A 48 years old, non-alcoholic male presented with gradual swelling of right upper abdomen two months. His complaints started with dull aching pain localized in right upper quadrant of abdomen. After a few days he noticed a swelling in right upper abdomen which gradually increased. There was no history of fever, vomiting, haematemesis or malena. On examination, there was a visible swelling over the right hypochondrium with engorged and tortuous abdominal and back veins (Fig. 1A &B) filling from below upwards. The patient had tender hepatomegaly (span 16 cm in right clavicular line) without palpable splenomegaly or ascites. Other systems examination revealed no abnormality.

Investigation revealed a normal hemogram(11.5gm/dl) and serum bilirubin (0.8mg/dl), total serum protein 6.7gm/dl, serum albumin 3.5gm/dl, aspartate aminotransferase(AST) 36 IU/L, alanine aminotransferase(ALT) 42 IU/L, alkaline phosphatase 950IU/L. Prothrombin time was 14.8 seconds (control 13.0seconds).Viral markers for hepatitis B and C were negative. Doppler ultrasound examination revealed an abscess cavity (12.5 x 13.2 cm) in the right lobe of liver compressing the inferior vena cava (Fig. 2A & B) and right and left hepatic veins (Fig. 3A & B) with loss of phasic variation of Doppler waves. Spleen was 12cm in its axis. Portal vein diameter was 14mm at porta. Ultrasound guided aspiration of the abscess cavity revealed “anchovy-sauce” pus. Upper G.I. endoscopy showed no varices. So a diagnosis of amebic liver abscess with Budd-Chiari Syndrome was made. Ultrasoundography guided tube drainage was given along with medical treatment. Within 24 hours of decompression of liver abscess abdominal and back veins collapsed.

Budd-Chiari Syndrome results from the occlusion of hepatic veins or inferior venacava. The important causes are thrombosis of hepatic veins or inferior venacava in the setting of polycythemia rubra vera, myeloproliferative syndromes, paroxysmal nocturnal hemoglobinuria, hepatocellular carcinoma etc. But Budd-Chiari Syndrome due to amebic liver abscess is rarely reported.1 Though fever is the characteristic feature of acute presentation of amebic liver abscess, older patients from endemic areas are more likely to have a subacute course, with weight loss and hepatomegaly and only about one third of patients with chronic presentations are febrile.2 As Amebic liver abscess is very much common in this part of country, it should be kept in mind before thinking of malignant lesion in patient with Budd-Chiari syndrome and abdominal swelling.

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