

National Liver EQA Scheme

Circulation B1: Spring-Summer
2010

65 responses

- New members are non-scoring for first 2 circulations – get used to response forms
- Give answers in two parts:
 - Morphological
 - Clinicopathological diagnosis
- Members agree about scoring during discussion at open meeting
- This time there is reduced time for discussion. The steering committee proposed draft scoring principles in advance, circulated to members 2 months ago requesting comments – only received two responses.
 - review at the end how this has worked

Score sheets for Liver EQA – submit typed/email or hand-written

- Secretary (Sophia) manages circulation, receives and anonymises responses and puts into a set for each case
- Organiser collates diagnoses and groups them under main headings for discussion at the open meeting, where a quorate number (at least 10) determine how points shall be awarded.
- 780 score sheets
- Allocate points, review original responses where necessary, according to marking scheme
- Secretary calculates total marks and sends to participants

Score sheets for Liver EQA – submit typed/email or hand-written

NATIONAL LIVER PATHOLOGY EQA SCHEME

Quality Assurance Reference Centre, Ground Floor, Rayntree House, 2 Capital Close, Capital Park West, Leeds LS27 8WH

Organiser: Dr J Wyatt Tel: (0113) 2067634 Fax: (0113) 2065420 E-mail: j.wyatt@leeds.ac.uk
 Secretary: Miss Sophia Kishan Tel: (0113) 246 6304 Fax: (0113) 246 6322
 E-mail: sophia.kishan@nhs.uk

Please return completed response forms to the secretary.

RESPONSE SHEET

Please fill in both boxes where appropriate, particularly in non-tumour cases.

Participant Code:.....7.....

Circulation: C1
Case number: 355
Information provided: Raised ALT and immunoglobulins, ANA +ve (1:640), antimitochondrial antibody +ve, negative M2, ultrasound showed fatty liver, no copper-associated protein.
Specimen: liver biopsy
Macroscopic description: 3 cores, measuring 6mm, 8mm and 20mm in length
Age & Gender: 49/female
Main Diagnosis:

Morphology:
 Mild/moderate macrovesicular steatosis, patchy portal lymphocyte rich infiltrate (aggregate) with small duct damage, suggestive of early granuloma formation

Clinicopathological (includes information from 'information provided' where necessary).
 Steatosis, in keeping with fatty liver disease, and bile duct lesion, in keeping with primary biliary cirrhosis

Necessary further information, sections, stains etc.

Exclude excessive alcohol / drugs to account for fat, MRCP for bile duct damage. Collagen stain for fibrosis.

Other comments:
 (e.g. particular or unusual features, to remind yourself of the case and to feed into collation of comments for discussion at the open meeting).

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RESPONSE SHEET

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Participant Code:.....81.....

Circulation: C1
Case number: 355
Information provided: Raised ALT and immunoglobulins, ANA +ve (1:640), antimitochondrial antibody +ve, negative M2, ultrasound showed fatty liver, no copper-associated protein.
Specimen: liver biopsy
Macroscopic description: 3 cores, measuring 6mm, 8mm and 20mm in length
Age & Gender: 49/female
Main Diagnosis:

Morphology: mild interface hepatitis with ^{portal} parenchymal activity. Focal B/D destruction & focal ^{portal} inflammation by acute chronic inflammation. No granulomas - mild steatosis also.

Clinicopathological (includes information from 'information provided' where necessary)
 Features suggest ~~steatosis~~ ^{possible} Biliary tract disease rather than PBC. Biochem features are of AIH & PBC - hence suggestive of 'overlap' syndrome. Necessary further information, sections, stains etc.
 Check Elastin for Copper / Steatosis may suggest. ^{AIH - clinically overlap.}
 Present Copper may be due to early phase of disease (C6 units).
 Check Retic & Van Gieson for fibrosis. Check virology to R/O HCV as cause of steatosis.
 Unusually Negative M2 difficult to fit with PBC.

Intended to write 2-part answers in the boxes

Example of GI EQA electronic direct entry database

Case numbers →

Participant
number ↓

Submitted On	Q01 - large intestine polyp	Q02 - colonic infarction
23/12/2009 13:25	Tubular adenoma, low grade dysplasia, benign mucosal entrapment in stalk with haemosiderin.	Colonic infarction. Arteries show very severe medial hypertrophy. EVG needed to check for past episodes of vasculitis.
31/12/2009 08:49	Tubular adenoma with pseudoinvasion	Colonic infarction with endarteritis/?vasculitis
08/01/2010 16:02	Tubulovillous adenoma with epithelial misplacement. No adenocarcinoma. [10]	Transmural large bowel infarction with arteriosclerosis of submucosal/subserosal arteries and intimal oedema of submucosal veins. No definite vasculitis. [10]
14/01/2010 11:05	Tubular adenoma, up to high grade dysplasia, torsion, clear cell metaplasia Sample whole lesion, levels on stalk	Infarction secondary to medium sized arteritis, likely polyarteritis nodosum Vasculitis screen advised
14/01/2010 15:42	Tubulovillous adenoma with low grade and focal high grade dysplasia.	Infarction with organising thrombi
15/01/2010 10:47	Tubulovillous adenoma with predominantly low grade and focal high grade dysplasia	Ischemic enterocolitis

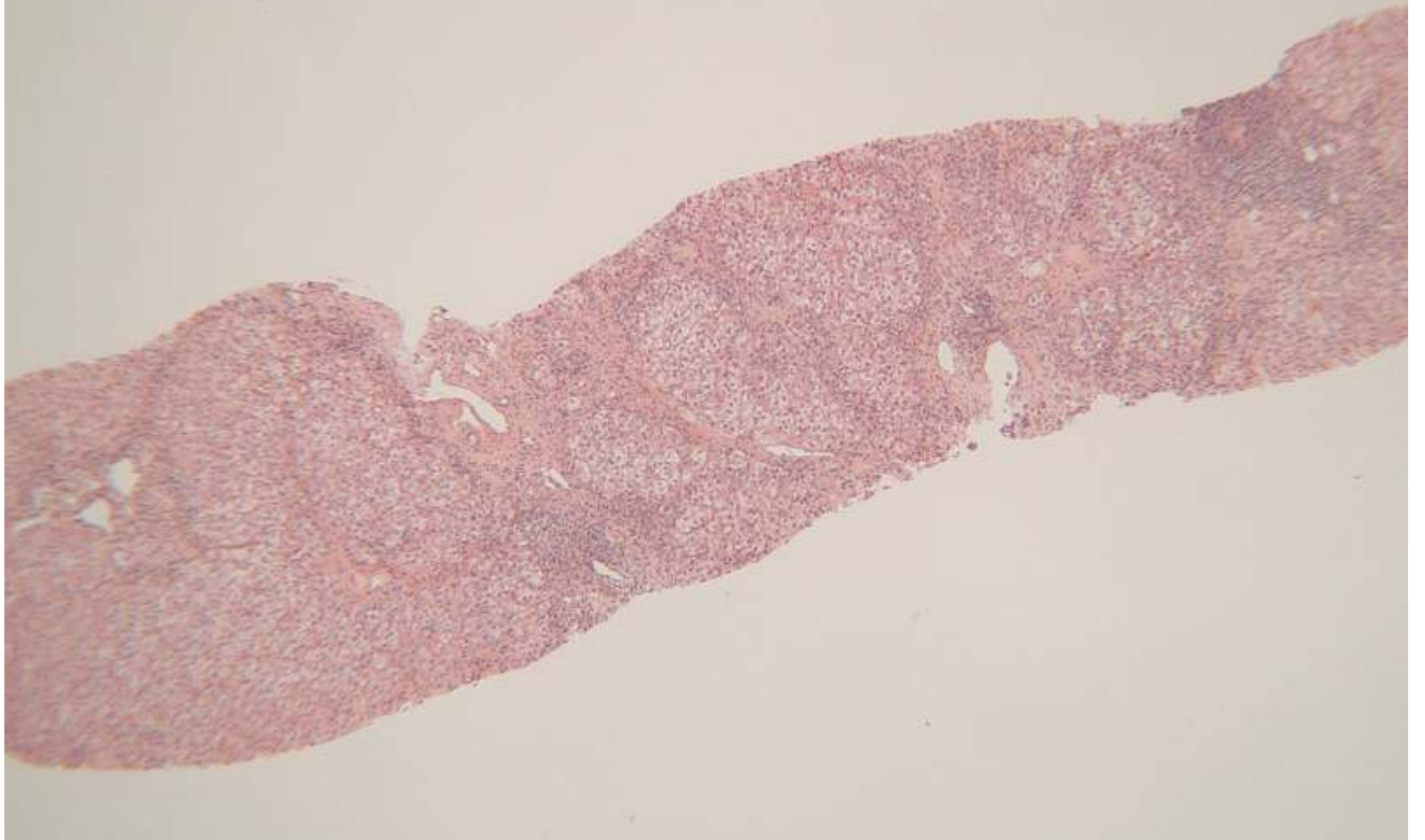
Changes to EQA scheme discussed and agreed during open meeting in Dundee

1. Electronic submissions – reasonable to require this from next time. JIW will explore direct entry into excel spreadsheet (as for GI EQA) will enable evaluation of responses to be shared.
2. Members voted to in future have both yearly circulations discussed during this annual liver update meeting, rather than one at the Pathological Society or BSG meeting = will ensure more members can attend. One hour programmed for each circulation.
3. The responses and proposed scoring of the steering committee will be circulated in advance as on this occasion. Responding to this (indicating agree, disagree, points for discussion/clarification) will be required of members. This will enable discussion of cases to be focussed on diagnosis/reporting rather than mechanics of scoring.
4. On average of last 5 circulations, responses received from 72% members. Looking into this – no responses at all from 7 members, and none in last 3 circulations from another 2 members. The Scheme Organiser will contact them to enquire of reasons with a view to resignation from the scheme unless unusual circumstances.

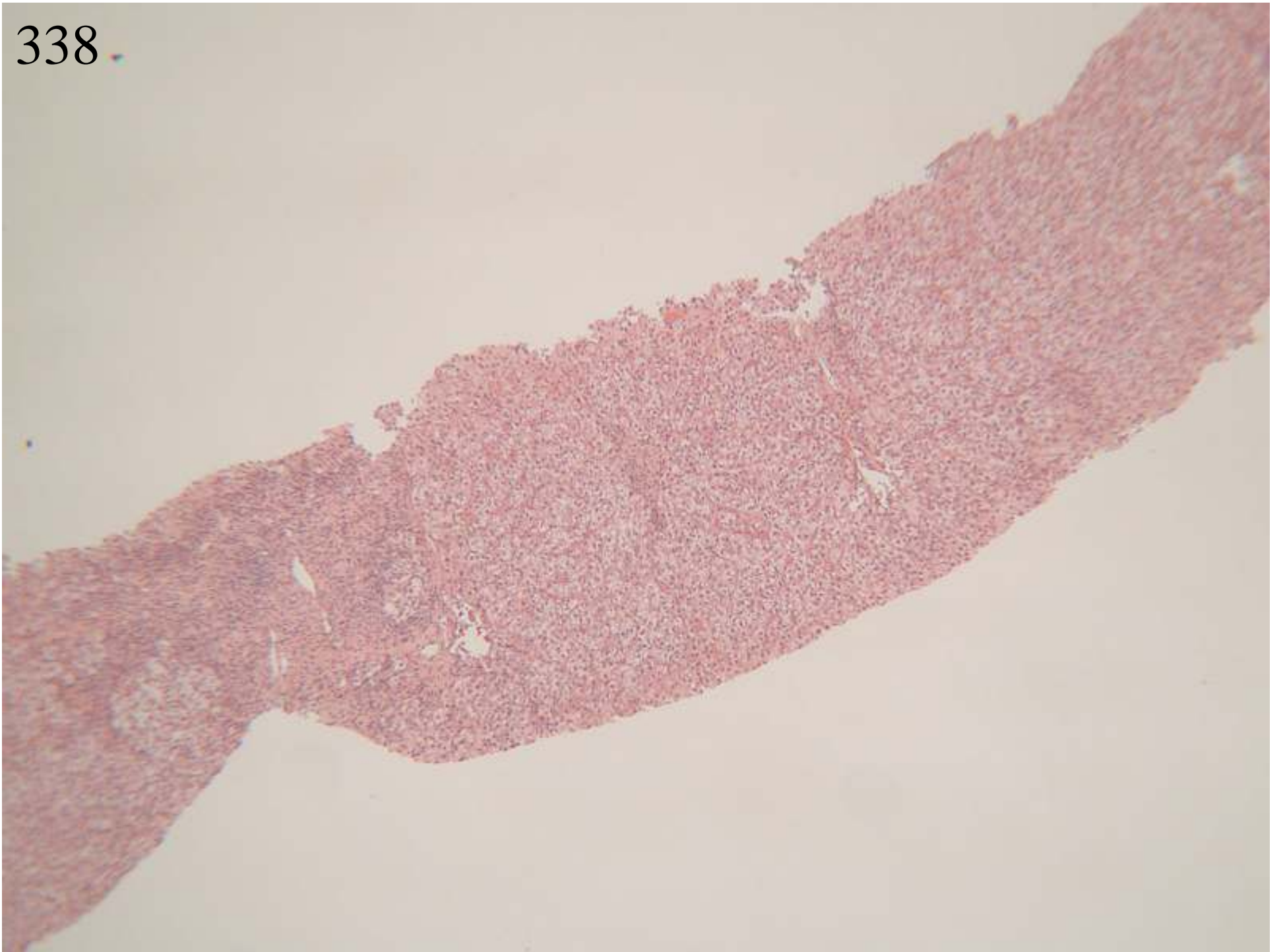
Case 338

- *Female, 16 years*
- *Abnormal LFTs, bruising, nosebleed for 3 weeks, tired, ? auto-immune hepatitis anti smooth muscle antibody 3+*
- *Liver biopsy 14mm core of liver*

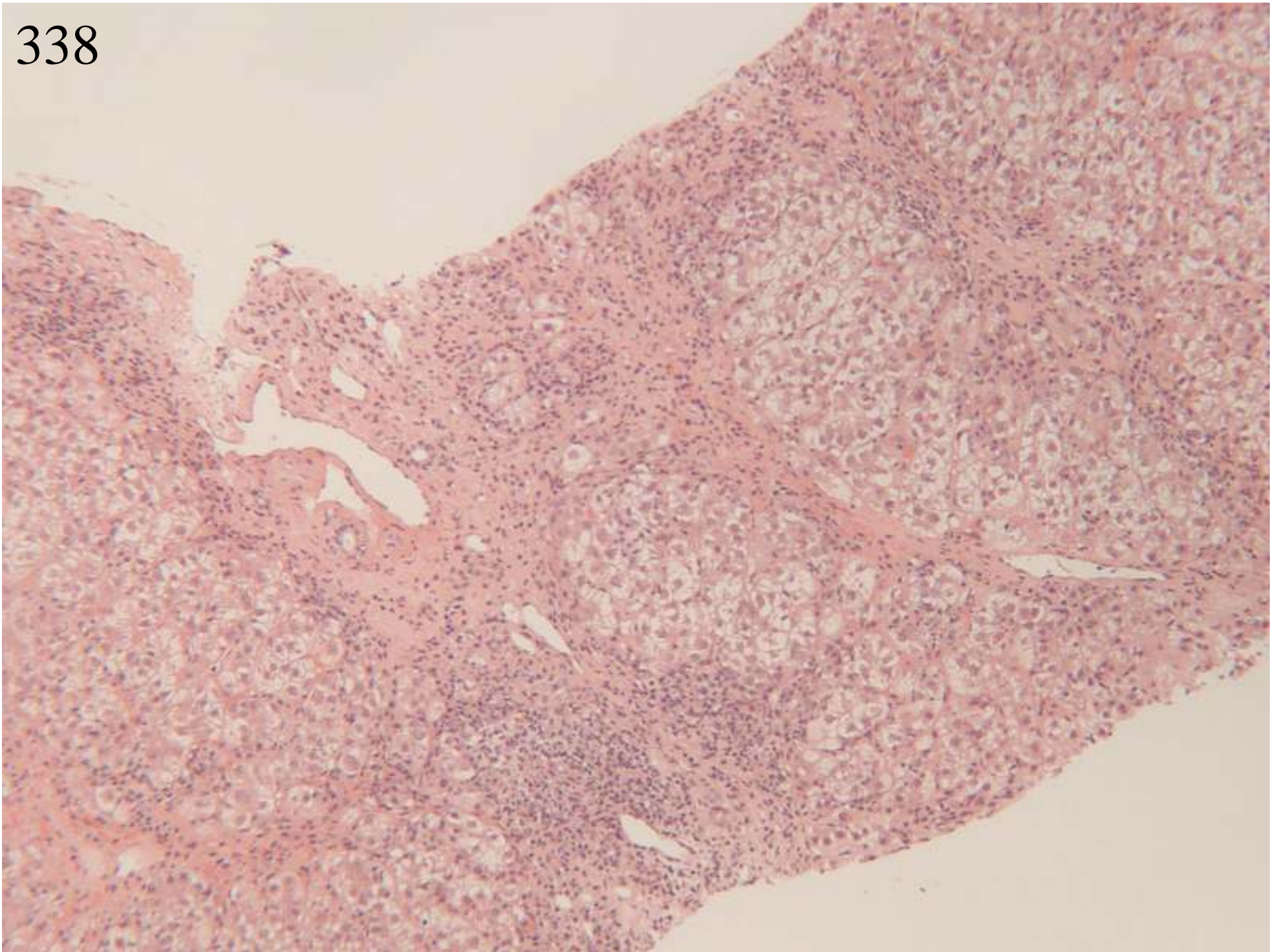
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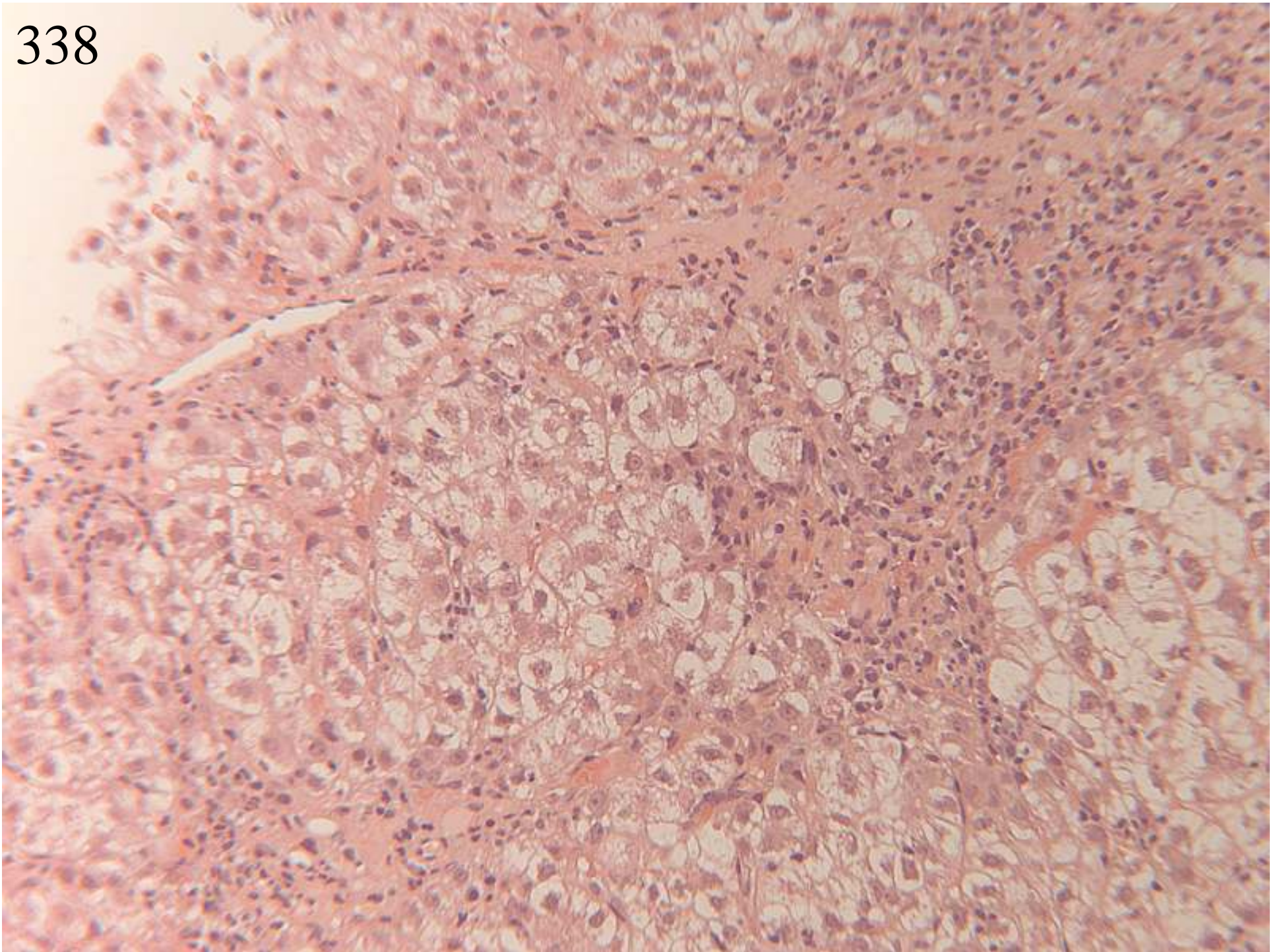
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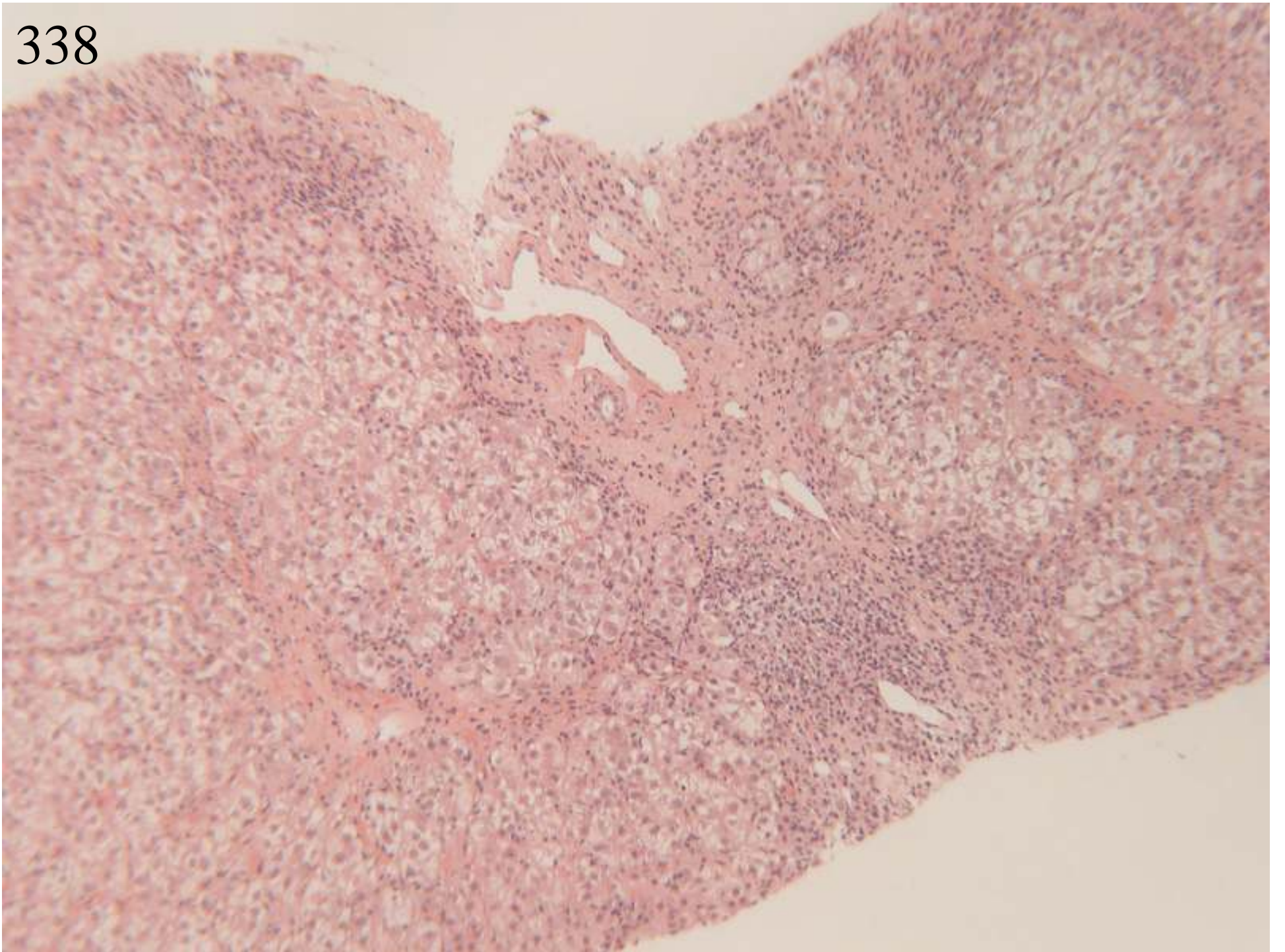
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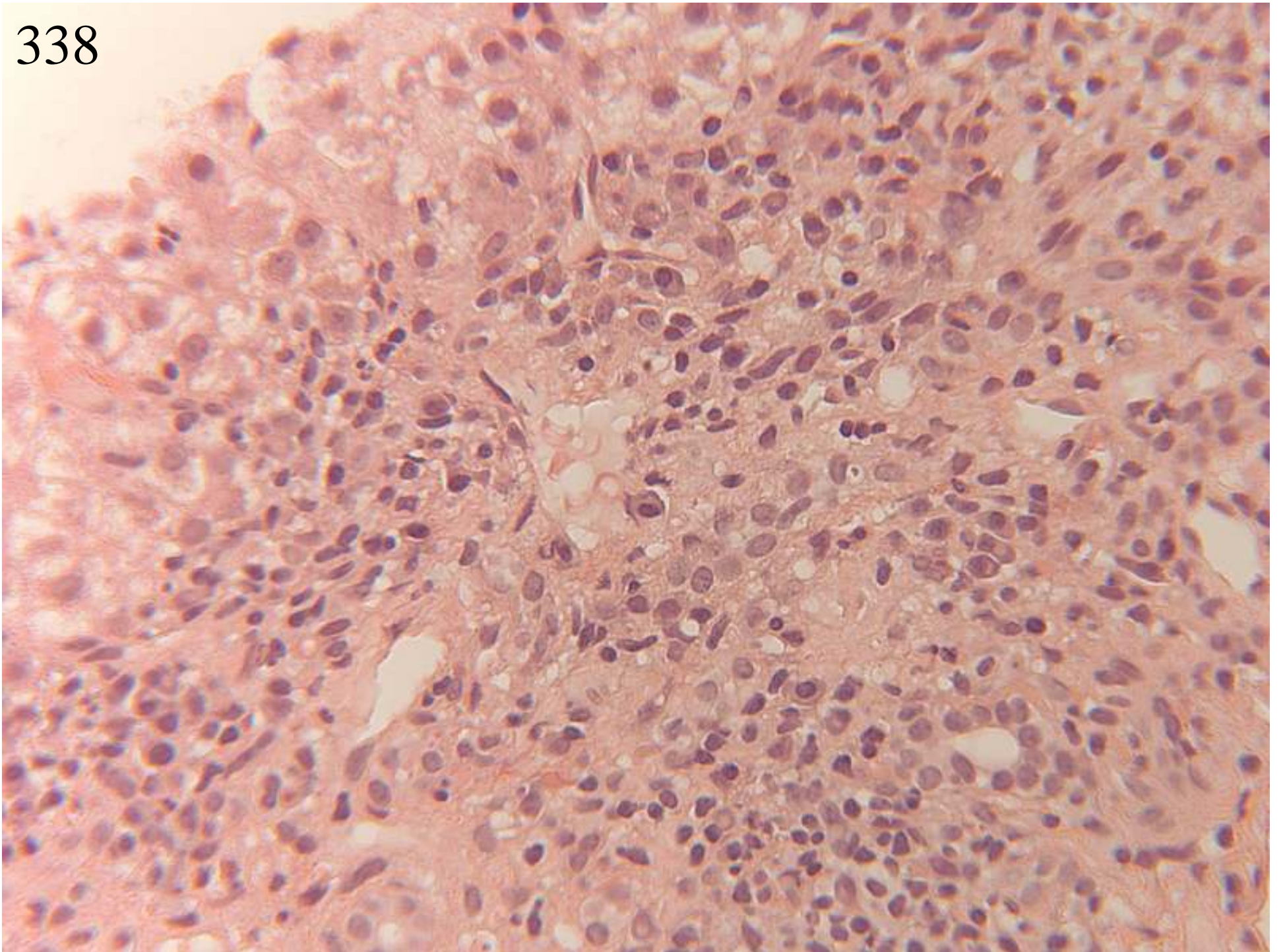
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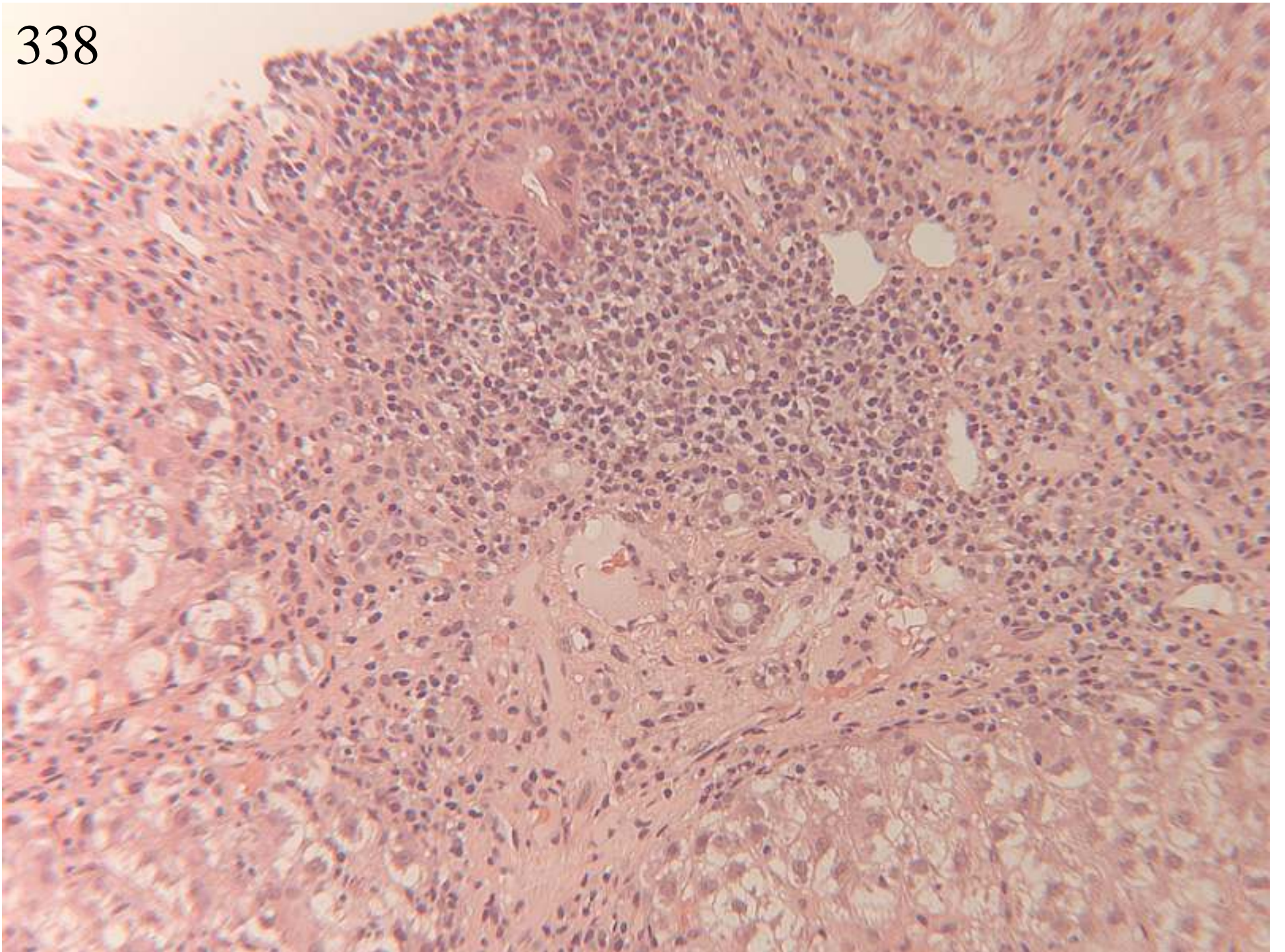
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- 16 hepatitis – acute with bridging hepatic necrosis
- 5 hepatitis NOS
- 4 chronic hepatitis
- 2 chronic hepatitis with bridging necrosis
- 2 severe hepatitis with possible cirrhosis
- 9 hepatitis with fibrosis or cirrhosis
- 24 cirrhosis
- 32 needs special stains to assess fibrosis

- 62 consistent with autoimmune
 - 2 ? overlap with PBC
 - 1 ?overlap with NASH
- 15 differentials e.g. drugs, viral
- 3 ? Wilson's

- 1 Autoimmune not mentioned in diagnosis (ground glass hepatocytes, favour Hep C)
- 1 cirrhosis/Mallory's /chronic active hepatitis, ? glycogen storage disease/?A1ATD/?NASH

Agreed scoring: any hepatitis (acute or chronic can be difficult in autoimmune hepatitis, and need connective tissue stains for chronicity) plus c/w autoimmune

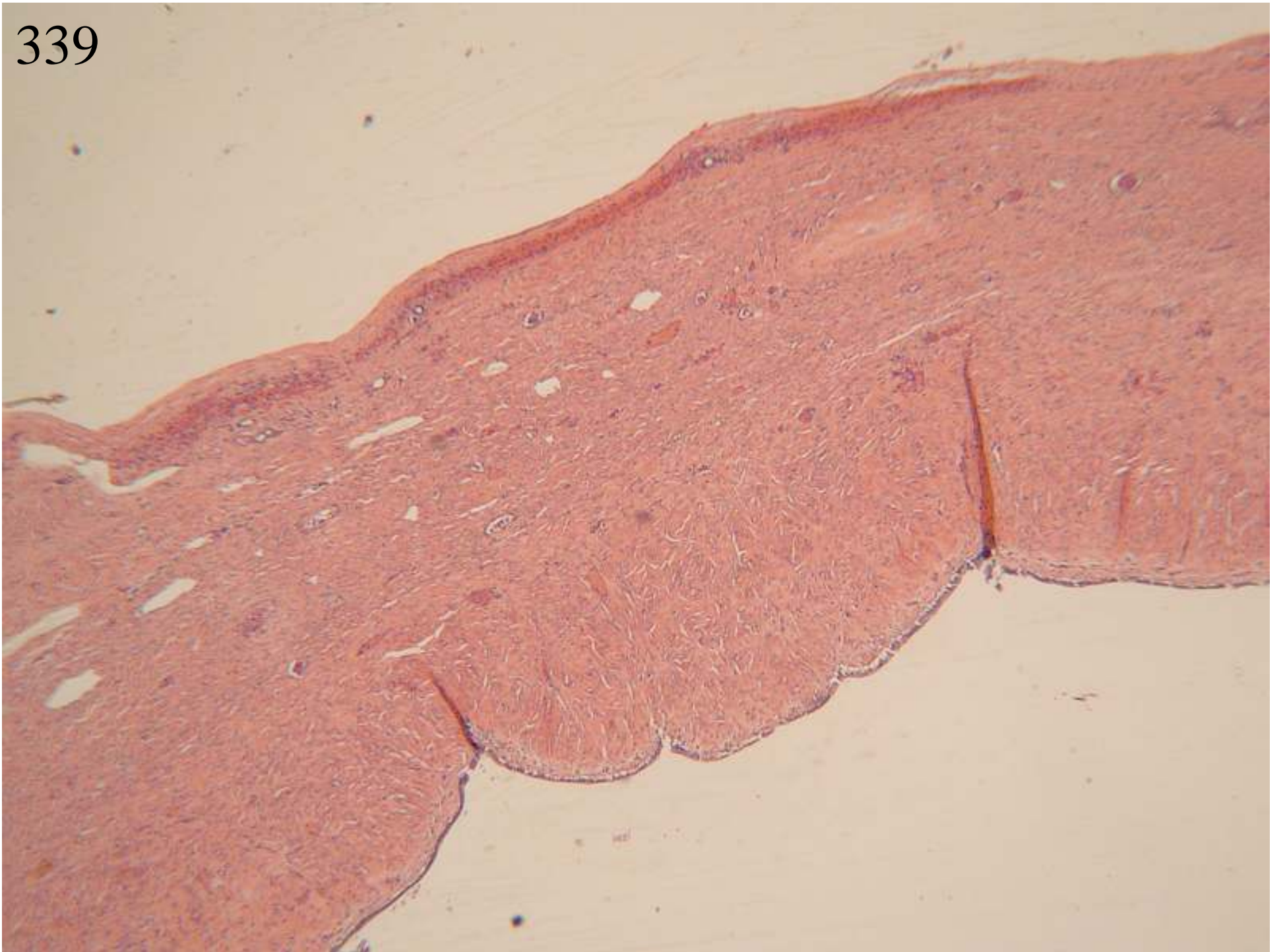
Case 338: original pathologist's diagnosis:

Autoimmune hepatitis

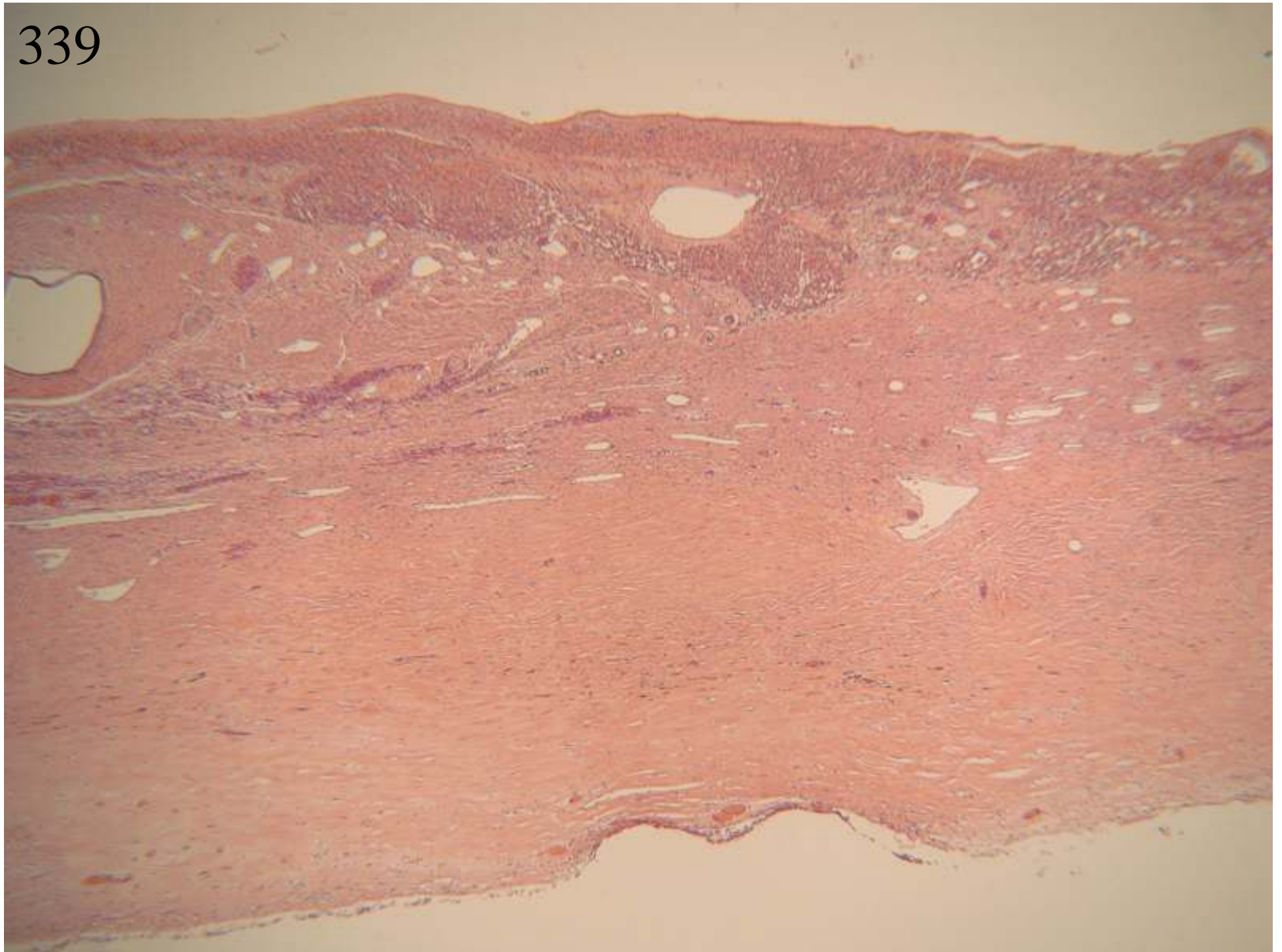
Case 339

- *male, 21 years*
- *Left hemihepatectomy for liver cyst ?hydatid*
- *Resection of liver cyst*
- *Cystic segment of liver 14X12X6cm. Outer surface smooth, focal calcification of wall. unilocular*

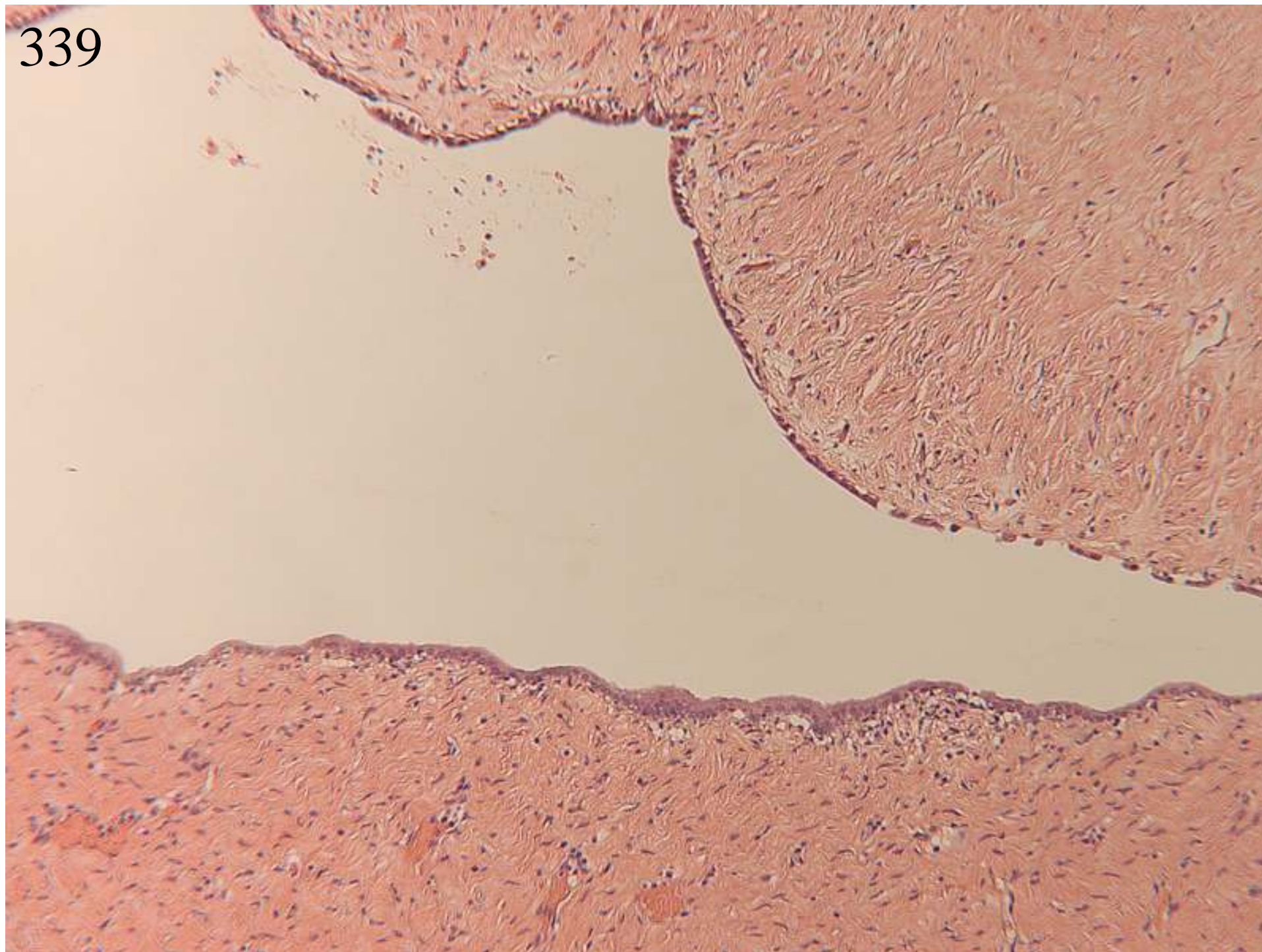
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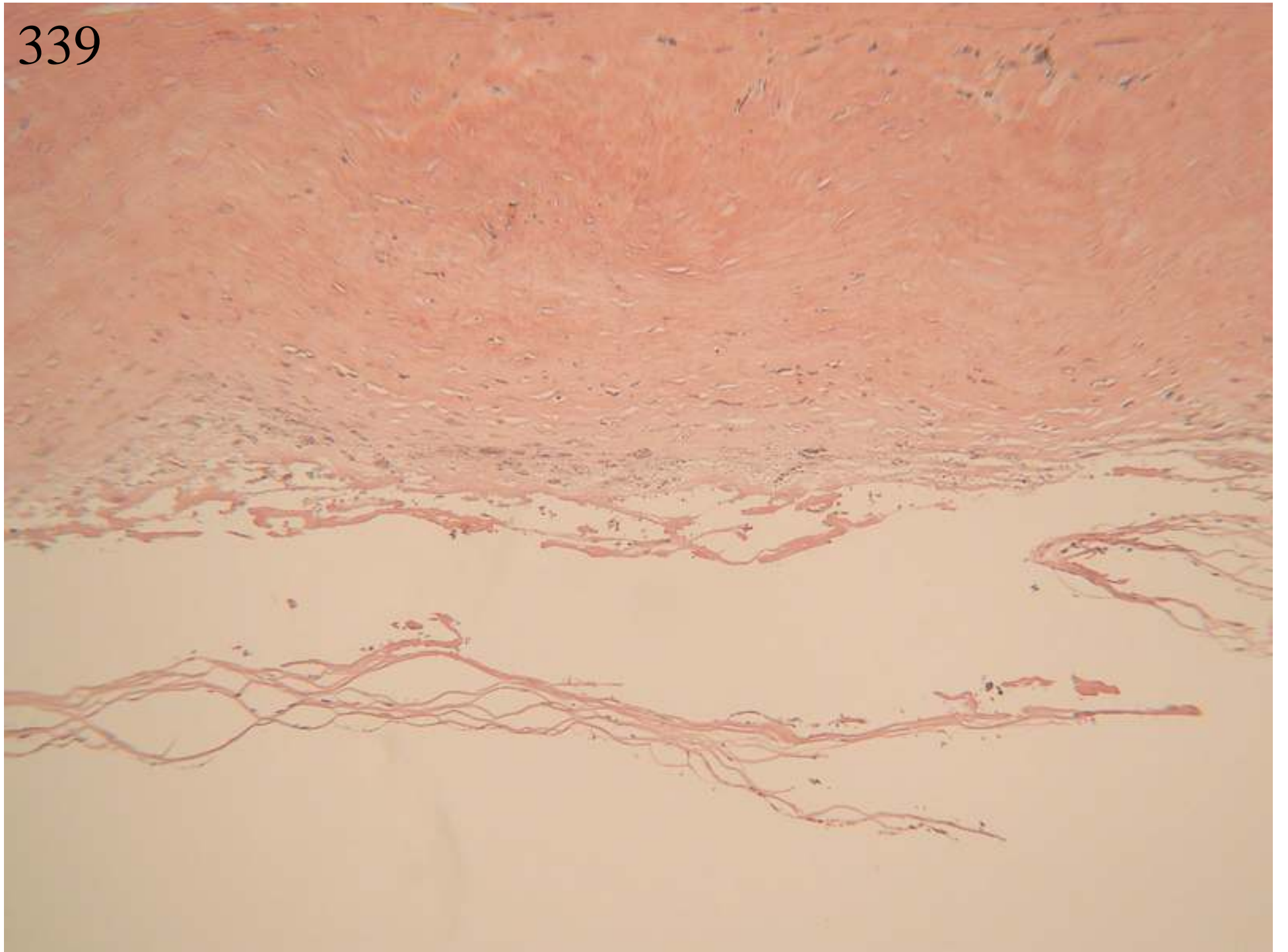
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53 solitary biliary/bile duct cyst

1 liver cyst NOS

1 fibrous walled cyst without lining

1 favours foregut duplication cyst (smooth muscle in wall),
extra blocks for ciliated epithelium

1 benign cyst/choledochal

1 solitary (non-parasitic) cyst

1 developmental/congenital cyst

1 solitary cyst

3 (hepato)biliary cystadenoma

1 biliary mucinous cystadenoma

Agreed scoring: accept any non-neoplastic cyst, reject cystadenoma. (on review of diagnoses – 5 marks for cystadenoma including a comment on absence of ovarian-like stroma, 0 marks for cystadenoma not further qualified)

Case 339: original pathologist's diagnosis:

solitary bile duct cyst

Discussion: preferred terminology is solitary biliary cyst.

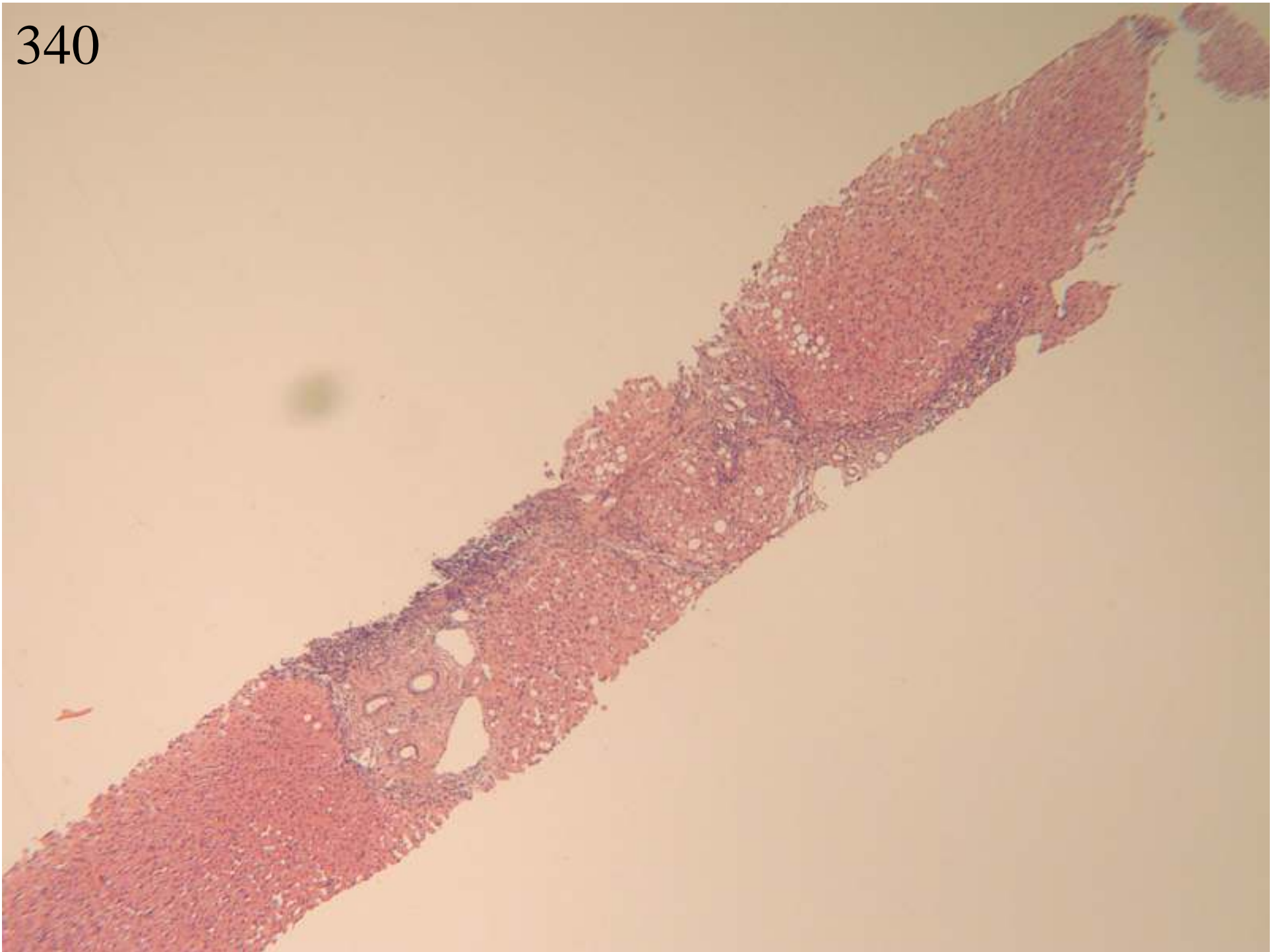
This one has no mesenchymal stroma (and is occurring in a male) therefore not an example of cystadenoma.

Although not the diagnosis in this case, it was noted that the new WHO terminology of cystic mucinous neoplasm (low grade or high grade) has replaced cystadenoma/ cystadenocarcinoma (presented elsewhere in this update meeting) – this is to be distinguished from the cystic variant of intraductal papillary neoplasm.

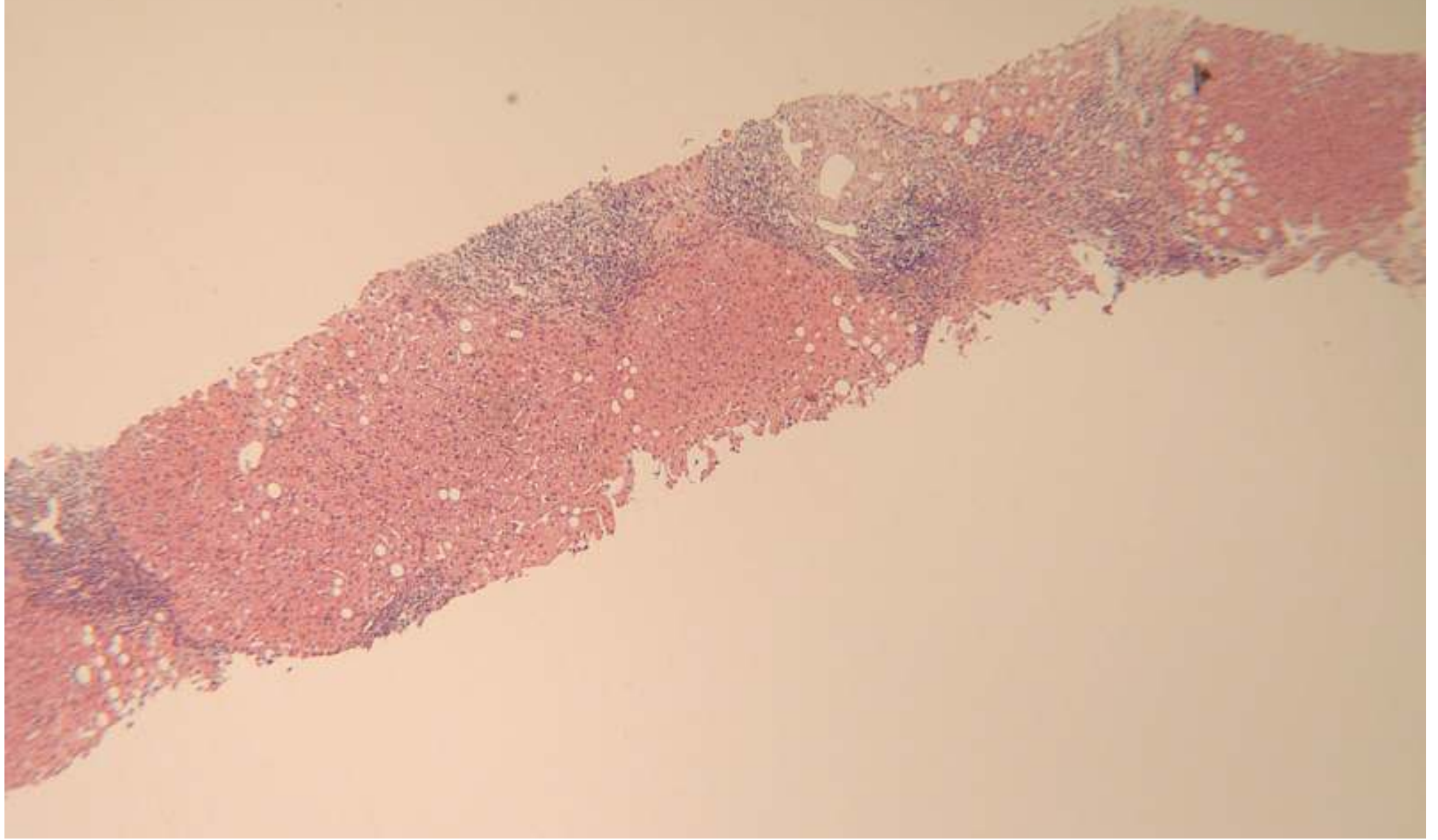
Case 340

- *male, 40 years*
- *Longstanding HCV infection. Intravenous drug use. Consideration for treatment, mildly abnormal liver function tests. No other factors in history*
- *Core biopsy of liver*

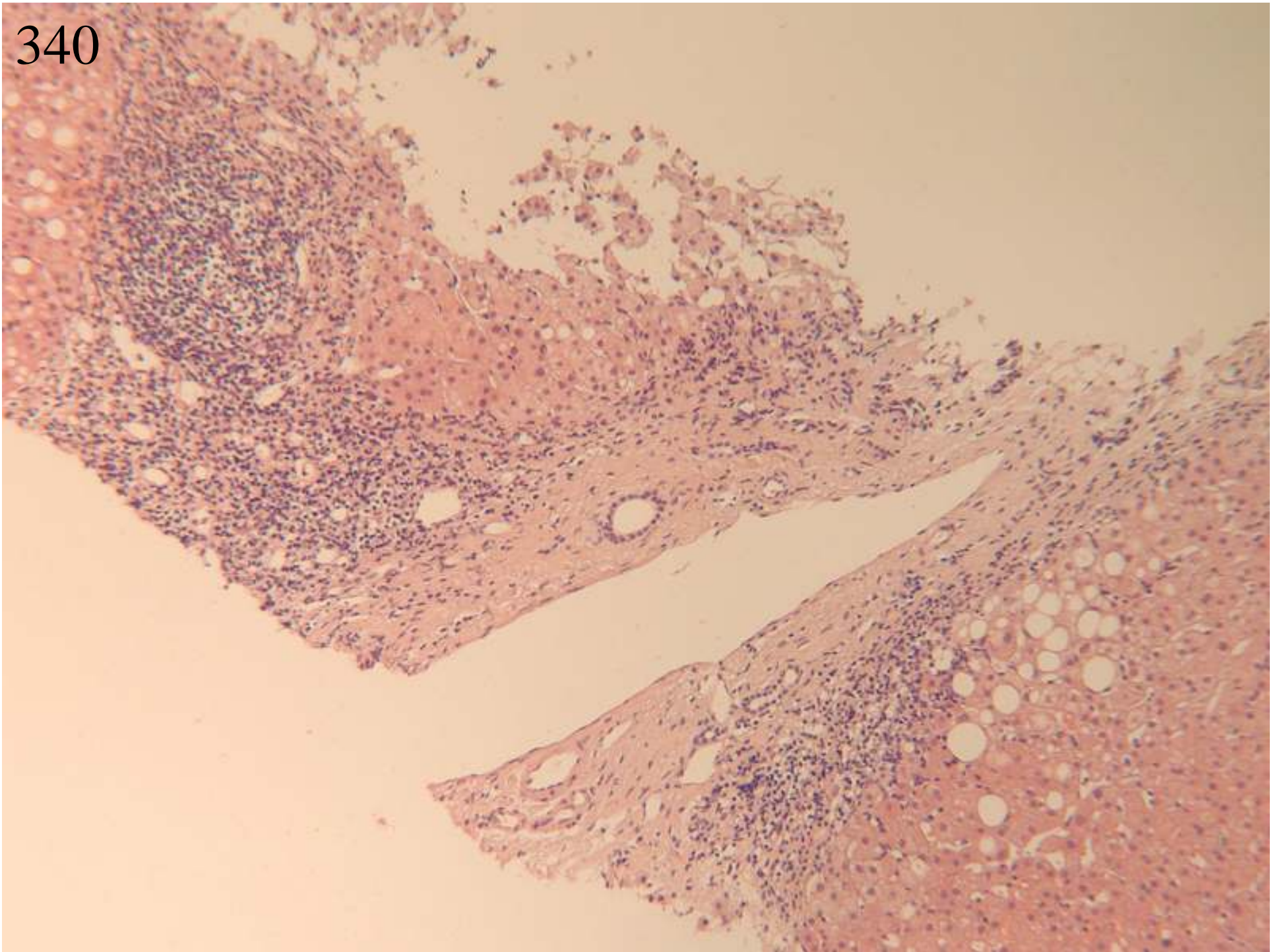
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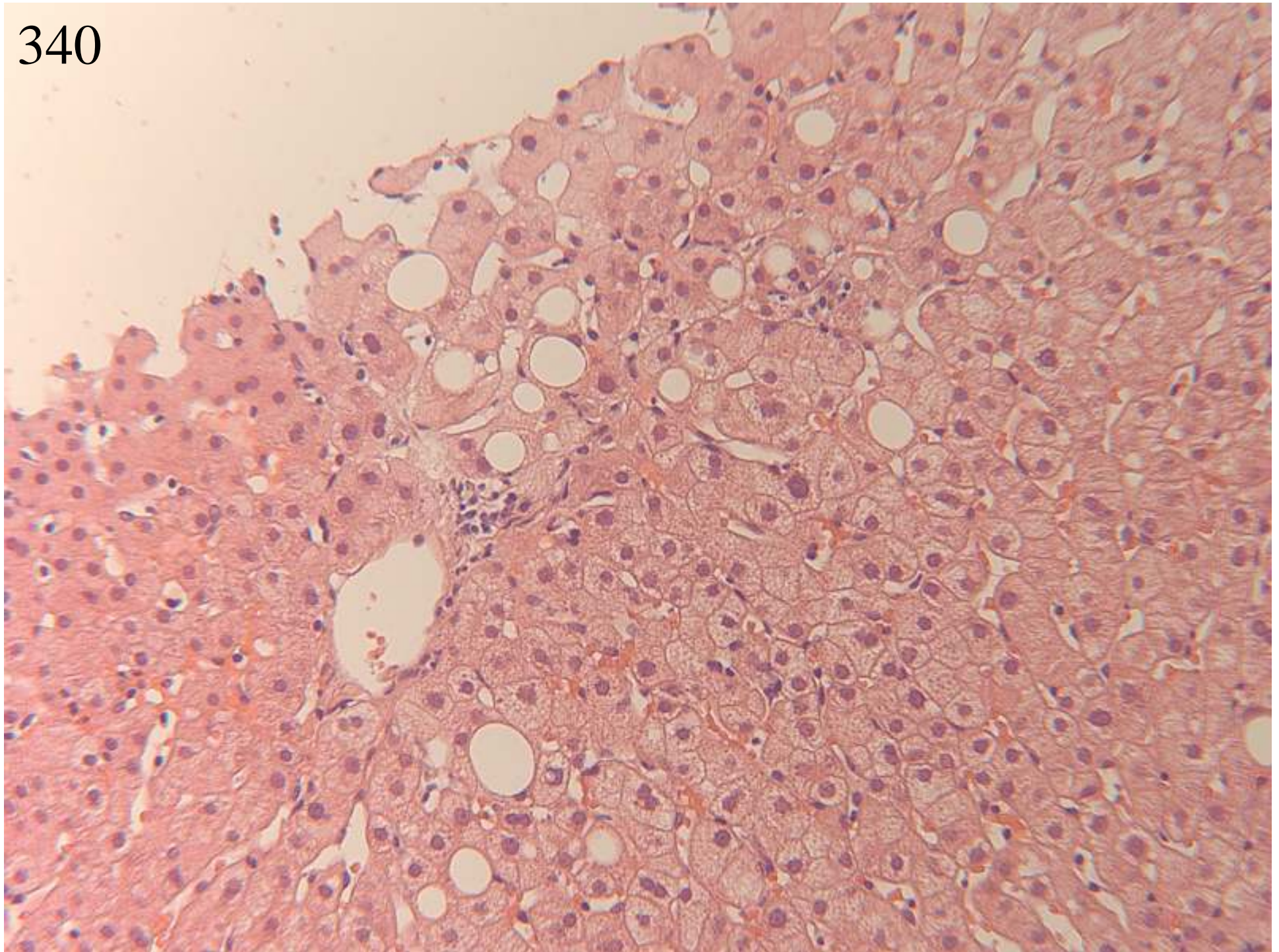
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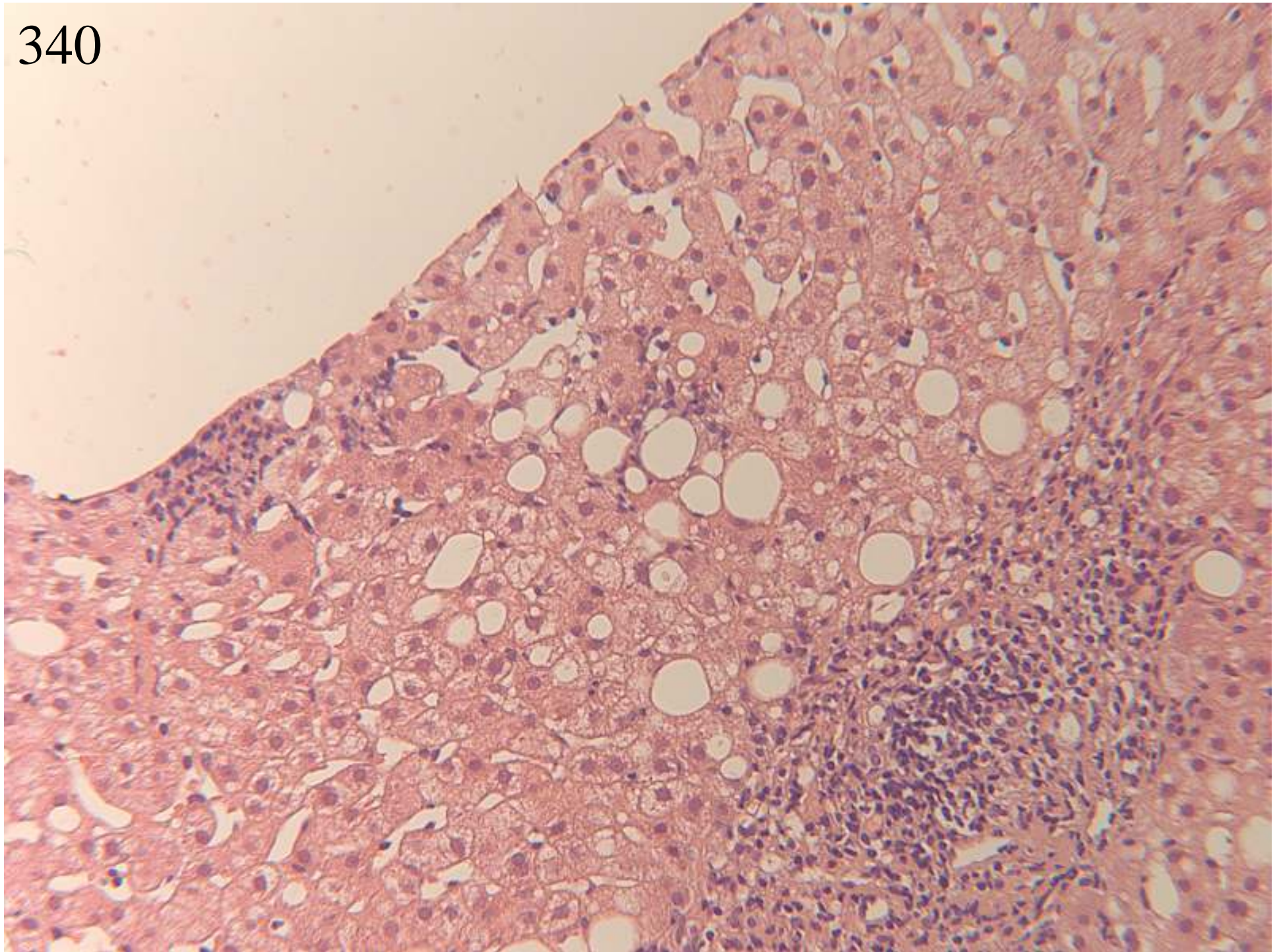
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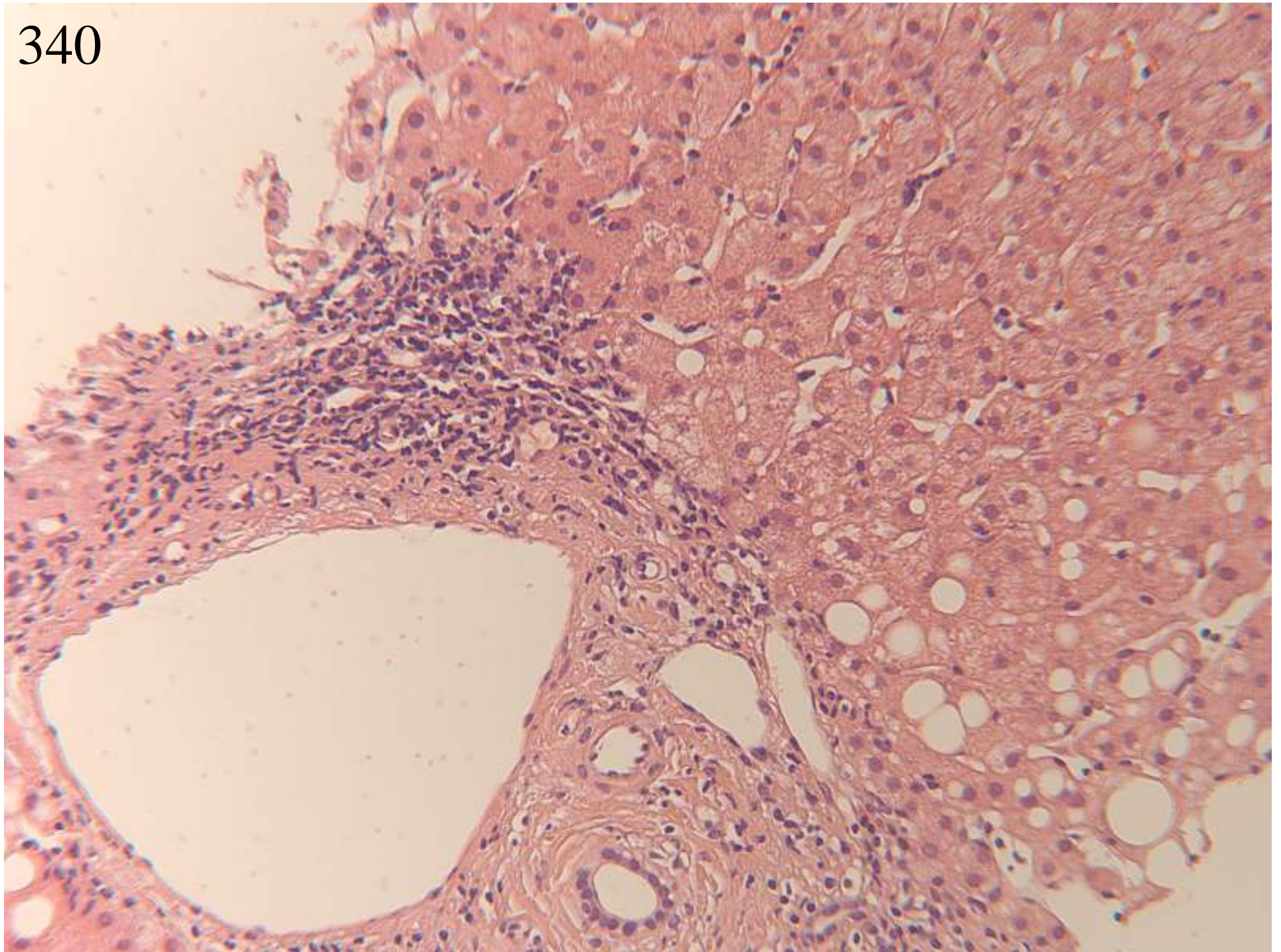
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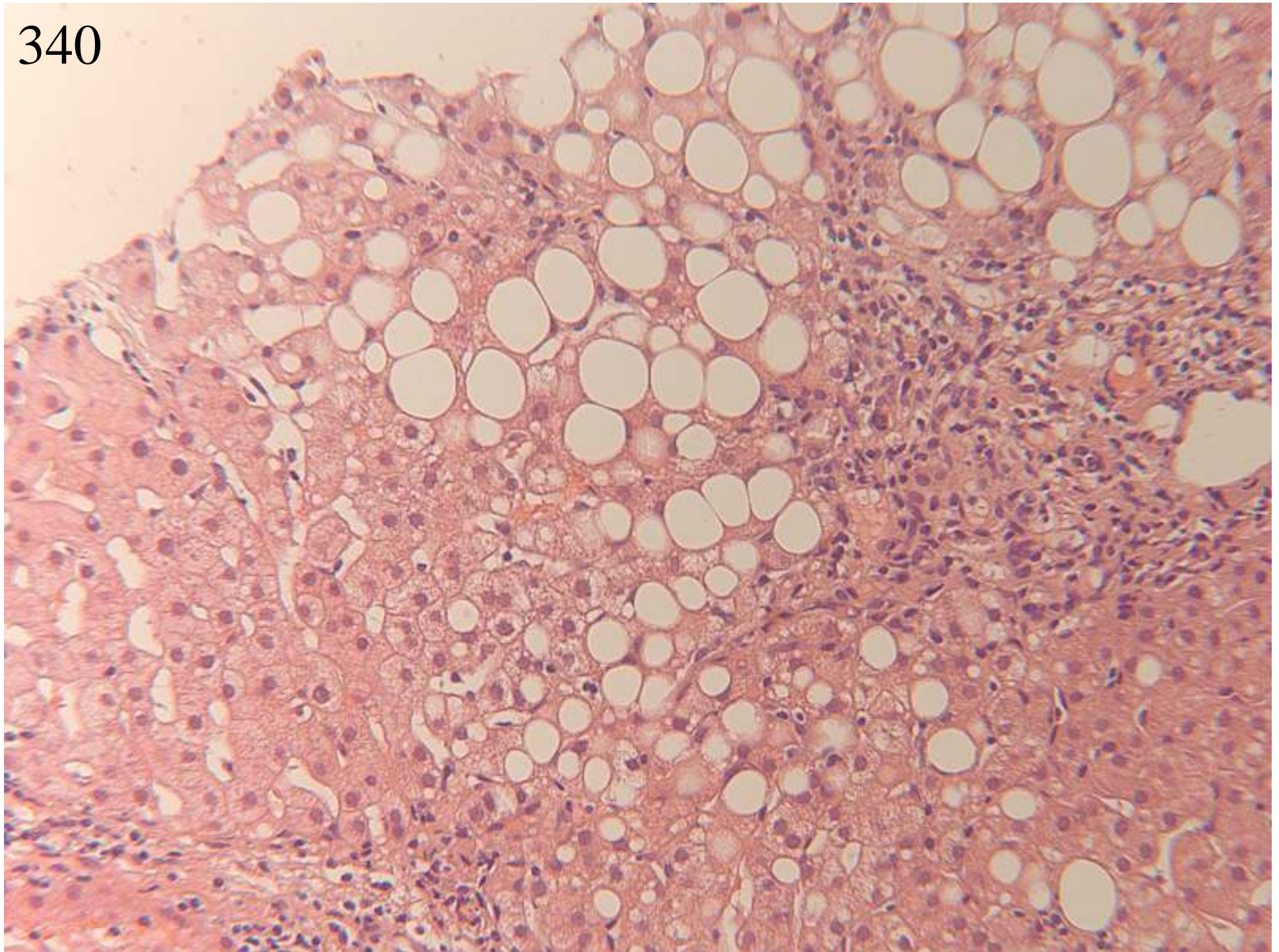
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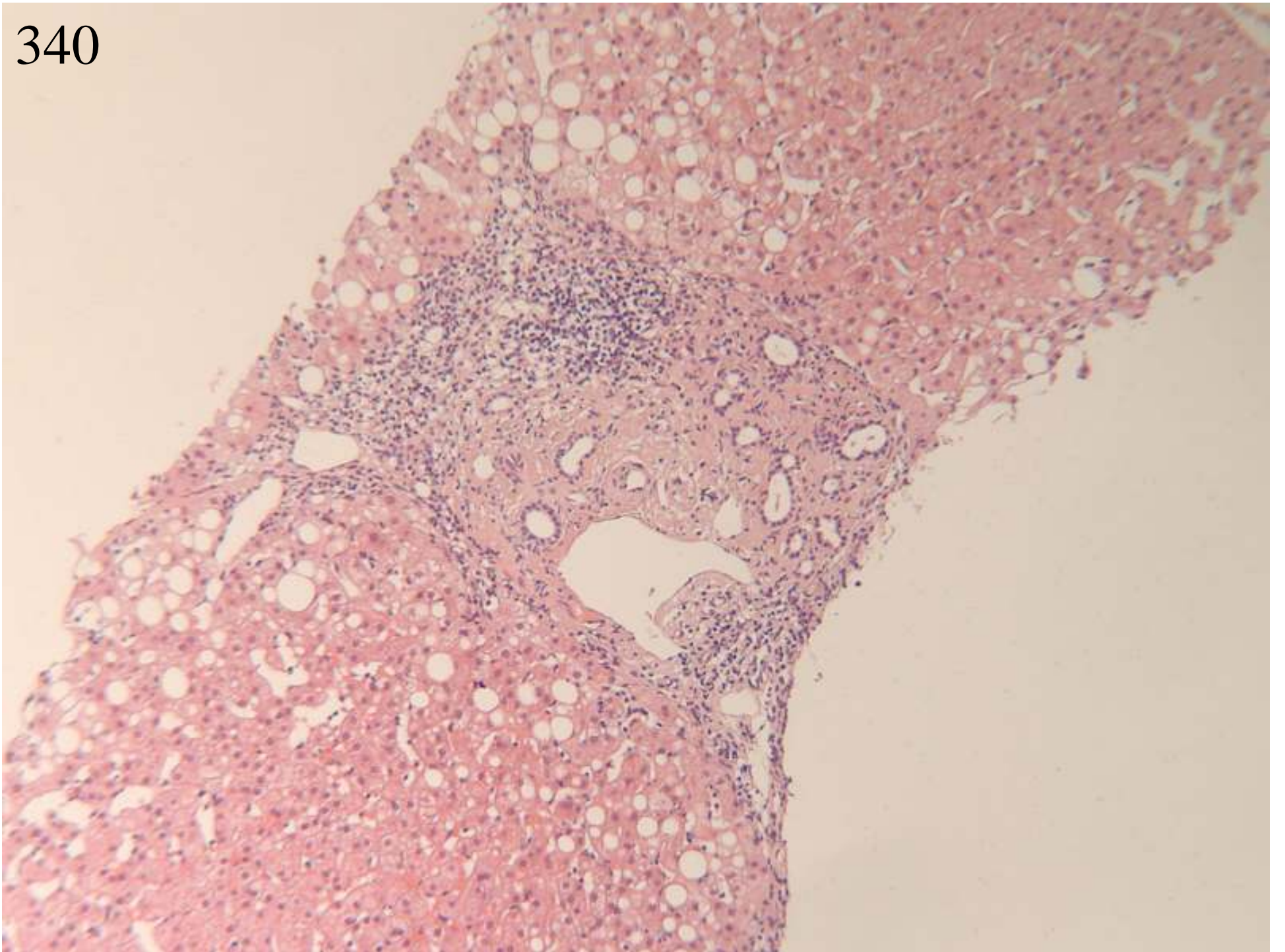
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61 hepatitis C

