中文題目：克雷白氏肺炎桿菌肝膿瘍併發敗血性肺栓塞

英文題目：Septic pulmonary embolism and liver abscess caused by *Klebesiella pneumoniae*

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Introduction:

Klebesiella pneumoniae is a common pathogen of liver abscess in diabetic patients. *K pneumoniae* liver abscess is associated with haematogenous dissemination and secondary foci of infection, particularly in the eye. Septic pulmonary embolism is an uncommon but lethal complication of *K pneumoniae* liver abscess. SPE can cause pulmonary infarction and metastatic abscess of lung. In our case report, we present a relatively young diabetic patient who expired due to this serious complication of *K pneumoniae* liver abscess.

Case presentation:

This 42 year-old male is a cooker and he has history of type 2 diabetes mellitus diagnosed for three years, but he didn't receive any medical treatment. In addition, he also has habit of alcohol drinking with Sorghum 200cc /day. However, he sufferred from fever with chill and general muscle sorenss since three days before admission. He ever visited local clinic for help. At there, common cold was diagnosed and he received some antipyretics as acetaminophen. Progressive SOB and cough with sputum occurred gradually. Due to dyspnea, he was sent to our emergent room in the evening of hospitalized day. At there, his vital signs are unstable as hypotension, tachycardia and tachypnea (BP- 97/68mmHg, T.P.R- 36.7C, 112/min, 28/min). Lab data showed no leukocytosis but bandemia, elevation of blood sugar and CRP level and hypoxemia (blood sugar: 667mg/dl, CRP:29.7mg/dl, PaO2-55mmHg under O2 simple mask 10L/min). CXR disclosed multiple nodular lesions over bilateral lung field (Figure1). Due to dyspnea and hypoxemia, intubation was done and antibiotics as Ertapenem 1g QD was given. Then he was admitted to our intensive care unit. At our ICU, chest and abdominal computed tomography was arranged and revealed multiple nodules and wedge-shaped infiltrations disseminated in the bilateral lungs and multifocal less-enhanced lesions in the both lobes of liver, and the biggest one with wedge shape in S8 (Figure 2). Liver abscess with multiple septic pulmonary embolism was highly suspected. Due to immature of liver abscess, percutaneous abscess drainage could not be done. Blood culture disclosed wild type *Klebesiella pneumoniae* which is sensitive to Ertapenem. During antibiotics treatment, the patient's hemodynamic status and oxygenation got worse. Followed CXR showed progression of bilateral lung infiltration (figure 3) and high FiO2 as 100% was given. At the fifth day after admission, the patient's blood pressure and heart rate dropped and he expired.

Conclusion:

K pneumoniae liver abscess is a dangerous infective disease of diabetic patients. Without adequate treatment including antibiotics and percutaneous abscess drainage, the risk of hematogenous dissemination is high and serious complications as endophthalmitis, septic lung embolism and meningitis may occurred. Thus early aggressive treatment is very important to decrease mortality or morbidity of the patients

