Caput medusae in alcoholic liver disease

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Abstract

Caput medusae and palmar erythema are cardinal signs in cirrhosis of liver with portal hypertension. Palmar erythema is described more often as a marker for alcoholic etiology of chronic liver disease. The peripheral stigmata of chronic liver disease are not routinely seen now a days due to early diagnosis and better therapy. We recently encountered an interesting patient of alcoholic liver disease with two classical signs of the disease and report the same for this unusual presentation.

Key words: Caput medusa, chronic liver disease, palmar erythema

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Introduction

The liver is the largest internal organ of the body and bears the burden of various metabolic functions. Chronic liver disease (CLD), including cirrhosis, is a commonly encountered disease in clinical practice. Excess alcohol consumption and infection with hepatitis B virus (HBV) and hepatitis C virus (HCV) are responsible for CLD in the majority of patients. The peripheral manifestations of CLD include spider angiomas, palmar erythema, icterus, pruritus, gynecomastia, etc. We recently encountered a patient of CLD with two rare peripheral stigmata.

Case Report

A 53-year-old man, a resident of India, with history of alcohol consumption of 60 gm/day for 20 years, presented with swelling of the legs, abdominal distension, and a collapsible localized swelling over the abdomen since 3 months. He denied any past history of jaundice and had no symptoms of encephalopathy or coagulopathy. Examination revealed a normotensive individual with pallor, pedal edema, spider nevi, parotidomegaly, and palmar erythema [Figure 1]. Abdominal examination revealed hepatomegaly, ascites, and a large caput medusae with collaterals [Figure 2]. Auscultation over the caput medusae revealed a Cruveilhier–Baumgarten murmur. Blood flow in the collaterals was not indicative of inferior vena cava obstruction. His serum bilirubin was 23.9 μmol/L, alanine aminotransferase 34 U/L, aspartate aminotransferase 45 U/L, alkaline phosphatase 98 U/L, serum proteins 54 g/L, serum albumin 32 g/L, and serum globulin 22 g/L. Ascitic fluid analysis revealed straw-colored fluid with proteins of 11 g/L and white blood cell count of 80/cu mm, with lymphocytes predominating. His SAAG (serum–ascites albumin gradient) was 2.1, which was suggestive of portal hypertension.

Upper gastrointestinal endoscopy revealed grade 3 esophageal varices, with no signs of recent hemorrhage. Sonography of the abdomen revealed enlarged portosystemic collaterals, with a recanalized umbilical vein. Viral marker screens to look for coexisting chronic hepatitis were negative. The patient was diagnosed as a case of alcoholic liver disease leading to cirrhosis with decompensation (in form of ascites and portal hypertension). Ascites was managed with salt restriction, diuretics, and propranolol; endoscopic ligation was done for the esophageal varices. The caput medusae was left alone as no specific treatment was deemed necessary for the same. During the last 8 months of follow-up, the edema and ascites have decreased

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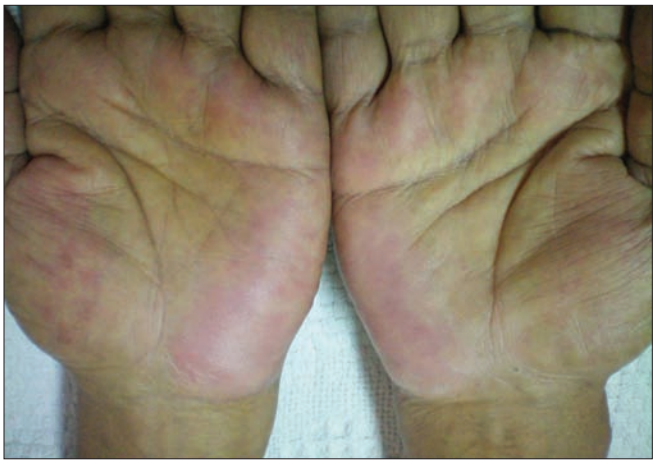

Figure 1: Photograph of hands showing palmar erythema

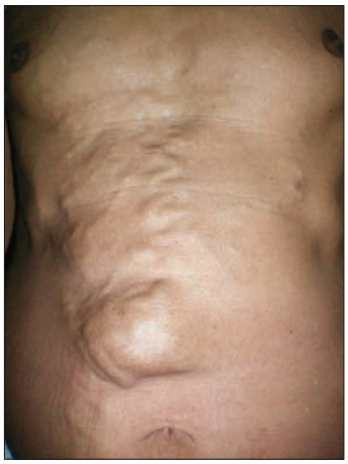

Figure 2: An unusually large caput medusae over the abdomen

considerably with medical management and there has been no evidence of encephalopathy, coagulopathy, or gastrointestinal bleeding.

Discussion

Caput medusae is one of the cardinal features of portal hypertension due to cirrhosis of the liver.[1] Blood from the portal venous system is shunted through the umbilical veins into the abdominal wall veins, which manifest as the caput medusae.[2] The term caput medusae (Latin for 'head of Medusa') originates from the apparent similarity to Medusa's hair once Minerva had turned it into snakes.[3] Palmar erythema is the exaggeration of the normal speckled mottling of the palm because of altered sex hormone metabolism. It is associated with alcoholic liver disease, pregnancy, thyrotoxicosis, rheumatoid arthritis, and a few dermatoses.

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