A Rare Case of DILI

Drug-induced liver injury (DILI) results in mild transaminitis, hyperbilirubinemia or acute fulminant liver failure from 5 to 90 days after consumption of the causative medication. We present a case of DILI presenting with elevated CA 19-9. 74-year-old non-alcoholic female with Hypertension, Osteoarthritis and Diabetes presented with a four-day history of nausea, jaundice and fatigue. SHE endorsed 2-3 months of weight loss, and darkening of skin. Home medications were fosrenolide, lisinopril, hydrochlorothiazide, bisoprolol and fuchisacose without recent changes. She reported taking green tea for many years and one to two doses of green-lipped mussel oil extract in the past month. On presentation, her body mass index was 34.15 and exam revealed icteric sclera, jaundice and hyperpigmentation. Labs were significant for AST 785, ALT 432, alkaline phosphatase 302, bilirubin 18.9, albumin 3.1. Further work-up revealed elevated CA 19-9 of 1656, AFP of 8.1, IgG of 1900, CEA of 2.1. Autoimmune and hepatitis panel resulted negative, except for positive Hepatitis B core and surface antibodies. Magnetic resonance cholangiopancreatography showed small hepatic lesions consistent with hemangiomas or cysts. Endoscopic ultrasound resulted in no pathology. Liver biopsy revealed chronic cholestatic hepatitis, markedly active bridging necrosis, parenchymal collapse, with focal fibrous septum formation, suggestive of drug or toxin induced liver injury. The patient’s hospital course was uneventful and she was discharged on day 8 with instructions to discontinue her herbal supplements. Upon further review, she had a similar admission one month prior, where she was admitted for transaminitis that resolved with cessation of all possible hepatotoxic medications. After the current admission, she was started on ursodiol and prednisone taper with resolution of her jaundice, transaminitis and hyperbilirubinemia. Most recent laboratory findings included AST 27, ALT 17, Alkaline phosphatase 79, bilirubin 0.8, albumin 4.0. This case illustrates the potential for rare drug-induced liver injury secondary to herbal supplements. These products, including lyprinol and green tea, may affect the liver individually or synergistically. CA 19-9 is increased in malignancy and sometimes in benign conditions such as gall bladder disease, pancreatitis or cirrhosis but rarely with DILI. Early recognition is critical for prevention of fulminant liver failure.

Portal Hypertension in Benign Recurrent Intrahepatic Cholestasis: A New Clinical Feature of a Rare Diagnosis
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Benign Recurrent Intrahepatic Cholestasis (BRIC) is an autosomal recessive condition that usually presents in the first two decades of life. It has a prevalence of less than 1 in 100,000 and is caused by mutations in either the ATP8B1 gene encoding the bile salt export pump (BRIC2) or the ABCB11 gene encoding the bile salt export pump (BRIC1). Both present with recurrent episodes of pruritus and jaundice, and features that can include malaise, hepatomegaly, and steatorrhea. BRIC has not been associated with portal hypertension. A 28-year-old male presented with 2 weeks of severe pruritus, nausea, 10 lb weight loss, and dark urine. He reported similar episodes occurring intermittently for the past five years but otherwise had a negative medical history. He took no prescribed, OTC or herbal medications and denied alcohol or drug use. His paternal grandfather had similar episodes of intermittent jaundice and pruritus without a known diagnosis. Examination revealed scleral icterus and mild hepatomegaly. There was no evidence of spider angioma, asterixis, or ascites. Labs were significant for an ALT 64 U/L, AST 43 U/L, bilirubin 4.6 mg/dL (direct 3.2 mg/dL), alkaline phosphatase 129 U/L, GGT 66 U/L, INR 0.9 and platelet count of 95,000 x10^6/mL. Testing for hepatitis A, B, and C, as well as ANA, AMA, ASMA, and ceruloplasmia were negative. Contrast enhanced abdominal CT showed evidence of portal hypertension with splenomegaly and large periportal varices (figure 1). Subsequent liver biopsy revealed evidence of cholestasis without fibrosis (figures 2 and 3). With supportive care, he had resolution of symptoms and complete normalization of his liver tests and platelet count. He did well for 1 year until developing a more severe episode treated with nasobiliary drainage. Given his relapsing course, portal hypertension with a normal GGT, family history, and extensive negative workup for other causes, he was diagnosed with BRIC. This case was unusual given the evidence of transient portal hypertension seen on both blood work and imaging, resolving after resolution of his episode. BRIC has been associated with hepatomegaly, but has not previously been associated with portal hypertension. We hypothesize that during episodes of cholestasis, liver swelling led to this transient portal hypertension. There are no known documented reports of BRIC presenting with portal hypertension.

Large Hemorrhagic Liver Cyst Causing Bile Duct Obstruction
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Complications of hepatic cysts are rare and only about 5% of patients develop symptoms. Reported complications include infection, intracystic hemorrhage, rupture, torsion, biliary fistula, and bile duct obstruction. A 51-year-old African American female with autosomal dominant polycystic kidney disease status post renal transplant presented with acute onset right sided abdominal pain. She had a known history of polycystic liver disease that was previously asymptomatic with normal liver tests. Physical