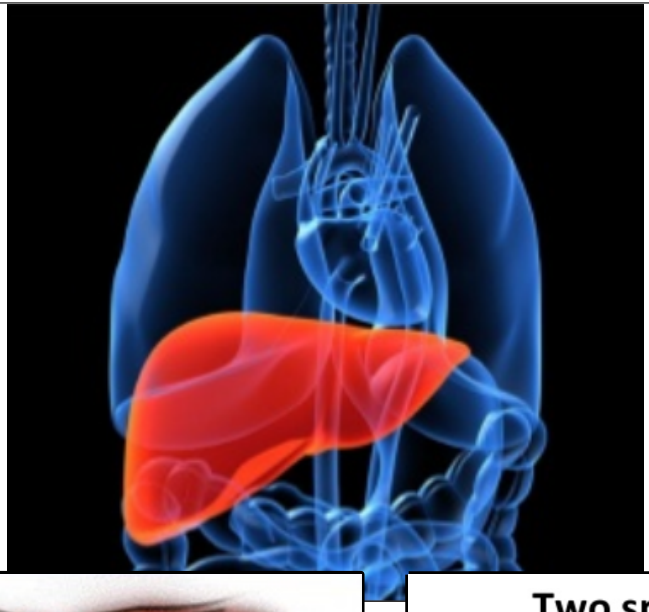
GNT block
Dec 2019

# Liver Cirrhosis

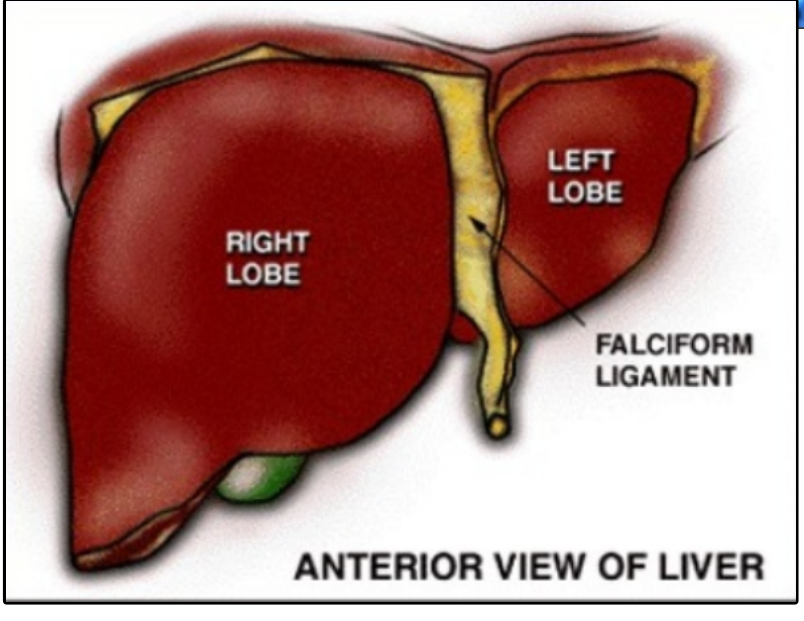
# Liver cirrhosis

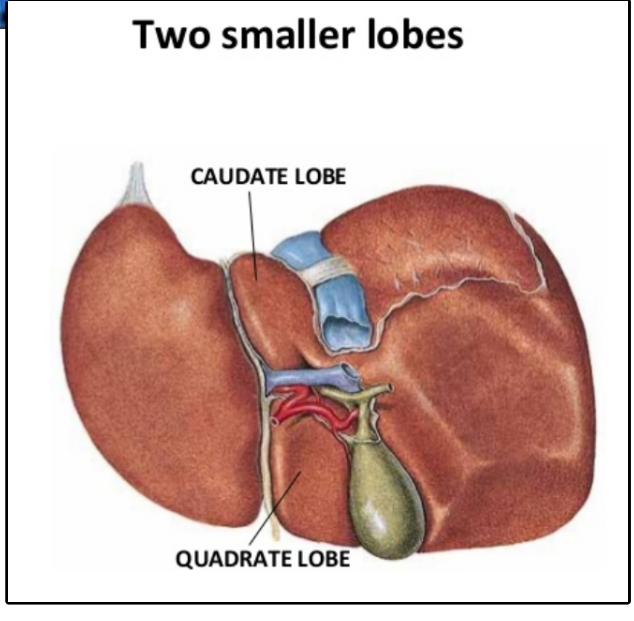
## Objectives:

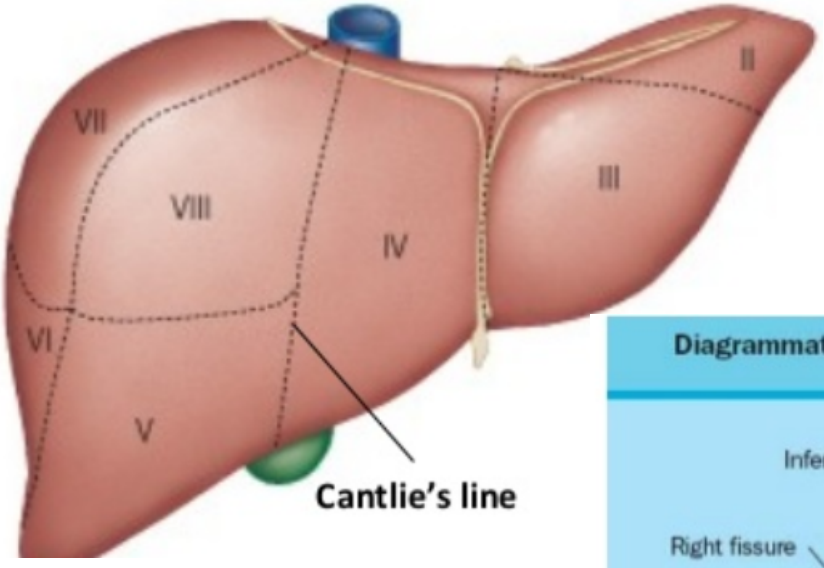
Define Cirrhosis.
Recognize the types of cirrhosis.
Recognize the causes and the pathogenic mechanisms leading to cirrhosis.
Describe the pathological findings in cirrhotic livers.

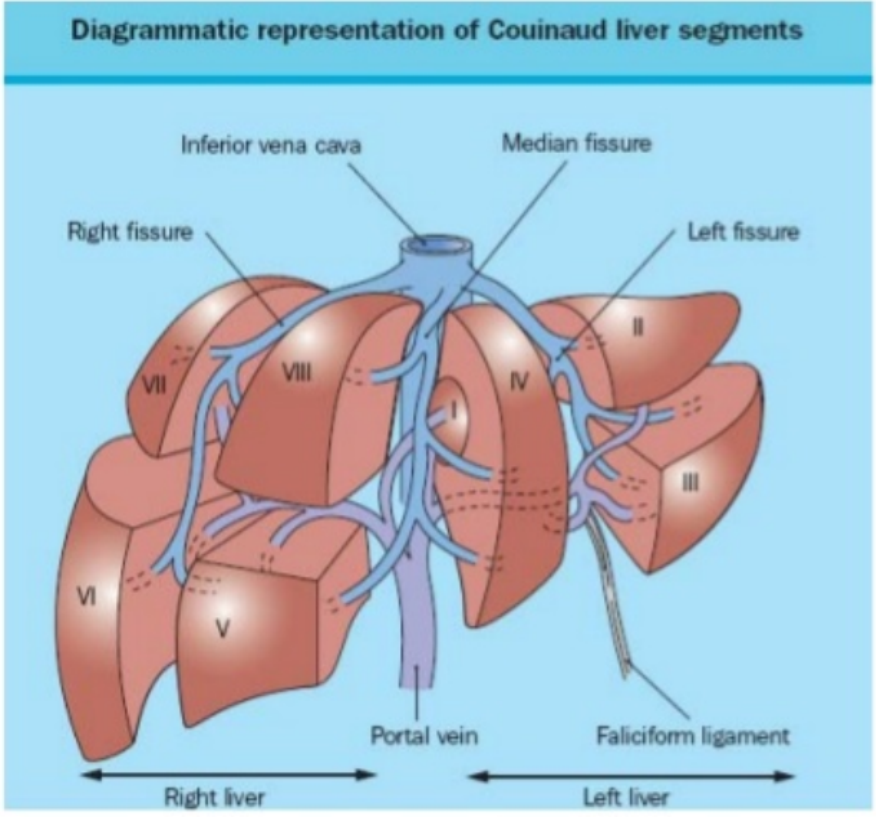


weighs 1400 to 1600 gm

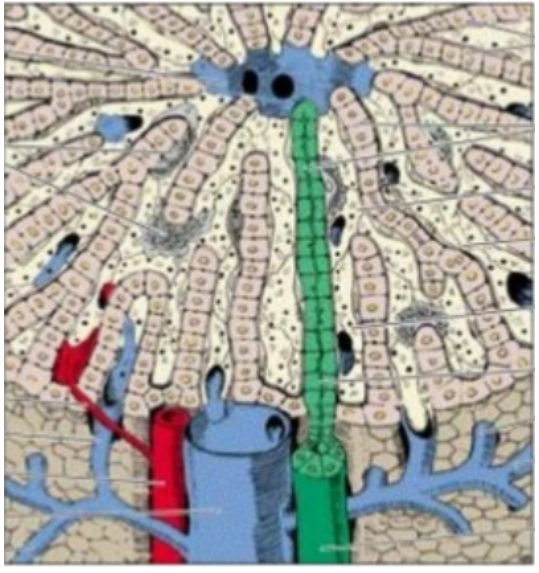


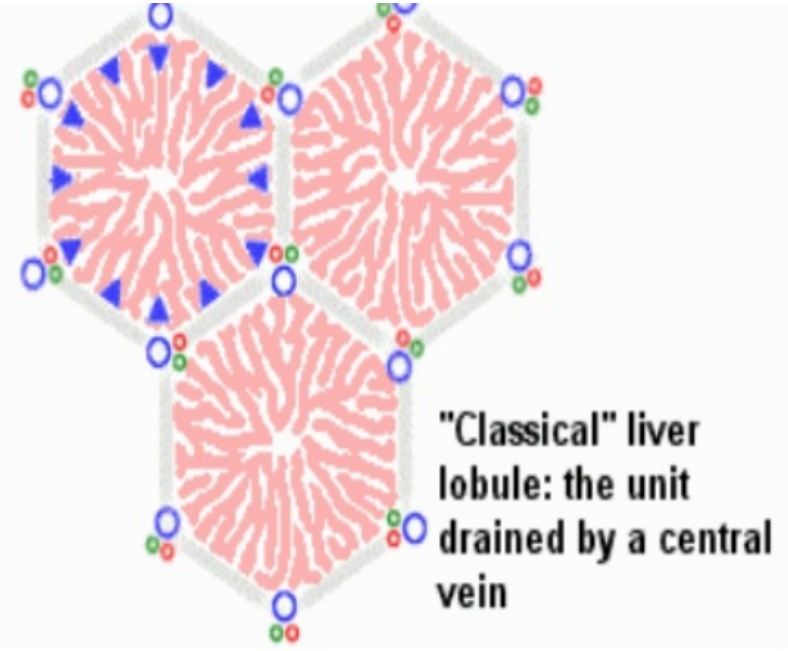




II
VII
III
VIII
IV
VI
V
Cantlie's line

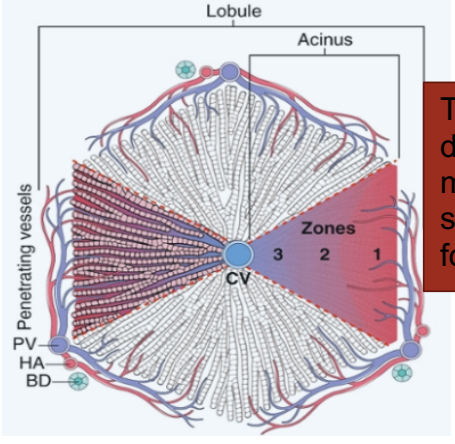

Diagrammatic representation of Couinaud liver segments
Inferior vena cava
Median fissure
Right fissure
Left fissure
II
VII
VIII
IV
I
III
VI
V
Portal vein
Faliciform ligament
Right liver
Left liver

- **The blood** flows from **periphery to centre.**
- **Bile** flows from **centre to periphery.**





"Classical" liver lobule: the unit drained by a central vein




Three zones each zone differs with respect to its metabolic activities and susceptibility to certain forms of hepatic injury.

