Pseudomonas aeruginosa is responsible for 95% of all otogenic skull base osteomyelitis [2],[3]. The overall mortality of the disease is 10-20 % and one third of the patients have long-term neurologic sequelae [5],[6].Our patient had an uncontrolled diabetes equivalent with an immunocompromised state so he was predisposed to severe infections. His Pseudomonas external otitis extended to the skull base.

Conclusion

Skull base osteomyelitis has to be suspected before an ENT infection associated with multiple nervous palsies especially in an immunocompromised or diabetic patient. External otitis in a diabetic patient requires searching for infectious, nervous and vascular local complications. A thorough clinical examination allows an early stage diagnosis, which along with an immediate treatment will improve the outcome of patients.

References


Figure 1. A. CT scan showing temporal bone lysis B. Left jugular vein thrombosis

Antibiotic therapy associated intravenous meropeneme and ciprofloxacin. The patient had a surgical mastoidectomy for nervous decompression. At a six-month evaluation the patient preserved a left peripheral facial palsy and mild dysphagia.

Discussion

There are very few reported cases of Collet Sicard syndrome due to a skull base osteomyelitis. The particularity of our clinical report is that we found no other article in the specialty literature describing this association of skull base osteomyelitis, arthritis, venous thrombosis, 5th and 9th to 12th nerve palsies.

The most common findings in cases of skull base osteomyelitis are: inflammatory or traumatic processes involving the head and the neck in association with standard infectious signs. Literature reviews [1], [4] suggest that immunocompromised and diabetic patients are predisposed to the condition.