JMSCR Vol||06||Issue||01||Page 32691-32692||January 2018

www.jmscr.igmpublication.org
Impact Factor 5.84
Index Copernicus Value: 71.58
ISSN (e)-2347-176x ISSN (p) 2455-0450
crossref DOI: https://dx.doi.org/10.18535/jmscr/v6i1.47

IGM Publication
Journal Of Medical Science And Clinical Research
An Official Publication Of IGM Publication

Ruptured Amoebic Liver Abscess with Pleuro Pericardial Effusion – A Case Report

Authors
Dr Sherry Garg, Dr Sophia Garg, Dr H.B.Prasad
Dr VMGMC, Solapur

Abstract
Amoebic liver abscess is the most frequent extra intestinal manifestation of Entamoeba histolytica infection. It is caused by the organism which enters the portal system from colon. Very often it ruptures into surrounding structures. We present here a case of ruptured amebic liver abscess, which was managed conservatively and discharged in a satisfactory treatment with diloxanide furonate and hematinics.

Introduction

Amoebiasis is endemic in tropical countries, affecting about 500 million people. Abdominal amoebiasis account for 3-9%[(1)]. The primary infection is colitis. Extra intestinal infections are due to embolization of *Entamoeba histolytica* into the liver through portal vein. Liver is the most common and lung is the second most common extra intestinal site of amoebiasis. Pleuro-pulmonary involvement occurs when a right lobe liver abscess ruptures through the diaphragm and produces an empyema[(2)]. Incidence of pleuropericardial effusion is higher in left left liver lobe abscess[(3)]. We present a rare case of amoebic liver abscess rupturing into lung and heart causing pleuropericardial effusion.

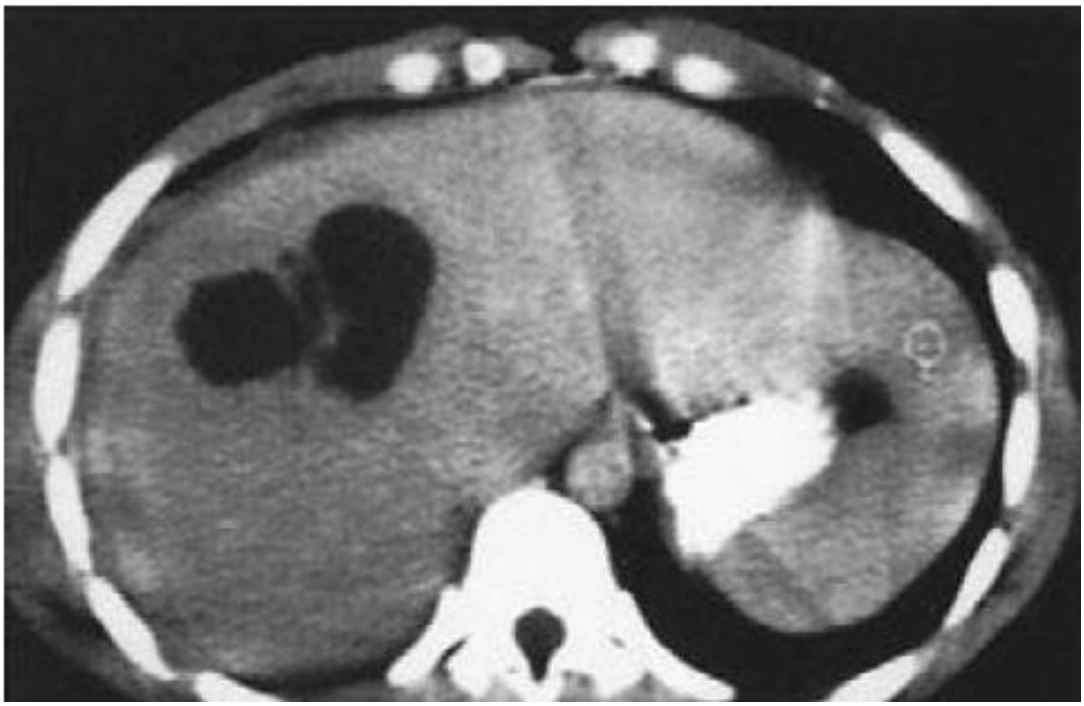
Case Report

A 17 year old female was admitted with complaints of pain upper abdomen and fever since 1 week. She had a history of vomiting since 4 days and developed acute breathlessness since 1 day. Pain was localized to right hypochondrium and epigastrium initially but was generalized gradually. She had low to moderate grade fever with chills which was followed by vomiting. It was associated with nausea and decreased appetite. She developed breathlessness of acute onset 6 days later. Past history was uneventful. On examination, she was pale, febrile, had tachycardia and pedal edema. Per abdomen was soft with hepatomegaly and tenderness in right hypochondrium and epigastrium. Breath sounds were decreased on right side and rhonchi were present.

On lab investigations she had haemoglobin of 6.2g/dl and white cell count 26000/cumm. Liver function tests were normal except SGOT which was 76IU/lt. Ultrasonography showed an ill defined, hypoechoic, irregular lesion with internal echoes msg 11.8 x 7.2 cm in left lobe of liver. It also showed mild pericardial effusion, right pleural effusion and mild ascites. On aspiration it showed anchovy sauce pus. CECT abdomen

showed hepatic abscess with transdiaphragmatic rupture with IVC thrombosis. 2 D ECHO was suggestive of early tamponade. Amoebic serology was positive.

.



She was managed non- operatively with iv - antibiotics, antiemetics, diuretics, hematinics and supportive care. She improved and gradually discharged on diloxanide furonate and haemtinics

Conclusion

Liver abscesses in the left lobe of liver carry a potential risk of rupture into pleuro-pericardial cavity which can be acutely fatal. Therefore awareness about this complication, the need for early diagnosis and prompt management by aggressive medical and surgical interventions can save a precious life.

References

1. Ravdin JI. Amebiasis. Clin Infect Dis. 1995;20:1453-66.
2. Huges MA, Petri WA. Amebic liver abscess. Infect Dis Clin North Am. 2000;14:565-82.
3. WHO Scientific Working Group. Parasite related diarrhoeas. Bull World Health Organ.1980;58:819-30.