# Cirrhosis

Cirrhosis refers to the diffuse transformation of the liver into regenerative parenchymal nodules surrounded by fibrous bands

It is among the top 10 causes of death in the Western world.

It is the end-stage of chronic liver disease

The chief worldwide causes are:

I. alcohol abuse
II. viral hepatitis

Other causes include:

3. biliary disease
4. iron overload

# Cirrhosis

Cirrhosis is defined by three characteristics

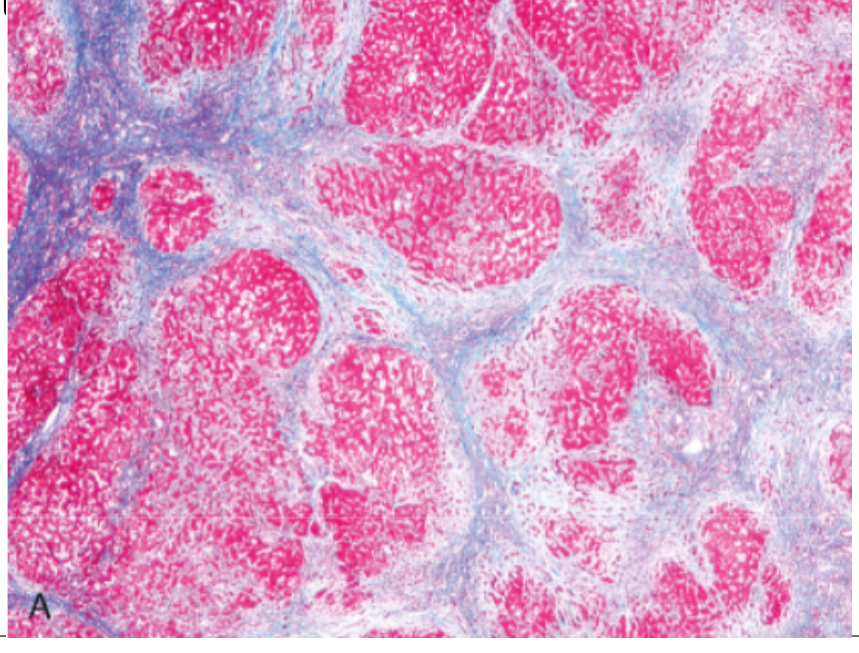
1)*Fibrosis* in the form of delicate bands or broad scars/septae

2)*Nodules* containing regenerating hepatocytes encircled by fibrosis, with diameters varying from very small (<3 mm, micronodules) to large (several centimeters, macronodules)

3)*Disruption of the architecture of the entire liver*

# Features of cirrhosis

*Vascular architecture is reorganized* by the parenchymal damage and scarring, with the formation of abnormal interconnections between vascular inflow and hepatic vein outflow channels *Fibrosis is the key feature of progressive damage to the liver.* Once cirrhosis has developed, reversal is thought to be rare



# Classifiation of cirrhosis

The classification is based on the underlying etiology.
Many forms of cirrhosis (particularly alcoholic cirrhosis) are initially micronodular, but there is a tendency for nodules to increase in size with time.

# Classifiation of cirrhosis based on causes

| | |
|---|---|
| Alcoholic liver disease | 60% to 70% |
| Viral hepatitis | 10% |
| Biliary diseases | 5% to 10% |
| Primary hemochromatosis | 5% |
| Wilson disease | Rare |
| α1-Antitrypsin deficiency | Rare |
| Cryptogenic cirrhosis | 10% to 15% |

# Classifiation of cirrhosis

## Other infrequent types of cirrhosis :

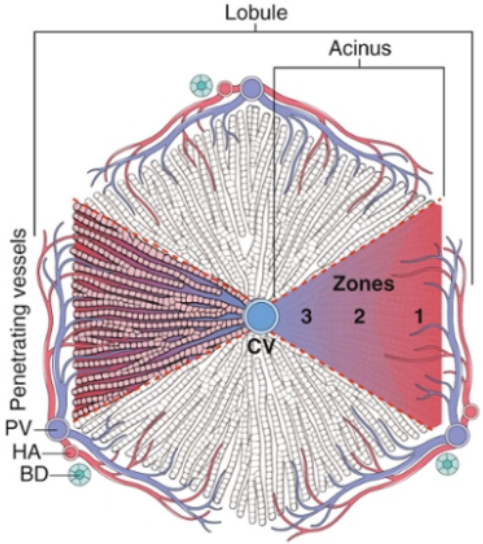
The cirrhosis developing in infants and children with galactosemia and tyrosinosis
Drug-induced cirrhosis (methotrexate, enalapril, vitamin A).
Severe fibrosis can occur in the setting of cardiac disease; called "cardiac cirrhosis"
In some cases there is no cause and these are referred to as *cryptogenic cirrhosis*

*Once cirrhosis is established, it is usually impossible to establish an etiologic diagnosis on morphologic grounds alone*

# Pathogenesis of cirrhosis

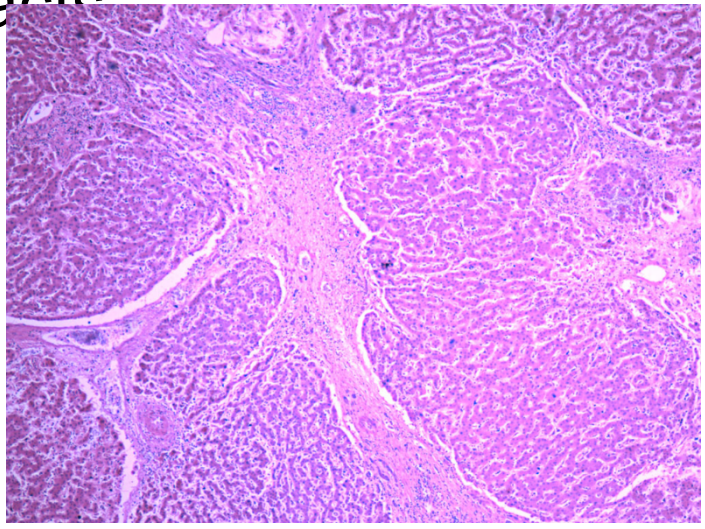
The pathogenic processes in cirrhosis are progressive fibrosis and reorganization of the vascular microarchitecture of the liver

In the normal liver, interstitial collagens (types I and III) are concentrated in portal tracts and around central veins. The type IV collagen(reticulin) is in the space of Disse.



# Pathogenesis of cirrhosis

In cirrhosis, types I and III collagen are deposited in the lobule, creating delicate or broad septal tracts

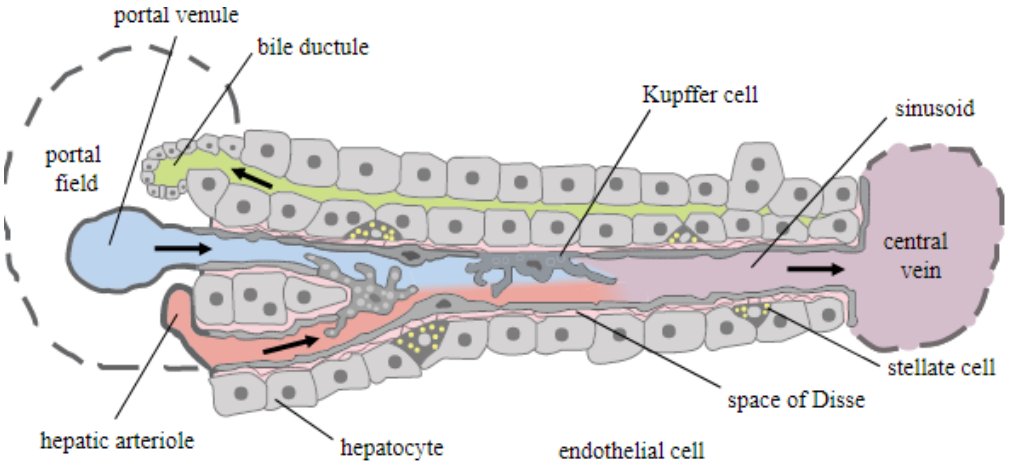


There is loss of  fenestrations in the sinusoidal endothelial cells (capillarization of sinusoids, that is the sinusoidal space comes to resemble a capillary rather than a channel for exchange of solutes between hepatocytes and plasma)

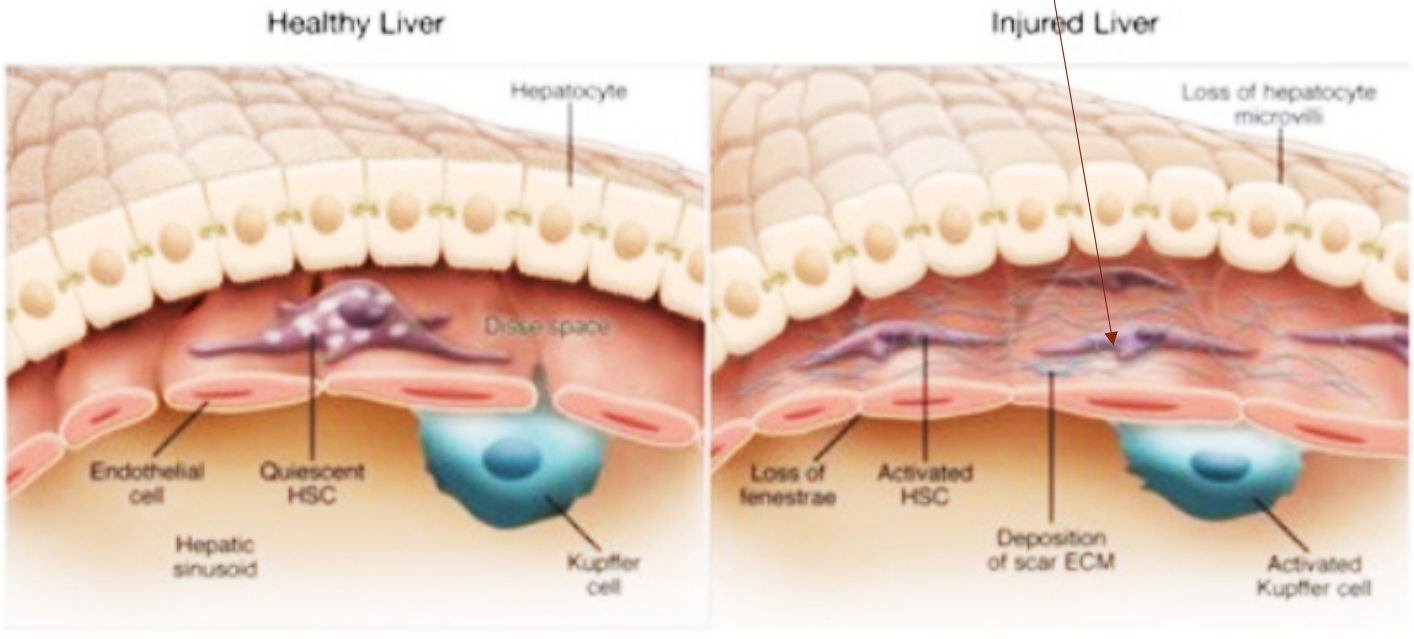
# Pathogenesis of cirrhosis

The major source of excess collagen in cirrhosis is the perisinusoidal stellate cells ( Ito cells), which lie in the space of Disse.

