Another case of alcohol – related liver disease? Stop and take a closer look!

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INTRODUCTION

Autoimmune hepatitis (AIH) is often seen in middle- aged females. The presence of a strong alcohol consumption history and male sex can sometimes be confounders resulting in a delay in accurate and timely diagnosis of autoimmune hepatitis.

CASE REPORT

- A 59-year-old male with history of alcohol use disorder with recurrent alcoholic hepatitis and hepatitis C presented with jaundice and pruritus.
- Review of systems was positive for long standing arthralgia. Physical examination was unremarkable except for jaundice
- Lab workup revealed AST & ALT both in 1000s with hyperbilirubinemia. Other findings include significantly elevated serum globulin levels and CRP. Viral hepatitis was positive for hepatitis C and E IgG antibodies. Hepatitis C viral load was undetectable. Serum transferrin saturation, ferritin and ceruloplasmin were within normal limits.
- Abdominal Ultrasound and CT of the abdomen and pelvis were significant for micronodular liver cirrhosis and splenomegaly suggestive of portal hypertension.
- Given the history of arthralgia with significant transaminitis, elevated globulin and CRP levels and negative acute hepatitis workup, autoimmune hepatitis was suspected.
- Liver biopsy revealed the presence of a significant number of plasma cells in advanced bridging fibrosis background.
- Additional workup revealed positive anti-nuclear and anti-smooth muscle antibodies suggestive of AIH type I.

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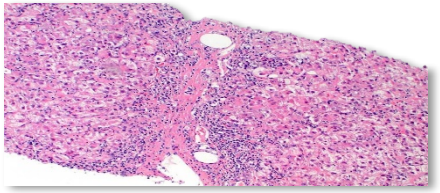

Figure 1 – Liver biopsy showing moderate to severe lobular and interface active hepatitis and hepatcytes ballooning (Low power 10X)

2(a) 2(b)

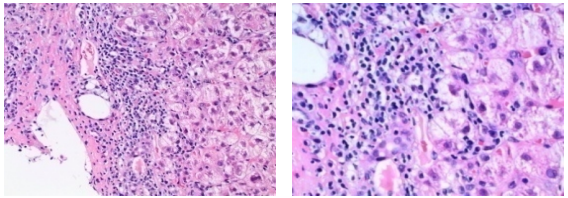

Figure 2(a) and 2(b) - Liver biopsy showing hepatocytes ballooning degeneration and mixed inflammatory infiltrates including lymphocytes and plasma cells (high power).

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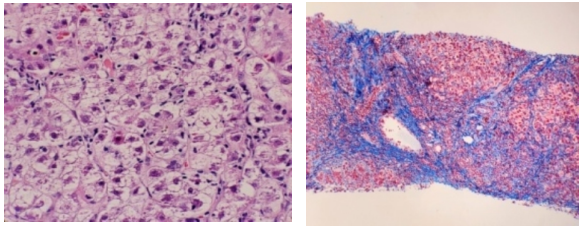

Figure 3 – Higher power of figure 2 showing bile disposition.
Figure 4 – Liver biopsy stained with trichome stain. It showed extensive sinusoidal and briding fibrosis with foci of early cirrhosis.

- He was initially given Prednisone 40 mg daily and then transitioned to mycophenolate mofetil for maintainence therapy.
- 3 months follow up, liver function tests normalized and the patient significantly improved clinically.

DISCUSSION

- Before diagnosing a patient with AIH, other causes of chronic hepatitis including alcohol induced hepatitis, drug-induced and viral hepatitis should be excluded.
- Determining the type of AIH holds clinical significance since patients with type I AIH respond well to steroids unlike type II which often carries a poor prognosis and requires early liver transplant.
- Patients with AIH need long-term monitoring for overlap syndromes like AIH- PSC, where primary sclerosing cholangitis (PSC) can occur many years later after AIH diagnosis.

CONCLUSION

It is important in patients with suspected clinical diagnosis of alcoholic hepatitis, to rule out other causes, including viral hepatitis, shock liver, and AIH. AIH is often a diagnosis of exclusion and early treatment initiation with steroids often leads to good long-term prognosis.

REFERENCES

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