HOSPITAL ESCOLA Álvaro Alvim

FBPN Fundação Benedito Pereira Nunes

fmc FACULDADE DE MEDICINA DE CAMPOS

Serviço e Disciplina de Clínica Médica

Sessão Clínica – 27/09/2021

Auditório Honor de Lemos Sobral- Hospital Escola Álvaro Alvim

Orientadora: Dra. Sandyelle da Silva Rocha

Relator: Dr. Gustavo de Araújo Neto (R2)

Debatedor: Dr. Hugo Freitas Viégas Fernandes (R1)

CASO CLÍNICO

• Identificação: Feminina, 24 anos de idade, negra, do lar, residente e procedente de Macaé - RJ.

• Admissão: 07/08/2021

• QP: “Comecei com dor na barriga e fiquei amarela”

•HDA: Paciente relata que na primeira quinzena de julho, iniciou quadro de dor abdominal intermitente em região de epigástrio, mal caracterizada, de forte intensidade, sem irradiação, associada à náuseas e vômitos esporádicos. Nega fatores atenuantes ou agravantes. Evoluiu com icterícia, colúria, e hipocolia fecal. Nega prurido. Refere perda ponderal não quantificada associada ao início do quadro. Procurou atendimento médico na cidade de origem, sendo internada no dia 11 de julho, onde realizou propedêutica dirigida e fez uso de antibioticoterapia (a qual não sabe relatar) por cerca de 7 dias. Relata melhora do quadro de dor abdominal, com retorno das náuseas há cerca de 7 dias. Nega uso de drogas durante os últimos 4 meses, bem como chás e suplementos. Nega febre durante o quadro e não percebeu adenomegalia. Nega artralgias.

CASO CLÍNICO

• HPP: HAS desde os 17 anos após a primeira gestação. Cessou anti-hipertensivo por conta própria há 4 meses. Fez uso de Primosiston® de 8/8h por cerca de 30 dias, prescrito por farmacêutico, devido à metrorragia há 2 meses. Nega alergia medicamentosa.

Medicamentos: Uso domiciliar: atenolol 25mg 12/12h – uso irregular e cessado há 4 meses.

Uso recente de Primosiston® e antibioticoterapia desconhecida pela paciente.

Cirurgias prévias: 4 cesáreas.

Hemotransfusão prévia: Ø

• H.Fis.: Ritmo intestinal fisiológico, com cerca de 01 evacuação/dia, sem elementos patológicos. Refere manutenção de colúria. G4P4A0 (sendo um natimorto) .04 cesáreas, última em 2018. DUM há 2 meses.

CASO CLÍNICO

• H. Familiar: Mãe - HAS; Pai- HAS; Irmão - faleceu aos 22 anos devido à complicações de HAS. Filhos saudáveis.

• H.Social: Tabagista há 10 anos com CT de cerca de 15 anos-maço; Etilista há 10 anos, com consumo diário de fermentados até 2018, com carga etanólica de 311g/dia. Há cerca de 02 anos, bebe aos finais de semana, com consumo de fermentados, chegando a 168g de etanol por final de semana; Já fez uso de cocaína por 6 meses, abstinente há 2 anos. Nega uso de drogas injetáveis. Tem 02 tatuagens e piercing.

CASO CLÍNICO - EXAME FÍSICO:

BEG, LOTE, ictérica ++/4+, acianótica, hidratada, normocorada, eupneica e afebril. Acantose nigricans. Flapping. Sem estigmas de hepatopatia crônica.

Peso: 98Kg ALT.:1,65m IMC: 36

PA: 140x100mmHg FC: 74bpm Sato2: 98%

•ACV: RCR 2T BNF sem sopros.

•AR: MV+, sem RA.

• ABD: globoso, depressível, RHA+, indolor à palpação superficial e profunda, timpânico à percussão. Traube timpânico. Hepatimetria 10cm. Ausência de macicez móvel.

•MMII: sem edemas.

Data	18/07/21	01/08/21	07/08/21	10/08/21
Hb/Ht	12/36	11/32	10/33	12/38
VCM/HCM	77/26	77/26	75/27	76/26
LG/Nt%	5960/62	7380/65	5920/61	16500/63
Plaquetas	330.000	220.000	141.000	120.000
Na/K		141/3,7	137/3,5	138/3,7
TGO	1286	466	471	387
TGP	1342	384	342	318
FA (até 300)	90	118	402	385
GGt	118	140	165	156
BT/BD	19,3/7,3	20/11	14/8	14,9/8,9
TAP%/INR			29/2,6	32/2,25
Albumina		2,6	2,2	2,3
Ur/Cr	25/0,98	19/0,7	12/1,0	21/0,8

Data	18/07/21	01/08/21	07/08/21	10/08/21
Amilase	74			
Lipase	32			
VHS/PCR	35/5	35/5	78/21	
Ferritina			341	
IST%			28	
IGG			3746	
FAN			1:160*	
AML			1:80	
LDH			396	
TSH/T4L				2,02/1,16

*FAN nuclear pontilhado

- **Sorologias 07/08/21**:
  - Anti-HAV IgM NR / anti HAV IgG reagente
  - HBsAg NR / anti-HBs reagente / anti-HBc total NR
  - Anti-HCV NR
  - CMV IgM NR / CMV IgG reagente
  - EBV IgM NR / EBV IgG reagente
  - HSV 1 e 2 IgM NR / HSV 1 e 2 IgG reagentes
  - Dengue IgM NR / Dengue IgG reagente

