Case Report

Tuberculous retropharyngeal abscess presenting as severe dyspnea

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INTRODUCTION

Tuberculous retropharyngeal abscess is an exceptional condition.1 The symptomatology is non-specific, and diagnosis remains difficult.2 When misdiagnosed, it can lead to neurological or life-threatening complications.2,3 The authors report a new case of airway obstructive retropharyngeal abscess revealing cervical Pott disease.

CASE REPORT

A 59 years old man, smoker, presented with recent worsening dyspnea and stridor. He reported history of dysphagia evolving since four months associated with posterior neck pain, left upper limb paresthesia, asthenia and progressive weight loss.

Physical examination on admission found a thin patient with stage 3 dyspnea, stiff neck with hyperflexion (Figure 1). There was no motor nor sensory neurological deficit.

Flexible fiberoptic endoscopy revealed a bulging mass originating from the retropharyngeal space, overhanging the larynx and coming into contact with the epiglottis (Figure 2).
Biological assessment objectified an inflammatory syndrome. Human immunodeficiency virus (HIV) test was negative.

Computed tomography (CT) scan showed a large retropharyngeal abscess, measuring 50.5×45.9 mm. Spondylodiscitis lesions were associated with vertebral dislocation involving C4, C5 and C6 vertebrae (Figure 3 and 4).

Per-oral incision of the retropharyngeal mass was made and 30 cc of puss aspirated.

Direct bacteriological assessment after Ziehl Nelsen staining on samples demonstrated positive results. GeneXpert test using Polymerase chain reaction (PCR) technique detected Mycobacterium tuberculosis.

Diagnosis of cervical Pott disease was retained. Anti-tuberculosis chemotherapy was initiated and wearing of a rigid cervical collar prescribed.

Infectious course was favorable and the patient referred to neurosurgeons for management of his cervical vertebral dislocation.

DISCUSSION

Tuberculous spondylodiscitis, or Pott disease, was first described in 1782 by Sir Percivall Pott. Cervical spine localization is uncommon, representing 3 to 5% of vertebral locations in tuberculosis disease. Presence of a perilesional abscess is classic, spreading to soft paravertebral tissues as a cold abscess in the retropharyngeal space. However, airway obstructive retropharyngeal abscess is an exceptional and potentially life-threatening condition.

The clinical picture is nonspecific. Dysphagia, dysphonia, dyspnea, neck pain, torticollis, and spinal deformities can reveal the disease. Our patient was referred for severe dyspnea. Insidious to severe neurological deficit can be found, due to inflammatory irritation or cervico-medullary compression.

Tuberculosis infectious symptoms, as night fever or sweats, asthenia and weight loss, are not always present.

Lateral X-rays of the cervical spine can be a useful diagnostic tool by showing vertebral destruction. CT scan demonstrates retropharyngeal abscess, destructive bone lesions of cervical vertebrae and disc involvement. CT scan also precise spinal statics. MRI
shows retropharyngeal abscess and improves analysis of neurological lesions.\textsuperscript{5,9,10}

Bacteriological examination, Enzyme-linked immunosorbent assay (ELISA), and PCR confirm tuberculosis diagnosis.\textsuperscript{5,7,9} Testing for HIV co-infection should be systematic.\textsuperscript{2,7}

Cervical Pott disease management is based on medical medication. Anti-tubercular multidrug therapy for a sufficient duration is necessary.\textsuperscript{4,5,7,9}

Surgical drainage of the abscess removes upper aerodigestive tract and cord compression.\textsuperscript{4,5,9}

Immobilization by a cervical collar, external fixation or adjunctive surgery is necessary to prevent neurological complications.\textsuperscript{5} The neurosurgical approach is indicated in cases of neurological involvement or medical treatment failure.\textsuperscript{4,6,7}

**CONCLUSION**

Retropharyngeal abscess related to Pott disease is a very rare condition. Respiratory and neurological complications make it potentially dangerous. Adequate management requires perfect collaboration between anesthesiologists, ENT specialists, neurosurgeons and infectious disease specialists.

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