

Witness Name: **GRO-B**

Statement No.: WITN1991001

Exhibits: WITN1991002-WITN1991017

Dated: 17 December 2019

EXHIBIT WITN1991017

INFECTED BLOOD PUBLIC INQUIRY

0204



DEPARTMENT OF
GASTROENTEROLOGY

City General, Newcastle Road, Stoke-on-Trent, ST4 4QC.
Telephone: 01782 612333. Facsimile: 01782 712832.

AMB/CTN **GRO-B**

22 April 1998

Clinic: 20 April 1998

Dr **GRO-B**

GRO-B

PRIVATE AND CONFIDENTIAL

Dear Dr **GRO-B**

re: **GRO-B**

Diagnosis: Hepatitis C antibody positive
 Abnormal liver function tests
 Post-transfusional hepatitis 1989

I reviewed this Practice Nurse who had a severe RTA in 1989, had a blood transfusion and was subsequently identified by the look back study. He had mildly abnormal LFT's in November and December 1996 with slight rises in his transaminases and Alk. Phos. He has been seen by my colleague, Dr. Howling, but is extremely distressed and depressed about the diagnosis and had not sought further intervention. He has however, cut back on his alcohol. He is otherwise completely well, takes no medication, is married with one child.

Today I discussed with him the risks of progression of liver disease. 80% of people who get Hep C get chronic infection. Around 80% of those get a mild chronic hepatitis and 20% appear to have a very, very, very insignificant inflammation in the liver. Of the 80% with chronic hepatitis a third progress to cirrhosis in less than 20 years. These patients particularly, have infection when they are older, over 50, male and drink alcohol. A third progress between 20-50 years and a third progress in greater than 50 years i.e. they never have problems in their lifetime from Hepatitis C. I think this is probably a more rosy picture than that given by Dr. Bowring. I also suggested the evidence that

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0205



Hepatitis genotypes were related to severity of disease was uncertain and I could see no merit in checking Mr [REDACTED] genotype, nor could I see a merit in looking for his viral load. I suggested to him the sure way to stage disease was to perform a liver biopsy. I also believe the risk of infection to spouse and children is extremely low but I understand that Mrs [REDACTED] is Hep C negative. It is also recommended that mothers should breastfeed their baby if they are Hepatitis C antibody positive unless there are risk factors for a high viral load such as co-infection for HIV. I see no reason to check HIV in Mr. [REDACTED] as I am sure his blood donor found to be Hep C positive, would have been checked for this. I give him a video with more information about Hepatitis C.

I have arranged an ultrasound scan, checked bloods for screen for other causes of liver disease with ferritin, ceruloplasmin, auto-antibodies, Hepatitis B markers. I have repeated his Hep C antibody and checked Hep C RNA and repeated liver function tests. If they are persistently abnormal, I believe we should proceed to a liver biopsy to stage disease and determine requirement for treatment either with interferon or interferon with ribavirin.

Yours sincerely,

ALISON M. BRIND
Consultant Gastroenterologist



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DEPARTMENT OF
GASTROENTEROLOGY

City General, Newcastle Road, Stoke-on-Trent, ST4 6QQ.
Telephone: 01782 553383. Facsimile: 01782 712852.

AMB/CTH **GRO-B**

19 August 1998

GRO-B

PRIVATE AND CONFIDENTIAL

Dear **GRO-B**

I am sorry to have missed you in the clinic. We reviewed your liver biopsy at our histological meeting and as reported, it was virtually normal. There was just a hint of mild inflammation but absolutely no scar tissue and no significant inflammation that I would feel would require treatment.

As my Registrar suggested, we should check your liver function tests on a 6 monthly basis. I would suggest that we repeat the liver biopsy in 3 years time. If there has been any progression in your liver disease we should then consider treatment. Also, if in the meantime, better treatments for Hepatitis C become available, we would consider treatment in your case simply to eradicate the virus from your blood.

I understand you were asking about Hepatitis C and your occupation. At present, there are no guidelines for Hepatitis C and there are no plans to screen health care personnel for Hepatitis C. There are guidelines for Hepatitis B that suggest patients with Hepatitis B in their blood should not perform exposure-related procedures. This usually involves putting at least one hand in the body and I believe these should be the guidelines for Hep C patients. You should also take sensible precautions if you have a cut or open wound. We will see you again as planned in the clinic in 2 months.

Yours sincerely,

ALISON M. BRUND
Consultant Gastroenterologist

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North Staffordshire Hospital **NHS**
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Ref: AMB/CTH **GRO-B**
1st May 2002
Clinic: 29 April 2002

Department of Gastroenterology
City General
Newcastle Road
Stoke-on-Trent
ST4 8QG

Tel: 01782 553101
Fax: 01782 712062

Dr **GRO-B**
GRO-B

Dear Dr **GRO-B**

Re: **GRO-B**

Diagnosis: Hepatitis C genotype 1a
Liver biopsy 1998 virtually normal. Liver function normal.

