baseline renal impairment following DAA therapy (Annals. 2014 Nov 4;161(9):634-A). While reduced RBV dose is recommended in renal impairment, this significantly reduces its efficacy (Hepatology. 2003 Sep;38(3):645-52). Current guidelines are vague regarding DAs in severe renal impairment. We describe a case of a patient with severe renal insufficiency and biliary disorder successfully treated with SOf and reduced dose RBV.

Case Report: This is a 61-year-old man with stage 4 CKD, bipolar disorder, and treatment-naive, genotype 2b HCV infection diagnosed in 2006. Liver biopsy revealed grade 3/4 chronic hepatitis and fibrosis stage 3/4. Use of IFN was contraindicated due to mental illness and likelihood of poor response with low dose RBV. Prior to treatment initiation, HCV RNA was 7,416,000 IU/mL; eGFR was 20 mL/min/1.73m2, and serum creatinine was 3.2 mg/dL. The patient began 12-weeks of reduced dose efuvirerin (200 mg) and standard dose SOf 400 mg daily. He completed the regimen with no adverse events. HCV RNA was undetectable at 6-weeks and remained undetectable at 6-weeks post-treatment. Creatinine and hemoglobin remained stable, +1.02 mg/dL and +1.08 g/dL respectively, throughout treatment.

Discussion: Complete clearance of virus suggests patient will achieve SVR12. As one of the first documented cases of successful treatment of chronic HCV genotype 2 in a patient with severe renal impairment using SOf and reduced dose RBV, we propose this regimen can be safe and effective in patients with chronic HCV infection and severe renal impairment.

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Atypical Presentation of Intrahepatic Cholestasis of Pregnancy
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A 22 year old healthy G1P0 female at 32 weeks of gestation presented to ED complaining of nausea, diarrhea, and right upper quadrant pain. Her family history was significant for her mother having pre-gestational diabetes during pregnancy. Her patient's vital and physical exam were normal with a gravid, non-tender abdomen. She had elevated AST and ALT (see Table 1) with normal bilirubin, amylase, lipase and bile acids. Extensive workup ruled out Hepatitis A, B, C, E as well as HIV, autoimmune hepatitis, hemochromatosis, Wilson's disease, celiac disease and thyroid dysfunction. There was no proteinuria. She had a transient mild thrombocytopenia, but there was no other evidence of hemolysis, microangiopathy or pre-eclampsia. Abdominal US, non-contrast MRI and MRSAP showed a normal bilary tree with no normal appearing liver. Her symptoms were attributed to a viral like illness which improved with IV fluids. Two weeks later, at 34 weeks pregnant, the patient presented with recurrent nausea and right upper quadrant pain and new complaints of diffuse body itching with no rash. She again had persistently elevated AST and ALT with normal bile acids (see Figure 1). Given high index of suspicion for intrahepatic cholestasis of pregnancy (ICP), she was started on ursodeoxycholic acid. She followed up at 36 weeks of gestation with improved itching and abdominal pain. Surprisingly, bile acids were nearly 15 times the upper normal limit. The patient was induced at 37 weeks of gestation and delivered via a non-complicated vaginal delivery. She followed up four weeks post-partum with resolution of her symptoms and normalization of AST, ALT and bile acids.

ICP is a poorly understood disease that classically presents in the third trimester of pregnancy with pruritus. Typically the only abnormal test is elevated bile acids, which is the most specific test for ICP and may precede physical symptoms. AST and ALT can be elevated, with ALT the more sensitive abnormality. The physical symptoms and lab abnormalities resolve quickly after delivery. Our case is unusual because the initial presentation was suggestive of a viral illness with normal bile acids and persistent elevation of liver enzymes. The bile acids remained normal even when the patient developed pruritus. Despite the use of ursodeoxycholic acid there was a subsequent steep rise in bile acids. This case illustrates that high clinical suspicion for ICP should remain even with normal bile acids level to prevent adverse fetal outcomes.

