



Brain Abscess, Cavernous Sinus Thrombosis, Subdural Empyema and Epidural Abscess

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Disclosures of Financial Relationships with Relevant Commercial Interests

- List of disclosures or “None”

Question #1

- 24-year-old female who presented with pain and swelling on the right side of her jaw that had been progressing over the last several weeks. She was unable to open her mouth. She denied fever or headache and had no past hospitalizations or illnesses. The patient had not been to the dentist within 10 years.
- T 99.8°F, P 88, RR 14, BP 110/80
- Exam revealed swelling and erythema along her right mandible



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Speaker: Allan Tunkel, MD, PhD



Question #1

Which of the following empiric antimicrobial regimens should be initiated?

- A. Ceftriaxone + metronidazole
- B. Vancomycin + cefepime
- C. Trimethoprim-sulfamethoxazole
- D. Voriconazole
- E. Liposomal amphotericin B

Predisposing Conditions for Brain Abscess

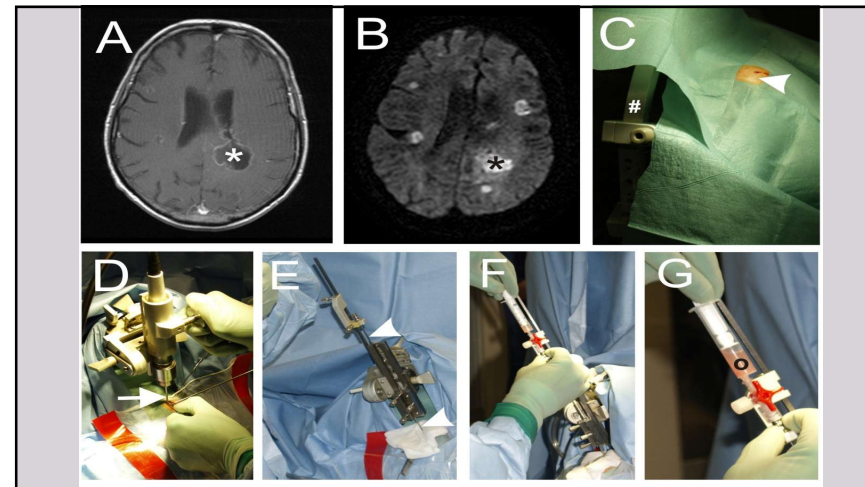
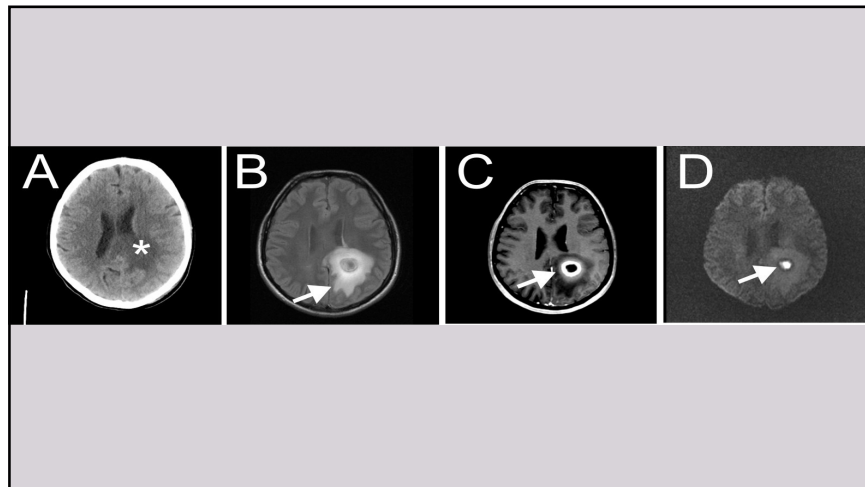
Condition	Relative Frequency (%)
Contiguous focus of infection (otitis media, mastoiditis, sinusitis, face or scalp infection, dental sepsis, osteomyelitis, penetrating head injury)	30-50
Hematogenous spread (lung abscess, empyema, congenital heart disease, bronchiectasis, infective endocarditis, compromised host, hereditary hemorrhagic telangiectasia)	~35
Cryptogenic	10-35

Principles of Brain Abscess Management

- MR imaging is the diagnostic procedure of choice; diffusion-weighted imaging increases diagnostic accuracy (sensitivity and specificity 96% for differentiation from cancers [PPV 98%; NPV 92%])
- Lumbar puncture is contraindicated
- Biopsy or aspiration (via stereotactic guidance) is needed for microbiologic diagnosis
- Begin empiric antimicrobial therapy based on underlying condition and pathogenesis of spread of infection to brain

