

in Japan [1], while drug-induced liver injury, including acetaminophen intoxication, is the major cause of acute liver failure in Europe and the United States [2]. Thus, acute liver failure is typically associated with fulminant viral hepatitis in Japan, and the diagnostic criteria for “fulminant hepatitis”, which are different from those for “acute liver failure” in Europe and the United States, were first established at the Inuyama Symposium in 1981 [3].

The therapeutic strategies for acute liver failure also differ between Japan and Europe and/or the United States. Cadaveric transplantation is considered as the first-line therapy for acute liver failure in Europe and the United States [2], while in Japan, artificial liver support, consisting of plasma exchange and hemodiafiltration, is usually provided first to patients with fulminant hepatitis [1], and liver transplantation, usually from living donors [4–6], is only scheduled when no clinical improvement is achieved with this conventional medical treatment [1]. Thus, the criteria for scheduling liver transplantation for patients with acute liver failure and/or fulminant hepatitis also differ between Japan and other countries.

In the present article, we discuss in detail the differences between Japan and Europe and/or the United States in the definitions, classifications, and diagnostic criteria for the disease subtypes of acute liver failure and/or fulminant hepatitis, and also the indications for liver transplantation in these patients. Also, we describe the clinical features of patients with acute liver failure in Japan, which were analyzed through a nationwide survey conducted using the diagnostic criteria revised in 2011 in reference to those in Europe and the United States.

Diagnostic criteria for acute liver failure in Europe, the United States, and Asian countries other than Japan

Epidemic hepatitis was a worldwide health problem in the early twentieth century, and it was already known, even in the 1920s, that differences existed in the clinical course even among patients with the fatal form of the disease, and that patients could be divided into those with fulminant, acute, or chronic forms [7]. Although most patients with fatal disease exhibited a subacute clinical course, with the patients dying between 4 and 6 weeks after the onset of the hepatitis symptoms, a patient showing a more rapid course was first reported in the great Swedish epidemic in 1927 [8]. This was the first case report of fulminant-type epidemic hepatitis although it was thought that such patients were seldom encountered elsewhere in the world. However, the concept of epidemic hepatitis changed with the occurrence of World War II; epidemic hepatitis changed to a hepatitis pandemic during World War II, with large outbreaks occurring in many parts of the world, especially

in armies. Lucke and Mallory [7] reported on the outbreak of epidemic hepatitis in the United States Army between August 1943 and April 1945, in which 104 of 196 patients (53 %) had a fatal course and died within 10 days of the onset of the hepatitis symptoms. Lucke and Mallory named this form of hepatitis, which was probably caused by hepatitis A virus (HAV) or hepatitis E virus (HEV) infection, the “fulminant form” of hepatitis.

By the end of World War II, the hepatitis pandemic had not spread to any extent in Europe or the United States, and the “fulminant form of hepatitis” was recognized as an infrequent, but intractable, disease in Western countries. Also, advances in the field of virology in the 1970s enabled hepatologists to evaluate patients with fulminant hepatitis for serum markers of HAV and hepatitis B virus (HBV) infection, and these two types of hepatitis viruses were found to account for a large proportion of the patients [9–11]. On the other hand, Trey et al. [12] reported that drugs such as halothane may also cause acute liver disease, similar in clinical course to fulminant hepatitis. They evaluated the etiology in 150 patients enrolled from 73 centers, and revealed that the cause of the hepatitis was presumed viral hepatitis in 70 patients (46.7 %) (including serum hepatitis and epidemic hepatitis in 24 and 46 patients, respectively), and drug-induced liver disease in 48 patients (32.0 %) (including 36 with halothane exposure as the culprit) [12]. These observations prompted hepatologists to use the nomenclature of “fulminant hepatic failure” instead of “fulminant hepatitis” for patients presenting with acute onset of massive liver necrosis. Then, in 1970, Trey and Davidson [13] proposed the now well-known diagnostic criteria for fulminant hepatic failure; they defined the condition as a clinical syndrome characterized by massive liver necrosis associated with severe impairment of hepatic function, manifesting as progressive jaundice, hepatic coma, and liver atrophy developing within 8 weeks of the onset of the first symptoms of the disease in individuals with no previous history of hepatic disease. Moreover, in 1986, Gimson et al. [14] suggested that patients showing hepatic encephalopathy as well as other evidence of hepatic decompensation developing more than 8 weeks but less than 24 weeks of the onset of the first symptoms be labeled as having late-onset hepatic failure (LOHF), a clinical syndrome related to fulminant hepatic failure.

In contrast, in France, Bernuau et al. [15] proposed the nomenclature of “fulminant and subfulminant liver failure” for patients with rapidly progressive hepatic failure; patients developing hepatic encephalopathy less than 2 weeks after the onset of jaundice were diagnosed as having fulminant liver failure, while those with hepatic encephalopathy developing between 2 and 12 weeks after the onset of jaundice were labeled as having subfulminant

liver failure. Also, the terminology of “subacute liver failure” was introduced in India in 1982 for patients showing progressive jaundice with ascites of 8 weeks’ duration, with otherwise typical features of acute viral hepatitis; the presence of hepatic encephalopathy was not a necessary criterion for the diagnosis of this condition [16]. While intense debate still continues on the definition and classification of patients showing rapid progression of hepatic failure, all hepatologists around the world, including those in Japan [17], agree that patients showing the most rapid onset of hepatic encephalopathy have the best chance of recovery with conventional medical treatment. Although geographic heterogeneity was found in the etiology and clinical features of acute liver diseases, standardization of the nomenclature and diagnostic criteria for patients showing rapidly progressive hepatic failure is required for reliable comparisons of the efficacies of various treatments and of the resultant outcomes among different countries.

Thus, in 1993, O’Grady et al. [18] redefined such syndromes as “acute liver failure” prefixed with “hyper” and “sub” to describe 2 cohorts at opposite ends of the clinical spectrum, based on the observation of a large series of patients treated at King’s College Hospital, London, between 1972 and 1985. According to this proposed classification, patients with hepatic encephalopathy developing within 7 days of the onset of jaundice are diagnosed as having “hyperacute liver failure”, which is often caused by acetaminophen intoxication [18]. In contrast, patients showing hepatic encephalopathy between 8 and 28 days and those with encephalopathy developing later than 28 days after the first onset of symptoms were diagnosed as having “acute liver failure” and “subacute liver failure”, respectively, with HAV or HBV infection and drug-induced liver damage being more frequently seen in the former cohort, and liver disease of indeterminate etiology being seen more frequently in the latter cohort [18]. It should be noted that patients with pre-existing symptomless chronic liver diseases were included in the disease entity of “acute liver failure” by O’Grady et al. [18], and in that of “fulminant liver failure” by Bernuau et al. [15], while such patients were excluded from the entity of “fulminant hepatic failure” by Trey and Davidson [13].

Criticisms were raised regarding the nomenclature and definition of “acute liver failure” proposed by the King’s College Hospital group, especially in France [19] and India [20]. Thus, the subcommittee of the International Association for the Study of the Liver (IASL) published revised recommendations on the nomenclature of acute and subacute hepatic failure in 1999 [21]. In this recommendation, two distinct disease entities, but not subgroups of a syndrome, were established; namely, “acute hepatic failure” and “subacute hepatic failure”. Patients without pre-

existing liver disease developing hepatic encephalopathy within 4 weeks of the onset of the disease symptoms are diagnosed as having acute hepatic failure. Acute hepatic failure is a potentially reversible liver disease and is classified into hyperacute and fulminant forms, defined by the development of hepatic encephalopathy less than 10 days and between 10 and 30 days, respectively, after the first onset of the disease symptoms. In contrast, patients developing hepatic encephalopathy between the 5th and 24th weeks after the first onset of symptoms are diagnosed as having subacute hepatic failure.

Consequently, until the beginning of the twenty-first century, hepatitis showing rapid progression was referred to by various names, including fulminant hepatitis [7], fulminant hepatic failure [13], fulminant liver failure [15], acute liver failure [18], and acute hepatic failure [21] (Table 1). However, “acute liver failure” came to be used predominantly as the most suitable umbrella term, because it can be assumed to include all of the other disease entities [22]. Thus, the Practice Guideline Committee of the American Association for the Study of Liver Diseases (AASLD) published a position paper for the management of “acute liver failure” in 2005 [2]. Acute liver failure is defined as “liver diseases characterized by the development of hepatic encephalopathy and coagulation abnormalities, usually characterized by an international normalized ratio (INR) of 1.5 or more, in patients without preexisting cirrhosis, and an illness of less than 26 weeks duration”. In this position paper, subgroups classified according to the interval between the onset of hepatic encephalopathy and the first onset of the disease symptoms; namely, the hyperacute, acute, and subacute types, were shown to be not helpful to predict the outcomes of the patients [2]. Despite the publication of this position paper by the AASLD, differences in the definitions are still seen in recent articles regarding acute liver failure [23], and these differences hamper the conduct of reliable meta-analyses.

