Serum HEV IgM positive
First reported outbreak of locally acquired hepatitis E virus infection in Australia
Hepatitis E
Epidemiologic Features

- Most outbreaks associated with fecally contaminated drinking water
- Minimal person-to-person transmission
- U.S. cases (6% seroprevalence):
  - History of travel to HEV endemic areas
  - Occupational contact with farm animals
  - Sporadic exposure

Clinical History

Case courtesy of Dr Y. Li, Advocate Christ Medical Center

- 7 y.o. F presented with 3 wk Hx of N&V and diarrhea
- Abdominal CT scan was unremarkable
- Monospot test equivocal
- TB = 0.6, AST = 74, ALT = 71, alk phos = 155
- HAV, HBV, HCV, HEV negative
- ANA, anti-SMA, anti-LKM negative
- Ceruloplasmin normal; 24 hour urine copper normal
- Alpha-1-antitrypsin phenotype is PiMM
- No medications, supplements, toxic exposure
- No travel history
- No family history of liver disease
Clinical Follow-up

- EBV serology negative
- After 3 mo LCTs remained abnormal
- Liver biopsy performed
How to sign out this case?

- **DX:** Mild portal & lobular inflammation
- **Comment:**
  - There is no evidence of AIH
  - Not typical of EBV hepatitis
  - There is no fibrosis
  - Quantitative copper could be performed to rule out Wilson’s disease
  - Could this be celiac disease???
False positive TTG can occur in chronic liver disease; anti-endomysial Ab more specific
Chance
One
Free
Wrong
Diagnosis!
Acute Hepatitis

Normal Liver

Chronic Hepatitis
70 y.o. M with bipolar disease and polysubstance abuse

Presents with jaundice, N&V, RUQ pain & fever – treated with Ibuprofen

Long Hx HCV hepatitis genotype 1a; viral load = 1719419 IU/mL

Cholecystectomy 1 year ago

PE: jaundice; scleral icterus

TB = 12.5, AST = 293, ALT = 219, alk phos = 327

HAV, HBV negative; ANA negative; HIV negative

Meds: Nifedipine; Atenolol; Ondansetron; Sertraline; Tramadol

U/S and CT scan reveal no biliary obstruction or stones
cholestatic rosette
significant lobular injury