EXHIBIT WIT3175016

Exhibit J

King's College Hospital NHS
NHS Foundation Trust

Institute of Liver Studies
Hepatology Service

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Dr Abid Suddle
Consultant Hepatologist/Transplant Physician

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Date: 22 February 2010

Discharge Summary - Dr Abid Raza Suddle

FAO: Dr Li & team

Private & Confidential
Dr Tucker
The Manor Practice
20 Southwick Street
Southwick
West Sussex
BN42 4TE

Dear Dr Tucker

Vincent Baker, DOB: GRO-C **Hospital No: P730079**
GRO-C West Sussex, GRO-C

Admission Date: 15 February 2010
Discharge Date: 3 March 2010

PROBLEM LIST

1. Subacute bacterial endocarditis (organism Streptococcus salivarius).
2. Large aortic valve vegetation greater than 1 cm.
3. Septic emboli leading to intracerebral embolism & haematoma 16 Feb 2010.
4. Chronic hepatitis C genotype 3a, Childs Pugh cirrhosis B.
5. Alcohol misuse and alcoholic liver disease.
6. Known oesophageal varices with previous banding.
7. Hypertension previously.

Many thanks for repatriating this gentleman back to Worthing Hospital. We transferred him to King's College Hospital on 15 February 2010 for further assessment with regards to his suitability for liver transplantation and also with regards to his infective endocarditis.

I shall briefly summarise his history for the benefit of our notes. He was initially seen at King's College Hospital in 2009 where he was considered for transplantation workup. This occurred in August 2009 and at that time, the only issues prohibiting

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him from listing was of ST-depression identified on a CPEX testing. He proceeded to undergo an angiogram in October 2009 which delineated no significant coronary artery disease. Prior to being reviewed in clinic in November, I understand he was admitted to Worthing Hospital with pyrexia of unknown origin identified as having infective endocarditis with the organism of Streptococcus salivarius identified on multiple cultures. He proceeded to have a six week course of antibiotic therapy with Penicillin and Gentamicin following which he was discharged and regarded as being stable. He then attended in February 2010 for a routine surveillance endoscopy and was found to be encephalopathic and was admitted into Worthing Hospital. At this time, he had further sets of blood cultures done which again grew the same organism of Streptococcus salivarius and he proceeded to have an echocardiogram performed on 2 February 2010 that identified no evidence of vegetation with a well preserved LV function and with no pericardial effusion.

On 4 February 2010, he proceeded to have a further echocardiogram performed which showed new evidence of vegetation on the left side of the aortic valve and moderate AR. He was then commenced on Benzylpenicillin and Gentamicin. Unfortunately, around week one of his antibiotic therapy, he developed sensorineural deafness and worsening renal function on Gentamicin and since then has been treated with Benzylpenicillin. Upon his transfer to King's College Hospital, he was haemodynamically stable. It was noted that he had a pancytopaenia with a marked thrombocytopaenia of 18 to 20 lower than his previous baseline of around 70. During his stay on 16 February 2010, he had a small seizure duration of around one minute. CT performed later that day demonstrated an intracerebral haematoma with likely source being from a septic embolus. On 17 February 2010, he was reviewed by the cardiologist infective endocarditis team and the cardiothoracic surgeons.

He had three indications for consideration of emergency aortic valve replacement and these were:

1. Vegetation > 1 cm.
2. Septic emboli.
3. Persistence of endocarditis despite six weeks of antibiotics.

It was also unclear whether he may also have root abscess at the base of the aortic valve which would be a further indication. However, in view of the fact that one, he is now a childs B/C cirrhotic and to the fact that he has had a intracerebral bleed within 24 hours, aortic valve replacement was felt to be to a high risk in view of the fact that his mortality from the liver perspective would be around 30% to 50% and the risk of having a large intracerebral bleed due to the requirement to be on Heparin for bypass would give him a very high risk of having a further intracerebral bleed. A decision was made therefore to continue with antibiotic therapy. The poor prognosis were explained to the patient and to his family by Dr Suddle on 18 February 2010. Following a long discussion, we explained that management of valve replacement would exceedingly high risk of death. Secondly and currently liver transplantation in the setting of acute active infection and a recent intracerebral haemorrhage would be totally contraindicated. Therefore, we felt it would be inappropriate management with liver transplant. In view of these exceedingly poor prognoses, a decision was made that this gentleman should not be fit for escalation to ITU if he was to deteriorate and we should transfer him back to his local hospital. Following transfer back to Worthing Hospital, if at the end of his antibiotic course you feel he is clinically more

stable, we could potentially re-discuss with regards to other options.

Laboratory Blood tests

Test	Value
Hb	8.6 g/dL
WBC	3.57 10^9/L
PLT	32 10^9/L
INR	1.54 Ratio
Sodium	130 mmol/L
Potassium	3.1 mmol/L
Creatinine	88 umol/L
Phosphate	0.79 mmol/L
Total Protein	53 g/L
Albumin	33 g/L
Bilirubin (Total)	40 umol/L
Alkaline Phosphatase	126 IU/L
Aspartate Transaminase	60 IU/L
Gamma-glutamyl Transferase	62 IU/L
Globulin	20 g/L
Calcium	2.19 mmol/L
Alpha-Feto Protein	2 kIU/L

Yours sincerely

Dictated but not signed

Dr Rajaventhan Srirajaskanthan
Specialist Registrar

cc: Vincent Baker
GRO-C
West Sussex, GRO-C