Spontaneous fistulisation of a liver abscess into the stomach

Sir,

Treatment of pyogenic liver abscess (PLA) includes antibiotics and drainage. We present a patient with PLA, who developed spontaneous fistulisation into the stomach.

CASE REPORT

A 44-year-old man without a relevant medical history developed abdominal pain. A subsequent upper gastro endoscopy was normal. Abdominal ultrasonography revealed a hypoechogenic structure localised in the left hepatic lobe. An abdominal computed tomography (CT) scan (*figure 1*) demonstrated a 5.5 cm hypodense round structure localised in liver segment II. On admission the body temperature was 36.6°C, and physical examination revealed a painless hepatomegaly. There was a moderate acute phase response. Blood cultures were negative and there was no evidence for presence of ecchinococcus or amoebiasis on serology. The diagnosis of PLA was made, and a usual antibiotics against pyogenic bacteria was initiated. Six days after admission, an ultrasonographical-guided puncture was planned, but was cancelled, as the PLA was not visible. A CT scan showed that the PLA had drained through a spontaneous fistula into the stomach (*figure 2*). The outcome was good and the patient was discharged.

Figure 1. *Abdominal CT scan with contrast medium performed before the patient's admission showing a 5.5 cm abscess of segment II of the liver (black arrow), located in the front of the anterior face of the stomach*

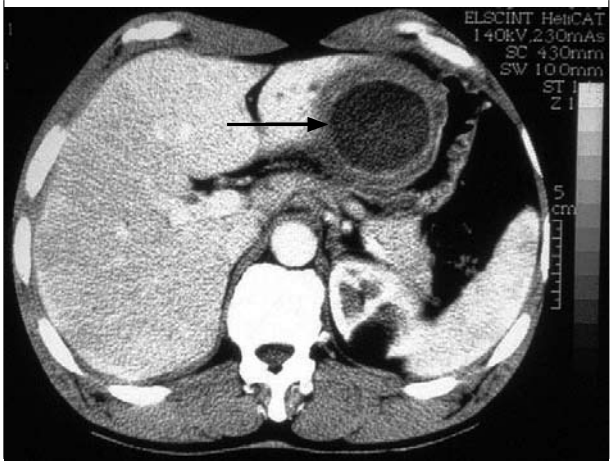
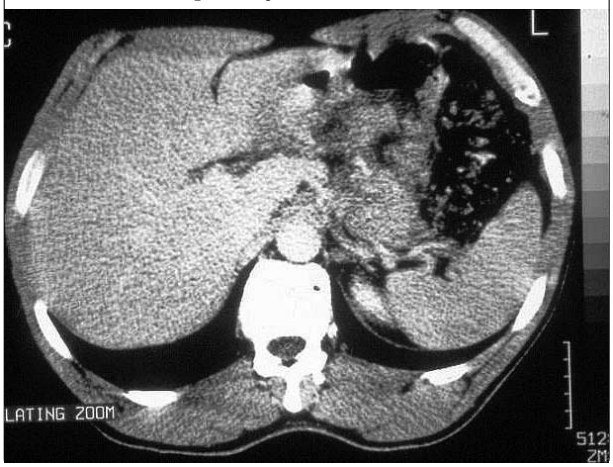


Figure 2. *Abdominal CT scan performed after six days of antibiotics showing the disappearance of the abscess secondary to its fistulisation into the stomach*



CONCLUSION

PLA occurs with an incidence of 22 to 446/100,000 admissions.[1,2] Predisposing risk factors are diabetes mellitus, alcoholism, malignancies, immunodeficiency or liver transplantation. The mean age ranges from 50 to 60 years old,[1,2] with a male predominance. The main aetiology is cryptogenic, followed by biliary and inflammatory bowel disease.[3]

The three most observed clinical symptoms are fever, right hyponchondrial pain and nausea. A hepatomegaly is found in 25% of cases.[1,4] PLA is usually solitary and located in the right liver lobe.[1,5] CT scan with contrast media is the gold standard technique to visualise PLA, although ultrasonography is a reliable imaging procedure.[1,6] An inflammatory syndrome with leucocytosis and elevation of transaminases are found in two out of three patients.[1,2,4] The two most frequent causative organisms are *E. coli* and *K. pneumoniae*.[1,2]

The treatment includes parenteral antibiotics and percutaneous drainages.[1,2,4]

In our case, drainage was postponed because of initial benefit of the antibiotics, but coincided with spontaneous fistulisation into the stomach, which explains the clinical improvement. This reinforces the concept of early drainage of PLA in order to avoid a spontaneous intra-peritoneal abscess rupture.

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