Definition, classification, and diagnostic criteria for fulminant hepatitis and acute liver failure in Japan

The definition and classification of fulminant hepatitis, the representative disease entity associated with acute liver failure in Japan, were established at the Inuyama Symposium in 1981 [3]. According to the Inuyama Symposium criteria, patients with hepatitis were diagnosed as having fulminant hepatitis when they developed grade II or more severe hepatic encephalopathy due to severe liver damage, as represented by prothrombin time values of $\leq 40\%$ of the standardized value, within 8 weeks of the onset of the hepatitis symptoms. Fulminant hepatitis was further

Table 1 Definition and classification of acute liver failure and related diseases

Year	Nomenclature (classification)	Parameters			Author	Affiliation or country	Reference
		Development of hepatic encephalopathy	PT	Pre-LD			
1930	Acute yellow liver dystrophy	ND	–	–	Bergstrand	Germany	[8]
1946	Fulminant form of epidemic hepatitis	ND	–	–	Lucke and Mallory	USA	[7]
1970	Fulminant hepatic failure	Within 8 weeks after disease symptoms onset	–	Absent	Trey and Davidson	USA	[13]
1981	Fulminant hepatitis (acute & subacute)	Within 8 weeks after disease symptoms onset (within 10 days and between 11 and 56 days, respectively)	≤40 %	Absent	Takahashi et al.	Japan	[3]
1982	Subacute hepatitis	Not necessarily present	–	–	Tandon et al.	India	[16]
1986	Late onset hepatic failure	Between 8 and 24 or 26 weeks after disease symptoms onset	–	–	Gimson et al.	England	[14]
1986	Fulminant liver failure and subfulminant liver failure	Less than 2 weeks and between 2 and 12 weeks, respectively, after jaundice onset	–	Absent or present	Bernuau et al.	France	[15]
1993	Acute liver failure (hyperacute, acute and subacute)	Within 7 days, between 8 and 28 days, and later than 28 days, respectively, after jaundice onset	–	Absent or present	O'Grady et al.	England	[18]
1999	Acute hepatic failure (hyper-acute and fulminant) and subacute hepatic failure	Within 4 weeks (less than 10 days and between 10 and 30 days) and between 5th and 24th weeks, respectively, after disease symptoms onset	–	–	Tandon et al.	IASL	[21]
2005	Acute liver failure	Preexisting illness of less than 26 weeks' duration	Usually INR ≥1.5	Absent	Polson and Lee	AASLD	[2]
2011	Acute liver failure [without or with coma (acute and subacute)]	Without or with encephalopathy within 8 weeks of disease symptoms onset (within 10 days and between 11 and 56 days, respectively)	≤40 % or INR ≥1.5	Absent	Mochida et al.	Japan	[30]

PT prothrombin time, Pre-LD preexisting symptomless liver diseases, ND not described, IASL International Association for the Study of the Liver, AASLD American Association for the Study of Liver Diseases

classified into 2 clinical types; that is, the acute and subacute types, on the basis of the hepatic encephalopathy developing within 10 days or between 11 and 56 days, respectively, after the onset of the hepatitis symptoms. Fulminant hepatitis in Japan is defined as histological evidence of hepatic inflammation, characterized by lymphocytic infiltration of the liver, associated with acute liver failure. Thus, the etiology of fulminant hepatitis comprises viral infections, including HBV carriers, autoimmune hepatitis, drug allergy-induced liver injuries, and hepatitis of indeterminate etiology.

The Intractable Liver Diseases Study Group of Japan, supported by the Ministry of Health, Labour and Welfare, last revised the diagnostic criteria for “fulminant hepatitis” in 2002 (Table 2) [1]. In this revision, 5 items clarifying the inclusion and exclusion criteria for the diagnosis of fulminant hepatitis were added as a footnote. We clarified that patients with preexisting chronic liver diseases, such as those with alcoholic hepatitis, were excluded from the

disease entity of fulminant hepatitis, whereas asymptomatic HBV carriers developing acute exacerbation of hepatitis were included as cases of fulminant hepatitis. Also, the significance of histological evidence of liver inflammation was emphasized, so that liver failure caused by drug or chemical intoxication, circulatory disturbances, acute fatty liver of pregnancy, Reye's syndrome, or Wilson disease were excluded from the diagnosis of fulminant hepatitis. Moreover, the definitions of subtypes of fulminant hepatitis were clarified; hepatitis patients with no or grade I encephalopathy, but showing prothrombin time values of ≤40 % of the standardized value were diagnosed as having “severe type of acute hepatitis”, while those with grade II or more severe hepatic encephalopathy developing between 8 and 24 weeks after the disease symptoms onset, with prothrombin time values of ≤40 % of the standardized value were diagnosed as having LOHF. Thus, the disease entity of LOHF in Japan differed from that in Europe and the United States [14], because patients with no

Table 2 Diagnostic criteria for fulminant hepatitis in Japan established by the Intractable Liver Diseases Study Group of Japan, supported by the Ministry of Health, Welfare and Labour (2003); from reference [1]

Fulminant hepatitis is defined as hepatitis with hepatic encephalopathy of grade II or more that develops in the patients within 8 weeks of the onset of disease symptoms, associated with severe derangement of liver function, including prothrombin time values of less than 40 % of the standardized value. Fulminant hepatitis is classified into 2 subtypes; the acute type and the subacute type, according to whether the encephalopathy occurs within 10 days and later than 11 days, respectively, after the onset of the symptoms.

Note 1: Patients with chronic liver diseases are excluded from the disease entity of fulminant hepatitis, but asymptomatic hepatitis B virus (HBV) carriers developing acute exacerbation are included as cases of fulminant hepatitis.

Note 2: Acute liver failure with no histological evidence of liver inflammation, such as that caused by drug or chemical intoxication, circulatory disturbance, acute fatty liver of pregnancy, or Reye's syndrome is excluded from the disease entity of fulminant hepatitis.

Note 3: The grading of hepatic encephalopathy is based on the criteria presented at the Inuyama Symposium in 1972.

Note 4: The etiology of fulminant hepatitis is based on the criteria established by the Intractable Liver Diseases Study Group of Japan in 2002.

Note 5: Patients with no or grade I encephalopathy, but showing prothrombin time values of less than 40 % of the standardized value are diagnosed as having acute hepatitis, severe type. Patients in whom the encephalopathy develops between 8 and 24 weeks after the disease onset, with prothrombin time values of less than 40 % of the standardized value are diagnosed as having late-onset hepatic failure (LOHF). Both are diseases related to fulminant hepatitis, but are regarded differently from fulminant hepatitis.

histological evidence of hepatitis and/or prothrombin time values of >40 % of the standardized value were excluded from the diagnosis of LOHF in Japan, even if they had grade II or more severe hepatic encephalopathy.

In the revision conducted in 2002, however, the definition and concept of fulminant hepatitis were not modified, because the diagnostic criteria established at the Inuyama Symposium were useful to characterize the clinical features of patients with acute liver failure in Japan. According to the nationwide survey of fulminant hepatitis and LOHF conducted by the Intractable Hepato-Biliary Diseases Study Group in Japan (formally the Intractable Liver Diseases Study Group of Japan), the clinical features of patients differed markedly when the disease types were defined based on the diagnostic criteria established in 1981 or based on the revised criteria established in 2002. In this survey, 1,094 patients with fulminant hepatitis, consisting of 543 with the acute type and 551 with the subacute type of fulminant hepatitis were included, and 92 patients with LOHF seen between 1998 and 2009 were enrolled [1, 24–29]. In regard to the etiology of hepatitis, viral infection accounted for 67.4 and 30.9 % of the patients with the acute and subacute types of fulminant hepatitis, respectively, and for 10.9 % of the patients with LOHF. In most patients with fulminant hepatitis caused by viral infection, irrespective of the disease type, the causative agent was HBV; transient HBV infection was more frequent in patients with the acute type (39.2 %) as compared to the subacute type (10.0 %) of fulminant hepatitis, while the frequency of HBV carriers was greater in patients with the subacute type (17.9 %) as compared to the acute type (7.2 %) of fulminant hepatitis. Autoimmune hepatitis was found in 1.8, 12.2, and 19.6 % of patients with the acute and subacute types of fulminant hepatitis and LOHF, respectively. Drug allergy-induced liver injury was seen in 9.0, 13.1, and 18.7 % of patients with the acute and

subacute types of fulminant hepatitis and LOHF, respectively. It is noteworthy that the etiology was indeterminate in 19.0, 40.8, and 40.2 % of patients with the acute and subacute types of fulminant hepatitis and LOHF, respectively. The outcomes of the patients also differed between these disease types. The survival rates of patients receiving medical treatment without liver transplantation were 53.7, 24.4, and 11.5 %, respectively, in patients with the acute and subacute types of fulminant hepatitis and LOHF seen between 1998 and 2003 [1], while these rates were 48.7, 24.2, and 13.0 %, respectively, in the corresponding categories of patients seen between 2004 and 2009 [24–29].

Although the diagnostic criteria for fulminant hepatitis in Japan [1, 3] merit consideration in clinical practice for the diagnosis of acute liver failure patients, they do need to be revised to fit with the criteria for acute liver failure adopted in Europe and the United States [2]. Thus, in 2006, the Intractable Hepato-Biliary Diseases Study Group in Japan constituted a task force to establish novel diagnostic criteria for “acute liver failure”, which includes the disease entity “fulminant hepatitis”. To establish such criteria for defining “acute liver failure” in Japan, two types of nationwide surveys were performed [30]; a survey of the commercial kits used for the measurement of prothrombin time at institutions to which hepatology specialists were affiliated, and a survey of acute liver failure patients who were excluded from the disease entities of fulminant hepatitis and LOHF. Consequently, “acute liver failure” in Japan (Table 3) came to be defined as an acute liver disease associated with prolongation of the prothrombin time, with an INR of 1.5 or more. To confirm the correspondence between the present criteria (Table 3) and previous criteria (Table 2), “prothrombin time values of ≤ 40 % of the standardized value” was also employed as a cutoff to define patients with acute liver failure. Patients without hepatic encephalopathy were also included in the disease

Table 3 Diagnostic criteria for acute liver failure in Japan (2011); from reference [30]

Patients showing prothrombin time values of 40 % or less of the standardized value, or international normalized ratios (INRs) of 1.5 or more due to severe liver damage within 8 weeks of the onset of disease symptoms are diagnosed as having "acute liver failure", where the liver function prior to the current onset of liver damage is estimated to have been normal based on blood laboratory data and imaging examinations. "Acute liver failure" is classified into "acute liver failure without hepatic coma" and "acute liver failure with hepatic coma"; no or grade I hepatic encephalopathy is present in the former type, while grade II or more severe hepatic encephalopathy is found in the latter type. "Acute liver failure with hepatic coma" is further subclassified into 2 disease types; the "acute type" and "subacute type", with grade II or more severe hepatic encephalopathy developing within 10 days or between 11 and 56 days after the onset of disease symptoms, respectively, in the two types.

Note 1: Hepatitis B virus (HBV) carriers and autoimmune hepatitis patients showing acute exacerbation of hepatitis in the normal liver are included under the disease entity of "acute liver failure". In the case of indeterminate previous liver function, the patients who are HBV carriers and those with autoimmune hepatitis are diagnosed as having "acute liver failure" when no liver function impairment preceding the exacerbation of the liver injury can be confirmed.

