Persistent back pain in a young woman

A 24-year-old woman from northern India came to our medical center because of lower back pain for the past 2 years. The pain was initially a dull, continuous ache and did not radiate. She had no fever, night sweats, weight loss, or other constitutional symptoms.

In addition, she had seen her local practitioner 1 year earlier because of burning during urination and occasional frequency. She had been found to have an 8-mm calculus in the lower calyx of the left kidney, for which she underwent two sessions of shock-wave lithotripsy, but she did not pass any stone fragments. Because her back pain continued, she sought medical treatment at our center.

On evaluation at our facility, she was found to have paraspinal muscle spasm and scoliosis. Her gait was antalgic. Sensations were normal over both lower limbs in all dermatomes. Power was grade 5 throughout, and deep tendon reflexes were normal. The straight-leg-raising test was positive for reproducible pain in the lower back and sciatic pain radiating down the back of both legs.

Laboratory testing showed that her hemoglobin was low at 9.7 g/dL (reference range 11.5–15.5), but the rest of the complete blood count was within normal limits. C-reactive protein was elevated at 70.7 mg/L (reference range < 6 mg/L). An enzyme-linked immunosorbent assay was negative for human immunodeficiency virus (HIV).

Nonenhanced computed tomography of the abdomen revealed destruction of vertebral body end plates and disks from the L2 lower end plate to the L5 superior end plate. The left transverse processes of the L3, L4, and L5 vertebral bodies were also destroyed. The scan also revealed bilateral psoas abscesses larger than 10 by 10 cm (FIGURE 1), with the right side larger than the left, and confirmed a stone in the left lower renal calyx (FIGURE 2).

She underwent bilateral ultrasonographically guided drainage of the abscesses. Culture of the thick pus that was aspirated grew Mycobacterium tuberculosis. Tu-

FIGURE 1. Noncontrast computed tomography shows bilateral large psoas abscesses (red arrows) and destruction of the vertebral plate.

FIGURE 2. A coronal reconstructed tomographic image shows involvement of multiple vertebral bodies (red arrows), as well as an 8-mm calculus in the lower left renal calyx (yellow arrow).
Spinal tuberculosis was started with isoniazid, rifampicin, pyrazinamide, and ethambutol. Her condition improved rapidly over the next 2 to 3 months. She completed 18 months of tuberculosis therapy.

Because her spine was stable, with no collapse of vertebrae, she did not require orthopedic intervention.

**REFERENCES**


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