Although Ito cells normally function is a vitamin A fat-storing cells, during the development of cirrhosis they become activated and transform into myofibroblast-like cells.



Ito cells produce collagen



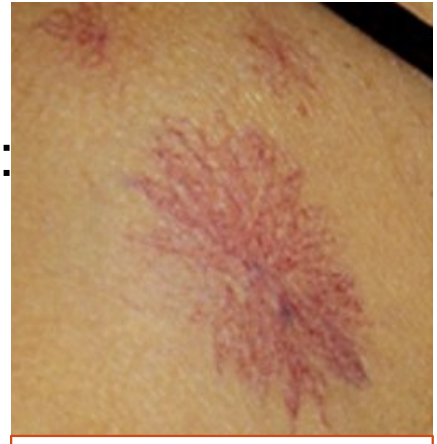
# Pathogenesis of cirrhosis

Collagen synthesis is stimulated by:

1) Chronic inflammation, with production of inflammatory cytokines
2) Cytokine production by activated endogenous cells (Kupffer cells, endothelial cells, hepatocytes, and bile duct epithelial cells)
3) Disruption of the normal extracellular matrix
4) Direct stimulation of stellate cells by toxins

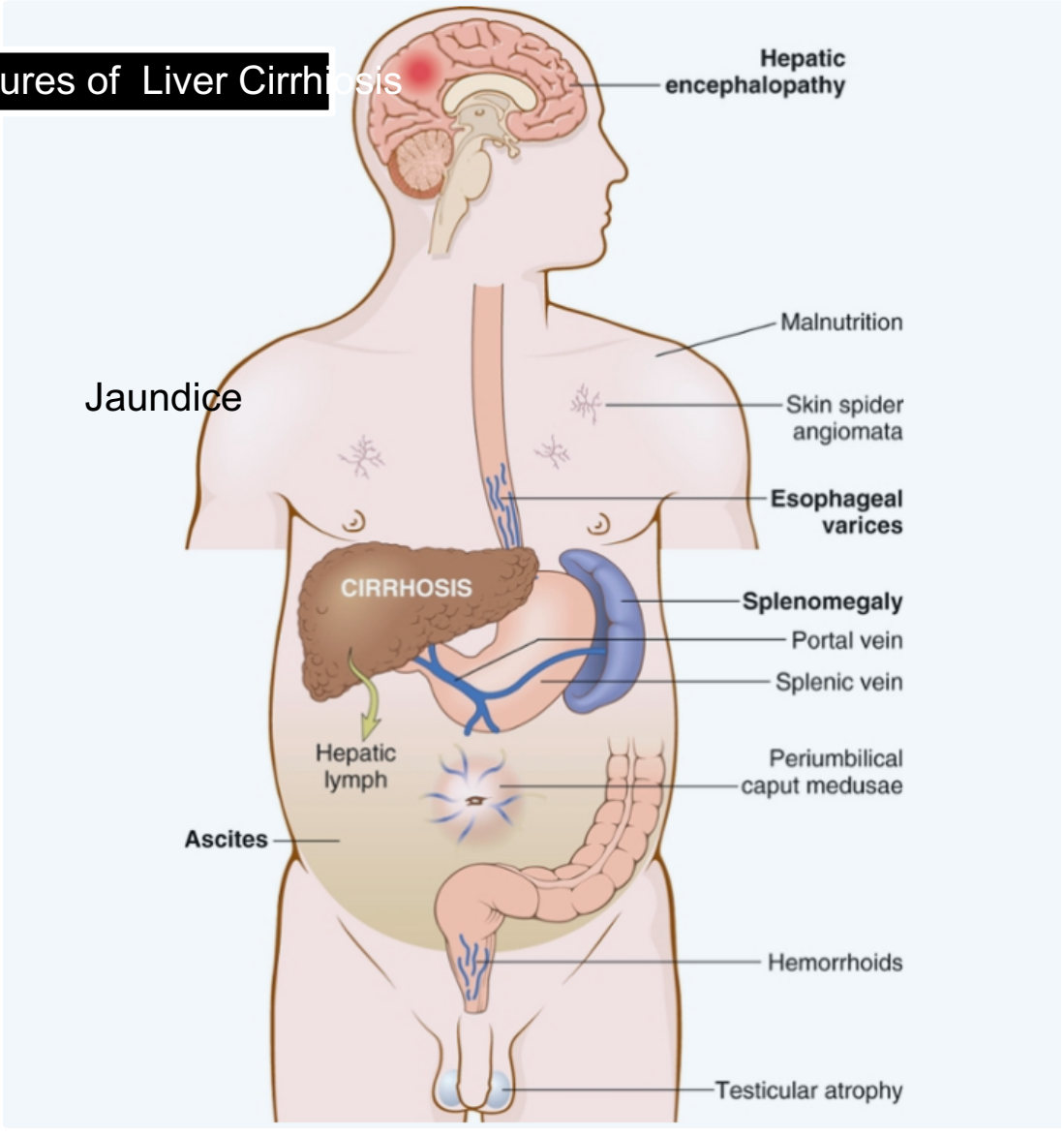
# Clinical Features

All forms of cirrhosis may be clinically silent.
When symptomatic they lead to nonspecific clinical manifestations: anorexia, weight loss, weakness, skin spider angiomata, osteoporosis, and, in advanced disease, frank debilitation
Jaundice
Incipient or overt hepatic failure may develop



Skin spider angiomata (cannot metabolize circulating estrogen)

# Clinical Features of Liver Cirrhosis



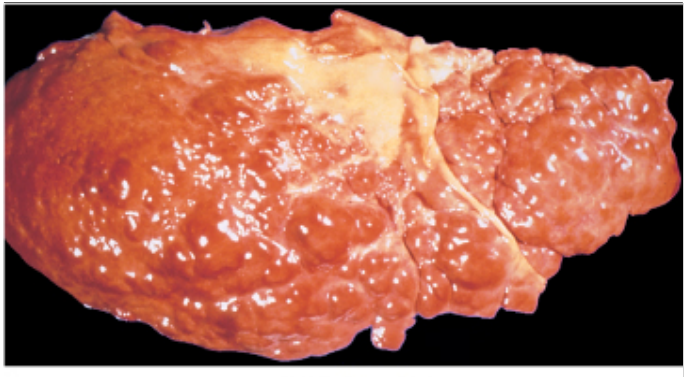
## Clinical Features

The ultimate mechanism of most cirrhotic deaths is

(1) progressive liver failure
(2) a complication related to portal hypertension
(3) the development of hepatocellular carcinoma

