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Rare cause of iliopsoas abscess in a patient with multiple myeloma

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Patients with multiple myeloma (MM) frequently develop infections with encapsulated organisms, such as the pneumococcus, as part of the natural history of this disease. Common sites of involvement with the Pneumococcus are brain and lungs. Pneumococcal infections outside respiratory and central nervous system are rare. In the literature only 15 cases for pneumococcal iliopsoas abscess have been reported to the best of our knowledge. We present a case of iliopsoas abscess secondary to pneumococcus in a patient with MM. A 64-year-old male with MM presented with fever, chills and worsening right hip pain. An MRI of pelvis done a month ago showed lytic lesions in the right iliac bone extending into sacroiliac joint along with suspicious soft tissue mass or infectious collection measuring 2.9x 1.9cm. Patient refused CT guided drainage at that time. He received palliative radiation therapy (RT) for right the hip pain. On the last day of RT, he developed chills with fever of 38.5 C and was admitted. Physical examination was normal except severely impaired range of motion of right hip. Laboratory evaluation showed normal white cell count and unremarkable urine analysis. Chest x-ray was negative for acute findings. CT of the abdomen and pelvis showed large abscess measuring 20x10 cm overlying the iliopsoas muscle. Patient was started on broad spectrum antibiotics including vancomycin and piperacillin/tazobactam. He underwent CT guided drainage of the abscess which yielded 400 ml of frank pus. Subsequently, cultures from the blood and abscess grew *Streptococcus pneumonia*. The patient declined IV therapy and was treated with Moxifloxacin for 8 weeks. In follow up, he was pain free and had returned to his baseline mobility. Patients with MM frequently develop infections with encapsulated organisms which is attributed to deficient immunoglobulin production along with decreased complement function and neutrophil migration. Pneumococcal infections outside respiratory and central nervous system are rare. Psoas abscess can either be primary or secondary. Primary psoas abscess occurs as a result of hematogenous or lymphatic seeding from a distant site. Risk factors include diabetes, intravenous drug use, human immunodeficiency virus infection, renal failure, and other forms of immunosuppression such as MM. The classical clinical trial for psoas abscess includes fever, back pain, and limb pain. Onset of symptoms is usually insidious, as in our case, which makes the diagnosis challenging. Skeletal and soft tissue infections with Pneumococcus are unusual however prognosis is generally good with prompt intervention and antibiotic therapy. In conclusion Pneumococcal iliopsoas abscess is a rare clinical entity. However, in patients with MM and other immunosuppressive disorders, suspicion for Pneumococcus as a cause of musculoskeletal infections should be considered.

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