INTRODUCTION: SARS-CoV2 infection. Endoscopic Retrograde Cholangiopancreatography exposed Mirizzi syndrome and a long-stent was placed into the bile duct. COVID-19 testing was negative. Liver enzymes showed minimal improvement and respiratory symptoms continued to worsen. Other laboratory tests as well as a detailed toxin intake (including alcohol) were negative. Due to the lack of improvement the patient underwent bronchoscopy and liver biopsy: The former showed budding yeast in the lungs and the latter liver granuloma with PAS positive yeast consistent with Histoplasma. Liver biopsy cultures were positive for Histoplasma capsulatum. The patient was placed on Itraconazole and discharged home upon improvement. Eight weeks post discharge her liver enzymes have almost completely normalized and symptoms have resolved.

DISCUSSION: Disseminated histoplasmosis affecting the liver is a relatively rare and often lethal complication of this infection. The confirmation of extra pulmonary disease is critical as the length of therapy extends from several weeks to one year. Histoplasma hepatitis has been reported in individuals undergoing immunosuppression, such as our patient, and a consistently reported characteristic has been a high AST to ALT ratio which can lead to an initial suspicion of alcoholic hepatitis. This should be kept in mind if the provided history is not compatible with toxin-related (alcohol) liver disease. Our patient also had a clinical presentation compatible with Mirizzi syndrome further obscuring the diagnosis. In this regard, alternative diagnoses should be thought of if there are no dramatic improvements of liver chemistries following recanalization of the bile duct.

SBP: The 2nd hospitalization he developed acute hypoxemic respiratory failure, liver dysfunction, and shock. Sars-Cov-2 PCR was positive. He passed away 5 days later. Patient 2: 62 year old male with a PMH of decompensated cirrhosis secondary to NASH who presented to the hospital with ascites. After lactulose treatment and paracentesis he was discharged after 2 days. Readmitted 10 days later for encephalopathy with an ammonia of 122 μ/mL, asterixis, and ascites. The patient was Sars-Cov-2 PCR positive. He was discharged after 5 days of supportive care, lactulose, and resolution of encephalopathy. 7 days later he was readmitted due to hepatic encephalopathy diagnosed with SBP secondary to Klebsiella bacteraemia. Patient 3: 57 year old male with a PMH of decompensated cirrhosis secondary to chronic Hepatitis C infection and alcohol abuse who presented with fever and dyspnea. Discharged after 2 weeks of inpatient care for COVID-19 and presented again 2 weeks later with encephalopathy and abdominal pain. Diagnostic paracentesis was negative for SBP and the patient was discharged after receiving supportive care, lactulose, and resolution of encephalopathy.

DISCUSSION: In all three patients acutely decompensated liver cirrhosis was intrinsically involved in their course. Patient 1 had decompenated liver cirrhosis just two weeks prior to his Covid19 diagnosis, and patients 2 and 3 had comorbid decompensated liver cirrhosis one week and two weeks, respectively, after their discharge from a previous Covid19-associated admission. This suggests that Covid19 is a risk factor for decompensation in patients with chronic liver disease and may be a marker for poor prognosis. Larger studies are needed to quantify its effects of atovaquone on liver chemistry.

Histoplasma Hepatitis Presenting as Mirizzi Syndrome

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INTRODUCTION: Hepatitis secondary to Histoplasmosis is a pathology that is complex and difficult to diagnose. We report a case that presented as Mirizzi syndrome with respiratory dysfunction that proved to be disseminated histoplasmosis with hepatic involvement.

CASE DESCRIPTION/METHODS: A 50 y/o female of adalimumab for rheumatoid arthritis presented with right-upper quadrant pain, a 5-day history of jaundice, fever and shortness of breath. Liver chemistries were elevated with alkaline phosphatase of 733 IU/L, total bilirubin of 7 mg/dL, AST 612 IU/L and ALT 202 IU/L. Abdominal ultrasonography revealed gallstones and mildly dilated common bile duct. A chest CT showed diffuse bilateral groundglass opacities. Based on the complex presentation and timing (mid March, 2020) the working diagnoses were gallstone disease with potential SARS-CoV2 infection. Endoscopic Retrograde Cholangiopancreatography exposed Mirizzi syndrome.