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Introduction

It is widely accepted that fractures of the femoral neck in patients with osteoarthritis (OA) of the hips are associated with an extra-capsular, inter-trochanteric type fracture pattern [1-3]. Intra-capsular fractures in these circumstances are unusual. is case report looks at a patient with septic arthritis of the hip presenting with an intra-capsular fracture of the femoral neck in an apparently osteoarthritic hip.

Case Report

An 88-year-old woman was admitted to hospital under the general physicians with a history of increasing confusion and decreased mobility. She was known to su er with mild dementia and lived in a warden controlled at. She was found at home by her daughter, unable to stand or walk and the patient denied having fallen. She was acutely confused and was initially seen by her general practitioner who diagnosed an urinary tract infection (UTI) and started Trimethoprim 200 mg twice daily (bd) and referred for admission to hospital.

On admission a history of recurrent UTIs, and atrial brillation was noted but no history of previous hip problems. She was on Digoxin and Aspirin. She was a non-smoker and non-drinker.

On examination, she was confused with a Glasgow coma scale score was 14/15. She had a temperature of 38° Celsius and she was mildly tachycardic. Her chest was clear and oxygen saturations were recorded as 98% on air. e Boehringer Mannheim (BM) test recorded a blood sugar of 7.3 mmol/L.

Abdominal examination revealed slight distension, it was so to palpation and bowel sounds were documented as “normal”. ere was tenderness on palpation of the right groin, and with passive movements of the right hip. ere was no shortening or external rotation of the right lower limb.

Full blood count (FBC) showed a white cell count (WCC) of 16.1×109 L-1 with a neutrophil count of 12.8×109 L-1. Urea and electrolytes were normal, and serum glucose was 9.7 mmol L-1. Urine dipstix were positive for nitrites and increased white blood cells con rming the diagnosis of a UTI. A chest radiograph showed no abnormalities and the abdominal radiograph showed faecal loading. An antero-posterior radiographic view of the pelvis showed gross osteoarthritis of the right hip, but no fracture (Figure 1).

e patient was treated for a UTI and referred to the physiotherapists for mobilisation. irteen days following admission, the patient developed a le upper respiratory tract infection (URTI) and melaena. e URTI was treated with a combination of Augmentin and Clarythromicin. An oesophagoscopy was booked to investigate the intestinal bleeding. Repeat FBC showed a haemoglobin count of 10.0 g dL-1, WCC 14.7×109 L-1 with a neutrophil count of 12.7×109 L-1. Two units of packed red blood cells were given.

Repeat radiographs of the right hip were taken (Figure 2).

ese radiographs were reported by one of the hospital’s consultant radiologists, and were found to show “severe OA of the right hip, but no fracture”. A Doppler ultrasound excluded a deep vein thrombosis. At 22 days following admission, the physicians reported that her le URTI was much improved.

e patient had a fall on the 26th day following admission. On examination the right leg was shortened and externally rotated. A third right hip radiograph showed a displaced fracture of the femoral neck (Garden type IV) (Figure 3).

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e presence of an intracapsular fracture in an osteoarthritic hip with a concomitant history of infection elsewhere, and raised in ammatory markers should have alerted us to the possibility of sepsis within the hip. Talbot et al. reported a pathological fracture of the hip following intracapsular spread of a psoas abscess [8]. eir case also involved a patient with radiographic osteoarthritis developing a subcapital fracture. It was felt that the OA might have o ered reduced resistance