Research A

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Introduction

Necrotising pneumonia has a mortality rate of 56-61% and is associated with necrotic ulcerations of the tracheal and bronchial mucosa, with massive haemorrhagic necrosis of interalveolar septa [1]. Commonly, young immune-competent individuals present with a history of progressive skin - so tissue infection and associated sepsis, before succumbing to respiratory involvement through likely haematogenous spread and resultant multi-organ disease [2]. We present a typical such case to demonstrate the challenges of making an early diagnosis, and review the evidence for anti-toxin therapy.

Case

A previously well 12 year old Somali boy presented to our Accident and Emergency department with a single day history of peri-orbital oedema, vomiting and fever to 39°C which was treated at home with Ibuprofen. He had no preceding atopic history and his only preceding skin infection was that of *tinea capitis* at 5 years of age. He had not previously

knee, which was drained of uid culturing further PVL *Staphylococcus aureus*. Subsequent MRI showed right sacroiliac osteomyelitis, right gluteal muscle in ammation with uid around le trochanter and right ankle. No repeated drainage procedures were necessary and he was discharged on the thirty- rst day of admission, whilst receiving 2.4 g of intravenous Ce riaxone by per-cutaneous catheter each morning, 300 mg of oral Rifampicin twice daily and 300 mg of oral Clindamycin four times daily. ese antibiotics were continued for 18 weeks, whereupon he was discharged from the orthopedic team and his local physiotherapy service without known long-term sequel. Our case did not experience any hair loss or peeling of nger-tip skin throughout his illness. His mother and father were screened for