She was afebrile, with distal femoral point tenderness, no evidence of knee joint involvement and 1/6 mid-systolic murmur at the pulmonic area. Intravenous flucloxacillin was commenced, with debridement and washout of the distal femoral lesion. Surgical specimens grew *Aggregatibacter aphrophilus* sensitive to ampicillin, with negative blood cultures. Transthoracic echocardiography showed no valvular abnormalities. Her mobility improved, and she was transitioned to amoxicillin, with planned duration of 3 months.

Aggregatibacter aphrophilus is a low virulence HACEK group bacterial pathogen with potential to cause osteomyelitis.² This case of an uncommon, low-virulence pathogen causing osteomyelitis shows the importance of aetiological diagnosis to guide appropriate management, especially in cases with indolent presentations.

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CLINICAL FEATURES OF SEPTIC ARTHRITIS WITH AND WITHOUT *KINGELLA KINGAE* DETECTION BY REAL-TIME PCR

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Aim: To evaluate the clinical features of *Kingella kingae* osteoarticular infections.

Method: We performed a retrospective audit of all children from whom we received a specimen for *K. kingae* real-time PCR (targeting *rtxA* and *cpn60*), as well as children with positive culture results from joint specimens, between May 2019 and April 2021. Microscopy and culture was performed according to standard protocols.

Results: Fifty-six children with features of osteoarticular infection subsequently confirmed by imaging, were included. The median age of children with *K. kingae* detected, compared to other pathogens, was 19 months versus 9 years. 53% versus 17% had recent respiratory infection. Median CRP was 32 versus 62 mg/L. Organisms were seen on fluid microscopy in 0% versus 67% of patients. 0% versus 28% grew the pathogen from blood cultures. Cefazolin was chosen for inpatient directed therapy in 82% versus 16% of cases. *K. kingae* was cultured from joint aspirates in only 2 cases.

Discussion: Patients with *K. kingae* septic arthritis have distinct clinical features, and molecular tests are important to confirm the diagnosis and direct targeted therapy. Molecular tests appear much more sensitive than routine culture for detection of *K. kingae* infection.¹

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A RARE CASE OF PERIPROSTHETIC *TRUEPERELLA BERNARDIAE* FOLLOWING A TOTAL HIP ARTHROPLASTY AND ANTIMICROBIAL STEWARDSHIP

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Trueperella bernardiae is a rare, anaerobic Gram-positive bacillus. Very few published clinical reports¹ of *Trueperella* infections, eludes its true incidence and pathogenicity. We share a case of a 70-year-old woman with recurrent peri-prosthetic joint infection (PJI) following a total hip arthroplasty.

A month after hip replacement, she presented with PJI, which was treated with extensive debridement and oral Ciprofloxacin in community for ESBL Enterobacteriaceae from peri-prosthetic samples. Five months later, she represented with peri-prosthetic collection which grew *Trueperella bernardiae*, during stage 1 hip revision. This was treated in hospital with six-weeks intravenous (IV) benzyl penicillin. A month after the second stage revision, she presents with hip re-collection that grew ciprofloxacin resistant *Escherichia coli*. She was managed in community with a 6-week IV carbapenem. However, 12 months later she developed a psoas abscess and subsequently elected for cessation of active management, leading to her demise.

This report emphasises on the emergence of antimicrobial resistance² Enterobacteriaceae due to constant antibiotic pressure, possibly causing a prosthetic joint infection by a rare *Trueperella bernardiae*, which was treated effectively by a narrow spectrum penicillin. This case report calls the need for antimicrobial stewardship³ while elucidating the existence of rare pathogens.

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