



# What Happens in Burma Stays in Burma:

## A Case of Psoas Abscess Presenting a Diagnostic Challenge

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### Case Presentation:

- 54 y/o M PMH Crohn's disease, HTN, prostate cancer presents with 10 days fever, N/V, left hip pain, 12 lb wt loss
- Returned 1 month prior from a 4 week trip to Burma; stayed in rural village, ate street food, hiked, contact with wildlife
- Initial vitals: T 38.7, BP 135/84, HR 116, RR 20, SpO2 98%
- Physical exam
  - Cardiac: RRR, no murmur, Lungs: CTA bilaterally
  - Abdomen: soft, non-tender
  - MSK: no joint swelling, tenderness or pain with ROM
  - Gait: antalgic, favoring right side, endorsing pain with left-sided weight bearing
- Notable initial labs: WBC 18.2, Hgb 11.9, Plt 517, CRP 670

### Diagnostic Studies:

- Blood cultures: no growth
- HIV, Malaria, EBV, RSV, typhoid, influenza: negative
- X-ray left hip: normal
- MRI left hip: large iliopsoas bursa fluid collection, concerning for an abscess (Figure 1)
- IR image-guided drainage: culture grew Streptococcus Viridans
- CT Abdomen/Pelvis: abscess redemonstrated in iliopsoas muscle, no fistula was identified between the abscess and adjacent bowel (Figure 2)

### Management & Outcome:

- Pigtail drain placed by IR and left until output <10cc/day
- Started on Ceftriaxone 2 g daily then transitioned to po Cephalexin 500 mg po q6H for 21 day course
- Colonoscopy after discharge: moderately severe proctosigmoiditis, no definite fistula identified

### Teaching Points:

- Crohn's disease is a systemic inflammatory disease with predominant GI symptoms but also a variety of extra-intestinal manifestations to look out for, including psoas abscesses
- Psoas abscesses:
  - primary: from hematogenous or lymphatic spread
  - secondary: from direct spread into the psoas muscle from adjacent structures including vertebrae, the aorta, the GI or GU tract
- Crohn's: most common disease associated w/ secondary psoas abscess
- Clinical triad: fever, back pain and antalgic gait
- Diagnosis: elevated inflammatory markers, confirm with CT or MRI
- Most common bugs: S. Aureus, E. Coli, E. Faecalis and S. Viridans
- Rx: source control (drainage) and prolonged abx course
- Avoid anchoring based on distracting elements of history (travel)
- Consider psoas abscess in Crohn's pt w/ hip or back pain + fever

