Autoimmune Hepatitis: A Risk Factor for Cryptogenic Cirrhosis
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Purpose: The etiology of cryptogenic cirrhosis (CC) is poorly understood. It is recognized that a significant number of patients with CC may result from nonalcoholic fatty liver disease (NAFLD) yet its cause in the others remains unknown. Occult autoimmune hepatitis or toxic liver injuries have been the other proposed causes of CC. The aim of the present study was to identify the clinical, biochemical, immunologic and histologic parameters of autoimmune hepatitis (AIH) in patients with CC to ascertain whether AIH is a causative risk factor for the disease.

Methods: Thirty five consecutive patients who had liver transplant for CC were studied. Clinical, biochemical, immunologic and histologic parameters were analyzed and the International Autoimmune Hepatitis (IAH) score calculated. Explant histology was reevaluated by a hepatopathologist for the inflammation, lymphoid aggregate, plasma cells, interface hepatitis, steatosis, perivenular and sinusoidal changes, glycogenated nuclei, Mallory hyaline, bile duct changes, hepatocyte necrosis and fibrosis.

Results: The mean age of patients was 53.7 ± 13 years, BMI was 29.6 ± 6.8 Kg M2 (range 21–42) and 57% were females. Diabetes was present in 42%; obesity in 63%, and 37% had concurrent illness. The liver chemistry revealed mild to moderate increase in aminotransferases (AST 85.5 ± 105, ALT 67 ± 70, AST/ALT 1.4 ± 0.6) and Alk Phos (187.7 ± 97.7). The ANA was positive in 17% and anti-smooth muscle antibody in 31%. Mean IAH score was 7.0 ± 3.0 and a score of 10 or greater was seen in 14%. However, in 60% of the patients with the high IAH score, the histologic features of residual NAFLD were also present. Liver histology showed cirrhosis in all. No interface hepatitis or plasma cell infiltrates were seen. Varying grades of centrilobular sclerosis (27 biopsies) and sinusoidal fibrosis (18 biopsies) indicative of residual NAFLD were seen in addition to Mallory hyaline seen in 23%.

Conclusion: Occult or burnt-out AIH diagnosed by clinical, biochemical and immunologic criteria may be a risk factor leading to CC in a subset of patients. In some patients, dual injury from NAFLD and chronic AIH resulting in CC is a possibility. It remains conjectural that, the classic histology of AIH may be altered or lost once the disease progresses to cirrhotic stage.

Capsule Endoscopy Can Discriminate between Large/Medium Varices and Small or No Varices: Defining the Threshold
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Purpose: Guidelines recommend surveillance endoscopy (EGD) in patients with portal hypertension. Risk of hemorrhage is correlated to variceal (EV) size and presence of endoscopic stigmata. Treatment is recommended when medium/large varices (M/L V) are present. Reports indicate that PillCam ESO (EC) is a sensitive tool for identifying M/L V when the varix comprises more than 25% of the circumference of the circular field view. We evaluated the ability of EC to discriminate small from M/L V using the current grading scale. In addition, we sought to identify a correlation between varix size by EC and endoscopic grade.

Methods: Patients underwent EC within 48 hours of EGD. A separate blinded investigator interpreted capsule findings for size of esophageal varices (M/L V if >25% of the lumen circumference is occupied; small if <25%, and absent if no EV detected), exact degree of circumferential occlusion if EV present, signs of risk, evidence of prior banding and degree of portal hypertensive gastropathy (PHG).

Results: 20 patients underwent EC and EGD. One EC was excluded due to rapid esophageal transit time. Sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) for EC as compared to EGD are shown in Table 1. The sensitivity of CE to identify M/L V was 22.2%. Reduction in the threshold for M/L V to 12.5% of the luminal circumference results in greater sensitivity, specificity, PPV, and NPV, see Table 2. CE detected risk signs in 4/9 cases. CE correctly identified PHG in 15/15 cases.