Two-dimensional echocardiography in the diagnosis of amoebic pericarditis

A case report

J. I. G. STRANG

Summary

A patient's pericardial effusion was confirmed by two-dimensional echocardiography, which also indicated an amoebic liver abscess as the source. The importance of routine liver scanning in investigation of pericardial effusion is emphasised.

Case report

A 62-year-old man was admitted to hospital moribund, with cardiac tamponade. He had a sinus tachycardia of 140/min, an unrecordable blood pressure, a jugular venous pressure greater than 15 cm in the erect position, palpable apex beat with increased cardiac dullness and on auscultation soft heart sounds and an extracardiac splashing sound were heard. The respiratory rate was 50/min and there was tender hepatomegaly of 14 cm. There was a 3-week history of cough, dyspnoea and shoulder pains, and a week before referral the patient had been seen at another hospital with pyrexia of 39°C, blood pressure 100/70 mmHg and a normal chest and heart. An enlarged tender liver became larger during the week. He had been referred with the provisional diagnosis of tamponade. Chest radiographs taken before referral showed a minimal increase in the size of the heart shadow. In view of the tamponade, immediate echocardiography was arranged. The patient's condition was such that ultrasonography was performed while he was seated in a wheelchair. A pericardial effusion was confirmed and immediate pericardiocentesis was performed.

The aspirate had the appearance of anchovy sauce and so the patient was moved to an examination couch for ultrasonography of the liver. This showed a large liver abscess (Fig. 1) communicating with the pericardial sac; further aspiration drained 500 ml of anchovy sauce material. The patient improved, the pulse rate falling to 112/min and his blood pressure rising to 90/60 mmHg with 10 mm of paradoxus. He was treated with intravenous and oral metronidazole and oral chloramphenicol and improved over the next 48 hours. Two days after admission ultrasonography was repeated and although the pericardial effusion was still present, no abscess cavity could be found in the liver. Three days after admission the patient complained of chest pain, the pulse rate was 120/min, blood pressure 100/70 mmHg with pulsus paradoxus of 10 mm, jugular venous pressure raised by 10 cm and increased cardiac dullness. To ensure adequate drainage of the pericardial sac an inferior pericardiotomy was performed and a rubber catheter was left in the pericardial sac for 4 days of underwater drainage. When the drain was removed a small amount of clear straw-coloured fluid flowed from the wound. The patient made an uneventful recovery. The anchovy sauce aspirate grew Escherichia coli.

Department of Medicine, Umtata Hospital, Umtata, Transkei

J. I. G. STRANG, B.SC., M.R.C.P.

Reprint requests to: Dr J.I.G. Strang, Dept of Medicine, Frere Hospital, PB 9047, East London, 5000 RSA.
Biliary ascariasis

A case report

O. LIFSCHITZ, J. TIU, R. A. SUMERUK, A. WEISS

Summary

The presenting features, diagnosis and management of biliary ascariasis in an adult woman are described and the literature is reviewed.


Biliary ascariasis in adults, rare in Western countries, is relatively common in other areas. Invasion of the biliary tree can occur,1-4 medical treatment is usually successful, surgical intervention being reserved for cases in which medical treatment fails or when there are complications.

Case report

A 62-year-old black woman was admitted to hospital with a 48-hour history of right upper quadrant colicky pain of acute onset, associated with nausea and vomiting. She had had two similar episodes of pain over the past year, and had undergone cholecystectomy and exploration of the bile ducts 4 years previously.

The patient was in good general condition with a blood pressure of 150/90 mmHg, a pulse rate of 98/min, and a temperature of 38°C. The total white cell count and total serum bilirubin, alkaline phosphatase and amylase values were moderately elevated.

A presumptive diagnosis of pancreatitis with possible cholangitis was made, and the patient was initially treated conservatively with intravenous fluids, nasogastric decompression, antispasmodics, analgesics and broad-spectrum antibiotics; the clinical features subsided within 3 days. Serum amylase and bilirubin levels fell to normal.

An intravenous cholangiogram showed a dilated biliary tree, with a linear filling defect extending from the left hepatic duct down to the common bile duct; a small stone in the right hepatic duct was also seen (Fig. 1).

A radiological diagnosis of Ascaris migration into the bile ducts and choledocholithiasis was made. At laparotomy the dilated bile duct was incised, a 30 cm long, dead Ascaris lumbricoides and a small soft stone were removed, and a T-tube drain was inserted. Postoperatively, vermifuges were prescribed. After a postoperative cholangiogram had proved normal, the T-tube drain was removed and the patient discharged on the 10th postoperative day.

Discussion

Ascaris lumbricoides is the commonest intestinal parasite in man. After ingestion of the ova, larvae migrate via the portal...