INFECTIVE CONDITIONS OF THE LIVER Ascending cholan

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- Ascending cholangitis is a potentially life-threatening emergency associated with infection of the biliary tree and usually associated with obstruction. It presents with clinical jaundice, rigors and a tender right upper quadrant (Charcot’s triad). The most common bacteria linked to ascending /uni00A0 chol - angitis /uni00A0 are gram-negative bacilli: Escherichia coli (25–50%), - Klebsiella (15–20%) and Enterobacter (5–10%). The diagnosis is confirmed by the finding of dilated bile ducts on ultra - sonography , an obstructive picture of liver function tests and organisms identified from blood cultures. Delay in appropriate treatment may result in multiorgan failur e secondary to sepsis - and broad-spectrum antibiotics, rehydration, and endoscopic - or percutaneous transhepatic drainage are urgently required. Biliary stone disease is a common predisposing factor although strictures, pancreatitis, pancreatic tumours and parasites may also be responsible. If an obstructive cause is identified it must be urgently treated by ERCP , sphincterotomy (± stent) or percutaneous drainage. Microbial contamination of the liver leading to a liver abscess continues to occur at a fairly constant rate of approximately 1/5000 hospital admissions. The incidence of causative organ isms varies and reflects changes in aetiology and geographical distribution. Bacterial, parasitic and fungal organisms can cause liver abscess but, worldwide, bacteria remain the most common; although infection is usually polymicrobial Klebsiella, Escherichia coli and the Streptococcus milleri group are the usual organisms identified. There is an increased incidence in the elderly , those with diabetes and the immunosuppressed and presentation is usu ally with anorexia, fever, malaise and right upper quadrant discomfort. The overall mortality has declined because of improv ed imaging and e ff ective antimicrobial therapy and the outcome is incr easingly dependent on the underlying cause and the presence of comorbidities. Biliary tract pathology is the most common source (35%), followed by portal spread from the gastrointestinal tract, including diverticulitis and appendicitis (20%). Other unusual aetiologies include contiguous spread from subphrenic or intra-abdominal collections, bacteraemia secondary to trauma or infected cysts and necrotic tumours following chemother apy . The cause is not identified in 10% of cases and a number of liver abscesses become recurrent (12–38% depending on whether the responsible organism is identified and whether the patient has diabetes). The diagnosis is suggested by the finding of a multiloculated cystic mass on ultrasonography or CT scan (Figure 69.18) and is confirmed by aspiration. Treatment of liver abscesses initially requires identification of the source, if possible, aspiration of the lesion for micro biology and culture (r epeated aspirations may be required) and treatment with appropriate antibiotics. Simple cysts containing debris, hydatid cysts, necrotic tumours

and non-infected haematomas (after unrecognised or occasional trivial trauma) can all be mistaken for abscesses. Antibiotic treatment using □ □ Theodor Albrecht Edwin Klebs , 1834–1913, Professor of Bacteriology successively at Prague, Czechoslovakia, Zurich, Switzerland, and the Rush Medical College, Chicago, IL, USA. Metronidazole and clindamycin provide wide anaerobic coverage and excellent penetration into the abscess cavity . Third-generation cephalosporins and aminoglycosides are - very e ff ective against most Gram-negative organisms.

Figure 69.18 Liver abscess. Computed tomography scan showing an air– /f_l uid level and rim enhancement (open arrow). The second lesion seen is a haemangioma (closed arrow).

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