| SrID | Question | Answers |
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| 1 | What is the role of corticosteroids in AIH with 1) Compensated Cirrhosis 2) Decompensated Cirrhosis | In cirrhosis with active inflammation on liver biopsy, steroids helps in clinical and histological improvement (DOI: 10.1016/j.jhep.2004.01.009). All the decompensated cirrhosis cases are to be worked up and put on transplantation list. If there is no transplant option available, steroids in selected decompensated cirrhosis patients can help (doi.org/10.1007/s12016-016-8583-2). https://www.youtube.com/watch?v=JEW9qaYRTpw answered at 1hr 12min time frame. |
| 2 | Any Biologics studied in AIH which isris not responding to Conventional therapy? | There are case series with infliximab and rituximab as salvage therapy in steroid non-responding AIH. Can be tried in refractory cases |
| 3 | 1) is liver biopsy always must for diagnosis, as sometime patient fulfill other criteria like high IGG, positive autoimmune markers in high titres and negative for viral serologies and they don't agree for liver biopsy ? | Liver biopsy is considered a prerequisite for the diagnosis of AIH. In the either of scoring systems, histology is mandatory for diagnosis. Biopsy can also help to identify additional pathologies like steatohepatitis and overlap features. If clinical suspicion is high and patient don’t agree for biopsy, you can discuss the option of steroids and response to steroids can be additional diagnostic feature of AIH. |
| 4 | If simplified scoring system score 7, can we start steroid +/- AZA or biopsy is must prior to steroid initiation? | Without biopsy, max score possible can be only 6 (probable AIH). Liver biopsy is considered a prerequisite for the diagnosis of AIH. In the either of scoring systems, histology is mandatory for diagnosis. Biopsy can also help to identify additional pathologies like steatohepatitis and overlap features. If clinical suspicion is high and patient don’t agree for biopsy, you can discuss the option of steroids and response to steroids can be additional diagnostic feature of AIH. |
| 5 | Is liver biopsy mandatory for diagnosis | Liver biopsy is considered a prerequisite for the diagnosis of AIH. In the either of scoring systems, histology is mandatory for diagnosis. Biopsy can also help to identify additional pathologies like steatohepatitis and overlap features. |
| 6 | when can treatment be stopped | In view of risk of relapse, most experts would recommend treatment for life-long. If one wants to stop, treatment should be continued for at least three years and for at least 24 months after complete normalisation of serum transaminases and IgG levels (biochemical remission). For patients with higher risk of relapse like patients with severe initial presentation and low tolerance of induction treatment, performance of a liver biopsy prior to treatment withdrawal is advisable. |

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| 7 | Pt evaluated for menorrhagia....lft done as routine work up....sgot sgpt 20 times, rest normal...no liver related symptoms. Pt denied liver biopsy. Probable autoimmune hepatitis on simplified score. What to do next? | The situation has to be worked as syndrome of “acute hepatitis” and worked up for all possible etiologies. If patient is asymptomatic for hepatitis and there is complete resolution of ALT/AST – you can monitor the case. During follow up, if clinical suspicion is high with positive AIH immunological markers and patient don’t agree for biopsy, you can discuss the option of steroids and response to steroids can be additional diagnostic feature of AIH only with written informed consent from patient. |
| 8 | Role of immunosupressants in decompensated AIH | In cirrhosis with active inflammation on liver biopsy, steroids helps in clinical and histological improvement (DOI: 10.1016/j.jhep.2004.01.009). All the decompensated cirrhosis cases are to be worked up and put on transplantation list. If there is no transplant option available, steroids in selected decompensated cirrhosis patients can help (doi.org/10.1007/s12016-016-8583-2). https://www.youtube.com/watch?v=JEW9qaYRTpw answered at 1hr 12min time frame. |
| 9 | management of autoimmune hepatitis coexisting with wilson disease Case scenario: 16 year old female with ALF, LFT- BIL-8.5/4, OT/PT-500/428, ALP-64, INR- 2.1 ANA- 2+, IgG total- 6000, Anti Ro and LC1 positive Ceruloplasmin-11, KF ring present, 24 hour urinary copper-98, USS abdomen- coaresened echotexture Not affording liver transplantation, how to proceed? | Manage both simultaneoulsy. Plasma-exchange has been shown to be of use in Wilsons. |
| 10 | Recurrence of autoimmune hepatitis post liver transplantation | Recurrent and ‘‘de novo’’ AIH may occur years after grafting and must be distinguished from acute rejection, chronic rejection, viral infection, and drug toxicity. Treatment of AIH following liver transplantation (recurrent or de novo) should follow the standard management principles of AIH. |
| 11 | If Patient of SLE have transaminitis, whether it will be regarded as autoimmune hepatitis | https://www.youtube.com/watch?v=JEW9qaYRTpw answered at 25min time frame. |
| 12 | Autoimmune hepatitis and pediatrics population..any difference in approach | In children with suspected AIH, look for overlap autoimmune sclerosing cholangitis. Children with AIH require higher doses of steroid (1-2 mg/kg BW) at initiation of therapy. Budesonide is less effective than prednisolone. The principles of management of AIH in children are otherwise similar as in adults. https://www.youtube.com/watch?v=JEW9qaYRTpw discussed at 51 min time frame. |

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| 13 | Autoimmune hepatitis and pregnancy | Controlled AIH is neither a contraindication to pregnancy nor to breastfeeding. Mild flares can occur in the first trimester and in particular after delivery and may require transient increase in immunosuppression. MMF is contraindicated. https://www.youtube.com/watch?v=JEW9qaYRTpw discussed at 52 min time frame. |
| 14 | Should Autoimmune markers should be tested in all patients of transaminitis,associated with other liver disease like HBV infection | Aza can be continued in pregnancy. It is unclear if Aza is absolutely safe in breast-feeding. |
| 15 | Is liver biopsy gold standard for autoimmune hepatitis.. | Liver biopsy is considered a prerequisite for the diagnosis of AIH. None of the individual histological findings is specific for AIH, but the presence of all three findings of interface hepatitis with portal lymphocytic or lymphoplasmacytic cells extending into the lobule, emperipolesis, and rosettes are considered typical of AIH. |
| 16 | Do u suggest doing igg4 and antitTG IgA in all patients with suspected AIH or in specific subset of patients? | AIH patients should be screened for celiac and thyroid diseases at diagnosis (ASLD AIH guidelines 2019). IgG4 screening only in few selected cases with clinical suspicion. |
| 17 | Sir the classification for acute autoimmune hepatitis as mild mod and severe Proposed by Czara et al.. is it validated ? Can we follow It for routines practice in deciding role of steroid vs transplant? | Acute severe AIH requires steroid on urgent basis while for cases with mild disease (which can be defined as HAI <4/18 on biopsy with no fibrosis with ALT < 3xULN), decision on steroids can be individualised |
| 18 | 1st time diagnosed AIH with normal liver enzymes; should we give immunosuppressant? if yes, what is the risk benefit ratio of such Rx ? | · In view of the progressive nature of AIH, all patients with active disease should receive treatment. In patients with mild disease (HAI <4/18 on biopsy with no fibrosis with ALT < 3xULN) or inactive disease, treatment can be individualized based on co-morbidities and patient preference. If no treatment, monitor them. (DOI: 10.1111/j.1478-3231.2008.01904.x) |
| 19 | In history we should always rule out food supplements and alternative medicines | Yes. It helps in evaluation of drug induced hepatitis. |
| 20 | How to interpret igG in cirrhosis patients suspected of AIH? | Selective elevation of IgG levels with normal IgM and immunoglobulin A levels is a hallmark of AIH. Measurement of all these could probably improve the diagnostic ability of IgG further, and in particular to exclude false-positive scores for patients with polyclonal B cell activation attributable to advanced cirrhosis or active inflammatory disease of other causes. Higher IgG elevation increase the probability of diagnosis (reflected in the original revised scoring system for AIH) |
| 21 | In the setting of liver failure can weskip doing liver Bx before starting treatment? | In AIH-ALF, patients benefit most from transplantation in view of poor response and high risk of infection with steroids. If steroids are planned, its preferable to perform a liver biopsy (TJLB) prior to steroids unless there are absolute contraindications. |

