ACUTE ABDOMEN IN PUERPERIUM DUE TO RUPTURE OF AMOEBIC LIVER ABSCESS

by

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A case is reported where the patient developed acute abdomen soon after delivery due to rupture of an amoebic liver abscess. Sen *et al* (1974) reported one such case from the same institution.

CASE REPORT

Mrs. K. K. aged 45 yrs. an unlooked case, mother of twelve children, delivered normally at term in a P.H.C. at 12 noon on 28-12-81. She had history of chronic intestinal amoebiasis. She was suffering from low grade fever for last 8 days. Soon after her delivery abdomen became gradually distended though she did not complain of much abdominal pain. By 8 P.M. on the day of delivery her condition deteriorated and abdomen was markedly distended.

Abdomen was uniformly distended. There was muscle guarding and rebound tenderness. No lump could be detected, neither the height of the uterus could be ascertained due to marked abdominal distension. Shifting dullness could not be elicited. Persistalic sound were absent.

Internal examination

Cervix was intact. No lump could be felt. Lochia was normal in color and quantity.

Management

Abdomen was opened by explorative right mid-paramedian incision. As soon as peritoneal cavity was opened it was observed that intestines were smeared with typical dirty-brown anchovy-sauce like pus. This prompted us to consider the possibility of rupture of amoebic liver abscess. The incision was extended upwards and on exploration an abscess cavity of about 3" in diameter was found in left lobe of liver. The right lobe was intact. The pus was sucked out of the abscess cavity. The abscess wall was scooped. The other abdominal vicera were duly explored and found healthy. There was no rupture of the uterus. Sterilization was done. The peritoneal cavity was thoroughly irrigated with warm normal saline. A Malecot catheter was kept at the abscess cavity and brought out through a stab wound in the left flank with the idea to drain abscess cavity. Another drain of corrugated rubber sheet was kept in the general peritoneal cavity which was brought through right flank. Abdomen was closed in layers. One bottle of blood was transfused during the operation.

Postoperatively Inj. metranidazole 500 mg was administered intravenously at 8 hourly interval for first 48 hrs. Thereafter metranidazole was continued orally for another 8 days. Inj. chloromycetin was continued for 7 days. The drain on the right and left side were removed 48 hrs. and 96 hrs. after the operation respectively. Bowel opened spontaneously on 3rd post-operative day. She was discharged in a favourable condition on 11th post-operative day. The histopathological examination of scooping materials from abscess wall confirmed the operative diagnosis of 'amoebic liver abscess'.

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References

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