A Clinical Presentation of a Very Rare Infection:
Parenchymal Fasciola Hepatica

Ferdane Sapmaz¹, İsmail Hakkı Kalkan², Sefa Guliter¹, Adem Nazlıoğlu³

¹Department of Gastroenterology, Kırıkkale University of Medicine, Kırıkkale, Turkey
²Department of Gastroenterology, Kırıkkale Higher Education Hospital, Kırıkkale, Turkey
³Department of Radiology, Kırıkkale University of Medicine, Kırıkkale, Turkey

ABSTRACT
Fascioliasis is primarily an infection of livestock such as cattle and sheep, caused by the flat, brown liver fluke Fasciola hepatica. Humans are accidental hosts. The diagnosis of infection depends on suspicion. Radiologic findings are specific. Usually, Computed Tomography (CT) and other imaging studies show hypodense migratory lesions of the liver. The development of a chronic liver abscess appears to be extremely rare. Here we present our case with hepatic abscess due to F. hepatica, which is a rare clinical presentation. (Turkiye Parazitol Derg 2013; 37: 305-6)

Key Words: Fasciola hepatica, parenchymal, rare

Received: 03.12.2012 Accepted: 14.04.2013

Letter to the Editor / Editöre Mektuplar

TO THE EDITOR

Fascioliasis is primarily a disease of herbivorous animals such as sheep and cattle and is a zoonotic infection caused by the trematode Fasciola hepatica (liver fluke). Humans become accidental hosts through ingesting uncooked aquatic plants such as watercress. The infection has two different phases; hepatic and biliary. The biliary phase usually presents with intermittent right upper quadrant pain, with or without cholangitis or cholestasis. The development of a chronic liver abscess appears to be extremely rare. Here, we present our case with hepatic abscess due to F. hepatica, which is a rare clinical presentation.

A 38 year old female patient was admitted to our outpatient clinic with complaints of abdominal pain in the previous two months. Her history was unremarkable for travelling, animal husbandry, hunting, drugs and agriculture, but she had a history of watercress intake. She was the only member in her family who had these symptoms or a history of watercress intake. She was the only member in her family who had these symptoms or a history of watercress intake. Her physical examination was normal. Her laboratory tests were as follows: leukocytes 8100/mm³, eosinophils 4050/mm³ (49%), platelets 296000/mm³, hemoglobin 11.8 g/dL, hematocrit %39.2, C-Reactive Protein (CRP) 25 mg/dL. Peripheral blood smear revealed eosinophilia as high as...
48% Of the white blood cells. Her serology was negative for hepatotropic viruses, and also Rose-Bengal, Wright agglutination, and Grubel-Widal tests were negative.

A CT scan showed multiple hepatic subcapsular hypodense lesions. According to the watercress intake history, eosinophilia and CT findings, *F. hepatica* indirect hemagglutination (IHA) test was performed and it was positive at a titer of 1/640 (Figure 1). The patient was treated with Triclabendazole 10 mg/kg/day once orally for two days after informed consent had been obtained. A follow-up abdominal ultrasonography in the third month of the treatment showed a marked decrease in the size of the lesions and revealed fibrotic sequelae secondary to inflammation.

*F. hepatica* infection has two different phases; hepatic and biliary. The flukes develop for 6-8 weeks in the hepatic phase. The patient is often asymptomatic in the hepatic phase. Abdominal pain, fever, urticaria are the common signs. The biliary phase usually presents with intermittent right upper quadrant pain, with or without cholangitis or cholestasis (1, 2).

The diagnosis of infection depends on suspicion. Radiologic findings are specific. Usually CT and other imaging studies show hypodense migratory lesions of the liver or subcapsular low attenuation regions in the liver (3, 4). The development of a chronic liver abscess appears to be extremely rare. Serologic tests and stool examination may help in confirmation of the diagnosis.

Triclabendazole and bithionol are effective agents for the treatment of fascioliasis.

In conclusion, the diagnosis of Fascioliasis, especially during the hepatic phase, is very difficult. The physicians in endemic areas particularly should be aware of the possibility of this infestation in patients who have fever, elevated liver enzymes, abdominal pain with eosinophilia and history of intake of watercress.

REFERENCES

---

**Figure 1.** Liver abscesses in fasciola