



CLINIC CASE

Multiple, large pyogenic liver abscesses treated conservatively: A case-report and review of the literature

Christos E. Lampropoulos^{a,*}, Ioanna Papaioannou^a, Zoi Antoniou^b, Kyriaki Ermidou^a, Efi Papadima^b, Nikos Spiliopoulos^a, Manolis Choustoulakis^c, Grigoris Apostolidis^a, Konstantina Alexopoulou^a, Panagiotis Heras^a

^a Department of Internal Medicine, General Hospital of Nafplio, Greece

^b Department of Radiology, General Hospital of Nafplio, Greece

^c Department of Surgery, General Hospital of Nafplio, Greece

Received 5 October 2011; accepted 5 October 2011

Available online 25 October 2012

KEYWORDS

Liver abscess;
Amebic abscess;
Laboratory diagnosis;
Treatment

Abstract Pyogenic liver abscesses are a rare cause of admission. Treatment consists of combined antibiotics' regimen and surgical intervention. An unusual case of a patient with multiple, large, pyogenic abscesses of the left lobe treated conservatively is described below.

© 2011 Sociedade Portuguesa de Gastreterologia Published by Elsevier España, S.L. All rights reserved.

PALAVRAS-CHAVE

Abcesso hepático;
Abcesso amebiano;
Diagnóstico
laboratoriais;
Tratamento

Múltiplos abscessos hepáticos proxémicos volumosos tratados de forma conservadora: relato de um caso e revisão da literatura

Resumo Os abscessos hepáticos piogénicos são uma causa rara de admissão. O tratamento consiste num regime combinado de antibióticos e intervenção cirúrgica. Um caso invulgar de um doente com vários abscessos piogénicos volumosos no lobo esquerdo tratados conservadoramente descrito abaixo.

© 2011 Sociedade Portuguesa de Gastreterologia. Publicado por Elsevier España, S.L. Todos os direitos reservados.

Introduction

Pyogenic liver abscesses are a rare cause of admission, with 3.59 cases per 100,000 people. They usually appear

as an acute disease with fever, right upper-quadrant pain and jaundice. Blood cultures are positive in 52% of the cases and the most common pathogens are *Streptococcus* species and *Escherichia coli* while in Asia the most common pathogen is *Klebsiella*. Treatment consists of combined antibiotics' regimen and surgical intervention (aspiration, drainage or resection) except solitary or small abscesses which are treated with antibiotics only.

* Corresponding author.

E-mail address: christosnina@hotmail.com (C.E. Lampropoulos).

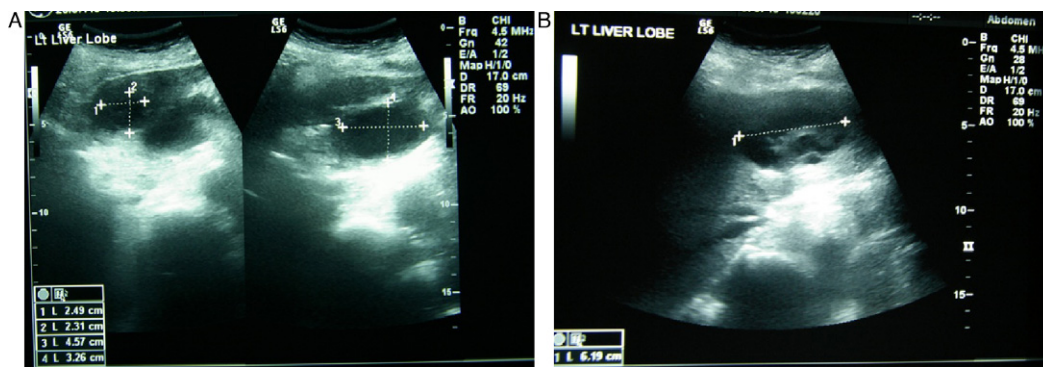


Figure 1 Abdominal ultrasound shows multiple hypoechoic cavities with diaphragms at the left liver lobe.

An unusual case of a patient with multiple, large, pyogenic abscesses of the left lobe treated conservatively is described below, with her consent.

