

## A RARE DIAGNOSIS WITH IRRELEVANT CLINICAL HISTORY OF ABSCESS PRESENTATION.- A CASE REPORT

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### ABSTRACT

A series of events following Rectus Abdominis muscle haematoma presenting as an anterior abdominal wall abscess is a rare cause of acute abdominal pain. The common causes include Trauma, Anticoagulation therapy, Coagulopathies, Previous surgeries, and subcutaneous injections. The occurrence of rectus sheath haematoma is a rare entity in males. Investigations of choice are USG abdomen and CT abdomen, where the latter is a confirmative investigation compared to former. Though it is a rare condition, failure to diagnosis can result in unnecessary diagnostic procedure and iatrogenic events.

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### INTRODUCTION

Anterior abdominal wall abscess following rectus abdominis haematoma is a rare entity in males with no previous history of trauma, anticoagulation therapy or Coagulopathies. Misdiagnosis is more common when these etiologies are absent and radiological imaging studies are unavailable. The treatment of choice for Rectus Abdominis Haematoma is usually conservative but surgery may be needed for progressing haematoma and a must treatment for rectus sheath abscess.

### CASE REPORT

A 49 yr old male labourer presented to the emergency department with acute lower abdominal pain for one week with a vague swelling in the left iliac fossa extending to the left suprapubic region. He is a known diabetic with no other predisposing factors like trauma, heavy weight lifting, chronic cough, anticoagulation therapy, Coagulopathies and previous surgeries.

On examination: At the time of admission patient was afebrile, BP was 110/70mm hg, PR – 66beats/min. Per abdomen revealed a vague tender mass in the LIF extending to Left suprapubic region with localised erythematous changes. Skin over the swelling was normal. Fothergill sign was positive.

Laboratory studies were as follows: Leucocytes 20,000/mm<sup>3</sup>, platelet 1.96lakhs /mm<sup>3</sup>, Hb -13.4gms, RBS – 196mg/dl. FBS 179mg/dl PPBS- 275mg/dl, Urea 31mg/dl, Creatine 1.1mg/dl, Urine routine – sugar 2+. epi 5-10cells, pus cells 3-7. bleeding time, clotting time, serum electrolytes, chest xray and ECG was normal. USG abdomen done reveals hematoma collection in the Rectus Abdominis muscle. So the patient was managed conservatively.

On the third day of hospitalisation patient presented with high grade fever of temp 102F, tachycardia of 110 beats/min and there was blister presentation over the swelling with well demarcation. So patient was started on broad spectrum antibiotics and CT Abdomen was done.

CT scan revealed irregular shaped encapsulated collections containing high fluid density contents and thin enhancing wall seen with one component lying within the intramuscular plane of the anterior abdominal wall (9.4x2.7x4.8)cms and a deep component lying in the pre-peritoneal fat plane(7.7x4x6)cms. Suggestive of parietal wall abscess. The collection indents the ventral bladder wall without any obvious intraperitoneal extension. Rest of the structures are unremarkable.

So the patient was taken for emergency Incision and Drainage of the anterior abdominal wall abscess with a lower left paramedian vertical incision over the abscess. The cavity was opened and around 250 ml of purulent material with toxic fluid was drained. Pus culture sensitivity revealed staphylococcus aureus sensitive to Gentamycin, Vancomycin, Imipenam, and Methicillin. Patient was started on Gentamycin with regular wound dressing. The wound granulated well and secondary suturing done. Post operative period was uneventful.

### DISCUSSION

Rectus abdominis muscle haematoma is a rare entity in males compared to females. Rectus abdominal muscles are enclosed in a sheath together with epigastric vessels. The lower segment of muscle is longest and it is more prone to shortening with contraction. This explains the higher incidence of haematoma in lower abdomen. Rectus sheath haematomas is due to the rupture of epigastric vessels or by tearing the fibres of rectus abdominis muscle with predisposing factor of trauma, anticoagulation therapy, Coagulopathies, complications resulting from surgeries and abdominal subcutaneous injections although it can develop spontaneously.

In this patient Rectus muscle haematoma with super adding co morbidity like diabetes mellitus has led to anterior abdominal wall abscess. These conditions may mimic different abdominal pathologies such as appendicitis, sigmoid diverticulitis, perforated ulcer,

intestinal obstruction, tumour, hernia or ovarian cyst torsion, ectopic pregnancy, abruptio placentae in females. Specific clinical history about the predisposing factors with a proper abdominal examination is virtually important.

USG and CT are the diagnostic method of choice. Whereas USG findings are non specific and inconclusive. CT permits the correct diagnosis. In our case although USG revealed a haematoma CT was required for further definition of the condition.

Majority of rectus sheath haematomas are managed conservatively whereas progressing rectus sheath haematomas or rectus sheath abscess should be managed surgically. The underlying cause of haematomas should be treated accordingly like discontinuing anticoagulation therapy, Vit k injection and fresh frozen plasma for Coagulopathies.



**FIGURE 1 Pre operative picture**



**FIGURE 2 Local necrotic tissue**



**FIGURE 3 Intra operative purulent discharge**



**FIGURE 4 Post operative picture**

### CONCLUSION

Rectus Sheath hematoma should be kept as a differential diagnosis in corresponding site organ pathology in abdomen. Abscess formation in rectus muscle is very rare. So this case is sent for its rarity.

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