RIGHT GLUTEAL SINUS OF OLD INJECTION ABSCESS MIMIC AS OBSTRUCTED INGUINAL HERNIA WITH ILIAC BONE PENETRATION
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ABSTRACT: 46 percent of hospitalized medical patients received at least one intramuscular injection during their stay.1 Only 0.4% were reported to have complications. Predisposing factors for iliac bone osteomyelitis are mild trauma, urinary tract infections and Crohn's disease.6

Here we are presenting a 29 year man with non-reducible tender swelling over right inguinal region since 2 days with previous history of intra-muscular abscess on Rt. gluteus. On investigation there was sinus tract extending retro-peritoneally from gluteal to inguinal region with penetration of Rt. iliac bone after 2 year of intra-muscular injection abscess repair. CONCLUSION: Intra-muscular abscess can present with gluteal syndrome but presented as inguinal swelling is very rare and not single reference of this type of case available in literature.

CASE REPORT: A 29 years old man presented with emergency department with non-reducible tender swelling over right inguinal region since 2 days with previous history of intra-muscular abscess on Rt. gluteal region treated with twice debridement 2 years back. On examination patient vitally stable with 4X4 cm pyriform tender non-reducible swelling with negative cough impulse and normal abdomen. On investigation his total count was 18,300/cumm rest of blood investigation within normal rang. Ultrasonography suggestive of strangulated right inguinal hernia with multiple internal echoes. On inguinal exploration there was large 4x4 cm thick wall sac on posterior to cord structure and sac contain only thick yellowish pus. As suspicious of inguinal hernia with appendicitis inguinal incision explored through deep ring but abdomen was absolutely normal and sac was arising from retroperitoneum sac excised and sent for histopathological report (HPR).

On HPR the sac had epithelial lining with chronic inflammatory changes. On 4th post-operative day patient presented with serous discharge from gluteal region. CT pelvis with contrast through discharging sinus done suggestive of sinus tract extending retro-peritoneally from gluteal region to inguinal region with penetration of Rt. iliac bone.

Patient was re-operated and total sinus tract excised from gluteal region, retro-peritoneal area to inguinal region with elevation periosteum of iliac bone.
Since last one year patient is in regular follow up without complication.

DISCUSSION: 46 percent of hospitalized medical patients received at least one intramuscular injection during their stay.1 Only 0.4% were reported to have had one of the following complications: abscess, indurations, erythema, wheal formation, persistent local pain, hematoma, bleeding, and subcutaneous fat nodularity. Fatal gas gangrene, distal ischemia due to intra-arterial injection of epinephrine, Paralysis from infiltration of the sciatic nerve.2-5

Chronic osteomyelitis of the pelvis mainly involves the ileum, more often than the ischium and the pubis, maybe because it is the largest bone of the pelvis with the richest blood supply.6, 7, 8-11
When considering the site - the right iliac fossa, with involvement of iliopsoas muscle, differential diagnosis of hernias, Skeletal tuberculosis, enlargement of iliopsoas bursa and pseudoaneurysms, eosinophilic granuloma and Ewing sarcoma, septic arthritis of the hip joint, are to be considered. Predisposing factors for iliac bone osteomyelitis are mild trauma, urinary tract infections and Crohn’s disease.

Clinically ileal osteomyelitis is distinguished in three syndromes the lumbar disc syndrome, the gluteal and the abdominal syndrome, depending upon the direction. If the inflammatory process extends towards the outer wall of the ilium is called as gluteal syndrome. The main complaint is pain in the buttock. Pelvic compression is again painful. Palpation reveals local tenderness, and in the most advanced cases an abscess. Far more unusual is the presence of a sinus. There is no neurological deficit.

In the abdominal syndrome, the inflammation extends anteriorly into the iliac fossa. Symptoms and signs are similar to those of an acute appendicitis or present themselves as chronic abdominal pain.

The diagnosis of osteomyelitis of the pelvis is difficult because of its rarity, its lack of early radiographic signs, and its ability to mimic other conditions. Computed tomography is useful for planning a surgical approach. MRI can delineate the extent of the infected bone to be removed. The long-term results of chronic pelvic osteomyelitis seem to be good. If the appropriate treatment is applied: wide surgical debridement, antibiotics intravenously and later orally, and prolonged bed rest. It is logical that the diagnosis of chronic pelvic osteomyelitis is often made late, so that surgical treatment is then mandatory. The periosteum is preserved for the regeneration of cancellous bone.

CONCLUSION: Intra-muscular abscess can present with gluteal syndrome but presented as inguinal swelling is very rare and not single reference of this type of case available in literature.

10. John R Haaga, Charles F Lanzieri Robert C Gilkeson; CT and MR imaging of whole body, 1705-7


Photo I: Rt gluteal chronic scar with central sinus opening.

Photo II: Inguinal dissection with retroperitoneal sac
Photo III: CT Pelvis with contrast sinogram Shows Rt. Ileac bone penetration with retroperitoneal contrast collection.

Photo IV: Gluteal tract dissection
CASE REPORT

Photo III: Rt. Extended inguinal incision with methylene blue tract & K-wire through ileal Penetration.

Photo IV: Complete Sinus Tract.

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