Contents

Thrice Monthly Volume 9 Number 2 January 16, 2021

OPINION REVIEW
291 Continuity of cancer care in the era of COVID-19 pandemic: Role of social media in low- and middle-income countries
Yadav SK, Yadav N

REVIEW
296 Effect of a fever in viral infections — the ‘Goldilocks’ phenomenon?
Belon L, Skidmore P, Mehra R, Walter E
308 Overview of bile acid signaling in the cardiovascular system
Zhang R, Ma WQ, Fu MJ, Li J, Hu CH, Chen Y, Zhou MM, Gao ZJ, He YL

MINIREVIEWS
321 Gut microbiota and inflammatory bowel disease: The current status and perspectives
Zheng L, Wen XL

ORIGINAL ARTICLE
334 Effective immune-inflammation index for ulcerative colitis and activity assessments

META-ANALYSIS
357 Limb length discrepancy after total knee arthroplasty: A systematic review and meta-analysis
Tripathy SK, Pradhan SS, Varghese P, Parudappa PP, Velagada S, Goyal T, Panda BB, Vanyambadi J

CASE REPORT
372 Lateral position intubation followed by endoscopic ultrasound-guided angiotherapy in acute esophageal variceal rupture: A case report
Wen TT, Liu ZL, Zeng M, Zhang Y, Cheng BL, Fang XM
379 Perioperative mortality of metastatic spinal disease with unknown primary: A case report and review of literature
Li XM, Jin LB
<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Authors</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>403</td>
<td>Coil embolization of arteriportal fistula complicated by gastrointestinal bleeding after Caesarian section: A case report</td>
<td>Stepanyan SA, Poghosyan T, Manukyan K, Hakobyan G, Hovhannisyan H, Safaryan H, Baghdasaryan E, Gemilyan M</td>
<td></td>
</tr>
<tr>
<td>416</td>
<td>Rare case of fecal impaction caused by a fecalith originating in a large colonic diverticulum: A case report</td>
<td>Tanabe H, Tanaka K, Goto M, Sato T, Sato K, Fujiya M, Okamura T</td>
<td></td>
</tr>
<tr>
<td>422</td>
<td>Intravitreal dexamethasone implant — a new treatment for idiopathic posterior scleritis: A case report</td>
<td>Zhao YJ, Zou YL, Lu Y, Tu MJ, You ZP</td>
<td></td>
</tr>
<tr>
<td>457</td>
<td>Paratesticular liposarcoma: Two case reports</td>
<td>Zheng QG, Sun ZH, Chen JJ, Li JQ, Huang XJ</td>
<td></td>
</tr>
<tr>
<td>476</td>
<td>Postoperative complications of concomitant fat embolism syndrome, pulmonary embolism and tympanic membrane perforation after tibiofibular fracture: A case report</td>
<td>Shao J, Kong DC, Zheng XH, Chen TN, Yang TY</td>
<td></td>
</tr>
<tr>
<td>482</td>
<td>Double-hit lymphoma (rearrangements of MYC, BCL-2) during pregnancy: A case report</td>
<td>Xie F, Zhang LH, Yue YQ, Gu LL, Wu F</td>
<td></td>
</tr>
<tr>
<td>Page</td>
<td>Title</td>
<td>Authors</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>489</td>
<td>Is sinusoidal obstructive syndrome a recurrent disease after liver transplantation? A case report</td>
<td>Liu Y, Sun LY, Zhu ZJ, Wei L, Qu W, Zeng ZG</td>
<td></td>
</tr>
<tr>
<td>496</td>
<td>Portal hypertension exacerbates intrahepatic portosystemic venous shunt and further induces refractory hepatic encephalopathy: A case report</td>
<td>Chang YH, Zhou XL, Jing D, Ni Z, Tang SH</td>
<td></td>
</tr>
<tr>
<td>516</td>
<td>Recurrent inverted papilloma coexisted with skull base lymphoma: A case report</td>
<td>Hsu HJ, Huang CC, Chuang MT, Tien CH, Lee JS, Lee PH</td>
<td></td>
</tr>
</tbody>
</table>
ABOUT COVER
Editorial Board Member of World Journal of Clinical Cases, Dr. Mukul Vij is Senior Consultant Pathologist and Lab Director at Dr Rela Institute and Medical Center in Chennai, India (since 2018). Having received his MBBS degree from King George Medical College in 2004, Dr. Vij undertook postgraduate training at Sanjay Gandhi Postgraduate Institute of Medical Sciences, receiving his Master’s degree in Pathology in 2008 and his PDCC certificate in Renal Pathology in 2009. After 2 years as senior resident, he became Assistant Professor in the Department of Pathology at Christian Medical College, Vellore (2011), moving on to Global Health City as Consultant Pathologist and then Head of the Pathology Department (2013). (L-Editor: Filipodia)

