

CONSULTANT: Dr Lee
ADMISSION DATE: 18.5.93
DISCHARGE DATE: 2.7.93



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G.P.: Dr.
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NAME:
DATE OF BIRTH:
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115001
NORMAN MORROW
GRO-A29
GRO-C

SUMMARY OF CASE

PRINCIPAL DIAGNOSIS/PROBLEMS

OPERATION(S) AND DATE(S)

1. Chronic liver disease
2. Haemophilia B
3. Hepatitis C infection
4. Excessive alcohol intake

History

This 63 year old gentleman with known severe Haemophilia B and Hepatitis C infection presented to the Haemophilia Centre with a three week history of intermittent abdominal pain. He had no history of vomiting and had a two day history of constipation although he was passing flatus per rectum. He had also noticed progressive abdominal swelling over the previous few days.

In his past medical history he has chronic arthropathy secondary to haemophilia and has Hepatitis C infection with some derangement of liver function tests on previous testing. He is also known to be a heavy alcohol drinker and some of his liver disease is thought to be secondary to this.

Drugs on admission:

Propranolol 80 mg BD
Cimetidine 400 mg nocte

He has recently stopped Spironolactone.

Social history

He is currently living with his wife, he is an ex-musician, and is a non-smoker drinking approximately half a bottle of whisky per day.

Examination

On examination no anaemia, cyanosis or lymphadenopathy, pulse 80 regular, blood pressure 130/90, heart sounds normal, bilateral leg oedema to mid-thigh, chest clear, abdomen distended non-tender, tympanic bowel sounds present.

DISCHARGE SUMMARY

Investigations:

Abdominal X-ray, faecal loading of the colon with distended loops of small bowel, chest X-ray clear, haemoglobin 9.7, platelets 116, white count 4.8, sodium 136, potassium 3.6, urea 4.2, creatinine 73, albumin 29, bilirubin 32, alkaline phosphate 135, AST 48, ALT 18 and Gamma GT 101.

Management

Initially it was thought that he might have an element of small bowel obstruction and he was treated conservatively with intravenous fluids and laxatives to clear out his large bowel. He was reviewed by the surgeons who felt that it was important to rule out an obstructive lesion in the colon and he therefore underwent a barium enema, which fortunately showed no cause of his obstruction. Although his abdomen settled slightly on treatment of his constipation, he still had gross abdominal distention and most of this was thought to be ascitic, secondary to chronic liver disease and after review by Dr Burrows, the hepatologist here, we commenced him on a low salt diet along with fluid restriction and diuretics in the form of Spironolactone and Frusemide. His stay was complicated by one apparent grand mal fit, which occurred while on the ward and lasted a few minutes.

Investigations, including a metabolic screen and CT scan revealed no obvious cause and it was thought that it was possibly likely to the strong opiates he was having for pain or possibly secondary to alcohol withdrawal. Upon admission he was commenced on Thiamin in an attempt to prevent this further. Over the period of the next few weeks his ascites gradually lessened and he was able to mobilize with the help of the occupational therapy and the physio. Due to his long bed bound stage he did develop some small pressure sores in the sacral area, but thanks to good nursing care these soon healed and required no more aggressive treatment. He was given prophylactic factor IX throughout his stay on a three times weekly basis to prevent any bleeding and he had no bleeding problems. He was also assessed by a dietician who recommended to him to partake of a low salt, but high protein diet and encourage him with supplements. Due to his long history of depression, despite managing to withdraw from a dose of Dexamphetamine which he has been taking for many years, he requested to be put back on this and after discussion with Dr Halperin we agreed to this at a 5 mg once daily dosage. He was discharged home on the 2nd July 1993 to be followed up by Sister Patricia Lilley from the Haemophilia Centre for weekly prophylaxis.

Drugs on discharge:

Spirolactone	200 mg daily
Thiamine	25 mg daily
Dexamphetamine	5 mg daily
Ranitidine	300 mg nocte
Co-dydramol	2 tablets PRN
Mucogel	10 ml PRN

We have advised Michael that if he does not want to relapse as far as his liver disease is concerned that he should abstain from alcohol completely in the future. We will continue to review him regularly in the Haemophilia Centre and give as much assistance as we can.

Yours sincerely,

GRO-C

Dr Lisa G Robinson MRCP, BSc
Senior House Officer

GAUL/BJE **GRO-A**