watery diarrhoea. The patient also had positive blood cultures for *Streptococcus bovis*—an organism often associated with gastrointestinal malignancy. He was referred to the general surgical team for further investigation. An iliofemoral deep vein thrombosis was suspected and this was confirmed with duplex. CT, done to investigate the abdominal pain and diarrhoea, revealed a 6.5 cm right internal iliac artery aneurysm, with no evidence of rupture, compressing the right iliac venous system. Thrombus was noted in the right common iliac vein and inferior vena cava. A filter was placed in the inferior vena cava and the right internal iliac artery aneurysm was treated by coil embolization.

At six months the lower limb oedema had completely resolved. Despite endoscopic and radiographic examinations the cause of the anaemia was never found.

COMMENT

Internal iliac artery aneurysms make up less than 0.5% of all intra-abdominal aneurysms.¹ Because of their rarity and their depth in the pelvis they are difficult to diagnose and tend to present late with symptoms from compression (urological and neurological symptoms, constipation, leg oedema, iliofemoral thrombosis^{1–3}), expansion, fistulation and rupture. Our two patients developed lower limb oedema due to venous and lymphatic compression, with subsequent cellulitis in one case and deep venous thrombosis in the other. We have not found a previous report of cellulitis as a presenting symptom of an internal iliac artery aneurysm. The natural history of these aneurysms is of expansion and eventual rupture. Rupture is associated with a 58% mortality.^{2,4} Surgical treatment poses a formidable technical challenge^{2,4} with a mortality of 10% even in cases treated electively.² Percutaneous coil embolization to thrombose the sac may obviate the need for an open procedure, but only a few case reports are available.³ If there is no proximal neck, stent grafts can be used to occlude the aneurysm origin.¹ Development of venous thrombosis after embolization of an internal iliac artery aneurysm has been reported previously—the result of continued pressure from the embolized aneurysm.² In a separate reported case, a patient was treated by venous thrombectomy, venous stenting and arterial coil embolization.⁵ In our case 2, venous stenting proved unnecessary.

Internal iliac artery aneurysms should be considered as a potential cause of cellulitis unresponsive to conventional treatment or as a rare cause of lower limb oedema and deep venous thrombosis. Percutaneous coil embolization with venous stenting can be an effective treatment in these circumstances.

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Crohn's disease and discitis

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J R Soc Med 2004;**97**:484–485

CLINICAL SECTION, 17 OCTOBER 2002

Abscess formation, from deep fissuring of the bowel wall or suppuration within lymph nodes and local fistulation, develops in as many as 20% of patients with Crohn's disease.¹ Several cases of vertebral and paravertebral infection have been described in association with enteric fistulas. Isolated discitis, however, has been little reported.

CASE HISTORY

A man of 58 consulted his general practitioner because of abdominal pain, diarrhoea and weight loss. An abdominal X-ray had shown partial obstruction of the large bowel and the possibility of air within the bowel wall. After admission to hospital he developed peritonitis from perforation of the descending colon and underwent left hemicolectomy, loop ileostomy and splenectomy (the inflamed colon being adherent to the spleen). Post-operatively he did well until the onset of high fever and leucocytosis due to an intra-abdominal collection. Percutaneous drainage of this collection resulted in a chronic colocutaneous fistula, specimens from which grew pseudomonas species. The fistula improved and he was discharged from hospital. A few weeks later, however, he had to be readmitted with recurrence of his intra-abdominal collection and the fistula. He also had severe back pain. Again the fistula grew pseudomonas species. A sinogram showed a possible connection to bowel at the

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colonic anastomosis, and an incidental finding was spondylolisthesis of the fifth lumbar and first sacral vertebrae (L5/S1).

After several weeks of severe back pain MRI of his lower back showed inflammation in the L5/S1 disc but no connection between the disc and the fistula (Figure 1 and Figure 2). Aspiration of the disc yielded pus from which pseudomonas species were grown. The patient was treated with long-term antibiotics and became free from back pain.

Figure 1 Coronal STIR MRI. High signal lateral to the left psoas muscle indicates inflammation in this area; however, the inflammation is not seen to extend directly into the L5/S1 disc space (black arrow). High signal at the L5/S1 disc space represents discitis (white arrow)

Figure 2 Coronal STIR MRI through posterior abdominal wall. High signal intensity lateral to left erector spinae muscles (arrow) indicates inflammation; however, this inflammation is not directly extending into the L5/S1 disc space

The fistula also healed. Subsequent colonoscopy revealed inflammation of the transverse and ascending colon, and biopsy appearances were compatible with Crohn's disease. He was started on azathioprine and the ileostomy was closed without incident.

COMMENT

The striking feature of this case was the apparent lack of a fistula from the gut to the infected disc. Pande and co-workers² described a patient not unlike ours with a presacral abscess and osteomyelitis of the L4 and L5 vertebrae, but the route of infection in that case was clearly an enteric fistula. We postulate that in our patient the route of infection was haematogenous, through the vertebral venous system and then retrogradely into the vertebral venous plexus.

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Facial eczema and sight-threatening glaucoma

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J R Soc Med 2004;**97**:485–486

Topically applied steroids are effective in the treatment of eczema, but when applied regularly to facial lesions can cause sight-threatening glaucoma.

CASE HISTORY

A man aged 42 was referred to eye casualty by his general practitioner after two months of intermittent and increasingly frequent blurring of vision in his left eye. He had atopic eczema (present from childhood)

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