Ateneo clínico

Dra. Paulina Brasó
Prof. Agdo. Dr. Julio Medina

Noviembre 2013

INVITADOS:

- Dra. Rosario Amorin
- Dr. Juan Martin
- Prof. Agda. Verónica Seija
- Prof. Felipe Schelotto

Antecedentes personales

- Sexo masculino, 69 años
- Procedente de Canelones, actualmente medio suburbano. Ingesta diaria de carne de cerdo.
- Perteneciente a mutualista CAAMEPA
- HTA en tto con diltiazem 120 mg/dia
- Fibrilación auricular crónica en tto con warfarina
- Cirrosis hepática con buen control
- QH hepático calcificado secuelar sgto VII (Cirugía 2010)
- Colecistectomizado
- Alcoholista en abstinencia
- Tabaquista en abstinencia. EPOC

Historia clínica

- FI: 21 julio de 2013
- M.C.: Fiebre de 7 meses de evolución
- E.A.: Comienza 7 meses previo al ingreso con episodios febriles de varios días de evolución autolimitados acompañados de sudoración y chucho de frío. Sin relación con otros síntomas o signos

- El paciente refiere varias consultas en estos meses sin diagnóstico claro. (Sin paraclínica)

Historia clínica

El paciente ingresa a sala para valoración con diagnóstico de Sindrome febril prolongado

- Ex físico al ingreso: paciente lúcido, febril 38,8° C axilar, buen estado general, normocoloreado sin lesiones de piel.
- No presenta adenomegalias ni visceromegalias
- CV: RI 110 cpm. Sin soplos. Normotenso.
- ABD indoloro blando
- Resto del examen sin alteraciones

Paraclínica al ingreso (21/7)

Leucocitosis (mm3)	Neutrófilos (mm3)	Hb (g/dl)	Hto (%)	Plaq (mm3)
15.700	12.710	13,3	41,1	205.000

