Spondylodiskitis Caused by Enterococcus: An Unusual Entity. A Case Report and Literature Review

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Spondylodiskitis caused by enterococcus is an entity anecdotaly described in medical literature. We report a case of lumbar spondylodiskitis caused by enterococcus faecalis of urinary origin in a male patient after being operated for prostate benign hyperplasia in the Hospital Son Llàtzer, Palma de Mallorca, Spain. Clinical, radiologic and evolutive features were revised. Through a bibliographical search 9 cases have been found in medical literature, although 2 of them were included in etiologic series of infectious spondylodiskitis with no more information. Together with our case we describe briefly the published characteristics of the 7 patients.

Key words: Spondylodiskitis. Enterococcus. Osteomyelitis.

Clinical Case

We present the case of one 79-year-old male, with a history of mechanical back pain after working related lumbar trauma at 48 years of age, who underwent a gastric ulcer repair at 65 and was surgically treated for a benign prostatic hypertrophy in the Hospital Son Llàtzer. We revisen las características clínicas, radiológicas y evolutivas de este caso. Al realizar una búsqueda bibliográfica se han encontrado 9 casos comunicados en la literatura médica, aunque 2 de ellos estaban incluidos en series etiológicas de espondilodiscitis infecciosas, sin más información. Se resumen, junto con nuestro caso, las características de los 7 pacientes publicados de los que se dispone de información clínica.

Palabras clave: Espondilodiscitis. Enterococo. Osteomielitis.
and 1 urine culture. It was started on treatment with ciprofloxacin 500 mg/12 h during 10 days. The 2 blood cultures in the urine culture were positive for *Enterococcus faecalis*. Three days after this episode, and showing a discrete clinical improvement, there was a reduction in disuria and urgency of the fever persisted, the patient presenting acute, invalidating lumbar pain without radiation, due to which he once again went to the emergency room and after taking x-rays of the lumber spine, that showed only agent related changes, was treated with anti-inflammatories and muscle relaxants. The patient was sent to the outpatient rheumatology consult in October 2003, after 5 months of lumber train of inflammatory characteristics that limited the patient more and more every day, and during the last 20 days was radiated to the gluteus and the posterior face of the right inferior extremity. The patient did not show fever, night sweats, or toxic syndrome during this period of time, and neither had he presented any other episode of cystitis.

On physical exploration there was an important limitation of lumbar spinal mobility in all planes, and spinal maneuvers (Nez and psoas) were positive with negative radicular signs (Lasegue and Bragard), and with normal reflexes. Laboratories tests were normal. Lumbar spine x-rays showed a reduction in the articular space between the second and third lumbar vertebrae, as well as an alteration in the morphology of the vertebral joint facets (Figure 1) that was not evident on the x-rays done on the initial evaluation in the emergency room. Magnetic resonance (MR) showed L2 and L3 spondylodiskitis with minimal pre-vertebral or bilateral psoas muscle affection. A bone scan with technetium and gallium confirmed the uptake of the radio marker in the above-mentioned zone. The presence of infectious spondylodiskitis in a patient with no fever, and no systemic affectionation, and the with normal lab results, a biopsy was done on the disc zone where cultures for bacteria, fungi, and mycobacteria (culture, Ziehl-Neelsen, and auramine stain) had been negative, and the pathologic study confirmed the presence of acute inflammation with no atypical findings present. Treatment was started empirically with amoxicillin-clavulanate 2 g/8 h and gentamycin 120 mg/12 h, and posteriorly the amoxicillin-clavulanate was changed to ampicillin 2 g/4 h. After biopsy the patient presented a worsening of clinical signs with fever and an increase in acute phase reactants (ESR 30 and PCR 14) that improved after a week of rest, and the lumber corset. The patient underwent 6 weeks of intravenous antibiotics treatment with the disappearance of inflammatory pain, and actually persists with discrete mechanical pain. On x-ray control after 3 weeks of antibiotic treatment and after biopsy, the disk space between L2-L3 had fused with a more noticeable sinking of the anterior zone (Figure 2), that was confirmed with a computerized tomography (CT) of the lumber spine. Clinical and radiologic evolution showed a resolution of the infectious process. Today, and after 24 months of treatment, the patient is asymptomatic and control x-rays have not been modified.

