Witness Name: Karen Fox

Statement No.: WITN2012001

Exhibits: WITN2012002 - WITN2012019

Dated: 16 March 2020

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Royal Free Hospital Pond Street London ฟฟร 2QG

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GMD/DICT/270			
23/12/2010			
Dr Postgate 87-89 Prince O' Kentish Town London NW5 3NT	f Wales Rd		

Dear Dr Postgate

Karen Fox - DOB: GRO-C 1963 Re:

Diagnoses:

1. Hepatitis Cigenotype 1 infection.

2. Pre-eclampsia and end stage renal failure, 1989

Long-term anticoagulation.

4. Two previous live related kidney transplants.

5. Cadaveric renal transplant 2000.

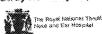
Nephrogenic fibrosing dermopathy, secondary to Gadolinium, 2000. 7. Renal transplant. Arterial thrombosis graft failure, November 2009.

8. Recent combination of pegylated interferon and Ribavirin for hepatitis C infection. Discontinued due to features of bone marrow suppression.

I was pleased to see this patient again today. I note that she has had several FibroScans. The FibroScan reading taken on 27th March 2010 showed a reading of 15.6/9.7/100%. She subsequently, on 6th October 2010, had an ELF test which showed a reading of 11.86; the interpretation is moderate to severe fibrosis. She had another FibroScan on 4th October 2010, which showed the median stiffness was 15.6 but the IQR was 9.7.

On balance these tests could reflect at least moderate fibrosis. However, her liver function is good, although her prothrombin time shows some worsening. I have explained that she is a long way away from any hepatic decompensation. It is most important that we continue to





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monitor her status carefully. It would be helpful in the future to be able to treat her hepatitis C with newer agents that are Interferon sparing, as these are developed over the next few years. I would have to be optimistic that we can reach that point at least for some patients.

I thought that we test her IL28b polymorphism which I have explained to the patient. She needs regular ultrasound surveillance and alpha-fetoprotein monitoring. I have also repeated the FibroScan again today. She will need careful monitoring. An ultrasound and alpha-fetoprotein have been booked. The transaminases are a spurious guide to a degree of fibrosis as these remain normal on dialysis in her case.

She may be a candidate for new direct acting antivirals when these are available given her sensitivity to Interferon. However these will worsen her anaemia and if we do decide to treat with a regimen of a direct acting antiviral say. Telaprevir or Boceprevir, together with Interferon and Ribavirin, we will have to anticipate quite severe anaemia with a necessity for an increasing EPO as well as the possibility of requiring blood transfusion to support her haemoglobin during treatment. However, treatment with these agents remains a possibility. It would be helpful to clear the hepatitis C virus to arrest the apparent progression of her disease.

Yours sincerely,

dictated & electronically reviewed

Professor G. M Dusheiko MB BCh FCP (SA) FRCP FRCP (edin) Professor of Medicine and Honorary Consultant

CC:

Ms Karen Fox

GRO-C