Case studies on acute gastroenterology

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Mr S, 70 year old man

- 2 months of:
- Anorexia, weight loss, painless jaundice
- Visiting from Rarotonga
- On methotrexate for ankylosing spondylitis for 2 years
- Once yearly blood tests- last liver function tests 1 year ago normal

Bloods

- Bilirubin 300
- ALP 500
- GGT 600
- ALT 670
- AST 540
- INR 1.3
- Creatinine not available

Question 1

- What would you do next?
- A) Refer to outpatient clinic
- B) USS
- C) CT
- D) Hepatitis serology
- E) General liver screen

Case 1 progress

- CT shows no biliary dilatation, no masses
- Hepatitis serology shows chronic HBV infection, HBeAg negative

- What is the test to differentiate between acute vs chronic HBV infection?

- What would you do next?

- General liver screen
- HBV DNA
- Take a more thorough drug history- (antibiotics, OTC supplements in the last 3 months)
- Paracetamol usage
- ETOH

Case 1

- Started on entecavir
- LFTs started to improve over 1 week
- Discharged for outpatient clinic follow up

Case 2

- 56 year old Indian man
- History of NAFLD with severe fibrosis
- IHD and diabetes
- Recently admitted with STEMI 2 months ago
- Stented x 3
- Current meds: Aspirin, Ticagrelor, Metformin, Atorvastatin, Metoprolol

- Presented with anorexia, nausea, vomiting, dehydration, jaundice after returning from holiday in Fiji
- Bloods: Bilirubin 300, GGT 500, ALP 600, ALT 500, AST 450, Creat 250

What is the differential diagnosis here?

- A) Acute viral hepatitis
- B) Malignancy
- C) Severe flare of NASH
- D) Ischemic hepatitis
- E) Drug induced hepatitis
- F) ETOH hepatitis

- What additional investigations would be helpful?

- Viral serologies negative (Hep A,B,C, D, E, CMV, EBV)
- USS NAD apart from fatty liver
- General liver screen pending

- What would you do next?

- Take a more thorough history
- Review all drugs
- Consider liver biopsy if suspicion of autoimmune etiology or no other cause found and worsening

Case 2- progress

- Daily LFTs and creatinine
- Slowly but surely improving
- Discharged after 1 week in hospital

Statin induced liver injury

- Up to 3% of patients have ALT elevations
- ALT >3ULN only in minority
- Most ALT abnormalities improve even with continued treatment
- Cholestatic/mixed hepatitis
- Autoantibody associated DILI with presence of ANA and antiSm with or without plasma cells on liver biopsy
- Overall risk of DILI 1:100,000
- Risk of Acute liver failure 1:1,000,000

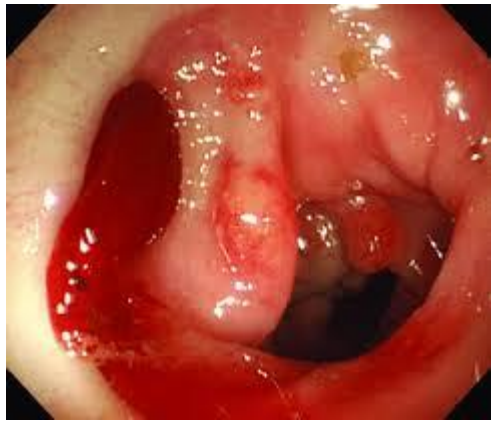
- US drug induced liver injury database
- 22/1188 over 8 years
- Can occur at anytime (range 34 days to 10 years, median 155 days)
- 10 (45%) patients with cholestatic picture
- 12 (55%) patients with hepatocellular injury
- 9 patients were hospitalised, 4 with liver failure and 1 died
- Median peak ALT 892U/L
- ?Dose related

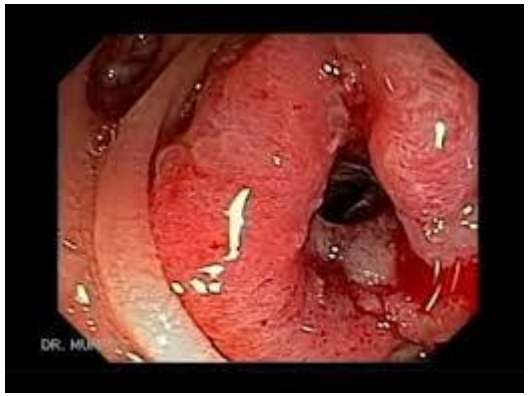
Case 3

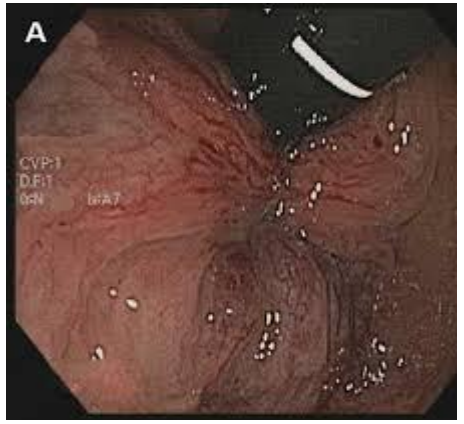
- 70 year old male
- Sudden onset fresh PR bleeding today x 4 episodes
- BP 120/70, P95. No other past medical history
- Abdomen soft non tender

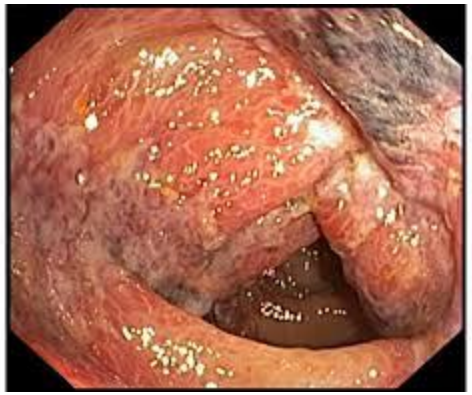
- What is your differential diagnoses at this point?

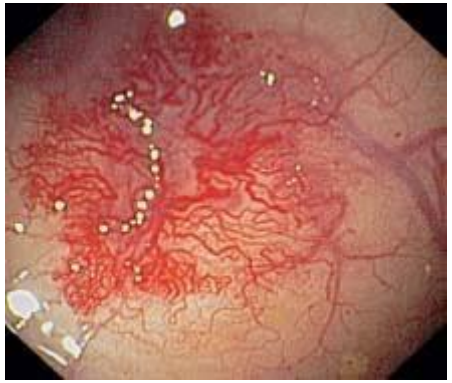
What is the differential diagnoses?

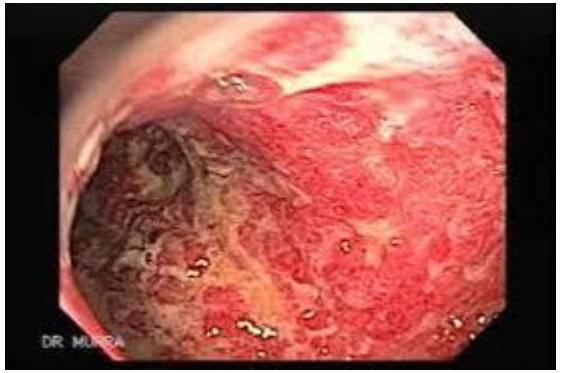












Don’t forget rapid transit UGI bleed

- Who do you decide to admit vs refer outpatient?
- Majority of lower GI bleeds stop spontaneously
- Acute colonoscopy usually unhelpful
- Admit if hemodynamic instability/comorbidities (eg on anticoagulation)
- Good history usually helps to clinch the diagnosis