Fungal Spondylodiscitis: Review

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Abstract

The term spondylodiscitis is an entity that refers to an infection that affects the vertebral body and intervertebral disks. These are commonly caused by pyogenic infections, particularly by Staphylococcus aureus, which responsible for 60% of them. Fungal spinal infections remain a rare pathology, although an increased incidence has been reported due to a progressively more susceptible population (immuno-deficient patient). Fungal spondylodiscitis diagnosis currently relies on the presence of risk factors, microbiology, serological tests (Antigen detection and antibody testing) and imaging such as magnetic resonance with contrast, being the most useful study. The gold standard for establishing a diagnosis of fungal infection is to obtain tissue for histological confirmation or culture; endoscopy is currently the ideal method for sampling. Medical management is the initial approach for most fungal infections of the spine. This usually involves a multidisciplinary approach with anti-fungal therapy under the supervision of infectious disease specialists and bracing with early mobilization, but there are clear indications for surgical treatment where mechanical stabilization by posterior approach and drainage and placement of structured autologous grafts anterior approach, in the same act or a second surgical stage.

Keywords: Spondylodiscitis; Fungal; Spine; Infections; Discitis; Immuno-deficient patient

Introduction

The spine infections that enclose ligamentous, discal and bony structures of the spine are known as spondylodiscitis, vertebral osteomyelitis or discitis. These are commonly caused by pyogenic infections, particularly by Staphylococcus aureus, currently responsible for 60% of them [1]. Non-pyogenic infections include Mycobacterium tuberculosis, disease known as Pott’s Syndrome [1,2]. Fungal infections have become more common as the number of patients with immuno-deficiency disorders has grown, given that this type of patients need antibiotic treatment to fight opportunistic bacterial infections, and this favors the growth of fungal flora [1]. Fungal infections have been reported in patients with acquired immuno-deficiency syndrome (AIDS), use of medication that lowers native immunological defenses and patients in critical care. For the most part, the main agent isolated has been Candida, on second place Aspergillus, and also Cryptococcus or Coccidioides [1-3]. Hemogenous spread is the most common path of infection. There are two theories supporting this; the venous theory and the arteriolar theory. Willey and Trueta [4] mention that the bacteria can conglomerate in the arteriolar network near the end plates. Batson [5] developed the venous theory, stating that retrograde flux of the pelvic venous plexus to the paravertebral plexus via veins from the meningoarachnoid complex can be given.

A fungal infection must be considered when the biopsies and cultures are negative and symptoms persist even after antibiotic therapy has been initiated [1,3].

Etiology

Fungal infections of the spine are uncommon. The frequently occur in immuno-suppressed hosts with mean age is 50 years old [1,3,6,7]. The incidence of fungal infections has risen markedly in recent years. Several factors have contributed to this increase; immuno-suppressive drugs, prolonged use of broad-spectrum antibiotics, widespread use of indwelling catheters, and AIDS [3,6,7]. Comorbid like diabetes, embolism or previous surgery are also relevant. After reaching bloodstream it reaches the vertebral body by the subcondral vascular heaves of the joint platforms, where it adheres given that the blood flow is slower [6,7].

Fungal infections of the spine are mainly caused by Candida and Aspergillus [1,8] for Candida organism to become pathogenic, the host must be immunocompromised [8]. Candida species are part of the normal flora and are commonly found on the skin and gastrointestinal tract [9]. Candida may gain access to the vascular system of susceptible patients via IV lines or monitoring devices and the implantation of prosthetic materials [8-10]. Candida spondylodiscitis should be considered in any patient with spinal symptoms and a history of candidemia, the infection shows symptoms usually weeks or months after the first candidemia episode [9-12]. Candida albicans It is the most common species found, however the infection by C. glabrata, is becoming more common, this may be secondary to the general trend of increasing Candida infections and widespread use of azole antifungals [13-16].

Aspergillus spondylodiscitis is due to Aspergillus fumigatus in 80% of cases followed by Aspergillus flavus, the organisms is pathogenic only in immuno-compromised host [8,17]. Aspergillus species are ubiquitous saprophytic fungi that produce numerous small spores. The small size of the spores allows for ready dispersion onto air currents from contaminated air-handling systems and deposition into human lung alveoli [1,8,17]. Patients with AIDS and chronic granulomatous disease, those on long-term antibiotics and IV drug abusers are especially at risk of developing the disseminated form [17-19]. Osseous involvement may occur by direct extension from the lung or by Hematogenous spread. The vertebral bodies are the most commonly infected sites by Aspergillus [18-21].