Note 2: In general, alcoholic hepatitis develops in patients with chronic liver diseases caused by habitual alcohol consumption. Thus, patients with alcoholic hepatitis are excluded from the disease entity of "acute liver failure". However, patients with fatty liver caused by alcohol intake and those with metabolic syndrome, including obesity, are diagnosed as having "acute liver failure" if etiologies other than habitual alcohol consumption are responsible for the acute injury in the liver, in the absence of prior impairment of liver function.

Note 3: Patients without histological evidence of hepatitis, such as inflammatory lymphocytic infiltration, are included under the disease entity of "acute liver failure". Thus, patients with liver damage caused by drug toxicity, circulatory disturbance, or metabolic disease and acute fatty liver of pregnancy are diagnosed as having "acute liver failure", while they are excluded from the disease entity of "fulminant hepatitis". In contrast, patients with liver injury caused by viral infection, autoimmune hepatitis, and drug allergy-induced hepatitis are included under the disease entities of "fulminant hepatitis" and "acute liver failure".

Note 4: The severity of hepatic encephalopathy is diagnosed according to the classification presented at the Inuyama Symposium in 1972 (Table 4). Also, hepatic encephalopathy developing in pediatric patients and infants is classified according to the criteria proposed by the 5th Workshop on Pediatric Liver Diseases in 1988 (Table 5).

Note 5: The etiology of "acute liver failure" is classified according to the criteria proposed by the Intractable Liver Diseases Study Group of Japan in 2002, with some modifications (Table 6).

Note 6: Patients showing prothrombin time values of less than 40 % of the standardized value or INRs of 1.5 or more and grade II or more severe hepatic coma between 8 and 24 weeks of the onset of disease symptoms are diagnosed as having late-onset hepatic failure (LOHF), as a disease related to "acute liver failure".

entity of acute liver failure, if they showed an INR of 1.5 or more. Thus, acute liver failure patients are classified into those with and without hepatic coma, and acute liver failure with hepatic coma is further subdivided into 2 disease types; namely, the "acute type" and the "subacute type," according to the interval from the onset of symptoms to the development of hepatic encephalopathy, similar to the case for fulminant hepatitis [1, 3].

Similar to the entity of acute liver failure in Europe and the United States [2], in Japan patients without histological evidence of inflammation in the liver, such as those with the disease caused by drug toxicity, circulatory disturbances, or metabolic diseases are also included in the disease entity of acute liver failure. In contrast, patients showing impaired liver function due to underlying chronic liver diseases before the worsening of the liver damage are excluded from the disease entity of acute liver failure. Thus, alcoholic liver disease patients are excluded from this entity, because they show clinical features consistent with acute-on-chronic liver disease. However, patients with underlying chronic liver diseases such as fatty liver and autoimmune hepatitis are included in the disease entity of acute liver failure, when the liver function impairment is retrospectively estimated to be minimal or absent prior to

the current exacerbation of the liver damage. Also, the criteria for classification of hepatic encephalopathy and etiology of hepatitis have been added as footnotes to the present criteria (Tables 4, 5, 6). In addition, patients with LOHF are defined as those showing prothrombin time values of ≤ 40 % of the standardized value or INRs of 1.5 or more and grade II or more severe hepatic coma between 8 and 24 weeks of the onset of the disease symptoms, and those without histological evidence of hepatitis are also included in the disease entity of LOHF, similar to the case of acute liver failure. On the other hand, the disease entity of "acute hepatitis severe type" was excluded from the footnote of the present criteria, because patients classified under such a disease entity can also be diagnosed as having "acute liver failure without hepatic encephalopathy".

Nationwide survey of patients with acute liver failure in Japan

Recently, the Intractable Hepato-Biliary Diseases Study Group performed a nationwide survey of patients with acute liver failure seen in 2010, in whom the diagnosis was made according to the criteria published in 2011 [30]. The

Table 4 Classification of hepatic encephalopathy in adult patients according to the grade of hepatic coma proposed by the Inayama Symposium in 1972; from reference [30]

Grade of coma	Psychiatric disorders	Reference items
I	Inversion of sleep pattern Euphoria and/or occasional depression Negligent attitude with shortened attention span	Recognized retrospectively in most cases
II	Disorientation of time or place and confusion Inappropriate behaviors, such as throwing away money or discarding items of value Occasional somnolent tendency; able to open eyes and respond appropriately to questions Makes impolite remarks, but follows doctors' instructions	Excitation state and, urinary and fecal incontinence are absent, but flapping tremor is found on physical examination
III	State of excitation and/or delirium, showing defiant behavior Somnolent tendency; sleeping most of the time Opens eyes in response to stimulation, but cannot follow the instructions of doctors, except for simple orders	Flapping tremor is observed, and the extent of disorientation is severe
IV	Coma; complete loss of consciousness Response to painful stimuli	Brushes off doctor's hands if touched and/or frowns in response to stimuli
V	Deep coma No response to painful stimuli	

Table 5 Classification of hepatic encephalopathy in pediatric patients and infants according to the grade of hepatic coma as proposed at the 5th Workshop on Pediatric Liver Diseases in 1988; from reference [30]

Grade of coma	Pediatric patients	Infants
I	Low-spirited from before (seems lethargic compared with previous physical activity level)	Does not laugh aloud
II	Obedient attitude with somnolent tendency Disorientation of time or place	Does not laugh even when being played with Cannot maintain eye contact with the mother (more than 3 months after birth)
III	Opens eyes in response to loud voice	
IV	Does not wake up in response to painful stimuli, but frowns and/or brushes off the item producing the stimulus with his/her hands	
V	No response to painful stimuli	

220 patients, consisting of 211 patients with acute liver failure and 9 patients with LOHF, were enrolled from 742 institutions with specialists in the fields of hepatology, gastroenterology, and/or acute medicine [31]. The 211 acute liver failure patients were classified into 96 (45.5 %) without hepatic coma and 115 patients (54.5 %) with

hepatic coma, with the latter group being further divided into 61 patients (28.9 %) with the acute type and 54 patients (25.6 %) with the subacute type (Fig. 1). Also, the acute liver failure patients were classified into 188 patients (89.1 %) with hepatitis and 23 patients (10.9 %) without hepatitis. The 188 patients with hepatitis consisted of 85 patients (45.2 %) without hepatic coma, and 103 patients with hepatic coma (54.8 %), with 54 patients (28.7 %) classified with the acute type and 49 patients (26.1 %) classified with the subacute type. The 23 patients without hepatitis were divided into 11 patients (47.8 %) without hepatic coma and 12 patients (52.2 %) with hepatic coma, including 7 (30.4 %) patients with the acute type and 5 (21.7 %) patients with the subacute type. In contrast, all patients with LOHF presented with hepatic coma and were classified as having the histological features of hepatitis (Fig. 1).

The etiologies of liver damage in patients with acute liver failure are shown in Fig. 2. Viral infection was determined as the cause in 43 of 96 patients (44.8 %) with acute liver failure without hepatic coma, 48 of 115 patients (41.7 %) with acute liver failure with hepatic coma, including 29 of 61 patients (47.5 %) with the acute type and 19 of 54 patients (35.2 %) with the subacute type, and 3 of 9 patients (33.3 %) with LOHF. The percentage of patients with liver injury caused by viral infections was smaller than that reported from the previous nationwide survey in Japan, especially in patients with acute type of

Table 6 Classification of etiologies of acute liver failure modified from the criteria proposed by the Intractable Liver Diseases Study Group of Japan in 2002; from reference [30]

I.	Viral infection
	1 Hepatitis A virus (HAV)
	2 Hepatitis B virus (HBV)
	(1) Transient infection
	(2) Acute exacerbation in HBV carrier
	i. Inactive carrier, without drug exposure
	ii. Reactivation in inactive carrier by immunosuppressant and/or anticancer drugs
	iii. Reactivation in transiently infected patients by immunosuppressant and/or anticancer drugs (de-novo hepatitis) ^a
	(3) Indeterminate infection patterns
	3 Hepatitis C virus (HCV)
	4 Hepatitis E virus (HEV)
	5 Other viruses
II.	Autoimmune hepatitis
III.	Drug-induced liver injuries
	1. Drug allergy-induced liver injury
	2. Drug toxicity-induced liver injury
IV.	Circulatory disturbance
V.	Infiltration of the liver by malignant cells
VI.	Metabolic diseases
VII.	Liver injuries after liver resection and transplantation
VIII.	Miscellaneous etiologies
IX.	Indeterminate etiology despite sufficient examinations
X.	Unclassified due to insufficient examinations

Patients with etiologies I, II, and III-1 are diagnosed as having “fulminant hepatitis” as well as “acute liver failure”, whereas those with etiologies III-2 and IV to VIII are diagnosed as having “acute liver failure”, but are excluded from the disease entity of “fulminant hepatitis”. Diagnostic criteria for the classification of etiology based on laboratory data should be established in the future

^a Serum hepatitis B surface (HBs) antigen-negative patients following transient infection with HBV are classified as HBV carriers, in whom HBV reactivation can be induced by immunosuppressant and/or anticancer drugs; however, the significance of this causative etiology needs to be evaluated further

liver failure with hepatic coma [1, 24–29]. In most of the cases of viral infection, the causative virus was HBV; transient infection was predominant in patients without hepatic coma and in those with acute-type liver failure with coma, whereas the incidence of asymptomatic carriers showing acute exacerbation of hepatitis was frequent in patients with subacute-type liver failure with coma. It is noteworthy that among the 25 asymptomatic carriers, there were 9 patients with de-novo HBV hepatitis, with negative test results for serum hepatitis B surface (HBs) antigen, who developed acute liver failure following therapy with

immunosuppressive and/or anticancer drugs through an increase of the serum HBV-DNA level.

Although a small number of patients with autoimmune hepatitis and drug allergy-induced liver damage were found among patients with each disease type, the etiology of liver failure remained indeterminate in most of the remaining patients, including 27 of 96 patients (28.1 %) with acute liver failure without hepatic coma, 39 of 115 patients (33.9 %) with acute liver failure with coma (including 17 of 61 patients [27.9 %] with the acute type and 22 of 54 patients [40.7 %] with the subacute type of liver failure), and 2 of 7 patients (22.2 %) with LOHF. Etiologies other than hepatitis that may have induced liver injury were found in 11 patients (11.5 %) with acute liver failure without hepatic coma and in 12 patients (10.4 %) with acute liver failure with hepatic coma (including 7 patients [11.5 %] with the acute type and 5 patients [9.3 %] with the subacute type of acute liver failure), while hepatitis was the cause of the liver injury in all the patients with LOHF. The etiologies of liver damage other than hepatitis were circulatory disturbance in 6 patients, hepatic infiltration by malignant cells in 5 patients, post-operative liver injuries in 4 patients, metabolic disease in 3 patients, hemolytic-phagocytotic syndrome (HPS) in 3 patients, and drug toxicity-induced liver injury in 2 patients.