Se solicitaron 2 hemocultivos, urocultivo

RxTx ingreso

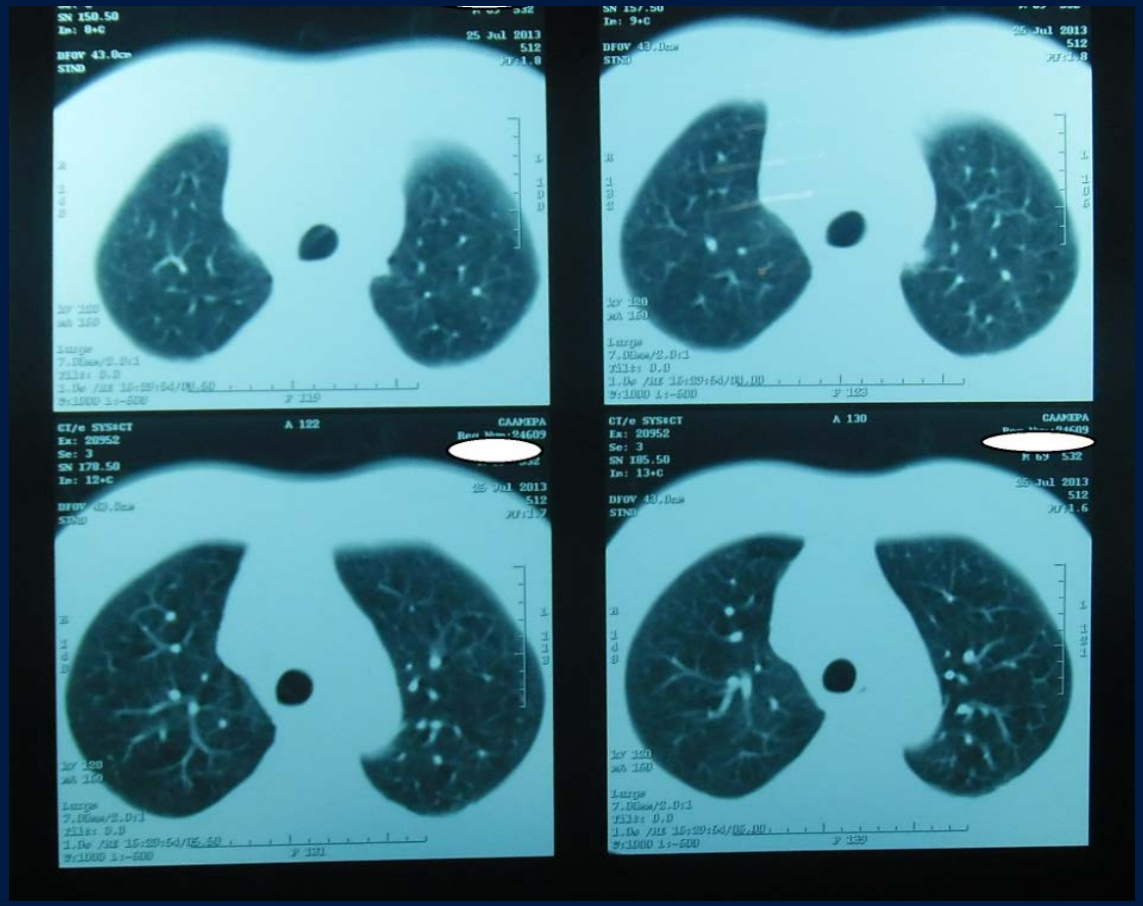
Evolución inmediata

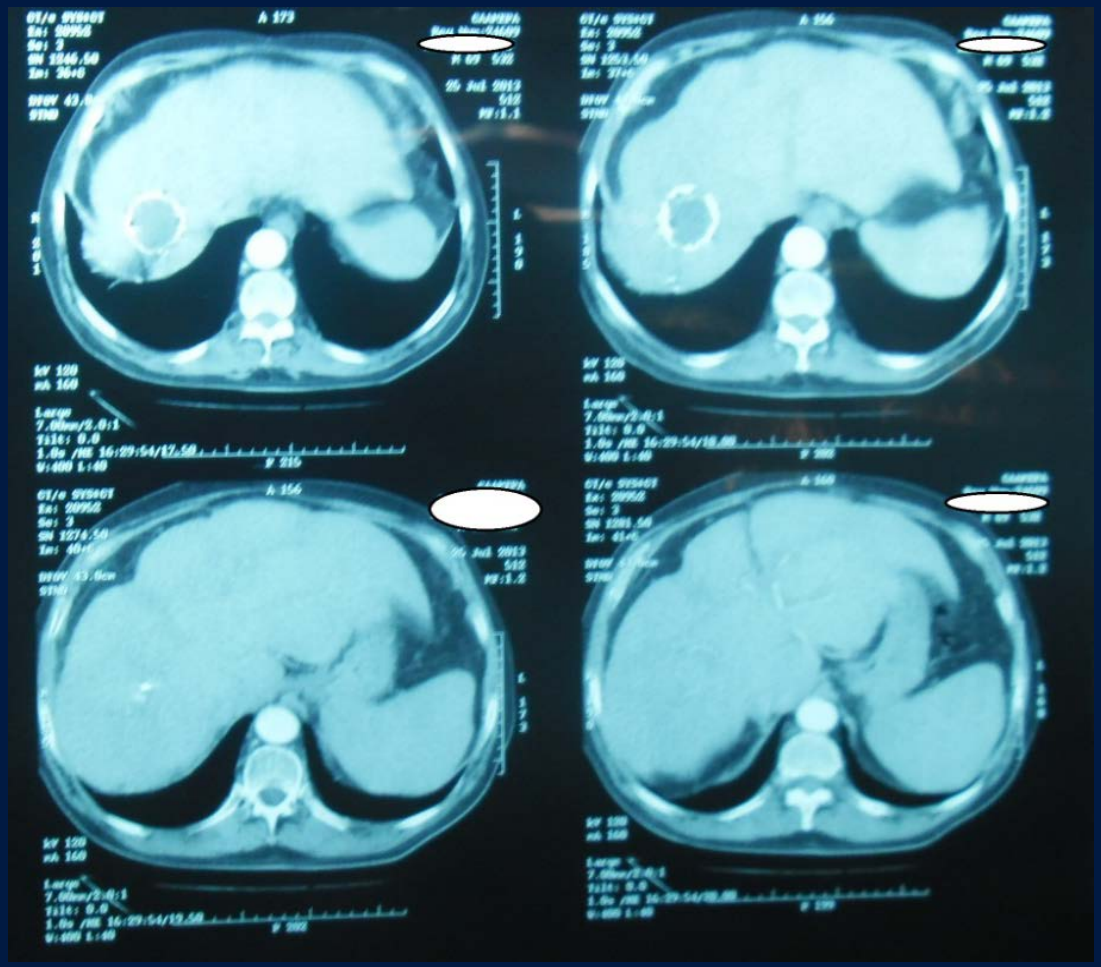
- ✓ Se realizó Ecocardiograma transtorácico: no evidenció vegetaciones
- ✓ Urocultivo: negativo

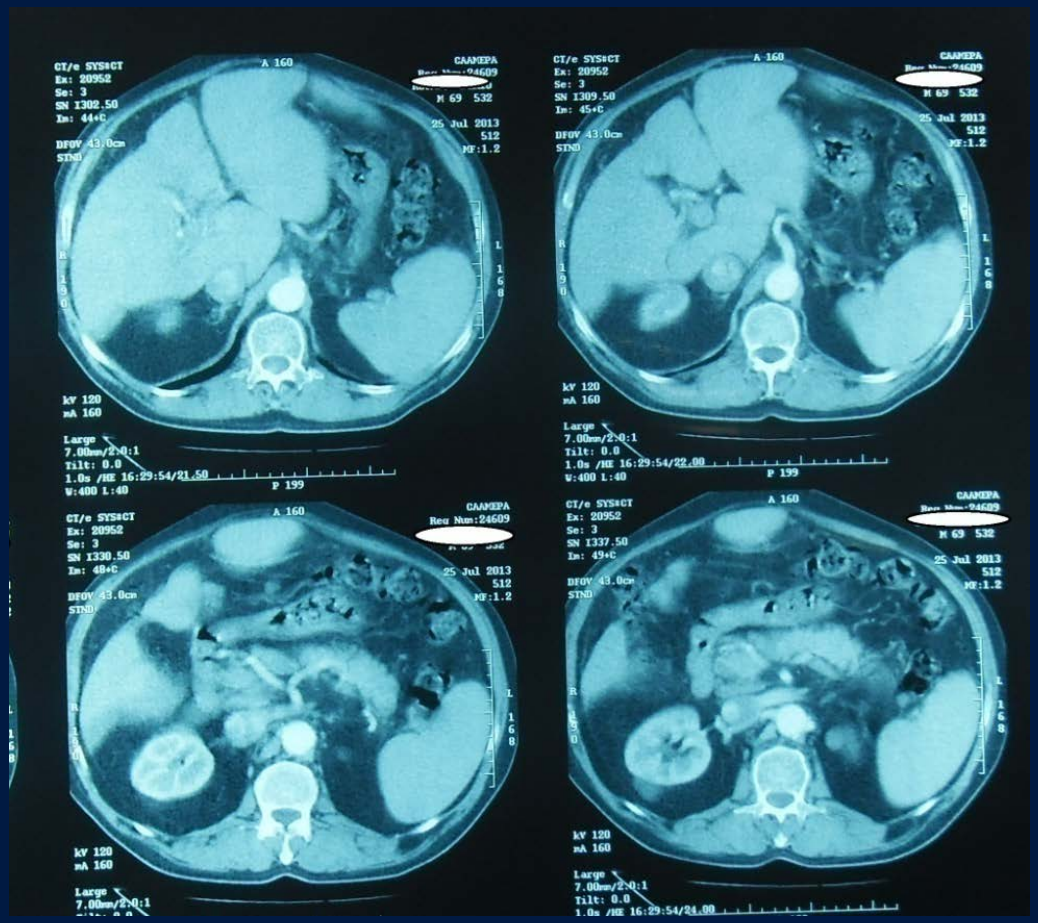
El 25/7 se informa 1 botella de HC: bacilo gramnegativo en estudio

El equipo tratante inició antibioticoterapia empírica con: ampicilina – sulbactam 1,5g c/6hs iv

TAC Toraco-abdomino-pélvica (25/7)



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mA 160
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7.00mm/2.0:1
Tilt: 0.0
1.0s /HE 16:29:54/24.00

TAC Toraco-abdomino-pélvica (25/7)

- Múltiples ganglios de pequeño tamaño (<1cm) en territorios laterotraqueales, prevasculares en ventana aorto pulmonar y subcarinales
- Micronódulos parénquima pulmonar
- Hígado: aumentado de tamaño a expensas de LI, en sgto 7 QH calcificado 5x4cm. Sin dilatación VB intrahep
- Bazo: aumentado de tamaño 15x8cm
- No adenomegalias abdominales ni pelvianas. Sin ascitis

- El 27/7 (6 días post ingreso) se informa:

1 botella: *Salmonella choleraesuis:*
Sensible a: ciprofloxacina, ampicilina, ceftriaxona

- Se realiza consulta con Infectologo.