Other fungi are endemic and are limited to specific geographic areas; the two most common endemic fungi that give rise to spinal infections are Coccidioides immitis and Blastomyces dermatitidis [8,22,23].

Coccidioidomycosis is a fungal disease caused by Coccidioides

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of osseous involvement [29-31].

conidia, the long bones, vertebrae, and ribs are the most common sites

involve one or multiple sites [27,28].

The other endemic fungal infection is Blastomyces dermatitidis

is a dimorphic fungus endemic in areas bordering the Mississippi

Ohio rivers. Primary infection in humans occurs by inhalation of conidia, the long bones, vertebral, and ribs are the most common sites of osseous involvement [29-31].

Cryptococcus, Candida, and Aspergillus are found worldwide. Cryptococcus neoformans is found in the soil and in pigeon feces. The disease is the fourth most common infection in HIV-infected patients [32]. Cryptococcosis may be localized to the lung or generalized. Central nervous system involvement is common in the disseminated form [33]. Osseous involvement occurs in approximately 5% to 10% of patients [34,35].

In immuno-suppressed patients rare fungal infections may occur, Blastoschizomyces capitatus has been found in spondylodiscitis which is a normal human flora of the skin an GI track, it mimics candidiasis but with a fatal course [36,37]. Scedosporium prolificans with only 2 cases reported can cause disseminated disease on immuno-suppressed persons, resistant to antifungal therapy requiring extensive debridement for cure [38,39]. Trichosporon funigemia is a rare and fatal fungal infection that occurs in patients with prolonged neutropenia associated with hematologic malignancies. Individuals susceptible to this pathogen should be in constant evaluation because spondylodiscitis can manifest years after the infection has cure. Diagnosis can be difficult because no clinical or laboratory values suggest infectious process it can confuse with oncologic pathology, and make a therapeutic delay, so an open biopsy or closed needle aspiration should be consider [40-42]. (Table 1)

Clinical Presentation

A typical patient with fungal spondylodiscitis debuts as lower back pain or dorsal pain, with at least a month since initial onset. Insidious, progressive, intermittent pain that usually progresses to constant pain is a very common clinical manifestation of this disease [1,8,22,43]. Only a third of the patients present fever and approximately 20% present neurological symptoms and the most common presenting complaint is diffuse back pain [1,8,28,32,43,44]. Patient risk factors are usually related to an impaired immune system but may also be due to environmental factors [8,44]. Patients with a history of immune disorders, malignancies, corticosteroid use, receiving parenteral nutrition, diabetes, solid organ transplantation, IV drug use, and patients with prolonged IV access sites or previous surgery are at especially high risk [8,45]. A physical examination of a patient with a suspected fungal infection of the spine is mandatory. A baseline neurological examination documenting any sensory or motor deficits can be used to determine progression or resolution of the disease process.

Assessment of spinal balance, especially in the sagittal plane gives an idea of advanced infections, causing spinal deformity. Signs of recent significant weight loss and cutaneous sequelae of disease may also be suggestive of fungal infection. A detailed pulmonary exam is especially important with suspected Aspergillus infections but also with Coccidiodes and Cryptococcus [43,44,45,46].

Diagnosis

Diagnosis of fungal spinal infections is often delayed and late initiation of antifungal therapy may be associated with a worse outcome, particularly in terms of neurological recovery [1,8,47]. A rise in inflammatory such as with cell count, erythrocyte sedimentation rates, and C-reactive protein levels can alert the possibility of a spinal infection [48,49]. However, these are not specific for fungal infections. Antibody and antigen tests are seldom helpful in the diagnosis of spinal infections for Candida and Aspergillus [48].

