

# Sternoclavicular Joint Pains: Diagnosis and Treatment

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## Editorial

Immunocompromised individuals, diabetics, and patients suffering from a variety of infectious diseases are all at risk. Treatment options range from antibiotics to invasive surgery, including reconstructive surgery. With the exception of a few rare cases where antibiotics alone are effective, joint resection and plastic surgery surgeries are required. Surgical intervention is required in the case of septic arthritis. A limited joint incision and debridement is only useful when the disease is in its early stages. The treatment regimen must involve local joint and bone excision, as well as comorbidities like mediastinitis. After the infection has been effectively treated, the defect in the chest wall demands subsequent reconstructive surgery using a pedicled pectoralis muscle flap. The sternoclavicular joint (SCJ) is physically and clinically significant due to its proximity to key neuro-vascular systems such as the subclavian arteries and the phrenic nerve [1].

Infections of this joint can conceal a number of ailments, causing delays in diagnosis and spreading to the bone and deep tissues. There is no comprehensive workup and treatment regimen for sternoclavicular joint infections in the literature. To acquire a better grasp of the current state of knowledge about the diagnosis and management of SCJ, the existing literature is reviewed. We searched PubMed for clinical trials, case reports, case series, retrospective cohort studies, literature, and systematic reviews after eliminating non-infectious etiologies of SCJ disorders. SCJ is caused by a damaged immune system, intravenous drug use, trauma, and arthropathies [2].

Many people who are ill, however, do not have any of these risk factors. SCJs cause fever, joint swelling, immobility, and vocal cord palsy or dysphagia, among other symptoms. While *Staphylococcus aureus* causes more than half of all cases of SCJ, other bacteria such as *Pseudomonas* and *Mycobacterium* are also frequent. If the infection is caught early enough, antibiotics or joint aspirations may be used to treat it. SCJ, on the other hand, is usually diagnosed after the disease has progressed to the soft tissue and bones, necessitating en-bloc excision with or without a muscle flap. Undertreatment can lead to a range of consequences, including simple abscesses, mediastinitis, and even sepsis. SCJs are rare but deadly diseases that must be detected and treated as soon as possible. The majority of cases of SCJ that are correctly treated resolve in months while maintaining full functionality. In order to avoid sticky shoulder capsulitis and limited range of motion, aggressive rehabilitation is necessary. The method for identifying sternoclavicular joint (SCJ) osteoarthritis (OA) in skeletal remains is examined, with particular attention dedicated to the

anatomy of the joint. The established palaeopathological SCJ OA diagnostic criteria were shown to be valid for both the sternal and clavicular surfaces of the SCJ, with eburnation indicating intra-articular disc perforation and severe disease [3,4].

Eburnation has been demonstrated to be uncommon in the SCJ, and if used as the only diagnostic criterion, the prevalence of SCJ OA in archaeological assemblages would be understated. The discovery of OA-like changes on the clavicular surface of the SCJ, albeit only in the attachment zone of the intra-articular disc, was a significant result. Because this part of the joint is non-articular and does not generally have articular cartilage, a diagnosis of OA would be incorrect, and it should instead be classified as an enthesopathy. SCJ OA has most likely been misidentified and overdiagnosed in the archaeological record in the past. Before this can be validated, more histological investigation into the disc attachment and associated degeneration is needed [5].

## Acknowledgement

None.

## Conflict of Interest

The author shows no conflict of interest towards this manuscript.

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**How to cite this article:** Womack, Jason. "Sternoclavicular Joint Pains: Diagnosis and Treatment." *J Clin Res* 6 (2022): 156.

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**Received:** 09 March, 2022, Manuscript No. jcre-22-67089; **Editor Assigned:** 11 March, 2022, PreQC No. P-67089; **Reviewed:** 17 March, 2022, QC No. Q-67089; **Revised:** 22 March, 2022, Manuscript No. R-67089; **Published:** 29 March, 2022, DOI: 10.37421/2795-6172.2022.6.156