



Author Response—High Altitude Liver Failure: An Infrequent Trigger

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Dear Editor,

We thank the author for showing his interest in our case and his constructive comments. We are glad in responding to the queries raised. We would like to structure our reply in a point-to-point manner in the order of the query.

1. Our patient traveled from Srinagar to Pahalgam via road and started the trek from there. He was not acclimatized. As mentioned in the manuscript, our patient developed symptoms within the first 24 hours, to be more precise he did develop dyspnea around 14 hours after exertion and was rushed to a medical facility there.

2. We do agree high altitude is not an established etiology of liver injury. However, experimental data and reports do suggest the possibility of high altitude and related liver injury via hypobaric hypoxia with exertion and related rhabdomyolysis which we attribute to in our case.^{1,2}

3 and 4. We acknowledge that we missed out mentioning hepatitis work up in the published manuscript. Upon arrival to our services, hepatitis A, B, C, E serology, tropical fever workup were done. Drug history, native medication history was elicited, cardiac workup to rule out congestive hepatopathy were done. Patient is a known case of autoimmune hepatitis diagnosed 1 year prior to the event as mentioned in the initial portion of the manuscript. He was not compliant to medications.

5. We did not do testing for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) as the clinical presentation is likely acute decompensation of liver disease and guidelines does not mandate routine testing for SARS-CoV-2 for all patients except upon clinical suspicion.

6. High-altitude sickness is more a systemic maladaptation predominately involving brain and lungs; however, other organs can be involved as well. Acute high-altitude illness is normally observed at an altitude more than 2,500 ft from the sea level.³

7. Our patient complained of muscle soreness which is not usually a sign of liver disease as rightly emphasized by the author,

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which along with acute renal injury (KDIGO 3) led us to send CPK levels and related workup which led us to the possibility of hypobaric hypoxia-related rhabdomyolysis which possibly might have triggered liver injury.

We once again thank the author for his valuable comments on our manuscript and hope this letter addresses all the queries.

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