

Not all pelvic masses in women are of gynaecological origin! Ikhatua EP, Kumar G, Thornton M.

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INTRODUCTION

We present an unusual cause of pelvic mass and pain in women. Perforation with generalized peritonitis may result from rupture of a diverticular abscess [1]. The most common feature is usually pain in the LLQ due to involvement of the sigmoid colon,[2] Nausea and vomiting occur due to bowel obstruction or ileus due to peritoneal irritation.[3] Patients may have localized peritoneal signs,[4] Elevated CRP and leukocytosis can support the diagnosis,[5] Differential diagnoses include some gynaecological conditions.

CASE DETAILS

56-year-old female referred from primary care as a case of "suspected ovarian malignancy". She presented with 3 weeks of gripping left lower abdominal pain, shooting down the left thigh, diarrhoea, vomiting, loss of appetite and feeling unwell. Previous treatment for breast cancer was noted. A firm, immobile palpable 20 weeks size mass was noted in the left lower abdomen.

She was admitted from the clinic for analgesia, intravenous fluids, anti-emetics & investigations.

WBC (high) = 18.1×10^9 g/L

CRP (high) = 248 mg/L

Serum sodium (low) = 129 mmol/L

CA125 (normal)= 16 U/L

CT Abdomen + Pelvis: hydronephrotic left kidney with hydroureter down to the pelvic brim. Large multi-locular abscess (11.6 X 7.3 X 8.0 cm) probably arising from perforated sigmoid colon with diverticular disease [Figure 1].

MANAGEMENT

Multidisciplinary involvement of Gynaecologist+ Colorectal surgeon + Interventional radiologist Percutaneous drainage of the abscess using the Seldinger technique performed

Intravenous tazocin and metronidazole for 3 days; thereafter oral co-amoxiclav based on sensitivity result, for a total of 14 days.

She was discharged home 3 days after the intervention.

Follow-up CT Abdomen + pelvis two weeks after: Large left pelvic collection had almost completely resolved. Residual 12mm collection in the left iliac fossa [Figure 2].

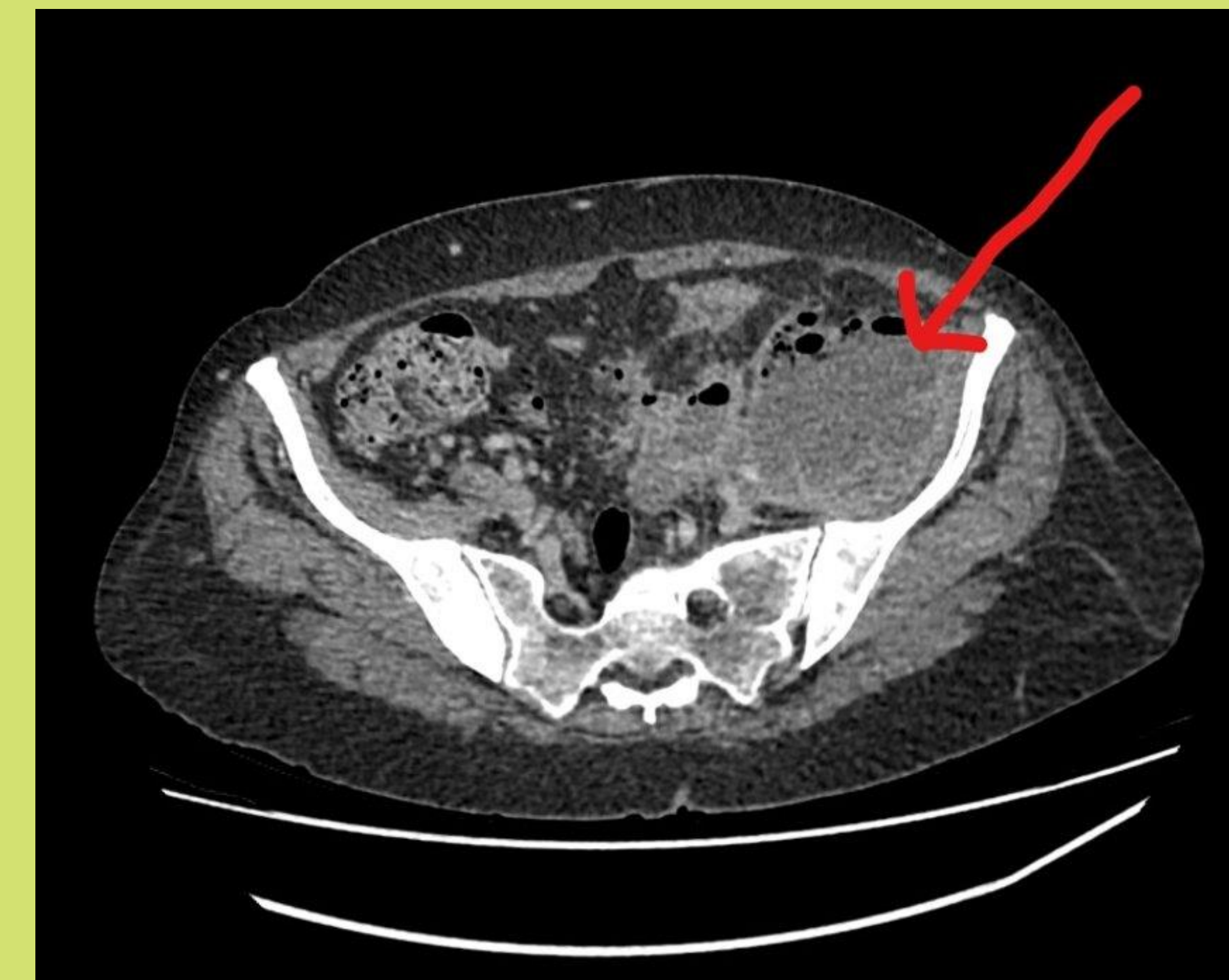


Figure 1: Before drainage of the pelvic abscess



Figure 2: After drainage of the pelvic abscess

CONCLUSIONS

- This case illustrates the need to think of bowel as a potential cause of pelvic mass in females and the need for urgent referral, admission and investigations for timely management with MDT involvement.
- A high index of suspicion for non-gynaecological causes in such situations enables appropriate management to ensure a good outcome as in this case.

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