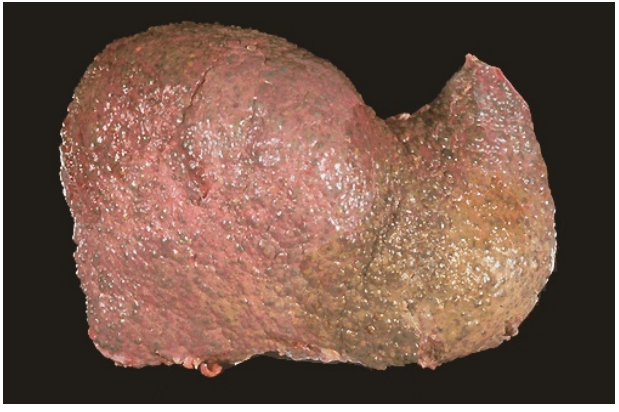
# Gross Features

## Macronodular cirrhosis



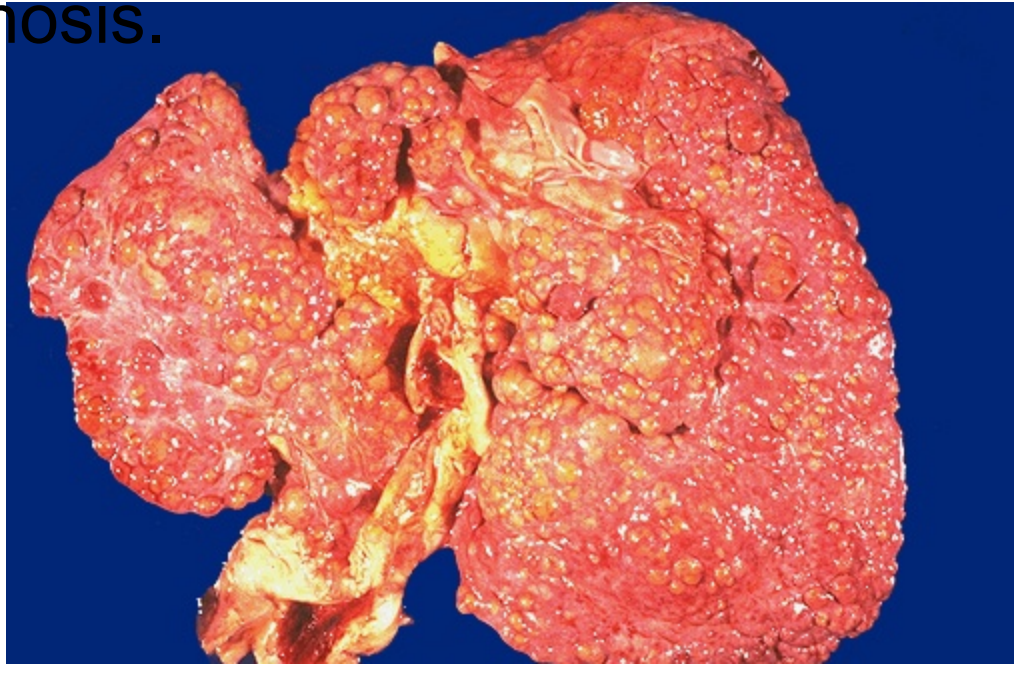


## Micronodular cirrhosis

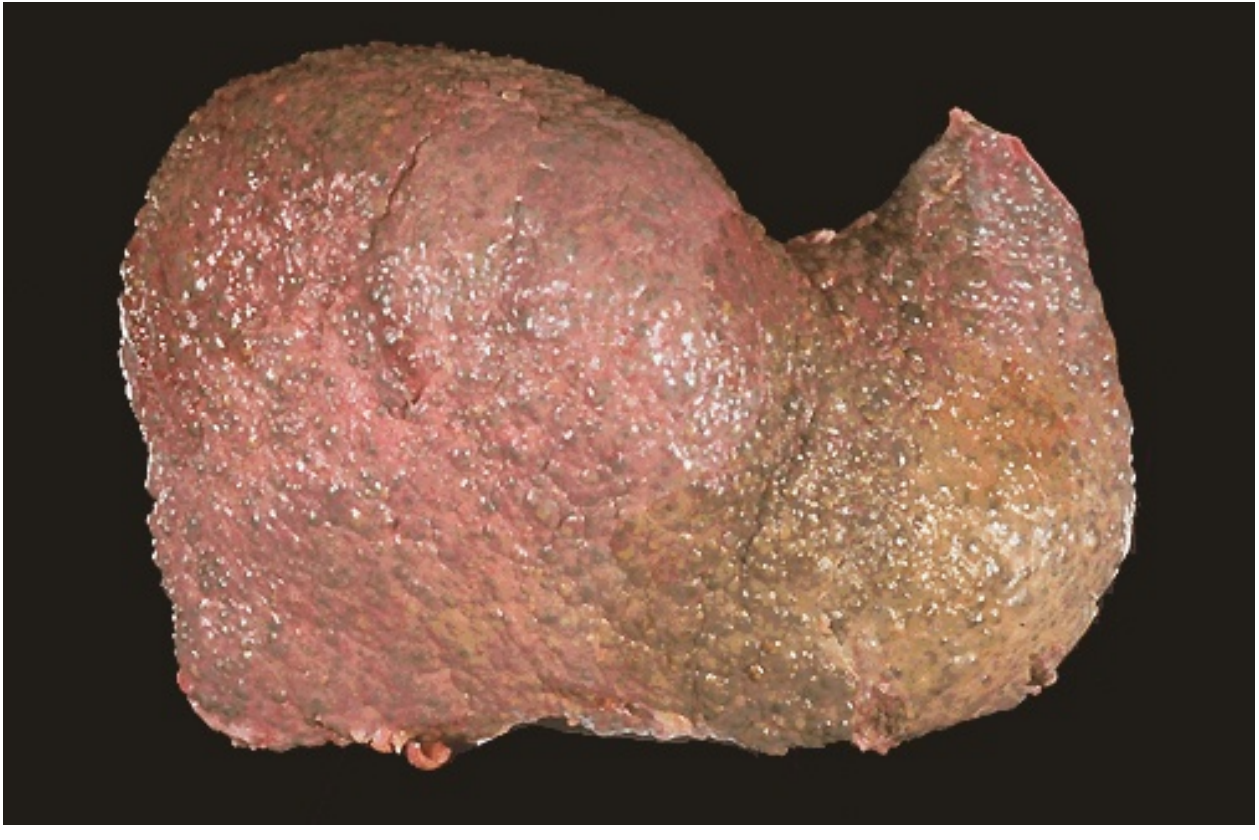


# Gross Features:

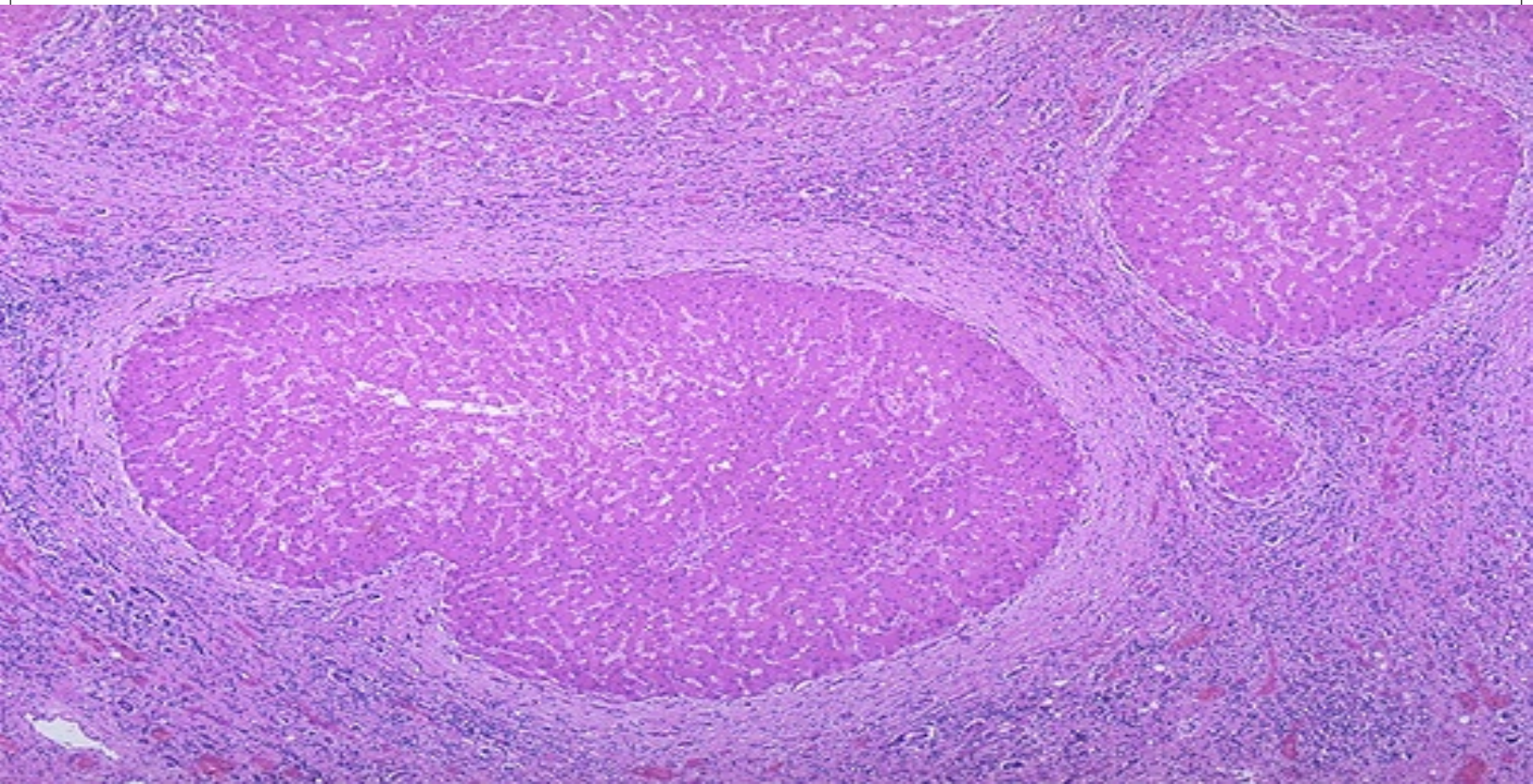
The nodules seen here are larger than 3 mm and, hence, this is an example of "macronodular" cirrhosis.



Micronodular cirrhosis : The regenerative nodules are quite small, averaging less than 3 mm in size. The most common cause for this is chronic alcoholism.



Regenerative nodules of hepatocytes are surrounded by fibrous connective tissue that bridges between portal tracts. Within this collagenous tissue are scattered lymphocytes as well as a proliferation of bile ducts.



# Morphology of common causes of liver cirrhosis

- Chronic Viral Hepatitis (hepatitis B and C virus)
- Autoimmune hepatitis
- Alcoholic liver disease
- Biliary Cirrhosis
  - Secondary biliary cirrhosis
  - Primary biliary cirrhosis
  - Primary sclerosing cholangitis

# Chronic Hepatitis: morphology

Some changes are shared with acute hepatitis.

Hepatocyte injury, necrosis, and regeneration

Sinusoidal cell reactive changes

Portal tract Inflammation:

- Confined to portal tracts *or*
- Spillover into adjacent parenchyma, with necrosis of hepatocytes ("interface hepatitis") *or*
- Bridging inflammation and necrosis

Fibrosis:

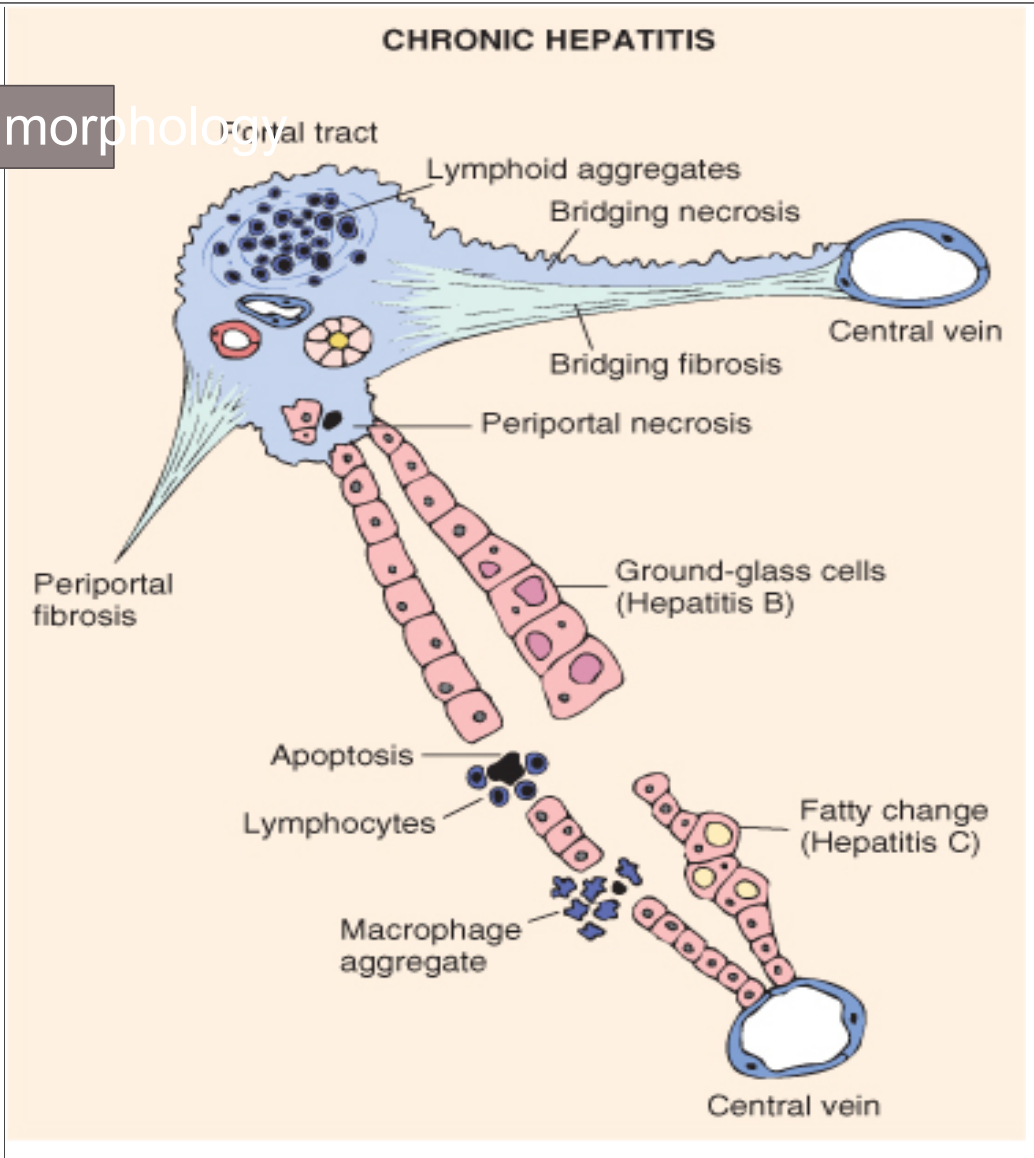
- continued loss of hepatocytes results in fibrous septa formation which ultimately leads to cirrhosis

