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An Interesting Case of Sub- Acute Budd Chiari Syndrome.

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ABSTRACT

Budd Chiari syndrome is due to occlusion of hepatic veins, which is characterised by ascites, abdominal pain, hepatomegaly. The disorder often presents as acute form and there by rapidly progressive and fatal. Early detection and management with diuretics, anti-thrombotic measures and by treating the underlying cause can prove beneficiary for the patient. WE are presenting a case of 38 years male with complaints of abdominal distention, abdominal pain, decreased oral intake, investigation showed elevated LFT(SGOT-873,SGPT-881,Tot. Bilirubin -1.4,ALP-139)and CECT Abdomen showed portal vein thrombosis with Inferior Vena Cava thrombosis found to be a case of acute **b**udd Chiari syndrome. Patient treated with anti-coagulants, diuretics ,and other supportive medications .

Keywords: Hepatic vein thrombosis, budd Chiari syndrome.

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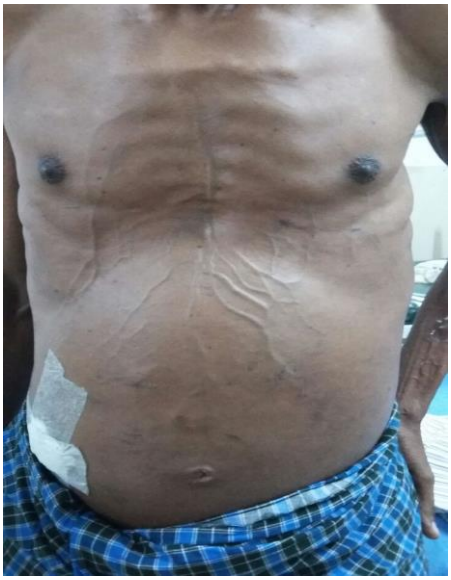
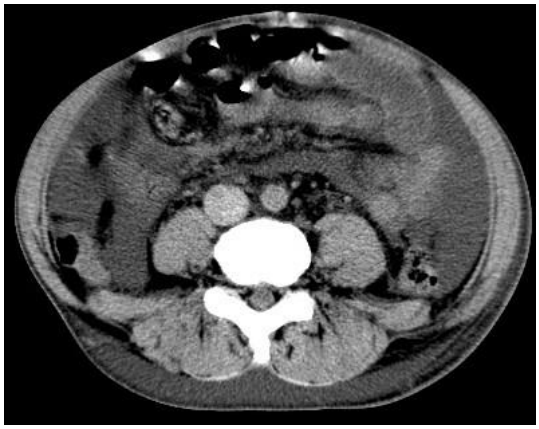
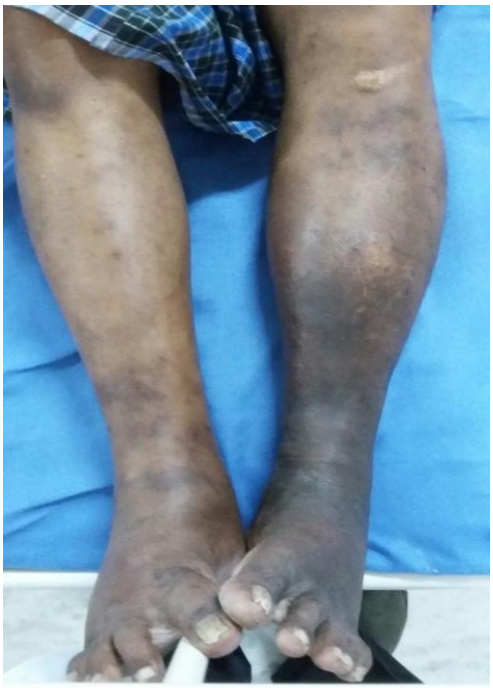
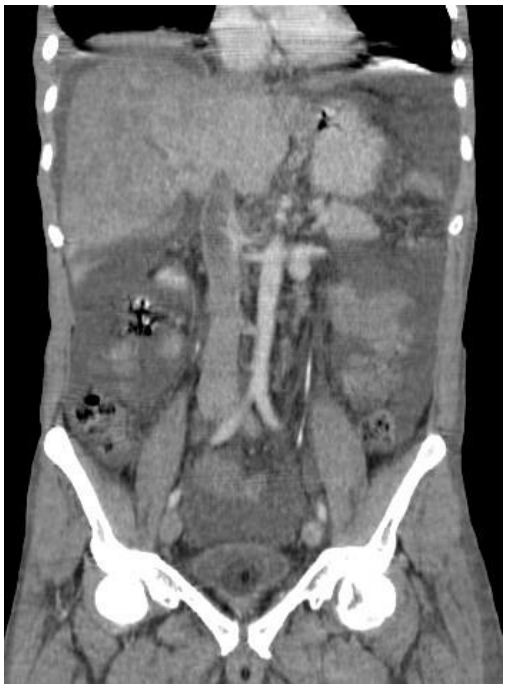
CASE BACKGROUND

