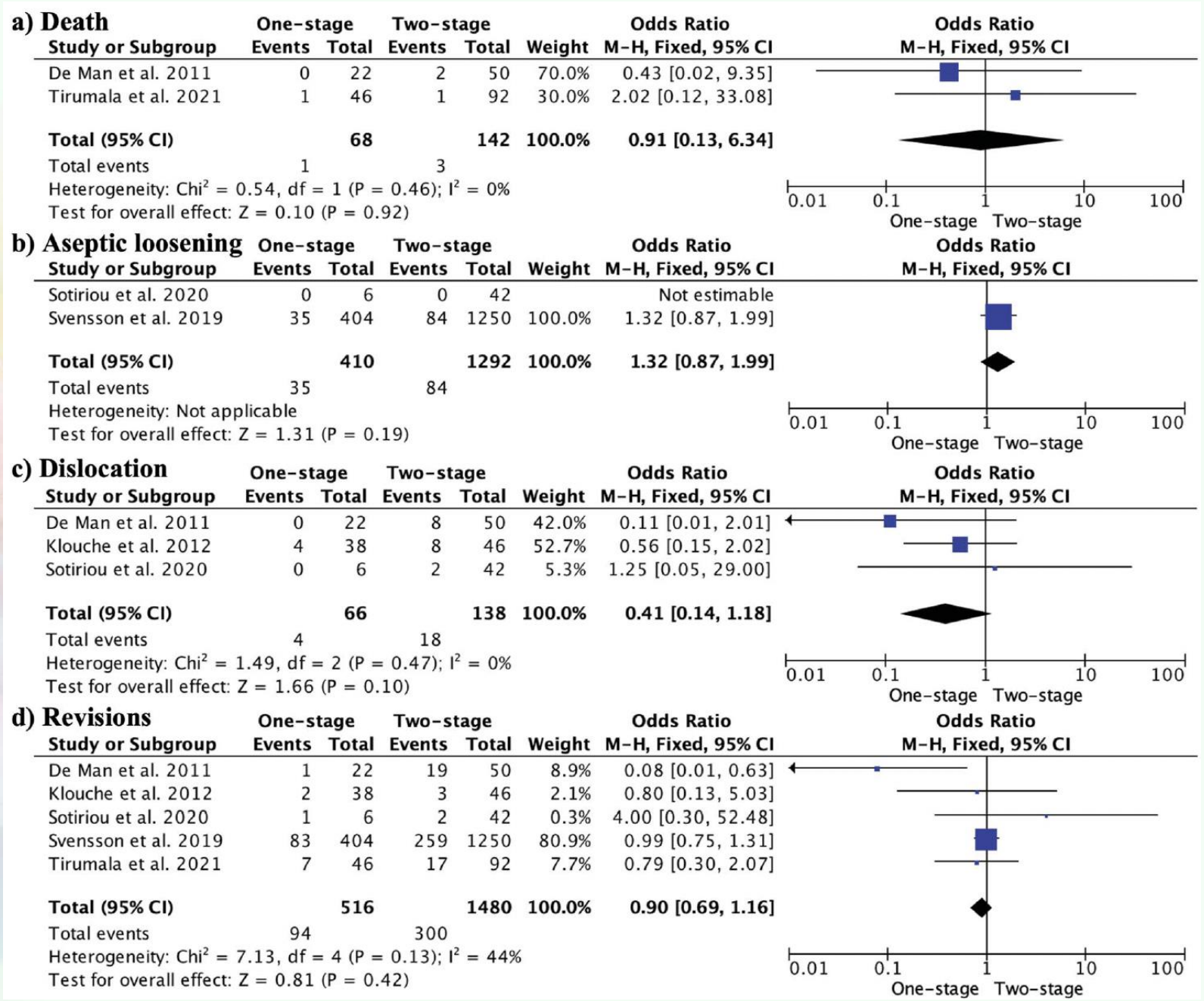


c) Gram-positive

Study or Subgroup	One-stage Events	Total	Two-stage Events	Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Choi et al. 2013	10	17	28	44	26.3%	0.82 [0.26, 2.56]
Oussedik et al. 2010	10	11	32	39	5.2%	2.19 [0.24, 19.99]
Sotiriou et al. 2020	7	9	36	46	10.7%	0.97 [0.17, 5.43]
Tirumala et al. 2021	28	46	54	92	57.7%	1.09 [0.53, 2.26]
Total (95% CI)		**83**		**221**	**100.0%**	**1.07 [0.61, 1.85]**
Total events	55		150			

Heterogeneity: $Chi^2 = 0.63$, df = 3 (P = 0.89); $I^2 = 0\%$
Test for overall effect: Z = 0.22 (P = 0.82)



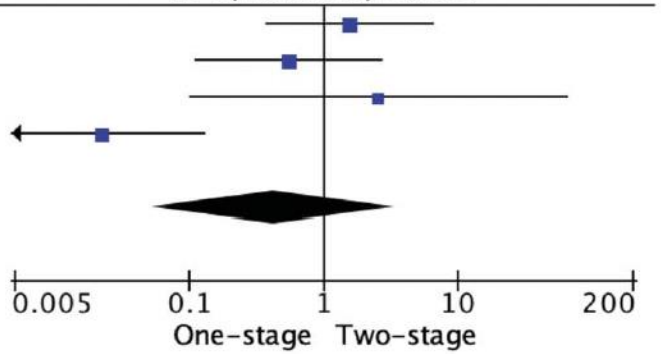

a) Death
One-stage
Two-stage
Odds Ratio
Odds Ratio
Study or Subgroup Events Total Events Total Weight M-H, Fixed, 95% CI
M-H, Fixed, 95% CI
De Man et al. 2011 0 22 2 50 70.0% 0.43 [0.02, 9.35]
Tirumala et al. 2021 1 46 1 92 30.0% 2.02 [0.12, 33.08]
Total (95% CI) 68 142 100.0% 0.91 [0.13, 6.34]
Total events 1 3
Heterogeneity: Chi² = 0.54, df = 1 (P = 0.46); I² = 0%
Test for overall effect: Z = 0.10 (P = 0.92)
0.01 0.1 1 10 100
One-stage Two-stage
b) Aseptic loosening
One-stage
Two-stage
Odds Ratio
Odds Ratio
Study or Subgroup Events Total Events Total Weight M-H, Fixed, 95% CI
M-H, Fixed, 95% CI
Sotiriou et al. 2020 0 6 0 42 Not estimable
Svensson et al. 2019 35 404 84 1250 100.0% 1.32 [0.87, 1.99]
Total (95% CI) 410 1292 100.0% 1.32 [0.87, 1.99]
Total events 35 84
Heterogeneity: Not applicable
Test for overall effect: Z = 1.31 (P = 0.19)
0.01 0.1 1 10 100
One-stage Two-stage
c) Dislocation
One-stage
Two-stage
Odds Ratio
Odds Ratio
Study or Subgroup Events Total Events Total Weight M-H, Fixed, 95% CI
M-H, Fixed, 95% CI
De Man et al. 2011 0 22 8 50 42.0% 0.11 [0.01, 2.01]
Klouche et al. 2012 4 38 8 46 52.7% 0.56 [0.15, 2.02]
Sotiriou et al. 2020 0 6 2 42 5.3% 1.25 [0.05, 29.00]
Total (95% CI) 66 138 100.0% 0.41 [0.14, 1.18]
Total events 4 18
Heterogeneity: Chi² = 1.49, df = 2 (P = 0.47); I² = 0%
Test for overall effect: Z = 1.66 (P = 0.10)
0.01 0.1 1 10 100
One-stage Two-stage
d) Revisions
One-stage
Two-stage
Odds Ratio
Odds Ratio
Study or Subgroup Events Total Events Total Weight M-H, Fixed, 95% CI
M-H, Fixed, 95% CI
De Man et al. 2011 1 22 19 50 8.9% 0.08 [0.01, 0.63]
Klouche et al. 2012 2 38 3 46 2.1% 0.80 [0.13, 5.03]
Sotiriou et al. 2020 1 6 2 42 0.3% 4.00 [0.30, 52.48]
Svensson et al. 2019 83 404 259 1250 80.9% 0.99 [0.75, 1.31]
Tirumala et al. 2021 7 46 17 92 7.7% 0.79 [0.30, 2.07]
Total (95% CI) 516 1480 100.0% 0.90 [0.69, 1.16]
Total events 94 300
Heterogeneity: Chi² = 7.13, df = 4 (P = 0.13); I² = 44%
Test for overall effect: Z = 0.81 (P = 0.42)
0.01 0.1 1 10 100
One-stage Two-stage

a) Success rate

Study or Subgroup	One-stage Events	One-stage Total	Two-stage Events	Two-stage Total	Weight	Odds Ratio M-H, Random, 95% CI
Choi et al. 2013	14	17	33	44	28.1%	1.56 [0.38, 6.44]
De Man et al. 2011	19	22	46	50	27.3%	0.55 [0.11, 2.70]
Klouche et al. 2012	38	38	45	46	18.2%	2.54 [0.10, 64.12]
Wolf et al. 2014	3	12	45	48	26.4%	0.02 [0.00, 0.13]
Total (95% CI)		**89**		**188**	**100.0%**	**0.42 [0.05, 3.37]**
Total events	74		169			

Heterogeneity: $Tau^2 = 3.50$; $Chi^2 = 15.36$, df = 3 (P = 0.002); $I^2 = 80\%$

Test for overall effect: Z = 0.82 (P = 0.41)

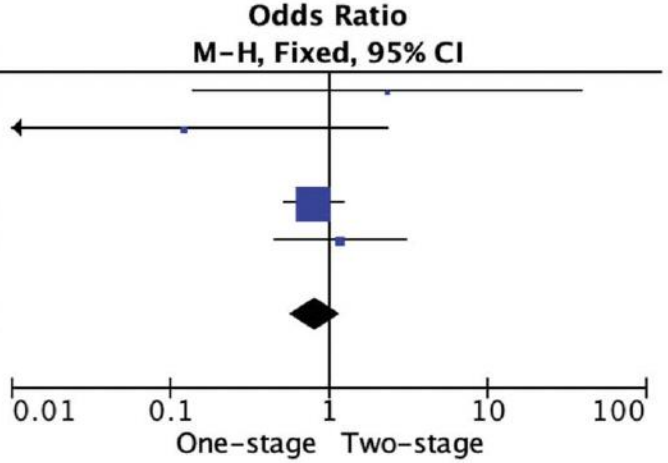


b) Reinfection rate

Study or Subgroup	One-stage Events	One-stage Total	Two-stage Events	Two-stage Total	Weight	Odds Ratio M-H, Fixed, 95% CI
De Man et al. 2011	1	22	1	50	1.0%	2.33 [0.14, 39.09]
Klouche et al. 2012	0	38	4	46	6.6%	0.12 [0.01, 2.35]
Sotiriou et al. 2020	0	6	0	42		Not estimable
Svensson et al. 2019	28	404	107	1250	79.8%	0.80 [0.52, 1.23]
Tirumala et al. 2021	8	46	14	92	12.6%	1.17 [0.45, 3.04]
Total (95% CI)		**516**		**1480**	**100.0%**	**0.81 [0.56, 1.19]**
Total events	37		126			

Heterogeneity: $Chi^2 = 2.69$, df = 3 (P = 0.44); $I^2 = 0\%$

Test for overall effect: Z = 1.06 (P = 0.29)

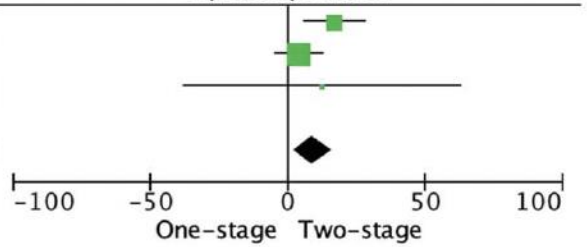


c) Harris Hip Score

Study or Subgroup	One-stage Mean	One-stage SD	One-stage Total	Two-stage Mean	Two-stage SD	Two-stage Total	Weight	Mean Difference IV, Fixed, 95% CI
Choi et al. 2013	77	14	17	60	30	44	37.3%	17.00 [5.92, 28.08]
De Man et al. 2011	84	17	22	80	18	50	60.9%	4.00 [-4.68, 12.68]
Oussedik et al. 2010	87.8	62.2201	11	75.5	109.513	39	1.8%	12.30 [-38.03, 62.63]
Total (95% CI)			**50**			**133**	**100.0%**	**9.00 [2.23, 15.78]**

Heterogeneity: $Chi^2 = 3.29$, df = 2 (P = 0.19); $I^2 = 39\%$

Test for overall effect: Z = 2.61 (P = 0.009)



Effect Size	Studies (N)	Participants (N)	Fixed-Effect Model (OR 95% CI)	I^2 (%)	*P*
Paprosky acetabular classification					
Paprosky I	2	156	[a]OR 8.90, 95% CI 4.00 to 19.78	76%	<0.00001
Paprosky II	2	156	OR 0.51, 95% CI 0.25 to 1.02	0%	0.06
Paprosky III	2	156	OR 0.07, 95% CI 0.02 to 0.28	35%	0.0002
Paprosky femoral classification					
Paprosky I	2	156	OR 3.46, 95% CI 1.31 to 9.11	0%	0.01
Paprosky II	2	156	[a]OR 1.48, 95% CI 0.19 to 11.59	88%	0.71
Paprosky III	2	156	OR 0.46, 95% CI 0.22 to 0.96	6%	0.04
Paprosky IV	2	156	OR 0.13, 95% CI 0.01 to 2.36	0%	0.17

Modalidad	Indicaciones	Contraindicaciones
1 tiempo (revisión directa)	- Infección crónica pero con **germen identificado y sensible** - Buen estado general - Buen stock óseo - Tejidos blandos adecuados - Sin sinus/fístula persistente	- ?Germen desconocido? o multirresistente - Fístula activa - Mal estado general - Múltiples cirugías previas fallidas
2 tiempos (revisión diferida)	- Infección crónica o polimicrobiana - Germen desconocido o resistente - Fístula o mal estado de partes blandas - Implante inestable o mala calidad ósea	- Paciente no apto para 2da cirugía (riesgo alto)

CASO 1

Cultivo — Se aisla:

Microorganismo 1 — Staphylococcus epidermidis

Estudio: INCIDENCIAS ANALÍTICAS

	S.epidermidis
Oxacilina	R
Gentamicina	R
Tobramicina	R
Levofloxacino	R
Fosfomicina	S
Eritromicina	R
Clindamicina	R
Vancomicina	S
Rifampicina	S
Linezolid	S
Trimetoprim/sulfametoxazol	R
Tigeciclina	S

VANCOMICINA

CASO 2

Estudio: BACTERIAS

Estudio: -- EXUDADOS --

Cultivo — Se aisla:

Microorganismo 1 — Pseudomonas aeruginosa

	P.aeruginosa
Cefepima	I
Ceftazidima	I
Aztreonam	R
Gentamicina	S
Ciprofloxacino	R
Levofloxacino	R
Piperacilina/tazobacta	I

S = Sensible; I = Sensible con aumento de la exposición al antibiótico (aumento de la dosis o
R = Resistente

CEFTAZIDIMA

Tratamiento inicial: betalactámicos, (glico)lipopéptidos

CASO 1

Cultivo — Se aisla:

Microorganismo 1 — Staphylococcus epidermidis

Estudio: INCIDENCIAS ANALÍTICAS

	S.epidermidis
Oxacilina	R
Gentamicina	R
Tobramicina	R
Levofloxacino	R
Fosfomicina	S
Eritromicina	R
Clindamicina	R
Vancomicina	S
Rifampicina	S
Linezolid	S
Trimetoprim/sulfametoxazol	R
Tigeciclina	S

VANCOMICINA

CASO 2

Estudio: BACTERIAS

Estudio: -- EXUDADOS --

Cultivo — Se aisla:

Microorganismo 1 — Pseudomonas aeruginosa

	P.aeruginosa
Cefepima	I
Ceftazidima	I
Aztreonam	R
Gentamicina	S
Ciprofloxacino	R
Levofloxacino	R
Piperacilina/tazobacta	I

S = Sensible; I = Sensible con aumento de la exposición al antibiótico (aumento de la dosis o
R = Resistente

CEFTAZIDIMA

Tratamiento inicial: betalactámicos, (glico)lipopéptidos

Tratamiento de continuación 

CASO 1

Cultivo — Se aisla:

Microorganismo 1 — Staphylococcus epidermidis

Estudio: INCIDENCIAS ANALÍTICAS

	S.epidermidis
Oxacilina	R
Gentamicina	R
Tobramicina	R
Levofloxacino	R
Fosfomicina	S
Eritromicina	R
Clindamicina	R
Vancomicina	S
Rifampicina	S
Linezolid	S
Trimetoprim/sulfametoxazol	R
Tigeciclina	S

CASO 2

Estudio: BACTERIAS

Estudio: -- EXUDADOS --

Cultivo — Se aisla:

Microorganismo 1 — Pseudomonas aeruginosa

	P.aeruginosa
Cefepima	I
Ceftazidima	I
Aztreonam	R
Gentamicina	S
Ciprofloxacino	R
Levofloxacino	R
Piperacilina/tazobacta	I

S = Sensible; I = Sensible con aumento de la exposición al antibiótico (aumento de la dosis o
R = Resistente

Tratamiento inicial: betalactámicos, (glico)lipopéptidos

Tratamiento de continuación 

Tratamiento habitual: valsartan/HCTZ, amlodipino, doxazosina, venlafaxina, trazodona, tramadol, Eutirox

Posología dalbavancina en IOA

antibiotics

Article

Dalbavancin as Suppressi
Osteoarticular Infections

Rosa Escudero-Sanchez [1,2,3]*, Laura Morata[4], Lu
Carrion[9], María Tasias Pitarch[10], Jose Luis del P
cía Pais[14], Pablo Bachiller Luque[15], Francisco Jav

Table 2. Variables related to dalbavancin administration.

Characteristics of dalbavancin administration		n (%)
Treatment type: Targeted		40 (93.0)
Empirical		3 (7.0)
First dalbavancin dose:	500mg	2 (5.0)
	1000mg	16 (38.1)
	1500mg	24 (57.1)
Subsequent regimens:		
500mg weekly		6 (14.0)
500mg every 2 weeks		1 (2.3)
1000mg weekly		3 (7.0)
1000mg every 2 weeks		8 (18.6)
1000mg every 3 weeks		1 (2.3)
1000mg monthly		2 (4.7)
1500mg every 2 weeks		11 (25.6)
1500mg every 3 weeks		1 (2.3)
1500mg monthly		10 (23.3)

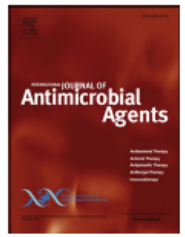
Posología dalbavancina en IOA

International Journal of Antimicrobial Agents 62 (2023) 106960

Contents lists available at ScienceDirect

International Journal of Antimicrobial Agents

journal homepage: www.elsevier.com/locate/ijantimicag



Expert Opinion on Dose Regimen and Therapeutic Drug Monitoring for Long-Term Use of Dalbavancin: Expert Review Panel

Eric Senneville[a,*], Guillermo Cuervo[b], Matthieu Gregoire[c,d], Carmen Hidalgo-Tenor François Jehl[g], Jose M. Miro[b,h], Andrew Seaton[i], Bo Söderquist[j,k], Alex Soriano[l,h], Florian Thalhammer[m], Federico Pea[n,o]

Box 1. Type of complex infections eligible for off-label dalbavancin use.

- Infective endocarditis (IE)
- Bone and joint infections (BJIs)
- Prosthetic joint infections (PJIs)
- Vascular graft infections (VGIs)
- Catheter-related bacteraemia and other Gram-positive biofilm-related infections

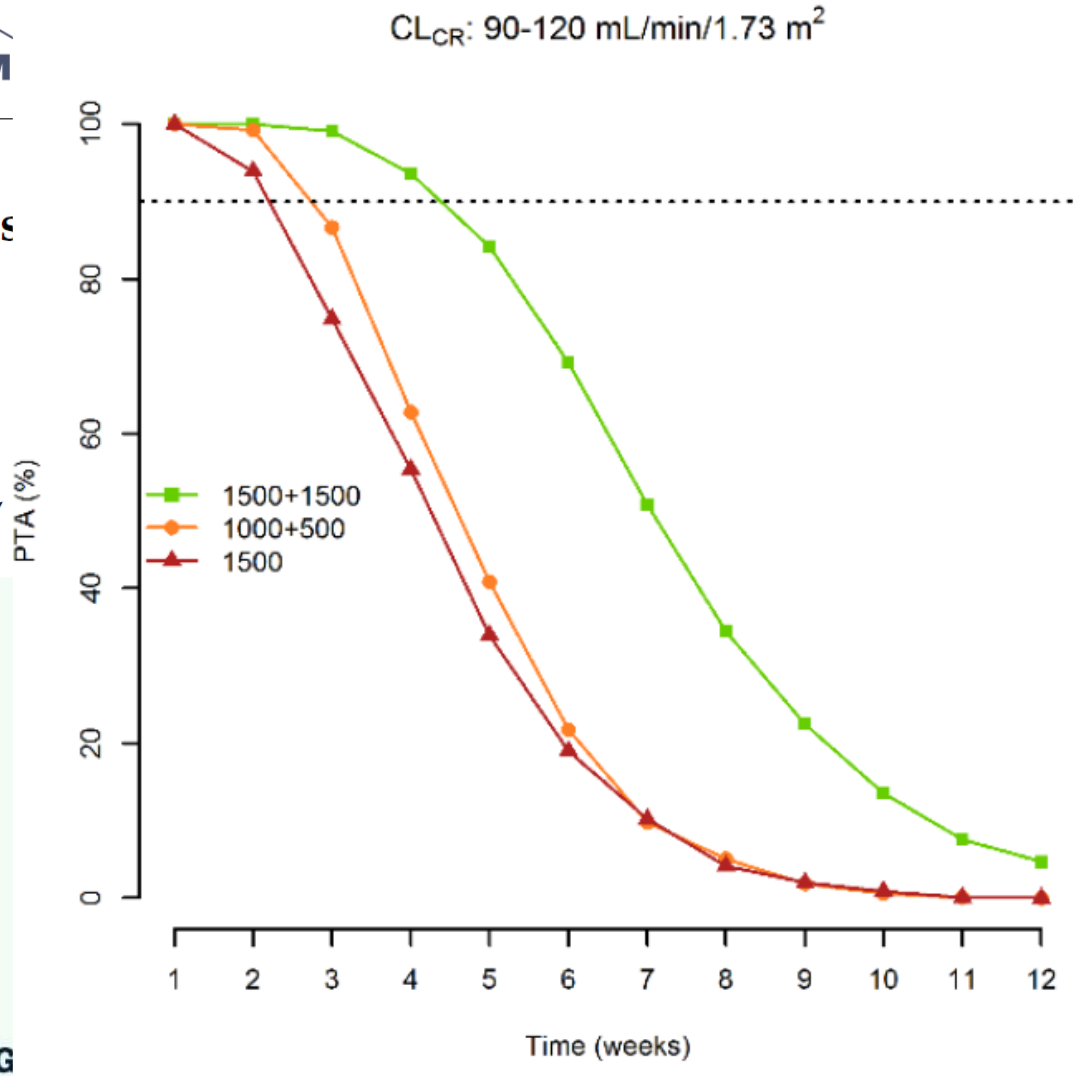
Posología dalbavancina en IOA

antibiotics

Article

Population Pharmacokinetic and Pharmacodynamic Analysis Dalbavancin for Long-Term Treatment of Subacute and/or Chronic Infectious Diseases: The Major Role of Therapeutic Drug Monitoring

Pier Giorgio Cojutti [1], Sara Tedeschi [2,3], Milo Gatti [1,3], Eleonora Zamparini [2], Marianna Meschiari [4], Paola Della Siega [5], Maria Mazzitelli [6], Laura Soavi [7], Raffaella Binazzi [8], Elke Maria Erne [8], Marco Rizzi [7], Anna Maria Cattelan [6], Carlo Tascini [5], Cristina Mussini [4], Pierluigi Viale [2,3] and Federico Pea [1,3,*]



