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PICTURES IN DIGESTIVE PATHOLOGY

Hepatocellular carcinoma presenting with Budd-Chiari syndrome, right atrial thrombus and pulmonary emboli

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CASE REPORT

A 47-year-old patient presented with a two-week history of right upper quadrant pain, abdominal distention and new onset of shortness of breath. He had a history of intravenous drug abuse, no alcohol consumption and denied any known liver disease. On physical examination, he was tachypneic and had dullness in the flanks.

His blood analysis at admission was as follows: hemoglobin, 12.9 g/dL; leukocyte count, 6,800/uL; platelet count, 63,000/uL; INR, 2.1; serum creatinine, 1.27 mg/dL; liver biochemistry tests were notable for marginal derangement, HBsAg was negative, anti-HCV was positive, HCV RNA was 367,498 IU/ml and alpha-fetoprotein was 992 mg/dL.

Abdominal ultrasound showed a right liver lobe mass (13 cm in diameter) with inferior vena cava (IVC) thrombosis and mild peri-hepatic ascites. A 2D echocardiogram showed a presumed right atrial tumor thrombus. A multiphasic contrast-enhanced abdominal tomography (CT) confirmed a hepatocellular carcinoma (HCC) with IVC obstruction and extensive tumoral thrombus to the right atrium (14 cm long) (Fig. 1). Chest CT also revealed bilateral pulmonary emboli, pleural effusions and pulmonary metastasis.

Given the advanced disease, he was discharged with best supportive care.

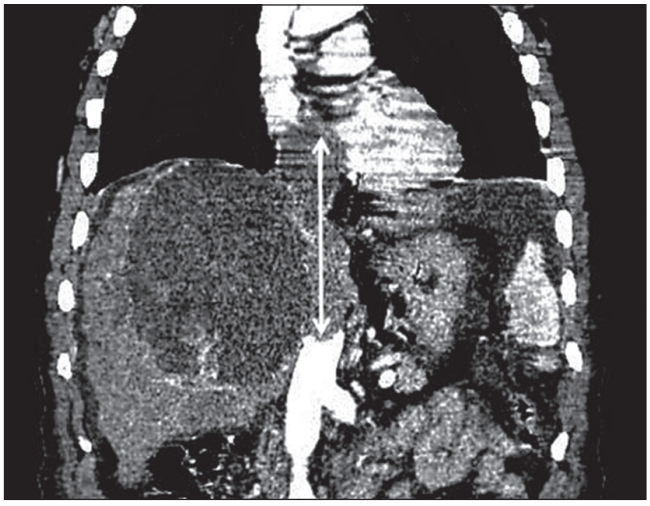

Fig. 1. Abdominal CT reconstruction showing the presence of a large hepatic mass (13 cm in diameter) invading the inferior vena cava and extending all the way to the right atrium (double-arrow).

DISCUSSION

Secondary Budd-Chiari syndrome (BCS) (1) is found in less than 1% of HCCs and is an extremely rare form of presentation (2,3). Here, we illustrate a rare case of HCC complicating chronic hepatitis C and presenting with secondary BCS, tumoral thrombus in the IVC extending into the right atrium and pulmonary embolism.

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