

Title:
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Autochthonous amoebiasis in Spain

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Dear Editor,

Amoebiasis is a parasitic infection caused by the intestinal protozoan *Entamoeba histolytica*. Transmission occurs via the fecal-oral route through the ingestion of contaminated food or water. It primarily affects the colon and liver, with a variable clinical spectrum (1), being more common in tropical regions and infrequent in our setting, where it is typically diagnosed in immigrants and tourists from endemic areas (1,2). However, an increase in autochthonous cases has been recorded in Spain, defined as those occurring in the native Spanish population without relevant epidemiological history (3). Migration patterns and commercial exchanges have been suggested as possible causes (2,3). In Spain, 24 cases of autochthonous amoebic liver abscess have been reported (2,4), and this study describes an additional case.

Case report

We present the case of a 56-year-old Spanish man with no relevant medical history who attended the Emergency Department due to abdominal pain located in the right hypochondrium, with fever of up to 39 °C that had persisted for seven days. He had

not travelled recently abroad and denied consuming contaminated food or water. Blood tests revealed leukocytosis (19,670/ μ l) with neutrophilia (16,800/ μ l) and elevated acute-phase reactants (CRP 40 mg/dl). An abdominal computed tomography (CT) scan was requested, which showed circumferential mural thickening of the caecum and a large cystic mass in the right hepatic lobe. Due to the suspicion of an infectious origin, empirical antibiotic therapy with ceftriaxone and metronidazole was initiated.

While hospitalized, further investigations were carried out with a colonoscopy, which revealed infectious-looking ulcers in the caecum and right colon (Fig. 1A). Biopsies were taken, but they were non-diagnostic. An abdominal ultrasound was performed, identifying a heterogeneous lesion in liver segments V, VI, and VIII, with echoes inside, likely related to gas bubbles. This finding was consistent with a liver abscess (Fig. 1B). An ultrasound-guided drainage was performed, yielding purulent material that was sent for microbiological analysis. Both serology and PCR on the sample tested positive for *Entamoeba histolytica*, while the culture was negative. The subsequent clinical course was favorable, with completion of treatment with metronidazole, followed by paromomycin.

Discussion

The most common lesions in intestinal amoebiasis are ulcers, typically crater-shaped, with ill-defined borders and covered by a central yellowish exudate (1). The liver is the most commonly affected extra-intestinal organ in amoebiasis, although liver abscesses occur in less than 1 % of cases (1). The infection reaches the liver via hematogenous spread through the portal system and the most frequent location is the right lobe (90 %), generally a single lesion (5).

The diagnosis is based on the identification of the parasite, with the determination of PCR for *Entamoeba histolytica* from a sample obtained via fine-needle aspiration of the liver abscess being particularly useful, offering a sensitivity close to 100 % (2). The treatment of choice is metronidazole (1,5).

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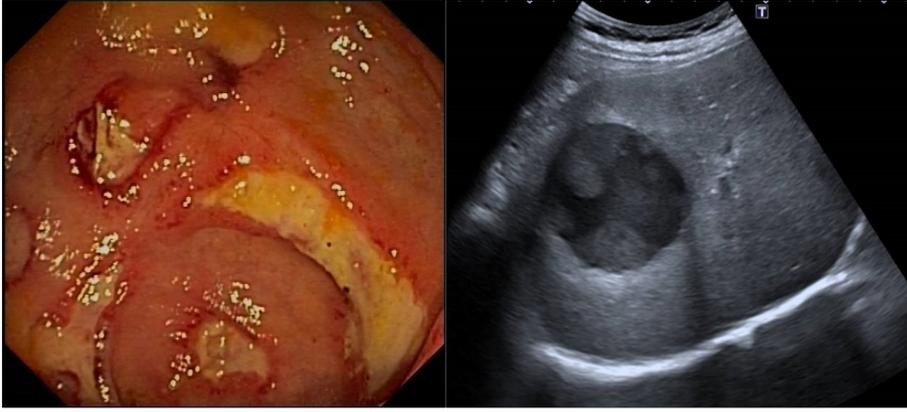


Fig. 1. A. Colonoscopy. Numerous deep ulcers covered with fibrin, ranging from 5 mm to 3 cm in size, were observed in the caecum and right colon, suggestive of an infectious etiology. B. Ultrasound. Normal-size liver with preserved echotexture and smooth edges. A heterogeneous lesion measuring 68 x 61 mm is identified in segments V, VI, and VIII, with echoes inside, consistent with a liver abscess.