Irvings
solicitors

Minster House
Paradise Street
Liverpool L1 3EU
Telephone: 0151 707 8333
Facsimile: 0151 707 8444
DX GRO-C LIVERPOOL

When calling please ask for: Mr Hazlehurst

Our ref: ADH/CS/M313

Your ref:

Date 14 August 1997

Mrs M Murphy
GRO-C
Liverpool
GRO-C

Dear Mrs Murphy,

Re: Your Claim

I enclose a copy of the additional report received from Dr Davies. You will see his comments in relation to the list of additional and supplemental questions which we sent to him.

I confirm I have continued to telephone virtually on a daily basis to receive the report from Professor Machin. I have now sent yet another urgent letter asking if we can have the report by return of post. I will continue to telephone and trust that we will have received the report by the latest the 18 August.

Yours sincerely,

GRO-C

IRVINGS

DAVIES, MERVYN, H.

William Augustine Murphy (deceased).....date 8/8/97

Supplementary medical report

RESPONSE TO ATTENDANCE NOTE of 5/8/97

1) The liver disease became clinically manifest following the knee operation. A clinical assessment of the patient had been made, by the haematologist, Dr Hay, by the anaesthetist, Dr Cohen and the orthopaedic surgeon Prof Klenerman. In addition, a junior doctor admitted Mr Murphy for the operation. None of these was able to diagnose the liver disease clinically. I do not think that there was a high likelihood that the disease could have picked up, other than by a liver biopsy and there was little to suggest that a biopsy was indicated. Even had cirrhosis been diagnosed, I do not think that the plan for surgery would have been altered, since I have previously commented that he had well compensated cirrhosis and it would have been anticipated that the surgery would have been relatively uncomplicated, although it is true to say that had the cirrhosis been known of, then this would have been discussed with the patient and presented as a relative risk, which increased the overall risk of the knee operation.

2) Mr Murphy's liver tests were noted to be abnormal for some years prior to the diagnosis of HCV in March 1992. I believe it would be very usual for haemophiliac patients to run with deranged liver tests, as consistent with the then Non A Non B hepatitis. The antibody to hepatitis C was discovered in 1989 and routine HCV screening was introduced in September 1991. I think it would have been normal for patients not to have been biopsied with deranged liver tests at that time. Measurement for HCV could not have been considered standard clinical practise prior to September 1991, since the BTS had not introduced the test prior to this because of lack of specificity. The delay between September 1991, when it was first introduced and March 1992 was not a long one. I do not think that delay in diagnosis was unreasonable or negligent.

3) I do not think that liver biopsy was indicated in this patient on the basis of the information available to the team prior to the knee surgery. There was no evidence clinically of cirrhosis, which is a difficult condition to pick up clinically. The presence of splenomegaly might have alerted the team of doctors to the presence of possible portal hypertension. The splenomegaly could have been considered a complication of portal hypertension, which could be associated with cirrhosis. The patient was monitored clinically and I think the standard of care was reasonable.

4) I have discussed the management of Mr Murphy's liver disease at some length in my summary. I think that his liver disease was appropriately managed, with very effective treatment of his varices. Mr Murphy's liver disease remained well compensated until late on and at that stage he was referred for liver transplantation. It became apparent that the decompensation was due to the development of a primary liver cancer. I have discussed previously that the routine screening of patients with cirrhosis for hepatoma is not accepted clinical practise and I have drawn attention to publications which detail the reasoning behind this.

William Augustine Murphy (deceased).....continued

5) I have previously noted that AFP's were reported as being normal in the correspondence. I have previously studied all of the case records and studied these again. I was not able to find the presence of an AFP prior to the measurement of 15/7/94, which was massively elevated and overlooked.

6) Mrs Murphy is correct in her interpretation of leaflets which describe an association between cirrhosis of the liver and primary liver cancer. This is the reason that some doctors tend to screen their cirrhotic patients for liver cancer. Nevertheless, this is not accepted clinical practise. There is significant doubt as to the benefit of screening for the development of primary liver cancer, which has been debated in the medical literature. Whilst some physicians believe there is value in screening, but others believe there is not value and indeed can be harm from such a screening process, it cannot be considered negligent if an individual physician chooses not to screen his patients for the development of hepatoma. It is true, as Mrs Murphy states, that screening would have alerted the doctors to a diagnosis of primary liver cancer at an earlier stage.

Signed GRO-C Dated 8/8/97

Dr Mervyn H Davies MD MRCP
CONSULTANT HEPATOLOGIST