the neck. This was reduced and held with percutaneous K-wires and a hip spica for six weeks. Subsequent follow-up has shown healing of the fracture and normal development of the hip both clinically and radiologically (Fig. 3).

**Discussion.** Fractures of the femoral neck in children are rare and the complication rate is high, with malunion, non-union, avascular necrosis and premature epiphyseal fusion. In the neonate diagnosis is difficult; arthrography, CT scanning and MRI are all helpful.

Clear guidelines as to treatment in children are not available, and a variety of methods have been advocated (Ingram and Bachynski 1953; Ratliff 1962; Leung and Lam 1986). All the reported series have a high incidence of complications (60%) regardless of the treatment used, even in initially undisplaced fractures treated conservatively as in Leung and Lam's 1986 series.

Transepiphyseal fractures are the rarest of the subgroups and are also reported to have the worst prognosis. Our case, however, indicates that a good outcome is possible.

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**FLEXION DEFORMITY OF THE HIP IN CROHN'S DISEASE**

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The development of a flexion deformity of the hip in a patient with Crohn's disease raises the possibility of a psoas abscess. The diagnosis can, however, be confused with one of septic arthritis, particularly in children (Smith et al 1982). We describe a patient with Crohn's disease who had both; he developed septic arthritis secondary to a psoas abscess.

**Case report.** A 31-year-old man presented with a seven-week history of difficulty in walking, associated with altered sensation over the outer aspect of the right thigh and pain in that groin. The leg was held semiflexed and could not be straightened. There was fullness in the right iliac fossa and decreased sensation in the distribution of the lateral cutaneous nerve of the thigh. The man was known to have Crohn's disease of the terminal ileum and was on prednisolone 7.5 mg daily.

A psoas abscess was diagnosed. This was reinforced by an intravenous urogram which showed a medially deviated ureter; the hip was considered to be normal. At laparotomy the terminal ileum was diseased and adherent to a large psoas abscess. A right hemicolectomy was performed and the psoas abscess drained abdominally. Despite normal recovery from the abdominal operation.

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the right hip pain persisted and prevented mobilisation. A sinogram on the 17th day showed that the psoas abscess communicated with the hip where there was a marked loss of joint space (Fig. 1). The patient was placed on traction and given intravenous cotrimoxazole. Later a hip spica was applied and the hip allowed to fuse in a position of function. By 18 months, bony union was occurring with 5° of adduction and 20° of flexion.

Discussion. Crohn’s disease is a granulomatous enteritis, usually in young adults, and commonly in the terminal ileum. Perforation of the deep fissures accompanying the granulomata leads to fistulation or to the development of a local abscess. The increasing prevalence of Crohn’s disease has made it a relatively common cause of psoas abscess, especially as tuberculosis in the United Kingdom is now rare (Kyle 1971; Bartolo, Ebbs and Cooper 1987). The diagnosis of this complication can be difficult and a delay in presentation as in this case is usual (Kyle 1971). An intravenous urogram often shows an abnormality but the most useful diagnostic tests are ultrasonography or computed tomography. The best treatment appears to be adequate drainage of the abscess coupled with eradication of the primary disease. Abdominal drainage of the abscess may be inadequate (Bartolo et al 1987), and a drain emerging through the groin might, in our case, have been better.

Arthritis occurs in some patients with active Crohn’s disease but suppurative arthritis is less common; it is usually haematogenous and direct spread from a psoas abscess is very rare, having been reported only twice before (London and Fitton 1970). One of these two patients died and the other had a hindquarter amputation.

Persistent hip flexion in the presence of a psoas abscess does not exclude a co-existent septic arthritis. The diagnostic feature is that with a psoas abscess, hip rotation in flexion is painless, whereas with septic arthritis it is not. Serial radiology, an isotope bone scan and early aggressive therapy might prevent the long-term complications of both disorders.

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