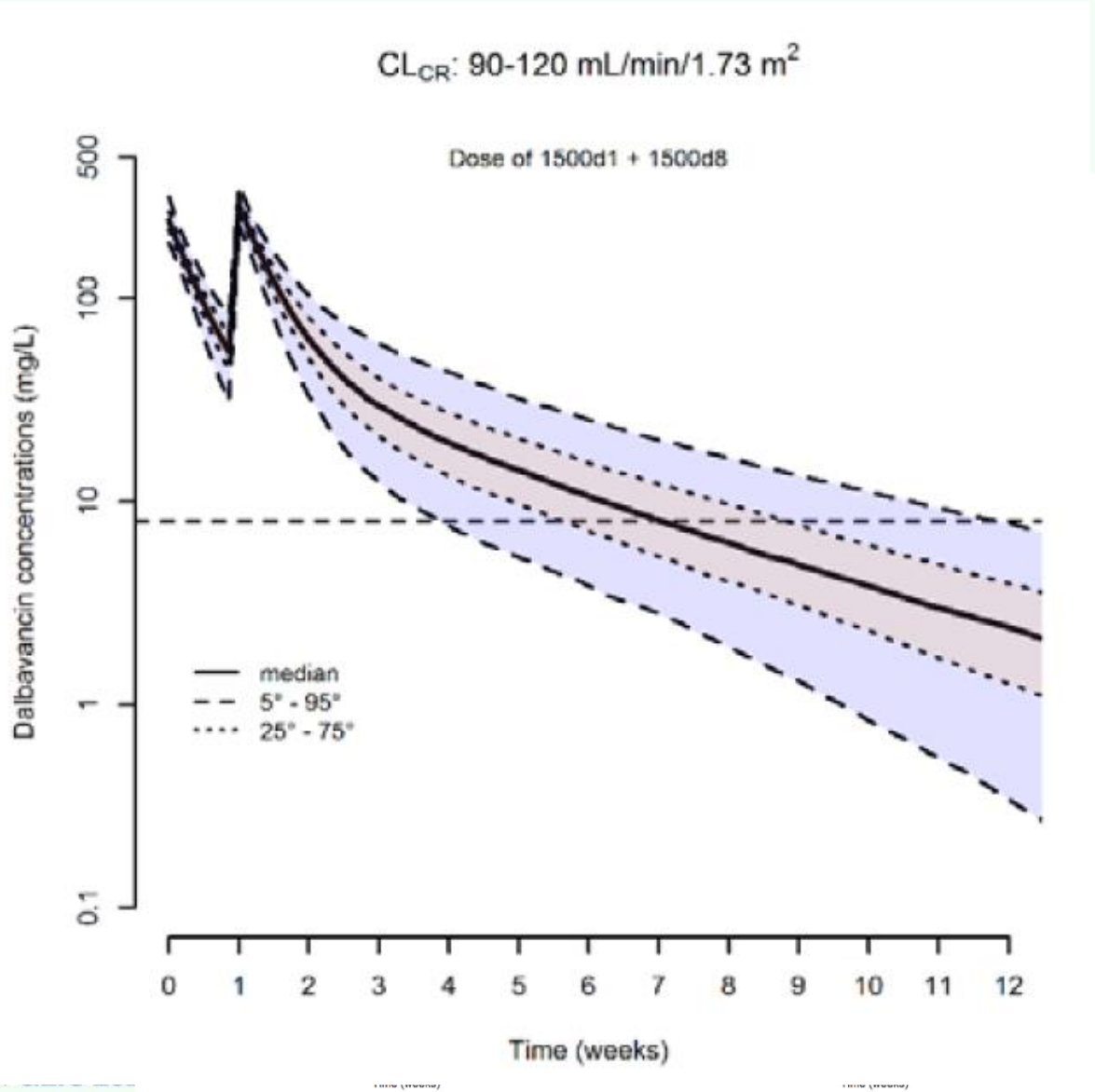
Posología dalbavancina en IOA

antibiotics

Article

**Population Pharmacokinetic and Pharmacodynamic Anal
Dalbavancin for Long-Term Treatment of Subacute and/o
Chronic Infectious Diseases: The Major Role of Therapeu
Drug Monitoring**

Pier Giorgio Cojutti [1], Sara Tedeschi [2,3], Milo Gatti [1,3], Eleonora Zamparini [2], Marianna Meschiari [4],
Paola Della Siega [5], Maria Mazzitelli [6], Laura Soavi [7], Raffaella Binazzi [8], Elke Maria Erne [8], Marco Ri
Anna Maria Cattelan [6], Carlo Tascini [5], Cristina Mussini [4], Pierluigi Viale [2,3] and Federico Pea [1,3,*]



International Journal of Antimic

Contents lists availa

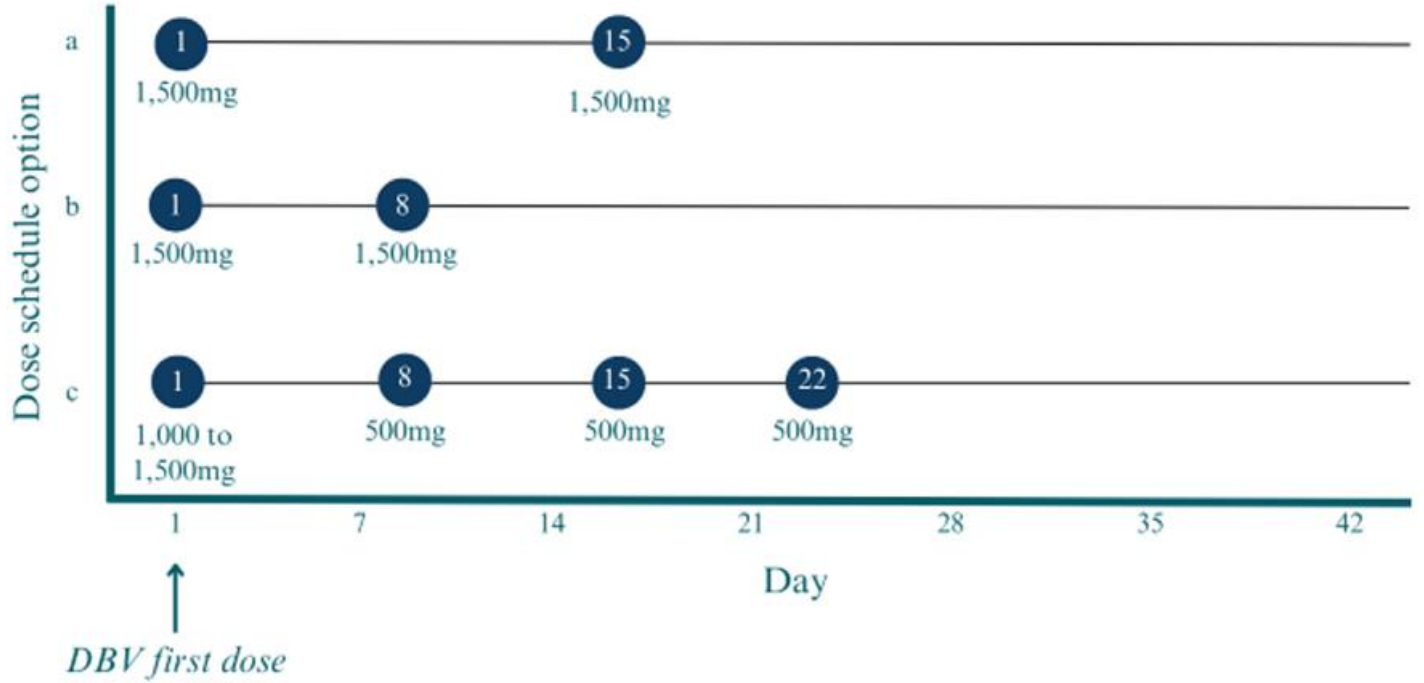
ELSEVIER

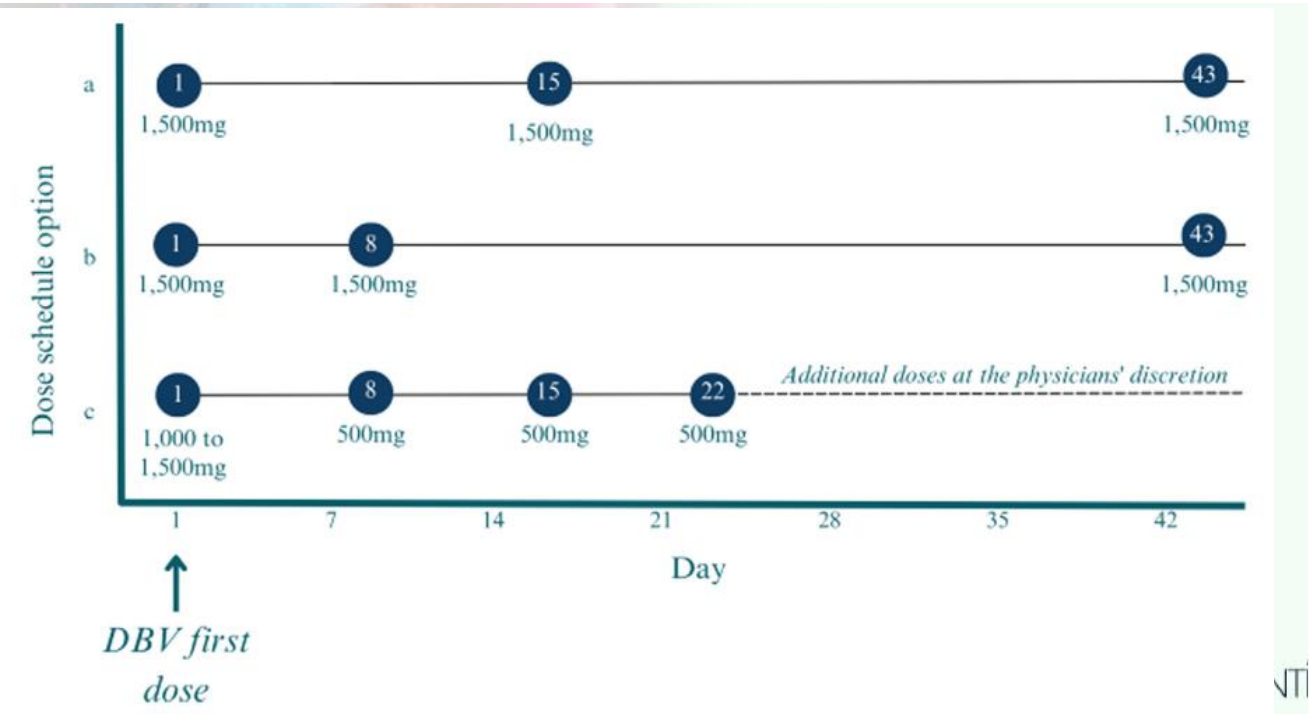
International Journal o

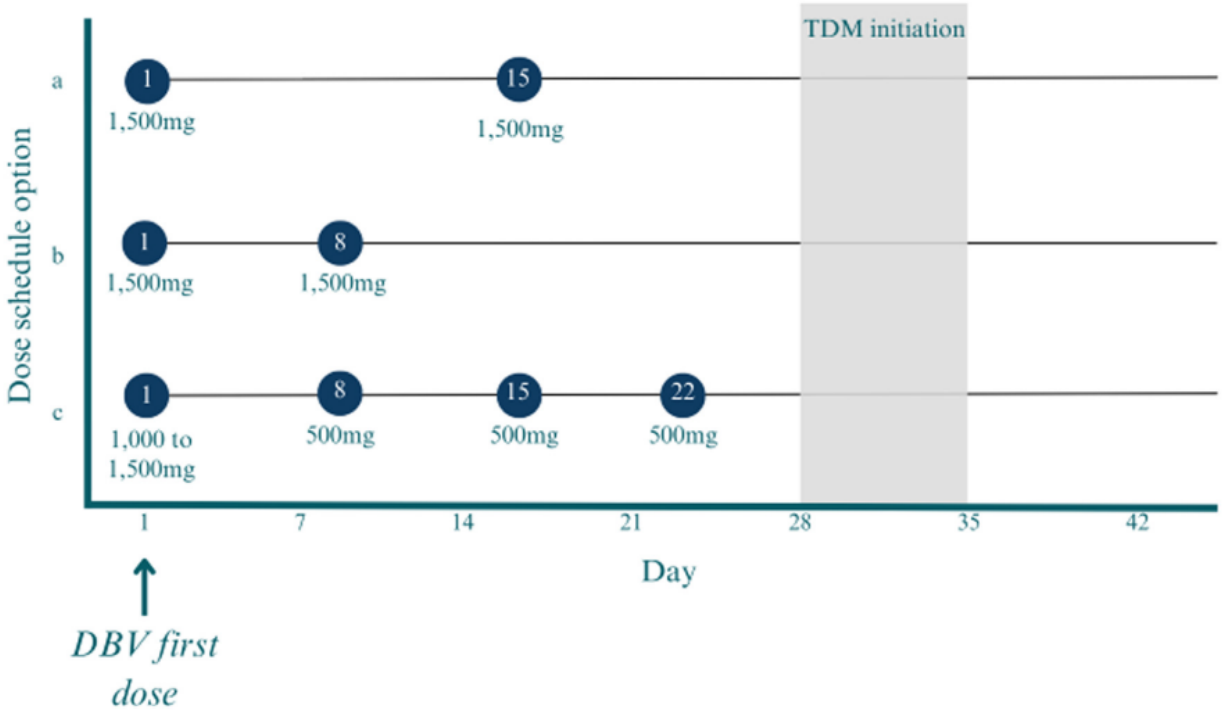
journal homepage: www.els

Expert Opinion on Dose Regimen and Th for Long-Term Use of Dalbavancin: Exper

Eric Senneville[a,*], Guillermo Cuervo[b], Matthieu Greg François Jehl[g], Jose M. Miro[b,h], Andrew Seaton[i], Bo S Florian Thalhammer[m], Federico Pea[n,o]







OPEN

Therapeutic Drug Monitoring Versus Fixed-Interval Dosing of Dalbavancin in Implant-Associated Spinal Infections: Grand Round/A Case Study

Jeroen P.A. Houwen. PharmD. Charlotte S. Hakkers. MD. PhD.† Valentijn A. Schweitzer, MD, aniël J. Touw, PharmD, PhD, D, PhD**

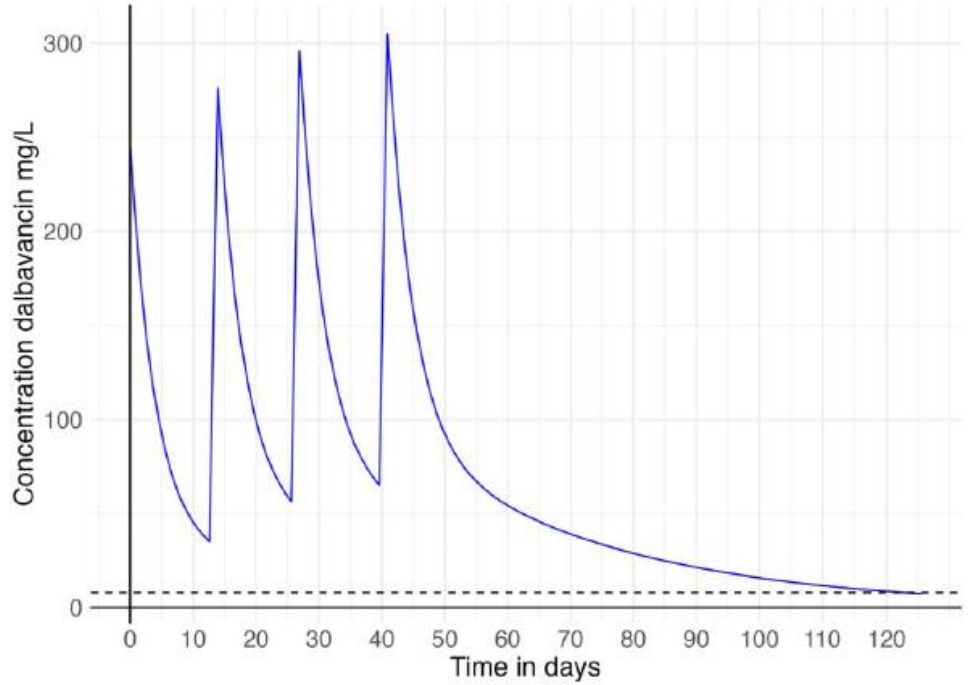


FIGURE 2. Case 2: Predicted dalbavancin concentrations over time. Dashed line represents the threshold of 8 mg/L, indicating the minimum plasma concentration required for adequate dalbavancin exposure.

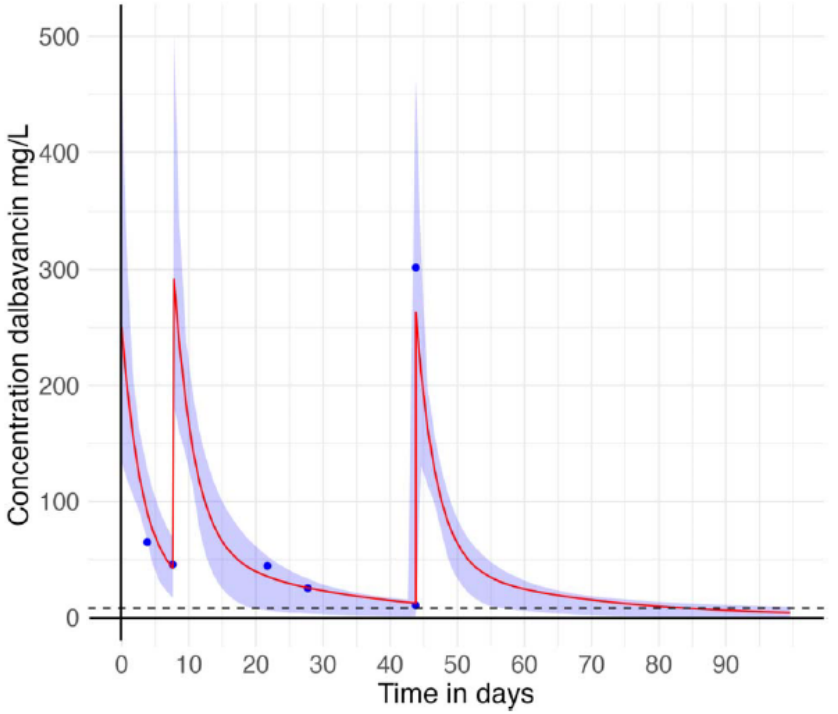


FIGURE 1. Case 1. Observed (blue dots) and predicted dalbavancin plasma concentrations (red line) over time. Shaded area represents the 95% confidence interval based on uncertainty of the model parameters. Dashed line indicates the threshold of 8 mg/L, reflecting the minimum plasma concentration considered adequate for dalbavancin exposure.

CASO 1

Cultivo — Se aisla:

Microorganismo 1 — Staphylococcus epidermidis

Estudio: INCIDENCIAS ANALÍTICAS

	S.epidermidis
Oxacilina	R
Gentamicina	R
Tobramicina	R
Levofloxacino	R
Fosfomicina	S
Eritromicina	R
Clindamicina	R
Vancomicina	S
Rifampicina	S
Linezolid	S
Trimetoprim/sulfametoxazol	R
Tigeciclina	S

VANCOMICINA

CASO 2

Estudio: BACTERIAS

Estudio: -- EXUDADOS --

Cultivo — Se aisla:

Microorganismo 1 — Pseudomonas aeruginosa

	P.aeruginosa
Cefepima	I
Ceftazidima	I
Aztreonam	R
Gentamicina	S
Ciprofloxacino	R
Levofloxacino	R
Piperacilina/tazobacta	I

S = Sensible; I = Sensible con aumento de la exposición al antibiótico (aumento de la dosis o
R = Resistente

CEFTAZIDIMA

Tratamiento inicial: betalactámicos, (glico)lipopéptidos

Tratamiento de continuación ?

Clinical Microbiology and Infection 30 (2024) 405–406

Contents lists available at ScienceDirect

Clinical Microbiology and Infection

journal homepage: www.clinicalmicrobiologyandinfection.com

Letter to the Editor

In vitro susceptibility to delafloxacin of *Pseudomo* resistance to other quinolones (ciprofloxacin and

J.D.D. Jordán-Chaves [1,*], Ruben Lobato-Cano [2], Javier Casas-Ciria Carolina Freyre-Carillo [1], J.D. Santotoribio [3], M.F. de-la-Rubia-Ma

[1] *Clinical Microbiology, University Hospital of Puerto Real, Cadiz, Spain*
[2] *Infectious Disease and Microbiology, Jerez de la Frontera University Hospital, Cadiz, Spain*
[3] *Clinical Biochemistry, University Hospital of Puerto Real, Cadiz, Spain*
[4] *Clinical Microbiology, Hospital Universitario Puerto del Mar, Cadiz, Spain*

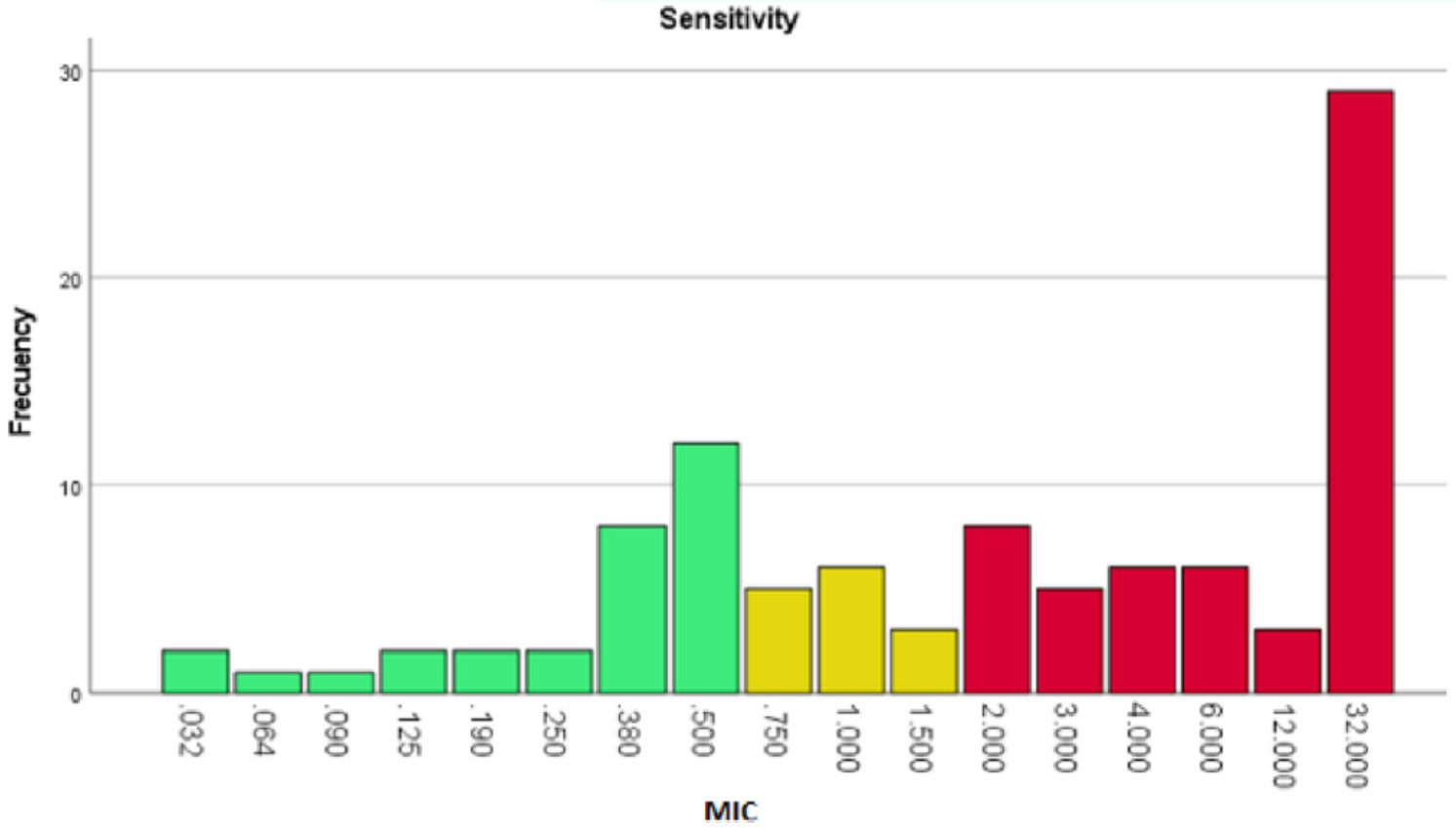
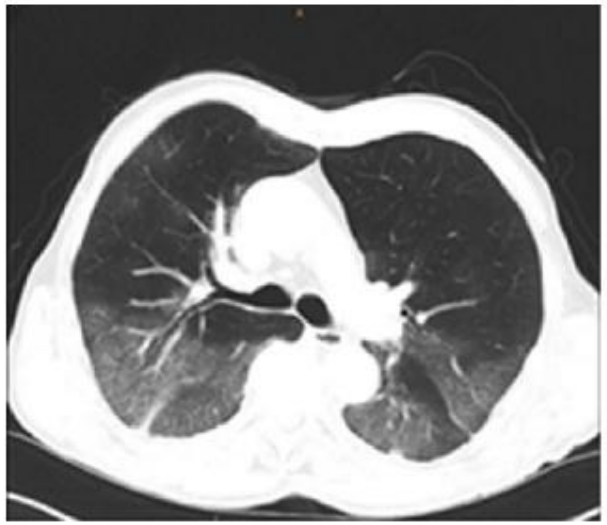


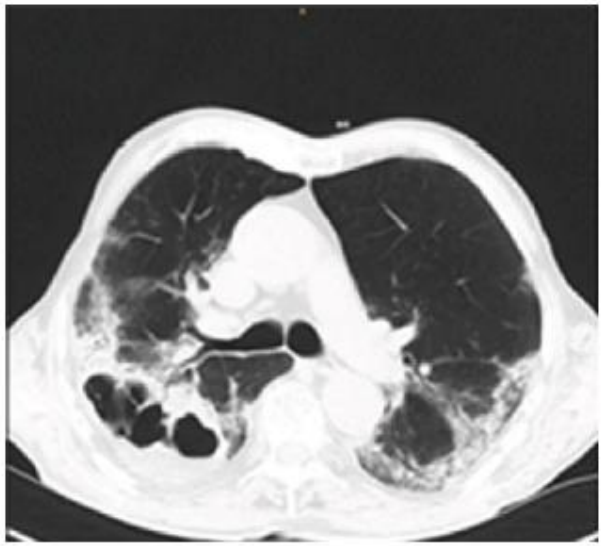
Fig. 1. Frequency of Delafloxacin MICs obtained in Pseudomonas aeruginosa Ciprofloxacin and Levofloxacin resistant strains.

