Pathology Reports

Collected:	Received:	Accession Number:	Pathologist:
04/18/2013 9:09:00	04/18/2013 9:28:00	SP-13-02373	Rudzinski, Erin R, MD

Clinical History / Notes:

Procedure: Laparoscopic liver biopsy
Preop Diagnosis: Acute liver failure
Clinical History: None given

1. No clinical history.

2. This **INITIAL** left a clue of another pathologist. (FYI, **M**ichael Lee **A**stion is medical director of Laboratory Medicine and Pathology team.)

3. The 2.0cm tissue from the surgeon became 1.3cm.

Gross Description:

Received fresh labeled LIVER BIOPSY is a single needle core biopsy fragment measuring 0.1 cm in diameter x 1.3 cm in length. The specimen is placed in formalin then wrapped and submitted in its entirety in a single cassette designated A1. [MA]

Microscopic Description:

H&E stained sections show a cirrhotic liver with bridging fibrosis and marked bile ductular proliferation. There is moderate inflammation in the portal tracts with scattered neutrophils, lymphocytes, and eosinophils. Bile ducts are present, although difficult to see with the marked portal expansion and ductal proliferation. Lobular inflammation is variable and predominantly lymphocytic in nature. There is variable cholestasis, with some nodules showing canalicular plugging and others showing only mild intracellular cholestasis. Acidophil bodies are readily identified. Hepatocytes are swollen with lacy cytoplasm and reactive appearing nucleoli. Rare areas show features of early hepatocyte necrosis with the blurring of cell junctions and hypereosinophilia. There is patchy mild macrosteatosis (<5%). A trichrome stain highlights the presence of bridging fibrosis, as well as pericellular fibrosis. Periodic acid shift stains with a without diastase reveal no diastase resistant globules.

4. Significantly underestimated steatosis. (A feature from acute starvation.)

Slide and stain summary: H&E 3 slides; PAS 1 slide; PAS-D 1 slide; trichrome 1

Electron Microscopy Findings:

Toluidine blue stained thick sections reveal cirrhotic liver with both periportal and pericellular fibrosis. There is mild portal inflammation. Examination by transmission electron microscopy shows mild cholestasis, and occassional hepatocytes with membranous debris but no evidence of storage disease. Bile canaliculi show normal microvillous architecture, without Bylers-type bile. Probable peroxisomes are identified. Mitochondria are present in normal numbers, and are without circular or paracrystalline arrays of cristae.

Final Diagnosis:

LIVER, NATIVE, CORE BIOPSY: CIRRHOSIS AND BILE DUCTULAR PROLIFERATION, SEE COMMENT

Comment

The biopsy shows established cirrhosis with marked bile ductular proliferation and variable cholestasis. There is ongoing hepatocyte injury, with scattered apoptotic cells, as well. PASd stain reveals no evidence of alpha-1 antitrypsin deficiency, and no abnormal mitochondria, bile or storage-type material are seen on electron microscopy. A definitive etiology for the patient's chronic liver failure is not evident from this biopsy.

5. Use "established" cirrhosis to cover acute injuries, most of which would be recoverable IF BEING TREATED PROPERLY.

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Preliminary findings were reviewed with Dr Simon Horslen on 4/19/13 at approximately 14:30h.

1 Several pathologists

T-62000, T-60650, M-76000, D5-80600, P1-03100

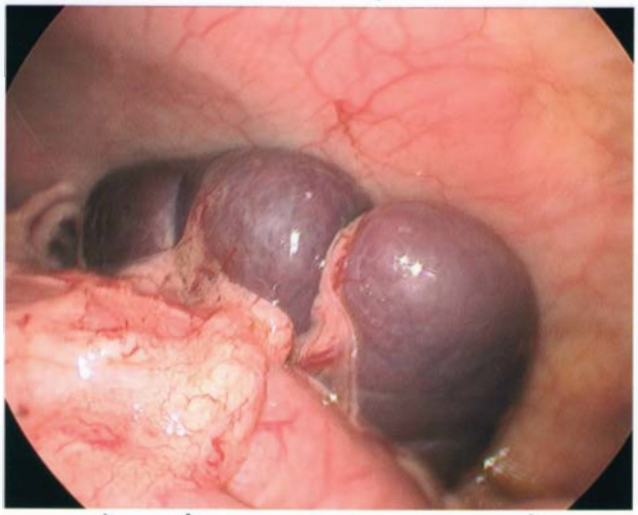
Diagnosis by: Erin R Rudzinski, MD
Electronic Signature

04/25/2013 ED: ERR

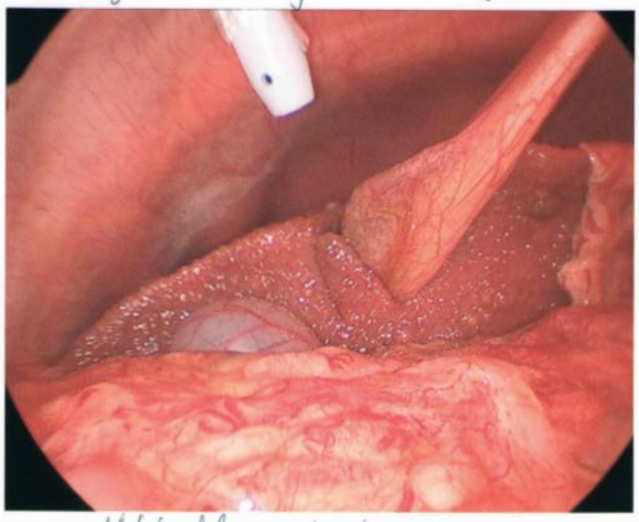
CO_2 inflation

spleen. enlarged.
disease for a while

3mm probe
looks like a developmental issue.
liver most polycystic
many small cysts. a big one on right



intestines look normal in color and appearance.

