

Multifocal Extensive Spinal Tuberculosis with Retropharyngeal Abscess

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Abstract:

An unusual case of a young boy presenting with spinal tuberculosis involving cervical & thoracic vertebrae, along with retropharyngeal abscess is reported. The patient presented with progressive quadriplegia, fever, night sweat and cervical lymphadenopathy. The lab studies confirmed tuberculosis and patient received anti-tubercular chemotherapy. After development of quadriplegia, spinal surgery was done. The post operative course was uneventful and the patient is on gradual neurological recovery.

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Introduction:

Skeletal tuberculosis (TB) usually constitutes 1–3% of extrapulmonary TB, and spinal involvement is about half of them.¹ TB of the cervical spine is so unusual that it comprises only 3% of cases of Pott's disease. In addition, retropharyngeal abscess as a presenting manifestation of tuberculosis of the cervical spine is rare.² The most dangerous area for skeletal TB is the cervical region, due to the greater risk of quadriplegia and death.³ This article describes an extremely rare case of multifocal Pott's disease, along with retropharyngeal and paravertebral abscess.

Case report:

A 13-year-old boy had 7½ months history of fever, anorexia, weight loss, and cervical lymphadenopathy with discharging sinus. Initially he was admitted in a tertiary care hospital, where, a CT scan of chest & neck revealed “retropharyngeal, pre & paravertebral abscess, multiple vertebral destruction, and cervical & right paratracheal lymphadenopathy” (Figure 1). For the last 6 months, he was on supervised anti-TB chemotherapy on the basis of FNAC of cervical lymph node which revealed caseating granuloma. Despite getting Anti-TB drugs, and symptomatic improvement in terms of resolution of fever, improvement of appetite and weight, he developed neck pain along with quadriplegia, 5 days before presenting to us.

On admission, both his upper and lower limb power was 0/5 with complete sensory loss up to C₂ and absent deep tendon reflexes with equivocal plantar response.

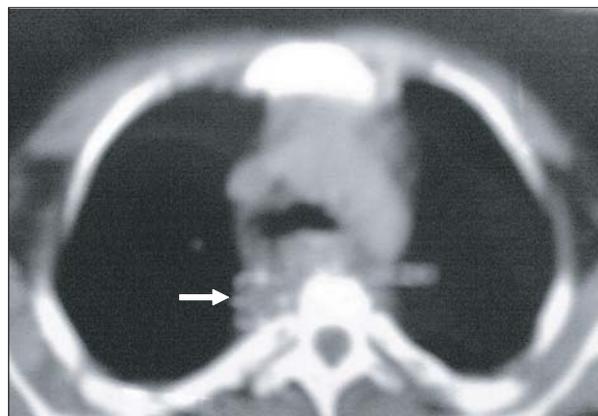


Fig.-1: CT scan of chest showing paravertebral abscess (arrow).

He had raised ESR (85 mm in the 1st hour) with positive Mantoux Test (20 mm after 72 hours). MRI of cervical & dorsal spine, done this time, showed “C4 & D4 vertebral body heights are reduced with anterior wedging causing localized kyphotic deformity with epidural extension of the perivertebral mass resulting in cord compression. Disk space between C4-C5 and D4-D5 are obliterated. Perivertebral mass at craniovertebral junction to C5 level and D2 to D4-5 level with epidural extension present. Atlanto-axial subluxation with an intervening mass are causing further cord compression (Impression: Features are suggestive of tubercular spondylodiscitis at multiple levels with epidural mass causing cord compression)” (Figure 2).

All other biochemical investigations, including random blood sugar, were normal.

Histopathological examination of tissue from intervertebral disc and paravertebral region of C₃-C₄ region showed caseating granuloma.

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