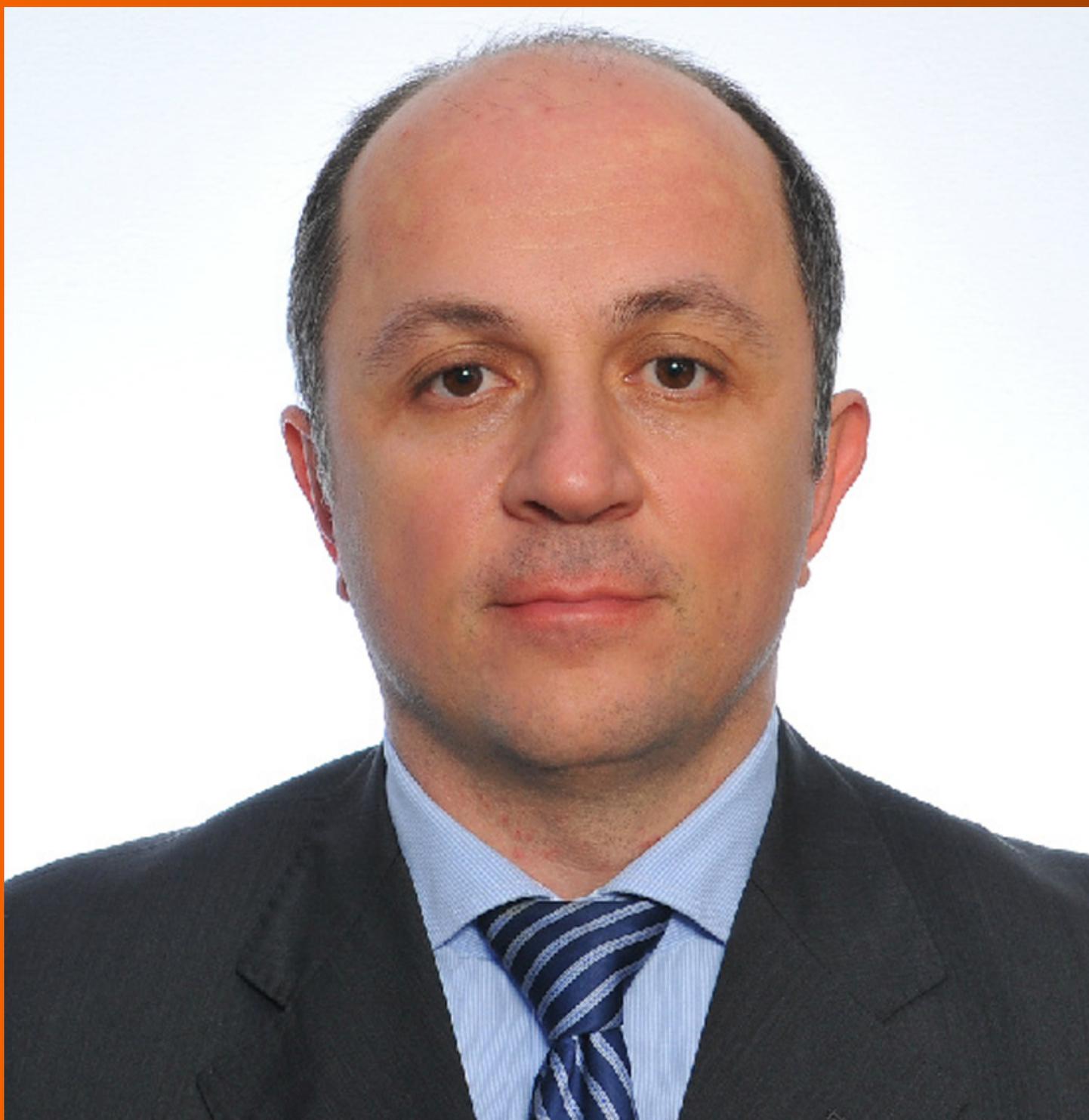


World Journal of *Clinical Cases*

World J Clin Cases 2019 November 26; 7(22): 3683-3914



Contents

Semimonthly Volume 7 Number 22 November 26, 2019

REVIEW

- 3683 Colorectal cancer: The epigenetic role of microbiome
Sabit H, Cevik E, Tombuloglu H

ORIGINAL ARTICLE**Case Control Study**

- 3698 Human podocyte injury in the early course of hypertensive renal injury
Sun D, Wang JJ, Wang W, Wang J, Wang LN, Yao L, Sun YH, Li ZL

