Diagnostic Images

Haematoma of liver

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The patient

A woman aged 42 years gave a history of falling against a low brick wall and landing on the right lower chest one week previously. She complained of severe right hypochondrial pain. Oral cholecystograph was normal and computed tomography was performed (Figures 1–4) after the cholecystogram and 4 months later (Figures 5 and 6).

Figure 1 Large ellipsoidal lesion in the right lobe of the liver with slightly higher attenuation centrally surrounded by low attenuation rim. Contrast medium from previous oral cholecystogram in bile duct in quadrate lobe (arrow). A – aorta, I – inferior vena cava, K – kidney, Sp – spleen, P – pancreas, St – stomach.

Figure 2 Enlarged view of the lesion (curved arrows).
Figure 3  Section 1.0 cm more caudally shows the lesion extending to the surface of the liver (curved arrow). Contrast medium in the common bile duct (arrow).

Figure 4  Section through distal right lobe showing contrast medium in gall bladder (GB) and common bile duct CBD producing streak artefacts (arrow). Oral contrast medium in stomach (St) and duodenum (D). K – kidney, L – liver.

Figures 5 & 6  Taken at same levels as Figures 1 and 3 respectively, 4 months later and showing complete healing of haematoma.

Comment

In Europe blunt trauma to the lower thorax or upper abdomen is the commonest cause of liver injury while Americans suffer more frequently from stab wounds or gunshot injuries. These injuries range from contusions and small lacerations with insignificant haemorrhage, intrahepatic haematomas with vascular complications to extensive lacerations requiring immediate surgery.

Lesser injuries in patients with stable vital signs can be investigated by computed tomography and sonography, accurately depicting the site and extent of the injury.

In this patient a typical subcapsular haematoma was demonstrated with no surrounding haemorrhage or peritoneal fluid. A follow-up scan done 4 months later showed complete resolution of the haematoma.

References