Aspergillus epidural abscess in a patient with obstructive airway disease

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Summary

A 54-year-old Chinese man with episodic bronchial asthma since 25 years of age was treated for pulmonary tuberculosis in 1976 because of left upper lobe lesions on chest radiograph. In 1981, he presented with an extradural mass compressing the thoracic spinal cord, thought to be tuberculosis but which on biopsy was found to be aspergillosis. Sputum culture, type one skin-prick reactivity and serum precipitating antibodies were positive for Aspergillus. Amphotericin B intravenously, then ketoconazole orally did not substantially improve his clinical course. He died about four months post-laminectomy.

KEY WORDS: aspergillosis, asthma, tuberculosis, epidural abscess.

Introduction

Aspergillus is an ubiquitous saprophytic fungus. Few species are pathogenic to humans. The infection usually involves the lungs, skin, external ears, paranasal sinuses, orbits and occasionally the bones and meninges. The central nervous system becomes infected either by haematogenous spread from the lungs or gastrointestinal tract (Young et al., 1970) or by direct invasion from the paranasal sinuses or orbit (Warder, Chikes and Hudson, 1975; Mukoyama, Gimple and Poser, 1969). Central nervous system or systemic aspergillosis almost always occurs on a background of underlying neoplastic disease, collagen-vascular disease or iatrogenic immunosuppression. Epidural abscess as a manifestation of aspergillosis is rare. Ingwer, McLeish and Tight (1978) reported such a case in a renal transplant recipient: we report such a presentation in a patient with obstructive airway disease not receiving corticosteroids.

Case report

In August 1981, a 54-year-old Chinese man was admitted to this hospital with progressive weakness, over one week, of both legs with corresponding loss of sensation. He had been asthmatic since the age of 25 years. Attacks of asthma were episodic with symptom-free intervals and he did not need maintenance therapy. He was a storekeeper and never smoked cigarettes. In 1976, he was diagnosed as having pulmonary tuberculosis and was treated for one year by his private practitioner. He was never on corticosteroid therapy.

In hospital, he gave a history of pain at the back of his left chest and over the thoracic spine lasting four months. It was increasing in severity and one week before admission, he developed neurological deficits in his legs. He had weight loss, cough with purulent sputum and for the last five years had bouts of haemoptysis.

Physical examination showed a febrile thin man with normal vital signs. Examination of the lungs was clear; the heart and abdomen were unremarkable. Neurological testing showed normal cranial nerves and upper limbs. There was decreased sensation to pin-prick below the fifth thoracic dermatome level. Bladder and bowel sphincters were normal. The left lower limb was weaker than the right, had an extensor plantar response and showed decreased proprioceptive sensation. Lower limb reflexes were hyperreflexive. No spinal tenderness was elicited.

A chest radiograph showed marked pleural thickening in the left upper zone with fibrotic changes in both upper and mid zones consistent with old tubercular changes. Lung fields were slightly hyperinflated. Radiographs of the thoracic spine were normal.

Laboratory evaluation included a peripheral white blood cell count of $8.7 \times 10^9$/litre with no eosinophilia, a haemoglobin of 10.7 g/dl, normal serum creatinine and electrolytes and an elevated erythrocyte sedimentation rate of 129 mm in the first hour. Lumbar puncture revealed xanthochromic fluid at normal pressure with 7 cells, a glucose level of 1.78
mmol/litre, a protein level of 4 g/litre and the presence of globulin. There were a few lymphocytes seen on the smear but no torula, acid-fast bacilli or other organisms. His arterial blood gas was normal.

In view of his previous tuberculosis history, he was started on second line anti-tuberculous chemotherapy (kanamycin, ethambutol, isoniazid, rifampicin and pyrazinamide) as for tuberculosis of the spine. A lumbar myelogram showed a complete block to the flow of dye at the fourth thoracic vertebra level due to extradural compression. Laminectomy of the third and fourth thoracic vertebrae revealed epidural granulomatous tissue densely adherent to the dura compressing the spinal cord at that level but not infiltrating it. The vertebrae were not involved.

Histologic staining of the tissue obtained revealed branching septate organisms that resembled Aspergillus. Subsequently this was grown on sputum culture. Precipitins to Aspergillus were present in the blood. Skin-prick test for immediate hypersensitivity using Bencard Testing Solutions Group M2 moulds (Aspergilli) was positive at 1 mm weal. His Mantoux test was negative using one tuberculin unit of purified protein derivative. His peripheral blood had a normal proportion of B and T cells and normal immunoglobulin levels.

Therapy with amphotericin B was poorly tolerated and only 231 mg were given intravenously in addition to the antituberculous therapy. He developed severe reversible liver and renal impairment. The neurologic deficits did not improve. When he recovered from the toxicity of amphotericin, he was started on oral ketoconazole 200 mg daily (on the 63rd postoperative day) but he died after a further 56 days (total dose of ketoconazole was 1120 mg) of respiratory failure due to his chronic lung disease and the complicating paraplegia.

Aspergillus species occur as a commensal in as many as 10% of random sputum samples and in such instances, no host response occurs. All immunological tests would be negative (Turner-Warwick, 1979). The weak positive skin-prick response to Aspergillus makes it unlikely that Aspergillus is responsible for his asthma as it has been shown that weals of 3 mm or greater are more likely to correlate with positive bronchial provocation testing to that allergen than smaller weals (Bryant, Burns and Lazarus, 1975). The absence of both blood eosinophilia and transient radiographic shadows rules out bronchopulmonary aspergillosis.

This patient's chest radiograph showed bilateral contracted upper lobes very suggestive of pulmonary tuberculosis for which he received treatment, but the same could be the chronic consequence of repeated Aspergillus infection as his sputum cultures were positive for Aspergillus. The negative Mantoux reaction could result from depressed delayed hypersensitivity. Aspergillosis accounts for the presence of precipitins in his blood to Aspergillus.

A primary pulmonary or gastrointestinal focus with subsequent local or haematogenous spread is the most frequent route of dissemination for the organism (Young et al., 1970). Our patient probably had a pulmonary source with metastatic localization in the epidural space. Even in the presence of meningitis smear and culture for Aspergillus in cerebrospinal fluid is rarely positive (Young et al., 1970). The most reliable method of diagnosis remains biopsy with histological examination and culture. Unfortunately, the culture was negative perhaps because of pretreatment of the specimen with sodium hydroxide solution before culture for mycobacteria.

Amphotericin B has not offered effective chemotherapy for systemic or central nervous system aspergillosis (Young et al., 1970; Bennett, 1974; Utitz, 1974). Recently, an oral antifungal agent, ketoconazole, was found to be efficacious in systemic fungal infections in animal models. The initial clinical evaluation in man was also promising with no toxicity noted (Borelli et al., 1979). At the recommended dosage of 200 mg daily, the present patient was given a total of 56 days therapy. It is difficult to evaluate the value of the therapy. The paraplegia remained static probably secondary to vascular thrombosis (Young et al., 1970). The fourth thoracic vertebra level is usually the anatomical watershed zone for the spinal cord's blood supply, and therefore an easily compromised situation.

References

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