PBLI #1: UTZ findings of Psoas Abscess

Abscess, psoas,

Collection of pus in the iliopsoas compartment. The iliopsoas compartment is an extraperitoneal space which contains the psoas and iliacus muscles. The compartment is closely related to the vertebrae, pancreatic tract, ileocaecal junction, and aorta. Any inflammatory condition of these organs can involve the psoas muscle. There are multiple causes of infection and abscess formation in this space. Historically, paraspinal spread of tuberculous spondylitis was the commonest cause of psoas abscess. Since the advent of effective antituberculous drugs, most cases of psoas abscess are now pyogenic, which may be secondary to a wide variety of diseases, including spinal infection, aortic graft infection, perinephric abscess, and bowel pathology such as Crohns disease, diverticulitis (see diverticulitis colon), appendicitis or perforated colon carcinoma (see carcinoma colorectal). Primary idiopathic pyogenic psoas abscesses are rare.

Plain radiographic signs of psoas abscess are of limited sensitivity and specificity, and are insufficient to guide management. At CT, a psoas abscess manifests as a hypodense near fluid density lesion causing enlargement of the psoas muscle. Rim enhancement of varying thickness is seen after intravenous contrast. Secondary findings include inflammatory obliteration of surrounding tissue planes, gas bubbles, and bone destruction. Marked wall thickening, rim calcification, or multiple cavities are features which suggest tuberculous rather than pyogenic infection. MRI findings are similar to CT, consisting of a fluid-filled lesion expanding the psoas muscle with rim enhancement after contrast. *Ultrasound typically demonstrates an anechoic or hypoechoic lesion in the psoas compartment.* CT guided aspiration and drainage can be used to confirm the diagnosis and as therapy. Psoas abscess should be distinguished from other causes of psoas enlargement, including hemorrhage and tumour.

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The Ultrasound shows a
6.5 x 8.8 x 14.0cm collection in the right iliac fossa, extending deep into the pelvis. This was suggestive of an Ilio-psoas abscess. The liver, gallbladder, kidneys and ovaries were normal

PBLI #2: Success rate of finding the appendix in the setting of Periappendiceal Abscess.

Immediate Abdominal Exploration and Appendectomy for Periappendiceal Abscess: A Preliminary Report

Heber Belarmino, M.D. Hector T Enriquez, M.D., Stephen Sixto Siguan, M.D.

9 out of 9 *(100%)* patients diagnosed with Periappendiceal Abscess underwent Immediate Appendectomy

Immediate Appendectomy in Patients with Phlegmon/Abscess

In *majority** of the cases appendix can be removed and abscess can be drained but persistently higher rates of complications have been reported in multiple studies. (J Pediatric Surg.2002.37 (6)

**There was no mention of exact statistics on immediate appendectomies*

A FIVE-YEAR REVIEW OF PERIAPPENDICEAL ABSCESS AT STO. TOMAS UNIVERSITY HOSPITAL

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A five-year review of periappendiceal abscess was conducted at the Sto Tomas University Hospital with at total of 56 patients included. Group I was composed of 34 patients (61%) treated conservatively with interval appendectomy and Group II was made up of *22 patients (39%) treated with immediate exploration and appendectomy.* In Group I, only 10 (29%) returned for interval appendectomy. The rest (71%) were lost to follow up. Group I included those who underwent appendectomy on the first admission, consisting of 15 patients (68%) explored with 48 hours. In Group I, two patients with other pathological conditions were misdiagnosed of periappendiceal abscess. SSI occurred in 1 (10%) patient and 7 patients (31.8%) in Group II.

*This implies that **100%** of patient who underwent exploration eventually had appendectomy.*