I reviewed **GRO-B**. Unfortunately, he has the genotype which responds less well to treatment. I gave him a 40% chance of responding after a full year's treatment. It is a grey area whether he should receive treatment or whether he should await developments. It is also very uncertain whether, with his mild disease, if he is going to progress into significant fibrotic disease. We plan to repeat his ALT on several occasions. If it is persistently normal, or virtually normal, he has a 95% chance of having very mild disease.

I have left him to consider whether he wishes to wait, whether he wishes to have a repeat liver biopsy to exclude significant disease, or whether he wishes to have treatment knowing his low response rate and his mild disease without a further biopsy. Investigations: full blood count, liver function. Review 2 months.

Yours sincerely

ALISON M. BRIND
Consultant Gastroenterologist

No trace of blood tests at Lab.

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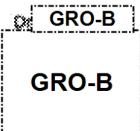
University Hospital of North Staffordshire **NHS**

NHS Trust

Ref: AMB/CTI **GRO-B**
22nd March 2005
Clinic: 21st March 2005

Department of Gastroenterology
City General
Newcastle Road
Stockton-on-Trent
ST4 8QQ

Tel: 01782 552383
Fax: 01782 712052



Dear Dr **GRO-B**

Re: **GRO-B**

I reviewed **GRO-B** in the clinic. His liver function has not deteriorated particularly with AST 47, ALT 60, albumin 44, glik phos. 61, gamma GT 48, bilirubin 35. I note when we first saw him it was 18 but was 27 last year. Full blood count is normal. He did appear to have rather a large spider naevus on his nose and one other on his arm. Although his last biopsy showed mild portal tract inflammation and no fibrosis I had minor concerns that there might have been progression in his liver disease.

He is fairly ambivalent about further treatment and asked my opinion. I admitted that at present, there was no alternative treatment on the horizon for at least 5 years; that as he aged, his risk of fibrotic liver disease increased but he was still at relatively low risk. I said that he had at least a 50% chance of responding to treatment. We would check this at 3 months and if he were a responder at 3 months, he would then have an 80% chance of response to treatment. With this information, he felt he would go for treatment and I will therefore arrange for him to be placed on our waiting list and hope he will be treated within the next year.

Yours sincerely

ALISON M. BRIND
Consultant Gastroenterologist



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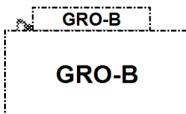
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University Hospital of North Staffordshire **NHS**
NHS Trust

Ref: AMB/CTH **GRO-B**
4th March 2006
Clinic: 2nd March 2006

Department of Gastroenterology
City General
Newcastle Road
Stoke-on-Trent
ST4 6QG

Tel: 01782 552383
Fax: 01782 712052



STRICTLY PRIVATE AND CONFIDENTIAL

Dear Dr **GRO-B**

Re: **GRO-B**

I reviewed **GRO-B** with his wife. There had been major concerns and upset as the HCV titre that I requested at 3 months was extremely delayed. It appears that initially Virology did not forward it to the reference lab for HCV viral titre. I am uncertain why this happened. We did get the result last week and I phoned **GRO-B** and his wife. It showed that there had been a significant fall in titre from 700,000 to less than 800. Treatment has therefore, initially been effective and should continue for one year.

GRO-B wife was also concerned that earlier on in treatment, the prescription had only been for 0.4ml of pegylated interferon and whether this was the full dose that **GRO-B** should have been receiving at 120ug. I unfortunately can find none of the documentation about this but am aware that pegylated interferon treatment syringes can be of different sizes and he may still have been receiving 120ug albeit in 0.4ml. I was also concerned about his neutrophil count but it is satisfactory today. He continues on pegylated interferon 120ug weekly with his ribavirin 600mg b.d. He will be seen again in the nurse led clinic in 3 weeks.

Yours sincerely

AJISON M. BRIND
Consultant Gastroenterologist

13 MARCH 2006 - 15083



University Hospital of North Staffordshire **NHS**

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DEPARTMENT OF GASTROENTEROLOGY

City General Hospital

Newcastle Road

Stoke-on-Trent

ST4 8QG

Tel: 01782 552383

Fax: 01782 712032

4th October 2006



SIMPLY PRIVATE AND CONFIDENTIAL

Dear Dr **GRO-B**

Re: **GRO-B**

I reviewed **GRO-B** in the clinic with his wife. He completed treatment on 10.9.06. End of treatment HCV RNA was below the detection limit of the assay. He is aware that there is still a chance of relapse; in all-comers this is about 50%, but I did agree that he had actually fully completed the 48 weeks treatment and it probably gave him a lower rate of relapse. There is nothing I can do in the interim to improve his chance of sustained response.

I will see him again in 6 months time. If he relapses, I would consider referral to Birmingham for some of the drug trials in protease inhibitors.

Yours sincerely

ALISON M. BRIND
Consultant Gastroenterologist



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