Witness Name: Ingrid Western
Statement No.: WITN2062001
Exhibits: WITN2062002-
WITN2062024
Dated: 14 August 2019

INFECTED BLOOD INQUIRY

EXHIBIT WITN2062011

LIVER TRANSPLANTATION AND HEPATOBILIARY MEDICINE

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DP/MC/525464

30th December 1999
clinic 23.12.99

Dr G Webster
Research Fellow to Professor Dusheiko
RFH

Dear George

Re: Ingrid Western dob GRO-C mobile Number GRO-C Home GRO-C
GRO-C

Diagnosis: Chronic Hepatitis C
Thrombocytopenia and Splenomegaly suggestive of portal hypotensive
Previous Hodgkin's disease in remission, following bone marrow transplantation 1988
Premature ovarian failure secondary to chemotherapy
HCV genotype 1A

Thank you for referring this fascinating lady who developed Hepatitis C as a consequence of her blood transfusions during her period with Hodgkins. In 1995 a liver biopsy showed developing cirrhosis with iron overload. The iron was principally kupffer cells bound as opposed to hepato-cytes. She commenced interferon 4.5 mg unit three times a week in June 1995 and continued this for three months but this was stopped when her platelet and white count fell. She had a combination of interferon and ribavarin commencing in February 1997. This stopped in May 1997.

In 1994 she was veno-sected approximately 20 units with a reduction in her ferritin but this was not continued. In addition she has had laser treatment for spider naevi. In herself she feels well although has intermittent pruritis. She continues to work and is self employed working in the media business. She is single. She takes alcohol occasionally and smokes occasionally (tobacco only). Her last ferritin was 2411.

On examination she has spider naevi. Her heart sounds were normal. Her chest is clear and abdominal examination revealed palpable hepatomegaly although I am afraid I was unable to feel the spleen. There was no evidence of ascites. She appears to have a cryoglobulin anaemic rash affecting her leg.

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Her most recent transaminases show that she has an ALT of 99 with a normal value of 17.

EXAMINATION

She looked well. Her blood pressure was 130/70. There was no clubbing, cyanosis, jaundice, pallor or oedema. Examination of the neck revealed a systolic thrill at right base, but there was no thyroid enlargement.

Examination of the chest and heart was within normal limits. She had a previous incision scar from her biopsy in the right axilla. Examination of the abdomen was normal and there was no hepatosplenomegaly. Examination of the extremities was within normal limits.

ASSESSMENT

Miss Western has elevated amino transferases following blood transfusion and is known to be hepatitis C positive, and therefore has chronic hepatitis C. She also has thrombocytopaenia with platelets from her most recent examination of 42,000. I believe that her hepatitis C warrants treatment but do not think she would be a good candidate for alpha interferon because of the risk of thrombocytopaenia, as you correctly point out in your referral letter.

It may be possible to treat her with ribavirin as this is a nucleoside analogue which has been known to suppress hepatitis C in a proportion of patients. We have obtained reasonable results in patients treated in a pilot study, and have now embarked on a placebo controlled study. It is difficult to obtain ribavirin through the NHS at the moment from this hospital, but I could make enquiries. Alternatively, Miss Western could be, if she agrees, entered into our trial of ribavirin shortly. She will evaluate what I have told her and see me in four weeks when we will make a decision as to whether we will try to obtain ribavirin for her through the NHS or whether she will enter the study. I hope we will see some improvement in her transaminases.

A liver biopsy is not mandatory at this stage, but if it is done it will be have to be done as a plugged procedure under CT guidance to reduce the risk of bleeding. I am not sure of the reason for the neck bruit, but thought an ultrasound of the carotids would be

GRO-C

G M Dusheiko FCP (SA) FRCP
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