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The typical patient with an amoebic liver abscess is a young adult male with a history of insidious onset of non-specific symptoms, such as abdominal pain, anorexia, fever, night sweats, malaise, cough and weight loss. These symptoms gradually progress to more specific symptoms of pain in the right upper abdomen and right shoulder tip, hiccoughs and a non-productive cough. A past history of bloody diarrhoea or travel to an endemic area raises the index of suspicion. Examination reveals a patient who is toxic and anaemic. The patient will have upper abdominal rigidity , tender hepato megaly , often with tender and bulging intercostal spaces and overlying skin oedema, a pleural e ff usion and basal pneumo nitis – the last fea ture is usually a late manifestation. Occasion ally , a tinge of jaundice or ascites may be present. Rarely , the patient ma y present as an emergency owing to the e ff ects of rupture of an abscess into the peritoneal, pleural or pericardial cavity . Clinical features

The larval stage in the lungs causes pulmonary symptoms – dry cough, chest pain, dyspnoea and fever – referred to as Loef fler's syndrome. The adult worm can grow up to 45 cm long. Wilhelm Loe ffl er , 1887–1972, Professor of Medicine, Zurich, Switzerland. Jean Martin Charcot , 1825–1893, French neurologist and Professor of Pathology at Hôpital Universitaire la Pitié-Salpêtrière, Paris, France. Ernst von Leyden , 1832–1910, Professor of Medicine, Berlin, Germany . to thrive, particularly in children, and abdominal pain. Worms that migrate into the common bile duct can produce ascending cholangitis and obstructive jaundice, while features of acute pancreatitis may be caused by a worm in the pancreatic duct. Small intestinal obstruction can occur, particularly in chil - dren, owing to a bolus of adult worms incarcerated in the ter - minal ileum. This is a surgical emergency . Rarely , perforation of the small bowel may occur from ischaemic pressure necrosis from the bolus of worms. A high index of suspicion is necessar y so as not to miss the diagnosis. If a person from a tropical country , or one who has recently returned after spending some time in an endemic area, presents with pulmonary , gastr ointestinal, hepatobiliary and pancreatic symptoms, ascariasis should be high on the list of possible diagnoses. Clinical features

As the parasite can colonise virtually every organ in the body , the condition can be protean in its presentation. When a sheep farmer who is otherwise healthy complains of a gradually enlarging painful mass in the right upper quadrant with the physical findings of a liver swelling, a hydatid liver cyst should be considered. The liver is the organ most often a ff ected. The lung is the next most common. The parasite can a ff ect any organ (Figures 6.10 and 6.11) or several organs in the same patient (Figure 6.12). The disease may be asymptomatic and discovered coin cidentally at postmortem or w hen an ultrasonography or CT scan is done for some other condition. Symptomatic dis ease presents with a swelling causing pressure e ff ects. Thus, a hepatic lesion causes dull pain from str etching of the liver capsule, and a pulmonar y lesion, if large enough, causes dys pnoea. Daughter cysts may communicate with the biliary tree, causing obstructive jaundice and all the usual clinical features associated with it in addition to symptoms attributable

to a parasitic infestation (Figure 6.13) . Features of raised intracra nial pr essure or unexplained headaches in a patient from a sheep-rearing community should raise the suspicion of a cere bral hydatid cyst. The patient may present as an emergency with severe abdominal pain f ollowing minor trauma, when the CT scan may be diagnostic (Figure 6.14). Rarely , a patient may present as an emergency with features of anaphylactic shock without any obvious cause. Such a patient may subsequently cough up white material that contains scolices that have travelled into the - - tracheobronchial tree from rupture of a hepatic hydatid on the diaphragmatic surface of the liver. -

TABLE 6.1 Classi /f_i cation of hepatic hydatid cyst Stage Description CL (cystic lesion) Unilocular anechoic cystic lesion without internal echoes or septations CE (cystic echinococcosis) 1 Uniformly anechoic cyst with /f_i ne internal echoes that represent protoscolices after rupture of a vesicle, called ‘hydatid sand’ CE 2 Cyst with internal septation representing the walls of the daughter cyst described as multivesicular, honeycomb, cartwheel or rosette formation 3A: daughter cysts with detached laminated membrane CE 3 (transitional stage) description of 3B- daughter cysts inside a solid matrix daughter cyst CE 4 Daughter cysts can no longer be seen (inactive/degenerative) Mixture of hypoechoic and hyperechoic features – like a bag of wool CE 5 Calci /f_i cation of the wall; either partial or complete (inactive/degenerative) Figure 6.10 Computed tomographic scan showing a hydatid cyst of the pancreas. A differential diagnosis of hydatid cyst or a tumour was considered. At exploration, the patient was found to have a hydatid cyst, which was excised. This was followed by 30 months of treatment with albendazole. The patient remains free of disease.

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Patients present electively with weight loss, chronic cough, malaise, evening rise in temperature with sweating, vague abdominal pain with distension and alternating constipation and diarrhoea. As an emergency , they present with features of distal small bowel obstruction from strictures of the small bowel, particularly the terminal ileum. Rarely , a patient may present with features of peritonitis from perforation of a tuber - culous ulcer in the small bowel (Figure 6.37) . Examination shows a chronically ill patient with a ‘doughy’ feel to the abdomen from areas of localised ascites. In the a mass may be felt in the right iliac fossa. In hyperplastic type, in - ano , which addition, some patients may present with fistula- is typically multiple with undermined edges and watery dis - charge. As this is a disease mainly seen in certain resource-poor countries, patients may present late as an emergency from intestinal obstruction. Abdominal pain and distension, consti pation and bilious and faeculent vomiting are typical of such a patient, who is usually in extremis. There may be involvement of other systems, such as the genitourinary tract, when the patient complains of frequency of micturition. Clinical examination does not show any abnor mality . The genitourinary tract should then be investigated. Summary box 6.24 Tuberculosis: clinical features /uni25CF /uni25CF /uni25CF /uni25CF

Stricture in the terminal ileum Perforation in the terminal ileum Figure 6.37 Emergency limited ileocolic resection: specimen showing a tuberculous stricture in the terminal ileum and perforation of a trans verse ulcer just proximal to the stricture. Intestinal tuberculosis should be suspected in any patient from an endemic area who presents with weight loss, malaise, evening fever, cough, alternating constipation and diarrhoea and intermittent abdominal pain with distension The abdomen has a doughy feel; a mass may be found in the right iliac fossa The emergency patient presents with features of distal small bowel obstruction – abdominal pain, distension, bilious and

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