DEPARTMENT OF MEDICINE

WARDS 4/5

Mrs E P Dyson

GRO-C

AJM/AW/515326M

26th March 1998

Dear Mrs Dyson

Thank you for your letter of 20.2.98. As you know I did not see you personally when you attended my clinic recently. We are frequently asked for reports by the Department of Social Security which are usually obtained on the standard form. I have enclosed with this letter an appointment for my clinic so that I can see you to assess your clinical condition personally. In addition perhaps you could obtain the necessary forms from the DHSS. Are you applying for a disability living allowance or attendance allowance? If you could fill me in with the details of the person who you are dealing with at the Department of Social Security I could write to them directly.

Yours sincerely

A J MORRIS
Consultant Physician & Gastroenterologist

Enc.

Consultant in Charge
R. I. RUSSELL
Consultant
J. F. MacKENZIE
Senior Biochemist
A. DUNCAN

Gastroenterology Unit

ROYAL INFIRMARY
GLASGOW
G31 2ER
TELEPHONE: 041-552 3535
EXT. GRO-C
DIRECT.
FAX. GRO-C

Mr C W Imrie
Consultant Surgeon
Ward 61
Royal Infirmary
Glasgow

JM/RS/515326

1st July 1994

Dear Mr Imrie,

Eileen Dyson GRO-C /58)
GRO-C

Please find enclosed the case notes of the above named patient. She is a patient who attends Dr Russell's Clinic with intermittently severe epigastric pain. She has a complex previous medical history which includes portal vein thrombosis, severe haemorrhage from gastric varices which required laparotomy, cholecystectomy for gall stones and subsequent ERCP and sphincterotomy for retained duct stone and finally several documented episodes of acute pancreatitis with a CT scan in December 1993 showing marked pancreatic swelling. Her overall clinical condition is complicated by the fact that she now has low grade hepatitis C as a result presumably of previous multiple transfusions. For the time being her liver function tests remain relatively normal. She is on pancreatic supplements and H2 receptor antagonists, but in view of the recurrent bouts of pain Dr Russell wondered, and I would tend to agree with him, whether she might have a further ERCP in assessment of the pancreas in particular. As her case history is rather complex, I feel you may wish to look at the case sheet yourself, but in the interim I wonder whether you would be prepared to send an appointment for ERCP on a Tuesday so that I will be present and perhaps be able to do the procedure.

Yours sincerely

GRO-C

J MORRIS
Senior Registrar

* HIGH RISK. WOULD NEED TO BE LAST ON ANY LIST *

ERCP

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No CLS
with Tape

DJG/VC/515326

Dr. McGill,
Health Centre,
138-144 Windmillhill Street,
MOTHERWELL.

Dict. 21.12.93
Typed 13.1.94

Dear Dr. McGill,

Eileen Dyson GRO-C .58
GRO-C

Diagnoses:
Portal Hypertension ? Secondary to Portal Vein Thrombosis and Cavenous Malformation of Portal Vein.
Chronic Pancreatitis.
Hepatitis C positive (abnormal liver function).
Previous Cholecystectomy.

Further to my discharge letter I reviewed this lady with her husband in the clinic and explained the results of our investigations to date. The only outstanding result was the result of her dual isotope fat absorption test which was in fact normal. We went into gross detail about the fact that she is Hepatitis C positive and has mildly abnormal liver transaminases. I told her that I thought it was important that she should have a liver biopsy before considering treatment with Interferon, and she had her husband are going to think about this. If in fact they decline liver biopsy they know that we will almost certainly treat her with Interferon in any case. As recorded in my discharge summary the CT scan showed the pancreas enlarged twice its normal size though her trypsin level and LUNDH test was normal, and her fat absorption was also normal reflecting normal function. I think it is worthwhile however trying her on Creon pancreatic enzyme supplements to see if this relieve some of the pain she is getting.

I have also checked her lipids and will review the result of the bowel titre she had at Monklands to consider whether this is a factor in her ongoing pancreatitis. She is going to ring me in the New Year with her thoughts about liver biopsy after discussing it with her husband in more detail.