Retrospective Cohort Study

- 3711 Relationship between acute hypercarbia and hyperkalaemia during surgery
Weinberg L, Russell A, Mackley L, Dunnachie C, Meyerov J, Tan C, Li M, Hu R, Karalapillai D

Retrospective Study

- 3718 Surgical treatment of patients with severe non-flail chest rib fractures
Zhang JP, Sun L, Li WQ, Wang YY, Li XZ, Liu Y

- 3728 Super-selective arterial embolization in the control of acute lower gastrointestinal hemorrhage
Lv LS, Gu JT

- 3734 End-stage liver disease score and future liver remnant volume predict post-hepatectomy liver failure in hepatocellular carcinoma
Kong FH, Miao XY, Zou H, Xiong L, Wen Y, Chen B, Liu X, Zhou JJ

Observational Study

- 3742 Treatment of hemorrhoids: A survey of surgical practice in Australia and New Zealand
Fowler GE, Siddiqui J, Zahid A, Young CJ

- 3751 Relationship between homocysteine level and prognosis of elderly patients with acute ischemic stroke treated by thrombolysis with recombinant tissue plasminogen activator
Li J, Zhou F, Wu FX

CASE REPORT

- 3757 Cystic fibrosis transmembrane conductance regulator functional evaluations in a G542X+/- IVS8Tn:T7/9 patient with acute recurrent pancreatitis
Caldrer S, Bergamini G, Sandri A, Vercellone S, Rodella L, Cerofolini A, Tomba F, Catalano F, Frulloni L, Buffelli M, Tridello G, de Jonge H, Assael BM, Sorio C, Melotti P

- 3765** Ulcerated intussuscepted jejunal lipoma-uncommon cause of obscure gastrointestinal bleeding: A case report
Cuciureanu T, Huiban L, Chiriac S, Singeap AM, Danciu M, Mihai F, Stanciu C, Trifan A, Vlad N
- 3772** Ultrasonographic evaluation of the effect of extracorporeal shock wave therapy on calcific tendinopathy of the rectus femoris tendon: A case report
Lee CH, Oh MK, Yoo JI
- 3778** Contrast-enhanced computed tomography findings of a huge perianal epidermoid cyst: A case report
Sun PM, Yang HM, Zhao Y, Yang JW, Yan HF, Liu JX, Sun HW, Cui Y
- 3784** Iatrogenic crystalline lens injury during intravitreal injection of triamcinolone acetonide: A report of two cases
Su J, Zheng LJ, Liu XQ
- 3792** Sagliker syndrome: A case report of a rare manifestation of uncontrolled secondary hyperparathyroidism in chronic renal failure
Yu Y, Zhu CF, Fu X, Xu H
- 3800** Pre-eclampsia with new-onset systemic lupus erythematosus during pregnancy: A case report
Huang PZ, Du PY, Han C, Xia J, Wang C, Li J, Xue FX
- 3807** Unilateral congenital scrotal agenesis with ipsilateral cryptorchidism: A case report
Fang Y, Lin J, Wang WW, Qiu J, Xie Y, Sang LP, Mo JC, Luo JH, Wei JH
- 3812** Metastatic infection caused by hypervirulent *Klebsiella pneumonia* and co-infection with *Cryptococcus meningitis*: A case report
Shi YF, Wang YK, Wang YH, Liu H, Shi XH, Li XJ, Wu BQ
- 3821** Allergic fungal rhinosinusitis accompanied by allergic bronchopulmonary aspergillosis: A case report and literature review
Cheng KJ, Zhou ML, Liu YC, Zhou SH
- 3832** Invasive aspergillosis presenting as hilar masses with stenosis of bronchus: A case report
Su SS, Zhou Y, Xu HY, Zhou LP, Chen CS, Li YP
- 3838** Retropharyngeal abscess presenting as acute airway obstruction in a 66-year-old woman: A case report
Lin J, Wu XM, Feng JX, Chen MF
- 3844** Thoracoscopic segmentectomy assisted by three-dimensional computed tomography bronchography and angiography for lung cancer in a patient living with situs inversus totalis: A case report
Wu YJ, Bao Y, Wang YL
- 3851** Single-lung transplantation for pulmonary alveolar microlithiasis: A case report
Ren XY, Fang XM, Chen JY, Ding H, Wang Y, Lu Q, Ming JL, Zhou LJ, Chen HW

