# Ileopectineal bursitis: orthopaedic cause for a lump in the groin

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The management of a lump in the groin with an unclear diagnosis is often surgical exploration. We present a cautionary tale of a patient with a groin lump arising from an osteoarthritic hip that was explored inappropriately, recurred and regressed only when the underlying cause was treated.

## CASE HISTORY

A woman aged 62 presented to a general surgeon in September 1993 complaining of a lump in the groin; she incidentally mentioned some discomfort in the left hip. Examination revealed a cystic swelling in the groin. Ultrasound confirmed a 12 cm long sausage-shaped cyst lying in front of the hip joint. The diagnosis was unclear and the surgeon decided to explore the lump. At operation, the capsule of the cyst incorporated the femoral vessels and nerve to such a degree that the cyst could not be completely removed and a partial resection of the cyst wall was performed. Histological examination showed fibrous tissue containing a light focal chronic infiltrate, with eosinophilic condensation on the surface. The diagnosis at this time was a cyst of unknown aetiology.

Although the lump initially decreased in size it subsequently recurred. In October 1994 the lump was aspirated, yielding thick mucus, but again it recurred. The pain in the patient's hip also worsened, as did her limp. By January 1995, the pain in her hip had superseded the lump as her main problem; review of her radiographs from 1993 showed moderate osteoarthritis with reduction of the joint space, cysts and early osteophytes, and she was referred to an orthopaedic surgeon.

When seen in March 1995 she had a walking distance of 100 m, was only able to climb stairs on all fours and had sleep disturbance due to the pain. Up-to-date radiographs showed severe osteoarthritis with obliteration of the joint space and a large osteophyte; total hip replacement was therefore proposed. At operation, the surgeon was easily able to pass his finger from the hip joint into the cyst where it herniated into the groin, and bimanually to palpate the femoral neurovascular bundle. Apart from occluding the mouth of the cyst to stop cement from entering the lump during implantation of the cup, nothing out of the ordinary was done at operation.

Histological examination of the synovium of the hip showed papillary projections covered by hyperplastic synovial cells with a dense focal chronic inflammatory infiltrate. The appearances were judged consistent with degenerative joint disease.

When last reviewed in July 1996 the patient was pain free. The lump in her groin was much smaller and no longer produced any symptoms. Since her hip replacement, the patient has returned to her favoured sport of windsurfing.

## COMMENT

This patient had a bursa arising from the front of the hip that became inflamed and distended and caused a swelling in the groin. Paterson[1] in 1987 reported a similar case of a patient presenting to a general surgeon with a lump in the groin which it transpired originated from the hip joint. On that occasion, the lump was explored and a synovectomy was performed with good results. In our patient, excision of the lump was unsuccessful and the lump did not settle until the underlying disease was treated. Since 1986, the senior author (WG) has seen four other cases of this sort, though less florid.

Just as in Baker's cyst of the knee, a bursa originating from the hip joint may be involved with disease affecting the joint, and become enlarged, inflamed and painful. The ileopectineal bursa lies between the hip joint and the iliopsoas, with the femoral neurovascular bundle overlying it in the femoral triangle (Figure 1), and we suggest that the diagnosis in this case was an inflamed ileopectineal bursa. In view of the rapid progression from mild to severe changes of osteoarthritis, this seems to have been an aggressive form

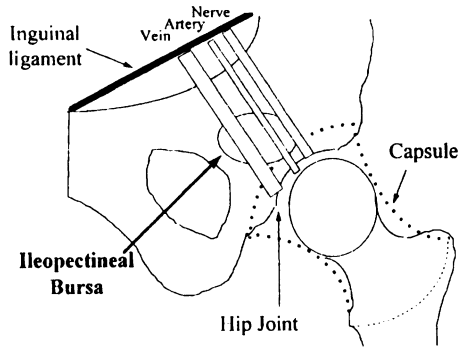


*Figure 1* **Relation of femoral neurovascular bundle to hip and ileopectineal bursa**

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of osteoarthritis with a marked synovial reaction. Ileopectineal bursitis may be associated only with aggressive osteoarthritis; it is not a normal feature of the osteoarthritic process. It has been described in only one case of osteoarthritis[2]; masses in the groin in association with rheumatoid arthritis seem to be more common[3,4].

