Mr. GRO-D, F.R.C.S.Ed.

Telephone:
[redacted]

GRO-D

16 August 1997

MEDICAL REPORT on:-

WILLIAM AUGUSTINE MURPHY (deceased),

(d.o.b. GRO-C 34)

GRO-C

LIVERPOOL GRO-C

INSTRUCTING SOLICITOR:

IRVINGS,

MINSTER HOUSE,

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MEDICAL REPORT PREPARED BY:-

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BACKGROUND.

I have been asked to prepare a report on WILLIAM AUGUSTINE MURPHY (deceased), in relation to his wife's potential claim against the GRO-C for damages for medical negligence following his death soon after a malignant liver tumour had been diagnosed during his assessment for a liver transplant operation, that operation being considered necessary as a result of cirrhosis of the liver, secondary to chronic hepatitis C with portal hypertension.

This report is based on a study of photocopies of his extensive hospital case notes from the GRO-D, (Hospital Records Number GRO-D); photocopies of his hospital case notes from the Freeman Hospital, Newcastle upon Tyne, (Hospital Records Number GRO-C); photocopies of his general practitioner records; photocopies of an Advice on Limitation and Further Enquiries, supplied to Irvings by Scott Donovan, dated 19th February, 1997; photocopies of a File Attendance Note dated 10.5.96; photocopies of two statements made by Maureen Murphy, dated 10th April 1995 and May 1997; a photocopy of his Death Certificate dated 5.9.94, and a photocopy of an article, "LITIGATION AND THE HEPATITIS C VIRUS" published in THE BULLETIN - March 1996 13.

Counsel has identified the involvement of general surgeons in his management from early 1992 onwards, and has requested that this claim be reviewed by a General Surgeon. However, it is clear from

my study of the above documents that much of the Expert Evidence in this case will have to be obtained from experts in the field of Haematology and Hepatology, and it would appear from your letter dated 15 July 1997 that this is already in hand.

I note that any allegations of negligence must fall within the three year period prior to the death of William Murphy on 3.9.94, and it is during this period that I have primarily concentrated on. However, it is the events prior to this period, apparently from November 1968 onwards, which caused the events in this three year period, and I have therefore dealt with the general surgical aspects during this period also.

William Augustine MURPHY (deceased).

SUMMARY OF CASE.

Mr. Murphy had a long recorded history of "gastric" problems.

In November 1968 his General Practitioner records note an episode of gastritis which presented as a haematemesis and melaena. This settled on conservative management, but he required a transfusion of six units of blood, as well as the administration of six units of cryoprecipitate.

In July 1969, a "small Duodenal Ulcer" was responsible for an episode of melaena, and a letter in his notes, dated December 1971, refers to a duodenal ulcer which has bled on three occasions, necessitating admission to hospital. A further episode of melaena was noted in November 1972.

In December 1978 he was once more admitted with melaena, requiring transfusion with both cryoprecipitate and fresh blood, and this was once more treated conservatively. This was complicated by the development of jaundice in March 1979, when he was diagnosed as suffering from acute hepatitis, and was found to have a positive Australia Antigen test.

In December 1980, he was once more hospitalised after a further bleed, which required cryoprecipitate and blood transfusion. Again, this settled on conservative management.

Over the years he had been prescribed many "anti-ulcer" preparations, which more latterly had included full treatment regimes of H2 Antagonists, as well as maintenance courses, but despite this he was once more readmitted in November 1981 with a further Gastro-intestinal bleed, requiring cryoprecipitate and blood transfusion. His hospital admission notes record a previous history of six previous admissions with this same problem which had required blood transfusion.

Despite settling initially on conservative management, and Mr. Murphy being discharged, he re-bled shortly afterwards and had to be re-admitted. This led to his truncal vagotomy and pyloroplasty operation on 24.11.81, when a scarred duodenal cap containing a small anterior ulcer was noted. Although his initial recovery from the surgery was uncomplicated, and he was discharged home on 4.12.81, he unfortunately developed a secondary haemorrhage and jaundice some 5 days later and had to be readmitted for further treatment, which was once more conservative. The bleeding stopped and he was once more discharged on 15.12.81. The jaundice was thought to be due to viral hepatitis as a consequence of his Factor VIII replacement.