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| 22 | An IgG level above Uln is given one point. An elevation of just 1.1 times is two points. Is the measurement of IgG always so consistent and reliable I such a narrow range | In the study the defined simplified diagnostic criteria, median of IgG levels in AIH patients was 1.44 x ULN (controls - 1.02 x ULN). Authors arbitrarily chose 1.1 x ULN and validated the score. The significance of higher IgG elevation was better reflected in the original revised scoring system. |
| 23 | When to suspect seronegative AIH? | When ANA, SMA and LKM1 autoantibodies are negative, seronegative AIH is diagnosed based on liver biopsy (features typical or compatible with AIH) and exclusion of other alternate etiologies. If ANA/SMA/LKM-1 antibodies are negative, testing for additional antibodies like SLA, atypical p-ANCA, LC1 or AMA (if overlap suspected) is helpful. |
| 24 | Should we do Anti-LKM1 initially in adults? | You can do ANA and SMA testing in suspected AIH in adults along with a liver biopsy. LKM-1 add significance in children. |
| 25 | When do u suggest doing anti LC, SLA in all patients of suspected AIH? | If ANA/SMA/LKM-1 antibodies are negative, testing for additional antibodies like SLA, atypical p-ANCA or LC1 is helpful in establishing diagnosis. |
| 26 | When to suspect seronegative AIH? | When ANA, SMA and LKM1 autoantibodies are negative, seronegative AIH is diagnosed based on liver biopsy (features typical or compatible with AIH) and exclusion of other alternate etiologies. If ANA/SMA/LKM-1 antibodies are negative, testing for additional antibodies like SLA, atypical p-ANCA, LC1 or AMA (if overlap suspected) is helpful. |
| 27 | In patients with , cirrhosis or dcld,with suspected AIH ,is it safe or mandatory to perform liver biopsy? | Liver biopsy is considered a prerequisite for the diagnosis of AIH. In case of ascites or coagulopathy, TJLB can be tried. If patient has ESLD and planned for transplant, then etiology can be diagnosed based on explant pathology. |
| 28 | is it possible to have a normal globulin level but have a high IgG? Do we still suspect elevated IgG if the globulin levels are normal? | In AIH, IgG and gamma globulin levels shows a close correlation (HEPATOLOGY 2008;48:169-176). As IgG is part of gamma globulin fraction, IgG elevation causes gamma globulin elevation though vice versa may not be true. Selective elevation of IgG levels with normal IgM and immunoglobulin A levels is a hallmark of AIH. |
| 29 | I have a newly diagnosed probabale AIH case (by simplified AIH score) who is covid positive. When should I do liver biopsy? Steroids have been started as a part of COVID treatment. | https://www.youtube.com/watch?v=JEW9qaYRTpw<br>answered at 1hr 4min time frame. |

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| 30 | Why periportal hepatocytes are primarily affected ? | Definitive reasons are not known.<br>- In general, Acute hepatitis-like inflammation predominantly affects the lobular parenchyma and can be associated with either zonal or non-zonal necrosis. For example, Centrilobular zone 3 necrosis is noted in mainly in patients with an acute onset AIH and probably early form of autoimmune hepatitis.<br>-Portal dominant inflammation with only mild to moderate lobular inflammation is more characteristic of chronic hepatitis-like injury, such as is seen in cases of chronic viral or autoimmune hepatitis. |
| 31 | Does Isolated elevation of IgG in cirrhotic patient significant with deranged LFT with negative liver biopsy for autoimmune ?? | No. Isolated IgG elevation can be due to polyclonal B cell activation attributable to advanced cirrhosis or active inflammatory disease of other causes. |
| 32 | Which serologic marker is important for relapse of AIH after treatment withdrawal? | Monitor with ALT,AST and IgG levels. |
| 33 | Does the lymphocytosis in the parenchyma vs within the fibrotic bands in cirrhosis have different outcome with treatment with steroids | Cirrhosis per se affects the outcome of steroids in AIH. There is no data studying the prognostic value of lymphocytic infiltration in fibrous bands vs lobular inflammation in steroid response although lymphocytic infiltration doesn't discriminate between lobules and fibrous bands. Steroids decrease lymphocytic infiltration in both lobules and fibrous bands. |
| 34 | any role of ANA titer value in diagnosis ? is it advisable to monitor titer for response to Rx? | Higher ANA titers have higher specificity then lower titers in diagnosis. No role of titre in monitoring. |
| 35 | MEANNG OF 1+ 2+ FOR ANTIBODY STRENGTH | They represent the strength of positivity of antibody. Both scoring systems are made with antibody reported in titers (ratios) with IIF method. |
| 36 | how to differentiate from type 1 and type 2 AIH ?? | According to the pattern of autoantibodies detected, a subclassification of the disease into three subtypes was proposed. Initially, two major types. AIH-1 is characterized by the presence of ANA and/or SMA. AIH-2 is characterized by anti-LKM1 or infrequently anti-LKM3 and/or anti-LC1. This was initially based on circulating autoantibodies alone but thereafter other differences have been reported. (AASLD AIH 2019 guidelines) |
| 37 | Please elaborate on management of refractory AIH? | In refractory cases, always ensure the treatment compliance, re-evaluate the diagnosis, review for overlap syndromes and optimization of drug doses. The current choices of second line immunosuppressive therapy include MMF and CNI (cyclosporin or tacrolimus). |
| 38 | is biopsy must before treatment? | Liver biopsy is considered a prerequisite for the diagnosis of AIH. In the either of scoring systems, histology is mandatory for diagnosis. Biopsy can also help to identify additional pathologies like steatohepatitis and overlap features. If clinical suspicion is high and patient don't agree for biopsy, you can discuss the option of steroids and response to steroids can be additional diagnostic feature of AIH. |

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| 39 | 1. IS THERE A CUT OFF LEVELS FOR AFP IN AIH 2.CAN AFP BE ELEVATED IN AIH WITHOUT HCC ? | No AIH specific cut-off for AFP was validated. AFP may be elevated in AIH with active hepatocyte regeneration. Still HCC has to be ruled out in all AIH cirrhosis with elevated AFP. https://www.youtube.com/watch?v=JEW9qaYRTpw answered at 1hr 10min time frame. |
| 40 | Is liver biopsy a must before stopping treatment? | In view of risk of relapse, treatment is usually life-long. If one wants to stop, treatment should be continued for at least three years and for at least 24 months after complete normalisation of serum transaminases and IgG levels (biochemical remission). For patients with higher risk of relapse like patients with severe initial presentation and low tolerance of induction treatment, performance of a liver biopsy prior to treatment withdrawal is advisable. |
| 41 | IS if the acute presentation is sero negative, when should we repeat it? or shall we immediately go for biopsy | Liver biopsy is considered a prerequisite for the diagnosis of AIH. When ANA, SMA and LKM1 autoantibodies are negative, seronegative AIH is diagnosed based on liver biopsy (features typical or compatible with AIH) and exclusion of other alternate etiologies. If ANA/SMA/LKM-1 antibodies are negative, testing for additional antibodies like SLA, atypical p-ANCA, LC1 or AMA (if overlap suspected) is helpful. |
| 42 | what would you prefer TJLB or percutaneous biopsy? | In case of ascites or coagulopathy or severe thrombocytopenia, TJLB preferred over percutaneous approach. |
| 43 | How will a sernegative AIH present.? | Seronegative AIH presentation can be same as seropositive AIH. When ANA, SMA and LKM1 autoantibodies are negative, seronegative AIH is diagnosed based on liver biopsy (features typical or compatible with AIH) and exclusion of other alternate etiologies. If ANA/SMA/LKM-1 antibodies are negative, testing for additional antibodies like SLA, atypical p-ANCA, LC1 or AMA (if overlap suspected) is helpful. |
| 44 | Role of liver biopsy in naive ACLF suspected AIH ? | Biopsy helps in diagnosing AIH even if it is seronegative AIH. https://www.youtube.com/watch?v=JEW9qaYRTpw answered at 47 min time frame. |
| 45 | should liver biopsy be done in decomansated CLD ?? | All the decompensated cirrhosis cases are to be worked up and put on transplantation list. If there is no transplant option available, steroids in selected decompensated cirrhosis patients can help (doi.org/10.1007/s12016-016-8583-2). https://www.youtube.com/watch?v=JEW9qaYRTpw answered at 1hr 12min time frame. |
| 46 | Role of biopsy in patient with decompsated cirrhosis suspected to have autoimmune etiology? | All the decompensated cirrhosis cases are to be worked up and put on transplantation list. If there is no transplant option available, steroids in selected decompensated cirrhosis patients can help (doi.org/10.1007/s12016-016-8583-2). https://www.youtube.com/watch?v=JEW9qaYRTpw answered at 1hr 12min time frame. |