2 HCV not mentioned in diagnosis

1 overlap syndrome, probably AIH and HCV

1 ?PSC, ?IgG4 disease, - not included chronic hepatitis or hepatitis C

Stage:

(Grade – see next slide)

13 cirrhosis

24 developing cirrhosis/Ishak stage 5

18 bridging fibrosis

1 portal fibrosis

5 no stage given (but all commented on need for special stains)

39 include steatosis

5 need orcein to exclude biliary disease

7 also incidental ductal plate malformation/VMC

Agreed scoring; require hepatitis C and some comment on stage - at least a mention of fibrosis and request for fibrosis stain.

340

Grade:

10 mild inflammation

22 moderate inflammation

3 marked inflammation

2 Confluent necrosis ? bridging

Ishak grades: 5: 11

6: 4

7: 7

8: 1

9: 1

Case 340: original pathologist's diagnosis:

Chronic HCV. Moderate marked necroinflammatory disease.
Significant fibrosis-bridging probable early cirrhosis

Discussion: responses need to include an indication that the histology is consistent with the clinical cause of disease, e.g. Hepatitis C in this case.

The spectrum of stage/grade is included in the collated responses so that individuals can see how their assessment compares with their peers.

Steatosis should be included in hepatitis C reports, since it is associated with more rapid progression and a reduced response to treatment.

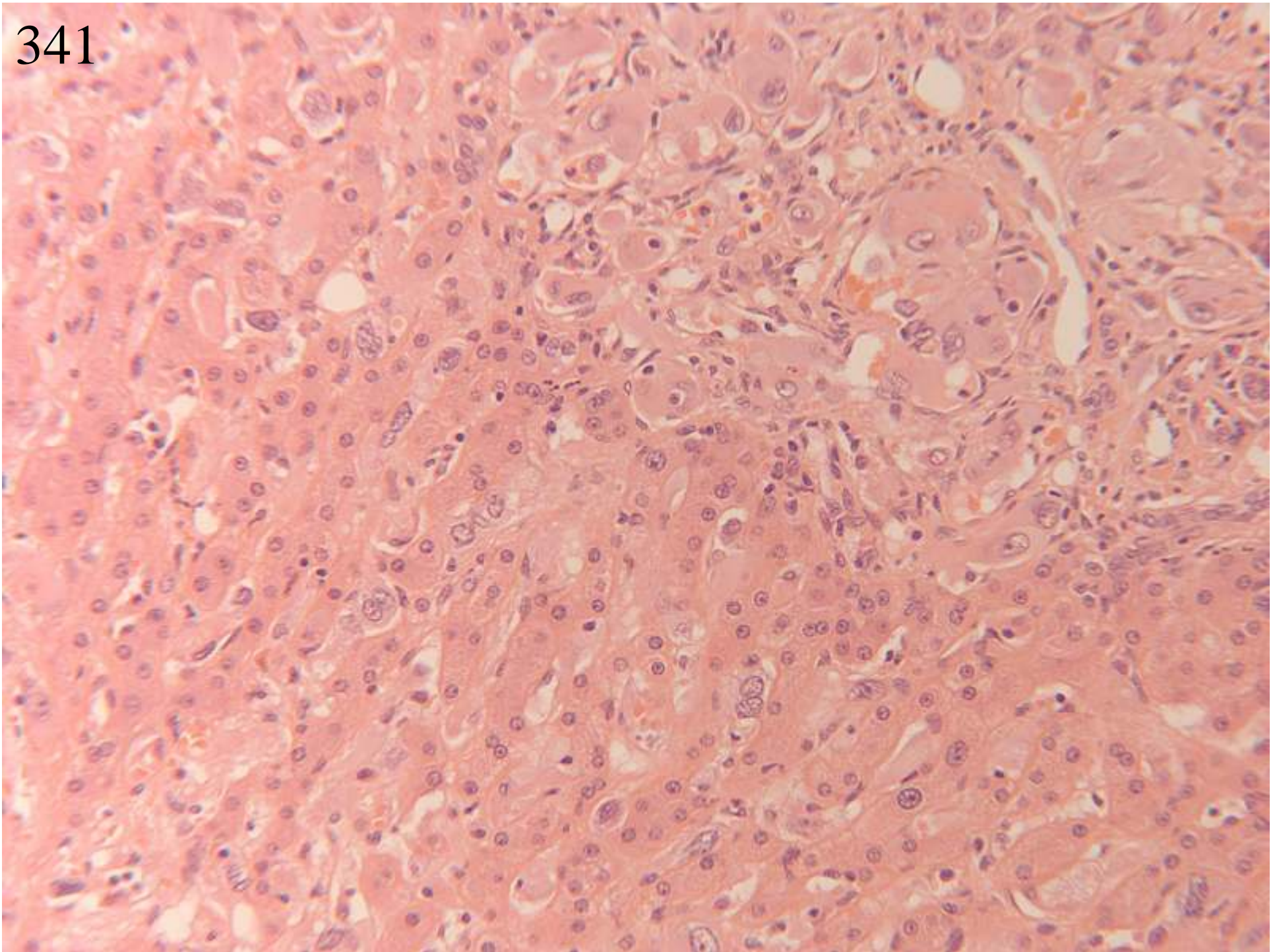
Case 341

- *female, 38 years*
- *Incidental space occupying lesion in right lobe of liver. Core biopsy of liver*
- *R hepatectomy*
- *Pale lesion 35mm in greatest dimension in a non-cirrhotic liver*

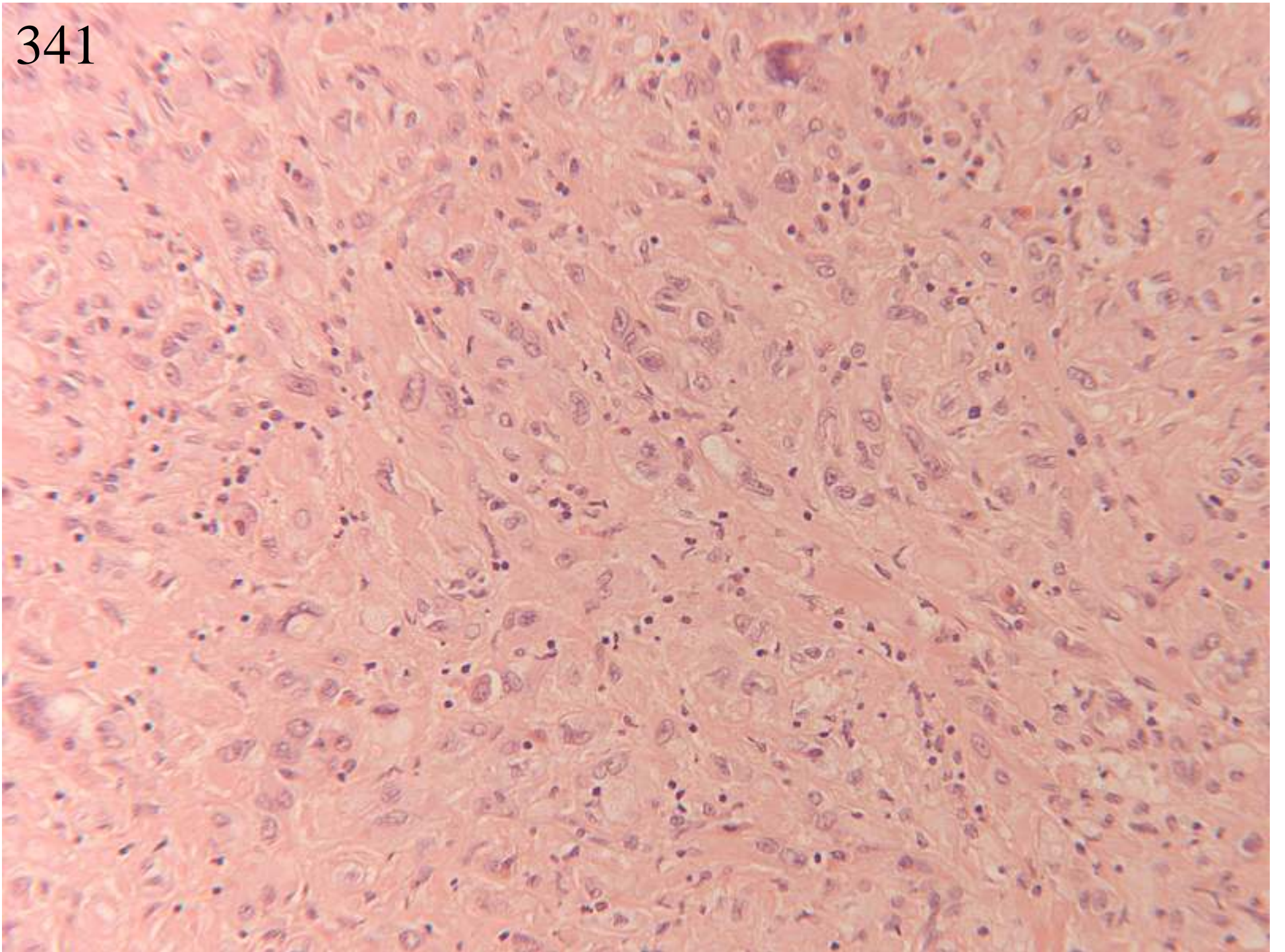
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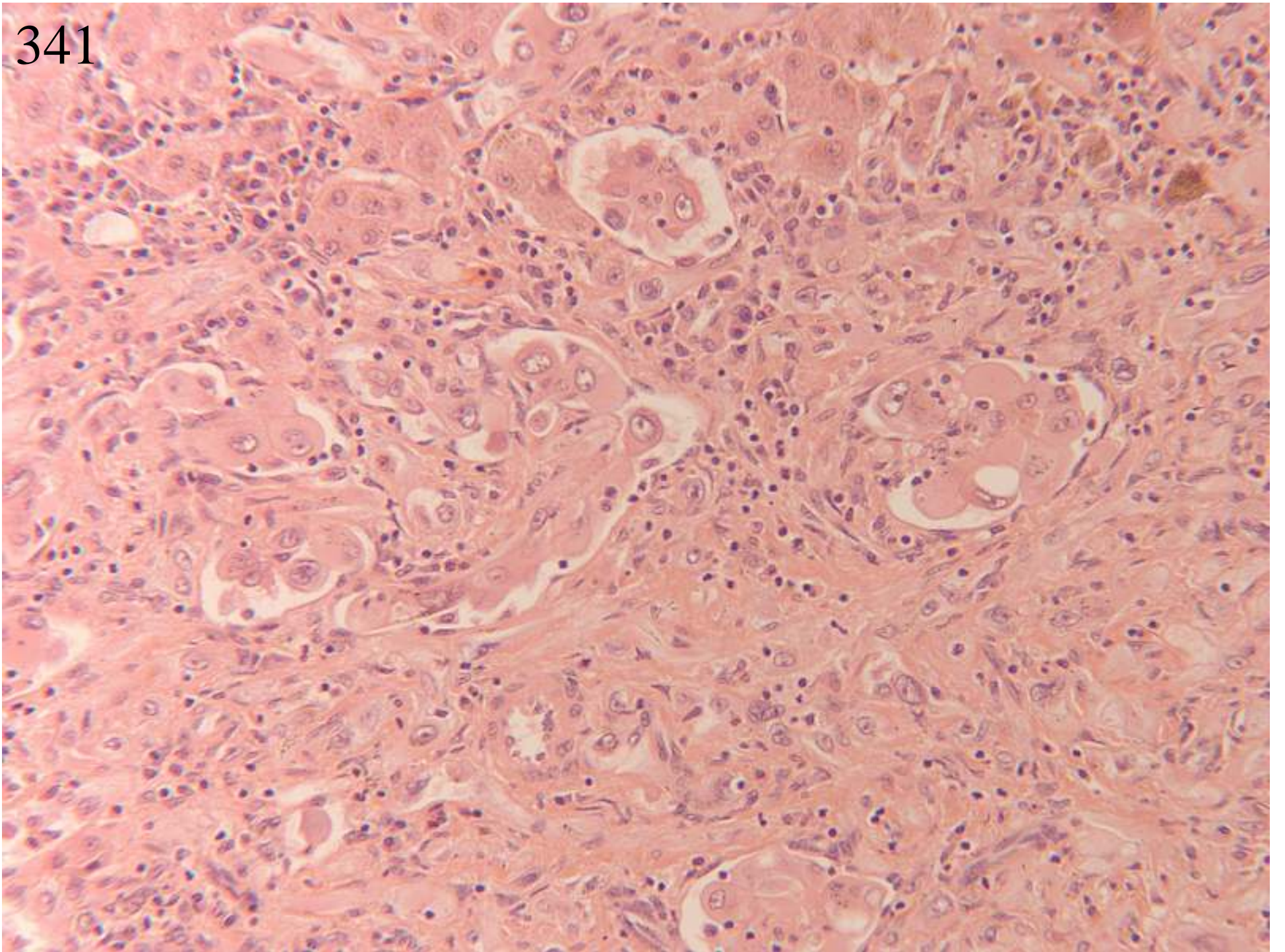
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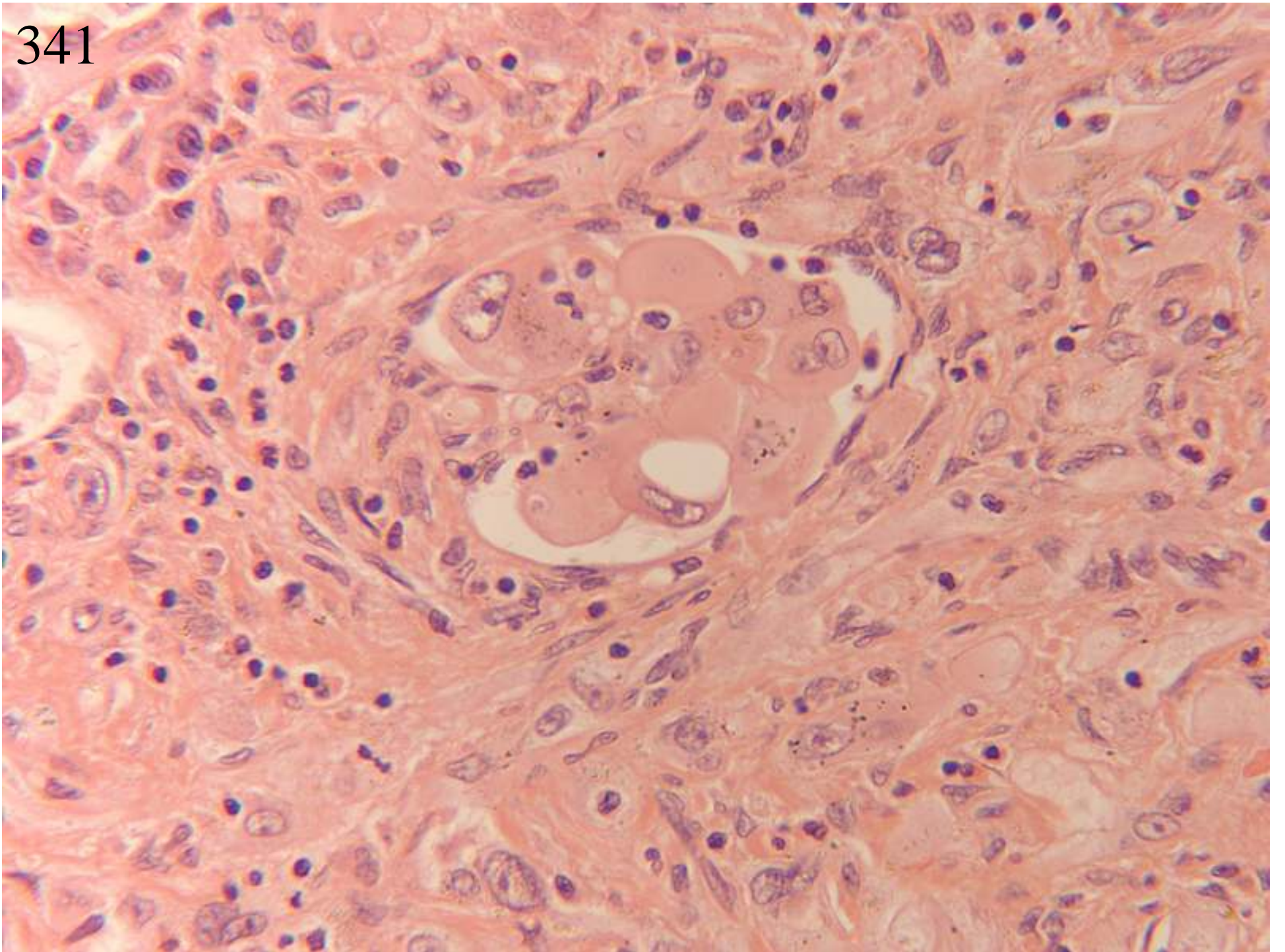
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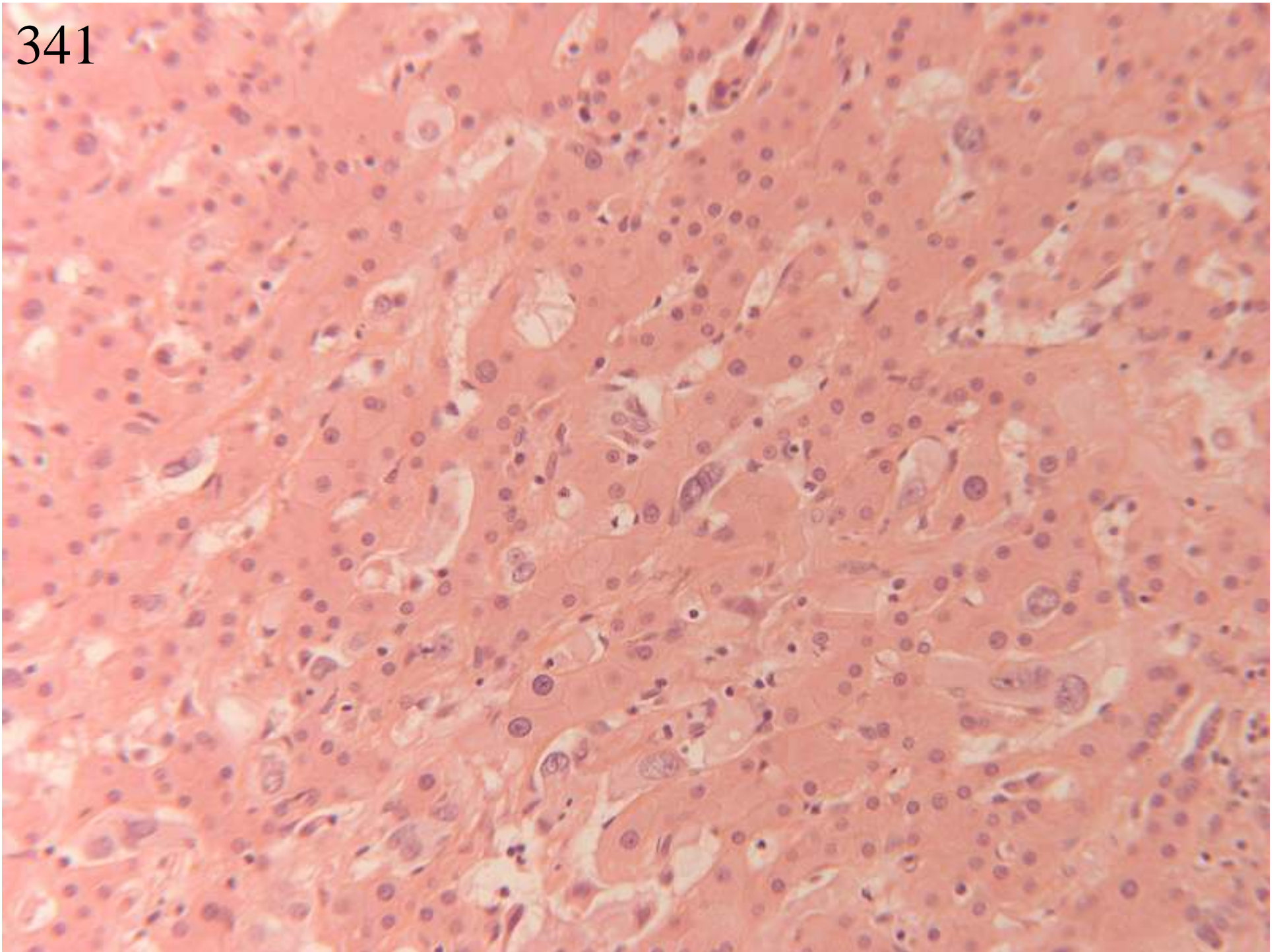
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- 12 malignant with wide differential, needs immunos
- 4 malignant, wide differential includes epithelioid haemangioendothelioma
- 28 epithelioid haemangioendothelioma
- 2 metastatic ? melanoma
- 1 probably malignant needs immunos
- 5 HCC
- 7 fibrolamellar HCC
- 2 FNH with atypia
- 2 Rosai Dorfman disease
- 2 ??angiomyolipoma
- 1 extramedullary haematopoiesis – megakaryocytes and fibrosis

Not sufficient consensus for scoring

Case 341: original pathologist's diagnosis:

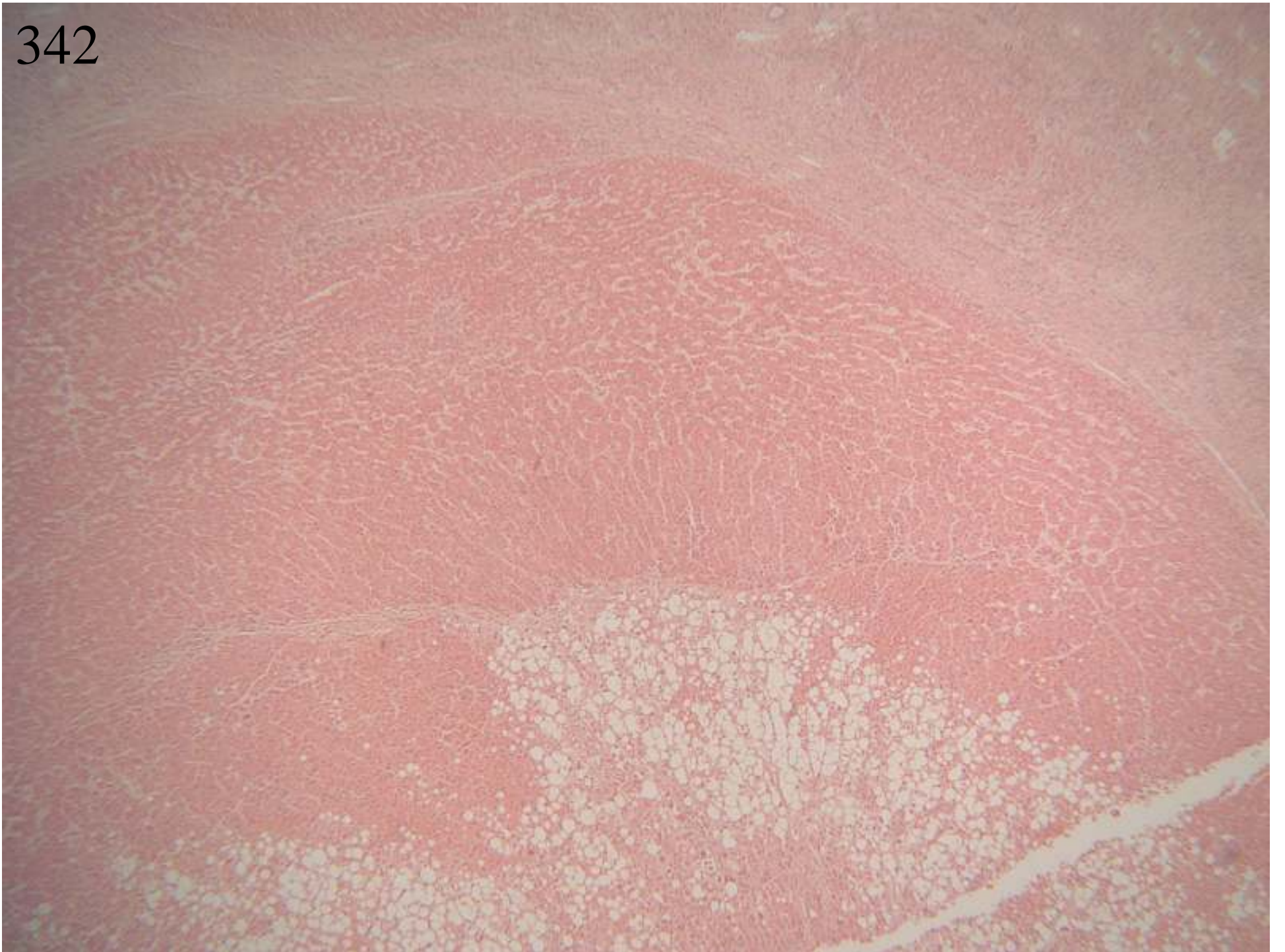
epithelioid haemangioendothelioma

Discussion – no time during the meeting. This case is at the angiosarcomatous end of the epithelioid haemangioendothelioma spectrum. Diagnosis confirmed by immunohistochemistry.