- 3859** Respiratory failure and macrophage activation syndrome as an onset of systemic lupus erythematosus: A case report
Sun J, Wang JW, Wang R, Zhang H, Sun J
- 3866** Diagnosis of gastric duplication cyst by positron emission tomography/computed tomography: A case report
Hu YB, Gui HW
- 3872** Peritoneal cancer after bilateral mastectomy, hysterectomy, and bilateral salpingo-oophorectomy with a poor prognosis: A case report and review of the literature
Ma YN, Bu HL, Jin CJ, Wang X, Zhang YZ, Zhang H
- 3881** Apatinib for treatment of a pseudomyxoma peritonei patient after surgical treatment and hyperthermic intraperitoneal chemotherapy: A case report
Huang R, Shi XL, Wang YF, Yang F, Wang TT, Peng CX
- 3887** Novel frameshift mutation causes early termination of the thyroxine-binding globulin protein and complete thyroxine-binding globulin deficiency in a Chinese family: A case report
Dang PP, Xiao WW, Shan ZY, Xi Y, Wang RR, Yu XH, Teng WP, Teng XC
- 3895** Diffuse large B-cell lymphoma arising from follicular lymphoma with warthin's tumor of the parotid gland - immunophenotypic and genetic features: A case report
Wang CS, Chu X, Yang D, Ren L, Meng NL, Lv XX, Yun T, Cao YS
- 3904** Exogenous endophthalmitis caused by *Enterococcus casseliflavus*: A case report
Bao QD, Liu TX, Xie M, Tian X

LETTER TO THE EDITOR

- 3912** Microbial transglutaminase should be considered as an environmental inducer of celiac disease
Lerner A, Matthias T

ABOUT COVER

Editorial Board Member of *World Journal of Clinical Cases*, Ridvan Hamid Alimehmeti, MD, PhD, Associate Professor, Lecturer, Surgeon, Department of Neuroscience, University of Medicine, Tirana 1000, Albania

AIMS AND SCOPE

The primary aim of *World Journal of Clinical Cases (WJCC, World J Clin Cases)* is to provide scholars and readers from various fields of clinical medicine with a platform to publish high-quality clinical research articles and communicate their research findings online.

WJCC mainly publishes articles reporting research results and findings obtained in the field of clinical medicine and covering a wide range of topics, including case control studies, retrospective cohort studies, retrospective studies, clinical trials studies, observational studies, prospective studies, randomized controlled trials, randomized clinical trials, systematic reviews, meta-analysis, and case reports.

INDEXING/ABSTRACTING

The *WJCC* is now indexed in PubMed, PubMed Central, Science Citation Index Expanded (also known as SciSearch®), and Journal Citation Reports/Science Edition. The 2019 Edition of Journal Citation Reports cites the 2018 impact factor for *WJCC* as 1.153 (5-year impact factor: N/A), ranking *WJCC* as 99 among 160 journals in Medicine, General and Internal (quartile in category Q3).

RESPONSIBLE EDITORS FOR THIS ISSUE

Responsible Electronic Editor: *Ji-Hong Liu*
 Proofing Production Department Director: *Yun-Xiaojuan Wu*

NAME OF JOURNAL <i>World Journal of Clinical Cases</i>
ISSN ISSN 2307-8960 (online)
LAUNCH DATE April 16, 2013
FREQUENCY Semimonthly
EDITORS-IN-CHIEF Dennis A Bloomfield, Bao-Gan Peng, Sandro Vento
EDITORIAL BOARD MEMBERS https://www.wjnet.com/2307-8960/editorialboard.htm
EDITORIAL OFFICE Jin-Lei Wang, Director
PUBLICATION DATE November 26, 2019

COPYRIGHT © 2019 Baishideng Publishing Group Inc
INSTRUCTIONS TO AUTHORS https://www.wjnet.com/bpg/gerinfo/204
GUIDELINES FOR ETHICS DOCUMENTS https://www.wjnet.com/bpg/GerInfo/287
GUIDELINES FOR NON-NATIVE SPEAKERS OF ENGLISH https://www.wjnet.com/bpg/gerinfo/240
PUBLICATION MISCONDUCT https://www.wjnet.com/bpg/gerinfo/208
ARTICLE PROCESSING CHARGE https://www.wjnet.com/bpg/gerinfo/242
STEPS FOR SUBMITTING MANUSCRIPTS https://www.wjnet.com/bpg/GerInfo/239
ONLINE SUBMISSION https://www.f6publishing.com

Retropharyngeal abscess presenting as acute airway obstruction in a 66-year-old woman: A case report

Jian Lin, Xiao-Mai Wu, Jia-Xi Feng, Mei-Fang Chen

ORCID number: Jian Lin (0000-0003-2510-9064); Xiao-Mai Wu (0000-0002-3115-3988); Jia-Xi Feng (0000-0003-4814-8648); Mei-Fang Chen (0000-0003-0070-0931).

