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*Original Article*

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# Single Time EUS Guided Aspiration of Caudate Lobe Abscess is less Painful

**Viswanath Reddy Donapati[1], Guduru R Srinivas Rao[2], Ravishankar Bagepally[3]**

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**Abstract**

***Background:*** Percutaneous drainage of the liver abscess may be difficult in caudate lobe abscess due to the anatomical position. It is also associated with significant pain and few complications. Surgical management of such abscesses is associated with morbidity. An alternative option is Endoscopic ultrasound guided aspiration or drainage through stomach wall in view of anatomic proximity to the caudate lobe.

***Methods:*** Five consecutive patients who presented with symptomatic caudate lobe liver abscess were selected from 2015 till 2019. In all the five patients, percutaneous drainage was considered difficult by the interventional Radiologist. In them, Endosonography guided aspiration/drainage was done through the gastric wall under sedation.

***Results:*** All the five patients had a successful clinical outcome with less pain following EUS guided abscess drainage.

***Conclusion:*** EUS guided aspiration or drainage of liver abscesses is feasible, less painful and a safe option in patients where percutaneous drainage may be difficult.

**Keywords:** Caudate Lobe Liver abscess; Endosonography (EUS); EUS guided Abscess Drainage; Painless, Ultrasound guided abscess drainage.

## Introduction

Liver abscess is infectious space occupying lesion in liver parenchyma. It could be Pyogenic or Amebic origin. The most common source is biliary followed by abdominal infection and hematogenous spread.

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In tropical countries, Amebic liver abscess is the more common variety found.[10-13]

In both the types, the right lobe of liver is the most common involved site nearly 70%. Involvement of the Caudate lobe is less common. The clinical presentation is similar in all types with Fever, pain abdomen and hepatomegaly with or without jaundice. Presentation can be with septic shock or peritonitis if there occurs a free rupture of abscess.

The mainstay of treatment is Antibiotics combined with drainage of abscess. Traditionally, percutaneous drainage of liver abscess is done in cases with features of impending rupture or left lobe abscess or not improving clinically with conservative management for 72 hours. If complicated or ruptured abscess, then surgical management is indicated.

Percutaneous aspiration is associated with few complications like pain, bleeding, biliary peritonitis and fistula formation.[13]

EUS guided aspiration or drainage of liver abscess has been described by several endosonographers with good results and safety.[1-8]

In this series we describe 5 cases of caudate lobe liver abscesses which were managed by aspiration under EUS guidance. The patients had good outcome with less pain and no complications were noted.

**Materials and Methods:**

It is a retrospective cohort study where 5 consecutive cases of caudate lobe liver abscess were included. They were taken for EUS guided drainage in view of difficult percutaneous access. They had not responded well to antibiotics.

EUS was done using the Olympus curvilinear echoendoscope.

Procedure was done under sedation using Propofol.

Imaging was done using the echoendoscope and abscess was identified and comfortable point to access was noted and a 19 G needle was inserted into the abscess avoiding vessels with the help of doppler mode. Aspiration of maximal possible volume was done using suction syringe. If thick pus was noted, sterile saline was injected and re-aspiration was done. Pus was sent for analysis. Antibiotics were continued and adjusted according to the sensitivity report. Patients were followed up with an ultrasound once discharged.

All the five patients showed good clinical response with complete resolution of abscess on follow up.

***Case 1:*** 58 year old man presented with epigastric pain, fever, and chills for 3 days. At the emergency department, he had features of severe sepsis. He was resuscitated and CT abdomen was done which demonstrated a 45 x 25 mm caudate lobe abscess. Because the hepatic abscess was inaccessible to percutaneous drainage, EUS-guided drainage was considered. EUS image is provided in Figure no. 1.

Nearly 70 ml of pus was aspirated from the abscess using 19 gauge access needle. Pus was sent for culture and sensitivity which grew Klebsiella pneumonia. Appropriate antibiotics were given and patient improved clinically. Follow up was done for 3 months when the check ultrasound howed resolution of the abscess.