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| 47 | which one score is better for diagnosis SIMPLIFIED OR REVISED SCORE | The simplified scoring system is most accurate for typical patients while the original revised diagnostic scoring system is preferable for patients with complex or unusual features. The original revised scoring system has greater sensitivity for AIH compared to the simplified scoring system (100% vs 95%), whereas the simplified scoring system has superior specificity (90% vs 73%) and accuracy (92% vs 82%), using clinical judgment as the gold standard. (Hepatology 2008;48:1540-1548) |
| 48 | Decompensated cld cases , liver biopsy role ?? | All the decompensated cirrhosis cases are to be worked up and put on transplantation list. If there is no transplant option available, steroids in selected decompensated cirrhosis patients can help (doi.org/10.1007/s12016-016-8583-2). https://www.youtube.com/watch?v=JEW9qaYRTpw answered at 1hr 12min time frame. |
| 49 | Cryptogenic cirrhosis - A possible seronegative Autoimmune hepatitis - Any approach ? | Seronegative AIH is diagnosed based on liver biopsy (features typical or compatible with AIH) and exclusion of other alternate etiologies. If ANA/SMA/LKM-1 antibodies are negative, testing for additional antibodies like SLA, atypical p-ANCA, LC1 or AMA (if overlap suspected) is helpful. |
| 50 | Would you recommend MRCP for all pts with suspected AIH or only for those with elevated ALP? | AIH with cholestatic laboratory findings, histological features of bile duct injury or loss, and concurrent chronic ulcerative colitis - MRCP to be done to assess for AIH-PSC overlap. In children, MRCP is done in majority of AIH cases in view of common and potential overlap with autoimmune sclerosing cholangitis. |
| 51 | Most specific antibody for AIH overall and for Type 1 AIH? | Specificity of Autoantibody when detected as isolated finding :ANA – 76%, SMA – 96%, LKM-1 - 99%, SLA - 99% (doi: 10.5009/gnl15352) |
| 52 | In modified scoring system, how many points can be given to autoimmune markers? | Addition of points achieved for all autoantibodies with maximum of 2 points. |
| 53 | Should liver biopsy also done in case of ALF sir? | In AIH-ALF, patients benefit most from transplantation in view of poor response and high risk of infection with steroids. If steroids are planned, its preferable to perform a liver biopsy (TJLB) prior to steroids unless there are absolute contraindications. If patient is taken up directly for transplant, then explant pathology will be enough. |
| 54 | How do you diagnose sero negative AIH | When ANA, SMA and LKM1 autoantibodies are negative, seronegative AIH is diagnosed based on liver biopsy (features typical or compatible with AIH) and exclusion of other alternate etiologies. If ANA/SMA/LKM-1 antibodies are negative, testing for additional antibodies like SLA, atypical p-ANCA, LC1 or AMA (if overlap suspected) is helpful. |
| 55 | Audio poor | Please check the youtube link of the talk on ISG webpage |
| 56 | In absence of antibodies, can IgG high alone should lead to liver biopsy in suspected case of AIH? | Yes. Around 20% of AIH can have negative ANA, SMA and LKM1 autoantibodies (seronegative AIH). Diagnosis is based on liver biopsy (features typical or compatible with AIH) and exclusion of other alternate etiologies. If ANA/SMA/LKM-1 antibodies are negative, testing for additional antibodies like SLA, atypical p-ANCA, LC1 or AMA (if overlap suspected) is helpful. |

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| 57 | Few patients with chronic hepatitis have positive autoimmune serology with non specific histology and raised 24 hr urinary CU, should they receive dual treatment trial ? | If the patient has features of AIH, they can be started on steroids and look for response. Also repeat the work up for Wilson disease and estimate copper in liver biopsy. Look for other causes of elevated 24 hr urine copper like cholestatic disease. |
| 58 | In obese female, with transaminitis, how to differentiate Between NASH and AIH | Serum autoantibodies and liver biopsy can help to differentiate NASH and AIH. Sometimes typical histological finding of both NASH and AIH in addition to meeting the criteria for both individually can be seen. In such instances, NASH-AIH overlap should be clinically treated as coexisting AIH and NASH. |
| 59 | Doesbconnective tissue diseases increases the risk of AIH | Autoimmune hepatitis can be associated with concurrent extrahepatic autoimmunity like thyroiditis, IBD, celiac, vitiligo etc. co-occurrence of autoimmune hepatitis (AIH) and connective tissue disorders or SLE is considered to be rare . |
| 60 | Is AIH is different in children? | In children with suspected AIH, look for overlap autoimmune sclerosing cholangitis. Children with AIH require higher doses of steroid (1-2 mg/kg BW) at initiation of therapy. Budesonide is less effective than prednisolone. The principles of management of AIH in children are otherwise similar as in adults. https://www.youtube.com/watch?v=JEW9qaYRTpw discussed at 51 min time frame. |
| 61 | Is rise in AST more specific or ALT more specific? | Both are important, though rise in ALT is more specific marker of hepatocyte injury. |
| 62 | What about Livér biopsy in advanced liver disease | All the decompensated cirrhosis cases are to be worked up and put on transplantation list. If there is no transplant option available, steroids in selected decompensated cirrhosis patients can help (doi.org/10.1007/s12016-016-8583-2). https://www.youtube.com/watch?v=JEW9qaYRTpw answered at 1hr 12min time frame. |
| 63 | Can acute viral hepatitis trigger autoimmune hepatitis?Is there any genetic predisposition for the same? | There were case reports and few series of autoimmune hepatitis related to viral hepatitis infection from various agents: HAV, EBV, CMV and HEV. Protracted, but not acute, HAV infection is strongly associated with HLADRB1 13:01, an allele that has been linked to an increased risk of pediatric AIH, though not confirmed. Systematic comparative studies failed to show elevations in viral seropositivity among patients with autoimmune hepatitis when compared to the general population, providing an argument against a major role for it having an etiological role. (Annu. Rev. Pathol. Mech. Dis. 2018. 13:247–92) |
| 64 | DILI vs AIH and specially AIH with superimposed DILI, does liver biopsy help ? | AIH with superimposed DILI may be difficult to diagnose on biopsy alone. Clinical details and biopsy together help in differentiating the two entities. A clinical diagnosis of DILI is supported by an acute onset, features of hypersensitivity, published literature on the implicated drug, latency period from drug exposure to liver injury, and absence of advanced fibrosis or cirrhosis at presentation. The histological findings of interface hepatitis, lobular hepatitis, plasma cells and eosinophils can be similar in AIH and DILI but DILI doesn't show advanced fibrosis or cirrhosis in most instances. |

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| 65 | After diagnosis of LTB after what time should Anti TNFs started | In latent TB (normal chest x ray and no past history of inadequately treated TB) – anti-TNF can be started along with treatment for LTB. |
| 66 | sir when to suspect hepatitis a induced AIH in the background of postive hep a | Protracted, but not acute, HAV infection is strongly associated with HLADRB1 13:01, an allele that has been linked to an increased risk of pediatric AIH, though not confirmed. (Annu. Rev. Pathol. Mech. Dis. 2018. 13:247–92). Whether HAV infection is an initiating event of AIH or cause of flare in undiagnosed AIH can be difficult to diagnose. |
| 67 | AST / ALT IN AUTO - IMMUNE HEPATITIS , HAS VARYING PATTERN TO SUSPECT IS'T TRUE | ALP:AST(or ALT) ratio is more important in AIH than AST/ALT ratios. Chronic cholestatic disorders are to be suspected in cases with higher ALP elevation. AST/ALT pattern may vary with the onset of advanced fibrosis in AIH itself. |
| 68 | Should we do liver biopsy in decompensated Cirrhosis With normal enzymes if we are suspecting AIH? | All the decompensated cirrhosis cases are to be worked up and put on transplantation list. If there is no transplant option available, steroids in selected decompensated cirrhosis patients can help (doi.org/10.1007/s12016-016-8583-2). https://www.youtube.com/watch?v=JEW9qaYRTpw answered at 1hr 12min time frame. |
| 69 | In liver biopsy If moderate bile ductular proliferation Or intrahepatic n intracanalicular cholestasis Should we give -5 mark among revised score | Biliary changes are given -3 among Revised scoring system. |
| 70 | IS THERE DIFFERENCE IN HISTOLOGY OF LIVER IN DRUG PRECIPITATED AIH AND AIH PER SE? | The histological findings of interface hepatitis, lobular hepatitis, plasma cells and eosinophils can be similar in AIH and DILI but DILI doesn't show advanced fibrosis or cirrhosis in most instances. |
| 71 | Child c Cirrhosis suspected AIH do we need transjugular liver Bx | All the decompensated cirrhosis cases are to be worked up and put on transplantation list. If there is no transplant option available, steroids in selected decompensated cirrhosis patients can help (doi.org/10.1007/s12016-016-8583-2). https://www.youtube.com/watch?v=JEW9qaYRTpw answered at 1hr 12min time frame. |
| 72 | If a person has ANA positive, whether doing other markers like Anti SMA add to diagnostic value | https://www.youtube.com/watch?v=JEW9qaYRTpw answered at 1hr 8min time frame. |
| 73 | Can we make diagnosis of AIH without Liver Bx | Liver biopsy is considered a prerequisite for the diagnosis of AIH. In the either of scoring systems, histology is mandatory for diagnosis. Biopsy can also help to identify additional pathologies like steatohepatitis and overlap features. If clinical suspicion is high and patient don't agree for biopsy, you can discuss the option of steroids and response to steroids can be additional diagnostic feature of AIH. |
| 74 | Advanced liver stage, how to make diagnose AIH,? When possible multiple etiologies are possible, | Liver biopsy and autoimmune markers can help diagnosis of AIH. In case of ascites or coagulopathy, TJLB can be tried. If patient has ESLD and planned for transplant, then etiology can be diagnosed based on explant pathology. |

