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Images in...

Non-contiguous spinal tuberculosis

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DESCRIPTION

A 26-year-old-man of Indian descent was referred to our rheumatology unit with 6 months of lower-back pain. He had lived in the UK for 5 years, travelling intermittently to holiday in India. His general practitioner detected a C-reactive protein of 55 mg/l and erythrocyte sedimentation rate of 95 mm/h and referred with a possible 'spondylo-arthritis'.

The patient gave a history of back pain with stiffness throughout the day. He admitted to fever, sweats and significant weight loss but denied having a cough.

On examination, he had slight limitation of lumbar-spine-flexion with no focal spinal-tenderness or clinical-sacroilitis. Straight-leg-raise was 80° bilaterally. Resisted hip-flexion caused exacerbation of lower-back pain. Power and knee-jerks were normal but ankle-jerks were reduced.

Chest-radiograph (figure 1) was normal and lumbar-spine x-ray (figure 2) revealed a fifth lumbar-spine pars-defect only. Renal, liver and bone profile was normal. Three early-morning-urine samples, blood cultures and HIV-serology were negative.

Fevers, sweats, weight loss and reduced ankle-jerks are considered atypical for a spondylo-arthritis. Malignancy or indolent spinal infection form important differential diagnoses. An urgent MRI-spine (figure 3) revealed multiple spinal-lesions and a para-spinal-abscess eroding the sacrum. Subsequent CT demonstrated a left sixth-rib-lesion, the biopsy and histology of which revealed non-caseous-granulomas and negative acid-fast-bacilli stain. Culture of this specimen yielded *Mycobacterium tuberculosis* after 4 weeks.

About 23% of patients with spinal-tuberculosis (TB) may have normal spinal-plain-radiographs.[1] Our case highlights the need for early spinal MRI in patients with suspected spinal TB, even when plain radiographs appear normal. TB-spondylitis frequently involves multiple-adjacent spinal-vertebrae; non-contiguous vertebral involvement, as seen here, is relatively uncommon.[2] Confusion with metastatic malignancy is possible; hence a tissue diagnosis is still essential.[2]

Figure 1 Chest radiograph was normal with no focal parenchymal lung pathology.

Figure 2 Lumbar spine x-ray demonstrating a fifth lumbar spine pars defect (white arrow).

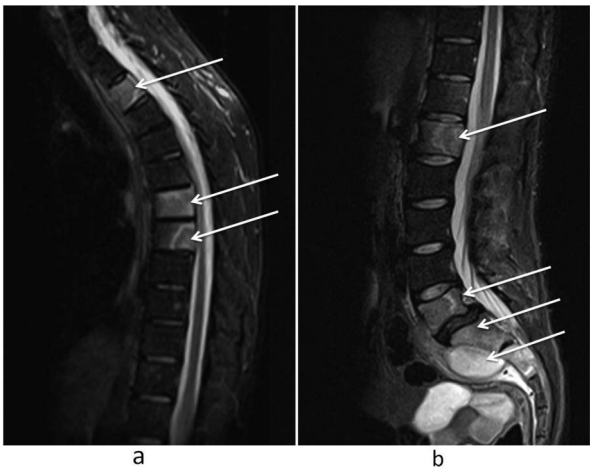

Figure 3 Sagittal MRI view of (A) thoraco-lumbar spine, (B) lumbo-sacral spine, demonstrating contiguous and non-contiguous spinal lesions as well as a 5.8×3.7 cm presacral abscess (white arrows).

Learning points

- In suspected cases of spinal tuberculosis (TB), early spinal imaging with MR is required, even if plain radiographs appear normal.
- A tissue diagnosis should be obtained whenever possible to exclude other pathologies (malignancy/infection) and to determine sensitivity to antituberculous treatment.
- Non-contiguous TB spondylitis is relatively uncommon but can be present even when plain radiographs appear normal, thus emphasising the need to MRI the whole spine.

Competing interests None.

Patient consent Obtained.

REFERENCES

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