INFECTIOUS SPONDYLODISCITIS EVOLVING WITH ARREFLEX AXIAL PARAPLEGIA: CASE REPORT

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BACKGROUND

Spondylodiscitis is a term that covers the infectious involvement of the intervertebral body and disc. Infection can occur through hematogenous dissemination, contiguity of nearby tissues or direct contamination as occurs in surgical procedures. Diagnosis most often happens late as the initial symptoms are nonspecific, which is confused with mechanical spinal pain. This report describes a case of spondylodiscitis that evolved with areflex axial paraplegia, requiring decompressive laminectomy.

CASE REPORT

A 75-year-old patient admitted for invasive coronary stratification after ST segment elevation myocardial infarction (STEMI). History of hypertension, diabetes, dyslipidemia, in addition to important smoking and alcohol consumption. During hospitalization he presented intense low back pain presentation without irradiation and within 5 days evolved with areflex axial paraplegia. Complementary tests showed normal blood count, cerebrospinal fluid analysis and blood cultures. A lumbosacral tomography showed spondylosis, diffuse disc bulge at levels L3 to S1, touching a ventral face of the dural sac. Electroneuromyography showed polyneuropathy with an axial pattern in the lower limbs, with an accentuated degree for the sensory component and a moderate to severe degree for the motor component, in addition to a marked rarefaction of potentials on the proximal and mid-distal muscles. In magnetic resonance imaging (MRI) of the thoracic and lumbar spine, an expansive central intramedullary lesion was described, involving the medullary cone, at the level of T11–T12, extending to L2–L3, with low contrast uptake, slight expansive effect in thoracic portion, and important effect the portion lumbar spine, in which infectious, ischemic, or neoplastic etiologies should have considered. Neurosurgery evaluation indicated decompressive laminectomy in L2–L3. Antibiotic therapy with vancomycin was then instituted, combined initially with meropenem, which was replaced by imipenem, due to nosocomial infection (urinary infection and pneumonia) by germs with sensitivity to these drugs, totaling 4 weeks of treatment, with progressive improvement of the condition.

CONCLUSION

Infectious spondylodiscitis presents insidiously most of the time, but in rare situations it can evolve with loss of aggressive muscle strength. In these situations, in addition to antibiotic therapy, a surgical approach for decompression may be necessary.

KEYWORDS

Spondylodiscitis, Paraplegia, Laminectomy.