A 35-year-old male presented to us with oedema discoloration of eyes and urine, gradually progressive lower limb oedema and abdominal distension since a month. On examination, vital signs were within normal limits but pallor, icterus, clubbing and bilateral pitting pedal oedema were noted. Systemic examination revealed an enlarged liver, up to 4cm below the lower costal margin and signs of ascites. There was no personal or family history of previous blood transfusions, joint pains or recurrent jaundice. There was no history of alcohol intake.

Laboratory investigations [Table/Fig-1] were suggestive of severe anaemia (hemoglobin 4.3 gm/dl; normal range 14-17 gm/dL). Increased reticulocyte count (16.5 %), lactate dehydrogenase (1562 U/L; normal range 225-450 U/L) and hyper bilirubinemia pointing to a hemolytic aetiology. Multiple drepnocytes (sickle cells) were noted on peripheral smear. A hemoglobin electrophoresis study showed a broad abnormal band (89.2%) corresponding to Hemoglobin S, suggestive of sickle cell anaemia. Other investigations suggestive of chronic liver disease included thrombocytopenia (85,000 normal range 150000-450000) elevated Aspartate Transaminase (92 U/L; normal range <49 U/L), alkaline phosphatase (211 U/L; normal range 28-111 U/L), hypoalbuninemia (2.2gm/dl; normal range 3.5-5 gm/dL) and hyperbilirubinemia pointing to life threatening sequestration crisis. Most patients, homozygous for sickle cell anaemia, present before adolescence. We report a case of an adult man with no prior symptoms who presented for the first time with decompensated cirrhosis, which was found to be due to underlying previously unrecognised sickle cell anaemia.

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CONCLUSION

It is important for clinicians to recognise the less well-known hepatic presentations of SCD and institute treatment as early as possible for their optimum care and prognosis.

REFERENCES


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