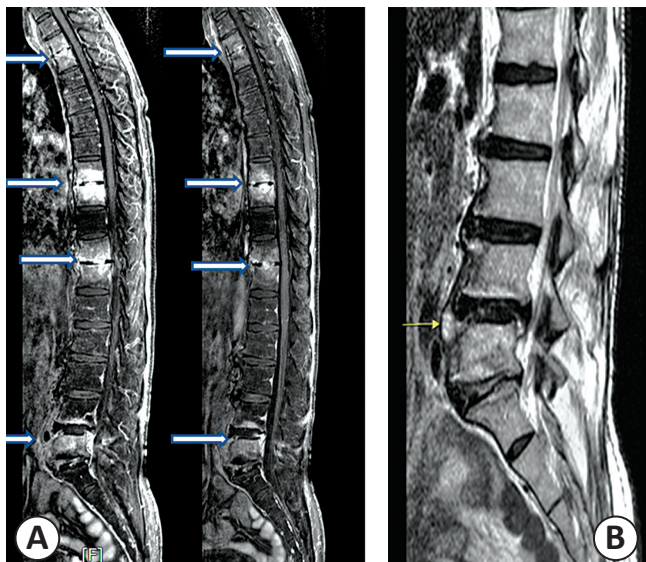


# Noncontiguous multiple-level brucellar spondylodiscitis with an epidural abscess

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A 57-year-old man presented with a 6-month history of low back pain with decreased range of motion, fever, chills, and sweating, especially at night. The lumbar and thoracic spine was tender, and his neck was stiff, with fixed flexion. His white blood cell count and erythrocyte sedimentation rate were 5,500/mm<sup>3</sup> and 25mm/h, respectively. The brucella capture test result was positive (1:320). Magnetic resonance imaging showed diffuse spondylodiscitis with an epidural abscess. The midsagittal image revealed increased signal intensity involving the T2–T3, T8–9, T11–12, and L4–5 disks and vertebral bodies (**Figure A**, arrows). Pathologic signal changes were detected, compatible with a 14 × 8-mm paraspinal abscess anterior to the corpus of the L5 vertebrae, with low signal intensity on T1-weighted images, high signal intensity on T2-weighted images, and post-contrast peripheral enhancement (**Figure B**, arrow).

Based on the clinical, laboratory, and radiological findings, multifocal brucellar musculoskeletal involvement was diagnosed. In the second week of treatment with 200-mg/day doxycycline, 600-mg/day rifampicin, and 1,600/320-mg/day trimethoprim/sulfamethoxazole, his clinical condition improved. The therapy was stopped after 3 months. No relapse was observed at the end of the sixth month. The frequency of spondylodiscitis in brucellosis is 2–53%. Involvement at multiple levels accounts for only 3.2–9% of patients with osteoarticular complications. Nonspecific clinical and radiological findings in this rare condition might lead to diagnostic difficulties. Early recognition of complicated cases is critical for preventing complications. Brucella spondylodiscitis should be considered in patients in endemic areas with chronic spinal pain.

## REFERENCES

1. Ulu-Kilic A, Karakas A, Erdem H, Turker T, Inal AS, Ak O, et al. Update on treatment options for spinal brucellosis. *Clin Microbiol Infect* 2014; 20:O75–O82.
2. Tekin R. Brucella pneumonia with microabscess and pleural effusion. *Rev Soc Bras Med Trop* 2015; 48:364.
3. Nas K, Gür A, Kemaloğlu MS, Geyik MF, Cevik R, Büke Y, et al. Management of spinal brucellosis and outcome of rehabilitation. *Spinal Cord* 2001; 39:223–227.

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