- **Beta HCG 07/08/21**: negativo

EXAME DE IMAGEM

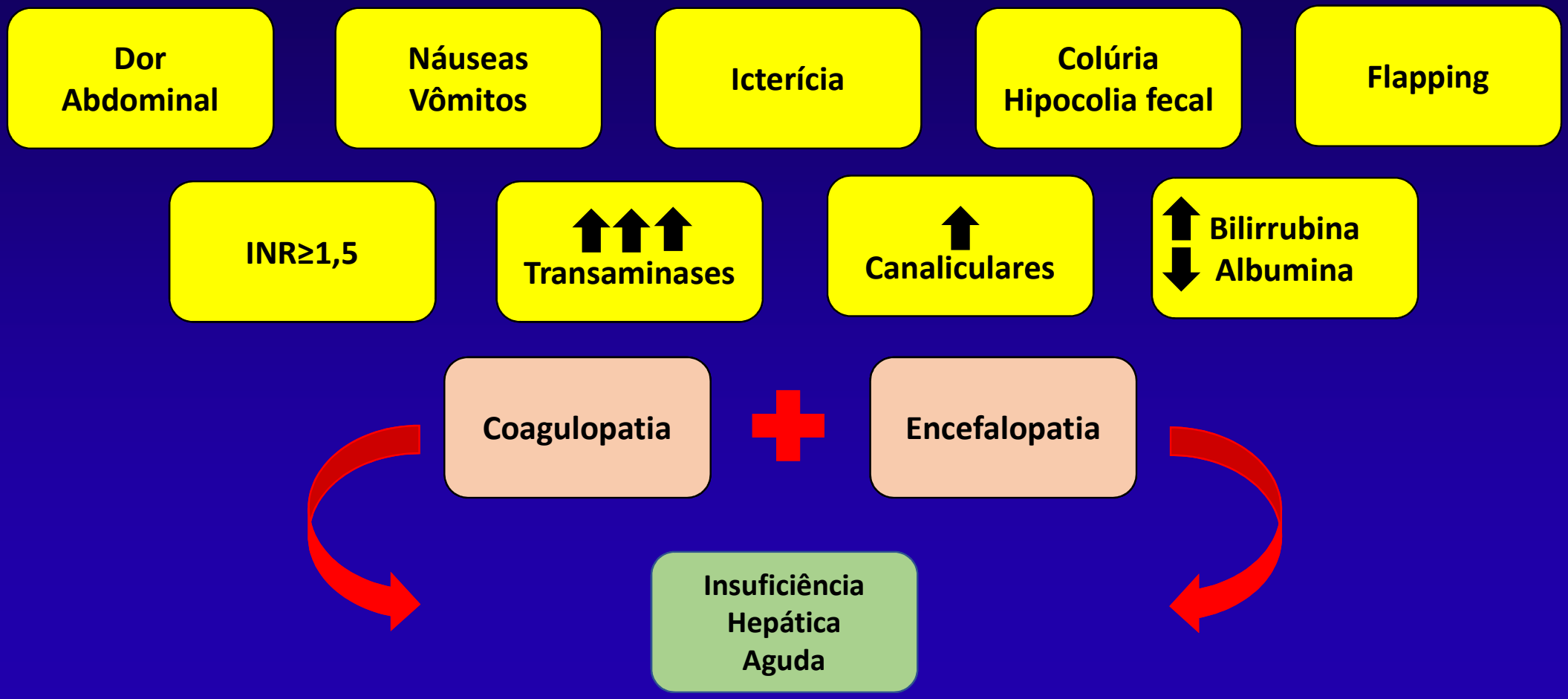
- **USG de abdome superior com Doppler de veia porta 10/08/2021:**

  - Fígado de contornos regulares e textura difusamente heterogênea. Baço 12cm. Sem sinais de trombose.