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Empiric Antimicrobial Therapy of Brain Abscess

Predisposing Condition	Antimicrobial Regimen
Otitis media or mastoiditis	Metronidazole + a third-generation cephalosporin ^a
Sinusitis	Vancomycin + metronidazole + a third-generation cephalosporin ^a
Dental sepsis	Third-generation cephalosporin ^a + metronidazole
Penetrating trauma or post-neurosurgical	Vancomycin + a third- or fourth-generation cephalosporin
Lung abscess, empyema, bronchiectasis	Vancomycin + metronidazole + a third- or fourth-generation cephalosporin + trimethoprim-sulfamethoxazole ^b
Bacterial endocarditis	Vancomycin ^c

^aceftriaxone or cefotaxime

^badd if *Nocardia* suspected, along with 1-2 additional agents

^cadditional agents may be used based on other likely microbial etiologies

Empiric Antimicrobial Therapy of Brain Abscess

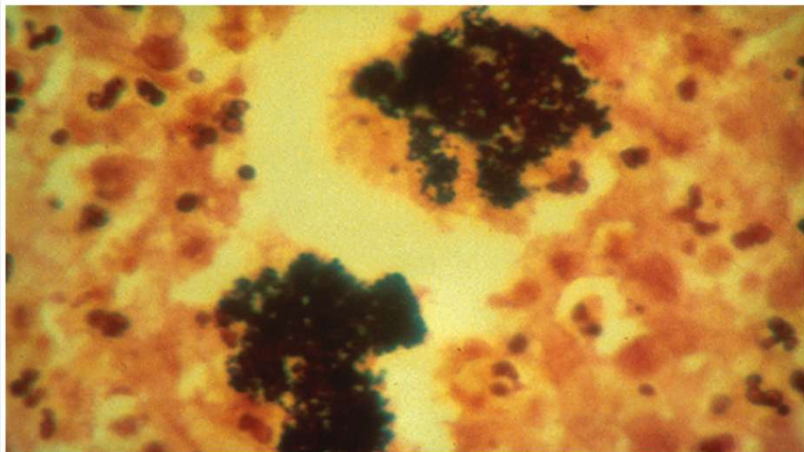
Predisposing Condition	Antimicrobial Regimen
Unknown	Vancomycin + metronidazole + a third or fourth generation cephalosporin; or vancomycin + meropenem
Transplant recipients	Add voriconazole + trimethoprim-sulfamethoxazole (plus additional 1-2 anti-nocardial agents) if <i>Nocardia</i> suspected
HIV-infected patients	Add pyrimethamine + sulfadiazine; consider isoniazid, rifampin, pyrazinamide, and ethambutol for possible tuberculosis

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Case Study

- 21-year-old member of a motorcycle gang thrown from his bike, and suffered a depressed skull fracture
- In the OR, a large subdural hematoma was evacuated
- Discharged in 5 days
- Returned by mother 5 days later because of bizarre behavior
- No headache, afebrile

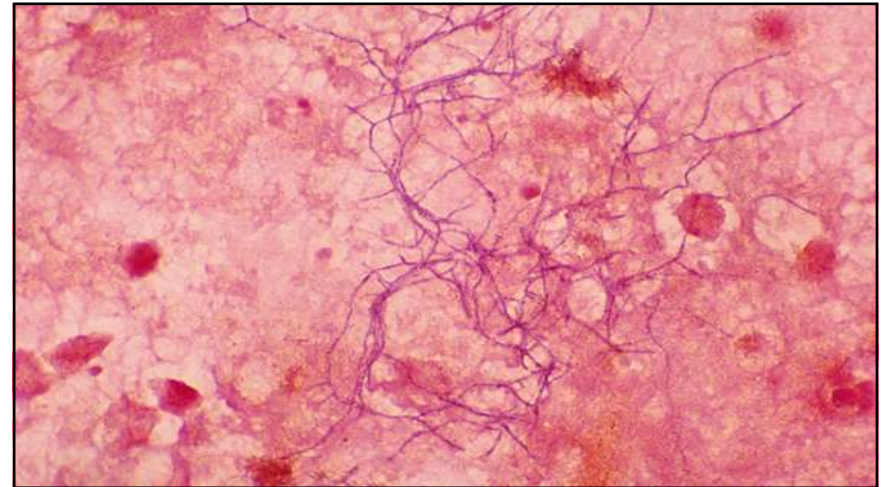
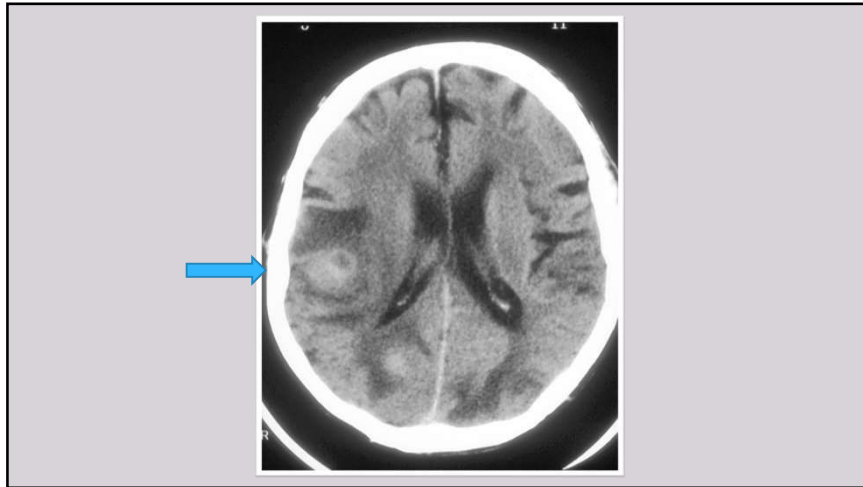