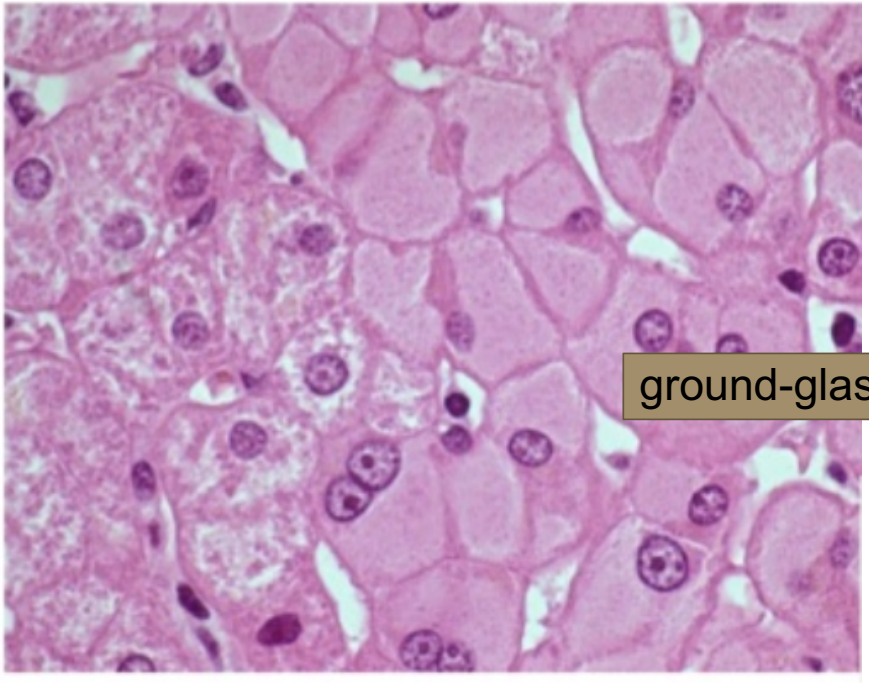
HBV: "ground-glass" hepatocytes, "sanded" nuclei

HCV: bile duct damage, lymphoid aggregate formation

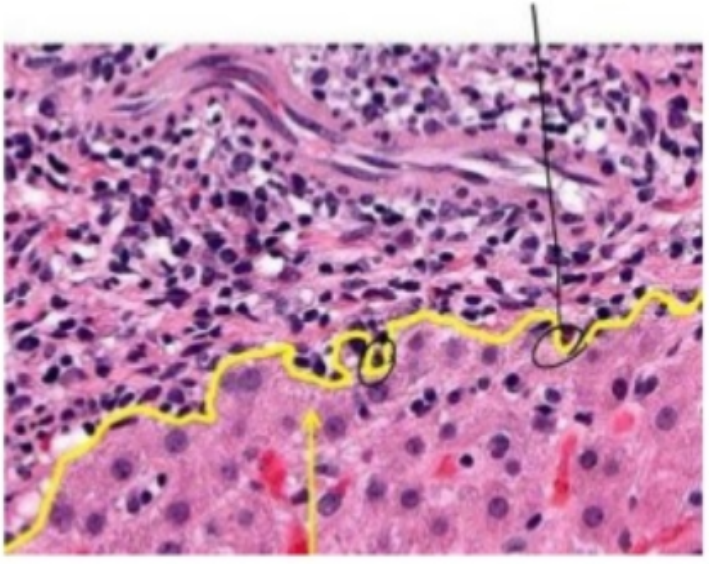
*Cirrhosis: The end-stage outcome*

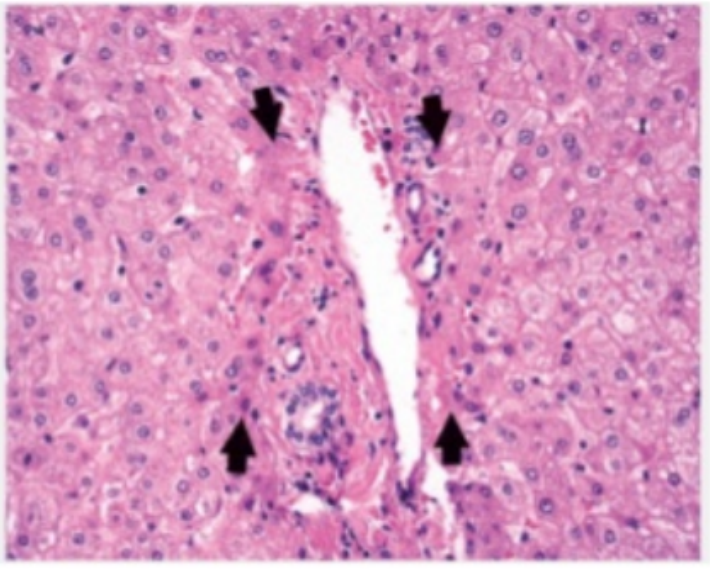
# Chronic Hepatitis, morphology



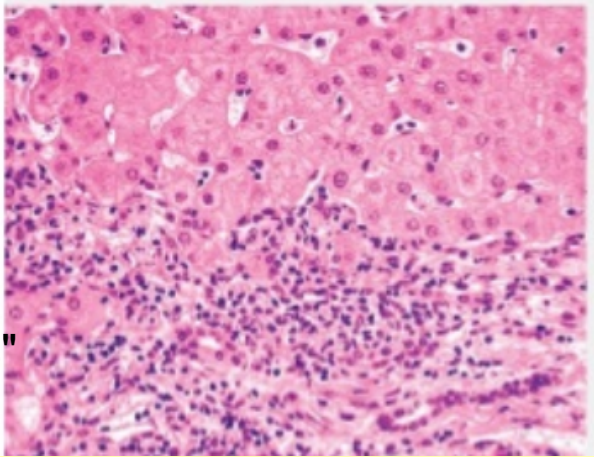



**HBsAg +ve**



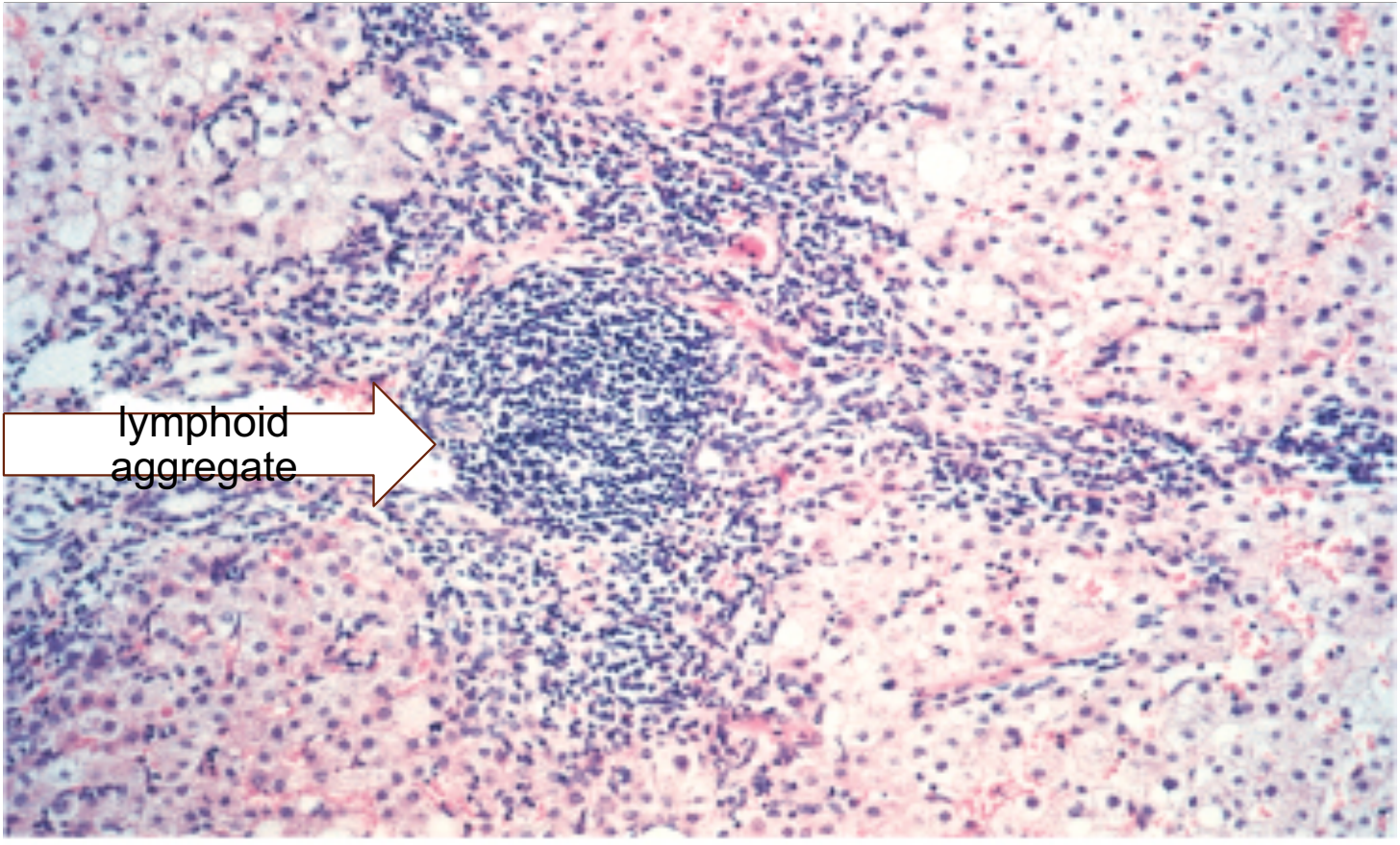


Spillover into adjacent parenchyma, with necrosis of hepatocytes " interface hepatitis"



