Thoracolumbar spondylodiscitis

Due to the aging society, the incidence of pyogenic spondylodiscitis is still rising.

Diagnosis

see Spondylodiscitis diagnosis.

Treatment

Thoracolumbar spondylodiscitis treatment.

Complications

Spinal epidural abscess.

Case series

2015

4350 procedures performed in 4037 patients (mean age=53.2 yr). Sixty percent of the patients were male. The majority of procedures were performed in the lumbar spine (98.4%), and the indication was mostly degenerative in nature (96.9%). The databases were then reviewed for any infectious complications.

Postoperative infection was recorded in 4 patients (0.09%). All of them occurred in the lumbar region after discectomy. These patients presented with discitis and underwent revision in the form of open debridement and fusion. The time lapse between the index surgery and revision was 56 days. All 4 patients recovered, with a mean follow-up of 7.5 years [1)].

2014

Of 107 cases, ranging between 17 to 83 years of age, 64 (59.8%) were male. Twenty-seven (25.2%) patients had diabetes mellitus.

Laboratory investigations revealed elevated CRP in 70 (65%) patients, elevated ESR in 65 (61%) patients, and elevated white blood cell (WBC) counts in 41 (38.3%) patients. Thirty-six (33.6%) patients were identified as having brucellar SD, and 5 (4.7%) patients were identified as having tuberculous SD. A total of 66 (61.6%) patients were determined to have pyogenic SD. The most frequently isolated microorganism was Staphylococcus aureus. Antibiotic therapy was given

intravenously to all pyogenic SD patients.

The incidence of SD has increased as a result of the higher life expectancy of older patients with chronic debilitating diseases and the increase of spinal surgical procedures. In patients with low back pain, SD should be considered as a diagnosis. For effective treatment, it is important to determine the etiology of the disease [2].

Case reports

2015

A patient with a history of L2 corpectomy and anterior spinal fusion presented with discitis at the L4/5 level and underwent an anterior lumbar interbody fusion (ALIF) supplemented with a locking plate placed anterolaterally for stability. Fifteen months after the ALIF procedure, he returned with a hardware infection. He underwent debridement of the infection site and removal of hardware. Results. Once hardware was exposed, removal of the locking plate screws was only successful in one out of four screws using a reverse thread screw removal device. Three of the reverse thread screw removal devices broke in attempt to remove the subsequent screws. A metal cutting drill was then used to break hoop stresses associated with the locking device and the plate was removed. Conclusion. Anterior locking plates add significant stability to an anterior spinal fusion mass. However, removal of this hardware can be complicated by the inherent properties of the design with significant risk of major vascular injury [3].

2014

A 46 year-old patient who had had lumbar pain for several weeks that irradiated to the right leg, and did not respond to NSAID treatment. The work-up included MRI, biopsy with draining of the collection and a universal PCR followed by 16S rDNA sequencing. The latter was used to make the microbiologic diagnosis, which identified Fusobacterium nucleatum as the causative agent. Final treatment consisted of clindamycin.

Spondylodiscitis due to Fusobacterium spp. is a rare and difficult to diagnose entity, due both to its clinical characteristics and to the difficulty in making the right microbiologic diagnosis [4].

1)
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