ASS 2022 – P 08

A Patient with Recurrent Sterile Abscesses involving Skin, Lymph nodes and Spleen; Aseptic Abscess Syndrome; A Case Report

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Background

Aseptic Abscess Syndrome is an autoinflammatory disorder which presents with recurrent episodes of fever associated with sterile abscess formation in the skin, lymph nodes and in visceral organs including spleen and liver. Despite neutrophil leukocytosis and elevation of inflammatory markers, extensive laboratory evaluation will not reveal any infective etiology. Although antibiotics fail to show any response, dramatic response is seen when treated with corticosteroids and other immunosuppressive agents. Aseptic Abscess Syndrome can occur as an isolated disease or in association with systemic inflammatory diseases such as inflammatory bowel disease, relapsing polychondritis and neutrophilic dermatoses. This is a rare case of isolated Aseptic Abscess Syndrome in a Sri Lankan patient which was successfully treated with corticosteroids.

Case Presentation

A 33-year-old male presented with recurrent episodes of fever associated with multiple abscess formation in skin and left axillary suppurative lymphadenopathy for four months duration. He had painful aphthous like oral ulcers and pustular pyoderma gangrenosum and erythema nodosum like lesions involving bilateral legs for 2 weeks. His investigations revealed neutrophil leukocytosis with elevated inflammatory markers and cross-sectional imaging revealed subcapsular splenic abscess, left sided mild pleural effusion and inflammatory left inguinal lymphadenopathy. His investigations did not reveal any infective etiology including cultures of aspirated purulent material from abscesses. Histology of abscess material showed heavy neutrophilic infiltrate without evidence of any bacterial infection. He had persistent fever and recurrent abscess formation despite repeated courses of intravenous antibiotics and surgical drainage. A diagnosis of Aseptic Abscess Syndrome was made. All antibiotics were discontinued and he was treated with high dose steroids with rapid resolution of fever, all skin abscesses, suppurative lymphadenopathy, erythema nodosum and pyoderma gangrenosum like lesions with rapid normalization of inflammatory markers. He was started on oral colchicine while tailing off steroids as an out-patient and repeat imaging showed resolution of splenic abscess and pleural effusion.

Conclusion

Aseptic abscess syndrome is a rare autoinflammatory disease. However, it is important for rheumatologists to consider it in the differential diagnosis, because of its frequent association with systemic inflammatory diseases. Failure to recognize it will lead to unnecessary surgeries and prolong courses of antibiotic therapy without any clinical improvement.

Key words: Aseptic Abscess, Autoinflammatory Disease, Corticosteroids.