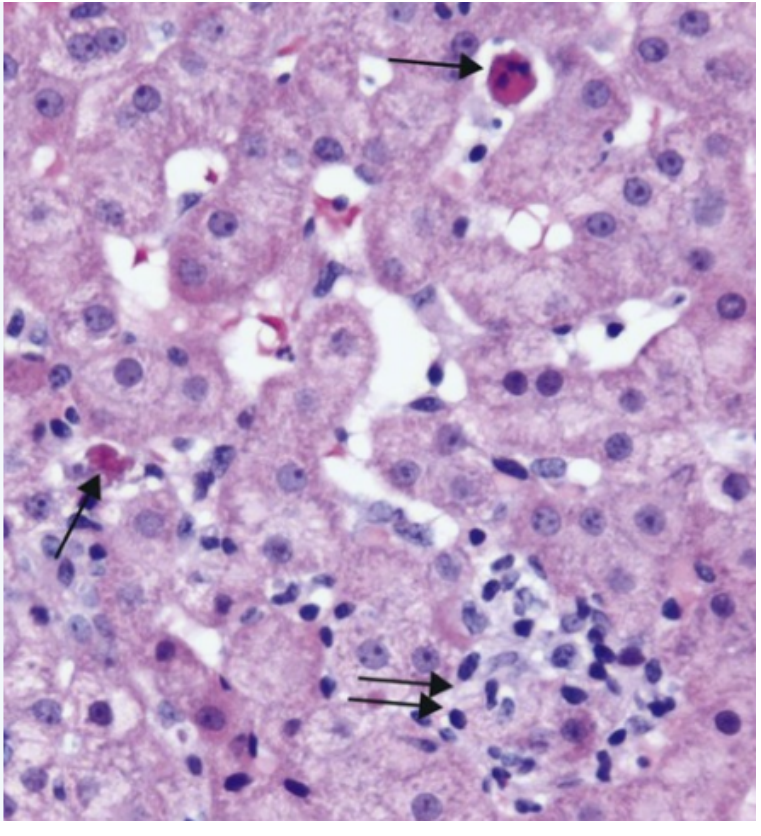
Piecemeal necrosis in Chronic hepatitis

# Chronic hepatitis, *morphology*

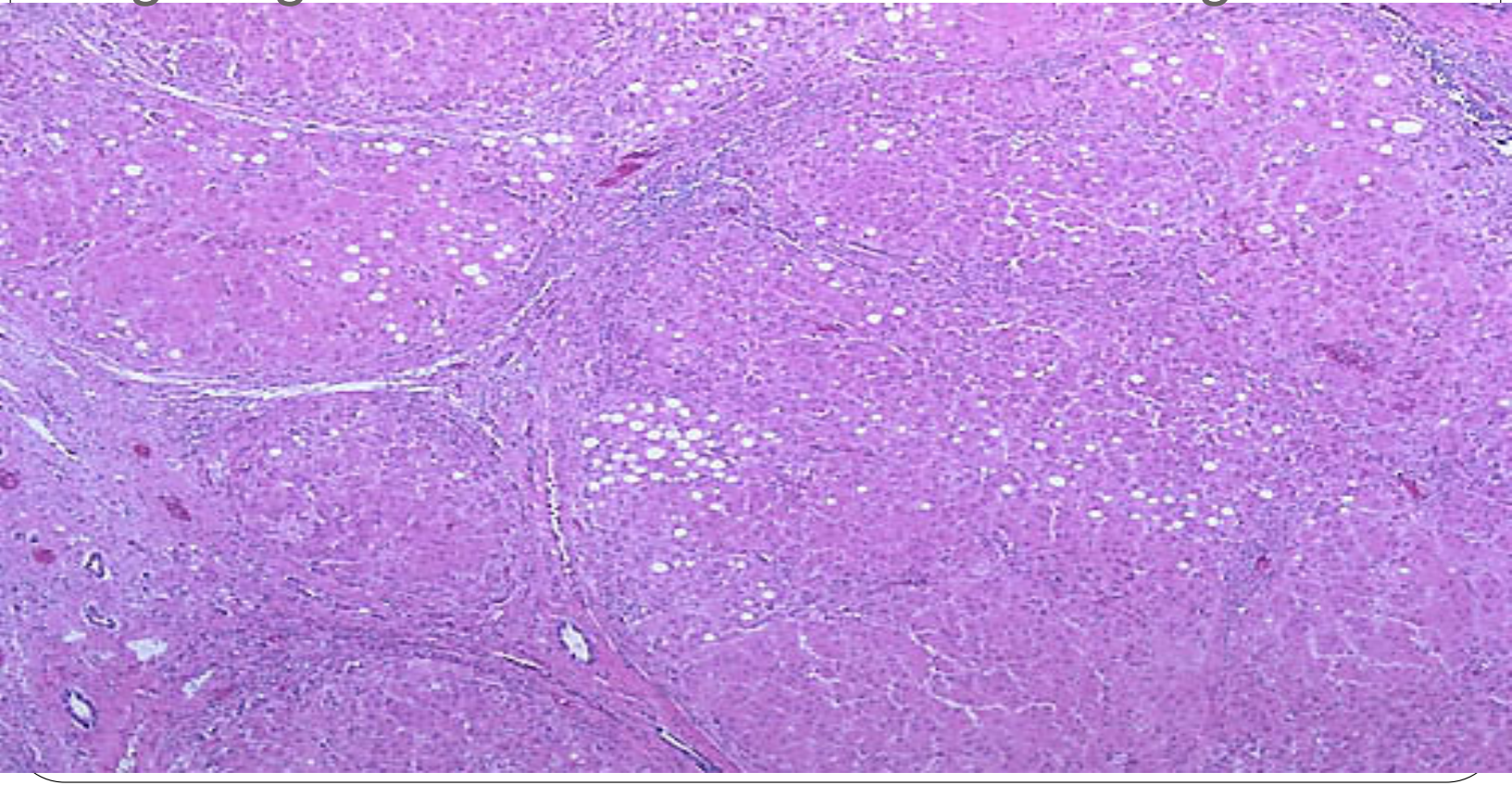


# Chronic hepatitis, *morphology*

apoptotic hepatocytes
(acidophil bodies)



Viral hepatitis C which is at a high stage with extensive fibrosis and progression to macronodular cirrhosis, as evidenced by the large regenerative nodule at the center right.



# Autoimmune hepatitis

# Autoimmune hepatitis

is a chronic hepatitis with histologic features like that of chronic viral hepatitis. This disease may run an indolent or severe course.

Two primary types of autoimmune hepatitis:

- Type 1 autoimmune hepatitis is most often seen in middle-age women and is characteristically associated with anti-nuclear and anti–smooth muscle antibodies.
- Type 2 autoimmune hepatitis is most often seen in children or teenagers and is associated with anti–liver kidney microsomal autoantibodies.

# Autoimmune hepatitis

Absence of viral serologic markers

Elevated serum IgG and γ-globulin levels (>1.5 times normal)

High serum titres of autoantibodies in 80% of cases, including antinuclear (ANA), antismooth muscle (SMA) and anti-mitochondrial antibodies.

anti–liver kidney microsome-1 antibodies and anti–liver cytosol-1 antibodies.

# Autoimmune hepatitis

In untreated severe disease, as many as 40% of patients die within 6 months of diagnosis, and cirrhosis develops in at least 40% of survivors.
Treatment include immunosuppressive therapy, and liver transplantation.
Associated with other autoimmune diseases eg. Rheumatoid arthritis, Sjogren's syndrome etc.

# Autoimmune Hepatitis

| | |
|---|---|
| Etiology | Unclear.<br>Triggers for the immune reaction may include viral infections or drug or toxin exposures |
| Sex predilection | Female predominance, particularly in young and perimenopausal women |
| Symptoms and signs | An acute clinical illness is a common presentation (40%)<br>Sometimes the disease is fulminant, progressing to hepatic encephalopathy within 8 weeks of onset |
| Laboratory findings | Elevated serum IgG and γ-globulin levels<br>High serum titers of autoantibodies in 80% of cases, including antinuclear (ANA), antismooth muscle (SMA), anti-mitochondrial antibodies |
| Important pathologic findings before cirrhosis develops | Necrosis and inflammation, indicated by extensive interface hepatitis<br>Plasma cell predominance |

# Intrahepatic Biliary Tract Disease

Three disorders of intrahepatic bile ducts:

Secondary biliary cirrhosis

Primary biliary cirrhosis

Primary sclerosing cholangitis

# Secondary Biliary Cirrhosis

# Secondary biliary cirrhosis

Prolonged obstruction of the extrahepatic biliary tree results in profound alteration of the liver itself .

The most common cause of obstruction in adults is extrahepatic cholelithiasis (gallstones), followed by malignancies of the biliary tree or head of the pancreas and strictures resulting from previous surgical procedures

Obstructive conditions in children include biliary atresia, cystic fibrosis, choledochal cysts (a cystic anomaly of the extrahepatic biliary tree)

# Secondary biliary cirrhosis: Morphology

Secondary inflammation resulting from biliary obstruction initiates periportal fibrosis, which eventually leads to hepatic scarring and nodule formation, generating secondary biliary cirrhosis.

Subtotal obstruction may promote secondary bacterial infection of the biliary tree (ascending cholangitis), which aggravates the inflammatory injury. Enteric organisms such as coliforms and enterococci are common cause.

# Secondary Biliary Cirrhosis

| | |
|---|---|
| Etiology | Extrahepatic bile duct obstruction: biliary atresia, gallstones, stricture, carcinoma of pancreatic head |
| Sex predilection | None. |
| Symptoms and signs | Pruritus, jaundice, malaise, dark urine, light stools, hepatosplenomegaly |
| Laboratory findings | Conjugated hyperbilirubinemia, increased serum alkaline phosphatase, bile acids, cholesterol<br>No increase in serum AMA or IgM |
| Important pathologic findings before cirrhosis develops | Prominent bile stasis in bile ducts, bile ductular proliferation with surrounding neutrophils, portal tract edema |

# Primary Biliary Cirrhosis

# Primary Biliary Cholangitis

Primary biliary cirrhosis is a chronic, progressive, and often fatal cholestatic liver disease, characterized by the destruction of intrahepatic bile ducts, portal inflammation and scarring, and the eventual development of cirrhosis and liver failure.

The primary feature of this disease is a nonsuppurative, granulomatous inflammatory destruction of medium-sized intrahepatic bile ducts.

Cirrhosis develops only after many years and not in all cases. Previously called Primary biliary cirrhosis

# Primary Biliary Cholangitis

middle-aged women,
female: male predominance (6:1).
Pathogenesis: autoimmune etiology, 90% of patients have circulating "antimitochrondrial antibodies."

# Primary Biliary Cholangitis

Clinical features:

pruritus, jaundice, hepatomegaly. Xanthomas and xanthelasmas arise owing to cholesterol retention.

Over a period of time patients develop portal hypertension and hepatic encephalopathy.

Serum alkaline phosphatase and cholesterol are elevated; hyperbilirubinemia is a late development.

90% of patients have circulating "antimitochrondrial antibodies."

Association with other autoimmune diseases (e.g., Sjögren syndrome)

# Primary biliary cirrhosis

## Morphology:

During the precirrhotic stage, portal tracts and bile ducts are infiltrated by lymphocytes and may exhibit noncaseating granulomatous inflammation. There is bile duct destruction.

With time, there is bile ductular proliferation, inflammation, and necrosis of the adjacent periportal hepatic parenchyma.

Over years to decades, relentless portal tract scarring and bridging fibrosis lead to cirrhosis.

# Primary Biliary Cholangitis

In most cases, the end-stage picture is indistinguishable from secondary biliary cirrhosis or the cirrhosis that follows chronic hepatitis from other causes

# Primary Biliary Cholangitis

| | |
|---|---|
| Etiology | Possibly autoimmune |
| Sex predilection | Female to male: 6:1 |
| Symptoms and signs | Same as secondary biliary cirrhosis ( Pruritus, jaundice, malaise, dark urine, light stools, hepatosplenomegaly) |
| Laboratory findings | Same as secondary biliary cirrhosis ( Conjugated hyperbilirubinemia, increased serum alkaline phosphatase, bile acids, cholesterol) plus elevated serum autoantibodies ( especially antimitochondrial antibody-AMA) |
| Important pathologic findings before cirrhosis develops | Dense lymphocytic infiltrate in portal tracts with granulomatous destruction |

# Primary sclerosing cholangitis

# Primary sclerosing cholangitis

Primary sclerosing cholangitis is characterized by inflammation and obliterative fibrosis of intrahepatic and extrahepatic bile ducts, with dilation of preserved segments.

Characteristic "beading" of a barium column in radiographs of the intrahepatic and extrahepatic biliary tree is attributable to the irregular strictures and dilations of affected bile ducts.

It is commonly seen in association with inflammatory bowel disease , particularly chronic ulcerative colitis

Males predominate 2:1

Pathogenesis: unknown.

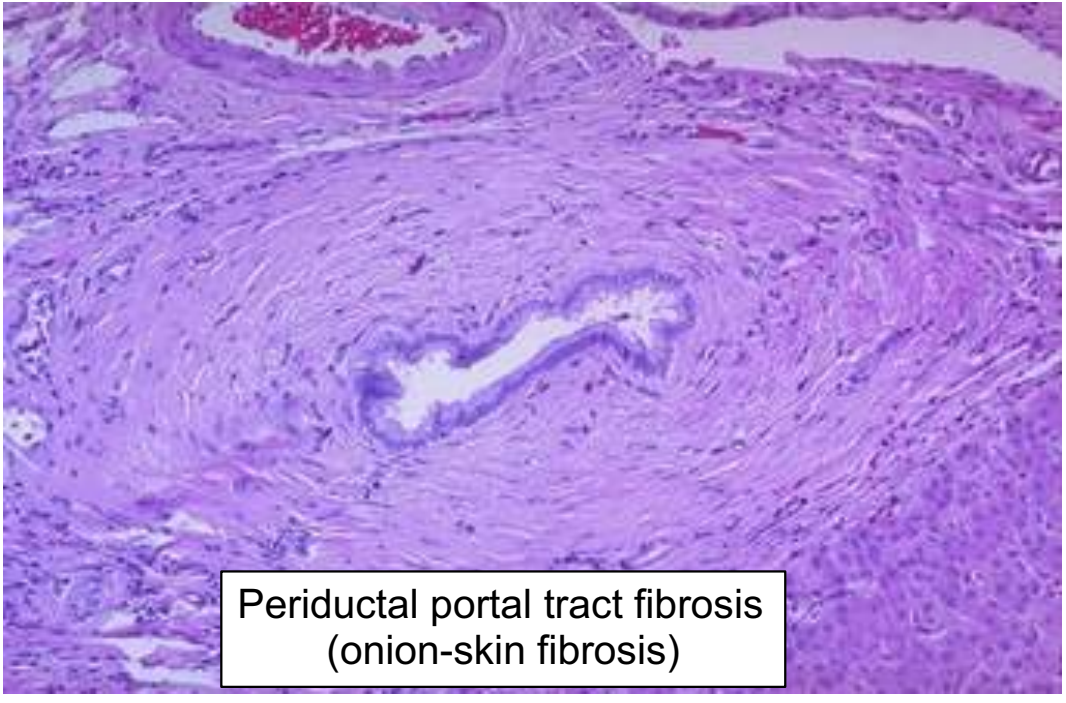
# Primary sclerosing cholangitis: Morphology

Primary sclerosing cholangitis is a fibrosing cholangitis of bile ducts, with a lymphocytic infiltrate, progressive atrophy of the bile duct epithelium, and obliteration of the lumen.