Among the 220 patients with acute liver failure and LOHF, 29 (13.2 %) underwent liver transplantation and the remaining 191 patients (86.8 %) were given conservative medical treatment, including artificial liver support (consisting of plasma exchange and hemodiafiltration). Liver transplantation was performed only in patients with hepatitis, while all of the patients without histological evidence of hepatitis received medical treatment alone. The survival rate of the 191 patients managed by medical treatment alone was 51.3 % (98/191), including 54.8 % (92/168) in patients with hepatitis and 26.1 % (6/23) in patients without hepatitis. In patients with hepatitis, the survival rate was 86.7 % (72/83) in the patients without hepatic coma, 31.7 % (13/41) in the patients with acute-type liver failure with coma, and 19.4 % (7/36) in the patients with subacute-type liver failure with coma, and 0 % (0/8) in those with LOHF; these values were greater than those in the patients without hepatitis: 45.5 % (5/11) in the patients without hepatic coma, 14.3 % (1/7) in patients with acute-type liver failure with coma, and 0 % (0/5) in patients with subacute-type liver failure with coma. In contrast, the survival rate in the patients treated by liver transplantation was 62.1 % (18/29). The overall survival rate, including the patients treated by liver transplantation, was 52.7 % (116/220).

Fig. 1 Classification of acute liver failure patients in Japan enrolled in a nationwide survey performed by the Intractable Hepato-Biliary Diseases Study Group in Japan [31]. ALF acute liver failure, LOHF late-onset hepatic failure

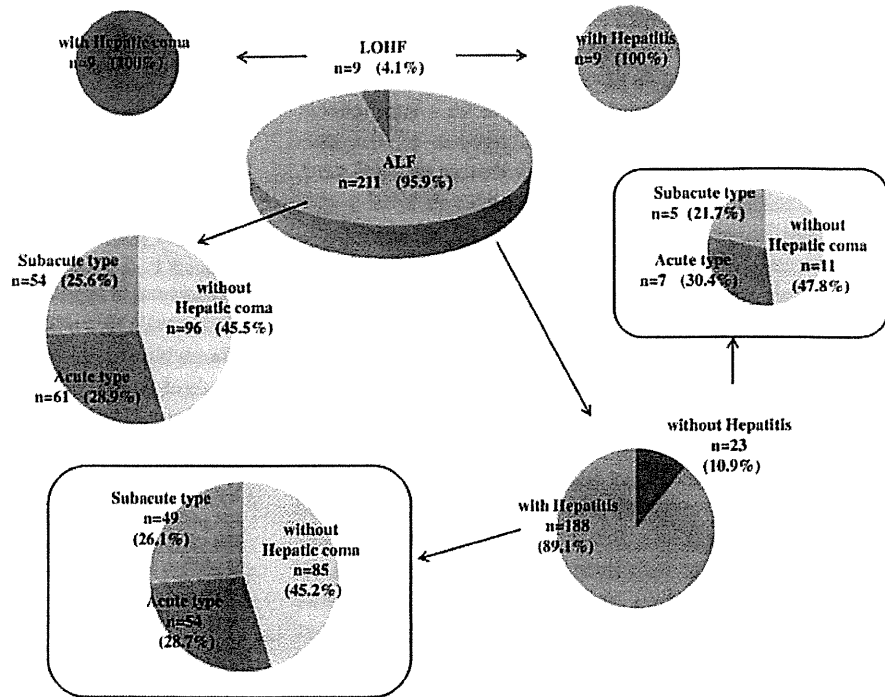
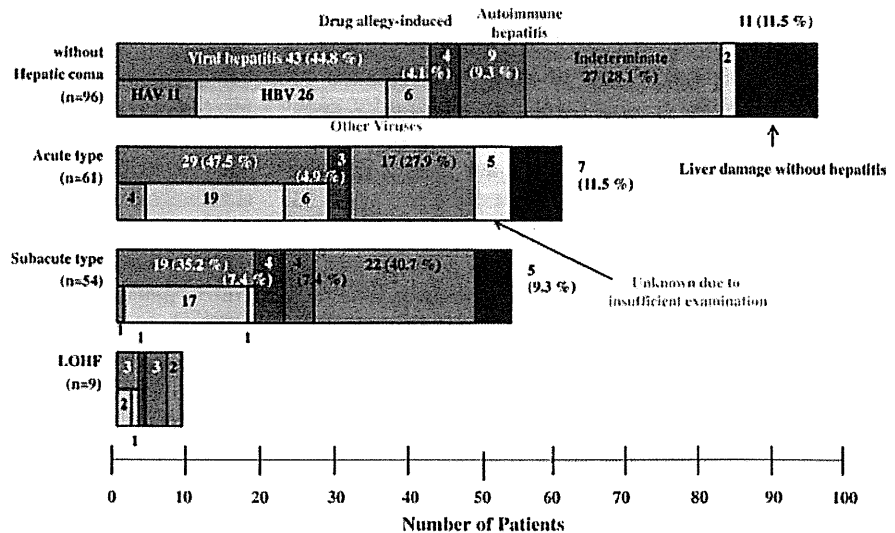


Fig. 2 Etiology of acute liver failure in Japanese patients enrolled in a nationwide survey performed by the Intractable Hepato-Biliary Diseases Study Group in Japan [31]. LOHF late-onset hepatic failure, HAV hepatitis A virus, HBV hepatitis B virus



Outcome prediction models and guideline for liver transplantation in patients with acute liver failure

Among the 220 patients with acute liver failure seen in 2010, 112 patients were diagnosed as having fulminant hepatitis or LOHF with the histological features of hepatitis [31]. The outcomes of these patients were as follows; 20 patients (17.9 %) and 65 patients (58.0 %), respectively, survived and died with medical treatment alone, and 27 patients (24.1 %) underwent liver transplantation. Liver

transplantation is inevitable for the rescue of most patients with acute liver failure, even in Japan, where artificial liver support, including plasma exchange, is provided for almost all patients. Thus, outcome prediction models with high sensitivity and specificity levels were required to determine the indications for liver transplantation.

Liver transplantation has been recognized as the standard therapy for patients with acute liver failure in Europe and the United States since the 1980s [32, 33]. Bismuth et al. [34] reported that liver transplantation should be

considered in patients with grade III or more severe hepatic encephalopathy, with plasma coagulation factor V activity levels of less than 20 % of the standardized values. Also, Emond et al. [35] reported that patients with brain edema due to encephalopathy, with prolongation of the prothrombin time after 24 or 48 h of intensive medical care, were candidates for liver transplantation. A similar outcome prediction model was published by Bernuau et al. [36] through multivariate analysis of the data of 115 patients with fulminant hepatitis due to HBV infection, in which plasma factor V activity levels, status of disappearance of HBs antigen, and the serum α -fetoprotein concentration were selected as independent predictors of survival. Moreover, in 1989, O'Grady et al. [37] published a guideline with selection criteria for liver transplantation in patients with acute liver failure, based on a multivariate analysis of the data of 588 patients seen between 1973 and 1985. In this guideline, the prognosis was estimated differently in patients with liver failure resulting from acetaminophen intoxication and in those with liver failure resulting from viral hepatitis or drug allergy-induced liver injury. In the former category of patients, the prognosis was estimated based on 3 parameters; namely, the arterial blood pH, peak prothrombin time, and the serum creatinine level. In contrast, in the latter category of patients, the prognosis was determined based on 5 parameters; namely, etiology of the disease, age of the patient, duration of jaundice before the onset of hepatic encephalopathy, peak prothrombin time, and the serum bilirubin level. This famous guideline, well known as the King's College Hospital criteria, was widely used around the world to determine the indications for liver transplantation in patients with acute liver failure [38–40]. Also, the usefulness of the model for end-stage liver disease (MELD), which was originally established to evaluate the prognosis of chronic liver failure patients [41], was assessed in comparison with the predictive accuracy of the King's College Hospital criteria in patients with acute liver failure [42–45].

However, the King's College Hospital criteria were found to be of limited usefulness for patients with fulminant hepatitis in Japan [46], and the predictive accuracy of these criteria adopted for patients seen between 1993 and 1995 was found to be only 55 % for the assessment conducted at the onset of hepatic encephalopathy, and 53 % for the assessment conducted on day 5 after the onset of encephalopathy. Thus, a new guideline that could be adopted for patients in Japan was established by Sugihara et al., based on the results of a project undertaken by the Acute Liver Failure Study Group of Japan in 1996 [46]. According to this guideline, the prognosis of patients with fulminant hepatitis is estimated through a two-step procedure (Table 7). First, the estimated prognosis is determined

Table 7 Guideline to determine the indications for liver transplantation for patients with fulminant hepatitis and LOHF (published by the Acute Liver Failure Study Group of Japan in 1996); from references [46, 47]

Patients may be registered as potential recipients of liver transplantation when at least 2 of the following 5 criteria are satisfied at the time of the onset of grade II or more severe hepatic encephalopathy

1. Age ≥ 45 years
2. Interval from the appearance of the initial symptoms to the development of hepatic encephalopathy ≥ 11 days
3. Prothrombin time < 10 % of the standardized value
4. Serum bilirubin concentration ≥ 18.0 mg/dL
5. Ratio of the direct to total bilirubin concentration < 0.67

If liver transplantation cannot be performed within 5 days of the onset of hepatic encephalopathy and intensive medical therapy, including artificial liver support, is undertaken, the prognosis of the patients is evaluated again. If both of the criteria listed below are positive at 5 days after the onset of hepatic encephalopathy, the prognosis is reassessed as "alive" and the patients are excluded from the candidate list for liver transplantation

