Minimally invasive endoscopic treatment for lumbar pyogenic spondylitis: a retrospective study in a tertiary referral center

Shih-Chieh Yang¹, Tsai-Sheng Fu², Hung-Shu Chen¹*, Yu-Hsien Kao¹, Shang-Won Yu¹, Yuan-Kun Tu¹

¹Department of Orthopaedic Surgery and Anesthesiology, E-Da Hospital, I-Shou University, Kaohsiung, Taiwan (ROC)
²Department of Orthopaedic Surgery, Chang Gung Memorial Hospital, Taoyuan, Taiwan (ROC)

*Corresponding author. Department of Orthopaedic Surgery and Anesthesiology, E-Da Hospital, I-Shou University, Kaohsiung, Taiwan (ROC)

Email addresses:

SCY: skyspine@gmail.com
TSF: fts111@adm.cgmh.org.tw
HSC: edaspine@gmail.com
YHK: ed102523@edah.org.tw
SWY: ed102270@edah.org.tw
YKT: ed100130@edah.org.tw
Abstract

Background

Spinal infections remain a challenge for clinicians because of their variable presentation and complicated course. Common management approaches include conservative administration of antibiotics or aggressive surgical debridement. The purpose of this study was to evaluate the efficacy of percutaneous endoscopic debridement with dilute betadine solution irrigation (PEDI) for treating patients with lumbar infectious spondylitis.

Methods

From January 2005 to July 2010, a total of 32 patients undergoing PEDI were retrospectively enrolled in this study. The surgical indications of the enrolled patients included single-level infectious spondylodiscitis, postoperative infectious spondylodiscitis, advanced infection with epidural abscess, psoas muscle abscess, pre-vertebral or para-vertebral abscess, multilevel infectious spondylitis, and recurrent infection after anterior debridement and fusion. Clinical outcomes were assessed by careful physical examination, Odom’s criteria, regular serologic testing, and imaging studies to determine whether continued antibiotics treatment or surgical intervention was required.

Results

Causative bacteria were identified in 28 (87.5%) of 32 biopsy specimens. Appropriate parenteral antibiotics for the predominant pathogen isolated from infected tissue biopsy cultures were prescribed to patients. Twenty-seven (84.4%) patients reported satisfactory relief of their back pain after PEDI. Twenty-six (81.3%)
patients recovered uneventfully after PEDI and sequential antibiotic therapy. No surgery-related major complications were found, except in 3 patients with transient paresthesia in the affected lumbar segment.

**Conclusions**

PEDI was successful in obtaining a bacteriologic diagnosis, relieving the patient’s symptoms, and assisting in the eradication of lumbar infectious spondylitis. This procedure could be an effective alternative for patients who have a poor response to conservative treatment before a major open surgery.

**Keywords:**

Betadine, Endoscopic debridement, Infectious spondylitis, Minimally invasive surgery.
Background

Spinal infections continue to be a considerable diagnostic and therapeutic challenge to clinicians because of their subtle presentation in the early stages. Medical imaging technology, laboratory tests, and a high degree of suspicion can help spinal surgeons make a correct diagnosis in a timely fashion to avoid severely debilitating complications [1-4]. Identifying the offending pathogen is critical to provide appropriate antibiotic therapy for medical treatment. Computer tomography-guided needle biopsy was previously recommended for isolating causative pathogens [5-7]. However, the aspirate often was inadequate and sometimes no organism was cultured. A delay in appropriate treatment for spinal infections can lead to structure instability, spinal deformity, sepsis, neurologic deficit, and even death.