Question #2

- 78-year-old male with multiple myeloma on chronic prednisone therapy; underwent aortic valve replacement with a bioprosthesis 5 years earlier; presented with new-onset seizures
- T 100.4o F, P 96, RR 18, BP 110/70 mmHg; Exam (-)
- CT scan revealed multiple ring-enhancing lesions
- TEE - no vegetations and normal bioprosthesis
- Empirically placed on vancomycin + cefepime
- Blood cultures negative

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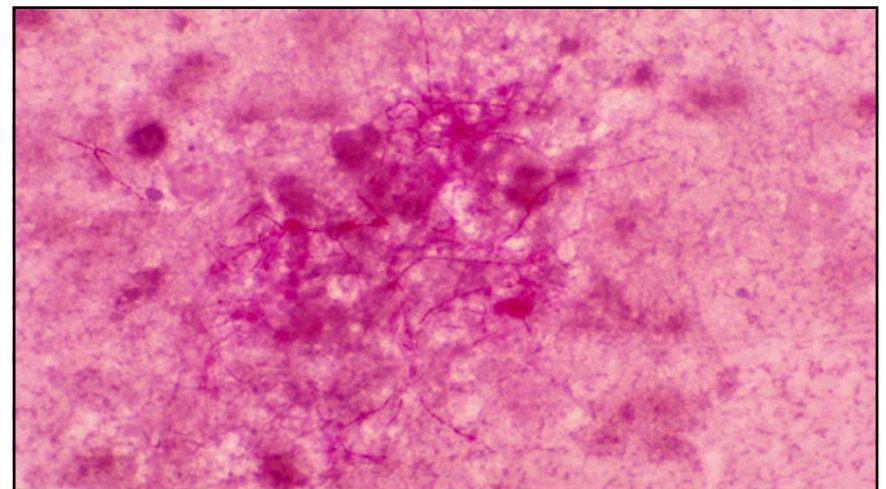
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Question #2

Which of the following antimicrobial regimens should be initiated?

- A. Penicillin + metronidazole
- B. Trimethoprim-sulfamethoxazole + imipenem
- C. Daptomycin + cefepime
- D. Liposomal amphotericin B + 5-FC
- E. Voriconazole

