ED QUICK QUIZ
WHAT IS THE DIAGNOSIS?

BACKGROUND

A 75 year lady with advanced non-alcoholic fatty liver disease has been brought to your department. She was an inpatient a week ago with large volume ascites which was drained prior to her discharge. For the last 48 hours she has felt unwell and her family have become very concerned.

Observations HR -110 BP -115/70 RR -18 Sats -95% o/a T -38.6⁰C.

On exam she is mildly jaundiced and lethargic but GCS 15. Her chest is clear with normal heart sounds, soft non tender abdomen with obvious ascites. Her skin is slightly yellowed but otherwise normal. You make a diagnosis of sepsis, start the sepsis 6 bundle and a septic screen. Your CXR and urine dipstick are normal. Lactate is 3 and the rest of your bloods are awaited.

QUESTIONS

1. What is the likely source of this woman’s sepsis?
2. What antibiotics would you use?
**ANSWERS & DISCUSSION**

1. Likely source

The likely source is spontaneous bacterial peritonitis.

SBP is the development of a monomicrobial infection of ascites in the absence of a contiguous source of infection. It is seen almost exclusively in patients with cirrhosis and portal hypertension.

Presentation of SBP:-

- Pyrexia and features of sepsis
- General malaise, N&V
- Abdominal discomfort or worsening ascites
- Asymptomatic
- Encephalopathy

Thought to be due to compromised immune defenses, inter-hepatic shunting of colonized blood and defective bactericidal activity within the ascitic fluid. Diagnosis is made by paracentesis - microscopy, gram stain and culture of the ascitic fluid.

2. Antibiotics

If SBP is suspected the patient should be treated with broad spectrum antibiotics for enteric organisms and gram positive cocci.

- Co-Amoxiclav or ciprofloxacin
- Vancomycin

Development of renal impairment occurs in 30% of patients with SBP and is one of the strongest predictors of mortality. There has been some evidence that IV albumin can reduce mortality in these patients but is not conclusive. The British Society of Gastroenterologists currently recommend that if patients have an increased serum creatinine or a rising serum creatinine to consider infusion of 1.5 g albumin/kg in the first six hours, followed by 1 g/kg on day 3.