EN SUMA:

69 años, sexo masculino

HTA, FAC

Cirrosis hepática

EPOC

Fiebre de 7 meses de evolución intermitente

HC (1de2): *Salmonella choleraesuis*

Planteo

Bacteriemia complicada a *Salmonella choleraesuis* con compromiso pulmonar a descartar compromiso endovascular (endocarditis infecciosas o aneurisma micotico)

Conducta

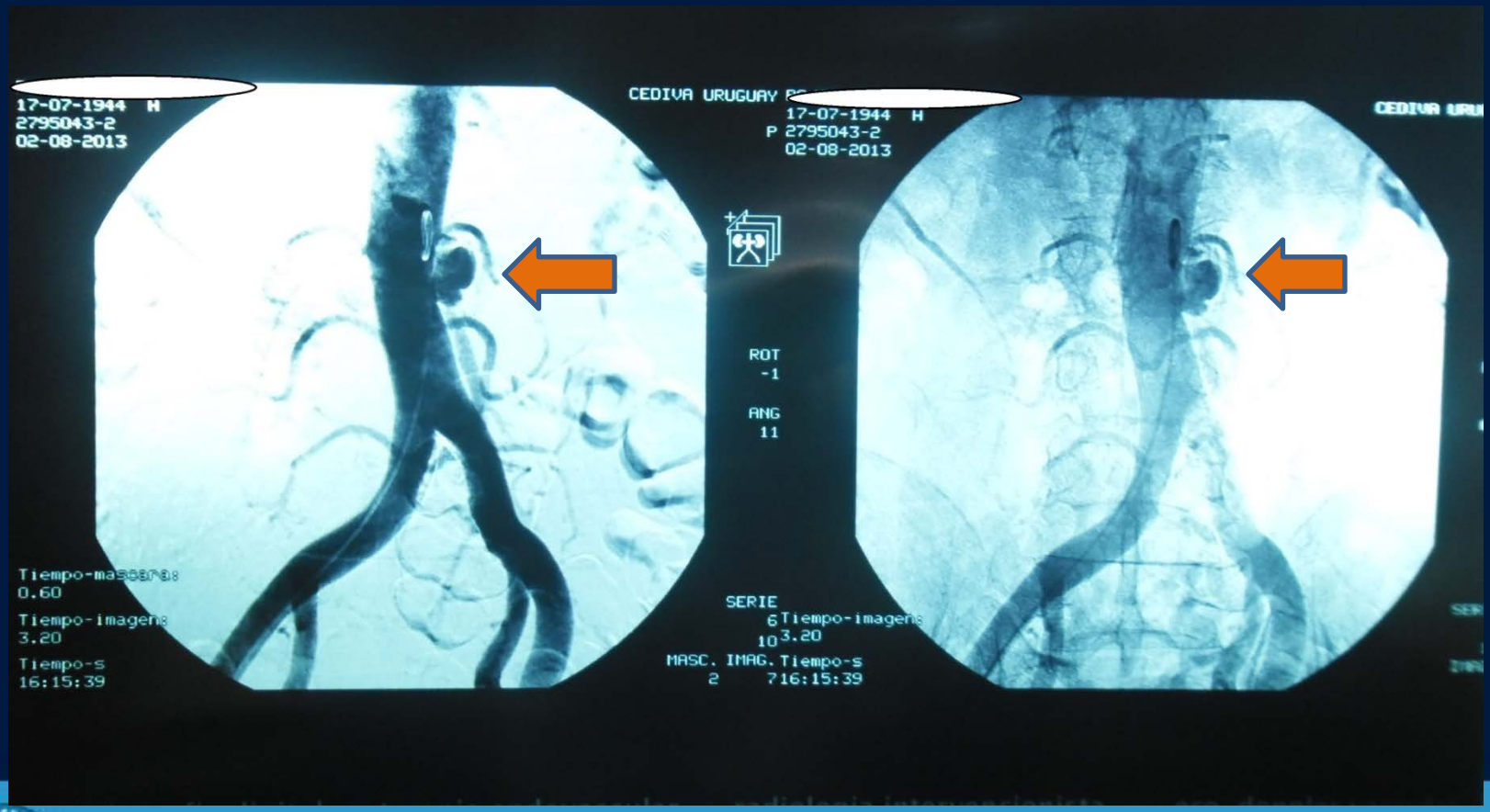
- ✓ Iniciar Ceftriaxona 2g iv.por 14 días (inicialmente)
- ✓ Control con PCR semanal
- ✓ Monitorear aparición o descartar aneurisma micótico
- ✓ Ecocardiograma transesofágico para descartar compromiso endocárdico

- ETE del 30/7/13

✓ No hay vegetaciones endocárdicas .
✓ Insuficiencia mitral leve a moderada.
✓ Insuficiencia aortica leve.

Arteriografía de aorta abdominal (2/8)

Arteriografía de aorta abdominal



Arteriografía de aorta abdominal

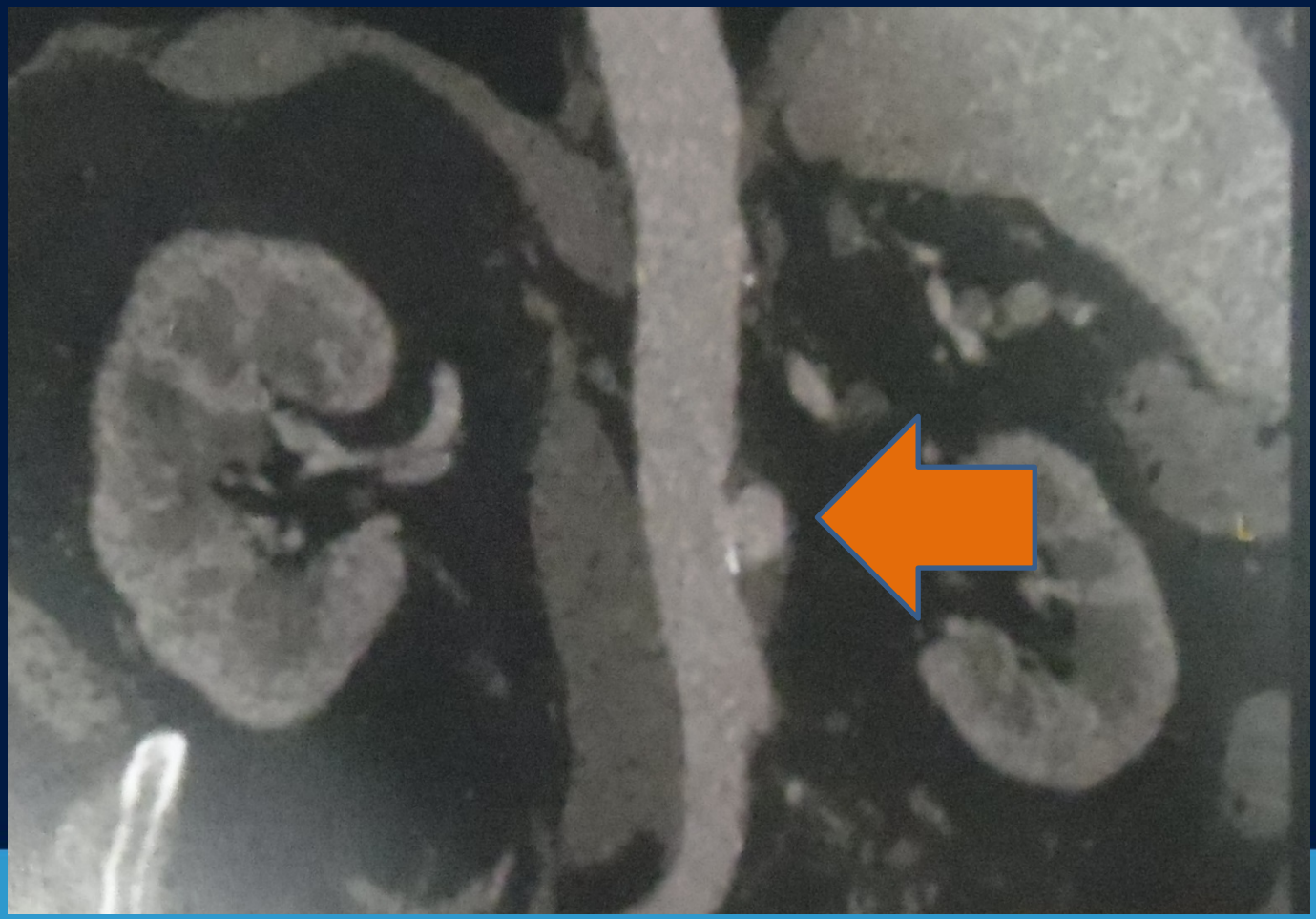
- *Aneurisma sacular de aorta abdominal adyacente al origen de la arteria mesentérica inferior probablemente en relación al antecedente de infección por Salmonella*

