

# Gastrointestinal and Liver Pathology at Rush

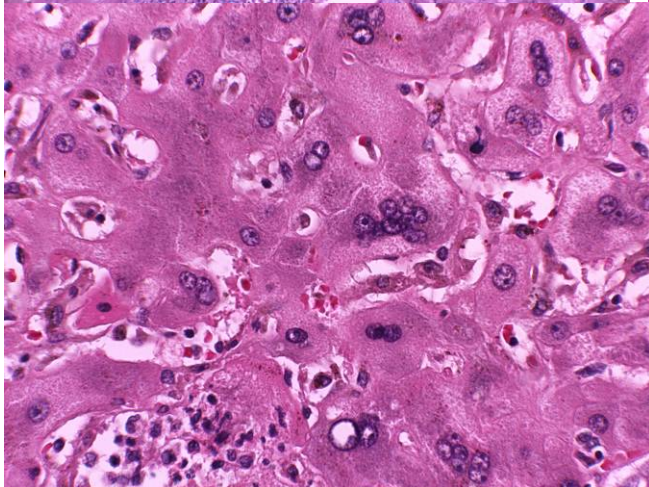
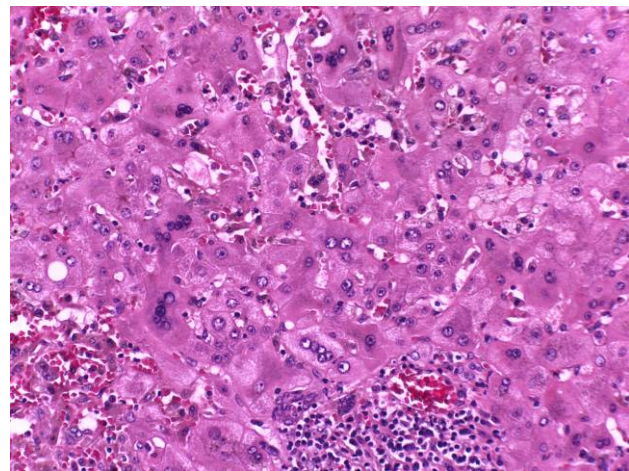
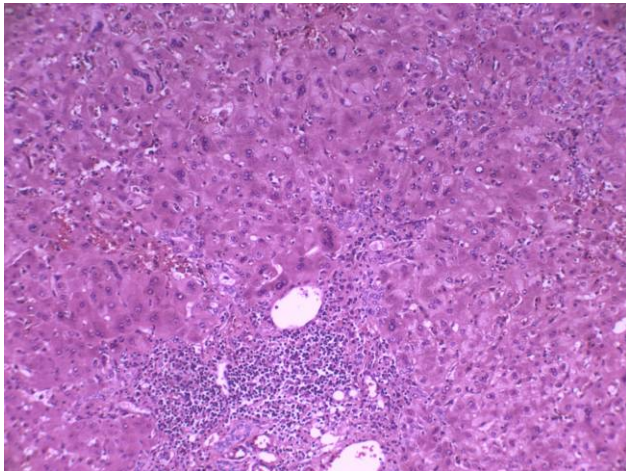
1750 W. Harrison St., Suite 570, Chicago, IL 60612 ♦ (312) 942-5227 phone ♦ (312) 942-4228 fax

---

## Case of the month – February 2009

*Contributed by Drs. Ajay Patel and Shriram Jakate*

A 56 year old male presented to the ER with bilateral knee pain, fatigue, abdominal pain, and deep jaundice of 3 days. He had a history of hemolytic anemia diagnosed 5 months prior to presentation. He had refractory ITP at the time treated with splenectomy. He did not have any alcohol or drug abuse history. He had no known hepatitis history. Laboratory tests revealed an elevated total bilirubin of 13.2 mg/dL, an elevated direct bilirubin of 9.5 mg/dL, an elevated alkaline phosphatase of 246 U/L, an elevated SGOT of 435 U/L, an elevated SGPT of 752 U/L, an elevated IgG of 2097 and an elevated IgA of 779. Viral and autoimmune serology were negative. Blood cultures were negative. CT and MRCP were normal as well. Within 10 days of admission, the bilirubin rose to 67 mg/dl and the INR rose to 2.95. The liver function tests continued to be elevated as well. The patient developed encephalopathy, acute renal failure requiring hemodialysis, and fulminant hepatic failure requiring transplantation.



*Figure 1 (upper left). Low power microphotograph of explanted liver. (x40 magnification)*

*Figure 2 (upper right). Medium power microphotograph of explanted liver. (x200 magnification)*

*Figure 3 (lower left). High power microphotograph of the liver. (x400 magnification)*