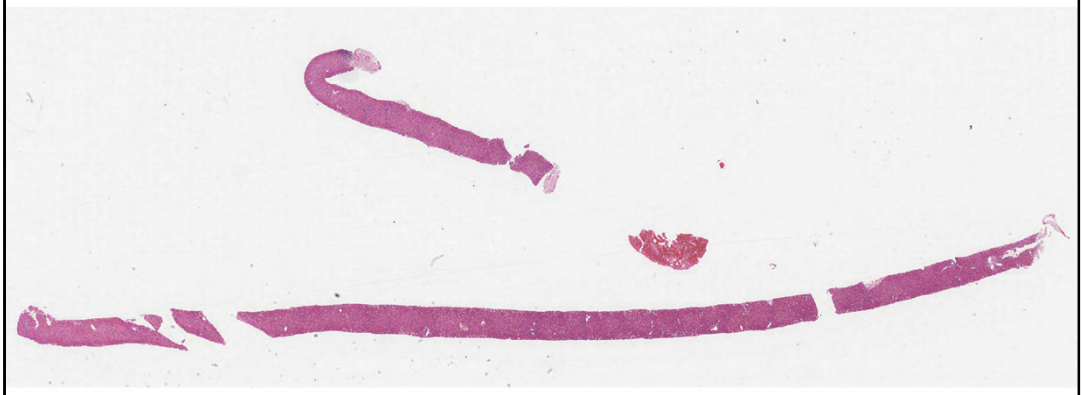
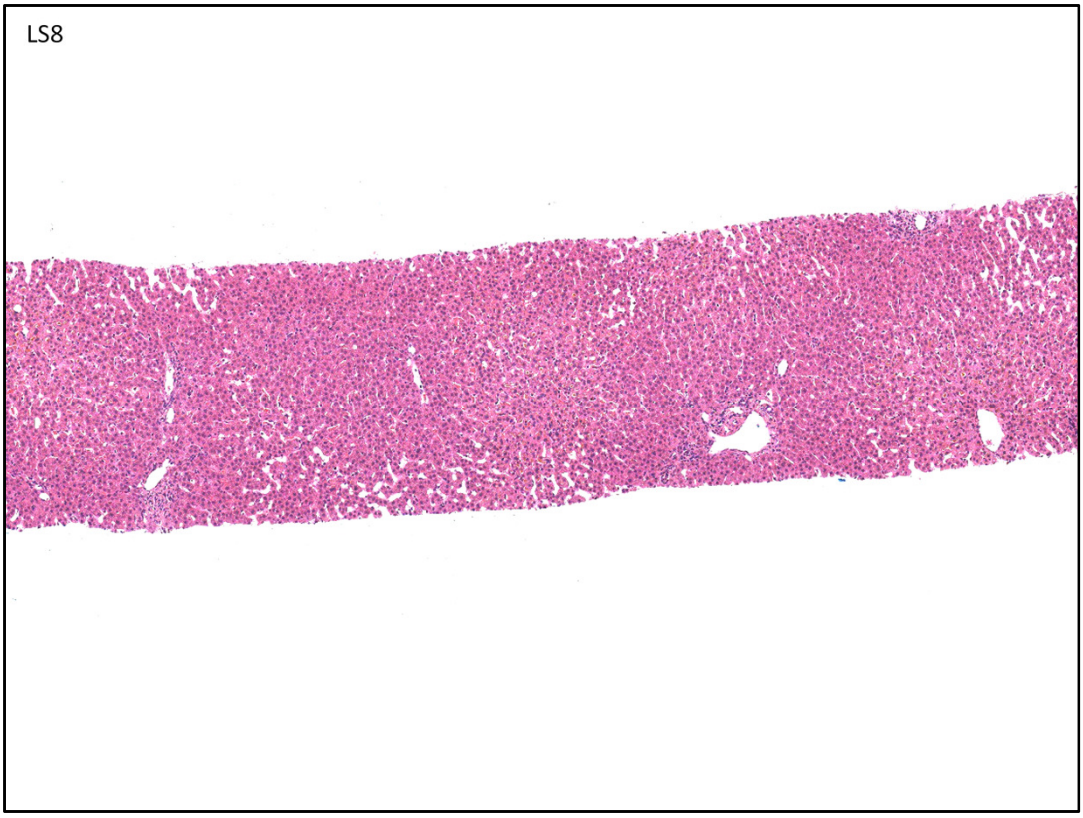
Case LS8 17 F

presented with 4 week history of increasing jaundice and itch. Started combined oral contraceptive pill 3 weeks prior to onset of jaundice. Viral and autoimmune serology negative.