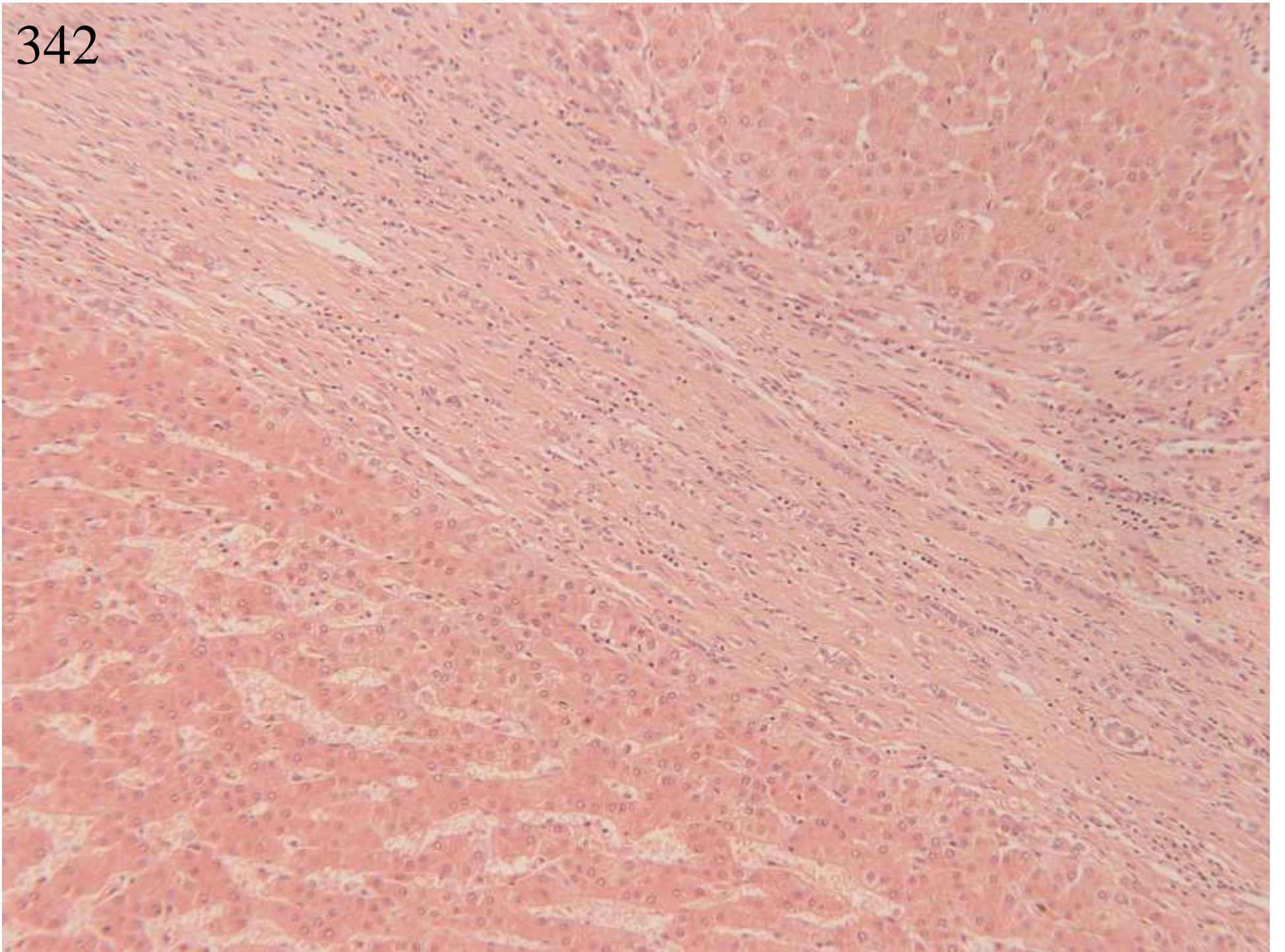
Case 342

- *male, 56 years*
- *Orthotopic liver transplant for HCV cirrhosis*
- *Explanted Liver*
- *6mm diameter green and white nodule in right lobe of a cirrhotic liver. Most of the rest of the liver consists of nodules 1-5mm diameter*

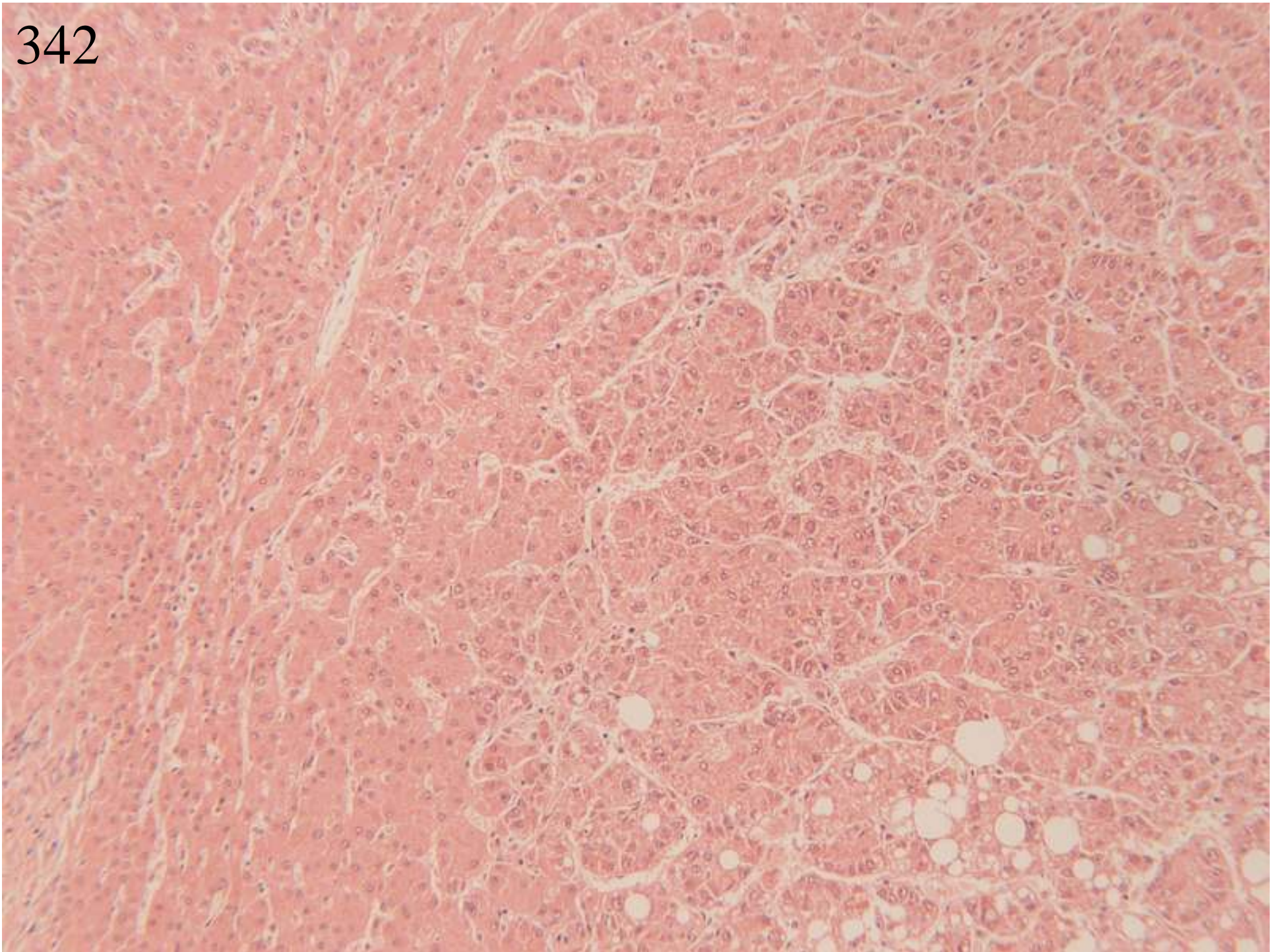
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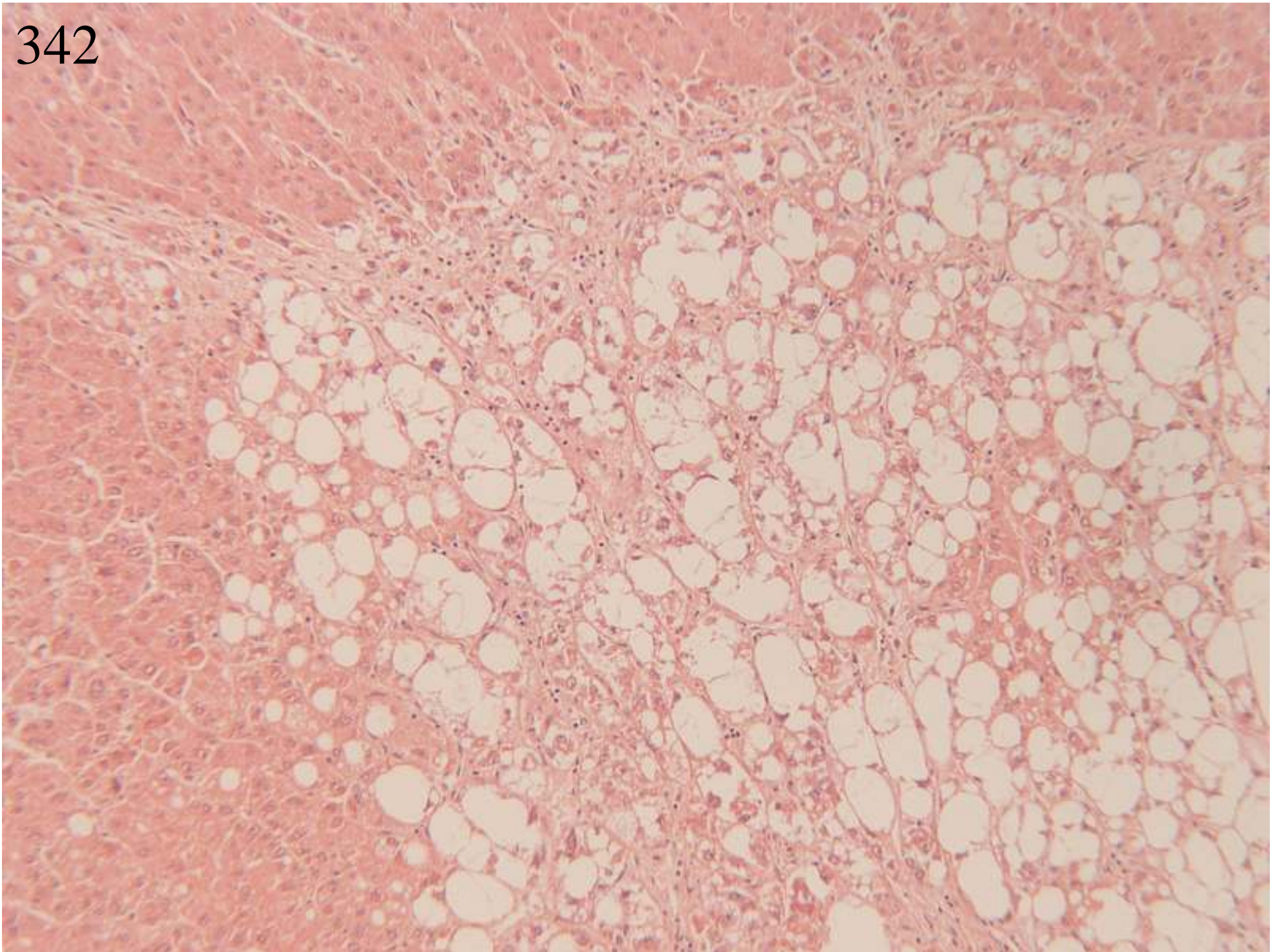
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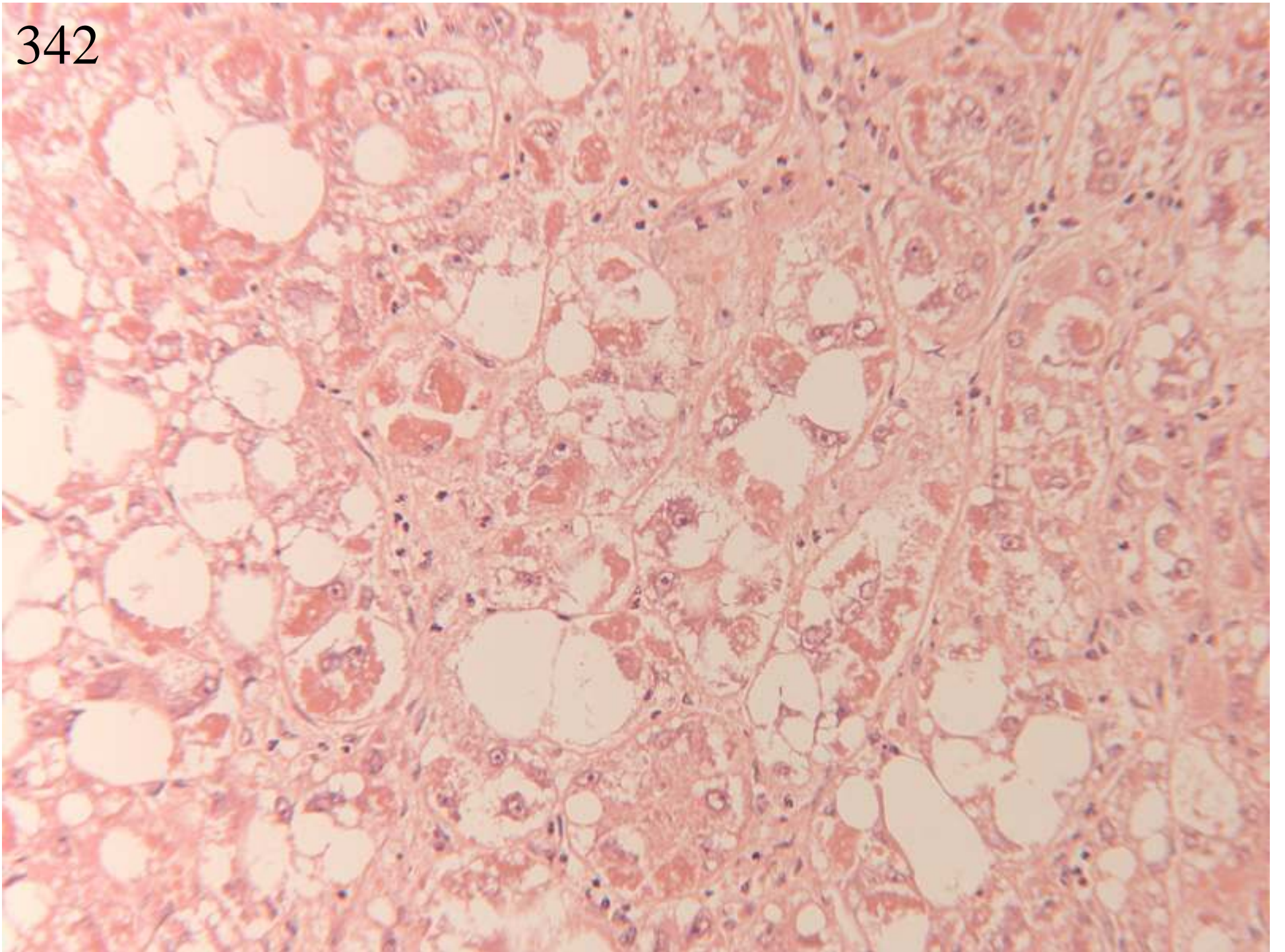
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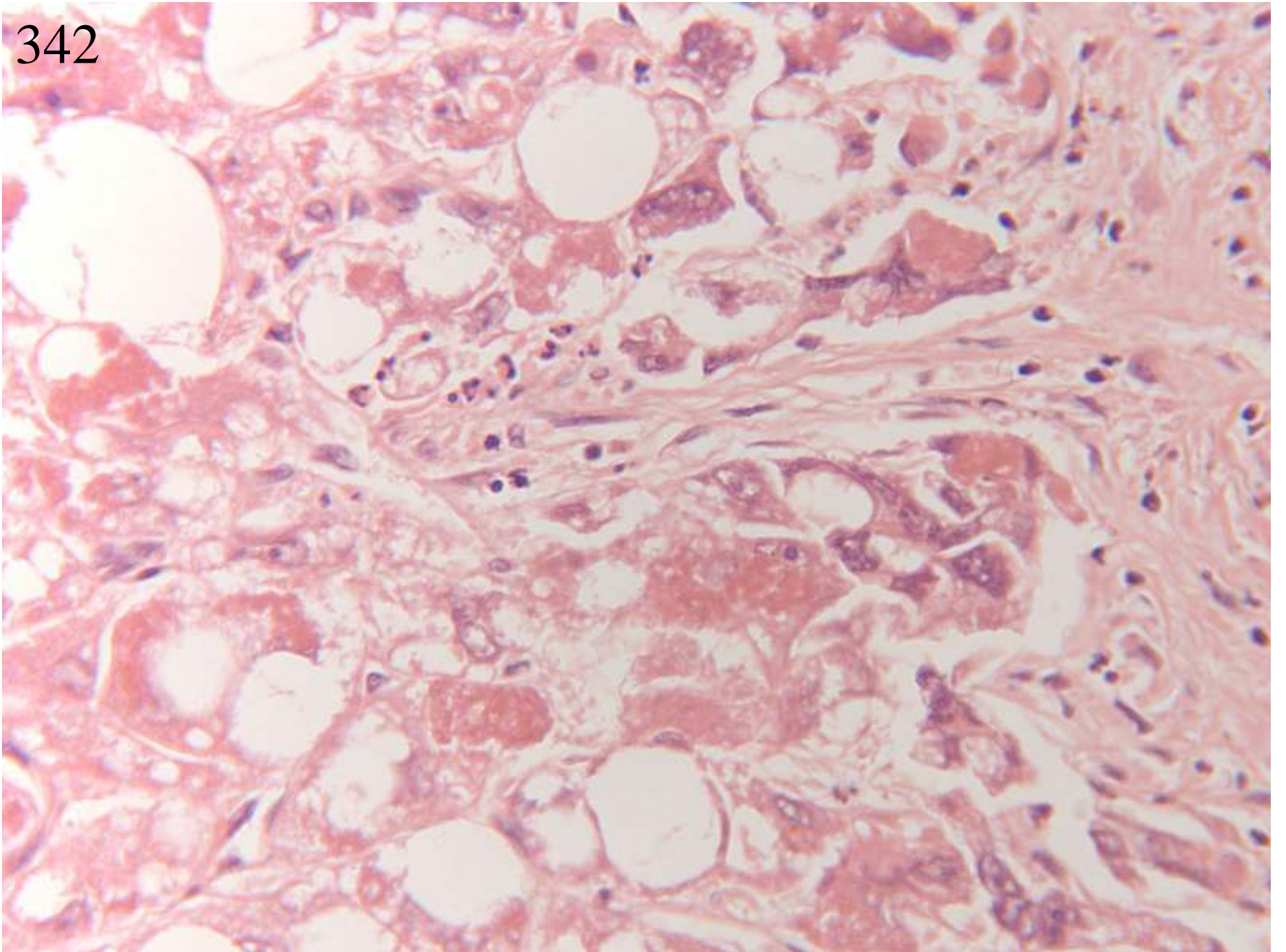
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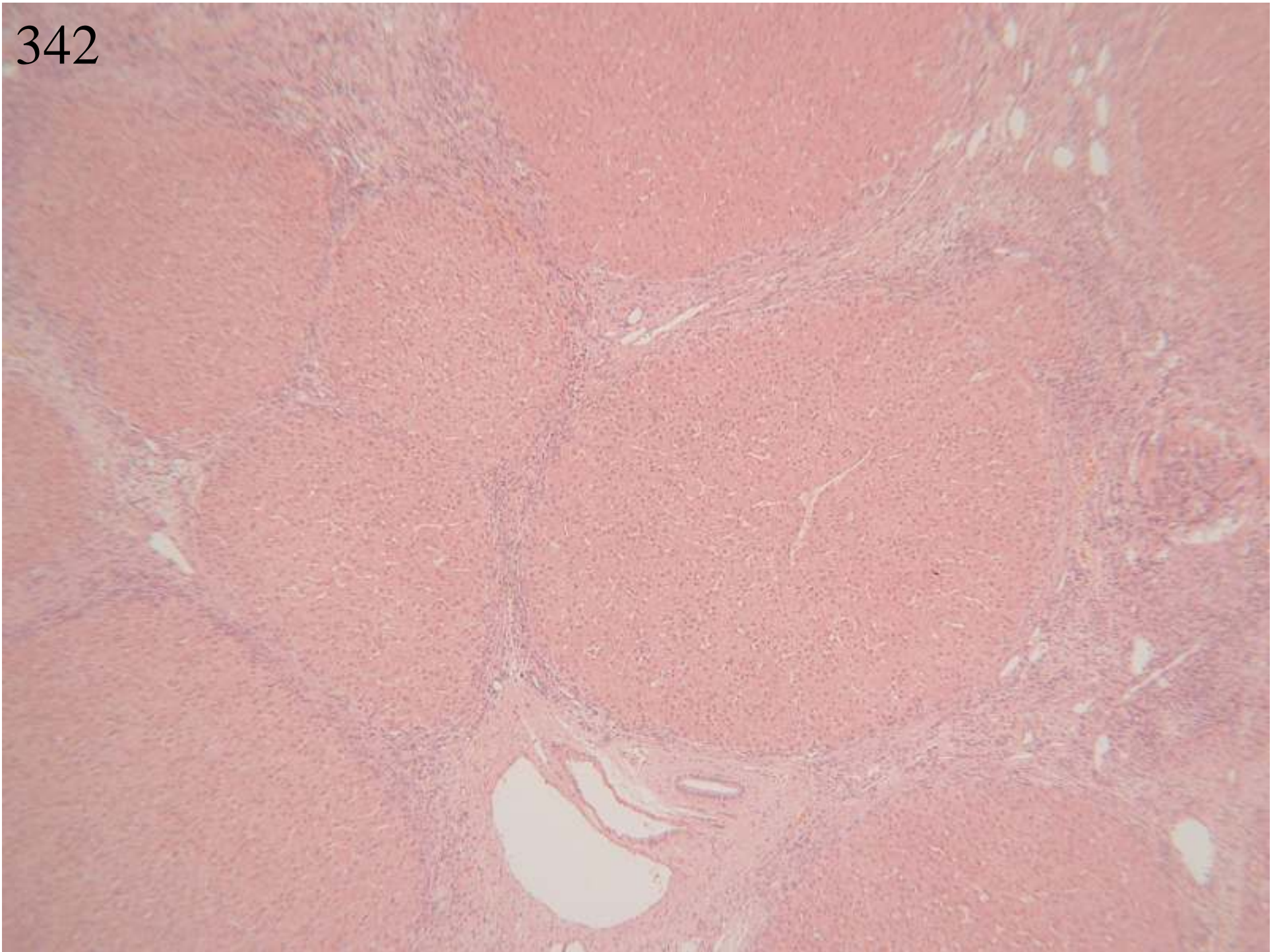
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- 32 HCC
- 9 dysplastic nodule ?HCC
- 13 dysplastic nodule
- 7 macro-regenerative nodule
- 1 macro-regenerative nodule ? atypical adenomatous hyperplasia
- 1 HCC or adenomatous hyperplasia
- 1 fatty change in nodule
- 1 FNH
- 1 PLCC (*-what's this? – assumed primary liver cell cancer*)

- 52 cirrhosis
- 13 stage not mentioned
- 21 c/w hepatitis C
- 41 hepatitis C not mentioned

Agreed scoring: accept dysplastic nodule or HCC.

Should HCC be at least in the differential? – but if so, there would be insufficient consensus(64% - normally require 80%) for the case to be scored – see next slide..

Case 342: original pathologist's diagnosis:

small hepatocellular carcinoma

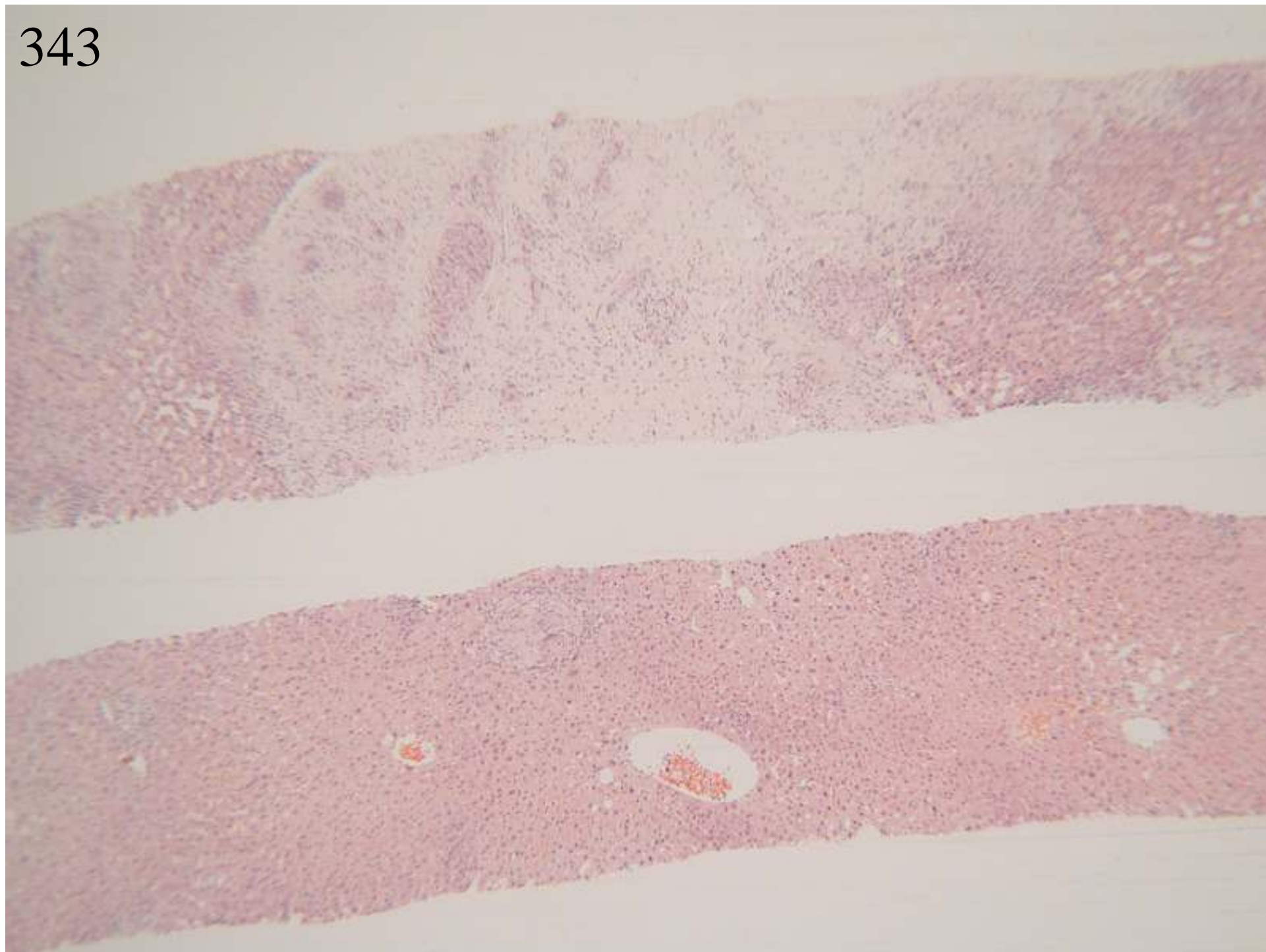
Discussion: Diagnosis of early HCC was a topic elsewhere in the update meeting. This case was considered to meet criteria at least for high grade dysplastic nodule. Adenomatous hyperplasia is not an appropriate term in the context of a cirrhotic liver.

It's good practice to include a comment on background liver but since on this occasion cirrhosis is already stated in the clinical information, responses not penalized for missing it out.

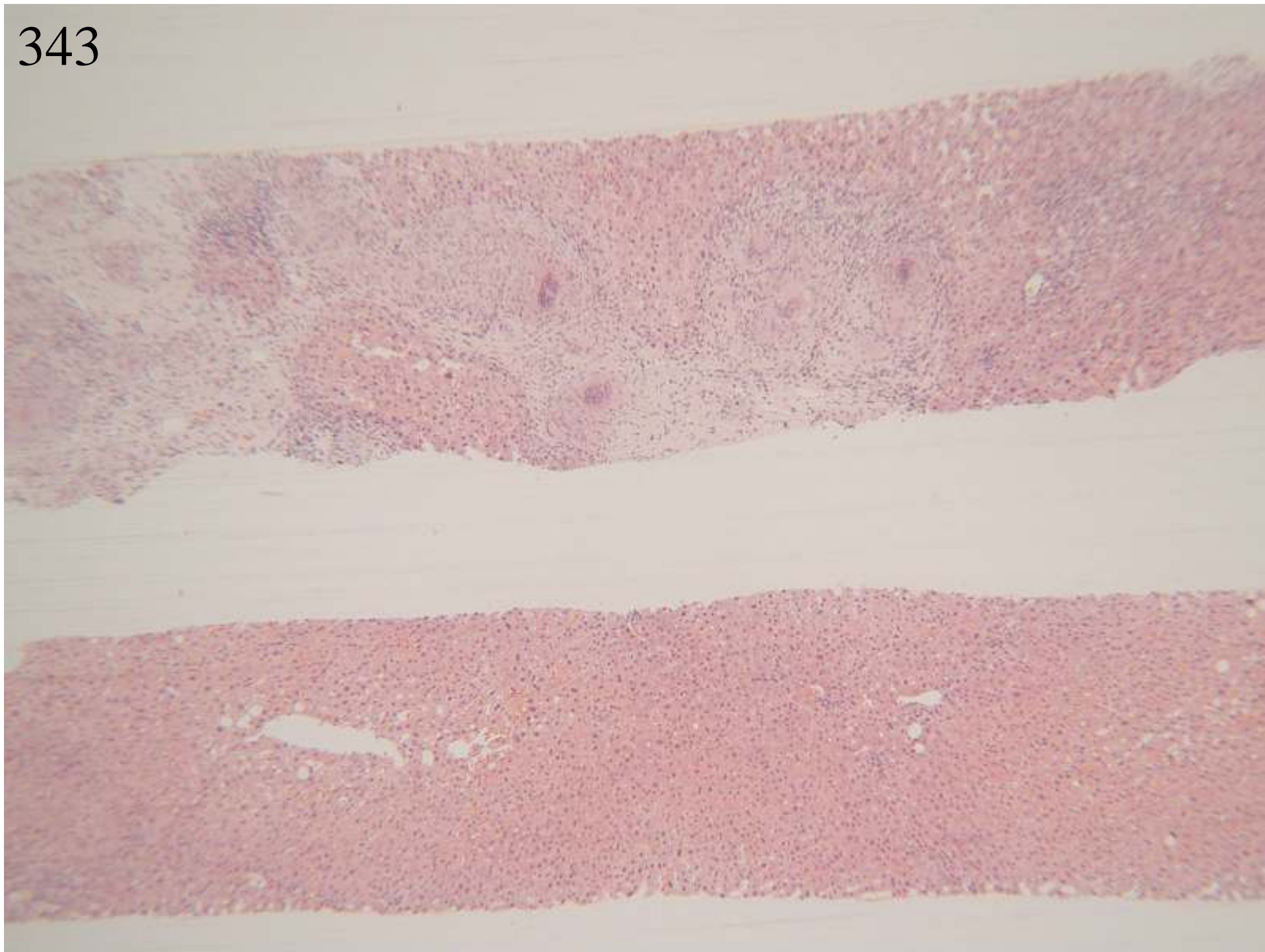
Case 343

- *male, 44 years*
- *Farmer who presented to the chest physicians with respiratory symptoms . On CT scan he had enlarged hilar nodes and an enlarged liver.*
- *Liver biopsy - 2 cores each 26mm long*

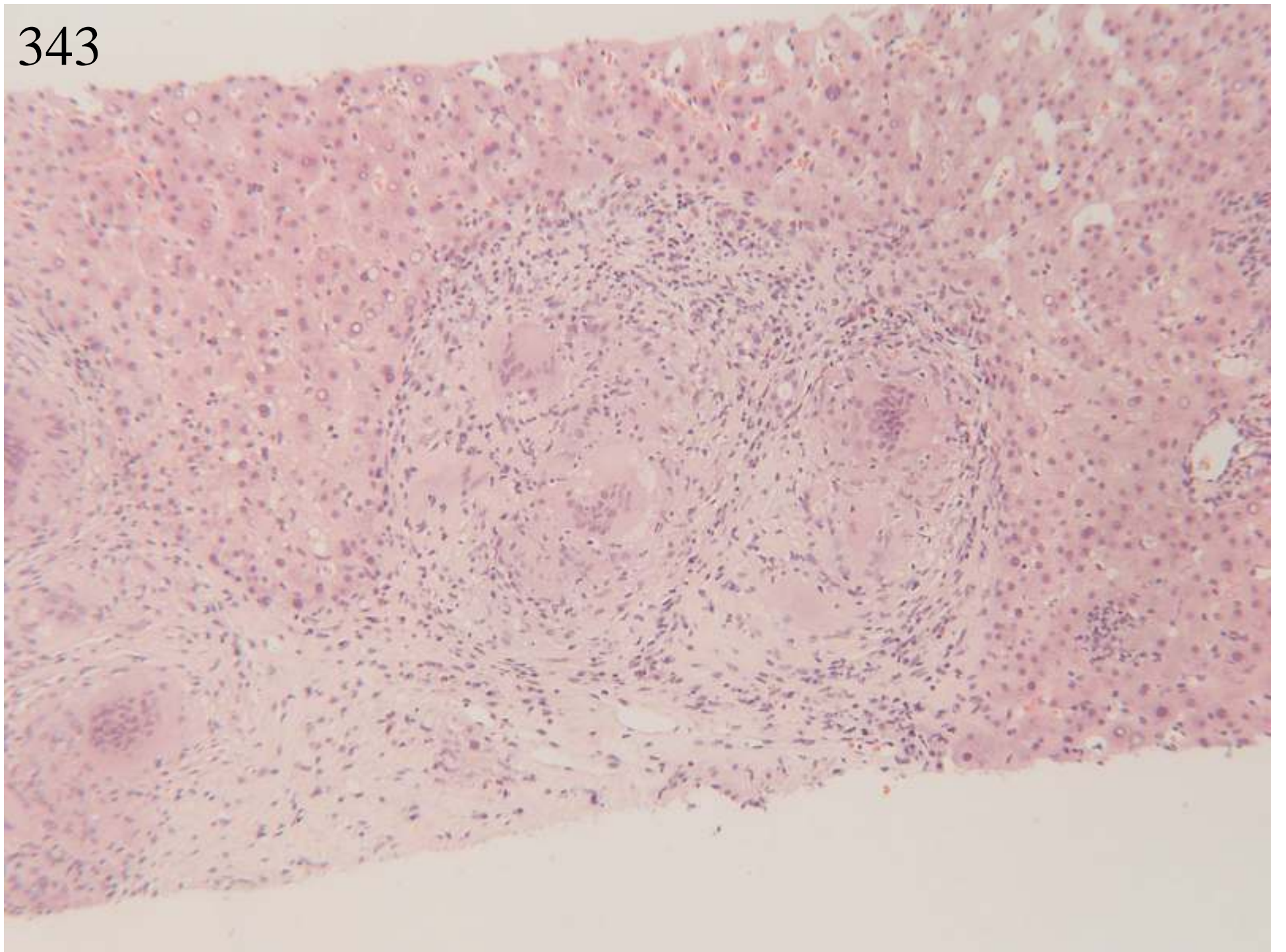
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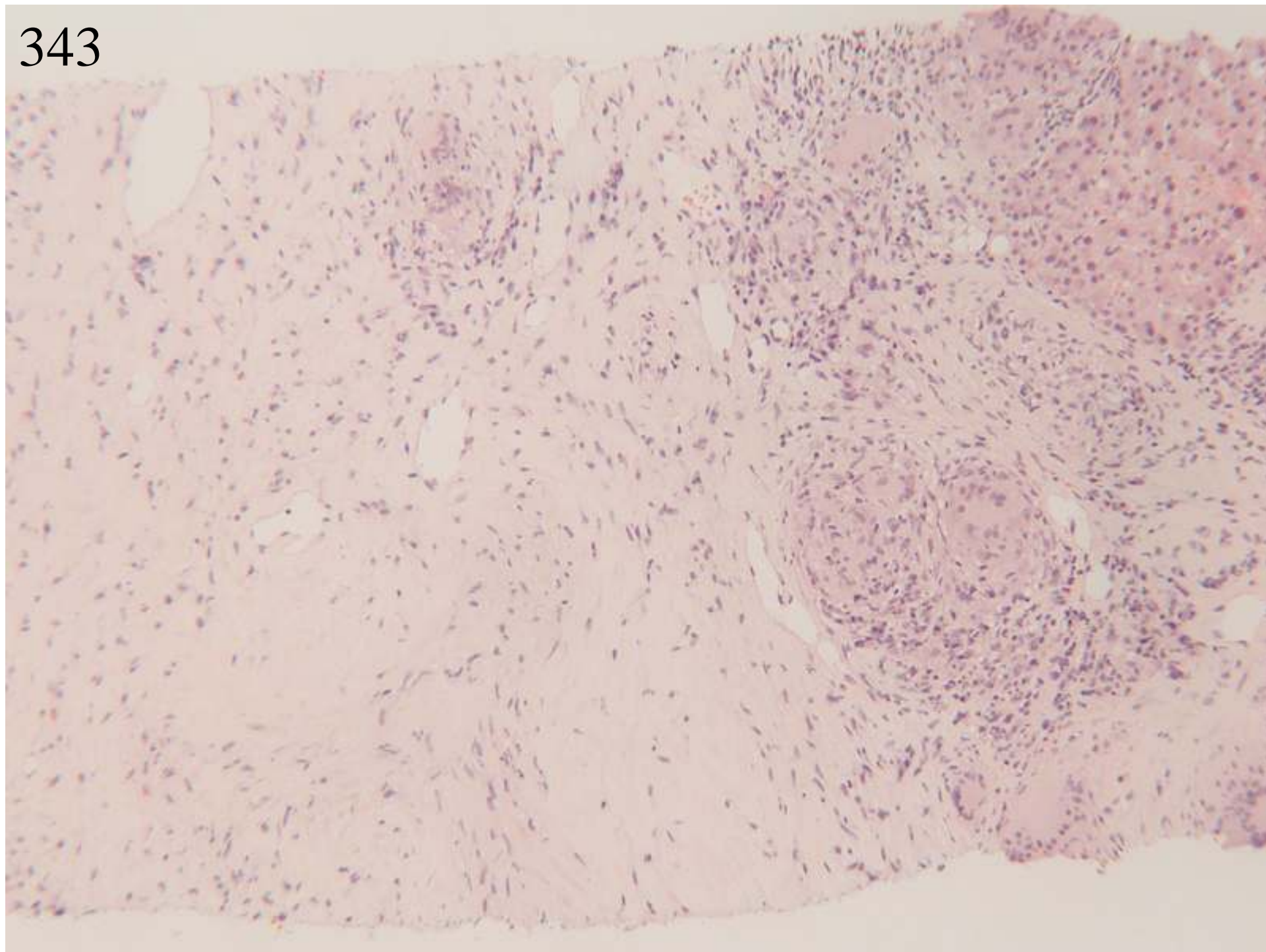
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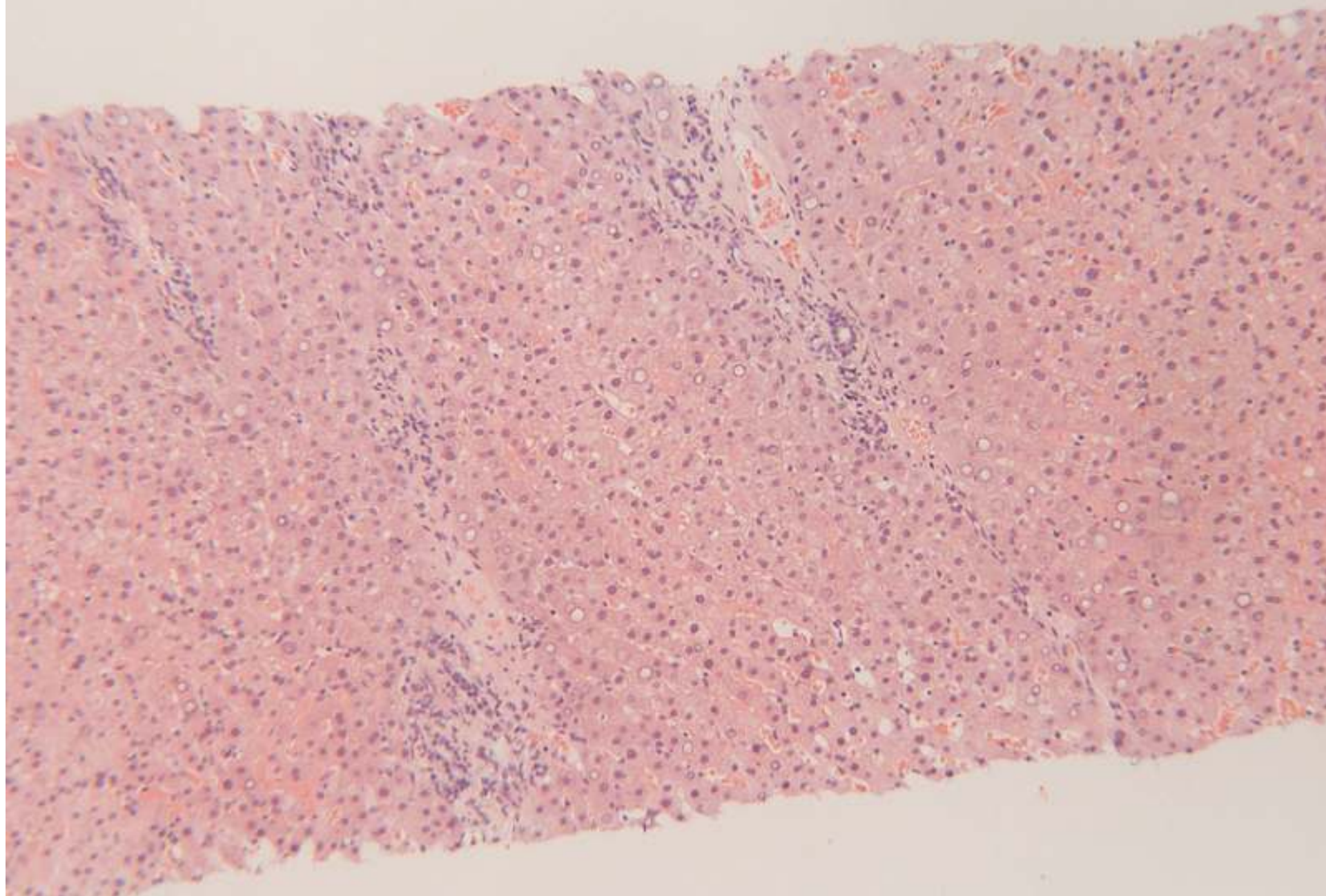
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64 granulomatous

