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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ACKNOWLEDGMENTS

Conflict of Interest: The editor in chief has reviewed the conflict of interest checklist provided by the authors and has determined that the authors have no financial or any other kind of personal conflicts with this paper.


Sponsor’s Role: None.

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AN UNUSUAL CASE OF CHOLECYSTITIS AND LIVER ABBSCESSES 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 after 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 acetysali-
cylic 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 pro-	ein (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-
 glutamyltransferase (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 fol-
lowing 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 nor-
mal. 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 thick-
ened 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
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.1 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.2 Esophageal conditions such as strictures and gastroesophageal reflux disease are also well-described risk factors.2,3 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, levallurterol, 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

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