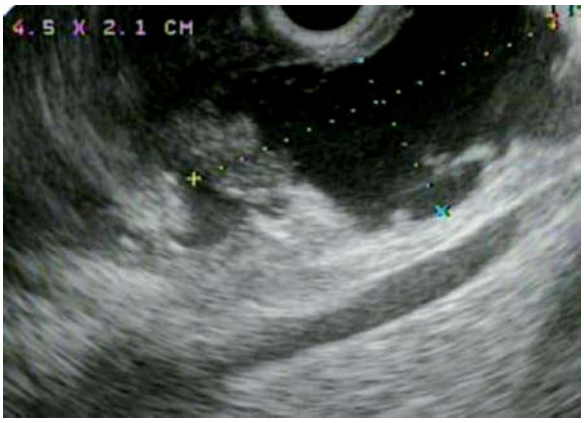


**Fig. 1:** Abscess in Caudate lobe of Liver.

***Case 2:*** 40 year old male with no comorbidities with history of significant ethanol intake, presented with pain abdomen and fever of 10 days duration. He was evaluated and noted to have a space ocupying lesion of 3.1x3 cm in caudate lobe. Alpha Feto Protein was normal. It was not accessible through ultrasound guidance in view of large vessels closeby. EUS showed a well defined lesion with hypoechoic nature in caudate lobe. EUS guided aspiration of the lesion revealed purulent material. 25cc of pus was aspirated and sent for analysis. He was treated with antibiotics as per the culture and sensitivity report. There were no malignant cells on cytology report. He was then managed with antibiotics and had uneventful recovery.

***Case 3:*** 55 year old female presented with pain abdomen of 20 days duration followed by fever, jaundice and then distension of abdomen with swelling of feet for 15 days duration. She was evaluated and noted to have a large liver abscess compressing the inferior venacava. Budd-Chiari syndrome like presentation was noted. Antibiotics were initiated and percutaneous aspiration was done, 100 ml of pus drained. Pigtail catheter placement into the abscess cavity could not be done. Patient had persisting pedal edema and ascites. He needed drainage of the abscess. Hence EUS was considered. EUS Image is provided in figure No. 2 and 3. EUS guided aspiration of the residual large abscess was done. 120 ml of pus was aspirated using 19G needle. Compression on the IVC was noted to be reduced. Patient had gradual resolution of symptoms following it.