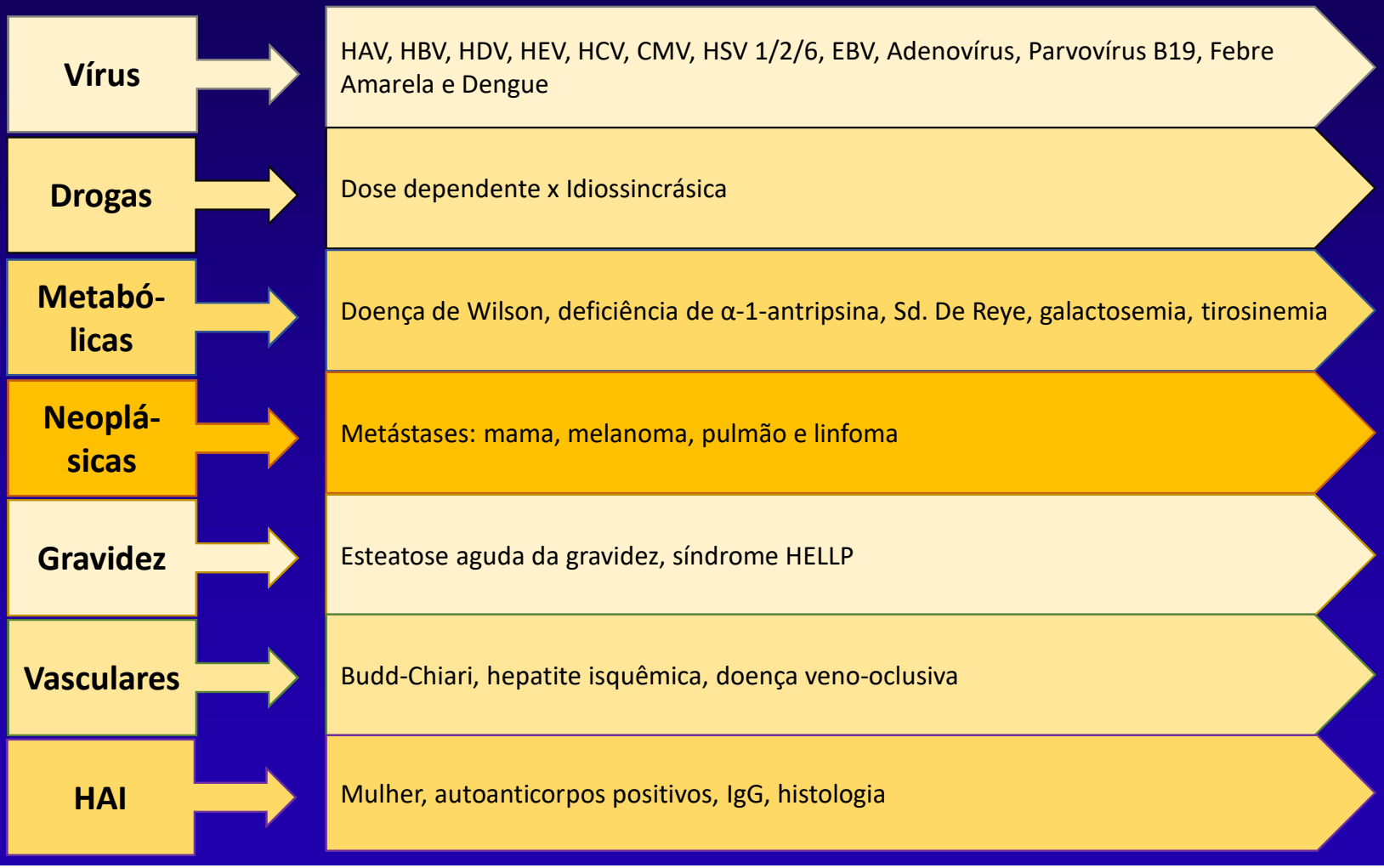
Hipóteses diagnósticas / conduta

Seguimento do caso

CONDUÇÃO DO CASO



CONDUÇÃO DO CASO



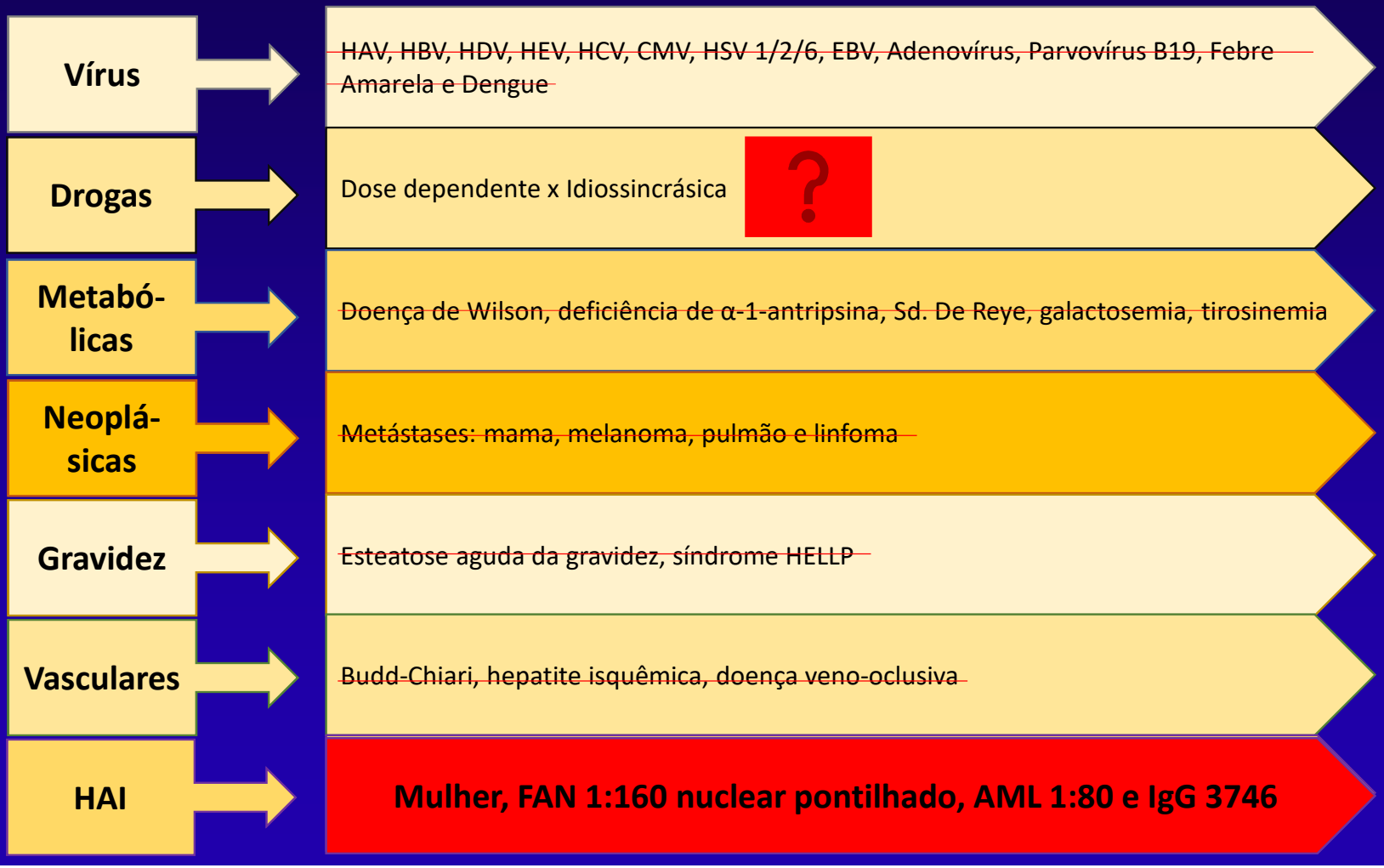
CONDUÇÃO DO CASO

IHA

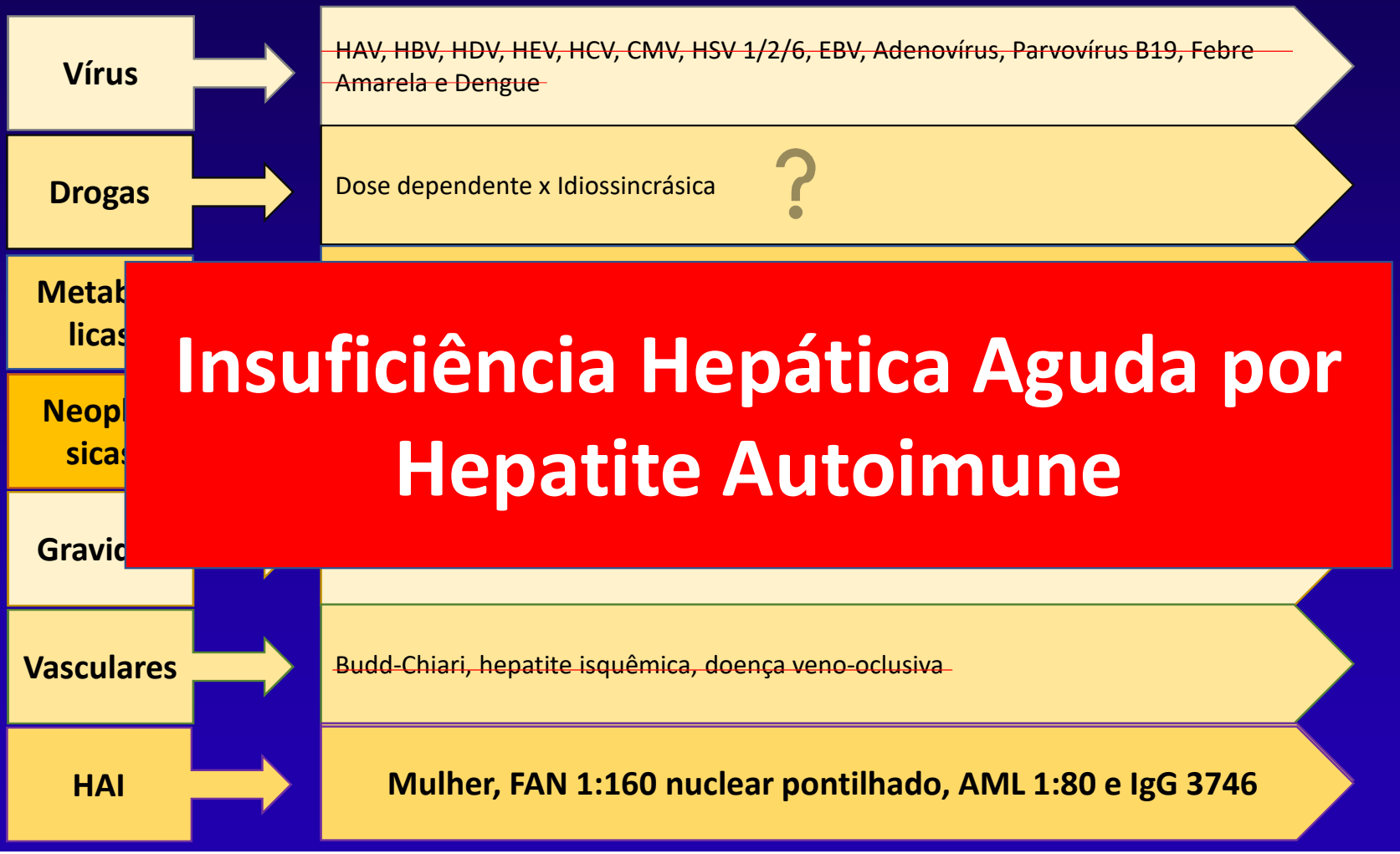
- História clínica com ênfase no uso de fármacos, drogas ilícitas, ervas e suplementos
- Avaliação epidemiológica para possível exposição viral
- Se mulher: avaliação quanto à presença de gestação e idade gestacional
- Imagem: US com doppler de veia porta
- Laboratório específico: HAV, HBV, HCV*, HIV**,HSV 1e2,HEV, CMV, EBV, FAN, AML,IGG, função hepática, transaminases e canaliculares. Lactato, LDH, Ur, Cr, gasometria arterial e hemograma.
- Testes adicionais: HEV-RNA, dengue, ceruloplasmina, cupriúria (principalmente se BT/FA>2)
- Testes a serem socilitados de acordo com a suspeita clínica: sorologia para Varicela zoster, parvovíus B19, biópsia hepática

