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A rare cause of cholangitis: *Fasciola hepatica*

Nadir bir kolanjit nedeni: Fasciola hepatica

To the Editor,

Fascioliasis is a zoonotic disease caused by liver flukes (1.) Although Turkey is regarded as mesoendemic for the disease, there are few cases reported (2, 6, 7).

The disease has a broad clinical spectrum ranging from an acute hepatic phase to a chronic biliary phase. The diagnosis of fascioliasis can be established when the eggs of *Fasciola hepatica* are found in feces, duodenal aspirates or bile or by using various serological tests (3, 14, 15). Imaging studies are also helpful (8, 16-18).

A 58-year-old female patient admitted to the emergency department with fatigue, malaise, loss of appetite, and abdominal pain. Her medical history revealed hypertension and hyperlipidemia for two years. On physical examination, she had pain on the right upper quadrant and her scleras were icteric. Laboratory investigation results were as follows: glucose: 127 mg/dl, aspartate aminotransferase: 541 U/L, alanine aminotransferase: 886 U/L,

Figure 1. ERCP demonstrated dilatation in intrahepatic bile ducts and common bile duct.

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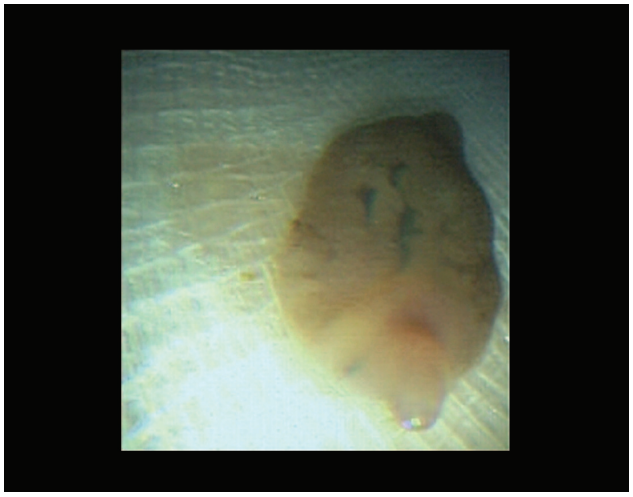

Figure 2. Extracted live Fasciola hepatica.

gamma glutamyl transferase: 659 U/L, alkaline phosphatase: 254 U/L, total bilirubin 5.4 mg/dl, conjugated bilirubin 3.39 mg/dl, white blood cell count: 12.7 K/mm3, polymorphonuclear leukocyte (PNL): 4400 (37.4%), lymphocyte: 4400 (34.6%), monocyte: 563 (4.42%), eosinophil count: 3200 (25.1%), hemoglobin: 15 g/dl, platelet count: 297.0 K/mm^3: 351,000, C-reactive protein: 53 mg/L, and erythrocyte sedimentation rate: 44 mm/h.

She tested negative for HBsAg, anti-hepatitis A virus (HAV)-IgM, anti-hepatitis B virus (HBV)-IgM, anti-hepatitis C virus (HCV), anti-Rubella IgM, anti-cytomegalovirus (CMV)-IgM, anti-toxoplasma IgM, anti-hepatitis E, Epstein-Barr virus (EBV)-VCA IgM, antinuclear antibody (ANA), antimitochondrial antibody (AMA), ASMA, and anti-liver-kidney microsomal antibody (LKM).

Ultrasonography revealed mild dilatation in intrahepatic bile ducts and gallbladder stones. Magnetic resonance cholangiopancreatography showed dilatation in intrahepatic and main hepatic ducts and millimetric filling defects in the middle portion of the common bile duct. The patient was considered as acute cholangitis and antibiotherapy (cephoperazone 2 g/day) was started. On the 6th day of treatment, the clinical signs and symptoms improved. Endoscopic retrograde cholangiopancreatography was performed, which revealed dilatation in the intrahepatic bile ducts and common bile duct. Filling defects in the middle portion of the common bile duct were visualized (Figure 1). After a standard sphincterotomy, balloon extraction to the choledochus was performed and two living *Fasciola hepatica* were extracted (Figure 2). Antihelminthic therapy was started and the liver function tests improved in the follow-up. Complete improvement was achieved after the extraction of *F. hepatica* and antihelminthic therapy. Fasciola may cause recurrent cholangitis and irreversible secondary biliary cirrhosis if untreated. Fascioliasis should be considered in the differential diagnosis in patients living in rural areas and in those with a history of watercress ingestion, especially when they present with eosinophilia, unexplained obstructive jaundice, recurrent cholangitis, or elevations in transaminases.

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