89 PELIOSIS HEPATIS IN A PATIENT WITH COELIAC DISEASE AND ON ORAL CONTRACEPTIVE PILL: A CASE REPORT

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Introduction Peliosis hepatis (PH) is a rare vascular condition which can be seen in a variety of settings. It is characterized by the presence of cystic blood-filled cavities distributed throughout the liver parenchyma. The epidemiology and pathophysiology of PH is not completely understood since most patients are asymptomatic and remain undiagnosed. It is usually an incidental finding on abdominal imaging or autopsy. No cause was found in 20–50% of cases but PH has been found to be associated with a variety of diseases, such as coeliac disease (CD), malignancy, diabetes mellitus, infection in patients with AIDS and haematologic disorders, and drugs such as oral contraceptives pills (OCP), azathioprine and methotrexate amongst others.

Method We report a patient who was diagnosed with peliosis hepatis whilst on OCP with concurrent new diagnosis of coeliac disease and dermatitis herpatiformis.

Results 27-year-old female presented to the medical assessment unit with 5-day history of flu-like illness and worsening pruritic skin rash affecting both ankles. She was previously well with no significant past medical history or family history of note. She has been on OCP regularly for at least one year. She was a non-smoker and consumed alcohol minimally. She also had a travel history to Australia and Southeast Asia two months prior to presentation. She has no other risk factors such as tattoo, piercing or intravenous drug use. Physical examination was non-contributory apart from symmetrical erythematous lesions on both ankles. Routine laboratory investigations revealed mixed-picture liver function test (LFT) derangement with normal full blood count (FBC), urea and electrolyte (U&E), coagulation, and albumin level. She was further investigated with liver autoimmune screen (ANA, AMA, ASMA, anti parietal cell antibodies, anti LKM antibodies) and viral screen (HBsAg, Anti-Hep C, EBV IgM, anti-CMV IgM, HIV) which were negative. She was managed conservatively and referred to gastroenterology outpatient clinic for further review.

Further laboratory investigations revealed elevated anti-tTG antibodies and P-ANCA were positive but with a low titre. Ultrasound of liver showed dilated hepatic ducts and this prompted further investigation with MRCP which showed widespread minimal variable intrahepatic ducts dilatations. She also had biopsy performed for the skin rash and this confirmed to be dermatitis herpatiformis. The initial impressions were CD and probable primary sclerosing cholangitis. Liver biopsy however showed massive peliosis of the liver parenchyma with marked distention of the hepatic sinusoids. The liver specimen showed no evidence of inflammation, granulomata, fibrosis, cirrhosis or malignancy.

As CD and OCP have been showed on literature review to be associated with PH, she has been advised to stop OCP use and to be strictly compliant with GFD. She is being followed in the gastroenterology outpatient clinic regularly for LFT monitoring.

Conclusion Management of peliosis depends on the cause. When a causative agent is suspected, withdrawal of that agent may result in resolution. If seen in the setting of HIV/AIDS, then treatment with antibiotic may be effective in eradicating B. henselae. If focal and haemorrhagic, resection may also be beneficial. In our case, patient is no longer on OCP and is strictly compliant with GFD. Currently, her LFT remains stable and skin rash has improved.