

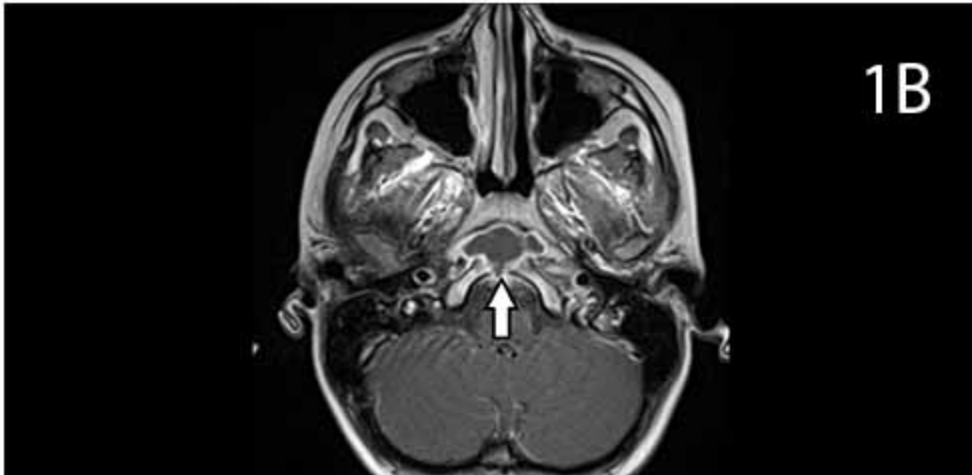
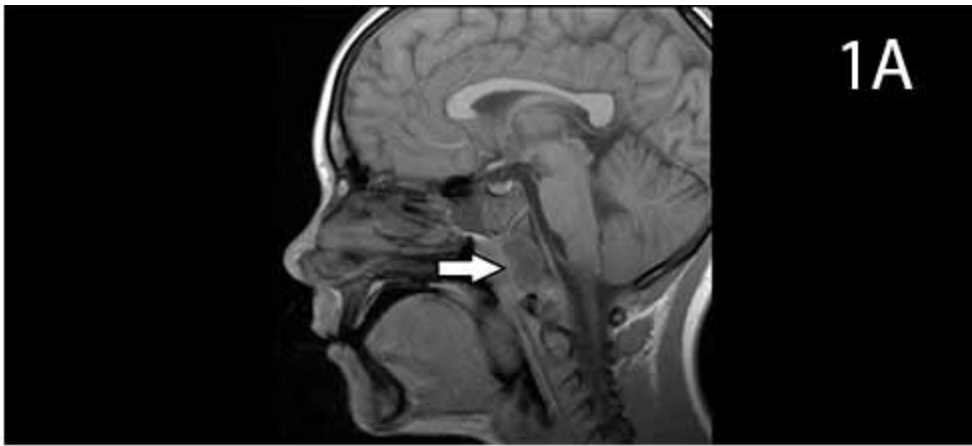
A Rare Cause of Neck Pain and Headache

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An 8-year-old boy presented with a history of 3 weeks of progressively worsening headache and transfer to our institution. Other than the 3 previous weeks of pain, he reported no prior history of His parents had initially felt he was just “sleeping wrong,” but a local emergency department (ED) concerns of meningitis on day 4 of the boy’s illness, The boy underwent a lumbar puncture in the He was diagnosed as having muscle spasms, and diazepam was prescribed.

However, the boy’s symptoms persisted after discharge from the ED, and his pediatrician at follow streptococcal pharyngitis and prescribed a 10-day course of amoxicillin. At this time, the boy had focal neurologic signs, and his pain was localized to the back of the neck at the base of the skull. subjective low-grade fevers that he had treated with acetaminophen and ibuprofen and that were warm showers. However, due to persistent headaches and neck pain, the boy was directly admitt after visiting his pediatrician for a third follow-up visit. At that time he underwent a computed tom head, and results showed a low-density area to the posterior aspect of the nasopharynx measurin was then transferred to our institution, where laboratory tests and magnetic resonance imaging (M

The results of laboratory tests revealed C-reactive protein of 94.6 mg/L (reference range, 0 to 4.9 sedimentation rate of 63 mm/h (reference range, 0 to < 20 mm/hr), and white blood cell count of 1 (reference range, 4500 to 13,000 cells/mm³) without left shift. Nasopharyngeal MRI (**Figures 1A-** osteomyelitis with a relatively discrete abscess cavity formed in the clivus without any other anatc other sources of infection were appreciated.

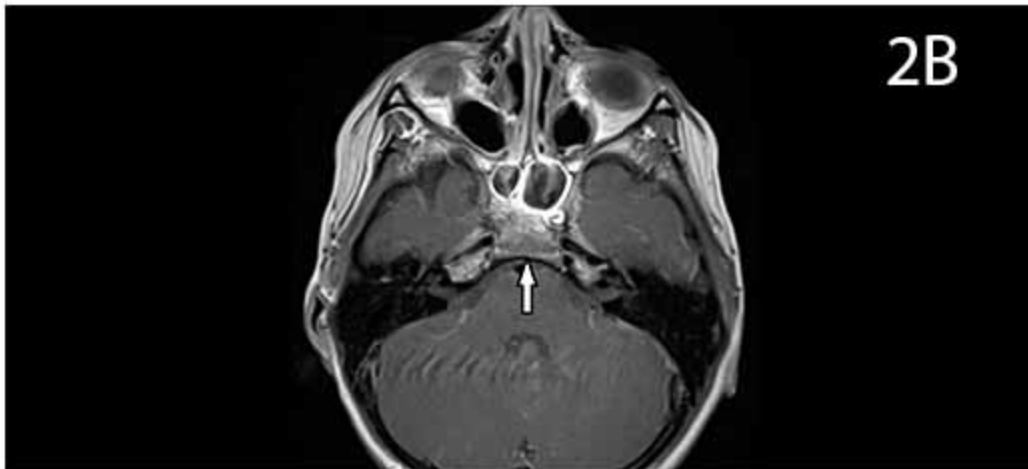


Figures 1A and 1B. Pretreatment, sagittal view and axial view.

The otolaryngology and neurosurgery departments were consulted, and antibiotics were delayed biopsy since the patient was stable without fever, had appropriate mentation, and had no focal ne

Forty-eight hours after admission, a pediatric otolaryngologist was able to perform a functional en with aspiration of purulent material, with possible cause of infection from the sphenoid sinus. Cult patient was started on ceftriaxone and clindamycin, and the aspirate grew microaerophilic *Streptc* protocol at our institution, no sensitivities were provided.

The boy was discharged on hospital day 11 with a peripherally inserted central catheter (PICC) lir total of 4 weeks of intravenous (IV) ceftriaxone and clindamycin before transitioning to oral cefdin complete a total of 6-8 weeks of antibiotics. . After 2 weeks of oral antibiotics, his inflammatory m normal range and antibiotics were discontinued. An MRI with and without contrast was conducted and revealed resolution of the abscess and new bone formation of the clivus (**Figures 2A-2B**).



Figures 2A and 2B. Posttreatment, sagittal view and axial view.

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