1. The hepatic encephalopathy shows improvement to grade I or less or attenuation by 2 or more grades
2. Prothrombin time improves to over 50 % of the standardized value

at the onset of hepatic encephalopathy based on 5 parameters, with the parameters associated with a poor prognosis being: (1) age older than 45 years, (2) interval of 11 or more days from the onset of the initial disease symptoms to the development of grade II or more severe hepatic encephalopathy, (3) prothrombin time less than 10 % of the standardized value, (4) serum bilirubin level of 18 mg/dL or more, and (5) ratio of the serum direct to total bilirubin levels of less than 0.67. Patients fulfilling 2 or more of the above criteria, with the estimated prognosis of "death," are enrolled as candidates for liver transplantation. Then, intensive therapy, including artificial liver support, is administered to these patients for 5 days if possible, and those showing improvement of both the prothrombin time and encephalopathy grade are excluded from the list of candidates for liver transplantation, with the estimated prognosis changed to "alive". Such reassessment after intensive treatment for 5 days seemed to improve the prognostic accuracy of the guideline in fulminant hepatitis patients in Japan, where artificial liver support can be undertaken for more than 90 % of the patients [1, 24–29]. According to a prospective study, in which the guideline was adopted for patients seen between 1993 and 1995, the predictive accuracy of the guideline was 76 % for the first assessment and 82 % for the reassessment [46]. On the other hand, when the guideline was adopted for patients seen between 1998 and 2003, the predictive accuracy was even worse; the accuracy values in the patients not receiving liver transplantation were 67 and 78 % among

Table 8 Scoring system to predict the mortality of patients with fulminant hepatitis and LOHF established by the Intractable Hepato-Biliary Diseases Study Group in Japan in 2010; from reference [48]

Score	0	1	2
O-C (days)	≤5	6–10	11≤
PT (%)	20<	5<, ≤20	≤5
TB (mg/dL)	<10	10≤, <15	15≤
D/T ratio	0.7≤	0.5≤, <0.7	<0.5
PLT (10 ⁴ /μL)	10<	5<, ≤10	≤5
Liver atrophy	Absent	Present	

PT prothrombin time, TB total bilirubin, D/T ratio ratio of direct to total bilirubin concentration, PLT platelets, O-C the interval between hepatitis onset and hepatic encephalopathy development

those with acute and subacute types of fulminant hepatitis, respectively, and the specificity of the guideline was extremely low, especially in patients with the subacute type of fulminant hepatitis [47]. Thus, the guideline to determine the indications for liver transplantation in acute liver failure patients in Japan needs to be updated.

Accordingly, the task force of the Intractable Hepato-Biliary Diseases Study Group established a novel scoring system for predicting the outcomes of patients with fulminant hepatitis and LOHF in 2011, through analysis of the data of 1,096 patients enrolled in a nationwide survey [48]. In this system, 6 parameters were identified and graded as 0, 1, or 2; the parameters were: the interval between disease onset and the development of hepatic encephalopathy, prothrombin time, total serum bilirubin concentration, ratio of direct to total bilirubin concentration in the serum, peripheral blood platelet count, and presence/absence of liver atrophy (Table 8). The predicted mortality was greater than 90 % in patients with a total score of 7 or more, with predicted mortalities of 80–90, 70–80, and 50–60 % in those with a total score of 6, 5, and 4, respectively, while the predicted mortality was less than 30 % in those with a total score of 3 or less. When the prognosis of the patients with a total score of 5 or more was judged as “death”, the predictive accuracy was 0.80, with sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) of greater than 0.70 even in the validation cohort [48].

Recently, we performed a cluster analysis of 1,022 patients with fulminant hepatitis and LOHF who were enrolled in a nationwide survey between 1998 and 2007, to evaluate the validity of the classification of acute liver failure in Japan; we used a self-organizing map (SOM), a data mining method that has been shown to be suitable for analyses of complex multidimensional relationships [49]. The results of the analysis revealed that the patients could be classified into three clusters, independent of the interval between the disease symptoms onset and the development

of hepatic encephalopathy, with the clinical outcomes differing markedly among the clusters [49]. This observation prompted us to postulate that data-mining methods may be useful to revise the outcome prediction system, and we established a decision-tree algorithm for prediction of the prognosis of acute liver failure patients [50]. The outcome of the patients at the onset of encephalopathy was predicted based on 5 items: the patients were classified into 6 categories, with mortality rates ranging between 89 and 23 %. The outcome of the patients was also predicted based on 7 items at 5 days after the onset of encephalopathy; the patients were classified into 8 categories with mortality rates ranging between 100 and 11 %. Also, we established outcome prediction models based on other data-mining methods, such as radial basis function (RBF) and back propagation (BP) (unpublished data). The usefulness of these models based on data-mining methods needs to be further investigated.

Conflict of Interest Satoshi Mochida received research grants from Chugai Pharmaceutical Co., Ltd., MSD, and Toray Industries, Inc., and lecture fees from MSD.

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Autoimmune acute liver failure: an emerging etiology for intractable acute liver failure

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Abstract Diagnosis of acute onset autoimmune hepatitis (AIH) is the most challenging task because of atypical clinicopathological features. We examined the nature of acute onset AIH consisting of nonsevere, severe, and fulminant AIH based on our published data and other published papers, and propose how to diagnose and treat this intractable hepatitis. We analyzed clinical, biochemical, immunological, radiological, and histological features of acute onset AIH. Thirty percent of fulminant hepatitis was due to AIH and autoimmune acute liver failure (ALF) was not rare. The important characteristic of acute onset AIH is its histological, radiological, and clinical heterogeneity. Sometimes acute onset AIH develops into ALF in a subacute clinical course without appropriate diagnosis and treatment, and becomes resistant to immunosuppressive therapy and has poor prognosis. Unenhanced computed tomography (CT) often shows heterogeneous hypoattenuation in autoimmune ALF. The revised original scoring system (1999) performed better in patients with acute onset AIH than the simplified scoring system (2008). Liver regeneration from periportal progenitor cells to mature hepatocytes was impaired in ALF, resulting in resistance to immunosuppressive therapy. Precise histological evaluation (the presence of centrilobular necrosis/collapse) along with the revised original scoring system and CT findings of heterogeneous hypoattenuation after systematic exclusion of other causes plays an important role in the diagnosis. The most important strategy for autoimmune ALF is to

diagnose and treat acute onset AIH before its development into ALF. Liver transplantation should be considered before the occurrence of infectious complications in the case of fulminant liver failure.

Keywords Autoimmune hepatitis · Severe hepatitis · Fulminant hepatitis · Acute liver failure · CT · Heterogeneity · Liver regeneration · Cytokeratin 7

Introduction

Acute liver failure (ALF) is a challenging clinical syndrome with multiple causes, characterized by the sudden loss of hepatic function in a person without preceding chronic liver disease. In the past Japanese surveys of ALF, a specific etiology could not be identified in 30–40 % of adult patients [1]. There are no specific therapies of proven benefit except for emergency liver transplantation. ALF is a worldwide problem despite its rare incidence because of its extremely high mortality. Especially, many patients with hepatitis B virus (HBV) carrier, autoimmune hepatitis (AIH), and unknown causes presented with a subacute clinical course, and their survival rates without liver transplantation were low, less than 20 % if they appeared with fulminant liver failure [1]; this is recognized everywhere around the world as well as in Japan [2–6]. Thus, the outcome of ALF is influenced by its etiology, making etiological consideration of ALF particularly important.

AIH is generally regarded as clinically and histologically “chronic” hepatitis, characterized by the presence of autoantibodies, hypergammaglobulinemia, and interface hepatitis and plasma cell infiltration found on histological examination [7, 8]. After the establishment of the criteria by the International AIH Group [9], the diagnosis of

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patients with AIH, autoimmune ALF, and also the recognition of acute onset AIH were made possible by the scoring system [10–12].

An acute presentation of AIH is common [10, 11], and severe or fulminant hepatitis (FH) is possible [12–14]. According to a recent Japanese nationwide survey, the number of patients with AIH showing the histological features of acute hepatitis has been increasing [15], and AIH phenotype presenting with acute hepatitis and ALF was proposed by the Autoimmune Hepatitis Study Group of Japan [16].

Early diagnosis is the most important aspect for the improvement of poor prognosis of fulminant AIH. But acute onset AIH sometimes does not show typical clinicopathological features and is difficult to diagnose [17]. Although the clinicopathological features of acute onset AIH have to be elucidated, a major problem is that there is no gold standard for making the diagnosis of acute onset AIH.

In this review, we describe the nature of acute onset AIH consisting of nonsevere acute, severe, and fulminant AIH, and propose how to diagnose and treat acute onset AIH including autoimmune ALF.

Trend of autoimmune ALF

The etiology of ALF has changed over time worldwide. Until 1995, the common causes were viral infection and non-acetaminophen drug-induced or toxin-induced liver failure in the USA and European countries, but after 1996, the etiology became acetaminophen overdose, unknown causes, and non-acetaminophen drug-induced failures; AIH has been thought to be a rare cause of ALF [3, 18, 19].

The etiology of FH was classified into the following categories: viral infection, AIH, drug allergy-induced liver injury and unknown (etiology unknown despite sufficient examinations available) according to the Japanese criteria according to the Intractable Liver Diseases Study Group of Japan, Ministry of Health, Welfare and Labor, 2003 [1]. Patients with HBV infection were further classified into two subgroups: acquired HBV infection and acute exacerbation of HBV carriers.

In a Japanese nationwide survey on patients with FH between 1998 and 2003, the etiology was viral infections in 48.0 % [hepatitis A virus (HAV) in 6.4 %, HBV in 38.8 % and other viruses in 2.7 %], drug allergy-induced infections in 9.3 %, AIH in 6.9 %, unknown causes in 32.8 %, and indeterminate causes in 3.0 % [1]. A specific etiology could not be identified in 30–40 % of adult patients in the past Japanese surveys.

In our patients, between 1990 and 1999 and before the establishment of the criteria of AIH by the International

AIH Group [9], the etiology of FH was viral infections in 55.6 % [HAV in 9.3 %, HBV in 44.5 %, and hepatitis E virus (HEV) in 1.9 %], AIH in 5.6 %, drug allergy-induced infections in 13.0 %, and unknown causes in 25.9 %. In patients, between 2000 and 2009, after the establishment of the AIH criteria, the etiology was viral infections in 46.4 % (HAV in 4.9 % and HBV in 41.5 %), AIH in 29.3 %, drug allergy-induced infection in 12.2 %, and unknown causes in 12.2 %. The number of patients with AIH increased significantly between 2000 and 2009 compared to the rate between 1990 and 1999 ($p = 0.002$). Differences in the numbers of HAV, HBV acquired, HBV carrier, and drug allergy-induced infections were not significant between the two periods. The number of unknown causes showed a decreasing trend, but the difference was not significant ($p = 0.08$) [20].