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| 75 | How to differentiate between AIH and Drug induces AIH? | Clinical details and biopsy together help in differentiating the two entities. A clinical diagnosis of DILI is supported by an acute onset, features of hypersensitivity, published literature on the implicated drug, latency period from drug exposure to liver injury, and absence of advanced fibrosis or cirrhosis at presentation. The histological findings of interface hepatitis, lobular hepatitis, plasma cells and eosinophils can be similar in AIH and DILI but DILI doesn't show advanced fibrosis or cirrhosis in most instances. |
| 76 | In case of positive autoimmune serology markers but normal LFT, do we need to treat these patients? Or do biopsy ? | In such cases, treatment is not indicated unless other indications are met like highly raised IgG. In case patient has cirrhosis, biopsy would be indicated to assess activity |
| 77 | what to do if lkm1 ,IgG, sma is negative..can we still lebel AIH? | For such cases, biopsy would be indicated and other etiologies should be ruled out by extensive evaluation. About 20-25% AIH may be seronegative |
| 78 | Khat leaves causes AIH. more common in middle east countries whats your comment on | Yes case reports are well described in literature. |
| 79 | how to manage AIH and type 1 DM ?? | In these cases, for induction of remission possibly lower dose steroids can be used as suggested in recent paper in CGH. This period has to be tided over with increased insulin and once we add Azoran and steroids are tapered, the treatment should be similar. The low dose steroids that we use for a long time in othere cases mat be stopped in these cases, depending on severity of liver disease. |
| 80 | where do you place fibrotest/APRI in follow up of these patient | Fibrotest and APRI can be used for follow up. However there are better markers like LSM on fibroscan for cirrhotics and liver function tests and IgG for biochemical remission. |
| 81 | Should Liver biopsy be probably mandatory as diagnosis using Simplified Score may not be possible without it? Secondly for treatment withdrawal biopsy will be required | Firstly, non invasive tests should be completed and other etiologies be ruled out. In case no etiology is found and criteria is not met, biopsy would be warranted. For treatment withdrawal, biopsy would be a good marker as histological remission lags behind biochemical remission and is the best marker of a response. |
| 82 | In a suspected case If ANA, autoimmune markers are positive with low titers how to go about | Biopsy would be indicated, to fulfil the criteria, if not already met. Also this should be repeated in times when patient is not having any infection of acute illness |
| 83 | What is the importance of transaminitis with equivocal IgA TTG | Celiac disease is now an established cause of cirrhosis and derranged LFT. Other etiologies of LFT derrangement should be ruled out and if clinicala scenario issuggesstive, UGIE and D2 biopsy mmay be helpful |
| 84 | How to differentiate lupus hepatitis from aih | Lupus hepatitis can have a picture similar to AIH. Needs to be managed as AIH what we discussed in the lecture |

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| 85 | Do titres of Antibodies matter? Many pts have mildly raised titres. | Absoulte titres have no role. Specific labs have cutoffs, and criteria also requires a specific titre for antibody. Mildly raised titres need to be confirmed when acute illness has passed and if equivocal, biopsy may help |
| 86 | If biopsy is inconclusive, shows cholestasis, is there role of whole exome sequencing to rule out other diagnosis | In case PFIC or BRIC is being suspected, IHC on liver biopsy would bemore helpful. For autoimmune hepatitis unlikely to be useful |
| 87 | Very good.. it's helping all gastroenterology pgs a lot.... | Thank you |
| 88 | Steroids in ACLF / decompensated cirrhosis with AIH, when to consider? Our cases have often worsened | There is limited data on steroids for decompensated cirrhosis with AIH. A pragmatic approach would be to get the patient to a compensated state as much as possible(ex. albumin increase to 3 or above, reduce ascites) then give a low dose steroids (0.5-0.6mg/kg) with a course of antibiotics. However, at sign of first worsening, steroids should be stopped. Similarly for ACLF |
| 89 | How can you evaluate Anti Hbc positive(other HBV markers negative) CLD with cirrhosis and positive auto immune markers? | In such a case, if HBV-DNA is also negative the disease is likely due to AIH. However, IgM antiHbc should be done seperately and DNA/HBsAg to be repeated after some time to tule out a window period |
| 90 | Do we need to work up for AIH routinely if liver enzymes less than three times in viral and drug history neg hepatitis. | Yes, it is part of routine evaluation of derranged LFT although can be done as a second line investigations if resources are limited. |
| 92 | Suspected AIH in pregnancy? How will you approach? Is liver biopsy safe ? | Approach would be similar to normal patient. If however the patient is already a known AIH, proper counselling would have to be done. Should be in remission for a year before conception. If cirrhotic, EVL should be done before conception or in 2nd trimester. Liver biopsy is not advised unless absolutely necessary in pregnancy. One possible scenario could be acute severe AIH during pregnancy which is usually seroneagtive. Most flares of AIH occur in post partum immune reconstitution phase when patient needs close monitoring. |
| 93 | A certain subgroup have "aih with cholestasis" who are seronegative for PBC.should they be given a concomitant trial of UDCA with steroids? | Yes, UDCA would help in such cases |

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| 94 | At times we see reports of asma positive marginally elevated in suspected autoimmune Pt's with herbals consumption , other autoantibodies negative. When exactly do we have to repeat autoantibodies as we don't have good liver biopsy facilities available | Probably 12 weeks would be a good time(similar to the approach adcised in APLA syndrome) |
| 95 | What are clinical indicators of aih | Malaise, jaundice, other autoimmune manifestations, cirrhosis and their decompensations |
| 96 | Should we treat decompensated cirrhotic patients ? | There is limited data on steroids for decompensated cirrhosis with AIH. A pragmatic approach would be to get the patient to a compensated state as much as possible(ex. albumin increase to 3 or above, reduce ascites) then give a low dose steroids (0.5-0.6mg/kg) with a course of antibiotics. However, at sign of first worsening, steroids should be stopped. Similarly for ACLF |
| 97 | What is your take in treating decompensated cld | There is limited data on steroids for decompensated cirrhosis with AIH. A pragmatic approach would be to get the patient to a compensated state as much as possible(ex. albumin increase to 3 or above, reduce ascites) then give a low dose steroids (0.5-0.6mg/kg) with a course of antibiotics. However, at sign of first worsening, steroids should be stopped. Similarly for ACLF |
| 98 | Should we treat AIH with ALT<3 times or in severe decompensation? | For ALT<3 ULN , treatment indications would include IgG>2 ULN or cirrhosis with significant activity on biopsy. There is limited data on steroids for decompensated cirrhosis with AIH. A pragmatic approach would be to get the patient to a compensated state as much as possible(ex. albumin increase to 3 or above, reduce ascites) then give a low dose steroids (0.5-0.6mg/kg) with a course of antibiotics. However, at sign of first worsening, steroids should be stopped. Similarly for ACLF |
| 99 | Role of Belimumab in treatment of AIH | Scant data, case reports. Will need individual decisions. May be in refractory cases can be tried after obtaining patients consent |
| 100 | SHOULD WE TREAT AIH-DECOMPENSATED CIRRHOSIS STAGE B? | There is limited data on steroids for decompensated cirrhosis with AIH. A pragmatic approach would be to get the patient to a compensated state as much as possible(ex. albumin increase to 3 or above, reduce ascites) then give a low dose steroids (0.5-0.6mg/kg) with a course of antibiotics. However, at sign of first worsening, steroids should be stopped. Similarly for ACLF |
| 101 | WHEN TO CALL FAILURE OF TREATMENT? | No response to 4 weeks of steroids in terms of reduction of enzymes derrangement or increasing decompensation. For Aza/MMF the duration would be longer - 8-12weeks as they take longer to act. |
| 102 | should we treat patient with decompensated cirrhosis with elevated enzymes | There is limited data on steroids for decompensated cirrhosis with AIH. A pragmatic approach would be to get the patient to a compensated state as much as possible(ex. albumin increase to 3 or above, reduce ascites) then give a low dose steroids (0.5-0.6mg/kg) with a course of antibiotics. However, at sign of first worsening, steroids should be stopped. Similarly for ACLF |
| 103 | How to assess the response to steroids and should the dose be reduced in hyperbilirubinemic patients ? | LFT and IgG can be monitored for response. No dose reduction is required for hyperbilirubinemic patients |