*Determinar infecção subjacente
**Implicação para potencial transplante

CONDUÇÃO DO CASO



CONDUÇÃO DO CASO



Insuficiência Hepática Aguda por Hepatite Autoimune

SISTEMA DE PONTUAÇÃO SIMPLIFICADO (2008)

Recurso/parâmetro	Discriminador	Pontuação
Anticorpos (máximo 2 pontos)		(0–2 pontos no total)
FAN ou AML+	≥1:40	+1
FAN ou AML+	≥1:80	+2
ou LKM+	≥1:40	+2
ouSLA/LP+	Qualquer título	+2
Nível de IgG ou γ-globulinas	>LSN	+1
	>1.1x LSN	+2
Histologia hepática (evidência de hepatite é necessária)	Compatível com HAI	+1
	Típico de HAI	+2
	Atípica	0
Ausência de hepatite viral	Não	0
	Sim	+2

Hepatite autoimune definitiva: ≥7;
Hepatite autoimune provável: ≥6.

Histologia hepática típica para hepatite autoimune = cada uma das seguintes características tem de estar presente, ou seja, hepatite de interface, infiltrados linfocíticos/linfoplasmáticos em espaços portais e estendendo-se para o lóbulo, emperipolese (penetração ativa de uma célula para dentro de uma célula maior), e formação de roseta hepática. **Histologia hepática compatível** para hepatite autoimune = hepatite crônica com infiltração linfocítica, sem todas as características consideradas típicas. **Atípico** = que mostra sinais de outro diagnóstico, como a esteatohepatite.

CONDUÇÃO DO CASO

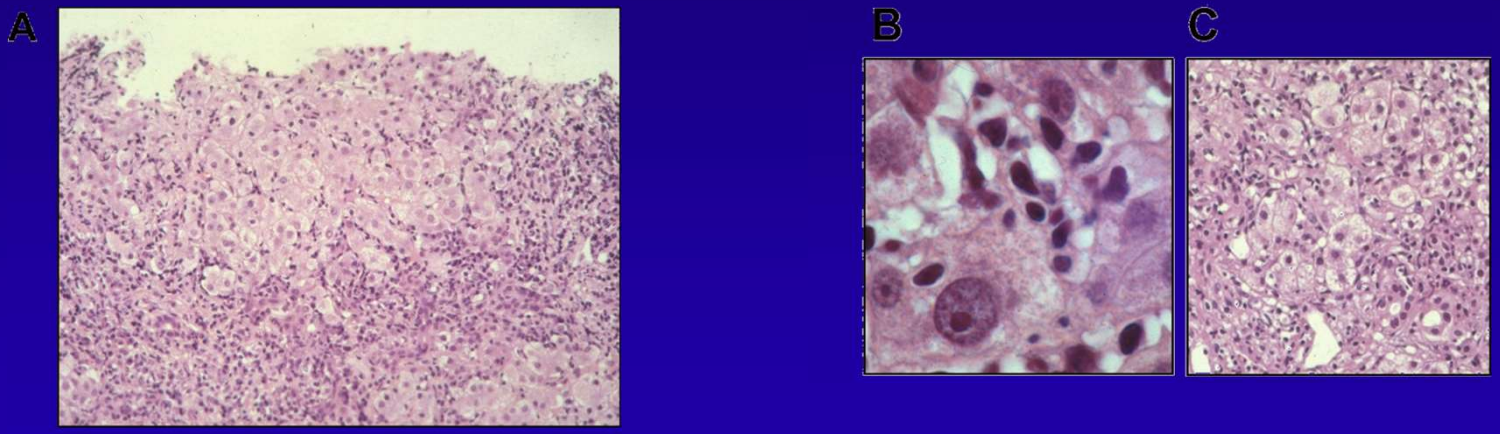
- 6 pontos nos Critérios Simplificados.
- Iniciado corticoterapia (prednisona 60mg/dia).
- King's College: não preenheu critérios de pior prognóstico.
- Melhora da encefalopatia hepática.
- Solicitado biópsia hepática.

Corticóide 08/08

Data	18/07	01/08	07/08	10/08	11/08	12/08	23/08
Hb / Ht	12,6 / 36	**11 / 32**	**10 / 33**	12 / 38			
VCM / HCM	**77 / 26**	**77 / 26**					
LG / NT %	5960 / 62	7380 / 65	5920 / 61	**16500 /**			
Plaquetas	330.000	220.000	181.000				
TGO / TGP	**1.286 / 1.342**	**466 / 384**	**471 / 242**	**387 / 218**	**289 / 195**	**242 / 163**	**55/70**
FA / GGt	90 / **118**	118 / **140**	**402 / 165**				98/100
BT / BD	**19,3 / 7,3**	**19,3 / 7,3**	**14 / 7,8**	**14,9 / 8,2**	**12 / 7,8**	**11/ 7,04**	**2,3/1,5**
TAP/INR			**29 / 2,6**	**- / 2,25**	**- / 2,04**	**- / 1,4**	**98/1,02**
Albumina		**2,6**	**2,2**	**2,3**		**2,5**	**3,0**

CONDUÇÃO DO CASO

- Biópsia hepática 27/08/21: Amostra de tecido hepático de 2cm, com visualização de 10 espaços porta. Presença de infiltrado inflamatório portal intenso, com atividade de interface e lobular, com plasmócitos facilmente reconhecíveis, balonização e rosetas hepatocitárias. O diagnóstico histológico foi de hepatite com intensa atividade, devendo considerar hepatite autoimune como primeiro diagnóstico.



- Iniciado Azatioprina 1mg/kg e desmame progressivo da prednisona.

