EXHIBIT "WITN3095001/4"

This is the exhibit marked "WITN3095001/4" referred to in the first witness statement of Jennifer Moira Cross dated 23 May 2019

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

Barnet Dialysis Review

22/06/2007

HISTORY:

I reviewed this gentleman in the haemodialysis clinic. He is fairly well. He came onto the end stage programme in 2005 after nephrotic syndrome and hypertension, which we think may relate to MCGN related to his hepatitis C. He has fairly good
liver function though a watermelon stomach and gastritis on a biopsy with eosophageal varices. He has been unresponsive to a combination of pegylated interferon and ribavarin, which in fact have left him with a pancytopenia, which presumably is
worse than usual because of his chemotherapy for AML in 1989.

He had heavy X-ray exposure during his PhD years when he did laser X-ray crystallography. He has been unresponsive to his first cycle of pegylated interferon for 6 months and pegylated rabavarin have been continued because of his ongoing
difficulties with joint inflammation and pain. He is anaemic at 7.7. Thrombocytopenic with platelets of 24 with a total white count of 2.2 despite suspending ribavarin 2 months- ago and pegylated interferon for the last 2 weeks with an anticipated
dose reduction. With regard to his liver his LFTs are essentially normal. His INR is .9. Bilirubin 17. PT normal. Although he has portal hypertension the hepatologist feel that his liver function is good. A liver biopsy in 2000 and 2002 showed
mild cirrhosis with no progression from the original biopsy. His current hepatitis C viral load is over 1 million. Dr Sweny noted that he had an abnormal echo in 2002 with LVH and impaired LV function. This has now improved and he has a blameless
echo with an ejection fraction of 60%, no LVH and no dilatation and in fact no diastolic dysfunction. In addition his cardiac thallium shows no reversible ischaemia. His exercise tolerance is limited to 100 yards partly because of general aches and
pains in his joints rather than breathlessness or chest pain.

ON EXAMINATION:

He was hypotensive. BP 86/47 sitting, 91/47 standing with a pulse of 61 on a beta blocker. There is no evidence of central veins nor pitting oedema. Chest clear.

From the point of view of renal / liver transplantation although Mr O-Beirne has suggested that his cardiac status is a contra indication to combined liver/kidney, in fact that appears normal and in my view would not be a contra indication to
combined transplantation. It seems the reason for not performing a combined liver/kidney at this stage is that in fact his liver function is rather good, and he is marginal in terms of age. Regarding renal transplantation alone ,a decision needs to
be made about relative risks of accelerating his hepatitis C related liver disease with the required immunosuppression which in general is heavier in single than incobbined transplantation. I think this must be high risk now that we know he is
unresponsive to anti hepatitis C treatment. Dr Sweny plans to make a decision about this in September on his review.

INVESTIGATIONS:

Calcium 2.23. Phosphate 1.55. PTH above target at 35. Hb 7.7. WCC 2.49. Platelets 25. % hypochromics 7.9 suggesting iron deficiency. Ferritin 1990 and his saturations are 97.5%.

PLAN:

1 Increase dry weight by 1kg

2 Stop renagel

3 Increase 1alfacalcidol to .5ug x 2 weekly

4 Reticulocyte count

5 No intervenous iron for the time being. When his ferritin drops below 800 and his saturations below 40% we could consider giving him 50mg monthly to see if this makes any diffirence to his haemoglobin as he may well be functionally iron deficient
despite his apparently elevated ferritin and iron saturations that are likely to relate to his chronic liver disease.

We will see him monthly on the unit and 6 monthly in clinic.

PROBLEM LIST:
19s acute myeloid leukaemia
Numerous blood tranfusions
1980s Hepatitis C genotype I
Iron overload cirrhosis
Portal hypertension
Varices
Initially unresponsive to Interferon and Ribavarine
Nephrotic Syndrome (? hepatitis C related MCGN)
Chronic renal failure
Haemodialysis
2005 Hypertension
Left wrist fistula
GI bleed (Aspirin and Clopidrogel)
A melon stomach
Laser therapy to stomach
June 2006 second course Interferon (Pegulated Interferon)
2000 Polyarthropathy
Chondrocalicnosis
Positive rheumatoid factor
Splenomegaly
Thrombocytopenia
Arterial calcification

MEDICATIONS:
NeoRecormon 10,000iu three times a week sc 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 x3/wk on HD
interferon
ribavarin
calcium acetate one with each meal
midodrine 5mg pre dialysis
renagel one with each meal

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