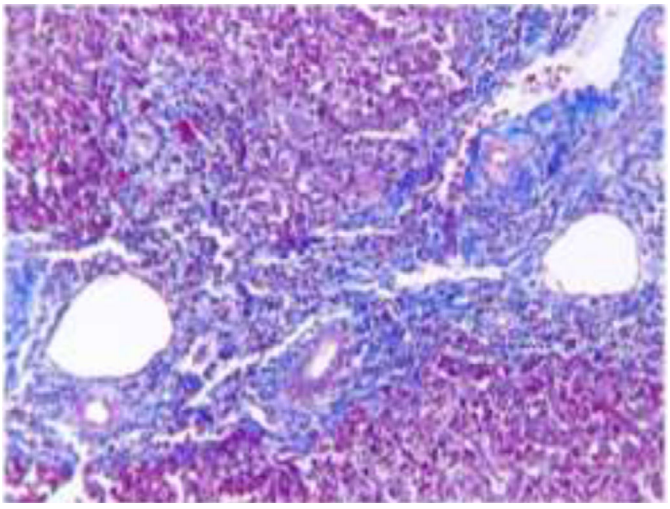

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Post-infantile giant cell hepatitis, management, six-year follow-up and re-transplantation, a successful case report during the pandemic

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Introduction and Objectives: HCG is a relatively common histological finding in newborns. In children, it presents with cholestasis, hyperbilirubinemia and inflammation; in the adult population, it remains poorly defined, with only 100 cases published in the literature during the last three decades.

Materials and methods: We present the case of a 20-year-old female patient with a history of herbal medicine and valproate, debuting six years ago with pain in the right hypochondrium, jaundice and fever with progression to liver failure, hepatotropic virus infections and autoimmunity were ruled out. Start liver transplant protocol with incompatible ABO organ, with induction with rituximab, immunoglobulin and basiliximab with post-surgical complications with resolved hemoperitoneum and pulmonary hemorrhage, with subsequent discharge and histopathological report of giant cell hepatitis explant, continuing immunosuppression for six years until readmission due to pruritus with liver biopsy that reported acute cellular rejection and ERCP with choledocho-choledochoanastomosis stenosis with endoscopic rehabilitation, with subsequent biochemical deterioration, starting basiliximab, steroids, plasma exchanges and MARS without improvement, subsequent ABO compatible retransplantation without complications. Currently no rejection data.

Discussion: HCGPI is a progressive, often fatal, disease process with a 50% survival rate without liver transplantation. The high mortality rate is caused by liver failure or sepsis as a result of immunosuppressive therapy.

Conclusion: HCGPI in our patient manifested acutely with rapid evolution toward liver failure. The use of valproate and herbal medicine were factors. Thanks to the possibility of using MARS as a bridge for the transplant, the result was optimal.

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Autoimmune hemolytic anemia as a paraneoplastic syndrome in hepatocarcinoma, case report

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Introduction and Objective: Hemolytic anemia can be associated with various types of solid tumors; however, in hepatocarcinoma, it is extremely rare.

Case Summary: Man 74 years old. Symptoms of two months with dyspnea, asthenia and adynamia. On physical examination, generalized pale skin and sclera, normal heart and lung area, soft, depressible abdomen, with peristalsis present, palpation of the liver edge 5 cm below the costal margin. Laboratories with leukocytes 6.1 103/Al, neutrophils #4.1, lymphocytes #1.3, HB 6.2 g/dL, HTC 16.8%, MCV 103fL, HCM 38pg, platelets 395.00 103/Al; BD 0.5 mg/dL, BI 2.80 mg/dL, BT 3.30 mg/dL, DHL 403 IU/L. Direct Coombs is performed positive dilution 1:128. FSP with anisocytosis, red blood cell agglutination, macrocytosis and macroplatelets, reticulocytes 1.48%, alpha-fetoprotein 12.7 IU/mL. Warm antibodies (IgG) attached to the erythrocyte membrane were documented. Simple and contrast-enhanced abdominopelvic tomography, with images suggestive of multifocal cellular hepatocarcinoma. Liver biopsy, which reports findings of hepatocarcinoma. Management with oral steroid drugs was initiated jointly, reversing the hematological alterations without requiring blood products.

Discussion: There are few cases in the medical literature on hematological alterations associated with solid tumor metastases. In this case, the hematological involvement of the patient was not due to metastasis but to a paraneoplastic syndrome since the first manifestation found was anemia with jaundice secondary to hemolysis.

Conclusion: The diagnosis must be reached by exclusion, ruling out other causes such as primary hematological alterations, metastases, or vascular processes.

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