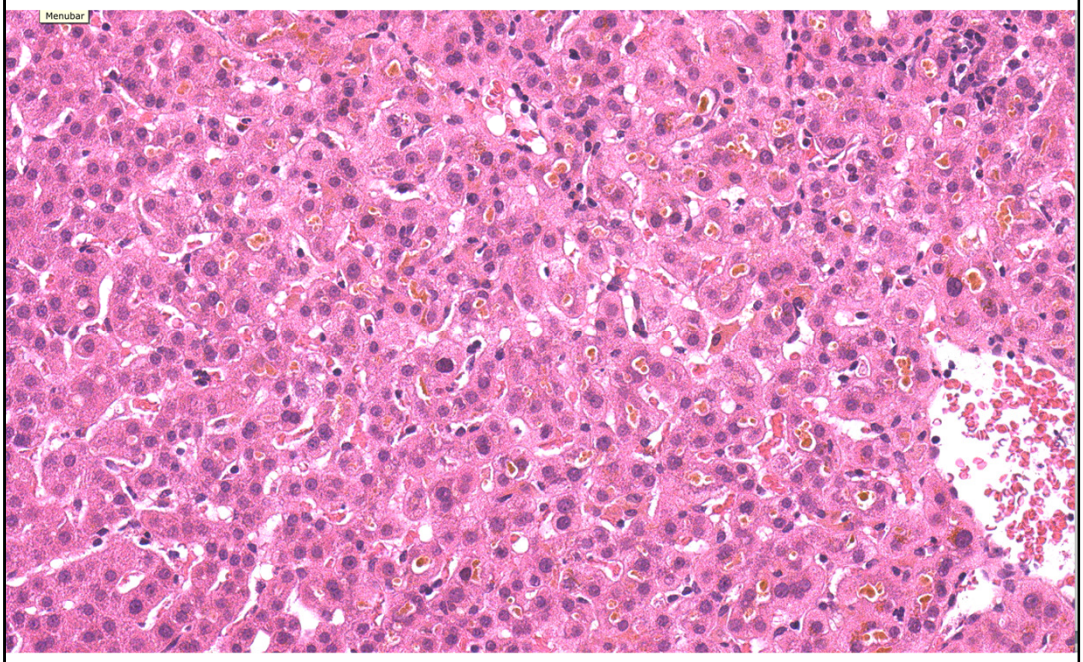
No additional stains





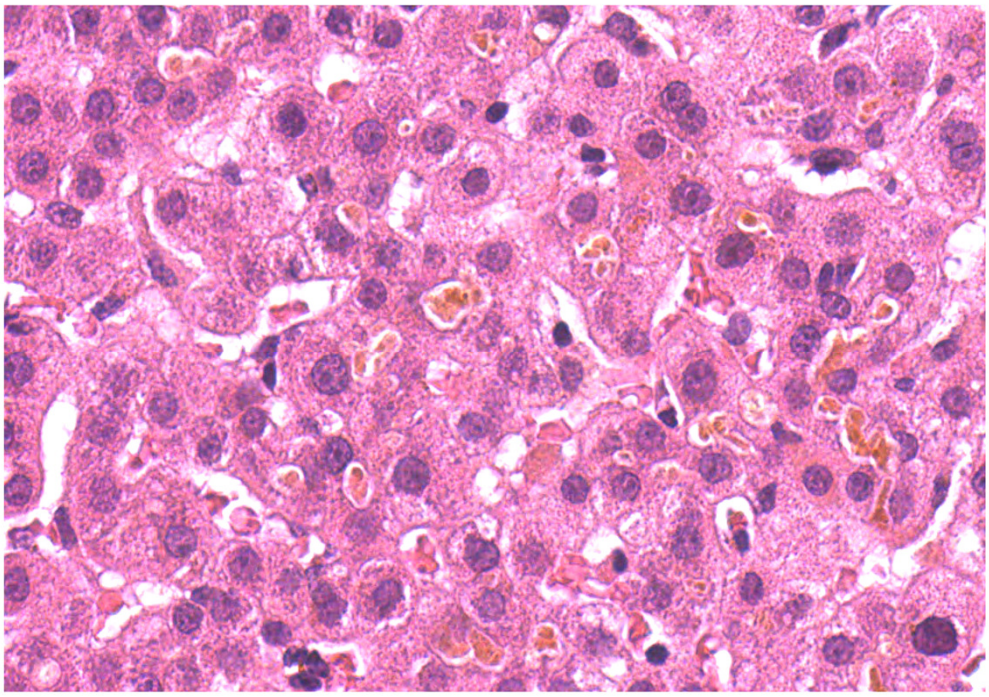
At low power – vascular relationships are preserved, there is some sinusoidal dilatation in perivenular areas.

