



LETTERS TO THE EDITOR

Successful urgent liver transplant due to fulminant autoimmune hepatitis during the height of the COVID-19 pandemic in Spain[☆]

Trasplante hepático urgente por hepatitis autoinmune en el epicentro de la pandemia COVID-19 en España

Dear Editor,

The novel SARS-CoV-2 coronavirus, COVID-19, has spread around the world since it was first reported in Wuhan, China, and has overwhelmed the health systems of many countries.¹

Spain has been one of the countries most affected by the pandemic, especially the Madrid region, where all planned procedures had to be cancelled and most non-emergency procedures had to be postponed.

Liver transplantation is the basic treatment for end-stage liver disease and liver cancer. Spain is among the leading countries in liver transplantation, with approximately 1000 liver transplants per year. Death and departure from the waiting list have decreased in recent years due to treatment for hepatitis C virus (HCV), improvements in treatment for liver cirrhosis and the development of new treatments for hepatocellular carcinoma (HCC).

However, some patients lack curative treatment alternatives, mainly those with fulminant hepatitis, acute-on-chronic liver failure, and HCC on the borderline of transplantation criteria (Milan criteria).

Due to a lack of evidence on the potential risk of virus transmission in donor tissue, the *Organización Nacional de Trasplantes* [Spanish National Transplant Organisation] (ONT) recommended the following during the pandemic²:

- Transplants should be limited to recipients in emergency or serious situations and to difficult-to-treat recipients.
- Brain-dead donors should take priority over asystolic donors.
- Haematopoietic transplants should be postponed.

[☆] Please cite this article as: Rodríguez-Gandía MA, López-Hervás P, Téllez L, Gajate L. Trasplante hepático urgente por hepatitis autoinmune en el epicentro de la pandemia COVID-19 en España. *Gastroenterol Hepatol.* 2020;43:537–538.

However, in practice, in March 2020, when health systems and intensive care units were overloaded, liver transplantation virtually stopped in the Madrid region.

A 49-year-old woman was admitted to our centre in March 2020 with a diagnosis of acute hepatitis, with total bilirubin 23 mg/dl, aspartate aminotransferase (AST) 1686 U/l, alanine aminotransferase (ALT) 2441 U/l, gamma-glutamyl transferase (GGT) 120 U/l, lactate dehydrogenase (LDH) 1299 U/l and alkaline phosphatase (AP) 273 U/l. Her prothrombin activity was 30% and her international normalised ratio (INR) was 2.27.

She had no significant abnormalities in her platelet count or in her white blood cell count. All viral serologies (HCV, hepatitis B virus [HBV], hepatitis B virus [HEV], cytomegalovirus [CMV], Epstein–Barr virus [EBV] and human immunodeficiency virus [HIV]) were negative.

The initial aetiological study did not enable diagnosis; immunoglobulins were normal, except for the presence of antinuclear antibodies (ANAs) with titres of 1/160.

The patient's only personal history of note was her diagnosis with hypothyroidism and corresponding treatment with thyroid hormone replacement therapy. Her symptoms began two weeks before admission. Her condition was not linked to any use of medicines, drugs or herbal products.

She had no symptoms of COVID-19, and a polymerase chain reaction (PCR) for SARS-CoV2 was negative.

An abdominal ultrasound and a CT scan showed no abnormalities.

A transjugular liver biopsy was performed, reported as "confluent bridging necrosis and abundant plasma cells, consistent with autoimmune hepatitis". Treatment with methylprednisolone was started at a dose of 40 mg daily, and the patient was discharged.

No clinical chemistry response was observed; six days later, the patient developed hepatic encephalopathy. It was decided to add the patient to the waiting list with "Urgency 0" status. Twenty-four hours later, she underwent liver transplantation with the liver of an asystolic donor. The patient left the ICU 24 h later and required further surgery for arterial bleeding after 48 h. Her condition subsequently improved with no complications and with normal graft function, and she was discharged 10 days later.

At the time of the liver transplantation, almost 60,000 cases of COVID-19 had been diagnosed in Spain, with 3500 confirmed deaths; around 30% of all cases were in Madrid.^{3,4}

Fulminant hepatitis with a need for emergency liver transplantation is a life-threatening condition that requires a great deal of coordination in a short period of time.

The Spanish health system, specifically its transplantation activity, has been hit hard since March 2020, and has been on the verge of collapse at times. However, the excellence of the Spanish system and the dedication and sacrifice of its transplant professionals and centres, which are extremely well-established in Spain, have enabled Spain to overcome this crisis and perform transplants even in the worst moments, thus demonstrating its leadership in solid organ transplantation.

Funding

This article did not receive any funding.

Authors

All authors contributed equally to the drafting of this article.

Conflicts of interest

No conflicts of interest.

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Miguel A. Rodríguez-Gandía^{a,b,*}, Pedro López-Hervás^c, Luis Téllez^{a,b,d}, Luis Gajate^e, on behalf of the Unidad de Trasplante Hepático

^a *Servicio de Gastroenterología y Hepatología, Hospital Universitario Ramón y Cajal, Madrid, Spain*

^b *IRYCIS*

^c *Servicio de Cirugía General y Aparato Digestivo, Hospital Universitario Ramón y Cajal, Madrid, Spain*

^d *CIBERehd*

^e *Servicio de Anestesia y Reanimación, Hospital Universitario Ramón y Cajal, Madrid, Spain*

* Corresponding author.

E-mail address: mrgandia@salud.madrid.org (M.A. Rodríguez-Gandía).

Sister Mary Joseph nodule: A historic sign we should not forget[☆]

Nódulo de la hermana María José: un signo histórico que no debemos olvidar

Dear Editor,

Recently, a patient with a Sister Mary Joseph nodule (SMJN), first reported in 1949, prompted us to conduct a brief clinical–epidemiological review. The patient, a 62-year-old man, presented with abdominal pain, constitutional syndrome and a nodular umbilical lesion that, months earlier, had been classified as an umbilical hernia (Fig. 1). Endoscopy revealed an unresectable gastric neoplasm. Metastatic gastric adenocarcinoma cells were identified in the nodule sample.

SMJN is a clinical sign in the form of a hard, irregular, purplish/reddish umbilical mass smaller than 5 cm. It is rarely painful (except when fissured/ulcerated, in which case it may also have serous, purulent or bloody discharge). The development of an SMJN should alert the clinician to a occult primary tumour in the abdominopelvic region and

peritoneal metastases,¹ though this only occurs in 1%–3% of these tumours. The manner in which metastatic spread occurs is unknown; contiguous, haematogenous and lymphatic metastatic spread (through remaining embryonic structures) have been posited.²

In this review of 68 cases with SMJN, 56% were female and the mean age was 63. The main histological type was adenocarcinoma (81%): stomach (17.7%), pancreas (17.7%), ovary (16.2%), colon (10.2%) and endometrium (8.8%), followed by haematological origin (7.4%) and, to a lesser extent, other types (sarcomas, mesotheliomas, etc) and locations (bladder, lung, etc). In 27% of cases, the site of the primary tumour was never found. Detection of an SMJN renders a



Figure 1 Sister Mary Joseph nodule in a patient with gastric adenocarcinoma.

[☆] Please cite this article as: Berdugo-Hurtado F, Caballero-Mateos AM, Vidal-Vílchez B. Nódulo de la hermana María José: un signo histórico que no debemos olvidar. *Gastroenterol Hepatol.* 2020;43:538–539.