36. ACUTE ABDOMEN IN PATIENTS WITH CIRRHOSIS –CASE PRESENTATION

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Introduction: Association between chronic liver disease and spontaneous bacterial peritonitis has been known for a long time. The presence of such an case raise important problems for the differential diagnosis and treatment. We bring this subject into the actuality through several presentations of clinical cases.

Presentation of cases

A. Evaluation of case Nr.1. Spontaneous bacterial peritonitis.

Patient P.M. aged 31 years with the liver suffering known, has been shown to the doctor with abdominal distension and abdominal pain, symptoms were gradually installed 7 days ago. Hemodynamically unstable, respiratory = 24 resp./min. Distended abdomen presenting vicious scar after celiotomy surgery (splenectomy in antecedent). Paraclinic exams: USG: ascites, portal vein thrombosis suspected (?). Laboratory: post-splenectomy thrombocytosis, leukocytosis, hyperbilirubinemia. Superior endoscopy: esophageal varices gr.II. Paracentesis with ascites fluid examination: spontaneous bacterial peritonitis. Is established syndromal treatment, low molecular weight heparin (therapeutic doses), pentoxifylline, diuretics, - clinical improvement. Discharged in relatively good condition, included in the waiting list for liver transplantation.

B. Evaluation of case Nr.2. Secondary bacterial peritonitis: acute appendicitis.

Patient A.M. the aged 47 years, older cirrhotic, generalized malaise, jaundice, sleepy, t^{o}-37, 5, shiver. Abdomen enlarged by ascites fluid, dolor on abdominal palpation mostly right wing , swelling of the abdominal wall, the sign Blumberg suspect. Was performed diagnostic paracentesis: cytology characteristic for secondary bacterial peritonitis. Laparoscopy in the differential diagnosis of ascites-secondary peritonitis attest micronodular cirrhosis, ascites fluid with fibrin widespread diffuse, acute appendicitis. Was practiced: laparotomy, appendectomy, betadine saline lavage, drainage. Postoperative train evolution, discharged cured surgically.

C. Evaluation of case Nr.3. Secondary bacterial peritonitis. Hepatogen perforated gastric ulcer.

CV patient, 43 years old, cirrhotic with multiple decompensations without ulcer history, is hospitalized in very serious condition. Temporo-spatially disoriented.Abdomen increased in volume, ascites, reponse umbilical hernia, caput medusa, peritoneal negative signs. Endoscopy performed 18 days prior to the pre-hospital attest esophageal varices gr.II , severe gastropathy. Abdominal ultrasound - liver hypoplasia, VP = 1.6 cm, ascites. Rx-abdominal on hollow - pneumoperitoneum absent. Paracentesis- opolescent ascitic liquid. Is established antibiotic therapy, diuretics, syndromal medication,metabolic correction. The surprise which reserve this case: through the nasogastric tube was evacuated about 9 liters of citric fluid similar to that from paracentesis, while noticing the decrease in volume of abdomen - clinical suspicion of perforated peptic ulcer? Parenchymal deterioration, CID - syndrome, hepatic coma, death. The autopsy found hepatogen antral ulcer perforated, ascites, peritonitis. The peculiarity of the case: diagnostic difficulty with important therapeutic and prognostic implications.

Conclusions:

1. The association of liver disease with ascites syndrome is a reality.
2. The ascites syndrome in a cirrhotic patient must be suspected as a secondary bacterial peritonitis.
3. The therapy endo-laparoscopic positively influence quality of life and prognosis.

Keywords: Peritonitis, ascites syndrome, cirrhosis