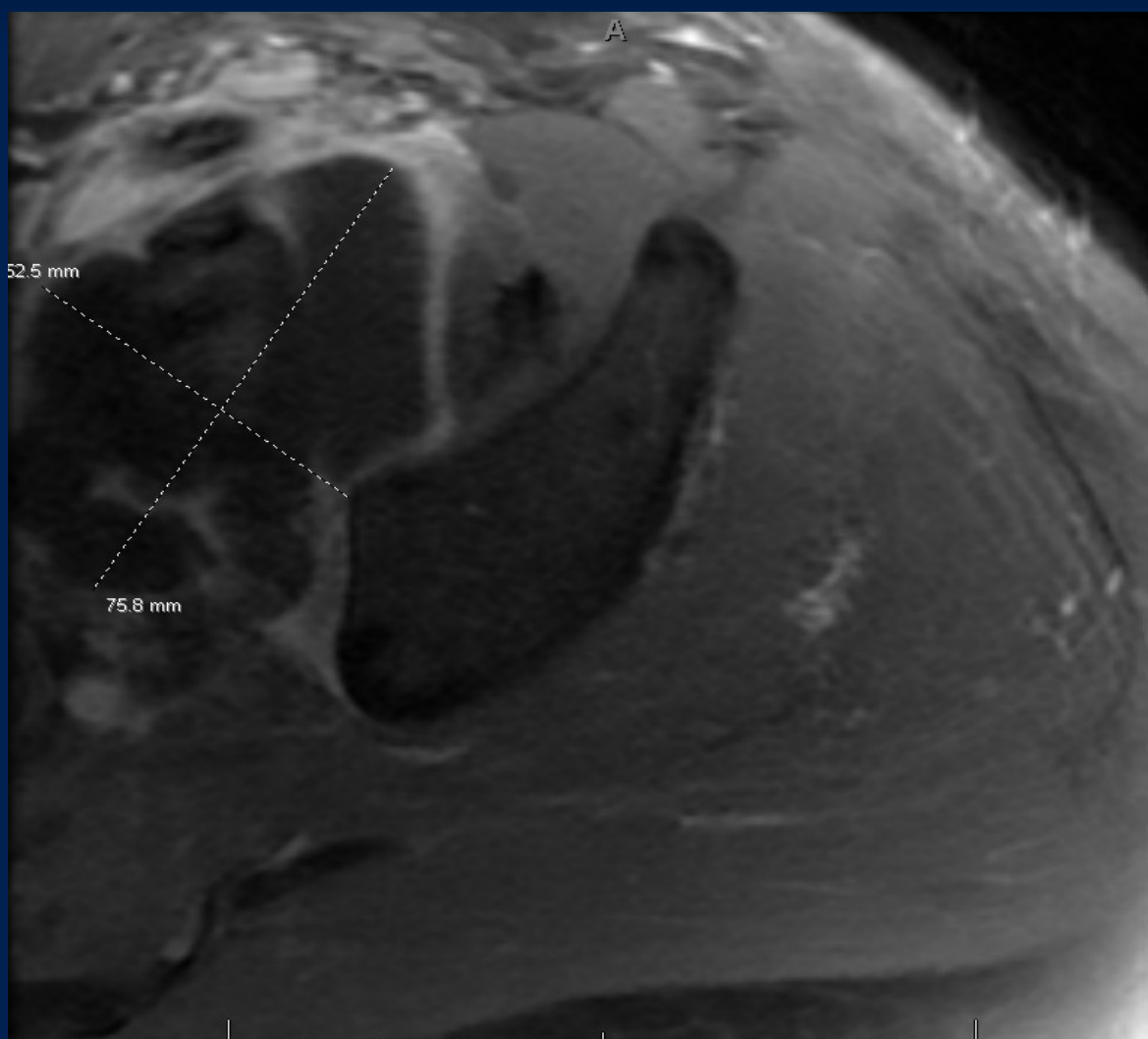


Figure 1. MRI Left Hip showing large iliopsoas bursa fluid collection concerning for an abscess

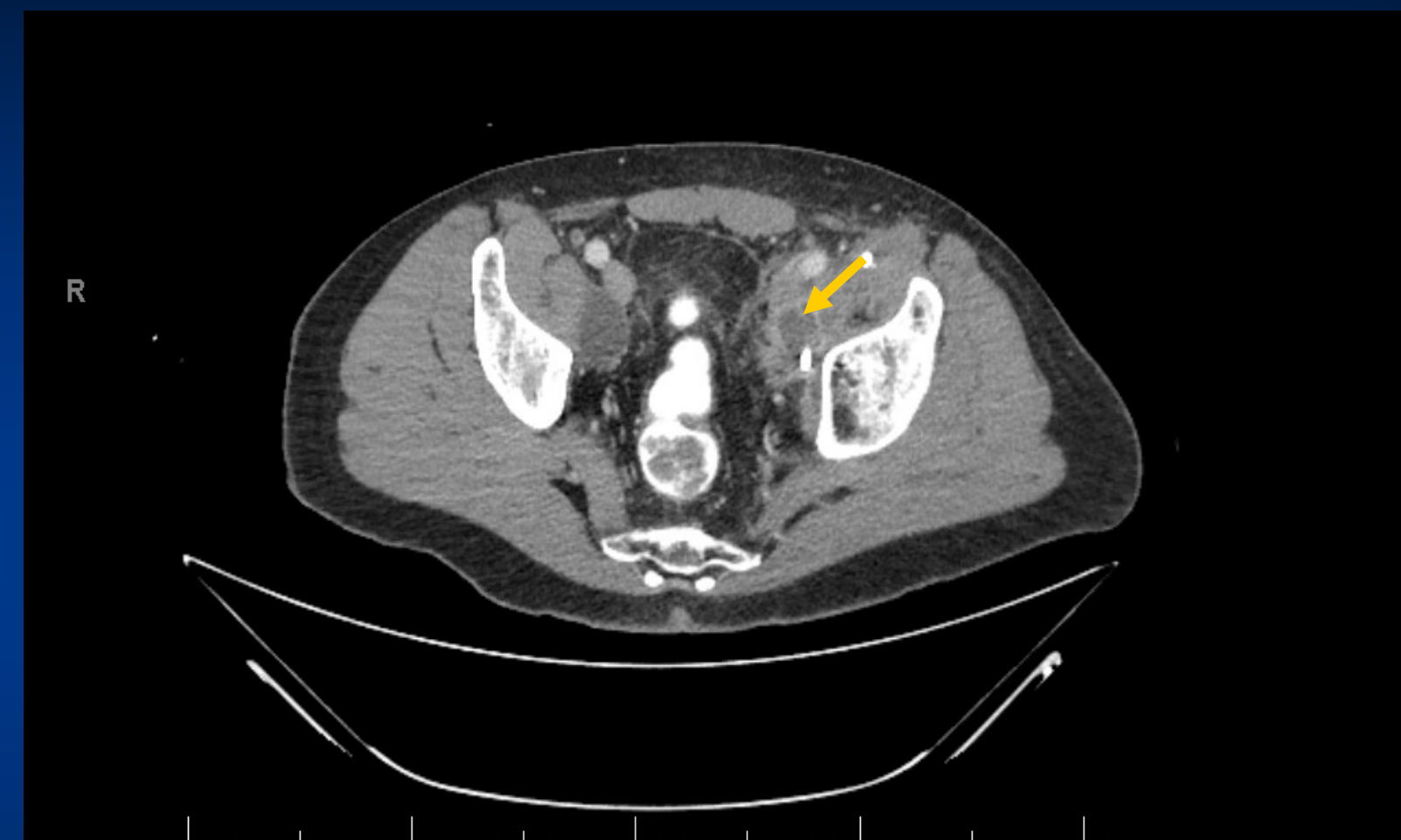


Figure 2. CT Abdomen/Pelvis showing collection within left iliopsoas muscle with enhancing wall and drain in place most consistent with an abscess. There is no evidence of connection to the bowel consistent with a fistula.

### References:

1. Santaella RO, Fishman EK, Lipsett PA. Primary vs secondary iliopsoas abscess. Presentation, microbiology, and treatment. Arch Surg. 1995 Dec;130(12):1309-13. doi: 10.1001/archsurg.1995.01430120063009. PMID: 7492279.
2. Mallick IH, Thoufeeq MH, Rajendran TP. Iliopsoas abscesses. Postgraduate Medical Journal 2004;80:459-462.
3. Shields D, Robinson P, Crowley TP. Iliopsoas abscess--a review and update on the literature. Int J Surg. 2012;10(9):466-9. doi: 10.1016/j.ijsu.2012.08.016. Epub 2012 Sep 5. PMID: 22960467.