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CASE REPORT OF CRYPTOGENIC LIVER CIRRHOSIS

General Medicine

Dr. Mit Pravinbhai Modh — 3rd Year Resident, Department of General Medicine, Smt. NHL Municipal Medical College & Smt. Shardaben Chimanlal Lalbhai Municipal General Hospital, Saraspur, Ahmedabad

Dr. Aliakbar Juzer Netterwala* — 1st Year Resident, Department of General Medicine, Smt. NHL Municipal Medical College & Smt. Shardaben Chimanlal Lalbhai Municipal General Hospital, Saraspur, Ahmedabad *Corresponding Author

Dr. Hitesh Ramjibhai Nandola — 3rd Year Resident, Department of General Medicine, Smt. NHL Municipal Medical College & Smt. Shardaben Chimanlal Lalbhai Municipal General Hospital, Saraspur, Ahmedabad

Dr. Kaushik Keshavbhai Hihor — 3rd Year Resident, Department of General Medicine, Smt. NHL Municipal Medical College & Smt. Shardaben Chimanlal Lalbhai Municipal General Hospital, Saraspur, Ahmedabad

ABSTRACT

Cryptogenic Cirrhosis remains a human clinical condition although recent advances allow for a better understanding of underlying conditions associations.

Typical patient are middle age with only minor liver enzymes abnormalities. Presentations range from incidentally discovered cirrhosis to complications of advanced portal HTN and hepatocellular cancer Clinico-pathological analysis of this patient indicates that the leading causes include previously unrecognized non Alcoholic-steatohepatitis (NASH), silent auto immune hepatitis , non- B, non-C viral hepatitis and occult past ethanol exposure.

KEYWORDS

INTRODUCATION:

CC is a condition that impairs liver function. People with this condition develop irreversible liver disease caused by starry of liver cirrhosis typically mid to late adulthood.

In early stages of CC, people have no symptoms. Signs and symptoms induce fatigue, weakness, loss of appetite, weight loss, edema, jaundice.

People with CC may develop portal HTN and can also lead to typeII DM and rarely HCC.

We report a case of cryptogenic cirrhosis in a young patient with pulmonary AV fistula with hepato pulmonary syndrome.

CASE REPORT:

A 27 year old female presented to our institution with 1 week history of breathlessness, fatigue and edema.

Patient has 1 week history of breathlessness which was present on rest and increased on exertion, not relieved by medication. Breathlessness was not associated with cough or hemoptysis.

Moreover breathlessness was acute in onset and gradually worsened over time. Patient also complained of chest pain which was acute in onset intermittent dull aching and retro sternal and increased on inspiration, associated with abdominal pain in right hypochondrial region which was dull aching and continuous. Patient developed fatigue and malaise gradually over a few days.

Patient also developed generalized swelling which was prominent over lower limbs.

Patient had similar complaints in past about 11 years back. Patient gave a negative history of fever, cough,hematemesis, loose stools and vomiting.

Patient also denied smoking, alcohol consumption or recreational drug use, the patient is from a moderate socioeconomic background.

Personal history from the patient included normal bowel bladder function, decreased appetite and sleep.

On general examination the patient is conscious co-op, well oriented in time, place and person with a fair general condition. Patient remained afebrile with a pulse rate of 110beats/min, maintain a blood pressure of 110/80 mm of hg and oxygen saturation of about 90% on room air.

Patient also had moderate pallor with grade IV clubbing with bilateral lower limb pitting edema and facial puffiness, there was no lymphadenopathy cyanosis and icterus.

Patient was negative for urine pregnancy test. On systemic examination of cardiovascular system there was presence of 1st and 2nd heart sound with a pericardial knock on auscultation associated with a machinery murmur in aortic, pulmonary and erb`s area radiating to the carotids and axilla. Pulmonary examination revealed normal vesicular breathing sounds with no crepts or rhonchi or significant decrease in air entry over lower zone of both the lung fields.

Abdominal examination appears to be soft and non tender without guarding or rigidity. Liver and spleen were not palpable and kidneys were not ballotable, there was no abdominal distension, nervous system examination revealed normal function with intact cranial nerves, sensory and motor components did not reveal any deficits with normal reflexes and downward planters.

Lab investigation for the patient revealed microcytic and hypochromic anemia (Hb 10.5) initially which deteriorated to 6.0, total WBC count was 4500 on admission which decreased to 1730 later on , absolute platelet count remained between 40000 to 50000.

Renal function test remain essentially normal along with serum electrolyte.

Liver function showed an abnormality in s.billirubin levels with total billirubin 4.0 and 3.0 direct and 1.0 indirect, which later increased to 11.1 with 7.7 direct and 3.4 indirect. liver enzymes remain normal. PT and aPTT was not altered.

Sputum AFB, AMA, ANA TFT were all within normal limits.

Abdominal sonography revealed a shrunken right lobe of liver with a size of 9.5 cm which showed corse echo texture and irregular surface suggesting changes of cirrhosis of liver.

Portal vein at splenoportal junction was 14mm and 12.5mm at portal hepatitis. Collaterals are noted at portal, perisplenic region hilum of spleen and linorenal ligament.

There was also gross splenomejgaly (21cm) with 41 X 30 mm sized hypoechonic lesion with intimal septation without vascularinty noted at lover pole of spleen.

Furthur there was mild free fluid in interbowel region, pelvis with mild paicaradial effusion. chest radiography showed soft tissue opacity in right middle zone with tiny nodular opacity in right middle zone and left lower zone.

Electrocardiogram remained within normal limb with normal sinus rhythm.