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LIVER TRANSPLANTATION

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COLONIC BLEED AFTER LIVER TRANSPLANTATION DUE TO MUCORMYCOSIS—A CASE REPORT AND REVIEW OF LITERATURE

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Gastrointestinal mucormycosis (GIM) is a rare but highly invasive, potentially lethal fungal infection in transplant recipients. Isolated colonic mucormycosis is very rare. We report the case of a patient with cryptogenic cirrhosis who developed lower gastrointestinal bleed on day 20 following her liver transplantation. Initial investigations were inconclusive. On surgical exploration, she was found to have a lesion in transverse colon. She underwent a segmental resection of the colon with colocolostomy. Further examination of the lesion revealed an ulcer with an eroded artery at its base. The contact smear from this lesion raised a suspicion of a fungal lesion, which on histology was confirmed as mucormycosis. She was started on i.v. Amphotericin B in the postoperative period. She responded well to the therapy and had an uneventful postoperative course after that. A review of the English literature revealed that this was the first instance of an isolated mucor infection of the colon in a liver-transplant recipient. Patients with GIM following liver transplantation who received only medical therapy died and those who received both surgical and medical therapy had a good survival outcome. Medical therapy alone is seldom likely to bring about cure as the penetration of the antifungal agent is impeded by the angio-invasive nature of the mucor with resultant thrombosis of blood vessels. Hence, a high index of suspicion and a low threshold for surgical intervention, when suspected, are needed to manage effectively this kind of rare complication.

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PROLONGED WEANING FOLLOWING LIVER TRANSPLANT—A CASE REPORT

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Background: Liver transplant is an established treatment modality for patients with end-stage liver disease. We describe the postoperative course of a liver-transplant recipient who had a prolonged ICU stay and critical care issues pertaining to the same.

Case Report: A 39-year-old gentleman with alcohol-related chronic liver disease, Child's class C, MELD 25, underwent a living-related liver transplant in our institute. He had received treatment for pulmonary Koch's disease 8 years ago and was presently having a fair exercise tolerance with a metabolic equivalent of task (MET) 4. Two-dimensional echocardiography revealed a concentric left ventricular hypertrophy, with a right ventricular systolic pressure of 52 mmHg and a mild pulmonary artery hypertension with a mean pulmonary artery pressure of 28 mmHg. The surgery lasted for 12 hours with an approximate blood loss of 5.8 L adequately replaced with 3 packed red blood cells, 7 fresh frozen plasma, 6 Cryo and 1 single donor platelet. After fulfilling all extubation criteria, the trachea was extubated on postoperative day (POD) 1 as per normal protocol. However, on POD 2, the patient became tachypneic, hypoxic, and the chest radiograph suggested a fluid overload which was managed conservatively with fluid restriction, diuretics, and non-invasive ventilation. On POD 3, he continued to deteriorate and was managed with invasive ventilation. Over the next week, he became symptomatically better and a trial of extubation was given which was unsuccessful. Subsequently, he developed pneumonia which was treated with sensitivity-directed antibiotics. The patient failed all subsequent spontaneous breathing trials and a percutaneous tracheostomy was eventually done. All efforts were made to contain the possible sources of infection in such critical immunosuppressed patients with due attention to adequate nutritional supplementation, aggressive physio- and psychotherapy; yet the patient did not improve. On the basis of clinical suspicion, antitubercular therapy (ATT) was started empirically with Isoniazid 300 mg, Rifampicin 450 mg, Ethambutol 800 mg and Moxifloxacin 400 mg. Within the next 3 weeks, the patient showed definite