Percutaneous endoscopic discectomy (PED) was first employed for treating uncomplicated herniated discs in the early 1980s [8]. Recently, numerous minimally invasive percutaneous endoscopic techniques for lumbar disc herniation and even spinal stenosis have been developed, with clinical outcomes comparable to those of conventional open surgery [9,10]. Some studies also reported that PED could be applied in the management of spinal infections [11-13]. Povidone-iodine (betadine) is a widely used antiseptic and disinfectant agent. It can eradicate most pathogens, including oxacillin resistant staphylococcus aureus, and no bacterial resistance has been reported [14-18]. Additionally, a lower concentration of 0.5% betadine has few cytotoxic effects [19,20]. The purpose of this study was to evaluate the diagnostic and therapeutic efficacy of percutaneous endoscopic debridement with dilute betadine solution irrigation (PEDI) in the treatment of patients with infectious spondylitis.
Methods

Patients

This study was approved by the Institutional Review Board of E-DA Hospital, a 1200-bed tertiary referral center (IRB number: EMPR-101-027). Thirty-two patients with infectious spondylitis underwent PEDI procedures between January 2005 and July 2010 at our institute. There were 9 women and 23 men with an average age of 57.4 years (range, 38-88 years). The patients’ medical records, including outpatient and emergency room notes, admission notes, inpatient progress and nursing notes, discharge summaries, procedure notes, surgical reports, radiology reports, pathology reports, and microbiology laboratory results were reviewed. The microbiology reports comprised microscopy and culture findings and any specific pathogens identified by either method. All of the patients presented with intractable back pain requiring narcotic pain control and bed rest. Infectious spondylitis was diagnosed on the basis of clinical examinations, including elevated erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) values, and radiographic and magnetic resonance imaging (MRI) findings.

The surgical indications of the 32 patients undergoing PEDI included single-level infectious spondylodiscitis, postoperative infectious spondylodiscitis, advanced infection with epidural abscess, psoas muscle abscess, pre-vertebral or para-vertebral abscess, multilevel infectious spondylitis, and recurrent infection after anterior debridement and fusion. Patients who sustained severe infection resulting in severe structural deformity or significant neurological deficit were excluded in this study.

Intervention

The patient was placed prone on a radiolucent frame suitable for fluoroscopy. All procedures were performed under local anesthesia with conscious sedation similar
to that used for standard lumbar discography. Under fluoroscopic guidance, the target site was located and the entry site was marked on the skin at a point 8–12 cm from the midline. After sterile preparation, draping, and local anesthesia, a spinal needle was inserted directly into the center of the target disc. A guide wire was introduced through the spinal needle into the central disc space, and the spinal needle was then withdrawn. After creating a small stab-wound incision (about 1 cm), a dilator and a cannulated sleeve were guided over the wire and progressed sequentially into the disc center. Fluoroscopy was repeated in 2 orthogonal planes to verify the correct position of the endoscope tip. The tissue dilator was then removed, and the cutting tool was inserted. The cutting tool, a cylindrical sleeve with a serrated edge at its distal end, was used to harvest a core of the biopsy specimen. Discectomy forceps were then inserted through the cannulated sleeve to extract additional tissue from the infected disc. Percutaneous debridement was conducted piecemeal by manipulating the biopsy forceps, flexible rongeurs, and shaver into different positions to withdraw as much tissue as possible under fluoroscopic monitoring. The same procedures were repeated on the other side. These 2 working sheaths were left on both sides for sufficient extirpation and extensive debridement of the infected intervertebral disc and even some endplate from different endoscopic direction.

After the biopsy and debridement procedures, at least 10,000 mL of dilute betadine solution was used for irrigation. Approximately 35 mL of povidone-iodine was diluted with 1,000 mL normal saline to achieve a 0.35% betadine solution for use during the operation. One portal was connected to a lavage fluid pump for the inflow and the other portal was connected to a suction bottle for the outflow, with continuous infusion (Fig. 1). The suction function is usually kept open from the beginning to the end of the procedure for further drainage of the lavage fluid and abscess. Finally, 2
drainage tubes were inserted into the debrided disc space and connected to a negative-pressure Hemovac. The biopsy specimen contained disc material and parts of vertebral endplates of adjacent vertebrae. Each biopsy specimen was examined for microorganisms and evaluated histopathologically.

**Outcome measures**

Clinical outcomes were assessed by careful physical examination, Odom’s criteria, regular serological tests, and imaging studies during admission, at 1 month after discharge and every 3 months to determine whether continued conservative treatment was sufficient or open surgical intervention was required.