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| 104 | 60 yr female cirrhotic AIH + HBV. Raised ALT/AST 2-3 time. How to treat | If diagnosis of both is confirmed and indications for treatment of both is fulfilled, then HBV should be treated first and after 1 month AIH can be treated. |
| 105 | mgt of patient with AIH on immunosupression who developed suputm positive TB | No change in management is required and TB has to be treated as per standard protocol. Although hepatotoxic agents may need to be reduced based on LFT and cirrhosis stage |
| 106 | role of biologicals in AIH/ | Role in refractory cases |
| 107 | Can patient who are on way to remission with prednisolone can be shifted to budesonide? | It would be preferrable to continue on the same medication as change in medication and doses could lead to relapse. |
| 108 | Thank you for your enriching session , we have a case 19 yr girl who presented with features of ALF evaluation showed features of both AIH score 6 ,liver box result awaited & Wilson's disease iKFring + low ceruloplasmin urinre cu 98 .responded to steroids dramatically .how will you proceed Thank you | I would repeat evaluation for Wilsons, as copper tests can be false in times of cholestasis and KF ring may also be visible. Biopsy would also help determine the actual cause and affect future management. |
| 109 | HOW WILL U DIFFERENTIATE AUTO IMMUNE HEPATITIS FROM AUTO IMMUNE PANCREATITIS ON BASIS OF IgG 4 POSITIVITY AS TRANSAMINASES AND BIL MAY BE SEEN INCREASED IN BOTH | Imaging(CT and ultrasound) would point to the organ affected. |
| 110 | wat is the drug to be chosen for a young lady withAIH having steroid induced side effect and developed Azathioprine induced pancreatitis, who z planning for pregnancy | Tacrolimus would be a possible alternative. MMF is to be avoided. |
| 111 | How do you manage Young male autoimmune hepatitis with moderate activity with bringing fibrosis associated with immune mediated glomerulonephritits ? Lupus. | Mangement should be along lines of SLE with organ involvement which would entail high dose steroids followed by maintainence. This would also take care of AIH/lupoid hepatitis. |

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| 112 | How common is autoimmune hepatitis in HIV and how to manage such patients ? | To the best of my knowledge, no difference in prevalence or management. Though they should be more careful of infections. Also, AIH may worsen at start of ART due to immune reconstitution during the initial pahse when CD4 cells increase |
| 113 | What immunosuppression should be given in patients of AIH after liver tranplantation? | Same as that to prevent reection. Most combinations would include steroids initially and MMF/Tacrolimus in the long run. If there is active disease in the new liver, steroids may be repeated to induce remission |
| 114 | How i can treat a patient of decompnsated cirrhosis due to AIH | There is limited data on steroids for decompensated cirrhosis with AIH. A pragmatic approach would be to get the patient to a compensated state as much as possible(ex. albumin increase to 3 or above, reduce ascites) then give a low dose steroids (0.5-0.6mg/kg) with a course of antibiotics. However, at sign of first worsening, steroids should be stopped. Similarly for ACLF |
| 115 | Sir kindly educate us about LT in AIH... Do indications of LT differ in AIH pts ? Do post-LT management changes in AIH pts ? | LT in AIH is for decompensated cirrhotics, for those who have cirrhosis with burnt out disease and show no response to standard of care and for those with acute sever AIH who show no response to steroids in 7-14 days or show worsening ex. development of encephalopathy. Post LT - steroids may need to be continued for longer in AIH patients than others. |
| 116 | When to say patient is non responder to prednisolone plus azathioprine? | No response to 4 weeks of steroids in terms of reduction of enzymes derrangement or increasing decompensation. For Aza/MMF the duration would be longer - 8-12weeks as they take longer to act. |
| 117 | Thank you for your enriching session .We have a case 19 yr old girl ALF presentation have features of both AIH&Wilsons disease she responded to steroids dramatically . How to proceed please | I would repeat evaluation for Wilsons, as copper tests can be false in times of cholestasis and KF ring may also be visible. Biopsy would also help determine the actual cause and affect future management. |
| 118 | Where we use Tacrolimus for AIH .... is it for Refractory AIH or any other indication?? | It can be used for refractory AIH as well as when other medications are not tolerated by the patient |

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| 119 | Many times young patient presenting with ALF is found to have both lower ceruloplasmin level,borderline raised 24hr U.copper and raised IgG and ANA positivity. If TJLB is not possible at our setup with ALF, how should we approach such patients without liver biopsy? How reliable are ALP/Bilirubin and AST/ALT ratios for differentiating? should we treat for both Wilson's and Autoiimune Hepatits? | It would be very difficult to manage without a liver biopsy and low reliability of enzyme ratios as markers. Best would be to get a biopsy at a referral centre as treating for both would not be the best approach. |
| 120 | Why AZA should be initiated after 2 weeks? Some opinion difference amongst various societes.. what u suggest? | New evidence suggests it can be added at the same time with steroids |
| 121 | In clinical practice , for maintenance therapy, what is the target transaminase level that you target? complete normalization or <1.5times elevation | Ideally, complete normalisation should be targetted, however, drug adverse effects are to be kept in check |
| 122 | role of steroids in patients who develop cirrhosis? | In compensated cirrhosis, if histology shows increased activity, steroids can be used. In decompensted there is shortage of data. |
| 123 | What should be the minimum dose (2.5mg/5mg) of prednisolone on which we should define a relapse? | Relapse definition does not include any criteria for steroid dose. It depends on the LFT |
| 124 | Duration of steroid therapy. When can we stop and continue monothearapy | Steroid therapy can be tapered once remission is acheived, once tapering starts after 4 weeks, 5mg every 2 weeks can be done. Most of the times patient can be maintained on a low dose of steroids - 5 - 7.5mg/day for prolonged periods to prevent replase. Howwever in case of side effects, it can be stopped completely |
| 125 | In AIH patients presenting with ACLF, what should be treatment prorocol? | There is limited data on steroids for decompensated cirrhosis with AIH. A pragmatic approach would be to get the patient to a compensated state as much as possible(ex. albumin increase to 3 or above, reduce ascites) then give a low dose steroids (0.5-0.6mg/kg) with a course of antibiotics. However, at sign of first worsening, steroids should be stopped. Similarly for ACLF |
| 126 | what dose of budesonide as maintenance of remission ? 3 mg or 9 mg per day ? | 3mg is usually sufficient to maintain remission, although iit should be combined with Aza |

