ROYAL FREE HOSPITAL
POND STREET
LONDON NW3 2QG

TELEPHONE 0171 794 0500

THE ROYAL FREE HAMPSTEAD
Royal Free Hospital
NHS TRUST

HAEMOPHILIA CENTRE & HAEMOSTASIS UNIT
Director: Dr Christine A Lee MA MD DSc (Med) FRCP FRCPath
Consultant: Dr K John Pasi MB PhD MRCP MRCPCH MRCPath
Senior Lecturer: Dr David J Perry MD PhD MRCP FRCPath

Tele No: 01718302068
Fax No: 0171 830 2178
E-mail: kjp@ GRO-C

PA/KB/919375

14 March 1997

Dr D Kirby
The Surgery
Nevills Road
Letchworth
Herts SG6 4TS

Dear Dr Kirby

**Re: Mark WARD DoB GRO-C 69**
**GRO-C**

**DIAGNOSIS:**
1. **SEVERE HAEMOPHILIA A (LEVEL 0 U/DL)**
2. **HIV POSITIVE (CD4 COUNT 5 X $10^6$)**
3. **HEPATITIS B/HCV CHRONIC HEPATITIS**
4. **GASTRITIS AND GASTRIC ULCER**
5. **PYREXIA OF UNKNOWN ORIGIN**

Mark has attended the Haemophilia Centre on a number of occasions over the last two weeks. His major symptoms are of epigastric pain, vomiting, anorexia, some associated loin pain, fever and night sweats, and more recently a dry cough but no shortness of breath on exertion. On examination he was very emaciated with no pallor or jaundice. He had shotty lymph nodes in the left sub-mandibular region and both groins. There was no oral candidiasis. He had a low grade fever. Cardiovascular and respiratory examination was unremarkable with oxygen saturations of 96% on air. His abdomen was firm with some tenderness in the epigastric region. There was no organomegaly.

Investigations

MSU - no white blood cells, occasional epithelial cells > $10^5$ E.coli/ml, sensitive to augmentin and cephalexin. EMUs for AFBs awaited, stool culture awaited. Haemoglobin 13.8, white count 5.0, platelets 156, no malarial parasites were seen. Urea and electrolytes normal, bilurubin 5, AST 21, ALT 15, alkaline phosphatase 180, CRP 34 mg/l (raised), CMV PCR negative, blood cultures x 2 negative, blood cultures for MAI x 3 awaited, CD4 count 5 x $10^6$, HIV viral load awaited. Chest x-ray clear, ultrasound of the renal tract normal with no evidence of haematoma. An endoscopy performed on 26 February showed moderate candidiasis in the oesophagus with mild anteral gastritis and a 3 mm ulcer in the antrum. A CLO test was negative, a CMV DEAFF test on the brushings was negative and the histology of the gastric biopsy showed chronic gastritis.

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Management and Progress

It was felt that Mark's dyspeptic symptoms reflected a simple gastric ulcer with associated gastritis. There was no evidence of helicobacter or a recurrence of his previous CMV gastritis. He was initially treated with a two week course of ranitidine without significant benefit and we have therefore changed him to omeprazole 20 mg once daily. Additionally he received a two week course of fluconazole 200 mg once daily for his fungal oesophagitis. On this regime his epigastric pain and vomiting appeared to be improving and his appetite is returning. The cause of Mark's loin pain is unclear but it may be associated with his urinary tract infection which was treated with a ten day course of oral cephradine with improvement in his symptoms. A follow-up MSU was clear. Currently Mark's major problem is of a persistent fever up to 38.5° with associated night sweats. Mark was reviewed by Dr Lee who felt that this fever was likely to represent an opportunistic infection associated with Mark's HIV. It was decided that he should be treated with an empirical trial of anti-mycobacterium avium intracellularie triple therapy. Additionally Dr Lee felt it would be helpful for him to restart on double anti-viral therapy with zidovudine and 3TC in order to decrease his HIV viral load. We may consider the further addition of a protease inhibitor at a later stage. Finally, in view of his low CD4 count we have restarted prophylaxis with septrin, fluconazole and clarithromyin. His drugs currently are as follows:
septrin 960 mg bd three times weekly, fluconazole 50 mg once daily, clarithromycin 500 mg bd, AZT 200 mg bd, 3TC 150 mg bd, rifabutin 300 mg once daily, ethambutol 700 mg once daily, omeprazole 20 mg once daily, metoclopramide 10 mg prn. I have explained the gravity of Mark's situation to both him and his partner and emphasised the importance of compliance with his drug therapy. We will of course monitor his progress very closely as an outpatient, but if you are at all concerned about his condition please do not hesitate to contact us. He will be reviewed by Dr Lee on Tuesday 18 March.

Yours sincerely

GRO-C

pp Dr Persis Amrolia
Registrar in Haematology