# An Unusual case of Ascites.

Dr. Bharath Gowda S

Dr. D. Y. Patil Medical College.

A 20 year old male, student, came with c/o

- Yellowish discoloration of eyes, abdominal distention, generalized weakness and easy fatigability since 2 months.

- Abdominal distention was insidious in onset, gradually progressive and was associated with pain abdomen. Yellowish discoloration of eyes was insidious in onset and was not associated with itching, clay coloured stools.

- No history of cough, fever, bleeding manifestations, weight loss, neuropsychiatric manifestations  or any other complaints .

- **PAST HISTORY :**
- No h/o similar complaints in the past.
- No h/o high risk behavior, blood transfusions, IV drug abuse, tattooing.
- **PERSONAL HISTORY :**
- Appetite was reduced.
- Sleep pattern was normal.
- Bladder & bowel were unaltered.
- No addictions.

# On Examination:

- The patient was conscious and oriented.
- Height- 162 cm, weight- 54 kg, BMI-20.6 kg/m2
- PR : 78/min BP : 110 / 70mmhg
- JVP - normal
- Mild Icterus was present.
- No significant lymphadenopathy.
- No features suggestive of acute hepatic failure(asterixis) and chronic hepatocellular failure (spider naevi, palmar erythema, gynecomastia, Loss of chest and axillary hair).

- **PA** : soft,

Liver palpable 3 cm below right coastal margin along MCL, firm in consistency, smooth surface and regular sharp margins.

Spleen is palpable 2 cm below left coastal margin, smooth and non-tender.

Shifting dullness noted on percussion.

- **CNS** : conscious and oriented
- **RS** : Bilateral air entry present, absent breath sounds in Right infra-axillary region.
- **CVS** : apical impulse present in Left 5th Intercostal space along Left MCL, S1S2 heard, no murmurs, no pericardial rub.

# Investigations

| | | | |
|---|---|---|---|
| **Hb** | **11.2 (13.3-16.2)** | Urea | 24 |
| TLC | 4700 | Creatinine | 0.84 |
| PLT | 276000 | **Total bilirubin** | **3.4(0-1.4)** |
| MCV | 78.04 | **Direct** | **1.5** |
| **HCT** | **33.7(38.8-46.4)** | **Indirect** | **1.9(0-0.9)** |
| MCH | 37.93 | **SGPT** | **54(0-40)** |
| MCHC | 32.8 | **SGOT** | **49(0-40)** |
| ESR<br>S.Albumin<br>PT INR | 19<br>3.2<br>1.07 | Serum electrolytes<br>HbsAg, HCV | WNL<br>Negative |

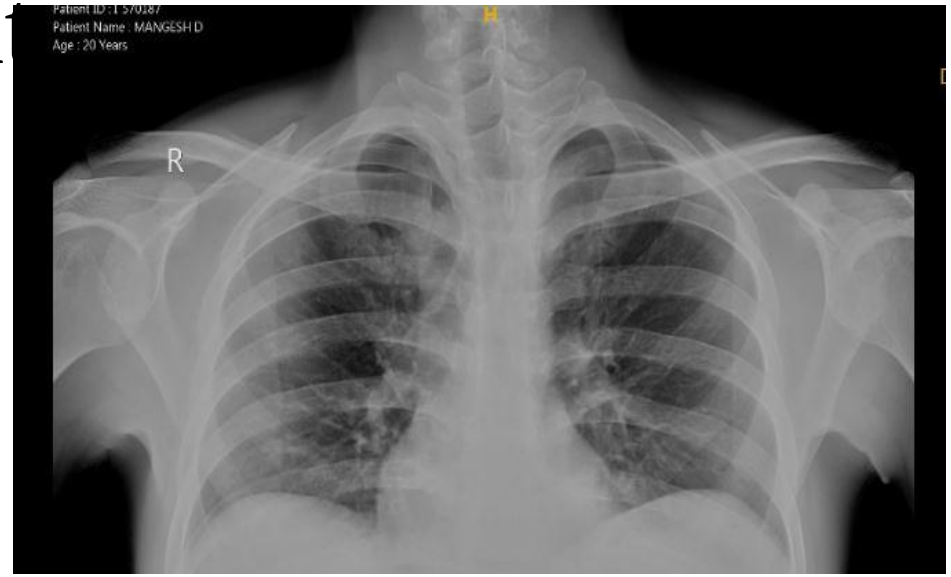
# WORKING DIAGNOSIS

- In view of history and investigations

**Jaundice, Ascites and Hepatosplenomegaly with differentials being –**

- **Acute Viral Hepatitis due to Hepatitis B.**
- **Abdominal Tuberculosis.**
- **Wilson’s disease.**
- **Veno-occlusive disease of Liver.**
- **Acute Budd-Chiari syndrome.**

