노인재활

게시일시 및 장소 : 10 월 19 일(토) 08:30-12:30 Room G(3F)

질의응답 일시 및 장소 : 10 월 19 일(토) 11:00-11:30 Room G(3F)

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Gluteus and Iliacus Muscle Abscess Secondary to MSSA Bacteremia in Patient with Polymyositis ; a ca

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Background

Polymyositis (PM) is a systemic inflammatory disorder that affects the skeletal muscles and other internal organs. The 5-year survival rates for these patients range from 52 to 95%, and primary causes of death are related to several cause including infectious manifestations. Several predisposing factors in patients with PM increase their risk of developing infections. The literature indicates that, not only do patients with PM have a high rate of infectious complication (up to 33%), infection is also implicated in 46% of deaths in this patient group, which makes it a significant prognostic factor. Observed major causes of infection include soft-tissue infection such as abscesses. We experienced intramuscular abscess in gluteus and iliacus muscles secondary to methicilin-sensitive staphylococcus aureus sepsis and it was hard to detect because the patient already reported weakness and pain in hip and thigh muscles due to PM. Since abscess in those muscle groups can be combined and mimic proximal motor weakness and pain like PM, clinicians should pay attention to that if a patient has risk factors.

Case report

A 61-year-old man visited our emergency department (ED) for general weakness. In the ED, vital signs showed blood pressure of 135/80mmHg, heart rate of 114/min, and body temperature of 37.9'C. And also, reported lab showed WBC of 13380/uL, CRP of 59.4mg/dL, and procalcitonin of 38.77ng/mL, and patient was diagnosed with sepsis. After that we started empirical antibiotics and five days later, Staphylococcus aureus was grown in blood culture and it was sensitive in penicillin, so we changed antibiotics to nafcillin. At the same time, we did abdominopelvic CT (APCT) scan to find any focus of sepsis, and it showed no evidence of intraabdominal pathology. However, his general weakness did not improve with antibiotics and still reported muscle weakness especially in proximal area. So we started empirical IV steroid IV immunoglobulin under suspicion of myositis and 10 days later, muscle biopsy in vastus lateralis muscle showed inflammatory myopathy. However, mild fever continued and patient's CRP was still high of 7.9mg/dL even with use of antibiotics, so we performed follow up APCT and it showed intramuscular abscess formation in right iliacus and gluteus maximus muscles. So we increased the dose of nafcillin, changed IV steroid into po steroid, and percutaneous drainage was done to

remove the abscess. Finally, patient's lab went down to normal range and showed CRP of 3.4mg/dL.

Conclusion

Patients with PM have multiple risk factors for infections that it can induce intramuscular abscess. If the abscess involves muscles controlling proximal strength, it can mimic symptoms of PM that clinicians could possibly ignore it. So, clinicians should pay attention to uncontrolled fever or consistent high level of inflammatory markers in patients with PM with IV immunoglobulin or high dose steroid to detect intramuscular abscess early.

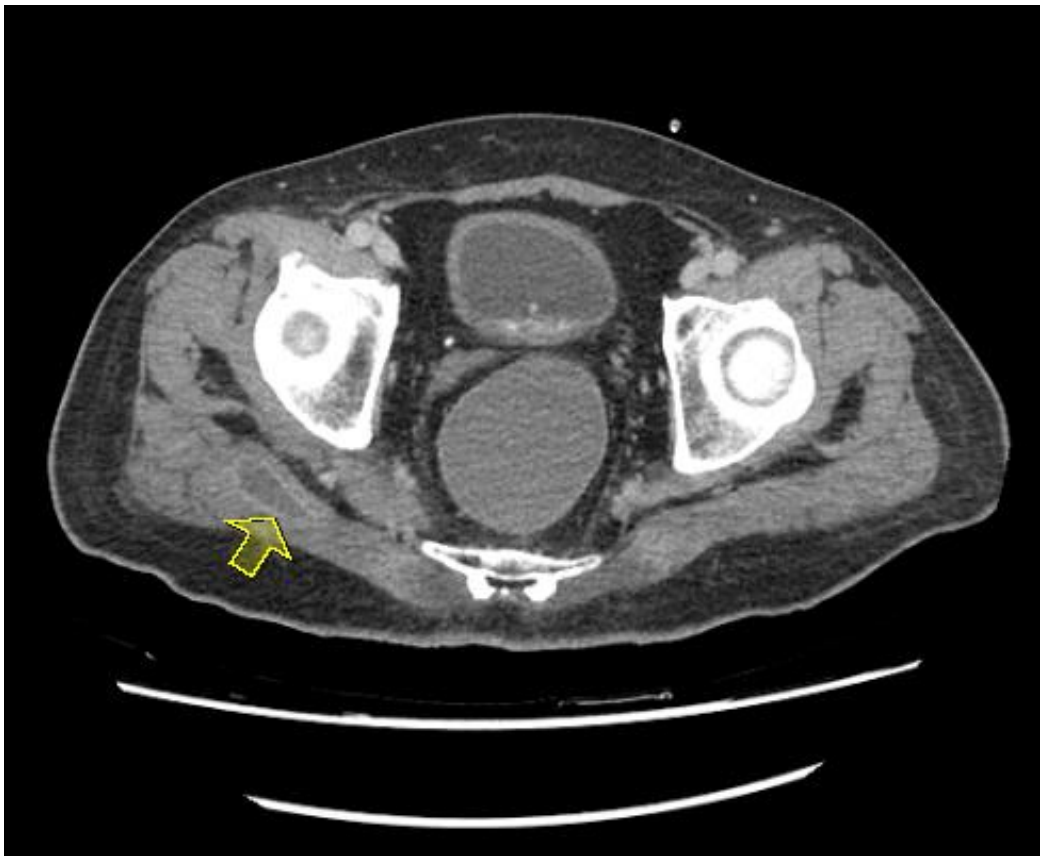

Figure 1. Abscess of gluteus maximus in APCT (Left: Before IvIg and steroid, Right: After IvIg and steroid)

Figure 2. Abscess of iliacus in APCT (Left: Before IvIg and steroid, Right: After IvIg and steroid)

Figure 3. Percutaneous drainage in right iliacus muscle