Recently, the Acute Liver Failure Study Group of the United States reported that 58 % of the 72 indeterminate ALF cases were considered probable for autoimmune ALF by blinded histological analysis [21], which is consistent with our experience [22].

The prognosis of ALF is influenced by its etiology. In the USA, acetaminophen overdose, HAV infection, ischemic liver injury, and pregnancy-related ALF had good spontaneous outcomes without liver transplantation in over 50 % of short-time survival [2, 14]. In contrast, unknown cause, non-acetaminophen drug-induced infection, HBV infection, AIH, and Wilson's disease had poor spontaneous outcomes of less than 25 % of short-time survival without liver transplantation. Mortality of FH in Japan is extremely high without emergency liver transplantation. Only 20 % of eligible patients undergo transplantation because of a shortage of donor livers, although the rate is gradually increasing [1].

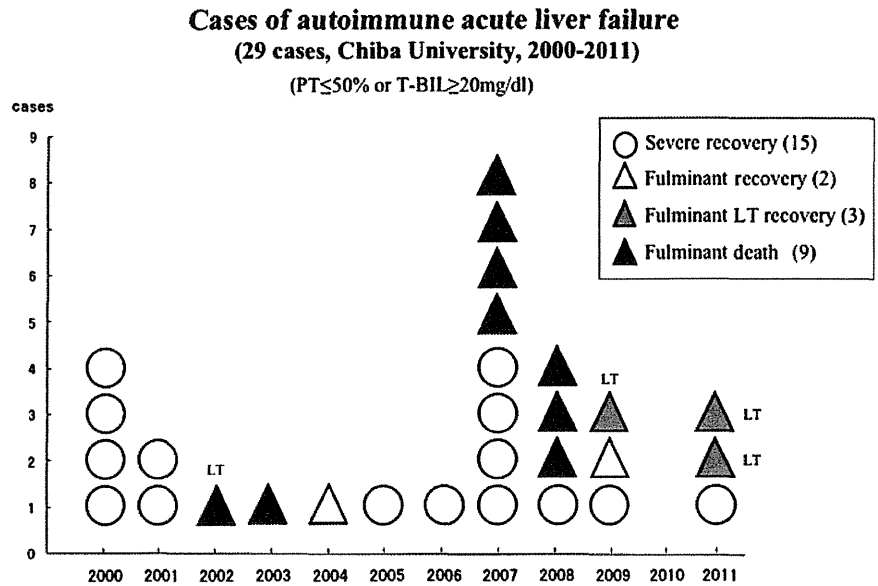
In Japan, the outcome of FH differed depending on not only disease etiology but also disease type. It was excellent in patients with HAV infection and poor in HBV carriers with acute exacerbation, AIH patients, and unknown-cause patients. Many HBV carriers, AIH patients, and unknown-cause patients presented the subacute type of FH, and their survival rate without liver transplantation was less than 20 % [1].

Figure 1 shows 29 cases of autoimmune ALF in our unit between 2000 and 2011. Fifteen were severe hepatitis (SH) and 14 FH. All of SH and two of FH cases survived without liver transplantation, three survived with liver transplantation, and eight died without liver transplantation because of liver failure. One received liver transplantation and died.

Clinical, biochemical, and immunological features of acute onset AIH

The diagnosis of autoimmune ALF was made after the establishment of the International AIH Criteria [9] and the

Fig. 1 Cases of autoimmune acute liver failure in our unit during 2000–2011. *LT* Liver transplantation



recognition of acute onset AIH with acute clinical presentation [10]. Nevertheless, the diagnosis is still difficult because some patients have no autoantibodies and/or no hypergammaglobulinemia, and at present they are being diagnosed as cryptogenic hepatitis.

We examined clinical, biochemical, and immunological features of 71 acute onset AIH patients between 2000 and 2011, consisting of 43 non-SH, 15 SH, and 13 FH cases. This study was carried out in accordance with the Code of Ethics of the World Medical Association (Declaration of Helsinki). Informed consent was obtained from all patients or appropriate family members.

A diagnosis of AIH was made based on the criteria of the International AIH Group defining the score for probable or definite AIH [9], and/or on liver histological findings compatible with AIH, consisting of interface hepatitis, centrilobular necrosis, and plasma cell infiltration. Eligibility criteria of clinically “acute onset” AIH, in addition to the AIH criteria described above, were as follows: (1) acute onset liver injury; (2) no histories of chronic liver injury; (3) negativity of active viral markers such as hepatitis A, B, C, and E viruses, Epstein–Barr virus (EBV), cytomegalovirus (CMV) and herpes simplex virus (HSV), drug-induced liver injury, and toxic and metabolic disorders; and (4) no signs of chronicity on the basis of physical examination, laboratory data, and abdominal ultrasound findings. Eligibility criteria of severe and fulminant AIH (autoimmune ALF), in addition to the criteria described above, were as follows: patients with the prothrombin time (PT) activity less than 50 % of control [or International Normalized Ratio (INR) ≥ 1.5] or total bilirubin (T-BIL) level more than 20 mg/dl during the disease course were defined as SH, and patients with the PT activity less than 40 % of control and hepatic encephalopathy were defined as FH.

The clinical and biochemical features of all patients at admission are provided in Table 1. The PT activity and T-BIL level were statistically different among nonsevere, severe, and fulminant patients, and immunoglobulin G (IgG) level and revised original AIH score before treatment were different between nonsevere and fulminant patients. Sex, mean age, alanine aminotransferase (ALT) level, antinuclear antibody (ANA) titer, and simplified AIH score before treatment were not different among the three groups. The mean duration from onset to admission to our unit was more than 40 days and also not different among the three groups [22].

In our experience, most acute onset AIH patients have conserved PT activities at clinical onset and high levels of continuous liver injury for more than a few weeks, after which they gradually develop ALF in “subacute” clinical courses [22]. Therefore, acute type of FH is rare in AIH.

The distribution of IgG level is shown in Fig. 2. The IgG level was normal [$<1.0 \times$ upper normal value, (UNV)] in 30 %, $1.0\text{--}1.5 \times$ UNV in 46 %, $1.5\text{--}2.0 \times$ UNV in 14 %, and $>2.0 \times$ UNV in 10 %. The distribution of the ANA titer is shown in Fig. 3. ANA was positive ($\geq 1:40$) in 92 %, $<1:40$ in 8 %, 1:40 in 14 %, 1:80 in 30 %, and $>1:80$ in 48 %. None of the patients was positive for liver kidney microsomal antibody-1. We could not examine antisoluble liver antigens because the examination of anti-SLA was not covered by the Japanese National Health Insurance.

It was reported that severe and fulminant patients had higher titers of ANA and higher levels of IgG than nonsevere patients because the time period from the onset of symptoms to the diagnosis of severe and FH was longer than that of nonsevere hepatitis [23, 24]. Our fulminant patients also had higher titers of ANA ($p = 0.03$) and higher levels of IgG ($p < 0.01$) than nonsevere patients, but

Table 1 Clinical features of patients

	Nonsevere	Severe	Fulminant
<i>n</i>	43	15	13
Sex (M/F) ^a	9/34	4/11	4/9
Age (years) ^a	53.9 ± 14.5	49.3 ± 14.1	55.2 ± 15.2
PT (%) ^b	87 ± 16	45 ± 9	24 ± 9
ALT (IU/l) ^a	686 ± 446	597 ± 515	590 ± 599
T-BIL (mg/dl) ^c	3.6 ± 3.7	13.2 ± 8.1	20.8 ± 7.8
ANA > 40 (fold) ^a	37	11	12
IgG (mg/dl) ^d	1,985 ± 654	2,389 ± 1,369	2,588 ± 888
Revised original score before treatment ^e	13.9 ± 3.5	14.6 ± 3.0	16.2 ± 3.2
Simplified score before treatment ^a	4.7 ± 1.6	4.5 ± 1.6	5.2 ± 1.4

Values are mean ± SD or number

^a No statistical significance among the three groups

^b Significant difference ($p < 0.001$) between nonsevere and severe by Welch's *t* test, between nonsevere and fulminant by Welch's *t* test, between severe and fulminant by Student's *t* test

^c Significant difference between nonsevere and severe by Welch's *t* test ($p < 0.001$), between nonsevere and fulminant by Welch's *t* test ($p < 0.001$), between severe and fulminant by Student's *t* test ($p = 0.018$)

^d Significant difference between nonsevere and fulminant by Student's *t* test ($p < 0.01$)

^e Significant difference between nonsevere and fulminant by Student's *t* test ($p < 0.05$)

we observed that the duration from onset to admission to our unit was not different among nonsevere, severe, and fulminant patients. We speculate that this shows the heterogeneous nature of the progression of AIH, and that the ANA titer and IgG level do not depend on the time duration but rather on the disease severity, based on our histological observation [22].

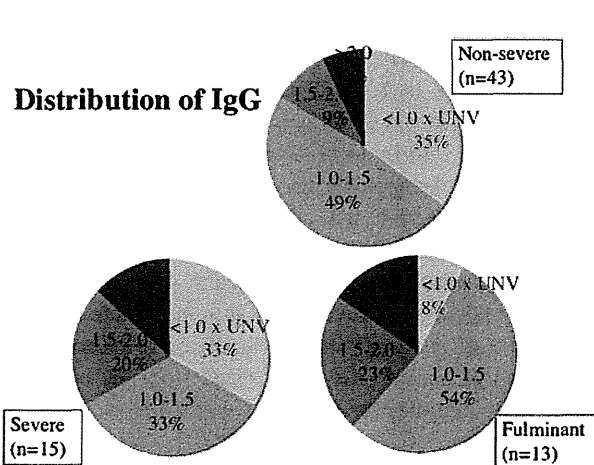


Fig. 2 Distribution of IgG levels in acute onset AIH patients

Histological features of acute onset AIH

There are no morphological features that are pathognomonic of AIH, but the characteristic histological picture is that of interface hepatitis with predominantly lymphoplasmacytic necroinflammatory infiltrates, with or without lobular involvement and bridging necrosis, often with the formation of liver cell rosettes [9]. Acute onset AIH shows centrilobular necrosis/collapse at the early stage of illness, an atypical histological pattern of AIH (Fig. 4) [10, 20, 21, 24–35].

