Posthepatectomy jaundice induced by paroxysmal nocturnal hemoglobinuria: A case report

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Author contributions: Liang HY wrote the manuscript; Xie XD, Wang M, and Yu Y collected the data and drew the diagram; Jiang GX contributed to citations and references; Cui JF contributed to the discussion and revision; all authors issued final approval for the version to be submitted.

Informed consent statement: Informed written consent was obtained from the patient for publication of this report and any accompanying images.

Conflict-of-interest statement: The authors declare that they have no conflict of interest.

CARE Checklist (2016) statement: The authors have read the CARE Checklist (2016), and the manuscript was prepared and revised according to the CARE Checklist (2016).

Open-Access: This article is an open-access article that was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in

Abstract

BACKGROUND
Jaundice is a major manifestation of posthepatectomy liver failure, a feared complication after hepatic resection. Herein, we report a case of posthepatectomy jaundice that was not caused by liver failure but by paroxysmal nocturnal hemoglobinuria (PNH)-induced hemolysis.

CASE SUMMARY
A 56-year-old woman underwent right hepatectomy and biliary tract exploration surgery due to hepatic duct stones. Prior to surgery, the patient was mildly anemic. The direct antiglobulin test was negative. A bone marrow biopsy showed mild histiocyte hyperplasia. After surgery, the patient suffered a progressive increase in serum bilirubin. Meanwhile, the patient developed hemolytic symptoms after blood transfusion. She was ultimately diagnosed with PNH. PNH is a rare bone marrow failure disorder that manifests as complement-dependent intravascular hemolysis with varying severity. After steroid treatment, the patient’s jaundice gradually decreased, and the patient was discharged on the 35th postoperative day.

CONCLUSION
PNH-induced hemolysis is a rare cause of posthepatectomy jaundice. It should be suspected in patients having posthepatectomy hyperbilirubinemia without other signs of liver failure. Steroid therapy can be considered for the treatment of PNH in such cases.
Key Words: Jaundice; Hepatectomy; Paroxysmal nocturnal hemoglobinuria; Case report

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Core Tip: We report a case of posthepatectomy jaundice that was not caused by liver failure but by paroxysmal nocturnal hemoglobinuria-induced hemolysis. After confirming the diagnosis, the patient received steroid therapy, and the jaundice gradually improved.

Citation: Liang HY, Xie XD, Jing GX, Wang M, Yu Y, Cui JF. Posthepatectomy jaundice induced by paroxysmal nocturnal hemoglobinuria: A case report. World J Clin Cases 2021; 9(32): 10046-10051
URL: https://www.wjgnet.com/2307-8960/full/v9/i32/10046.htm
DOI: https://dx.doi.org/10.12998/wjcc.v9.i32.10046

INTRODUCTION
Although the safety of liver resection has improved with advanced operative techniques and perioperative management, posthepatectomy liver failure (PHLF) remains a challenge for patients undergoing hepatectomy and a concern of hepatic surgeons[1]. Postoperative hyperbilirubinemia and an increased international normalized ratio (INR) are the major manifestations of PHLF according to the definition of the International Study Group of Liver Surgery[2]. Herein, we report a case of posthepatectomy jaundice that was not caused by PHLF but by paroxysmal nocturnal hemoglobinuria (PNH)-induced hemolysis. There have been no previous reports of posthepatectomy jaundice caused by PNH.

CASE PRESENTATION

Chief complaints
The subject was a 56-year-old female with a chief complaint of abdominal pain and fever.

History of present illness
Ten days before admission, the patient visited a local hospital for acute right upper quadrant abdominal pain. The pain was moderate, tolerable, and persistent. Additionally, the patient suffered from fever, with a temperature of up to 39 degrees Celsius. She did not complain of vomiting or diarrhea. An abdominal ultrasound revealed bile duct stones. After cefoperazone anti-infection treatment, the patient’s symptoms were relieved, and the patient was transferred to our hospital.

History of past illness
The patient had undergone cholecystectomy for gallbladder stones 20 years prior to presentation at our hospital.

Personal and family history
The patient had a previous history of mild anemia and did not have a remarkable family medical history.

Physical examination
On physical examination, the patient was conscious and cooperative. The abdominal region was flat and soft.

Laboratory examinations
The patient’s preoperative laboratory examinations were only mildly abnormal: Hemoglobin (Hgb) 91 g/L, white blood cell count, 9800/μL; platelet count, 107 × 10⁹
Total bilirubin (TBIL), 58.6 µmol/L; direct bilirubin (DBIL), 35.3 µmol/L; aspartate aminotransferase (AST), 33.5 U/L; albumin, 38.7 g/L; C-reactive protein, 32.4 mg/dL; prothrombin time, 10.8 s; INR, 0.98; indocyanine green retention rate at 15 min, 5.5%. The result of direct antiglobulin test was negative, and bone marrow biopsy showed mild histiocytic hyperplasia.

Imaging examinations
Magnetic resonance imaging revealed right intrahepatic bile duct stones and common bile duct stones (Figure 1). The future liver remnant was 49%.

FINAL DIAGNOSIS
The patient was diagnosed with hepatolithiasis and choledocholithiasis. After surgery, she was diagnosed to have PNH induced hemolysis causing postoperative jaundice.

TREATMENT
Open surgery was performed after the preoperative examinations were completed. Intraoperative ultrasonography reconfirmed that the right intrahepatic bile duct was extensively dilated with stones. The common bile duct was approximately 1.4 cm. Eventually, right hepatectomy and biliary tract exploration with intraoperative choledochoscopic lithotripsy, without hepaticojejunostomy, were conducted. The operation proceeded successfully without a requirement for blood transfusion. The operating time was 250 min, and the estimated blood loss was less than 100 mL.

