Use of a Percutaneous Diskectomy Device to Facilitate the Diagnosis of Infectious Spondylitis

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SUMMARY: For evaluation of suspected infectious spondylitis, 19 consecutive patients underwent imaging-guided spine biopsy with needle aspiration and a percutaneous diskectomy device to determine if the diskectomy device provided diagnostic value. In 79% of cases, the diskectomy device yielded a specimen when needle aspiration failed. A significantly greater yield of specimen was observed with the diskectomy device, and >50% of cases with failed needle aspiration had biopsies positive for infection.

Technique

Nineteen patients underwent imaging-guided percutaneous spine biopsy during their clinical evaluation for suspected infectious spondylitis. Eleven patients were men, and 8 were women. All patients were adults with a mean age of 72 years. Patients were referred for biopsy after clinical and MR imaging findings resulted in a working diagnosis of spine infection. Four patients had undergone prior open spine surgery and 1 had a recent appendectomy. No procedures were performed by an experienced interventional neuroradiologist using coaxial technique, local lidocaine anesthetic at the puncture site, and either intravenous sedative/analgesic or intravenous anesthetic. A posterior, lateral, and extradural approach was used to access the disk. An initial aspiration attempt was made by using a 20-gauge spinal needle. The 20-gauge spinal needle was exchanged over a 22-gauge removable hub needle for a 12-gauge bone biopsy needle. A bone biopsy of the vertebral endplate was also obtained with the bone biopsy needle. All specimens were submitted for microbiologic and pathologic analysis. Patients were monitored in a recovery area postprocedure before leaving the department.

Results

In 15 of the 19 patients, the diskectomy device yielded a specimen when needle aspiration (20 or 17 gauge) did not. In 3 of 4 patients in whom needle aspiration yielded a specimen, the biopsy was positive for infection. Not 1 single needle aspiration yielded disk tissue. Furthermore, not 1 single endplate biopsy yielded disk material as noted in the pathology report. In comparison, all 19 percutaneous diskectomy procedures yielded disk specimens in adequate amounts for both microbiologic and pathologic analysis. A significantly greater yield of specimen was observed (minimum, 3 mL of tissue fragments and fluid) in all 19 patients compared with <1 mL of fluid in 3 of 4 patients with needle aspiration (Table). In 8 of 15 patients with failed needle aspiration, the percutaneous diskectomy device yielded specimens positive for infection. Of the 11 patients who had biopsies that were positive for infection, 4 patients were already on empiric intravenous antibiotics. Of the 8 patients with no microbial growth on biopsy, 3 were already receiving empiric intravenous antibiotics. Histopathologic analysis of bone and disk tissue confirmed the presence of inflammation in 2 endplate biopsies and 2 disk biopsies, respectively. In all, 4 patients had undergone recent open spine surgery and 1 had a recent appendectomy. No technical failures with the diskectomy device and no procedure-related complications were observed.

Discussion

Use of a percutaneous diskectomy probe provides a valuable adjunct to needle aspiration in the biopsy of suspected diskitis because it increases the probability of obtaining infected disk material without any major modification to the technique or approach. The initial experiences with this technology reported the use of aspiration biopsy with a nucleotome. For cep nucleotomy, percutaneous endoscopic diskectomy, and flexible biopsy forceps with antibiotic irrigation have also been reported with varying success.

The percutaneous diskectomy device in our study is used in the treatment of patients with low back pain and sciatica who...
have a nonextruded disk and have failed conservative management. The utility of this device for the removal of disk material has been previously demonstrated. This system has certain advantages compared with the previously reported devices. First, its 13- or 17-gauge size is optimal for a percutaneous application and is well-tolerated by patients. The device is compact and handheld; this feature facilitates quick and ready coaxial deployment by the operator. It is disposable and is made for single-patient use. It is simple to use, and the learning curve for operators who perform spinal procedures, such as biopsies or diskography, is immediate. It can be easily monitored by using fluoroscopic guidance.

In our series, additional use of the percutaneous diskectomy device after needle aspiration did not measurably lengthen the procedure time, change the sedation protocol, or increase patient recovery time. Use of the percutaneous diskectomy device did reliably obtain a satisfactory amount of disk tissue for both microbiologic and histopathologic analysis. This facilitated the diagnostic work-up and directly altered disk tissue for both microbiologic and histopathologic analysis. The utility of this device for the removal of disk material increases the cost of the spine biopsy. By using the device in cases of failed aspiration, an increased specimen yield increases the probability of obtaining an organism-specific diagnosis. This minimizes the use and cost of long-term broad-spectrum antibiotics. Furthermore, increasing specimen yield can decrease cases of delayed or no diagnosis and can decrease the hospital length of stay. With the evolution of new percutaneous techniques, local treatment approaches at the disk space level can potentially be developed that may further improve outcomes in this patient population.

Our study was limited in that there was a small patient sample size; nevertheless, the basic finding of improved specimen yield in cases of failed aspiration remains. Another inherent limitation to our study was that 7 of our 19 patients were receiving antibiotics before the biopsy. It is possible that more positive cultures would have resulted if empiric therapy had not been initiated. The use of automated percutaneous diskectomy devices for a biopsy of suspected spine infection can decrease cases of delayed or no diagnosis and can decrease the hospital length of stay. With the evolution of new percutaneous techniques, local treatment approaches at the disk space level can potentially be developed that may further improve outcomes in this patient population.

References

Specimen yield and biopsy-outcome comparison without and with the diskectomy device

<table>
<thead>
<tr>
<th>Specimen</th>
<th>Average Specimen Volume (mL)</th>
<th>Positive Biopsy</th>
<th>Complication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needle aspiration</td>
<td>4/19 (21%)</td>
<td>3/19 (16%)</td>
<td>0</td>
</tr>
<tr>
<td>Percutaneous diskectomy</td>
<td>19/19 (100%)</td>
<td>11/19 (58%)</td>
<td>0</td>
</tr>
</tbody>
</table>

Fig 1. Photograph of the percutaneous diskectomy device with its collection chamber and probe. The arrow indicates the depth gauge of the guide needle.

Fig 2. A close-up photograph of the handheld device shows purulent material (arrow) in the collection chamber in this patient with biopsy-proved Enterococcus infection.