LS8

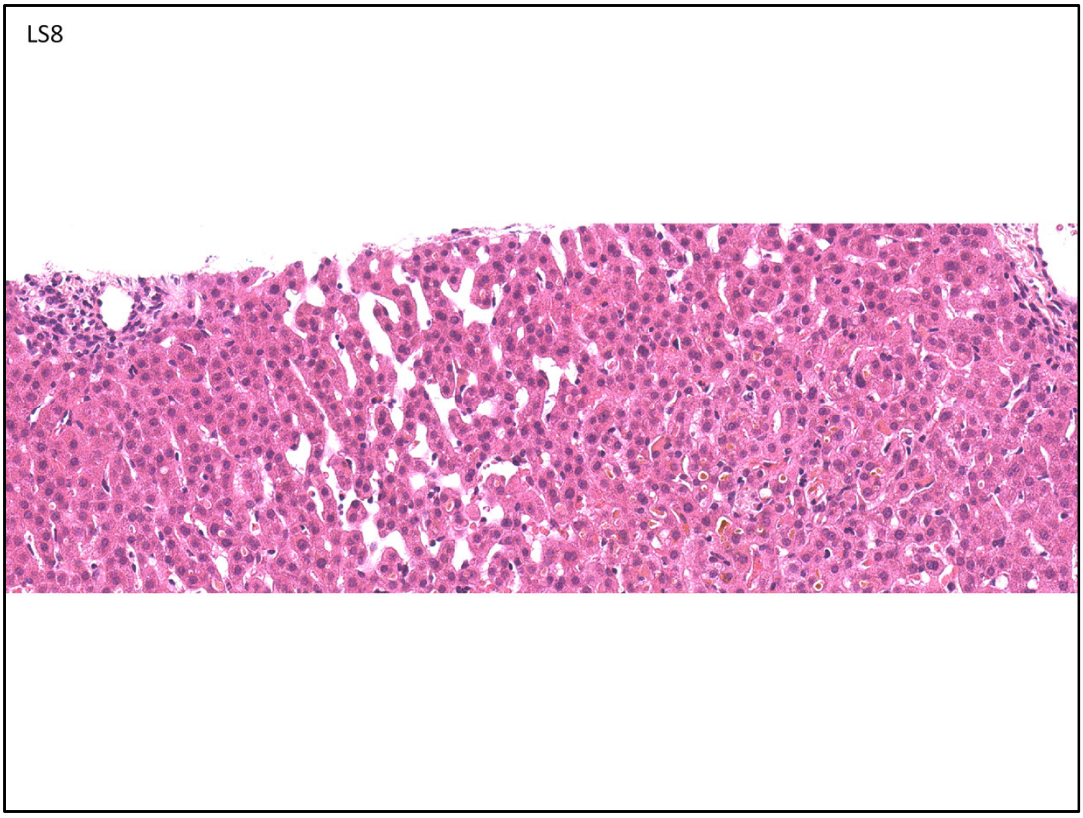


Bilirubinostasis, formation of bile plugs within inter-cellular canaliculi is very well seen. Canaliculi are present between adjoining hepatocytes; as cholestasis progresses, the hepatocytes re-arrange into pseudoglandular structures surrounding the plugged canaliculi, these are cholestatic rosettes.

