

Spondylodiscitis with Primary Psoas Abscess in a Neonate

Primary psoas abscess is rare in neonates [1]. Spondylodiscitis, although reported in older children, is extremely uncommon in newborns [2]. Co-existence of these two conditions is even rarer and reported in adult patients [3]. We report a case of neonatal spondylodiscitis with primary psoas abscess following infection with methicillin resistant staphylococcus aureus (MRSA), hitherto unreported in this age group.

A full term, 26-day-old boy, (birth weight 2.8 kg) presented with fever and excessive crying for last five days. An indurated swelling was noted over thoracolumbar region. Systemic examination was unremarkable. Investigations revealed hemoglobin 9.2 g/dL, total leucocyte count 23000/cmm, neutrophil 69%, lymphocyte 28%, eosinophil 2%, monocyte 1% and platelet 2.6 lacs/cumm. C- reactive protein was 25 mg/dL. Blood culture detected isolates of MRSA. X-ray thoracolumbar region showed angulation at T12-L1 vertebra. Ultrasonography (USG) demonstrated a hypo-echoic shadow indicating paraspinal collection. Culture of aspirated specimen detected the same organism sensitive to vancomycin. Magnetic resonance imaging (MRI) of spine showed destruction of intervertebral disc and vertebral bodies at T12-L1 along with a left sided psoas abscess and skiagram of chest and hip, USG of abdomen and hip were normal. Gastric aspirate for acid fast bacilli was negative. Patient responded to parenteral vancomycin and amikacin, and USG guided aspiration without any surgery. The abscess reduced gradually as demonstrated by serial USG. He was discharged following four weeks of antibiotic therapy.

Neonatal psoas abscess presents with tender swelling in the back, leg or groin, restricted leg movement or excessive cry. It can be primary following hematogenous

dissemination from any occult source or secondary to local infection or trauma [3]. *Staphylococcus aureus* is the commonest organism for primary abscess while *Escherichia coli*, *Klebsiella spp.*, *Bacteroides spp* are implicated in secondary ones [3].

Reports of primary neonatal psoas abscess in the literature are very few [1, 4, 5]. Discitis is commonly seen in infants whereas vertebral body infection is more common in adults [5]. Discitis with vertebral body destruction following primary psoas abscess was a unique presentation in our case. Septic hip arthritis, proximal femoral osteomyelitis and tubercular paravertebral abscess are close mimickers, which were excluded. A high index of suspicion is essential for early diagnosis. MRI spine should always be done to exclude spondylodiscitis. Antibiotics with surgical drainage are the treatment of choice. But, early initiation of appropriate antibiotics for adequate duration might bring a favorable outcome.

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