Hindawi
Case Reports in Pulmonology
Volume 2022, Article ID 1008330, 5 pages
https://doi.org/10.1155/2022/1008330

Case Report

Ciprofloxacin-Resistant *Pseudomonas aeruginosa* Lung Abscess Complicating COVID-19 Treated with the Novel Oral Fluoroquinolone Delafloxacin





Antimicrobial susceptibility testing (Thermo Fisher Scientific, Massachusetts, USA) of *P. aeruginosa* showed resistance to meropenem, imipenem, ciprofloxacin, gentamicin, and tobramycin. Antibacterial treatment was switched on August 28th, 2020, to piperacillin/tazobactam 4.5 g tid i.v.,

¿Cuánto tiempo?

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Antibiotic Therapy for 6 or 12 Weeks for Prosthetic Joint

L. Bernard, C. Arvieux, B. Brunschweiler, S. Touch
C. Boeri, G. Gras, J. Druon, P. Rosset, E. Senne
G. Le Moal, J. Michon, H. Aumaître, E. Fores
C. Chirouze, F.-A. Dauchy, E. Devaud, B. Mar
E. Stindel, A. Dinh, P. Bemer, B. Giraudeau

Subgroup	6-Wk Therapy	12-Wk Therapy	Risk Difference (95% CI)
	no. of patients with event/total no. (%)		*percentage points*
All patients	32/190 (16.8)	15/188 (8.0)	8.9 (2.2 to 15.6)
Surgical procedure			
Débridement	23/75 (30.7)	11/76 (14.5)	16.2 (2.9 to 29.5)
Two-stage revision	6/40 (15.0)	2/41 (4.9)	10.1 (–3.1 to 23.3)
One-stage revision	3/75 (4.0)	2/71 (2.8)	1.2 (–4.8 to 7.1)
Affected joint			
Hip	19/122 (15.6)	9/117 (7.7)	7.9 (–0.2 to 16.0)
Knee	13/68 (19.1)	6/71 (8.5)	10.7 (–0.9 to 22.2)
Episode of prosthetic joint infection			
First	27/162 (16.7)	13/160 (8.1)	8.5 (1.4 to 15.7)
At least the second	5/28 (17.9)	2/28 (7.1)	10.7 (–7.0 to 28.4)

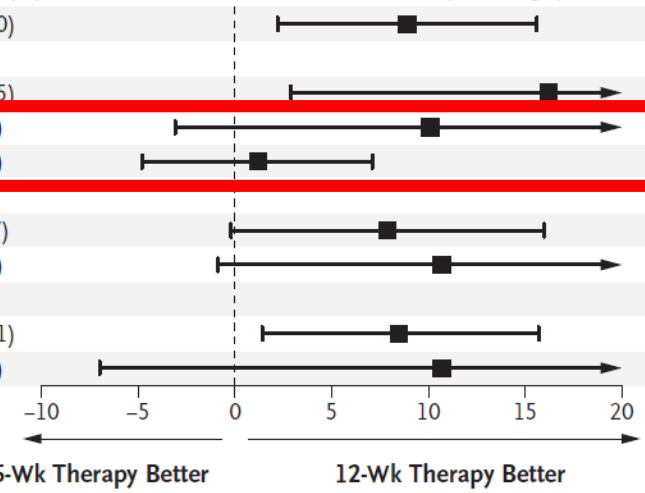


Figure 2. Exploratory Subgroup Analyses of Persistent Infection within 2 Years after the Completion of Antibiotic Therapy (Primary Outcome).

¿Cuánto tiempo?

J Antimicrob Chemother 2019; **74**: 2394–2399
doi:10.1093/jac/dkz202 Advance Access publication 18 May 2019

Journal of Antimicrobial Chemotherapy

Four versus six weeks of antibiotic therapy for osteoarticular infections after implant removal: a randomized trial

Mohamed Benkabouche[1]†, Guillaume Racloz[2,3]†, Hervé Spechbach[1], Benjamin A. Lipsky[4], Jean-Michel Gaspoz[1] and Ilker Uçkay [2,4,5]*

[1]Department of Community Medicine, Geneva University Hospitals and Faculty of Medicine, Geneva, Switzerland; [2]Orthopaedic Surgery Service, Geneva University Hospitals and Faculty of Medicine, Geneva, Switzerland; [3]Orthopaedic Service of Surgery, Pourtales Hospital, Neuchâtel, Switzerland; [4]Service of Infectious Diseases, Geneva University Hospitals and Faculty of Medicine, Geneva, Switzerland; [5]Infectiology, Balgrist University Hospital and Faculty of Medicine, Zurich, Switzerland

*Corresponding author. Balgrist University Hospital, Forchstrasse 340, 8008 Zurich, Switzerland. Tel: +41-44-386-1111; Fax: +41-44-386-3709;
E-mail: Ilker.Uckay@balgrist.ch orcid.org/0000-0002-5552-0973
†Equal contribution as first authors.

Table S1. Characteristics of patients with four versus six weeks of systemic antibiotic therapy after removal of the infected orthopaedic implant (ITT & PP analyses)

ITT analysis n = 123	Six weeks n = 61	Four weeks n = 62	*p*-value *
Female sex	23 (37%)	25 (41%)	.67
Median age	65 years	62 years	.27
Immune suppression[+]	18 (29%)	20 (33%)	.65
Bacteraemia	8 (13%)	4 (7%)	.24
Median ASA-Score[16]	2	2	.13
Psychiatric co-morbidity	25 (40%)	24 (39%)	.91
Haematogenous origin of infection	9 (15%)	7 (11%)	.62
Primary surgical site infections	23 (38%)	19 (31%)	.53
Serum CRP level on admission (median)	37 mg/L	23 mg/L	.24
Visible osteosynthesis material	7 (11%)	11 (18%)	.29
Removed arthroplasties	24 (39%)	15 (25%)	.09
- with temporary spacers	18 (30%)	13 (21%)	.28
- re-implantation after infection	17 (29%)	13 (21%)	.37
- median interval between stages	8 weeks	6 weeks	***.01***
Duration of intravenous therapy (median)	5 days	3.5 days	.09
Complete clinical remission	58 (94%)	58 (95%)	.71
Complete microbiological remission	60 (97%)	60 (98%)	.57
Significant antibiotic-related adverse events	22 (35%)	17 (28%)	.36

PP analysis n = 117	Six weeks n = 60	Four weeks n = 57	*p*-value *
Female sex	20 (35%)	25 (42%)	.47
Median age	63 years	63 years	.36
Immune suppression[+]	15 (26%)	20 (33%)	.41
Bacteraemia	7 (12%)	4 (7%)	.30
Median ASA-Score[16]	2	2	.22
Psychiatric co-morbidity	22 (39%)	24 (40%)	.88
Haematogenous origin of infection	9 (15%)	7 (12%)	.52
Primary surgical site infections	22 (37%)	18 (32%)	.36
Serum CRP level on admission (median)	42 mg/L	23 mg/L	.35
Visible osteosynthesis material	5 (9%)	11 (18%)	.13
Removed Arthroplasties	23 (40%)	15 (25%)	.08
- with temporary spacers	18 (30%)	13 (23%)	.38
- re-implantation after infection	17 (28%)	13 (23%)	.49
- median interval between stages	8 weeks	6 weeks	***.01***
Duration of intravenous therapy (median)	4 days	3.5 days	.23
Complete clinical remission	54 (95%)	57 (95%)	.95
Complete microbiological remission	55 (97%)	59 (98%)	.53
Significant antibiotic-related adverse events	19 (33%)	17 (28%)	.56

¿Cuánto tiempo?

CLINICS 2007;62(2):99-108

CLINICAL SCIENCES

PROSPECTIVE STUDY OF THE TREATMENT OF INFECTED HIP ARTHROPLASTIES WITH OR WITHOUT THE USE OF AN ANTIBIOTIC-LOADED CEMENT SPACER

Henrique Berwanger Cabrita, Alberto Tesconi Croci, Olavo Pires de
Ana Lúcia Lei Munhoz de Lima

Systemic antibiotics were given for 3 weeks, according to infectious disease protocols. The empiric therapy was

Table 10 - Recurrence of infection after first and second stages, by treatment group

Recurrence of infection	After first stage	After second stage	Overall
Control group	7 (23.3%)	3 (8.1%)	10 (33.3%)
Study group	2 (5,2%)	2 (6.1%)	4 (10.5%)
P	0.04	0.01	0.002

¿Cuánto tiempo?

Journal of Antimicrobial Chemotherapy (2009) **64**, 392–397
doi:10.1093/jac/dkp177
Advance Access publication 28 May 2009

JAC

Two-stage revision of infected hip arthroplasty using an antibiotic-loaded spacer: retrospective comparison between short-term and prolonged antibiotic therapy

Pan
[1]*Department*
Chang Gung
Chia-Yi, Taiwan

Patients and methods: We reviewed 99 patients with PHI who were managed with SEA using an ALCS from February 2002 to October 2005. A standard (4–6 week) antibiotic treatment course was administered in the first 46 patients and a short-term (1 week) therapy was adopted in the subsequent 53 patients.

Results: Eight patients (four in each group) had persistent infection following the first attempt of surgery and antibiotic treatment; in three of them the infection was cured by additional debridement prior to re-implantation. Forty-two (91%) patients in the long-term group and 47 (89%) patients in the short-term group were free of infection ($P=0.67$) at an average follow-up of 43 months (range, 24–60 months). Five (11%) patients developed complications related to prolonged antibiotic therapy. The short-term treatment resulted in a shorter hospital stay (18 versus 43 days, $P<0.001$) and a lower direct medical cost (US$13732 versus US$21756, $P<0.001$).

¿Cuánto tiempo?

The use of two-stage exchange arthroplasty with depot antibiotics in the absence of long-term antibiotic therapy in infected total hip replacement

I. Stockley,
B. J. Mockford,
A. Hoad-Reddick,
P. Norman

From Sheffield Teaching Hospitals Trust, Sheffield, England

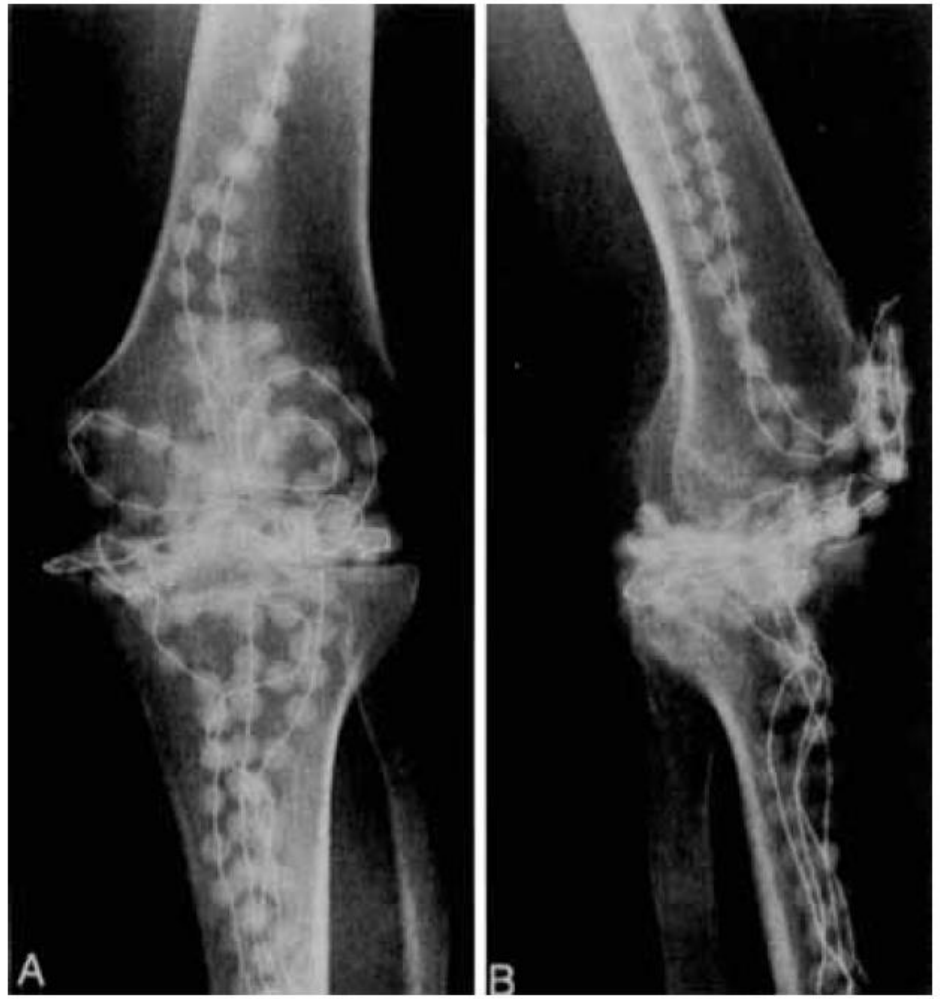
We present a series of 114 patients with microbiologically-proven chronically-infected total hip replacement, treated between 1991 and 2004 by a two-stage exchange procedure with antibiotic-loaded cement, but without the use of a prolonged course of antibiotic therapy. The mean follow-up for all patients was 74 months (2 to 175) with all surviving patients having a minimum follow-up of two years. Infection was successfully eradicated in 100 patients (87.7%), a rate which is similar to that reported by others, but where prolonged adjuvant antibiotic therapy has been used. Using the technique described, a prolonged course of systemic antibiotics does not appear to be essential and the high cost of the administration of antibiotics can be avoided.

¿Cuánto tiempo?

CLINICAL ORTHOPAEDICS AND RELATED RESEARCH
Number 295, pp. 96–101

A Comparison of Gentamicin-Impregnated Polymethylmethacrylate Bead Implantation to Conventional Parenteral Antibiotic Therapy in Infected Total Hip and Knee Arthroplasty

CARL L. NELSON, M.D.,* RICHARD P. EVANS, M.D.,** J. DAVID BLAHA, M.D.,†
JASON CALHOUN, M.D.,‡ STEPHEN L. HENRY, M.D.,§
AND MICHAEL J. PATZAKIS, M.D.§§



Group I, debridement and the implantation of gentamicin–polymethylmethacrylate (PMMA) beads; and Group 2, debridement and conventional parenteral systemic antibiotic therapy. After initial

1990. Twenty-eight patients (22 total hip arthroplasties and six total knee arthroplasties) who had periprosthetic infections were treated according to a prospective, randomized protocol. After initial debridement for their infections, patients were ran-

months to 5.6 years). Infection recurred in two patients treated by debridement and the implantation of gentamicin–PMMA beads (15%) and in four patients treated with debridement and conventional systemic antibiotic therapy (30%). All recurrences

Enferm Infecc Microbiol Clin. 2017;35(3):189–195

Enfermedades Infecciosas y Microbiología Clínica

www.elsevier.es/eimc

Consensus statement

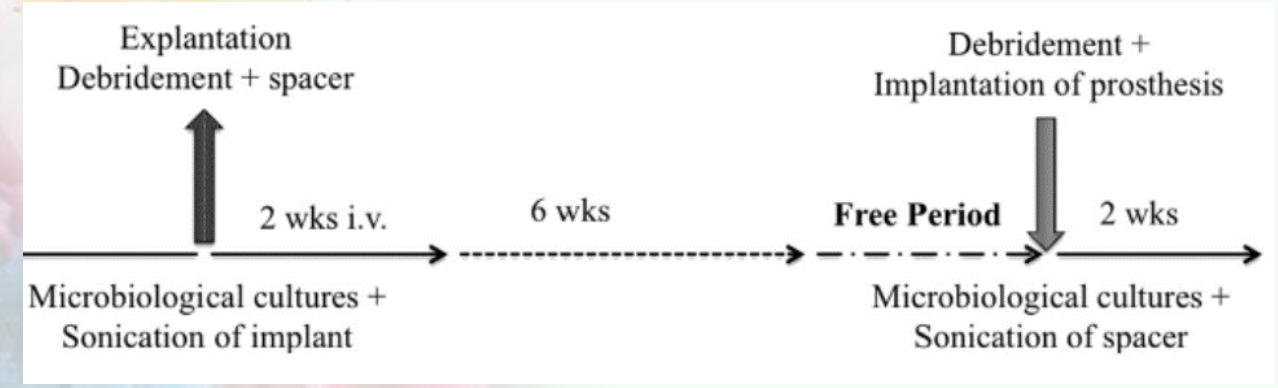
Executive summary of management of prosthetic joint infections. Clinical practice guidelines by the Spanish Society of Infectious Diseases and Clinical Microbiology (SEIMC)

- The two-step exchange procedure should include a targeted intravenous antimicrobial treatment for 4 to 6 weeks (**A-II**), or 1–2 weeks of intravenous antibiotics followed by oral antimicrobials with good bioavailability for a total duration of 6 weeks (**B-II**).
- In chronic PJI caused by CNS, "universal" anti-staphylococcal antimicrobial therapy (i.e. glycopeptides, daptomycin, or linezolid) may be considered after the first-step surgery (prosthesis removal), because this carries a lower rate of positive cultures during the second-step surgery (re-implantation) (**C-III**).
- Shortening the systemic antimicrobial treatment could be considered for cases of PJI due to low-virulent microorganisms, such as CNS or Propionibacterium acnes, as long as the first-step surgery has included a thorough and exhaustive debridement of the joint, and a cement spacer loaded with antibiotics active against the microorganism responsible for the infection has been used (**B-II**).

Caso 1: Vancomicina 5 días + dalbavancina 1500 mg 2 dosis separadas 8 días

Caso 2: Ceftazidima 10 días + delafloxacino 18 días

El reimplante



The Journal of Arthroplasty 34 (2019) 704–709

Contents lists available at ScienceDirect

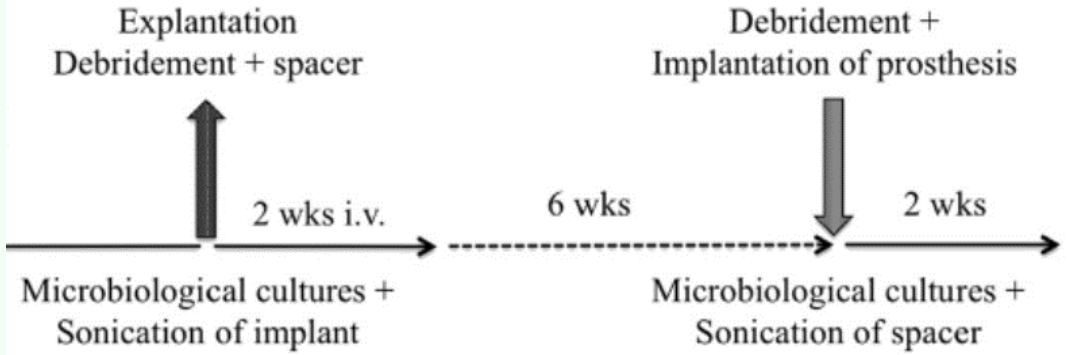
The Journal of Arthroplasty

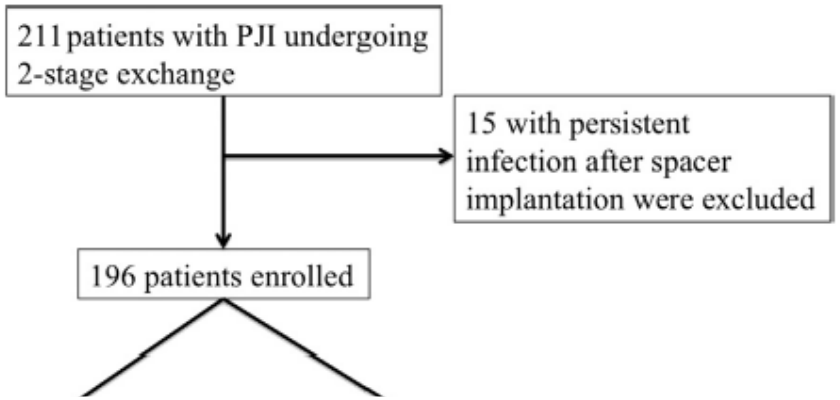
journal homepage: www.arthroplastyjournal.org

Complications - Infection

Continuous Antibiotic Therapy Can Reduce Recurrence of Prosthetic Joint Infection in Patients Undergoing 2-Stage Exchange

Tiziana Ascione, MD [a, *], Giovanni Balato, MD, PhD [b], Massimo Mariconda, MD [b], Renato Rotondo, MD [c], Andrea Baldini, MD [d], Pasquale Pagliano, MD [a]





Question 5: Should there be an antibiotic holiday period prior to reimplantation?

Consensus:. No existen pruebas concluyentes que apoyen unas vacaciones ATBs tras la interrupción del tratamiento ATB y antes de la cirugía de reimplantación como medio para garantizar la erradicación de la infección.
Delegate Vote: Agree: 74%, Disagree: 22%, Abstain: 4% (Strong Consensus).

