ANICTERIC HEPATITIS, A RARE EXTRAINTESTINAL MANIFESTATION FOLLOWING CAMPYLOBACTER INFECTION - A CASE STUDY

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Aims

Introduction Campylobacter infection is not uncommon in children, and extraintestinal manifestations following Campylobacter infection is a recognized entity, although hepatitis is rare. We present a case of anicteric hepatitis associated with Campylobacter infection in a 13-year-old boy.

Methods

A previously healthy 13-year-old boy was admitted to the paediatric department with a 4-day history of fever and crampy abdominal pain which was localized to the right upper quadrant. He reported loss of appetite and nausea.

Results

He was not encephalopathic. His clinical examination was unremarkable, except for diffuse tenderness on deep palpation of the abdomen, especially of the right upper quadrant.

His stools were normal initially but 48 hours after admission he developed severe diarrhoea.

Discussion

The viral hepatitis (Hepatitis A IgM, Hepatitis B surface antigen, Hepatitis C IgM, Hepatitis E IgM, and IgG) panel, Epstein-Barr virus (IgG for nuclear antigen, IgM, and IgG for viral capsid antigen), Cytomegalovirus (IgM and IgG) and Parvovirus B19 (IgM and IgG) screening were negative. Pandemic coronavirus virus was not detected on PCR testing. The auto-antibody panel for autoimmune hepatitis (Anti-nuclear antibody, Anti-smooth muscle antibody, Anti-mitochondrial antibody, Liver kidney microsomal antibody) were normal. The ceruloplasmin level and Alpha-1 anti-trypsin levels were not low. The ultrasound scan of the abdomen revealed normal hepatic architecture, making a chronic liver disease less likely. An alternative explanation for high transaminases were not found. Alpne was elevated (181 IU/L) on admission. The full blood count showed elevated white cell count with neutrophil leukocytosis, and C-reactive protein level and Alpha-1 anti-trypsin levels were not low.

Conclusion

Discussion Campylobacter infection has been associated with extra-intestinal manifestations like Guillain-Barre Syndrome, pancreatitis, erythema nodosum, haemolytic uremic syndrome, thrombotic thrombocytopenic purpura, haemolytic anaemia, glomerular nephritis, and reactive arthritis. Hepatitis is a rare complication of Campylobacter infection and is rarely reported in medical literature.

BEROTRALSTAT PROPHYLAXIS FOR HEREDITARY ANGIOEDEMA – AN AUDIT OF USE IN A COHORT OF PATIENTS AT A TERTIARY CENTRE

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Aims

Hereditary Angioedema is a rare disorder, affecting 1:10-50,000. In 2021 the National Institute for Health and Care Excellence (NICE) published guidance on the use of Berotralstat for preventing recurrent attacks of hereditary angioedema (HAE)1 in children 12 years and older. Berotralstat is an oral plasma kallikrein inhibitor which has the end result of inhibiting bradykinin and therefore reducing vasodilation, vascular permeability and ultimately reducing oedema and pain in HAE. Prior to the new recommendations children with recurrent attacks of angioedema would have had limited treatment options. Although attenuated androgens are licenced for use they may not be a practicable solution due to lack of availability, intravenous access or needlephobia, or concerns about appropriate use due to pubertal status.

As Berotralstat is currently a new and unique treatment, we wanted to audit our single centre experience in a cohort of children with hereditary angioedema, some of whom have had access through early access schemes ahead of this guidance.

Methods

We audited the 27 patients that the team manages who have hereditary angioedema (HAE). We focused on the age ranges, age of onset of symptoms, current prophylaxis, number of symptomatic episodes, emergency care plan and access to emergency therapy.

Results

Our cohort included four patients who are being managed on Berotralstat, all over the age of 12 years. Three of these patients had non C1 HAE, with one having a mutation in the FXII gene (HAE-FXII). The rest of the patients were on prophylaxis as shown in table 1.

Treatment that was stopped in favour of Berotralstat included:

Patient 1) No active prophylaxis – Failed Tranexamic Acid
Patient 2) Tranexamic acid
Patient 3) Tranexamic acid
Patient 4) Desogestrel and Tranexamic acid prior use of Lanadelumab

All patients on long term prophylaxis (Tranexamic Acid, Berotralstat or Lanadelumab) had a meaningful reduction in attack frequency.