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Case Report

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# AN UNUSUAL CASE OF EXTRA PELVIC EXTENSION OF PSOAS ABSCESS IN A CASE OF ADPKD

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## ABSTRACT

Large Abscesses in ADPKD are unusual. Psoas abscess presenting as big palpable mass is rare. Herein we present a patient with large Psoas abscess presenting with extra pelvic extension down the gluteal region.

**KEYWORDS:** ADPKD, Psoas abscess, gluteus muscle.

## CASE DETAILS

A 45 years aged woman, a known case of ADPKD presented with right loin pain and low grade fever of one month duration. She had history of painful movements of right hip joint. There was history of painful swelling near the right loin area extending to right gluteal region. On examination, her vitals were stable. Her temperature was 100 F .Local examination of hip joint showed partial flexion with decreased range of movements. There was a swelling in the right loin area of 10x10 cm extending to right gluteal region.(fig1) Tenderness and inflammatory edema were present. Renal angle tenderness could not be elicited on right side due to diffuse swelling.

Her hemoglobin was 6.2gm/dl, serum creatinine was 7.1mg/dl, ESR was 130 mm at the end of first hour.Her TLC was 23,000 cells/mm3 and platelets were adequate. CUE showed traces of albumin and bland sediment. Ultrasound abdomen showed enlarged bilateral kidneys with multiple cortico medullary cysts RK was 15cm and LK was 16cm.Psoas muscle showed altered echogenicities. In view of suspicion of Psoas abscess, plain CT scan abdomen was done. There was evidence of 13x8 cm abscess in right Psoas muscle extending into right paraspinal area and into right gluteal reagion. There was 8x3 cm abscess collection in right gluteus muscle and 5x3 cm collection in right iliacus muscle. Lower part of right kidney and the collection were abutting each other though no apparent communication between the kidney and the hypo density could be made out (fig2). Spine and vertebral bodies were normal. Bowel loops were apparently normal. Echocardiography did not show features of endocarditis.

A contrast CT scan abdomen could not be done in view of renal insufficiency. Under ultrasound guidance, a pigtail catheter drainage of 2.5litres of thick brown muddy pus was done. Pus on culture grew Pseudomonas aeruginosa. She was placed on meropenem and metronidazole. After 8 sessions of hemodialysis, there was improvement in urine output and serum creatinine stabilised at 3 mg/dl. A repeat ultrasound at the time of discharge did not show collection. Her serum creatinine remained at 2.8mg/dl.

Psoas abscess with extra pelvic extension is rare. Our patient had an abscess in right Psoas muscle of 13x 8cm extending to right paraspinal area extending down along the Psoas muscle insertion and probably tracking over the iliac bone on to the gluteus muscles. Primary Psoas abscess occurs due to seeding from distant infection and secondary, if there is a source of contiguous spread. In our patient, there was no evidence of renal infection or cyst infection, bowel perforation. Hence, this was thought to be primary psoas abscess with an extension into gluteal region. Yoo etal reported a case of primary Psoas abscess with extra pelvic extension. Our patient had acute kidney injury due to sepsis, in addition to the extra pelvic extension.

Psoas abscess due to Pseudomonas in the absence of predisposing factor appears to be unusual. Pseudomonal infections occur in the presence of diverticular perforation, recent surgeries, prolonged hospitalizations, epidural or spinal procedures and vertebral osteomyelitis. disciitis, catheter related infections.

Psoas abscess due to pyelonephritis in ADPKD was reported by Sweet etal. But Psoas abscesss with extensive extension into lateral abdominal wall and gluteal region has not been reported. This is probably the first case of ADPKD presenting with an extensive psoas abscess. Early recognition and proper drainage of pus would yield optimistic outcome.

**Points of interest in this case are two fold**

1. Unusually large Psoas abscess with extra pelvic extension due to Pseudomonas in a case of ADPKD.
2. Early, and apt treatment may yield favourable outcome.

**Learning Points**

1. The illustrated case showed a rare presentation of clinically palpable psoas abscess with extension in to the gluteal region.
2. In addition to clinical suspicion, need for a thorough radiological evaluation and intervention is emphasized.
3. Pseudomonas related psoas abscess can occur with out any other underlying cause.
4. Appropriate selection of antibiotics and drainage would yield a favourable outcome even in huge psoas abscess.

Written informed consent for the case to be published was obtained in vernacular language from the patient for publication of case report including images.

**REFERENCES**

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2. Sweet R, Keane WF. Perinephric abscess in patients with polycystic kidney disease undergoing chronic hemodialysis Nephron, 1979; 23(5): 237-40.