# Treatment




- Tab. Frusemide 20mg BD.
- Tab. Aldactone 50mg BD.
- Dextrose solution

- **Chest X ray** was normal.
- **Ascitic fluid analysis-** High SAAG, high protein with normal cytology

| | | | |
|---|---|---|---|
| Cells | 40 | Ascitic Albumin | 0.4 |
| DLC (N/L) | 30/10 | (Serum Albumin) | 3.2 |
| Ascitic protein | 3.1gm% | SAAG | 2.8 |
| ADA | 13 | Ascitic fluid C/S | No growth |

**USG and Portal vein Doppler**

Liver- 10.4 cm with altered echotexture, No caudate lobe hypertrophy. Spleen- 13.1 cm (enlarged). Normal Portal vein and Hepatic vein. Mild to moderate ascites

**Triphasic CECT of Abdomen pelvis revealed**

- Atrophic right hepatic lobe, hypertrophic left lobe with persistent ill-defined hypo dense areas in right hepatic lobe and caudate lobe-likely due to necrosis.
- Non-visualisation of right hepatic and middle hepatic vein-likely thrombosed, opacification of left hepatic vein.
- Mild splenomegaly. Marked ascites and Bilateral pleural effusion.

Findings suggest possibility of Budd-Chiari syndrome.

**Repeat Portal vein Doppler** confirmed thrombosis of right and middle hepatic vein with absent flow in left hepatic vein.

- **Prothrombotic work-up**
- Lupus anticoagulant-moderately positive
- Anti- Beta 2-Glycoprotein I-IgM - Positive
- Anti- Beta 2-Glycoprotein I-IgG- Negative

  Repeated after 12 weeks
- Anti- Beta 2-Glycoprotein I-IgM - Negative
- Anti- Beta 2-Glycoprotein I-IgG – Positive.
- Anti- Cardiolipin IgM and IgG- negative
- ANA by Elisa, blot and IF- Negative.
- Protein C & S, Factor 5 Leiden, Anti Thrombin activity,

Homocysteine, Factor VIII activity were normal.

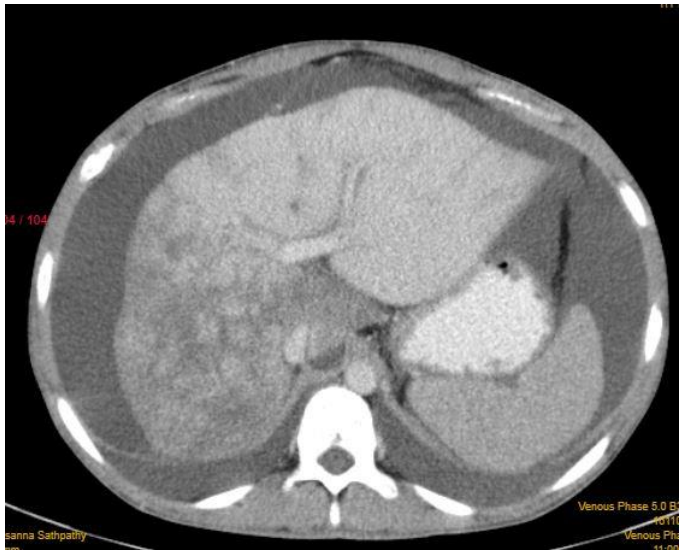
Patient was started on

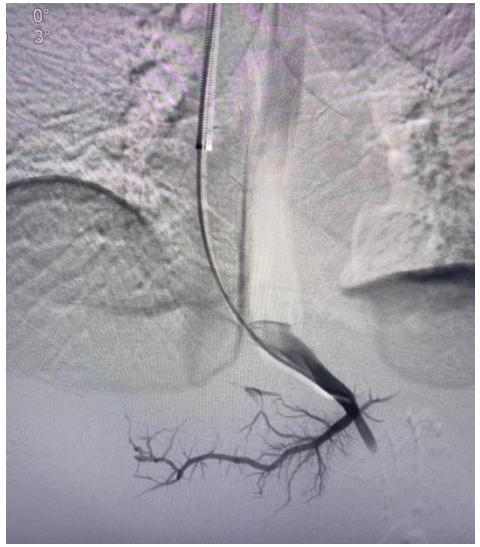
- Low molecular weight Heparin 60 mg BD bridged with Tab. Warfarin and to be continued life long.

