References

- Abbott, C. E., and Poutasse, E. F. (1961). *Cleveland Clinical Quarterly*, **28**, 283.
- Hamilton, G. R., Getz, R. J., and Jerome, S. (1953). *Journal of Urology*, **69**, 203.
- Jantet, G. H., Foot, E. C., and Kenyon, J. R. (1962). *British Journal of Surgery*, **49**, 404.
- Maldonado, J. E., Sheps, S. G., Bernatz, P. E., DeWeerd, J. H., and Harrison, E. G. (1964). *American Journal of Medicine*, **37**, 499.
- Myhre, J. R. (1956). *Circulation*, **14**, 185.
- Nicoloff, D. M. (1964). *American Journal of Surgery*, **108**, 82.
- Norris, A. D. C., Murray, M., Mantell, B. S., and Singh, M. (1971). *British Journal of Urology*, **43**, 395.
- Scheiffley, C. H. (1960). *Journal of the American Medical Association*, **174**, 1625.
- Schoenfeld, M. R., and Bernstein, R. (1971). *American Journal of Medicine*, **50**, 845.
- Wise, G. J., Bosniak, M. A., and Hudson, P. B. (1967). *British Journal of Urology*, **39**, 170.

Case of Pyomyositis Occurring in London

D. W. ROGERS

British Medical Journal, 1973, 3, 679

Pyomyositis—the formation of abscesses in one or more skeletal muscles—is a common cause of hospital admission in tropical countries, where its incidence does not appear to be related to any particular racial, social, or nutritional factor (Robin, 1961). Its occurrence has only rarely been reported in the indigenous population of temperate countries and such reports are found principally in the older literature (Holm 1924; Ryle, 1948). A recent account described three cases successfully treated in Boston, but all three patients had arrived from tropical countries within the previous three months (Levin *et al.*, 1971). The disease is here reported in a Londoner of Irish extraction, who gave no history of travel overseas.

Case Report

The patient was aged 51. In 1937 he had been admitted to hospital for two years with spinal tuberculosis which had left him with a pronounced kyphosis. In 1955 reactivation of his tuberculosis was treated with streptomycin and isoniazid, and in 1957 he was given further treatment with para-aminosalicylic acid and isoniazid. In 1965 he was seen as an outpatient suffering from a productive cough, but there was no evidence of a recrudescence of tuberculosis.

On 2 March 1971 he was admitted to hospital complaining of pain in the left buttock and leg for the past 12 days. Ten days before admission he had been seen by his general practitioner who noted that movement at the hip was limited by pain and that the patient was afebrile, and he prescribed phenylbutazone. Four days before admission the patient had noticed a swelling developing in the left buttock.

On admission he had a temperature of 101°F (38.3°C) and was sweating profusely. His left buttock and thigh were red, oedematous, and tender, and movement at the hip was severely limited. His pulse rate was 128/min and blood pressure 100/55 mm Hg. Physical examination was otherwise non-contributory.

His chest x-ray film examination showed changes of pleural thickening at the left base. X-ray film examination showed no lesion of the bones of the left hip, and this was confirmed by repeat films. Analysis, microscopy, and culture of urine showed nothing abnormal. Sputum grew commensals only and Löwenstein cultures were sterile. Blood cultures on admission and on three subsequent occasions were sterile. His white blood count was 25,500/mm³ (70% neutrophils, 20% band cells) and his E.S.R. was 115 mm in the first hour (Westergren).

Initially his swelling was thought to be a severe cellulitis and he was treated with intramuscular penicillin 1 megaunit six-hourly, subsequently increased to 2 megaunits six-hourly. Despite this he continued to have a swinging fever and the oedema of his leg increased.

Fluid exuding through the skin was sterile. Six days after admission his antibiotic therapy was changed to intravenous cephaloridine 2 g eight-hourly. On the 13th day after admission definite fluctuation could be felt within what was now a tense, red, tender, localizing swelling over the lateral left thigh and buttock. The swelling was explored (Professor N. L. Browse) and showed a vast abscess cavity lying in an intermuscular position deep to the gluteus maximus and fascia lata (see figure). About 800 ml of pus were drained. The greater trochanter formed the floor of the abscess cavity but the bone felt normal. Postoperatively intravenous cephaloridine was continued for three days by which time the patient was afebrile. The postoperative course was uneventful apart from a chest infection, and he was discharged from outpatients very well three months after admission.

Histology of the muscle taken at operation from the abscess wall showed non-specific chronic inflammation with some acute inflammatory cells. There was no evidence of tuberculosis or fungus, and though Gram-positive cocci were seen in the pus obtained, culture of the pus was sterile. Subsequent swabs from the wound grew a coagulase-positive staphylococcus resistant to penicillin, and a similar organism was grown from a nasal swab taken the day after operation.

Extent of abscess.

Comment

The patient's clinical course corresponded with that of tropical myositis seen in Africa, where it is a cause of considerable morbidity (Taylor and Henderson, 1972). A week of localized pain and tenderness, not apparently associated with pyogenic infection, was followed by abscess formation, which eventually necessitated surgical intervention. In the tropics, extramuscular complications such as pneumonia, septic arthritis, or anaemia may obscure the diagnosis of the abscess. The absence of recent reports of the disease in non-tropical countries may indicate that occasional cases are occurring unrecognized.

The diagnostic difficulties and appropriate treatment should be borne in mind when patients present with tenderness and swelling related to the skeletal muscles.

I thank Dr. M. D. Rawlins for suggesting that this case should be reported, and Professors W. I. Cranston, M. S. R. Hutt, and N. L. Browse for their advice and encouragement.

References

- Holm, G. (1924). *Acta Chirurgica Scandinavica*, **51**, 415.
- Levin, M. J., Gardner, P., and Waldvogel, F. A. (1971). *New England Journal of Medicine*, **284**, 196.
- Robin, G. C. (1961). *Journal of Tropical Medicine and Hygiene*, **64**, 288.
- Ryle, J. A. (1948). *Natural History of Disease*, 2nd edn., p. 226. London, Oxford University Press.
- Taylor, J. F., and Henderson, B. F. (1972). In *Medicine in a Tropical Environment*, ed. A. G. Shaper, J. W. Kibukamusoke, and M. S. R. Hutt. London, B.M.A.