Although the first mention of joint problems relating to his haemophilia were recorded in December 1971, these became more prominent during the 1980's, and he was managed by the haematologists. with the regular usage of Factor VIII.

At a routine review in their clinic in July 1987, he was noted by the haematologist to have been jaundiced x 2, although it is not clear whether this had happened over the preceding 6 months, or whether it applied to the previous recorded episodes of jaundice. However, he was noted on examination at this visit to have a palpable liver and "slight splenomegaly".

In April 1990, he was noted to have a left inguinal hernia, and was referred to Mr. Leinster's clinic, where he was seen on 22.5.90. In the absence of significant problems from this, no active management was advised at that stage because of the haemophilia, but on 22.10.90 the hernia became more painful, and subsequently irreducible.

It was therefore repaired on 24.10.90, when operative findings indicated that this was mainly an encysted hydrocele of the cord, although a small indirect sac and weak posterior wall were also present. The hydrocele was excised, and the hernia repaired in standard fashion. He made an uneventful recovery from this, and was discharged on 27.10.90.

His left knee then became problematical, and he was put on Professor Klenerman's Waiting List for a left total knee replacement. Prior to it being performed, he was reviewed by Dr. C. Hay, Consultant Haematologist, and in a letter dated 7 October 1991, he writes:-

"He is increasingly disabled with his left knee and can hardly walk. The pain is quite severe and keeps him awake at night. I am sure he justifies knee replacement and is now again very anxious to go through with the operation..... the patient accepts the usual risks which have been explained to him in detail both by yourself and us."

Dr. M. Cohen, Consultant Anaesthetist, performed a thorough anaesthetic check prior to surgery, and concluded that "this patient is fit for the proposed surgery".

A left total knee replacement was performed on 10.12.91. Although the operation itself appears to have been straightforward, a post-operative Deep Vein Thrombosis was suspected, although this was never confirmed.

A significant haemarthrosis developed post operatively, which significantly delayed his recovery, and eventually on 28.1.92, the joint was re-opened, and the haemarthrosis evacuated. From then on, the rate of his recovery improved, and he was discharged home about a month later.

Whilst he was an in patient however, a further haematemesis was noted on 4.1.92, following the administration of Voltarol, which was subsequently stopped, and an episode of "spitting frank blood" is also recorded.

On 13.1.92, marked testicular swelling was noted, but this was part of a general "oedematous state", tied in with possible ascites and possible elevation of his JVP, thought to be due to liver dysfunction secondary to chronic liver disease.

The following day Dr. Hay saw him and added Frusemide to the Spironolactone which had already been started and wrote the comment quoted by Mrs. Murphy:-

"Had we appreciated the severity of his liver disease we would not have proposed surgery in the first place. I think that his recent bleed probably reflects haemophilia, diminished platelets, mildly disordered coagulation secondary to liver disease....I have told him his liver disease (of which he is aware) has worsened and is contributing to his bleeding tendency. I have spoken with his wife and have told her I think he has cirrhosis. He and she are also aware of the risk of infection."

However, on 16.1.92, Dr. Hay was of the opinion that the coagulopathy contributing and complicating his haemophilia was DIC ? cause, rather than liver disease, although the low urea and albumin and fluid overload suggested hepatic damage.

An ultrasound on this day showed gross ascites with a large spleen. The liver had a homogenous texture, but was essentially normal. "No varices were demonstrated but cirrhosis will need to be considered."

The following day, Dr. Johnson was of the opinion that he had chronic decompensated liver disease and a degree of DIC.

A gastroscopy was performed on 20.1.92, which was normal apart from showing "3 columns of varices from 32 cm. No evidence of a recent bleed from varices."

Tests of liver function (LFT's) had been performed throughout his stay in hospital on this occasion.

On 6.12.91, pre-operatively, LFT's were as follows:-
Alk. Phos 96 (35-130), Albumin (Alb) 33 (30-50), Globulin (Glob) 35 (23-35), Total Bilirubin (Bili) 21 (2.0-17.0), Alanine Amino Transferase (ALT) 179 (7-45), and Gamma Glutamyl Transferase (GGT) 37 (0-65).

