

Witness Name: Professor Helen Reeves

Statement No.: WITN3450001

Exhibits: WITN3450002

Dated: 13 June 2019

**INFECTED BLOOD INQUIRY**

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**EXHIBIT WITN3450002**

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# The Newcastle upon Tyne Hospitals



NHS Foundation Trust

Gastroenterology and Liver Unit

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For the attention of Wendy Dunlop

Report on the death of Mr Michael P Dorricott

Date of Death: 3<sup>rd</sup> of April 2015, 07:10 am

This pleasant 47 year old gentleman who used to work for McVities was first referred to the Newcastle upon Tyne Hospitals NHS Foundation Trust in December 2014. In fact the majority of his previous medical care was not in Newcastle and he was referred to us from Cambridge where he had been a patient for many years. He was first seen by us on the 5<sup>th</sup> of February 2015, having elected to be seen at the Royal Free Hospital in London prior to us, hence our delay coming to know him. He was married and had 2 daughters aged 24 and 18. He had lived in Sedbergh in Cumbria since 2008, commuting to Cambridge and subsequently London and then Newcastle for his medical care. This report is made largely from the referral letters in his Newcastle notes, as well as information from the patient and his family.

Mr Dorricott had haemophilia, as documented in a referral letter dated 10<sup>th</sup> of December 2014 from Professor Graham Alexander, Consultant Hepatologist at Cambridge University Hospitals NHS Foundation Trust. This was also documented in a referral letter from Professor Tim Maya Honorary Consultant in Medical Oncology at the Royal Free Hospital in London. Mr Dorricott was diagnosed as having Hepatitis C in 1996 which has been attributed to his receiving treatment for his haemophilia, as indicated in his referral letters.

Initially for his Hepatitis C Mr Dorricott was treated with Interferon and Ribavirin, which was the standard therapy at the time. This did work and his Hepatitis C progressed to cirrhosis. In 2000 he had a liver transplant for complications of his cirrhosis. In the early post operative period he reportedly developed an aggressive fibrosing cholestatic hepatitis, complicating recurrent Hepatitis C. This improved on immunosuppression regime which included the drug Sirolimus. Professor Graham Alexander reports that the graft managed for a number of years, but that Mr Dorricott then developed Hepatocellular Carcinoma in the transplanted liver. This was a complication of the Hepatitis C recurrence with its aggressive course. Imaging at the time reportedly showed 2 lesions, which were of a size within the stage for consideration for re-transplantation for HCC. He received a 2<sup>nd</sup> liver graft in 2008. Reassuringly this graft worked well and in fact his Hepatitis C viral infection was finally cleared after retreating with Interferon and Ribavirin. Not so encouraging was that the explant histology at the time of his 2<sup>nd</sup> transplant showed that his tumour was an advanced one. The details of this are not clear in his referral letter but the term "unfavourable" would imply that it was moderately to poorly differentiated with evidence of microvascular invasion. The risk of recurrence with unfavourable explant histology is high.

In fact Mr Dorricott did very well for a number of years. His immunosuppression regime was altered from the Sirolimus after clearing his Hepatitis C virus infection because it was suspected to be a major contributor to significant peripheral lymphodema which was problematic for him. Following the 2<sup>nd</sup> transplant there was the suspicion of HCC recurrence on his imaging in the left lobe, which was finally confirmed on biopsy early in 2014.

At that time the disease in the left lobe was thought to be fairly advanced as it involved at least the left branch of the portal vein. At Cambridge University Hospital he was treated with selective internal radiotherapy (SIRT) with a reported partial response on imaging. Unfortunately the left portal vein thrombus subsequently extended towards the main portal vein and into the right portal vein, with evidence of tumour invasion in these large vessels within the liver. It was at that point that Mr Dorricott was initially referred to Newcastle in December 2014, with the hope that we would be able to offer him palliative medical therapy with Sorafenib. Mr Dorricott was keen however to explore other options first and he went to see Professor Tim Mayer at the Royal Free Hospital in London. Professor Mayer documented him as being relatively asymptomatic with his only past medical history other than that documented above as been hypertension. Mr Dorricott was reported as being a non smoker with a performance status of 1. There was also a comment in the letter stating that Mr Dorricott had not drunk alcohol till February 2014, following his diagnosis of recurrent Hepatocellular Cancer. At that point he had been drinking 4 cans of beer per day. Professor Mayer discussed with Mr Dorricott different palliative options, none of which had proven efficacy in patients with Hepatocellular Carcinoma complicating liver transplantation. The latter also excluded him from clinical trials. After some discussion he was treated with a combination of palliative 5 Fluorouracil and Oxaliplatin, with a predicted response rate in the region of 10%. Mr Dorricott remained on his other medications at the time, including Ramipril for his hypertension, Omeprazole, and Tacrolimus and Azathioprine, the latter two being his immunosuppression for his transplant.

