To be or not to be……..in operating theatre for pelvic abscess

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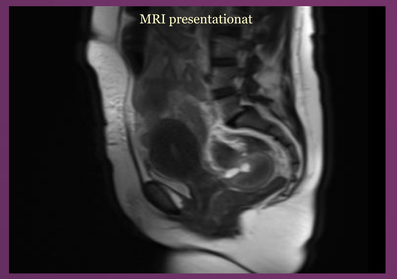
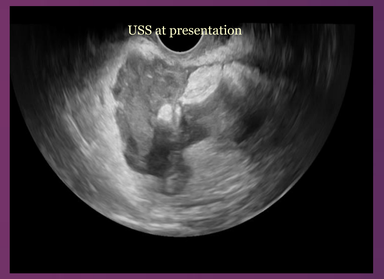
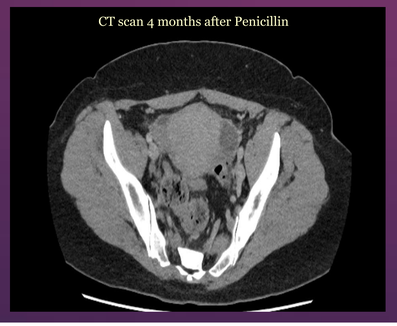
Introduction: Pelvic abscesses are often encountered in gynecology. The common causes in gynecological practice are STI's, post-operative complications, prolonged use of IUCD, ruptured appendix. Management options include treatment with antibiotics and surgery. Actinomycosis associated with IUCD use are reported often, but rare.

Case presentation: We present a 46 year old patient, three previous normal births, in a marital relationship with acute onset of abdominal pain with mild pyrexia. Patient had mild tachycardia, general abdominal distension with significant tenderness; Pelvic assessment revealed IUCD. Swabs taken, copper coil removed and sent for microscopy and C/S. CRP: 520, Hb: 117, WCC: 26x10. CT scan revealed significant abdomino-pelvic collection involving bowel and omentum; Ca125 of 151. IV antibiotics commenced for PID in line with departmental protocol. Pelvic USS scan and MRI showed bilateral pelvic masses. Culture from vaginal swab and IUCD did not show any micro organisms and negative for STI's. Gyne Oncology MDT review concluded benign pathology (PID) and surgical management was advised.

Symptoms improved on IV antibiotics and patient discharged home with gynecology OP follow up to plan elective surgery as advised by MDT. Consultant reviewed patient in clinic. Although culture did not yield actinomyces like organisms, it was concluded that actinomycosis is most likely the cause of her pathology. Commenced long term oral Penicillin V for actinomycosis rather than surgical intervention.







CT 4 months after Penicillin V showed significant improvement. USS in 8 months showed complete resolution of disease.

Discussion: Actinomycosis following IUCD use is commonly reported and often leads to abdomino-pelvic collection, giving a confusing impression of PID or malignancy. Good history and clinical judgement are necessary to establish accurate diagnosis of Actinomycosis as cultures for Actinomyces may be negative. Actinomyces cause slowly progressive granulomatous disease affecting all abdomino-pelvic organs and retro-peritoneal space leading to abscesses. Untreated abdomino-pelvic actinomycosis can lead to visceral perforation. Good clinical judgement and long term treatment with Oral Penicillin V was all that was necessary and not surgery.

Conclusion: It is vital to consider possibility of actinomycosis in women presenting with abdomino-pelvic collection with IUCD. Imaging often confuses picture with malignancy. Treatment with long term Penicillin upward of 12 months may be necessary and **NOT** surgical intervention.