

Psoas Abscess Extended to the Anterolateral Abdominal Wall Complicating Acute Appendicitis

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Abstract

Case Report

A psoas abscess is a purulent collection of the psoas muscle, most often secondary to a locoregional infectious focus that may be intra- or retroperitoneal. Appendicitis ranks second (16%) after crohn's disease (60%) among digestive etiologies of psoas abscesses. Its etiological diagnosis can prove difficult. Imaging is therefore essential. We report the case of a psoas abscess extending to the anterolateral abdominal wall complicating acute appendicitis in a 24-year-old female patient admitted to the emergency department for an appendicular syndrome associated with psoitis. Imaging (abdominal CT scan) showed a huge collection in the psoas muscle extending to the right anterolateral abdominal wall. The procedure consisted of appendectomy with copious lavage and drainage with two delbet blades.

Keywords: psoas abscess, crohn's disease, acute appendicitis, acute appendicitis.

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INTRODUCTION

Psoas abscess is a rare pathology, generally secondary to the extension of an intra- or retroperitoneal infection. Diagnosis is difficult due to misleading symptoms. Delays in diagnosis and treatment can have a serious impact on functional prognosis. Acute retrocoecal appendicitis is the second most common digestive etiology for psoas abscesses, presenting an insidious clinical picture in over half of cases. Surgery should be considered rapidly in cases of large abscesses, or if percutaneous drainage fails.

CASE REPORT

We report the case of a 24-year-old woman with no specific pathological history who presented to the

emergency department with abdominal and lumbar pain that had been evolving for four weeks in a febrile context. Clinical examination revealed a fever of 39°C, with right iliac fossa and right flank defensiveness, associated with right lumbar swelling extending to the right iliac fossa and psoitis. Biological tests showed hyperleukocytosis at 17,000/mm³ and CRP at 140 mg/l. Abdominal computed tomography (figure 1) showed a collection in the right iliac fossa that appeared to communicate with collections in the psoas muscles and the right abdominopelvic wall, with an enlarged retrocoecal appendix measuring 12 mm. Surgery consisted of a McBurney appendectomy, evacuation of purulent collections from the psoas after sampling for bacteriological study, and drainage. With appropriate antibiotic therapy following antibiotic susceptibility testing, the post-operative course was straightforward.

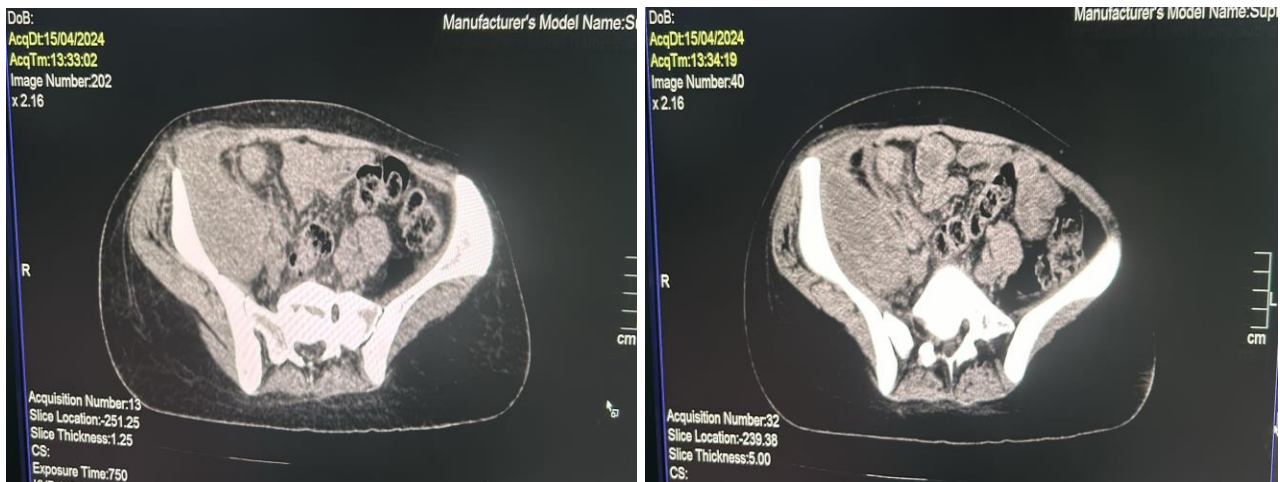


Figure 1: Right iliac fossa collection appearing to communicate with collections from the psoas muscles and the right abdominopelvic wall, with an appendix measuring 12 mm

DISCUSSION

Psoas abscesses are uncommon: 5-10% of abdominal suppurations. The clinical signs of psoas abscesses are not very specific, which explains the difficulty and frequent delay in diagnosis. Symptomatology is essentially marked by fever and abdominal and/or lumbar pain. This pain can often radiate to the hip or knee, leading to functional impotence. Biology plays little part in the diagnosis. It reveals an infectious and inflammatory syndrome with accelerated sedimentation rate and hyperleukocytosis, while blood cultures usually remain negative. The diagnosis of psoas abscess is supported by imaging data, with CT the key diagnostic test with 95% specificity. It can be used to study the extent of the collection, its volume, and any compartmentalization. In the case of multilocular abscesses, partitions are enhanced after intravenous injection of contrast medium. A CT scan can be used to determine the extent of the abscess, and to look for secondary causes (renal, digestive and bone). Treatment of abscesses is based on antibiotic therapy for a total duration of at least eight weeks, which may or may not be combined with puncture, percutaneous drainage or surgery. The indications for surgical drainage are large abscesses, multilocular non-communicating abscesses, abscesses secondary to digestive disease, and failure of percutaneous drainage. Progress depends on early management. Progress depends on early management.

CONCLUSION

Psoas abscess is a rare pathology. The initial borrowed symptomatology makes for a difficult and, above all, late diagnosis. However, the clinical triad of

fever, iliac and/or lumbar pain and renal abdominal mass is of great semiological value. Psoitis, though specific to psoas muscle involvement, is very often inconstant. Computed tomography is the most sensitive diagnostic tool. Digestive etiology, particularly appendicitis, should always be sought.

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