



Concomitant Bilateral Sacroiliitis and Lumbar Spondylodiscitis Secondary to *Staphylococcus aureus* Sepsis

Hasan Tahsin Gözdaş¹ , Mustafa Hızal²

A 59-year-old man presented to our hospital with a one-week history of fever and progressive lumbar and gluteal pain. He was a farmer and had a previous medical history of lumbar disc hernia. He mentioned that he lifted heavy loads. During the physical examination, his gluteal and lumbar joint movements were extremely restricted; thus, he was unable to actively move and walk due to severe pain. Laboratory findings were as follows: white blood cells, 25.6 K/uL (n=4.5–11); neutrophils, 18.8 K/uL (n=1.8–7.3); alanine aminotransferase, 139 U/L (n=0–55); aspartate aminotransferase, 113 U/L (n=5–34); C-reactive protein, 173.9 mg/L (n=0–5); erythrocyte sedimentation rate, 101 mm/h (n=0–15). He was admitted to the inpatient clinic with a presumptive diagnosis of lumbar spondylodiscitis. After obtaining blood cultures, the intravenous administration of 4×1.5-g ampicillin–sulbactam was initiated. The Rose Bengal, Wright tube agglutination, and tuberculin skin tests were negative.

Lumbar magnetic resonance imaging (MRI) showed spondylodiscitis at L1-2 and L3-4 levels, and it also showed a 15×11.5-mm right paraspinal abscess (Fig. 1a, b). Pelvic MRI revealed bilateral active sacroiliitis (Fig. 2).

Owing to bilateral sacroiliitis, ankylosing spondylitis was suspected. However, HLA B-27 was found to be negative. Thereafter, methicillin-sensitive *Staphylococcus aureus* was grown in two bottles containing blood cultures. The intravenous administration of 4×1.5-g ampicillin–sulbactam was continued for one month. Clinical and laboratory findings showed improvement, and the patient was discharged with the oral administration of 2×1-g amoxicillin–clavulanic acid. Physical medicine and rehabilitation outpatient control was recommended. After three months of treatment, he was able to actively move and walk. Control lumbar MRI showed regression in the size of the abscess and spondylodiscitis, and pelvic MRI showed prominent regression in sacroiliitis findings. The treatment was completed in six months.

Staphylococcus aureus is a common infectious agent. When it enters the bloodstream, it may cause various metastatic infections such as spondylodiscitis, osteomyelitis, infective endocarditis, and meningitis (1–3). The present interesting case also shows that *S. aureus* bacteremia may cause concomitant bilateral sacroiliitis and lumbar spondylodiscitis, which may exacerbate lumbar and gluteal pain, leading to serious restriction in the patient's lower limb movements.

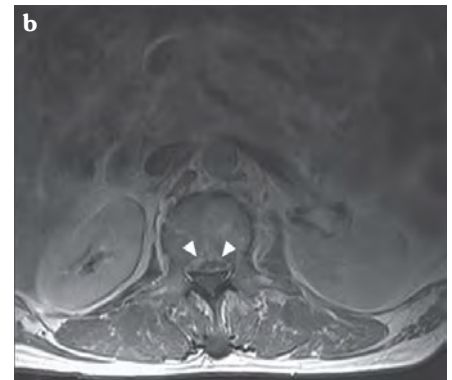


Figure 1. a, b. Lumbar MRI showing spondylodiscitis and paraspinal abscess

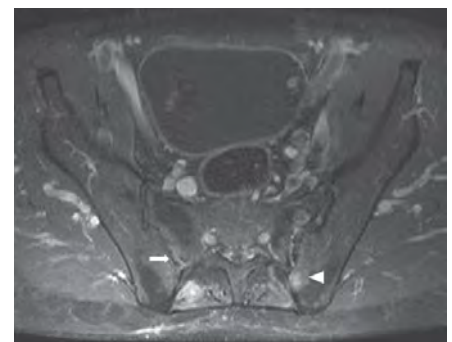


Figure 2. Pelvic MRI showing bilateral active sacroiliitis

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¹Department of Infectious
Diseases and Clinical
Microbiology, Abant İzzet
Baysal University Faculty of
Medicine, Bolu, Turkey
²Department of Radiology,
Abant İzzet Baysal University
Faculty of Medicine,
Bolu, Turkey

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Correspondence
Hasan Tahsin Gözdaş,
Department of Infectious
Diseases and Clinical
Microbiology, Abant İzzet
Baysal University Faculty of
Medicine, Bolu, Turkey
Phone: +90 374 254 10 00
e-mail:
dr.htgozdas@yahoo.com.tr

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