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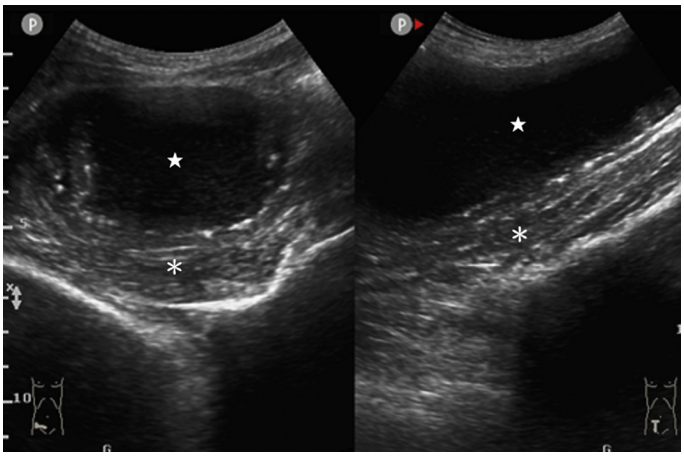

Figure 1. Point-of-care ultrasonography of the bilateral flanks, revealing fluid collection (stars) over iliopsoas compartments (asterisks), with inner wall thickening and some internal echogenicity.

Figure 2. MRI showing destruction of L1 and L2 (arrowhead) vertebral bodies, complicated with abscess formation of the bilateral psoas muscles, which demonstrate rimlike enhancement in a postgadolinium T1 fat-saturation sequence (arrows).

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A 29-year-old man presented to the emergency department (ED) with low back pain for 1 year. He had found it hard to walk upright for 1 month. He denied having any injury, fever, concurrent illnesses, or infectious contact history. He was afebrile, with a tender low back. His WBC count was 14.5×10^6/μL and the sedimentation rate was elevated, at 26 mm/h. An infectious process was queried, and the emergency physician's bedside ultrasonography of the bilateral flanks demonstrated a fluid collection over the iliopsoas compartments, with inner wall thickening and internal echogenicity (Figure 1). The diagnosis was confirmed with spinal magnetic resonance imaging (MRI) (Figure 2).

For the diagnosis and teaching points, see page e44.
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DIAGNOSIS:

Pott's disease complicated with bilateral psoas abscesses. Spinal MRI showed destruction of L1 and L2 vertebral bodies, complicated by abscess formation of the bilateral psoas muscles. Pott's disease is a combination of arthritis and osteomyelitis of the vertebrae, caused by extrapulmonary tuberculosis. Damage typically occurs at the anterior aspect of the vertebral body adjacent to the subchondral plate.[1] This is diagnostically challenging because of nonspecific symptoms that may include back or hip pain or leg weakness,[2] and spinal MRI is required for identification.[3] ED ultrasonography may expedite the diagnostic process.[4]

The patient had the abscesses drained, and *Mycobacterium tuberculosis* was confirmed on culture.

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