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AN UNUSUAL PRESENTATION OF ISCHIORECTAL ABSCESS

Pages with reference to book, From 76 To 77

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INTRODUCTION

Neglected ischio-rectal abscess can result in spread of infection in various anatomical planes and mislead the attending physician. In such complicated cases CT scan can be very helpful.

CASE REPORT

A 49 year old male patient was admitted with a seven day history of fever and incontinence of fluid faeces and painful swelling of the left thigh. He had schizophrenia and had been on stelazine for 10 years. During the present illness he had received treatment for malaria and typhoid. He was referred to Aga Khan University Hospital with a possible diagnosis of femoral vein thrombosis. On examination, he looked toxic, temperature was 104°C, pulse 120/minute, abdomen slightly distended, fluid thrill was present and bowel sounds were normal. The left thigh was warm and its circumference increase compared to the right. All peripheral pulses were palpable. Rectal examination showed an ischio-rectal abscess of horseshoe variety with multiple sinuses discharging pus. Plain films of the abdomen showed some distended loops of small bowel suggesting ileus and the possibility of a soft tissue mass in the left side of the pelvis. The white cell count was 30.2×10^1 dl, routine hematological and biochemical investigations including random blood sugar were normal. U-scan of the abdomen was unrewarding; doppler studies showed a patent left femoral vein. The patient was examined under anaesthesia and a large ischio-rectal abscess was drained. A thorough search was made for an internal opening, which was not found¹. The organisms cultured from the pus were E. coli and klebsiella. Following this procedure the patient did not improve, continued to be toxic and the white cell count remained elevated. CAT scan of the abdomen and pelvis showed a large abscess cavity starting at the lower pole of the left kidney and extending down to the retroperitoneal space lateral and posterior to the psoas muscle then finding its way anterior to the left iliacus muscle. The abscess further tracked down into the anterior thigh till the level of the greater trochanter. Medially it tracked along the left lateral wall of the pelvis and appeared to be continuous with the apex of the ischio-rectal fossa. There was large amount of gas in the abscess cavity at various sites. Under CT guidance a size 20 Pr drain was inserted into the abscess cavity, from an extra peritoneal posterior approach², 900cc of pus was drained. With this valuable information a further EUA was performed. The retroperitoneal abscess was drained extraperitoneally and the thigh was drained by means of a separate vertical incision. The ischio-rectal cavities were re-explored and communication with retroperitoneal space was confirmed. Thereafter there was remarkable improvement in the patient's condition. Two further dressings under anaesthesia were required for residual debris³. He was discharged after 19 days hospital stay.

DISCUSSION

This case report highlights two important aspects of patient management, (i) patients who have psychiatric disorders are poor historians and their illness may progress to an advanced stage before appropriate medical attention is sought. This is partly the result of a disturbed mental status and failure to appreciate the gravity of their problems, (ii) anatomical planes of an ischio-rectal abscess and role of

CT scan in complicated cases. Pus may track up from the ischiorectal fossa to the lateral pelvic space and extend in the retroperitoneal space as high as the lower pole of kidney and may further track down to the anterior thigh behind facia iliaca. CT scan is a useful method to detect these ramifications of a complicated ischiorectal abscess and has both diagnostic and therapeutic implications.

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