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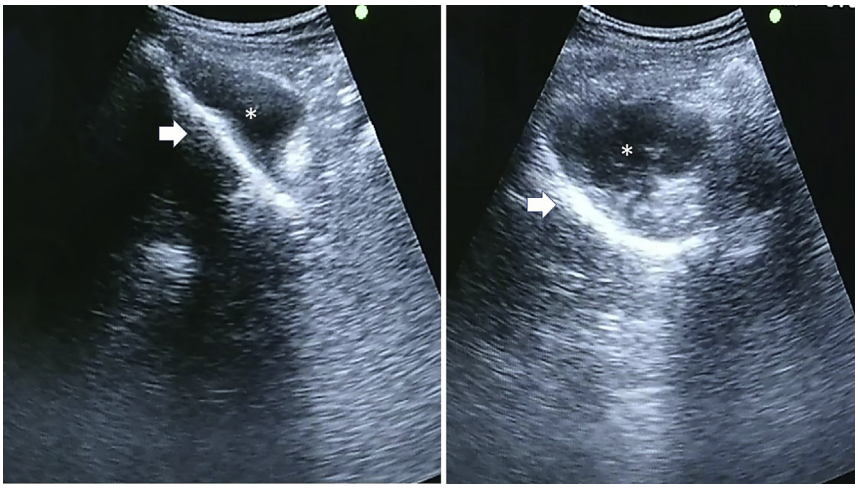

Figure 1. Ultrasonographic images in the transverse plane, located at the right lower quadrant of the abdomen. An anechoic lesion with debris over the right side of the lower abdomen (left panel, asterisk). The hyperechoic part is the right iliac crest (left panel, arrow). A multilocular lesion with debris and reverberation artifact, resulting from an abscess over the right side of the lower abdomen (right panel, asterisk). The hyperechoic part is the right iliac crest (right panel, arrow).

Figure 2. Noncontrast-enhanced CT demonstrating a 7-cm hypoattenuating lesion adjacent to the right iliacus muscle (asterisk), a finding that indicated right iliacus abscess.

[Ann Emerg Med. 2019;74:e87-e88.]

A 78-year-old man with poorly controlled type 2 diabetes mellitus presented to the emergency department with a 4-day history of fever, right flank pain, paraphasia, and slow withdrawal from painful stimuli. Vital signs showed a temperature of 38.8°C (101.8°F) and a blood pressure of 87/55 mm Hg. Physical examination revealed cold and clammy skin. He had a Glasgow Coma Scale score of E2V3M4, WBC count of 28,870/mm^3, c-reactive protein level of 26.1 mg/dL, creatinine level of 2.24 mg/dL, and normal urinalysis result. Point-of-care ultrasonography was used to investigate potential infectious processes causing septic shock (Figure 1, Video). The diagnosis was confirmed with noncontrast computed tomography (CT) after intravenous fluid resuscitation and broad-spectrum antibiotics (Figure 2).

For the diagnosis and teaching points, see page e88.
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DIAGNOSIS:

Isolated iliacus abscess. Iliopsoas abscess is uncommon, with an incidence of 0.4 per 100,000 persons.[1,2] Risk factors include AIDS, renal failure, intravenous drug abuse, and diabetes mellitus.[1-3] The mortality of primary and secondary abscess is 2.4% and 19%, respectively.[3] Causative organisms may be polymicrobial and frequently originate from the gastrointestinal or urinary tract.[1,4]

The diagnosis is challenging and often delayed because of ambiguous presentation without the classic triad: limp, back pain, and fever.[3] Ultrasonography may expedite the diagnostic process and provide therapeutic guidance, especially for an unstable patient. CT can pinpoint the location of the abscess, origin of infection, and complications. Treatment modalities include antibiotics alone for abscesses up to 60 mm or combined with percutaneous or surgical drainage.[4]

The patient recovered uneventfully after broad-spectrum antibiotics and percutaneous drainage. Culture of the abscess grew *Klebsiella pneumoniae*.

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