Mallory's ('alcoholic') hyaline in primary biliary cirrhosis

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SYNOPSIS Mallory's ('alcoholic') hyaline has been found in hepatocytes in 18 of 70 patients with primary biliary cirrhosis. These inclusions have previously been noted in only three cases of primary biliary cirrhosis. Current views on the nature of Mallory's hyaline are briefly discussed.

Mallory, in 1911, first described the presence of hyaline material in the cytoplasm of liver cells, especially in cases of alcoholic cirrhosis. This material comprises an eosinophilic ramifying meshwork predominantly distributed around the nucleus of the hepatocyte. Its high incidence is of considerable help in the diagnosis of alcoholic liver disease. However, similar inclusions have also been described in Indian childhood cirrhosis (Smetana, Hadley, and Sirsat, 1961; Nayak, Sagreiya, and Ramalingaswami, 1969), Wilson's disease (Popper, 1968), benign and malignant hepatocellular tumours (Edmondson, 1958; Norkin and Campagna-Pinto, 1968), and also in end-stage cirrhosis of varying aetiology (Baggenstoss and Stauffer, 1952; Popper, Rubin, Krus, and Schaffner, 1960; Becker, 1961; Scheuer, 1968). In the present communication the occurrence of hyaline in hepatocytes in primary biliary cirrhosis is reported.

Materials and Methods

Liver biopsy and/or necropsy material was available from 70 patients in whom the clinical, biochemical, serological, and histological findings were consistent with a diagnosis of primary biliary cirrhosis (Goudie, MacSween, and Goldberg, 1966; Scheuer, 1967; Sherlock, 1971). Paraffin-embedded sections of these were routinely stained with haemalum and eosin (H & E), Masson's trichrome, Gordon and Sweet's reticulin, periodic acid Schiff (PAS), and Perls' iron reaction.

Results

Mallory's hyaline was present in hepatocytes of 18 in the 70 patients, an incidence of 26%. In none of these patients was there a documented history of alcoholic abuse. In 12 of these the hyaline was noted in biopsy material, in four it was noted in necropsy material, none having been detected in an earlier biopsy, in one instance it was present in both necropsy material and in a biopsy taken three years earlier, and in one hyaline was identified in postmortem liver, there having been no earlier biopsy. The hyaline bodies tended to occur in groups, in areas adjacent to portal tracts and connective tissue septa. Cirrhosis was established in 17 of the 18 livers examined. The exception was a female of 29 in whom the only clinical features of her liver disease were a mild degree of pruritus and hepatomegaly, but in whom the biopsy showed typical features of early primary biliary cirrhosis. In none of the livers was there any significant degree of fatty infiltration.

In five instances hyaline deposits were present in fairly considerable amounts, but in the remainder there were only scanty to moderate deposits. In the one patient in whom hyaline was seen in both biopsy and necropsy material considerably greater amounts were present at necropsy. The typical features of primary biliary cirrhosis noted in the biopsy in this patient are shown in fig 1, and in fig 2 the hyaline deposits in hepatocytes are illustrated.

The presence of hyaline did not correlate with any other clinical or biochemical parameter of the disease.

Discussion

There are only brief references in the literature to the occurrence of Mallory's ('alcoholic') hyaline in primary biliary cirrhosis. Becker (1961) noted hyaline in six of 13 non-alcoholic white South Africans with biliary cirrhosis, but of unspecified type. Ament and Fenster (1970) reported Mallory's hyaline in hepato-
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Fig 1 Liver biopsy showing typical features of primary biliary cirrhosis with involvement of a small bile duct, a diffuse and focal chronic inflammatory cell infiltrate of the portal area, and a small giant cell granuloma. Haematoxylin and eosin × 66.

Fig 2 Liver from necropsy of same patient showing hyaline inclusions (arrowed) within a number of hepatocytes. Haematoxylin and eosin × 266.

cytes from three patients with chronic cholestasis, and in whom the overall histological appearances were compatible with primary biliary cirrhosis. Keeley, Iseri, and Gottlieb (1972) found typical hyaline inclusions in a liver biopsy from a 62-year-old woman with primary biliary cirrhosis and in whom none were seen on biopsy six years previously. Popper (1971) demonstrated the presence of hyaline in chronic aggressive hepatitis and observed that its occurrence in mechanical biliary obstruction and in bile infarcts was now recognized.

The distribution of the hyaline in the present material was adjacent to portal tracts and connective tissue septa, and corresponded to the distributional pattern of peripheral cholestasis which is seen in primary biliary cirrhosis. However, in no instance were any hepatocytes seen which contained both retained bile and hyaline. Whether there is a direct relationship between the hyaline and the cholestasis is not readily apparent.

The nature and origin of hyaline inclusions, while of considerable interest to hepatologists, still remain in doubt. Their distribution and tinctorial properties are well documented, and on electron microscopy they have been shown to have a distinct fibrillar character (Biava, 1964; Flax and Tisdale, 1964; Smuckler, 1968; Iseri and Gottlieb, 1971; Yokoo, Minick, Batti, and Kent, 1972). Whereas some workers have suggested an origin from giant mitochondria (Porta, Bergmann, and Stein, 1965; Steiner, Jézéquel, Phillips, Miyai, and Arakawa, 1965), more recent observations seem to leave little doubt but that the hyaline has no limiting membranes and is readily distinguished from such organelles.
References


Addendum

Since this article was prepared for publication Gerber and his colleagues (Gerber, Orr, Schaffner, and Popper, 1973) have also drawn attention to hyaline inclusions in primary biliary cirrhosis. They could not detect a morphological relationship between hyalin and cholestasis or any other hepatocellular abnormalities.

Reference

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