中文題目：腹部X光影像中，一個被忽略的軟組織腫塊
英文題目：A Neglected Abdominal Soft Tissue Mass in A Kidney, Ureter and Bladder X-ray Film
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***Background**: Klebsiella pneumoniae* belongs to the normal flora of the human mouth and intestine. It is prevalent in Taiwan, causing community-onset pyogenic liver abscess or biliary tract infection. Hospital-acquired *K. pneumoniae* infection could occur in patients as a form of pneumonia. The main presentations of biliary tract infection were pain, weight loss, fever and jaundice. The presentation of such disease could be hard to be identified in bed-ridden patient with poor verbal expression. The diagnosis of acute cholecystitis by an imaging study of the Kidney, Ureter and Bladder (KUB) was easily missed.

***Method**:* A case report. Herein we presented the case of a 77-year-old woman who was admitted to coronary care unit (CCU) due to non-ST elevation type myocardial infraction complicated with sustained ventricular tachycardia, ventricular fibrillation and cardiogenic shock. Coronary angiography revealed 2-vessel-disease and she underwent drug eluting stent inserted to left anterior descending branch of coronary artery. The patient has underlying disease of hypertension and end stage renal disease, receiving maintenance hemodialysis through atria-venous shunt. During CCU admission period, atrial fibrillation with rapid ventricular response and fever developed. The patient did not present with upper respiratory symptoms, diarrhea, nor pyuria. There was a recently changed central venous catheter. Physical examination found abdominal distention and tenderness on right upper quadrant area. The presentation of tenderness was presented by visual analogue scale. We arranged a supine KUB X-ray for assessment of infection focus and initial KUB reading was negative finding. The fever workup showed leukocytosis (14,800/μg, normal range: 3,400/ug ~ 9,100/ug), high-level C-reactive protein (229.9 mg/L, normal range: <5mg/L) and Extended-spectrum β-lactamases K. pneumoniae (ESBL-KP) isolated in the blood culture. We further arranged a computed tomographic scan of the abdomen, which revealed severe gallbladder distension with gallstone, suggested acute cholecystitis with impending perforation. We traced back to initial KUB and an abdominal soft tissue shadow on right upper quadrant could be suspected. The patient received percutaneous transhepatic gallbladder drainage and turbid purulent fluid was drained out. The culture of gallbladder bile also yielded ESBL-KP, which was consistent to blood culture strain. We used antibiotic of doripenem and colistin for infection control. The patient had improved in clinical condition and infection parameter. She was transferred to ordinary ward 1 week later.

Unfortunately, in-hospital cardiac arrest happened in the next day due to ventricular arrythmia, and the patient died in no response to cardiopulmonary resuscitation.

Conclusion: Attack of acute cholecystitis occur in hospitalization is easily missed, especially if patient stayed in otherwise specialized unit. Our case highlighted the importance of reading in distended gallbladder shadow on KUB in order to early diagnosis and management.