27 commented on fibrosis

12 commented on sinusoidal dilatation

4 commented on ductopaenia

8 sarcoid as only cause

11 sarcoid most likely, alternative causes not listed

35 sarcoid most likely, with differentials listed

6 list of differentials that includes sarcoid, but not most likely

1 Brucellosis, exclude TB, sarcoid, drugs

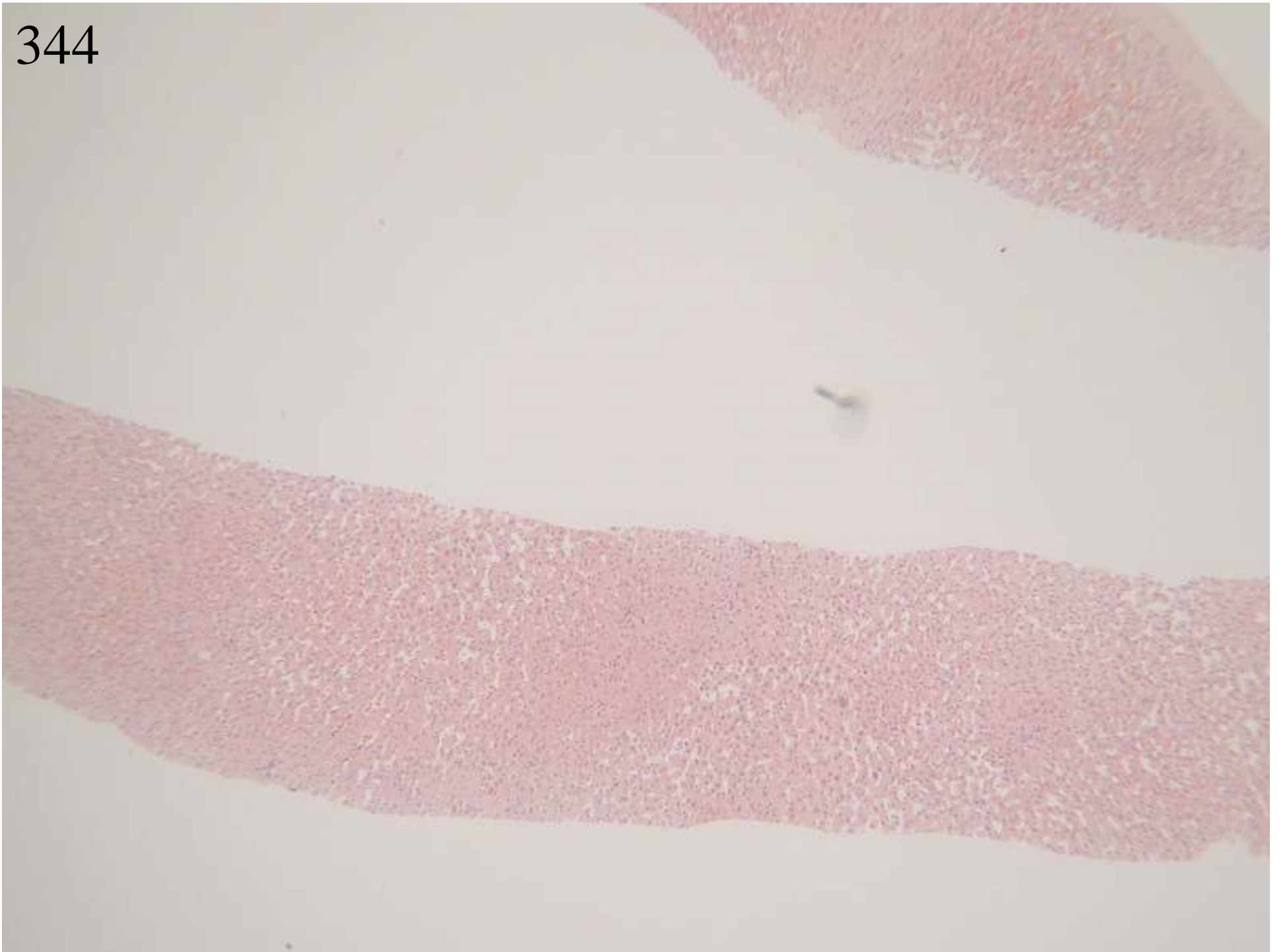
1 most likely TB, sarcoid not mentioned in differentials

Agreed scoring: accept diagnosis that includes granulomatous inflammation and sarcoid as main diagnosis or in differential

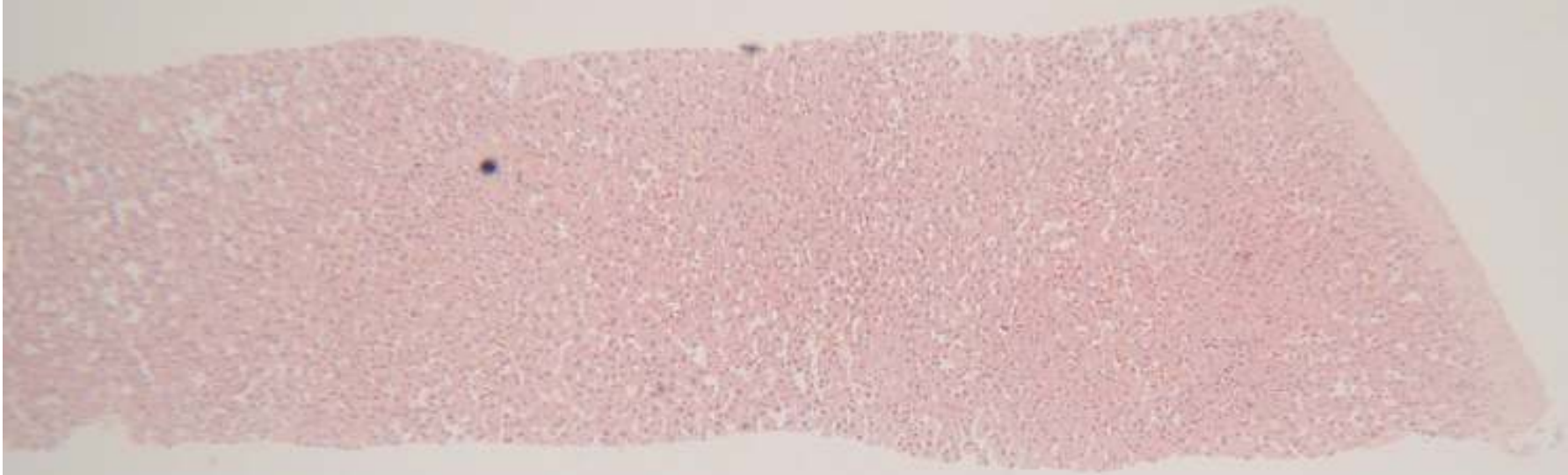
Case 344

- *male, 63 years*
- *Previous diagnosis of non cirrhotic portal hypertension, ?cirrhosis, has CRF due to diabetes*
- *Liver biopsy - Four cores, 4mm to 17mm in length*

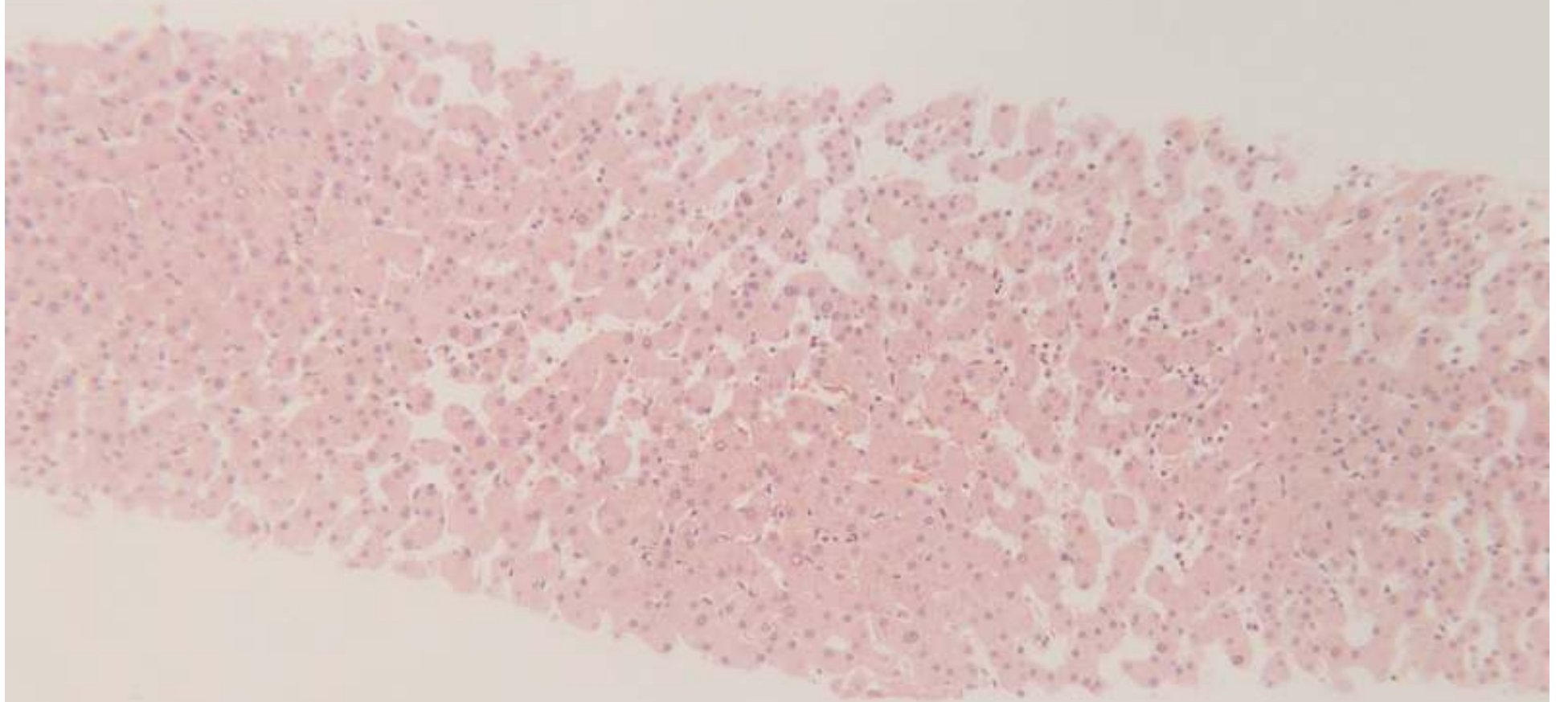
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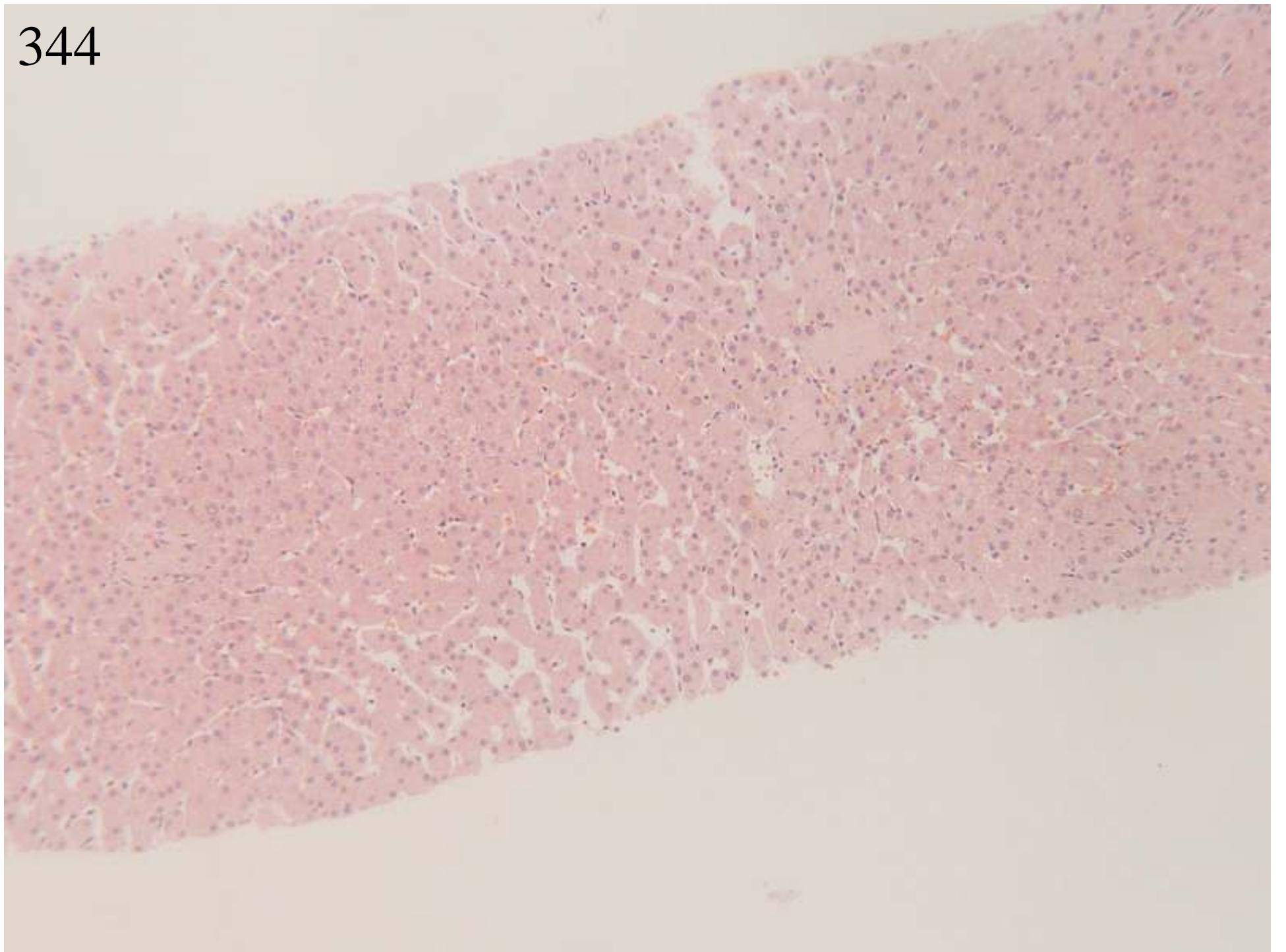
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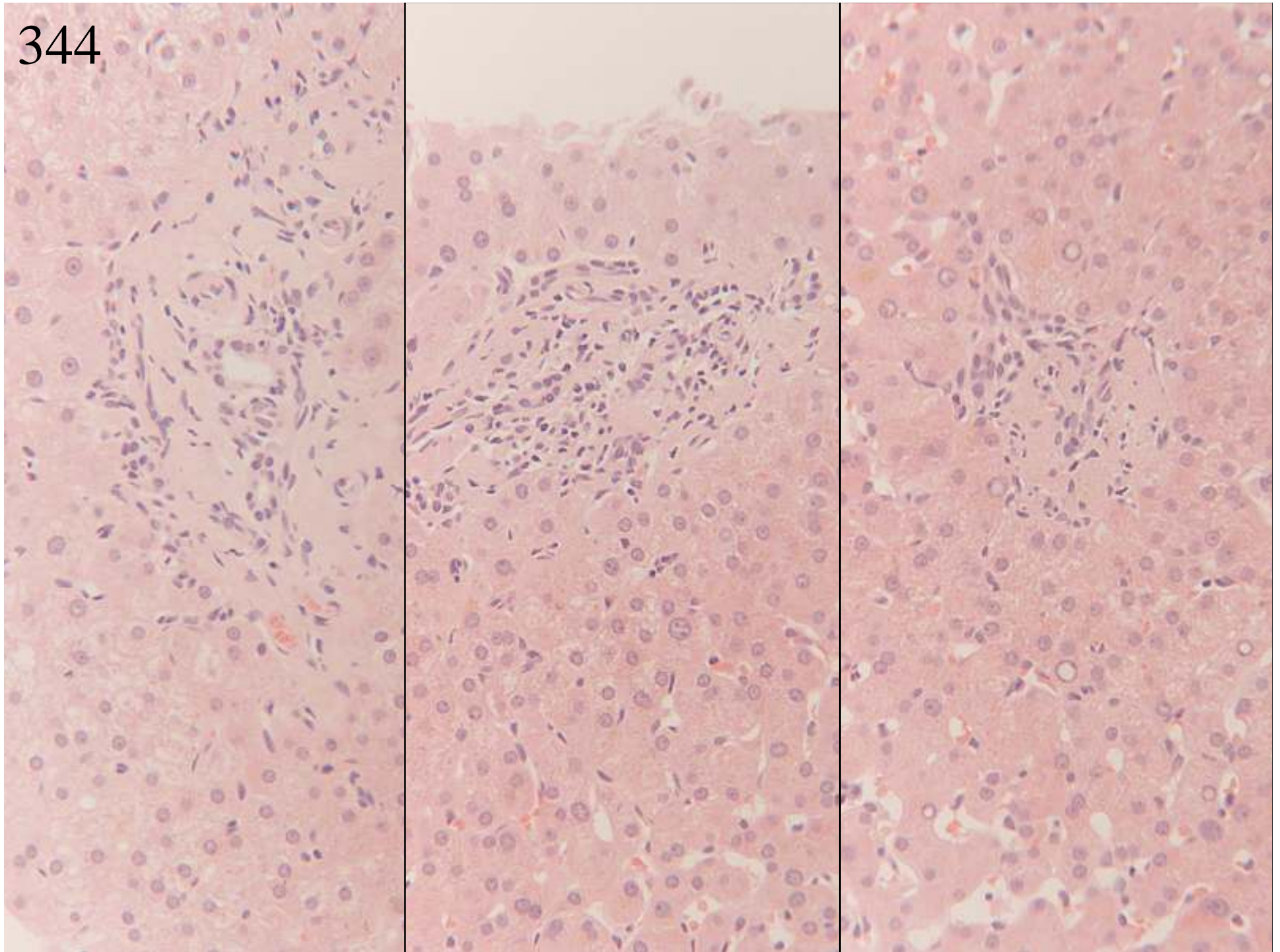
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- 13 nodular regenerative hyperplasia
- 1 nodular regenerative hyperplasia v. incomplete septal cirrhosis
- 23 descriptive, consistent with non-cirrhotic portal hypertension
 - 1 non-cirrhotic portal fibrosis
 - 1 hepato-portal sclerosis
 - 1 possible hepatic vein thrombosis, exclude adenoma
 - 1 sinusoidal dilatation, ? cause
- 3 veno-occlusive disease
- 1 portal vein thrombosis
- 5 venous outflow obstruction, ?BCS
- 2 chronic passive congestion
- 1 outflow obstruction or regenerative hyperplasia
- 1 consistent with a vascular problem, cirrhosis not mentioned

5 descriptive, no diagnosis, but includes 'no cirrhosis' and discussion of perfusion changes/lack of portal vein branches

1 description, non-specific

1 normal

1 amyloid? Eosinophilic material (only diagnosis)

1 haemochromatosis with focal fibrosis

1 drug induced bland cholestasis, exclude iron

1 diabetic changes, no cirrhosis

Agreed scoring – either can't score, or accept any description suggesting a vascular/perfusion abnormality - members voted to accept the suggested scoring.

Case 344: original pathologist's diagnosis:

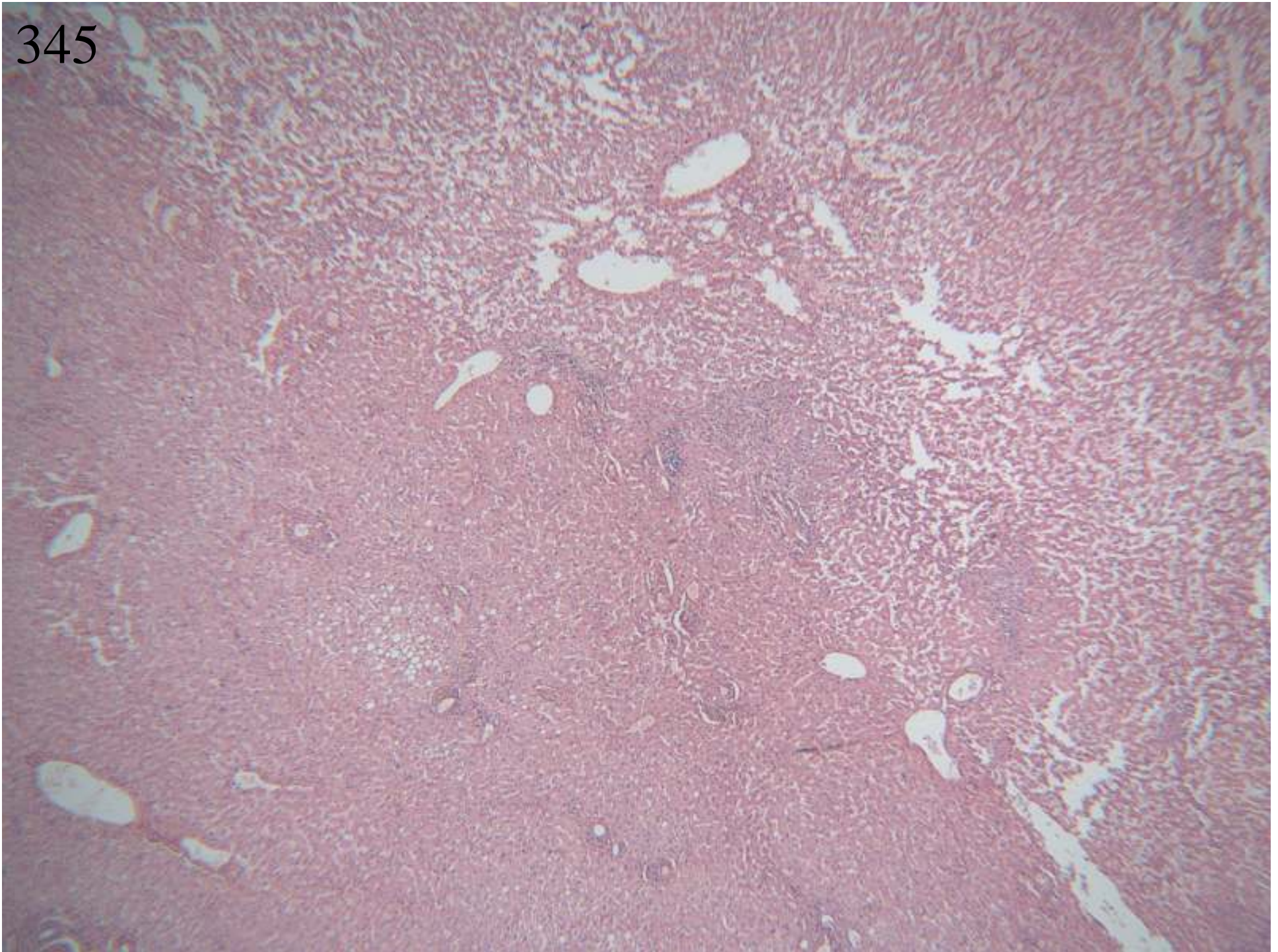
Features compatible with diagnosis of non cirrhotic portal hypertension

Discussion: histopathology of non-cirrhotic portal hypertension had been the subject of the preceding presentation (Hubscher). Features include nodular regenerative hyperplasia, disappearance of portal veins, absence of inflammation and variable sinusoidal fibrosis up to 'incomplete septal cirrhosis'

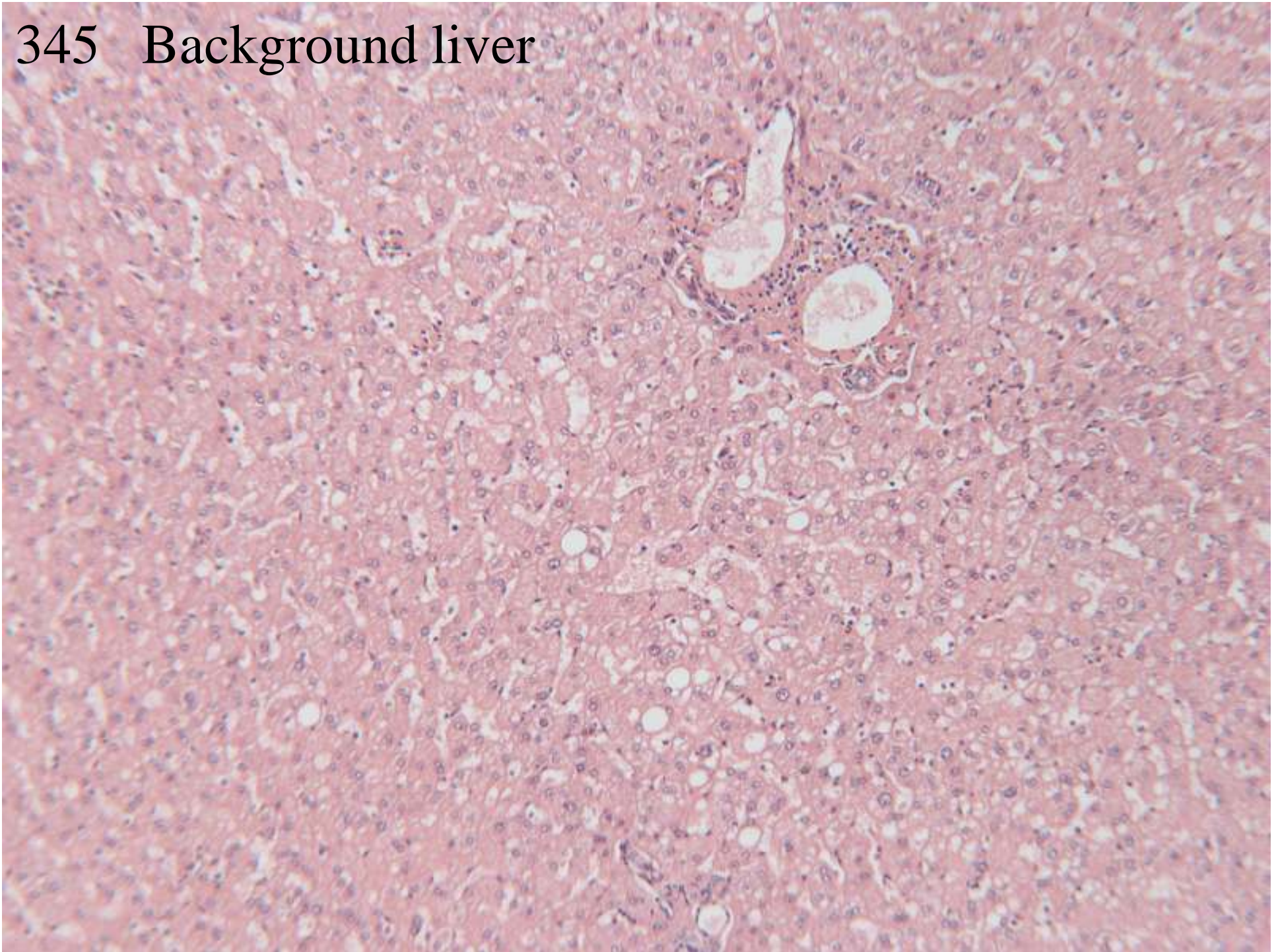
Case 345

- *female, 44 years*
- *Lesion in right lobe of liver. ?Focal nodular hyperplasia.*
- *Right hepatectomy:*
- *Portion of liver measuring 150x125x65mm and weighing 688g. on slicing there is a pale greenish nodule with a variegated cut surface measuring up to 65mm in maximum diameter. There is another nodule 45mm in maximum diameter situated towards one end of the specimen.*
- *This block B6= 1st nodule with adjacent liver*

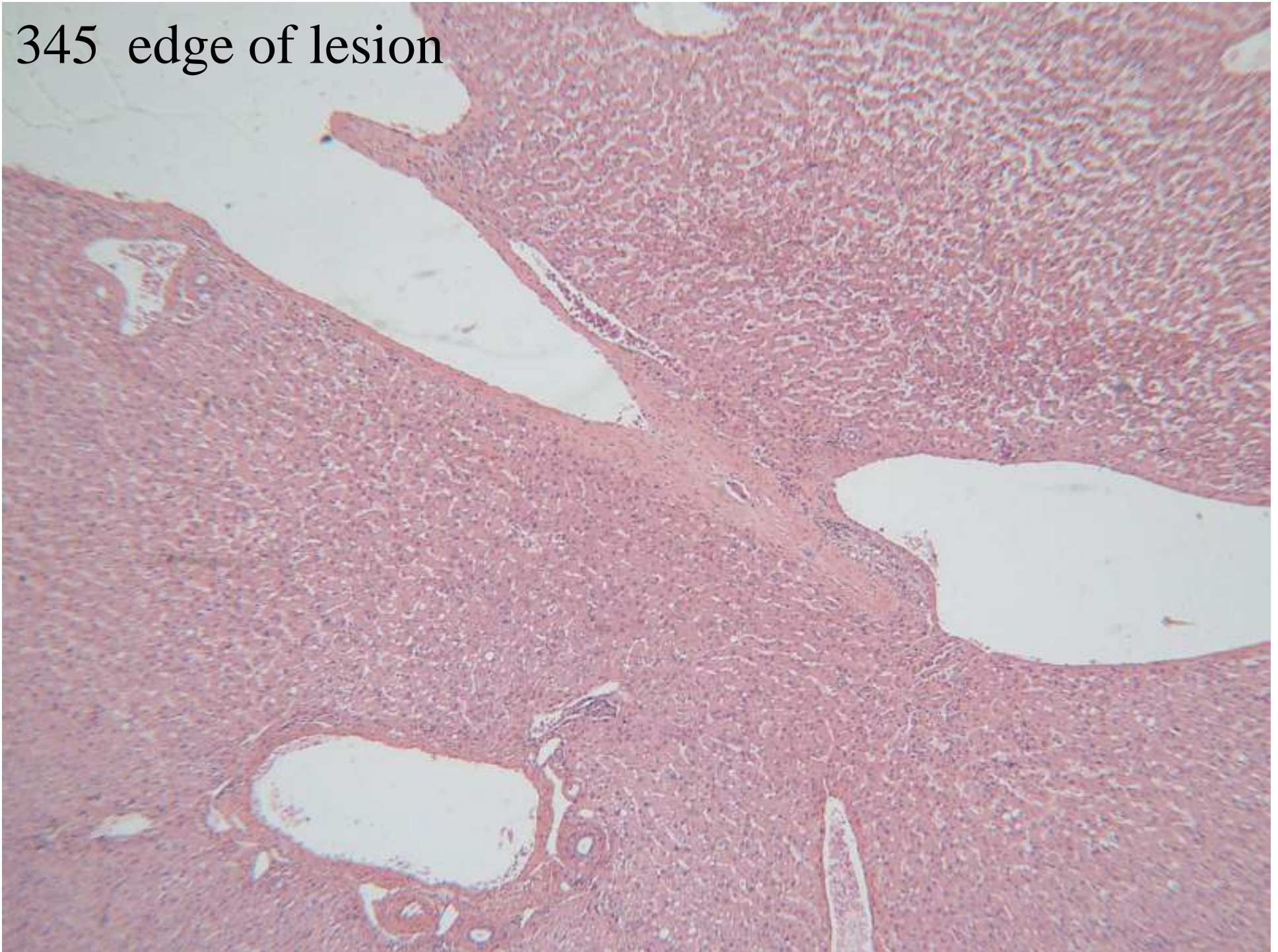
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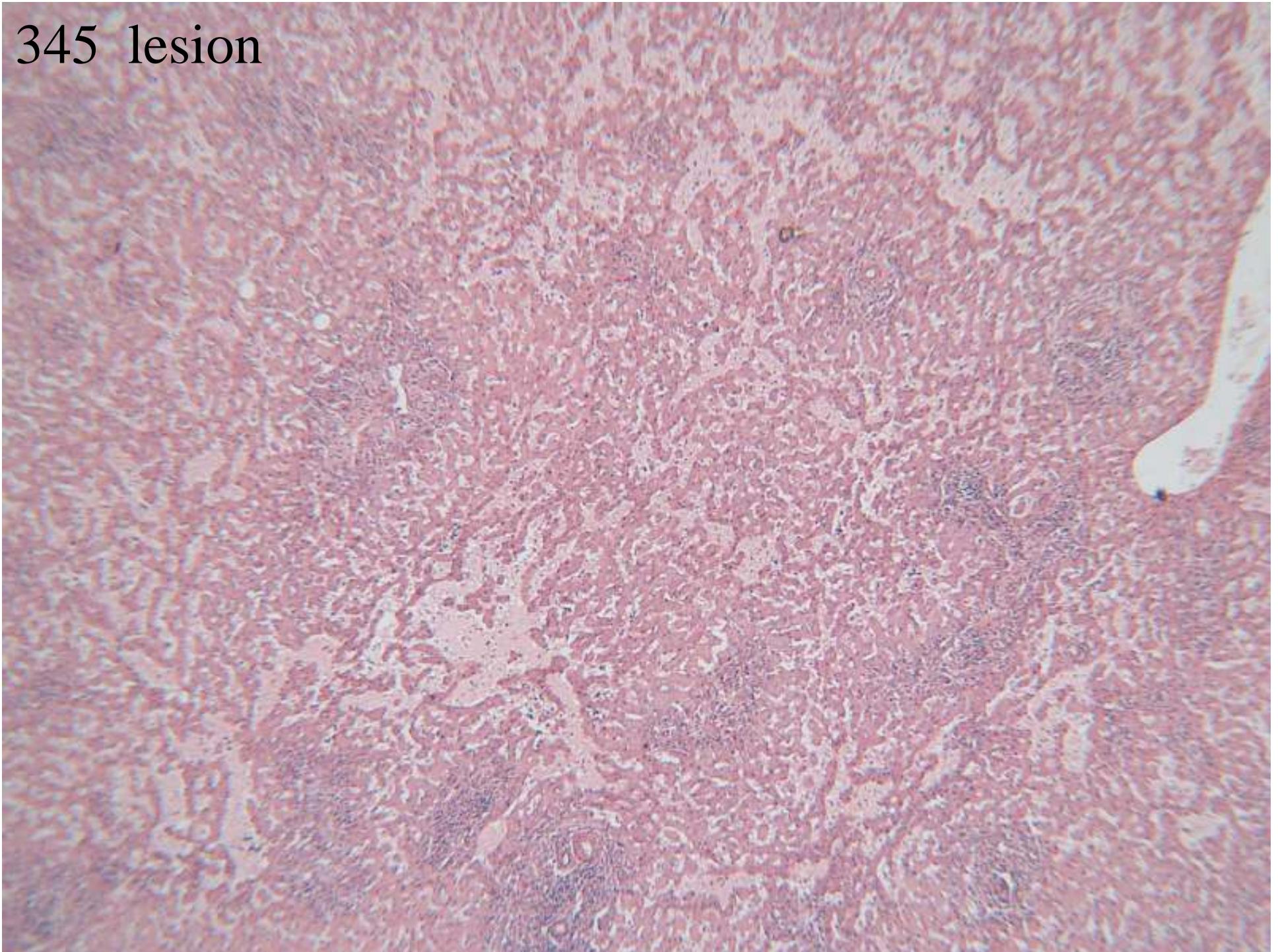
345 Background liver