Subsequently Mr Dorricott developed a temperatures with septicaemia and confusion. As he lived in Sedbergh and his care was being managed by Cambridge and London, optimising this became increasingly difficult. He was treated with antibiotics and attended our hospital trust for the first time on the 5<sup>th</sup> of February 2015. At that time he did have extensive cancer in his liver involving major vessels confirmed on imaging reviewed in our own Multidisciplinary Meeting. Mild ascites was also noted, without evidence of metastases. The assumed source of infection for Mr Dorricott was his chest as he had been coughing up a lot of phlegm with some haemoptysis. Cause of concern that he may in fact of developed a pulmonary embolus we admitted him to our ward from the clinic. During his time with us imaging ruled out pulmonary emboli and an up to date CT scan of his abdomen showed a 9 x 5 cm mass at his portal hiatus engulfing his portal vein and common bile duct with associated biliary dilatation. Tumour thrombus was seen in his main and right and left extra hepatic portal veins to the compliments of his superior mesenteric vein. As an inpatient he was commenced on IV diuretics with a good diuresis to try and relieve him of his uncomfortable peripheral oedema. This was successful. His Azathioprine was stopped and his Tacrolimus levels monitored and kept to a relatively low level. He received Co-Amoxycilav for his chest infection. At the time of discharge we hoped that he would cover his performance status and former well preserved liver function.

Our own Oncologist Dr Kate Sumpter was involved in these discussions and we hoped to be able to offer him palliative Sorafenib.

Unfortunately that was never to be. Mr Dorricott did have some fairly good quality time at home with his family, but his pyrexia reoccurred with recurrence of pleuritic chest pain. This again initiated investigations to exclude pulmonary emboli. During these times he was treated with Tinzaparin and our own Haematologists were involved and discussions regarding the management for his haemophilia. They confirmed that following his transplants his levels of factor 8 had normalised, and that his factor 5 deficiency was very much improved. His pulmonary emboli were not confirmed on any of his imaging and we did not in fact formally heparinise him. He did receive further courses of antibiotics, with an additional source of infection most likely being his dilated biliary tree. Our Palliative Care Team and his own GP in Sedbergh were involved in trying to optimise his supportive care.

Unfortunately slowly but surely deteriorated. He was a large man (height 185 cm, weight 140 – 150 kilograms) who was quite difficult to nurse satisfactorily at home. On the 26<sup>th</sup> of March he was admitted to our trust via the Royal Victoria Infirmary markedly unwell, deeply jaundiced with evidence of sepsis and renal failure. He received full supportive care including intensive care monitoring and renal support. At his and his family's request he was transferred to Intensive Care at the Freeman Hospital on the 28<sup>th</sup> of March. We were primarily treating an e coli septicaemia and trying to support him with naso gastric feeding. However, after lengthy discussions with both Mr Dorricott - who was intermittently encephalopathic with his deteriorating liver function – as well his wife and daughters, our Palliative Care Team supervised his final days and he died very peacefully on the morning of the 3<sup>rd</sup> of April 2015.

There is little doubt given his history and imaging that Mr Dorricott died of an advanced aggressive Hepatocellular Carcinoma reoccurring in his 2<sup>nd</sup> liver transplant. This was not unsurprising given the unfavourable histology in his initial graft, in which he had developed a cancer on a background of aggressive recurrent Hepatitis C. There are few proven treatments available for patients with Hepatocellular Carcinoma and in fact Mr Dorricott received a number of these – including a liver transplant with curative intent, and subsequently SIRT to try and treat the recurrence. No medical therapy has proven to be beneficial for advanced disease complicating liver transplantation he elected after careful discussion to be treated with 5 FU and Oxaliplatin in the first instance. This is a cytotoxic therapy which in a relatively fit young person with preserved liver function might be expected to have a greater effect on tumour burden than treatment with the cytostatic medical therapy Sorafenib. Sadly for Mr Dorricott his disease was aggressive and I think the subsequent recurrent infections and deteriorating liver function reflected infiltration of his liver with tumour and obstruction of his portal venous and biliary systems.

Regarding the cause of his death I would suggest:

1. (a) Liver failure secondary to
1. (b) Hepatocellular carcinoma secondary to
1. (c) Hepatitis C virus infection

Please do not hesitate to get in touch to discuss this further. My secretary's contact details are on the front of this letter, but I can be contacted on my mobile phone during the course of the day which is 07973197616.

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