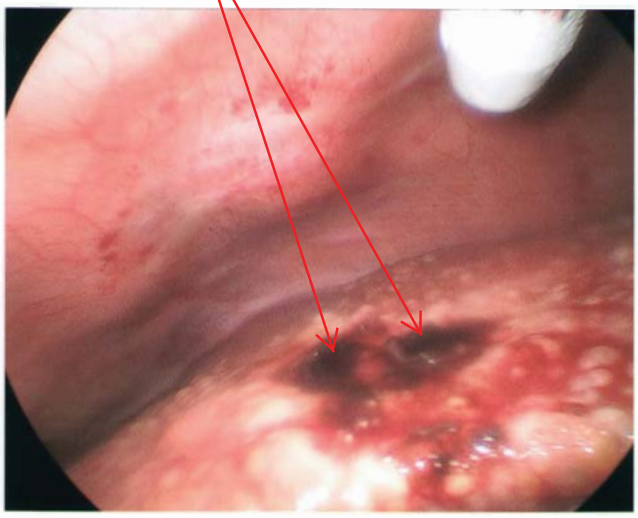


gallbladder looks fine.

fluid (edema) very little

5. Missing one specimen

two biopsy sites.
changed current to help stop bleeding



lost 10~12 ml blood.

Op Note

Date of Service: 04/18/2013 0:00:00
Authored By: Healey, Patrick J, MD

Operative Report

Document may Not be Signed/Finalized. See End of report for Electronic Authentication of Signature.

OPERATIVE REPORT

XIE, JIANHUA DRACO
DOB: 09/16/2012 M -MR #: 01-27-55-67 PATIENT LOCATION: SUR-R6

DATE OF OPERATION: 04/18/2013

PREOPERATIVE DIAGNOSIS: Liver failure.

POSTOPERATIVE DIAGNOSIS: Liver failure.

OPERATION: Laparoscopy with liver biopsy.

SURGEONS: Patrick Healey, MD, Attending; Janice Kang, MD, Resident in Surgery.

INDICATIONS: Jianhua is a 7-month-old boy who presented to the Intensive Care Unit this past week with profound liver failure. He had hyperammonemia, severe coagulopathy, jaundice with ascites and splenomegaly. With intensive care medical support, diuresis, and appropriate management, he has clinically improved, though remains with borderline hypoglycemia, INR of 2.8, and ammonia of over 100. His diagnostic workup has not yielded a definitive diagnosis to date and liver biopsy was requested. Because of his ascites and degree of coagulopathy, percutaneous biopsy was deemed to be at unreasonable risk so surgical biopsy was requested. After description of the procedure and discussion of the potential risks and complications, informed consent was obtained.

1 Several Pathologist

FINDINGS: Liver was small and firm with diffuse micronodular cystic change visible subcapsular. There were also some slightly larger macrocysts which correlated with those seen on a CT scan earlier. A 2 cm core liver biopsy was obtained from the right lobe.

PROCEDURE: The patient was taken to the operating room and positioned supine. General anesthesia was administered and the baby was then intubated endotracheally. A separate IV was then started. A surgical time-out was done confirming patient identification and consent of procedure, among other standard elements. The abdomen was then widely prepped and draped in a sterile fashion.

The baby had a large umbilical hernia. A small 5 mm transverse incision was made just to the right of the umbilical hernia overlying the rectus. Using an open Hassan technique, the dissection was carried down through the layers of the abdominal wall, identifying the anterior sheath, posterior sheath, and peritoneum. The peritoneum was entered sharply and a PDS suture was then placed around the defect. A 5 mm port with this Veress step introducer was then placed into the peritoneal cavity and pneumoperitoneum established to 8 cm

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of pressure. Laparoscopy was then performed and the above findings noted. Under laparoscopic guidance, a second port, 3 mm, was then placed in the right upper quadrant at roughly the anterior axillary line. Through this working port, the omentum was moved off of the liver revealing a chronic-appearing contracted firm liver with multiple small and medium size cysts visible on its surface. The spleen was enlarged and lobulated. Under laparoscopic guidance then using a spring-loaded Tru-Cut needle, a biopsy was taken in the right lobe just to the right of the gallbladder fossa. A sample was a good sample and this was sent then fresh to Pathology. The biopsy site bled briskly initially and this was controlled with electrocautery without too much difficulty. The abdomen was then irrigated and excess fluid and blood clot evacuated. Biopsy site was reinspected and noted to remain hemostatic. After pathologic confirmation of adequate biopsy, the pneumoperitoneum was released and the ports removed. The wounds were closed in layers with PDS in the muscle fascia, Vicryl in the subcutaneous layer and in the subcuticular skin. Steri-Strips were applied to both incisions.

The patient tolerated this procedure well, was extubated in the operating room, and transferred to the recovery room in stable condition.

Please note, I was present for and performed this entire procedure with Dr. Kang.

Electronically Authenticated by
Patrick J Healey, MD 04/20/2013 12:24 P

Patrick J Healey, MD , Attending Physician, Surgery

PJH/srl Doc #2944494 d: 04/19/2013 08:46 P t: 04/19/2013 09:12 P (1562796-)
cc: cc Pediatric Assoc Redmo
Julie E Wen, MD