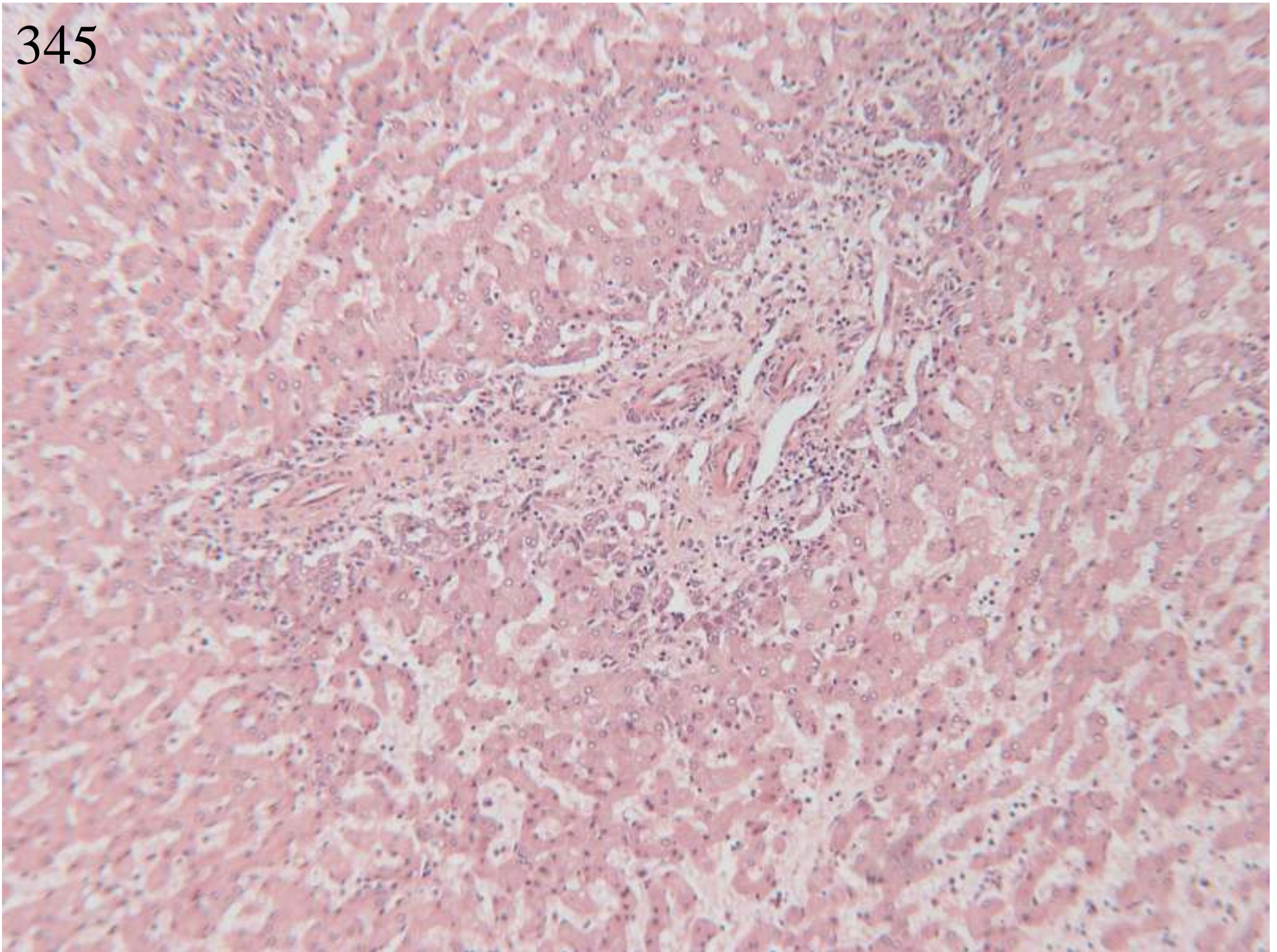
345 edge of lesion



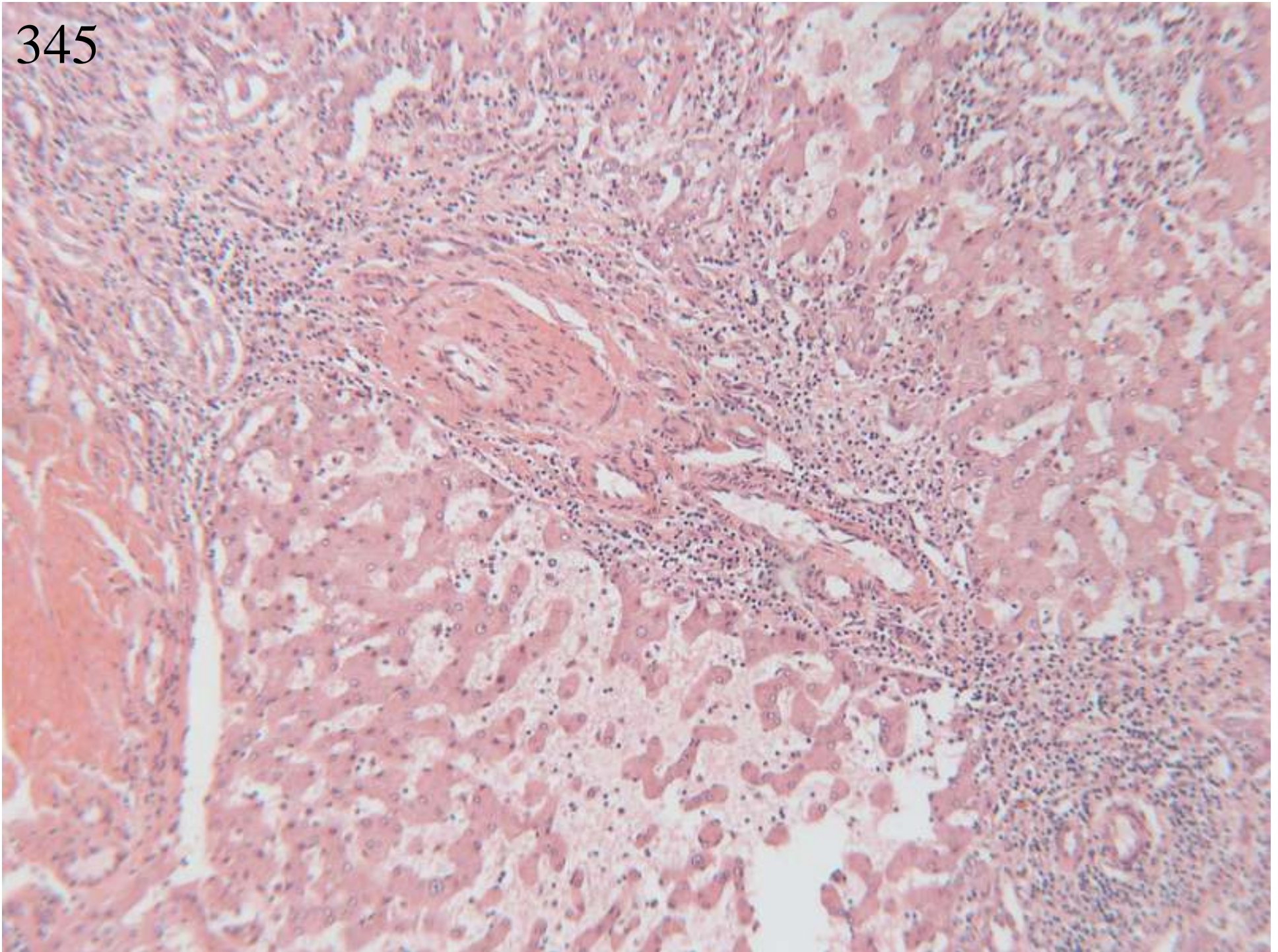
345 lesion



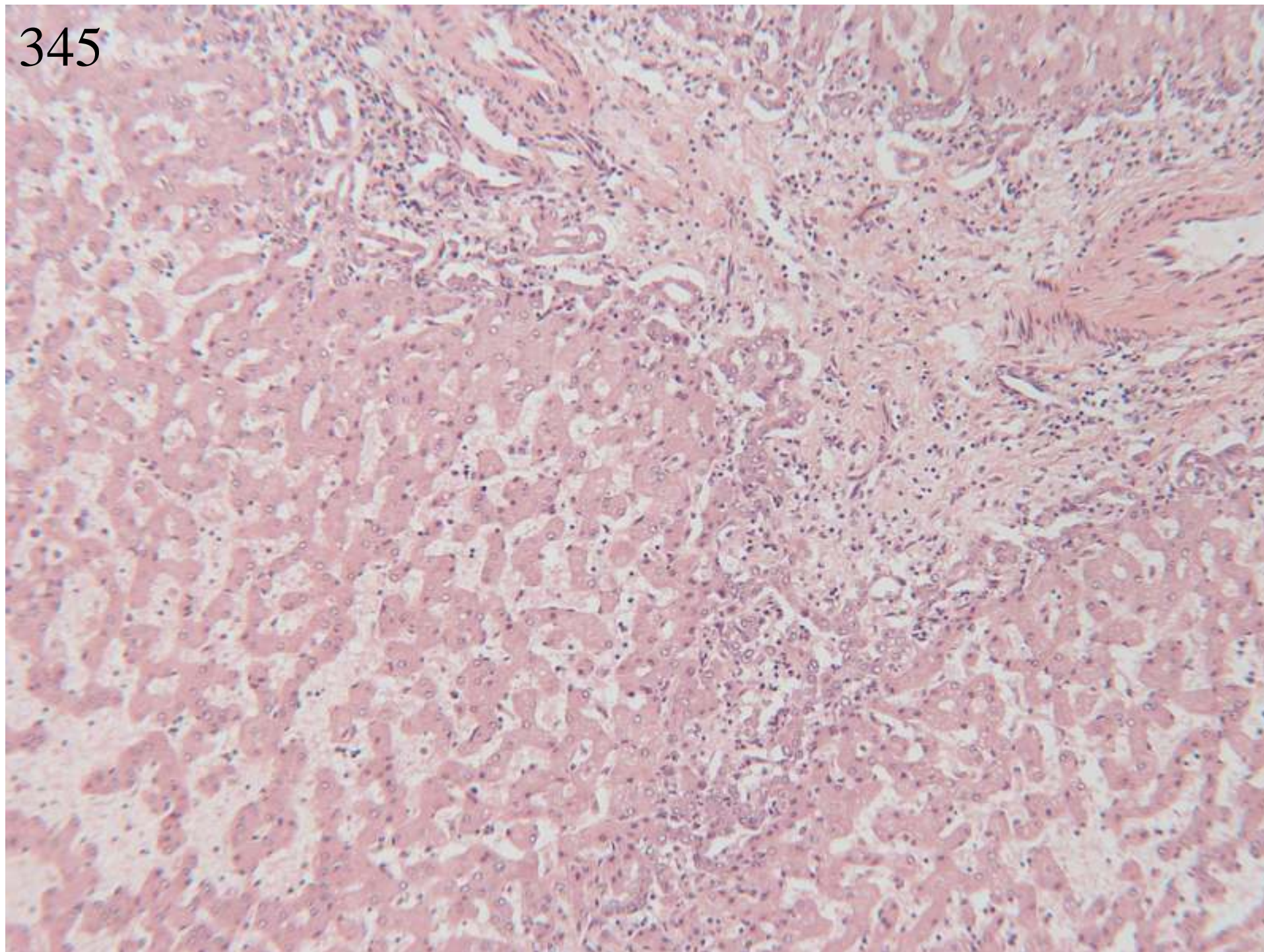
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345 Case not scored, see below.

32 telangiectatic adenoma/telangiectatic FNH/inflammatory adenoma

12 FNH NOS

6 adenoma NOS

1 liver cell adenoma with peliosis

1 description - ? lymphoproliferative process

1 ?early FNH or outflow obstruction

1 ?inflammatory pseudotumour, ?odd hamartoma

1 benign, ? hamartomatous

2 peliosis hepatitis

1 HCC (unequivocal one line diagnosis)

1 large regenerative nodule

1 sinusoidal dilatation, differential diagnosis hepatic vein obstruction

1 cholangiocarcinoma

1 some features of regenerative nodule

1 passive venous congestion, differential diagnosis FNH

Agreed scoring: accept any diagnosis of adenoma or FNH. If need to include adenoma in diagnosis, there would be insufficient consensus (61%), the case would be excluded from scoring.

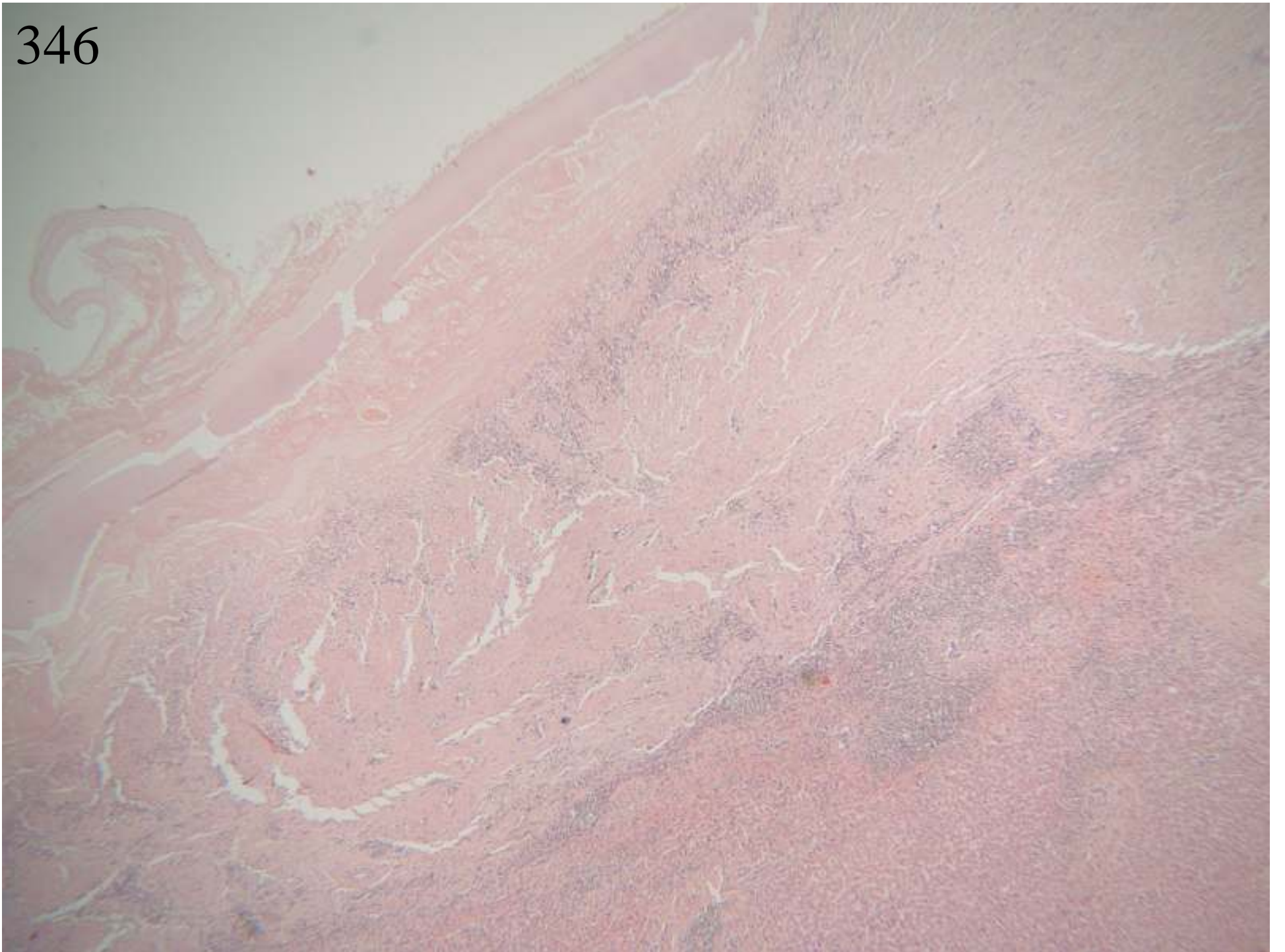
Discussion during the meeting – that inflammatory adenoma is distinctive and not a form of FNH, FNH diagnosis should be rejected. This case therefore has insufficient consensus for scoring

Case 346

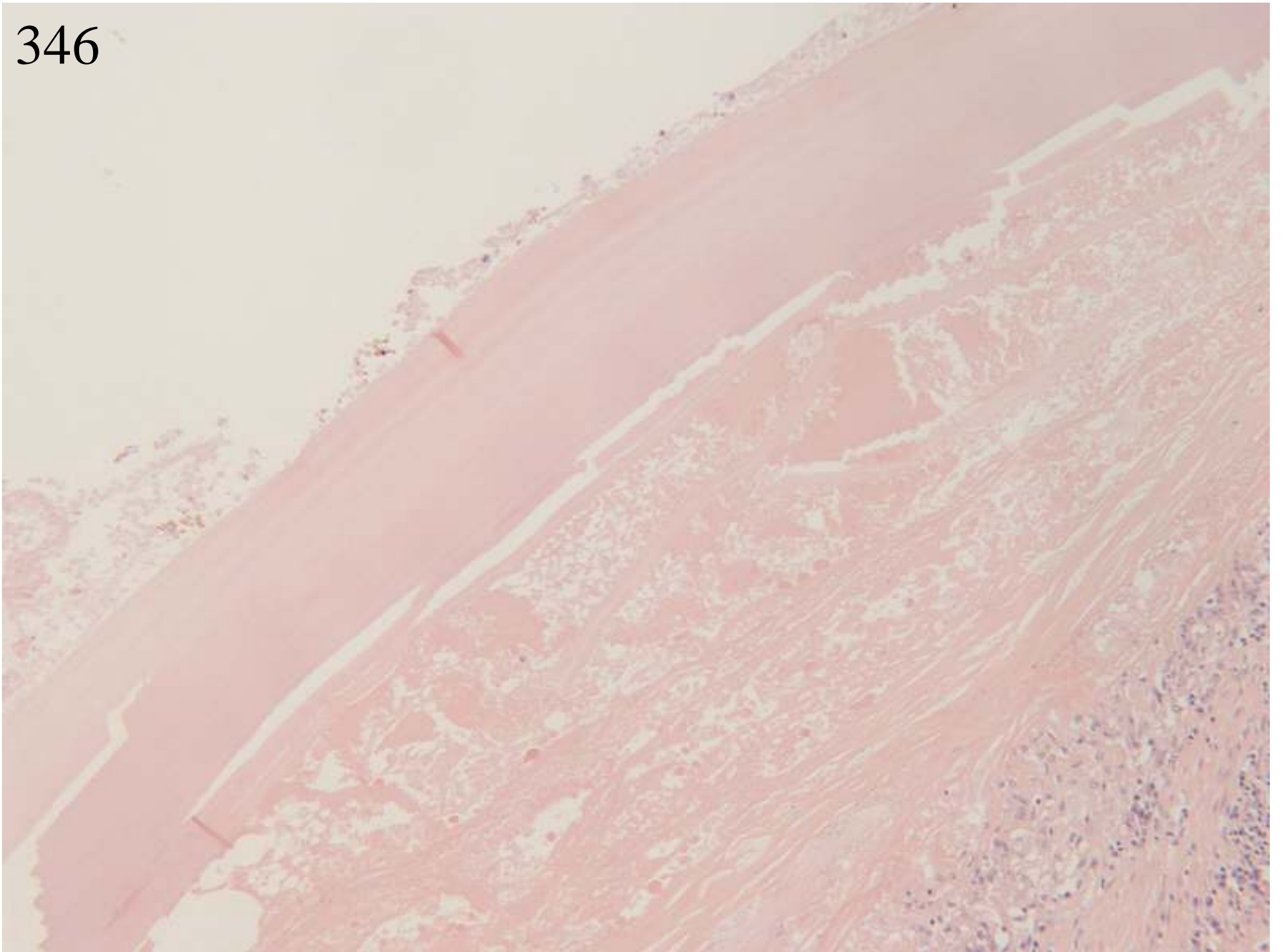
- *female, 33 years*
- *Hydatid cyst left lateral liver. .*

- *Left lateral segment:*
- *specimen weighs 295g, segment II & III, measuring 12x7.5x7cm, which includes an intact cyst 7.5cm in diameter at the ?superior aspect of the specimen*

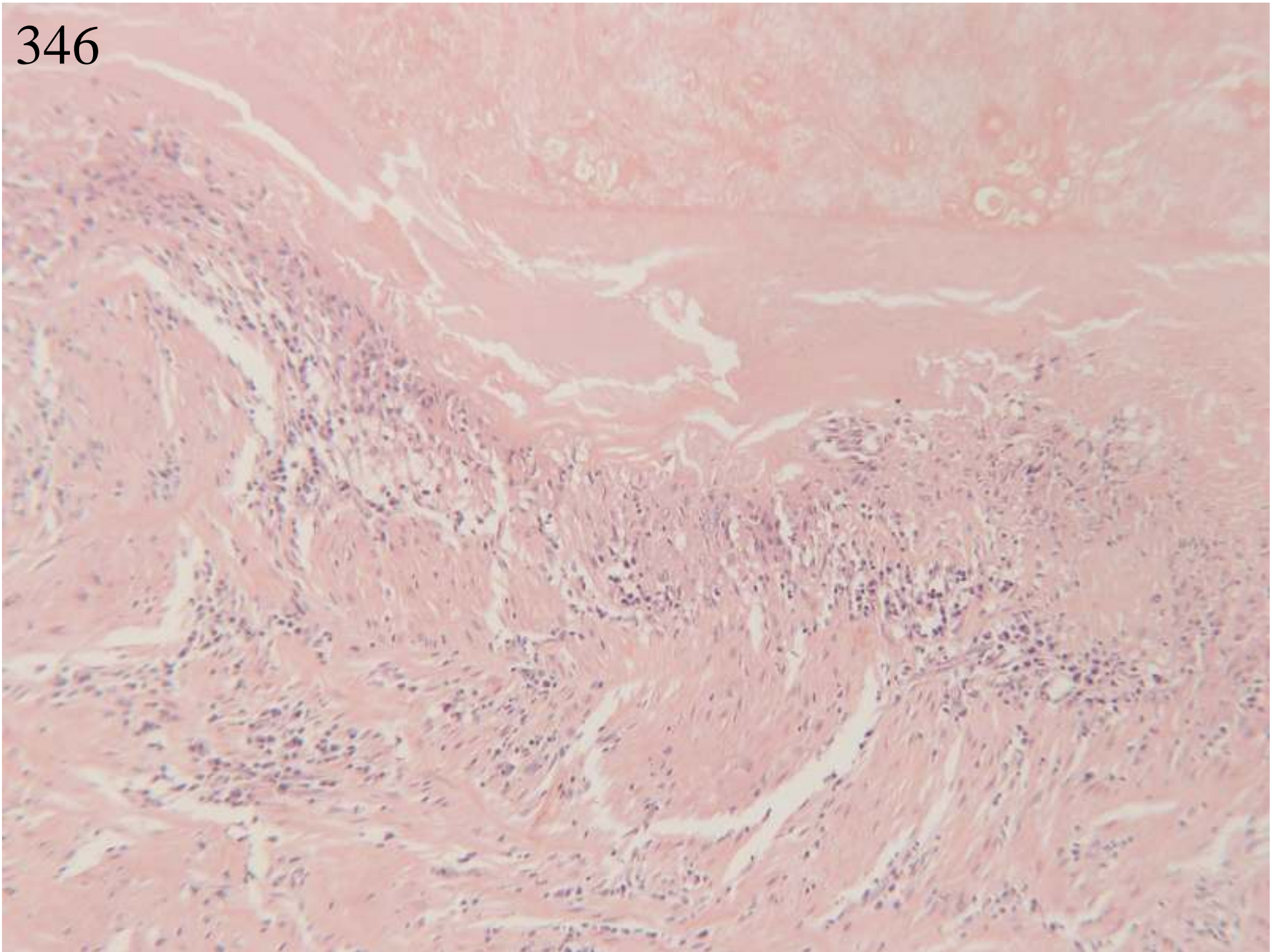
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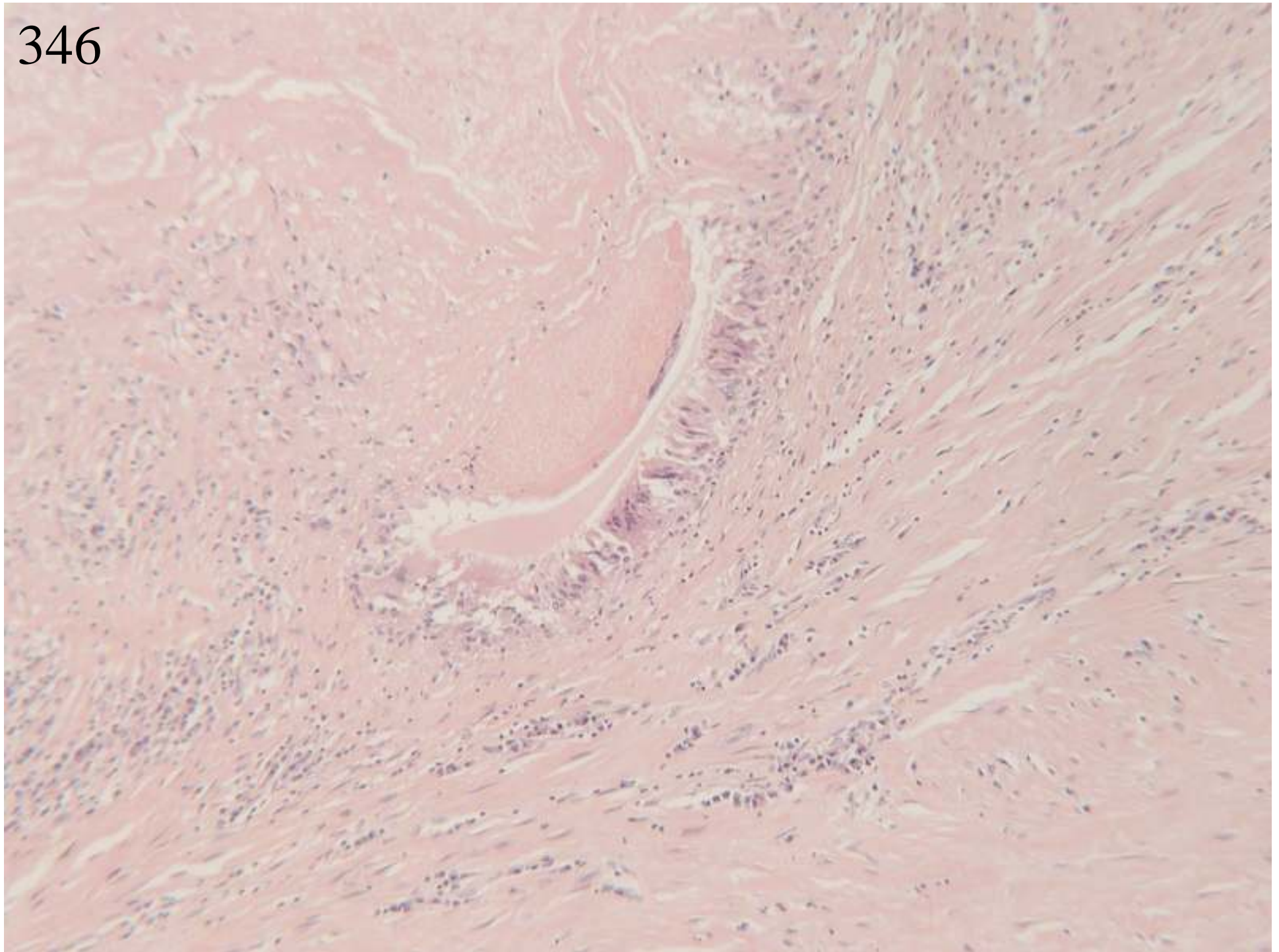
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346

57 hydatid cyst

2 cyst consistent with parasitic infection/hydatid

1 granulomatous cyst, no evidence of hydatid

1 description, doubt hydatid, refer for tropical medicine evaluation

1 chronic amoebic abscess

1 granulomatous liver cyst, rule out hydatid disease

2 biliary cystadenoma – no hydatid features, some columnar epithelium

Agreed scoring: accept answers including hydatid

Case 346: original pathologist's diagnosis:

Hydatid cyst

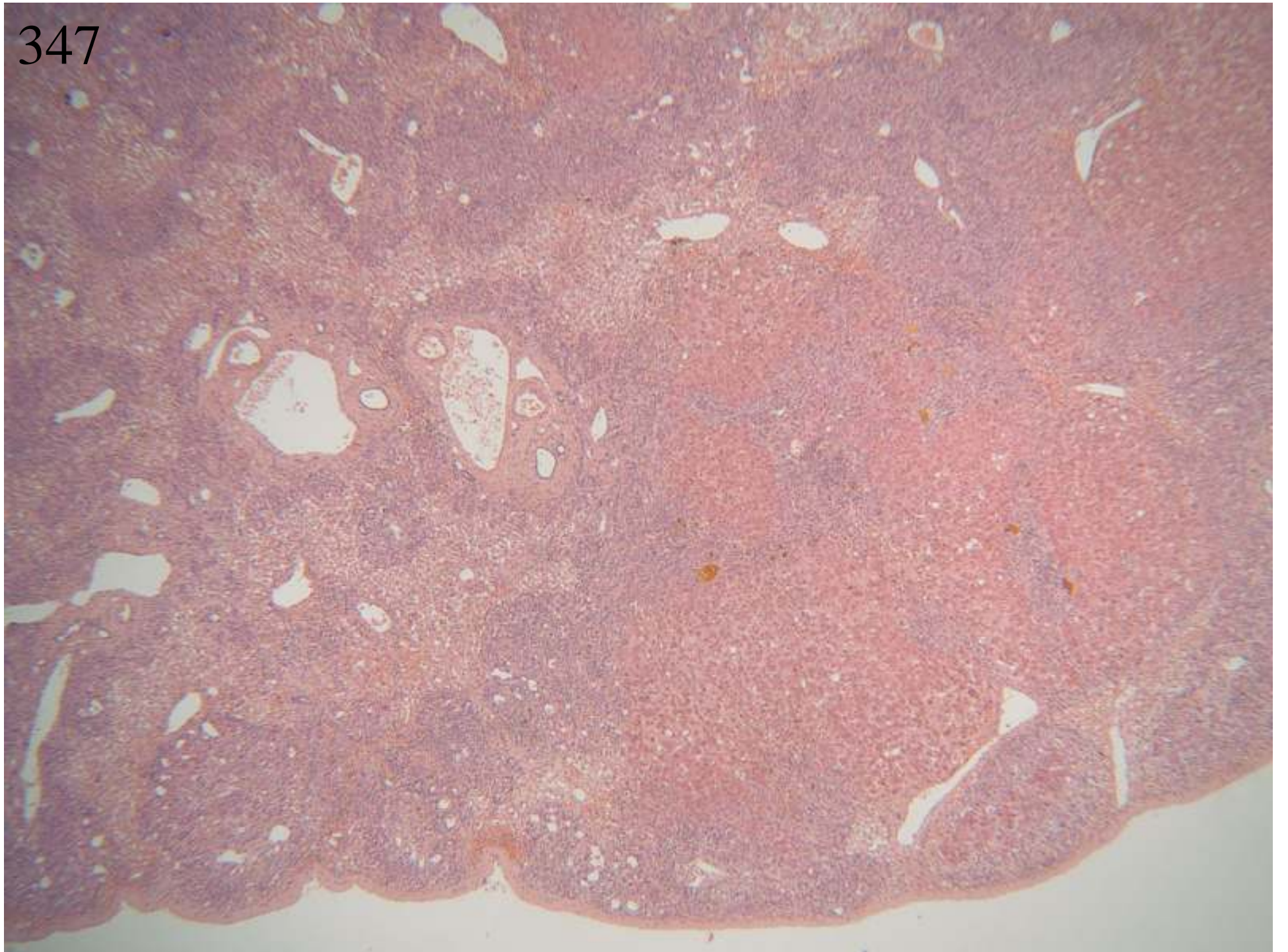
Discussion: the laminated membrane pathognomonic of hydatid cyst is well demonstrated in this case. A line of histiocytes (4th photo) resembles epithelium, and may have accounted for the diagnoses of cystadenoma.

