Spotting of a Amebic Liver Abscess in the United States

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INTRODUCTION

Amebic liver abscess represents a common extraintestinal manifestation of Entamoeba histolytica infection, particularly prevalent in developing countries of South America and Asia and not commonly seen in the United States, where it makes up less than 10% of all liver abscess. After fecal-oral transmission, the protozoan colonizes the gastrointestinal (GI) tract and gains access to the liver via the superior mesenteric vein and subsequently the portal vein. Symptoms typically manifest approximately 4 weeks after exposure and encompass a spectrum of GI symptoms including mild to severe right upper quadrant pain, accompanied by constitutional symptoms such as fatigue, anorexia, weight loss, and fever. Diagnostic evaluation and management of amebic liver abscess a proper history and physical, imaging, serological testing, pharmacotherapy with agents such as metronidazole, and potentially drainage procedures.

CASE SCENARIO

42-year-old man who presented with 4 months of worsening right upper quadrant pain with anorexia and 7-10kg of unintentional weight loss. History was significant for alcohol consumption and recent migration from India to Argentina and now to the United States. Work-up showed mild leukocytosis of 12.6, isolated elevated alkaline phosphatase at 408 IU/L and imaging showing 12.6 x 16cm hypodense lesion in the dome of the right hepatic lobe with cystic features surrounded by hypo-attenuated hepatic parenchyma.



Coronal and axial cuts of CT showing the large lesion in the dome of the right hepatic lobe just below the diaphragm causing it to be elevated.



Thick, grey purulent output after CT guided drain placement resembling anchovy paste.

CASE SCENARIO CONT'D

Given his travel history, isolated elevated alkaline phosphatase, RUQ pain in a setting of a liver abscess, suspicion for an amoebic liver abscess rather than a pyogenic was high, therefore serologies were collected and patient was started on Metronidazole. Furthermore, since the abscess was larger than 5cm and at the dome of the right lobe, there was increased risk of rupture, particularly into the right pleural space, therefore CT-guided drain was placed which removed thick, grey material resembling anchovy paste, further confirming the diagnosis.

Once initial serology resulted it confirmed our diagnosis of amoebic liver abscess with it being positive for E. histolytica.

CONCLUSION

Although an uncommon cause of liver abscesses in the United States, a degree of clinical suspicion should be employed when evaluating patients with vague GI symptoms in a setting of an liver abscess for amoebiasis, especially with increase in travel to and immigration from endemic areas in recent times.

REFERENCES

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