

Case Report

Fungal iliopsoas abscess: A rare entity

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Abstract

Iliopsoas abscess is a rare entity that can present with unclear clinical features. The organisms responsible for infection are gram-negative germs (*Escherichia coli*, *Klebsiella* spp., *Pseudomonas aeruginosa*, *Proteus mirabilis*, *Enterobacter* spp.) and gram-positive cocci (*Staphylococcus aureus*, *Staphylococcus epidermidis*, *Streptococcus agalactiae*, *α-hemolytic streptococci*, especially *Streptococcus mitis*). It can also be of tuberculous etiology. We present a rare case of Iliopsoas abscess caused by candida albicans.

Keywords: Iliopsoas abscess, Candida albicans

1. Introduction

Iliopsoas abscess was first described by Mynter in 1881 who referred to this as psoitis¹. Depending on the presence or absence of underlying disease iliopsoas abscess may be classified as primary or secondary. Primary cause includes Diabetes mellitus, Intravenous drug abuse, AIDS, Renal failure, Immunosuppression^{2,3,4}. In over 88% of the patient with iliopsoas abscess, *Staphylococcus aureus* is the causative organism⁵. Crohn's disease is the commonest cause of secondary iliopsoas abscess⁶. Secondary iliopsoas abscess is commonly caused by streptococcus species (4.9%) and E coli (2.8%)⁵. Mycobacterium tuberculosis as a cause of iliopsoas abscess is common in the developing countries. The other causative organisms include proteus⁷, *Pasteurella multocida*⁸, *bacteroides*⁹, *clostridium*¹⁰, *Yersinia enterocolitica*¹¹, *Klebsiella*¹², methicillin resistant *Staphylococcus aureus*¹³, *salmonella*¹⁴, *Mycobacterium kansasii*¹⁵, and *Mycobacterium xenopi*¹⁶. Only few cases of *candida albicans* as a cause for iliopsoas abscess are described in the literature¹⁷. We present one such case of iliopsoas abscess caused by candida albicans.

2. Case report

A 55 year old male presented in emergency department with a 7 days history of left lower abdominal, left lower limb and low back pain. There was no history of fever, chills, dysuria, trauma or mass per abdomen. There was no history of diabetes mellitus, tuberculosis or any other medical illness. Physical examination revealed typical psoas spasm and patient was lying with left hip joint flexed. There was minimal tenderness in left iliac fossa but no mass felt. Left thigh showed features of cellulites. There was no spine tenderness or deformity. His total white cell count was normal. Other blood investigations were normal. His spine x-rays were normal. Ultrasound revealed left iliopsoas abscess with subcutaneous

edema of left thigh. Ultrasound guided aspiration was done which revealed pus. Pus was sent to clinical laboratory for culture, which revealed numerous candida albicans. Therapeutic aspiration was done under ultrasound guidance and patient was given oral fluconazole for 10 days. Patient's review course was uneventful and is doing well with 4 months of follow up.

3. Discussion

Iliopsoas abscess is a rare entity. Primary iliopsoas abscess is generally associated with immunocompromised state. The present case has no such features. Patients presents typically with classical signs of psoas abscess ie. Lower back pain, thigh pain, limping and psoas sign. All above features were present in our case. X-rays of spine was normal. Literature suggests magnetic resonance imaging or contrast computed tomography for early diagnosis.¹⁸ Ultrasound can be helpful to diagnose psoas abscess as it was done in our case. Generally, psoas abscess is caused by gram-positive cocci (especially *Staphylococcus aureus*) or gram-negative bacteria. The present case is distinctive as it shown candida albicans as an unusual cause for psoas abscess.

4. Conclusion

Thorough clinical examination, Laboratory examination and suitable imaging modalities can help to make the accurate diagnosis of this rare entity. *Candida albicans* though it is not common but should be kept in mind to cause iliopsoas abscess.

References

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