LS8

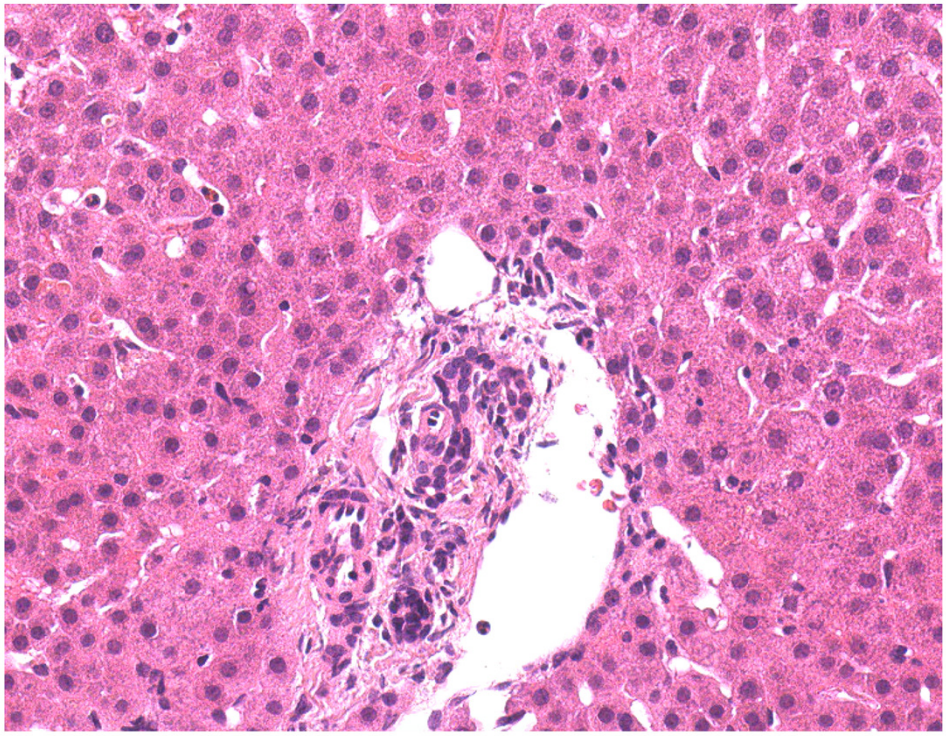


Despite the prominence of the bile stasis, there is very little evidence of hepatocyte injury. Hepatocytes are relatively uniform in size, without swelling/ballooning, acidophil body formation or inflammatory infiltrate. With time, PASD positive scavenger macrophages may become more prominent.