**Results**

**Patients**

All 32 patients met the inclusion criteria, and their medical records were analyzed in this study. Table 1 presents a summary of these patients’ data, including age, sex, involved level, offending pathogens, and clinical outcome after PEDI. Fifteen patients with single-level infection, 4 with multilevel infection (3 with 2-level infection and 1 with 3-level infection), 5 with postoperative infection, 5 with paraspinal abscess, and 3 with epidural abscess were enrolled in this study. The most prominent clinical sign of infectious spondylitis was back pain, which was detected in all 32 patients before PEDI. One week after PEDI, 2 patients had excellent outcomes, 25 had good outcomes, 4 had fair outcomes, and 1 had a poor outcome according to Odom’s criteria. A total of 27 patients (84.4%) reported satisfactory relief of their back pain after PEDI. Of these 27 patients, 2 experienced recurrent intractable pain with progressive kyphotic deformity identified radiologically, and underwent surgical
treatment at 2 and 5 months after PEDI, respectively. Four of the remaining 5 patients who had persistent infection and severe back pain after PEDI underwent anterior debridement accompanied by autograft interbody fusion within 2 weeks after PEDI. Among these 4 patients, 1 had a single-level infection and the other 3 had advanced infection with multilevel involvement.

**Isolated pathogens**

Causative bacteria were isolated in 28 (87.5%) of 32 infected tissue biopsy cultures. Of these 28 patients, 2 patients had 2 different pathogens cultured. Seventeen patients were infected with staphylococcus aureus, 8 with the oxacillin resistant strain and 9 with the oxacillin sensitive strain. Three patients had haemophilus influenzae infection, 2 had streptococci viridans, 2 had pseudomonas aeruginosa, and the other 6 had prevotella species, mycobacterium tuberculosis, enterococcus faecalis, escherichia coli, klebsiella pneumoniae, and candida albicans infection, respectively. Systemic antibiotics and anti-tuberculous or anti-fungal chemotherapy were administered according to sensitivity studies for identified pathogens. There were no pathogens isolated from the other 4 patients (12.5%). Two of them had good outcomes after PEDI, but the other 2 had persistent back pain. Short-term broad-spectrum antibiotics were administrated after PEDI in these patients. Three of the 4 patients recovered uneventfully after treatment with broad-spectrum antibiotics. The other one underwent surgical intervention for intractable back pain and was proved to have staphylococcus aureus infection by open surgical biopsy.

**Clinical outcomes**

Overall, 6 of 32 patients underwent anterior debridement and fusion with autograft because of persistent severe back pain, failure to identify the pathogens, or
progressive infection. In addition to 2 patients with single-level infection, 1 with paraspinal abscess and the other 3 with multilevel infections were included. Extensive osteolytic destruction of the vertebral body with spinal instability or kyphotic deformity was observed in these 6 patients. Twenty-six patients responded to PEDI and were successfully treated with at least a 6-week course of parenteral antibiotics therapy or full-course antimicrobial chemotherapy (Figs. 2 and 3). The changes in serological values before and after PEDI are shown in Table 2. Elevated CRP values returned to reference ranges with a mean period of 4.2 weeks in these patients, whereas elevated ESR irregularly decreased to half of the original pretreatment values within a mean period of 3.4 weeks (Fig. 4). No recurrent infection was found among these patients during at least 24 months of follow-up (average, 38.5 months; range, 24-60 months). No surgery-related major complications were noted, except in 3 patients who complained of transient paresthesia in the affected lumbar segment.

Discussion

Conservative therapy with sensitive antibiotics and bracing is adequate for most patients with infectious spondylitis. A delay in diagnosis and treatment is common in all forms of spinal infection because of their early indolent course [1-4]. Rezai et al. reported that 25% of patients who were initially treated nonsurgically had unsuccessful medial therapy.4 Surgical intervention is typically reserved for patients with failed antibiotics therapy, intractable back pain, significant neurological deficit, large epidural abscesses, extensive vertebral body destruction, severe kyphotic deformity, or spinal instability [21-24]. However, major spinal surgery consisting of
anterior debridement and bone grafting with or without supplemental instrumentation is often related to undesired postoperative complications.

