Pylephlebitis caused by perforated jejunal diverticulosis

Introduction
- The purulent thrombophlebitis of the portal vein and mesenteric venous system is a rare but serious condition with a mortality of 11-25%.
- It often occurs in combination with intraabdominal inflammation like pancreatitis, diverticulitis or appendicitis.
- We report a case of pylephlebitis of the portal venous system caused most probably by jejunal diverticulitis.

Conclusion
- Pylephlebitis as a rare condition should always be kept in mind when intraabdominal infection is coincident with thrombosis of the portal and mesenteric veins.
- Immediate control of the infection with empiric antibiotic therapy and anticoagulation are the cornerstones of therapy.

Discussion
- Pylephlebitis can cause a variety of systems. It may occur up to 30 days after abdominal infection and thus pylephlebitis may be missed. Lab tests are nonspecific, leucocytosis and increased liver enzymes may occur.
- A CT scan may help to show the extent of thrombosis and to detect the underlying inflammation. Furthermore, potential complications like liver abscess, splenic infarction or bowel ischemia can be ruled out. Treatment options comprise antimicrobial therapy and early re-canalization to prevent complications.
- Even systematic thrombolysis is discussed in serious cases. Another therapeutical option is surgical thrombectomy.
- Individual treatment and interdisciplinary approach depending on the extent of the thrombosis, microbiological results and personal risk factors is necessary.

Patient
- A 46-year-old male patient presented with convulsive epigastric pain, nausea, fever, chills and diarrhea
- Clinical workup showed defense of the abdomen, leucocytosis of 9.2 Giga/L and CrP of 119 mg/l. A CT scan revealed a long-segment, partial portal venous thrombosis as well as gas in the portal venous system. Additionally extensive jejunal diverticulosis was found. Probably a jejunal diverticulitis led to the septic thrombosis.
- Initially antibiotic therapy and anticoagulation with heparin were administered. Due to increasing abdominal defense, fever and hypotension, a diagnostic laparoscopy was performed to rule out bowel ischemia. No signs of ongoing diverticulitis or any other intraabdominal infection were found. During the further course recurrent fever episodes occurred. Blood samples showed polymicrobial bacteraemia and antimicrobial therapy was adjusted.
- He received moxifloxacin for further four weeks and rivaroxaban for six months.

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