Proceedings of the International Consensus Meeting on PJI 2018

Continuous therapy	104	10	2.72 (1.17-6.30)	.02	3.32 (1.31-8.44)	.01
Holiday period	65	17				
Bacterial growth	146	18	3.17 (1.26-7.90)	.02	3.96 (1.53-10.19)	.01
No bacterial growth	23	9				
Gram-positive growth	133	10	8.18 (2.75-24.3)	<.001	—	NS
Gram-negative growth	13	8				
Oral therapy	110	12	2.33 (1.02-5.30)	.03	—	NS
Intravenous therapy	59	15				
Absence of immunocompromisation	108	11	2.58 (1.12-5.90)	.03	2.73 (1.1-7.3)	.04
Presence of immunocompromisation	61	16				

CI, confidence interval; NS, not significant.

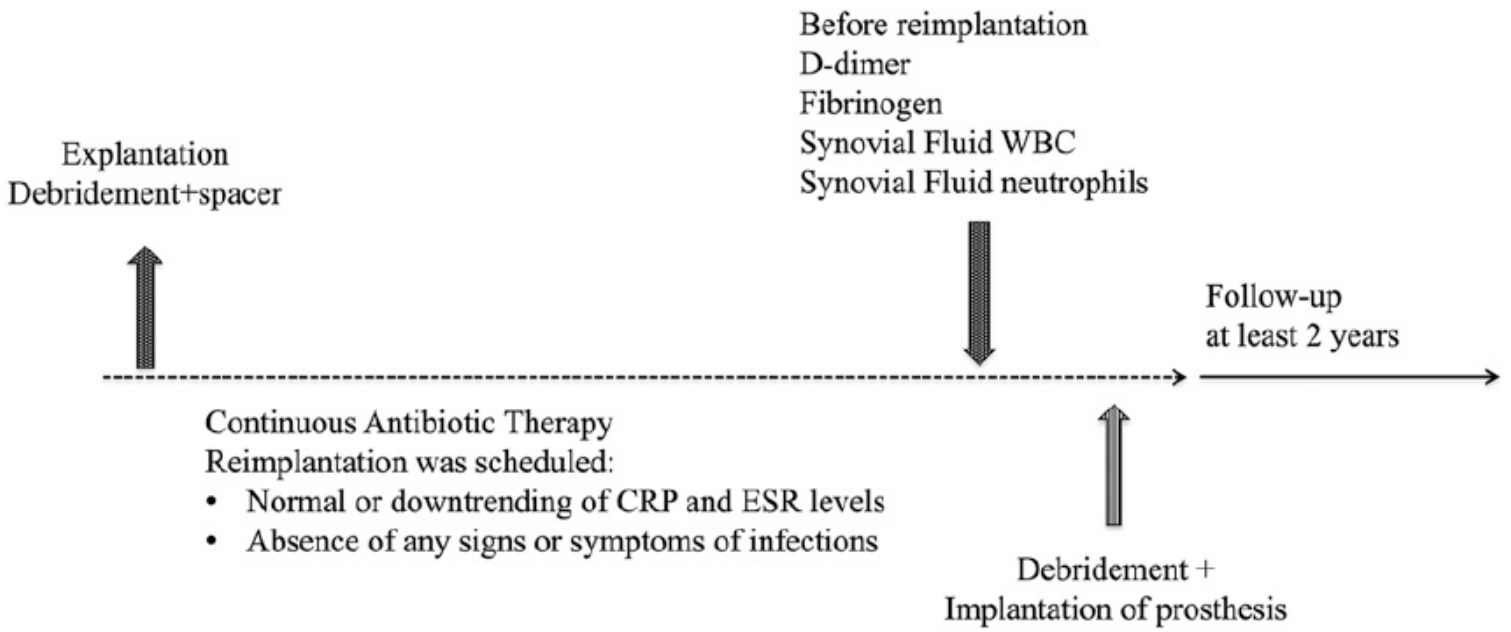
El reimplante

- *Monitoring of CRP during the follow-up is advisable; the persistence of high values is suggestive of treatment failure* **(B-III)**, *but its total normalization must not be a condition for deciding the end of therapy* **(B-II)**.

El reimplante

Ideal Timing of Reimplantation in Patients with Periprosthetic Knee Infection Undergoing 2-Stage Exchange

A Diagnostic Scoring System



El reimplante

Ideal Timing of Reimplantation in Patients with Periprosthetic Knee Infection Undergoing 2-Stage Exchange

A Diagnostic Scoring System

TABLE III Pre-Reimplantation Diagnostic Parameters in Patients with and without Recurrent Infection*

	Median (IQR) Level		
	Patients with Infection (N = 19)	Patients without Infection (N = 134)	P Value†
ESR *(mm/hr)*	31 (16-53)	23.5 (11-43)	0.091
CRP *(mg/L)*	9.3 (2.2-21.5)	3.35 (2-7.2)	0.1
Fibrinogen *(ng/mL)*	450 (301-562)	392.5 (314.5-481)	0.23
D-dimer *(ng/mL)*	1420 (970-2833)	907.5 (575.5-1564.5)	0.008
SF-WBC count *(cells/μL)*	1290 (934-2798)	439 (263-872)	<0.001
SF-PMN percentage	63 (53-75)	34 (27-51)	<0.001

*IQR = interquartile range, ESR = erythrocyte sedimentation rate, CRP = C-reactive protein, SF = synovial fluid, WBC = white blood cell, PMN = polymorphonuclear leukocyte. †Mann-Whitney U test.

TABLE IV Diagnostic Parameters for Pre-Reimplantation D-Dimer, SF-WBC Count, and SF-PMN Percentage at the Proposed Threshold*

	D-Dimer	SF-WBC Count	SF-PMN Percentage	D-Dimer >1110 ng/mL, SF-WBC Count >934 cells/μL, SF-PMN Percentage >52%
Threshold	1110 ng/mL	934 cells/μL	52%	
Sensitivity	74% (66%-80%)	68% (60%-76%)	73% (66%-80%)	47% (39%-56%)
Specificity	61% (52%-68%)	90% (84%-93%)	90% (83%-94%)	99% (95%-99%)
Positive predictive value	0.21 (0.13-0.29)	0.50 (0.42-0.58)	0.52 (0.44-0.60)	0.82 (0.75-0.87)
Negative predictive value	0.94 (0.89-0.97)	0.95 (0.90-0.98)	0.96 (0.91-0.98)	0.93 (0.87-0.96)
Area under the curve	0.69 (0.57-0.81)	0.79 (0.67-0.92)	0.82 (0.70-0.94)	0.73 (0.58-0.88)

*Data are given with the 95% confidence interval in parentheses. SF = synovial fluid, WBC = white blood cell, PMN = polymorphonuclear leukocyte.

El reimplante

Ideal Timing of Reimplantation in Patients with Periprosthetic Knee Infection Undergoing 2-Stage Exchange

A Diagnostic Scoring System

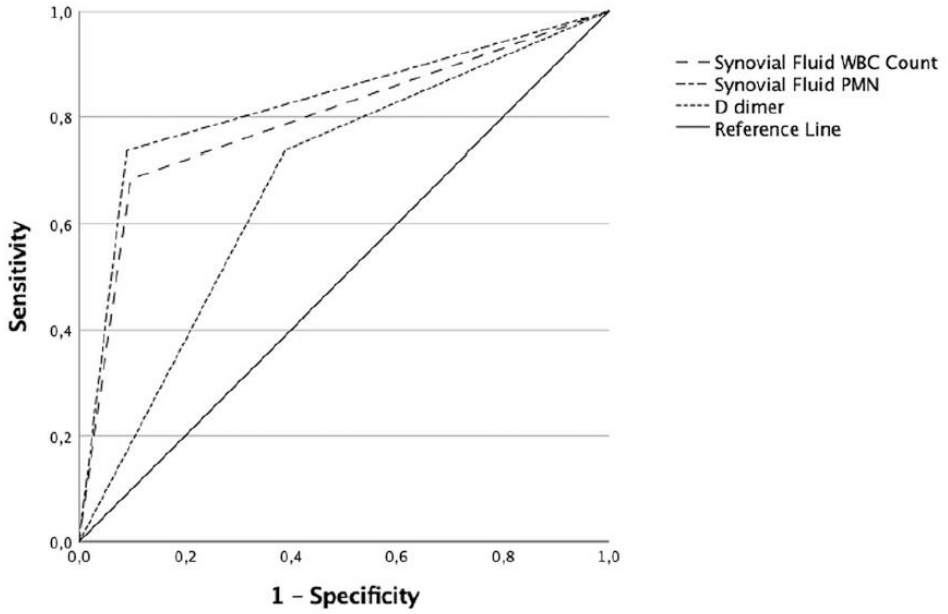


TABLE V Simple Importance-Based Beta Coefficients for the 3 Diagnostic Parameters*

Variable	Beta	Standard Error	P Value†	Score
Serum D-dimer >1110 ng/mL	1.52	0.75	0.041	1.5
SF-WBC >934 cells/μL	2.13	0.74	0.004	2
SF-PMN percentage >52%	2.18	0.74	0.003	2

*SF = synovial fluid, WBC = white blood cell, PMN = polymorphonuclear leukocyte. †Age- and sex-adjusted multivariable logistic regression analysis.

El reimplante

Ideal Timing of Reimplantation in Patients with Periprosthetic Knee Infection Undergoing 2-Stage Exchange

A Diagnostic Scoring System

TABLE VII Distribution of the Scores According to Outcome*

Score	Patients with Infection *(no. [%])*	Patients without Infection *(no. [%])*	Sensitivity	Specificity
0	1 (5%)	69 (51%)	94%	51%
1.5	2 (11%)	44 (33%)	84%	84%
2	2 (11%)	11 (8%)	74%	93%
3.5	3 (16%)			
4	2 (11%)			
5.5	9 (47%)			

Based on our findings, patients with a score of >2 should not undergo reimplantation but rather be considered for repeat debridement and spacer exchange as they are at a high risk of recurrent PJI. Patients with a score of ≤2 can undergo definitive reimplantation with the lowest risk of recurrence.

El reimplante. ¿Qué profilaxis?

European Journal of Clinical Microbiology & Infectious Diseases
https://doi.org/10.1007/s10096-024-04838-3

ORIGINAL ARTICLE

Impact of antibiotic prophylaxis in second-stage surgery in joint prosthesis infection treated with two-stage exchange. A multicenter case–control study

Jose M. Barbero Allende[1,2] · Encarnación Fernández Antón[3,4] · Joan Gómez-Junyent[2,5,6] · Lluisa Sorlí Redó[2,5,7,8] · Dolors Rodríguez-Pardo[2,9,10] · Óscar Murillo Rubio[2,10,11] · Marta Fernández Sampedro[2,10,12] · Rosa Escudero-Sánchez[2,10,13,14] · Manuel García Gutiérrez[2,10,15] · Ma Eugenia Portillo[2,16,17] · Ignacio Sancho[17,18] · Alicia Rico Nieto[2,10,19] · Laura Guio Carrión[2,20,21] · Alex Soriano Viladomiu[22,23] · Laura Morata Ruiz[2,22,23] · Francisco José de Abajo Iglesias[24,25]

Only before surgery ($n=62$)	
Cefazolin	48 (17.3%)
Cefazolin + teicoplanin	4 (1.5%)
Cefuroxime	3 (1.1%)
Vancomicyn	2 (0.8%)
Vancomicyn + ceftriaxone	1 (0.4%)
Teicoplanin	1 (0.4%)
Teicoplanin + ceftriaxone	1 (0.4%)
Teicoplanin + ertapenem	1 (0.4%)
Teicoplanin + meropenem	1 (0.4%)
Before and after surgery ($n=183$)	
Vancomicyn + ceftazidime	28 (10.7%)
Teicoplanine + ceftazidime before and vancomicyn + ceftazidime after	20 (7.6%)
Cefazolin	16 (6.1%)
Teicoplanin + gentamicin	14 (5.3%)
Teicoplanin + meropenem before and vancomicyn + meropenem after	11 (4.2%)
Cefazolin before and vancomicyn + ceftazidime after	10 (3.8%)
Vancomy	5 (1.9%)
Cefazolin before and levofloxacin after	4 (1.5%)
Cefazolin before and linezolid after	3 (1.1%)
Ceftriaxone	3 (1.1%)
Teicoplanin	3 (1.1%)
Teicoplanin + ertapenem	3 (1.1%)
Teicoplanin + meropenem	3 (1.1%)
Teicoplanin + gentamicin before and teicoplanin after	3 (1.1%)
Teicoplanin + aztreonam before and vancomicyn + aztreonam after	2 (0.8%)
Cefazolin + vancomicyn	2 (0.8%)
Teicoplanin + ceftazidime	2 (0.8%)
Teicoplanin + cefepime	2 (0.8%)
Teicoplanin + levofloxacino before and vancomicyn + levofloxacino after	2 (0.8%)
Cloxacilin	2 (0.8%)
Cloxacilne before and after and cefadroxil oral	1 (0.4%)
Cefuroxime	1 (0.4%)
Cefazolin before, cefuroxima after and levofloxacin oral	1 (0.4%)
Cefazolin before and cotrimoxazol after	1 (0.4%)
Cefazolin before and meropenem after	1 (0.4%)
Cefazolin before and amoxicilina/clavulánico after	1 (0.4%)
Cefazolin before and vancomicyn after	1 (0.4%)
Cefazolin before and vancomicyn + rifampicin after	1 (0.4%)
Cefazolin before and vancomicyn + ceftriaxone after	1 (0.4%)
Cefazolin before and vancomicyn + ceftazidime after	1 (0.4%)
Cefazolin before and daptomicyn + ampicilina after	1 (0.4%)
Cefazolin before and daptomicyn + ceftazidime after	1 (0.4%)
Cefazolin before, ceftazidime after and ciprofloxacin oral	1 (0.4%)
Cefazolin before, teicoplanin after and levofloxacin oral	1 (0.4%)
Cefazolin before, linezolid after and doxycycline oral	1 (0.4%)
Cefazolin before and linezolid + meropenem after	1 (0.4%)
Cefazolin before and vancomicyn + rifampicin after	1 (0.4%)
Cefazolin before, vancomicina + ceftazidima after and amoxi/clav oral	1 (0.4%)
Cefazolin + amikacin	1 (0.4%)
Cefazolin + teicoplanin before, teicoplanin after and cotrimoxazol oral	1 (0.4%)
Cefazolin + teicoplanin before, teicoplanin after and levofloxacin oral	1 (0.4%)
Cefazolin + teicoplanina before, teicoplanin anfter and cotrimoxazol + linezolid oral	1 (0.4%)
Cefazolina + ciprofloxacino preimplante y ciprofloxacino postoperatorio	1 (0.4%)
Cefazolin + amikacina	1 (0.4%)
Cefuroxime before, levofloxacin after and doxycycline oral	1 (0.4%)
Ceftazidime + amikacin	1 (0.4%)
Vancomicy before and linezolid + imipenem after	1 (0.4%)
Vancomicy before and after and minocycline oral	1 (0.4%)
Vancomicy before and daptomicyn + ciprofloxacin after	1 (0.4%)
Vancomicy before, vancomicyn and rifampicin after and cotrimoxazol oral	1 (0.4%)
Vancomicy before, linezolid after and levofloxacin oral	1 (0.4%)
Vancomicyn + ertapenem	1 (0.4%)
Vancomicyn + cefepime before and vancomicyn + ceftazdime after	1 (0.4%)
Vancomicyn + ciprofloxacin before and vancomicyn after	1 (0.4%)
Teicoplanin + ceftriaxone befors and vancomicyn + meropenem after	1 (0.4%)
Teicoplanin before and teicoplanin + rifampicin after	1 (0.4%)
Teicoplanin before and after and cotrimoxazol oral	1 (0.4%)
Teicoplanin + amikacin before and teicoplanin + ceftazidime after	1 (0.4%)
Teicoplanin + ceftazidima before, teicoplanine after and linezolid oral	1 (0.4%)
Teicoplanin + rifampicin	1 (0.4%)
Daptomicyn + ertapenem befors + linezolid after	1 (0.4%)
Daptomicyn + gentamicin	1 (0.4%)
Clindamycin + gentamicin before and clindamicina after	1 (0.4%)
Linezolid + meropenem	1 (0.4%)
Linezolid + ertapenem	1 (0.4%)
Linezolid before and after and clindamicina oral	1 (0.4%)
Fluconazol	1 (0.4%)
Only after surgery ($n=15$)	
Vancomicyn + ceftazidime	9 (3.4%)
Vancomicyn + aztreonam	1 (0.4%)
Teicoplanyn + ceftazidime	1 (0.4%)
Teicoplanyn + aztreonam	1 (0.4%)
Teicoplanyn + meropenem	1 (0.4%)
Daptomicyn + ertapenem	1 (0.4%)
Linezolid + meropenem	1 (0.4%)

El reimplante. ¿Qué profilaxis?

European Journal of Clinical Microbiology & Infectious Diseases
https://doi.org/10.1007/s10096-024-04838-3

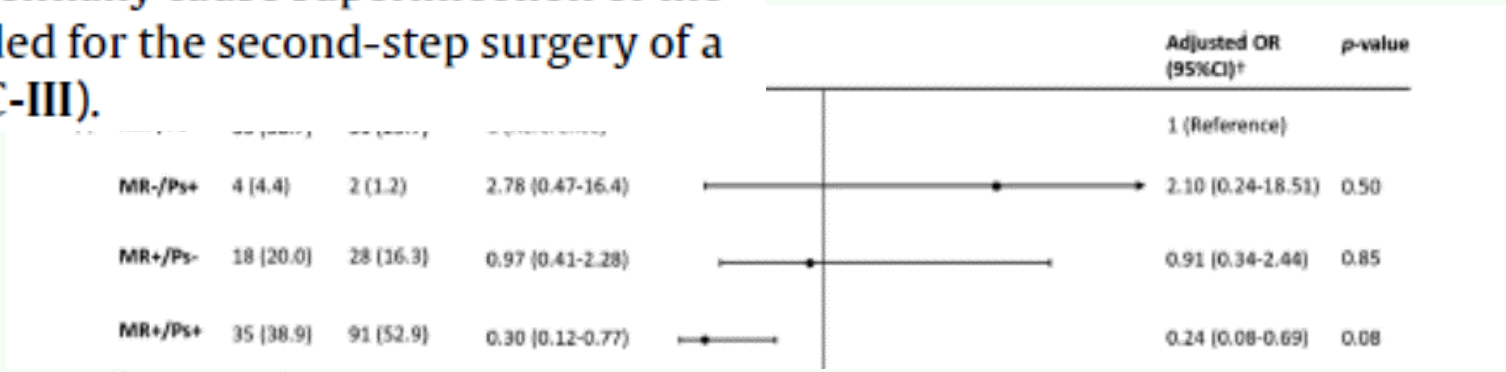
ORIGINAL ARTICLE

Impact of antibiotic prophylaxis in second-stage surgery in joint prosthesis infection treated with two-stage exchange. A multicenter case–control study

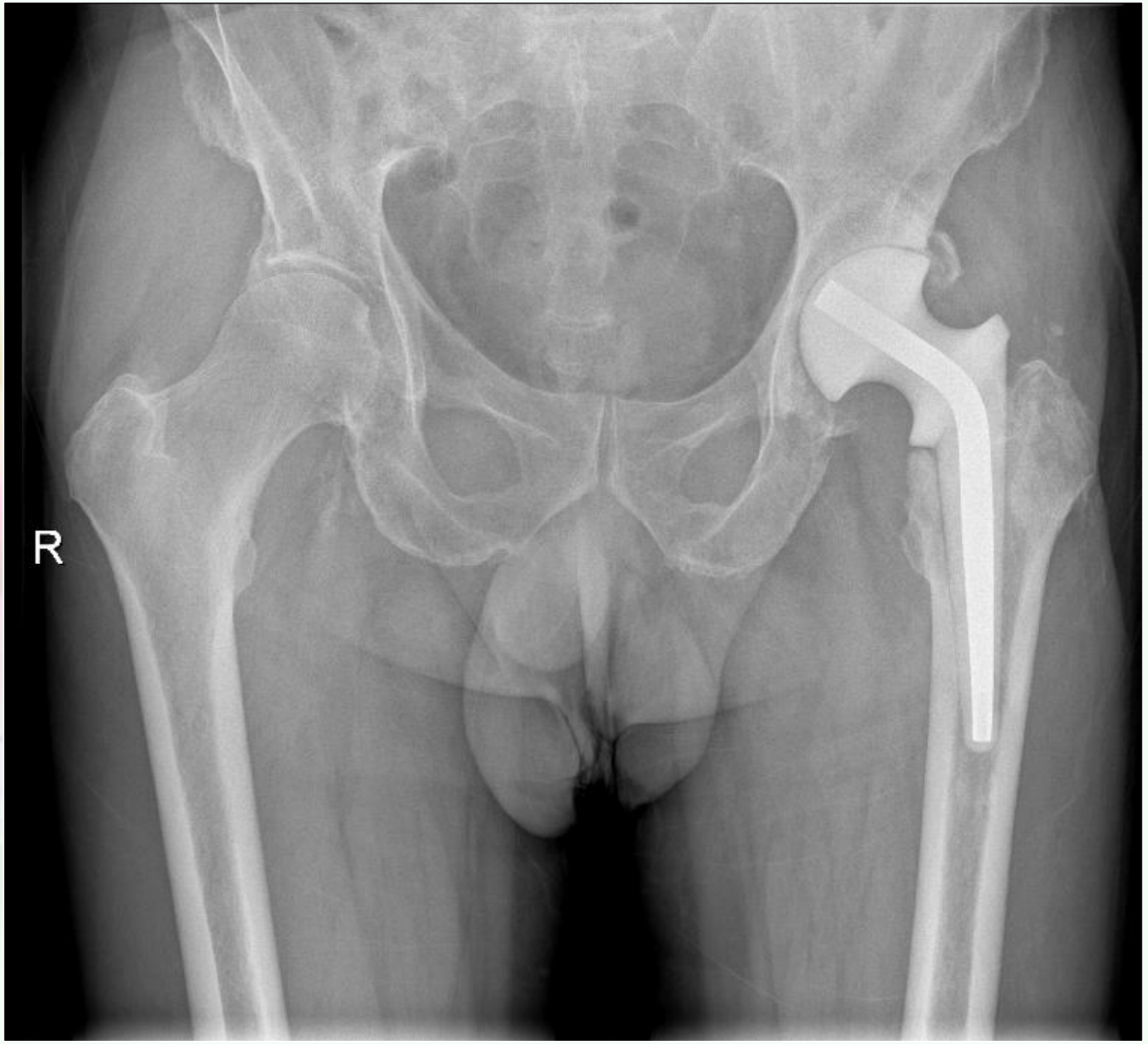
Jose M. Barbero Aller
Dolors Rodríguez-Par
Rosa Escudero-Sánch
Alicia Rico Nieto[2,10,19]
Francisco José de Aba

What is the best prophylaxis for the second-step surgery and how long should it be prescribed?

