Synchronous Ruptured Amoebic Liver Abscess With Caecal Perforation - A Rare Case Presentation

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INTRODUCTION

Diseases caused by Entamoeba histolytica manifest as acute infectious diarrhoea clinically, and pathologically as ulcerative and inflammatory lesion in the caecum and the entire colon. The organism, during the invasive stage, gains access to the liver via the portal vein where marked tissue destruction occurs resulting in a liver abscess. Liver abscess and colon perforation are the clinical syndromes associated with amoebiasis. Intra-abdominal rupture of liver abscess and caecum perforation are rare occurrences which complicate the severe form of invasive disease caused by E. histolytica. Management of a complicated severe form of invasive amoebiasis is challenging.

CASE HISTORY

A 64-year-old male, a chronic alcoholic (>30 years), normotensive and non-diabetic, presented with loose stools and right-side abdominal pain for one week. On examination, guarding and tenderness were found in the right hypochondrium with right lateral chest-wall tenderness, simulating liver abscess. Digital rectal examination yielded no abnormality. Laboratory investigations revealed leucocytosis, raised blood urea and creatinine, hypoprotinemia and mild elevation of liver enzymes. Computed tomography of the abdomen revealed a ruptured huge liver abscess with free fluid and minimal right-side pleural effusion (figure 1). A provisional diagnosis of ruptured liver abscess with septicemia was made and the patient was taken up for emergency laparotomy.

Laparotomy revealed ruptured liver abscess in the right lobe (superolateral aspect), with caecal perforation (figure 2) with severe peritoneal faecal and pus contamination. During surgery, the patient went for severe hypotension, hence tube caecostomy and peritoneal toileting with tube drainage of the liver abscess cavity was performed.

After three days, after stabilizing the patient with blood transfusion, albumin infusion and under the cover of broad spectrum antibiotics and metronidazole, relaparotomy and right hemicolectomy (figure 3) with ileotransverse anastomosis (figure 4) were performed. The drain was removed on the 10th postoperative day and the patient was discharged on the 15th postoperative day. Histopathological examination of the specimen showed amoebic ulcers of the caecum with transmural involvement (figure 5).
Amoebic liver abscess (ALA) is the most common manifestation of extraintestinal amoebiasis. The causative agent is a protozoan, Entamoeba histolytica. Ten percent of the world’s population harbors E. histolytica in their colon, 10% of them may develop invasive amoebiasis and 1–10% of these patients develop amoebic abscess in their liver\textsuperscript{11,12}. ALA is common in tropical countries\textsuperscript{13} and prevalent mainly among the lower socioeconomic class living in unhygienic conditions. Poor hygiene, contaminated drinking water, malnutrition, hepatic dysfunction, low host resistance, alcohol intake, delayed or inadequate treatment are all responsible for the disease in the lower socioeconomic group. Early and correct diagnosis of ALA is imperative because delayed diagnosis and treatment leads to
complications. The diagnosis of digestive amoebiasis and systemic complication may be delayed in non-endemic areas, leading to advanced and complicated stages of the disease. The surgical approach is most efficient to treat a large liver amoebic abscess and intraperitoneal collections.

Multidisciplinary approach was the successful key in the management of the patient, including antiparasitic therapy and antibiotic prophylaxis, intensive care and multiple surgical approaches.

Faecal peritonitis with concomitant ruptured liver abscess usually leads to severe septicaemia. If not detected at an early stage, mortality and morbidity are very high. Prevention of infection and early detection may reduce the high mortality and morbidity of this disease.

References
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