Clinical picture

A patient with fever and jaundice

A 24-year-old patient presented with fever for 10 days and jaundice that developed over the last 3 days prior to his admission. Initially, he complained of vague abdominal pain and later he suffered from diarrhea.

On admission, the temperature was 39°C, he was mildly jaundiced, the abdomen was soft and no peritoneal signs were detectable. Notable laboratory test were as follows: white cell count, 20 100/mm³; C-reactive protein, 157 mg/l; albumin, 3.1 g/l; total bilirubin, 4.1 mg/dl; (direct 2.3) aspartate aminotransferase 96 U/l; alanine aminotransferase 125 U/l; and alkaline phosphatase 331 U/l. Blood culture yielded no growth.

Serological test for hepatitis viruses A, B and C were negative, Coxiella burnettii (Q fever) was negative as well.

Computed tomography (CT) with radio contrast (below) showed thrombosis of the portal and the superior mesenteric veins (Figure 1A) and swollen appendix (Figure 1B).

Oral ciprofloxacin 500 mg b.i.d and metronidazole 500 mg t.i.d were administrated with subcutaneous low-molecular weight heparin. Fever and jaundice resolved within 4 days and he was discharged after 11 days. Treatment was ensued with these antimicrobials for 6 weeks and with warfarin for 3 month, resulting in uneventful recovery.

Septic thrombophlebitis of the portal vein and its tributaries (pyelophlebitis) is a rare and potentially severe ascending infection arising usually from a primary gastrointestinal infectious process. The most common sources are diverticulitis, appendicitis and infected pancreatic necrosis, and other causes are bowel perforation and pelvic infections; however, in some cases no abdominal source could be identified. The diagnosis of pyelophlebitis should be sought when sepsis associated with non specific abdominal complaint and abnormalities in liver function are encountered. CT imaging enables early diagnosis and therapy of this complication. Some radiological findings in abdominal CT study are diagnostic for pyelophlebitis in the appropriate clinical setting, and can be divided as follows: (i) involvement of the mesenteric branches, intrahepatic branches and the portal trunk itself; (ii) intrahepatic abnormalities; and (iii) the primary abdominal source.
Broad-spectrum antibiotic therapy directed against common enteric bacteria species and the anaerobic *Bacteroides fragilis* is the mainstay of therapy, and is usually prescribed for 4–6 weeks. Anticoagulants are usually prescribed as well, and a recent literature review suggested that their use results in a higher rate of recanalization and decreased mortality.³

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**References**