These were checked again on 11.12.91, and again on 13.12.91, when the results were:- Alk. Phos 73 (35-130), Alb 26 (30-50), Glob 26 (23-35), Bili 24 (2.0-17.0), ALT 83 (7-45), and GGT 21 (0-65).

LFT's (15.1.92):- Alk. Phos 96 (35-130), Alb 27 (30-50), Glob 35 (23-35), Bili 35 (2.0-17.0), ALT 43 (7-45), and GGT 27 (0-65).

LFT's (20.1.92):- Alk. Phos 100 (35-130), Alb 28 (30-50), Glob 36 (23-35), Bili 29 (2.0-17.0), ALT 40 (7-45), and GGT 23 (0-65).

LFT's (11.2.92):- Alk. Phos 112 (35-130), Alb 32 (30-50), Glob 36 (23-35), Bili 18 (2.0-17.0), ALT 77 (7-45), and GGT 26 (0-65).

LFT's (19.2.92):- Alb 32 (30-50), Glob 36 (23-35), Bili 21 (2.0-17.0), and GGT 28 (0-65).

Haematology and clotting investigations had also been performed on a very regular basis.

After discharge he developed gynaecomastia related to the Spironolactone, which had to be changed, and he also complained of intermittent pruritis, although his LFT's stayed at about the level they were at the time of his discharge, although the ALT fell to within normal range. His hepatitis state was checked and he was found to be Positive for Hepatitis C.

Mr. Murphy had had his hepatitis state checked previously. Checks had been made at regular intervals from February 1986 until July 1989. This had been the last check done prior to March 1992. His HIV status had also been checked, and was negative.

On 18.4.92, he was admitted under Dr. Hay, having bled from his varices. This was confirmed by gastroscopy the same day after he had been referred to the "GI bleed team" and subsequently transferred to the Surgical High Dependency Unit.

A decision was taken by Professor Shields on 20.4.92 to perform another gastroscopy and treat the varices with sclerotherapy, which was done in conjunction with the haematologists on 21.4.92. He was finally discharged on 27.4.92, by the haematologists, after they had actively managed him following his sclerotherapy.

10 He was readmitted again by the haematologists on 30.4.92 after a further bleed. Again, he appears to have been managed primarily by the haematologists, apart from having a further diagnostic gastroscopy, and insertion of a central line. This was followed by further sclerotherapy on 5.5.92. The Haematologists were left to discharge him when they were happy, which they did on 11.5.92.

A further melaena led to his readmission on 14.5.92, when again gastroscopy confirmed bleeding varices to be the source. He was managed conservatively, again in conjunction with the Haematologists, until further sclerotherapy was performed on 19.5.92. He was then discharged by the haematologists on 22.5.92.

Mr. Murphy's next admission took place on 7.6.92, under the joint
11. care of Professor Shields and Dr. Hay. This was an elective admission, the intention being to do a "full liver work up".

However, Dr. Hay was not happy for this to happen, and "considers it essential to restrict investigations to OGD and Sclero and anything else vital. Clearly prognostic indicator assessment is not vital. He was therefore discharged after full explanation and apologies, to be readmitted at the end of the month for further endoscopy and sclerotherapy, this being performed when the haematologists were happy, on 30.6.92. He was discharged the following day.

A review took place by Dr. Hay on 10.8.92, regarding his haemophilia, orthopaedic problems and liver state, and Mr.

Sutton, Senior Registrar to Professor Shields saw him on 19.8.92 when it was arranged to re-scope him electively about the end of December.

However, he was re-admitted on 8.9.92 with dysphagia, and again after numerous consultations with the haematologists, underwent gastroscopy again later that day, when the varices were noted to be obliterated, but food debris was adherent to the lower end of the oesophagus. He was discharged on 10.9.92 after eating all meals.

Follow up continued under the care of the haematologists, and he was readmitted on 11.1.93 for a further endoscopy, performed on 12.1.93, which again showed the varices to be satisfactorily thrombosed. He was discharged by the haematologists the following day.

On 14.1.93 he was reviewed by Professor Klenerman, where he was noted to have "quite a good range of movement for him which he is happy with and which is pain free".