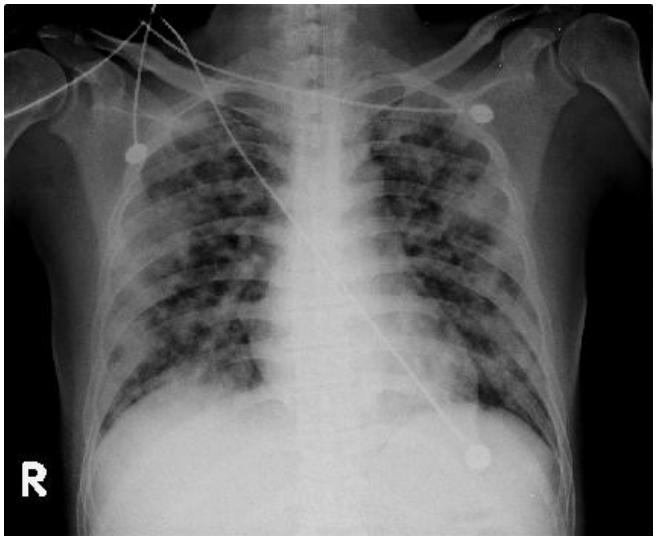

Figure1

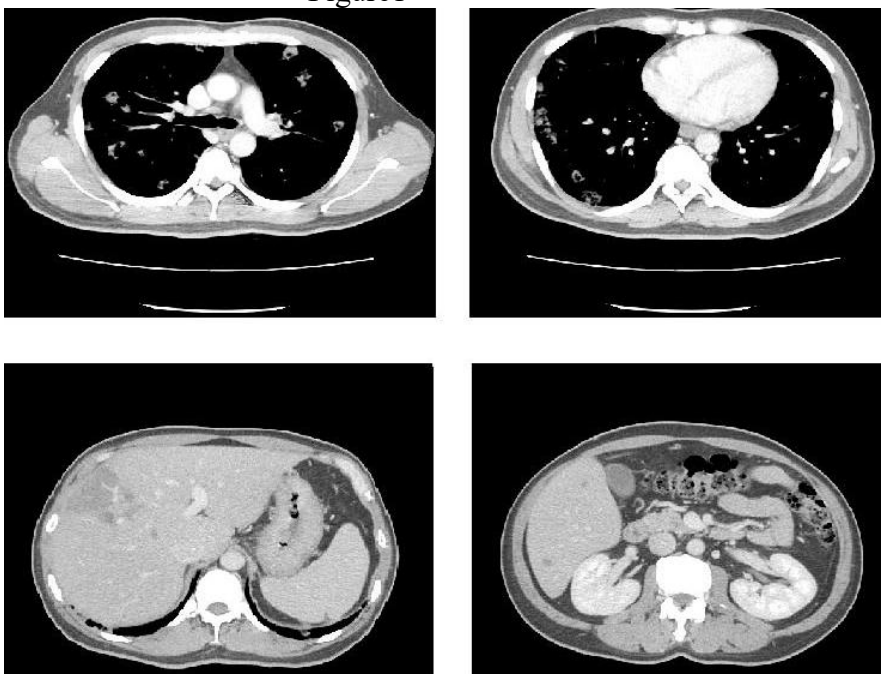

Figure2

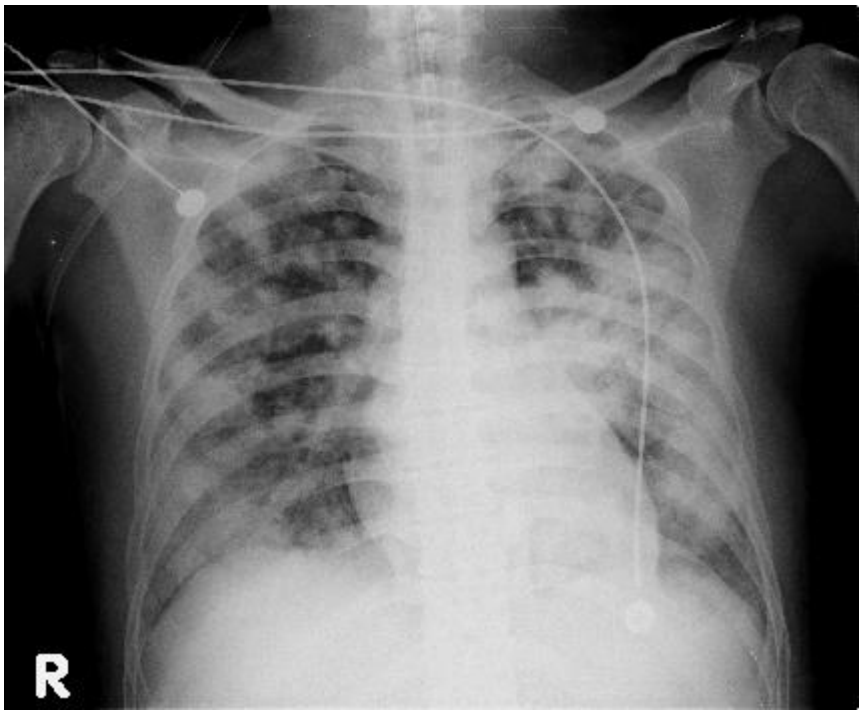

Figure3