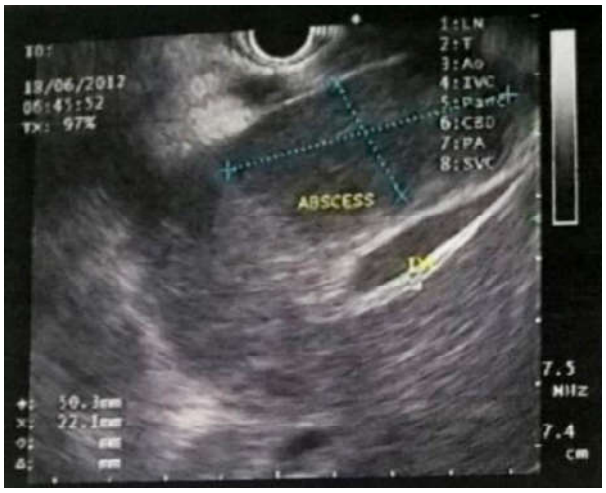


**Fig. 2:** Abscess partially compressing IVC.

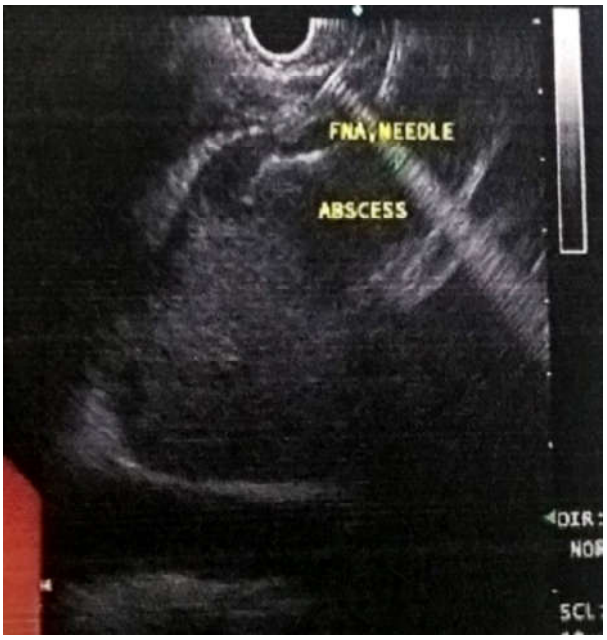


**Fig. 3:** Aspiration of abscess.

***Case 4:*** 50 year old male with history of significant alcohol intake, presented with pain abdomen and fever. Jaundice was noted on examination with tender hepatomegaly. Evaluation was suggestive of abscess measuring 5.5x4 cm in caudate lobe of liver and hepatitis. Percutaneous aspiration was not feasible, because of difficult access. EUS image is provided in Figure No. 4. EUS guided aspiration of the abscess was done using 19G needle. Patient improved with course of antibiotics for 6 weeks. Resolution of the abscess was documented on ultrasound after 3 months.

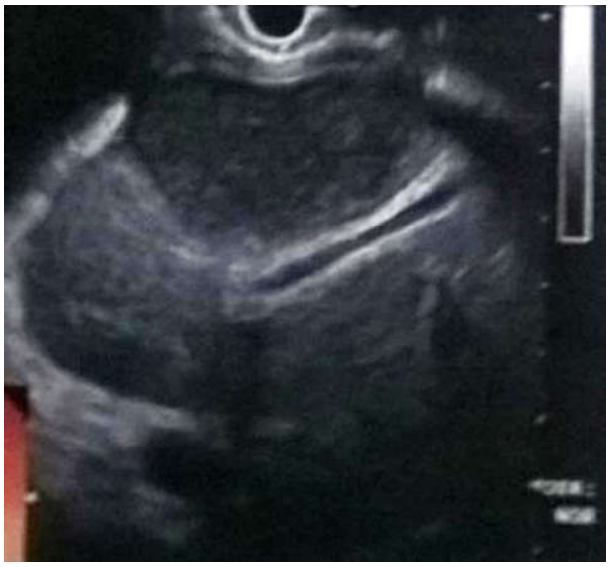

**Fig. 4:** Abscess in caudate lobe.

***Case 5:*** 32 year old male presented with pain in right upper quadrant with general debility of 10 days duration. There was no history of fever. Anorexia was present. Ultrasound abdomen showed a well defined heterogenous predominantly hypoechoic lesion suggestive of abscess of 5.1x4.9 cm in Caudate lobe of liver. EUS guided aspiration of pus was done and patient had good clinical response with antibiotics following that.

### *Discussion and review of literature*

Liver abscess is collection of pus and necrotic material within liver parenchyma. Usually right lobe of liver is affected. In about 30% of cases the left lobe may be involved. In about 20% of cases multiple abscesses may be seen.[10]

Traditional approach to managing liver abscess includes antibiotics, drainage of the abscess percutaneously or surgically.

Percutaneous aspiration is easily available, can be done bedside, with lower cost, good technical success of 100% and clinical success of >85%.[10-13] Even multiple abscesses can be attended at a time while doing the procedure. However, it may be associated with significant pain, bleeding risk, risk of biliary peritonitis and fistula formation.

Some locations in liver may be difficult to access percutaneously for drainage particularly caudate lobe abscess due to presence of large vessels close by. In patients with ascites and respiratory distress, percutaneous drainage is not recommended. Even in confused and agitated patient, percutaneous drainage is not advisable because of risk of

accidental removal by patient. Surgical management is indicated in case of rupture liver abscess which has higher morbidity and mortality. Hence an alternative approach for abscess drainage may be considered. In this regard, several case reports of successful drainage of liver abscesses under EUS guidance have been reported.[1-9] Literature search was done for endoscopic ultrasound guided liver abscess drainage procedure.

