found to be prolonged in patients with hyperbilirubinemia as opposed to those without, as was the
case with our patient. Thrombocytopenia has also been described as a rare feature of
*Coxiella burnettii* infection. Given this clinical picture, it is important to consider Q fever for a direct
hyperbilirubinemia, prolonged fever, and thrombocytopenia in patients with a potential exposure
history. It is also essential to consider oral transmission of *Coxiella burnetti* as a potential rare mode
of transmission.

**2435**

### An Uncommon Case of Hepatic Abscess From Fish Bone Ingestion: A Case Report With Successful Conservative Management

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**INTRODUCTION:** Accidental ingestion of foreign bodies is infrequently seen in clinical practice
and can be fatal. Liver abscess from enterohepatic migration of an ingested foreign body is extremely
rare and is usually associated with perforation, peritonitis from rupture of the hepatic abscess and
sepsis. Lack of specific symptoms, unacknowledged ingestion by the patient and a low clinical
suspicous, complicate our arrival at an accurate diagnosis. Here, we report a case of hepatic abscess
secondary to fish bone ingestion, without peritonitis, that was managed conservatively and without
extraction of the foreign body.

**CASE DESCRIPTION/METHODS:** Our patient is a 64 y/o lady who came in with sharp, right
sided abdominal pain, fever and anorexia for a week. She was febrile upon arrival with leukocytosis
and mild transaminitis with total bilirubin 2.7. Other monitored vitals were stable. CT abdomen
revealed a 6.9 cm abscess at the junction of the right and left hepatic lobes which was promptly
drained percutaneously by IR. Despite clinical improvement with drainage and antibiotics, persistent
leukocytosis was appreciated. A repeat CT showed a small residual liver abscess and a sharp, linear
radiopaque foreign body adjacent to the pylorus with perigastric stranding. Upon further questioning,
patient recollected having had fish prior to onset of symptoms. Endoscopy was unsuccessful in
identifying the exit tract from the upper GI tract. Reimaging confirmed migration of the fishbone
towards the falciform fissure and gastrohepatic ligament. The position of the fish bone posed
a challenge for percutaneous extraction and Surgery recommended against exploratory laparotomy as
patient had marked clinical improvement. Follow up imaging a month later showed the fish bone to
be in stable position, in an asymptomatic patient.

**DISCUSSION:** 80% – 90% of ingested foreign bodies usually pass through the gut without any
intervention. Foreign body ingestion is generally an unconscious event, that the patient rarely recalls,
which complicates the preoperative diagnosis in most cases. In the case of liver abscess unresponsive
to drainage and antibiotic therapy, this possibility needs to be entertained, despite its low incidence.

Besides antibiotics and abscess drainage for size ≤5 cm, surgical or endoscopic retrieval of the foreign
body has always been the conventional treatment. However, medical management should be con-
sidered for patients, like ours, without signs of severe sequelae.

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**2436**

### Lysosomal Acid Lipase Deficiency: A Missed Diagnosis Spanning All Ages

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**Figure 1.** CT abdomen cross-sectional image of liver.

**Figure 2.** Repeat image showing migration of fish bone at the level of the falciform fissure/
gastrohepatic ligament.

**Figure 3.** Coronal CT scan demonstrating the large axillary mass of the primary MCC
tumor.

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