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IMAGE OF THE MONTH

Unusual complication after chemoembolisation of hepatocellular carcinoma over liver cirrhosis: Liver abscess and pylephlebitis*



Complicación infrecuente tras quimioembolización de hepatocarcinoma sobre hígado cirrótico: absceso hepático y pileflebitis

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A 74-year-old male with hepatocellular carcinoma in segment 6 (Fig. 1) with underlying alcoholic cirrhosis, Child-Pugh B8, treated with transarterial chemoembolisation (TACE). Five days later, he developed pain in the right hypochondriac region, without fever. Abdominal computed tomography scan showed an abscessed lesion $60 \times 100 \times 60$ mm in size in segment 6, extending to the perihepatic space, with a collection $160 \times 22 \times 135$ mm in size and pylephlebitis (Figs. 2 and 3). This was treated with intravenous meropenem and ultrasound-guided percutaneous drainage with catheter placement. Subsequent scans showed the collection decreasing in size (Fig. 4).

TACE is the treatment of choice in Barcelona Clinic Liver Cancer stage B (BCLC-B) hepatocellular carcinoma, and is also effective in unresectable liver metastases.¹⁻³ It is minimally invasive, but it can have serious complications such as liver abscesses.^{1,4} These are rare, with an incidence of

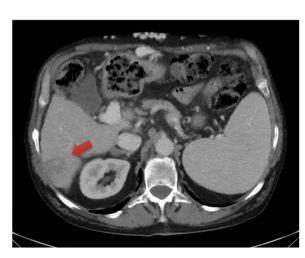


Figure 1 Cross-sectional view of abdominal computed tomography with intravenous contrast showing a space-occupying lesion $40\times30\,\text{mm}$ in size in liver segment 6 compatible with hepatocellular carcinoma.

0.2–5%, but have high morbidity and mortality rates.^{1,2,4} Risk factors are biliary disorders (sphincterotomy or biliary anastomosis), advanced age, diabetes, a large tumour and portal thrombosis.^{1,4} Sphincter of Oddi dysfunction has been

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Figure 2 Cross-sectional view of abdominal computed tomography with intravenous contrast showing an abscessed lesion in liver segment 6 with air bubbles in its interior.



Figure 3 Coronal section of abdominal computed tomography with intravenous contrast showing an abscessed lesion extending to the perihepatic space, from right subphrenic to right subhepatic spaces, with air inside.



Figure 4 Cross-sectional view of abdominal computed tomography with intravenous contrast showing thrombosis of the right portal vein compatible with pylephlebitis.

suggested as a pathogenic mechanism, as it would allow bacteria to access the hepatic circulation, infecting necrotic tissue.² The clinical context is important for differentiating between an abscess and the presence of gas in the embolised lesion due to necrosis a few days after embolisation. Moreover, unlike post-embolisation syndrome, which usually occurs early, abscesses may appear more than a week later.¹

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