

Witness Name: Royal Free Hospital (Jennifer Moira Cross)
Statement No. WITN3095001
Date: 23 May 2019

EXHIBIT "WITN3095001/3"

This is the exhibit marked "WITN3095001/3" referred to in the first witness statement
of Jennifer Moira Cross dated 23 May 2019

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William Spellman, 18/12/1943, NHS No.4227741688

12/09/2006

Pretransplant Clinic – Tuesday

HISTORY:

Complains of severe tiredness, limited exercise tolerance and of very poor general energy levels. William was reasonably well until he developed his myeloid leukaemia in 1980 which was complicated by hepatitis C which has now left him with cirrhosis, portal hypertension and splenomegaly. Probably as a complication of his hepatitis C he developed nephrotic range proteinuria and drifted into chronic renal failure (? hepatitis C related MCGN). He also has a melanoma stomach which bled when he was given Aspirin and Clopidogrel. This has been treated with laser. Currently he is quite incapacitated by painful polyarthropathy. He unwilling to accept a live donor from the family. I note he continues to drink 20 to 30 units of alcohol. He describes some new constipation with his stools being light yellow in colour. His appetite is poor particularly after analgesics. He has vomited occasionally. He has had one episode melaena. There is no respiratory symptoms apart from a little bit nasal congestion. His exercise tolerance is limited to 200 yards on the flat and he avoids hills. He can just about manage one flight of stairs on a good day. He says he is stopped more by weakness in his muscles rather than breathlessness or chest pain. He denies any palpitations or orthopnoea. He is generally weak and stumbles but there has been no episodes of loss of consciousness. He continues to work as a part time Physics teacher.

EXAMINATION:

He is rather wasted and does not look a strong and fit candidate for transplantation. He had some koilonychia. There was quite marked muscle wasting and he is rather thin. Heart sounds were normal, all pulses were present, no bruits, chest clear, no lymphadenopathy. The spleen was easily palpable. Rectal examination was unremarkable, external genitalia were normal. I did not do a detailed neurological examination.

INVESTIGATIONS:

Phosphate 1.85, albumin 32, alkaline phosphatase 128, AST and ALT normal, gamma GT 262, LDH 316, IgG 23, CRP 1, thyroid function below normal, PSA 1.8, Hb 12.5, platelet count 59, MCV 111.8 (? alcohol), ? hypochromic cells 4.1, reticulocyte count 2.1, iron saturations 50, ferritin 90, APT slightly raised at between 36.5 and 40.5. His last liver biopsy was in 2002 and showed mildly active cirrhosis with little evidence of progression since the last biopsy and less evidence of iron overload. Rheumatoid factor 62, complements normal. HCV RNA level 3 million. A recent chest x-ray and ECG revealed a bradycardia of 55/min. Sinus rhythm otherwise essentially unremarkable. Apart from some T wave flattening in AVL. Blood group O rhesus

positive. A cardiac ECHO from 2003 showed a dilated left ventricle with moderate global systolic impairment with an ejection fraction of 49%. Moderate concentric LVH.

PLAN:

He is not an attractive proposition for transplantation and must be considered to be at high risk. Quite apart from increased immunosuppression exacerbating his hepatitis C, he clearly has quite significantly impaired left ventricular function. We need a more up to date ECHO. Although there has not been much a response at this stage to Interferon it would be foolish to list him for transplantation until he has completed the course successfully or otherwise. It would be helpful to have an opinion from the liver team as to the state of his liver the likely effect of increased immunosuppression. He has to be considered quite high risk at least 2% or possibly more of not surviving the transplant procedure. Nevertheless the evidence suggests that patients with hepatitis C live longer after renal transplantation than if they remain on dialysis. I have asked him to have an ECHO and an isotope stress cardiac test. I have written to Dr Patch asking for his opinion. I have arranged to review him in a year by which time we should have been able to see whether or not the Interferon has done any good. In the meantime he should not be activated on the transplant waiting list.

PROBLEM LIST:

1980s acute myeloid leukaemia
Numerous blood transfusions
1980s Hepatitis C genotype I
Iron overload cirrhosis
Portal hypertension
Varices
Initially unresponsive to Interferon and Ribavirin
Nephrotic Syndrome (? hepatitis C related MCGN)
Chronic renal failure
Haemodialysis
2005 Hypertension
Left wrist fistula
GI bleed (Aspirin and Clopidogrel)
A melon stomach
Laser therapy to stomach
June 2006 second course Interferon (Pegulated Interferon)
2000 Polyarthropathy
Chondrocalcinosis
Positive rheumatoid factor
Splenomegaly
Thrombocytopenia
Arterial calcification

MEDICATIONS:

NeoRecormon 10,000iu three times a week sc cont

Calcichew 1 tab tds po cont

Ketovite T tab od po cont

Folic acid 5mg od po cont

Propranolol 40mg bd po

Anusol prn to haemorrhoids

Lidocaine 2% gel prn to arthritic knuckles

omeprazole 20mg bd

1-alfacalcidol 0.25micrograms once weekly po HD

TO:

Dr Andrew Davenport

Consultant Nephrologist

Renal Unit

Royal Free Hospital

Miss Lord, Mr Al-Akraa, Mr P Vietch, Mr Bimbi Fernando

Alison Richardson, Tissue Typing Lab, Joyce Grant

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Dr David Patch

Consultant Hepatologist

University Department of Medicine

Royal Free Hospital

FROM:

Paul Sweny MD FRCP