HEPATITE AUTOIMUNE

Review Article

Autoimmune Hepatitis—Immunologically Triggered Liver Pathogenesis—Diagnostic and Therapeutic Strategies

Elisabeth Sucher,[1] Robert Sucher,[2] Tanja Gradistanac,[3] Gerald Brandacher,[4] Stefan Schneeberger,[5] and Thomas Berg[1]

[1]*Division of Hepatology, Clinic and Polyclinic for Gastroenterology, Hepatology, Infectiology, and Pneumology, University Clinic Leipzig, Germany*
[2]*Department of Visceral, Transplant, Thoracic and Vascular Surgery, Division of Hepatobiliary Surgery and Visceral Transplant Surgery, University Clinic Leipzig, Germany*
[3]*Department of Pathology, University Clinic Leipzig, Germany*
[4]*Department of Plastic and Reconstructive Surgery, Vascularized Composite Allotransplantation (VCA) Laboratory, Johns Hopkins University, Baltimore, Maryland, USA*
[5]*Department of Visceral, Transplant, and Thoracic Surgery, University Clinic Innsbruck, Tirol, Austria*

Correspondence should be addressed to Elisabeth Sucher; elisabeth.sucher@medizin.uni-leipzig.de

Received 26 June 2019; Revised 15 September 2019; Accepted 21 September 2019; Published 25 November 2019

Guest Editor: Qingdong Guan

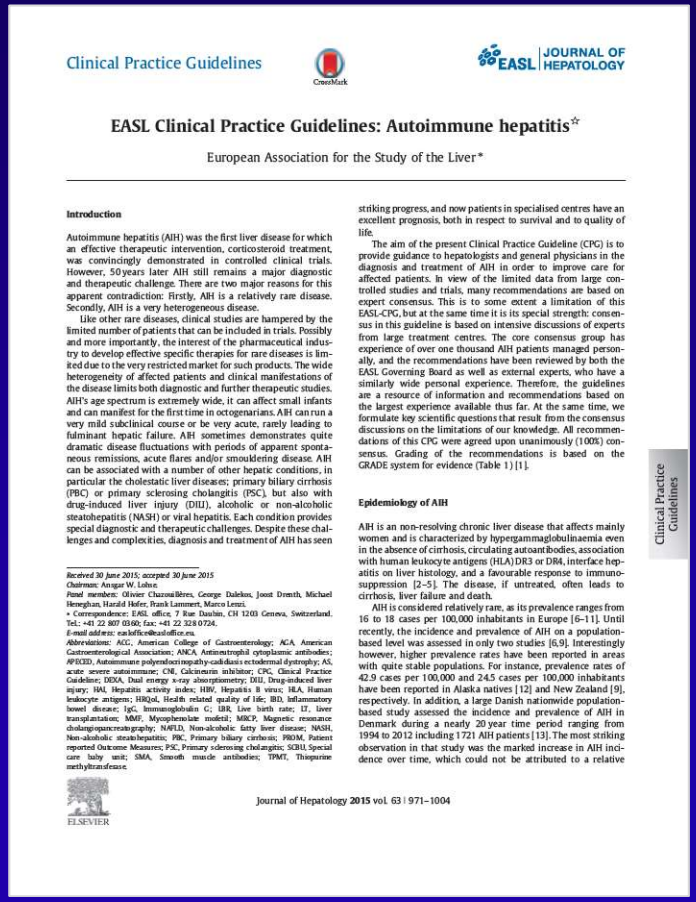
Autoimmune hepatitis (AIH) is a severe liver disease that arises in genetically predisposed male and female individuals worldwide. Diagnosis of AIH is made clinically applying diagnostic scores; however, the heterotopic disease phenotype often makes a rapid determination of disease challenging. AIH responds favorably to steroids and pharmacologic immunosuppression, and liver transplantation is only necessary in cases with acute liver failure or end-stage liver cirrhosis. Recurrence or development of de novo AIH after transplantation is possible, and treatment is similar to standard AIH therapy. Current experimental investigations of T cell-mediated autoimmune pathways and analysis of changes within the intestinal microbiome might advance our knowledge on the pathogenesis of AIH and trigger a spark of hope for novel therapeutic strategies.

1. Introduction

Autoimmune hepatitis (AIH) is a complex immune-mediated liver disease that is diagnosed histologically by interface hepatitis and high serum levels of alanine aminotransferase (ALT), aspartate aminotransferase (AST), and immunoglobulin G (IgG) and the presence of autoantibodies [1]. The initial perception of AIH as a chronic inflammatory liver dysfunction which mainly affects young Caucasian women [2] has been amplified to both sexes of all age groups and all ethnic societies worldwide [3]. AIH can be asymptomatic or present in various forms from subclinical disease to acute liver failure and end-stage liver disease [4].

Specific diagnostic criteria and scoring systems have been established which include analysis of autoantibodies (ANA, SMA, anti-LKM1, and anti SLA); immunoglobulins (IgG), viral markers (IgM anti-HAV, HBsAg, HBV DNA, and HCV RNA) and histological findings [5]. According to the antibody profile, AIH can be divided into two subtypes. The presence of ANAs and or anti-smooth muscle antibodies (SMA) may indicate AIH type 1 (AIH-1), and anti-liver kidney microsomal antibody type one (LKM1) and anti-LKM3 and/or anti-liver cytosol type one antibody (LC1) are disease markers for AIH type 2 (AIH-2) [6].

The exact mechanisms for the immune tolerance breakdown in AIH have not been described yet, but there is growing



Clinical Practice Guidelines

JOURNAL OF HEPATOLOGY

EASL Clinical Practice Guidelines: Autoimmune hepatitis☆

European Association for the Study of the Liver*

Introduction

Autoimmune hepatitis (AIH) was the first liver disease for which an effective therapeutic intervention, corticosteroid treatment, was convincingly demonstrated in controlled clinical trials. However, 50 years later AIH still remains a major diagnostic and therapeutic challenge. There are two major reasons for this apparent contradiction: Firstly, AIH is a relatively rare disease. Secondly, AIH is a very heterogeneous disease.

Like other rare diseases, clinical studies are hampered by the limited number of patients that can be included in trials. Possibly and more importantly, the interest of the pharmaceutical industry to develop effective specific therapies for rare diseases is limited due to the very restricted market for such products. The wide heterogeneity of affected patients and clinical manifestations of the disease limits both diagnostic and further therapeutic studies. AIH's age spectrum is extremely wide, it can affect small infants and can manifest for the first time in octogenarians. AIH can run a very mild subclinical course or be very acute, rarely leading to fulminant hepatic failure. AIH sometimes demonstrates quite dramatic disease fluctuations with periods of apparent spontaneous remissions, acute flares and/or smouldering disease. AIH can be associated with a number of other hepatic conditions, in particular the cholestatic liver diseases; primary biliary cirrhosis (PBC) or primary sclerosing cholangitis (PSC), but also with drug-induced liver injury (DILI), alcoholic or non-alcoholic steatohepatitis (NASH) or viral hepatitis. Each condition provides special diagnostic and therapeutic challenges. Despite these challenges and complexities, diagnosis and treatment of AIH has seen striking progress, and now patients in specialised centres have an excellent prognosis, both in respect to survival and to quality of life.

The aim of the present Clinical Practice Guideline (CPG) is to provide guidance to hepatologists and general physicians in the diagnosis and treatment of AIH in order to improve care for affected patients. In view of the limited data from large controlled studies and trials, many recommendations are based on expert consensus. This is to some extent a limitation of this EASL-CPG, but at the same time it is its special strength: consensus in this guideline is based on intensive discussions of experts from large treatment centres. The core consensus group has experience of over one thousand AIH patients managed personally, and the recommendations have been reviewed by both the EASL Governing Board as well as external experts, who have a similarly wide personal experience. Therefore, the guidelines are a resource of information and recommendations based on the largest experience available thus far. At the same time, we formulate key scientific questions that result from the consensus discussions on the limitations of our knowledge. All recommendations of this CPG were agreed upon unanimously (100%) consensus. Grading of the recommendations is based on the GRADE system for evidence (Table 1) [1].

