

PRIMARY PSOAS ABSCESS

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PRİMER PSOAS ABSESİ

ÖZET

Primer psoas abseleri nadir görülmekte olup genellikle stafilokok enfeksiyonları sonucu görülmektedir. Başlangıç semptomları psoas kası inflamasyonu ve kalça eklemi enfeksiyonlarıyla benzer olduğundan ilk tanının konulması güç olabilmektedir. Bu çalışmada, 1988-1996 yılları arasında Cumhuriyet Üniversitesi Tıp Fakültesi Üroloji Kliniğinde gördüğümüz 4 primer psoas abseli olgularımızı sunduk. Hastalığın gelişimi ve patofizyolojisi literatür eşliğinde tartışıldı.

Anahtar kelimeler: psoas absesi

SUMMARY

Primary psoas abscess is relatively rare condition and is usually staphylococcal in nature. The initial diagnosis may be difficult because of the similarity between the symptoms of psoas muscle inflammation and septic hip joint. We report 4 cases of primary psoas abscess between 1988-1996. The clinical presentation of the process and pathophysiology are discussed briefly.

Key words: Psoas abscess

Infection within the psoas muscle is commonly due to direct extension from contiguous structures such as the spin, kidney, bowel loops and pancreas(1). However, primary psoas abscess is a much less common phenomenon(2). A primary psoas abscess has no obvious focus of infection. The common pathogen is staphylococcus aureus (88.4% of the cases). Other pathogens reported were streptococcus (4.9%) and Escherichia coli (2.8%). One case has been reported caused by proteus and 1 case due to pasteurilla multocida has also been described. It is believed that hematogeneous spread occurs from an occult source, analogous to acute osteomyelitis. Often a history of trauma is noted. Hematoma due to trauma may be the pathogenesis. Others have implicated tropical myositis. Some physicians have suggested low socioeconomic class and poor nutrition as risk factors(3).

Case 1

A 56 year-old man, presented with a four month history of left lumbar pain, particularly upon extension of the ipsilateral leg, intermittent fever, fatigue and a progressively increasing left lumbar mass for fifteen days. There were several antibiotherapies on past history. Physical examination revealed chronically ill appearing man, the temperature of 39,5 C, left lumbar mass with pain, decrease left leg movement . There were no urinary symptoms.

Urinalysis, chest X-R, excretory urography were normal. Blood tests showed leucocytosis with a left shift, anemia and an elevated erythrocyte sedimentation rate. CT scan showed a diffuse fluid collection in left psoas body. CT-guided percutaneous drainage failed Staph. aureus was isolated from aspiration material. He was treated by appropriate antibiotherapy, followed by open surgical drainage. After 23 day's hospitalization , We could not contact with him.

Case 2

A 5 year-old child with a 1 month history of several wounds on his face and bosoms' skin. He was hospitalized in pediatric clinic for evaluation of septic arthritis. His symptoms include a muscle spasm on his left leg , inability to walk and high fever. The diagnosis of arthritis was eliminated, by joint aspiration. After urological consultation , the patient reevaluated in urology clinic. Excretory urography showed deviation of left ureter to medial side and demonstrated retroperitoneal abscess .that emerged from lower pole kidney , spreading to bone pelvis under US study. CT scan was not performed. When he was explored , there were no abnormality on kidney and retroperitoneal space. However ,the abscess was seen in psoas muscle. Culture of the abscess

content yielded staph. Aureus that was treated by adequate antibiotherapy. The hospitalization time was fifteen days. Three months after discharge, the abscess cavity was not seen under US control.

Case 3

A 1,5 year-old child was hospitalized for evaluation of a left inguinal mass, high fever and symptoms due to urinary obstruction. On psychical examination, he had the temperature of 38,5 C, a supra pubic mass of which border was not determined on left lumbar region (probably bladder). He had leucocytosis (total white blood count 25.600mm³). Urinary culture was normal in catheterized urine specimens. Excretory urography showed a dilatation of the left kidney and proximal ureter while distal ureter could not be seen, and bladder deviation to right side. US revealed a hyper echoic mass that was surrounded by capsule. This mass emerged from posteroinferior of left kidney and spreaded to bladder level. CT scan demonstrated a diffuse collection in psoas muscle. The psoas muscle abscess was drained with left paramedian incision. Cultures of the abscess fluid yielded staph.aureus. He was in hospital for 20 days. Six months after discharge, there was no cavity on US study.

Case 4

A 20 year-old man presented with a 2 month history of a high fever intermittently, fatigue, left lumbar pain and inability to walk over last ten days. In hospital, the temperature was 37,5 C. He had a pain with left lumbar mass and also there was a pain when ipsilateral left leg kept in extension position. He had no urinary symptoms. Urinary analysis, chest X-R, excretory urography, were unremarkable. Blood tests showed leucocytosis with a left shift and an elevated erythrocyte sedimentation rate. There was a collection in psoas muscle on US study. Aspiration of the left psoas muscle under CT guidance yielded see pus. Cultures of the abscess fluid yielded staph. aureus. The abscess was drained percutaneously for 4 days. Then we repeated US study and the abscess was still there. We decided to perform open surgical drainage with subcostal incision. During operation, there was 150 cc pus that was drained completely. He was hospitalized for 15 days. After he discharges, he has not come to clinic for control yet.

DISCUSSION

Psoas muscles arise in the abdomen and iliac regions bilaterally and course downward and laterally to insert on the lesser trochanter of the femur. Distally, the muscle forms a conjoined tendon with the iliacus and courses under the inguinal ligament(4). The psoas muscle is associated closely with all the major abdominal and pelvic structures. Thus, it is subject to any infectious processes in this region and provide a pathway for progression into the posterior mediastinum or the anterior thigh (5).

The etiology of primary psoas abscess remains speculative. Although the hematogenous origin of these infections seem likely (2) Some predisposing factors should be kept in mind such as IV drug use, alcoholism, skin infection, immunosuppressive treatment and trauma. There was a skin infection in only one patient.

Psoas abscess are characterized by a flexion deformity of the thigh, a tender mass in the flank or lower abdominal quadrant. Scoliosis, fever, chills, weight loss and fatigue are often present. Urological symptoms are usually absent (2,6). In younger patients the symptoms may be insidious enough to delay the diagnosis significantly (5,7). The initial diagnosis may be difficult because of the similarity between the symptoms of psoas muscle abscess and septic hip joint (8,9,10).

Routine laboratory evaluation is rarely helpful in localizing the disease process. Anemia, elevation of the sedimentation rate and leucocytosis are often found, but these parameters are nonspecific. Urinalysis is usually negative (2,5,11).

The diagnosis is made most often by a CT is diffuse enlargement of the psoas with a control low density area corresponding to an abscess cavity (12,13) On excretory urography, ureter and bladder may be replacement with respect to localization of abscess(11).

The treatment of psoas abscess includes drainage and antibiotic therapy (6,12). Image - guided percutaneous drainage of psoas abscess is a technically simple, safe and effective method (14,15) and it appears to be an effective alternate to open surgical drainage (16). However, The patients with multiloculated abscess had open surgical drainage in our experience.

In conclusion, primary psoas abscess is much less common and the diagnosis is often delayed, leading to significant morbidity and mortality. We have to get alert when the patients

have musculoskeletal signs of hip flexion and scoliosis with intermittent fever for a while. We do not have to hesitate to prefer open surgery while the percutaneous catheter drainage is inadequate since the abscess could be multiloculated. In addition to surgery, it is reasonable to start immediate antistaphylococcal therapy in patients in whom have not a history of crohn's disease, nephrolitiasis, leading to secondary psoas abscess.

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