- Se realiza consulta con cirujano vascular quien solicita Angiotomografía multicorte con reconstrucción 3D para definir morfología del aneurisma

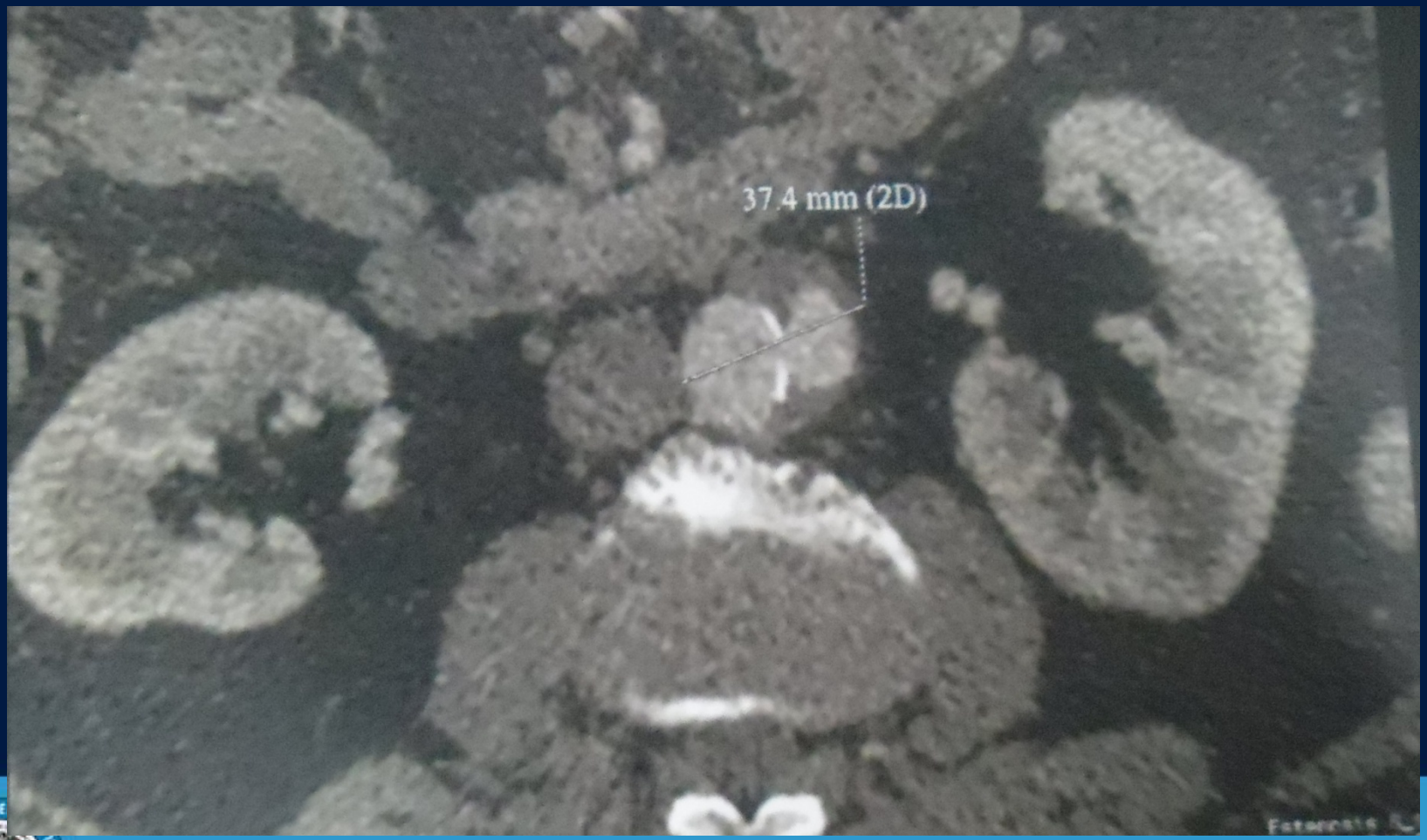
AngioTAC Tóraco abdomino pélvica (12/8)

Angio-TAC

Angio-TAC



Angio-TAC



AngioTAC Tóraco abdomino pélvica (12/8)

- *Aneurisma micótico sacular en la pared lateral izquierda de la aorta (30 mm diámetro) a la altura del origen de la mesentérica inferior*

Diagnóstico

- Bacteriemia a *Salmonella choleraesuis* complicada con aneurisma micótico a nivel de la aorta abdominal infrarrenal y compromiso pulmonar

