Spinal Infection Guidelines

Suspected Spinal Infection *
Discitis / Osteomyelitis / Epidural Abscess / Pyomyositis

* See Notes point 5 for suspected post operative spinal surgery infections

Baseline Bloods and Inflammatory Markers
Minimum 2 x Blood Cultures (from separate sites)
X-Ray Spine (erect sitting / standing if able)
Culture Urine +/- Sputum or other

Septic and / or Neurological Deficit

⊕ Emergency MRI

⊖ MRI < 2/7

Confirms Diagnosis of Spinal Infection

Emergency MRI →

1. Discuss with Spinal Team ASAP
2. ? Transfer for (urgent) surgery
3. Discuss with Microbiology and start empirical antibiotics until surgical samples cultured
4. If non surgical management then as per right

MRI < 2/7 →

Abscess / Collection
Deformity / Destruction
Pyomyositis
(→ as per left)

Uncomplicated
Discitis /
Osteomyelitis
(→ below)

1. Inform Spinal Team
2. Consider biopsy in ALL cases when patient stable:
   - Consider and arrange ***early*** biopsy if: adequate radiological target, or no obvious primary source, or lumbar discitis (risk of gram negative infection), or broad differential (immunocompromised, healthcare associated infection)
3. Routine cultures positive ***then*** start appropriate antibiotics
4. Routine cultures negative then biopsy required
5. Consider brace for duration of treatment

NOTES:

1. Antibiotics for a minimum of 6 weeks as directed by Microbiology (combined therapy often appropriate), consider early peripheral IV long line, IV to oral conversion guided by clinical status, inflammatory markers and Trust IV-oral switch policy. Stop when CRP normal and patient well then recheck bloods 2 weeks later.
2. Erect X-Ray Spine (in brace) to check for progressive deformity at intervals as advised by Spinal Team.
3. Interval MRI if deteriorates, develops neurological deficit or no improvement.
4. Echo if: Staph aureus bacteraemia present in the absence of an identifiable source, or multiple positive blood cultures with organism that causes endocarditis (alpha haemolytic streptococci, enterococci), or signs consistent with endocarditis (new murmur, peripheral stigmata of endocarditis, multiple sites of infection), or significant risk factor for endocarditis (previous valve surgery, IVDU, immunocompromised). Consider if patient fails to respond to treatment, has recurrent infection, is diabetic or alcoholic.
5. The pathway for post operative spinal surgery infections (+/- metalwork) will vary and ALL cases must be discussed with the Spinal Team ASAP