



**D/D**

Pain in the back and left thigh > 1yr

Blood investigations normal

## **Diagnosis**

1. Tuberculosis Discitis
2. Infective discitis
3. Ganglion

## **Case Report**

Ms W is a forty-eight years of age and is a caretaker in a local school. She does not give any history of previous medical issues with her back, but states that on 11/6/2012 she was mowing the lawns. She says that she lifted the lawn mower to put it on the trailer when she felt pain in the back, but this pain was not bad enough for her to stop working. She continued working and then on 25/06/2012 which was a clean up day and she picked up chairs of the young children to place it on top of the table and noted that her back got progressively stiff and pain was bad and on that night she had to go to the Accident and Emergency Department. She had an MRI performed of her lumbar spine that showed extruded disc at L3-L4 level. She had two CT guided steroid injections and she states that the injection did not make any difference. She was seen on several occasions by the orthopedic registrar and specialists and then she was again admitted in the Hospital on 16/04/2013. It was suggested that she was worsening with left anterior thigh and knee pain. Assessment revealed marked sensory changes [Hypoesthesia] over the anterior aspect of the left knee (L3 dermatome). Left knee jerk reduced. Knee extension power was difficult to assess because of pain. She underwent a repeat MRI that showed a different pathology at L3-L4 [Fig 1] with a possibility of discitis causing abscess in the adjacent vertebral body. Blood investigations did reveal normal ESR and CRP. On 16/4/2013 CT guided biopsy at L3/4 did not reveal any polymorphs or organisms on culture. No acid fast bacilli were grown on mycobacteria culture. Her back and left leg pain continued. She underwent open biopsy, bone grafting and fusion of L3-L4 with pedicle system. Intra-operatively there was no evidence of infection. Histology report did find a ganglion cyst.

anterior thigh and knee pain increased considerably and was persisting even after 6 months. Post op MRI of the spine was unremarkable, blood investigations were within normal limits and an MRI of knee was normal. She was referred for a second opinion. She was analgesic and walked with fairly stiff left knee gait [touch weight bearing] with two crutches. She was very hyperesthetic around the knee with skin color changes. Skin was shiny around the left knee. These changes fit into diagnosis of chronic regional pain syndrome. There was marked stiffness of the knee with movement of 30 degrees from fixed flexion of 20 degrees. Palpation, muscle testing and knee reflexes were not possible because of increased sensitivity around the knee. We performed electromyography of the lower extremities and the results showed chronic L3 radiculopathy. The 3-phase bone scan showed only non-specific findings.

On an updated MRI of the lumbar spine, there was no evidence of focal disc herniation and compression of the thecal sac or nerve root, and the fixation device was in good position according to the contrast enhancement lumbar MRI findings.

A diagnosis of neurogenic type 2 CRPS from chronic irritation of L3 nerve root was made. She was referred to the pain team for pain management and she received medications (anti-inflammatory drugs, analgesics, and gabapentin at the same time, with the physiotherapist for TENS, grade desensitization therapy and mobilization with feedback. She was provided psychological consultation and antidepressants at the neuropsychology centre. Furthermore, the patient received local injection therapy that included epidural block at the pain clinic, but she did not show any satisfying improvement of the symptoms. Presently she has been considered for a permanent spinal cord stimulator as she had a successful trial of stimulation with a temporarily (1 week) implanted electrode.