中文題目：爆發式HBs抗體陽性的隱匿性B型肝炎狀似急性猛爆型肝炎:一病例報告

英文題目：Flare-up of Anti-HBs-Positive Occult Hepatitis B Mimicking Acute Fulminant Hepatitis: A Case Report

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Background: Occult hepatitis B is a characterized by negative HBsAg, positive anti-HBs or anti-HBc and low viral replication (<200 IU/mL). HBV DNA amplification assay is the gold standard assay for diagnosing the disease. Cases with higher HBV viral load are generally due to infection with HBV surface gene escape mutants that are not recognized by current assays. However, the suppression of viral replication may be discontinued in a patient with occult hepatitis B when an immunosuppressive status occurs, leading to flare-up of occult hepatitis B with typical, severe or sometimes fulminant course.

Case Report: A 51 years old man without known major disease was brought to our ER due to fever, chills, nausea, vomiting and diarrhea for one week. There was no contact and travel history recently. His family had no similar symptoms in recent days. At our ER, his consciousness changed and vital signs were: temperature, 36.5℃; heart rate, 87 bpm; respiratory rate, 18 breaths per minute and blood pressure, 151/96 mmHg. On physical expansion, chest breath sound was clear and there was no abdominal tenderness or muscle guarding. Jaundice was noted. There was no chest pain, no tarry stool and no concurrent medication. High level of SGOT/SGPT (546/6091 IU/L), bilirubin level (T/D, 10.03/8.96 mg/dL), ammonia (180 umol/L), BUN (101 mg/dL), creatinine (12.5 mg/dL); lipase, 2690 IU/L and coagulopathy were found. He was admitted to our ICU on 11 December 2012. As hemodynamic status was unstable, endotracheal tube was inserted with ventilator support. Other laboratory data showed WBC, 15,300//μL; platelet count, 91,000/μL; CRP, 33.4 mg/L; procalcitonin, 7.25 ng/mL; LDH, 794 IU/L; albumin, 3.7 g/dL; lactate, 14.5 mmole/L and α-feto protein, 6.3 ng/ml. The abdominal echo showed non-distended gallbladder wall thickening, ascites and right pleural effusion. Results of hepatitis markers were anti-HAV IgM (negative), anti-HCV (negative), anti-HBc IgM (positive), HBeAg (negative), anti-HBe (positive), HBsAg (negative), anti-HBs (positive) and HBV viral load (4008 IU/mL), indicating acute flare-up of occult chronic hepatitis B infection. Lamivudine and lactulose were given. The hepatitis and acute renal failure subsided gradually, but the consciousness did not recover with frequent seizure episodes. Brain MRI revealed diffuse brain edema complicated with descending transtentorial herniation and central herniation. Phenytoin and subsequent valproic acid were used. His general condition improved gradually with normalization of bilirubin and creatinine. Then he was transferred to ward. EEG and brain CT favored hypoxic-metabolic encephalopathy. For residual drowsy consciousness and neurologic defects, he was transferred to a local hospital for rehabilitation and chronic care.

Conclusion: We report a patient with fulminant hepatic failure due to acute flare-up of occult hepatitis B, which was recognized by negative HBsAg, positive anti-HBs and high HBV viral load (flare-up). Early diagnosis by testing HBV viral load is essential and lamivudine therapy in time may achieve a good clinical outcome.