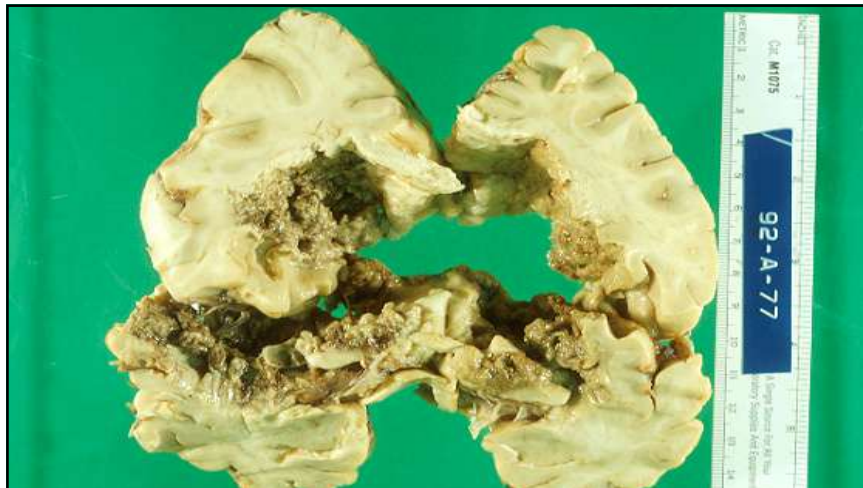
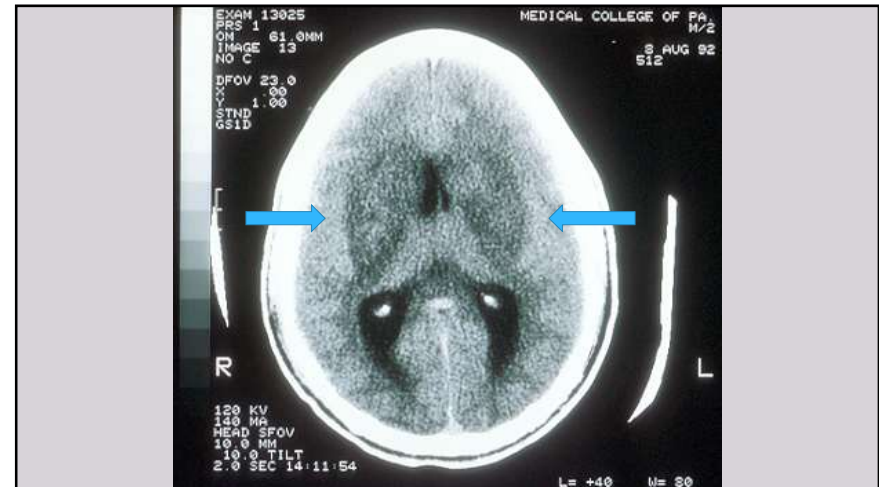


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Case Study

- 24-year-old injection drug user who, while injecting intravenous drugs with his girlfriend, fell out of the second story window of his apartment. When he did not return for 48 hours, she found him unresponsive on the ground and called fire rescue
- T 103oF, P 150, RR 32, BP 110/76 mmHg
- On exam, he was comatose without evidence of head trauma
- WBC 13,000/mm³, profound metabolic acidosis

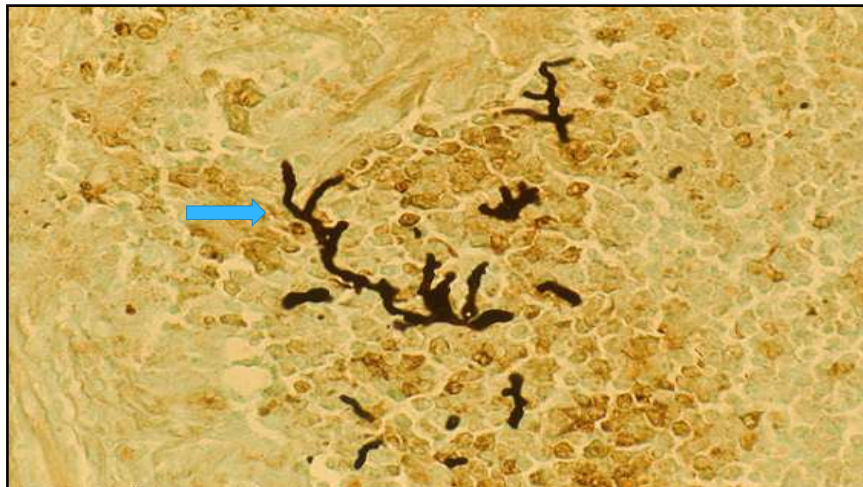
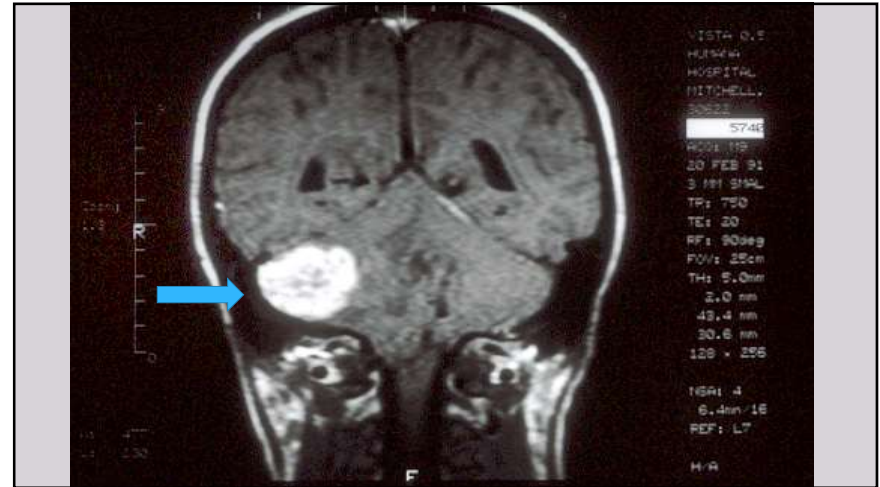