-

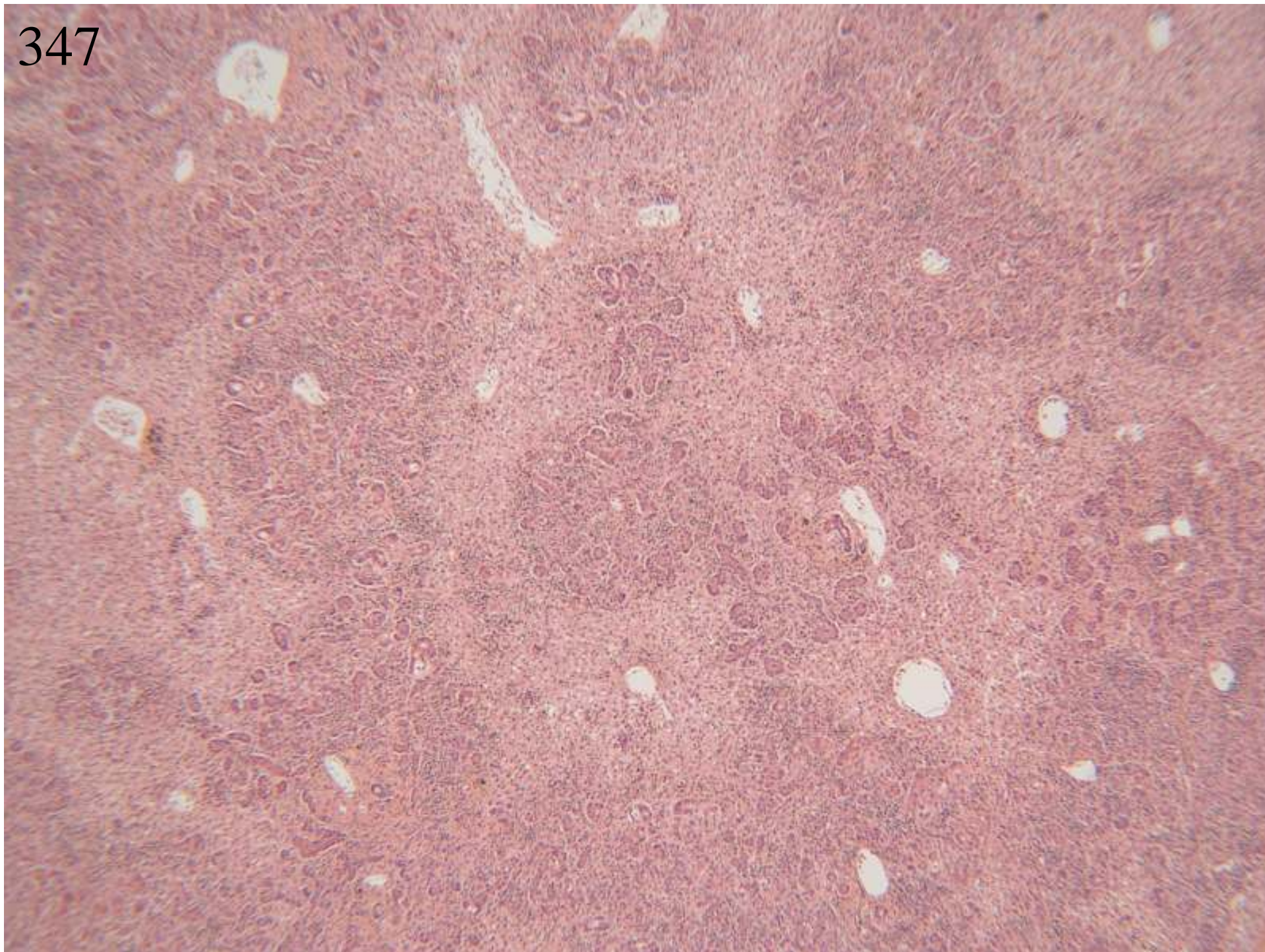
Case 347

- *female, 51 years*
- *Emergency liver transplant for acute liver failure. Looked like acute-on-chronic liver disease at laparotomy*
- *Liver*
- *Bile stained liver, 970g, 20x14x6cm. Cut surface shows large areas of confluent necrosis, involving almost all of the right lobe and segment IV. Segments II-III and V-VI are relatively less affected, and show bile stained nutmeg pattern. There are no tumours.*
-

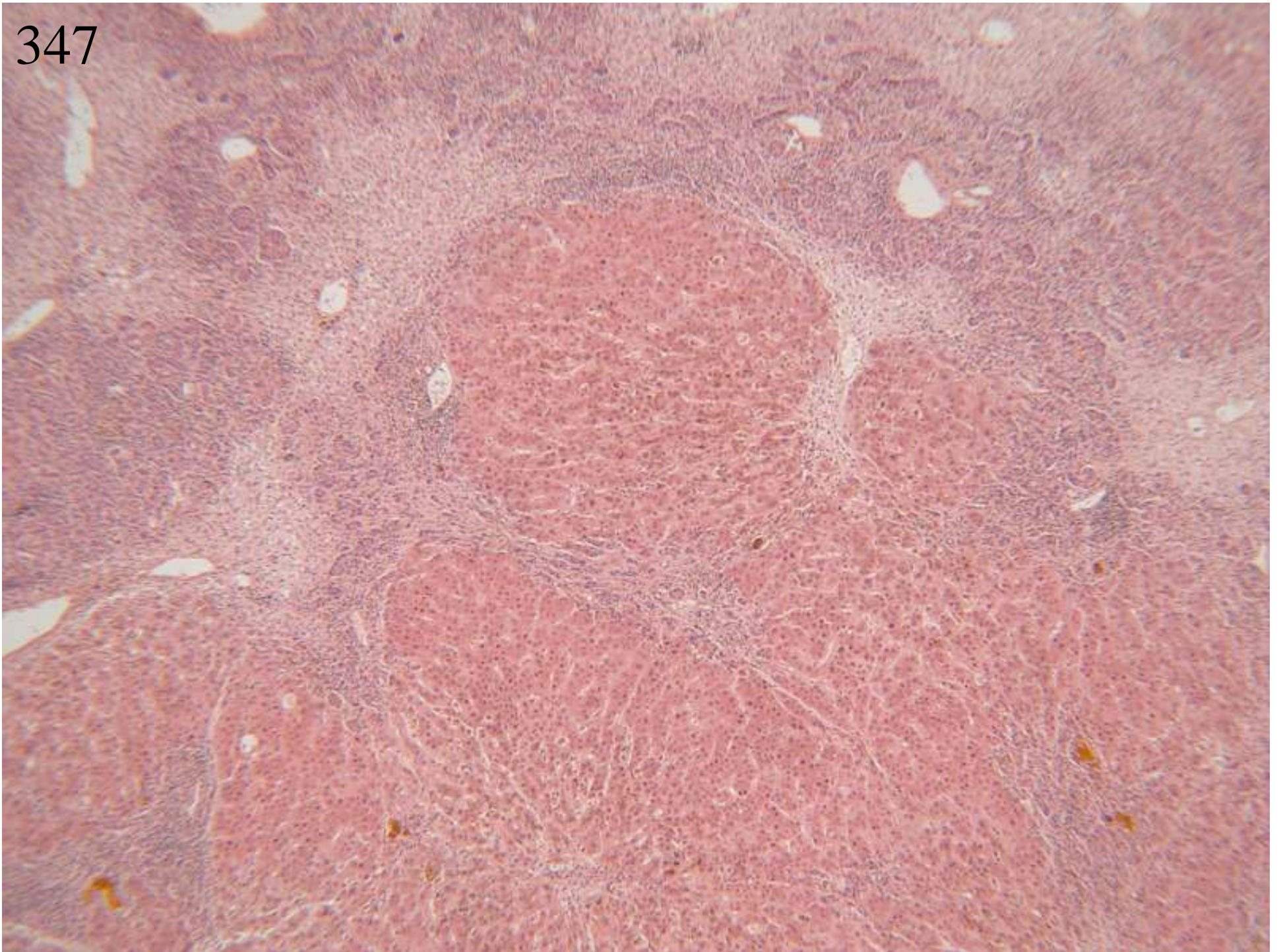
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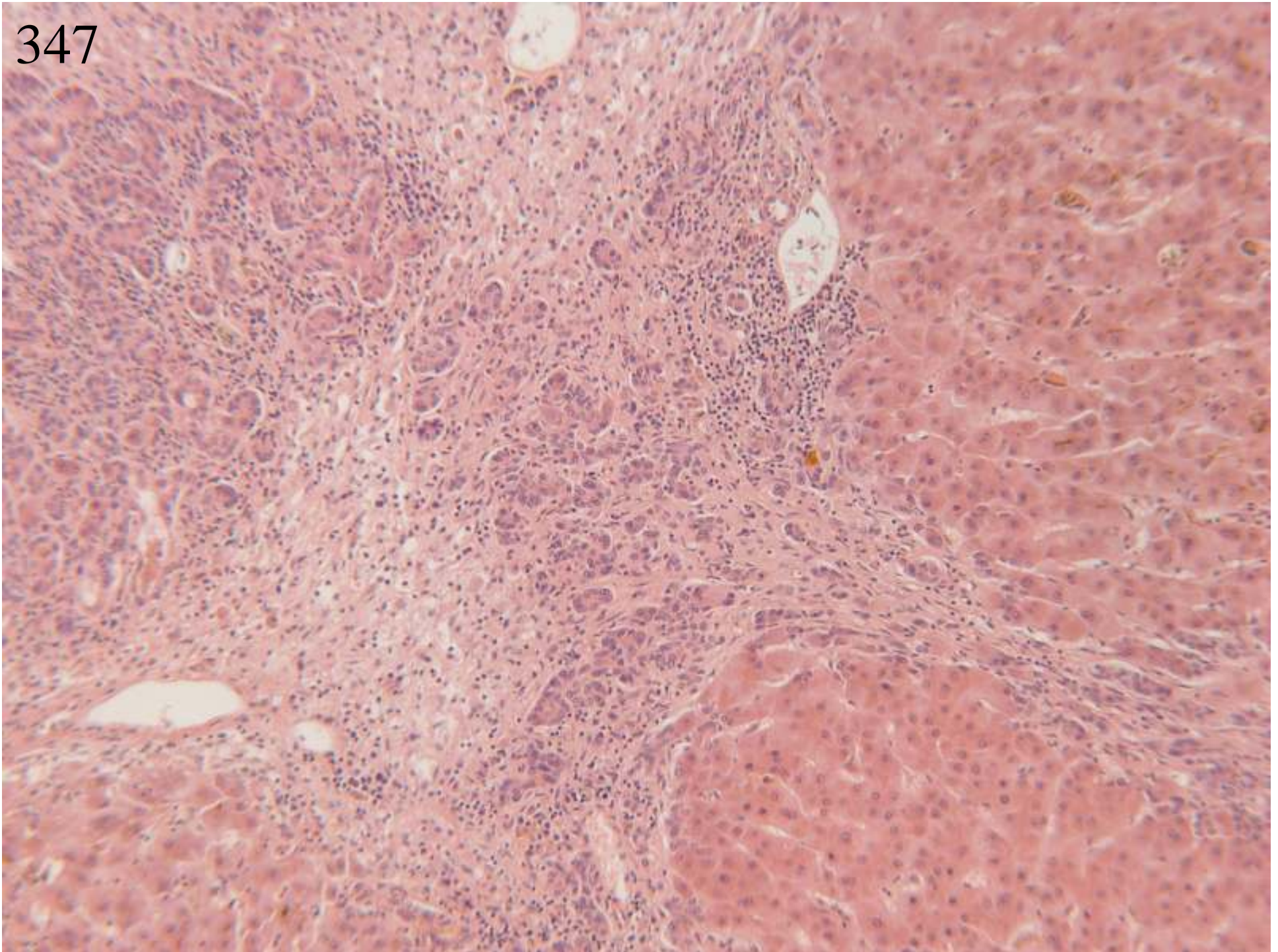
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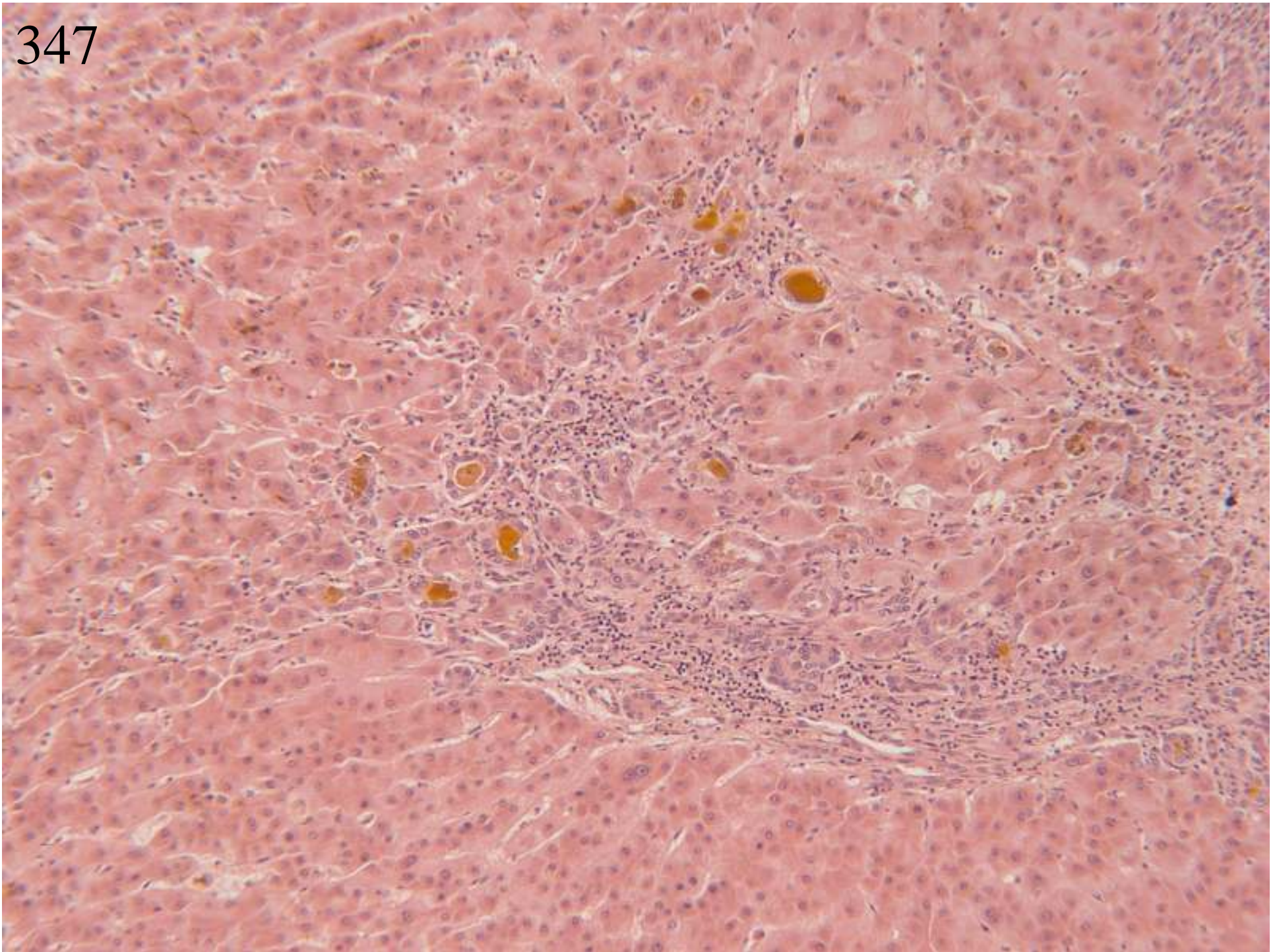
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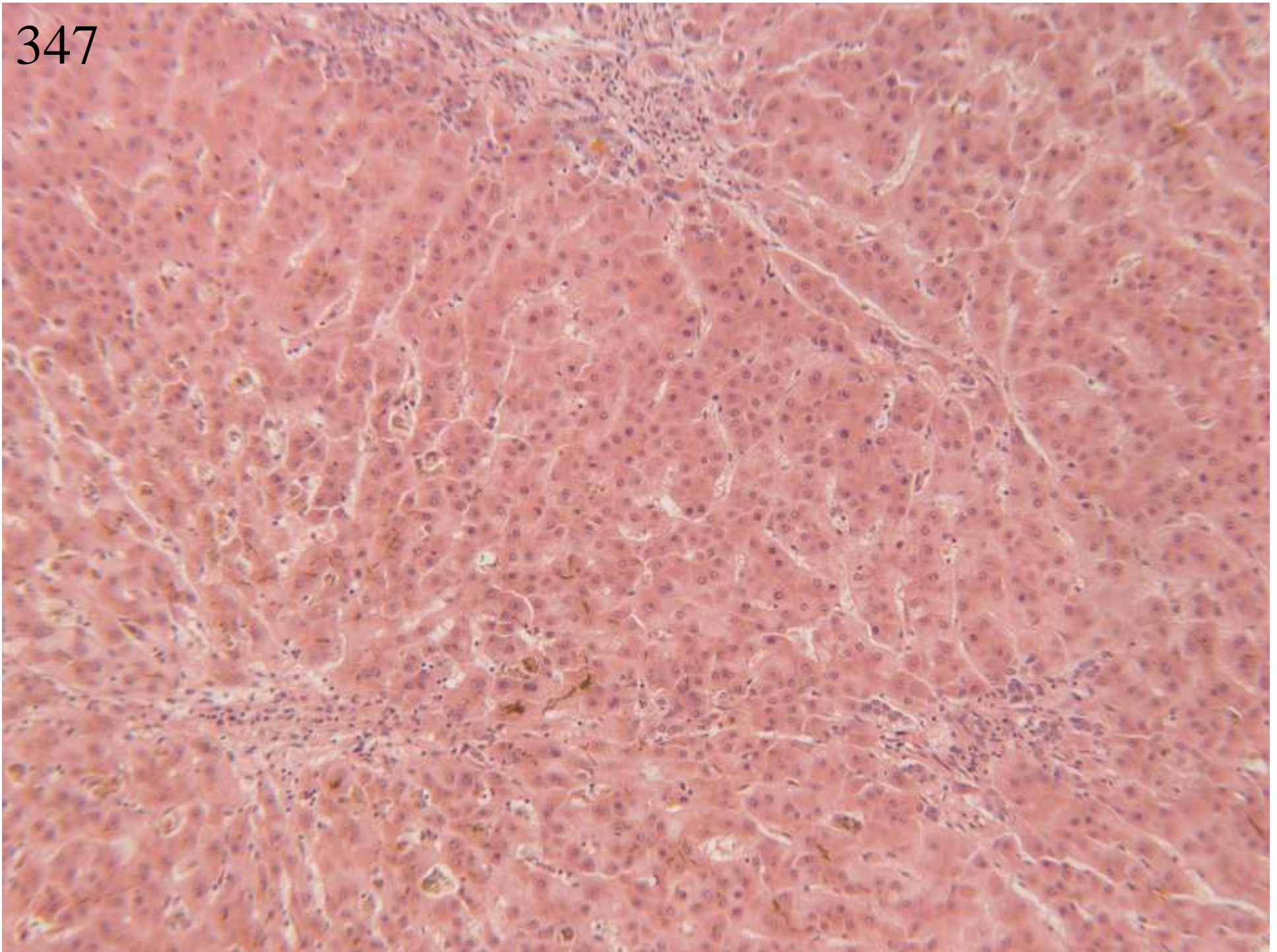
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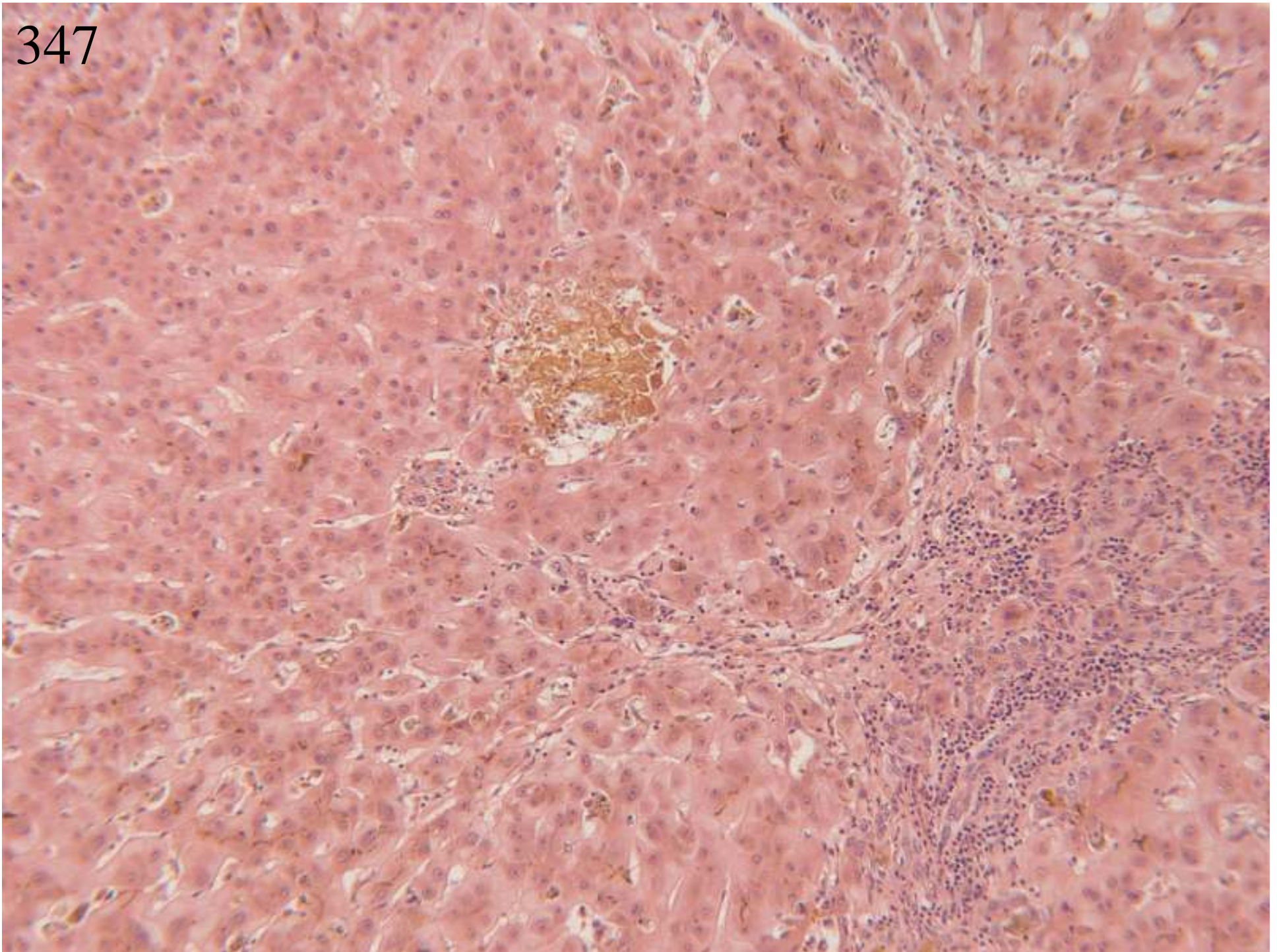
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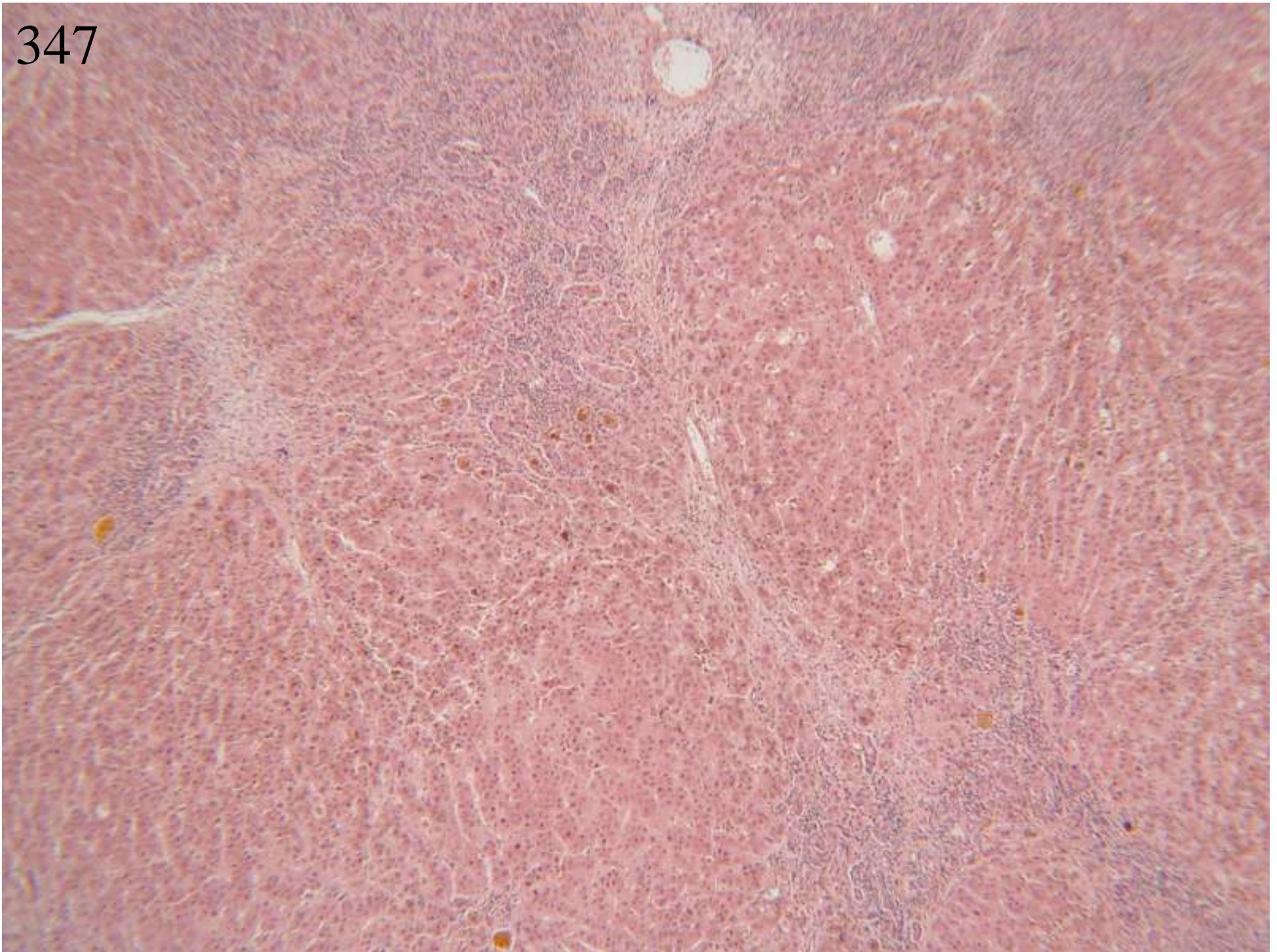
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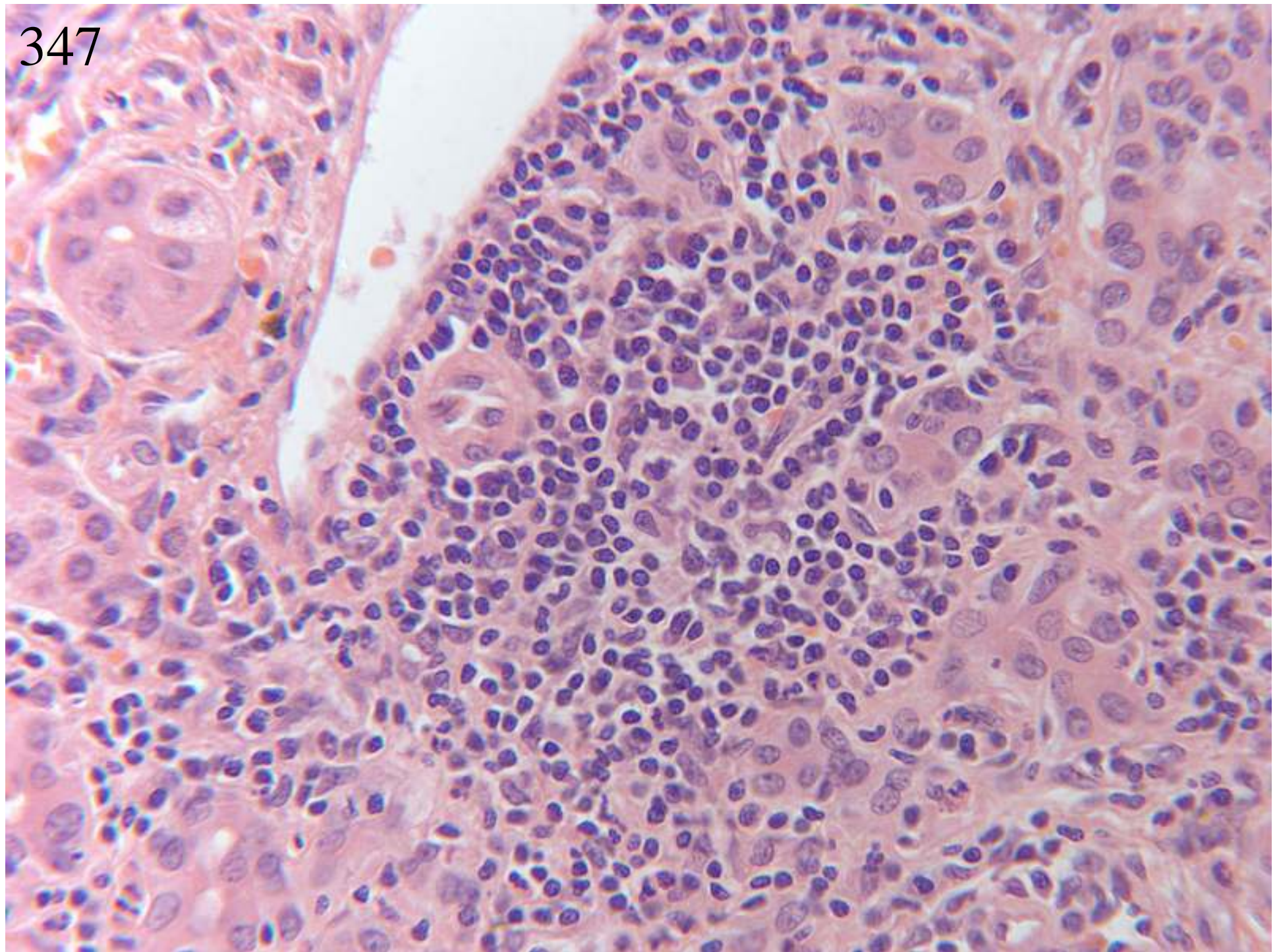
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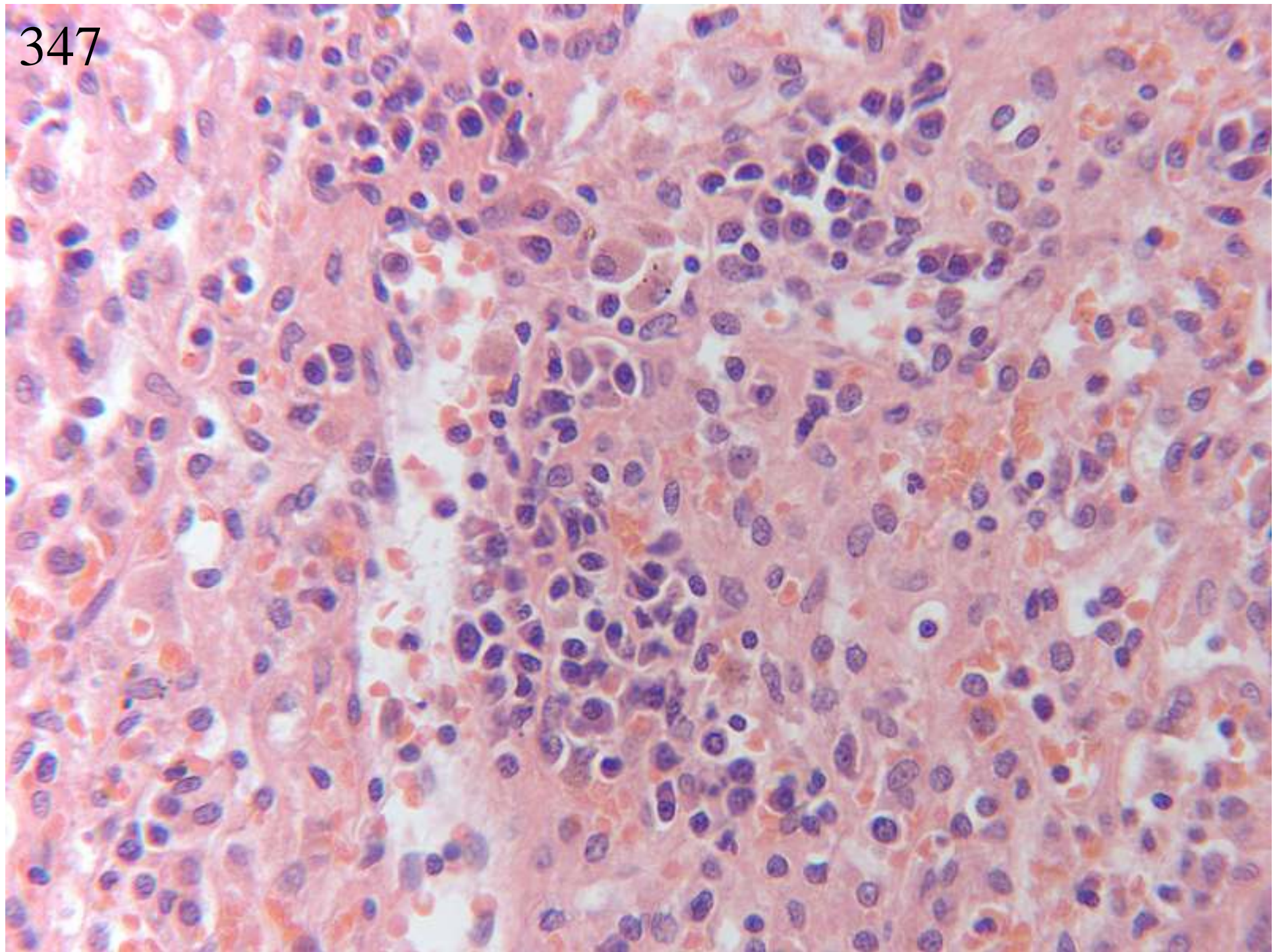
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347

- 42 severe acute hepatitis/panacinar necrosis/massive necrosis/acute
- 4 massive hepatic necrosis NOS
- 2 submassive hepatic necrosis
- 2 fulminant acute on chronic hepatitis, background AIH cirrhosis
- 1 acute hepatitis on background of cirrhosis
- 1 active chronic hepatitis with panlobular necrosis
- 1 **nodular liver with collapse**
- 1 subacute cholestatic hepatic necrosis excl. AATP and parenteral nutrition
- 1 severe acute liver failure with bridging necrosis and cholestasis ? drug induced
- 1 zonal necrosis NOS
- 1 **cirrhosis, cholestasis, exclude cholangiocarcinoma**
- 1 **cirrhosis with ductular proliferataion, cholestasis and inflammation in vessels.**
- 1 acute on chronic hepatitis due to ? biliary obstruction/PBC/PSC (jigsaw pattern)
- 1 massive zone 3 necrosis, no ground glass hepatocytes to suggest viral
- 1 **map like pattern of injury in acute liver failure**
- 1 acute sepsis with confluent necrosis and chronic hepatitis
- 1 **cirrhosis, liver rejection acute (allograft)**
- 1 **vascular obstruction, parenchymal extinction, nodular hyperplasia**
- 1 **description ‘ incomplete Hepatocellular loss and regeneration’**

347 contd

- 42 aetiology differential includes drugs/viral/autoimmune
- 7 aetiology not discussed (plus others included in list of morphological diagnoses above)
- 1 drug as only cause
- 1 consistent with seronegative hepatitis
- 1 ?acute onset AIH
- 1 vascular obstruction

Proposed: Either not suitable for scoring, or could include if accept any answer which implies severe acute hepatitis, massive necrosis etc (favoured by steering committee)

Members voted to include this case in scoring. – therefore scored on morphology, not evaluated for aetiology. Half marks given for answers that implied the correct disease process (shown here in brown)

Case 347: original pathologist's diagnosis:

Discussion: This is a classical example of severe acute hepatitis, familiar to those working in transplant centres. There are areas of multiacinar confluent necrosis over which the capsule is depressed and wrinkled, and elsewhere bridging necrosis between rounded expansile regenerative parenchymal areas.