An artificial liver support system was required on the 8th and 11th postoperative days due to hyperbilirubinemia. The patient received a blood transfusion (erythrocyte suspensions, 3 U; and plasma, 400 mL) because of a decrease in Hgb to 65 g/L on the 12th postoperative day.

The patient was treated with steroids after the diagnosis of postoperative jaundice caused by PNH induced hemolysis was made. The treatment protocol is shown in Figure 2. On postoperative day 14, the patient started steroid treatment with methylprednisolone at a dose of 2.0 mg/kg/d. The patient's jaundice gradually stabilized. The dose of methylprednisolone was reduced to 1.5 mg/kg/d after 1 wk, 1.0 mg/kg/d after 2 wk, 0.75 mg/kg/d after 3 wk, and 0.5 mg/kg/d after 4 wk. The dose of 0.5 mg/kg/d was maintained for 4 wk, and 0.25 mg/kg/d was maintained for an additional 4 wk.

OUTCOME AND FOLLOW-UP
After surgery, the patient suffered a progressive increase in serum bilirubin (Figure 3A). Paradoxically, the AST and INR were mildly elevated postoperatively and declined gradually (Figure 3B). Postoperative ultrasound did not reveal intra- or extrahepatic bile duct dilatation. These results did not resemble the typical presentation of PHLF. During this time, the patient presented with low back pain and hemoglobinuria after the blood transfusion. Hemolytic screening was subsequently implemented. The direct antiglobulin test was repeated, and the result was still negative. The serum-free Hgb was elevated to 117 mg/L. The results of the glucose-6-phosphate dehydrogenase test and erythrocyte osmotic fragility test were negative. The flow cytometry analysis showed that CD59 was absent on the 27% of erythrocyte surface. Flow cytometry to detect populations of CD55 or CD59 deficient blood cells is firmly established as the method of choice for the diagnosis and monitoring of PNH. Thus, this patient's postoperative hyperbilirubinemia was confirmed to be caused by PNH-induced hemolysis.

The patient's jaundice gradually improved after steroid treatment (Figure 4). The patient was discharged on the 35th postoperative day. At discharge, the TBIL of the patient had decreased to 198.3 µmol/L. When followed up at 6 mo after surgery, the patient's Hgb was 85 g/L, and TBIL was 48.3 µmol/L.
DISCUSSION

PNH is a rare and acquired hematopoietic stem cell disorder that is characterized by the destruction of blood cells via the complement system due to a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs), such as CD55 and CD59, on the blood cell surface, resulting in symptoms such as hemoglobinuria[3]. For the diagnosis of PNH, flow cytometry is recommended to identify a deficiency of GPI-APs in peripheral blood cells[4,5]. In this patient, CD59 absence on the surface of 27% of erythrocytes was an important factor in the diagnosis of PNH. In terms of treatment, complement inhibition therapy in the form of eculizumab has improved treatment prospects for PNH patients in developed countries[6,7]. However, high costs and access difficulties have limited the utilization of eculizumab in China, and steroid therapy is still the preferred treatment to control hemolytic attacks in PNH patients[8].
In this case, the patient's hyperbilirubinemia was relieved after the administration of methylprednisolone, and the treatment achieved relatively favorable outcomes.

There were several points that deserve our attention in this case.

First, the severity of hemolysis varies in PNH patients. There are some PNH patients with insidious onset that have no characteristic manifestations[9]. This patient only presented with mild anemia and elevated bilirubin preoperatively, which is also common in patients with bile duct stones. Moreover, the preoperative bone marrow biopsy showed no significant abnormalities. The patient was not diagnosed with PNH until hemolytic symptoms developed after blood transfusion.

Second, in this patient, it is possible that transfusion of plasma, rather than erythrocyte suspension, aggravated the patient’s hemolysis. PNH may induce complement-dependent intravascular hemolysis[10]. Plasma transfusion might replenish the depleted complement, thus exacerbating the occurrence of hemolysis in PNH erythrocytes. Although the use of washed red blood cells for transfusion in PNH patients has been recommended previously, recent studies have found that transfusion of homozygous red blood cells does not significantly increase the occurrence of hemolysis in PNH patients[11].

Third, it has been reported that chronic hemolysis may lead to increased bilirubin excretion, resulting in an increased incidence of hepatobiliary stones[12]. Therefore, theoretically, PNH patients have a higher chance of hepatobiliary stones. There have been reports of cholecystectomy in patients with PNH[13], but there have been no reports of hepatectomy in patients with PNH. Surgery may be one of the clinical conditions that triggers PNH-induced hemolysis[14]. Perisurgical induction of eculizumab has been reported in a patient with PNH to inhibit surgery-triggered hemolysis[13,15].

Last, the jaundice caused by hemolysis typically features elevated indirect bilirubin (IBIL)[16]. However, the postoperative DBIL elevation was more significant in this patient. The liver is the main metabolic site for bilirubin. The IBIL produced by hemolysis is transported to hepatocytes and combined with glucuronde to form DBIL, which is subsequently excreted into the bile ducts[17]. Right hemicolectomy may lead to a reduction in liver size and a decrease in the liver’s ability to metabolize and excrete bilirubin. In the event of increased IBIL production from hemolysis, it is possible that the residual hepatic capacity to metabolize DBIL is greater than the hepatic capacity to excrete DBIL. This has not been reported in previous reports and may need to be validated in further animal experiments.

CONCLUSION

PNH-induced hemolysis is a rare cause of posthepatectomy jaundice. It should be suspected in patients having posthepatectomy hyperbilirubinemia without other signs of liver failure. Steroid therapy can be considered for the treatment of PNH in such cases.
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