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# RESEARCH ARTICLE

## RIGHT ILIAC FOSSA MULTI-DRUG RESISTANT ESCHERICHIA COLI ABSCESS AFTER ABDOMINAL HYSTERECTOMY FOLLOWED BY SUCCESSFUL USG GUIDED ABSCESS DRAINAGE

**Ani Chandanan[1,*], Asha Saxena[2], Charu Yadav[2], Neha Kumari [3], Jyotika Parmar[3], Priyanka Yadav[3] and Isha Mishra[3]**

From [1]Professor, [2]Assistant Professor, [3]Junior Resident, Department of Obstetrics and Gynaecology, T. S. Misra Medical College and Hospital, Lucknow, Uttar Pradesh, India

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**ABSTRACT**

This case report describes patient who underwent Total Abdominal Hysterectomy complicated by gaping of wound followed by Right Iliac fossa abscess. Due to increasing concern for intra pelvic collection in the setting of Right lower quadrant tenderness and fever (On and Off) for 21 days, the decision was made to proceed with an USG guided Ascitic Tap followed by Malecot's Catheter placement. A substantial amount of blood along with pus was evacuated via Malecot's catheter.

***Corresponding author:*** **Ani Chandanan**



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# INTRODUCTION

A pelvic abscess is a serious, pus-filled infection in the pelvic region, often a complication of appendicitis, diverticulitis, inflammatory bowel disease, or gynecological issues like Pelvic Inflammatory Disease (PID), sometimes following surgery as a postoperative complication. Pelvic abscess most commonly occurs as potentially life-threatening post-operative condition which may clinically present with high grade fever, tenderness and pain in lower abdomen, abnormal vaginal bleeding or discharge and palpable pelvic mass associated with raised inflammatory marker such as C Reactive Protein (1).This potentially life-threatening sequelae includes wound infection, Pelvic abscess, and Septic pelvic Vein Thrombophlebitis , which require early recognition , accurate diagnosis and immediate hospitalization are essential regardless of abscess size(2)

# CASE REPORT

A 44-year-old female P5L4A3 presented to the Gynaecology Outpatient Department with history of Heavy menstrual bleeding for 1 year with mild anemia. Here her initial work up and clinical examination was done. On USG Uterus was Bulky (85x60x 53mm) with Thickened Endometrium. Endometrial Biopsy was performed which suggested of Disordered Proliferative Endometrium with secretory changes. Patient was managed medically for 6 months and later she again had complaint of Heavy menstrual Bleeding and her Endometrial Thickness was 19 mm so, decision of Total Abdominal Hysterectomy was taken and performed and Intra operatively a Subserosal Fibroid of 4cms X 4 cms on Anterior wall of uterus was present and Uterus was Bulky – 10 weeks size .Histopathological Examination of the speciemen suggested of Cervicovaginal portion –within normal limits , Cervix – Chronic cervicitis, Endometrium – Leiomyoma and Adenomyosis seen , Right Ovary –Hemorrhagic Corpus Luteum , Left Ovary : Cystic follicles with Corpus Albicans , B/L Fallopian Tubes: within normal limits, B/L paratubal cyst – within normal limits. On day 2, patient had multiple episodes of fever (on and off) which was managed symptomatically and her fever profile was sent.In fever Profile, ESR and CRP were raised . On Day 3 USG Whole Abdomen+ Pelvis was performed which showed collection in Right Iliac fossa of approx. 100 cc.Blood culture was sterile.Surgical opinion was taken and Patient was kept on higher antibiotic and antipyretic .On day 21- repeat USG was done in which collection in peritoneal cavity in right Iliac fossa region extending in Right Lumbar region with 2 communicating pocket of 60cc and 18cc respectively with multiple septations.So, decision of Diagnostic and Therapeutic USG guided Ascitic Tap with Malecot's catheter insertion was taken and ~25 ml serosanguinous fluid aspirated and sent for CBNAAT, ADA, Biochemistry and Cytology R/M and drain was kept insitu. On

Ascitic Fluid Culture Report Multidrug Resistant E. Coli was present and CBNAAT negative. On repeat USG after 3 days of Ascitic tap small amount of fluid remained and fever subsided and patient got discharged 6 days after Drainage.


