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GURLING: Uraemia in Myelomatosis

Summary

1. The histories of four cases of myelomatosis are reported in which death occurred in uraemia.

2. The pathogenesis of the renal lesion is discussed.

3. The need to distinguish the renal and haematological manifestations of myelomatosis from other forms of renal failure with secondary anaemia is emphasized.

BIBLIOGRAPHY


INTRAPERITONEAL RUPTURE OF AN AMOECIC ABSCESS OF THE LIVER

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Rupture of an amoebic abscess of the liver into the general peritoneal cavity is uncommon, very few cases being recorded in the literature and none from the British Isles. The following case is therefore reported.

Case Record

A well-built man of 37 was admitted on May 8, 1952, with severe epigastric pain for previous eight hours.

He had a long history of amoebic dysentery and hepatitis, beginning with a short attack of dysentery in Assam in 1944. In 1945 he was invalided home. Whilst on the troopship he had a severe attack of dysentery. He spent two periods in hospital of about four weeks on arrival in the United Kingdom. Amoebae were found in his stools at that time. He was demobilised at the end of 1945. In 1947 he was in the Jersey General Hospital with pyrexia and constipation, and again in 1949, with sweats and abdominal pain.

In February 1952 he was admitted to Roe-hampton Hospital complaining of abdominal pain, sweats, pyrexia and constipation. Amoebae were found in his stools and his liver was enlarged. A full course of anti-amoebic treatment was given and he was discharged in mid-April. He continued to have vague abdominal discomfort until his acute abdominal pain commenced on May 8, 1952.

Condition on Admission

He had a sunken grey face. Pulse 128, respiration 24, and temperature 99. His abdomen was rigid but not board-like and slightly distended. Tenderness was maximal in his right hypochondrium. Dullness to percussion in his right iliac fossa and right flank was present. There was no diminution of liver dullness. The liver edge was not palpable. The release sign was positive. There was no tenderness P.R. There were no abnormal signs in the chest.

A diagnosis of perforated peptic ulcer was made with, in view of the past history, an alternative diagnosis of a ruptured amoebic abscess.
Treatment

An immediate laparotomy was performed. The abdomen was found to contain between four and five pints of pinkish glutinous fluid. The liver was enlarged and the left lobe indurated. After much searching a hole was found high up and posteriorly on the left lobe leading into a large cavity. It could only just be reached with a finger and was impossible to visualise. A large tube drain was inserted up to the liver and out through the left flank. The peritoneal cavity was sucked dry and the abdomen closed.

A course of Distaquaine penicillin, 300,000 units daily, was begun at once and continued until the drain was removed. Emetine hydrochloride, 1 gr. daily for ten days, was given intramuscularly.

The patient made a rapid recovery. The drain was shortened on the fourth day; and thereafter daily until it was removed after fourteen days. The sinus was healed at the end of four weeks.

The pus was sterile on culture and contained no amoebae or cysts. His stools contained no cysts, blood or mucus.

When discharged on June 6 he felt better than he had done for several months. He still had a slight enlargement of the left lobe of the liver.

Discussion

Rupture of an amoebic abscess of the liver into the general peritoneal cavity may be difficult to diagnose if there are no signs of liver enlargement clinically, as in the present case where if there had not been a recent history of amoebiasis the diagnosis would not have been considered. Most of the cases diagnosed before operation have been cases already under treatment for an amoebic abscess of the liver, as the two cases reported by Biggam and Ragab (1931), and the case reported by Chang and Robertson (1934). Others have been diagnosed as other acute abdominal conditions, Labry (1925) and Benedetti Valentini (1929) both reported cases provisionally diagnosed before laparotomy as acute appendicitis, owing to maximal pain in the right iliac fossa.

Manson Bahr (1948) considers this complication of liver abscess to be very serious; a number of cases do survive, however, if treated on ordinary surgical principles. Ludlow (1926) had four recoveries in a series of five treated by laparotomy.

Several cases are reported as making satisfactory recovery following repeated paracentesis, coupled with emetine intramuscularly. Biggam and Ragab (1931), Chang and Robertson (1934), Ludlow (1926). This treatment might well have been successful in the present case if the diagnosis had been made and confirmed by aspiration, as the pus was sterile and contained no amoebae or cysts, no doubt owing to the course of treatment he had just completed.

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