Reply to Correspondence

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\textbf{Running Head:} Reply to Correspondence

\textbf{Keywords:} Autoimmune hepatitis, Histology, Diagnosis

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Dear Editor,

I would like to appreciate Dr. Haeryoung Kim and Dr. Sook-Hyang Jeong for their Correspondence as a reply to my editorial entitled “Evaluation of the histological scoring systems of autoimmune hepatitis (AIH): A significant step towards the optimization of clinical diagnosis.” As a general hepatologist, I read the Correspondence from two pathologists with great interest. Firstly, though their study entitled “Comparison of four histological scoring systems for autoimmune hepatitis (AIH) to improve diagnostic sensitivity” clearly validated lobular hepatitis as an important histological component in the diagnostic process for AIH, even for that with acute presentation, in Correspondence they pointed out and thought seriously about the relevance of cooccurrence of at least mild interface hepatitis in the lobular hepatitis-predominant AIH cases. Indeed, lobular and (portal)interface hepatitis are topologically distinct pathological features, but may not only coexist, but might also transit in the liver of AIH. Moreover, the components of each lesion are lymphoplasmacytic infiltrates in common. I could paraphrase this issue into the outstanding question, namely, how are lobular and interface hepatitis in AIH spatiotemporally associated with? Spatial transcriptomic analysis of the lobular hepatitis-predominant AIH cases with mild interface hepatitis may give us clues to this question and deepen our understanding for the pathognomonic features of each pattern of hepatitis in AIH.

Secondary, they highlighted another diagnostic conundrum in Correspondence, that is, the differentiation between AIH and drug-induced liver injury with AIH-like features (DI-AIH), again with regard to the context of demarcated hepatic inflammation. Though a previous literature from relatively large cohort of patients diagnosed at the Mayo Clinic have not been able to distinguish between classical AIH (n=237) and DI-AIH (n=24) in histological analysis, the fact that suspected drugs in the study were predominated only by minocycline (n=11) and nitrofurantoin (n=11) may be a threat to external validity of their analysis. In that sense, I agree with their comment for the importance of reevaluation of histological differences between AIH and DI-AIH with existing histological scoring systems by a multicenter or multinational study, including cases of wide range of suspected drugs, coupled with sufficient clinical information.

I should finish this Reply with the encouragement to our colleagues, hepatologists and pathologists, to continue active communication to optimize the histological diagnosis of AIH, as being emphasized by Dr. Haeryoung Kim and Dr. Sook-Hyang Jeong. Bidirectional dialogue over laboratory findings, medication history, and histopathological interpretation of liver biopsies among us, even with assistance from artificial intelligence.
in the future, is surely a driving force to tackle the unmet needs of AIH, a disease with dynamic and rather heterogenous manifestation.
REFERENCES