Case report

An 85-year-old lady presented with fever (up to 39°C) and rigors, dyspnea and abdominal pain the last 24 h. Her medical history included dementia and hypertension under treatment as well as cholecystectomy 35 years ago with ERCP one year later because of cholangitis. The only clinical finding was tenderness of the right hypochondrium. Laboratory investigation showed: WBC: 17,800/ μ L, Ht: 37.7%, Hb: 12.0 g/dL, ESR: 100/1 h, glucose: 184 mg/dL, urea: 71 mg/dL, creatinine: 2.2 mg/dL, SGOT: 73 IU/L, SGPT: 58 IU/L, proteins: 6.5 g/dL, albumin: 2.6 g/dL, CRP: 16.3 mg/dL (normal value <0.5) and metabolic acidosis with compensatory respiratory alkalosis from gas analysis. The rest of laboratory findings (ALP, γ GT, LDH, bilirubin, CPK, amylase and electrolytes) were normal. Chest X-ray revealed small bilateral pleural effusions (exudates after aspiration) and heart ultrasound showed small pericardial effusion. An abdomen ultrasound showed multiple hypoechoic cavities with diaphragms at the left lobe (the largest were 6.2, 5.6 and 4.6 cm respectively, Fig. 1). Abdominal computerized tomography (CT) showed multiple hypodense cavities of left liver lobe (the largest was 7 cm) with irregular, thick, ill-defined borders, presence of air in the intrahepatic bile ducts and faint, thin wall enhancement after intravenous contrast administration (Fig. 2). Patient was suffering from multiple liver abscesses with sepsis (SIRS with organs dysfunction: temperature > 38°C, WBC > 12,000/ μ L, respiratory rate > 20 breaths/min and heart rate > 90 beats/min due to infection with acute renal failure, pleural and pericardial effusions). The patient was repeatedly advised by surgeons to undergo a surgical intervention (fine needle aspiration or resection), but she denied any kind of operation. A combined drug regimen was immediately started (IV ciprofloxacin 400 mg \times 2 with metronidazole 500 mg \times 3). After one week, ciprofloxacin was substituted by ampicillin/sulbactam (12 g/day) and amikasin (1 g/day) as there was no improvement. Blood cultures were negative. Fever was sustained up to 38°C the first two weeks with gradual remission the next five days. The patient was discharged

afebrile five days later with per os treatment (ciprofloxacin 1 g/day and metronidazole 1.5 g/day) for two weeks. Her blood tests were normal apart from Ht (28.3%) and Hb (9.4 g/dL) and the effusions (both pleural and pericardial) were absorbed.

Although the patient had a previous history of biliary disease, no underlying pathology was identified as cholangitis was not apparent (normal bilirubin), no malignancy or any other intra-abdominal inflammation was detected and no recent surgery was performed on the patient, suggesting a probable cryptogenic disease. Antibodies against echinococcus and *Entamoeba histolytica* were twice negative (indirect fluorescent antibody test, IFAT) with four weeks' interval (to avoid any initial false-negative results). Although symptoms and imaging suggested pyogenic abscesses, serology was twice repeated to exclude other abscesses' etiology as there are neither diagnostic (but only highly suggestive) clinical nor radiological criteria for their differentiation. In addition, negative blood cultures and the patient's refusal for surgical intervention complicated differential diagnosis. Serial ultrasounds and CT scans every two months revealed gradual reduction of abscesses' size (less than 2 cm in the last examination, Fig. 2).

Discussion

Liver abscesses are more commonly pyogenic or amoebic. Pyogenic abscesses may be caused mainly by ascending biliary (gallstones, cholangitis and malignancies) or portal tract sepsis (diverticulitis, inflammatory bowel disease, intra-abdominal inflammation and malignancies) and in lesser degree by superinfection of cysts or necrotic tissue, trauma or hematogenous dissemination. Nevertheless, in many cases (up to 25% of patients) no underlying cause is found and the disease is defined as cryptogenic. The most common pathogens are *Streptococcus* species (29.5%), *E. coli* (18.1%), *Staphylococcus* species (10.5%) and *Klebsiella* (9.2%)¹. *E. coli* is the most organism in abscesses of biliary or portal origin while Gram-positive cocci account for most cases of hematogenous or cryptogenic disease. Abscesses are usually present in elderly patients with history of diabetes and they are multiple in many cases. Jaundice, low albumin and pulmonary complications (pleural effusions) are common. In ultrasound they may appear as a cavity with thick or irregular borders and hypoechoic or

Download English Version:

<https://daneshyari.com/en/article/3311131>

Download Persian Version:

<https://daneshyari.com/article/3311131>

[Daneshyari.com](https://daneshyari.com)