AIMS AND SCOPE
The primary aim of World Journal of Clinical Cases (WJCC, World J Clin Cases) is to provide scholars and readers from various fields of clinical medicine with a platform to publish high-quality clinical research articles and communicate their research findings online.

WJCC mainly publishes articles reporting research results and findings obtained in the field of clinical medicine and covering a wide range of topics, including case control studies, retrospective cohort studies, retrospective studies, clinical trials studies, observational studies, prospective studies, randomized controlled trials, randomized clinical trials, systematic reviews, meta-analysis, and case reports.

INDEXING/ABSTRACTING
The WJCC is now indexed in Science Citation Index Expanded (also known as SciSearch®), Journal Citation Reports/Science Edition, Scopus, PubMed, and PubMed Central. The 2020 Edition of Journal Citation Reports® cites the 2019 impact factor (IF) for WJCC as 1.013; IF without journal self cites: 0.991; Ranking: 120 among 165 journals in medicine, general and internal; and Quartile category: Q3. The WJCC’s CiteScore for 2019 is 0.3 and Scopus CiteScore rank 2019: General Medicine is 394/529.

RESPONSIBLE EDITORS FOR THIS ISSUE
Production Editor: Jia-Hui Li; Production Department Director: Ya-Jie Ma; Editorial Office Director: Jin-Lei Wang.

NAME OF JOURNAL
World Journal of Clinical Cases

ISSN
ISSN 2307-8960 (online)

LAUNCH DATE
April 16, 2013

FREQUENCY
Thrice Monthly

EDITORS-IN-CHIEF
Dennis A Bloomfield, Sandro Vento, Bao-gan Peng

EDITORIAL BOARD MEMBERS
https://www.wjgnet.com/2307-8960/editorialboard.htm

PUBLICATION DATE
January 16, 2021

COPYRIGHT
© 2021 Baishideng Publishing Group Inc

© 2021 Baishideng Publishing Group Inc. All rights reserved. 7041 Koll Center Parkway, Suite 160, Pleasanton, CA 94566, USA
E-mail: bpgoffice@wjgnet.com https://www.wjgnet.com
Is sinusoidal obstructive syndrome a recurrent disease after liver transplantation? A case report

Ying Liu, Li-Ying Sun, Zhi-Jun Zhu, Lin Wei, Wei Qu, Zhi-Gui Zeng

**ORCID number:** Ying Liu 0000-0001-9087-899X; Li-Ying Sun 0000-0003-1101-7994; Zhi-Jun Zhu 0000-0001-7031-2083; Lin Wei 0000-0002-0435-3829; Wei Qu 0000-0002-4484-5940; Zhi-Gui Zeng 0000-0003-1457-7495.

**Author contributions:** Liu Y was involved in concept/design, data collection, data analysis/interpretation, drafting the article and critical revision of the manuscript; Sun LY conceived and designed the study; Zhu ZJ, Wei L, Qu W and Zeng ZG participated in the performance of the research; All authors issued final approval for the version to be submitted.

**Supported by** Beijing Municipal Science & Technology Commission, No. Z181100001718220.

**Informed consent statement:** Informed written consent was obtained from the patient for publication of this report and any accompanying images.