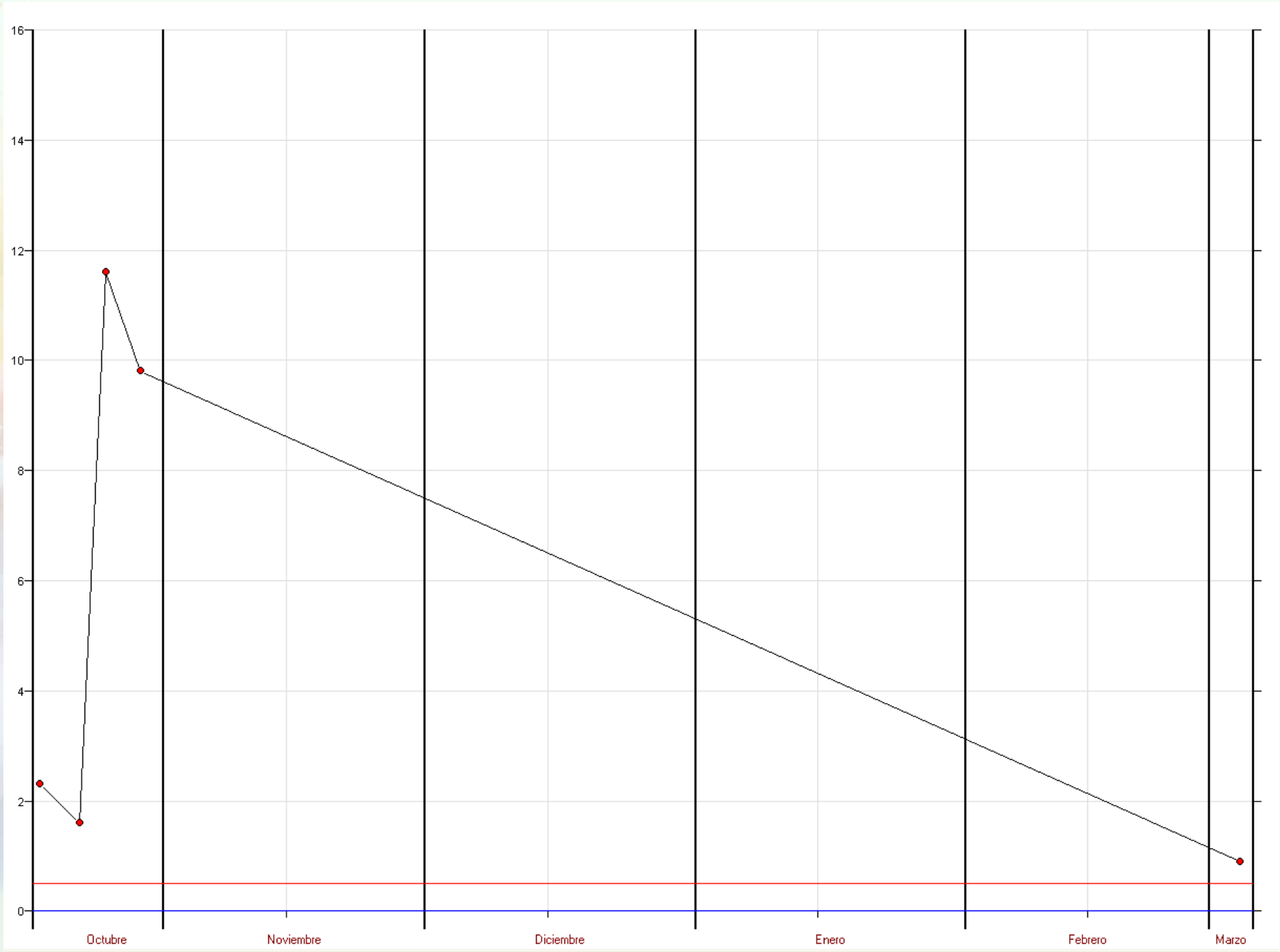
- Wide-spectrum antibiotic prophylaxis including nosocomial microorganisms that may potentially cause superinfection of the new prosthesis is recommended for the second-step surgery of a 2-step exchange procedure (**C-III**).

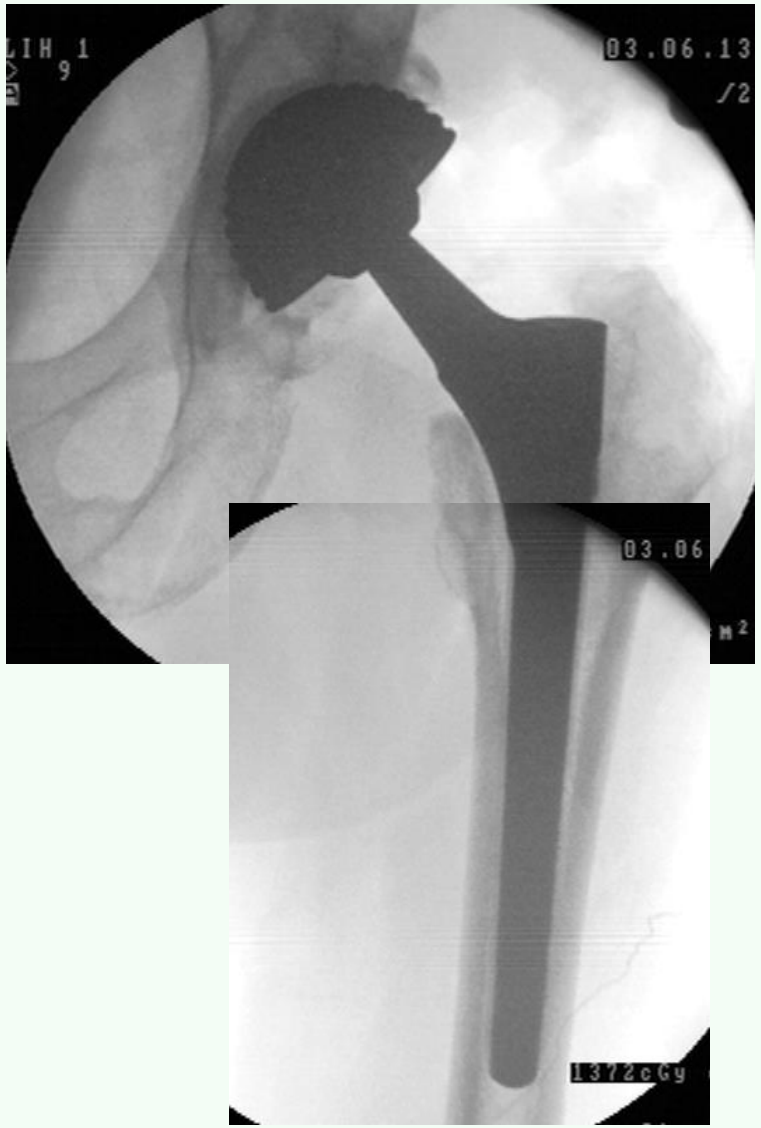


				Adjusted OR (95%CI)†	p-value
				1 (Reference)	
MR-/Ps+	4 (4.4)	2 (1.2)	2.78 (0.47-16.4)	2.10 (0.24-18.51)	0.50
MR+/Ps-	18 (20.0)	28 (16.3)	0.97 (0.41-2.28)	0.91 (0.34-2.44)	0.85
MR+/Ps+	35 (38.9)	91 (52.9)	0.30 (0.12-0.77)	0.24 (0.08-0.69)	0.08

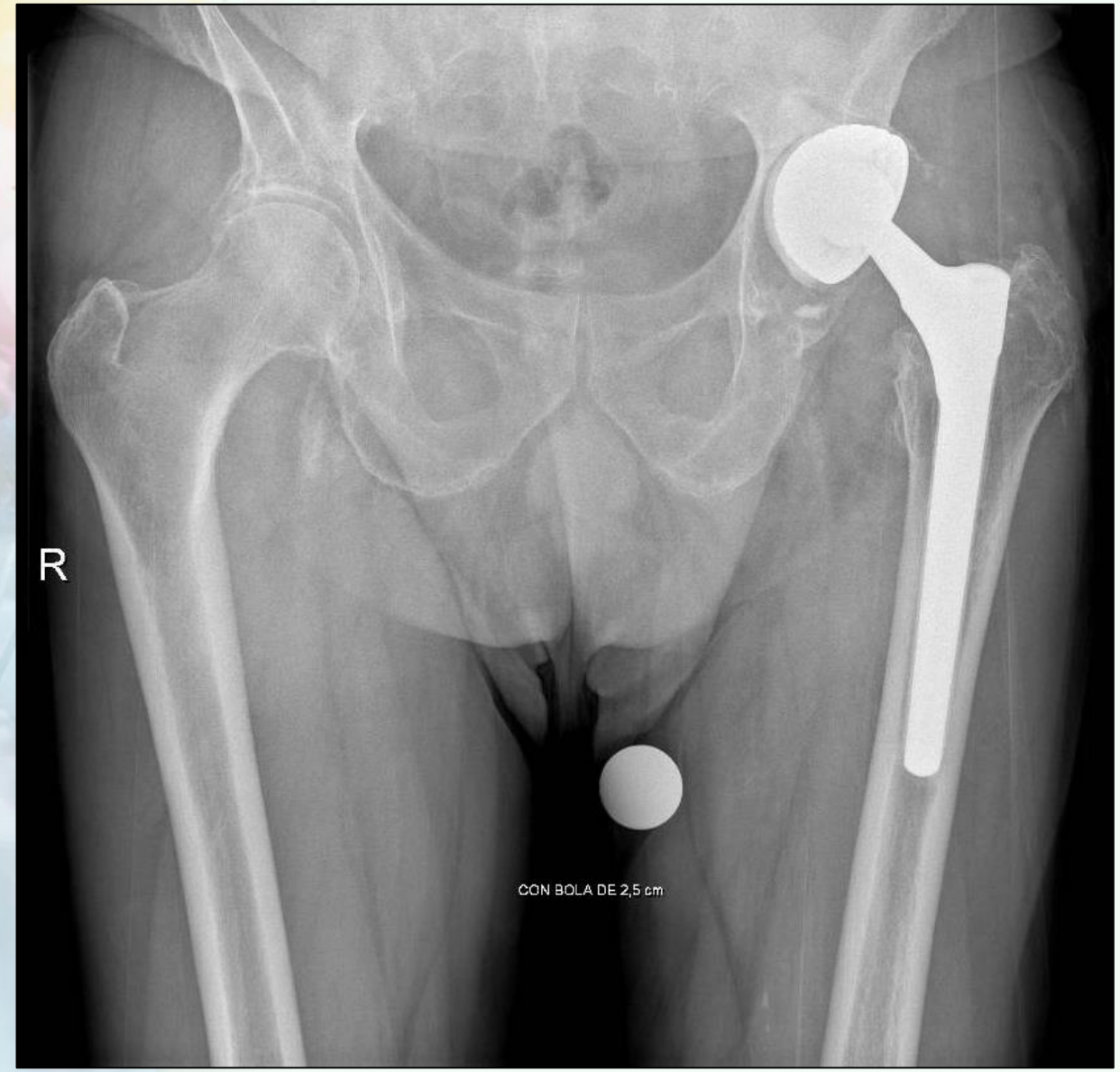

R

PCR


16
14
12
10
8
6
4
2
0
Octubre
Noviembre
Diciembre
Enero
Febrero
Marzo



248827


R
CON BOLA DE 2,5 cm

El valor de los CIOP

33889181 28/01/2025 10:18:00 TEJIDO ARTICULAR- SINOVIAL	33889177 28/01/2025 10:18:00 TEJIDO ARTICULAR- SINOVIAL	33889173 28/01/2025 10:18:00 TEJIDO ARTICULAR- SINOVIAL	33889182 28/01/2025 10:18:00 LIQUIDO ARTICULAR
Staphylococcus epidermidis			

El valor de los CIOP

The Journal of Arthroplasty 39 (2024) 839–845

Contents lists available at ScienceDirect

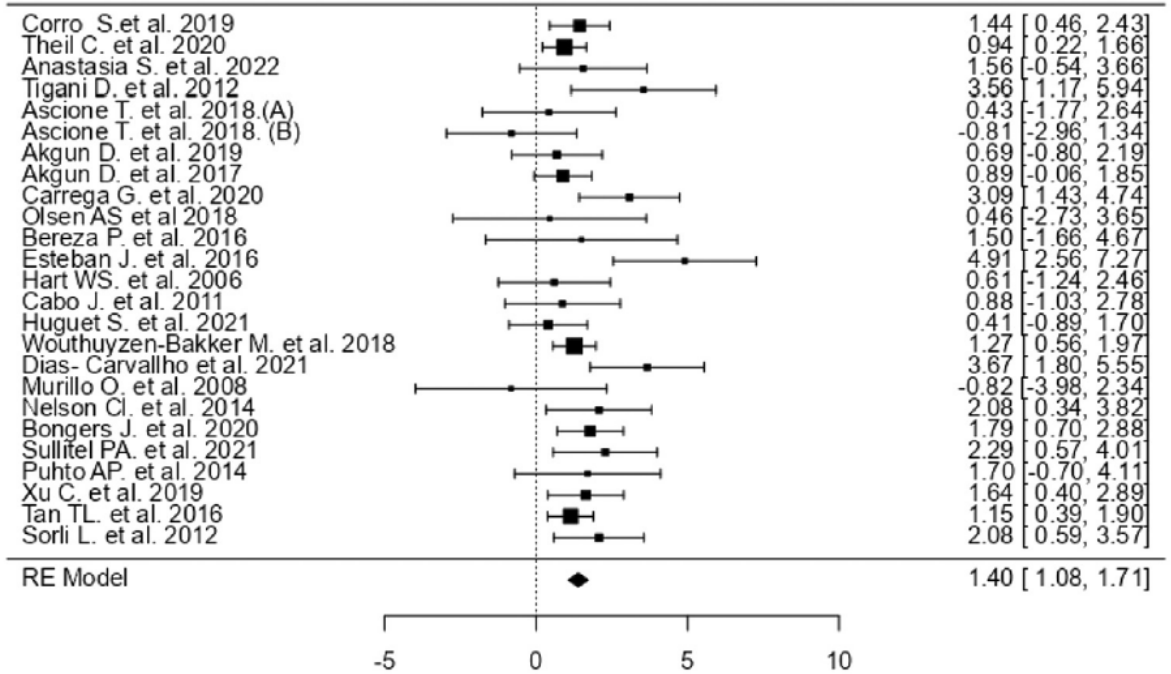
The Journal of Arthroplasty

journal homepage: www.arthroplastyjournal.org

Systematic Review and Meta-Analysis

Impact of Positive Cultures During the Second St Exchange: Systematic Review and Meta-Analys

Marta Sabater-Martos, MD [a,*], Laia Boadas, MD [a], Rihard Tre
André Grenho, MD [c], Pablo Sanz-Ruiz, MD, PhD [d], Leonard C
Danguole Vaznaisiene, MD, PhD [f], Matteo Ferrari, MD [g], Alex



Positive Culture During Reimplantation Increases the Risk of Subsequent Failure in Two-Stage Exchange Arthroplasty

Timothy L. Tan, MD, Miguel M. Gomez, MD, Jorge Manrique, MD, Javad Parvizi, MD, FRCS, and Antonia F. Chen, MD, MBA

TABLE II Results

Variable	Culture-Positive Group, N = 33	Culture-Negative Group, N = 234	OR (95% CI)	HR (CI)	P Value
Follow-up* *(mo)*	52.1 (0.2-130.4)	47.7 (3.7-162.9)	—	—	0.475
Treatment failure†	15 (45.5)	49 (20.9)	2.53 (1.13-5.64)	—	0.023
Reinfection†	13 (39.4)	46 (19.7)	2.32 (1.25-4.29)	—	0.007
Mortality†	2 (6.1)	3 (1.3)	1.89 (0.20-17.59)	—	0.571
Months to reinfection*	8.8 (0.2-57.7)	13 (0.3-67.1)	—	2.00 (1.05-3.82)	0.034

*The values are given as the mean, with the range in parentheses. †The values are given as the number, with the percentage of the group in parentheses.

during reimplantation. The treatment failure rate did not differ ($p = 0.73$) between cases with ≥2 positive cultures (36.4%) and 1 positive culture (50%).

The Journal of Arthroplasty 35 (2020) 2996–3001

Contents lists available at ScienceDirect

The Journal of Arthroplasty

journal homepage: www.arthroplastyjournal.org

Complications - Infec

Do Positive Cul Risk for Reinfec Infection?

C. Theil, MD *, Soph
J. Schwarze, MD, B.

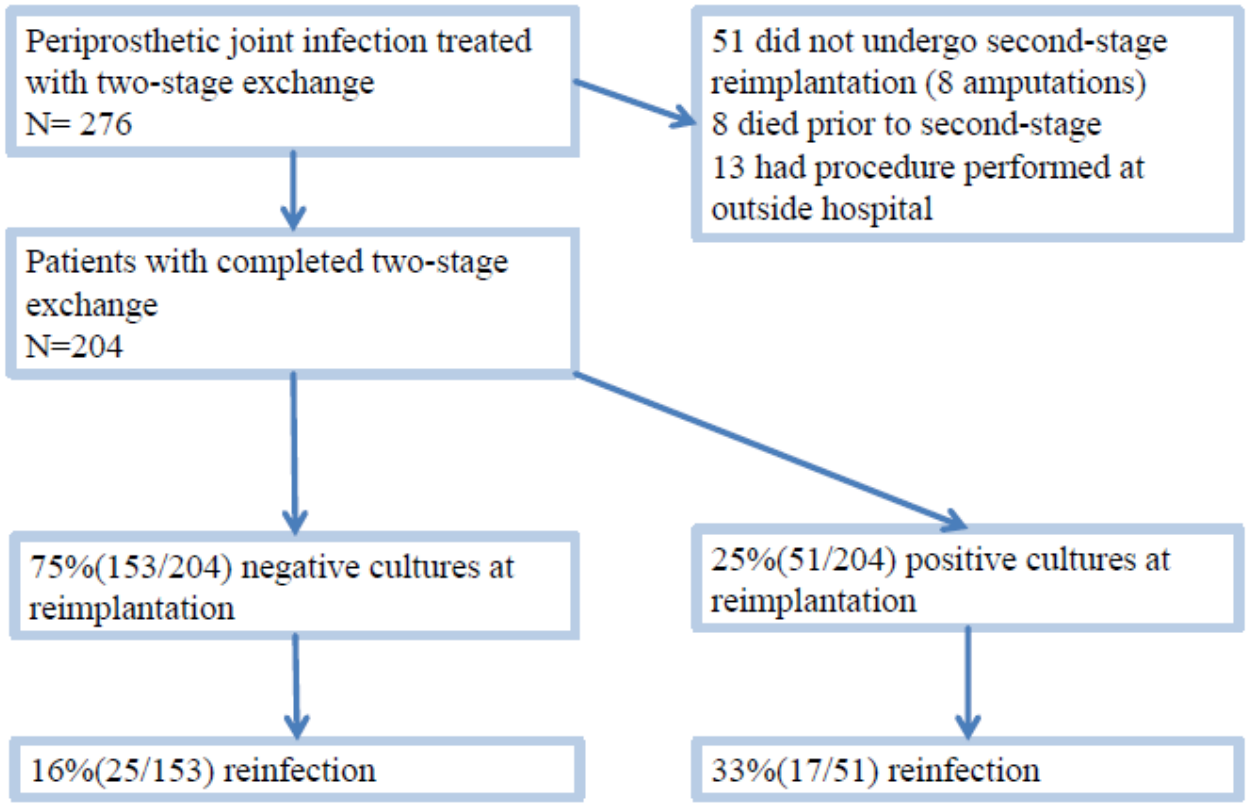


Fig. 1. flow diagram showing inclusion and exclusion of patients.

months (IQR 5-19). Patients with a single positive culture during reimplantation surgery had a significantly higher risk for reinfection as well (HR 2.421 (95% CI 1.139-5.143), $P = .021$). Furthermore, a

The Journal of Arthroplasty 34 (2019) 1025–1031

Contents lists available at ScienceDirect

The Journal of Arthroplasty

journal homepage: www.arthroplastyjournal.org

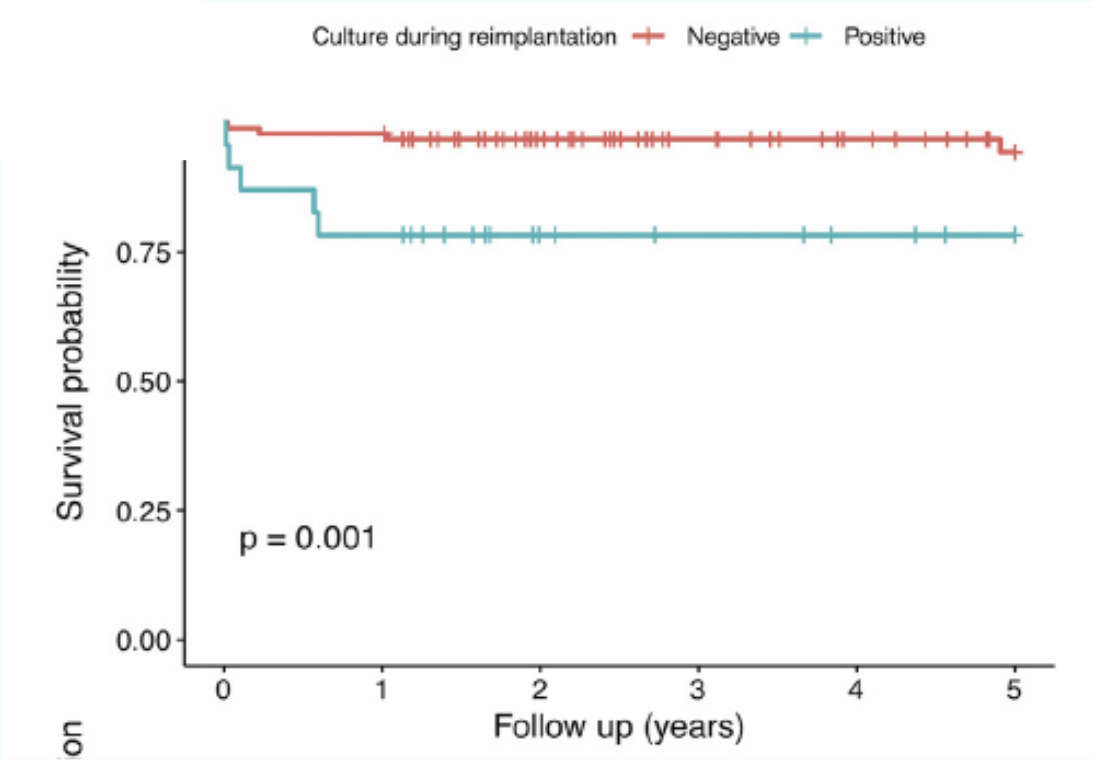
Review

Positive Culture During Reimplantation Increases the Risk of Reinfection in Two-Stage Exchange Arthroplasty Despite Administrating Prolonged Antibiotics: A Retrospective Cohort Study and Meta-Analysis

Chi Xu, MD [a], Timothy L. Tan, MD [b], Ji-Ying Chen, MD [a, *]

[a] Department of Orthopaedic Surgery, General Hospital of People's Liberation Army, Beijing, People's Republic of China
[b] Department of Orthopaedic Surgery, Rothman Institute at Thomas Jefferson University, Philadelphia, PA

2012 to 2016. Of them, 23 had positive culture during reimplantation and were treated with 2 weeks of intravenous and 4 weeks of oral antibiotics following reimplantation. All patients had a minimum follow-