Tratamiento

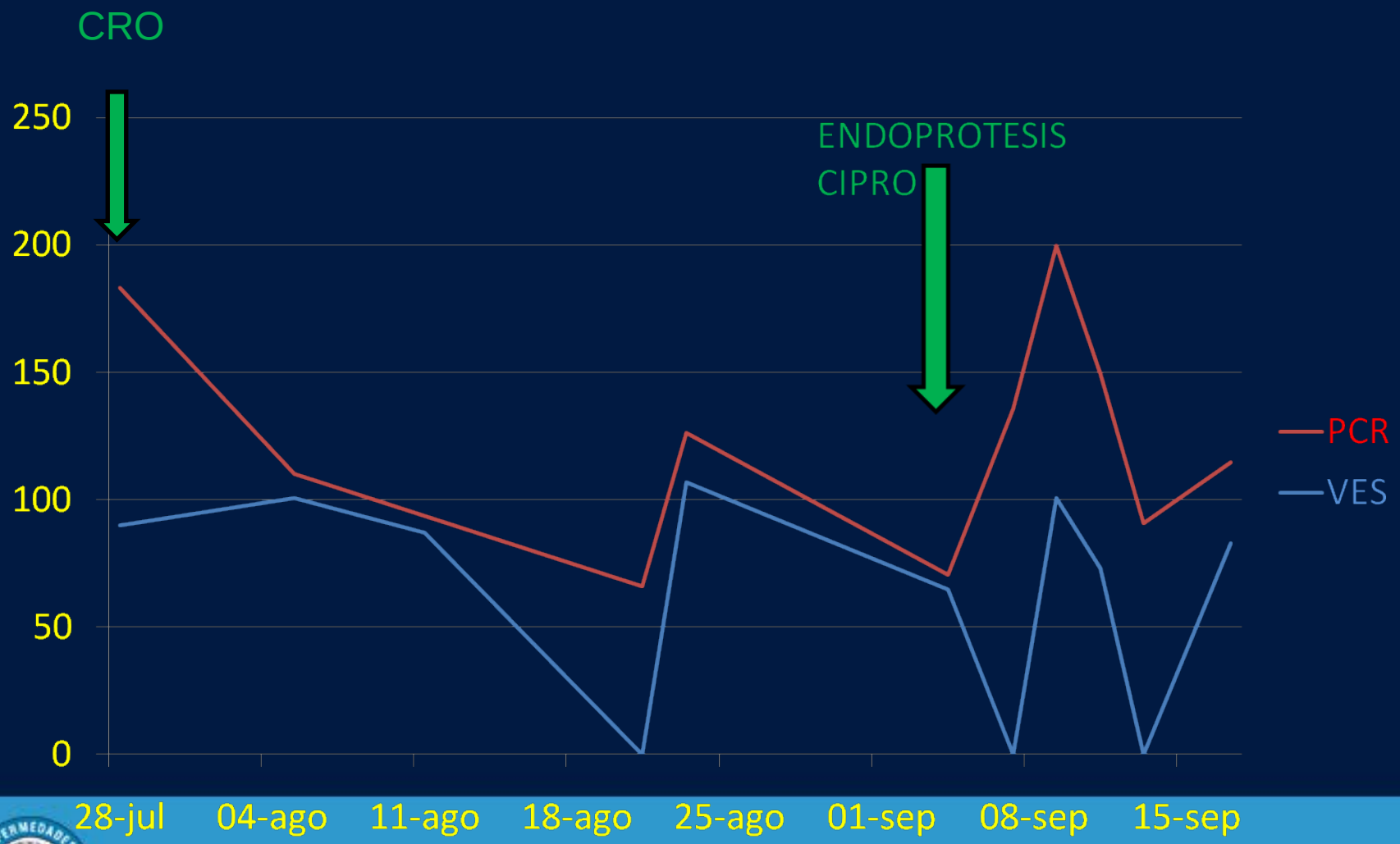
- Es una *urgencia* quirúrgica dado que la evolución natural es hacia la expansión y rotura con una mortalidad mayor al 80%
- Debe tener abordaje quirúrgico endovascular y médico (antibioticoterapia iv)
- El procedimiento planteado es **el implante de endoprótesis vía femoral**

