

노인재활

게시일시 및 장소 : 10 월 19 일(토) 08:30-12:30 Room G(3F)

질의응답 일시 및 장소 : 10 월 19 일(토) 11:00-11:30 Room G(3F)

P 3-139

Infective Spondylitis with Paraplegia Caused by Salmonella Typhi : A Case Report

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Spondylitis caused by typhoid fever is known to be an extremely rare in persons with normal immune systems. We report on a case of infective spondylitis caused by salmonella typhi infection contracted after traveling to Southeast Asia in a healthy adult. A 66-year-old woman visited our neurosurgery department for sustained back pain during 2 months. Otherwise from some degenerative changes, the initial simple films were negative. But on further follow up, simple films revealed suspicious findings of endplate erosions on T10-11 level (after 2 months from the first visit). Further inquiry revealed that the patient had travelled to Laos 4 months previously, and had gastroenteritis manifested by diarrhea and abdominal pain 7 days after returning to home. Magnetic Resonance Imaging and blood culture confirmed infective spondylitis caused by Salmonella Typhi. Even after 2 weeks of appropriate antibiotic treatment, motor weakness on both legs(Medical Research council scales; G1/G0) developed compelling a decompressive laminectomy on the T9-11 level. After surgical treatment, she was referred to the department of rehabilitation medicine for bedside physical and occupational therapy and transferred to the department of rehabilitation medicinefor comprehensive rehabilitation. When the patient was transferred to our department (after 3 months from operation), Medical Research council scalesof bilateral hip flexors were grade 2, those of bilateral knee extensors, ankle dorsiflexors, long toe extensors and ankle plantar flexors were grade 3. Nerve conduction study and electromyography was performed 5 months after the onset of paraplegia. In sensory nerve conduction study, bilateral sural nerves showed normal findings. In motor nerve conduction study, bilateral peroneal and tibial nerves showed decreased amplitudes. In Somatosensory evoked potential, bilateral median nerves showed normal findings, but bilateral tibial and pudendal nerves showed no response. Bulbocavernous reflex latency was within normal range. In electromyography, bilateral L4, L5, S1 paralumbar muscles showed abnormal spontaneous activities. And bilateral Gastronecmius,Tibialis Anterior, Gluteus Maximus, Peroneus longus, Rectus femoris, Tensor fascia lata, Vastus lateralis muscles showed abnormal spontaneous activities and decreased recruitment patterns. The result indicated thoracic myelopathy and bilateral lower lumbar & lumbosacral

radiculopathies (both L4-S1 main). After taking 6 months rehabilitation program for lower extremity weakness, she could walk a few meters with a low walker.