Editor – An apparently well and active man of 69 years on medication for ischaemic heart disease consulted my deputy GP with a 2 day history of pain above his right knee. He had had a long car journey one week before and was concerned about deep venous thrombosis, though he was taking low dose aspirin. The leg was normal on examination, but he was admitted to hospital. His D-dimer test was normal and he was promptly discharged.

He consulted me 3 days later, with muscle pain in his lower right quadriceps above the knee. He was found to have a small effusion of the knee joint and a patch of inflamed eczema on his right shin, and was prescribed some cream containing betamethasone and fusidic acid.

Five days later still, he had similar pain above his left knee, and had tender points in right and left quadriceps near SP10. He was given acupuncture into these areas with 2 needles on each side using standard safety precautions: once-only use of sterile sheathed needles and no touch technique. The skin was not cleansed, as this is not normally recommended for acupuncture.

The next day he developed severe pain in his left quadriceps muscle and required a home visit. The muscle was very tender and swollen over several centimetres, and there was slight redness round the needle entry points. The right side was normal, and he was apyrexial. I considered that the likely diagnosis was muscle infection; I also considered early necrotising fasciitis, but did not make this diagnosis. I prescribed a seven day course of flucloxacillin 500mg qid to which he made a full satisfactory response as one would expect. Neither I nor the patient wished him to have any more acupuncture.

Two weeks later he was feeling unwell, lethargic, and complained that ‘all’ his muscles felt tired. Polymyalgia was considered but the story was not typical and I felt there was some other significant pathology going on. I therefore arranged for him to have blood tests on the next possible day, after the New Year holiday.

Four days later, now one month after he originally presented, he again asked for a home visit as he had been vomiting for four days, was anorectic, and generally unwell. On examination, he was mentally hazy, pyrexial, had a tachypnoea and his oxygen saturation (SpO2) was 91% on air. He had a very red, hot, painful area of skin over the right ankle. He was admitted to hospital immediately with a suspicion of septicaemia and pneumonia in addition to his cellulitis.

Once in hospital, the staff noted from his records that at the time of his first admission he had had a neutropenia of 0.5 x 10^3. This must have been present at the time of acupuncture, but the information had not been forwarded to me by the hospital. At that time, his Hb was 10.8g/dl, platelet count 150 x 10^9/L and WBC 1.7 x 10^9/L. All these readings had fallen since a routine blood test four months earlier, when his Hb was 13.2g/dl, platelets 163 x 10^9/L, WBC 8.4 x 10^9/L, neutrophils 7.0 x 10^9/L.

On his second admission, he was found to have frank pancytopenia, with Hb 8.7g/dl, platelets 68 x 10^9/L, WBC 1.9 x 10^9/L, neutrophils 0.5 x 10^9/L. Within two days he had developed acute renal failure. Although he was given maximal treatment with antibiotics, fluids, and ultimately ventilation and inotropes, he developed multi-organ failure and died three weeks later. A bone marrow biopsy showed only ‘reactive’ changes. No underlying bacterium was isolated from multiple specimens, though he had raised ASO titre at the time of death that was not present at the time of admission. He had negative tests for hepatitis B and C, HIV, mycoplasma, CMV, EB virus and erythrovirus.

In the event of infection after acupuncture, doctors should be alert to the possibility of neutropenia or other immune deficiency underlying the condition, even though the patient may seem well.

Acupuncture with significant infection, in a ‘well’ patient

Roger Simmons
Kinloch Medical Practice
Perthshire, Scotland
roger@rsimmons9.f2s.com
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Roger Simmons

*Acupunct Med* 2006 24: 37
doi: 10.1136/aim.24.1.37

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