**Discussion**

In total, 8 cases of spondylodiskitis due to *Enterococcus* sp. were analyzed, including the one referred above, whose clinical and progression characteristics are outlined in Tables 1 and 2. Two more cases that corresponded to a spondylodiskitis etiology series without a description of their clinical characteristics were not included in the discussion. Three episodes affected women (cases 2, 3, and 7) and 5 men (cases 1, 4, 6, and 8), with a mean age of 74 years (interval, 64-79 years). The most...
commonly associated comorbidity was diabetes in 4 cases, followed by osteoarthritis in 2 and a history of lumbar trauma in 2, with and without fracture, respectively. Only 1 of the patients had been surgically intervened in the zone where the posterior infection occurred (case 5) (Table 1). From the clinical standpoint all patients presented pain in the spinal localization affected (5 lumbar, 2 dorsal, and 1 cervical). In spodyloarthritides—indeedently of the causal agent—pain is localized and sensibility upon examination of the segments affected is present in at least 90% of patients. In general, the pain is insidious and progresses slowly in 3 weeks to 3 months. Six patients had fever, 1 mild fever, and only 1 patient did not present a fever. In 2 patients (cases 6 and 7), neurologic signs were the first manifestations, respectively presenting flaccid paralysis and paresthesia of the lower limbs. In this illness, fever and peripheral leukocytosis are absent approximately in 50% of patients, and between 6% and 15% present sensorimotor neurologic defects. The focal origin of bone infection was urinary in 4 cases, and the rest were endocarditis, surgical wound infection, catheter infection, and unknown origin (Table 2). In 5 episodes, *E. faecalis* was the responsible species, while *E. raffinosus* was implicated in another. *Enterococcus sp.*

![Figure 2. Control x-ray taken at 3 months of antibiotic treatment and after biopsy that shows a fused L2-L3 disk space and sinking of the anterior zone.](image)

**TABLE 1. Clinical Characteristics**

<table>
<thead>
<tr>
<th>Case Number</th>
<th>Age</th>
<th>Gender</th>
<th>Comorbidity</th>
<th>Clinical Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1 (García et al)</td>
<td>77</td>
<td>Male</td>
<td>Diabetes</td>
<td>Lumbar pain, fever, and chills for 5 weeks</td>
</tr>
<tr>
<td>Case 2 (García et al)</td>
<td>75</td>
<td>Female</td>
<td>None</td>
<td>Lumbar pain, fever for 1 month</td>
</tr>
<tr>
<td>Case 3 (Zamora et al)</td>
<td>73</td>
<td>Male</td>
<td>Diabetes</td>
<td>Dorsal pain, fever</td>
</tr>
<tr>
<td>Case 4 (Melzer et al)</td>
<td>64</td>
<td>Male</td>
<td>Kidney failure (hemodialysis)</td>
<td>Lumbar pain, fever</td>
</tr>
<tr>
<td>Case 5 (Summers et al)</td>
<td>74</td>
<td>Female</td>
<td>Diabetes, coronary heart disease, osteoarthritis, spondylolisthesis, spinal canal stenosis</td>
<td>Lumbar pain, fever and chills</td>
</tr>
<tr>
<td>Case 6 (Sandoe et al)</td>
<td>73</td>
<td>Female</td>
<td>Rheumatoid arthritis, osteoarthritis, D5 fracture, coronary heart disease</td>
<td>Dorsal pain, fever, flaccid paralysis both legs</td>
</tr>
<tr>
<td>Case 7 (Lee et al)</td>
<td>77</td>
<td>Male</td>
<td>Diabetes</td>
<td>Cervical pain, paresthesia upperlimbs, fever for 4 days</td>
</tr>
<tr>
<td>Case 8 (case described)</td>
<td>79</td>
<td>Male</td>
<td>Prostatectomy, lumbar trauma</td>
<td>Lumbar pain for 5 months</td>
</tr>
</tbody>
</table>
resistant to vancomycin and *S. aureus* resistant to methicillin coinfected another patient, and, finally, *E. faecium* and *S. epidermidis* were considered responsible in the last case (case 5). An MR was done in 5 of the 8 described cases, in 2 a CT was done and the other 2 only underwent spinal x-rays. In the majority of patients, a microbiologic diagnosis was done, using blood cultures, urine cultures or both simultaneously. Biopsy was done in only 3 patients (cases 5, 6, and ours) with a microbiologic confirmation of claws into a (5 and 6). Only in the case described was a bone scan undertaken in which an important uptake of technetum in the L2–L3 region was noticed with the rest of a scan being normal. This relation to the treatment received, penicillin, and gentamicin were used during 6 months, followed by 2 weeks of oral amoxicillin in 2 episodes (cases 1 and 2), another 3 (cases 3, 7, and 8), ampicillin and gentamicin (in 1 during 6 weeks and in the other 2 there is no data about the length of treatment), as well as quinupristine dallopristine (case 5) in another 2 patients. In case 4, vancomycin and rifampycin was used but was afterwards changed according to the results of the antibiogram. Of the 8 described cases, 6 evolved to complete recovery and 2 died (cases 3 and 6), one due to multi-organ failure and the other one to pulmonary thromboembolism and heart failure. In conclusion, spondyloskittus due to enterococcus is an infrequent entity, and there are very few described cases. The majority of cases present themselves in older patients with comorbidity, most frequently diabetes mellitus. The diagnosis is reached by clinical examination and imaging (x-rays and/or MR) and is confirmed microbiologically in the majority of cases through blood cultures. The infection originated by *E. faecalis* (including the case described) constitutes 5 of the 8 cases, and is the most frequently described species. The majority of cases continue want to complete cure, and are only treated with antibiotics, associated with analgesia, anti-inflammatorys, and orthopedic corset.

**References**