

Not just back pain: *Candida* spondylodiscitis in an elderly patient

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Introduction

Candida is a rare cause of spondylodiscitis. Its indolent course and nonspecific clinical features often delay diagnosis, particularly in elderly patients with multiple comorbidities.

Case Presentation

An 88-year-old woman presented with progressive lower back pain and immobility over several months. Her medical history included hypertension, hyperlipidemia, type 2 diabetes mellitus, Grave's disease, osteoporosis, chronic kidney disease, and previously treated rectal adenocarcinoma. She was afebrile and hemodynamically stable. Examination revealed lumbar spine tenderness. Inflammatory markers (ESR, CRP) were elevated without leukocytosis; blood cultures were negative. Magnetic resonance imaging (MRI) of the thoracolumbar spine demonstrated spondylodiscitis involving L1–L3, with intraosseous involvement, paravertebral extension, and bilateral psoas abscesses (Fig. 1A).

An initial computed tomography-guided biopsy was non-diagnostic. She was empirically treated with cefazolin and ciprofloxacin, later escalated to piperacillin-tazobactam, without improvement. A repeat biopsy two months later yielded *Candida albicans* from paravertebral fluid, susceptible to fluconazole. Retrospective review revealed a prior episode of *Candida albicans* fungemia following gastrointestinal ulceration 10 months earlier, treated with a 2-week course of fluconazole. No metastatic complications such as endocarditis or endophthalmitis were identified.

Given her age and multiple comorbidities, conservative management was pursued. She received oral fluconazole for 18 months, with improvement in inflammatory markers and serum (1-3)- β -d-glucan (Fig. 1B). Serial MRI demonstrated resolution of bilateral psoas abscesses with stable spondylodiscitis and paravertebral collection.

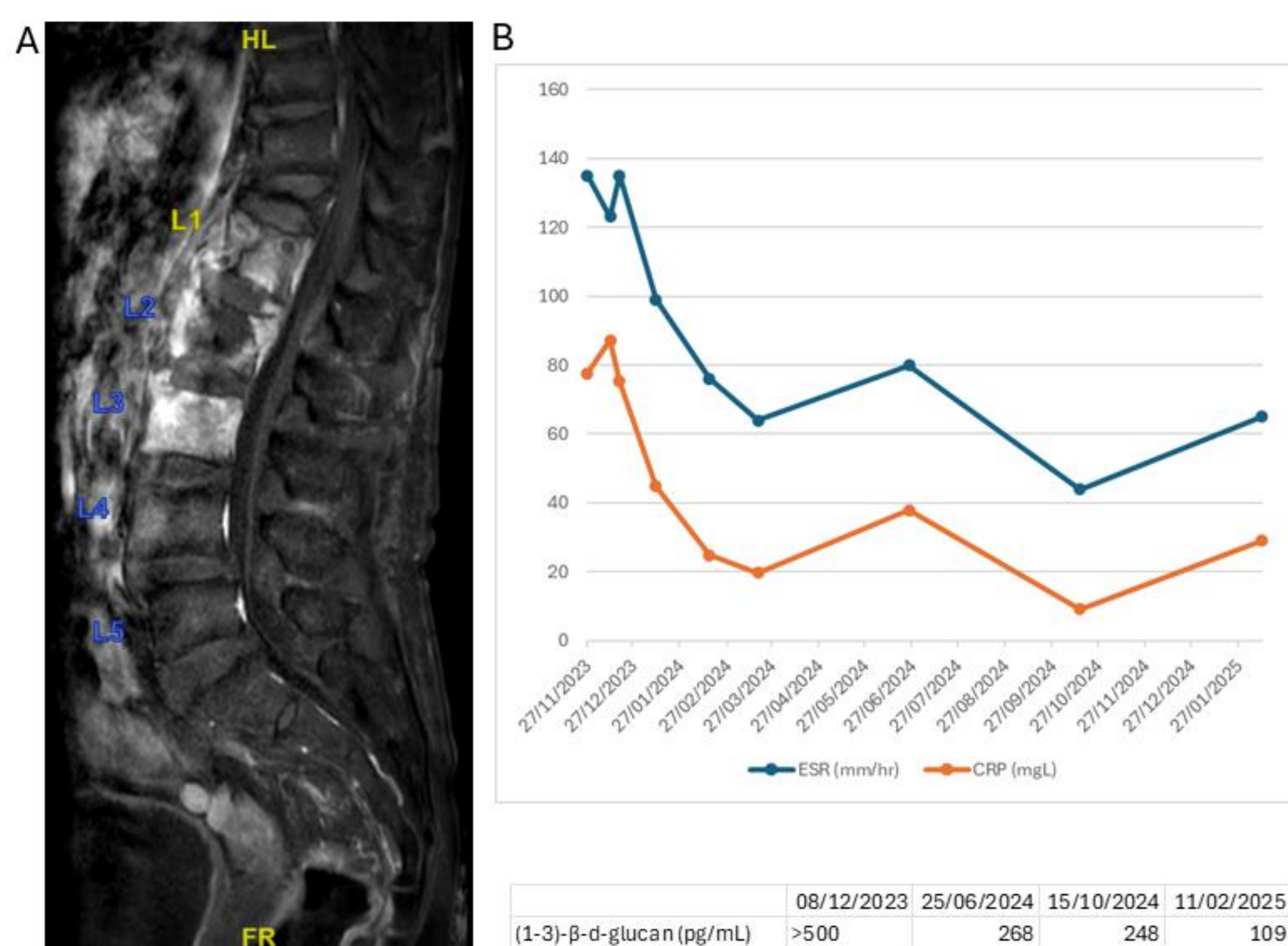


Fig. 1 (A) The T1-weighted MRI of the thoracolumbar spine with contrast at diagnosis. (B) Inflammatory markers (ESR and CRP) and (1-3)- β -d-glucan trend over the treatment course.

Conclusion

This case highlights the diagnostic challenge of *Candida* spondylodiscitis, particularly with negative blood cultures and inconclusive initial biopsy. Prior candidemia warrants high suspicion, and early repeat biopsy is key for diagnosis and targeted therapy.