Yours sincerely,

D.K. George,
Registrar

COPY PAGE

CONSULTANT

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW C4

Telephone No. 041-552 3535
Ext. WITN3362002

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
25/11/93	3/12/93	64	GRO-C /55	515326M

DISPOSAL: Home

FOLLOW UP: Gastro Clinic 2 weeks

NAME AND ADDRESS: Eileen Dyson
GRO-C

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS

		I.S.C. CODE
1.	Portal hypertension ? secondary to portal vein thrombosis and cavenous malformation of the portal vein	
2.	Pancreatitis	
3.	Hepatitis C positive (abnormal liver function)	
4.	Previous cholecystectomy	
5.		
6.	KG/RS/17th December 1993 - Typed Dictated 13th December 1993	

DISTRIBUTION OF LETTERS

Dr McGill
Health Centre
138-144 Windmillhill Street
Glasgow
SMRO, GRI

OPERATION		CODE
1.	Duel isotope fat absorption test (DIFA), Lundh test, Upper GI endoscopy, Doppler Ultrasound	
2.	scan, CT scan, Nutritional screen	
3.		

Dear Dr McGill,

This interesting lady was admitted to the ward for investigation having attended Dr Russell's Clinic for a second opinion of a gastrointestinal problems. She has a complicated past medical history of which you are no doubt aware, dating back to 1989. At this time she was admitted as an emergency to Monklands Hospital with haematemesis and eventually had a laparotomy for uncontrolled bleeding from gastric varices. At this time a dilated portal venous system was obvious and a bleeding gastric varice was oversewn. Subsequent investigations in Monklands Hospital suggested a cavenous malformation of the portal vein and portal vein thrombosis. However, repeat Doppler ultrasound scan in 1991 suggested flow of blood in the tortuous dilated vessels around the portal hepatis were in fact towards the liver, rather than away from it. Subsequently she developed problems with abdominal pain with abnormal liver function tests and ultrasound scan showed stones in the gall bladder. A cholecystectomy was performed in Monklands Hospital and subsequently a sphincterotomy of the common bile duct performed due to a retained stone in the cystic duct. The cystic duct was not possible to disect out at the time of cholecystectomy due to her abnormal dilated veins. She has also had a couple of admissions to Monklands Hospital with documented acute pancreatitis and stays at home when she develops less severe symptoms, which she treats herself with Pethidine analgesia. Also of note from the history is that following blood transfusion given at the time of child birth she developed jaundice.

Her current problems are of right upper quadrant and epigastric pain, intermittent abdominal distention and swelling of her ankles and fingers and intermittent diarrhoea, occasionally loose, pale and difficult to flush away. Inspite of the suggestion of malabsorption she felt that a low fat diet in fact made her symptoms worse.

FORM H1514

COPY PAGE

On examination she looked well with no abnormality of the cardiovascular or respiratory system. There was no stigmata of chronic liver disease, and apart from abdominal scarring no abnormality was detected in the abdominal system.

She was investigated with various blood tests as well as investigations above. Results are Hb 14.7, white cell count 4.7, platelets 169, ESR 3, CRP <5, ferritin 47, U's and E's normal, glucose normal, amylase normal, calcium normal, albumin 49, globulin 27, bilirubin 10, alk phos 200, AST 42, ALT 72, gamma GT 52, copper 17.5, seroplasmin 269 (both normal), transferrin saturation 30%. Doppler ultrasound of abdomen showed multiple collateral vessel in the porta hepatis and around the portal vein. The portal vein however appeared patent as were the right and middle hepatic veins. CT scan of abdomen showed extensive varices in the epigastrium and splenic helum. The swelling of the pancreas to about twice the normal size, but no mass lesion or fluid collection seen. There was no pseudo cyst or ascites or calcification. Splenic size was normal. Contrast medium for dynamic scan was not injected in view of the patients history of hay fever. Hepatitis B surface antigen negative, hepatitis C positive. Urine test showed trypsin activity fractionally above the normal range with 75. Gastroscopy normal. Result of DIFA test awaited. Urinalysis no protein loss in urine.