Blood culture is very accessible but has low sensitivity (50-70%), this can be improved with centrifugation, and nevertheless only 51% of the patients mentioned in the reviews have blood culture results [6]. Biopsy of the lesion must be done for diagnostic confirmation. (1→3)-β-D-glucan (BDG) levels are useful with sensitivity and specificity reported up to 90% in patients with invasive candidiasis [49]. This test is positive in other fungal infections as aspergillosis and fusariosis, even though, high false positives rates have been reported. The detection of fungal nucleic acid via polymerase chain reaction (PCR) holds promise as a diagnostic tool. So far technology has demonstrated high sensitivity and specificity for detecting isolates of Candida and Aspergillus [48,50].

Diagnosing fungal spondylodiscitis is currently based in risk
factors, microbiology, blood tests, antigen detection/antibody testing and imaging. The gold standard to establish a fungal infection diagnosis is to obtain a tissue sample for histological or culture confirmation [51,52]. The sample can be obtained by computed tomography guided needle aspiration (CT FNAC), the procedure can be repeated in case negative cultures are reported. If negative cultures persist, biopsy should be considered [53].

Endoscopic biopsy can be performed, accompanied by a discectomy at the same time and drainage. It has been demonstrated that the best sample is obtained when computed tomography (CT)-guided fine needle aspiration cytology (FNAC), which is why this is the preferred choice nowadays. The culture obtained by biopsy permits differentiation of the microorganism causing the infection in more than half of the patients [8,28,50-53].

If the first sample results as a negative culture, a second sampling is indicated and current recommendations are to obtain a minimum of 6 samples of different parts of the lesion [51]. Open biopsy will eventually be discouraged. The samples must be sent for stains in search of mycobacteria, fungi and histological analysis to dismiss malignancy [51-53].

Histology

Biopsy and histopathology assessments are critical in the diagnosis of fungal infections. Accurate diagnosis is dependent on the skill of the pathologist and adequacy of organisms received in aspirates or tissue biopsies. It is important that microscopic appearances are correlated with microbiology findings, as well as other tests for specific host antibodies, fungal antigens, and fungal antibodies [54,55].

Image Studies

The imaging of fungal infection is fairly nonspecific and mimics either tuberculous or pyogenic infection. Plain x-rays can be useful, nevertheless, visible changes can only be viewed after a few months after infection has taken place, and does not help differ infection from bony destruction. Certain patterns do occur more commonly with certain fungal infections, paravertebral soft-tissue swelling with involvement of the posterior structures is more common in late Coccidioides infections [56,57]. With Blastomyces, collapse and gibbous deformity tend to be seen more commonly [8,58]. In Cryptococcus, lytic lesions within vertebral bodies can resemble those in coccidioidomycosis or the cystic form of tuberculosis with discrete margins and surrounding abscess formation [57-60]. In fungal infections of the spine, CT (Figure 1) and MRI (Figure 2) are effective in determining the extent of disease spread. In contrast to pyogenic infections, fungal infections often spare the disc. When the causative agent is Candida or Aspergillus, the infection is focused on the intervertebral body space, decreasing its height, causing destruction of the end plates and adjacent bone and the presence of paraspinal abscesses [32,44,59]. A hypo-intense image is seen in T2 as in short-tau inversion-recovery (STIR) (more sensitive than T2) in the bony marrow, suggesting the presence of underlying fibrosis due to the indolent infectious process, very different from pyogenic infections that are significantly more aggressive [59,60] (Figures 3 and 4) (Table 2).

There are no radiological findings that can help differentiate fungal infections (Candida and Aspergillus mainly) from other discitis. The positron emitting tomography with fluorine 18 fluorodeoxyglucose (FDG PET) shows promising results when Magnetic resonance imaging (MRI) has no clear signs [11,12,50,60] (Figure 5).

Figure 1: CT and MRI. Axial view of the spine with fungal infection.

Figure 2: CT and MRI. Sagittal view of the spine with fungal infection.

Figure 3: Sagittal and coronal views of the CT scan show the extent of bone fragmentation and sclerosis.

Figure 4: Magnetic resonance imaging of thoracic spine with contrast show involvement of T8, T9 vertebral bodies with associated pre-vertebral soft tissue inflammation.