Colocada la endoprotesis quedó resuelto el aneurisma aórtico

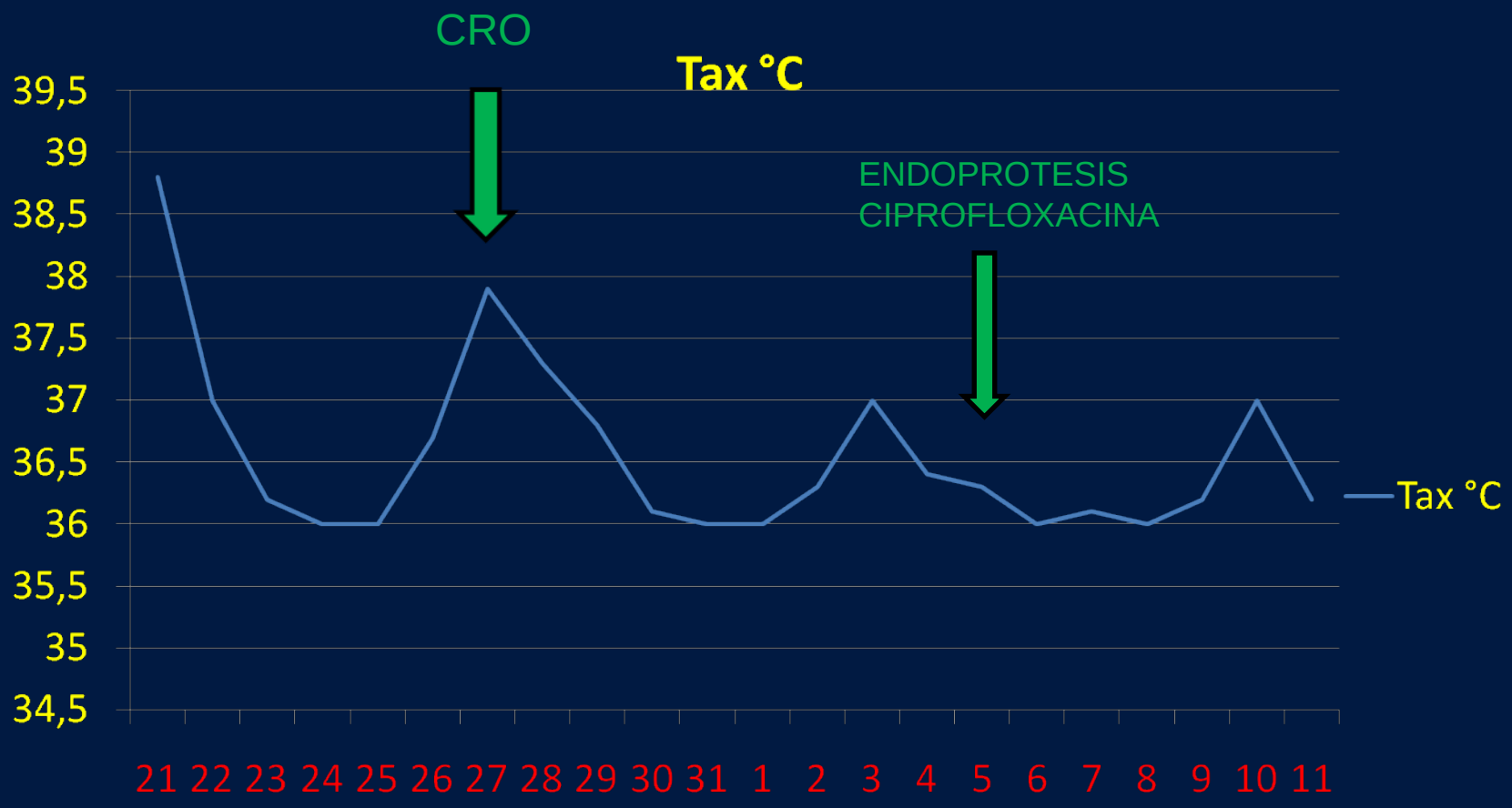
Paraclínica

Fecha	GB (mm3)	N (mm3)	Hb (g/dl)	Plaq (mm3)	VES (mm/h)	PCR (mg/dl)
21/7	15.700	12.710	13,3	205.000		
28/7	10.900	7.690	13,7	207.000	90	93,1
5/8	4.900	3.400	12,0	130.000	101	9,3
11/8	5.400	4.200	14,1	130.000	87	6,9
21/8	5.300	2.530	12,7	123.000		66,1
23/8					107	19,1
4/9	7.900	4.630	12,3	124.000	65	5,5
7/9	15.500	11.600	12,9	126.000		135,6
9/9	7.900	4.910	12,6	122.000	101	98,6
11/9	6.100	3.680	12,0	111.000	73	76,2
13/9	5.600	2.760	13,0	160.000		90,7
17/9					83	31,8

Reactantes de fase aguda



Curva térmica



CRO: ceftriaxona

- El paciente presentó excelente evolución.
- Duración del tratamiento antibiótico 8 semanas.
- Cumplió 6 semanas de tratamiento antibiótico iv en base a ceftriaxona y ceftriaxona + ciprofloxacina
  - Ceftriaxona 2g c/12hs iv inicialmente luego 2g día iv
  - Ciprofloxacina 400mg c/12hs iv
- Cumplió 2 semanas más de tratamiento vo con cefuroxime y ciprofloxacina
  - Cefuroxime 500 mg c/8hs vo
  - Ciprofloxacina 500 mgc/12 hs vo

REVISION

SALMONELLA

- ✓ BGN, anaerobio facultativo, pertenece a la flia Enterobacteriaceae
- ✓ 2 especies: *S. entérica* y *S. bongori*
- ✓ Varios serotipos: entre ellos *choleraesuis*
- ✓ *Choleraesuis* es patógeno porcino y también humano
- ✓ Causa septicemia con poca participación intestinal
- ✓ Capacidad para: invadir íntima arterial normal, para causar la infección endotelial en la presencia de la aterosclerosis

Pegues D, et al. Mandell, Douglas, and Bennett's Principles and Practice of Infectious Diseases, 7th ed. 223

PATOGENIA

- ✓ La bacteria entra por vía oral, penetra el enterocito y de allí se replica en las placas de Peyer.
- ✓ Por vía hematógena llega al pulmón, los riñones, las arterias de gran calibre y el sistema nervioso central.

- ✓ Comúnmente asociadas con ciertos animales como pollos y cerdos, mientras que en humanos la infección por estos microorganismos se asocia con alimentos contaminados e insuficiente cocción.

Cheng-Hsun Chiu et al. *Clin. Microbiol. Rev*. 2004;17(2):311-322

Toro Rendón L, et al. Medicina & Laboratorio 2010; 16: 447-457

- ✓ *S. entérica* serovar *choleraesuis* es un serovar altamente invasiva entre los serovares de *Sañmonella* no tifoidea
- ✓ Se ha reportado aumento de virulencia y resistencia a múltiples antimicrobianos en *S. choleraesuis* (por ej: ciprofloxacina)

Cheng-Hsun Chiu. *Nucleic Acids Research,* 2005, vol 33, No.5

CLINICA

- ✓ Los serotipos de *salmonella* no tifoidea son la principal causa de trasmisión alimentaria (vía oral)
- ✓ Gastroenteritis autolimitadas, sin necesidad de tto ATB
- ✓ 5% desarrollan bacteriemias

Cheng-Hsun Chiu et al. *Clin. Microbiol. Rev*. 2004;17(2):311-322

- ✓ Los serotipos *choleraesuis* y *dublín*, muestran una predilección mucho mayor para causar bacteriemia en los seres humanos .
- ✓ Estos serotipos invaden rápidamente el torrente sanguíneo con poca o ninguna afectación intestinal
- ✓ Serotipo *cholerasuis* tiene la mayor invasividad (medida en términos de índice de invasión , que es el número de aislamientos extraintestinales dividido por el número total de aislamientos)

Cheng-Hsun Chiu et al. *Clin. Microbiol. Rev*. 2004;17(2):311-322

Una complicación temida de bacteriemia por *Salmonella* en los adultos es el desarrollo de endarteritis infecciosa (aortitis o aneurisma micótico)

El sitio más común de la infección es la aorta abdominal, más precisamente su porción infrarrenal (88%)

Cheng-Hsun Chiu et al. *Clin. Microbiol. Rev*. 2004;17(2):311-322

- Factores de riesgo para aneurisma micótico por *Salmonella*

Neoplasia maligna

Cirrosis hepática

LES

Uso de corticoides previo

Terapia inmunosupresora

Infección por VIH

Diabetes

Edades extremas

Chen PL, et al.. J Intern Med. 2007;61:91-100

- ***ANEURISMAS INFECCIOSOS:*** son dilataciones aneurismáticas de origen infeccioso, en arterias previamente enfermas o sanas; generalmente, son arterias con ateroesclerosis, necrosis quística de la capa media o con defectos congénitos.

Jiménez C, et al. Rev Colomb. Cir. 2011;26:214-221

- La mayoría de los aneurismas infecciosos se producen por *Staphylococcus*, *Streptococcus* , *E. coli* y *Salmonella,* siendo las subespecies *chloraesuis* y *typhimurium* las más virulentas para la pared arterial.

Hombres (>70%)

Edad >60 años

Período prodrómico previo a manifestaciones aórticas:
1 semana a 8 meses

✓ Clínica:

Dolor abdominal (>85%)

Fiebre y malestar general (>75%)

LUO CY, et al.. J Vasc Surg. 2003;38:975-82.

- ✓ Paraclínica:

Aumento de la leucocitosis

Aumento de reactantes de fase aguda (PCR)

- ✓ Imagen

AngioTAC con reconstrucción 3 D (aneurisma sacular, multilobulado y cuello corto)

Arteriografía: no estaría indicada

LUO CY, et al.. J Vasc Surg. 2003;38:975-82.