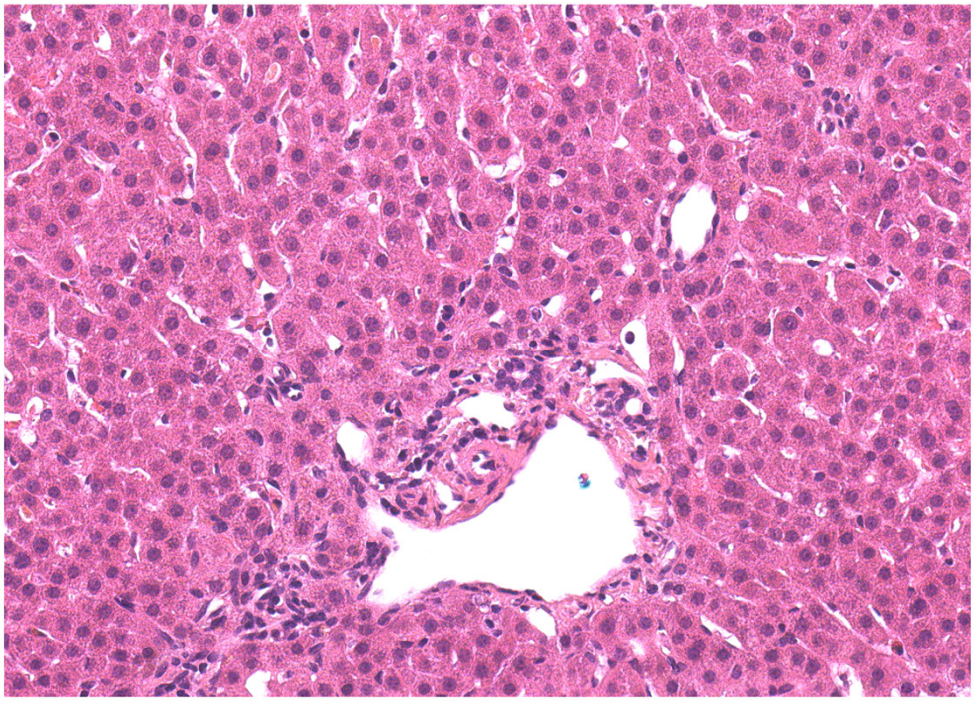


The portal tracts are near-normal. There is some sinusoidal dilatation, but this is not associated with hepatocyte plate attenuation/atrophy, nor is there any extravasaion of red blood cells into the sub-endothelial space of Disse, if present this would be an indication of venous outflow obstruction.

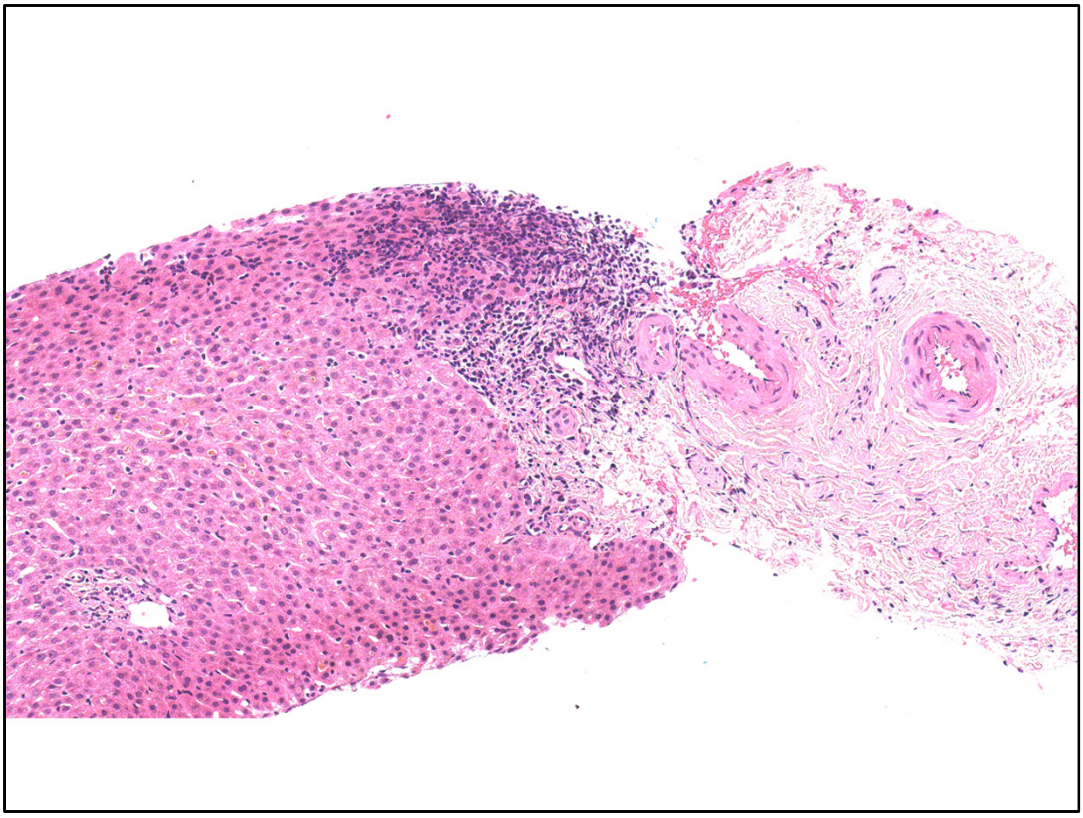
LS8



LS8



There is no inflammatory infiltrate in the small portal tracts.



There is a single area of inflammation at the edge of one portal area – but this is not a generalised feature and so is of uncertain significance and not an indication of a ‘hepatitis’.

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No additional stains

A	Haemangiomatosis due to OCP
B	Bland cholestasis due to OCP
C	Drug induced liver injury - cholestatic
D	Familial recurrent intrahepatic cholestasis
E	Cholestatic hepatitis