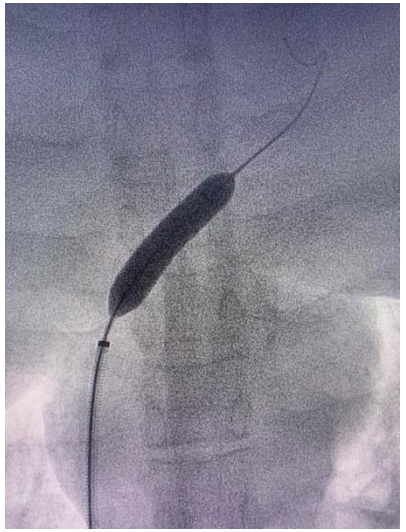
Patient was posted for **Interventional therapy-**

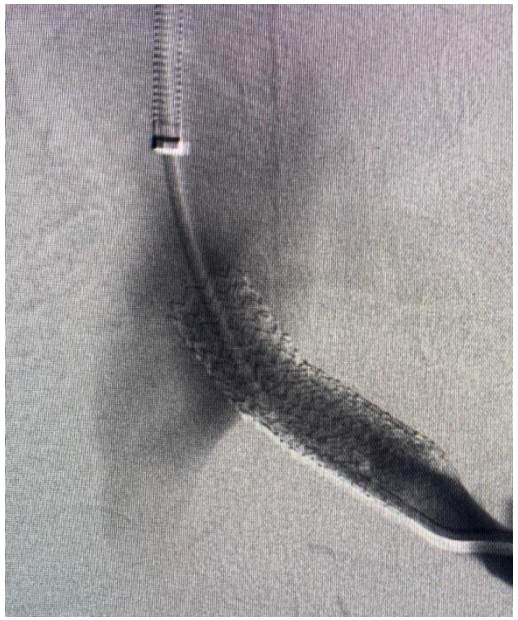
- Good flow was noted in right and middle hepatic vein, opacification and stenosis noted in ostium of left hepatic vein.
- Ballon mounted stent (9*37mm) was placed in left hepatic vein.

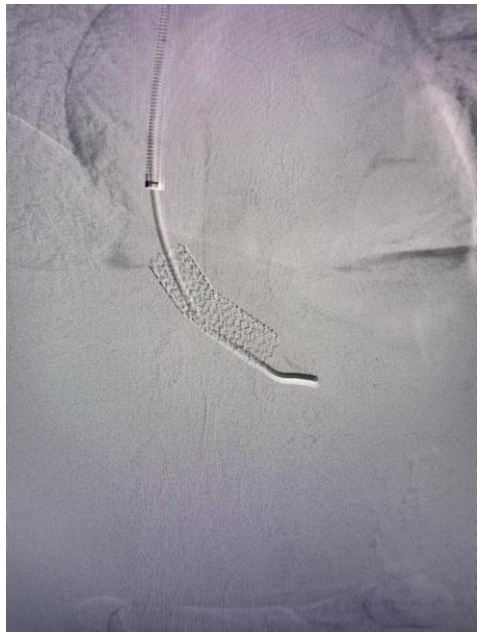
**Doppler** confirmed good flow in right and middle hepatic vein, patent stent in left hepatic vein.

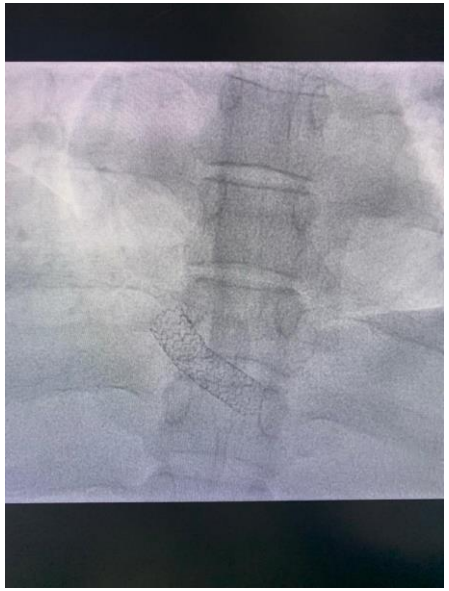

Venous Phase 5.0 B
Venous Ph











# Discussion.

- Budd-Chiari syndrome is defined as the obstruction of hepatic veins or terminal Inferior Vena cava.
- Causes are hyper coagulable states, Malignancies predominantly Myeloprofilerative disorders, infections like hydatid cysts, liver abscess, schistosomiasis, Tuberculosis.
- APS ( Anti-Phospholipid syndrome) are predominantly common in females and it requires 1 clinical criteria ( arterial/ venous thrombosis) and 2 out of 3 APS antibodies.
- APS is common in females.
- Treatment of APS includes life long anticoagulation therapy.