

DIAGNOSIS

Bacterial culturing of the punctate remained negative. Due to the peripheral eosinophilia, a parasitic infection was suspected. Serology of *Entamoeba histolytica*, schistosomiasis, toxocarasis, echinococcosis, and strongyloides were negative. However, *Fasciola hepatica* serology was markedly positive (indirect haemagglutination titre 1:20480 [reference range < 160]). A single oral dose of triclabendazole 10 mg/kg was given, after which, his complaints resided, laboratory results normalized, and the abscesses resolved.

Fascioliasis is a food-born trematode liver fluke infection caused by *Fasciola hepatica* and *Fasciola gigantica*. It is an increasing public health problem¹ and classified as a neglected tropical disease.² *Fasciola hepatica* is endemic to Asia, Oceania, the Americas, and Europe.³ Ruminants such as sheep and cattle are the common hosts. Humans are incidental hosts who acquire the infection by the ingestion of contaminated freshwater plants or water.² The life cycle of *Fasciola hepatica* begins with adult flukes releasing their eggs in the biliary ducts of their host.⁴ These eggs are passed in the stool and embryonated in water, releasing miracidia who subsequently invade snails. Miracidia develop into cercariae which leave the snails and encyst (metacercariae) on freshwater plants. Metacercariae are then ingested by definitive hosts, excyst in the duodenum and migrate through the peritoneal cavity and liver parenchyma into the biliary ducts, where they develop into adult flukes. Clinically, fascioliasis can present during the acute (i.e., liver) or chronic (i.e., biliary) phase. The acute phase starts approximately two to three months after ingestion and is caused by metacercariae migrating through the liver. Patients present with fever and abdominal pain, sometimes accompanied by anorexia, nausea, vomiting, myalgia, coughing, or

urticaria. The chronic phase, after approximately six months, is usually asymptomatic, but can also manifest with biliary colic, cholangitis, jaundice, or pancreatitis due to biliary tract obstruction. Treatment with one dose of triclabendazole, taken with a fatty meal, is a very effective cure. However, as this drug is only registered for veterinary use in the Netherlands, it may be hard to obtain. The present case shows that fascioliasis can present with liver abscesses and that peripheral eosinophilia forms a potential diagnostic clue.

CONCLUSION

Fascioliasis can present as liver abscesses.

DISCLOSURES

All authors declare no conflicts of interest. No funding or financial support was received.

REFERENCES

1. Keiser J, Utzinger J. Emerging Foodborne Trematodiasis. *Emerg Infect Dis.* 2005;11:1507-14.
2. Mas-Coma S, Bargues MD, Valero MA. Human fascioliasis infection sources, their diversity, incidence factors, analytical methods and prevention measures. *Parasitology.* 2018;145:1665-99.
3. Mas-Coma MS, Esteban JG, Bargues MD. Epidemiology of human fascioliasis: a review and proposed new classification. *Bull World Health Organ.* 1999;77:340-6.
4. Marcos LA, Terashima A, Gotuzzo E. Update on hepatobiliary flukes: fascioliasis, opisthorchiasis and clonorchiasis. *Current Opinion in Infectious Diseases.* 2008;21:523-30.