ORIGINAL RESEARCH PAPER

General Surgery

A CASE REPORT ON HEPATOGASTRIC FISTULA IN A CASE OF LIVER ABSCESS

KEY WORDS:

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INTRODUCTION –

Liver abscess is a common cause of febrile illness in India. It usually presents with fever and right upper quadrant abdominal pain. Upper gastrointestinal bleeding is not a commonly described clinical presentation of liver abscess. In liver abscess, upper gastrointestinal bleeding would usually be attributed to nonsteroidal anti-inflammatory drug-induced esophagitis, erosive mucosal disease, or duodenal or gastric ulcer, as would be expected in any febrile illness. I present a case report of a patient who presented with febrile illness and upper gastrointestinal bleed due to a ruptured liver abscess perforating into the stomach.

AIMS AND OBJECTIVES –

The primary objective of this case report is to delineate the presentation and management of a patient presenting with a hepatogastric fistula in a case of liver abscess.

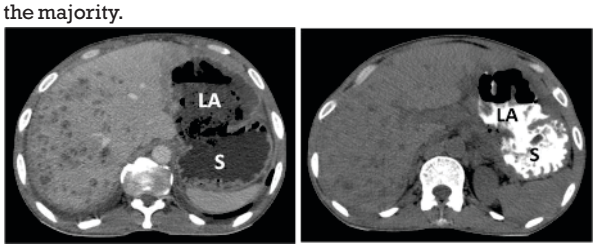
MATERIALS AND METHODOLOGY-

The case report was made on the rare presentation of a common clinical entity using material provided by the government of Gujarat within the BJ medical college and the imaging and interventional methods within the limits of our department .

RESULTS-

The resultant fistulous communication between the abscess cavity in liver with the stomach cavity is termed as a hepatogastric fistula. Such a fistula has also been described following transarterial embolization, radiotherapy for hepatocellular carcinoma, percutaneous radiofrequency thermal ablation of hepatocellular carcinoma, pyogenic liver abscess, iatrogenic injury of the stomach, percutaneous catheter drainage of liver abscess, metal stent placement to decompress an obstructed biliary system in case of benign or malignant biliary obstruction, or by direct infiltration of stomach by hepatocellular carcinoma. Rupture of liver abscess into the stomach may present with persistent severe abdominal pain , recurrent or bilious vomiting, or hematemesis as in our case. Hematemesis in these cases is usually due to tearing of the mucosal surface. Involvement of hepatic artery or portal vein branches has not been reported.
In cases of liver abscess rupturing into the stomach, abdominal CT scan and UGIE usually establish the diagnosis. The presence of multiple air foci within the abscess cavity on imaging is a significant suggestive finding as it is seen only in few other conditions such as infection with gas-forming organisms, bland tissue infarction with necrosis, and recent instrumentation or surgery. Endoscopic picture may be mistaken for a gastric ulcer and a high index of suspicion is required for making this diagnosis.

There is no clear consensus regarding the management of hepatogastric fistula due to rarity of the condition and variable presentation. Conservative management includes keeping patient nil per oral, percutaneous drainage of liver abscess, antibiotic therapy, proton pump inhibitors, and decompression of the stomach. A nasojejunal tube may be passed distally for initial feeding purpose or alternatively a distal feeding jejunostomy can be made. Spontaneous closure of the fistula can be anticipated within 4–6 weeks in the majority.



A **B**

CT images of the abdomen. (A) Abscess in the left lobe of liver communicating with the stomach. (B) Oral contrast in the stomach entering the abscess cavity in the left lobe of the liver. LA, liver abscess; S, stomach.

CONCLUSION-

Gastric perforation of liver abscess is a very rare complication of liver abscess. Clinical presentation is varied and it may present with upper gastrointestinal bleed. Endoscopic picture usually mimics gastric ulcer and a high index of suspicion is required to make this diagnosis.

Diagnosis is confirmed by CT scan and UGIE. A definitive consensus regarding management is still lacking and approach must be individualized according to clinical presentation.

REFERENCES-

1. Singh M, Kumar L, Kumar L, et al. Hepatogastric fistula following amoebic liver abscess: an extremely rare and difficult situation. *OA Case Report* 2013;2:38
2. Bailey and Love's Short Practice of Surgery *28th Edition*
3. Sabiston Textbook of Surgery *21st Edition*