CASE REPORT

Retro-peritoneal haemorrhage presenting as hip pain

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INTRODUCTION

Pain referred to sites distant from the pathology is a constant trap to the unwary clinician. The case of a patient who died from uncontrollable retroperitoneal haemorrhage within 24 h of admission with acute hip pain is presented.

CASE REPORT

A 45-year-old man was seen in the accident and emergency department with a 3-h history of right hip pain of sudden and spontaneous onset occurring while he was sitting down tending to his usual daily duty as a multi-storey car park attendant. The pain was severe and episodic. He was sweaty and nauseous with a BP of 100/65, a regular pulse of 100 per minute and a temperature of 36.7°C. He held his right hip semi-flexed and resisted passive movements, external rotation in particular. However, his hip joint was not tender on palpation. He was diagnosed as suffering from Von Recklinghausen's Neurofibromatosis as a child when he underwent spinal surgery. General examination revealed cutaneous neurofibromatosis and gross thoracolumbar kyphoscoliosis; there was no abdominal abnormality, and his thoracolumbar spine and renal angles were not tender. Pelvis, hip and abdomen X-rays were normal. He was admitted for observation and he required opiate analgesia. Baseline investigations revealed normal serum area, electrolytes and amylase. His Hb was 12.4 g/dl, Hct 0.36 and WCC $28.8 \times 10^9/l$ with 80% neutrophils. Urinalysis showed no abnormality.

The following morning (14 h after admission), he felt marginally better. On re-examination he had slight right-sided lower abdominal tenderness. His Hb was 11.1g/dl, Hct 0.34 and WCC $30.6 \times 10^9/l$. Surgical exploration for a suspected retro-caecal appendix, presenting atypically, revealed a right retroperitoneal haematoma around and

within the psoas muscle, which was evacuated and drained but no source of bleeding could be identified. Peri-operatively, the patient required several pints of blood and he subsequently developed disseminated intravascular coagulation (D.I.C.). He was re-explored but died shortly afterwards from uncontrollable haemorrhage.

Autopsy confirmed D.I.C. as the cause of death. Micro-scopic examination showed diffuse infiltration of the right psoas muscle by neurofibromatosis with erosion of blood vessels.

DISCUSSION

Haemorrhage from erosion of the vessel wall by tumour is a recognized complication of Neurofibromatosis (Francis & Mackie, 1987). Three cases of retroperitoneal haemorrhage associated with neurofibromatosis have been reported in the literature. In 1978, Mansfield *et al.* described a patient who complained of abdominal pain and subsequent hypovolaemic shock secondary to retroperitoneal haemorrhage. The haematoma was successfully evacuated and the patient survived the operation. Subsequently, Keenan *et al.* (1982) and Shelton (1983) reported cases of retroperitoneal haemorrhage presenting with upper abdominal and back pain followed shortly afterwards by fatal hypovolaemic shock.

The above case is unusual in its presentation. The symptoms may be attributed to stretching of the psoas muscle and femoral nerve by the expanding haematoma. (Curry & Bacon, 1974). Like the case of the leaking aortic aneurysm presenting with ureteric colic (Moran *et al.*, 1987), the presented case highlights the potential difficulty in the diagnosis of retroperitoneal haemorrhage.

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