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| 127 | How long to give azathioprine? Minimum dose to maintain? During pregnancy aza safe? | AIH treatemnt is life long. The dose needs to be adjusted as per response. Genereally, a 1-2mg/kg dose is used. It is safe during pregnancy |
| 128 | sir which regimen u prefer in your patients EASL or APASL | Both are good. I would suggest taper steroids are as per patients response. Guidelines are for direction. Not individual patient management |
| 129 | Is the treatment protocol same for all spectrum of AIH? | For non cirhotics and compensated cirrhotics the protocol is similar. For decompensated cirrhotics, there is paucity of data |
| 130 | How to titrate budesonide..???? | Start at 9mg per day and taper after 4 weeks by 3mg gradually |
| 131 | WHEN WE CALL TREATMENT FAILURE IN INDUCTION PHASE ? | No response to 4 weeks of steroids in terms of reduction of enzymes derrangement or increasing decompensation. For Aza/MMF the duration would be longer - 8-12weeks as they take longer to act. |
| 132 | Which scedule you follow in treatment AASLD oe EASL? | Both are good |
| 133 | In refractory AIH would you routinely recommend evaluating for IBD as it is important? | No, it is to be routinely evaluated in patients with PSC and in pediatric patients with AIH |
| 134 | Whether to start steroids and aza simultaneously or as sequential therapy as aza itself is hepatotoxic and can mask response | Aza will take time to act(nearly 4 weeks) so yes, both can be started together. |
| 135 | Should we do TPMT before starting Aza? Patient developing anemia with Aza: what do you use as 2nd line in practice? | TPMT ideally is to be done before starting although in India, NUDT15 polymorphism is more important. 2nd line is either MMF or Tacrolimus |
| 136 | Which serology marker is used for Relapse of AIH ? | Persistent ASMA is a marker of non response. However, for relapse, liver enzymes are the best marker |
| 137 | Role of liver biopsy in dencompensated cirrhosis for diagnosing AIH | In cases when criteria is not fulfilled, and other workup is negative biopsy may help if the diseased liver still shows signs of activity and can point to AIH. In ascite, transjugular biopsy is to be preferrred |
| 138 | We have used Adalimumab in refractory AIH with associated IBD | Yes, iboth infliximab and adalimumab have shown good results in AIH with IBD |
| 139 | Can we use deflazacort inplace of prednisolone | LImitation of studies, Budesonide can be used |
| 140 | Whether we can use 6 MP in half dose in pts who are not tolerant to aza | Yes, it can be tried |

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| 141 | 50 F; transaminitis 2-3 fold ANA strongly positive ASMA positive AMA week positive Normal ALP liver biopsy: PBC+AIH( not real typical features) What is ur take | If IgG is also elevated(2x ULN), should be treated for AIH. No need to treat PBC currently |
| 142 | AIH flare - awaiting Elective surgery, what is time period after which its safe to undergo surgery under anesthesia ? | Since it is elective, only once patient is in remission as tissue repair and healing would also be impaired with derranged liver functions. |
| 143 | SLA test in relapse ? | Antibodies ususally dont help in management of relapse. Management is clinical |
| 144 | Sharing a recent case scenario of 21yr old boy, previously treated as lean NAFLD since 9 months. OLd Fibroscan 9.4kpa While on maintanence vit E and antioxidant,SGOT/PT goes up > 8-10ULN and persisting for 3months, and 6kg weight loss. Reevaluation shows IgG >1.1ULN, borderline positive for Anti LC1,rest all antibodies negative. CAMS ruled out on repeated questioning. Liver bx - Mild distortion of lobular architecture by expanded portal tract by moderate inflammatory cell infiltrate composed ofl | Should be treated as AIH. |
| 145 | Do the early response at 8 weeks applicable for AS AIH with Alf as mortality is highest during first 4 weeks | AIH-ALF ideally liver transplant is the best option.Individual decision to treat with steroids can be taken with close monitoring |
| 146 | long term maintenance dose | 5-7.5mg per day of prednisolone and Aza-2mg/kg |
| 147 | Acute fulminant AIH- oral vs iv steroids? Indications of early LT? Diagnosis and Management of burned out disease in AIH? | Oral or iv steroids both ca be used, early LT if encephalopathy develops or patient shoes no response by day 7-14. Burnt out disease with AIH should be managed as cryptogenic cirrhosis with standard of care and without immunosuppressin unless disease is active again. |

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| 148 | In induction, do we taper steroids after ALT normalization or based on weekly tapering irrespective of ALT levels ? | Start tapering after 4 weeks irrespective of ALT |
| 149 | Can predni dose may be increased to more than 1 mg/kg if insufficient response? | Yes, higher dose can be given but no clear established advantage |
| 150 | AIH with celiac disease is GFD is enough or one should start Rx of AIH | If there is adequate evidence to diagnose AIH and fulfile criteria of treatment like IgG>2x ULN, ALT>5x ULN or biopsy with activity etc. then should be treated for AIH also |
| 151 | How to treat NASH plus AIH. Do steroids worsen NASH in such situation? | Around 17 to 30 % AIH has evidence of NAFLD and affect the outcome. Lowest possible dose or complete tappering of steroid if possible and life style changes should be advised |
| 152 | can we give filgrastim to patient having azathioprine induced leucopenia if patient is cirrhotic ? | No reduction of dose or 2nd line treatment |
| 153 | Can we use Tac or MMF if patient is compensated cirrhosis | Yes can be used as 2nd line in patients with cirrhosis with activity after discussing with patients under close monitoring for sideffects and any decompensation |
| 154 | A non responding transaminitis/ igG on prednisolone plus Aza: if we have ruled out other etiologies, whether repeat biopsy would be of any help to rule out any alternative diagnosis? | ALready ruled out other etiology no role of repeat biopsy |
| 155 | If we use pred and aza simultaneously, how worse aza deteriorates liver function? | Ideally Aza should not be used when bil is elevated > 5 mg/dl as first line |
| 156 | Wat to do with Child A cirrhosis ( probable AIH related ) who falls under treatmnt category ? Budesonide vs prednisolone | prednisolone should be used in all cirrhotic patient |
| 157 | is decompensated cirrhosis not an exception to treatment ? | Manage conservatively and put on transplant list. Individual cases decision to be taken |
| 158 | Sir, how's vitamin D deficiency related to non response? | 70 to 80 % of AIH patients have vit D deficiency. Vit D can regulate the expression of immune regulatory gene by binding to its Vit D receptor. However studies are required to understabd its epigentic role in AIH |

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| 159 | While falling back on second line Drugs should we stop steroid in them? | Low dose steroid with any 2nd line drug can be used |
| 160 | When to say non responder? | Two terminology used are 1 . Treatment failure - Worsening biochemical and histological parameter inspite of good complaince to standard therapy |
| 161 | Is liver biopsy safe in ALF? Would every ALF without etiology require biopsy? | Role of biopsy in AIH related ALF is very important. TJLB should be done . No not every ALF require biopsy for diagnosis |
| 162 | If patient presents with acute severe AIH with recent onset decompensation....and biopsy is not feasible... how to proceed ???? | conservative management is advised as already decompensated. |
| 163 | What dose of budesonide is required | Usual starting doses are 9 mg |
| 164 | Will you work up your patient with acute severe autoimmune hepatitis like presentation for EBV, HSV and CMV | As planning for immunosupression all possible viral etiology should be ruled out |
| 165 | Finally what should be dose of pred in AS- AIH? | 0.5 - 1 mg/kg shown good response with decrease chances of infection |
| 166 | PLZ CALRAIFY HOW TO ASSESS AT D7 OF STEROIDS FOR AIH ACLF FOR CONSIDERING LT | Probably this means AS AIH in this case patient should be monitored for biochemical response specially bilirubin and infection. If there is no response should be consider for LT |
| 167 | IN CASE OF ALF OR ACLF WITH SOFT SUGGESTION OF AIH LIKE ONLY ANA POSITIVE OR ONLY IgG raised is it advisable to start therapy as a desperate measure or one should do extensive workup and TJLB | No biopsy should be done emperical steroid has no role |
| 168 | Is there any role of IV methyl prednisolone In management of ALF related to AIH ? | No |
| 169 | DCLD AIH patients with no feasibility of LTx, any role of medical management? | Should be manage like anyother DCLD |
| 170 | In jaundiced patient is there any cut off for initiating azathioprine? | should see for steroid response and observe for 2 weeks before starting AZA |

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| 171 | Can MMF be used as first line therapy instead of AZA? As AZA takes few weeks to have effect ! | AZA is first line in case of intolerance or side effect can use MMF. |
| 172 | Histology in ALF, Severe Acute hepatitis due to AIH | Pan lobular necorsis , Plasma cell infilteration , central perivenulitis , lymphoid follicle , |
| 173 | In AS AIH, iv steroid vs. oral steroid, which one is better in the beginning? If iv steroid is better, which molecule? | Prednisone or prednisolone both can be used |
| 174 | Patient on immunosuppressant, present with fever, mild opportunity infection and another patient present with septic shock, how will u manage both patient, when to consider restarting immunosuppressant? | Immunosuppression should be stopped in both the cases |
| 175 | Is there a case to give a steroid trial in AS-AIH AlF with early grades of HE (I or II) and what would be the optimal mode (oral vs iv) and dose in such cases? | In ALF steroid not recommended |
| 176 | management of AIH in pregnancy, is azathioprine safe??? | Yes it is safe |
| 177 | CAN YOU RECOMMEND DEFLAZOCORT INSTEAD OF PREDNISOLONE IN PATIENT NOT ABLE TO TOLERATE PREDNI OR METHYL PREDNI | Case reports are available but RCT is require for recommendation |
| 178 | WILL STEROIDS HELP IN AIH CIRRHOSIS? AND DECOMPENSATED CIRRHOSIS? | Helpfull in AIH cirrhosis |
| 179 | wat s the reason for low inciidece of hcc in AIH? | Excellent question. I do not have a specific answer |
| 180 | How to treat viral hepatitis induced ACLF with treatment naive AIH related chronic disease. | Viral hepatitis should be treated as recommended and later AIH can be treated once ACLF resolved |
| 181 | Would you perform liver biopsy in setting of ALF/ACLF? | Yes |

