

CASE STUDY:- DISCITIS

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PHYSIOCLINICPLUS

SUBJECTIVE HISTORY:

A 73 year old gentleman presented with a 4 month history of low back pain with no history of trauma. He had a 20 year history of low back pain, but the pain over the last 4 months had been significantly worse. The pain was intermittent and initially it radiated into the right leg and increased with cough and sneeze. The patient reported that the pain seemed to be moving into the left groin where it was more constant and pulsating in nature. It increased when he went upstairs and generally decreased with rest and Ibuprofen. He also described bilateral leg weakness that he felt had come on with the back pain, meaning that he could only walk for approximately ¼ mile and gait disturbance. He felt he was pulling to the right when walking. He was suffering from severe fatigue, which had been worse over the last few months. He was not suffering from night pain, but he did have night sweats, which he felt had been worse recently. He described a recent cough, shortness of breath, which was worse when he was in a cold room and a racing pulse. He had lost 2 lbs in weight recently, but this had been deliberate. He suffered from urinary frequency, which disturbed his sleep but this was not new. Ibuprofen appeared to give him constipation.

PAST MEDICAL HISTORY:

Chronic low back pain.

Discectomy at L5 4 years ago. This had left him with a partial foot drop on the right.

3 years ago- enlarged prostate.
PSA blood test 2 weeks earlier-
no results available

Chest X-ray 1 month ago - clear.

Oedematous ankles.

Hypercholesterolemia.

FAMILY HISTORY:

His father died of stomach cancer age 59

MEDICATIONS:

Fluconide 20 years
Simvastatin

Aspirin
Glucosamine
Vitamins

SOCIAL HISTORY:

This gentleman was about to retire from a part time job. He was a non smoker and drank very little alcohol. He felt that his mobility had severely decreased over the last few months, due to fatigue and weakness. He also described suffering from some recent memory loss.

OBJECTIVE ASSESSMENT:

On examination he had a slow lumbering gait and appeared tired. Assessment of his lumbar spine revealed that flexion to approx 40 degrees increased the tightness across his thoracic spine but did not increase his leg pain. He achieved 10 degrees of lumbar extension due to stiffness only. Side flexion was reduced in both directions with no significant increase in his symptoms. SLR was limited to 70 degrees in both legs, with the right experiencing pain underfoot on dorsiflexion and no increase in symptoms on the left. Prone knee bend was positive in the front of the left thigh. The L3 myotome was significantly decreased on the right, as was L4. The dermatomes were normal, as were the reflexes. Babinski and Clonus were normal. He did however have significant pain in his thoracic spine when he tried to lie prone.

Testing of the right hip did not provoke his symptoms in any direction. Testing of the left hip revealed some discomfort on end range flexion and extension was tight on that side.

DIFFERENTIAL DIAGNOSES

Serious underlying pathology due to Red flags:

Bilateral leg weakness,
Gait disturbance,
Age
Severe fatigue
Night sweats
Thoracic pain
Non segmental symptoms
Recent cough, shortness of breath, and a racing pulse.

Possible diagnoses:

Secondary metastases from a primary cancer e.g. prostate.
Myeloma
PMR

Vascular Pathology eg AAA as indicated by pulsating pain in the left groin
Infection indicated by recent night sweats, fatigue and malaise.

INVESTIGATIONS:

An MRI scan was requested along with blood tests including FBC, CRP, ESR, Ren, Hep, bone, PSA, Thyroid.

BLOOD RESULTS:

ESR 73
CRP100

Neutrophils	9.25	RBC	3.84	HCT	32.9
WBC	11.20	Hb	10.2	MCH	26.6

DISCUSSION:

There were a number of red flags with this patient. Age, gait disturbance, bilateral leg weakness and general severe fatigue. He also described significant night sweats and objective assessment revealed thoracic pain. These findings were sufficient to give a strong suspicion of underlying pathology. During the initial assessment he described a racing pulse, some shortness of breath and a cough. This gentleman had had a recent clear chest X-ray. But they could have been indicators of lung pathology, infection or cardiac pathology.

Although there were a significant number of red flags this patient did not present as being overly distressed. He was not in extreme discomfort and his range of movement was relatively pain free. The movement causing him the most pain was lying prone which caused him to cry out at the pain in his thoracic spine.

Once noted, the red flags were acted on by the requesting of an urgent MRI scan and the appropriate blood tests. 2 days later however the patient became so ill that he was admitted into intensive care. He was found to have an infected spinal disc as determined by MRI scan (level unknown as this was verbally reported by G.P. who did not have the full result). The plan had been to drain the disc and commence antibiotics. It was then that the patient was discovered to have bacterial endocarditis and septicaemia. Subsequently this patient went into renal failure, which resolved and on the last report he was still in hospital awaiting a mitral valve replacement. He remained however very poorly.

By close questioning of this patient it was possible to identify red flags which then could be acted on with speed. The patient was sent with a covering letter to A+E documenting all the relevant information. Unfortunately this patient's condition was very advanced and the full outcome is not known. It does however highlight the need to be able to identify red flags in occupational health.