Treatment

Antifungal treatment is the first choice of treatment in fungal
spondylodiscitis. Treatment guidelines establish that the primary regimen is the use of de amphotericin B for 2-3 weeks followed by fluconazole for 6-12 months [61]. Liposomal amphotericin B (AmBisome) is a lipid-associated formulation of the broad-spectrum polyene antifungal agent amphotericin B. It is active against clinically important yeasts and molds, including Candida spp., Aspergillus spp., Cryptococcus neoformans, and Trichosporon spp. [69]. It has been proven that combined treatment (surgical and medical) relieves pain quicker, allows histological diagnosis and stabilizes the spine [62,64,65,70].

Medical treatment failure, the onset of neurological deficit or progression of symptoms, particularly when imaging studies demonstrate the nervous compression, are clear indications for surgical treatment, having to realize debridement, decompression and stabilization [71-73] (Table 3).

Also, significant deformity can be considered a surgical indication. Surgical treatment is accepted when abscesses are damaging neurological structures. Early decompression maximizes functional recovery but after 48 hrs the prognosis is uncertain [73]. The goal of surgical treatment is to debride, sample, drain, decompress and stabilize the spine, which can be done in the same surgery or in a second look [73,74]. Therefore, laminectomy without stabilization is contraindicated, because progression to kyphosis is a certainty and could cause further damage to the neurological structures [72,73].

Until very recently, minimally invasive techniques had a primary indication in mild cases with little bony destruction. Currently, this technique can be used in more severe cases. Currently, open surgery is the gold standard [73-75].

Surgical approach depends on the dominant side of the infection. Anterior approach is the standard procedure for debridement of the vertebral body and stabilization. Although, given the instability in these cases, posterior initial approach is recommended for mechanical stability followed by anterior approach [75].

Autologous iliac crest graft or fibular bone graft are the ideal structural grafts, given that the rib graft has been proven insufficient unless is vascularized [76,77]. Tricortical graft is needed for two reasons: as a biological matrix and as structural support. This prevents the kyphosis postoperatively [73-78].

**Conclusions**

Fungal Spinal infections remain a rare pathology, although an increased incidence has been reported due to a progressively more susceptible population (particularly in patients with immunocompromised) and improved diagnostic acuity.

In an immuno-deficient patient with lumbar pain, progressive onset that has atypical changes in the spine imaging, negative cultures and has persistent symptoms despite of antibiotic treatment, fungal infection should be considered.

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**Table 2: Fungal Spondylodiscitis: Imaging findings.**

<table>
<thead>
<tr>
<th>Findings</th>
<th>Correlation</th>
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<tbody>
<tr>
<td>Disc space</td>
<td>T2 hyperintensity, enhancement, height loss</td>
</tr>
<tr>
<td>Vertebral body (VB)</td>
<td>Endplate destruction, T1 hypo, T2 hyperintensity, enhancement. Osteolysis/bone destruction/bone erosion</td>
</tr>
<tr>
<td>Paraspinal/epidural space involvement</td>
<td>Small paraspinal abscesses, ill-defined inflammation</td>
</tr>
<tr>
<td>Anterior sub-ligamentous spread</td>
<td>Common</td>
</tr>
<tr>
<td>Adjacent vertebral levels involvement</td>
<td>Uncommon</td>
</tr>
<tr>
<td>Multilevel involvement</td>
<td>Common (Coccidioidomycosis)</td>
</tr>
<tr>
<td>Deformity (Gibbous)</td>
<td>Mainly in Blastomycosis</td>
</tr>
</tbody>
</table>

**Table 3: Indications for surgical intervention in fungal spondylodiscitis.**

1. Medical treatment failure
2. Significant or progressive neurologic deficits
3. Large paraspinal abscess with local mass effect
4. Progressive deformity with or without incapacitating spinal pain

**Figure 5: Fungal spondylodiscitis management algorithm.**

Treatment of fungal spondylitis is often delayed because of difficulty with the diagnosis. Delay in the diagnosis led to poorer results in terms of neurologic recovery. Patients should be given a guarded prognosis and informed of the many possible complications of the disease.

The initial treatment should be medical, with antifungal drugs. The duration of treatment is important. Surgical treatment should be considered in patients with neurologic involvement, collapsed vertebrae, and persistent infection in spite of medical treatment. Questions remain whether instrumentation is necessary and safe in the surgical treatment of fungal infections of the spine.

Conflict of Interest

The authors, their immediate families, and any research foundation with which they are affiliated have not received any financial payments or other benefits from any commercial entity related to the subject of this article.

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References