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A Giant Liver Cyst Successfully Treated With Alcohol sclerotherapy
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Symptoms of polycystic liver disease are due to both the number and size of cysts; treatment is usually directed at the largest cyst. Simple percutaneous cyst aspiration is associated with a high recurrence rate. Alcohol sclerotherapy, laparoscopic cyst drainage and cyst resection have been used to treat cysts ranging from 5-20 cm. We report the successful treatment of symptomatic giant liver cyst with alcohol sclerotherapy. A 44 year old otherwise healthy female was evaluated for a 2-day history of worsening epigastric abdominal pain and fullness. Laboratory investigations revealed normal liver enzymes and function and mild normocytic anemia. Abdominal ultrasound (US) and computed tomography (CT) scan showed multiple hepatic cysts with a dominant cyst measuring 27 cm in diameter. The dominant cyst was treated by a CT-guided percutaneous drainage followed by alcohol sclerotherapy. A total of 3.5 liters of dark brown fluid was aspirated and 50 mL of 98% absolute alcohol was injected as sclerosing agent. Cystic fluid analysis was unremarkable and consistent with the diagnosis of polycystic liver disease. Abdominal pain and fullness immediately and completely resolved. The procedure was well tolerated without immediate complications. The liver enzymes remained stable within normal range along with synthetic function of the liver.

To our knowledge this is the largest reported liver cyst that was safely and successfully treated with CT-guided percutaneous aspiration and alcohol sclerotherapy. This procedure should be considered before exploring more invasive and costly treatment options.

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Cholestasis: A Paraneoplastic Syndrome

Hodgkin's lymphoma (HL) must be included as a differential in cases of fever of unknown origin and idiopathic cholestasis with non specific hepatitis on liver biopsy. Early bone marrow examination in such cases may allow timely therapy and improve morbidity and mortality.

A 60-year-old African American man presented with a two month history of recurrent high grade fever and progressive jaundice. He was treated multiple times with empiric antibiotics. Past history was significant for hypertension, alcohol and tobacco use. He denied any history of travel, new medication intake or prior malignancy. Examination revealed pale, emaciated and weak old man with no lymphad
Liver Abscess with Ulcerative Colitis: A Complication Rarely Seen

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Introduction: Liver abscess is a known complication of Crohn’s disease, however, they are very rarely seen in a patient with Ulcerative Colitis (UC) and only few such cases have been reported in literature so far. We will discuss about the atypical presentation of such abscess in a patient with UC which delays diagnosis and appropriate treatment.

Case: A 50-year-old male with history of UC, on maintenance dose of prednisone 15mg/day, was admitted to the hospital with complaints of abdominal pain, fever and chills for 1 week. Laboratory findings were significant for leukocytosis of 15,100/mm3. Patient was started on empiric broad spectrum antibiotics for concern of sepsis. CT scan of abdomen showed 4 lesions in the liver that were absent 3 years ago and raised suspicion for metastatic disease, leading to biopsy of the lesions. On the 3rd day of hospitalization, he developed acute hypoxic respiratory failure with ARDS along with worsening of abdominal pain. Repeat CT scan of abdomen showed increase in the size of the hepatic lesions consistent with hepatic abscesses. On day 6, liver biopsy grew rare gram positive alpha hemolytic streptococci followed by absence of malignancy reported on day 8. A final diagnosis of liver abscess was made and they were drained on day 10 eventually leading to clinical improvement. Repeat CT scan 2 weeks later showed near complete resolution of the abscesses.

Discussion: Liver abscess is a well-known complication of IBD. However, it is very rarely associated with UC and so far only 10 cases have been reported. High suspicion leading to early recognition is necessary to treat it appropriately. High dose of corticosteroids and active disease usually predisposes patients to develop this complication as witnessed in 8 of the 10 cases reported previously. However, our patient had well controlled symptoms with a low dose prednisone and went on to develop multiple liver abscesses. Experts recommend considering this diagnosis in febrile patients with IBD having inconsistent clinical findings for IBD exacerbation. Also, presence of multiple hepatic lesions is usually seen with metastatic cancer, as suspected in our patient, leading to delay in diagnosis and appropriate treatment which consists of drainage of the abscesses.

Conclusion: Liver abscess is a very rare complication of ulcerative colitis. To our knowledge, this is the first case where multiple liver abscesses in a patient with UC was complicated with ARDS due to delay in diagnosis because of atypical presentation in a patient with well controlled UC.