

hepatitis, and gastroenteritis, B Lorber et al. 1996; permission conveyed through Copyright Clearance Center, Inc.)

A number of agents exhibit excellent activity against aerobic gram-negative bacilli. Because death in intraabdominal sepsis is linked to gram-negative bacteremia, empirical therapy for intra-abdominal infection always needs to include adequate coverage of gram-negative aerobic, facultative, and anaerobic organisms. Even if anaerobes are not cultured from clinical specimens, they still must be covered by the therapeutic regimen. Empirical antibiotic therapy should be the same as that discussed above for secondary peritonitis. Most clinical treatment failures are due to failure to drain the abscess and thereby achieve source control. The appropriate duration of antibiotic treatment for abdominal abscesses depends on whether the presumptive source of the intraabdominal infection has been controlled. With adequate source control, antibiotic treatment may be limited to 4 or 5 days.

■ VISCERAL ABSCESSSES

Liver Abscesses The liver is the organ most subject to the development of abscesses. In one study of 540 intraabdominal abscesses, 26% were visceral. Liver abscesses made up 13% of the total number, or 48% of all visceral abscesses. Liver abscesses may be solitary or multiple; they may arise from hematogenous spread of bacteria or from local spread from contiguous sites of infection within the peritoneal cavity. In the past, appendicitis with rupture and subsequent spread of infection was the most common source for a liver abscess. Currently, associated disease of the biliary tract is most common. Pylephlebitis (suppurative thrombosis of the portal vein), usually arising from infection in the pelvis but sometimes from infection elsewhere in the peritoneal cavity, is another common source for bacterial seeding of the liver.

Fever is the most common presenting sign of liver abscess. Some patients, particularly those with associated disease of the biliary tract, have symptoms and signs localized to the right upper quadrant, including pain, guarding, punch tenderness, and even rebound tenderness. Nonspecific symptoms, such as chills,