

IMAGES IN EMERGENCY MEDICINE

Pediatrics

Mild hepatomegaly in a 14-year-old boyNicole E. Kozar PA-C¹ | Courtney E. Nelson MD² | Magdy W. Attia MD¹¹ Emergency Department, Nemours Children's Hospital, Wilmington, Delaware, USA² Emergency Department-Bryn Mawr, PA, Nemours Children's Hospital, Wilmington DE, USA**Correspondence**

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Email: Magdy.Attia@nemours.org**Informed consent:** Informed consent was obtained from the responsible party.**1 | Patient Presentation**

A 14-year-old male presented to the pediatric emergency department (ED) with a 1-week history of general malaise. Three weeks before, he underwent laparoscopic appendectomy for perforated appendicitis. He returned to the ED 2 weeks after surgery with back pain and was ultimately discharged home after unremarkable computed tomography (CT) imaging. Three days later, he presented again with persistent back and abdominal pain. Abdominal radiographs suggested constipation and he was discharged home after receiving an enema. Three weeks post surgery, he presented for his third postoperative ED visit with fatigue, general malaise, and a 1-day history of vomiting and anorexia. He denied abdominal pain and back pain. Initial vital signs included tachycardia and mild tachypnea, and he was found to be febrile on arrival. Initial blood pressures were normal. On physical examination, the patient was ill appearing but awake, alert, and following commands. He had no abdominal or costovertebral angle tenderness but did have mild hepatomegaly. His extremities were warm and well perfused. Due to his ill appearance, work up was initiated. Our patient's ED course was complicated by hypotension. He was treated with antibiotics for presumed sepsis and ultimately required vasopressors and was admitted to the intensive care unit.

2 | DIAGNOSIS**2.1 | Hepatic abscess post appendectomy**

The initial work up showed elevated inflammatory markers and a CT revealed a large, 4.3 x 5.3, x 7.9 cm hypoattenuating lesion in the poste-



FIGURE 1 Computed tomography demonstrating hepatomegaly and a large heterogeneous, hyperechoic focal lesion in the posterior right lobe of the liver concerning for hepatic abscess

rior aspect of the right liver lobe concerning for hepatic abscess. While he was an inpatient, his abscess was drained twice by interventional radiology. Because of persistent infection, the patient was ultimately taken to the operating room for open debridement and partial hepatectomy. After 3 weeks on intravenous antibiotics, the patient was discharged home on oral antibiotics.

Appendicitis is the most common atraumatic condition requiring surgical intervention in pediatrics.¹ Over one-third of cases involve perforation of the appendix, as was seen in this case. Although postoperative wound infection, intraabdominal abscess, ileus, and partial

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small bowel obstruction have been well studied, the literature on hepatic abscess post appendectomy is more scarce.² In 2015, Muyldermans et al described the first reported case of a hepatic abscess due to migration of an appendicolith.³ Another case report detailed an adult male with persistent back pain following appendectomy who was ultimately diagnosed with a hepatic abscess. Although surgical site infections and localized intraabdominal abscesses tend to present with focal pain and discomfort, hepatic abscesses have a more vague presentation, with fever being the most common associated symptom.⁴ Albeit uncommon, given the significant morbidity and mortality associated with hepatic abscess post appendectomy, it is important to maintain a broad differential while evaluating postsurgical patients.

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How to cite this article: Kozar NE, Nelson CE, Attia MW. Mild hepatomegaly in a 14-year-old boy. *JACEP Open.* 2021;2:e12508. <https://doi.org/10.1002/emp2.12508>