Summary

MR.D A Jimosingho, eighty four years old retired heavy vehicle driver who engaged with paddy farming with a past medical history of essential hypertension for which he has been on regular treatment and was well controlled over the years presented with a progressive lower backache over two weeks duration which was radiating down his anterior thigh and was gradually increasing in severity to which it made him bed bound for the past 5 days. It was associated with high grade fever for 2 days with chills and rigors. There was no bowel bladder incontinence. On examination there was tenderness on deep palpation over the lower lumber spine and left buttock area with the development of an early pressure sore with immobilization. There was grade 4 power over the proximal muscles of left lower limb with increased pain with hip extension and internal rotation. Investigations had increased WBC count with polymorpho nuclear leucocytosis and raised inflammatory markers. Blood culture report was positive for MRSA after 24 hours of incubation. According to the clinical presentation, examination findings and raised inflammatory markers the possibility of a deep seated abscess either paravertebral or psoas, dual pathology like lumbosacral radiculopathy with another focus for septicaemia and hip joint septic arthritis was considered as differentials and radiological investigations were carried out to narrow down the diagnosis. X ray lumbosacral spine which was done at the admission showed reduced disc spaces between L1-L2, L2-L3, L3-L4 and L4-L5 with degenerative changes. Contrast enhanced CT spine revealed severe osteoporotic spine with degeneration without evidence of abscess formation. With persistent blood culture positivity and high degree of clinical suspicion of possible deep seated abscess, MRI lumbosacral spine was carried out which

revealed a 1.6cm×2.3cm focal lesion in left psoas suggestive of abscess formation with evidence of degenerative disease of the spine. An empirical antibiotic which was started with the admission was later changed according to the sensitivity pattern of the blood culture and was continued for twenty eight days and CT guided percutaneous drainage of the abscess was arranged five days following the admission. Around 200cc of pus drained which was cultured positive for MRSA staphylococcus aureus and TB PCR was negative. Oral rifampicin 600mg daily was added as an adjunctive to the antibiotic regimen by the microbiology team for possible underlying spondylodiscitis[1]. Patient was symptomatically improved and inflammatory markers came down and blood culture became negative with the above treatment.