OXFORD

QJM: An International Journal of Medicine, 2019, 709–710

doi: 10.1093/qjmed/hcz062
Advance Access Publication Date: 8 March 2019
Clinical picture

CLINICAL PICTURE

Amoebic cardiac tamponade

A 25-year-old male admitted with fever, chills and pain in the upper abdomen for 1 month. Physical examination revealed mild epigastric tenderness. The remainder of the examination was unremarkable. Laboratory investigation revealed peripheral leucocytosis (21 700 per mm^3), conjugated hyperbilirubinaemia (total, 6.78 mg/dl; conjugated, 3.66 mg/dl), elevated liver transaminases (alanine aminotransferase, 2117 IU/l; aspartate aminotransferase, 1393 IU/l) and normal alkaline phosphatase. Abdominal computed tomography showed an abscess of ∼5 ×6 cm in the left lobe of the liver (Figure 1A). About 100 ml of reddish-brown pus was obtained on ultrasound-guided percutaneous drainage, and intravenous metronidazole was started. However, the next day the patient developed sudden onset dyspnoea, hypotension, muffled heart sounds and engorged neck veins. Transthoracic echocardiography revealed massive pericardial effusion with tamponade. Therapeutic pericardiocentesis with percutaneous pigtail catheter placement obtained about 500 ml of reddish-brown pus (Figure 1B and C).

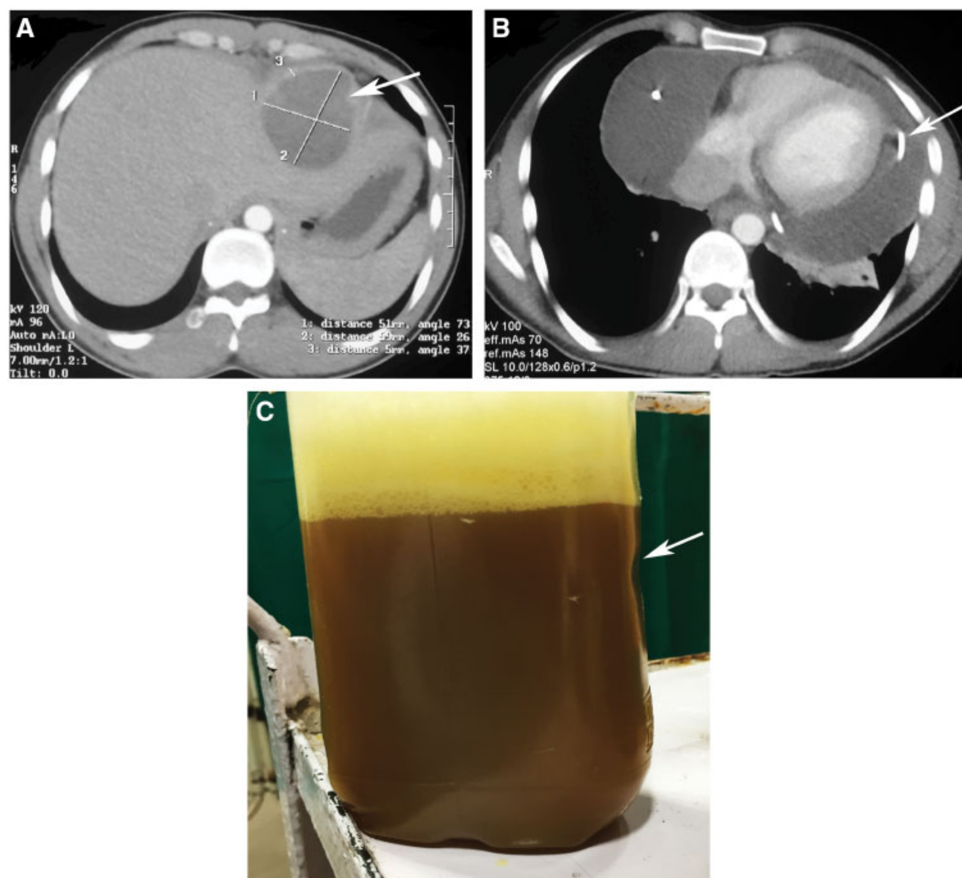

Figure 1. (**A**) Computed tomography showing an abscess of ∼5×6 cm in left lobe of the liver (arrow); (**B**) computed tomography showing massive pericardial effusion with pericardial catheter *in situ* (arrow) and (**C**) reddish-brown chocolate coloured pus obtained after therapeutic pericardiocentesis (arrow).

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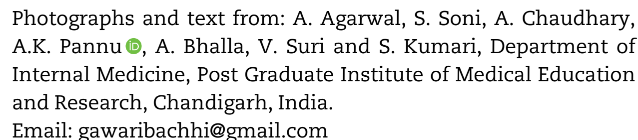
Amoebic serology was positive, and polymerase chain reaction testing of the pericardial tissue showed *Entamoeba histolytica*. Given non-resolving pericardial pus, the patient subsequently underwent surgical pericardiotomy. He gradually improved and discharged on oral luminal amoebicide diloxanide. At 1-year follow up, he remained asymptomatic with normal echocardiography.

Amoebic liver abscess is the most common extra-intestinal site of *E.histolytica* infection and usually presents as a single abscess of the right lobe. Abscess in the left lobe is uncommon, smaller in size and usually lacks classical clinical presentation such as right upper quadrant pain, tenderness or hepatomegaly. This results in a delay in the diagnosis, causing more complications.

A left lobe abscess is close to the pericardium necessitating percutaneous drainage, as a pericardial rupture almost always requires immediate surgical pericardiotomy.[1–3] For amoebic pericarditis with tamponade, a reasonable approach is a therapeutic pericardiocentesis for initial hemodynamic stabilization followed by surgical pericardiotomy for non-resolving effusion despite 2–4 weeks of metronidazole therapy.

Funding

None.



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Conflict of interest: None declared.

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