Clin Orthop Relat Res (2017) 475:56–61
DOI 10.1007/s11999-016-4890-4

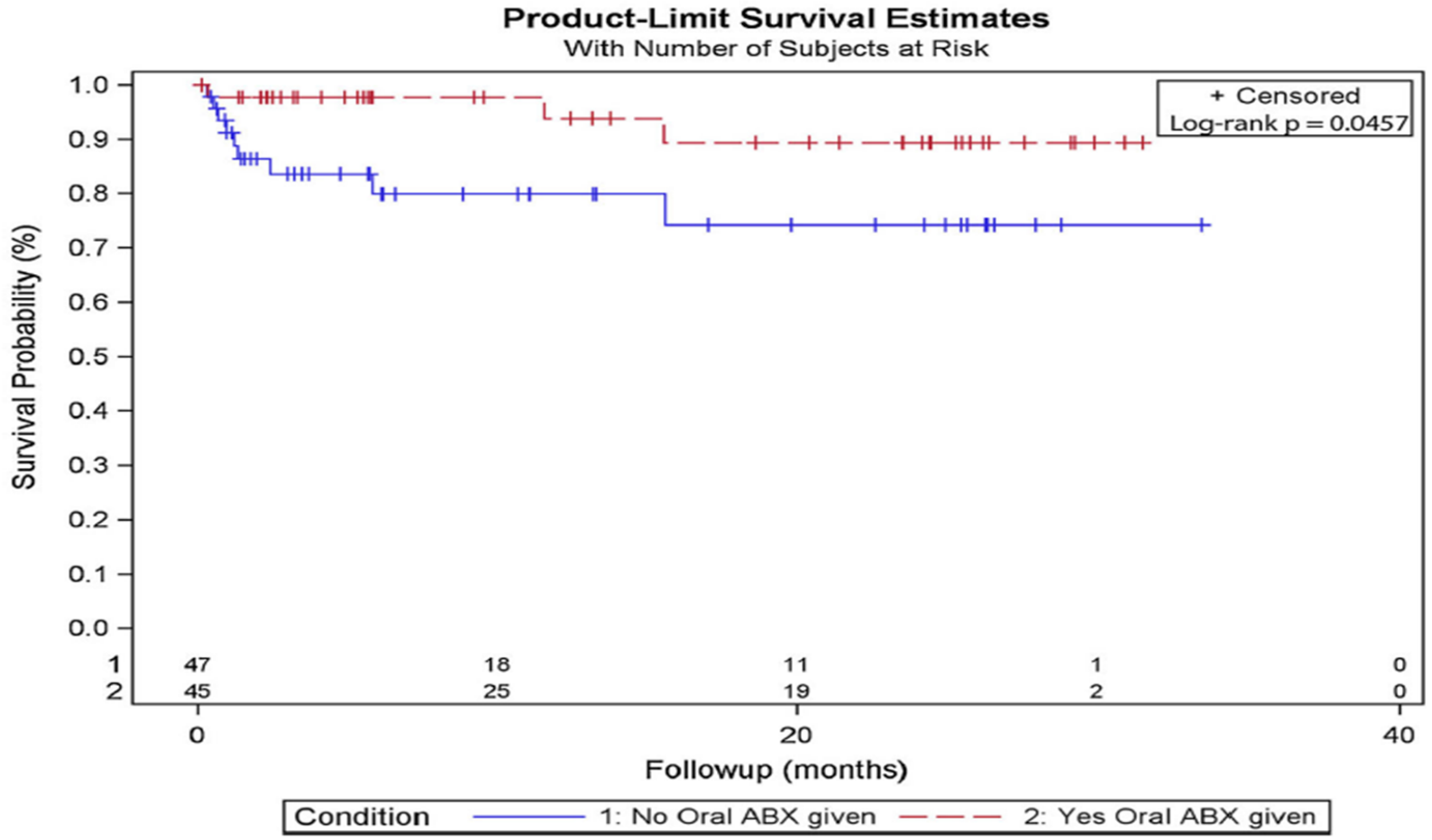
Clinical Orthopaedics and Related Research®
A Publication of The Association of Bone and Joint Surgeons®

SYMPOSIUM: 2016 KNEE SOCIETY PROCEEDINGS

The Mark Coventry, MD, Award: Oral Antibiotics Reduce Reinfection After Two-Stage [illegible] Randomized Controlled Tria

Jonathan M. Frank MD, Erdan Kayupov MS
John Segreti MD, Erik Hansen MD, Curtis H
Katherine Belden MD, Brian Roslund Pharm
Javad Parvizi MD, Craig J. Della Valle MD,
The Knee Society Research Group

Published online: 7 July 2016



A log-rank survival curve for oral antibiotics versus control for all spacers used is shown. ABX = antibiotics

CLINICAL ARTICLE OPEN ACCESS

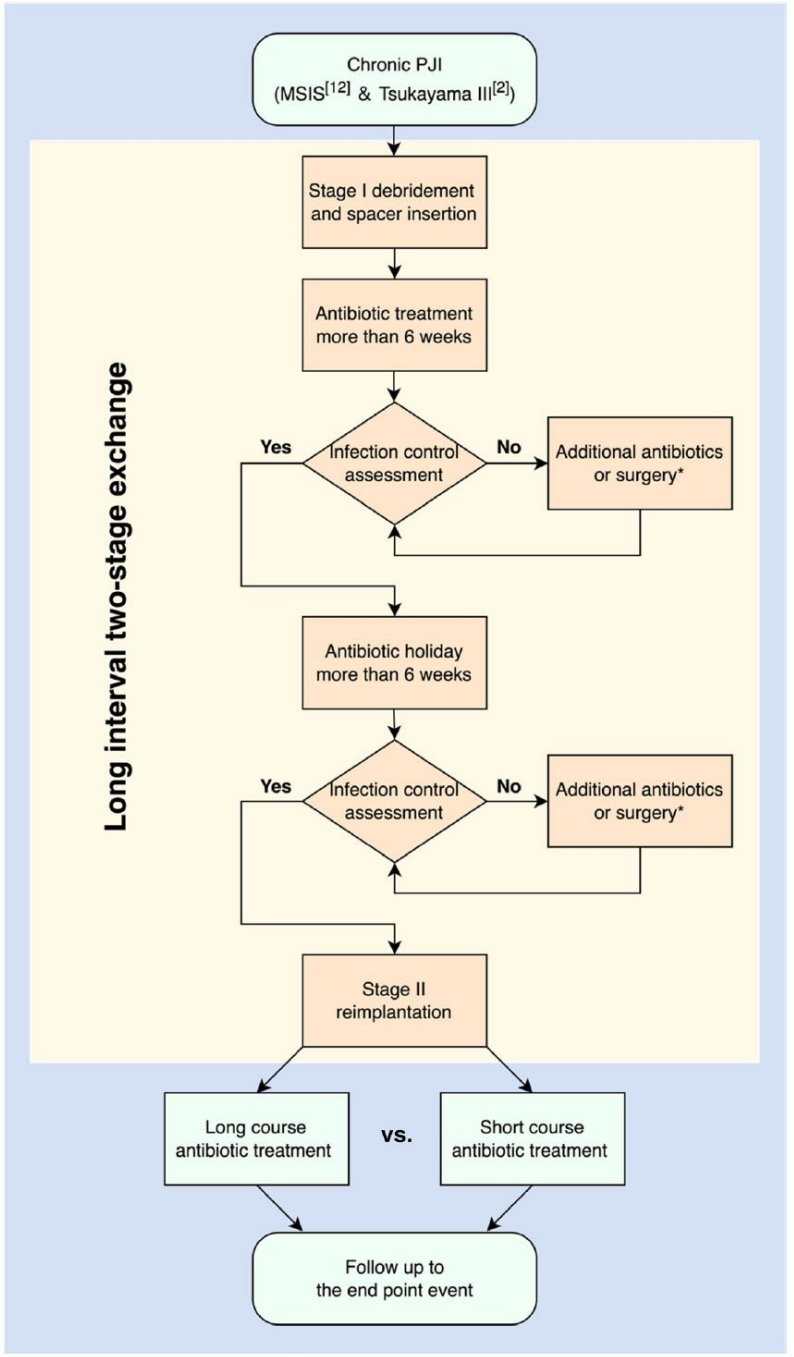
Can "LITE" Procedure Combined With a Short Course Antibiotic Treatment Be Effective in Treating the Chronic PJI?—A Prospective Randomized Controlled Trial

Yang Chen[1,2,3] | Haiqi Ding[1,2,3] | Qijin Wang[1,2,3] | Zida Huang[1,2,3] | Chaofan Zhang[1,2,3] | Wenbo Li[1,2,3] | Yansheng Lin[4] | Yufeng Guo[4] | Xinyu Fang[1,2,3] | Wenming Zhang[1,2,3]

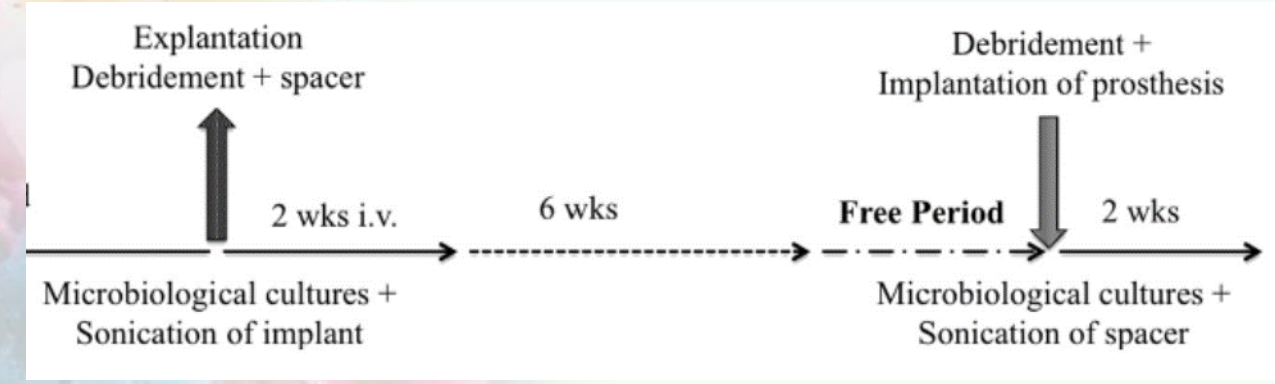
[1]Department of Orthopaedic Surgery, National Regional Medical Center, Binhai Campus of the First Affiliated Hospital, Fujian Medical University, Fuzhou, China | [2]Department of Orthopedic Surgery, The First Affiliated Hospital of Fujian Medical University, Fuzhou, China | [3]Fujian Provincial Institute of Orthopedics, The First Affiliated Hospital, Fujian Medical University, Fuzhou, China | [4]Department of Orthopedic Surgery, Changtai County Hospital, Zhangzhou, China

TABLE 3 | Evaluation of the efficacy of "LITE" procedure in combination with antibiotics.

	Short course group ($n = 30$)	Long course group ($n = 30$)	Statistic value	p
Antibiotic-related complications, n (%)	0 (0)	6 (20)	N/A	0.024
Abnormal liver function, n (%)	0 (0)	6 (20)		
Hematopoietic dysfunction, n (%)	0 (0)	1 (3.3)		
Uncontrolled infection or reinfection, n (%)	1 (3.3)	1 (3.3)	N/A	1.000



El reimplante



The Journal of Arthroplasty 34 (2019) 704–709

Contents lists available at ScienceDirect

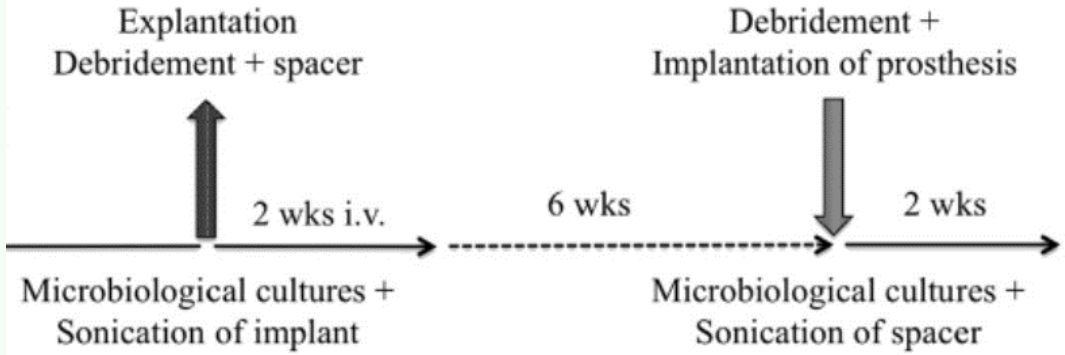
The Journal of Arthroplasty

journal homepage: www.arthroplastyjournal.org

Complications - Infection

Continuous Antibiotic Therapy Can Reduce Recurrence of Prosthetic Joint Infection in Patients Undergoing 2-Stage Exchange

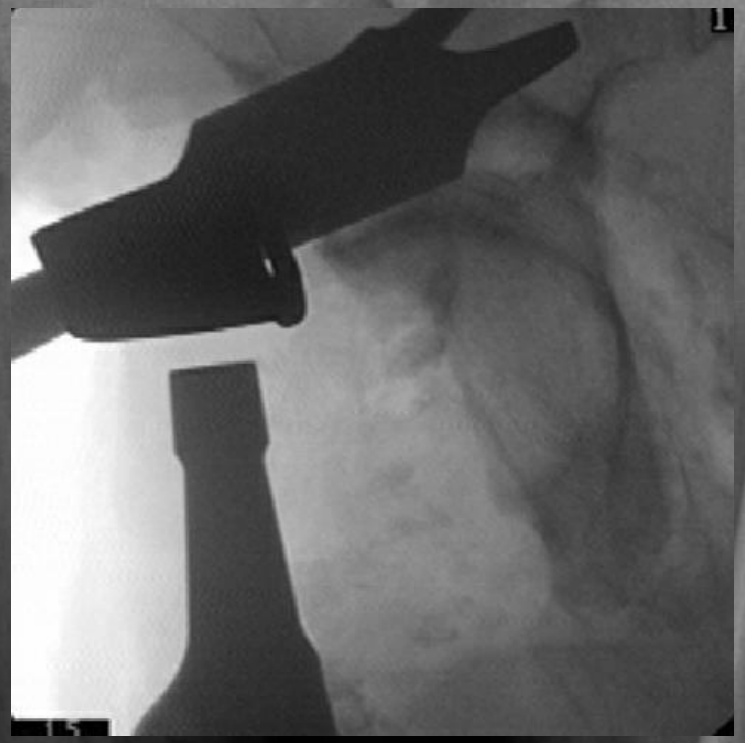
Tiziana Ascione, MD [a,*], Giovanni Balato, MD, PhD [b], Massimo Mariconda, MD [b], Renato Rotondo, MD [c], Andrea Baldini, MD [d], Pasquale Pagliano, MD [a]



M 63 años

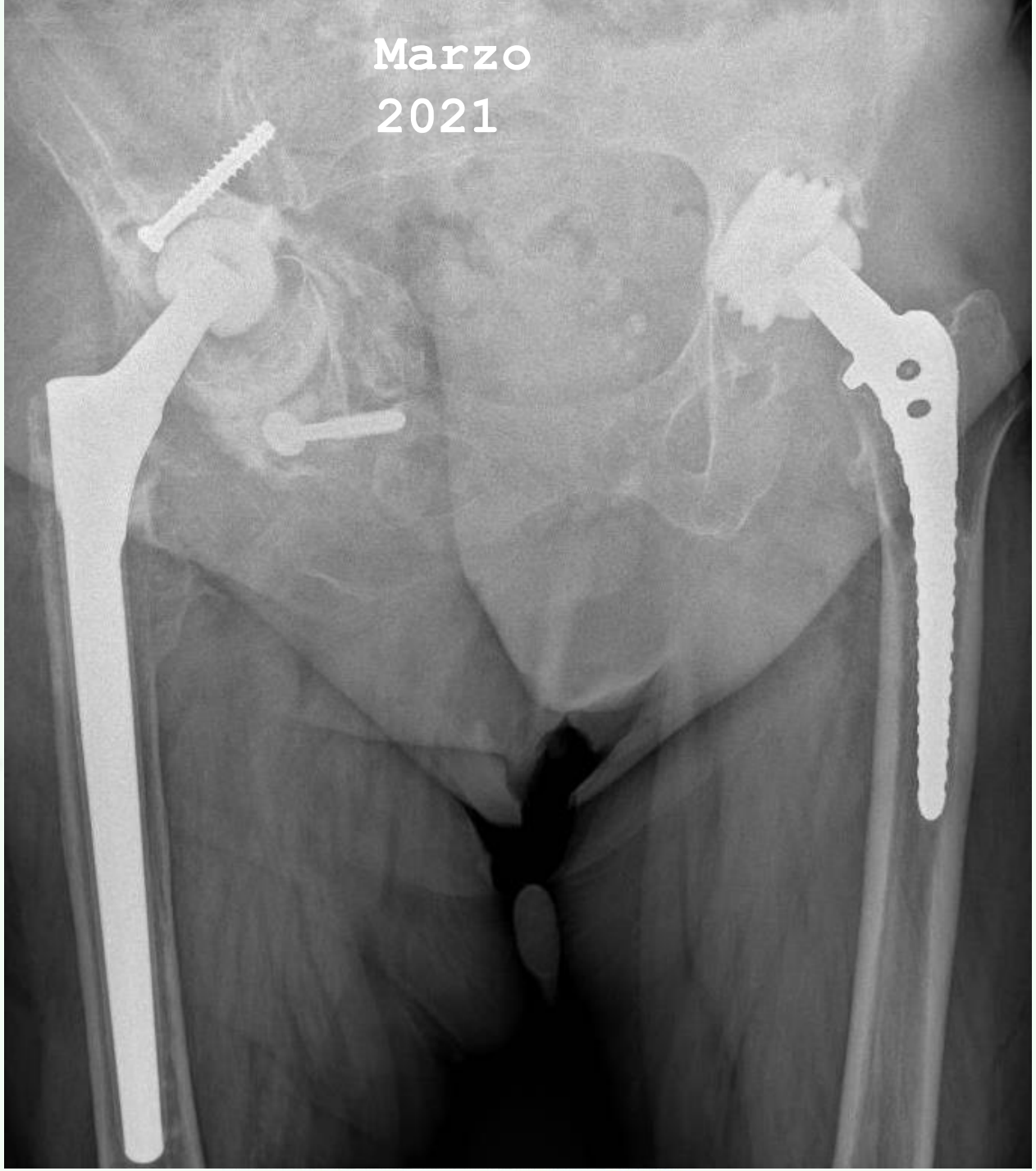
Septiembre
2015

479410



M 69 años

479410

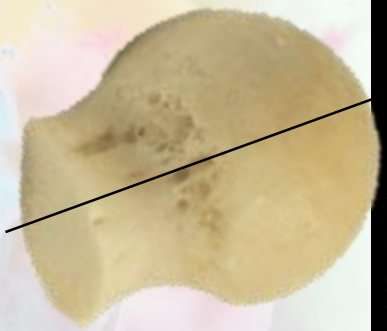


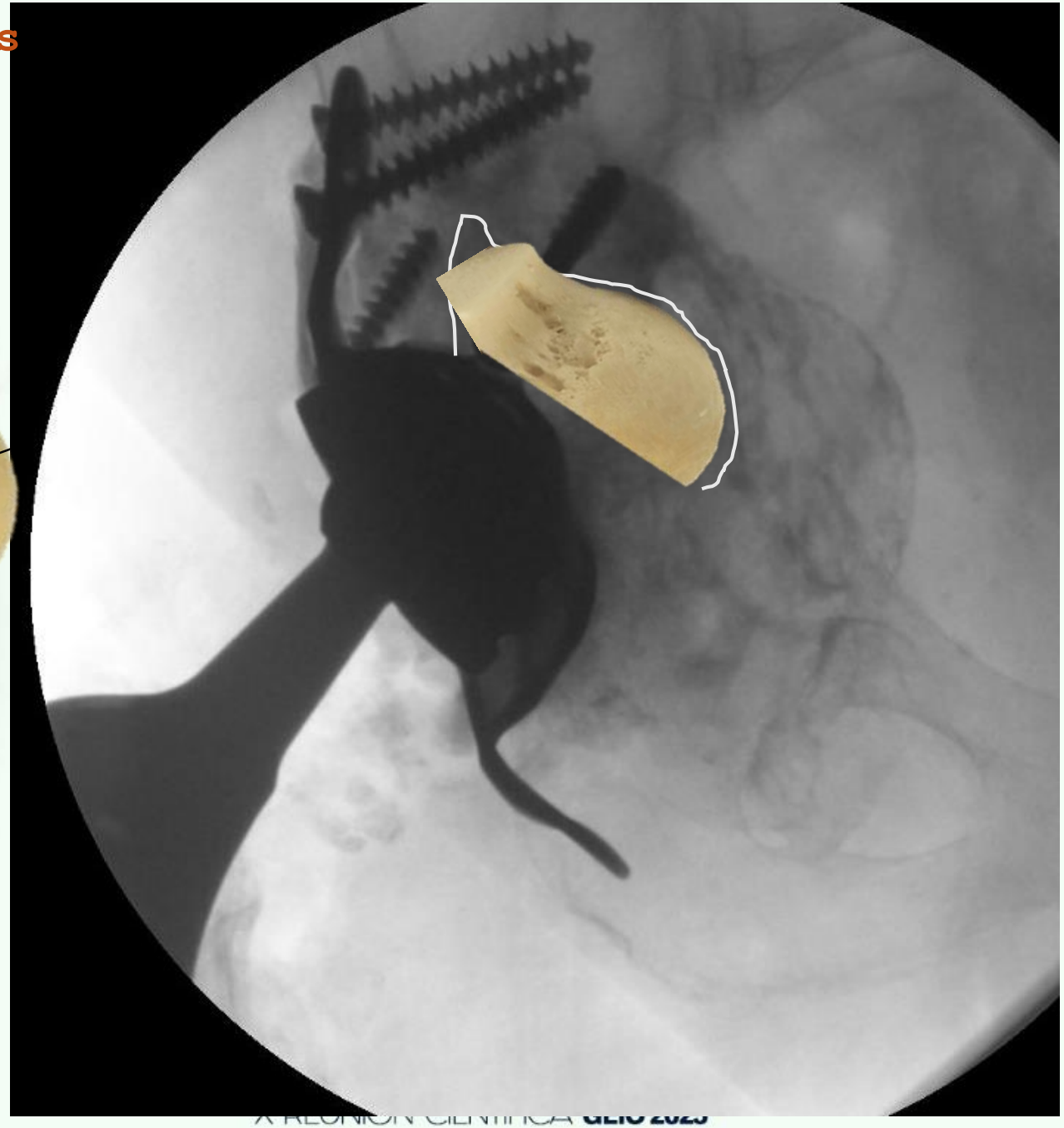
Cultivos (-) Desde Girdlestone

PCR y VSG (-) siempre

M 69 años

479410





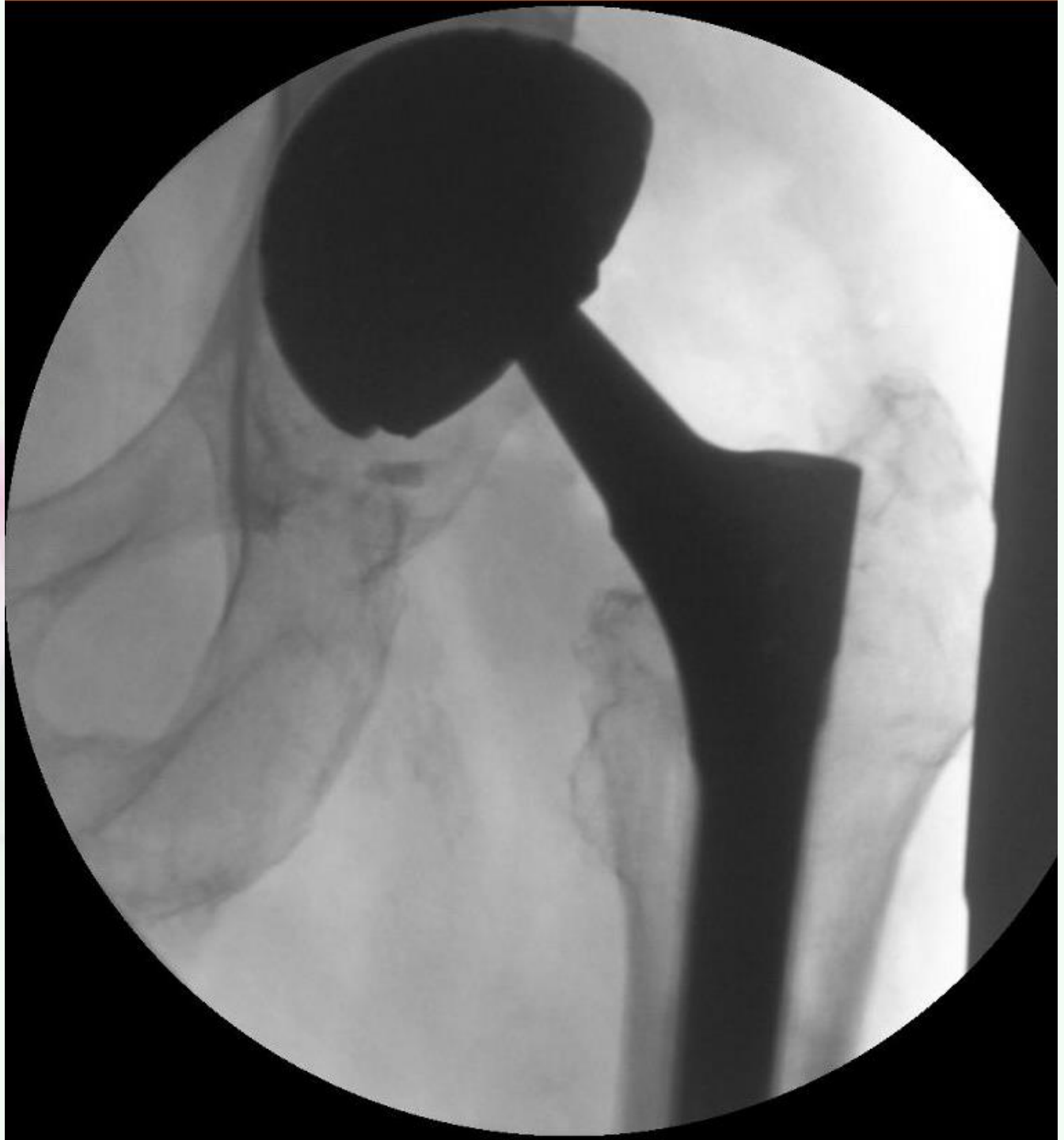
Factores de riesgo cardiovascular: Exfumador. Hipercolesterolemia. Hipertensión arterial.

