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CASE REPORT

Primary Sclerosing Cholangitis

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My patient is a male man, born on 1978. On 25/10/2000 referred from a colleaque GP as a case of "recurrent bloody stool of one week duration, associated with dizziness". PCV 31%.

On 26/10/2000 : seen at the (general clinic), referred him to GI clinic as { suspect UC ,CD}, for colonoscopy.

T.Colonoscopy done by a colleague endoscopist on 7/11/2000 showed: inflamed, edematous mucosa of whole large bowel, (terminal ileum not entered), consistent with? Chronic IBD. Biopsies were taken.

Histopathology report on 13/11/2000: chronic IBD, consistent with Crohn's disease. The rectum was not involved.

Visits to the Out Patient Clinic:

21/11/2000: diarrhea three times/day, watery, no blood, weight loss, +ve arthralgia (1-2 months duration). Plan: to start with Prednisolone 40 mg/d for 2 weeks.

13/12/2000: Lab: CRP – ve, ESR 50 mm/1st hr, PCV 34%, stool analysis normal, ALT 74 iu/l, AST 164 iu/l. Motions 1-2/d, soft stool, no blood. Plan: keep on prednisolone 8 tab/d for further 2 weeks.

10/1/2001: stool ---2/d,well formed, plan to decrease prednisolone 5 mg /wk until he is on 10 mg/d, add Salazopyrine 500 mg/ twice daily.

11/4/2001: seen by a resident: stool 2/d, no diarrhea, no pain, same Rx (prednisolone 10mg/d, salazopyrine 1 gr/d).

31/10/2001: doing well, no weight loss, on prednisolone 5mg/d, salazopyrine 1gr/d. plan: Hb, Urea, SGOT, SGPT, and Stool for occult blood. Same Rx.

8/5/2002: SGOT 51 iu/l, SGPT 35 iu/l, PCV 38%, ESR 5 mm/1st hr, stool for occult blood –ve. Had been on prednisolone 5 mg/d, sulfasalazine 1 gr/d. well formed stool. Same Rx.

6/11/2002 : I saw him for the first time(I had started my work at this hospital as gastroenterologist on 9/2002), clinically was asymptomatic, looked underweight, distended abdomen, no organomegally. Plan: Stop steroids. Ask for CBC, LFT, and consider upper endoscopy to check for intestinal biopsy to R/O malabsorptive syndrome, follow up colonoscopy, TFT.

28/12/2002: clinically doing well. No diarrhea.

Lab: ALT 47 iu/l, AST 36 iu/l, ALP 279, T. protein 60, Albumin 41, Ca 2.2, Po4 1.2, Hb 14gr, PCV 42%, WBC 8100, ESR5mm/1sthr.Plan: endoscopy +TFT. Later on consider: colonoscopy

4/2/2003: upper endoscopy showed multiple aphthus erosions were seen at the post- bulbar area, Bx's taken.

19/2/2003: Histopathology Report: 1-Gastric biopsy chronic gastritis, moderate activity, mild H. pylori are seen. No atrophy or metaplasia.2- Duodenal biopsy: consistent with mild non specific inflammation.

2/4/2003: Doing well, no complaint. He stopped all medications upon himself. Plan: Ba Follow Through, M.V.

23/4/2003: Ba.F.T was normal. Clinically: just has mild itching since two days. Plan: LFT.

14/6/2003: C/O Pruritis. Lab: increased liver enzymes, mostly ALP, gamma –GT (cholestatic type). LFT asked on 23/4, Done on 4/5: ALT 76, AST 91, ALP 165, Bilirubin: Normal U/S on 24/5: no definite focal liver lesion. LFT on 3/6: ALP 1435, ALT 156, AST 96, GGT 311. Another reading without date showed: ALP 1587, AST 96, and ALT121.Should R/O PSC. Plan: MRCP.

20/8/2003: HBsAg –ve, TSH 5.3(0.4-4.0), T3 2.1(1.5-4.1), T41.1(0.8-1.9). MRCP: The peripheral intra hepatic and extra hepatic biliary tree is not visualized which could be due to strictures. Plan: ERCP, Repeat LFT, Lipids, Viral markers. Admission for ERCP on 24/8/2003: ALP 1035, ALT 153, AST 180, PT 12.8, HCV Ab –ve, ESR 16, PCV 46%, S.Lipids normal,

ERCP on 25/8/2003: Low lying cystic duct, thin, irregular intrahepatics with stricturing and dilatation areas, mostly consistent with primary sclerosing cholangitis. Post-ERCP mild amylasemia was noted.

On 30/8/2003 I gave him a prescription with (Ursodeoxycholic Acid) 250 mg three times daily (his body weight is around 50 Kgr).

Re- seen on 12/2003: doing well, no itching. Normal liver enzymes.