The concentric periductal fibrosis around affected ducts ("onion-skin fibrosis") is followed by their disappearance, leaving behind a solid, cordlike fibrous scar.

As the disease progresses, the liver becomes cirrhotic like that seen with primary and secondary biliary cirrhosis

# Primary sclerosing cholangitis



# Primary sclerosing cholangitis

| | |
|---|---|
| Etiology | Unknown, possibly autoimmune; 50-70% associated with inflammatory bowel disease |
| Sex predilection | Female to male: 1:2 |
| Symptoms and signs | Same as secondary biliary cirrhosis ( Pruritus, jaundice, malaise, dark urine, light stools, hepatosplenomegaly) insidious onset |
| Laboratory findings | Same as secondary biliary cirrhosis ( Conjugated hyperbilirubinemia, increased serum alkaline phosphatase, bile acids, cholesterol) plus elevated serum IgM, hypergammaglobulinemia |
| Important pathologic findings before cirrhosis develops | Periductal portal tract fibrosis, segmental stenosis of extrahepatic and intrahepatic bile ducts |

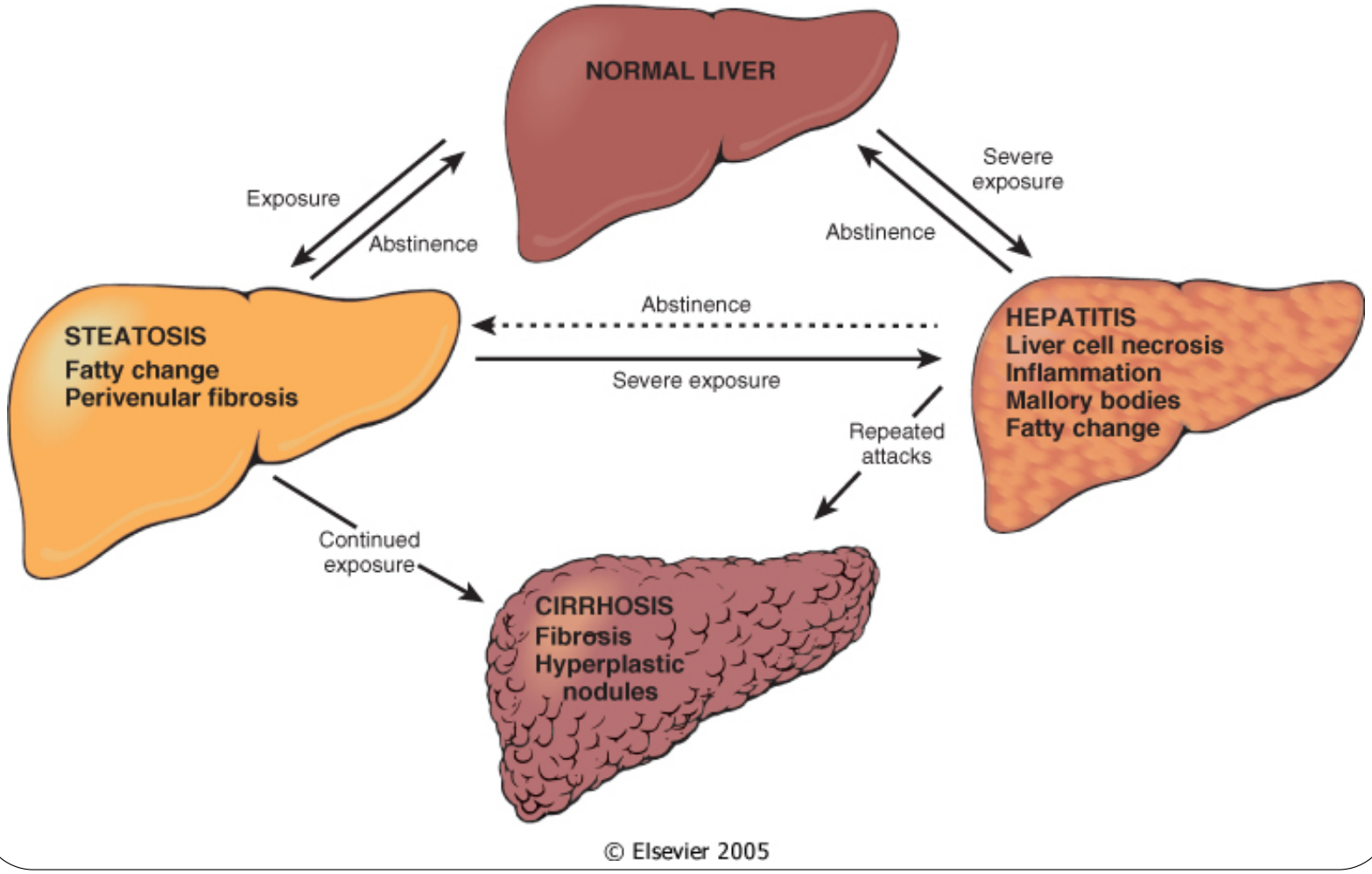
| Parameter | Primary Biliary Cholangitis | Primary Sclerosing Cholangitis |
|---|---|---|
| Age | Median age 50 years | Median age 30 years |
| Gender | 90% female | 70% male |
| Clinical course | Progressive | Unpredictable, but progressive |
| Associated conditions | Sjögren syndrome (70%) | Inflammatory bowel disease (70%) |
| | Scleroderma (5%) | Pancreatitis (≤25%) |
| | Thyroid disease (20%) | Idiopathic fibrosing diseases (retroperitoneal fibrosis) |
| Serology | 95% AMA-positive | 0%–5% AMA-positive (low titer) |
| | 20% ANA-positive | 6% ANA-positive |
| | 40% ANCA-positive | 65% ANCA-positive |
| Radiology | Normal | Strictures and beading of large bile ducts; pruning of smaller ducts |
| Duct lesion | Florid duct lesions and loss of small ducts only | Inflammatory destruction of extrahepatic and large intrahepatic ducts; fibrotic obliteration of medium and small intrahepatic ducts |

# Alcoholic liver disease

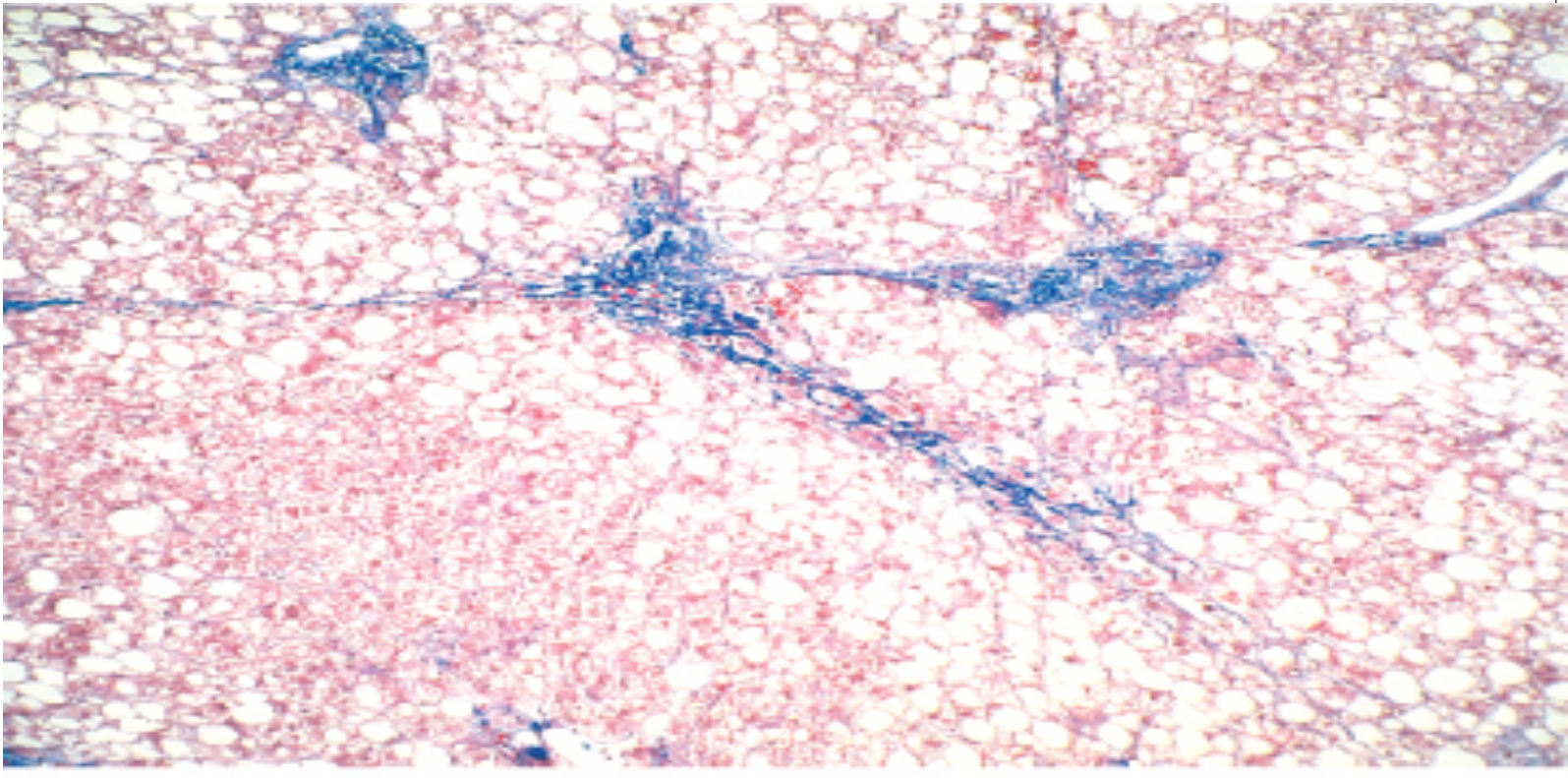
Three features:

Steatosis (fatty change)
Hepatitis (steatohepatitis)
Fibrosis

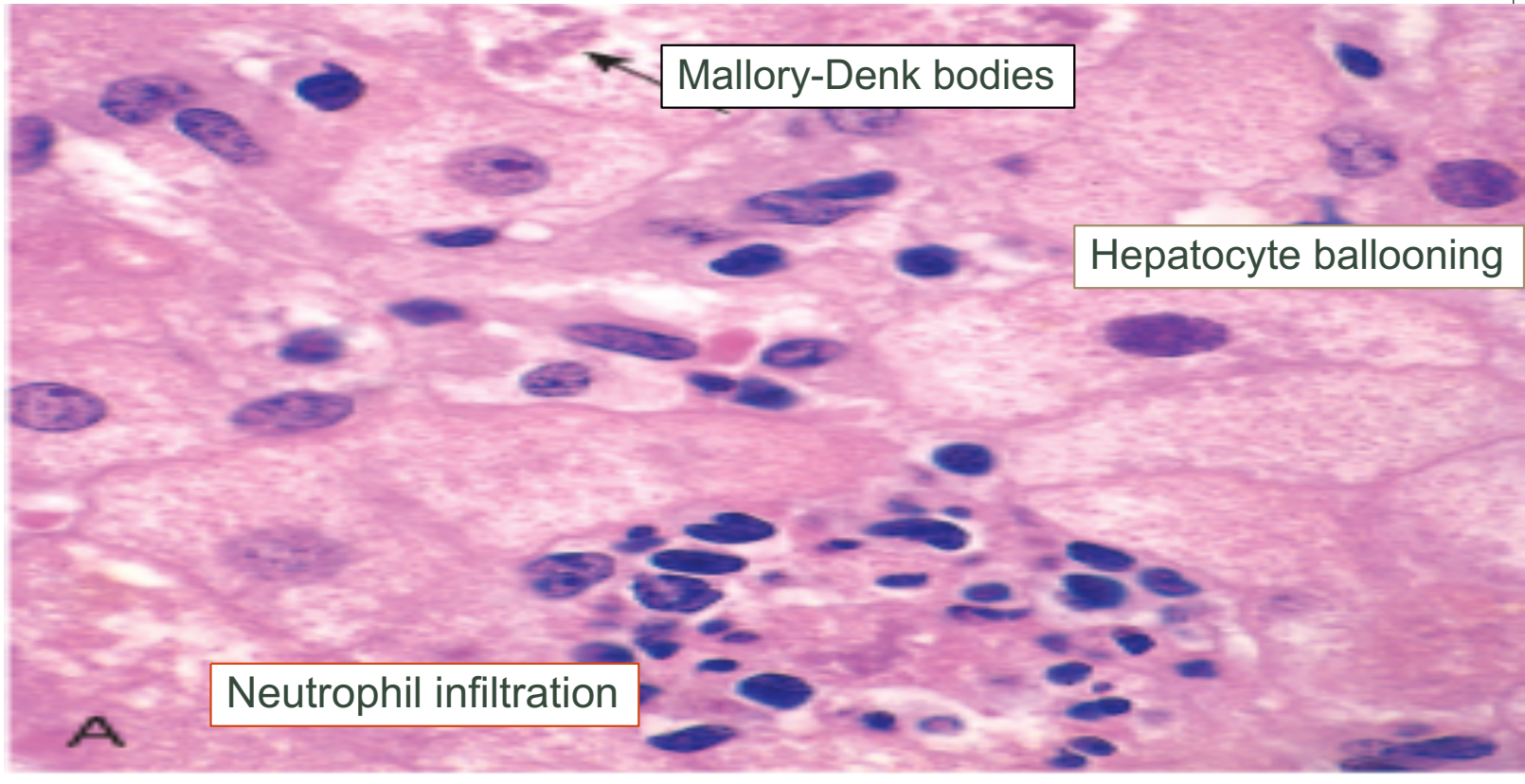
# Alcoholic liver disease



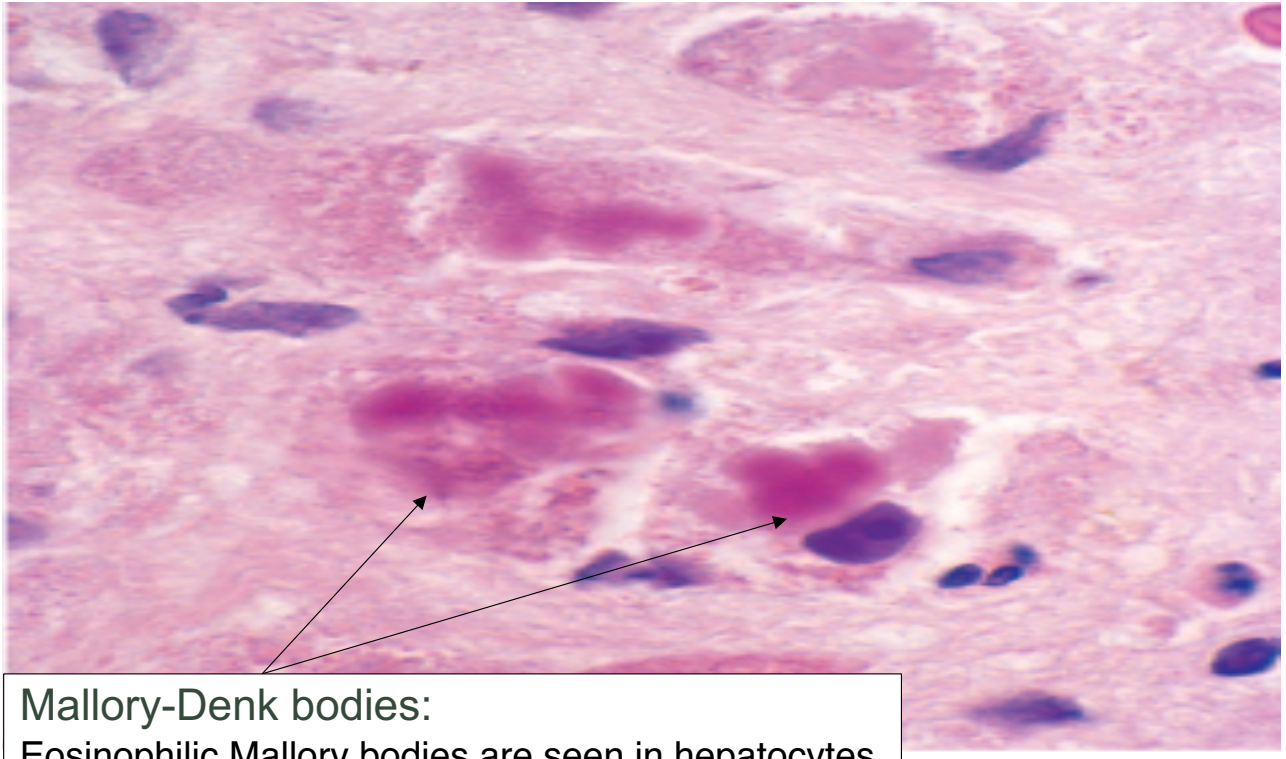
# Alcoholic liver disease



# Alcoholic liver disease



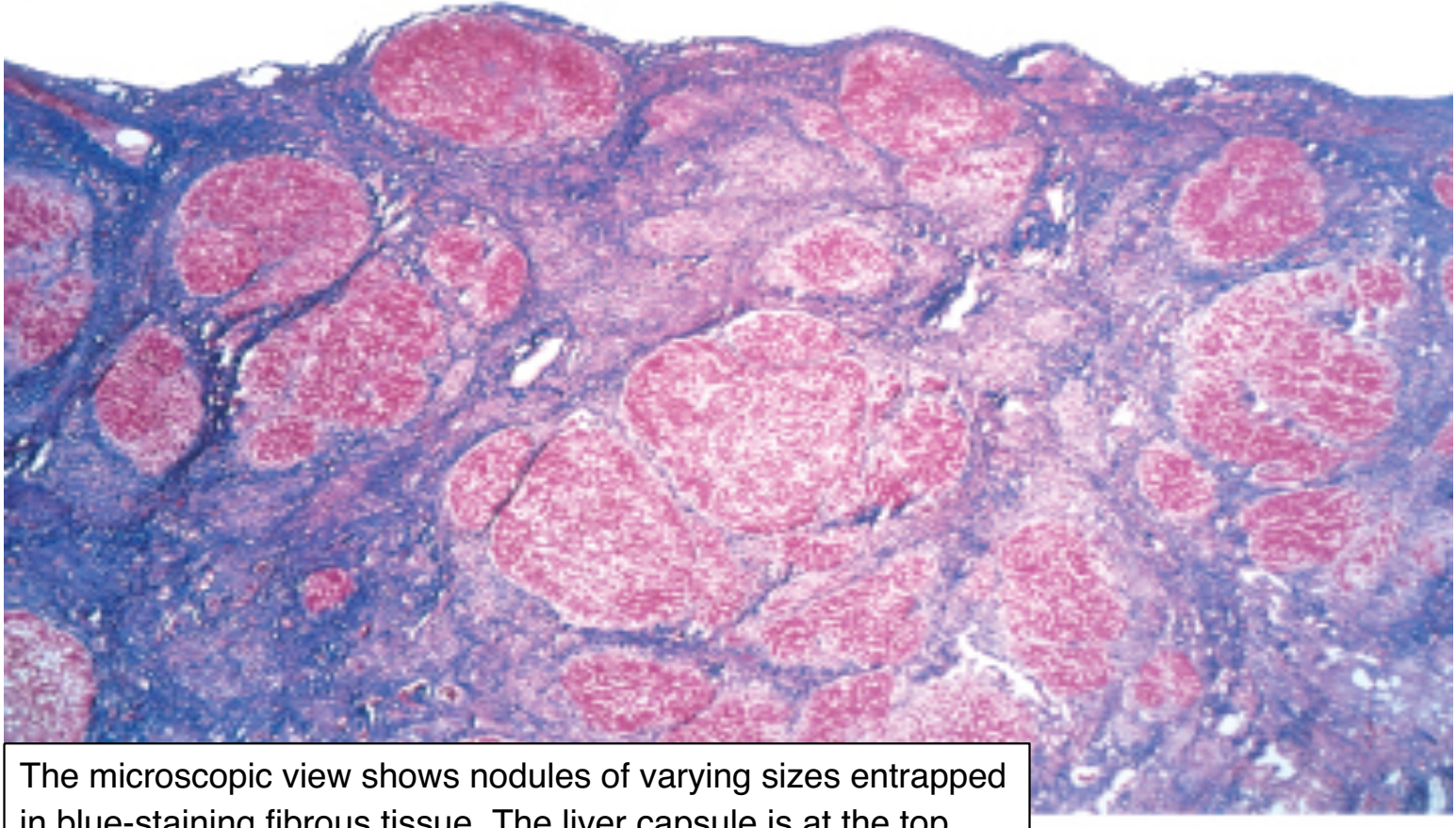
# Alcoholic liver disease



Mallory-Denk bodies:

Eosinophilic Mallory bodies are seen in hepatocytes

# Alcoholic liver disease
# Cirrhosis



The microscopic view shows nodules of varying sizes entrapped in blue-staining fibrous tissue. The liver capsule is at the top

# Alcoholic liver disease

The causes of death are:

- Hepatic failure
- Massive gastrointestinal hemorrhage
- Intercurrent infection (to which affected individuals are predisposed)
- Hepatorenal syndrome
- Hepatocellular carcinoma (3%–6% of cases)

Associated with ulcerative colitis
Mallory-Denk bodies
Periductal portal tract fibrosis
Female to male: 6:1
Extrahepatic bile duct obstruction
Elevated serum antimitochondrial antibody
Granulomatous destruction of bile ducts
Bridging necrosis
Increased serum alkaline phosphatase
Ascending cholangitis
Lymphoid follicle
Elevated serum antinuclear (ANA ) and antismooth muscle (SMA)
Plasma cell predominance
Neutrophil infiltration
Interface hepatitis
Ground-glass cytoplasm
Micronodular cirrhosis
lymphoid aggregate
Associated with Sjogren's syndrome

1. Chronic Viral Hepatitis
2. Autoimmune hepatitis
3. Alcoholic liver disease
4. Biliary Cirrhosis

A. Secondary biliary cirrhosis
B. Primary biliary Cholangitis
C. Primary sclerosing cholangitis