A 58 year-old gentleman presented with a one-week history of progressively worsening dysphagia, odynophagia, and severe neck pain that radiated to his right shoulder and was precipitated by movement. He denied otalgia, trismus, hoarseness, weight loss, recent infections, and history of trauma. The patient’s past medical history was significant for poorly-controlled diabetes mellitus type 2, cellulitis of the right lower extremity, and hypertension. The patient was afebrile, but his temperature remained slightly elevated throughout his hospital course with a Tmax of 99.3°F. Upon admission, his heart rate was 116 and respiratory rate was 31.

Physical examination of the oral cavity and oropharynx demonstrated the patient to have poor dentition but was otherwise within normal limits. There was no cervical lymphadenopathy detected, but the patient’s posterior cervical spine was tender to palpation. Flexible fiberoptic laryngoscopy did not reveal any masses or lesions, and the patient’s true vocal cords had normal range of motion. Neurological exam was otherwise unremarkable.

Labs were obtained and revealed a minimally elevated white blood cell count of 11.4. His hemoglobin A1c was 12.4 and blood glucose upon presentation to the emergency department was 400. The patient was admitted to the internal medicine service and was initially placed on an insulin drip and treated for diabetic ketoacidosis. Although he did not appear overtly toxic, the infectious disease service was consulted, blood cultures were drawn, and the patient was then placed on broad-spectrum iv antibiotics as an infectious source was placed high on the differential diagnosis.

A plain radiograph of the cervical spine was ordered initially in the emergency department that showed slight cervical kyphosis, C5-6 disc space narrowing, and no prevertebral soft tissue swelling. CT scan of the neck with contrast revealed prevertebral soft tissue swelling most prominent at the C2-4 level. MRI with gadolinium of the cervical spine was next ordered to rule out osteomyelitis, which can rapidly progress to severe life-threatening infection.

Although still considered a rare disease, acute calcific prevertebral tendinitis has been appearing with increased frequency in the literature. This fact could be attributed to improved diagnostic imaging or a higher index of suspicion among clinicians. We believe this case to be the first where the patient presented with a complicating condition such as diabetic ketoacidosis. A thorough history and physical exam coupled with this disease entity’s characteristic imaging appearance allows a prompt diagnosis to be made. As a result, further diagnostic testing and prolonged inpatient hospitalizations can be avoided. Moreover, patients will not be subjected to unnecessary surgical procedures that are associated with potentially significant morbidity.

REFERENCES