Noh et al[1] have successfully done drainage of caudate lobe abscess under EUS guidance which could not be done percutaneously.

John koehane[2] et al have successfully drained transgastrically caudate lobe abscess.

Itoi et al and Shei Wei et al also have successfully drained caudate lobe abscesses under EUS guidance. Hiroshi et al have drained liver abscess under EUS guidance using a metal stent.[3,4,8]

We aspirated the pus under EUS guidance in the cases described. We have done a single time procedure which was painless to the patient as compared to percutaneous drainage method. We have not placed any stent inside the abscess. Antibiotics were continued along with supportive care. Patients recovered well and were noted to have complete resolution of abscess on follow up.

Therapeutic endoscopic ultrasound is expanding in clinical application from it being the first line in managing pancreatic and peripancreatic collections to the latest in failed ERCP for EUS guided biliary access. EUS guided Liver abscess drainage also is a feasible, safe and reliable option where percutaneous aspiration is not feasible as described in multiple case reports. However there are certain limitations for EUS guided liver abscess drainage.

***Limitations of EUS guided drainage of liver abscesses include the following***

- Limited availability of EUS and accessories
- Technical expertise and skill, manpower.
- Right lobe liver abscess may not be easily accessible for EUS guided procedure.
- Cost of procedure
- Need for anaesthesia and intubation if needed

***Implications***

Endosonography guided liver abscess drainage is one newer modality to manage difficult caudate lobe abscess drainage and which is safe and efficacious, less painful method.

There is however a need for more evidence like a randomised trial before considering as first line in management of liver abscess drainage.

## Conclusion

Endoscopic ultrasound guided caudate lobe liver abscess aspiration or drainage is a technically feasible, less painful and safe alternative option in patients where percutaneous access is difficult.

## Acknowledgement

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*Review Article*

Gastroenterology International
Volume 6 Number 1-2, January - December 2021

# Recovery Rate and Hospitalization Stay Patient Treated with Corticosteroids Alone, Along with Antiviral Oral and Intravenous: Faviparavir & Remdesivir: 40 Patients Clinical study

**Mayank Chugh[1], Satender Tanwar[2]**

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Mayank Chugh, Satender Tanwar/Recovery Rate and Hospitalization Stay Patient Treated with Corticosteroids Alone, Along with Antiviral Oral and Intravenous: Faviparavir & Remdesivir: 40 Patients Clinical study/Gastroenterology International. 2021;6(1-2):17-19.

**Abstract**

COVID 19 is a deadly Pandemic and effecting people throughout the world. Whole world is looking for the varied option for treatment and the second wave has almost caused the lot of mortality and morbidity.[1] Lot of patient came out with the complications such as Mucormycosis, raised glycemic level with many more adverse reaction.

The corticosteroids being the most important remedy later proved to the disease enhancement and complication. In the similar way the antiviral drugs used are either Oral and intravenous not caused much of reduction n the mortality and hospitalization stay.

No specific antiviral drugs have been approved for the treatment of COVID-19. Favipiravir is a promising drug for COVID-19 that decreases the hospital stay and the need for mechanical ventilation.[2]

In this present study the 40 patient have been treated with three groups made treated with Corticosteroids alone, along with Antiviral Oral and Intravenous: Favipiravir & Remdesivir.

After analyzing the data is found that none of the antiviral has made significant reduction in the hospitalization stay treated at IPD of chugh Multispeciality Hospital.

Thus concluded that patient treated along with corticosteroids along with Antiviral oral and intravenous doesn't make any significant changes in the hospital stay.

**Keywords:** COVID; Pandemic; Antiviral; Oral; Intravenous; Corticosteroids; Favipiravir and Remedisivir.

## Introduction

The virus that causes COVID-19 is mainly transmitted through droplets generated when an infected person coughs, sneezes, or exhales. These droplets are too heavy to hang in the air, and quickly fall on floors or surfaces.[3]

You can be infected by breathing in the virus if you are within close proximity of someone who has COVID-19, or by touching a contaminated surface and then your eyes, nose or mouth. COVID-19 affects different people in different ways. Most infected people will develop mild to moderate illness and recover without hospitalization.[4]

- Most common symptoms:
- Fever
- Dry cough
- Tiredness.

