Wegener's Granulomatosis Mimicking a Thoracic Spondylodiscitis

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A 40-year-old man with a noninformative medical history presented to the emergency department with thoracic back pain, night sweats, and low-grade fever of 1 month duration. Examination was unremarkable, but laboratory findings showed nonspecific elevation of acute phase reactants (fibrinogen and C-reactive protein). Plain chest radiograph (not

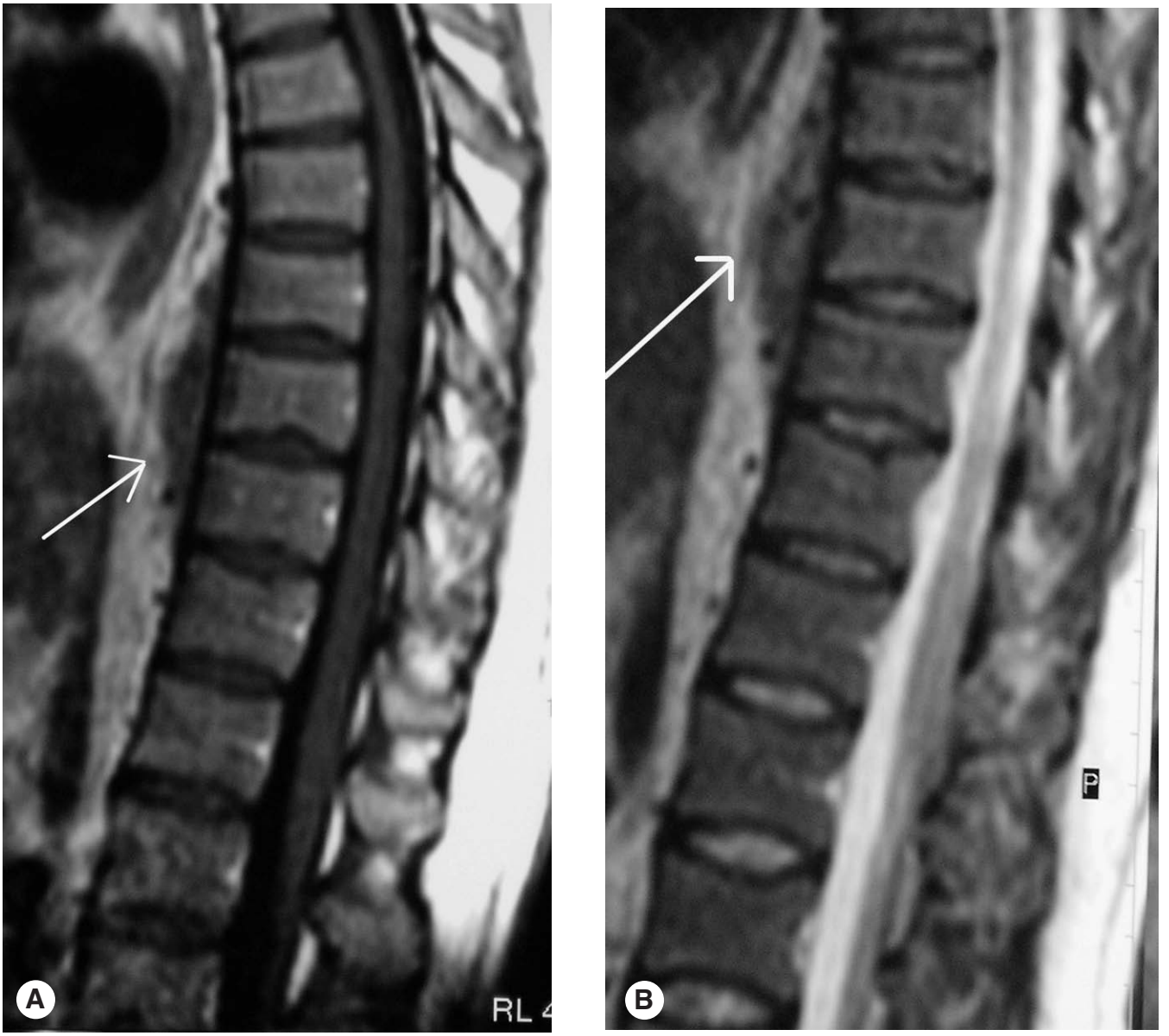

Figure 1. Sagittal T1 (A) and T2 weighted (B) MR images of the thoracic spine show a fusiform soft-tissue prevertebral mass (arrow) extending from the level of T8 to T10.