He was subsequently noted by the haematologists to have bleeding from his tongue, for which he was referred to the Department of Oral Surgery, and a recurrence of his inguinal hernia, for which he was referred back to Mr. Leinster. On 10.3.93 he was seen in Professor Shields' Clinic, when repeat LFT's and AFP were requested. These results are not filed in the notes.

Dr. Hay continued to see him on an Out Patient basis, and referred him to the Dermatologists, with a leg ulcer.

Mr. Leinster reviewed him on 11.5.93 with his recurrent inguinal hernia, and noted his ascites, and a symptomatic improvement since being on diuretics. He sought Professor Shields' advice, which was to leave well alone unless symptoms or complications necessitated otherwise.

A further endoscopy was performed on 31.8.93, in conjunction with the haematologists. Spider naevi were noted on clinical examination, as was an everted umbilicus. The variceal state was satisfactory, and he was discharged by the haematologists the following day.

Follow up continued under the dermatologists and Dr. Hay. The latter, on 26.10.93, requested Professor Shields to review him with a view to possible surgery for his recurrent hernia.

He was readmitted on 14.11.93 with abdominal pain. This settled spontaneously, and he was discharged. When he was seen by Professor Shields, it was decided to try the effects of a further truss.

Dr. Hay continued to see him with his haemophilia problems, managing his oedema and ascites, and referred him to the ophthalmologists with eye problems. A chalazion was subsequently dealt with under local anaesthetic, in conjunction with the

haematologists, on 18.2.94.

A decision was made on 23.2.94, in the light of increasing problems, to repair his recurrent inguinal hernia, and he was admitted for this on 14.3.94, when an umbilical hernia and possible ascites were noted. However, to suit the haematologists, he was discharged the following day, to be readmitted on 21.3.94, for surgery on 22.3.94.

After suitable preparation, surgery was performed on this date, when a huge sac full of ascitic fluid only was noted, with a small defect at the deep ring. Gross venous collaterals were present over the sac and the cord, making surgical dissection quite bloody.

Orchidectomy was performed at the same time as excision of the hernial sac, prior to standard repair of the hernia. A suction drain was left in the scrotum, but this failed to prevent a considerable scrotal swelling developing. He also developed an increase in the amount of ascites, (which required an increase in his diuretics,) and haematoma formation in the area of his wound. He was eventually discharged on 3.4.94.

On 17.4.94, he was reviewed by the haematologists, when his scrotum was still hard and tender. An ultrasound was arranged, and this subsequently confirmed the scrotal swelling to be just a haematoma.

i.e. somebody is now suspicious?

On 4.5.94, an honorary registrar to Professor Shields, who, from the records, would not appear to have seen Mr. Murphy previously, put him on the waiting list for a repair of his umbilical hernia, and exploration of his scrotal swelling.

This decision was subsequently vetoed and his name was removed from the waiting list.

Dr. Hay saw him one week later, when his ascites had increased, and he added Frusemide on alternate days to try to improve matters. The required result had been achieved when Dr. Hay saw him next, two weeks later, at which time the scrotal haematoma had started to improve. He also queried when his next variceal inspection should be.

Mr. Hartley saw him on 1.6.94, when it was explained to Mr. Murphy why he should not undergo repair of his umbilical hernia and exploration of his scrotum. From the comment (1/52 finals) on page 267, I suspect that Mr. Murphy was being brought up as a case for the students' examinations.

a bit much.

On 8th June, Mr. Hartley wrote to Dr. Gilmore, Consultant Gastroenterologist, asking him to see Mr. Murphy with a view to offering "any other medical management". A handwritten note (page 1423) on this letter reads as follow:- "note I saw him with CMRH - liver transplant assessment discussed".

Hartley covers himself.
Gilmore covers himself. In other words they suspected Hays mismanagement.

He continued to be seen by the haematologists, and then a letter, dated 13 July 1994, states that Dr. Gilmore has recently seen him in Dr. Hay's clinic, and will be arranging his admission within the next week or two. His November 1993 virology is noted, showing evidence of infection for Hepatitis A, B and C, although he remains negative for HIV.

Whilst he was being assessed by Dr. Gilmore, the haematologists continued to play and active role.