Author contributions: Chen MF, Lin J, and Feng JX designed this case report; Lin J and Wu XM wrote the manuscript.

Informed consent statement: The patient provided informed written consent.

Conflict-of-interest statement: The authors declare that they have no conflict of interest.

CARE Checklist (2016) statement: The authors have read the CARE Checklist (2016), and the manuscript was prepared and revised according to the CARE Checklist (2016).

Open-Access: This article is an open-access article which was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>

Manuscript source: Unsolicited manuscript

Received: August 1, 2019

Jian Lin, Xiao-Mai Wu, Jia-Xi Feng, Mei-Fang Chen, Division of Pulmonary and Critical Care Medicine, Wenzhou Medical University Affiliated Taizhou Hospital, Linhai 317000, Zhejiang Province, China

Corresponding author: Mei-Fang Chen, MD, Associate Chief Physician, Division of Pulmonary and Critical Care Medicine, Wenzhou Medical University Affiliated Taizhou Hospital, No. 150 Ximen Road, Linhai 317000, Zhejiang Province, China.

chenmeifang1979@163.com

Telephone: +86-576-85199238

Abstract

BACKGROUND

Adult retropharyngeal abscess (RPA) is extremely rare, and most cases reported in the literature were related to tuberculous infection. We present a case of RPA with acute airway obstruction as the main manifestation in a 66-year-old woman that was considered to be non-tubercular suppurative inflammation in the retropharyngeal space.

CASE SUMMARY

A 66-year-old woman complaining of chills and fever was admitted to our hospital. She was initially diagnosed with an acute upper respiratory tract infection. She lost consciousness twice during hospitalization. She regained consciousness immediately upon emergency tracheal intubation. Acute upper airway obstruction was suspected as arterial blood gas analysis showed obvious acute retention of carbon dioxide before the second tracheal intubation. The diagnosis of RPA was confirmed by computed tomography and magnetic resonance imaging. *Kocuria kristinae* was isolated from blood samples taken from both hands. The patient recovered and was subsequently discharged after receiving antibiotic therapy together with surgical incision and drainage of the abscess.

CONCLUSION

Clinicians should be alert to the possibility of RPA in patients with acute airway obstruction. Surgical incision and drainage is an effective treatment for RPA.

Key words: Retropharyngeal abscess; Airway obstruction; *Kocuria kristinae*; Intubation; Surgery; Case report

©The Author(s) 2019. Published by Baishideng Publishing Group Inc. All rights reserved.

Peer-review started: August 1, 2019
First decision: September 9, 2019
Revised: September 30, 2019
Accepted: October 5, 2019
Article in press: October 5, 2019
Published online: November 26, 2019

P-Reviewer: Isik A
S-Editor: Wang J
L-Editor: Filipodia
E-Editor: Liu JH



Core tip: Adult retropharyngeal abscess is extremely rare as degeneration of the lymph nodes in the retropharyngeal space occurs after the age of 5 years, and most adult retropharyngeal abscesses are related to cervical spine tuberculosis. In this case report, the patient was considered to have acute non-tubercular suppurative inflammation in the retropharyngeal space. The clinical course of the patient was not straightforward, in that the initial manifestation was acute upper airway obstruction and the diagnosis of retropharyngeal abscess was only confirmed after two tracheal intubations when relevant examinations were performed.

Citation: Lin J, Wu XM, Feng JX, Chen MF. Retropharyngeal abscess presenting as acute airway obstruction in a 66-year-old woman: A case report. *World J Clin Cases* 2019; 7(22): 3838-3843

URL: <https://www.wjnet.com/2307-8960/full/v7/i22/3838.htm>

DOI: <https://dx.doi.org/10.12998/wjcc.v7.i22.3838>

INTRODUCTION

Retropharyngeal abscess (RPA) involves suppurative inflammation of the retropharyngeal space, and mostly refers to acute suppurative lymphadenitis. RPA is most common in infants and children younger than 5 years and is associated with acute upper respiratory tract infection or lymphadenitis^[1]. Adult RPA is very rare as the lymph nodes in the retropharyngeal space gradually degenerate after the age of 5 years. RPA may lead to complications such as acute airway obstruction, jugular necrotizing fasciitis, mediastinitis, aspiration pneumonia, thrombosis of the jugular vein, carotid artery erosion, and sepsis when diagnosis and treatment of the disease are delayed or the disease progresses, and some severe cases are life-threatening^[1-3]. Herein, we present a case of RPA with acute airway obstruction as the main manifestation in a 66-year-old woman. The patient recovered and was subsequently discharged after undergoing tracheal intubation twice and treatment with surgical incision and drainage of the abscess.