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Case Study

- 11-year-old boy with chronic granulomatous disease on chronic TMP-SMX therapy noted the onset of a mild headache which lasted 10 minutes
- Two weeks later at a routine physician visit, the patient had no complaints and denied recurrence of the headache
- On examination, the patient had normal vital signs and a normal neurologic examination
- The physician ordered an MR imaging of the head

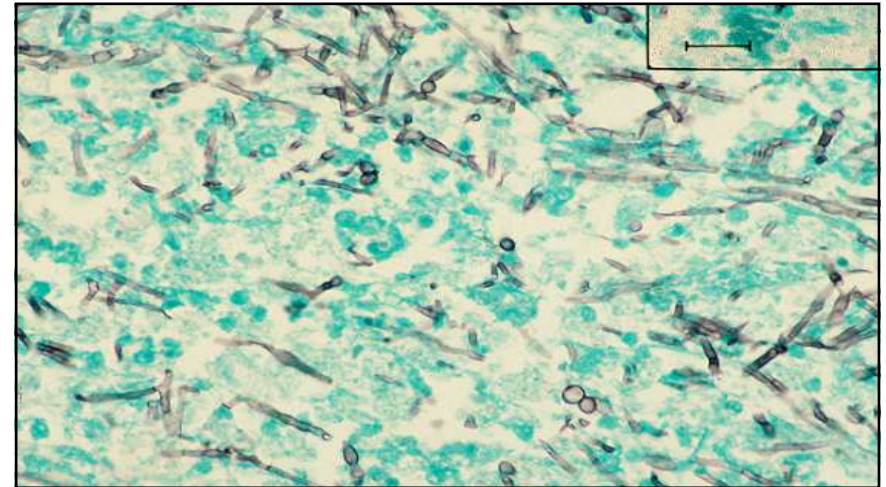
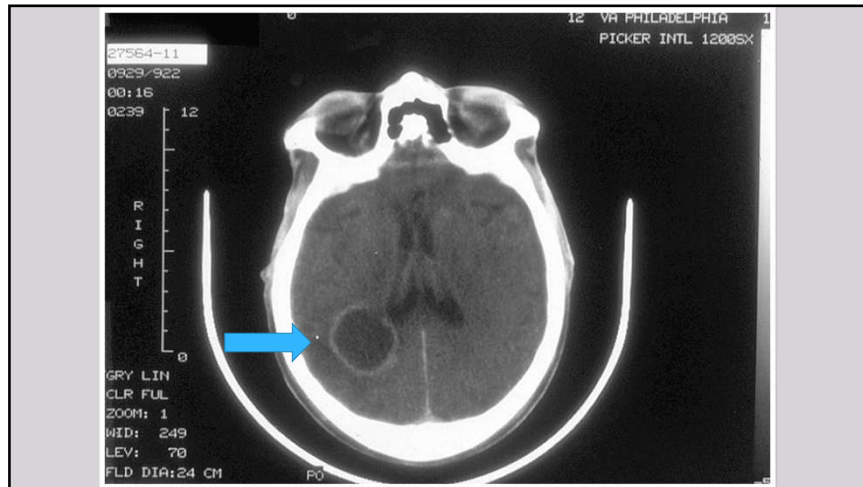


Case Study

- 80-year-old male with CLL on chronic prednisone therapy presented to the VA Hospital with sepsis and ARDS. Course complicated by VDRF and multiple nosocomial infections, including candidemia for which he received 4 weeks of IV liposomal amphotericin B. After completing the course of therapy, he developed altered mental status
- T 101.0 F, P 100, RR 20, BP 120/76
- Neurologic exam left-sided hyperreflexia and Babinski

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Principles of Brain Abscess Management

- Optimal management usually requires a combined medical and surgical approach (aspirate if >2.5 cm)
- Fungal brain abscess often requires combined medical and surgical therapy
- Initiate corticosteroids with evidence of cerebral edema or mass effect causing increased ICP