Epidemiology of AIH

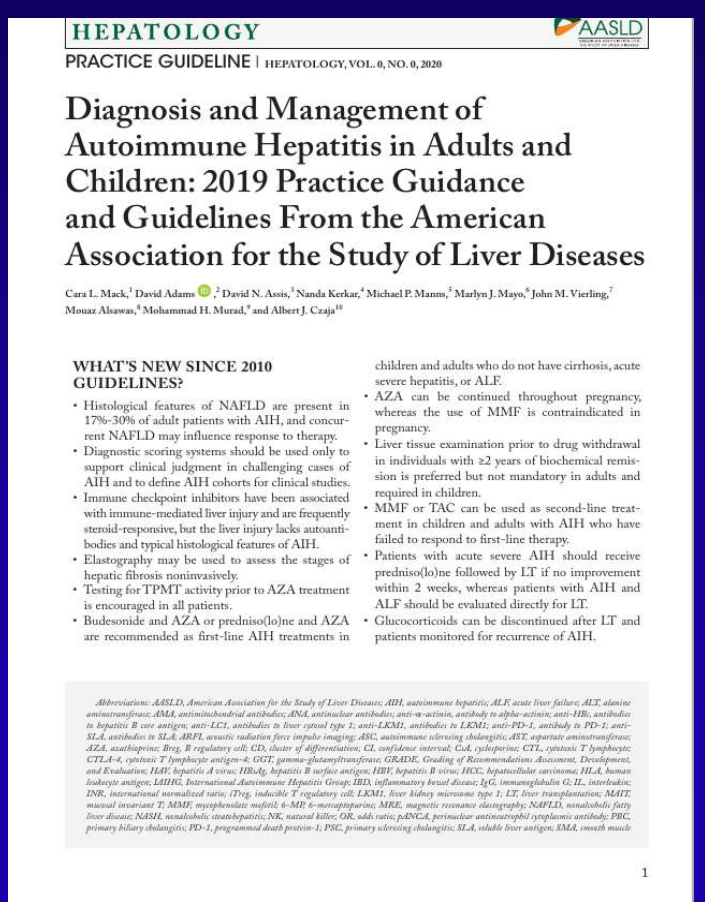
AIH is an non-resolving chronic liver disease that affects mainly women and is characterized by hypergammaglobulinaemia even in the absence of cirrhosis, circulating autoantibodies, association with human leukocyte antigens (HLA) DR3 or DR4, interface hepatitis on liver histology, and a favourable response to immunosuppression [2–5]. The disease, if untreated, often leads to cirrhosis, liver failure and death.

AIH is considered relatively rare, as its prevalence ranges from 16 to 18 cases per 100,000 inhabitants in Europe [6–11]. Until recently, the incidence and prevalence of AIH on a population-based level was assessed in only two studies [6,9]. Interestingly however, higher prevalence rates have been reported in areas with quite stable populations. For instance, prevalence rates of 42.9 cases per 100,000 and 24.5 cases per 100,000 inhabitants have been reported in Alaska natives [12] and New Zealand [9], respectively. In addition, a large Danish nationwide population-based study assessed the incidence and prevalence of AIH in Denmark during a nearly 20 year time period ranging from 1994 to 2012 including 1721 AIH patients [13]. The most striking observation in that study was the marked increase in AIH incidence over time, which could not be attributed to a relative

Received 30 June 2015; accepted 30 June 2015
Chairman: Ansgar W. Lohse.
Panel members: Olivier Chazouillères, George Dalekos, Joost Drenth, Michael Heneghan, Harald Hofer, Frank Lammert, Marco Lenzi.

* Correspondence: EASL office, 7 Rue Daubin, CH 1203 Geneva, Switzerland. Tel.: +41 22 807 0360; fax: +41 22 328 0724.
E-mail address: easloffice@easloffice.eu.

Abbreviations: ACG, American College of Gastroenterology; ACA, American Gastroenterological Association; ANCA, Antineutrophil cytoplasmic antibodies; APECED, Autoimmune polyendocrinopathy-candidiasis ectodermal dystrophy; AS, acute severe autoimmune; CNI, Calcineurin inhibitor; CPG, Clinical Practice Guideline; DEXA, Dual energy x-ray absorptiometry; DILI, Drug-induced liver injury; HAI, Hepatitis activity index; HBV, Hepatitis B virus; HLA, Human leukocyte antigens; HRQoL, Health related quality of life; IBD, Inflammatory bowel disease; IgG, Immunoglobulin G; LBR, Live birth rate; LT, liver transplantation; MMF, Mycophenolate mofetil; MRCP, Magnetic resonance cholangiopancreatography; NAFLD, Non-alcoholic fatty liver disease; NASH, Non-alcoholic steatohepatitis; PBC, Primary biliary cirrhosis; PROM, Patient reported Outcome Measures; PSC, Primary sclerosing cholangitis; SCBU, Special care baby unit; SMA, Smooth muscle antibodies; TPMT, Thiopurine methyltransferase.



HEPATOLOGY

AASLD

PRACTICE GUIDELINE | HEPATOLOGY, VOL. 0, NO. 0, 2020

Diagnosis and Management of Autoimmune Hepatitis in Adults and Children: 2019 Practice Guidance and Guidelines From the American Association for the Study of Liver Diseases

Cara L. Mack,[1] David Adams,[2] David N. Assis,[3] Nanda Kerkar,[4] Michael P. Manns,[5] Marlyn J. Mayo,[6] John M. Vierling,[7] Mouaz Alsawas,[8] Mohammad H. Murad,[9] and Albert J. Czaja[10]

WHAT'S NEW SINCE 2010 GUIDELINES?

- Histological features of NAFLD are present in 17%-30% of adult patients with AIH, and concurrent NAFLD may influence response to therapy.
- Diagnostic scoring systems should be used only to support clinical judgment in challenging cases of AIH and to define AIH cohorts for clinical studies.
- Immune checkpoint inhibitors have been associated with immune-mediated liver injury and are frequently steroid-responsive, but the liver injury lacks autoantibodies and typical histological features of AIH.
- Elastography may be used to assess the stages of hepatic fibrosis noninvasively.
- Testing for TPMT activity prior to AZA treatment is encouraged in all patients.
- Budesonide and AZA or predniso(lo)ne and AZA are recommended as first-line AIH treatments in children and adults who do not have cirrhosis, acute severe hepatitis, or ALF.
- AZA can be continued throughout pregnancy, whereas the use of MMF is contraindicated in pregnancy.
- Liver tissue examination prior to drug withdrawal in individuals with ≥2 years of biochemical remission is preferred but not mandatory in adults and required in children.
- MMF or TAC can be used as second-line treatment in children and adults with AIH who have failed to respond to first-line therapy.
- Patients with acute severe AIH should receive predniso(lo)ne followed by LT if no improvement within 2 weeks, whereas patients with AIH and ALF should be evaluated directly for LT.
- Glucocorticoids can be discontinued after LT and patients monitored for recurrence of AIH.

