11/5/21 Morning Report with @CPSolvers

***Case Presenter**: Lynna Alnimer (@LynnaAlnimer) - Ascension Providence MSUCHM IM* ***Case Discussants**: CPSolvers family <3*

CC: 41 M, generalised fatigue

HPI: 41 M, presented w Fatigue ,fever and abnormal liver function tests and jaundice for 1 month.
1 week ago- was at home when symptoms began, took Tylenol for fever- highest recorded was 104 F, tested neg for Covid 19 twice.
Associated w clay coloured stool, dark colored urine
Also had nausea and loss of appetite leading to weight loss.
No itching, no change in bowel habits or abdominal pain
Update: Discontinued HCQ, started Prednisolone with the suspicion of drug induced liver injury

PMH:
Discoid Lupus

Meds:
HCQ 100 mg BD

Fam Hx:
-

Soc Hx:
Originally from Africa
No recent travel

Health-Related Behaviors:
No smoking or hx of drinking alcohol

Sexually active -
monogamous relationship w/ wife

Allergies:
-

Vitals: **T**:101 F **HR**: 79 bpm **BP**:125/80 mmHg **RR**: 14/min **SpO_2**: Normal on ambient air

Exam:
Gen: Alert, oriented
HEENT: Scleral icterus bilaterally
CV: Normal examination
Pulm: Normal exam
Abd: No visceromegaly or tenderness
Neuro: Normal exam
Extremities/Skin: No rashes or lesions visualised

Notable Labs & Imaging:
Hematology: WBC:3.44 Differential: Normal Hgb:12.8 Plt: 117K
Chemistry: Na: 138 K:3.8 Cl: 106 Cr:1.1 glucose: 106
AST:619 ALT:658 Alk-P: 284 T. Bili: High/ Abnormal D. Bilirubin:3.1
Albumin:3.3 Inr: 1.0 Pt:12.5
HAV Ab: Neg,HBsAg and Ab: Neg HCV RNA and Ab: Neg. EBV: Neg, HSV: Neg, HIV: Neg
ASA: Low Salicylate: low
Anti DSDna: Neg Anti-RNP Ab: Neg ANa: speckled. Wilson's workup: Neg
T.B: 0.6 Alk Phos: 62 Ast: 22, Alt: 23
Imaging:
EKG:
Abd USG: Normal study
MRCP: No biliary obs
Liver Bx: Portal fibrosis, lobular inflammation consisting of plasma cells, eosinophils
Final Dx: Drug induced Liver Injury Sec to HCQ
Outcome: The patient's liver function tests and symptoms improved on discontinuing the drug

Problem Representation:
41 y/o M with acute febrile, cholestatic jaundice with with past h/o discoid lupus on HCQ.Found to have direct hyperbili and TS on labs w portal fibrosis and lobular inflammation on liver biopsy.

Teaching Points (Brodie):
Race and medicine: Linked preferably to social determinants of health rather than genetic propensity to disease states.
Jaundice/ Liver problems: Parenchyma or the biliary tract- to be teased apart with history and investigations. History: The combination of clay colored stool and high-colored urine is a marker for direct hyperbilirubinemia. Investigations: The liver enzymes provide the biggest clues.
Lupus and hepatitis: Acute, subacute (drug-induced) and chronic cutaneous lupus (discoid-lupus) [in that order for systemic involvement]. Discoid lupus: scarring form of lupus, has some propensity towards systemic lupus. **SLE with anti-ribosomal P** can cause hepatitis with or without Anti-SMA or anti-LKM. AIH can also be seronegative, bx clinches the diagnosis with a pathology picture of lymphoplasmacytic infiltrate with hypergammaglobulinemia.
Infectious hepatitis: Parasites:Strongyloides, Malaria, Leishmania, TB, Bartonella, lepto, I virus: hepatotropic viridae, dengue, yellow fever, hanta.
Drug and hepatitis: high transaminasemia (often super-high). DILI (drug-induced liver injury) can have protean manifestation ranging from acute liver failure, subacute to chronic. It can have a cholestatic-hepatocellular-mixed presentation.
HILI: herbal induced liver injury: consider ruling out in history.
Cholestatic: PBC, PSC, Pancreatic Ca, Cholangioca, IgG4-RD, HCC, Metastatic CA with lymphadenopathy, parasites, AIH.