A 38 year old male with no known co-morbidities came to outpatient department with complaints of abdominal distention, abdominal pain, Bilateral leg swelling, occasional breathlessness on & off for 5days. On-Examination patient thin built, emaciated, abdomen distention , dilated veins over epigastric region, chest wall and back extending up to umbilicus, Bilateral pitting pedal oedema , discolouration of left leg. His vitals were stable , systemic examination Bilateral crepts , abdomen distended, tense , milking of veins (flow downwards – upwards){Valsalva manoeuvre}.shifting dullness, fluid thrill, (+). Investigations revealed SGOT-873, SGPT-881, ALP- 139. ON repeated examination shows elevated values of SGOT, SGPT. CECT ABDOMEN revealed liver appears mildly enlarged, branching hypo density noted in the region of left and middle hepatic veins on non-contrast CT, on Portal phase images caudate and central lobe of liver shows homogenous enhancement, on hepatic venous phase images hypo density noted in the right, middle, and left hepatic vein. Other special investigation (Protein-c, protein-s, Factor V)- were negative. Patient was then treated with Anti-coagulant, diuretics and other supportive medications . patient condition improved and patient was referred to surgical gastroenterologist for Inferior Vena Cava filter and the patient is doing well and is on regular follow up [1].









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DISCUSSION

The most probable findings of hepatic vein thrombosis results from any interruption of normal blood flow from liver. Normally liver receives 70-80% of its blood flow from portal vein and the remaining from hepatic arteries[1]. Mixing of hepatic arterial blood with portal venous occur at hepatic sinusoidal. Blood is then collected in terminal venules which deliver blood to large sub lobular vein, which then forms the hepatic vein. There are two groups of hepatic veins. They are upper and lower group. The upper group consists of a large veins (right, left, middle) which emerge through the upper part and directly drains into Inferior Vena Cava[2]. The lower group consists mainly variable no. of small vein from right lobe and these enter Inferior Vena Cava on its posterior surface , just below diaphragm.

The venous obstruction in cases of **b**udd -chiari syndrome may be limited to the involvement of one or more hepatic veins. These occlusion may sometimes occur isolated are can be associated with Inferior Vena Cava obstruction also either sub diaphragmatic occlusion or extension of thrombus from distal vena cava or from hepatic veins can cause Budd-chiari syndrome[3]. Any raise in right atrial pressure can lead on to hepatic congestion by a decrease in the normal pressure gradient of blood flow across liver. These congestions can also present with symptomsa and signs of budd-chiari syndrome. Other conditions which presents with features similar to Budd-chiari are Alcoholic hepatitis, Viral hepatitis, hepatic malignancies.

MANAGEMENT OF BUDD-CHIARI: the main motive of management in Budd-chiari syndrome is to prevent progression of thrombus, control or to manage ascites, and in general prognosis without treatment is always fatal. Diuretics has got an important role in managing ascites but has got no long term outcome.

(A) The patient was treated with diuretics as he had a large ascites with Portal Hypertension. He was put on hepato protective drugs, after confirmation of the presence of thrombus in Inferior Vena Cava, hepatic veins the patient was treated with Un-fractionated Heparin5000 IU[4]. Patient was then referred to surgical gastroenterologist for Inferior Vena Cava Filter. Following which patient is doing well and is on regular follow up.

SUMMARY

The Budd-chiari syndrome is an rare entity of presentation ,where most patient present with acute symptoms of abdominal pain& distension, the most common & frequent condition that can cause hepatic vein thrombosis are haematological disorders, certain tumours can also be associated with vascular thrombosis include hepatocellular carcinoma, renal cell carcinoma. In cases of hepatic vein being thrombosed only a little can be done. Various measures can be taken to prevent progression of the disease. Early diagnosis and early measures can prevent fatality.

REFERENCES

[1] Book- Sleisenger and Fordtran's gastrointestinal and liver disease, 9th edition, volume -2 , pages1371-1374.