Abbreviations: AASLD, American Association for the Study of Liver Diseases; AIH, autoimmune hepatitis; ALF, acute liver failure; ALT, alanine aminotransferase; AMA, antimitochondrial antibodies; ANA, antinuclear antibodies; anti-α-actinin, antibody to alpha-actinin; anti-HBc, antibodies to hepatitis B core antigen; anti-LC1, antibodies to liver cytosol type 1; anti-LKM1, antibodies to LKM1; anti-PD-1, antibody to PD-1; anti-SLA, antibodies to SLA; ARFI, acoustic radiation force impulse imaging; ASC, autoimmune sclerosing cholangitis; AST, aspartate aminotransferase; AZA, azathioprine; Breg, B regulatory cell; CD, cluster of differentiation; CI, confidence interval; CsA, cyclosporine; CTL, cytotoxic T lymphocyte; CTLA-4, cytotoxic T lymphocyte antigen-4; GGT, gamma-glutamyltransferase; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; HAV, hepatitis A virus; HBsAg, hepatitis B surface antigen; HBV, hepatitis B virus; HCC, hepatocellular carcinoma; HLA, human leukocyte antigen; IAIHG, International Autoimmune Hepatitis Group; IBD, inflammatory bowel disease; IgG, immunoglobulin G; IL, interleukin; INR, international normalized ratio; iTreg, inducible T regulatory cell; LKM1, liver kidney microsome type 1; LT, liver transplantation; MAIT, mucosal invariant T; MMF, mycophenolate mofetil; 6-MP, 6-mercaptopurine; MRE, magnetic resonance elastography; NAFLD, nonalcoholic fatty liver disease; NASH, nonalcoholic steatohepatitis; NK, natural killer; OR, odds ratio; pANCA, perinuclear antineutrophil cytoplasmic antibody; PBC, primary biliary cholangitis; PD-1, programmed death protein-1; PSC, primary sclerosing cholangitis; SLA, soluble liver antigen; SMA, smooth muscle

REVISÃO

➢ Definição:

- “A HAI é uma doença inflamatória hepática imunomediada de causa incerta . Os pacientes podem ser assintomática ou apresentar-se em várias formas, desde doença subclínica até insuficiência hepática aguda e doença hepática em estágio terminal”.

REVISÃO

➢ Epidemiologia

- A **incidência anual** varia de **0,67 a 2,0 casos por 100.000**
- **Prevalência anual** varia de **4,0 a 24,5 por 100.000** pessoas.
- A **proporção de mulheres para homens** é de **4: 1** e ainda maior (10: 1) na HAI tipo 2.
- A **mortalidade** é **mais alta** durante o **primeiro ano** de diagnóstico.
- HAI ocorre em **todos os grupos étnicos** e em **todas as faixas etárias**.
- **Distribuição bimodal** geralmente com picos por volta da puberdade e entre a 4ª e 6ª década.
- Uma **proporção significativa** de pacientes tem **mais de 65 anos**.

ESPECTRO CLÍNICO: DOENÇA HETEROGÊNEA

Declaração da Diretriz*	
Deve ser considerado em qualquer paciente com doença hepática aguda ou crônica, particularmente no contexto da hipergamaglobulinemia	**II-2**
Diagnóstico rápido e oportuno é crucial, pois a HAI não tratada tem uma alta taxa de mortalidade	**I**
~ 1/3 de adultos e 1/2 de crianças com HAI têm cirrose na apresentação	**II-2**

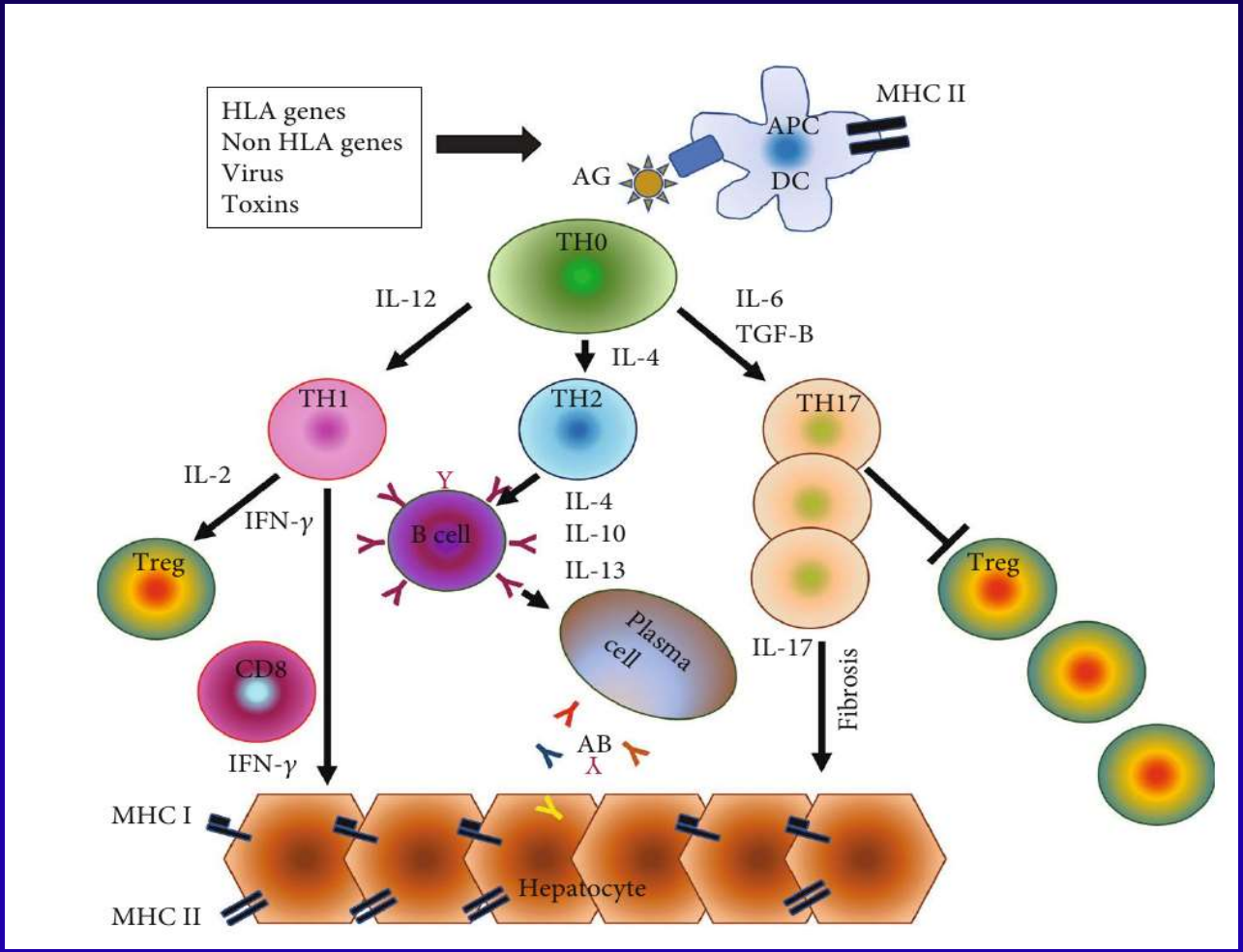
EASL CPG AIH. J Hepatol 2015;63:971–1004