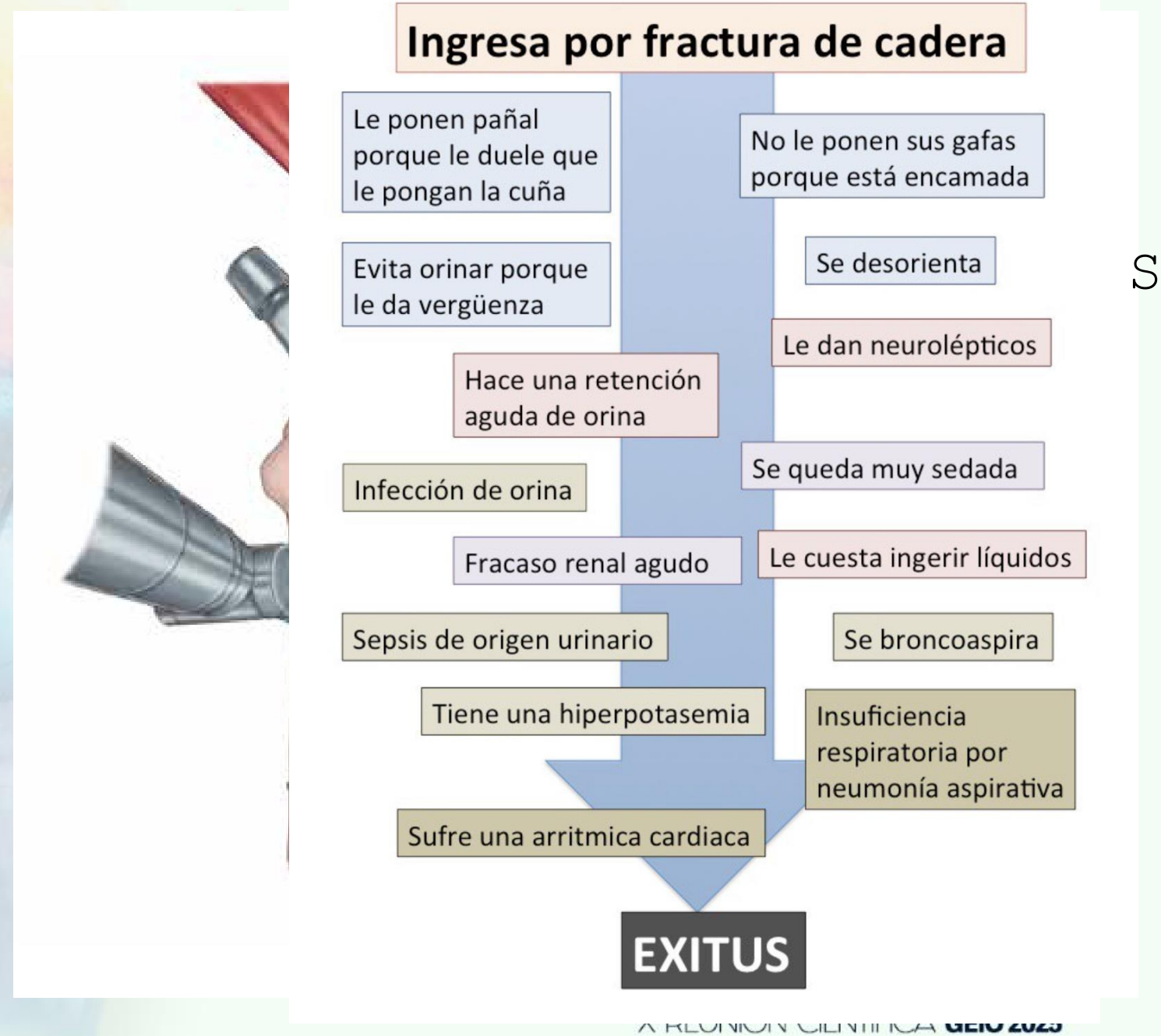
Antecedentes personales: Prótesis de cadera complicada con infección. Adenocarcinoma de próstata intervenido quirúrgicamente. Pólipos colónicos. Sin alergias medicamenteosas conocidas. Adenocarcinoma de pulmón intervenido. (Lobectomía inferior derecha).

Antecedentes familiares: sin interés.

Historia cardiovascular: Sustitución valvular aórtica con prótesis mecánica (Bjork Monostrut) en septiembre de 1989 por doble lesión aórtica con insuficiencia predominante. En postoperatorio de segunda intervención por infección protésica de cadera, episodio de fibrilación auricular que revirtió farmacológicamente con amiodarona endovenosa. Ablación de flutter en 2017. Diagnosticado posteriormente de disfunción protéisa por lo que fue reintervenido en Julio de 2020 mediante implante de bioprótesis Perceval. Toracocentesis evacuadora de 1700 ml en postoperatorio. En la revisión practicada refiere encontrarse estable tras cirugía de cadera izquierda. Síndrome del túnel del Carpo bilateral. En tratamiento con Amoxicilina.

Medicación habitual: Lixiana 30 mg (0-1-0), amlodipino 5 mg (0-0-1), parapres 32 mg (1/2-0-0), Zarator 20 mg (0-0-1), emconcor 2,5 mg (0-1/2-0), dilutol 5 mg (1/2-0-0).





Sangrado femoral. 1,

Carga

The NEW ENGLAND JOURNAL of MEDICINE

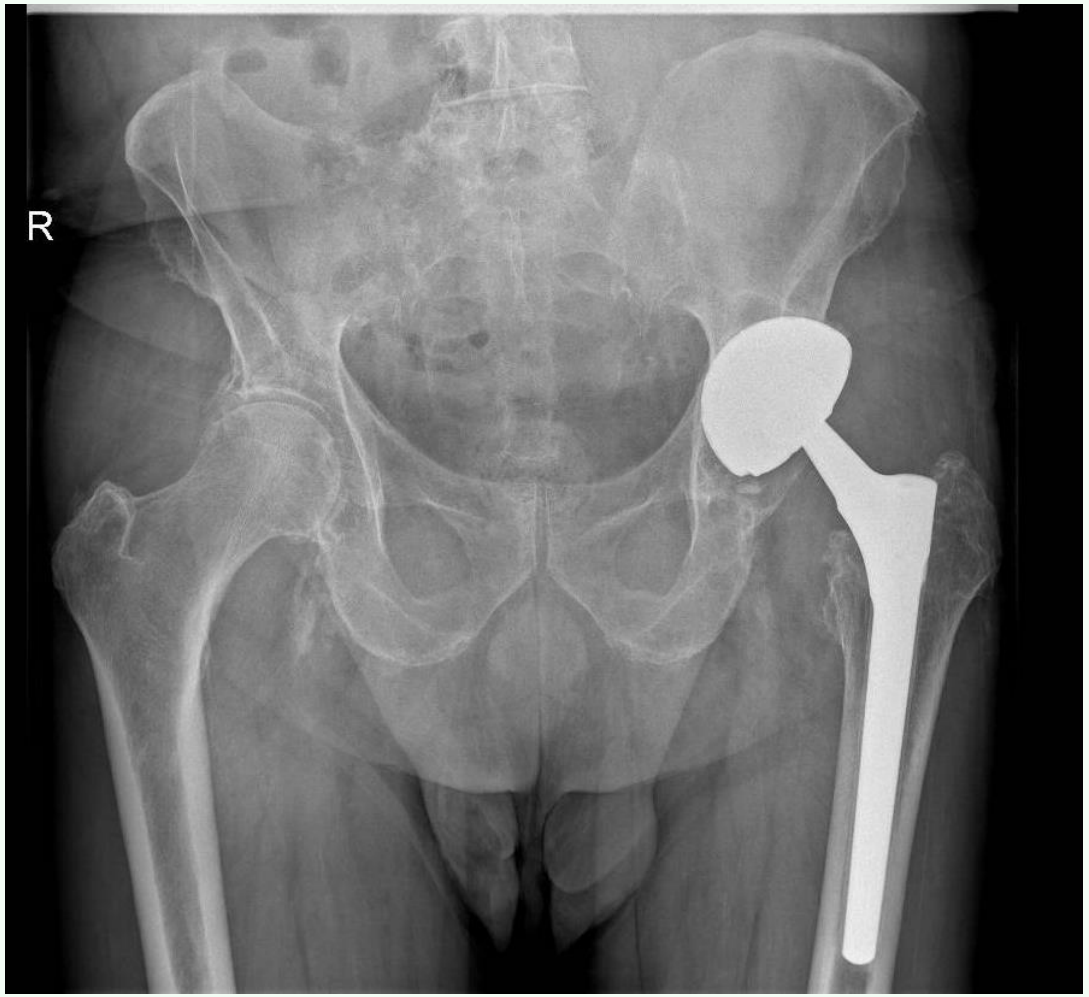
REVIEW ARTICLE

C. Corey Hardin, M.D., Ph.D., *Editor*

Periprosthetic Joint Infection

Robin Patel, M.D.

- *Mortality at 5 years after hip PJI is 21% (4 times as high as age-based rates).*
- *10 years is 45% (vs. 29% in patients with noninfected total hip arthroplasties).*
- *Two-stage revisions, 1-year mortality is 13% for total hip arthroplasties and 9% for total knee arthroplasties.*



INTERNATIONAL
CONSENSUS MEETING (ICM)

HK67: Is there a role for sub radical exchange (leaving some implants) arthroplasty in patients with chronic PJI?

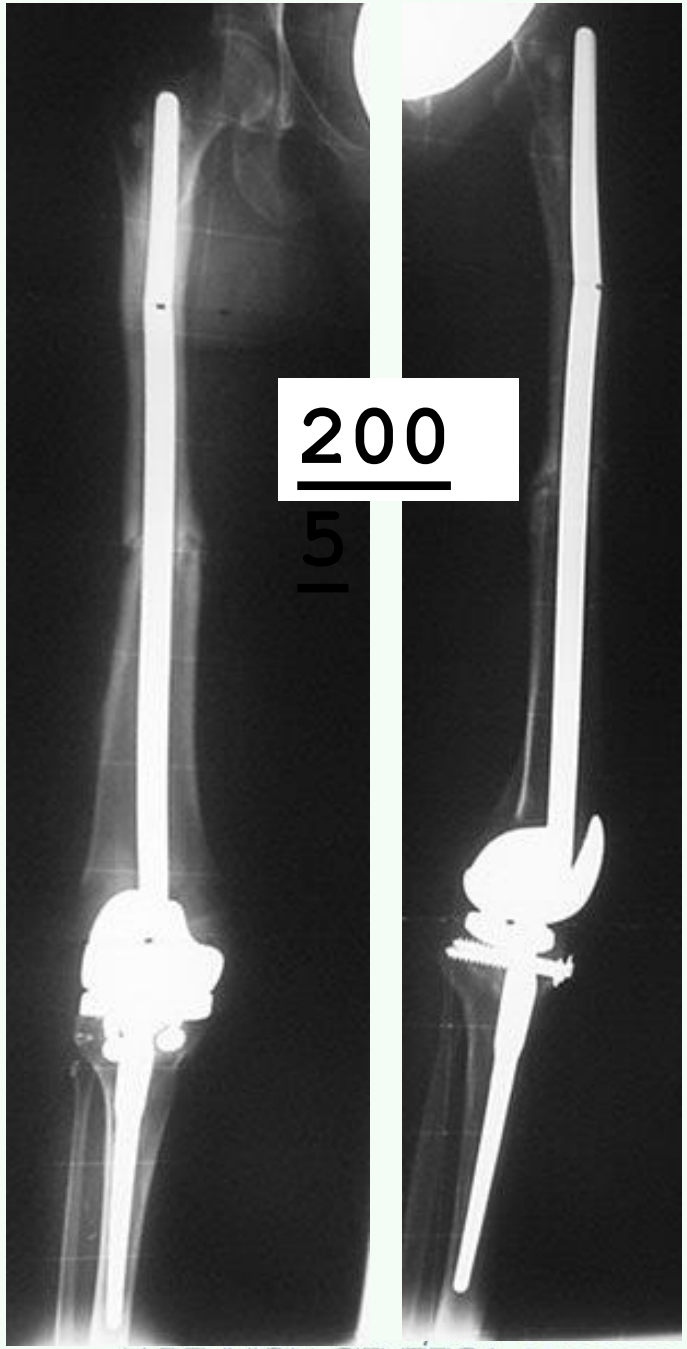
Adolph V. Lombardi, Jr., MD, FACS; Walter Ricioli, Jr, MD; Baochao Ji, MD, PhD; Ireneusz Babiak, MD, PhD, Erik N. Hansen, MD, Victor M. Ilizaliturri Sánchez, MD; Ali Parsa, MD, Ivan De Martino, MD

Response/Recommendation: Sub-radical exchange arthroplasty, that is, leaving parts of implants in place, may be considered during management of patients with chronic periprosthetic joint infections when a component is proven to be well-fixed and its removal precludes opportunity for future reconstruction.

Level of Evidence: Moderate

The success rate for patients treated with two-stage partial exchange was significantly higher at a longer final follow-up (P=0.0051), with 88.3% free of re-infection at a mean of 4.6 years compared with 79.5% at 3.6 years for patients undergoing one-stage partial exchange. However, the higher eradication rate must be balanced with the substantial complications observed between the two stages and the interval mean duration of 18.1 weeks, extending up to 96 weeks, and the burden and impact of those factors on the patient's quality of life.

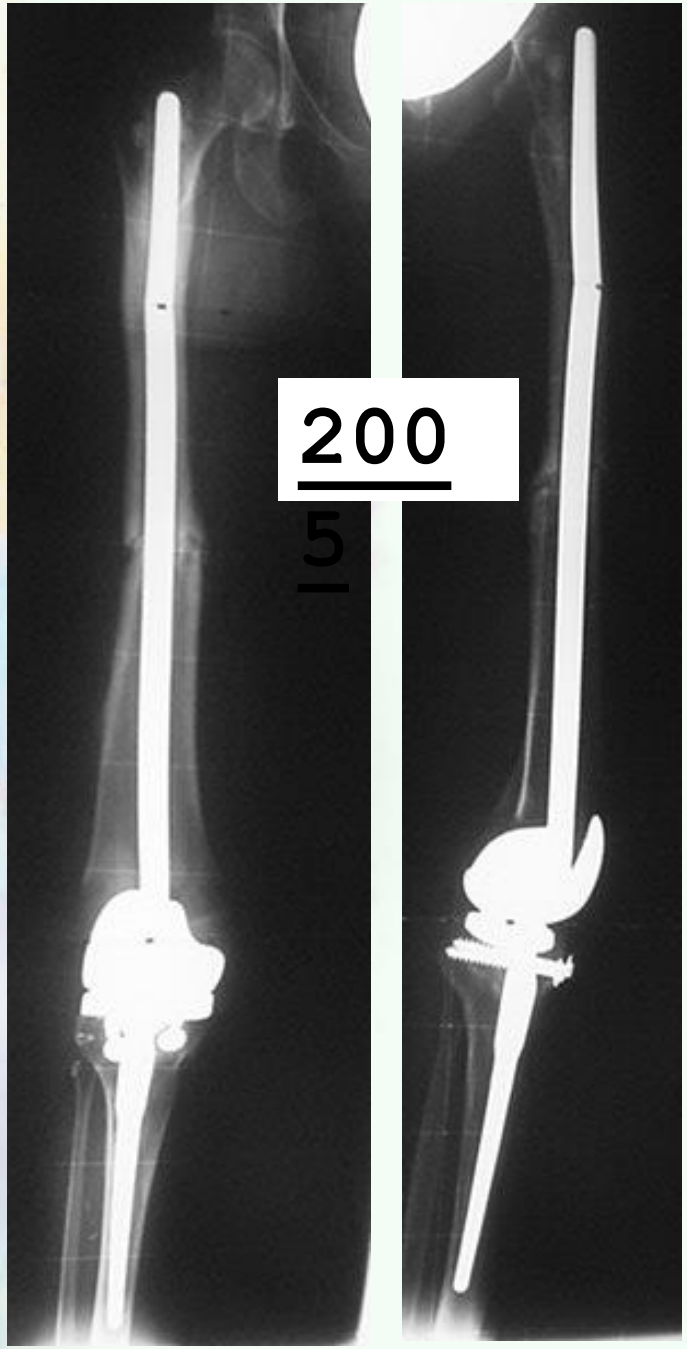
M 46



1994 (Otro centro)→
Dos tiempos

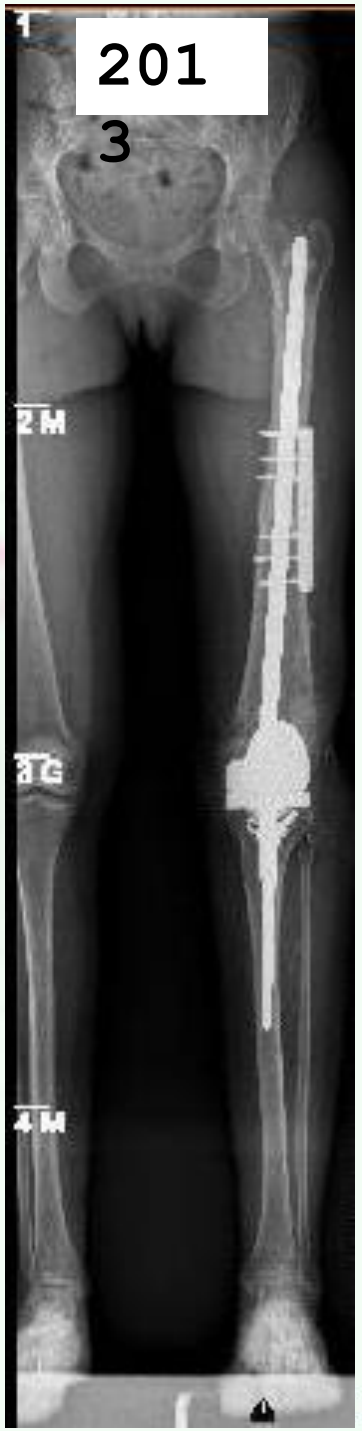
543190

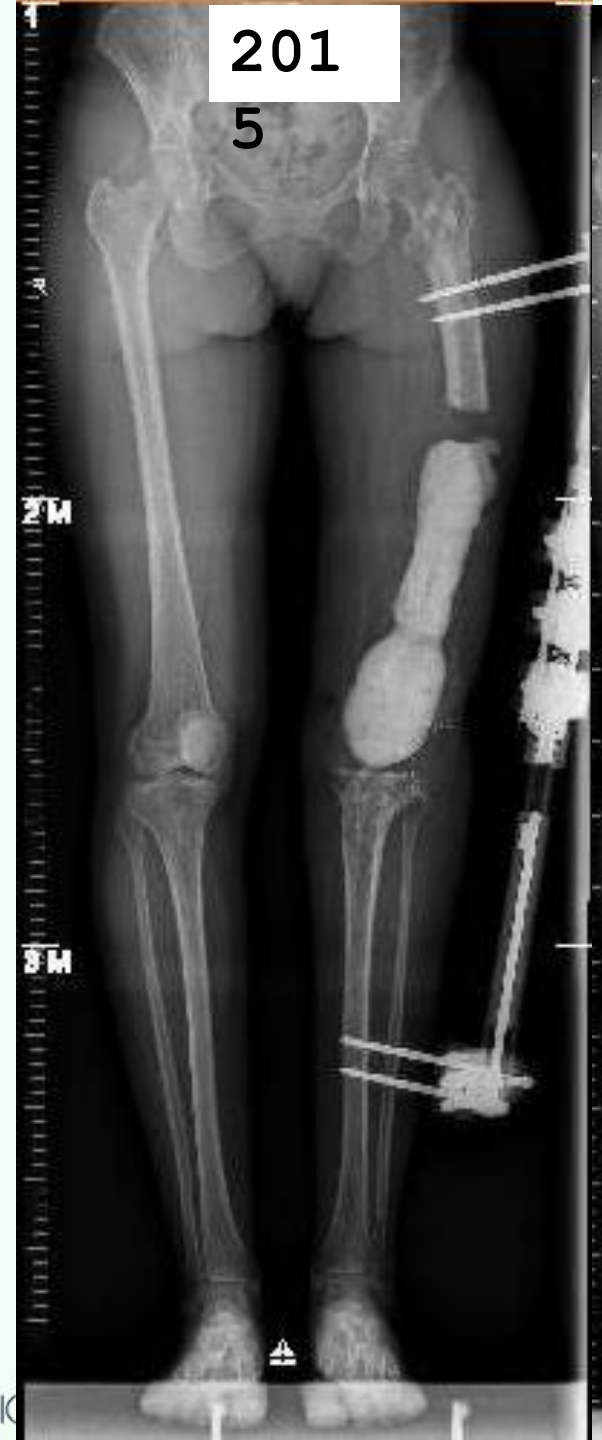
M 46

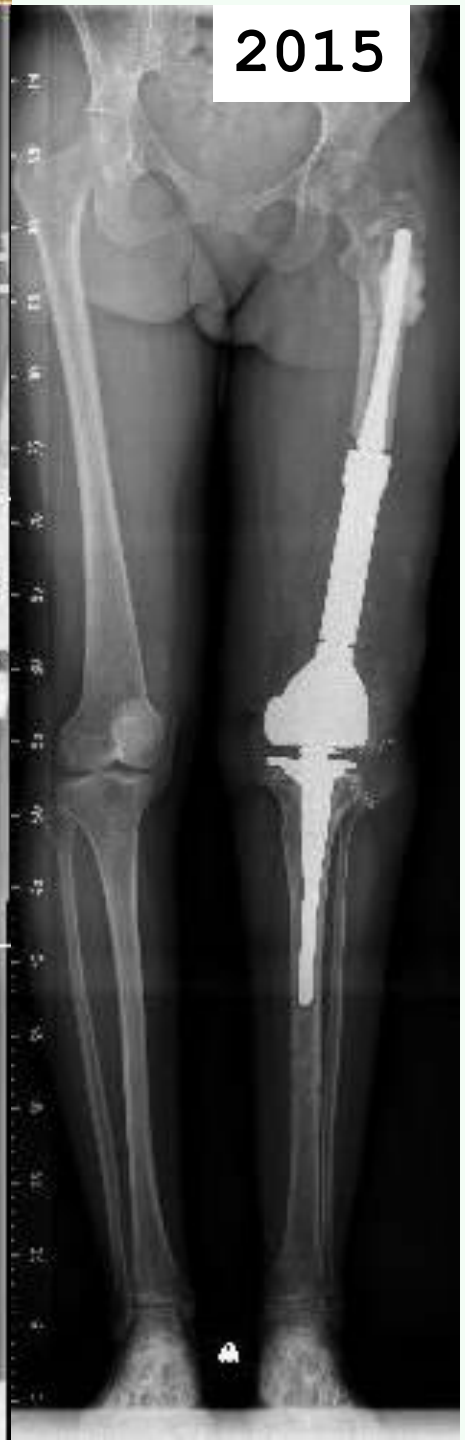


1994 (Otro centro)→ OS de tercio distal de fémur izquierdo resección y colocación de prótesis de rodilla → Infección de la prótesis → recambio en dos tiempos (sin conseguir la curación).