Several minimally invasive methods have been used to treat infectious spondylitis. Computed tomography-guided percutaneous catheter drainage has been approved as an efficient and safe procedure in the management of early-stage spondylodiscitis [25]. Haaker et al. treated 16 patients with spondylodiscitis by using percutaneous lumbar discectomy. They concluded that it is a useful and minimally invasive technique for the conservative treatment of lumbar discitis, although the causative pathogens could be identified in only 45% of the cases [26]. Percutaneous suction, aspiration, drainage, and continuous irrigation with local administration of antibiotics have also been found to be effective in patients with early-stage pyogenic spondylitis and even spinal infection accompanied by iliopsoas abscesses [27-30]. However, the continuous irrigation method restrained the patients to their beds and limited their postoperative ambulation and activities.

The minimal invasiveness and simplicity of PED have led the authors to apply it as a modality for treating patients with infectious spondylitis. Direct endoscopic observation makes possible the direct collection of sufficient amounts of samples from the infected region for microbiological examination. Eradication and debridement of the infected and necrotic tissue from a disc and even an epidural space can be achieved under endoscopic monitoring. During the irrigation procedure, the disc debris and turbid abscess can be washed out by dilute betadine solution through the suction sheath. Moreover, postoperative negative-pressure Hemovac drainage in larger-diameter can continuously suck out the pathogens from the infected area. A combination of effective debridement with dilute betadine solution irrigation and full-course specific antimicrobial therapy resulted in favorable outcomes in current study.
Povidone-iodine is a widely used antiseptic and disinfectant agent. It can eradicate most pathogens, including oxacillin resistant staphylococcus aureus, and no bacterial resistance has been reported [14-18]. In an experimental research, Kaysinger et al. found that the inhibitory effect of betadine on embryo chick tibia and osteoblast cells is significant at concentrations of 5% betadine or higher [19]. In contrast, few cytotoxic effects were observed at a lower concentration (0.5% betadine). Goldenheim reported that 1%, 5%, or 10% povidone-iodine preparations do not have a deleterious effect on wound healing in animals and humans [20]. In a clinical study [31], spinal surgical wounds were soaked with dilute betadine solution before wound closure, and outcomes were compared with those of irrigation with normal saline. A 10% povidone-iodine solution was diluted to achieve a concentration of 3.5% betadine, possessing maximal bactericidal activity and minimal cytotoxicity. No wound infection occurred in patients who received betadine irrigation during the follow-up period.

Twenty-six patients with infectious spondylitis were successfully treated with PEDI in this series. This minimally invasive technique produces less morbidity than open surgery and provides effective relief to the patient’s back pain by reducing the intradiscal pressure and preserving adequate stability. These patients could ambulate with brace protection as early as possible after PEDI. Patients who sustained epidural or paraspinal abscesses could also be treated by this method and avoid having to undergo open anterior or posterior decompression surgery. A connection generally exists between these abscesses and the infected disc, which is the actual origin of spinal infection. After aggressive debridement of the infected disc and neighboring vertebral endplates, a cavity was created and even the sticky abscesses could be washed out by pressurized irrigation with betadine solution. With postoperative
negative-pressure Hemovac suction, the pathogens in the infected tissue can be removed continually.

Six patients eventually underwent open surgery for poorly controlled infections and considerable mechanical back pain caused by progressive destruction. Three of 4 patients with multilevel infections who experience medical therapy failure received open anterior debridement and autograft interbody fusion with supplemental posterior fixation. Only 1 elderly patient with 2-level infections responded to PEDI. However, this patient still complained of mild back soreness with progressive kyphotic deformity. Therefore, the effectiveness of this procedure for extensive destruction of vertebral bodies and multilevel infections may be limited, from the viewpoint of either surgical technique or clinical prognosis.

