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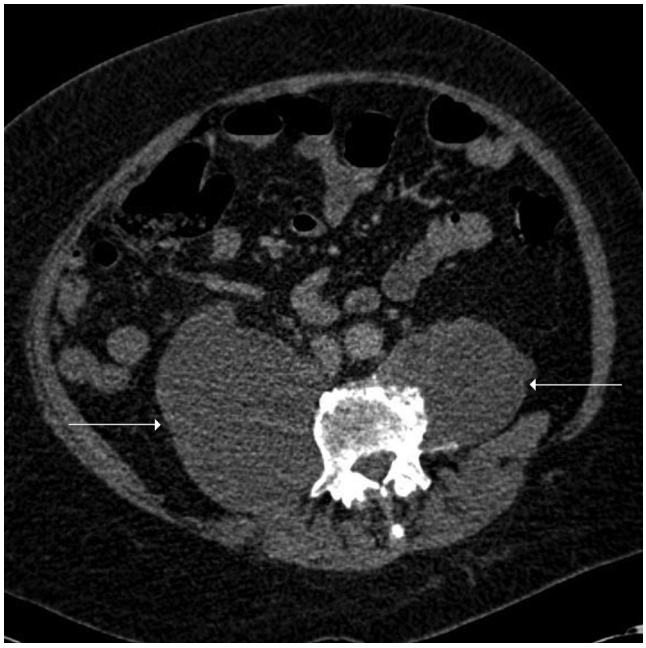

Figure 1. CT of the abdomen and pelvis (axial view).

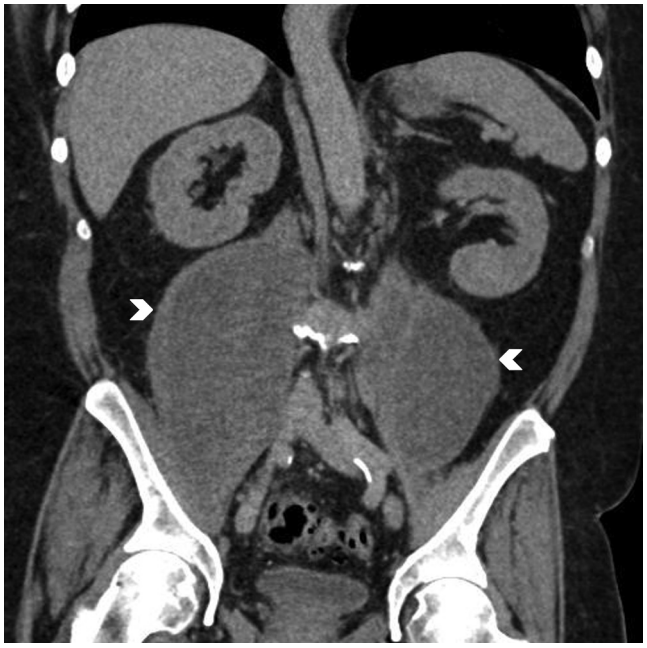

Figure 2. CT of the abdomen and pelvis (coronal view).

[Ann Emerg Med. 2019;73:e81-e82.]

A 58-year-old man with a history of hypertension and chronic back pain presented to the emergency department with worsening right-sided back pain radiating to his groin. His pain was worse with movement and associated with nausea and vomiting. The patient was initially hypotensive, with a blood pressure of 66/41 mm Hg, a pulse rate of 138 beats/min, and temperature of 100.8°F (38.2°C). On physical examination, the patient was pale and diaphoretic, with his legs flexed at the hips. His abdomen was soft and nontender. His sacrum and right groin were both tender to palpation but no hernia was appreciated. Although his urinalysis showed only 2 WBCs, his laboratory results were significant for a leukocytosis level of 18,000/mL and hemoglobin level of 5.4 g/dL. Computed tomography (CT) of the abdomen and pelvis was obtained (Figures 1 and 2).

For the diagnosis and teaching points, see page e82.
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DIAGNOSIS:

Bilateral psoas abscess. Psoas abscess is a rare condition, with an unclear incidence worldwide.[1] Patients with psoas abscesses tend to have fever, back pain, and difficulties with ambulation. They often present with leukocytosis and anemia, with definitive diagnosis by CT scan.[2] The most common bacterial cause of psoas abscess is *Staphylococcus aureus* by hematogenous or lymphatic spread, but direct seeding from adjacent structures is also possible. Treatment typically includes antibiotics and abscess drainage. The patient in this case began receiving vancomycin and piperacillin-tazobactam, and his blood pressure responded to fluid boluses. He underwent drainage of his psoas abscess by interventional radiology and was discharged on hospital day 8, receiving 2 weeks of antibiotics.

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2. Mallick IH, Thoufeeq MH, Rajendran TP. Iliopsoas abscesses. *Postgrad Med J*. 2004;80:459-462.