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Editorial Open Access

Spinal Epidural Abscess in Head and Neck Surgery

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Editorial

The incidence of spinal epidural abscess is extremely rare and even more unique in otolaryngology. We encountered a case of lumbar spinal epidural abscess in an 80-year-old diabetic patient after partial glossectomy and neck dissection performed for cancer. Our patient had an uneventful procedure with an expected immediate postoperative hospital course; however, she returned to the hospital one week postoperatively with back pain and lower extremity weakness and paresthesias. On initial evaluation, her symptoms were mild enough that they could have been attributed to her baseline physical function given her old age, history of diabetes, and postoperative debilitation. We did decide to have the neurosurgeons evaluate her, and her exam findings were concerning enough that they obtained magnetic resonance imaging of her spine. We were very surprised to find that she had a lumbar spinal epidural abscess. She was taken to the operating room immediately for drainage by the neurosurgeons and was started on a 6-week course of Ceftriaxone.

This example illustrates the importance of specialists. While we all at some point learned how to perform a neurologic exam, our general examination skills fall away as we become more specialized in our fields. Had we simply brushed off her initial symptoms, we could have put her health and life in serious jeopardy [1].

We found that the patient also developed an infection at the site of previous neck dissection as well as a urinary tract infection. Curiously, cultures from the neck abscess, urine, blood, and epidural abscess grew *Klebsiella pneumoniae*. Her diabetes and resultant immunosuppressed state undoubtedly contributed to her infectious complications. We thought the source of infection was her urine; however, the infectious disease physicians deemed the etiology to be her neck infection despite the rarity of *K. pneumoniae* in soft tissue infections. Regardless of the source, the immediate involvement of our neurosurgery colleagues ultimately led to her recovering almost all of her neurologic function 6-months postoperatively.

We think that the combination of her age and history of diabetes put her at increased risk. We do tend to exercise some caution in deciding to operate on elderly patients; however, surgical resection is often the primary curative treatment option for squamous cell carcinoma, especially in oral cavity cancers. Diabetes alone would not be a contraindication to surgical resection. It was not until after the patient's operation that we discovered how poorly controlled her diabetes truly was as her hemoglobin A1C was 9.0. We do tend to err on the side of obtaining perioperative clearance for patients of older age and with significant medical comorbidities, and we did receive clearance from this patient's primary care provider. As far as we know, she had never had a procedure in the past, so it would have been difficult to predict her development of infectious complications.

Our understanding of the systemic consequences of the procedures we perform was heightened as a result of this case. One of the most important lessons is knowing and understanding our own limitations and asking for assistance from colleagues when it is warranted.

References

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