Antimicrobial Therapy of Brain Abscess

Organism	Antimicrobial Therapy
<i>Actinomyces</i> sp. ^a	Penicillin G
<i>Bacteroides fragilis</i> ^a	Metronidazole
Enterobacterales ^a	Third- or fourth-generation cephalosporin, or another agent based on in vitro susceptibility
<i>Fusobacterium</i> sp. ^a	Metronidazole
<i>Pseudomonas aeruginosa</i>	Ceftazidime or cefepime or meropenem
<i>Staphylococcus aureus</i>	Nafcillin, oxacillin, or vancomycin
<i>Strep. milleri</i> ; ^a other streptococci ^a	Penicillin G

^adepending on pathogenesis of infection, may be isolated as part of a mixed infection¹¹¹¹

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Antimicrobial Therapy of Brain Abscess

Organism	Antimicrobial Therapy
<i>Nocardia asteroides</i>	Trimethoprim-sulfamethoxazole + imipenem; add third drug in those with severe disease, or those failing standard therapy
<i>Mycobacterium tuberculosis</i>	Isoniazid + rifampin + pyrazinamide $\pm$ ethambutol

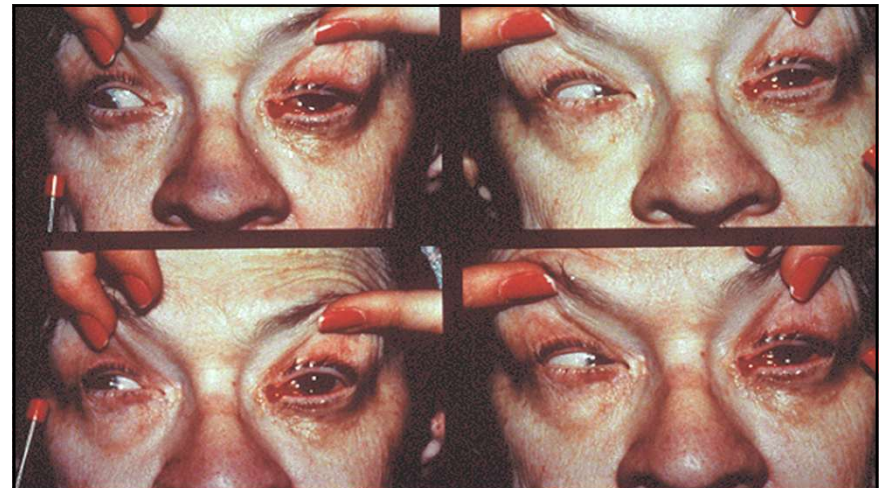
Antimicrobial Therapy of Brain Abscess

Organism	Antimicrobial Therapy
<i>Aspergillus</i> sp.	Voriconazole
<i>Candida</i> sp.	Liposomal amphotericin B ^a
Mucorales	Liposomal amphotericin B
<i>Scedosporium</i> spp.	Voriconazole

^aAddition of 5-flucytosine should be considered

Question #3

- 79-year-old female is transferred from a nursing home for failure to thrive as a result of decreased oral intake. A nasogastric tube is placed via the left nares for enteral hyperalimentation
- One week into her hospital course, the patient develops fever to 101.5o F, and left periorbital edema and chemosis
- CT scan of the head without contrast reveals opacification of the sphenoid sinus



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Question #3

Which of the following studies should be performed to establish the diagnosis?

- A. CT scan of the head and sinuses with contrast
- B. MR imaging with MR venography
- C. Cerebral angiography
- D. Positron emission tomography of the head
- E. Lumbar puncture

Epidemiology and Etiology of Septic Cavernous Sinus Thrombosis

Risk Factors	Etiologic Agents
Paranasal sinusitis	Staphylococci (60-70%)
Facial infection	Streptococci (~17%)
Dental infection	Gram-negative bacilli (~5%)
	Pneumococci (~5%)
	<i>Bacteroides</i> sp. (~2%)

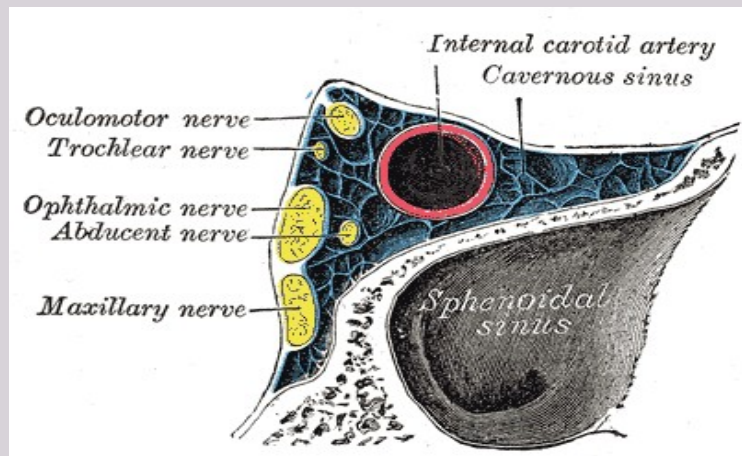
Clinical Features of Septic Cavernous Sinus Thrombosis

