■ CASE REPORT

Lemierre's syndrome

AN UNUSUAL MANIFESTATION OF SPINAL INFECTION

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We report a case of Lemierre's syndrome complicated by an epidural abscess. This manifestation of Lemierre's syndrome has not been described previously.

Lemierre's syndrome is caused by an acute oropharyngeal infection with secondary septic thrombophlebitis of the internal jugular vein and frequent metastatic infections. There has been a resurgence in this rare condition in recent years but many clinicians remain unaware of it.¹

Case Report

A 43-year-old woman presented with a two-day history of neck and back pain and a one-day history of acute confusion with weakness in both legs. Three weeks earlier she received treatment from her general practitioner with a course of erythromycin for a sore throat, fever and swollen glands in the neck. She had other-

wise been healthy with no past medical history of note and no recent overseas travel.

On admission to hospital she was confused, agitated, febrile and tachycardic. There was decreased air entry to the lung bases bilaterally. Neurological examination of the patient revealed flaccid weakness in both lower limbs and diminished reflexes bilaterally. The upper limbs were normal and cranial nerve examination was unremarkable. There was a neutrophilia and an elevated C-reactive protein of nearly 400.

MRI scanning demonstrated a collection lying anterior to the spinal cord extending from C1 to T5, a posteriorly placed epidural collection extending from T3/4 to approxi-

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Fig. 1

MRI scan showing an epidural abscess extending from C1 to T5.

Fig. 2

MRI scan showing epidural collection extending from T11 to L3.

Fig. 3

CT scan showing bilateral lower lobe consolidation and effusions.

mately T5, and a further collection extending from T11 to L3 (Figs 1 and 2). The CT scan of the chest, abdomen and pelvis revealed bilateral lower lobe consolidation and pleural effusions (Fig. 3), and low-density areas within both psoas muscles consistent with small abscesses.

A T9 laminectomy was performed which exposed an epidural abscess from which 3 to 4 ml of pus was drained. The following day an anterior C3 foraminotomy was performed enabling the evacuation of pus from an epidural and intradural abscess. Enhanced cultures using the polymerase chain reaction grew *Fusobacterium necrophorum*. Treatment was commenced with fluconazole, metronidazole, and meropenem. Post-operatively, she retained power

in the upper limbs. There was initially no neurological improvement in the lower limbs. However, she made a slow recovery and one year later is able to walk without walking aids and has no splinter disturbance. There is a left foot-drop for which she wears an appropriate splint.

Discussion

Lemierre's syndrome is caused by the anaerobic bacterium, *F. necrophorum* and typically affects healthy teenagers and young adults. It was described by Lemierre in 1936 who published a series of 20 patients.² He described a group of "anaerobic postanginal septicaemias" with a characteristic pattern of septicaemia, thrombosis of the internal jugular vein and septic emboli which arose secondary to infections of the head and neck, particularly the oropharynx. In the preantibiotic era the condition was relatively common, however, with the widespread use of antibiotics the prevalence declined and it may now be overlooked.³

There has been a resurgence of reports since 1990, with recent data suggesting that the incidence is rising.⁴ However, lack of awareness of the condition may lead to a delay in establishing the diagnosis. To our knowledge this is the first reported case of Lemierre's syndrome involving the epidural space.

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