Clinicopathological Correlation Meet

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Case 4

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Patient Particulars

- Name : Vaishnavi Dhyaneshwar Bele
- Age / Sex : 8 year/FCH
- Informant : Father
- Resident of Latur , Maharashtra

- Presented with **Chief complaints :**

- Yellowish discolouration of skin & sclera since 2 years

- Generalised itching since 1 year

- No history of vomiting , pain abdomen , constipation, loose stools , fever, weight loss , loss of appetite , hematemesis/malena , lethargy

History of presenting Illness

- 8 year old female child presented with complaints of **yellowish discolouration of skin and sclera since 2 years** , **insidious onset** , noticed initially in the eyes & later **progressed** over time and can be noticed over face
- Itching since 1 year, insidous onset , **generalised** (more severe in palms & soles), intermittent, which **usually worsens at night & with warm environment** , relieved with cold environment , at times disturbing sleep & daily activities
- **Passage of Dark coloured urine**
- No history of vomiting , pain abdomen , constipation, loose stools , fever, weight loss , loss of appetite , hematemesis/malena , lethargy , change in stool colour/Frothy stools, no signs of liver failure

- **Past History :** No significant past history , No H/o Blood transfusion

- **Antenatal History :**

- Booked case , Regular ANC Visits , Uneventful , ANC Scans -Normal

- **Birth History :** FT/LSCS/2.6kg/AGA/CIAB/No NICU Stay , Mother HBsAg Negative

- **Post Natal history :** No Significant Antenatal history

- **Family History :** 2nd born child to NCM ,

No significant family history of similar illness

- **Immunisation history :** Fully Immunised till 5 years of age as per NIS at PHC
- **Developmental history :** Attained appropriately as per age
- **Dietary history :** Vegetarian
- Belongs to lower middle socioeconomic class , 4 members in the family with 2 separate rooms with 1 bathroom
- **Allergy & drug history :** No known history of any allergy/not on any drug
- **Personal history :** Vegetarian diet , Normal bowel & bladder habits , normal sleep pattern , actively plays with siblings , goes to primary school

General physical examination

- Child is Conscious, cooperative , oriented to time, place and person , sitting comfortably on bed & obeying commands.
- On Skin , **Scratch nail marks present.**
- Temp : 98.3 F , PR - 88/min , RR - 24/min , PP - wf + , Spo2 - 98% on RA , PP - Wf , BP - 106/62 mmHg(50-90p)
- No Pallor
- **Icterus present** (Dark yellow coloured)
- No cyanosis , clubbing , lymphadenopathy , edema

Anthropometry

		Percentile
Weight	**18 Kg**	Between 3rd-10th percentile
Height	**114 cm**	Between 3rd-10th percentile
BMI	**15.43**	Between 10th-25th percentile

Interpretation : Normal

Systemic Examination

- Per abdomen -

- Inspection - Flat in shape , symmetrical , inverted umbilicus , moving equally with respiration , no localised swelling or visible veins

- Palpaption - No local rise of temperature , tenderness on superficial/deep palpation , no organomegaly , Guarding/rigidity - absent

- Percussion - Tympanitic sound heard

- Auscultation - Bowel sounds heart at left to the umbilicus

- CNS - Conscious & oriented
- CVS - S1S2 heard with no added sounds
- RS : BLAE + , No added sounds

Investigation

Parameters	Observed Value	
Hb	12.1 gm/dl	
TLC	7800/microL	
Platelets	2.6 lakhs	
PCV	38.10 %	
DLC (N/L)	39/46 %	
Billirubin(T)	**3.29 mg/dl**	
CB	**2.39 mg/dl**	
SGOT	**185 U/L**	
SGPT	**118 U/L**	
ALP	**351 U/L**	
Total Protein	**7.7 gm/dl**	
Albumin	**4.2 gm/dl**	
Globulin	**3.5 gm/dl**	
A:G Ratio	**1.20**	

Parameters	Observed Value	
PT/INR	13.30 sec/1.11	
GGT	**132 U/L**	
aPTT	38.60 sec	
HBsAg	NR	
HCV	NR	
HIV	NR	
Urea	0.38 mg/dl	
Creatinine	19 mg/dl	
Na	138 mmol/L	
K	4 mmol/L	
Cl	103 mmol/L	

RADIOLOGICAL INVESTIGATION

- **USG AP - Mild hepatosplenomegaly with hypoechoic lesion in liver**

- **MRCP** -

- Mild Hepatomegaly & Chronic hepatic parenchymal disease ? , Chronic active haptitis?

- Pericaval LN/Subcentrimetric sized LN at porta hepatis - likely reactive

- **No obstructive pathology noted**

- Mild Splenomegaly

- No Ascites

- X-Ray Chest - NAD

- **USG Guided liver Biopsy** was done under short GA , Uneventful & sample sent for HPE.

Differential Diagnosis

- Hepatitis (Chronic)
- Cholestatic liver disease/Intrahepatic cholestasis
- Allagille Syndrome
- Wilson’s disease
- Autoimmune Hepatitis

Treatment

- During Hospital stay , treated with

 - Bile acid sequestrant (Cholestyramine)
 - Ursodeoxycolic acid
 - Rifampicin

- Currently under treatment pediatric gastroenterologist & follow up in native district Latur

Thank You