Symptoms

Headache (52%)
Facial pain
Vision loss
Fever
Double vision

Signs

Periorbital edema (73%)
Chemosis
Papillitis
Oculomotor palsies
Proptosis

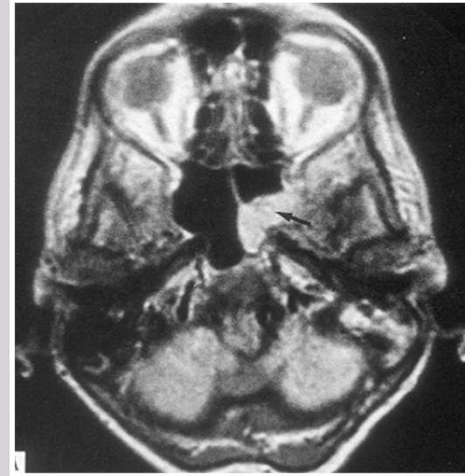


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Radiologic Findings in Septic Cavernous Sinus Thrombosis

- MR imaging
- Noninvasive diagnostic procedure of choice
- MRA and MRV can directly visualize cerebral vasculature
- Fullness in cavernous sinus region
- Paranasal sinus fluid



Management of Septic Cavernous Sinus Thrombosis

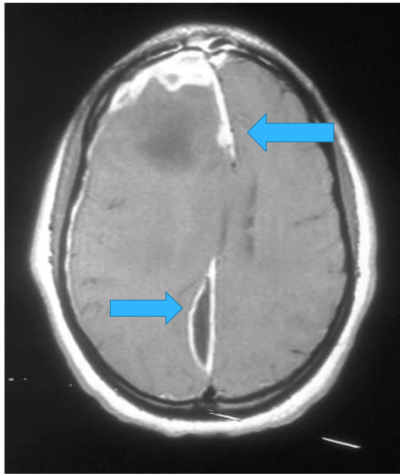
- Culture and drainage of infected sinuses
- Antimicrobial therapy (vancomycin + metronidazole + 3rd or 4th generation cephalosporin)
- Anticoagulation - Yes
- Corticosteroids - No

Question #4

- 22-year-old man with a history of paranasal sinusitis presents with fever, severe headache, neck pain, and seizure
- On physical examination, T 102°F and he is lethargic
- Laboratory studies normal

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Question #4

In addition to appropriate antimicrobial therapy, what other management should be performed?

- A. Lumbar puncture
- B. External ventricular drain
- C. Dexamethasone
- D. Burr hole drainage
- E. Craniotomy

Cranial Subdural Empyema and Cranial Epidural Abscess

Risk Factors	Etiologic Agents
Sinusitis (50-80%)	Staphylococci (10-15%)
Otogenic	Streptococci (25-45%)
Head trauma	Gram-negative bacilli (3-10%)
Neurosurgery	Other anaerobes (8%)
Hematogenous	Others (8%)
Meningitis	Unknown (20%)

Cranial Subdural Empyema and Cranial Epidural Abscess

Subdural Empyema (Acute Course)

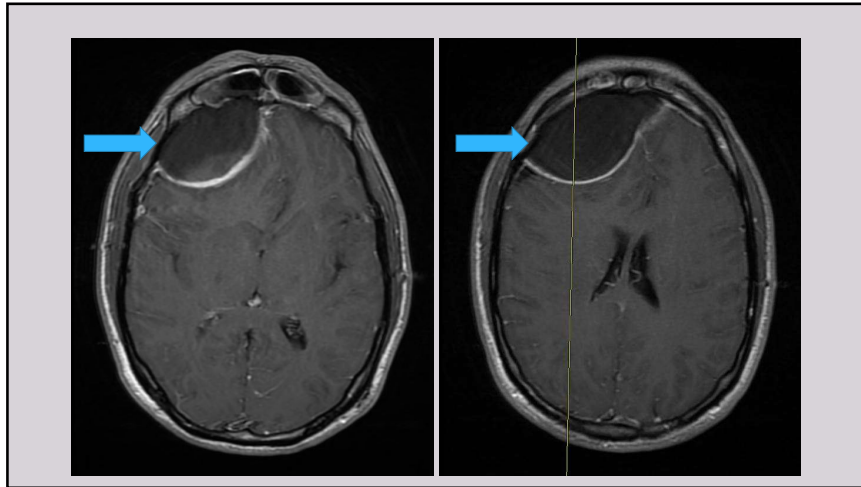
- Fever
- Headache
- Depressed consciousness
- Hemiparesis
- Seizures
- Nuchal rigidity
- Gaze palsies/ataxia

