



**CASE REPORT –A RARE CASE OF EARLY PREGNANCY
COMPLICATED BY BILATERAL PSOAS ABSCESS**

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ABSTRACT

Psoas abscess, especially bilateral, is a rare clinical condition, which may be missed in day to-day clinical practice by general practitioners, unless there is a high clinical suspicion. And since occurrence in pregnancy is even rarer, its prompt diagnosis and effective management can result in good outcome. The following case report is a rare case of bilateral Psoas Abscess during early pregnancy and its management.

KEYWORDS: Psoas abscess, pregnancy, practitioners.



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INTRODUCTION

Psoas abscess is rare during pregnancy. There are a few reported cases in literature. Psoas abscess has been known to occur subsequent to normal deliveries, abortion, and caesarean sections^{1,2,3,4}. Case of primary pyogenic psoas abscess caused by *Staphylococcus aureus*. Because psoas abscess is rare, has an insidious onset and is uncommonly discussed in primary care medical literature, primary care physician may miss the diagnosis^{1,2}. A total of 434 cases of psoas abscesses have been reported². Psoas abscess may be classified as primary or secondary, depending on the presence or absence of underlying disease.

CASE REPORT

30 years old Mrs. Noron, coming from Pallavaram, belonging to socio-economic class 3, came to Department of Obstetrics and Gynaecology, Sree Balaji Medical College, Chromepet, with history of 45 days of amenorrhea, with regular periods, married since 14 years, had two full term normal delivery and had two spontaneous abortions with LMP on 11.04.2011 came with complaints of severe low back pain for the past two years, pain radiating to both thighs, lower abdominal pain on and off, history of white discharge present, no history of burning micturition, no history of fever, no history of trauma, no history of bleeding per vagina. Bowel and bladder habits normal. She took treatment for the same complaints for past two years. No past history of any surgeries or other medical illness. She has no adverse social habits and taking mixed diet, no significant family history. On examination, general condition fair, afebrile, no pallor, not icteric, no pedal edema, breast and thyroid normal. Vitals- pulse rate: 80 per minute, B.P : 110/70 mm Hg, C.V.S: S1S2 present, R.S : NVBS heard. On per abdominal examination, an ill defined mass of 6x6cm in left lumbar region, which was tender on palpation, mild guarding and rigidity present, bowel sounds are well heard. Also lumbo sacral and both sacroiliac joint

tenderness present. On speculum examination erosion seen in both cervical lips. On per vaginal examination movements of cervix tender, os closed, cervix pointing upwards, soft. Right and anterior fornix free, left fornix tenderness present, uterus retroverted and is of 5 to 6 weeks size. Same mass felt high up in left iliac fossa. Investigations taken, Hb- 10.1gm%, PCV-33.6%, BT-1min 55 sec, CT- 4min, BLOOD SUGAR: random-99mg%, fasting-74%, Urine routine-normal, HIV-non reactive, VDRL-negative, HbsAg-non reactive, blood group-A positive, LFT-SGOT:75IU, ALP:542 IU, other parameters are within normal limits, USG ABDOMEN: bilateral adnexal cyst with single live intrauterine pregnancy of 7+ or - 1 week gestation, right adnexa: 9.2x7.5cm with internal echoes, left adnexa: 6.3x7.2cm with internal echoes, CT ABDOMEN: gravid uterus of 6 weeks size of gestational sac is present, cystic lesion of size 7.5x7.4cm on right side and 4.3x4.4cm on left side in psoas muscle plane, extends from L2,L3, with vertebral body destruction suggestive of bilateral psoas abscess [tuberculous etiology].

DIAGNOSIS

Single live intrauterine pregnancy of 6 weeks gestational age with bilateral psoas abscess with vertebral body destruction.

