Online Case Report

A diverticular 'pain in the bottom'

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This is the case of a 40-year-old man with a gluteal abscess as the first presentation of diverticular disease. As well as the unusual site, imaging revealed the lack of a connective tract between the abscess and the abdominal cavity or retroperitoneum. In addition, a lack of gastrointestinal symptoms made this case very unusual. Hence, this highlights the need for a high index of clinical suspicion when the usual clinical pointers that guide to the diagnosis of diverticulitis are absent.

Keywords: Diverticular disease – Gluteal abscess

Case Report

A 40-year-old male presented to the surgical emergency unit with a 4-day history of pain in the right lower back. There had been no change in bowel habit or abdominal pain. He had no past medical history of note. He was acutely unwell with rigors and a temperature of 39°C. Within 24 h of admission, he had developed jaundice, septic shock, disseminated intravascular coagulation and renal failure, requiring admission to the intensive care unit.

Blood cultures, taken on admission revealed a pure growth of *Escherichia coli* and intravenous antibiotics were started. Following admission to the ICU his clinical picture improved, but he began to complain of severe right buttock pain. The area was highly inflamed and tender and a gluteal abscess was diagnosed. Because the abscess developed after the onset of the acute illness, it seemed likely to be a consequence of the generalised sepsis rather than the cause. Hence, computerised tomography (CT) was carried out to look for a focus of origin of the sepsis. It revealed multiple sigmoid diverticulae with a pericolic abscess as well as a large gluteal abscess (Fig. 1). There were also multiple foci of low attenuation in both kidneys and liver, which appeared to be infective in nature. The gluteal abscess had

no connection to either the abdominal cavity or retroperitoneum. The gluteal abscess was drained under general anaesthesia, the pericolic abscess began to resolve and the patient continued to improve.

Discussion

The striking features in our patient were a gluteal abscess as a presentation of diverticular disease with the absence of a track from the abdomen or retroperitoneum, and the lack of gastrointestinal symptoms, which may have indicated underlying diverticulitis in this young patient.

A gluteal abscess is a rare presentation of diverticular disease, with few reports of such cases published. However, there are numerous reports in the literature of thigh abscesses resulting from intra-abdominal sepsis.^{1,2} The origin of these abscesses appears to be through direct extension of the infection to the thigh,¹ for example, along the psoas muscle, through the femoral canal² or by way of the obturator foramen. In our case, there was no track identified on CT to suggest direct spread from the retroperitoneum or abdominal cavity (Fig. 1). A track may not always be identifiable on imaging; however, if one were present, it would be expected to have led to an

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Figure 1 CT scan showing the gluteal abscess, sigmoid diverticulitis and pericolic abscess.

abscess on the left from the sigmoid colon, whereas our patient had a right gluteal abscess. Therefore, it seems that the route of spread was haematogenous, via the portal system to the systemic blood supply. This is supported by the finding of further abscesses in the liver and in both kidneys.

Another rare aspect of this presentation is the lack of gastrointestinal symptoms, which has been previously described.² This may represent a subgroup of patients with an atypical presentation, in whom diagnosis is difficult, and highlights the need to have a high index of suspicion.

Diverticular disease in the young

This is a case of a 40-year-old man who became critically ill due to the complications of diverticulitis. The traditional teaching is that diverticular disease is uncommon in the young, with the reported incidence for patients under 40 years of age varying from 2–29%.³ The incidence increases greatly in those aged 40–50 years, with one report showing 72%⁴ of those diagnosed with diverticulitis under 50 years of age. It is commonly thought that diverticulitis is more severe

in this younger population^{3,5} and when treated conservatively, has a high recurrence rate.⁵ Hence, it is thought by some that early surgical intervention is indicated in a young patient, in order to prevent serious complications.^{3,5}

In contrast, there have been several studies suggesting that diverticulitis is no more aggressive in the young. West *et al.*⁴ studied the patients admitted to a single institution with diverticular disease. They found no significant difference between those aged under/over 50 years in terms of recurrence, need for surgery and complication rates.

The management of our patient involved intravenous antibiotics and surgical drainage of the gluteal abscess. A laparotomy and drainage of the pericolic abscess with resection of the sigmoid colon was not performed in the acute setting. The outstanding issue at this point is whether to perform a sigmoid resection as an elective procedure.

Conclusions

This patient had a rare and severe presentation of diverticulitis – one where the usual clinical pointers to the underlying problem were absent. The gluteal abscess and a high index of clinical suspicion guided us to the true nature of the disorder. However, the correct long-term management of these patients still remains unclear.

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