The pathological characteristics of the patients are summarized in Fig. 5. Histological examination was performed in 62 of 71 patients, with 60 % of them showing acute hepatitis, exhibiting zonal, submassive, and massive necrosis with or without plasma cell accumulation in portal and centrilobular areas. Forty percent of the patients showed chronic hepatitis. The proportion of the acute form increased with disease severity ($p = 0.02$).

Burgart et al. [36] reported that only 4 % of recent onset AIH patients showed lobular hepatitis without portal inflammation, concluding that most patients with recent onset AIH had histological evidence of chronic hepatitis. After 2000, histologically acute AIH has been reported, and the presence of acute AIH has been recognized. Ninety percent of our fulminant patients showed acute presentation histologically (Fig. 5) [37]. Recently, Stravitz et al. reported that histological features of autoimmune ALF were the centrilobular changes in the study of indeterminate ALF patients by blinded histological analysis of the Acute Liver Failure Study Group of the United States [21]. Their histological features were consistent with our results as well as the percentage of AIH in unknown/indeterminate ALF described above.

The mean duration from the onset to histological examination was more than 70 days and not different

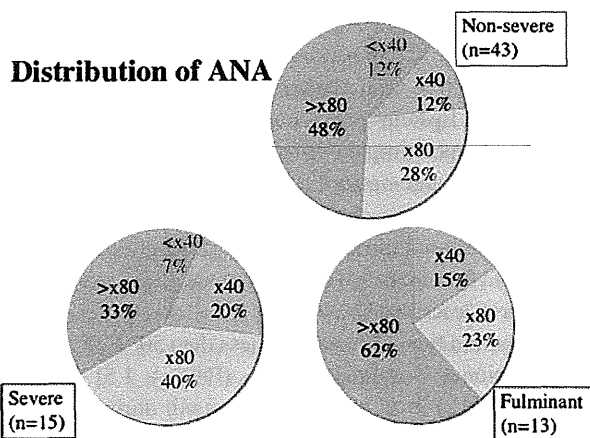


Fig. 3 Distribution of antinuclear antibody titers in acute onset AIH patients

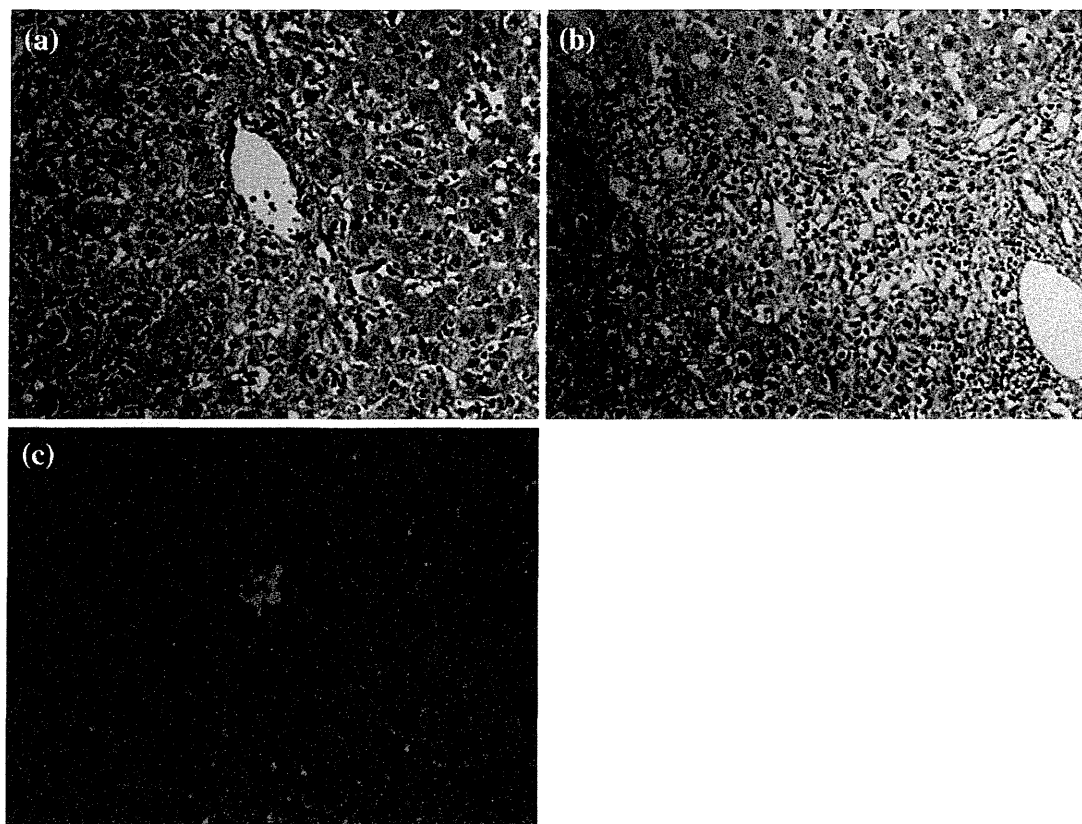


Fig. 4 Liver histology of patients with acute onset AIH. **a** Plasma cell infiltration seen in the perivenular necrosis in nonsevere hepatitis. **b** Centrilobular necrosis/collapse with plasma cell infiltration

observed in nonsevere hepatitis. **c** Massive hemorrhagic necrosis with plasma cell infiltration observed in fulminant hepatitis

among histological features (chronic hepatitis, severe acute hepatitis, and massive/submassive necrosis) [22]. This shows the heterogeneous nature of the histological progression of AIH, and the disease severity depends on the advanced histology rather than on the time duration.

AIH scoring system by the International AIH Group

Diagnostic criteria for AIH based on the clinicopathological features were created by International AIH Group in 1993 [38] and revised in 1999 [9], and were widely accepted and incorporated into clinical practice, although they were intended purely for scientific purposes (Table 2).

The revised original criteria from 1999 provided clinical guidelines for the diagnosis of AIH, but they were complex. To resolve these difficulties, a simplified scoring system for routine clinical practice was proposed in 2008 [39]. The simplified criteria include the titer of autoantibodies, level of IgG, liver histology and the absence of viral hepatitis as variables (Table 3).

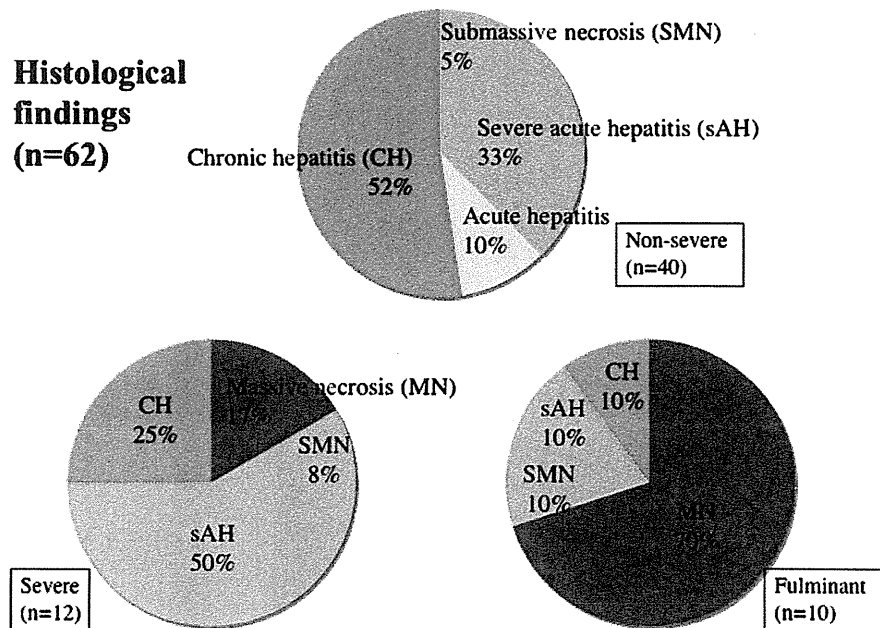
Czaja reported that the revised original system is useful for diagnosing patients with atypical features of AIH and

that the simplified scoring system has superior specificity and predictability and can exclude diagnosis in diseases with concurrent immune manifestations, concluding that each system can support but not supersede the clinical diagnosis [40]. Yeoman et al. [41] reported that the simplified criteria retain high specificity but exhibit lower sensitivity and that only 24 % of fulminant AIH patients were diagnosed based on the simplified criteria, but 40 % on the revised original criteria.

In the revised original criteria, the AIH score ranged from 7 to 22 before treatment in our acute onset AIH patients. Twenty-nine (41 %) of 71 patients were diagnosed as “definite” AIH (score >15), 36 (51 %) as “probable” (score 10–15), and 6 (8 %) as “nondiagnostic” (score <10). Six nondiagnostic patients were all nonsevere (Fig. 6). The mean score was 13.9 ± 3.5 (7–20) in nonsevere, 14.6 ± 3.0 (10–22) in severe, and 16.2 ± 3.2 (11–20) in fulminant patients.

In the simplified criteria, the AIH score ranged from 2 to 7 before treatment. Ten (14 %) of 71 patients were diagnosed as “definite” AIH (score ≥ 7), 20 (28 %) as “probable” (score ≥ 6) and 41 (58 %) as “nondiagnostic” (score <6; Fig. 7) [37].

Fig. 5 Pathological characteristics of acute onset AIH patients



The mean score was 4.8 ± 1.7 (2–7) in nonsevere, 4.5 ± 1.6 (2–7) in severe, and 5.2 ± 1.4 [2–7] in fulminant.

In our acute onset AIH patients, 92 % were diagnostic using the revised original criteria, but only 42 % were diagnostic by the simplified criteria. In acute onset AIH patients, especially in nonsevere ones, the titer of autoantibodies and level of IgG were low, and liver histology often showed acute hepatitis showing centrilobular necrosis/collapse, with the total points becoming lower as a result. The revised original scoring system (1999) performed better in patients with acute onset AIH than the simplified scoring system (2008) [37].