CASE PRESENTATION

Chief complaints

A 66 year-old woman was admitted to our hospital due to chills and fever on September 4, 2013.

History of present illness

Two days prior to admission, she developed chills and fever (maximum temperature 39.5 °C) accompanied by pharynx pain, chest tightness, and headache. She had no cough, sputum, wheezing, dysphagia, hoarseness, weight loss, or edema of lower extremities. The patient was initially diagnosed with acute upper respiratory tract infection on admission.

History of past illness

The patient had a history of type 2 diabetes mellitus for 4 years and denied a history of respiratory disease, trauma, or foreign-body ingestion.

Physical examination

The patient was well built and nourished. Her temperature was 39.1 °C, pulse rate was 125 beats per min, respiratory rate was 24 breaths/min, and blood pressure was 110/68 mmHg. She had no clubbing, icterus, or generalized lymphadenopathy. Clinical examinations of the respiratory, cardiovascular, gastrointestinal, and nervous systems were normal.

Laboratory examinations

Routine laboratory examinations revealed a leukocyte count of 9900/μL with segmented neutrophils (88%), an elevated erythrocyte sedimentation rate (79 mm/h), and increased C-reactive protein (42.9 mg/dL, reference range 0.8 mg/dL).

Imaging examinations

Computed tomography (CT) of the lung, magnetic resonance imaging (MRI) of the brain, and an ultrasonic study of the heart and liver were normal.

Further diagnostic work-up

On the 1st day, treatment with intravenous amoxicillin, levofloxacin, and ribavirin was initiated. On the 2nd day, the patient's body temperature remained at 39.0 °C, and the preliminary result of blood culture was gram-positive cocci; therefore, the antibiotics were changed to teicoplanin and moxifloxacin. On the 5th day, the patient's body temperature lowered, but dyspnea was suddenly worsened. The patient then went into respiratory and cardiac arrest, lost consciousness, and developed systemic cyanosis. Arterial blood gas analysis showed that arterial partial pressure of carbon dioxide was 52 mmHg, arterial partial pressure of oxygen was 57 mmHg, and pH was 7.35. The patient received cardiopulmonary resuscitation, intravenous epinephrine, and emergency tracheal intubation, and a simple breathing bag was used. She gradually regained consciousness and restored spontaneous rhythm. The patient was transferred to the Respiratory Intensive Care Unit. Penicillin-sensitive *Kocuria kristinae* was isolated from blood samples 5 d after the procedure (blood samples from both the left and right hand revealed the same bacterium); thus, a diagnosis of sepsis was made and intravenous antibiotic therapy was changed to vancomycin and piperacillin-tazobactam.

In the afternoon of the 6th day, mechanical ventilation was withdrawn and the patient was extubated as the bedside chest radiograph showed no obvious abnormalities and evaluation of arterial blood gas analysis met the weaning criteria. On the 8th day, the patient developed dyspnea again. Her heart and respiratory rates slowed, she lost consciousness again and arterial blood gas analysis showed an arterial partial pressure of carbon dioxide of 82 mmHg, arterial partial pressure of oxygen of 259 mmHg, and pH value of 7.06. She gradually regained consciousness following emergency tracheal intubation and mechanical ventilation. Acute airway obstruction was considered as arterial blood gas analysis showed obvious acute retention of carbon dioxide before the second tracheal intubation. Her symptoms rapidly improved after the second intubation, respiratory secretions were less, and a radiological examination was normal; however, the cause of a possible airway obstruction was unclear. As central nervous system diseases could not be ruled out, a lumbar puncture was performed. Analysis of cerebrospinal fluid showed a high leukocyte count (350/μL, reference range 0-8/μL) with lymphocytes (75%), no *Cryptococcus*, and an increased protein level (132 mg/dL, reference range 8-43 mg/dL), which indicated the possible presence of intracranial infection, but cerebrospinal fluid culture was negative. On the 9th day, a CT scan of the neck demonstrated soft tissue swelling of the nasopharyngeal and oropharyngeal wall, and occlusion of the nasopharyngeal and oropharyngeal cavity. Bedside flexible bronchoscopy was performed that revealed edema of the nasopharynx and oropharynx mucosa. MRI was performed on the 13th day that showed obvious soft tissue swelling and thickening in the anterior region of the neck, with stenosis of the nasopharynx, oropharynx, and upper airway (Figure 1A).

FINAL DIAGNOSIS

The diagnosis of RPA was established.

