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A rare case of pyogenic liver abscess rupturing into stomach and intraperitoneal cavity.

KEYWORDS

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Objective- To acknowledge a rare complication of pyogenic liver abscess.

Materials and methods- A 60 year old male, chronic alcoholic was presented with a pain in right upper abdomen and fever with chills since 2 weeks and localized distension of right upper abdomen since 2 days in emergency to our hospital. On general examination tachycardia, low blood pressure with bilateral pedal odema was present. Per abdomen guarding was present in right hypochondriac and epigastric region while rest of the abdomen soft. Laboratory report suggestive of sepsis with elevated white blood cell count, slightly abnormal liver function and deranged renal function test. Abdominal sonography and plain CT abdomen revealed multiple liver abscess in both lobes of liver with communication between abscess of left lobe of liver and lesser curvature of stomach. Patient underwent laparotomy after resuscitation in emergency, intraoperatively there was plenty of pus and communication of liver abscess of left lobe and lesser curvature of stomach with rent approximately of size 10 x 2cm. We have given peritoneal lavage, intraoperative USG guided aspiration of abscess in right lobe, primary closure of perforation and feeding jejunostomy done. Drain kept in ruptured liver abscess cavity.

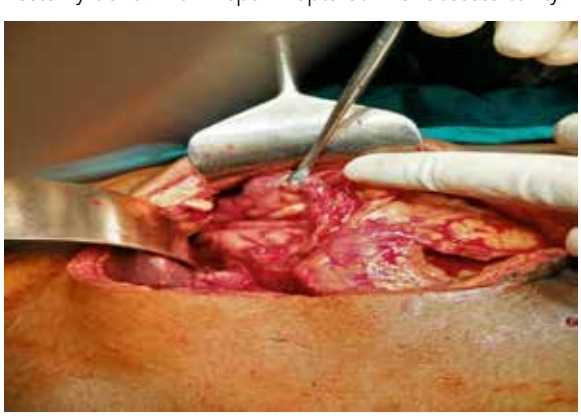

Figure showing perforated stomach with rules tube in situ and retracted liver.

Feeding was started on the day 1 through feeding jejunostomy tube. Oral feeding started on day 3. Oral dye study done on day 5 and there was no evidence of leak. Patient developed low output biliary fistula which was managed conservatively. Patient was discharged on day 20.

Discussion- Pyogenic liver abscess occurs with an incidence of 22 to 446/100,000 admissions.[1,2] Predisposing risk factors are diabetes mellitus, alcoholism, malignancies, immunodeficiency or liver transplantation. The mean age ranges from 50 to 60 years old,1,2 with a male predominance. The main aetiology is cryptogenic, followed by biliary and inflammatory bowel disease.[3] In 1938, Ochsner and Debakey published largest series of pyogenic and amoebic liver abscesses in the literature. The complications of liver abscess were not uncommon in that series and reported to result from rupture of the abscess into adjacent organs or body cavities, resulting in pleuropulmonary and intraabdominal complications. Pleuropulmonary complications are the most common and have been reported in 15 to 20% of early series including pleurisy, pleural[1] effusion, empyema and bronchohepatic fistula. Intraabdominal complications included subphrenic abscess and rupture into the peritoneal cavity, stomach, colon, venacava, or kidney.[4] The treatment includes parenteral antibiotics and

percutaneous drainages, in case of rupture and signs of peritonitis surgical intervention has to consider.[1,2,5.]

Conclusion- whenever there is communication with gastrointestinal tract it has to open and only percutaneous aspiration will not suffice at the same time we need to repair the viscera and reestablishment of gastrointestinal tract has to be done. Also in such case of emergency even a large perforation of stomach managed by primary closure, instead of doing extensive resection of stomach.

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