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| 182 | Can you comment about AIH in pregnancy | preconception remission of disease recommended and AZA should be continued and postpartum should be monitor more frequent for activity |
| 183 | What are the results of AIH Decompensated Cirrhosis treated with steroids? | I dont have a clear answer. Good outcomes get published. Poor outcomes are not published. Personal experience- if you what to treat- get to a compensated stage- take a call. Keep close FU, consider low doses. Take written consent from patient |
| 184 | Is tha HCC surveillance in a AIH (without cirrhosis) patient must ? | yes |
| 185 | Any difference in response to treatment in seropositive AIH vs. seronegative AIH? | No difference in response |
| 186 | Sir,if pt with AIH on steroids developes sepsis/SBP, do we stop steroids in such pts ? | Stop steroid and list patient for LT |
| 187 | Can you high light more on Denovo - AIH particularly regarding autoimmune markers in them | De novo hepatits diagnosis as like AIH |
| 188 | Do we need a biannual ultrasound and AFP estimation for AIH without cirrhosis? | No |
| 189 | Role of plsma exchnge in ALF AIH and ACLF AIH. | Case series and reports are available |
| 190 | CHANCES OF RECURRENCE AFTER LIVER Tx? | Recurrence rate 8-12 % in first year and 36-68% in 5 years |
| 191 | When to stop steroid in AIH | after complete response trail of stopping of steroid can be tried but AZA sholud be continued. Recommendation is to conitue low dose steroids |
| 192 | How to manage AIH in pregnancy? | Standard management should be continued. Preconception remission associated with good pregnancy related outcome |
| 193 | Should we use drugs even in case of decompensated cirrhosis in form of ascites? | No |
| 194 | How do we make diagnosis of AIH in patients with established cirrhosis with negative autoantibody | After ruling out all other causes biopsy is usefull and Revised diagnostic criteria should be applied |
| 195 | Should we treat AIH Child C cirrhotic with normal liver enzymes? If not, monitor with what and how frequently? | No managment of decompensated cirrhosis and LT listing |

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| 196 | Can we stop steroids after 3 months of induction if LFT is normal or should continue 5mg along with AZA till histological remission? | one should continue low dose steroid |
| 197 | HOW TO MANAGE AIH IN PREGNANT WOMEN ?? | same as normal AIH , Preconception remission is recommended and post partum close follow is required |
| 198 | Which preparation of budesonide to be used in AIH ? Controlled releas? Or other | 3 mg TDS |
| 199 | Can normal IgG rules out AIH in case of only ANA positivity? | No |
| 200 | Do we need to rule out occult hep b before starting treatment? | Yes |
| 201 | Sir, till what stage of CTP in cirrhosis do u give steroids? | Compensated cirrohsis |
| 202 | What r the patients on whom u want to start steroids in cirrhosis | compensated cirrhosis with activity on biopsy |
| 203 | Should we try budesonide in cirrhotic patients? rather then giving pred. | No |
| 204 | What is the dosage regime for budesonide in adults? | 3 mg TDS |
| 205 | Any Evidence of resolution of cirrhosis in AIH in ped population after starting treatment | No |
| 206 | Management of decompensated cirrhosis(AIH Related)_ immunosuppression? | No immunosuppresion in DCLD |
| 207 | When should we start screening of hcc in AIH? | All cirrhotic patients |
| 208 | If pt in remission with Aza do we switch to steroids during pregnancy? | No |
| 209 | Minimum maintenence dose in patients on prolongeed remission? | 5 mg Steroid and AZA depends on adjusted doses |
| 210 | Sir what is management in covid cases with aih | If decomsated after covid immunosupression should be reduced and manage accordingly |

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| 211 | HOW TO DISTINGUISH AND MANAGE DOSE OF AZA AND MMF IN AIH CIRRHOSIS WITH PANCYTOPENIA DUE TO HYPERSPLENISM? | Pretreatment TLC should help |
| 212 | Should treatment be given to newly diagnosed Decompensated CHILd C cirrhosis | no |
| 213 | Sir if u say low steroid dose like 0.5 mg per kg it means pred alone or pred +aza | Initialy it steroid alone should be given to see for response |
| 214 | Sir what should be treatment options for decompensated Cirrhosis with AiH as etiology depending on Meld and Child Stage ? | Manage conservatively and place on transplant list. Individual cases decision to be taken |
| 215 | Management of AIH in decompensated CLD child B, C ? Drug of choice? | Standard DCLD management |
| 216 | For how much duration of treatment, after which we should check weather patient is responded or non responded ? | 2 weeks of steroid treatment atleast |
| 217 | Is iMRCP maging for asc PSC to be done for all ped patients diagnosed with AIH..to rule out Acute sclerosing Cholangitis | Only suspected patients with AIH PSC overlap should undergo MRCP |
| 218 | Ideally after how many days of steroids should we add AZA during induction | After 4 weeks and normalization of LFT AZA can be start safely |
| 219 | can steroids be considered in management of AIH patients with large varices? | Depends on CTP and LFT and activity |
| 220 | Sir,how long should we give induction with budesonide | Till remission and tapper |
| 221 | what is the maximum dose of AZA you can give | 1 -2 mg /kg |

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| 222 | What is the outcome of patients with infliximab related flares in transaminases in UC with PSC. Do they switch from a PSC to a autoimmune phenotype | Depends on other parameter and other causes of Transminases should be ruled out |
| 223 | Sir, in an elderly patient with AIH can we add azathioprine in view of drug side effects? | Elderly respond well to treatment yes can be added |
| 225 | Will u treat decompensated liver disease due to AIH with no transplant option | Conservative management |
| 244 | What is the dose of infliximab if used in AIH | Case reports suggest a dose of 5mg/kg |
| 246 | 76 y/o/female CTP B LEAN PATIENT history of HAV 6 months back probably unmask AIH IgG high Transaminitis LFT 500 probably prolong icteric hepatitis can we start steroid without biopsy no will for LT | Ideally biopsy, individual decision to start steroids is clinical. I will not consider 76 years old patients for LT |
| 247 | MAFLD with ASMA positive IgG 1.2 times upper limit AST 70 will you treat for AIH | I will suggest a liver biopsy to clear the status of AIH. Steroids are known to increase steatosis. |
| 248 | Patient of AIH, also had HBsAg positive. How to monitor and treat her? | Need to add antivirals as you are planning to use steroids > 10 mg/d for long periods. Monitor with HBV DNA, LFT and fibroscan |
| 249 | how to manage post liver transplant AIH recurrence, specially when indication of transplant is treatment non response? | Tough question. No easy answer. Multiple combination of drugs may be an option. Few case reports. Suggest reading this doi: 10.1016/j.transproceed.2013.09.028. |
| 274 | is there any maintenance dosage for budesonide as for prednisone | 3 mg should do fine |
| 277 | How often you monitor biochemically for pancreatitis when pt is on AZA | No need for biochemical monitoring in a asymptomatic person |
| 280 | Is there any role of injectable steroid in acute severe AIH?? | Yes, can be used |

