Massive hiatal hernia can present with symptoms or signs of cardiovascular or respira-

tory dysfunction and can constitute a radiological differential diagnostic problem.

Figure 1 Chest radiograph on admission.

Figure 2 Chest radiograph after aspiration of fluid and air.

Retroperitoneal abscess presenting with a buttock swelling and anaemia

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Figure 1 Left hydronephrotic kidney and retroperitoneal abscess (white dot in the hydronephrosis).

Figure 2 Retroperitoneal abscess in communication with the left buttock (white dot in buttock abscess).

A 68 year old woman presented to the accident and emergency department with nausea, anorexia, night sweats, and weight loss of 3.5 stone. She had an 18 year history of a staghorn calculus in a non-functioning left kidney. She had a tense, tender 6 × 4 cm swelling over her left buttock with a balottable left kidney. She was afebrile. Urinalysis was normal. Her erythrocyte sedimentation rate (ESR) was raised at 130 mm/hour as was the C reactive protein at 116 mg/l (normal <20). She had a normochromic anaemia, with a moderate leucocytosis and a thrombocytosis. Computed tomography showed a hydronephrotic left kidney (fig 1) with a retroperitoneal abscess involving the psoas and quadratus lumborum muscles extending into the left buttock (fig 2). A total of 700 ml of pus was drained. A nephrectomy was performed one month later.

Retroperitoneal abscess is not common. Most arise from the gastrointestinal tract.¹ Pyonephrosis with a psoas abscess is rare. Patients may have a prolonged history of urinary tract infection, staghorn renal calculi, or hydronephrosis.² Symptoms may be subtle and include dysuria, vomiting, pyrexia, loin pain, and weight loss. The classical signs of a loin bulge and hip flexion are unusual.¹ Urinalysis may be negative.³ The combination of a raised ESR >100 mm/hour and raised C reactive protein differentiate with a 100% sensitivity between a hydronephrotic and a pyonephrotic kidney.⁴ The anaemia of chronic disease may be an additional pointer.^{2,5}

Ultrasound has a limited ability to demonstrate an infected hydronephrosis or small abscess.⁵ High resolution computed tomography has enabled the three compartments of the

retroperitoneal space—the perirenal and the anterior and the posterior pararenal—to be further delineated.⁶ The posterior renal fascia had been thought to insert into the anterior portion of the psoas. It is now recognised that insertion is more commonly into the posterior psoas or the quadratus lumborum muscles, explaining the buttock mass in this case.

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Persistent “haematoma”

Michael J Clancy

A 71 year old woman noticed a persistent swelling over her right tibial tuberosity after a blow to that area some 10 weeks earlier. Attempted aspiration by her general practitioner was unsuccessful and she was referred to her local accident and emergency (A&E) department for further aspiration of the “haematoma”. On examination there was a 6 cm fluctuant swelling from which no blood could be aspirated. Under local anaesthesia the lesion was incised, “loculi broken down and 50–70 ml of blood expelled”. The wound was closed and on review two weeks later the swelling appeared to be resolving.

The patient represented 10 weeks later with a recurrence of the swelling and underwent an ultrasound examination that showed a solid, highly vascular, well defined oval shaped mass in the subcutaneous tissue immediately over the tibial periosteum but with no evidence of local invasion. This was confirmed by magnetic resonance imaging (fig 1).

The patient had the lesion completely excised. Histologically the tumour was unusual and thought to be a pleomorphic hyalinising angiectatic tumour of soft parts, which has only recently been described.¹ There is a risk of local recurrence with this tumour type, which has been tentatively designated as a low grade sarcoma.

Soft tissue tumours presenting to A&E departments are likely to be rare and the diagnosis delayed.² Persistence and the recurrence of the swelling point to this lesion not being a simple haematoma.

Figure 1 The sagittal T1 weighted magnetic resonance image through the lower leg showing a 6 cm well defined mass (larger white arrow) which is sitting on top of the apparently uninvolved fascia (smaller curved white arrow); T = tibia.

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