# Liver Transplant in a Parturient with Autoimmune Hepatitis Complicated by Placental Abruption

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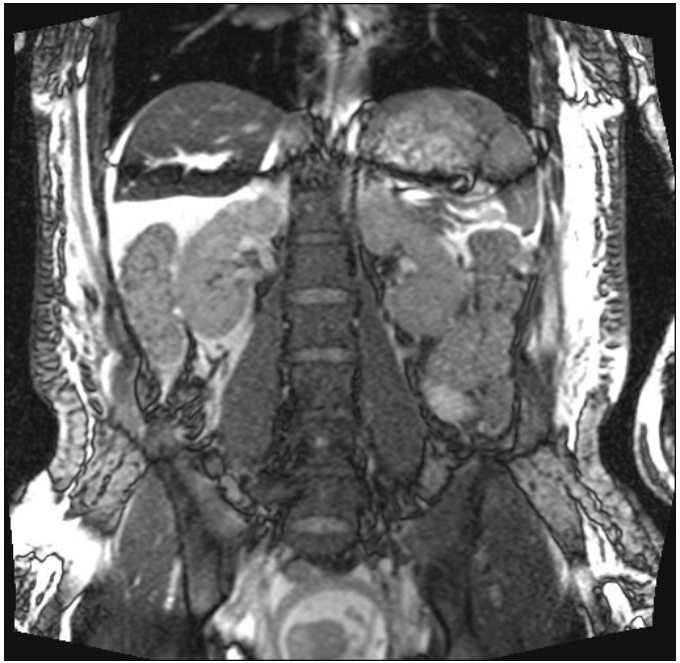
## Background

Acute liver failure in pregnancy is rare, can be highly fatal, and requires prompt recognition for optimal maternal and fetal outcomes

We report successful multidisciplinary care for a parturient receiving liver transplant secondary to acute liver failure, which was complicated by intraoperative placental abruption leading to fetal demise and requiring emergent D&E after reperfusion



# Case Presentation

- 31 yo G2P1001 at 14w6d with new onset nausea, vomiting and jaundice found to have acute liver failure secondary to biopsy proven seronegative autoimmune hepatitis
- Labs: MELD (3.0): 33 | Cr 0.8 | Na 132 | T.Bili 20.7 | AST 2130 | ALT 1249 | INR 2.86
- Initial multidisciplinary plan: D&E after stabilization with liver transplant


### Admitted at 14w6d □ transplant at 16w2d

Workup for etiology of liver failure and progressive decline in status. High dose steroids ineffective for autoimmune hepatitis, listed 1A for liver transplant. Plan for D&E after normalization of coagulation profile, if required.

### Anhepatic phase of liver transplant with profuse vaginal hemorrhage

Placental abruption identified with intrauterine fetal demise, urgent dilation and evacuation after graft reperfusion. Products: 9 RBCs | 7 FFP | 3 platelet | 3g fibrinogen concentrate.

### Uneventful recovery, weaned off of all vasopressors

Extubated on postoperative day 1, successful transplant, hemodynamics stabilized.

# Discussion

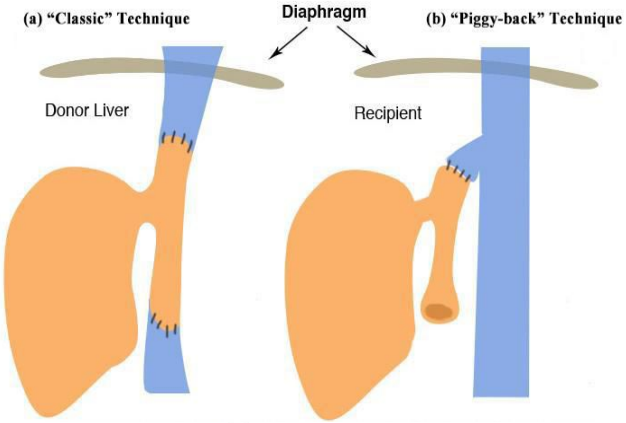
## Conflicting Physiology

- Pregnancy hypercoagulability vs liver failure coagulopathy

## Surgical Technique Considerations

- Bicaval vs piggyback (side to side anastomosis)
- Systemic bypass in addition to portal bypass may have reduced the uterine congestion associated with caval clamping

Successful maternal and fetal outcomes are possible and have been reported (Kimmich et al.)




| Conventional Technique | Piggyback Technique |
|---|---|
| Removes IVC | Preserves IVC |
| Often requires bypass | Avoids venovenous bypass in most cases |
| Greater hemodynamic instability | Less hemodynamic disturbance |
| Longer anhepatic time | Shorter anhepatic time |