中文題目：沙門式桿菌引起之化膿性動脈瘤在一類風濕性關節炎病人

英文題目：Nontyphoid samonella-infected mycotic aneurysm in a patient with rheumatoid arthritis

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Abstract

Mycotic aneurysms are uncommon of all aortic aneurysms and the overall mortality is about 50% after treatment. The cultures from blood or the aneurismal content include salmonella species, staphylococcus aureus, streptococcus pneumoniae and mycobacterium tuberculosis. Immunocompromised patients including HIV infection and patients with received immunosuppressive agent may develop fulminating bacteremia, which leads to the formation of infected aneurysms. A 60-year-old male presented, and was admitted, to our hospital with a 1-week history of intermittent chills and high fever. He has rheumatoid arthritis for two years with regular medication of hydroxychloroquine, methotrexate, sulfasalazine and low-dose prednisolone (5mg daily). The patient had a history of type 2 diabetes for which he was under regular medication. General malaise and dyspnea would occur during the episode of fever. On admission to our hospital, his blood pressure was 129/74 mm Hg, and his body temperature was 39 °C. His heart sounds were normal with no murmur; the lungs were clear to auscultation. The abdomen was soft without palpable masses or tenderness; the liver and spleen were not palpable. The patient had mild back pain. A complete blood count revealed 9,000 leucocytes/uL and 221,000 platelets/uL, with mild anemia (hemoglobulin: 9.4 g/dL). The C-reactive protein level was 24 .1 mg/dL and the erythrocyte sedimentation rate, 64 mm/h. Urine analysis and culture yielded negative results. Two blood cultures obtained before intravenous antibiotic administration tested positive for samonella group D. No vegetations or signs of infective endocarditis were detected on transthoracic echocardiography. Computed tomography showed a saccular aneurysm arising from the abdominal aorta, with fatty stranding, free air-bubbles and periaortic fluid accumulation. Mycotic aneurysm was confirmed. The patient received surgical management for debridement of abscess and intravenous cefatriaxone 2 gm daily continuously for 8 weeks. The patient had an excellent clinical response, and was discharged two months later with no recurrence of fever.