Question 24 – January 22

A 26 year old male presents to clinic for hospital follow up. He was recently admitted to the hospital with acute cholangitis. Magnetic resonance cholangiopancreatography (MRCP) showed multiple dilatations and strictures throughout the intrahepatic and extrahepatic biliary tree, with a dominant stricture on the common hepatic duct. The gallbladder had no stones or polyps, pericholecystic fluid, or wall dilatation. The patient underwent endoscopic retrograde cholangiopancreatography (ERCP) with balloon dilatation and stent placement; samples were obtained for cytology, fluorescence in situ hybridization (FISH), and bile duct biopsy. Samples obtained were negative for malignancy. He received antibiotics and was discharged home with plans for stent removal in 4 weeks. Today in clinic he is well with no pain or fevers. Laboratory studies reveal:

AST 20
ALT 40
ALP 340
TB 1.5 mg/dL
Platelet count 186,000/µL
WBC 8,000/µL
INR 1.0
IgG4 100

Which of the following management strategies would you recommend at this time?

A. Repeat MRCP
B. Refer for cholecystectomy
C. Perform liver biopsy
D. Refer for liver transplantation
E. Perform colonoscopy

Answer: E

This patient has primary sclerosing cholangitis presenting with acute cholangitis. The diagnosis was already made by MRCP (and ERCP), and a liver biopsy is not indicated. In patients with disproportionately elevated aminotransferases, a liver biopsy may be performed to diagnose or exclude overlap syndrome. There is no need to follow-up on the stricture that soon, but repeat magnetic resonance imaging can be performed in 6 to 12 months depending on the patient's clinical progress. Cholecystectomy would be indicated in the setting of acute cholecystitis or if polyps 8 mm or larger were present. An evaluation for liver transplantation is not needed yet. Indications for liver transplantation in patients with PSC include recurrent cholangitis, malignancy and complications associated with the development of portal hypertension. More important at this time is to rule out inflammatory bowel disease (IBD) by performing a colonoscopy with random biopsies, even if the patient is asymptomatic. If IBD is confirmed, annual colonoscopy is indicated.

Reference

Chapman et al. AASLD Practice Guidelines. Diagnosis and Management of Primary Sclerosing Cholangitis. Hepatology 2010.