✓ Tratamiento

Antibióticos solo: mortalidad 95% (ruptura aórtica 80%)

Reconstrucción quirúrgica in situ + ATB específica y prolongada (4-6 semamas): mortalidad 38 a 50%

Reconstrucción extraanatómica + ATB específica y prolongada (4-6 semanas): mortalidad 23%

Endoprótesis ?

ATB amplio espectro: Cefalosporina de 3ra generación + Fluorquinolona por 6 semanas

Jiménez C, et al. Rev Colomb. Cir. 2011;26:214-221

CASOS CLINICOS REPORTADOS

INTERNAL MEDICINE

□ CASE REPORT □

Infectious Aortitis Caused by *Salmonella* Dublin Followed by Aneurysmal Dilatation of the Abdominal Aorta

Masafumi Nakayama[1,3], Koichi Fuse[1], Masahito Sato[1], Masaaki Okabe[1], Shigeki Misumi[2], Akira Yamashina[3], Kazuo Yamamoto[1], Shinpei Yoshii[1] and Yoshifusa Aizawa[4]

Caso clínico Japones
Mujer 67 años Dolor abdominal, HC *S. dublin* ,imagen: gas a lo largo aorta abd, 11 dias post tto atb, imagen pseudoaneurisma rodeando absceso peri-aortico. Tto bypass extra-anatómico

Volver al índice de la revista

Documento Ant | Documento Sig.

Pseudoaneurisma micótico por *Salmonella enteritidis* en paciente con fiebre de origen desconocido

Redondo Orts, M.; Serrano Martínez, J.L.; Navarrete Navarrete, N.; Sabio Sánchez, J.M.;
Publicado en Med Intensiva. 2013;37:365-6.

Caso clínico Español
varón de 68 años con AP de síndrome de Sjögren, hepatitis y trombocitopenia autoinmunes en tratamiento con corticoides orales, hipertensión arterial, fibrilación auricular paroxística
Fiebre vespertina 38, 2 semanas
HC neg, imagen aneurisma, luego HC + S. *enteritidis.* Manejo quirúrgico y ATB CRO+Cipro

Brazilian Journal of Infectious Diseases
Print version ISSN 1413-8670

Braz J Infect Dis vol.11 no.4 Salvador Aug. 2007

http://dx.doi.org/10.1590/S1413-86702007000400018

IMAGES IN CLINICAL INFECTIOUS DISEASES

Mycotic thoracoabdominal aortic aneurysm caused by *Salmonella cholerasuis*

Ziba Jalali[I]; Miguel Madariaga[I]; Ali Khoynezhad[II]

Case Report

Salmonella enterica Serotype Choleraesuis Infection of the Knee and Femur in a Nonbacteremic Diabetic Patient

Alexander M. Sy,[1] Jagbir Sandhu,[2] and Theodore Lenox[3]

[1] *Department of Medicine, Metropolitan Hospital Center, New York Medical College, 1901 1st Avenue New York, NY 10029, USA*
[2] *Department of Pathology, Metropolitan Hospital Center, New York Medical College, New York, NY 10029, USA*
[3] *Division of Infectious Diseases, Department of Medicine, Metropolitan Hospital Center, New York Medical College, New York, NY 10029, USA*

Correspondence should be addressed to Alexander M. Sy; toshi_sy@yahoo.com

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Osteoarticular infections caused by *Salmonella* are rare. The rates of osteomyelitis and septic arthritis due to *Salmonella* are estimated to be less than 1% and 0.1%-0.2%, respectively (Kato et al., 2012). *Salmonella enterica* serotype Choleraesuis is a *nontyphoidal Salmonella*, highly pathogenic in humans, usually causing septicemic disease with little or no intestinal involvement. Serotype Choleraesuis accounts for a small percentage of published studies of *Salmonella* infections in the United States. It is not commonly reported in joint fluid and bones in contrast to serotype Enteritidis and Typhi, where a considerable number of cases have been published. Chen et al. in Taiwan found that 21% of bacteremic patients with this infection subsequently develop focal infections such as septic arthritis, pneumonia, peritonitis, and cutaneous abscess (Chen et al., 1999, Chiu et al., 2004). In contrast, our patient presented with localized osteoarticular infection with *Salmonella enterica serotype Cholerasuis*, but without evidence of bacteremia.

Hombre, 48 años, DM 2
2 sem dolor rodilla derecha, agrega fiebre y extensión dolor.
Liq sinovial: *S. enterica* serotipo choleraesuis. OM

Clin Infect Dis. 1999 Oct;29(4):862-8.

Aortitis due to Salmonella: report of 10 cases and comprehensive review of the literature.

Soravia-Dunand VA, Loo VG, Salit IE.

Department of Medicine, Toronto Hospital, University of Toronto, Ontario, Canada.

Abstract

We describe ten cases of aortitis due to Salmonella that were treated at the University of Toronto-affiliated Hospitals between 1978 and 1997. Predisposing conditions included hypertension, diabetes mellitus, and myelodysplastic syndrome. Main presenting symptoms were fever and abdominal and back pain. The most frequent site involved was the abdominal aorta, followed by the thoracic aorta. All but one patient were treated with intravenous bactericidal antibiotics; seven also underwent surgery, four with axillobifemoral grafts and three with in situ grafts. Four of seven patients died within 1 month of the surgical procedure (three patients with in situ grafts and one patient with axillobifemoral graft). We also reviewed the pathogenesis, clinical and laboratory characteristics, and treatment of 140 cases of aortitis due to Salmonella reported in the literature since 1948. The use of bactericidal antibiotics, together with early surgical intervention and long-term suppressive antibiotic therapy, has led to improved survival.

J Microbiol Immunol Infect. 2007 Jun;40(3):240-7.

Extraintestinal focal infections in adults with Salmonella enterica serotype Choleraesuis bacteremia.

Chen PL, Wu CJ, Chang CM, Lee HC, Lee NY, Shih HI, Lee CC, Ko NY, Wang LR, Ko WC.

Department of Internal Medicine, National Cheng Kung University Hospital, Tainan, Taiwan.

Abstract

BACKGROUND AND PURPOSE: Salmonella enterica serotype Choleraesuis, which is associated with severe human infections and multidrug resistance, poses a serious problem in Taiwan. The aim of the study was to investigate the epidemiology and clinical features of S. Choleraesuis bacteremia.

METHODS: Medical records and antimicrobial susceptibility of blood isolates were investigated for 43 adults (> or =18 years old) with S. Choleraesuis bacteremia from 1999 to 2005.