**Conflict-of-interest statement:** The authors declare that they have no conflicts of interest.

**CARE Checklist (2016) statement:** The authors have read the CARE Checklist (2016), and the manuscript was prepared and revised according to the CARE

**Abstract**

**BACKGROUND**

Sinusoidal obstructive syndrome (SOS) is a disease that damages hepatic sinusoidal endothelial cells, resulting in progressive occlusion and fibrosis of the lobular central vein and the occurrence of intrahepatic sinusoidal portal hypertension. However, SOS after liver transplantation (LT) is uncommon and potentially fatal. Here, we report a rare case of second-time recurrence of SOS post-LT.

**CASE SUMMARY**

A 22-year-old woman received a living donor LT due to SOS. Four years later, she developed abdominal distention and ascites with no apparent cause. She was diagnosed with recurrence of SOS and underwent rLT. But 2 mo post rLT, the patient suffered from aggravated jaundice and ascites again. She was diagnosed with second-time recurrence of SOS post-rLT according to computed tomography and liver pathology. After treatment with warfarin anticoagulation and immunosuppressant conversion, she gradually recovered with improvement of liver function and liver pathology. During the 17-mo follow-up period, she was in good condition with normal liver function and no ascites.

**CONCLUSION**

SOS can be a recurrent disease after LT, and autoimmune antibody and genetic sequencing should be screened before LT. For susceptible patients, anticoagulant drugs should be used for an extended period, and tacrolimus or other pathogenic agents should be avoided. Early diagnosis and treatment can improve the prognosis of patients and avoid graft failure or death.

**Key Words:** Sinusoidal obstructive syndrome; Liver transplantation; Recurrence;
Checklist (2016).

Open-Access: This article is an open-access article that was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution NonCommercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/

Manuscript source: Unsolicited manuscript

Specialty type: Medicine, research and experimental

Country/Territory of origin: China

Peer-review report’s scientific quality classification
Grade A (Excellent): 0
Grade B (Very good): B, B
Grade C (Good): 0
Grade D (Fair): 0
Grade E (Poor): 0

Received: September 20, 2020
Peer-review started: September 20, 2020
First decision: September 29, 2020
Revised: October 9, 2020
Accepted: November 29, 2020
Article in press: November 29, 2020
Published online: January 16, 2021

P-Reviewer: Rauchfuss F
S-Editor: Fan JR
L-Editor: Filipodia
P-Editor: Li JH

Sinusoidal dilatation and congestion; Patchy enhancement; Case report

©The Author(s) 2021. Published by Baishideng Publishing Group Inc. All rights reserved.

Core Tip: Sinusoidal obstructive syndrome (SOS) is a complex entity with incompletely defined pathogenesis. It is also an uncommon complication after liver transplantation. We reported a rare case of SOS that recurred twice in liver allografts. We believed that this condition is uncommon and has rarely been reported in liver transplant recipients.

Citation: Liu Y, Sun LY, Zhu ZJ, Wei L, Qu W, Zeng ZG. Is sinusoidal obstructive syndrome a recurrent disease after liver transplantation? A case report. World J Clin Cases 2021; 9(2): 489-495
URL: https://www.wjgnet.com/2307-8960/full/v9/i2/489.htm
DOI: https://dx.doi.org/10.12998/wjcc.v9.i2.489

INTRODUCTION
Sinusoidal obstructive syndrome (SOS) is a rare disorder with a unique etiopathogenesis related to endothelial toxicity leading to fibrotic obliteration of the hepatic centrilobular veins with congestion and hemorrhage[1,2]. Liver transplantation (LT) is an effective treatment for SOS patients with severe liver failure. SOS after LT is very rare with an incidence of 1.9%-2.9%, but it includes a risk for graft failure. Some cytotoxic drugs and/or immunologic responses may be associated with this entity, but the causes and pathophysiological processes of SOS after LT are not well known[3]. Onset of SOS is characterized by ascites, hepatomegaly and jaundice. Here, we describe an unusual case of second-time recurrence of SOS after liver retransplantation (rLT).