The ultrasound of his liver on 20.7.94 showed the well defined round mass (6.5 cm diameter) in the left lobe of the liver, which on ultrasound had "no characteristic appearances", making it impossible to differentiate between a regenerative nodule and tumour. Cytological examination of his ascitic fluid showed no malignant cells. His AFP was taken on 15.7.94, and was reported as 9280 micrograms per litre.

Prior to his discharge, a further gastroscopy was performed, and it would appear that his varices were once more injected. He was discharged on 4.8.94.

However, he was readmitted on 7.8.94 with grade 11 encephalopathy, and, on recovering from this, he was transferred to Newcastle for their assessment, where they report, on their MR Abdomen, the presence of an approximately 7 cm diameter mass in the left lobe, likely to represent a hepatoma.

His AFP was measured and reported as >100,000 micrograms per litre, NOT 10,000, as Mrs. Murphy writes.

On the basis of these investigations, Mr. Murphy was transferred back to Liverpool, where it was decided to try the effects of intravenous Adriamycin, to see if this would shrink down the hepatoma. The decision was taken to check on his varices first, for which he was admitted on 29.8.94. He went home the following day, but was readmitted on 3.9.94 with severe abdominal pain and hypotension, thought to be due to a bleed. Despite treatment, he died on 3.9.94. No post mortem was performed.

COMMENTS.

1. There is no doubt in my mind that the right decision was made in 1981 to perform an operation for his duodenal ulcer.

He had been admitted to hospital on several occasions with bleeds, which had required blood transfusions and cryoprecipitate, but the frequency of the bleeds had increased, despite being on an H2 antagonist.

When he was admitted on the first occasion in November 1981 with his bleed, this was managed, apparently successfully, by conservative measures, but on the second admission, coming so soon after the first, the decision was taken, quite correctly, in my opinion, to perform surgery.

This successfully prevented any further ulcer bleeds, although the surgery was complicated by a secondary haemorrhage some 15 days after the initial surgery.

He also subsequently had one more gastro-intestinal bleed, but this followed the administration of Voltarol, after his Total Knee Replacement in 1992, and of course he had numerous bleeds into his gastro-intestinal tract from his oesophageal varices, which were a reflection of his chronic liver disease and portal hypertension, not ulcers, and which would not have been affected in any way by the previous ulcer surgery.

He also developed hepatitis after this, but there was also a history of hepatitis in 1979.

It would be interesting to know the opinion of your haematologist and hepatologist as to the likely time he became infected with hepatitis C; whether this could have happened in relation to one or other of these episodes of known hepatitis, or whether it could have been acquired at a much later date, bearing in mind when Hepatitis C testing first became available, and that no Hepatitis testing at all was done between July 1989 and March 1992.

Liver function tests were abnormal as long ago as 1987, and I suspect that he was already suffering from cirrhosis at this time, but again this is a question for your hepatologist.

On page 4 of her statement, Mrs. Murphy claims that it was blood transfusions during his duodenal ulcer operation in 1981 which were the most likely cause of his infection and cirrhosis.

Blood transfusions were administered both before and after this time, together with platelets, cryoprecipitate, fresh frozen plasma, etc., and in any case, the ulcer surgery could quite reasonably be described as "life-saving". This fact should be borne in mind when "laying blame" to the cause of the hepatitis and cirrhosis.

2. Mr. Murphy was adequately assessed prior to his total knee replacement in December 1991, when he was deemed to be fit for the procedure.

His knee was also giving him considerable problems.... increasingly disabled.... can hardly walk.... pain quite severe and keeps him awake at night.... very anxious to go through with the operation.... accepts the usual risks.

"Confusion" appears to exist in the minds of the haematologists as to just how much a part his haemophilia and DIC problems played in the complication of a haemarthrosis, and how much was the result of liver problems. Again this problems could perhaps be clarified by your other experts, and also whether or not the administration of heparin during the period when he was suspected of having a DVT could have contributed to the post operative problems which he had.

The "retro-spectroscope" is a valuable instrument to have, to assess cases that have "gone wrong", but as a "layman" in terms of hepatic and haematological problems, I would have thought that on the basis of the pre-operative work up, the problems Mr. Murphy encountered could not have been foreseen pre-operatively, and that, given his problems, it was a perfectly reasonable decision to proceed with the surgery, provided the haemophilia was managed correctly. Again this is a matter for your other experts.