No specific antiviral drugs have been approved for the treatment of COVID-19. This study aimed

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to evaluate the efficacy of favipiravir in treatment of COVID-19. This was a multicenter randomized controlled study including 96 patients with COVID-19 who were randomly assigned into a chloroquine (CQ) group and a favipiravir group. Favipiravir is a promising drug for COVID-19 that decreases the hospital stay and the need for mechanical ventilation.[5]

Corticosteroids patients with severe COVID-19 can develop a systemic inflammatory response that can lead to lung injury and multisystem organ dysfunction. It has been proposed that the potent anti-inflammatory effects of corticosteroids might prevent or mitigate these deleterious effects. The Randomised Evaluation of COVID-19 Therapy (Recovery) trial, a multicenter, randomized, open-label trial in hospitalized patients with COVID-19, showed that the mortality from COVID-19 was lower among patients who were randomized to receive dexamethasone than among those who received the standard of care.[6]

The safety and efficacy of combination therapy of corticosteroids and an antiviral agent targeting severe acute respiratory syndrome coronavirus 2 (Sars-CoV-2) for the treatment of COVID-19 have not been rigorously studied in clinical trials. However, there are theoretical reasons that such combination therapy may be beneficial in patients with severe disease.

Rationale for Use of Corticosteroids in Patients with COVID-19both beneficial and deleterious clinical outcomes have been reported with use of corticosteroids (mostly prednisone or methylprednisolone) in patients with other pulmonary infections.[7]

Corticosteroids have been studied in critically ill patients with acute respiratory distress syndrome (Ards) with conflicting results. Seven randomized controlled trials that included a total of 851 patients evaluated use of corticosteroids in patients with Ards.

***Remedisivir:*** The Union Health Ministry on Friday has revised the dosage of the antiviral drug Remdesivir, being administered to hospitalized COVID-19 patients from the earlier six-days to five-day treatment.

According to the Health Ministry, remdesivir drug is only for restricted emergency use on patients with moderate disease (those on oxygen support). The drug can not be administered to a pregnant or lactating mother and children below the age of 12 years. Also, the drug is not recommended to a patient with severe renal impairment and a high level of liver enzymes.[8]

The Central Health Ministry has issued a fresh clinical management protocol for COVID-19 patients on Friday. In the latest protocol, the ministry has informed the dosage of remdesivir should be - 200 mg IV on day 1 followed by 100 mg IV daily for 4 days (5 days in total).

Favipiravir A recent outbreak of coronavirus disease 2019 (COVID-19) caused by the novel coronavirus designated as severe acute respiratory syndrome coronavirus 2 (Sars-CoV-2) However, there are no specific antiviral therapies for COVID-19, using the agents which approved or in development for other viral infections is one of the potentially quickest ways to find treatment for this new viral infection.[9]

Favipiravir is an effective agent that acts as a nucleotide analog that selectively inhibits the viral RNA dependent RNA polymerase or causes lethal mutagenesis upon incorporation into the virus RNA. In view of recent studies and discussion on favipiravir, in this mini review we aimed to summarize the clinical trials studying the efficacy and safety of favipiravir in patients with COVID-19.[10]

COVID-19 has led to a major worldwide health and economic crisis, with more than 27 million people having contracted the disease and more than 800,000 deaths. No specific antiviral drugs have been approved for the treatment of COVID-19.[11] Favipiravir acts as a purine analogue and is incorporated in place of guanine or adenine and thereby inhibits viral replication. It has been used for treatment of some life-threatening infections such as Ebola, Lassa fever, and rabies, and its therapeutic usefulness has been established in these diseases.[12]

Data about the efficacy of favipiravir in the treatment of COVID-19 are very scarce. Therefore, the aim of the study was to evaluate the efficacy of favipiravir in treatment COVID-19

**Data Collected**

| Group-A | Group-B | Group-C |
|---|---|---|
| Corticosteroids | Favipirivir | Remidesivir |
| 20 Patients | 10 Patients | 10 Patients |

**Observations**

Following Data has been collected and observations has been made such as out of 40 patients studied total, 20 patients treated with corticosteroids and 10

has been treated with Favipiravir and remaining 10 has been treated with Remidesivir.