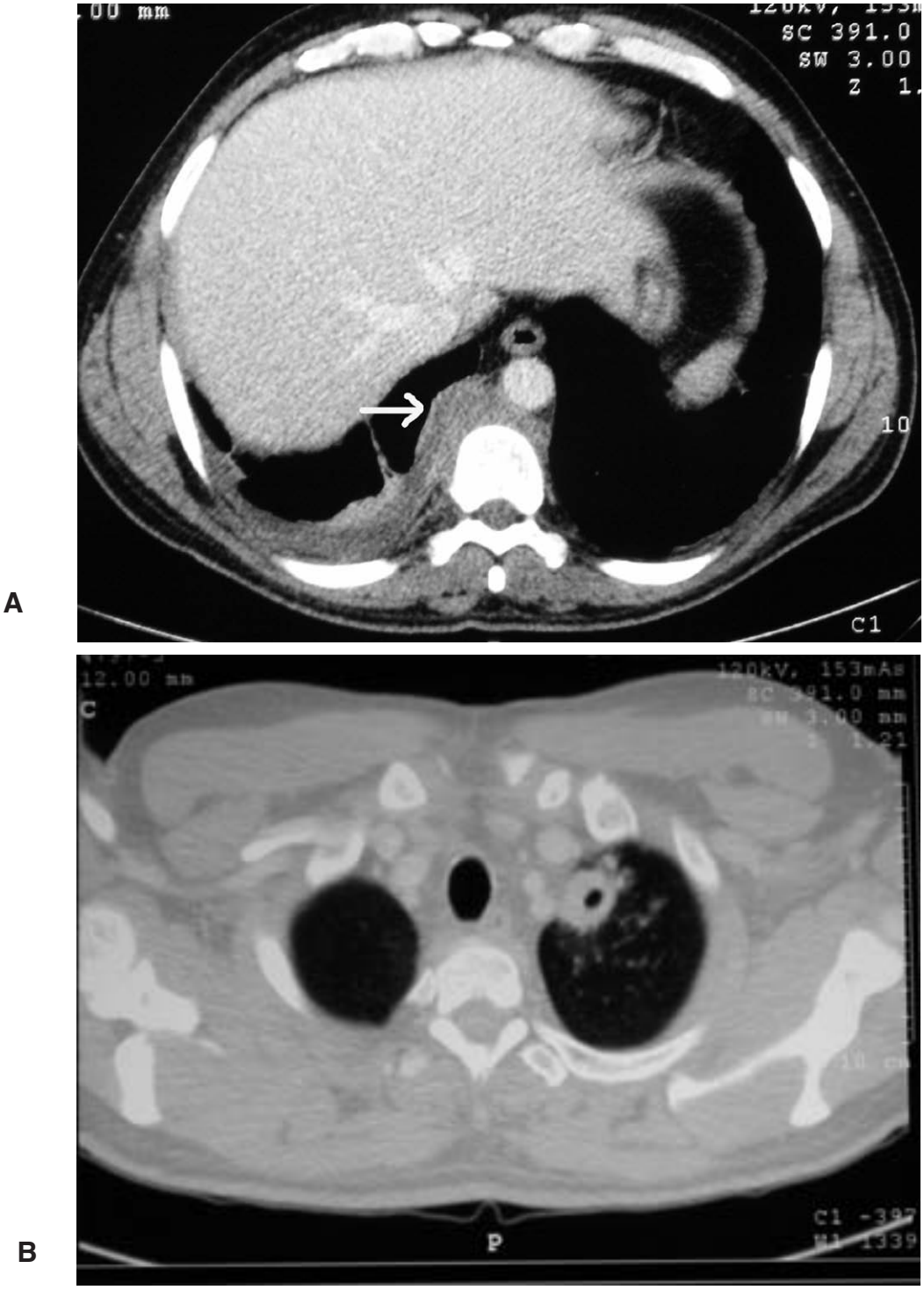

Figure 2. Axial thoracic CT image at the level of T9 (A) shows a small right pleural effusion and the prevertebral soft-tissue mass (arrow) wrapping the anterior aspect of the T9 vertebra and displacing anteriorly the descending thoracic aorta. Axial thoracic CT image (lung window) at the level of the pulmonary apex (B) shows a cavitary lung nodule in the left upper lobe.

shown) revealed a subtle widening of the lower left paravertebral line. A presumptive clinical diagnosis of thoracic spondylodiscitis was elicited, and he was admitted for further examinations. Thoracic spine magnetic resonance imaging (MRI) revealed a fusiform prevertebral soft-tissue mass extending from T8 to T10 (Figure 1); however, the morphology and sig-

nal intensity of the vertebral bodies and intervertebral disks were within normal limits, thus excluding the diagnosis of vertebral osteomyelitis or spondylodiscitis. Five days after admission, he developed cough, facial tenderness, and rapidly progressing renal insufficiency. Thoracic computed tomography (CT) scan showed the prevertebral soft-tissue mass, a small right pleural effusion, and multiple scattered small cavitary lung nodules (Figure 2). Both serum antineutrophil cytoplasmic antibodies and antibodies to proteinase-3 were positive, and he was then diagnosed as having Wegener's granulomatosis. Standard treatment with cyclophosphamide and glucocorticoids resulted in marked improvement, and he was in complete remission (no evidence of prevertebral mass on followup MRI) 6 months after initiation of therapy.

The presentation of Wegener's granulomatosis as a prevertebral mass mimicking infectious spondylodiscitis is extremely rare, but it should be recognized when associated with more common signs and symptoms of the disease, as early specific treatment is essential for a favorable outcome.

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