DISCITIS FOLLOWING TWO LEVEL LAMINECTOMY: Good Reason to Try Conservative Means like Cox® Technic Protocols Before Other Measures

presented by
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HISTORY:

An agitated, anxious and very pain-filled 46 year old caucasian man presented to our office December 26, 2007. He had experienced 5 months of excruciating pain in his low back, without radiculopathy, following infection as a result of 2 level laminectomy. (L4/5 July 2007). This man felt relief from his sciatica after the surgery for 5 days only. Thereafter, he started feeling increasing rigidity, pain and fever. He visited his surgeon 8 days after the surgery when stitches were to be removed. The patient was perceived to have post-surgical infection and was placed on 3 antibiotics (for 3 months) and rested in the hospital. The surgeon decided not to operate as he felt curettage was not in order. The patient remained in very excruciating pain for 3 months after the surgery during which the pain subsided only moderately.

EXAMINATION WHEN SEEN BY THE CHIROPRACTOR:

Vital signs were normal and the medical history unremarkable. The patient was barely able to stand. Rolling over in bed was painful. The standing examination revealed a guarded rigid thoracolumbar spine without antalgia. Bowstring sign was normal. Flexion was limited to 40% of normal, extension limited to 20% of normal, both sides lateral bending were guarded and diminished by 25% of normal. Rotation was decreased by 20% of normal. Kernigs and Soto Hall were normal. (The patient reported that when these maneuvers were attempted within the first 2 post-surgical months, it was very painful.) Dejerine triad was minimally positive. Sitting SLR was normal, while Milgram's test could not be performed for the pain in the low back and gluteal areas. SLR was bilaterally positive at 65 degrees, with Braggards being normal. Pin prick testing was normal in lower back and leg dermatomes. Placing the patient prone on the table was very difficult, and he was very apprehensive in attempting this as it was his most painful position.
He had great difficulty rising from the prone position to sitting and to return himself to full weight bearing position.

The lateral plain lumbar film revealed marked destruction of the anterior longitudinal ligament and destruction of a sizeable portion of the anterior-superior disc and vertebral body. There was no posterior vertebral motor unit destruction noted. The x-ray studies were not available for showing as they sometimes are not here in Honduras.

Consideration of possible arachnoiditis was considered. Arachnoiditis is a debilitating condition characterized by severe stinging and burning pain, persisting into the low back, legs or throughout the whole body. Additionally, weakness and paresthesias are often noted in the legs. A crawling sensation, or as if water were trickling down the legs is perceived often. Severe spasmodic, shooting pains, as electric shocks, with muscle cramps, and uncontrolled twitching is noted. Bowel and bladder symptoms as well as sexual dysfunction had been reported. It is long recognized as a rare complication of spinal surgery, particularly after multiple complex surgeries and with trauma to the spine. Advanced spinal stenosis may instigate arachnoiditis. Chemical myelograms (dyes) have resulted in arachnoiditis. There has been a concern with the preservatives in epidural steroid injections, especially if the meds enter the CSF. Additionally it is infection-induced for those that affect the spine: viral, fungal, TB, meningitis.

Treatment of this discitis case included intrathecal pump implantation under the skin distributing pain medicine to the spinal cord. Physiotherapy including TENs and hydrotherapy to generate heat do help with the stiffness and poor mobility. Surgery is not indicated as it increases scar tissue and exposes the already irritated spinal cord to more trauma. (courtesy Edgar G. Dawson, MD.)

In calling the patient now several months after the intrathecal implant, he reports less pain and a returned ability to go to work.

This sequelae is fortunately something which is avoided with conservative Cox® management of spinal discs.