**Figure 1.**

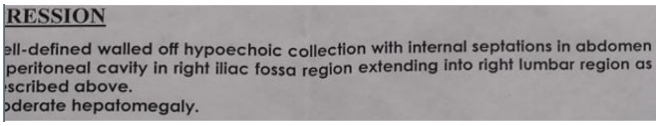


**Figure 2.**

**Figure 3.**


**Figure 4.**

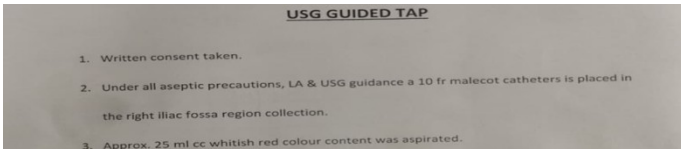


**Figure 5.**

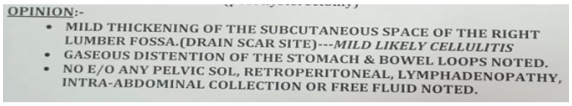


**Figure 6.**

**Table 1. Patient Lab Investigations**

| | Hb(g/dl) | TLC (/mm$^{3)}$ | Platelet | ESR | CRP | Urine R/M |
|---|---|---|---|---|---|---|
| PRE -OP | 8.0 | 7,300 | 3,12,000 | | | |
| PRE-OP | 11.6 | 8,400 | 2,60,000 | | | WNL |
| POD –4 | 10.9 | 6,800 | 2,34,000 | | 116.36 | |
| POD -7 | 8.1 | 12,700 | 1,89,000 | | | |
| POD 11 | 10.1 | 14,000 | 2,12,000 | | 177.35 | Pus cells-7-9 |
| POD 14 | 10.1 | 11,600 | 3,22,000 | | 109.91 | |
| POD-17(Malecot's -Day 1) | 9.4 | 9,900 | 7,62,000 | 54 | 127 | |
| POD-21(Malecot's Day-5 | 10.7 | 13,600 | 6,66,000 | 50 | 45.99 | |

# DISCUSSION

Postoperative intra-abdominal abscess is a recognized but uncommon complication following abdominal hysterectomy. The development of a right iliac fossa (RIF) abscess after hysterectomy may result from contamination during surgery, devitalized tissue, hematoma formation, or spread of infection from adjacent pelvic structures. Risk factors include prolonged operative time, excessive blood loss, poor aseptic conditions, underlying anemia, diabetes mellitus, obesity, and pre-existing pelvic infection (3). The RIF is an unusual site for abscess formation after hysterectomy and may pose a diagnostic challenge. Clinical presentation is often nonspecific and may include fever, lower abdominal pain, localized tenderness, leukocytosis, and delayed recovery in the postoperative period. In some cases, symptoms may appear days to weeks after surgery, leading to delayed diagnosis.

This case highlights a rare but potentially life-threatening complication of Right iliac fossa abscess after Abdominal Hysterectomy.In our case abscess in Rt iliac fossa occurred due to multi drug resistance E.coli. This case is notable for the development of a postoperative intra-abdominal collection with multidrug-resistant organism growth following an otherwise uncomplicated hysterectomy. It emphasizes the need for a high index of suspicion in patients with persistent postoperative fever, even when initial investigations are inconclusive. Early intervention with image-guided drainage can be both diagnostic and therapeutic, preventing progression to more severe sepsis or the need for surgical re-intervention. Timely intervention can reduce patient's long-term morbidity (4). USG-guided abscess drainage has emerged as an effective and safe alternative to exploratory surgery. It reduces morbidity, avoids general anesthesia, shortens hospital stay, and allows faster recovery. Image-guided drainage combined with appropriate broad-spectrum intravenous antibiotics targeting aerobic and anaerobic organisms forms the

cornerstone of management. Culture-sensitive antibiotic therapy further improves outcomes. Surgical re-exploration is reserved for patients who fail percutaneous drainage, have multiloculated abscesses not amenable to drainage, or develop generalized peritonitis (5). Early recognition and prompt intervention are essential to prevent serious complications such as septicemia, wound dehiscence, prolonged hospitalization, and increased mortality. With timely diagnosis and USG-guided drainage, the prognosis of postoperative intra-abdominal abscess following hysterectomy is generally favorable. Many studies show high success in simple abscesses treated percutaneously (~95%), but decreased success in complex or multiloculated collections (~69%). Comparative analysis with surgical drainage suggests similar overall success, but percutaneous approaches are preferred due to lower invasiveness and cost.

# CONCLUSION

USG-guided percutaneous drainage, combined with appropriate antibiotic therapy, offers a safe, minimally invasive, and effective treatment option, reducing the need for surgical re-exploration and associated morbidity. Success rates can vary based on abscess characteristics, with complexity and multi-loculation being predictors of reduced percutaneous success. Timely diagnosis and prompt intervention result in favorable outcomes and play a crucial role in preventing serious complications such as sepsis and prolonged hospitalization.

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