ABSTRACT

It is a concise review of retropharyngeal abscess, we report a case of long and torpid evolution with multiple subtreatments that masked the symptoms for a long time, increasing the risk of provoking severe morbidity and complications.

INTRODUCTION

Retropharyngeal abscess is defined by the infection between the posterior pharyngeal wall and the prevertebral fascia, it is an uncommon condition, most common in children by extension of oropharyngeal infections, in adults is caused by trauma after ingestion of foreign bodies that damage the esophagus or the trachea, tracheal intubation and less frequently untimely tooth infections. Many studies have shown that most of these abscesses are polymicrobial type and dominant organisms in order of frequency: streptococcus, staphylococcus and anaerobes. Some less common causes, such as tuberculosis, syphilis and vertebral fractures. Patients may present fever, sore throat, dysphagia, dysphonia, drooling, neck stiffness and sepsis. The inspection can be a bulge in the posterior pharyngeal wall. The lateral neck radiograph is often sufficient to make the diagnosis. Typically an extension of the prevertebral soft tissue in this area is seen in adults at the level of C2: C6 7 mm and 22 mm. Others radiological signs that can be seen are the loss of the normal lordosis of the cervical spine, presence of air or foreign body in soft tissue. CT is useful for diagnosis of early-stage infections while allows differentiation between cellulitis and abscess, is also useful in defining the vascular structures and their relationship to the infectious process defines exactly like that space or spaces are involve. MRI has a higher resolution than CT and is able to evaluate the retropharyngeal space with a series of sequences, including diffusion. But this test is not used routinely for the diagnosis of this condition, but has specific indications, especially when complications suspicion.

This picture hardly spontaneously resolves being potentially lethal therefore requires intravenous antibiotics and sometimes surgery drainage. The complications are potentially dangerous and include paravertebral posterior extension (osteomyelitis, discitis, epidural abscess) lateral extension involving the carotid and jugular vein, anterior compression, compromising the airway, lower extension to the mediastinum and mediastinitis resulting in systemic dissemination sepsis.
Material and Methods:

- Female, 54 years old, male, transferred from Hospital Dr. Gustavo Dominguez (Santo Domingo de los Tsáchilas), who has 18 days: severe neck pain, dysphagia, odynophagia, temperature rise and paresthesias in all four limbs, progressing to quadriplegia.

Images

Figure 1, contrasted CT Cervical (axial C3 - C4 - C5): Displayed space occupying lesion, hypodense with gas in the interior and peripheral enhancement, located at the rear of hypopharynx whose diameter is approx AP . 2.5 cm. Moves laterally vascular structures.

Fig 2, RM cervical spine (Sagittal T2): A Danger level space displayed space occupying lesion, complex liquid content, fusiform, extending from C1 to C6, with a larger diameter approx. 12 cm. The spinal cord shows diffuse thickening and increased signal relative to the level inflammatory process from C3 to C4 C6. En - C5 discopathy displayed regressive, with increased signal relative to discitis.
Fig 3, cervical spine MRI (Sagittal T1): The objective of the signal change normal bone marrow in the bodies of C4, C5 and C6 intrasubstance regarding edema.

Fig 4, cervical spine MRI (Sagittal STIR): In the fat suppression sequence corroborates the trabecular edema in C4, C5 and C6 and the inflammatory process at the level of the spinal cord.

Fig 5, cervical spine MRI (sagittal T1 Gadolinium): After administration of paramagnetic contrast enhancement exists in the vertebral bodies C4, C5 and C6. Meningeal enhancement is also observed in the anterior aspect of the dural sac from C2 to C6 level. It objective fusiform extradural lesion extending from C2 to C4 corresponding to epidural abscess.

Fig 6, brain MRI (T2 - Axial): Displayed increased signal level left and right cerebellar hemisphere and bilateral occipital.
RESULTS

Displays space-occupying lesion, hypodense with gas in the interior and peripheral enhancement, located at the back of the hypopharynx AP diameter is approx. 2.5 cm. Displaces laterally vascular structures (Fig. 1). A space Danger level displays space-occupying lesion of complex liquid content, fusiform, extending from C1 to C6, with a larger diameter approx. 12 cm. (Fig. 2). The findings are consistent with retropharyngeal abscess. The spinal cord has diffuse thickening and increased signal relative to the level inflammatory process from C3 to C6. C4-C5 regressive discopathy displayed with increased signal relative to discitis (Fig. 2).

It signal change objective normal bone marrow bodies C4, C5 and C6 in relation intrasubstance edema (Fig. 3).

In the fat suppression sequence confirms the trabecular edema C4, C5 and C6 and the inflammatory process of the spinal cord level (Fig. 4).

After administration of paramagnetic contrast enhancement exists in the vertebral bodies C4, C5 and C6. Meningeal enhancement is also observed in the anterior aspect of the dural sac from C2 to C6 level. It objective fusiform extradural lesion extending from C2 to C4 corresponding to epidural abscess (Fig. 5).

Displayed increased signal level left and right cerebellar hemisphere and bilateral occipital cortical level (Fig. 6). With

DISCUSSION

Optimal management retropharyngeal abscess has been subject to debate for over a century, major advances in modern imaging techniques, has made possible the diagnosis of this infection in its early stages and more exact location coupled with the widespread use of antibiotics have mortality changed infeccioso inherent in this process.10

The lateral neck radiograph and cervical CT is more accurate diagnostic tests for the detection of this pathology. The TAC has limitations when it comes to differentiating between cellulitis and abscess but has a high sensitivity to confirm proximal esophageal rupture and presence of abscess. The lateral neck radiograph is the most specific test (with a reported sensitivity of 80%), as evidenced by increased retropharyngeal space and the presence of gas prevertebral.3 Suspecting the presence of a foreign body and if any of the above tests detect the presence of it in the neck, you should perform a thorough exploration 11, using other techniques such
as upper endoscopy. Several authors cite the TAC with Gallium-67 as a diagnostic method with high sensitivity to detect this condition and subsequent seguimiento12. MRI has a higher resolution than CT and is able to evaluate the retropharyngeal space with a series of sequences, including diffusion. But this test is not used routinely for the diagnosis of this condition, but has specific indications, especially when complications suspicion.

In our case, the patient for 18 days receive ineffective treatments, table masking and delaying the diagnosis, reaching a rare but lethal complications associated with epidural abscess and subsequent mieltitis occipital and cerebellar infarction probably related to septic thrombi.

CONCLUSION

In conclusion, like many authors, we need the immediate realization of a lateral radiograph or CT of the neck and antibiotic prophylaxis in all patients with suspected retropharyngeal abscess box, since the mechanism of production, potential complications and lethality of this pathology.

REFERENCES


