

## Case Report

# Pseudocyst of the Psoas: a case report

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### ABSTRACT

Psoas abscess is usually tuberculous or pyogenic in etiology. Pancreatitis of the tail of pancreas can cause psoas pseudocyst, especially on the left side. Infection of such pseudocysts can mimic pyogenic psoas abscess, and is more common in diabetics. We report a 25-year-old non-diabetic man with acute severe pancreatitis, who developed infected left psoas abscess on follow up. The psoas abscess was managed successfully by percutaneous drainage and antibiotics.

**Keywords:** Flexor spasm, Percutaneous drainage, Psoas, Pseudocyst

## INTRODUCTION

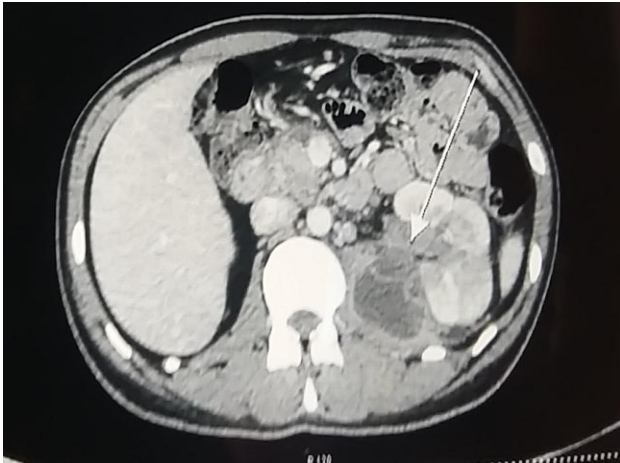
Psoas abscess is common in the developing world with the common etiologies being tuberculosis and pyogenic infections. Chronic pancreatitis can present with myriad of complications like pseudocyst, pseudo aneurysm, pancreatic abscess, splenic vein thrombosis etc. Psoas abscess secondary to pancreatitis is rarely reported.<sup>1</sup> Infected pseudocysts secondary to Pancreatitis of the tail of pancreas can present with flexor spasm, mimicking a psoas abscess. This is more common in diabetic patients with pancreatitis.

## CASE REPORT

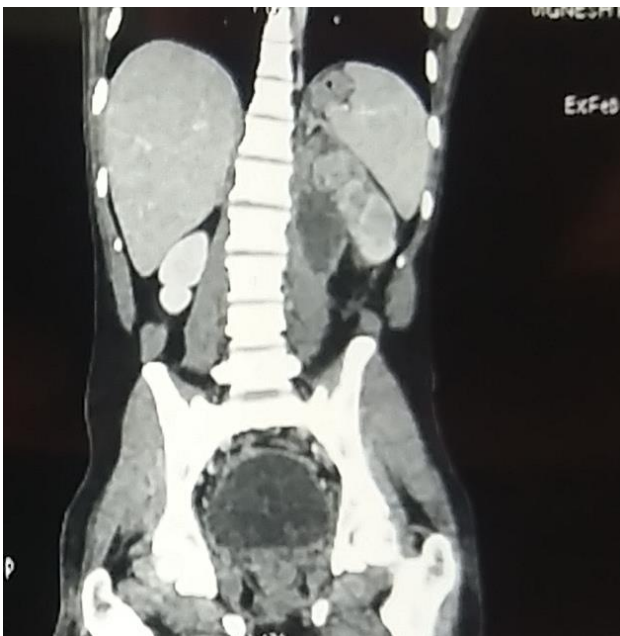
A 25-year-old chronic alcoholic presented with features of acute severe pancreatitis which was managed conservatively. Contrast enhanced computerized tomography (CECT) of the abdomen and pelvis showed edematous pancreas with no evidence of fluid collections around the pancreas. After 2 months, the patient presented with history of fever and left lumbar pain for one week duration. On examination, the vitals were

stable. General examination was unremarkable. Abdomen was soft. There was no mass palpable. Flexor spasm was evident in the left lower limb. Laboratory values are as follows: Blood sugar 120 mg/dl, Urea 20 mg/dl, creatinine 0.6 mg/dl, total counts-15000 cells/ mm<sup>3</sup>, with 70 percent neutrophils. Liver function test-normal. Serum calcium - 9 meq/dl. Serum Amylase 50 IU/L. X- ray of the abdomen and spine were normal. CECT abdomen was done which showed a normal appearing pancreas with no calcifications. A well capsulated collection of size 10 \* 8\*5 cm was seen in the left psoas muscle around the tail of pancreas. Left kidney was normal (Figures 1 and 2).

CT guided percutaneous drainage was done using a pigtail catheter. The fluid was turbid on aspiration. Biochemical analysis of the fluid was as follows: amylase 2400 IU/L; leucocytes - 400 / mm<sup>3</sup>. Culture of the fluid grew *E.coli* sensitive to Meropenem. Hence the patient was started in intravenous meropenem. The clinical condition of the patient improved well with drainage and antibiotics.



**Figure 1: CECT abdomen transverse section showing the left Psoas muscle pseudocyst (arrow).**



**Figure 2: Coronal section showing the left Psoas abscess.**

## DISCUSSION

The incidence of psoas abscess is 12/100,000/year and is mostly tuberculous or pyogenic in origin. Predisposing factors include diabetes, immunosuppression, intravenous drug use, genitourinary

infections, osteomyelitis, discitis, etc. The present case doesn't have any of these predisposing factors. Pancreatitis causing psoas abscess is rarely reported in literature.<sup>2</sup>

The triad characteristic for psoas abscess: fever, pain in the flank and limitation of hip movement as described by Mynter is rarely seen.<sup>1</sup> A positive Psoas sign may be the only indication of a psoas involvement in pancreatitis. CT is better than Ultrasound to visualize such collections due to their retroperitoneal location.<sup>3</sup> Small abscess can be managed conservatively with antibiotics. Large, symptomatic, infected abscesses require drainage-preferably percutaneous drainage.<sup>4</sup> The prognosis depends on the early diagnosis and treatment of this peculiar condition.

## CONCLUSION

This case has been presented for its rarity and to emphasize the importance of cross sectional imaging studies in follow up of patients with pancreatitis.

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