TREATMENT

The patient underwent incision and drainage of the RPA under general anesthesia on the 14th day. Histopathology of surgical specimens showed inflammatory necrosis with granulation tissue (Figure 2), and the culture of pus was negative. MRI demonstrated stenosis of the upper airway that was alleviated after surgery (Figure 1B).

OUTCOME AND FOLLOW-UP

The patient had an uneventful recovery in the postoperative period and was discharged from hospital on 26 September 2013. In the 70-mo follow-up period, she was asymptomatic and had no recurrence of RPA.

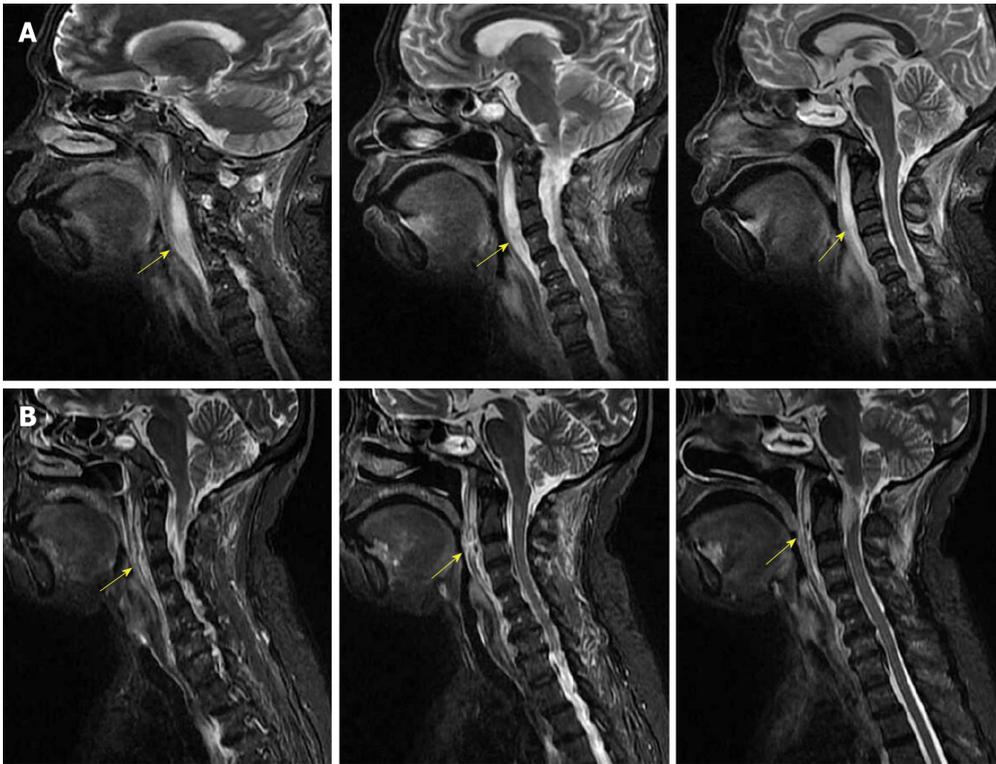


Figure 1 MRI findings. A: Contrast-enhanced MRI shows the retropharyngeal abscess and obvious upper airway stenosis (yellow arrow); B: MRI suggests that upper airway stenosis was significantly alleviated after surgery (yellow arrow). MRI: Magnetic resonance imaging.

DISCUSSION

The retropharyngeal space extends longitudinally downward from the base of the skull to the posterior mediastinum. Its posterior border is the prevertebral fascia, and its anterior boundary is the posterior portion of the pretracheal fascia. There is loose connective tissue and abundant lymph nodes within the retropharyngeal space during infancy. The lymph nodes are arranged in two rows at the midline of the neck and receive lymphatic drainage from the nasal cavity, paranasal sinuses, nasopharynx, and soft palate; thus, infectious diseases of the ear, nose, pharynx, and throat may spread through the lymph nodes resulting in RPA. RPA in infants is mostly associated with acute upper respiratory tract infection and generally has an acute course^[1]. Adult RPA is extremely rare as degeneration of the lymph nodes in the retropharyngeal space occurs after the age of 5 years. Most adult RPAs have a chronic course and are associated with cervical spine tuberculosis that spreads through the retropharyngeal space and forms a “cold abscess”^[4-5]. Due to the special anatomical location of the retropharyngeal space, an abscess can cause a series of serious complications such as jugular necrotizing fasciitis, mediastinitis, empyema, aspiration pneumonia, acute airway obstruction, or asphyxia if it spreads to the surrounding tissues^[1,6]. Acute upper airway obstruction caused by RPA is rare. Hoffmann *et al*^[2] analyzed 101 cases of retropharyngeal abscesses in children and found that only three cases had acute upper airway obstruction. In our case, the patient was an elderly woman with a dangerous clinical course that presented as acute upper airway obstruction, and her symptoms were improved after tracheal intubation, surgical drainage of the abscess, and antibiotic therapy.

