Painless jaundice as a result of metastatic disease?

A 67-year-old man presented for an abdominal computed tomogram (CT) following development of rapid onset jaundice (bilirubin 74 umol/litre, alanine aminotransferase 62 U/litre, alkaline phosphatase 451 U/litre, C-reactive protein 123 mg/litre, white cell count $8.4x10^9$/litre), right upper quadrant pain and anorexia. There was no history of foreign travel. He had been given antibiotics for a cough and coryzal symptoms 1 week previously. Multiple low-attenuation liver lesions with irregular borders consistent with widespread hepatic metastases were seen on CT (*Figure 1*), and biopsied under ultrasound. Aspirates sent for histology were culture-negative at 4 days and were positive for the presence of white cells only. He was investigated for a colonic primary; colonoscopy showed diverticular disease only. He developed low-grade pyrexia so oral ciprofloxacin and clindamycin were commenced to cover biliary sepsis.

CT of the pneumocolon, performed 11 days later, showed marked reduction in the size and number of liver lesions.

Dr Ne Siang Chew *is Radiology Registrar,* **Dr Yasmin Pasha** *is Specialist Registrar in Gastroenterology and* **Dr Nasir Khan** *is Consultant in Radiology, Chelsea and Westminster Hospital, London SW10 9NH*

Correspondence to: Dr NS Chew

Discussion

This patient had multiple liver abscesses, confirmed on liver biopsy. Repeat CT (*Figure 2*) showed resolving lesions.

Pyogenic liver abscesses are the commonest visceral abscess. The incidence increases with age, is more common in diabetics and men (the male:female ratio is 3.3:1.3). Biliary pathology is currently the commonest cause (previously appendicitis-related). This patient may have had diverticulitis-related aetiology.

Frequently polymicrobial microorganisms with anaerobes are isolated; others include *Staphylococcus aureus*, *Streptococcus pyogenes*, *Strep. milleri* or *Klebsiella pneumoniae*.

Clinical features include pyrexia of unknown origin, prominent systemic symptoms and right upper quadrant pain, tenderness. Elevated alkaline phosphatase, the commonest biochemical finding, is present in 67–90%.

Diagnosis is usually made radiologically and confirmed with aspiration and culture of abscess material. Chest-X-ray may reveal raised right hemidiaphragm, pleural effusion or atelectasis. The differential diagnosis includes simple cysts, malignancy and amoebic abscess.

Larger (>3 cm) abscesses may require antibiotics and drainage. Smaller abscesses respond to antibiotics alone. In all cases the organism responsible and aetiology should be sought. Follow-up imaging monitors response to therapy. BJHM

Figure 1. Initial abdominal computed tomogram.

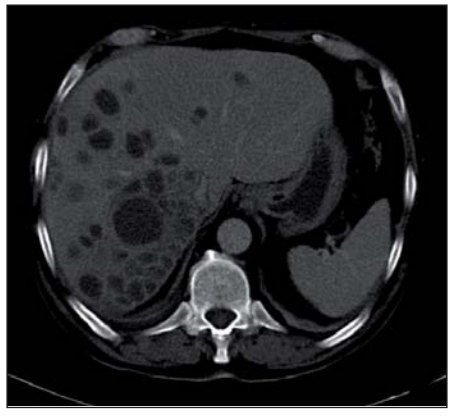

Figure 2. Computed tomogram pneumocolonography after 7 days on ciprofloxacin.