RESULTS: The proportion of S. Choleraesuis in non-typhoidal Salmonella bacteremia increased in the latter three years (2003-2005). The elderly with aged-related disorders, and younger patients receiving immunosuppressive therapy for their underlying diseases were two high-risk groups. Twenty cases (47%) had extraintestinal focal infections, including 10 cases of mycotic aneurysm, six of osteomyelitis, and 4 pleuropulmonary infections. Univariate analysis revealed that age > or =50 years was associated with occurrence of endovascular infection (p=0.008), while immunosuppressive therapy was negatively associated with endovascular infection (p=0.043). Significant resistance to first-line antimicrobial agents (i.e., ampicillin, trimethoprim-sulfamethoxazole or chloramphenicol) was noted. All strains were resistant to nalidixic acid, and 56% were resistant to ciprofloxacin. Few (<5%) isolates were resistant to ceftriaxone, and all were susceptible to cefepime, aztreonam, imipenem, meropenem and ertapenem. Multivariate analysis showed that shock (odds ratio [OR], 20.6; 95% confidence interval [CI], 1.8-239.4; p=0.016) and apyrexia (OR, 36.2; 95% CI, 3.7-358.2; p=0.002) were independent risk factors for mortality.

CONCLUSION: S. Choleraesuis bacteremia was usually complicated with extraintestinal focal infections in the elderly. With a high level of resistance among S. Choleraesuis, fluoroquinolones should be avoided for critically ill patients with suspected Salmonella bacteremia.

TRATAMIENTO

The feasibility of endovascular aortic repair strategy in treating infected aortic aneurysms

Chung-Dann Kan, MD, PhD,[a] Hsu-Ting Yen, MD,[b] Chung-Ben Kan, MD,[c] and Yu-Jen Yang, MD, PhD,[a] *Tainan, Kaohsiung, and Chia-Yi, Taiwan*

Background: Open surgical treatment for an infected aortic aneurysm has a high rate of surgical morbidity and mortality and does not guarantee eradication of the infected nidus. The use of endovascular aortic repair (EVAR) might simplify the procedure and provide a good alternative for this critical condition, but this remains to be proved. This study assessed the efficacy and outcome of EVAR with an adjunctive antibiotic treatment strategy.

Methods: We focused on the experiences and results of the management of infected aortic aneurysms with positive blood cultures. We drew the blood for culture study, immediately prescribed broad-spectrum antibiotics, performed EVAR procedures, and followed this with sensitive antibiotics and adjunctive procedures.

Results: Twelve consecutive patients (mean age, 70 years) were included in this EVAR strategy. Three patients had thoracic, two thoracoabdominal, and the remaining seven had infected abdominal aneurysms. Ten *Salmonella*, one *Staphylococcus*, and one *Streptococcus* spp were identified. There was no hospital death. Three patients underwent computed tomography (CT)-guided drainage, and one underwent open laparotomy debridement. Mean follow-up was 24 months. One late death occurred but was unrelated to reinfection. All patients seemed well, with no evidence of EVAR graft infection at a mean follow-up of 23.6 months.

Conclusions: This small multi-institutional study summarizing the experiences of patients with an infected aortic aneurysm managed by EVAR and an aggressive antibiotic strategy revealed that this EVAR strategy might be a suitable approach to treating this disease. These favorable results may be typical for *Salmonella* infection, which was present in most of the patients. Further experience is needed to assess whether this therapeutic strategy works equally well in aneurysm infection caused by other organisms. (J Vasc Surg 2012;55:55-60.)

TRATAMIENTO

Ann Vasc Surg. 2013 Sep 28. pii: S0890-5096(13)00345-2. doi: 10.1016/j.avsg.2013.02.021. [Epub ahead of print]

Treatment of Infected Abdominal Aortic Aneurysm Caused by Salmonella.

Lee CH, Hsieh HC, Ko PJ, Chou AH, Yu SY.

Department of Anesthesiology, Chang Gung Memorial Hospital, Chang Gung University, Taoyuan, Taiwan.

Abstract

BACKGROUND: We reviewed the outcomes of patients treated for nontyphoidal Salmonella-infected abdominal aortic aneurysm (AAA) treatment at a single center.

METHODS: This was a retrospective chart review of 26 patients with nontyphoidal Salmonella-infected AAA. Four patients underwent medical therapy alone, while 22 patients underwent surgical therapy. Revascularization method selection was dependent on preoperative antibiotic response in the surgical therapy group.

RESULTS: The in-hospital mortality rate for the surgical therapy group was 14%, while the rate for the medical therapy group was 100%. Overall survival for the surgical therapy group was 82%, while the reinfection rate was 9%. In the surgical therapy group, 2 patients had periaortic abscesses and underwent in situ prosthetic graft replacement; none developed graft-related complications or died in the hospital. Kaplan-Meier analysis and log-rank testing revealed no significant differences in graft-related complication and overall survival rates between in situ prosthetic graft group and extra-anatomic bypass group. Salmonella choleraesuis had a higher antimicrobial resistance rate than other isolates. The predictors of survival were clinical presentation of abdominal pain and receiving surgical therapy.

CONCLUSIONS: If patients with Salmonella-infected AAAs have good responses to preoperative antibiotic therapy, in situ prosthetic graft replacement is a viable revascularization method, even in the situation of periaortic abscess presentation formation.

Trabajos uruguayos

Autor	Revista	Tipo de trabajo	Aportes
Torres, M.E et al	J. Clin. Microbiol. 2001	Clínico Epidemiológico	Etiología esporádica de diarrea en niños
Bentancor, L et al	J. Clin. Microbiol. 2004	Epidemiología molecular	Demuestra diversidad genética circulando en nuestro país
Vignoli, R et al	Antimicrob. Agents Chemother. 2006	Molecular	Descripción nueva beta-lactamasa TEM -144 en *S. enterica* serovar derby
Macedo-Viñas M et al	J. of Infectious Diseases. 2009	Vigilancia de la resistencia antibiótica y detección de integrones (76-00)	Cambio en la resistencia de *S. typhimurium*

Trabajos uruguayos

Autor	Revista	Tipo de trabajo	Aportes
Bentancor, L et al	J. Clin. Microbiol. 2010	Prevalencia	S. derby emerge como patógeno zoonotico capaz de causar infecciones en humanos
Bado, I et al	Antimicrob. Agents Chemother. 2012	Reporte de 1er caso	1er aislamiento en humano de *S. enteritidis bla* CTX-M-14 en A. del sur
Cordeiro, N et al	J. of Global Antimicrobial Resistance. 2013	Reporte de caso	Identificación 1er gen *bla* CMY-2 en *S. entérica* serovar Typhimurium

Conclusiones

- ✓ Tener presente al aneurisma micótico como complicación de la Infección por *Salmonella*
- ✓ Sospecharlo y agotar posibilidades diagnósticas
- ✓ Primer examen a solicitar frente a sospecha de aneurisma es la AngioTAC multicorte con reconstrucción 3D
- ✓ Tratamiento quirúrgico y médico (ATB)
- ✓ Pensarlo, sospecharlo y diagnosticarlo cambia radicalmente el tratamiento y la supervivencia de los pacientes