“Tubercular cold abscess” was excluded as our patient was an adult with no history of oropharyngeal trauma or foreign-body ingestion. Borgohain^[4] described a case of tubercular RPA caused by cervical tuberculosis in an 18-year-old Indian man who had a good prognosis after fine needle aspiration drainage of the abscess and antitubercular therapy. In our patient, we should be alert to whether RPA was caused by tuberculosis, as China is a tuberculosis prevalent country. However, this patient’s presentation did not support tuberculosis according to the following clinical data: (1) No evidence of cervical tuberculosis was found on CT images; (2) She had a series of symptoms of acute-onset systemic inflammatory response syndrome that did not meet the criteria of “tubercular cold abscess”; (3) The patient’s intracranial infection was not thought to be tubercular meningitis according to the analysis of monism as tubercular meningitis always has more severe neurological symptoms such as high

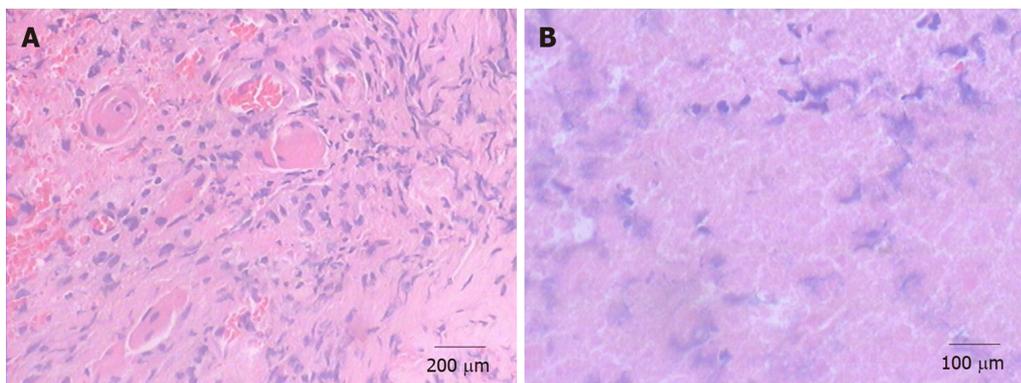


Figure 2 Histopathology findings. A: Histopathology shows granulation hyperplasia (magnification $\times 200$) in the retropharyngeal abscess tissues; B: Inflammatory necrosis (magnification $\times 400$) in the retropharyngeal abscess tissues. HE: Hematoxylin and eosin.

fever, severe headache, positive meningeal irritation signs, and no response to general antibiotics. The patient was responsive to antibiotic treatment; (4) Biopsy findings revealed inflammatory necrosis and granulation tissue with negative acid-fast staining that did not conform to the typical tubercular granuloma with caseous necrosis and positive acid-fast staining; and (5) Acid-fast bacilli were not found in pus or sputum samples. Therefore, the patient was determined to have acute non-tubercular suppurative inflammation of the retropharyngeal space.

Staphylococcus aureus is a common pathogen of retropharyngeal abscesses^[3,7]. The patient had blood cultures (from left and right hands at the same time) on admission when she had chills and fever. The culture results suggested *K. kristinae*, which were believed to be reliable and in line with systemic inflammatory response syndrome and sepsis. Unfortunately, pus culture of the RPA and cerebrospinal fluid culture were negative, which may have been related to the use of broad-spectrum antibiotics for several days. *K. kristinae* is a gram-positive coccus that is often found in the environment and on human skin. *K. kristinae* infections are uncommon but are increasingly being recognized, especially in immunocompromised patients^[8]. The patient was in the high risk population for *K. kristinae* infection as she suffered from diabetes and her normal blood glucose control was unknown. Systemic sepsis leading to metastatic retropharyngeal space abscess is extremely rare. Thus, it is inferred that the patient inhaled the bacterium into her upper respiratory tract, causing the RPA, sepsis, and intracranial infection.

