

# Case Report

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## Prostatic Abscess Presenting as Constipation

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### Abstract

**Introduction:** Prostatic abscesses are uncommon urologic infections, often underdiagnosed due to their nonspecific symptoms and clinical overlap with acute bacterial prostatitis.

**Case:** A 53-year-old diabetic man presented with constipation, abdominal pain, and urinary symptoms, and imaging revealed a large prostatic abscess compressing the rectum. Cultures showed *Klebsiella pneumoniae*, and treatment included intravenous antibiotics followed by transurethral unroofing of the abscess.

**Discussion:** This case highlights the atypical presentation of prostatic abscess and underscores the importance of prompt imaging and intervention.

**Keywords:** Prostatic Abscess, *Klebsiella pneumoniae*, Diabetes Mellitus, Transurethral Unroofing, Constipation, Urologic infections.

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### Introduction

Prostatic abscesses are uncommon urologic infections, often underdiagnosed due to their nonspecific symptoms and clinical overlap with acute bacterial prostatitis.<sup>1,2</sup> CT and MRI play a crucial role in establishing the diagnosis and determining extent, especially in atypical presentations like this case, where the patient's initial complaint was constipation rather than urinary or systemic symptoms. Diabetes mellitus is a well-established risk factor for prostatic abscess, likely due to impaired host defenses and increased risk of urinary tract infections.<sup>3,4</sup> While *Escherichia coli* remains the most common pathogen, *Klebsiella* species can also be identified, particularly in diabetic patients.<sup>4,5</sup> The emergence of resistant organisms necessitates culture-guided therapy and a low threshold for surgical intervention.<sup>2</sup> Abscesses larger than 2 cm typically require drainage, with transurethral resection or unroofing preferred for centrally located or loculated collections.<sup>5,6</sup> This case highlights the importance of early imaging in high-risk patients and the utility of CT in differentiating abscess from malignancy.

### Case

A 53-year-old man with a history of type 2 diabetes mellitus, hypertension, and hyperlipidemia presented with six days of constipation and inability to pass flatus. He endorsed diffuse abdominal pain and increased urinary frequency and urgency but denied dysuria or fevers. Physical examination revealed diffuse abdominal tenderness and severe pain on digital rectal exam. The prostate was enlarged and exquisitely tender without discrete masses. A contrast-enhanced CT of the abdomen and pelvis revealed a large, heterogeneous hypodense collection involving the entire left hemi-prostate, measuring 4.1 × 4.7 × 5.1 cm (Figure 1). The lesion demonstrated peripheral enhancement and extended superiorly and posteriorly, abutting the rectosigmoid junction with loss of the intervening fat plane. MRI confirmed a large lobulated cystic lesion compressing the rectum, though without frank invasion. Blood and urine cultures both grew *Klebsiella pneumoniae*. The patient was started on intravenous ceftriaxone and later transitioned to trimethoprim-sulfamethoxazole. Urology performed cystoscopy with transurethral unroofing of the abscess. A

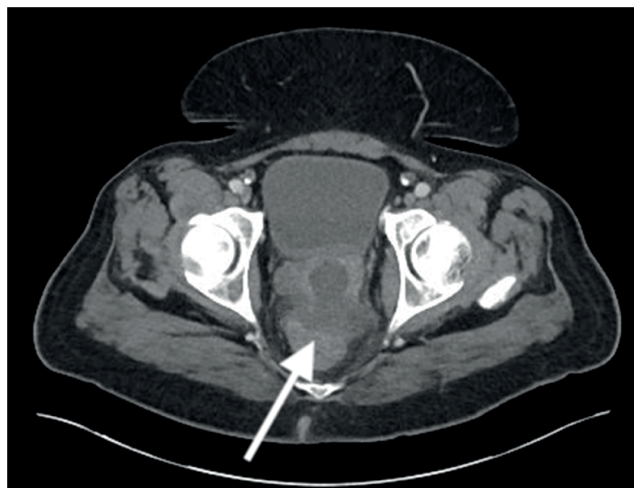
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large purulent cavity in the left posterior prostate was drained and a Foley catheter was placed for continuous bladder irrigation. Follow-up imaging showed interval improvement of the abscess and partial resolution of the fluid collection.



**Figure 1.** Axial computed tomography (CT) scan of the abdomen, pelvis demonstrates a large, heterogeneous hypodense collection involving the entire left hemi-prostate, posterior to the urinary bladder, consistent with a prostatic abscess (white arrow).

### Discussion

This case demonstrates an atypical presentation of prostatic abscess, with constipation rather than urinary symptoms as the chief complaint. A prostatic abscess is a localized collection of purulent material within the prostate gland and most commonly arises as a complication of acute bacterial prostatitis.<sup>1,2,3,9</sup> Distinguishing acute bacterial prostatitis from a prostatic abscess based solely on presenting symptoms, medical history, and physical examination is clinically challenging. Without prompt recognition and treatment, a prostatic abscess may progress to severe urosepsis, septic shock, and death. CT and MRI are essential tools for diagnosing prostatic abscess, assessing extent, and distinguishing it from malignancy. Although the incidence has decreased significantly with the widespread and appropriate use of antibiotics, prostatic abscesses remain relatively common in developing countries and among high-risk populations. These include patients undergoing urologic procedures such as prostate biopsy, individuals with end-stage renal disease on hemodialysis, patients receiving chemotherapy, and individuals with HIV/AIDS.<sup>4,5,9</sup> Diabetes mellitus contributes significantly to susceptibility, and organisms such as *Klebsiella pneumoniae* are frequently identified in this population.<sup>3,4</sup> Culture-guided antimicrobial

therapy and early urologic involvement are fundamental to management. Transurethral drainage is preferred for large, centrally located, or multiloculated abscesses due to its superior evacuation, reduced recurrence rates, and shorter hospital stay. Conservative management alone is rarely sufficient for abscesses of this size.<sup>7</sup> Additionally, shared decision-making promotes patient understanding and improves adherence to treatment plans.<sup>8</sup> In contemporary practice, prostatic abscesses pose notable diagnostic and therapeutic challenges, contributing to substantial morbidity. Furthermore, many clinicians have limited experience with the condition due to its infrequent presentation.<sup>9</sup> This case underscores the importance of maintaining a broad differential diagnosis in diabetic patients presenting with abdominal or pelvic symptoms and emphasizes the role of timely imaging in preventing complications such as sepsis, fistula formation, or abscess extension.

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