Bilateral thigh pain after treatment for prostate cancer

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DESCRIPTION

A 78-year-old man presented with 6 weeks' debilitating thigh, groin and gluteal pain, weight loss and morning stiffness in the absence of fevers. His history was significant for prostate cancer (T₁N₀M₀) treated initially by brachytherapy in 2001 and then transurethral resection of the prostate (TURP) in 2003. Plain x-ray of hips and pelvis, rheumatological screening and creatine kinase were normal while his C reactive protein (CRP) was 83 mg/l (N<5 mg/l). Ongoing symptoms prompted a CT scan of his abdomen and pelvis (figure 1).

The CT demonstrated bilateral adductor compartment collections (figure 1A). A CT cystogram (figure 1B) demonstrated a sinus track towards the adductor regions bilaterally with associated pubic symphysis osteomyelitis. A cystoprostatectomy with ileal conduit diversion confirmed pubic symphysis

osteomyelitis and necrotic prostate that cultured *Candida albicans* and *Pseudomonas aeruginosa*. Postoperatively, he required a 6-week intravenous antibiotic course followed by a 3-month oral antibiotic tail. He has remained well off the antibiotic therapy.

Pubic symphysis osteomyelitis arising from a fistulous communication after urological surgery or instrumentation has been reported in the literature, predominately as an acute presentation,¹ often years following the initial management.²

Chronic pubic symphysis osteomyelitis with bilateral adductor abscesses is rarely reported. Unilateral and bilateral thigh abscesses have been reported following female incontinence surgery and transurethral resection of the prostate.³ Thigh abscess formation predominately occurs acutely, unilaterally, secondary to haematogenous osteomyelitis or gynaecological procedures. Readers should be aware that abscess development may occur years after prostate cancer treatment and that the presentation may be indolent.

Figure 1 (A) Postcontrast axial CT scans through the pelvis and upper thigh demonstrate bilateral adductor musculature collections, with thin rim enhancement and minimal surrounding fat stranding (arrows). (B) Coronal CT through the pubic symphysis demonstrates a 'Y'-shaped tract extending from the sinus track towards the adductor regions bilaterally as a cause for the adductor collections demonstrated in (A). Erosive, destructive changes of the pubic symphysis in keeping with osteomyelitis (arrows). A gas locule is demonstrated on the right (white arrowhead).

Learning points

- ▶ Thigh abscess, secondary to fistula formation, can have an acute or chronic presentation following prostate cancer treatment.
- ▶ Thigh abscesses may clinically present in an indolent manner and mimic rheumatological conditions.
- ▶ Combined surgical management and prolonged antimicrobial therapy are required for its cure.

Competing interests None.

Patient consent Obtained.

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REFERENCES

- 1 Matsushita K, Ginsburg L, Mian BM, et al. Pubovesical fistula: a rare complication after treatment of prostate cancer. *Urology* 2012;80:446–51.
- 2 Pesce F, Richetti R, Rubilotta E, et al. Vesico-crural and vesicorectal fistulas 13 years after radiotherapy for prostate cancer. *J Urol* 2002;168:2118–19.
- 3 Chung SD, Lu CW, Chiu B, et al. Urethro-subcutaneous fistula and bilateral abscesses of the thighs. *Int J Infect Dis* 2009;13:e523–4.

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