## Conclusions

The patients treated with Corticosteroids, favipiravir and Remedisivir as stated above has been analyzed and found that there were much significant statistical variation in the patients treated with above drugs either in the hospitalization and symptoms such as fever, cough, and respiratory distress.[13] The study may need to be conducted on large group of sample size for further understanding and variables.

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*Case Report*

Gastroenterology International
Volume 6 Number 1-2, January - December 2021

# Acute Abdomen Unusual Presentation of Pancreatitis: Late Rise of Serum Amylase than the CTSI of Balthazar Scoring

**Mayank Chugh[1], Satender Tanwar[2], Jaideep Bagri[3]**

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**Abstract**

Acute abdomen is considered as the high level of suspicion and high index of clinical exposure with judicious examination and relevant investigations, none of the one can masters in all. It all requires the judicious use of the all the things together to bring out the best in the provisional diagnosis and best in the interest of the sick presented in emergency room with limited history and blood investigation carried out by practitioner at the different place. Sometimes the things will be made more complicated when the diagnosis and blood investigation doesn't matches even with the radiological investigations.

This text has been designed to explain the importance of each other with each one in the better and contained manner to help the learner and the medical students those who are wish to work in emergency field and the emergency arrives with young gentleman with acute abdomen.The case discussed here is the live example of combination and importance of the altogether.

**Keywords:** Acute Abdomen; Balthazar Scoring; Pancreatitis; Serum Amylase.

## Introduction

Acute Abdomen Vs Acute Pancreatitis along with relevant investigations: Acute abdomen is a condition that demands urgent attention and treatment. The acute abdomen may be caused by an infection, inflammation, vascular occlusion, or obstruction. The patient will usually present with sudden onset of abdominal pain with associated nausea or vomiting. An acute abdomen refers to a sudden, severe abdominal pain. It is in many cases a medical emergency, requiring urgent and specific diagnosis. Several causes need immediate surgical treatment.

Acute pancreatitis means inflammation of the pancreas that develops quickly. The main symptom is tummy (abdominal) pain. It usually settles in a few days but sometimes it becomes severe and very serious. The most common causes of acute pancreatitis are gallstones and drinking a lot of alcohol.

The enzyme marker of pancreas determine (1) the incidence and magnitude of elevation in admission serum amylase and lipase levels in extra pancreatic etiologies of acute abdominal pain, and (2) the test most closely associated with the diagnosis of acute pancreatitis. Both serum amylase and lipase elevations were positively associated with a correct diagnosis of acute pancreatitis ($P < 0.001$) with diagnostic efficiencies of 91 and 94 percent, respectively. A close correlation between elevation of admission serum amylase and lipase

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was observed (r = 0.87) in both extra pancreatic and pancreatic disease processes. Serum amylase and lipase levels may be elevated in non pancreatic disease processes of the abdomen. Significant elevations (greater than three times upper limit of normal) in either enzyme are uncommon in these disorders. The strong correlation between elevations in the two serum enzymes in both pancreatic and extra pancreatic etiologies of abdominal pain makes them redundant measures. Serum lipase is a better test than serum amylase either to exclude or to support a diagnosis of acute pancreatitis.

The CT severity index is the sum of the scores obtained with the Balthazar score and those obtained with the evaluation of pancreatic necrosis: 0-3: mild acute pancreatitis. 4-6: moderate acute pancreatitis. 7-10: severe acute pancreatitis.

The CT severity index (CTSI) is based on findings from an enhanced CT scan to assess the severity of acute pancreatitis. The severity of acute pancreatitis CT findings has been found to correlate well with clinical indices of severity.