PROCEDURE

Patient willing for MTP, so Tab. Mifepristone 200 mg given orally, suction and evacuation with check curettage done till uterine cavity is empty. Uterus contracted well. Incision and Drainage done for psoas abscess by Orthopaedic department. Post-operatively patients put on IV antibiotics and stable. Anti-Tubercular Treatment started after LFT.

ABSCCESS FLUID ANALYSIS: Biochemistry: sugar-40mg/dl; protein-9.2mg/dl; microbiology: AFB : negative, culture and sensitive: no growth, gram stain: pus cells presents, no organisms seen, pathology: occasional lymphocytes.

DISCUSSION

Bacteriology

Staphylococcus aureus is the pathogen in 80% of cases of primary psoas abscess. Other pathogens include *Serratia marcescens*, *Pseudomonas aeruginosa*, *Haemophilus aphrophilus* and *Proteus mirabilis*. Secondary psoas abscess is usually caused by enteric bacteria. These include *Escherichia coli*, streptococcus species, enterobacter species, and *Salmonella enteritidis*. Methicillin resistant *Staphylococcus aureus* is also a known pathogen. *Mycobacterium tuberculosis* continues to be an important pathogen, in areas of the world where tuberculosis is still common, also evidenced by recent case reports of psoas abscess caused by *M kansasii* and *M xenopi*.

Disease site Conditions

Gastrointestinal Diverticulitis, appendicitis, Crohn's disease, colorectal carcinoma, appendiceal tumor Genitourinary Urinary Tract infection, extracorporeal shock wave lithotripsy, cancer. Musculoskeletal Vertebral osteomyelitis, lumbar Infections spondylodiskitis, infectious sacroiliitis, septic arthritis. Others Endocarditis, femoral artery catheterization, infected abdominal aortic aneurysm, hepatocellular carcinoma, trauma, intrauterine contraceptive device, acupuncture, spinal surgery sepsis, suppurative adenitis, long-term hemodialysis or peritoneal dialysis cause multiloculated psoas abscesses. Scheepers et al.³ have reported psoas abscess secondary to spontaneous abortion followed by curettage + IUCD insertion. Yet another case of secondary psoas abscess has been reported by Saylam et al.⁴ after caesarean section.

Treatment

Treatment involves the use of appropriate antibiotics, as well as drainage of the abscess. Adjustments should be based on the report of abscess fluid culture and sensitivity testing. In case of psoas abscess believed to be primary, antistaphylococcal antibiotic therapy should be

started before final bacteriologic diagnosis. However, the identification of non-staphylococcus organisms in some patients with primary psoas abscess and the identification of staphylococcus in patients with secondary psoas abscess, makes it prudent in all cases of psoas abscess to start treatment with broad spectrum antibiotics pending final bacteriologic diagnosis⁵. Coverage should include staphylococcal and enteric organisms for which agents such as clindamycin, antistaphylococcal penicillin, and an aminoglycoside may be used. Drainage of the abscess may be done through CT- guided percutaneous drainage or surgical drainage^{5,6}. Percutaneous drainage is much less invasive and is effective for draining uniloculated abscess. Surgical drainage is associated with shorter hospital stay (15.9 vs 28.5 days). Antibiotics are sometimes continued up to two weeks after complete drainage of the abscess.

Prognosis

With appropriate treatment the prognosis is generally good. Primary psoas abscess has a better prognosis, the mortality rate being only 2.4%. Secondary psoas abscess has a mortality rate of 18.9%. The major cause of death is delayed or inadequate therapy. Mortality in undrained cases approaches 100%, with sepsis being the usual cause of death.

CONCLUSION

Psoas abscess is a rare condition and even more rare is early pregnancy associated with bilateral psoas abscess. As such high clinical suspicion, meticulous clinical examination corroborated with laboratory and ultrasound/CT scan help to clinch the diagnosis. The main stay of treatment is incision and drainage of the abscess and appropriate antibiotic therapy. The management of the pregnancy depends upon the gestational age and the patient's personal preference to continue the pregnancy in view of antibacterial/antitubercular treatment.

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