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A CASE OF LIVER ABSCESSES WITH SPETIC EMBOLI IN THE LUNGS

General Medicine

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ABSTRACT

A **liver abscess** is a pus-filled mass inside the liver. Common causes are abdominal conditions such as appendicitis or diverticulitis due to haematogenous spread through the portal vein. Patients typically present with non-specific constitutional symptoms, RUQ abdominal pain, and tenderness. The most common underlying condition in people with pyogenic liver abscess is biliary tract disease. Treatment of pyogenic abscess focuses on both timely administration of broad-spectrum antibiotics and drainage of the abscess. Here I present a case of liver abscess with complications which responded to the treatment after proper diagnosis.

KEYWORDS

INTRODUCTION:-

Liver abscesses are purulent collections in the liver parenchyma that result from bacterial, fungal, or parasitic infection. Infection can spread to the liver through the biliary tree, hepatic vein, or portal vein, by extension of an adjacent infection, or as a result of trauma. One or multiple abscesses can be present. Fungal liver abscess can occur in immunocompromised hosts. Amoebic liver abscess is a complication of amoebiasis.[1]

Case Report:-

The patient was a married male, aged 50 yrs, who presented with chief complaints of-

- Fever for the past 10 days
- Generalised weakness for the past 10 days
- Night sweats for the past 1 week
- Cough for the past 1 week
- Pain abdomen for the past 1 week

The patient complained of fever for the past 10 days before admission which was gradual in onset and persisted throughout the day. It was associated with chills and was moderate to high grade. There was no history of any diurnal variation.

Patient also complained of generalised weakness which had been present for the past 10 days before admission. Patient felt difficulties in doing his routine activities due to it. Patient had also been experiencing night sweting associated with fever for the past 10 days before admission. There was no history of any weight loss.

Patient also had history of cough present for the last 7 days before admission. It was productive of white to yellowish coloured sputum, moderate in amount and there was no diurnal variation. There was no history of any haemoptysis. Patient also complained of pain abdomen which had been present for 7 days. It was localized to the right hypochondrium with no radiation. Pain was more on deep inspiration and on movement also. It is of dull, aching type of pain. There was no history of vomiting.

Patient was an old case of type II diabetes mellitus, coronary artery disease, old anterior wall MI. There was no history of similar complaints in the past. The treatment History had nothing significant. There was no family history history of diabetes mellitus, hypertension, coronary artery disease, tuberculosis. The personal history showed that the patient was vegetarian, no addictions, bowel and bladder normal.

On general physical examination, the patient was conscious, cooperative, lying comfortably in the bed. Patient was febrile (Temp 1020F). The pulse rate was 104/ min, regular, other pulse parameters normal. The respiratory rate was 24/min, abdominothoracic. The BP was 130/80 mmHg, right arm supine position. Pallor was present, no icterus, cyanosis, clubbing, lymphadenopathy, edema. The JVP was not raised. On respiratory system examination, there were bilateral crepitations in the infrascapular areas. Dull note was present in these areas. On per abdomen examination, there was tender hepatomegaly felt 1 finger below the right costal margin in the mid-clavicular line. Other systemic examination was normal.

On investigation:-
Hb:- 6.7 gm%, TLC:- 13,100/mm3, Polys – 73%
Viral Markers :- Negative
Bl Urea :- 24 mg% Sr Bilimibin(T):- 1.4 mg%
Sr. Creat :- 1.2 mg% Sr Alb : 3.5 gm%
Sr. Calcium :- 9.0 mg% Sr AST/ALT :- 26/15
BG & RH Typing :- A+ Alk P :228 IU/L, GGT :- 179 IU/L

USG Abdomen:- Air shadowing is seen in IHBR, hypoechoic lesions measuring 3x2.7 and 3.9 x 2.1 cm are seen in left lobe of the liver.

FLP :- normal Hb A1c:- 5.3 % ECG : normal
Urine Exam:- normal, RBS :- 248 mg%
CXR :- showed NHO bilateral lower zones

CECT Adbomen :-
(1) Multiple hepatic SOLs, likely abscesses with subcapsular fluid collection along the left lobe of liver.
(2) Pneumobilia with IHBRs & CBD is dilatation hyperdense mass in CBD lumen.
(3) Abdominal lymphadenopathy
(4) Multiple soft tissue nodules in the visualized lung parenchyma likely septic emboli alongwith patch of consolidation & cystic bronchiectasis.

The patient was started on treatment :-
Tab Diapride, Tab Plagerine-A, Tab Shelcal, Tab Avas, Tal Angiplatt, Tab Sorbitrate, Tab Pan, Inj Tazomac, Inj Dalacin-C, Inj Albudac, Inj Metrogyl, Inj Emeset, Inj Inem

The patient responsed to the treatment and the fever subsided and the liver abscess receded in size and the septic emboli in the lungs revolved. The patient was discharged in good condition. Patient has been in regular follow up in the OPD and has been doing well.

DISCUSSION:-

The three major forms of liver abscess, classified by etiology, are as follows:

- Pyogenic abscess, which is most often polymicrobial, accounts for 80% of hepatic abscess cases in the United States
- Amebic abscess due to Entamoeba histolytica accounts for 10% of cases
- Fungal abscess, most often due to Candida species, accounts for fewer than 10% of cases. The liver receives blood from both systemic and portal circulations. Increased susceptibility to infections would be expected given the increased exposure to bacteria.2 However, Kupffer cells lining the hepatic sinusoids clear bacteria so efficiently that infection rarely occurs. Multiple processes have been associated with the development of hepatic abscesses. The right hepatic lobe is affected more often than the left hepatic lobe by a factor of 2:1. Bilateral involvement is seen in 5% of cases. The predilection for the right hepatic lobe can be attributed to anatomic considerations. The right hepatic lobe receives blood from both the superior mesenteric and portal veins,

whereas the left hepatic lobe receives inferior mesenteric and splenic drainage. It also contains a denser network of biliary canaliculi and, overall, accounts for more hepatic mass. Studies have suggested that a streaming effect in the portal circulation is causative. Untreated, pyogenic liver abscess remains uniformly fatal. With timely administration of antibiotics and drainage procedures, mortality currently occurs in 5-30% of cases. The most common causes of death include sepsis, multiorgan failure, and hepatic failure.[3]

CONCLUSION:-

Liver abscess has a high rate of mortality and a number of complications most of which are fatal. Large abscesses may need drainage of the pus collected. Others may be cured with antibiotics. One has to be vigilant in patients presenting with pain in the right hypochondrium for this diagnosis and to prevent the complications from occuring.

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