The imaging, histological, microbiological, operation notes and the typical lateness of extramuscular involvement with pyomyositis suggest that the associated femoral head destruction was aseptic. The iliacus inserts into the psous muscle tendon, which inserts into the femoral neck. Perhaps inflammation at this site interrupted the blood supply to the femoral head. The osteonecrosis of the hip may also be unrelated to the pyomyositis, given the existence of independent risk factors for this condition, although this appears the least likely.

Diagnosis requires clinical suspicion highlighting the importance of considering pyomyositis in the context of immunosuppression and thigh pain. This case illustrates the usefulness of MRI, which is sensitive for detecting subtle fascial and muscle signal changes as well as staging osteonecrosis. MRI criteria for pyomyositis help differentiate other causes of muscle tenderness and swelling, and can be used to monitor therapeutic response [9]. MRI should be the imaging modality of choice in suspected pyomyositis, and in this case it confirmed osteonecrosis, which is previously unreported in association with pyomyositis.

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Symptoms without pathology

Sir, Peter Croft’s wise words [1] are slightly marred by his reference to the American College of Rheumatology criteria for fibromyalgia as diagnostic criteria rather than as classification criteria for reporting purposes [2]. There are no diagnostic criteria, as even the ‘tender points’ are circular reasoning and self-reported (and in many instances, learned). The sooner we abandon fibromyalgia as a diagnosis and treat the very real physical and psychological symptoms that characterize chronic pain, the better off we and the patients will be [3–6].

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