Heterogeneity and radiological findings of autoimmune ALF

One of the pathological characteristics of acute onset AIH is its histological heterogeneity, especially in severe and fulminant AIH (autoimmune ALF). Histological heterogeneity leads to the radiological and clinical heterogeneity.

Computed tomography (CT) is one of the best imaging modalities for evaluating ALF. At an early stage of ALF, CT depicts a reduced size but nondeformed liver, associated with diffuse, localized, or heterogeneous hypoattenuation and localized or map-like hyperattenuation as well as dilatation of the portal vein, splenomegaly, and ascites. Hypoattenuation corresponds to massive hepatic necrosis and hyperattenuation reflects preserved parenchyma at an early phase and regeneration at a late phase [42].

In the present study, too, an area of hypoattenuation found on unenhanced CT has been associated with massive

necrosis of hepatocytes [43]. We identified an area of hypoattenuation on CT when liver attenuation was less than spleen attenuation on unenhanced scans. Fatty liver was ruled out by ultrasound; an area of hypoattenuation on CT was detected as a hypoechoic area on ultrasound. If an area of hypoattenuation was present, it was assessed as diffuse or heterogeneous (Figs. 8, 9). Our analysis revealed that autoimmune ALF showed heterogeneous hypoattenuating areas and viral one showed diffuse ones with significance (Table 4). Thus, heterogeneous hypoattenuation on unenhanced CT was a characteristic CT imaging feature of autoimmune ALF compared with the viral one [44]. This finding could be one of the tools for diagnosing autoimmune ALF in combination with clinicopathological features.

CT would be useful especially in patients in whom histological examinations cannot be performed because of coagulopathy and ascites. Furthermore, serial CT examinations depict changes in hypoattenuations and hyperattenuations, and we can evaluate the degree of liver regeneration and treatment response [44].

Liver regeneration in acute onset AIH

In the normal liver, mature hepatocytes proliferate and reconstitute the liver mass for the replacement of necrotic and apoptotic hepatocytes within the lobules in the primary proliferative pathway. This pathway is impaired easily by a variety of insults, leading to the activation of a secondary proliferative pathway of hepatic progenitor cells (PCs). They are bipotential cells that reside primarily in the periportal area and become the source of regenerating

Table 2 Revised original scoring system by the International AIH Group [9]

Parameters/features	Score
Female sex	+2
ALP/AST/ALT	
<1.5	+2
1.5–3.0	0
>3.0	–2
Serum IgG above normal	
>2.0	+3
1.5–2.0	+2
1.0–1.5	+1
<1.0	0
ANA, SMA or LKM-1	
>1:80	+3
1:80	+2
1:40	+1
<1:40	0
AMA positive	–4
Hepatitis viral markers	
Positive	–3
Negative	+3
Drug history	
Positive	–4
Negative	+1
Average alcohol intake	
<25 g/day	+2
>60 g/day	–2
Liver histology	
Interface hepatitis	+3
Predominantly lymphoplasmacytic infiltration	+1
Resetting of liver cells	+1
None of the above	–5
Biliary changes	–3
Other changes	–3
Other autoimmune diseases	+2
Optional additional parameters	
Seropositivity for other defined autoantibodies	+2
HLA, DR3 or DR4	+1
Response to therapy	
Complete	+2
Relapse	+3
Interpretation of aggregate scores	
Pre-treatment	>15: Definite AIH 10–15: Probable AIH
Post-treatment	>17: Definite AIH 12–17: Probable AIH

Table 3 Simplified scoring system by the International AIH Group [39]

Variables	Cutoff	Points
ANA or ASMA	≥1:40	1
ANA or ASMA or LKM-1 or SLA	≥1:80	2
	≥1:40	2
	Positive	2
IgG	>Upper normal limit	1
	>1.10 times upper normal limit	2
Liver histology (evidence of hepatitis is a necessary condition)	Compatible with AIH	1
	Typical AIH	2
Absence of viral hepatitis	Yes	2
Interpretation of aggregate scores		
≥6: Probable AIH		
≥7: Definite AIH		

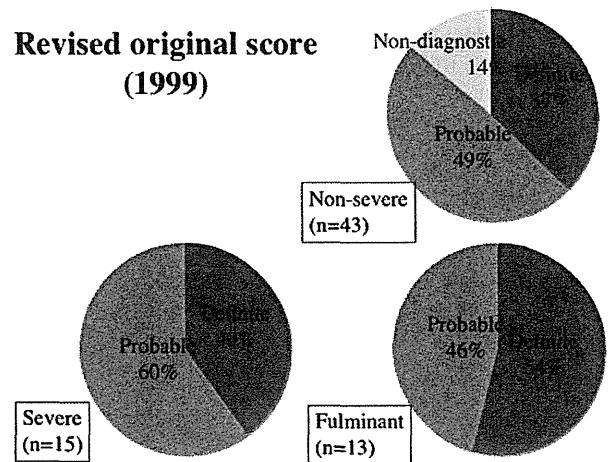


Fig. 6 Discrimination of acute onset AIH patients using the revised original scoring system

hepatocytes, as well as cholangiocytes and draining ductules. A byproduct of the activation of this secondary proliferative pathway is the so-called ductular reaction (DR) [45]. But histological liver cell regeneration from massive/submassive necrosis as a result of severe and fulminant AIH has not been examined in detail.

The state of liver regeneration, DR, is observed by cytokeratin 7 (CK7) immunostaining (Fig. 10). Isolated small PCs, intermediate hepatocytes, and bile ductular reactions could be stained with CK7, and they could be distinguished by their morphologic characteristics. The

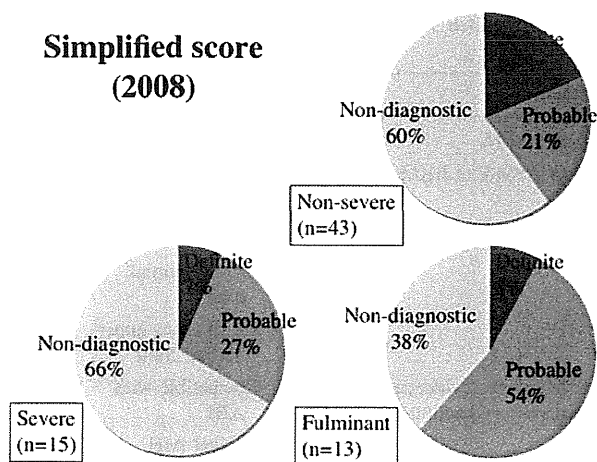


Fig. 7 Discrimination of acute onset AIH patients using the simplified scoring system

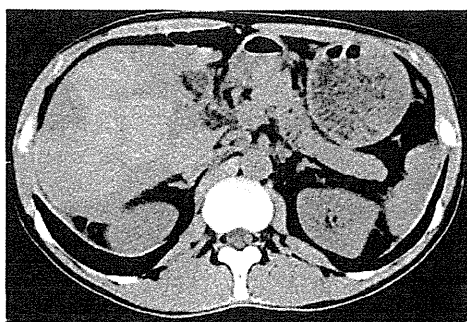
pattern of CK19 staining showed a lower intensity with fewer visualized cells than those of CK7, and CK19 was positive in transitional cells in the bile ductular lineage and bile duct cells and negative in progenitor cells, transitional cells in hepatocytic lineage, and hepatocytes; therefore, CK7 is superior to CK19, as a marker of liver regeneration.

Bile ductular reactions consist of bile ductules with poorly defined lumina located at the portal parenchymal interface, arranged in anastomosing cords, and lined with small cells with little cytoplasm, and show strong homogeneous cytoplasmic and membranous CK7-staining patterns. PCs are isolated small cells and show a strong homogeneous cytoplasmic and membranous staining pattern located distal to the bile ductular reactions and occasionally in the sinusoids. Intermediate hepatocytes are defined as cells intermediate in size with histochemical staining between progenitor cells and hepatocytes, and show a variable cytoplasmic and membranous staining pattern in the periportal areas and occasionally with extension into the lobular areas [46].

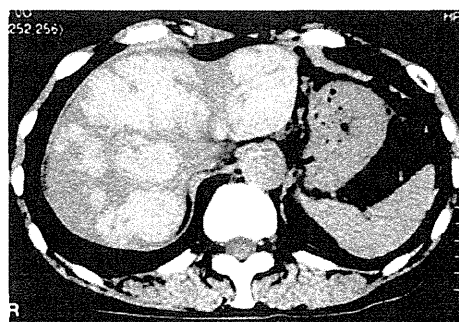
In our analyses of acute onset AIH patients by CK7 staining, more intermediate hepatocytes and intralobular PCs were found in nonsevere and recovered AIH patients, suggesting that liver regeneration was not impaired in these patients. On the other hand, the marked formation of bile ductules was found in periportal areas, but intermediate hepatocytes and PCs were not seen in fulminant and dead cases, suggesting that liver regeneration was impaired [47]. We suggest that the differentiation from periportal PC to intermediate and mature hepatocytes is maintained in

Heterogeneous hypoattenuation

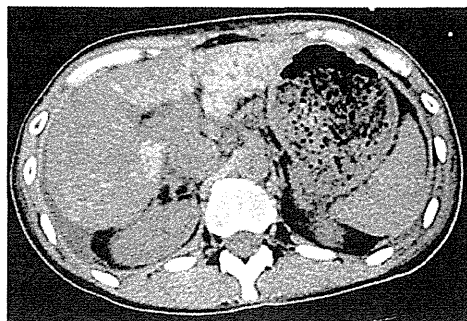
Non-severe



Severe



Fulminant



Fulminant

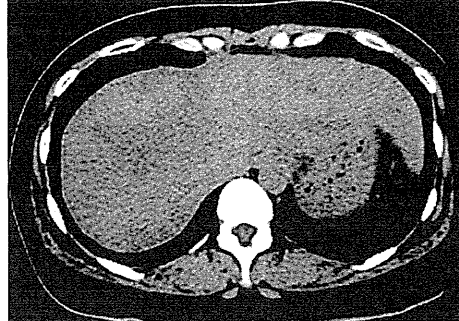


Fig. 8 Heterogeneous hypoattenuation pattern on unenhanced CT in acute onset AIH. Patients with autoimmune ALF often show a variety of heterogeneous hypoattenuation