SOME ASPECTS OF AMOEBIC LIVER ABSCESS

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Intestinal amoebiasis is fairly common in this part of world but liver involvement too is equally of high incidence. Majority of the people are treated for amoebic hepatitis avoiding the complication of amoebic liver abscess which many at time presents and baffles most of us and the diagnosis is delayed. In my experience besides the unusual presentation of liver abscess there have been few interesting observation which are of great significance as to their possible mechanisms.

Classically a case of amoebic liver abscess presents with increasing discomfort, mild to moderate pain over the right side of chest or right hypochondrium with or without a history of fever and on examination, liver is usually enlarged and quite tender, intercostal tenderness is elicited an X-ray Chest usually shows raised diaphragm on the right side. There should be no difficulty in the diagnosis in such cases. But not all patients present so classically. There are many ways of presentation and we should be aware of this so that we may think of this possibility at least. In real emergency even the possibility is not entertained because of the funny way of presentation. Following are the ways the patients presented in my series—

1. Patient admitted from emergency with massive haemoptysis—? Tuberculosis one case. Needing Repeated B. T and X-ray showing opacity on the whole right side chest.
2. Patient admitted as a case of acute abdomen with perforation and features of shock. This is the time when liver abscess bursts into the chest (Plura, Pericardium, lungs).
3. Patients admitted with high fever 105 – 106 with chills, irritating cough, liver being normal, and small shadow in the chest mimicking consolidation in right midzone or apex. Radiological diagnosis being consolidation either due to Tuberculosis or inflammatory.
4. Patient admitted with a history of chest pain on right side and X-ray chest showing slight pleural effusion.

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5. Chronic pain over right shoulder region with marked emaciation, X-ray shoulder, cervical spine normal mimicking possibility of cancer.
6. Patients coughing out small amount of amoebic pus mistaking some body for pulmonary tuberculosis specially so if there is some shadow in the chest— and if the attending doctor does not care to see the colour of the sputum.
7. Patient may come with a swelling epigastric region not tender very recent history mimicking a growth specially in old age group.
8. Patient with dyspnoea, enlarged liver and oedema legs almost mimicking congestive heart failure.
9. Deep jaundice, this is usually associated with pain right side.

Certain points are of real importance in the diagnosis specially when the scanning facility is not available and one has to depend on clinical evaluation.

1. History of amoebic dysentery either of recent origin say for example 3-4 weeks or history of chronic amoebiasis is given by almost 50 p.c. of the people which is of great help at least to suggest the possibility.
2. Hepatic enlargement with tenderness — This is usually present at the initial stage but after the abscess ruptures into the lungs or pleure, the liver may not be palpable at all or just palpable. Same holds true about the tenderness. Though tenderness still may be elicited on the intercostal space.
3. Polymorphonuclear leucocytosis along with high ESR is almost invariable say for examples, 12-40,000. total white count have been seen in our series. Sedimentation rate varies from 60-120mm.
4. Radiology is of great importance in most of the cases. Only those cases who present with extensive pleural effusion or isolated consolidation type of shadow in the right side of lung are not of value. Otherwise in rest of cases it is of real value.

The usual radiological findings are as follows

1. Just raising of right hemidiaphragm is the commonest and is usually seen in the following situation too.
2. Slight pleural reaction.
3. Lower basal opacities.
4. Only one particular part of diaphragm is pushed up.
5. Slight disruption of diaphragmatic alignment.
6. Encysted fluid coming up in quick succession.

There are few words of caution, because some times we may be completely misguided by the finding and treat the individuals in a different line. Say for example.

Patient coming to us with fever of some days duration and his urine showing Albumin + few puscells, should not be treated as a case of U.T. infection because it has been seen in most of cases of amoebic liver abscess and I think it is a toxic manifestation.

Patient coming to us with chest pain not related to respiration and X-ray chest showing pleural reaction though from all practical point of view, specially in our country, this is a case of tubercular pleuresy we should not forget the possibility of amoebic liver abscess because it can present exactly the same way.

Fever is not always a constant feature so its absence never rules out the possibility. A patient with massive haemoptysis- rather uncontrollable and X-ray showing Rt. sided massive pleural effusion-should be investigated for amoebic liver abscess.

Some interesting observation

There has been some interesting observation during the study of this series on chronic alcoholic, as they are vulnerable for other infection are very prone. As a matter of fact any condition lowering the resistance of the individual may precipitate the latent amoebiasis into fulminating amoebic liver abscess as we notice in a patient who after undergoing partial gastrectomy, for acute haemetemesis developed deep obstructive type of jaundice on 7th day of surgery. Later on we aspirated amoebic pus from liver.

Two young boys in twenties, both chronic alcoholic consuming more than a pint every day had—

1. Swelling of the legs and feet improving as the primary condition improved.
2. Jaundice, really very deep jaundice has been observed, are usually obstructive.
3. Bursting of abscess into the chest can still occur even after institution of the therapy so once the diagnosis is made and if the patient is in pain, the abscess has to be aspirated.