While rash is the presenting symptom in most (83%) adult cases, abdominal pain and arthritis can precede its development (Pillebout et al, 2002). Importantly, the former may mimic an acute abdomen, leading to unnecessary explorative laparotomy, and approximately 6% of patients will develop gastrointestinal complications, such as intussusception, gastrointestinal bleeding, bowel ischaemia and perforation, necessitating surgery (Cull et al, 1990; Katz et al, 1991). Overall 1% of adults with Henoch–Schönlein purpura will go on to develop chronic kidney disease and since this can develop up to 4 months after the initial presentation it is essential to follow up all patients (Pillebout et al, 2002).

Conclusions

Henoch–Schönlein purpura-related peritonitis and nephritis in the adult is rare, but the former may lead to unnecessary laparotomy and the latter is associated with considerable morbidity. Henoch–Schönlein purpura should therefore be actively considered as a diagnosis in all patients where the presentation of an acute abdomen is atypical. BJHM

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Brogan PA (2007) What's new in the aetiopathogenesis of vasculitis? *Pediatr Nephrol* **22**(8): 1083–94

Cull DL, Rosario V, Lally K, Ratner I, Mahour GH (1990) Surgical implications of Henoch-Schonlein purpura. *J Pediatr Surg* **25**(7): 741–3

Katz S, Borst M, Seekri I, Grosfeld JL (1991) Surgical evaluation of Henoch-Schonlein purpura. Experience with 110 children. *Arch Surg* **126**(7): 849–53

Lawee D (2008) Atypical clinical course of Henoch-Schonlein purpura. *Can Fam Physician* **54**(8): 1117–20

Pillebout E, Thervet E, Hill G, Alberti C, Vanhille P, Nochy D (2002) Henoch-Schonlein Purpura in adults: outcome and prognostic factors. *J Am Soc Nephrol* **13**(5): 1271–8

Saulsbury FT (2002) Epidemiology of Henoch-Schonlein purpura. *Cleve Clin J Med* **69**(Suppl 2): SII87–9

Tuberculous psoas abscess mimicking soft tissue tumour

A 62-year-old Caucasian school dinner lady presented to her family doctor with a 2-year history of recurrent urinary tract infections. She was otherwise well, with no significant past medical history. Full blood count, urea and electrolytes, and bone biochemistry were normal. Urine culture was sterile. An abdominal ultrasound scan detected a left-sided mass in the iliolumbar region and scarring of the left kidney. The patient was referred to the authors' sarcoma unit with a suspected retroperitoneal soft tissue tumour causing obstructive renal damage.

A computed tomography scan of the trunk demonstrated a large cystic mass within the left psoas muscle. The left kidney was atrophied, with parenchymal calcification and cystic change, although it was not hydronephrotic. Additional computed tomography findings included mediastinal lymph node calcification and destruction of the L1/2 intervertebral disc with partial collapse of adjacent vertebral bodies (*Figures 1* and *2*). These radiological signs suggested a unifying diagnosis of multi-focal tuberculosis, with a psoas abscess and involvement of the left kidney and spine. The diagnosis was confirmed upon aspiration of pus from the psoas mass, which yielded a growth of acid-fast bacilli. The patient was commenced on anti-tuberculous medication and is currently well on dual agent maintenance therapy.

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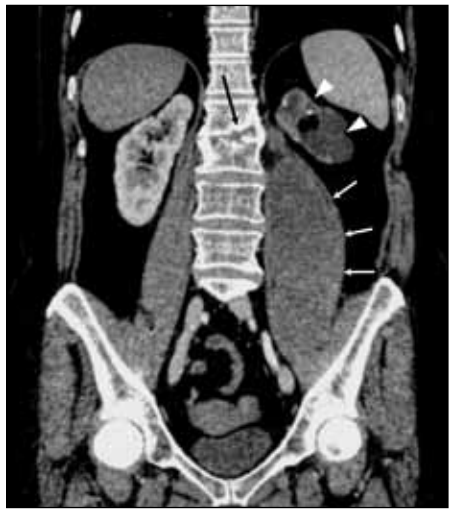
Figure 1. Computed tomography scan showing left psoas abscess (white arrows), atrophic left kidney (arrowheads) and destroyed L1/2 intervertebral disc (black arrow).



Discussion

Chronic tuberculosis can be difficult to diagnose as presenting lesions may mimic other pathologies leading to delays in treatment. This case highlights the importance of considering tuberculosis even in patients not traditionally thought to be at high risk. BJHM

Figure 2. Computed tomography scan showing calcified mediastinal lymph node (arrow).