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| 281 | In case of AIH with acute on chronic liver failure, can we safely start steroids? What are the contraindications to steroid therapy | Its not absoultely safe. The published study used in patients with no infection an dno HRS. |
| 282 | in acute severe hepatitis or acute decompensation, should we use oral or i.v. steroid? if i.v. what dose? | Either oral or iv: 1 g methylprednisolone for 3 consecutive days followed by i.v. 1 mg/kg/day prednisolone or i.v. 1.5 mg/kg/day prednisolone from the beginning. Refer to this article: https://onlinelibrary.wiley.com/doi/abs/10.1111/hepr.13252 |
| 283 | how will we define Steroid resistant AIH ? is their any duration and dose of steroid?? | Usual time frame is 6 months. Standard regimens as per the guidelines. No absolute cut-off doses of steroids. |
| 284 | whats your comment on consumption of khat leave causing / precipitating AIH , have seen many patients from Middle east | Yes case reports are well described in literature. |
| 285 | In new AASLD guidelines It says azathioprine is contraindicated in decompensated Cirrhosis | Ideally LT |
| 286 | Young patient with severe acne on prednisolone Can we switch to budesonide | Yes |
| 287 | How to go ahead in case of steroid causing decompensation in case of a cirrhotic female with raised transaminases?? | LT |
| 288 | Sir, is risk of relapse after transplantation similar with autoimmune ALF and ACLF | Relapse can occur. No clear published data on differences in rates of reccurence after ALF and ACLF |
| 289 | Is a very high level of IgG (more than 2000) but normal LFT, and compensated cirrhosis, enough to start treatment? | No |
| 290 | What should be the dose of steroid in patient with AIH induced ALF if transplant is not an option | Either oral or iv: 1 g methylprednisolone for 3 consecutive days followed by i.v. 1 mg/kg/day prednisolone or i.v. 1.5 mg/kg/day prednisolone from the beginning. Refer to this article: https://onlinelibrary.wiley.com/doi/abs/10.1111/hepr.13252 |
| 291 | once patient goes in remission when to stop steroids | Can stop steroids at 6-9 months |

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| 292 | How to treat combination of chronic viral hepatitis on TAF and AIH | Conitinue therapy for both |
| 293 | We have one patient had Leipzig score of 4 started on penicillamine devloped bone marrow suppression Her liver biopsy had severe interface hepatitis Should we start steroids in this patient | I am not sure if the patient has AIH. Need to rreconsider the diagnosis. Interface hepatitis alone is not a criteria for starting steroids |
| 294 | raised PT/INR could biopsy be done | Consider TJLB |
| 295 | Uncontrolled DM with AIH, aproach regarding steroid dosage? | consider low dose and switch to Aza |
| 296 | Uncontrolled DM with AIH, aproach regarding steroid dosage? | consider low dose and switch to Aza |
| 297 | Role of IgG in monitoring treatment? how frequenctly it should be repeated? | 6 monthly |
| 298 | As interface hepatitis can be seen in many liver diseases biopsies . How to differentiate AIH from other cases | Liver biopsy has no definite features of AIH, finding are suggestive. I have discussed the biopsy findings in the talk |
| 299 | EASL suggests Aza be started only when S.Bilirubin is below 6. Should it be FOLLOWED? | YEs |
| 300 | Sir, how to approach a pt with AIH on steroids and other immunosuppression , now present with SBPor sepsis ? | Manage with antiobiotics/albumin as per standard recommendations. List for LT |
| 301 | Role of steroids if at all in AIH ACLF | Yes can be used in select patients. Ideal patients I have mentioned in the talk. |
| 302 | Role of Obeticholic acid in AIH-PBC overlap ? | Yes can be used. We will have a seperate session on overlap |
| 303 | is ana hep2 more specific than ana? | ANA is not specific for AIH |
| 304 | Any role IVIG in AIH related ALF | Case reports are there in literature |
| 305 | Any significance of types of aih | Yes, have discussed in talk on the slide role of autoantibodies |
| 306 | Compensated cirrhosis, only SMA +ve (1:40 titre, rest all marker negative What to do next? | Take a clinical decision to treat as per the LFT reports and patients consent for therapy |

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| 307 | Patient presented with ALF started on steroids, and contd on azathioprine for 3 years with no flares, with normal biochemistry, can we stop the medications without biopsy | Ideally biopsy should be done |
| 308 | in acute decompensation of AIH cirrhosis with elevated enzymes >3ULN, should immunosuppression started? | Yes |
| 309 | How to manage Covid 19 positive case with ALF/ACLF-AIH should we proceed for LT and what may be outcome | LT to be considered for ALF and ACLF (COVID negative patients) |
| 310 | Role of liver biopsy in patient with overlap syndrome? | Yes, should be done to clear the diagnosis and will help in management and prognostication |
| 311 | AIH and SLE | Question is incomplete |
| 312 | Role of steroids in decompensated AIH patients...Dose and monitoring | In cirrhosis with active inflammation on liver biopsy, steroids helps in clinical and histological improvement (DOI: 10.1016/j.jhep.2004.01.009). All the decompensated cirrhosis cases are to be worked up and put on transplantation list. If there is no transplant option available, steroids in selected decompensated cirrhosis patients can help (doi.org/10.1007/s12016-016-8583-2). https://www.youtube.com/watch?v=JEW9qaYRTpw answered at 1hr 12min time frame. |
| 313 | Patient with AIH- ALF, transplant facility not available, non responsive to steroids. Is there any role of plasmapheresis? | Yes plasmapheresis can be tried |
| 314 | is there any role of plasma pharesis in AlF/ACLF in AIH | Yes plasmapheresis can be tried |
| 315 | Is there any cut off bilirubin level above which AZA should not be given? | Guidelines recommend not to give above5/6 mg/dl, |
| 316 | NUDT polymorphism assessment prior to AZA Initiation? | TPMT ideally is to be done before starting although in India, NUDT15 polymorphism is more important. 2nd line is either MMF or Tacrolimus |
| 317 | Monitoring of CBC and lft in test mutated homozygous patient | TPMT ideally is to be done before starting although in India, NUDT15 polymorphism is more important. 2nd line is either MMF or Tacrolimus |
| 318 | Role of plasmapheresis in alf-aih? | Yes can be tried, if patient consents. No large published data |

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| 319 | congratulatios dr shalimar and dr makharia | Thank you |
| 320 | What are the results of AIH Decompensated Cirrhosis treated with steroids? | In cirrhosis with active inflammation on liver biopsy, steroids helps in clinical and histological improvement (DOI: 10.1016/j.jhep.2004.01.009). All the decompensated cirrhosis cases are to be worked up and put on transplantation list. If there is no transplant option available, steroids in selected decompensated cirrhosis patients can help (doi.org/10.1007/s12016-016-8583-2). https://www.youtube.com/watch?v=JEW9qaYRTpw answered at 1hr 12min time frame. |
| 321 | how about mrcaptopurine if aza cant be given ? | yes can be tried |
| 322 | Middle aged female with conjugated hyperbilirubinemia with high ALP, with elevated enz- 300, associated with IBD, MRCP normal, no e/o cirrhosis, patient has persistent jaundice and OT/PT- 2 times normal,with initial response to steroids and azathioprine, now not responding to azathioprine or steroids with persistent jaundice ( Bn-5, OT/PT-100), what to do next | normal MRCP- picture of IBD, rule out PSC- liver biopsy. Rule out other causes. Hiking immunosuppression may help. Addition of UDCA can be tried. |
| 330 | When to suspect seronegative AIH? | Same as seropositive AIH |
| 329 | Should we do liver biopsy in decompensated Cirrhosis With normal enzymes if we are suspecting AIH? | Ideally decompensated cirrhosis should be on LT list- if you have treatable etiology. Biopsy help to treat a specific cause if available. LFT may not correlate with acitivity on liver biopsy |
| 328 | While falling back on second line Drugs should we stop steroid in them? | Can stop or continue in low doses |
| 327 | Thankyou sir | Thank you |
| 326 | Please provide some data on overlap syndromes sir. | We are going to have a full session on overlap in the coming weeks |
| 325 | Excellent talk Dr. Shalimar. Kudos to Dr. Makharia and team ISG for great management of master classes. | Thank you |

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| 324 | If patient presents with acute severe AIH with recent onset decompensation....and biopsy is not feasible... how to proceed ???? | Rule out all causes. Take a clinical call, with written consent for patients. prefereably do a liver biopsy |
| 323 | In a case of remission for atleast 2 yrs When can we stop immunosuppression Should we do liver biopsy prior to stopping If histology still shows mild activity How will we proceed Advise lifelong treatment or reassess later for stoppage If to reassess when and will liver biopsy again required One more If patient is on second line drugs due to intolerance or non responsiveness How long can u give Same as steroids Can we stop in them if on remission | Ideally life long therapy in AIH. Most patients will relapse if off therapy. Any activity on biopsy increases risk of relapse. As per expert guidelines- observe for biocemical remission for 2 years, IgG should be normal, liver biopsy normal for stopping therapy. Even if you stopd keep patient under close FU |