CASE PRESENTATION

Chief complaints
A 27-year-old woman came to our center due to aggravated abdominal distension and ascites for 1 mo.

History of present illness
Two months ago, she received rLT from a donation after cardiac death in our center for recurrence of SOS after LT. She recovered well and was discharged on postoperative day 25 under treatment with methylprednisolone, tacrolimus, mycophenolate mofetil and warfarin. One month later, she developed progressive abdominal distension and mild elevation of transaminase with no apparent cause. Abdominal ultrasound showed massive ascites without vascular abnormality.

History of past illness
Five years ago, she underwent a living donor LT for SOS (Figure 1). Initially she recovered well with an immunosuppressive regimen of cyclosporine A and mycophenolate mofetil. One year ago, she developed abdominal distension and ascites. She was diagnosed with recurrence of SOS by computed tomography (CT) and histopathology (Figures 1 and 2). She was treated with diuretics and anticoagulants, but her ascites and abdominal distension were aggravated, along with jaundice. She had no abnormal personal and family history.

Physical examination
Her body temperature, blood pressure, heart rate and breathing rate were within normal limits. Main positive signs were cutaneous and sclera icterus with abdominal bulge and shifting dullness.
Figure 1 Hepatic venography. A and B: Native liver showed marked sinusoidal dilatation and congestion in centrilobular regions and extensive bridging fibrosis and necrosis linking central to central areas; C: Explanted first liver graft characterized by massive perivenular congestion and hemorrhage with marked sinusoidal dilatation. Portal tract was not remarkable; D: Two months after liver retransplantation, liver biopsy was performed to clarify the diagnosis. The second liver graft liver pathology showed sinusoidal dilatation and congestion; E: In addition to warfarin, tacrolimus was switched to cyclosporine A. Two months after treatment, perivenular congestion and sinusoidal dilatation were alleviated and were only observed in the focal perivenular area; F: Nine months later, there was no perivenular congestion and only mild sinusoidal dilatation.

Laboratory examinations
Laboratory results suggested that alanine aminotransferase was 61 IU/L, glutamic oxaloacetylase was 39.9 IU/L, alkaline phosphatase was 90 IU/L, glutamyl transpeptidase was 103 IU/L, total bilirubin was 40.85 μmol/L, direct bilirubin was 31.7 μmol/L and creatinine was 130 mol/L. Tacrolimus trough level was 12.4 ng/mL. Testing for thrombophilia showed that she was positive for anticardiolipin antibody (ACL). Protein C, protein S and homocysteine were negative.

Imaging examinations
Abdominal ultrasound showed hepatomegaly with heterogenous echoes and seroperitoneum. CT revealed hepatomegaly with patchy enhancement and ascites (Figure 2). Then transjugular venography and liver biopsy were performed. Hepatic venography showed no stenosis of the hepatic vein or inferior vena cava, but hepatic
venous pressure gradient was 21 mmHg. Liver pathology showed sinusoidal dilatation and congestion (Figure 1).

**FINAL DIAGNOSIS**

On the basis of these findings, she was diagnosed with second-time recurrence of SOS post-rLT.

**TREATMENT**

Based on our past experience and literature review, tacrolimus was stopped and replaced with cyclosporine A, and warfarin was continued at 3 mg/d and was adjusted according to International Normalized Ratio (2-3).

**OUTCOME AND FOLLOW-UP**

After treatment, ascites gradually decreased with improvement of liver and renal function. Four months post-rLT, CT and histological examination were reviewed. The results showed that hepatomegaly, heterogeneous enhancement, sinusoidal dilatation and congestion were all relieved (Figures 1 and 2). During the 17 mo follow-up period, she was in good condition with normal liver function and no ascites.