SUBCLASSIFICAÇÃO

HAI-1	• **Quase 90% dos casos de HAI** • **Detecção de FAN, AML ou anti-SLA/LP** • **Associação com HLA DR3, DR4 e DR13** • **Qualquer idade**	• **Geralmente excelente resposta ao tratamento** • **taxas de recaída variável após a retirada De medicamentos**
HAI-2	• **Até 10% dos casos de HAI** • **Anti-LKM1, anti-LC1 e raramente anti-LKM3** • **Associação com HLA DR3 e DR7** • **Início geralmente na infância/juventude adulta**	• **Às vezes, falha no tratamento** • **taxas de recaídas frequentes após a retirada de medicamentos;**
HAI-3	• **Até 10% dos casos** • **Apenas anti-SLA/LP positivo**	• **É necessário Imunossupressão ao longo da vida na maioria.**

Anti-SLA/LP: anticorpo antiantígeno solúvel do fígado / pâncreas e fígado; Anti-LKM1/3: anticorpo microssomal do Tipo 1/3 do fígado/rim; Anti-LC1: anticorpo antiantígeno do citosol hepático do Tipo 1.

PATOGÊNESE


HLA genes
Non HLA genes
Virus
Toxins
MHC II
APC
DC
AG
TH0
IL-12
IL-6
TGF-B
IL-4
TH1
TH2
TH17
IL-2
IFN-γ
Treg
B cell
IL-4
IL-10
IL-13
Plasma cell
IL-17
Fibrosis
Treg
CD8
IFN-γ
AB
MHC I
MHC II
Hepatocyte

DIAGNÓSTICO

O diagnóstico é baseado exclusivamente em achados clínicos, sorológicos, bioquímicos e histológicos indicativos.

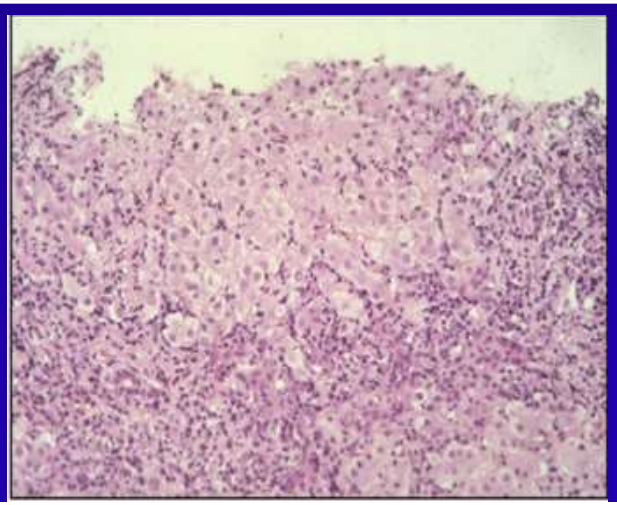
SISTEMA DE PONTUAÇÃO SIMPLIFICADO (2008)

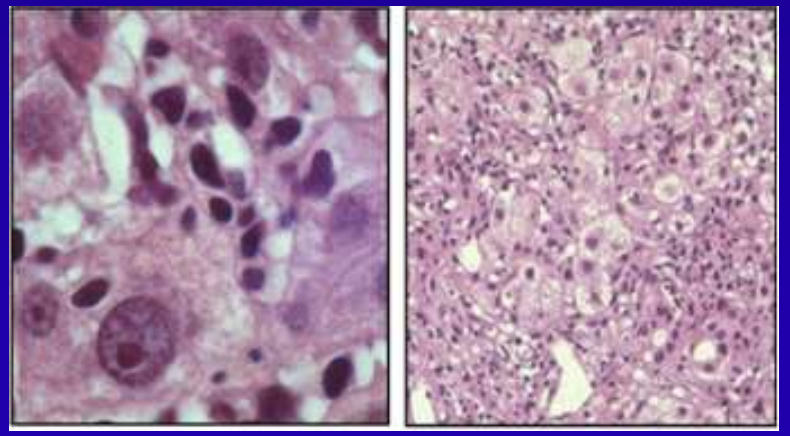
Recurso/parâmetro	Discriminador	Pontuação
Anticorpos (máximo 2 pontos)		(0–2 pontos no total)
FAN ou AML+	≥1:40	+1
FAN ou AML+	≥1:80	+2
ou LKM+	≥1:40	+2
ouSLA/LP+	Qualquer título	+2
Nível de IgG ou γ-globulinas	>LSN	+1
	>1.1x LSN	+2
Histologia hepática (evidência de hepatite é necessária)	Compatível com HAI	+1
	Típico de HAI	+2
	Atípica	0
Ausência de hepatite viral	Não	0
	Sim	+2

Hepatite autoimune definitiva: ≥7;
Hepatite autoimune provável: ≥6.

Histologia hepática típica para hepatite autoimune = cada uma das seguintes características tem de estar presente:

- ✓ hepatite de interface, infiltrados linfocíticos/linfoplasmáticos em espaços portais e estendendo-se para o lóbulo,
- ✓ emperipolese (penetração ativa de uma célula para dentro de uma célula maior)
- ✓ formação de roseta hepática.





Histologia hepática compatível para hepatite autoimune :

- Hepatite crônica com infiltração linfocítica, sem todas as características consideradas típicas.

Atípico :

- Mostra sinais de outro diagnóstico, como a esteatohepatite.

REVISÃO

➢ **Tratamento**:

- Prednisona e azatioprina.
- O tratamento na HAI moderada a severa melhora os testes de funções hepáticas, os sintomas e prolonga a sobrevida.
- Nos doentes sintomáticos ou com fibrose ou cirrose avançada deve ser sempre iniciado tratamento, pois representa um preditor de bom prognóstico.

REFERENCES

1) Merriman RB, Tran TT. AASLD practice guidelines: the past, the present, and the future. Hepatology 2016;63:31-34.
2) Manns MP, Czaja AJ, Gorham JD, Krawitt EL, Mieli-Vergani G, Vergani D, et al. Diagnosis and management of autoimmune hepatitis. Hepatology 2010;51:2193-2213.
3) Guyatt GH, Oxman AD, Vist GE, Kunz R, Falck-Ytter Y,

Alonso-Coello P, et al. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. BMJ

2008;336:924-926.
4) Goldet G, Howick J. Understanding GRADE: an introduction. J Evid Based Med 2013;6:50-54.
5) Gatselis NK, Zachou K, Koukoulis GK, Dalekos GN.

Obrigado.