Epidural Abscess (Indolent Course)

- Headache
- Fever
- Seizures
- Focal neurologic signs
- Altered mental state

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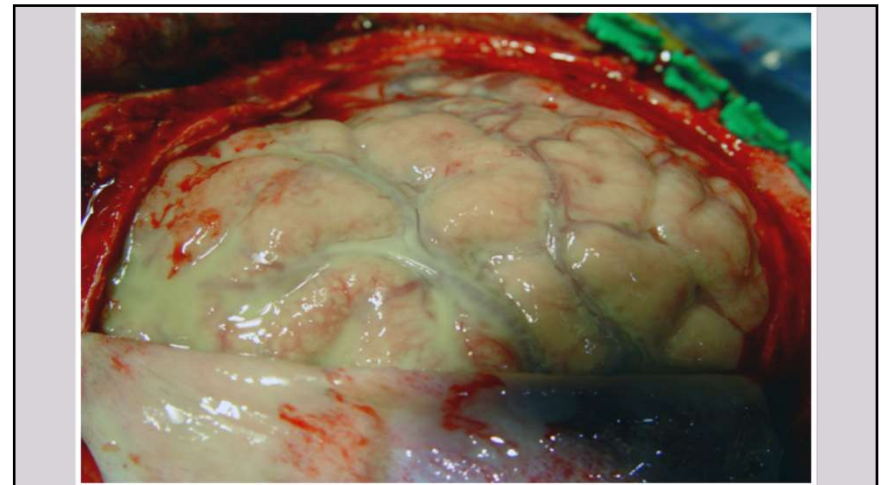
Principles of Management of Cranial Subdural Empyema

- MR imaging (diagnostic procedure of choice) provides better clarity of detail and can differentiate empyema from most sterile effusions and chronic hematomas; diffusion-weighted imaging adds to value of MRI
- Empiric antimicrobial therapy based on pathogenesis of infection
- Surgical therapy (burr holes or craniotomy) is imperative; better outcome with craniotomy

Surgical Management of Cranial Subdural Empyema

Surgical Procedure	Mortality Rate
Burr hole(s)	23.3%
Craniectomy	11.5%
Craniotomy	8.4%

Nathoo et al. Neurosurgery 2001;49:872



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Epidemiology of Spinal Epidural Abscess

- Incidence of ~5-8 infections per 10,000 hospital admissions
- Usually occurs secondary to hematogenous dissemination (~50% of cases)
- Contiguous foci (~1/3rd of cases)
- Unidentified source (20-40% of cases)
- Diabetes mellitus identified in up to 50% of patients

Etiology of Spinal Epidural Abscess

Organism	Relative Frequency (%)
Staphylococci	50-90
Streptococci	8-17
Gram-negative bacilli	12-17
Other anaerobes	2
Other	2
> 1 organism	5-10
Unknown	6

Clinical Stages of Spinal Epidural Abscess

- Back pain and tenderness at the level of infection
- Radicular pain and paresthesias
- Impaired spinal cord function; motor paresis and sensory deficits
- Complete paralysis

Pathogenesis of Spinal Epidural Abscess

- Pathogenesis of spinal cord injury
 - Direct mechanical compression by an expanding abscess (with or without vascular damage)
 - Disruption of vascular supply from septic thrombophlebitis
- Potential for neurologic impairment higher in cervical and thoracic locations

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Principles of Management of Spinal Epidural Abscess

- MR imaging is the diagnostic procedure of choice; can visualize the spinal cord and epidural space, and can identify accompanying osteomyelitis, intramedullary spinal cord lesions, and joint space infection
- Microbiologic diagnosis by blood cultures or image-guided biopsy (unless surgery is imminent)



Principles of Management of Spinal Epidural Abscess

- Empiric antimicrobial therapy should include an antistaphylococcal agent (i.e., vancomycin) and coverage for gram-negative bacilli
- Surgical therapy imperative in the presence of neurologic dysfunction (best if <24-36 hours of complete paralysis)
- Nonsurgical therapy only for patients with an unacceptably high surgical risk or no neurologic deficits at diagnosis; patient must be followed carefully for clinical deterioration

Questions

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