Management of amoebic liver abscess

Patient with liver abscess, usually complain from fever.

In amoebic liver abscess, the fever is of low grade (in contrast to pyogenic liver abscess in which there is high grade fever).

The patient also complains from upper abdominal pain, anorexia, nausea & weight loss.

The patient may mention a history of dysentery, but is not always.

Examination:

- General examination reveals a patient who is pale & toxic; a combination that gives him an earthy look.

The patient may also have fever, tachycardia & sweating.

- Chest examination may reveal poor air entry and dull percussion on the right lower lobe which may indicate right lung basal abscess or pleural effusion.
- Abdominal examination shows tender hepatomegaly.

For diagnosis:

1) **Positive stool tests** & serological tests are useful diagnostic aids in non endemic areas.
2) **Blood picture**, commonly shows leukocytosis & anemia.
3) The diagnosis of amoebic liver abscess rests mainly on imaging by **ultrasound** or **CT scan** (unilocular cystic lesion). They can also show the size, site & number of the abscesses.

   Also the diagnosis needs **isolation of the parasite from the liver lesion**.
4) **An improvement** in the general & local conditions after 3 days of treatment with metronidazole confirms the diagnosis.
5) **Chest X-ray** is needed to detect pleural effusion & pulmonary collapse. Chest X-ray, also commonly reveal elevated right copula of the diaphragm.

Treatment is by one of the following:

1) Conservative treatment
2) Ultrasound guided percutaneous aspiration
3) Open drainage.

- **Conservative treatment** is highly successful. Metronidazole is the drug of choice. It is given in dose of 800 mg three times daily for 7-10 days.
- **Ultrasound guided percutaneous drainage indicated for:**

1) Failure to respond to 3 days treatment with Flagyl
2) For large abscess.

The site of aspiration depends on the site of abscess.

If the abscess is anterior, the needle is introduced below the costal margin anteriorly.

If the abscess is posterior, the needle is introduced through the tenth intercostals space posteriorly.

Few days later, ultrasound repeated. If the abscess cavity recollected & is more than 5 cm, aspiration is repeated.

- **Open drainage indicated in:**

1) Presence of secondary infection 2) if the abscess is pointing

3) If aspiration is difficult because of multiloculous abscesses or due to the presence of thick pus.

Open drainage which is rarely needed is done through the bed of the 12^{th} rib posteriorly (the usual site for the amoebic abscess) through an extra pleural approach.

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