An unusual case of cholecystitis and liver abscesses in an older adult

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started to develop just days after he started levetiracetam and resolved within 5 days of cessation.

The reduction in mobility and the psychotic symptoms were most likely due to levetiracetam. Given that there is not sufficient literature on such side effects involving older adults and the unique feature of reduced mobility, it was felt that this warranted highlighting.

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REFERENCES

AN UNUSUAL CASE OF CHOLECYSTITIS AND LIVER ABSCESSES IN AN OLDER ADULT
To the Editor: A 76-year-old man was admitted to the emergency department (ED) for anorexia, weight loss of 5 kg in 2 months, fatigue, and anhedonia after his sole sister’s death. He had no other complaints: no abdominal pain, transit abnormalities, fever, or chills. He had a history of type 2 diabetes mellitus, severe chronic kidney failure, peripheral neuropathy, hypertension, stage 2 lower extremity vascular disease, hypothyroidism, and atrial fibrillation. His regular medication consisted of acetylsalicylic acid, venlafaxine, hydrochlorothiazide, torasemide, levothyroxine, atenolol, and insulin.

Upon admission, he was awake and responsive but weak and appeared depressed. Temperature, blood pressure, and heart rate were normal. Abdominal examination showed active bowel sounds, no tenderness or rebound tenderness, and no masses. Lower liver border was not palpable, and Murphy maneuver was negative.
Initial laboratory values showed normocytic anemia (hemoglobin 10.0 g/dL), leukocytosis with no left shift (white blood cell count 14,000 cells/μL) and C-reactive protein (CRP) of 246 mg/dL. Electrolytes were normal despite severe chronic renal failure (calculated creatinine clearance of 21 mL/min according to the Cockroft formula). Liver enzymes were normal except for a slightly high gamma-glutamyltranspeptidase (76 IU/L, normal <40 IU/L) and bilirubin (1.75 mg/dL, normal <1.46 mg/dL).
Because of suspected depression, he was referred to a specialized geriatric ward where a combined follow-up by geriatricians and psychiatrists is provided. During the following days, he developed no new symptoms but still refused any food. Biological inflammatory markers remained high. Liver enzymes remained unchanged except for normalization of bilirubin values. Chest X-ray was normal. Urine and blood cultures were negative. The dose of venlafaxine was doubled at admission to 75 mg/d and thereafter remained unchanged.
Because of persistent inflammation, he underwent a thoracoabdominal computed tomography scan without contrast injection. The imaging revealed a dilated gallbladder (9.6 × 5.3 cm in the axial cross-section) with thickened walls, compatible with acute cholecystitis, and multiple hypodense lesions of liver segments V and VIII, suggestive of liver abscesses (Figure 1).
Cholecystectomy and surgical drainage were performed. Cultures grew Escherichia coli. He was prescribed ceftriaxone for 3 weeks. He was discharged 2 months later, after a normal abdominal ultrasound and major mood improvement. Signs and symptoms consistent with normal grieving remained.

DISCUSSION
We present the case of an older adult with acute cholecystitis and multiple liver abscesses, with no suggestive symptoms except for anorexia and biological signs of inflammation. Atypical presentation of acute cholecystitis is frequent in older adults, with 5–25% presenting without...
pain and 30–50% without fever. Gallbladder disease in older adults has one of the highest discrepancy rates (70%) between ED and hospital discharge diagnosis. Acute cholecystitis mortality rate in both older adults and people with diabetes mellitus is higher than in the general population.

Pyogenic liver abscess is a life-threatening disease and may appear in single or multiple form. The main bacterium isolated in multiple abscesses is *E. coli*. In a previous study, multiple abscesses were of biliary origin in 45% of cases and were related to an overall mortality rate of 22%, regardless of the therapeutic strategy taken. Medical treatment alone was associated with the highest mortality rates (28.9%); 44% of patients had concurrent diabetes mellitus.

This case illustrates the unusual presentations that can be encountered in older adults. This individual had a highly atypical case of cholecystitis and liver abscesses, with symptoms suggesting depression. Physical and laboratory findings were almost entirely normal. Persistent elevation of CRP was the principal indication of severe somatic illness in this case. Physicians should not rely purely on physical and biological findings but should also be alert to psychiatric symptoms that may be masking a medical illness, thereby ensuring proper diagnosis and treatment.

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ACHALASIA IN A NONAGENARIAN PRESENTING WITH RECURRING ASPIRATION PNEUMONIA

To the Editor: Approximately 10% of community-acquired pneumonia cases are thought to be aspiration pneumonia. Aspiration pneumonia is more common in older adults than in younger individuals. Common risk factors for aspiration pneumonia are neurological disorders, including stroke, dementia, and Parkinson’s disease. Esophageal conditions such as strictures and gastroesophageal reflux disease are also well-described risk factors.

Despite being a known risk factor for aspiration pneumonia, achalasia often does not make the list of differential diagnoses in evaluating aspiration pneumonia in older adults because of its rare incidence. A case of a nonagenarian who developed recurrent episodes of aspiration pneumonia secondary to achalasia is presented. Treatment of achalasia resulted in resolution of dysphagia and prevention of aspiration pneumonia.

A 91-year-old white man presented to the hospital with a productive cough and wheezing for 2 weeks. He had begun experiencing dyspnea and low-grade fever 1 day before admission. He denied recent travel, sick contacts, chest pain, palpitations, abdominal pain, nausea, or vomiting. He complained of difficulty swallowing solids and frequent regurgitation. His past medical history included atrial fibrillation, hypertension, mitral regurgitation, transient ischemic attack, colon cancer, and hemicolecctomy 7 years before hospitalization. His outpatient medications included metoprolol, omeprazole, baclofen, ferrous sulfate, levallutrol, and docusate sodium. Vital signs on admission were temperature, 99.8°F; blood pressure, 124/69 mmHg; and pulse, 100 beats/min. Wheezing was heard in the right lower lung field on auscultation. Chest X-ray showed findings of right middle lobe consolidation. He was treated for community-acquired pneumonia.

Review of his past medical records revealed that he had presented to the primary care physician four times over 15 months with complaints of productive cough, dyspnea, or both, two of which had resulted in hospitalization. There was no history of pneumonia during 5 years before the onset of this sequence of respiratory illnesses. He had seen his primary care physician 2 months before complaining of dysphagia and regurgitation of food 10–15 minutes after eating. Two months after hospitalization, he underwent a barium esophagram, which showed that the esophagus was dilated throughout its course in the chest except at the gastroesophageal junction, where there was a smooth tapering to a narrowed gastroesophageal junction (Figure 1). Subsequent upper endoscopy showed a dilated esophagus with stasis-related esophagitis. There was resistance to passage of a scope consistent with achalasia. He underwent serial upper endoscopies with botulinum toxin injections to the lower esophageal sphincter. Symptoms of dysphagia and regurgitation resolved after treatment, and he remained free of pneumonia for 2 years after resolution of achalasia symptoms.

Achalasia is a Greek term that means “failure to relax.” It is an uncommon esophageal disease characterized by impaired peristalsis in the distal esophagus and failure of the lower esophageal sphincter relaxation. It is a rare