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Acute cholangitis (AC) in the setting of iron overload with suspected Epstein-Barr virus (EBV) infection

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Acute cholangitis (AC) is an infection of the biliary tract caused by biliary obstruction and stasis. The most common symptoms are fever and abdominal pain, which are seen in 80% of patients. A 47 year old male presented with a three week history of scleral icterus, dark urine and pale stools, consistent with jaundice. He complained of fatigue, but denied any abdominal pain, fever, chills, nausea or vomiting. Laboratory results were significant for AST 959 IU/L, ALT 1563 IU/L, alkaline phosphatase 199 IU/L, total bilirubin 24.0 IU/L, direct bilirubin 19.9 IU/L, total iron 246 mcg per dL, ferritin 5008 ng/mL and transferrin saturation 85%. An acute hepatitis panel was negative and an abdominal ultrasound and CT scan were unremarkable. Serology results for EBV included: IgG 279, EB-EA (early antigen) >150, EB-NA (nuclear antigen) 544 and a normal IgM. Reactivation of EBV was suspected and a diagnosis of EBV hepatitis was made. The patient did not improve with supportive measures, prompting a liver biopsy, which showed acute inflammation, periportal fibrosis and neutrophillic infiltration and cholestasis of the biliary tree, which was consistent with AC. MRCP was unremarkable for biliary dilatation. The patient was managed supportively and gradually improved. This case presented major challenges to clinicians including the lack of classic symptoms and biliary dilatation on imaging, the apparent iron overload and the presence of a recent EBV infection. Biliary dilatation is very common, but is not necessary for the diagnosis of AC. Mild cases can be managed with close observation.

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Cardiac torsion after excision of a huge mature cystic teratoma

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Cardiac torsion is a rare complication following pericardiectomy but has a high mortality rate, reported at 30 to 64% in some case reports. Cardiac herniation has been noted in some literature after a pneumonectomy with partial pericardiectomy. There are no case reports on cardiac torsion after excision of a teratoma. This is a case of J.F., 52 year old female with a 12 year history of a progressively enlarging mediastinal cyst. Computed tomographic scan made a few months prior to admission showed a 15×10×20 cm mediastinal cyst displacing the trachea and the heart to the left hemithorax. She underwent median sternotomy with excision of the cyst and en bloc partial pericardiectomy. Intraoperatively, the cyst was 20×20 cm with thick, calcified wall and adherent but not invading the middle and lower lung lobes and the diaphragm. The middle and lower lobes were collapse and non-expanding. Patient had episodes of hypotension postoperatively but was corrected after blood transfusion. Chest radiograph was done immediately after the operation, which showed lower lobe opacity on the right. On physical examination, she had edematous bilateral upper extremities and face. On the third postoperative day, the patient became hypotensive requiring inotropic support. Hypotension was persistent despite fluid resuscitation and with maximum inotropic requirements. Repeat chest radiograph revealed the apex of the heart located at the right chest. Confirmatory echocardiography showed cardiac torsion. She was immediately brought to the operating room for emergency sternotomy and repositioning of the heart. Intraoperatively, the heart herniated out the pericardial space. The cardiac apex was shifted to the right. Repositioning was done and the pericardium was reconstructed using a felt to hold the heart in place. Patient, however, arrested during sternal closure and succumbed to severe metabolic acidosis.

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