Endotracheal intubation, tracheotomy, fine needle aspiration drainage, or emergency surgical drainage should be performed when acute upper airway obstruction is caused by an RPA. Intubation may result in rupture of the abscess and suffocation. Borgohain^[4] adopted ultrasonography-guided needle aspiration drainage together with antitubercular therapy that achieved a good effect with partial neurological recovery in a patient with a huge tubercular RPA. Compared to surgical drainage, ultrasonography-guided fine needle aspiration has many advantages such as less invasive, repeatable drainage, and local injection of drugs, but surgery has become a more appropriate choice when the abscess is large or the pus is sticky and difficult to drain. Hoffmann *et al*^[2] recommended that conservative medical treatment should be chosen if the retropharyngeal abscess is less than 20 mm in pediatric cases, and surgical treatment should be chosen if the abscess is greater or equal to 20 mm. At times, tracheotomy is an emergency substitute for tracheal intubation in order to alleviate the airway obstruction immediately and prevent rupture of the abscess^[1]. In our patient, intubation was an emergency option to relieve airway obstruction as throat CT or MRI had not been performed, and we were unaware of the RPA when acute airway obstruction occurred. Of course, the key to successful treatment in this patient was powerful antibiotic therapy and the subsequent combination of surgical incision and drainage.

CONCLUSION

The case in the present report is relatively rare for the following reasons: (1) The patient had an adult-onset acute RPA, which is rare in clinical practice; (2) The clinical course of the patient was not straightforward, in that the initial manifestation was acute upper airway obstruction, and the diagnosis of retropharyngeal abscess was only confirmed after two tracheal intubations when relevant examinations were

performed; and (3) *K. kristinae* isolated from the patient's blood is a relatively rare pathogen causing sepsis, and its combination with intracranial infection indicated the presence of severe systemic inflammatory response syndrome in this patient. The patient was in good condition during the 70-mo follow-up period.

ACKNOWLEDGEMENTS

We are grateful to Abigail Howard (School of Medicine, the University of Chicago) for revision of this manuscript.

REFERENCES

- 1 **Ozbek C**, Dagli S, Tuna EE, Ciftci O, Ozdem C. Giant retropharyngeal abscess in an adult as a complication of acute tonsillitis: case report. *Ear Nose Throat J* 2009; **88**: E20-E22 [PMID: [19924652](#)]
- 2 **Hoffmann C**, Pierrot S, Contencin P, Morisseau-Durand MP, Manach Y, Couloigner V. Retropharyngeal infections in children. Treatment strategies and outcomes. *Int J Pediatr Otorhinolaryngol* 2011; **75**: 1099-1103 [PMID: [21705095](#) DOI: [10.1016/j.ijporl.2011.05.024](#)]
- 3 **Hari MS**, Nirvala KD. Retropharyngeal abscess presenting with upper airway obstruction. *Anaesthesia* 2003; **58**: 714-715 [PMID: [12790821](#) DOI: [10.1046/j.1365-2044.2003.32694.x](#)]
- 4 **Borghain B**. Prompt restoration of airway along with rapid neurological recovery following ultrasonography-guided needle aspiration of a tubercular retropharyngeal abscess causing airway obstruction. *Singapore Med J* 2011; **52**: e229-e231 [PMID: [22173262](#)]
- 5 **Garg A**, Wadhwa R, Gulati SP, Kishore D, Singh J. Giant retropharyngeal abscess secondary to tubercular spondylitis. *Indian J Tuberc* 2009; **56**: 225-228 [PMID: [20469736](#)]
- 6 **Chen CH**, Wang CJ, Lien R, Chou YH, Chang CC, Chiang MC. Mediastinal and retropharyngeal abscesses in a neonate. *Pediatr Neonatol* 2011; **52**: 172-175 [PMID: [21703562](#) DOI: [10.1016/j.pedneo.2011.03.011](#)]
- 7 **Shin JH**, Sung SI, Kim JK, Jung JM, Kim ES, Choi SH, Kim YJ, Ahn KM, Chang YS, Park WS. Retropharyngeal abscess coinfecting with *Staphylococcus aureus* and *Mycobacterium tuberculosis* after rhinoviral infection in a 1-month-old infant. *Korean J Pediatr* 2013; **56**: 86-89 [PMID: [23482861](#) DOI: [10.3345/kjp.2013.56.2.86](#)]
- 8 **Cheung CY**, Cheng NH, Chau KF, Li CS. An unusual organism for CAPD-related peritonitis: *Kocuria kristinae*. *Perit Dial Int* 2011; **31**: 107-108 [PMID: [21282396](#) DOI: [10.3747/pdi.2010.00125](#)]



Published By Baishideng Publishing Group Inc
7041 Koll Center Parkway, Suite 160, Pleasanton, CA 94566, USA
Telephone: +1-925-2238242
E-mail: bpgoffice@wjgnet.com
Help Desk: <https://www.f6publishing.com/helpdesk>
<https://www.wjgnet.com>

