Comment on the new classification of surgical treatment of spinal tuberculosis

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Received: 29 March 2008 / Revised: 31 March 2008 / Accepted: 1 April 2008 / Published online: 24 May 2008
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We read with great interest the article “A new classification system for the surgical treatment of spinal tuberculosis” by Oguz et al. [1]. The idea of a classification system for surgery in spinal tuberculosis (TB) is fascinating. Aggressive surgical therapy was the treatment available for spinal TB in the pre-antibiotic era. With the advent of effective bactericidal drugs and proven success of combination chemotherapy, the indications for surgery in the management of spinal TB have decreased in patients responsive to chemotherapy. Tuli’s middle-path regimen is widely followed in most resource-poor settings with good success rates [2]. Short-course chemotherapy regimens have been documented to lead on to cure of the disease [3]. The British Medical Research Council (BMRC) conducted randomised controlled trials on spinal TB patients comparing surgery and ambulatory chemotherapy [4]. The Hong Kong wing of the trial showed a small but significant advantage of surgery over chemotherapy in preventing progression of kyphosis, but the Madras wing failed to show any advantage of surgery over chemotherapy in 10 years follow-up of the patients. Surgery was recommended only in patients younger than 15 years with an initial kyphotic angle more than 30° at presentation. The idea of drainage of all cold abscesses is not agreeable. Cold abscesses have been known to regress dramatically after drug treatment and drainage may be necessary only in large abscesses not responding to chemotherapy. A uniform spontaneous healing of sinuses has been documented and

all sinuses do not need curettage [2]. Recent studies confirm this outcome. Bhojraj et al. in two independent studies of patients with thoracic, and lumbar and lumbosacral tuberculosis with varying presentations including abscesses concluded that tuberculosis of the spine in adults can largely be managed by multidrug chemotherapy. Attempts at classifying spinal TB for surgical management have been done on the basis of magnetic resonance imaging (MRI) findings [5]. Four types of presentation have been described with different surgical procedures for each type. The indications for surgical intervention mentioned are spinal deformity >30°, significant neurological deficit at presentation, failure of a non-operative trial of management for 6–8 weeks, persistent severe pain and neurological deficit which did not resolve or which developed while on medical treatment.

Conservative management is recommended in cranio-cervical tuberculosis with any extent of vertebral destruction though surgery may be indicated for neurological deficit, an atlantodental interval greater than 5 mm on flexion/extension view, doubtful diagnosis and progressive deformity. We agree that a computed tomography (CT)-guided biopsy may be needed to establish the diagnosis. The indications for surgery have not been clearly mentioned in each subgroup. The IA and IB subgroups may not require surgery in the first instance. A larger study group and longer follow-up may be necessary before expanding the indications for the surgical treatment of spinal tuberculosis.

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