Letters to the Editor

for 3 days, followed by oral prednisolone 60 mg daily. Prednisolone was tapered over 2 months, and then discontinued. Visual acuity slowly improved and the eye pain disappeared. Seven months after the onset of symptoms, ophthalmologic examination revealed a visual acuity of 0.7 in the right eye and 1.0 in the left. The visual field defect returned to normal, although mild residual visual blurring was still present in the right eye.

Optic neuritis is often idiopathic, but may occur in association with demyelinating disease such as multiple sclerosis or bacterial, viral, mycotic, and parasitic infections. It has been on rare occasions associated with systemic inflammatory conditions such as systemic lupus erythematosus (2), Behçet’s disease (3) and relapsing polychondritis (4-7). Optic neuritis is clinically characterized by acute or subacute visual loss, often associated with retrobulbar pain or pain with eye movement. It usually affects patients at a relatively young age (15 - 45 years). Loss of visual acuity, decreased color vision, and a central scotoma are generally present in the affected eye. An afferent pupillary defect almost invariably occurs in the acute phase, and the VEP usually shows a prolonged latency (3, 8). The clinical course is characterized by a rapid deterioration of vision followed by steady recovery, with most patients gradually recovering their vision over the next several weeks.

In our ankylosing spondylitis patient, ischemic optic neuropathy and optic neuritis were the primary possibilities to be considered in the differential diagnosis. Ischemic optic neuropathy is described as an infarction of the optic nerve head. It usually affects patients 50 to 70 years of age, showing a sudden and painless onset. Visual acuity varies from 1.0 to no light perception, and altitudinal or arcuate visual field defects are typical. Ophthalmologic examination shows a swollen optic disc, often with hemorrhages. There is usually little or no recovery of lost visual function. The patient’s age and the pattern of visual field defect, as well as the lack of recovery, are helpful to distinguish this condition from optic neuritis (3, 8).

Our patient was 47 years old and presented with pain in the right eye and frontal head. She experienced a sudden onset of visual loss and showed a nearly complete recovery over time, both typical characteristics of optic neuritis. Fundus examination revealed no swelling in the disc. Although a faint filling defect at the disc margin was detected on fluorescent angiography, it did not correspond with the visual field defect. Therefore, the visual field defect was not considered to be ascribable to vascular insufficiency. These findings favor the diagnosis of optic neuritis rather than ischemic optic neuropathy.

Optic neuritis and multiple sclerosis (MS) are known to be associated (9), and a relationship between ankylosing spondylitis and MS has been reported (10). Therefore, the possibility of incipient MS had to be considered in our patient. Although she did not show any neurological signs indicative of MS until August 1998, the optic neuritis in our patient could have represented the initial presentation of MS. The absence of oral ulcer, genital ulcer, or skin symptoms pertinent to Behçet’s disease, and the limitation of joint symptoms to the axial joints, exclude the possibility of this disease in our patient, however.

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References

Involvement of transitional lumbosacral joints in spondyloarthritis

Sir,

Unusually formed joints may exist between the enlarged transverse process of transitional lumbosacral vertebrae and the wings of sacrum (Fig. 1) (1). These can be either unilateral or bilateral and may have synovial membrane. Osteoarthritis has been observed in such joints (1).

Figure 1a demonstrates that transitional lumbosacral joints may also be involved by the inflammatory process of spondyloarthritis. Figure 1b shows an anteroposterior view of the pelvis of a 29-year-old B27-positive man suffering from psoriasis, inflammatory low back pain, alternate buttock pain and plantar fasciitis. Grade 2 sacroiliitis of the left sacroiliac joint (solid arrow) together with sclerosis and erosion of the transitional lumbosacral joints.

![Fig. 1.](image-url)
Psoas abscess secondary to perinephritic infection: A rare cause for an uncommon pathology

Sirs,

Psoas abscess is uncommon in developed countries. In this setting the large majority of cases occur secondary to another infection, most frequently from the gastrointestinal tract. Perinephritic abscess has been rarely referred as a primary cause of psoas abscess because these infections usually remain localized in the renal area (1, 2). We present here a patient who developed a silent psoas abscess as a consequence of a perinephritic infection, probably due to long-standing nephrolithiasis.

A 61-year-old man was admitted to our hospital for a four-month history of dull pain in the right thigh with progressive swelling of the antero-internal side where a fistula had developed during the latter days. He had no medical antecedents except for a long history of right renal calculi and uretero-pelvic duplicity. Physical examination showed swelling of the right thigh, especially on the antero-internal face where a draining fistula could be seen. There was no fever and the rest of the examination was unremarkable. Blood cell counts were normal and the erythrocyte sedimentation rate was 53 mm/hr. Urine sediment contained 20 white cells, 2 red cells and more than 10,000 colonies of bacteria per high power field. A tuberculin skin test was negative. Radiographs of the chest, lumbar spine and right hip were normal and in the x-ray of the abdomen the right psoas edge was erased.

An abdominal ultrasonography study disclosed renal calculi in the right kidney and a hypoechoic mass (2 cm diameter) below the inguinal area and anterior to the iliopsoas muscle. A radionuclide scan after intravenous injection of 67Ga citrate showed focal areas of concentration in the right thigh. A fistulography study was performed, demonstrating that the contrast extended from the internal aspect of the thigh up to the level of the lower edge of the first lumbar vertebral body, close to the iliopsoas aponeurosis. A retrograde pyelographic examination disclosed a mildly hydronephrotic kidney and no clear contrast extravasation. Finally, a CT scan of the abdominal cavity and right thigh showed an irregular aspect of the inferior calyx group of the right kidney with swelling of the peri-ureteral area (Fig. 1A), and a large collection involving the entire right iliopsoas muscle and extending down to the thigh beneath the fascia lata, creating a draining sinus (Figs. 1B-D). Cultures of both the urine and drained fluid yielded colonies of gram negative enterobacteria identified as *Proteus mirabilis*.

The patient was treated with antibiotics (ofloxacin 400 mg bid) for four weeks with total recovery. Several months later the patient underwent an extracorporeal shock wave lithotripsy procedure, covered by antibiotics, for his nephrolithiasis. Psoas abscess has been rarely linked to perinephritic abscesses. This latter entity is associated with renal calculi in up 80% of patients (3). Likewise, *Proteus mirabilis* is a frequent ureopathogen associated with renal calculi, given its capacity to split urea and form ammonium hydroxide, which increases the urinary pH and potentiates the formation of stones and renal cell toxicity (4). However, this type of infection usually remains localized in the perirenal area encapsulated by the Gerota’s fascia. In fact, after a thorough review of the literature we found only 3 additional cases (5, 6). We have also found two reports of sterile perirenal pseudocysts (urinomas) with further psoas involvement in patients with nephrolithiasis, one spontaneous and the other occurring after a surgical procedure for the lithiasis (7, 8).

Psoas abscess can be classified as either primary or secondary. The primary forms are the most common in developing countries, *Staphylococcus aureus* being the most frequent etiologic agent. In the secondary forms the microorganism depends on the primary pathology, and in more than 50% of the cases the abscess is polymicrobial. It has been pointed out that Crohn’s disease, followed by appendicitis and colon neoplasm, are the

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**Fig. 1.** Composite figure showing the main CT scan findings. **A:** Irregular aspect of the inferior calyx group of the right kidney with swelling of the peri-ureteral area (arrowheads). **B:** Abscess involving the right iliopsoas muscle (arrow). **C** and **D:** Abscess extension into the thigh beneath the fascia lata (arrows).