**DISCUSSION**

SOS is a rare but fatal complication after LT, which can lead to graft failure and death. Although the pathogenesis of SOS after LT remains unknown, it is reported to be associated with azathioprine or tacrolimus\(^3\), episodes of acute rejection\(^4\), oxaliplatin-containing chemotherapy\(^5\), irradiation\(^6\) and intake of pyrrolizidine-alkaloid-containing plants\(^7\). In our case, the patient’s primary disease was SOS of unknown cause. After rLT, SOS recurred for the second time similar to the episode after the first LT. After withdrawal of tacrolimus, the patient experienced rapid clinical improvement, which was confirmed by imaging and histological examination. Tacrolimus may have potential cytotoxicity for endothelial cells and precipitate their dysregulation as reported\(^8\).

In this case, it is strange that SOS occurred in the native liver and in the two subsequent liver allografts. We hypothesize that there may be something unusual in the patient initiating the thrombotic process. In our case, test for thrombotic disorder showed that ACL was positive. ACLs have been found in some patients with autoimmune disorder, acute infection or cardiovascular disease, and they have been associated with arterial and venous thrombosis\(^9,10\). Therefore, the patient likely had a form of thrombotic disorder leading to recurrence of SOS. Anticoagulation therapy...
with warfarin was administered at a dose of 3 mg/d. We performed a literature review and retrieved only two cases\textsuperscript{[11,12]} in which SOS recurred sequentially in the two liver allografts (Table 1). In the case Fiel et al\textsuperscript{[12]} reported, the patient also tested positive for high levels of ACL antibodies. Ansari et al\textsuperscript{[13]} observed that whole exome sequencing can find high-risk patients with genetic susceptibility in pediatric patients with SOS after hematopoietic stem cell transplantation\textsuperscript{[13]}. Some gene variants are associated with SOS in children receiving intravenous busulfan and cyclophosphamide before hematopoietic stem cell transplantation\textsuperscript{[14]}. Therefore, repeated relapse of SOS is probably associated with antibody-mediated autoimmune response or genetic susceptibility. In these patients, SOS may be a recurrent disease after LT, and autoimmune antibody and genetic sequencing should be screened before LT. During the post-LT period, anticoagulant drugs should be used for a long time and tacrolimus or other potential pathogenic agents should be avoided.

**CONCLUSION**

We reported a rare case of SOS that recurred twice in liver allografts. Treatment of anticoagulation and immunosuppressant adjustment can be effective in reducing the symptoms. Although the patient has remained asymptomatic after drug adjustment, close monitoring is still needed in case of a third relapse. Though this is a single case, with the greater understanding of the disease, further studies will be of great help for the investigation of pathogenesis.
Table 1 Summary of the cases reported

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Year of publication</th>
<th>Age in yr</th>
<th>Gender</th>
<th>Primary disease</th>
<th>Operation</th>
<th>IS</th>
<th>ACR post LT</th>
<th>Time of first SOS occurrence</th>
<th>ACR post rLT</th>
<th>Time of second recurrence</th>
<th>Pathologic findings</th>
<th>Complication post third LT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martins et al. [1]</td>
<td>2007</td>
<td>20</td>
<td>F</td>
<td>Type I autoimmune cirrhosis</td>
<td>LT</td>
<td>CsA/FK506 + Pre + Aza</td>
<td>Yes</td>
<td>2 yr</td>
<td>Yes</td>
<td>3 yr</td>
<td>Fibrous obliteration of centrilobular veins by connective tissue</td>
<td>Biliary stenosis; autoimmune hepatitis</td>
</tr>
<tr>
<td>Fiel et al. [2]</td>
<td>1999</td>
<td>37</td>
<td>F</td>
<td>Primary sclerosing cholangitis</td>
<td>LT</td>
<td>FK506 + Pre + Aza</td>
<td>No</td>
<td>2 mo</td>
<td>No</td>
<td>20 mo</td>
<td>Obliteration of terminal hepatic venules by dense fibrosis</td>
<td>-</td>
</tr>
</tbody>
</table>

ACR: Acute cellular rejection; IS: Immunosuppressant; LT: Liver transplantation; rLT: Liver retransplantation; SOS: Sinusoidal obstructive syndrome.

REFERENCES