***CT Severity Index Grading of Pancreatitis (Balthazar Score)***

- A: Normal Pancreas: 0
- B: Enlargement of Pancreas: 1
- C: Inflammatory changes in Pancreas and Peripancreatic fat: 2
- D: Ill-defined single Peripancreatic fluid collection: 3
- E: Two or more poorly Defined Peripancreatic fluid Collections: 4

***Pancreatic necrosis***

- None: 0
- ≤30%: 2
- >30-50%: 4
- >50%: 6

***Treatment and Prognosis***: The CT severity index is the sum of the scores obtained with the Balthazar score and those obtained with the evaluation of pancreatic necrosis:

- 0-3: Mild acute Pancreatitis.
- 4-6: Moderate acute Pancreatitis.
- 7-10: Severe acute Pancreatitis.

**Case Discussion**

A young male with no comorbid earlier with sudden onset of epigastric and chest pain evaluated by cardiologist at nearest scope available for the patient found to have raised TLC 17.4 cells/ Cumm3 and with normal electrocardiography, Ultrasonography found to have Hepatomegaly. The patient later refer to gastroenterologist for the evaluation.

*On Arrival in Emergency the Patient Evaluated*

- Afebrile
- Normotensive.
- No respiratory distress.
- Complaint of Epigastric pain abdomen.
  - ✓ On Examination – P/A Epigastric Tenderness with Rebound in Right Lower Quadrant / Mc Burney Tenderness ?? Appendicitis.
  - ✓ CVS – S1 & S2 Normal.
  - ✓ Respiratory – Bilateral Equal Air Entry.
  - ✓ Routine Investigation Sent Patient Kept NPO. Serum Amylase was Normal, Leukocytosis (15.6), Thrombocytopenia (1.23 lakh) with Other parameter normal. NCCT abdomen was planned as the USG was normal on Same day To Rule out Appendicitis as it was Strongly Suspected.
  - ✓ NCCT – S/O Acute Pancreatitis with Fat Stranding with Severity score 3.
  - ✓ Patient Kept NPO, RT Aspiration and Broad Spectrum antibiotics and Analgesic.
  - ✓ On day 2 – Serum Amylase was repeated and found to have Raised Amylase 443 IU/l with Decreased Platelet to 0.93 L.
  - ✓ Patient passed flatus with bilious fluid in aspirated bag, Soft abdomen and symptomatically improving.

**Conclusion**

The case Discussed here is suggestive of Acute abdomen is magic box, patient diagnosed timely saves many organs before landing into MODS. The case discussed of young man suggestive of nothing sometimes contributory in acute abdomen, A clinician dealing with acute abdomen must open window from all sided not to miss the pathology on day of arrival and successive days.

Acute pancreatitis might have normal serum amylase on Day 1 but rises subsequent, RLQ (right Lower quadrant tenderness and Raised TLC may not always be appendicitis to rule out by USG/ CT Abdomen. Decision are no longer when the surgical need arrives of diagnostic laparoscopy if everything comes non significant in a persisting pain abdomen patients.

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**Standard journal article**

[1] Flink H, Tegelberg Å, Thörn M, Lagerlöf F. Effect of oral iron supplementation on unstimulated salivary flow rate: A randomized, double-blind, placebo-controlled trial. J Oral Pathol Med 2006; 35: 540–7.

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Kidd EAM, editors. Dental caries: The disease and its clinical management. Oxford: Blackwell Munksgaard; 2003. pp 7–27.

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[8] World Health Organization. Oral health surveys - basic methods, 4th edn. Geneva: World Health Organization; 1997.

**Reference from electronic media**

[9] National Statistics Online—Trends in suicide by method in England and Wales, 1979–2001. www.statistics.gov.uk/downloads/theme_health/HSQ20.pdf (accessed Jan 24, 2005): 7–18. Only verified references against the original documents should be cited. Authors are responsible for the accuracy and completeness of their references and for correct text citation. The number of reference should be kept limited to 20 in case of major communications and 10 for short communications.

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