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Department of Haematology

He remained well until 1.4.92 when he was re-admitted for investigation of severe headache. He had been noticing difficulties with his memory at this time and he underwent a brain scan. This was carried out on 8.4.92 and demonstrated cerebral atrophy. He was treated symptomatically and was discharged to be re-admitted for his final admission on 19.5.92, at which time it was clear that his memory loss was acute, he had severe frontal headache, he had liver failure related to his carrier status for Hepatitis B and Hepatitis C, he had gross loss of weight and it was a thankful situation that his condition deteriorated rapidly and he went into a coma and died on GRO-A 1992.

The patient had been on AZT for two years up until his admission to hospital in August 1991. In January his CD4 count was 130, April it fell to 70, it maintained its level at 70 and at the time of admission to hospital it had dropped to 10, thereafter it was seldom detectable until his death. The patient died in coma from a mixture of hepatic failure, cirrhosis, viral hepatitis and HIV progressing to AIDS. He had a further confirmatory brain scan which indicated complete cerebral atrophy on 27 May.

In summary; severe haemophilic who was a carrier for Hepatitis B and Hepatitis C who developed HIV illness commencing with seborrheoic dermatitis, oral candidasis and despite AZT treatment his CD4 counts progressed to 0. He had had at least two episodes of PCP infection with aspergillosis and died with weight loss, cerebral atrophy.

I apologise for the length of this report but hope that it is adequate for your purposes. I have now re-found the pink follow-up form but really it does not seem very appropriate to try and fill it in but I will fill in a couple of results and send it with the letter.

With apologises for the long delay,

Yours sincerely

E E Mayne
Consultant Haematologist

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Department of Haematology

30 November 1992

Dr Ann Marie Swart
Concorde Trial Physician
MRC HIV CLinical Trials Centre
Department of Clinical Epidemiology
Royal Brompton National Heart
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LONDON SW 3 6NP

Dear Dr Swart

I apologise for the long delay in making a response to your letter of 25 September 1992 regarding the patient enrolled in the Concorde Trial AX11012. I also regret having mislaid the follow-up form, however I will provide you with as much information that I can in letter form and hope that it will suffice. I realise fully that you are attempting to complete all the records on these patients for early in the New Year.

The patient was admitted to the Haematology Unit on 23 August 1991 with a two week history of productive cough, severe night sweats, central chest pain etc. A diagnosis of PCP pneumonia was made. Initially he was treated with high dose Co-trimoxazole and Diflucan in addition to the standard nursing care. He was also given Methylprednisolone 125 mgs daily for several days, however by 1st September his condition had continued to deteriorate and he was therefore changed to intravenous Pentamidine. Ten days later his sputum cultured Aspergillus and he was also given intravenous Amphotericin. His condition gradually improved but by 18 September he developed severe epigastric pain and had a serum amylase elevated at 1145 U/l. A diagnosis of pancreatitis complicating Pentamidine was made. The patient was fit for discharge on 14 October and he went home on Diflucan and other medications such as Frusemide, Ranitidine and Sandocal.

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