A rare view: giant liver abscess with underlying liver metastases
Leonor Vasconcelos Matos,1 Patricia Moniz,2 Jorge Oliveira Dantas,3 Arturo Botella3

DESCRIPTION
Liver abscess (LA) refers to a suppurated cavity caused by the invasion of liver parenchyma, most commonly by Gram-negative bacteria. Although rare, it is potentially life-threatening. Giant LA (>10 cm) is even more uncommon.1 Symptoms and signs are non-specific and the diagnosis relies essentially on imaging with ultrasound (US) and CT scan. Treatment is based on antimicrobials, abscess drainage and approach to the underlying disease.2 For pyogenic LA, prompt initiation of empirical broad-spectrum intravenous antibiotics,2 usually a third-generation cephalosporin plus metronidazole, is essential with subsequent adjustment to culture and sensitivity, usually for 10–14 days, depending on clinical and radiological response. Together with CT scan or US-guided percutaneous catheter drainage (PD), it is the initial treatment of choice.1 However, large LA >5 cm predicts failure of PD and the need for surgical drainage.3 Malignancy and multiloculation are also risk factors for therapy failure. The best outcome is achieved with close coordination of a multidisciplinary team and rigorous drain management protocol.1 We report the case of a 74-year-old woman with pancreatic carcinoma with liver metastasis that required a biliary prosthesis. She presented with fever, abdominal pain and jaundice and was diagnosed with cholangitis, starting intravenous antibiotics, adjusted to blood cultures (Streptococcus anginosus, Raoultella...
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planticola and Enterobacter cloacae). An endoscopic retrograde cholangiopancreatography showed occlusion of the prosthesis, then replaced. After 5 days of unresolved infection, a new CT scan revealed multiple liver metastases and abscesses (figure 1). A CT-guided percutaneous drainage was performed: E. cloacae, Enterococcus faecalis and Candida glabrata were isolated in the pus, and antimicrobials adjusted. After 4 days, the patient got worse, with signs of severe organ failure. CT scan revealed a giant subcapsular liver abscess, with 16 cm, and worsening of the previous abscesses (figures 2-4). The patient died 2 days later.

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Learning points

► Giant liver abscess is a very rare disease, but with up to 46% mortality.
► Prompt initiation of parenteral broad-spectrum antibiotics, early ultrasound or CT to confirm diagnosis, percutaneous drainage, tissue culture and repeated scans, if sepsis persists, are the main approaches to achieve the best optimal outcome.
► Giant size and multiloculation are predictors of failure of percutaneous drainage and need for surgical drainage.

REFERENCES