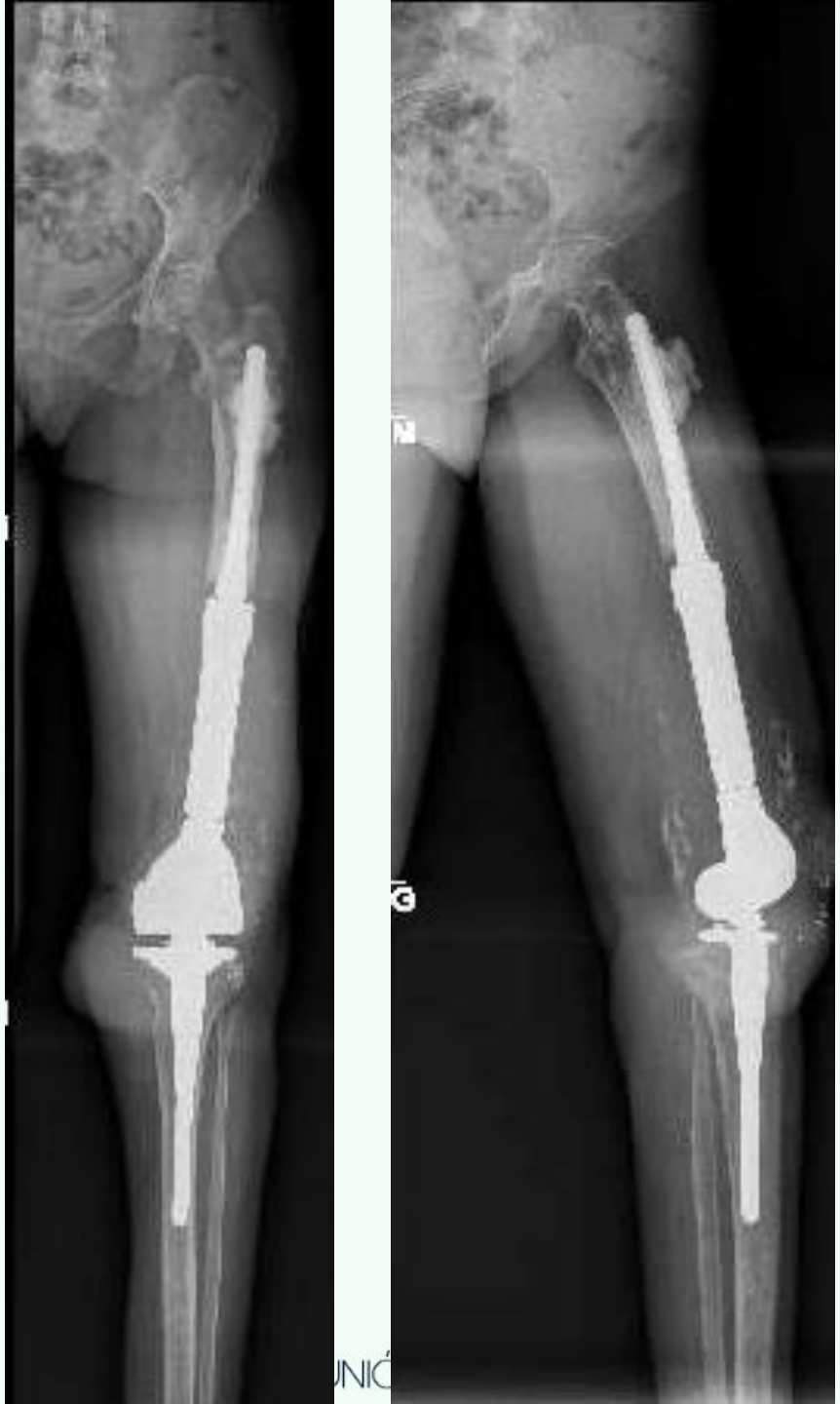
2005 (CUN) → Dos tiempos (tampoco resolvió la infección)


201
3
2M
3G
4M

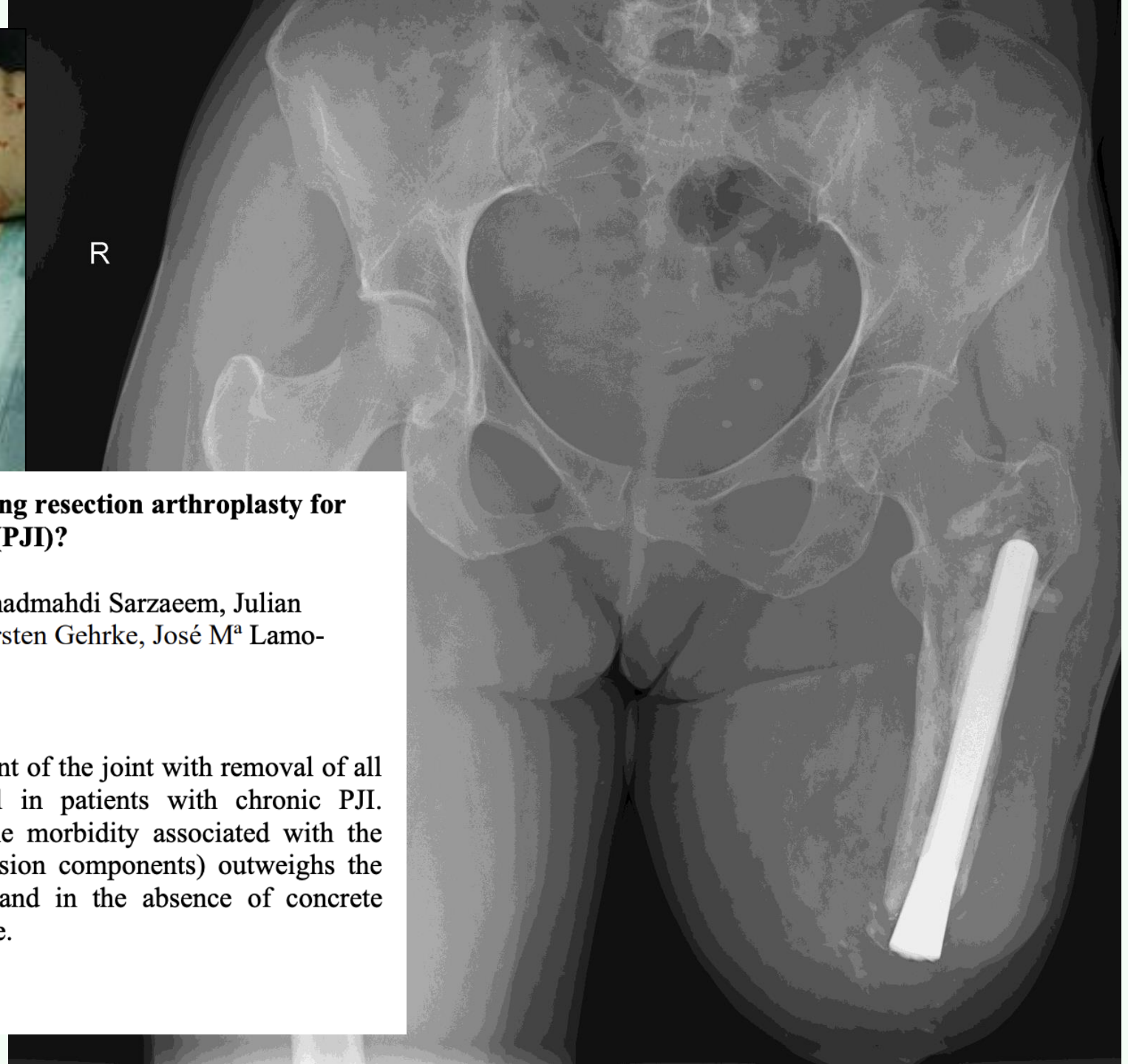

201
5
2M
3M


2015

2022



INTERNATIONAL
CONSENSUS MEETING (ICM)

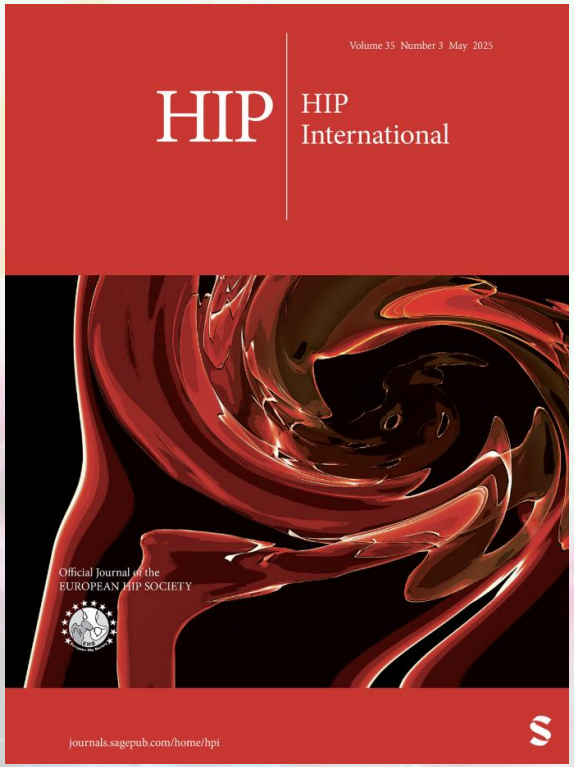


HK66: Should all foreign material be removed during resection arthroplasty for patients with chronic periprosthetic joint infection (PJI)?

Pablo Sanz-Ruiz, Ernesto Muñoz-Mahamud, Mohammadmahdi Sarzaeem, Julian Guerra-Perez, Christian Hipfl, Stergios Lazarinis, Thorsten Gehrke, José Mª Lamo-Espinosa.

Response/Recommendation:
Yes, whenever possible. Complete surgical debridement of the joint with removal of all components and implants should be ultimate goal in patients with chronic PJI. However, there may be specific situations where the morbidity associated with the removal of well-integrated components (usually revision components) outweighs the benefits of their removal. In these specific cases, and in the absence of concrete evidence, retaining parts of implants may be acceptable.

Level of Evidence: Limited



Title: Partial Two-Stage Exchange for Chronic Periprosthetic Joint Infection after Total Hip Arthroplasty: A Comprehensive Meta-Analysis

Results: Thirteen studies with a total of 239 patients were included. The pooled Infection eradication rate of patients was 88% [95% CI: 77-92%], while the treatment failure rate was 14% [95% CI: 8-17%]. The stability of the implant was achieved in 89% of patients [95% CI: 85-93%], while functional scores improved on average by 37.77 points with a 95% CI of 12.84-62.70. Complication rates related to infection,

The success rate for patients treated with two-stage partial exchange was significantly higher at a longer final follow-up (P=0.0051), with 88.3% free of re-infection at a mean of 4.6 years compared with 79.5% at 3.6 years for patients undergoing one-stage partial exchange. However, the higher eradication rate must be balanced with the substantial complications observed between the two stages and the interval mean duration of 18.1 weeks, extending up to 96 weeks, and the burden and impact of those factors on the patient's quality of life.

Lo que viene

Open access Protocol

BMJ Open

Single-stage surgery with antibiotic-loaded hydrogel-coated implants versus two-stage surgery for chronic periprosthetic hip joint infection in French tertiary referral hospitals: the SINBIOSE-H non-inferiority, randomised, controlled trial study protocol

Bertrand Boyer ,[1,2] Celine Cazorla,[3,4] Anne Carricajo,[5] Céline Chapelle,[8,9] Emilie Presles,[10] Paul Zufferey ,[11] E

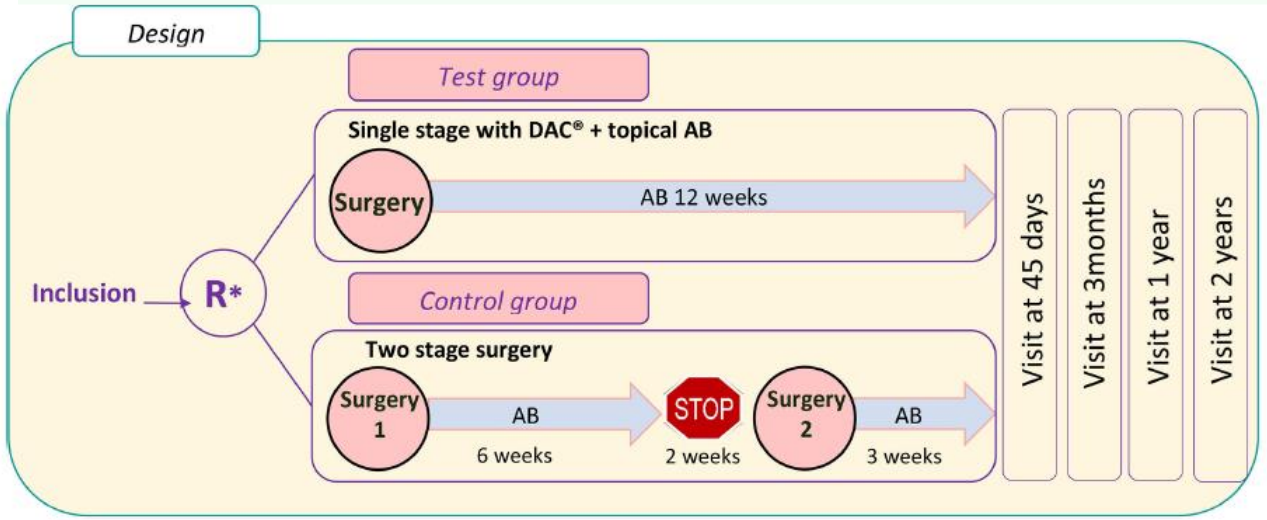


Figure 1 SINBIOSE-H protocol. AB, antibiotics; DAC, Defensive Antiadhesive Coating; *R, randomisation the day bef surgery.

Lo que viene

TABLE 1 Investigator-initiated trials in PJI management[a]

Trial name	Phase	Surgical strategy	Intervention	Status	Key outcome measure	Key results
ROADMAP	3	DAIR vs revision for late acute PJI	Multiple interventions: surgical strategy comparison, 6 vs 12 weeks of antibiotics for single stage, extended vs no prophylaxis post-second stage, rifampicin vs non-rifampicin regimens	First patient recruited in March 2025	Treatment success at 12 months (composite of survival, clinical cure, antibiotic discontinuation, prosthesis retention)	Not yet available
SOLARIO	3	All surgical strategies with complete source control	Short (≤7 days) vs long (≥4 weeks) systemic antibiotics with local antibiotic therapy for bone and joint infections including PJI	Completed 2024	Treatment failure within 12 months after surgery	Short course non-inferior to long course; better safety profile (82.8% vs 54.1% adverse-event free at 6 weeks). Results are aggregate for all orthopedic infections; PJI-specific results not yet published
RiCOTTA	3	DAIR only	Monotherapy vs combination therapy with rifampicin	Recruiting (66 patients enrolled as of April 2025)	Treatment success at 15 months after DAIR	Not yet available
RIFAMAB	3	DAIR only	Rifabutin vs rifampicin for staphylococcal PJI	Recruiting (10/30 sites as of December 2024)	Treatment failure within 1 year	Not yet available
OPTION	3	One-stage vs two-stage revision	One-stage vs two-stage exchange arthroplasty	Ongoing (completion December 2025)	Treatment success at 1 year (absence of reoperation for PJI)	Interim analysis: 98% vs 94% success; no significant difference between groups
CORGI	2	Two-stage revision (post-reimplantation phase)	Omadacycline vs standard-of-care oral antibiotics for bone and joint infections including PJI	Recruiting (primary completion December 2025)	Treatment success at 2 weeks post-therapy completion	Interim safety data: 59 patients enrolled (only 5% PJI, 88% diabetic foot infections)
LITE	3	Two-stage revision (LITE procedure)	Short course (2 weeks) vs long course (12 weeks) antibiotics post-reimplantation	Completed	Infection control rate (composite of clinical cure and antibiotic discontinuation) at 24 months	Identical infection control rates (96.7% vs 96.7%); the short course had fewer complications and lower costs
ProHipQ-OA	3	Primary THA for osteoarthritis	Single vs multiple dose antibiotic prophylaxis in primary THA	Ongoing	PJI incidence at 90 days	Not yet available
ProHipQ-F	3	Primary THA for fractures	Single vs multiple dose antibiotic prophylaxis in fracture-related THA	Ongoing	PJI incidence at 90 days	Not yet available
TKA Antibiotic Prophylaxis	3	Primary TKA	Single vs multiple dose antibiotic prophylaxis in elective TKA	Ongoing	PJI incidence at 90 days	Not yet available

[a]PJI, prosthatic joint infection; DAIR, Debridement, antibiotics, implant retention; THA, total hip arthroplasty; TKA, total knee arthroplasty.

Isler B *et al*. Antimicrob Agents Chemother 2025;69(10):e0033825.

Lo que viene

TABLE 2 Industry-sponsored trials in PJI management[a]

Trial name	Phase	Surgical strategy	Intervention	Status	Key outcome measure	Key results	R
VT-X7 APEX	1	Two-stage revision	Novel vancomycin-tobramycin delivery system vs standard antibiotic-loaded cement spacers	Completed	Safety and efficacy in two-stage exchange	Demonstrated safety	(
VT-X7 APEX-2	2	Two-stage revision	Vancomycin-tobramycin delivery system	Recruiting (began early 2023)	Safety and treatment efficacy compared to the SoC	Demonstrated safety; three device-related complications and three cases of acute kidney injury in the experimental group. Treatment efficacy not available.	(
PLG0206	1b	DAIR only	Engineered antibacterial peptide as surgical irrigation in addition to systemic antimicrobials	Completed	Safety and tolerability	93% (13/14) infection-free at 180 days; no treatment-related serious adverse events	(
TRL1068 Phase 1	1	Two-stage revision	Monoclonal antibody for biofilm distruption in addition to SoC antimicrobials	Completed	Safety and bacterial elimination	Complete bacterial elimination in 3/11 treated patients; all remained infection-free through 169 days	(
TRL1068 Phase 2	2	DAIR only	Monoclonal antibody for biofilm distruption with the DAIR procedure	Site initiation to begin in May 2025	Efficacy and safety with the DAIR procedure	Not yet available	(
TNP-2092 Tissue Distribution	1	Primary arthroplasty	Tissue distribution and pharmacokinetics in primary arthroplasty	Completed	Bone and synovial fluid concentrations	Achieved concentrations exceeding the minimum biofilm bactericidal concentration for *S. epidermidis*	(
TNP-2092 Cohort study	1	Not applicable	Dose escalation study in healthy Chinese participants	Completed	Safety and pharmacokinetics	Safe and well-tolerated up to 400 mg IV; comparable pharmacokinetics to the US population	(
Afabicin Phase 2	2	Not specified (bone and joint infections)	Afabicin vs standard of care for staphylococcal bone and joint infections	Ongoing	Safety, tolerability, and efficacy	Preliminary: Safety demonstrated. All 20 patients (17 afabicin, 3 SoC) were treatment responders at the end of the treatment	(
PhagoDAIR	2	DAIR only	Anti-Staphylococcal bacteriophages for *S. aureus* PJI with DAIR	Study status uncertain due to Phaxiam bankruptcy	Clinical control of infection at week 12	80% infection control rate in the first 20/64 patients	(
GLORIA	2	DAIR only	Anti-Staphylococcal bacteriophages for *S. aureus* PJI with DAIR	Study status uncertain due to Phaxiam bankruptcy	Clinical cure and safety up to 3 months	Not yet available	(

[a]DAIR = debridement, antibiotics, and implant retention; THA = total hip arthroplasty; TKA = total knee arthroplasty; PJI = prosthetic joint infection; SoC = standard of care.

Isler B *et al*. Antimicrob Agents Chemother 2025;69(10):e0033825.

Lo que viene

Received: 20 October 2021 | Revised: 11 April 2022 | Accepted: 16 April 2022

DOI: 10.1002/jor.25345

REVIEW

Journal of Orthopaedic Research®

Current treatments for biofilm-associated periprosthetic joint infection and new potential strategies

Anabelle Visperas[1] | Daniel Santana[1,2] | Alison K. Klika[1] | Carlos A. Higuera-Rueda[3] | Nicolas S. Piuzzi[1]

Journal of Clinical Medicine

MDPI

Review

Unconventional Therapies in Periprosthetic Joint Infections: Prevention and Treatment: A Narrative Review

Daniyil Semeshchenko [1,2,*], Pablo A. Slullitel [1], Alicia Farinati [2], Agustin F. Albani-Forneris [1], Nicolas S. Piuzzi [3] and Martin A. Buttaro [1]

X REUNIÓN CIENTÍFICA GEIO 2025

Conclusiones (opinables)

- 1T = 2T en casos seleccionados.
- Opción de recambio parcial.
- Cemento con antibiótico en 1T.
- 4 semanas de ATB sistémico (4-5 días iv); ¿7-14 días? ¿ninguno?
- Dalbavancina 3 gr / delafloxacino.
- No vacaciones antibióticas (programar 2T al alta del 1T).
- Profilaxis ATB 2T con antiestafilococo meticilin-resistente + antipseudomonas.
- ¿Profilaxis ATB oral postoperatoria? Siempre? si CIOP +? Cuanto tiempo?

Conclusiones (no opinables)

Manejo multidisciplinar mejora resultados

microorganisms

MDPI

Article

The Impact of Antibiotic Therapy Options and Multidisciplinary Approach in Prosthetic Joint Infections

João Lucas [1,2,*], José Queirós [3], Daniel Soares [2,4], André Carvalho [2,4], Filipa Pereira [2,4], Cláudia Santos [3,4], Ricardo Sousa [2,4,5] and Miguel Araújo Abreu [3,4,5,6]

1 Orthopaedic and Traumatology Department, ULS do Alto Ave, 4835-044 Guimarães, Portugal
2 Orthopaedic and Traumatology Department, ULS Santo António, 4099-001 Porto, Portugal
3 Abel Salazar Institute of Biomedical Sciences, Porto University, 4050-313 Porto, Portugal
4 Porto Bone and Joint Infection Group (GRIP), ULS Santo António, 4099-001 Porto, Portugal
5 Hospital Lusíadas, Av. da Boavista 171, 4050-115 Porto, Portugal
6 Infectious Diseases Department, ULS Santo António, 4099-001 Porto, Portugal
* Correspondence: joaopflucas21@gmail.com

Conclusiones (no opinables)

Manejo multidisciplinar mejora resultados

microorganisms MDPI

Article

Table 6. Treatment outcomes according to team

	MDT	Orthopedic Team
	n = 36	n = 33
Mean age (±SD)	67.1 ± 11.8	71.7 ± 11.1
ASA Score	2.5 ± 0.7	2.7 ± 0.7
Cure Rate		
DAIR	7/7 (100%)	10/21 (47.6%)
One-stage	9/10 (90%)	3/3 (100%)
Two-stage	12/19 (63.2%)	6/9 (66.7%)


Moltes gràcies