

# Diagnosis and Strategies of Treatment for Sternoclavicular Arthritis

Jason Womack\*

School of Medicine, University of Texas, USA

## Editorial

The sternoclavicular joint (SCJ) suffers from septic arthritis, which is a very uncommon condition. Because of significant consequences such as mediastinitis and generalised sepsis, prompt identification and treatment are required. Immunocompromised people, diabetics, and patients with various infectious disorders are all at risk. Antibiotics to extensive surgery, including reconstructive surgeries, are among the treatment possibilities. Aside from a few rare cases where antibiotics alone are sufficient, joint resection followed by plastic surgery operations is required. Septic arthritis necessitates surgical intervention. Only when the disease is in its early stages can a limited joint incision and debridement be effective. Local joint and bone resection, as well as comorbidities such as mediastinitis, must all be included in the treatment plan. The defect in the chest wall necessitates additional reconstructive surgery utilising a pedicled pectoralis muscle flap after the infection has been successfully treated. Because of its proximity to key neuro-vascular systems like the subclavian arteries and the phrenic nerve, the sternoclavicular joint (SCJ) is anatomically and clinically significant.

Infections of this joint can mask a variety of illnesses, delaying diagnosis and spreading to the bone and deep tissues. In the literature, there is no systematic workup and treatment protocol for sternoclavicular joint infections. The existing literature is reviewed in order to gain a better understanding of the present state of knowledge about the diagnosis and management of SCJI. After removing non-infectious etiologies of SCJ diseases, we searched English articles in PubMed for clinical trials, case reports, case series, retrospective cohort studies, literature, and systematic reviews. Immunocompromised state, intravenous drug use, trauma, and arthropathies are all risk factors for SCJI.

However, many people with illness do not have any of these risk factors. Fever, joint swelling, immobility, and vocal cord palsy or dysphagia is all symptoms of SCJIs. While *Staphylococcus aureus* is responsible for more than half of all SCJI cases, other bacteria like *Pseudomonas* and *Mycobacterium* are also common. Antibiotics or joint aspirations might be used to treat the infection if it is detected early. The majority of instances with SCJI, on the other hand, are discovered after the disease has spread to the soft tissue and bones, necessitating en-bloc excision with or without a muscle flap. Undertreatment can result in a variety of complications, ranging from simple abscess formation to mediastinitis and even sepsis. SCJIs are uncommon

but dangerous infections that require early detection and treatment. Most cases of SCJI that are properly treated resolve completely in months while keeping full functionality. Aggressive physiotherapy to prevent sticky shoulder capsulitis and limited range of motion are important aspects of good healing. The approach for diagnosing sternoclavicular joint (SCJ) osteoarthritis (OA) in skeletal remains is evaluated, with special focus paid to the joint's architecture. The existing palaeopathological diagnostic criteria for SCJ OA were shown to be valid for both the sternal and clavicular surfaces of the SCJ, with eburnation indicating intra-articular disc perforation and severe illness [1-5].

Eburnation was shown to be uncommon in the SCJ, and if employed as the sole diagnostic criterion, the incidence of SCJ OA in archaeological assemblages would be underestimated. The detection of alterations typical of OA but limited to the attachment zone of the intra-articular disc on the clavicular surface of the SCJ was an important finding. As this area of the joint is non-articular, and not normally covered with articular cartilage, a diagnosis of OA would be inaccurate and instead it should be considered as an enthesopathy. It is likely that SCJ OA has been incorrectly identified and over-diagnosed in the archaeological record in the past. More histological research into the disc attachment and its degeneration is required before this can be confirmed.

## References

1. Ali, Barkat, Timothy R. Petersen, Anil Shetty and Christopher Demas, et al. "Muscle flaps for sternoclavicular joint septic arthritis." *J Plast Surg Hand Surg.* 55 (2021): 162-166.
2. Kraus, Jason. "A complicated case of sternoclavicular septic arthritis." *JAAPA* 34 (2021): 12-14.
3. Mohamed, Ahmed I., Muhammed Elhady Muhammed Elgasim, and Gerard Markey. "Clostridium Perfringens Septic Arthritis of the Sternoclavicular Joint." *J Emerg Med* 61 (2021): 169-171.
4. Gupta, Vikas, Durga Prasanna Misra, Namita Mohindra and Niraj Kumari, et al. "Sternoclavicular joint arthritis as the initial presentation of sarcoidosis." *Eur J Rheumatol* 5 (2018): 142.
5. von Glinski, Alexander, Emre Yilmaz, Valentin Rausch and Matthias Koenigshausen, et al. "Surgical management of sternoclavicular joint septic arthritis." *J Clin Orthop Trauma* 10 (2019): 406-413.

**How to cite this article:** Womack, Jason. "Diagnosis and Strategies of Treatment for Sternoclavicular Arthritis." *Clin Med Case Rep* 6 (2022):189

\*Address for Correspondence: Jason Womack, School of Medicine, University of Texas, USA, E-mail: [Jwomack@gmail.com](mailto:Jwomack@gmail.com)

**Copyright:** © 2022 Womack J. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

**Received** 01 January, 2022, Manuscript No. cmcr-22-53804; **Editor assigned:** 04 January, 2022, PreQC No. P-53804; **Reviewed:** 06 January, 2022, QC No. Q-53804; **Revised:** 12 January, 2022, Manuscript No. R-53804; **Published:** 18 January, 2022, DOI: 10.37421/2684-4915.2022.6.189