3. I would respectfully beg to differ with the opinion you have obtained from learned Counsel "that from 1991 onwards the deceased was seen principally by general surgeons....."

On all occasions he was either admitted under the haematologists, and surgery was performed by surgeons who were "mere technicians", or he was admitted under surgeons who performed their technical procedures, whilst the management of the patient as a whole was performed by the haematologists.

The most obvious example of this is in relation to his admission for a liver work up in 1992. At this time he had developed his oesophageal varices, and they had been successfully treated and were no longer bleeding.

in other words the Hep teams were the only ones Hay ever stopped.

Dr. Hay vetoed this work up, and prevented an adequate work up being performed.

It would appear, reading between the lines, that a significant disagreement existed between Professor Shields and Dr. Hay over this, and as the patient was primarily under the care of Dr. Hay, it was Dr. Hay's wishes which over-ruled those of Professor Shields'.

Dr. Hay continues in overall charge of Mr. Murphy, making use of general surgeons, orthopaedic surgeons, dermatologists, eye and oral surgeons, as and when necessary, managing not only his haemophilia, but also his liver problems, oedema and ascites,

in other words, all the other right people are called except the Heps.

what point here?

until presumably as a result of discussions during "final examinations", Dr. Gilmore eventually sees Mr. Murphy and assesses him for liver transplantation, prior to referral to Newcastle.

4. Even though Dr. Hay manages Mr. Murphy throughout the period in question, the surgical team do perform an AFP test on 10.3.93. This result is not filed in his notes. Why not?

On 15.7.94, his AFP was 9280. On 17.8.94 the level was >100,000, not >10,000, as Mrs. Murphy quotes. Is your hepatologist able to interpret these results in terms of the duration of the existence and activity of this particular hepatoma?

On ultrasound it may well have not been possible to differentiate between a regenerative nodule and a tumour; a much more refined technique, which was performed in Newcastle would be able to throw much better light on this nodule's identity.

these could have been PI's in Liverpool because 9280 not noted.

It is quite possible that the identity of this nodule could have been better clarified by further investigations in Liverpool, but this would quite likely have led to a delay in seeking Newcastle's assessment and advice.

Alternatively, it may have prevented a "needless trip" to Newcastle, but if further clarification is needed on this point, then a radiological opinion should be sought, as should the comments of your hepatologist. (No such nodule was present on his

get them there

ultrasound in January 1992.)

5. The decision to delay chemotherapy until after his variceal state had been checked was, I am sure, the right decision. Mr. Murphy's medical conditions made him difficult enough to manage without the added complication of a variceal haemorrhage in someone who was suffering from the myelosuppressive effects of recent chemotherapy on top of his other haematological and liver problems. Whether or not this was the sole reason for the delay I do not know.

6. Unfortunately no post mortem was performed so we do not know the exact cause of Mr. Murphy's death.

However, in view of the time scale involved, on the balance of probabilities, I think it highly unlikely that even if chemotherapy had been given the moment he returned to Liverpool, then the ultimate outcome would not have been any different; the administration of chemotherapy may even have advanced his demise.

CONCLUSION.

This is indeed a most unfortunate, but extremely complicated case, and I can find no fault with his surgical management, either in relation to his vagotomy and pyloroplasty in 1981, or in his surgical management throughout the period in question.

In 1981, surgery was life saving, and although hepatitis C could have been acquired at this time, had no surgery been performed, I am sure that this would have led to his death. I also question whether or not hepatitis C was acquired at this time, or in relation to transfusions of blood and it's products either in the years before or indeed after the surgery. Unfortunately, a gap exists between July 1989 and March 1992, when his hepatitis state was not checked.

You do not enclose Mrs. Murphy's enclosures, but she refers, on Page 12 of her statement, to the document, Hepatitis C - The Facts. If this is accepted haematological / hepatological practice, then Dr. Hay's standard of care has obviously been sub-standard; this must be a matter for your other experts to decide, as must his overall management during the period in question, when, although Mr. Murphy was under the care of other consultants, his overall management was in the hands of Dr. Hay.

GRO-C

G. LITTLE, FRCSEd.,
CONSULTANT SURGEON.