

Letter to Editor Regarding: “Acute Spinal Epidural Abscess of the Cervical Spine Caused by Streptococcus Constellatus Leads to Paraplegia in an Adult: A Case Report” [Letter]

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Dear editor

After carefully reviewing the article by Zhang et al with great interest, we would like to provide some necessary clarifications to the readers of your esteemed journal.¹ Spontaneous spinal epidural abscesses (SEA) can be classified into two types: a) primary, which originates from a remote focal infection by hematogenous spread (arterial or venous) or direct infiltration into the epidural space through lymphatic vessels, and b) secondary, which arises per continuitatem from an adjacent infection (such as spondylodiscitis or paravertebral abscess).² In primary spinal epidural abscesses, there is no involvement of the vertebral bodies and intervertebral discs, while in secondary spinal epidural abscesses there is bone destruction as a result of spondylodiscitis.

In our opinion, the case described by Zhang et al appears to be a secondary SEA, since the computed tomography (CT) of the cervical vertebrae shown in Figure 1 is characteristic for the presence of spondylodiscitis of C6–C7, with destruction of the lower end plate of C6 and the upper end plate of C7, and is suspicious for a ventrally located paravertebral abscess, which is surprisingly asymptomatic. The magnetic resonance imaging scan confirms the CT findings, and also visualizes a ventrally located SEA resulting from the spondylodiscitis, which compromises the spinal cord. Considering these imaging findings, we believe that posterior decompression in the cervical region would unlikely provide adequate debridement of the affected structures and, thus, was unnecessary.² In this case, an anterior surgical approach is indicated, enabling simultaneous evacuation of the paravertebral abscess, the infection within the C6-C7 disc, and the ventrally located SEA, as well as excision of the damaged structures and anterior stabilization, as executed during a second surgical intervention by the authors.³

We fully agree with Zhang et al on the significance of timely diagnosis in the management of SEA. However, we must express our disagreement with the notion that the clinical presentation of vertebralgia in the cervical region, body temperature exceeding 38 °C, acute onset (occurring within two days), pronounced neurological symptoms, and laboratory evidence of leukocytosis, accelerated erythrocyte sedimentation rate, and elevated C-reactive protein mirrors the typical clinical presentation of cervical spondylotic myelopathy. The existing literature supports the understanding that such a combination of clinical and paraclinical features should prompt the consideration of SEA as part of the differential diagnosis.⁴

Our comments should not be interpreted as diminishing the significance of the paper by Zhang et al.¹ On the contrary, we fully endorse the conclusion that prompt surgical intervention and effective antibiotic therapy are imperative for achieving favorable outcomes in this challenging disease.

Disclosure

The authors report no conflicts of interest in this communication.

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