When a lump in the groin is detected, one begins by excluding the more usual diagnoses such as hernia. When the swelling is cystic, irreducible and filled with mucus and the patient complains of hip pain and limp, underlying hip disease should always be considered.

## REFERENCES


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# Kasabach–Merritt syndrome and Down's syndrome

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The Kasabach–Merritt syndrome (KMS)—giant haemangioma, thrombocytopenia, consumption coagulopathy, anaemia and low levels of coagulant factors[1]—is an infrequent but often fatal complication of rapidly growing haemangiomas in infants[2]. We report a case of KMS in a child with a giant haemangioma and Down's syndrome.

## CASE HISTORY

A girl was born at 36 weeks' gestation to a 43-year-old gravida by caesarean section. She was admitted to the neonatal unit because of prematurity. Her mother had been positive antenatally for the VDRL and *Treponema pallidum* haemagglutination assay and had been treated with penicillin. The baby weighed 3200 g; she was mildly asphyxiated at birth and was resuscitated with bagging and head box oxygen. On examination she had the clinical features of Down's syndrome. The length and head circumference were between 25th and 50th centile. Liver and spleen were soft, palpable 3 cm and 1 cm below the costal margin. There was a diffuse haemangiomatous swelling over the left leg with soft tissue hypertrophy. There was a disparity of 3 cm between the left and right legs. On the ninth day of life there was a grade 3/6 systolic murmur over the precordium (patent ductus subsequently identified). The other systems were normal. Laboratory investigations were as follows: random blood sugar less than 1.0 mmol/L; total leucocyte count $32.3 \times 10^9$/L; red blood cells $4.65 \times 10^{12}$/L; haemoglobin 19 g/dL; haematocrit 58.3%; platelet count $61 \times 10^9$/L; serum electrolytes, arterial blood gases, calcium and urea normal; plasma triiodothyronine, thyroxine, and thyroid stimulating hormone normal.

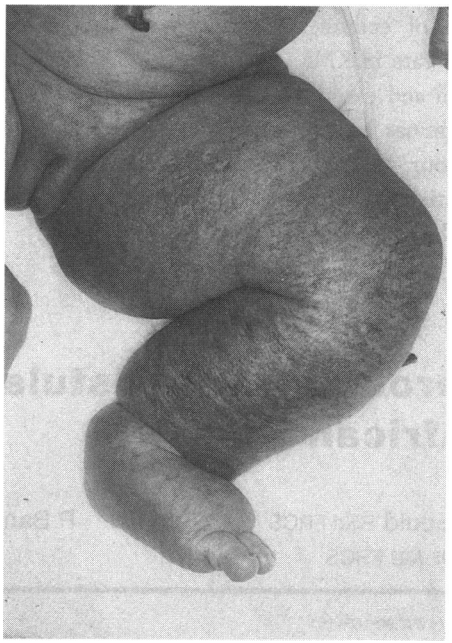

*Figure 1* **Cavernous haemangioma with hemihypertrophy of the left lower limb**

Platelet counts on the eighth and ninth days of life were 36 and $85 \times 10^9$/L. Sonographic appearances of brain, liver and kidneys were normal. She was treated for eight days with oral prednisolone 2 mg/kg per day in divided doses. On the eleventh day of life the platelet count was near normal. Karyotyping revealed 46XX/47/XX.X21. At eight months the haemangioma had disappeared but soft tissue hypertrophy persisted (Figure 1).

## COMMENT

Kasabach–Merritt syndrome usually affects children less than one year of age and in two-thirds of cases[1–3] onset is

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