

Case Report

Unique challenges in management of alcoholic hepatitis with large left sided ischio-rectal abscess- A case report

Bhavin Vasavada, Hardik Patel

Abstract

Alcoholic hepatitis is a condition with high mortality and morbidity. It is routine to have infectious complications with alcoholic hepatitis. However, ischio-rectal abscess with its unique management challenges has not been described in the literature. We describe here a case of ischio-rectal abscess with alcoholic hepatitis, and how the post-operative course is much more complicated due to underlying alcoholic hepatitis.

Keywords: Alcoholic hepatitis; ischio-rectal abscess; perianal abscess.

Author affiliations:

Department of Surgical gastroenterology and hepatobiliary surgery, Shalby Hospitals, Ahmedabad, India.

Correspondence:

Dr. Bhavin Vasavada, Consultant surgical gastroenterologist and hepatobiliary surgeon, Shalby Hospitals, Ahmedabad, India.

Email: drbhavin.liversurgeon@gmail.com

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Introduction

Alcoholic hepatitis (AH) is an acute hepatic inflammation associated with significant morbidity and mortality.¹ Infectious complications are common with alcoholic hepatitis and are associated with high morbidity and mortality, particularly in severe alcoholic hepatitis.² perianal abscess has been described in cirrhotic patients, but to our knowledge, acute perianal abscess with alcoholic hepatitis and its unique management challenges have not been described in the literature. We hereby report a case with a large left-sided ischio-rectal abscess and its unique management challenges.

Case report

A 43-year-old male patient presented to us with peri-anal pain. He was a chronic alcoholic with a recent history of change in drinking pattern in the last three months with heavy drinking daily. On examination, he was having redness and induration in the left perianal region suggestive of perianal abscess. His bilirubin level was 10.2 mg/dl, Alanine transaminase (ALT) was 172, Aspartate transaminase (AST) was 74, INR was 2.07, White blood cells count was 17000, procalcitonin 2.1, and creatinine 1.5. His ultrasonography showed fatty liver with mild free fluid in the abdomen. His vitals were normal. Based on history, physical examination, and investigations he was provisionally diagnosed as a perianal abscess superimposed on alcoholic hepatitis. The patient's Maddrey's Discriminant function score was 79.2

suggestive of a poor prognosis. However, steroids were not started as the patient was having an active infection on examination. He underwent left perianal abscess drainage. Intra-operatively he was found to have a large ischioanal abscess with approximately 100 cc pus drained out. He was discharged the next day, however after 3 days he came to the emergency with severe perianal pain, and perianal bleeding. On examination it was bleeding from the granulation tissue without any sign of infection., his vitals were normal. His fresh bilirubin was still 10.4, with ALT of 200 and AST of 88 and INR was 2.4. White blood cell counts were 14000 and procalcitonin level of 1.2, confirming altered liver functions were due to alcoholic hepatitis rather than sepsis. His hemoglobin was 6.9 and he was transfused one packed cell volume and fresh frozen plasma. Subsequently, the bleeding subsided and the patient was discharged again. After four days patient again presented with granulation tissue bleed, with normal vitals with a good healing wound. But, again bilirubin was 7.2, Inr was 1.8, hemoglobin 6.4, WBC count normalized to 8000, and procalcitonin level 0.45. This time colonoscopy was performed which failed to show any internal source of bleeding. As, this time infective markers stabilized we started prednisolone 40mg/day to treat alcoholic hepatitis, following this after 1-week patient came for follow-up with no complaints of fresh bleeding, the patient had slight perianal pain but otherwise, bilirubin decreased to 2.1, Inr 1.31, white blood count decreased to 7000. The patient was continued on prednisolone for 28 days and after that it was. Stopped. At the time of stopping prednisolone, his liver function tests were normalized with no fresh complaints. The patient was advised to complete abstinence from alcohol.

Discussion

Alcoholic hepatitis is a serious disorder with high morbidity and mortality, and one of the most serious conditions in the spectrum of alcohol use disorders.⁴ Alcoholic hepatitis is

mainly a clinical diagnosis, with a history of a recent change in drinking, neutrophilia with left shift, and ALT/AST ratio of more than 2. It may be or may not be associated with liver cirrhosis.⁵ Sepsis is very common in alcoholic hepatitis and is one of the leading factors responsible for mortality.⁶

To our knowledge, large perianal abscess with alcoholic hepatitis is not described in the literature before. It requires drainage in the background of highly abnormal liver function and underlying physiology. Bleeding complications from healing wounds can also be severe due to an abnormal coagulation profile. It also becomes difficult to determine the timing of interventions like steroids. Steroids are associated with postoperative infectious complications⁷ but also are at present standard treatment for alcoholic hepatitis.

There was also a diagnostic dilemma to differentiate whether derangement of liver functions was due to infection or alcoholic hepatitis. So, it becomes difficult to evaluate initially Maddrey's Discriminant function score. We did not do a liver biopsy to confirm alcoholic hepatitis due to earlier need to drainage of perianal abscess and also clinical diagnosis and cost factor involved in trans jugular liver biopsy, as there was a risk of bleeding with ultrasonography-guided biopsy in the background of altered coagulation profile.

Conclusion

In a patient with a typical history of recently altered drinking patterns and heavy drinking, alcoholic hepatitis should always be kept in mind.

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