SHORT COMMUNICATION

Cholestatic jaundice is a form of Stauffer's syndrome

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SHORT COMMENTARY

Stauffer syndrome is an uncommon paraneoplastic condition linked to Renal Cell Cancer for a long time (RCC). It used to be known as non-metastatic nephrogenic hepatic dysfunction syndrome without jaundice because of this relationship. In the absence of direct hepatobiliary blockage or jaundice, it is characterized by reversible anicteric elevations in liver enzymes, alkaline phosphatase, Erythrocyte Sedimentation Rate (ESR), thrombocytosis, prolonged prothrombin time, and hepatosplenomegaly. In the literature, a rare atypical variant of this disease with jaundice was recently discovered. When there are no hepatic metastases, both types of Stauffer syndrome must be considered when there is unexplained cholestasis. As a result, a previously unknown malignancy could be diagnosed and treated more quickly. We give a detailed review of the literature on the icteric form of Stauffer syndrome, emphasising its association with a variety of cancers as well as the diagnostic issues it poses.

Stauffer syndrome, also known as Block-Stauffer-Rothmand's Syndrome, Thomson-Rothmand's Syndrome, 'nephrogenous hepatosplenomegaly', or 'nephrogenous hepatic dysfunction,' was first described in 1961 by an American gastroenterologist named Maurice H. Stauffer. In the absence of hepatic metastases, he observed that individuals with Renal Cell Carcinoma (RCC) showed abnormal liver function tests, hepatosplenomegaly, and nonspecific hepatitis type histopathological alterations. Surprisingly, the correction of these anomalies occurred after the tumour was removed [1].

Cholestasis is a common symptom in pancreatic, hepatic, gallbladder, and ampullary carcinomas, among others. It's commonly caused by a blockage in the major bile duct or widespread hepatic metastases, but it can also be a side effect of other cancers. Stauffer's syndrome is a rare paraneoplastic manifestation of Renal Cell Carcinoma (RCC) with elevated alkaline phosphatase, erythrocyte sedimentation rate, 2-globulin, and -glutamyl transferase, thrombocytosis, prolonged prothrombin time, and hepatosplenomegaly without hepatic metastasis or jaundice [2].

In the recent literature, three examples of an uncommon version of this disease with jaundice have been identified. We discuss the case of a patient who appeared with stomach pain and cholestatic jaundice and was diagnosed with RCC during the initial workup. After removing the tumour surgically, the jaundice and liver dysfunction disappeared totally. This case demonstrates the diverse presentations of RCC, as well as the relevance of evaluating Stauffer's syndrome and its variant in the differential diagnosis of anicteric and icteric cholestasis, which could lead to the early detection and treatment of an underlying cancer [3].

Cholestasis as a paraneoplastic illness has been widely described in patients with malignant lymphohyperplastic syndromes and renal cell carcinoma. Stauffer's syndrome is characterised by non-metastatic nephrogenic hepatic failure without jaundice. The occurrence of cholestatic jaundice due to paraneoplastic tumours is relatively rare. According to the findings, a patient with pruritus and cholestatic jaundice in the right kidney was diagnosed with Renal Cell Cancinoma (RCC). Liver failure and cholestatic icterus have both been associated to RCC. Following surgical removal of the tumour, jaundice and liver dysfunction progressively returned to normal. Cholestatic jaundice can be caused by malignancies via well-known processes. Through an unknown pathogenetic mechanism, paraneoplastic disorders linked to cancer can cause a reversible form of cholestasis.

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