This study has several limitations. First, we examined only 32 cases. Second, the retrospective nature of this study does not allow including patients undergoing different treatment methods for comparison, as well as lacks randomization because of ethical and legal considerations. The feasibility and benefits of PEDI for infectious spondylitis need to be rigorously evaluated in a large patient population with prospectively controlled comparison groups. Third, the enrolled patients had different kinds of spinal infections, such as early-stage infection or advanced infection, single-level infectious spondylodiscitis or multilevel infections, and spinal infection with or without epidural or paraspinal abscess. Thus, careful classification of patients through meticulous clinical examination and comprehensive image studies can further evaluate the efficacy and indications of this procedure in different stages and severities of spinal infection.
Conclusions

On the basis of the findings obtained from this study, we propose that PEDI is an effective alternative to extensive open surgery for the treatment of single-level infectious spondylodiscitis or even complicated infection with epidural or paraspinal abscesses. It is successful in obtaining a bacteriologic diagnosis, relieving the patient’s symptoms, and assisting in the eradication of lumbar infectious spondylitis. Extensive anterior or posterior surgery is not always necessary in these cases. Additionally, the clinical course can be repeatedly evaluated and the treatment strategy can be modified accordingly after the PEDI procedure.

Abbreviations

CRP: C-reactive protein; ESR: Elevated erythrocyte sedimentation rate; MRI: Magnetic resonance imaging; PED: Percutaneous endoscopic discectomy; PEDI: Percutaneous endoscopic debridement with dilute betadine solution irrigation.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

SCY wrote the original manuscript, helped in the data analysis, and contributed to the interpretation and presentation of the data. TSF was responsible for the analysis and the interpretation of the data and contributed to all parts of the work of this study. HSC co-coordinated the study design, carried out the literature search, data analysis
and drafting of the manuscript. YHK and SWY were responsible for the data acquisition, helped in the analysis and the interpretation of the data. YKT provided expert clinic advice in the field, design and structure and critically revised the manuscript. All authors read and approved the final manuscript.

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References


**Figures**

**Figure 1 - PEDI procedure.**

Two portal working sheaths were used for percutaneous endoscopic debridement followed by dilute betadine solution irrigation (PEDI) for treating patients with lumbar infectious spondylitis (A). A negative-pressure Hemovac with 2 drainage tubes was inserted through the sheaths for further continuous drainage of the offending pathogens (B).

**Figure 2 - Epidural abscess treated by PEDI.**

L4-5 infectious spondylitis was diagnosed in a male patient. Sagittal T1- and T2-weighted and contrast magnetic resonance imaging (MRI) showed L4-5 epidural abscess with compression of neural elements (A). After PEDI treatment, sagittal T2-weighted MRI at 6 months follow-up demonstrated the disappearance of the abscess (B). Lateral computed tomograph revealed L4-5 disc space narrowing leading to spontaneous fusion (C).

**Figure 3 - Presacral abscess treated by PEDI.**

L5-S1 infectious spondylitis was diagnosed in a male patient. The lateral radiograph showed L5-S1 superior endplate erosion (A). Sagittal T2-weighted MRI demonstrated presacral abscess (B). Postoperative sagittal T2-weighted MRI revealed the abscess
was eradicated by PEDI (C). Postoperative lateral radiograph showed L5-S1 disc space collapse leading to spontaneous fusion (D).

**Figure 4 - ESR and CRP changed by PEDI.**

Percentage changes in serological values, before and after PEDI, in successfully treated patients.

### Tables

**Table 1 - Patients characteristics and outcomes.** *(Additional files 1)*

Patients’ Demographic Data and Clinical Outcomes.

**Table 2 - Changes of ESR and CRP before and after PEDI.** *(Additional files 2)*

Periods of Highest Preoperative Erythrocyte Sedimentation Rate (ESR) and C-reactive Protein (CRP), and Time to Return to Normal Value in 26 Patients Successfully Treated by Percutaneous Endoscopic Debridement with Dilute Betadine Solution Irrigation.
Additional files provided with this submission:

Additional file 1: table 1.doc, 55K
http://www.biomedcentral.com/imedia/6874999081073961/supp1.doc
Additional file 2: table 2.doc, 53K
http://www.biomedcentral.com/imedia/1048590233103698/supp2.doc