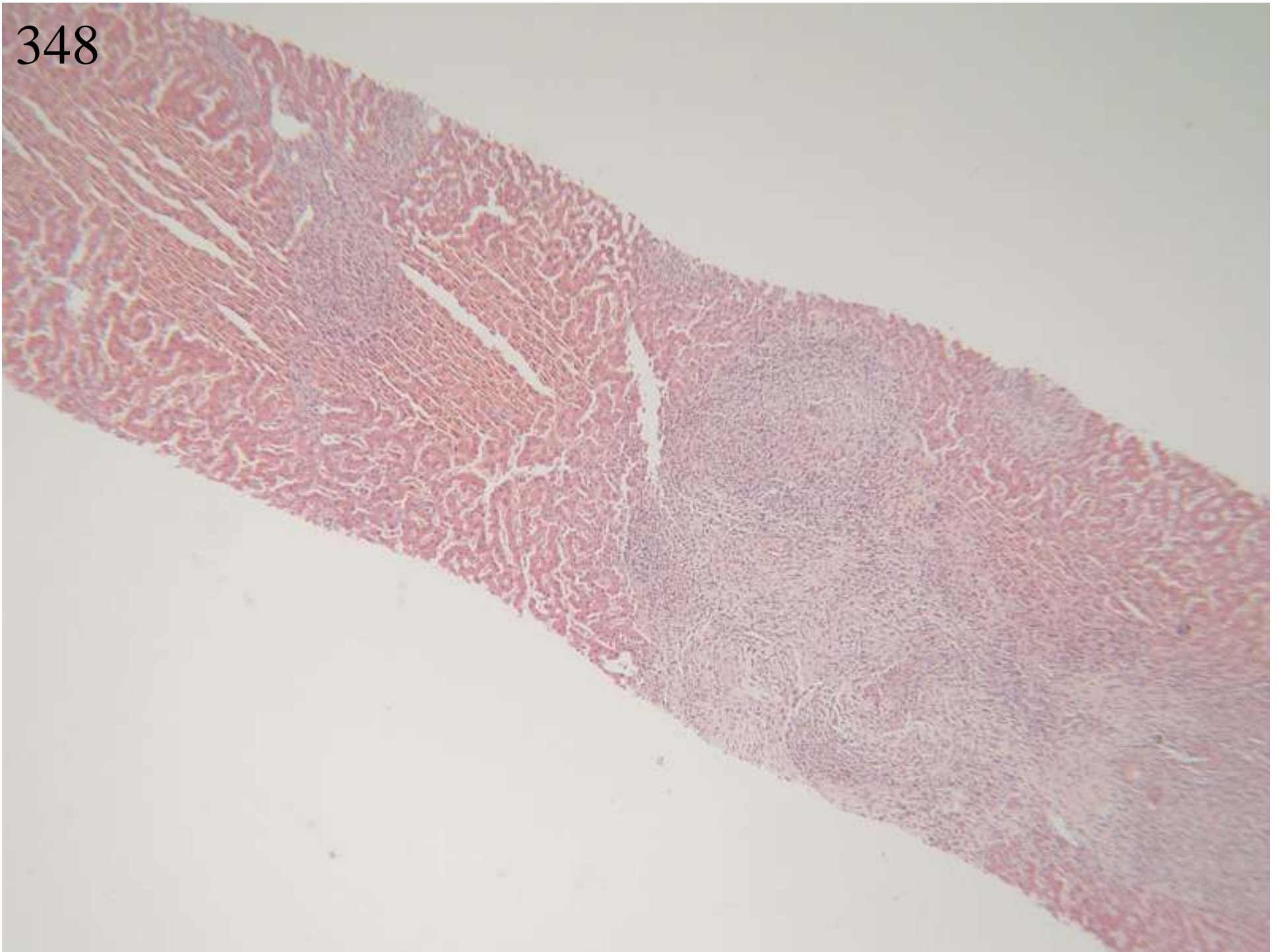
Case 348

- *male, 42 years*
- *Known TB on treatment. Special stain: ZN is negative*
- *Liver biopsy – one core.*
-

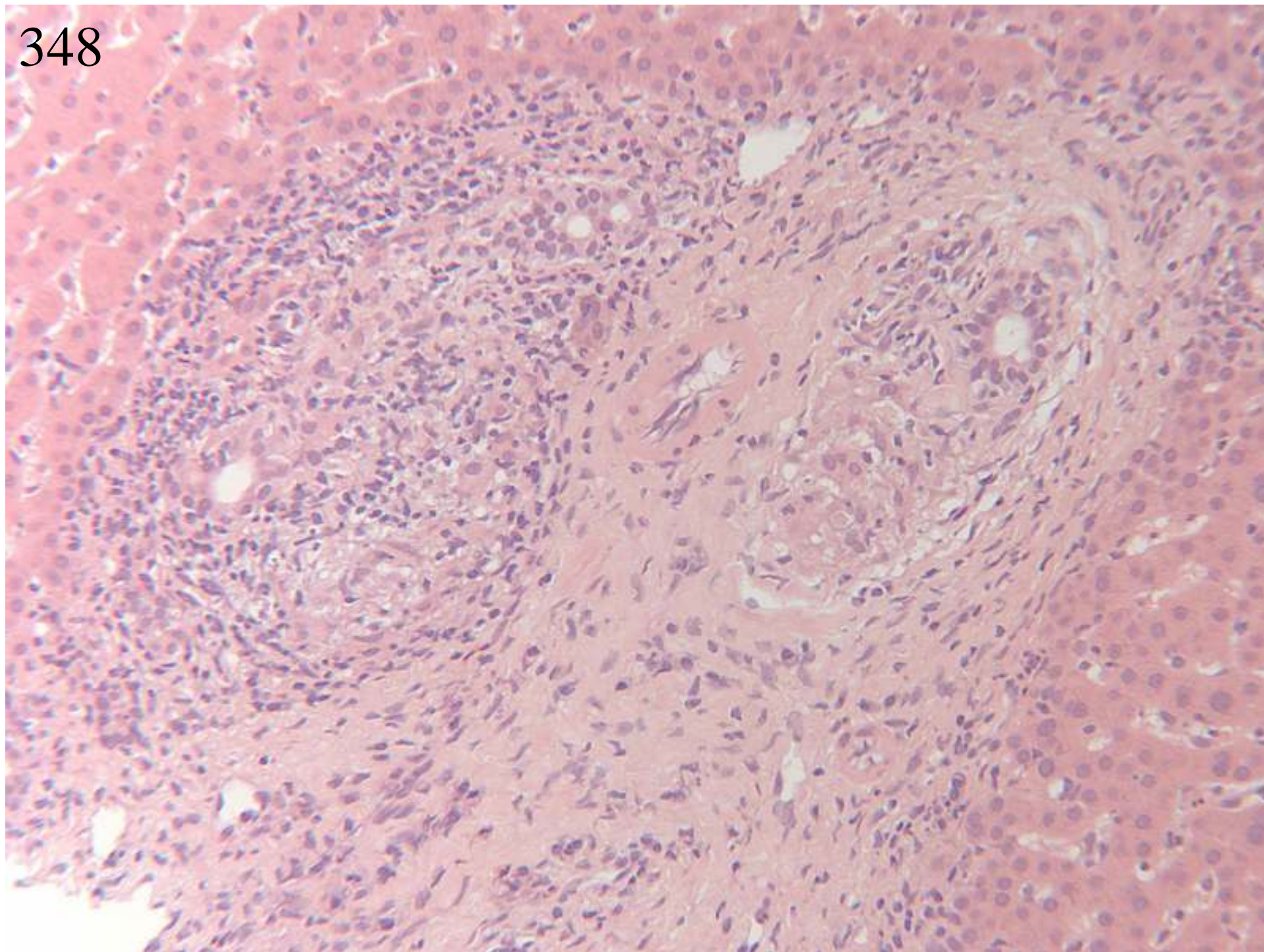
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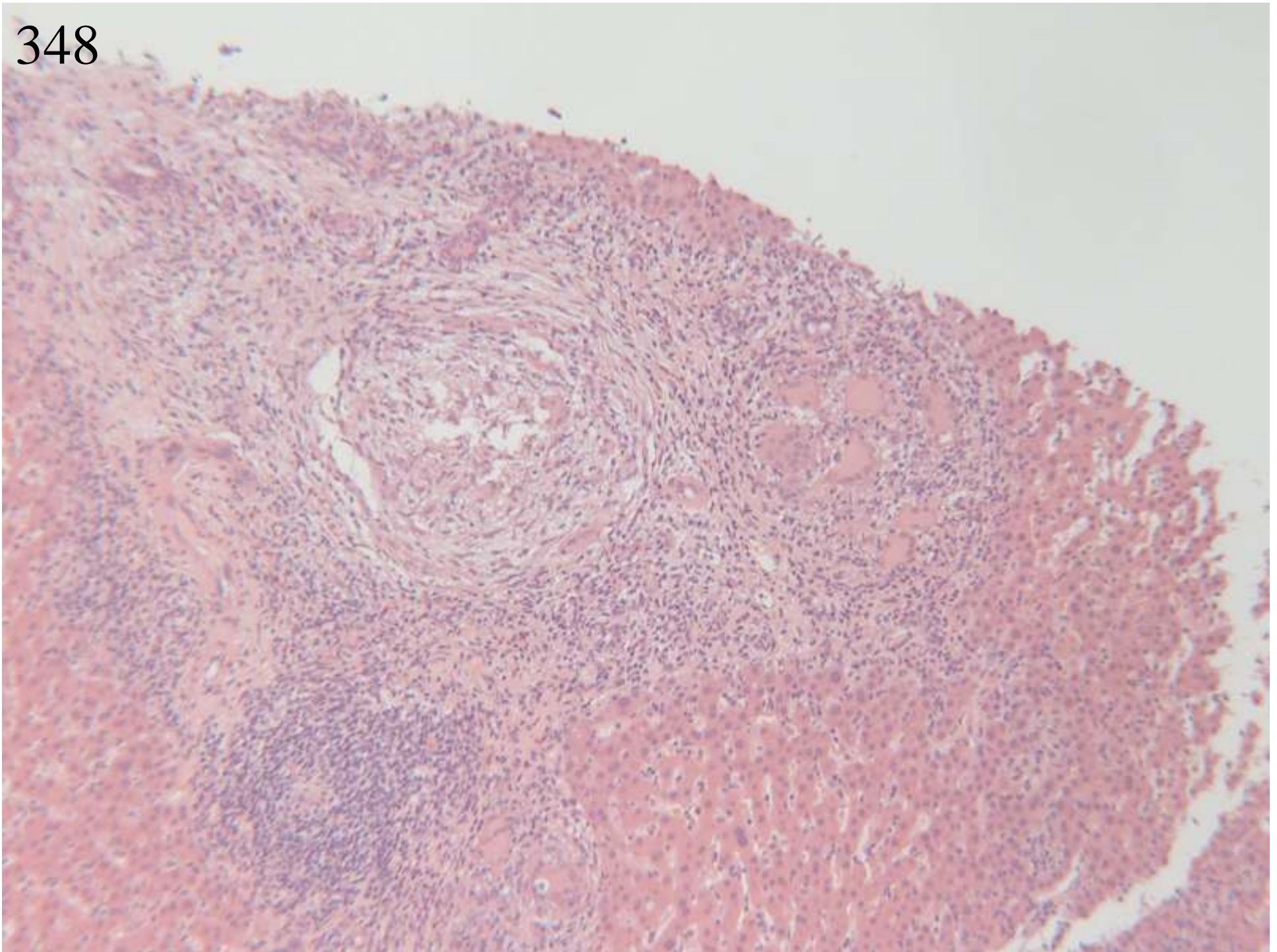
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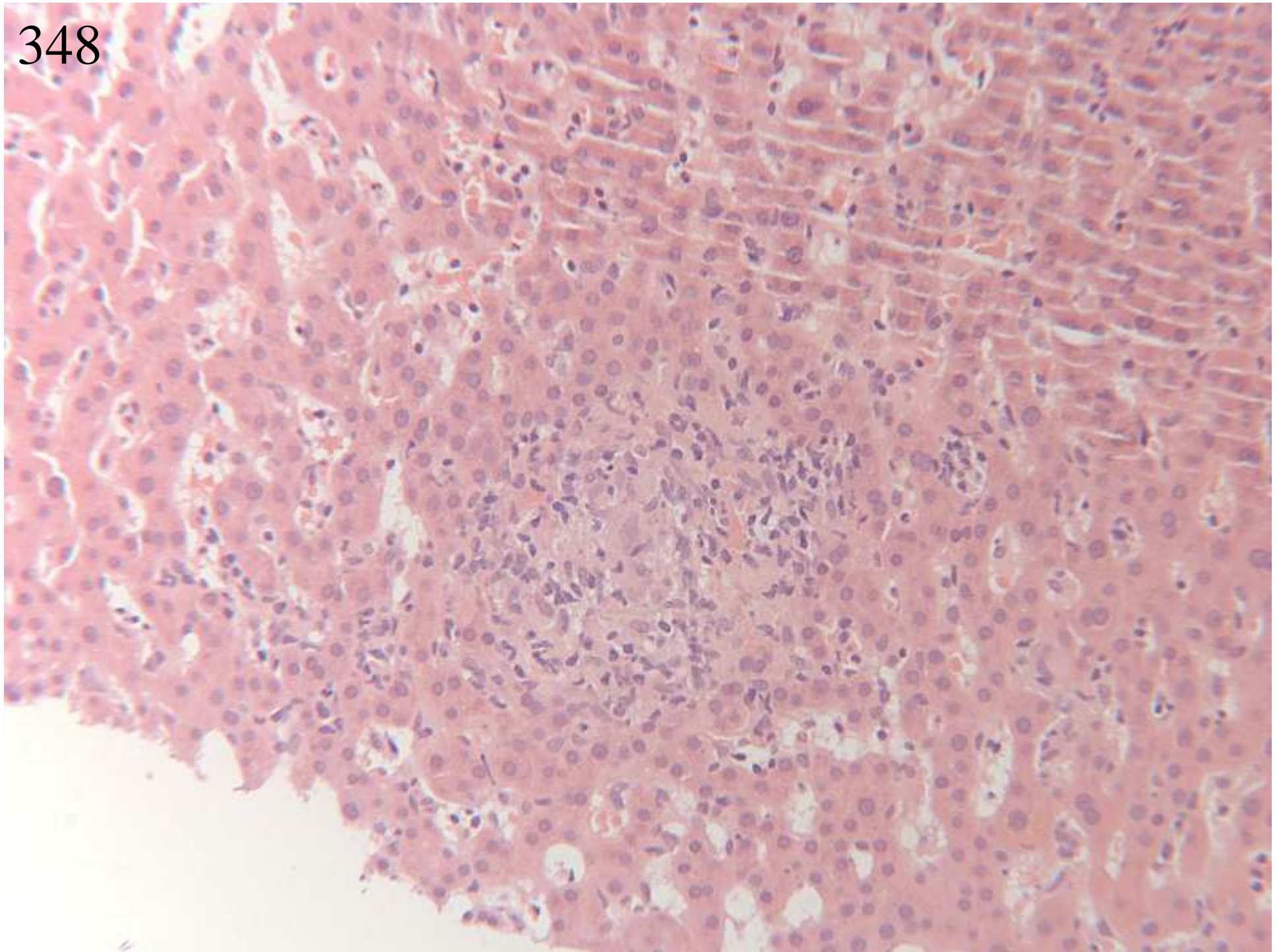
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348

51 hepatitis with granulomas

4 numerous granulomas NOS

8 granulomatous hepatitis with bile duct damage

1 granulomatous hepatitis with fibrosis

20 TB as only aetiology mentioned

32 TB favoured with differential diagnosis – a few include isoniazid toxicity as cause of granulomas

5 differential includes TB among others

3 differential – no mention of TB

3 PBC, exclude TB

1 unusual for TB, favour sarcoid

1 granulomatous liver disease, although under ‘other comments’ discussion of TB, sarcoid, drugs

Agreed scoring: require granulomas and include TB in differential

Case 348: original pathologist's diagnosis:

Granulomatous inflammation consistent with the clinical diagnosis of tuberculosis

*Discussion – why do a liver biopsy in this situation?
– presumably to distinguish drug reaction from inflammation due to TB. This would be possible if the drug reaction is hepatitic, but anti-TB drugs can occasionally give a granulomatous pattern of injury.*

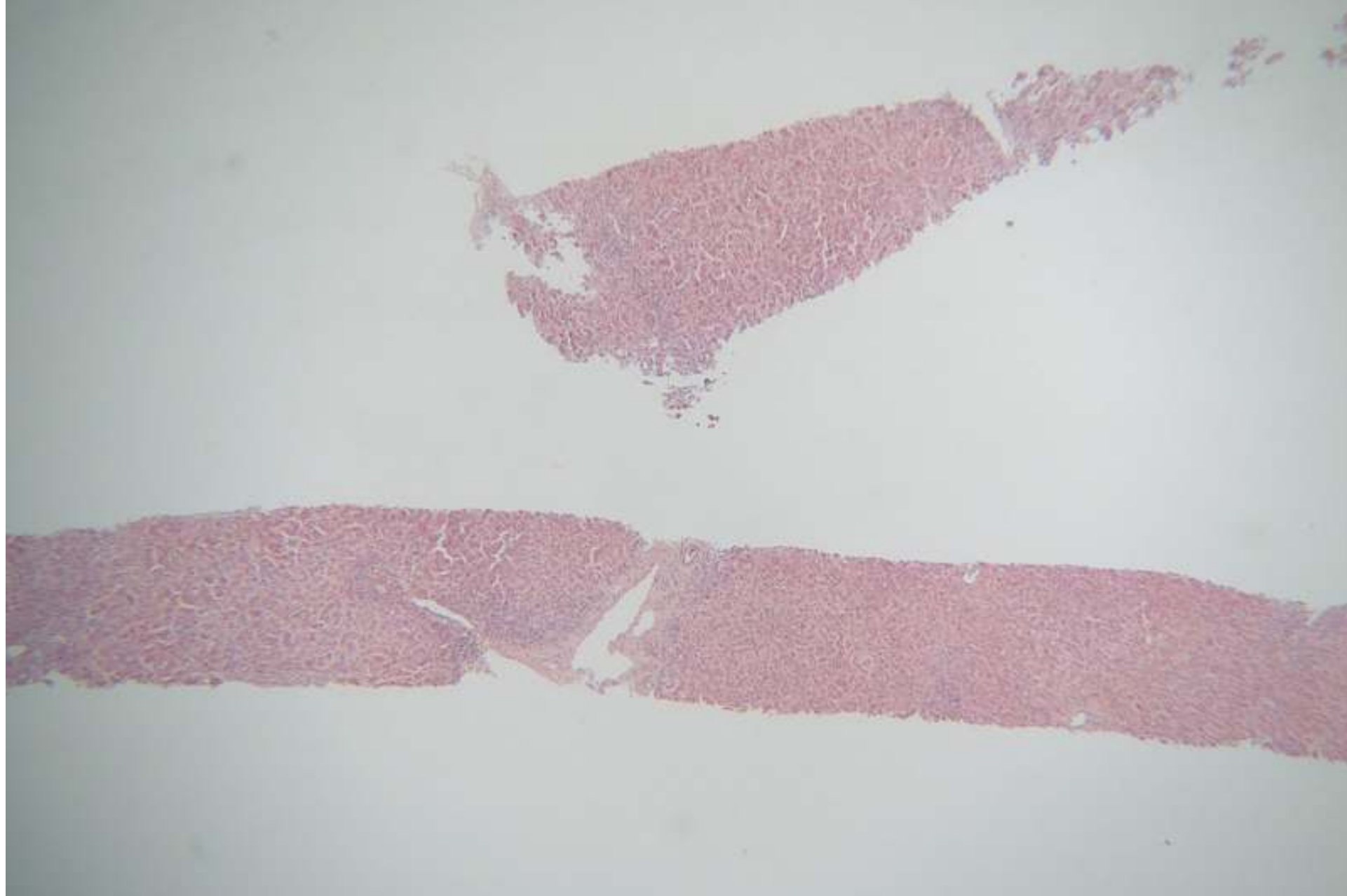
Case 349

- *female, 77 years*
- *Autoimmune hepatitis*

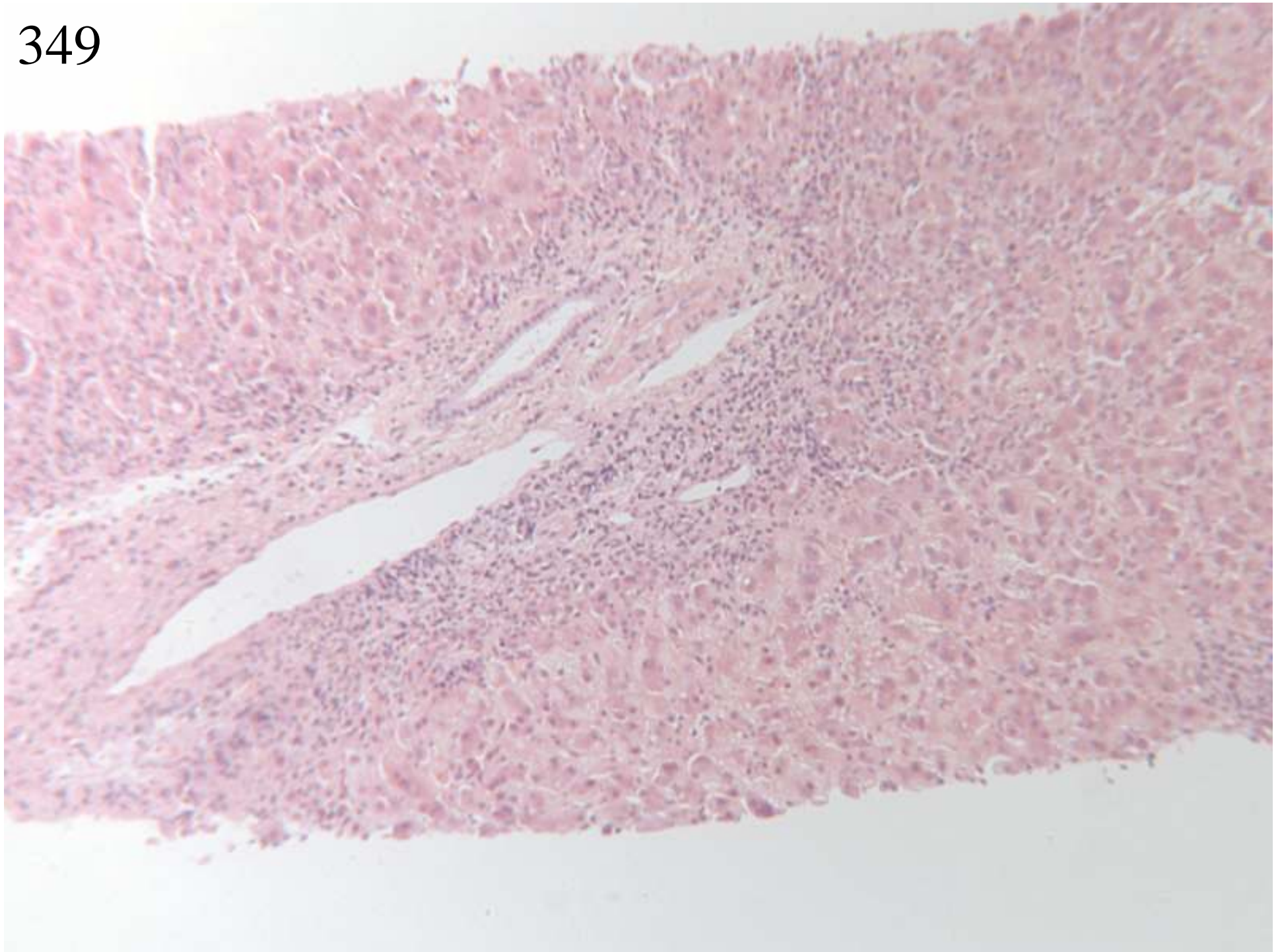
- *Liver biopsy – two cores.*

-

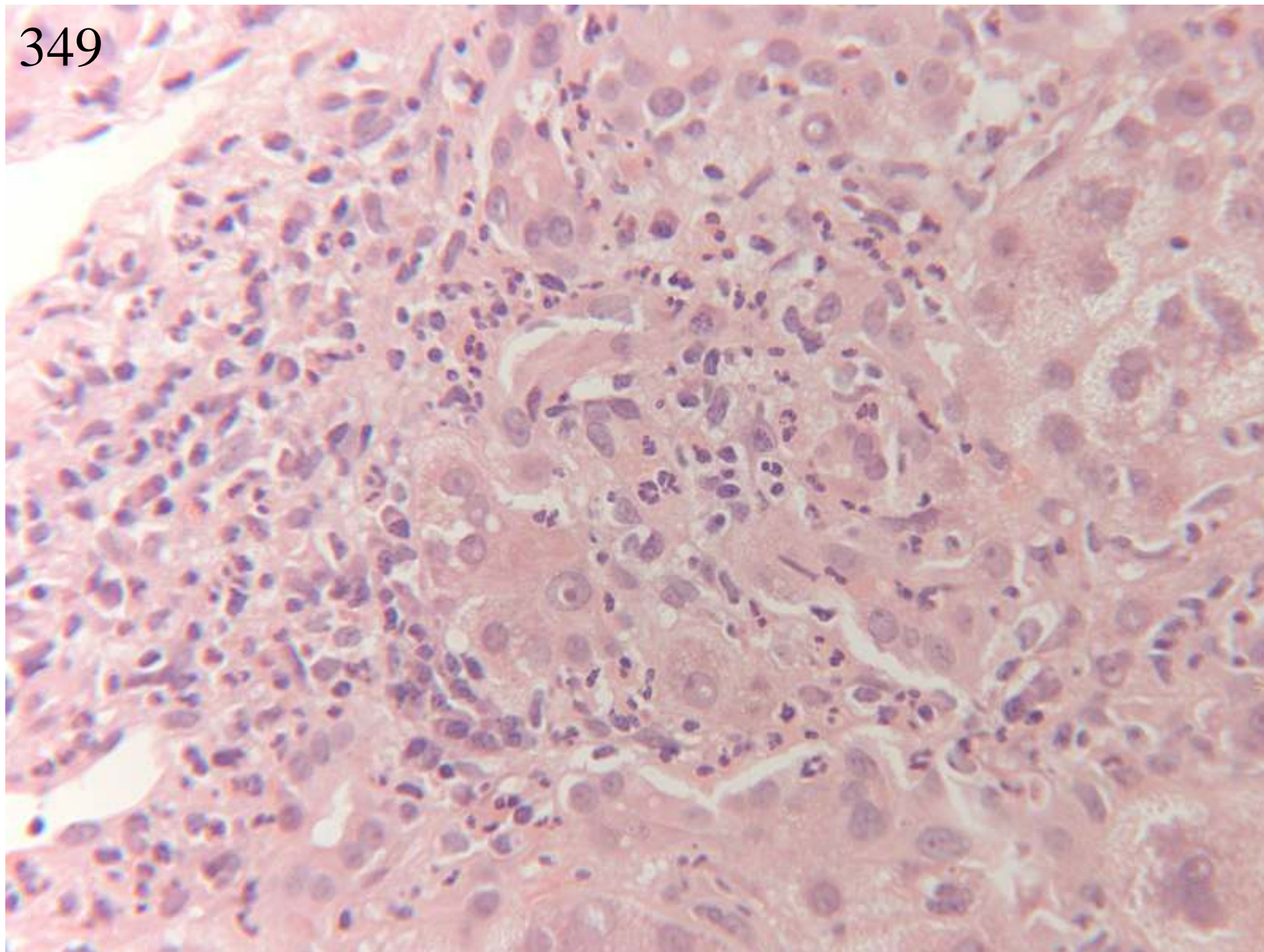
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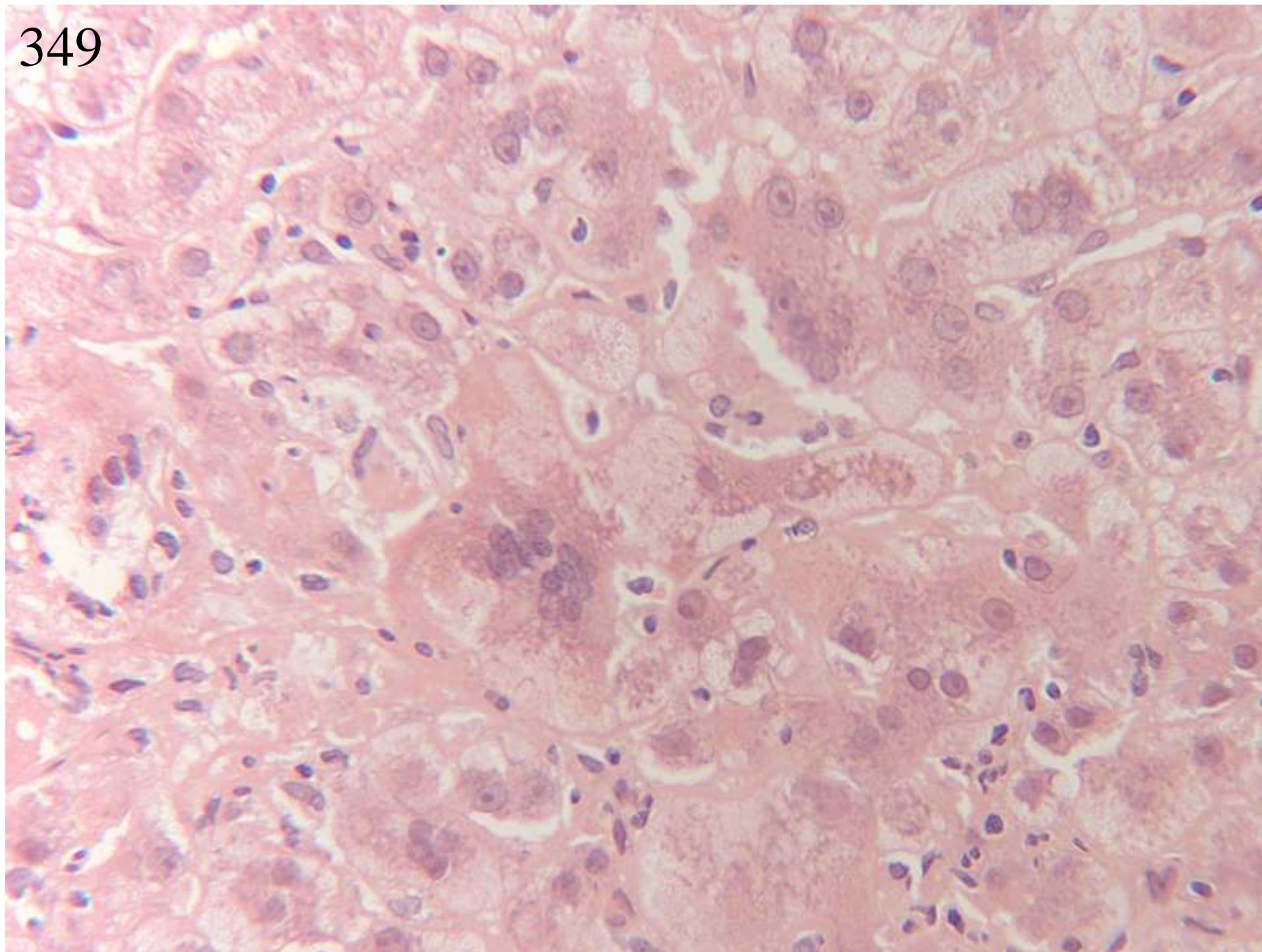
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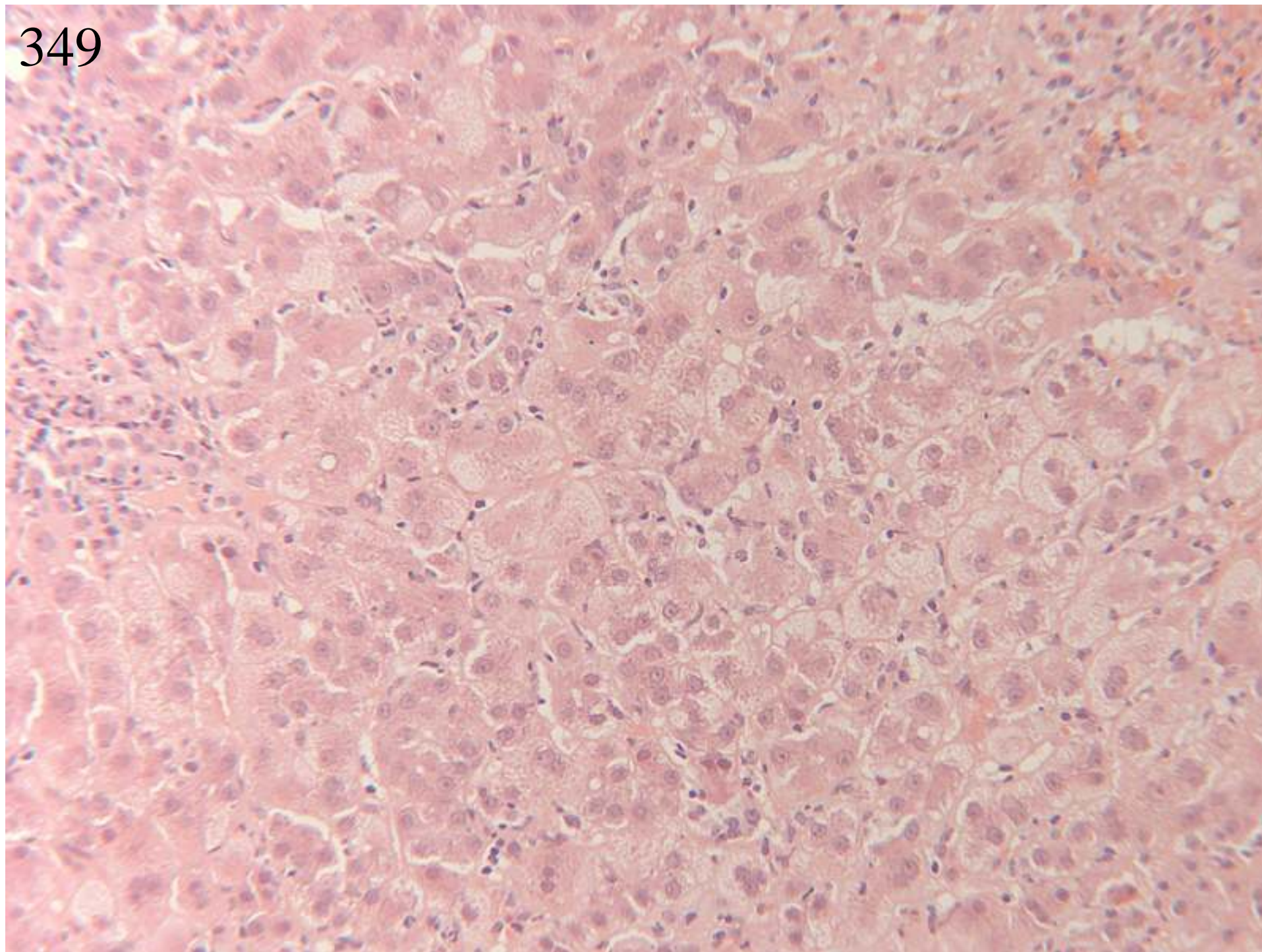
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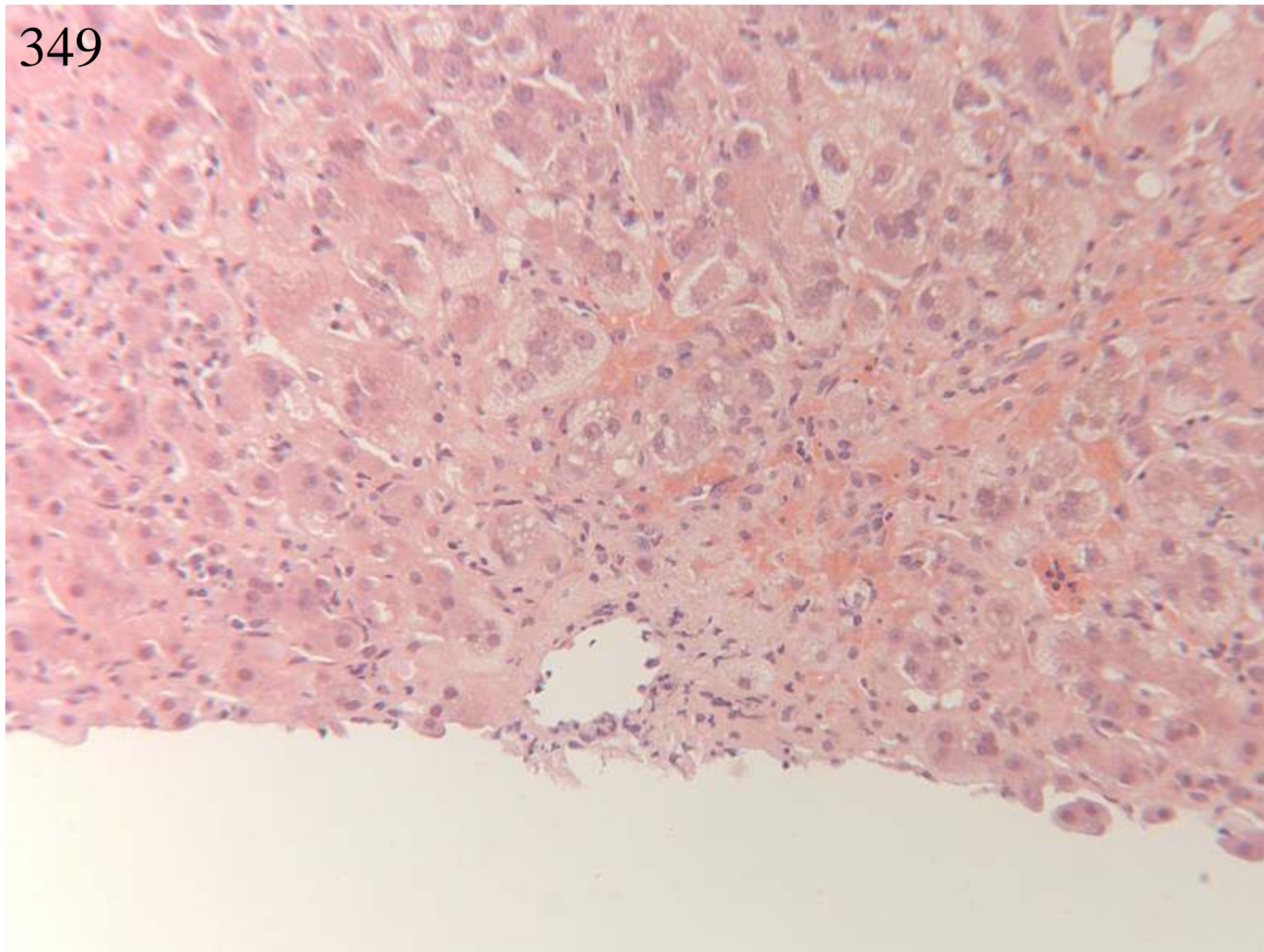
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Morphology:

56 acute hepatitis

Of which:30 bridging/confluent necrosis
 23 giant cell transformation of hepatocytes
 31 cholestasis
 30 plasma cells

6 chronic hepatitis

1 IFH, polymorphs, ductular reaction

1 duct obstruction, no features of AIH

1 acute cholangiolytic hepatitis

1 'primary lesion is cholangitis'

349 contd

Clinicopathological

- 22 c/w autoimmune hepatitis
- 20 c/w AIH and includes differential diagnosis
- 7 AIH among differential, not favoured
- 2 drug reaction more likely than AIH
- 2 ? overlap
- 1 AIH with ascending cholangitis
- 2 drug induced cholestasis v. large bile duct obstruction
- 2 large bile duct obstruction NOS
- 3 no aetiology suggested
- 2 'insufficient for sensible diagnosis'
- 1 Mallory's hyaline, ? alcohol also
- 1 'is this post transplant liver, if so then this is rejection reaction'
- 1 describes neutrophils/Mallory/balloon degeneration/cholestasis, clinicopath = hep A/B/C etc

Agreed scoring: either not suitable, or could include if accept any responses of acute hepatitis and autoimmune in differential. Members voted to include for scoring on this basis.