The most significant new finding to date is the fact that she is hepatitis C positive fitting in with the history of post transfusion jaundice. In view of her mildly deranged transaminases she will require a liver biopsy and trial of Interferon therapy. We will discuss this with her when we see her in the Clinic on 21st December 1993. Discharge medication nil.

Yours sincerely

D K GEORGE
Registrar

GENERAL PRACTITIONERS NAME and ADDRESS

COPY PAGE

CONSULTANT

GLASGOW ROYAL INFIRMARY
84, CASTLE, STREET, GLASGOW C.4.

Telephone No. 041-552 3535
Ext.

WITN3362002

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
6/1/94	7/1/94	66	GRO-C /58	515326

DISPOSAL: Home

FOLLOW UP: Gastro Clinic 2 weeks

NAME AND ADDRESS:
Eileen Dyson
GRO-C

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS

		I.S.C. CODE
1.	Portal hypertension ? secondary to portal vein thrombosis and cavenous malformation of portal vein	
2.	Pancreatitis	
3.	Hepatitis C positive (abnormal liver function tests)	
4.	Chronic persistent hepatitis	
5.	Previous cholecystectomy	
6.	KG/RS/19th January 1994 - Typed Dictated - 19th January 1994	

DISTRIBUTION OF LETTERS
Dr McGill
138-144 Windmillhill Street
Motherwell
ML1
SMRO, GRI

OPERATION		CODE
1.	Liver biopsy	
2.		
3.		

Dear Dr McGill,

Further to my last discharge summary this lady was admitted for liver biopsy which was performed uneventfully. Histology of the biopsy showed changes of chronic persistent hepatitis, but no active hepatitis. She will be reviewed in the Clinic with these results for consideration of Interferon therapy.

Yours sincerely

D K GEORGE
Registrar

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No. 1514

CONSULTANT

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW C4

Telephone No. 041-552 3535
Ext.
WITN3362002

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
25/11/93	3/12/93	64	GRO-C /55	515326M

DISPOSAL: Home

FOLLOW UP: Gastro Clinic 2 weeks

NAME AND ADDRESS: Eileen Dyson
GRO-C

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS

		I.S.C. CODE
1.	Portal hypertension ? secondary to portal vein thrombosis and cavenous malformation of the portal vein	
2.	Pancreatitis	
3.	Hepatitis C positive (abnormal liver function)	
4.	Previous cholecystectomy	
5.		
6.	KG/RS/17th December 1993 - Typed Dictated 13th December 1993	

DISTRIBUTION OF LETTERS

Dr McGill
Health Centre
138-144 Windmillhill Street
Glasgow
SMRO, GRI

	OPERATION	CODE
1.	Duel isotope fat absorption test (DIFA), Lundh test, Upper GI endoscopy, Doppler Ultrasound	
2.	scan, CT scan, Nutritional screen	
3.		

Dear Dr McGill,

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FORM H1514

COPY PAGE

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She was investigated with various blood tests as well as investigations above. Results are Hb 14.7, white cell count 4.7, platelets 169, ESR 3, CRP <5, ferritin 47, U's and E's normal, glucose normal, amylase normal, calcium normal, albumin 49, globulin 27, bilirubin 10, alk phos 200, AST 42, ALT 72, gamma GT 52, copper 17.5, seroplasmin 269 (both normal), transferrin saturation 30%. Doppler ultrasound of abdomen showed multiple collateral vessel in the porta hepatis and around the portal vein. The portal vein however appeared patent as were the right and middle hepatic veins. CT scan of abdomen showed extensive varices in the epigastrium and splenic helum. The swelling of the pancreas to about twice the normal size, but no mass lesion or fluid collection seen. There was no pseudo cyst or ascites or calcification. Splenic size was normal. Contrast medium for dynamic scan was not injected in view of the patients history of hay fever. Hepatitis B surface antigen negative, hepatitis C positive. Urine test showed trypsin activity fractionally above the normal range with 75. Gastroscopy normal. Result of DIFA test awaited. Urinalysis no protein loss in urine.

The most significant new finding to date is the fact that she is hepatitis C positive fitting in with the history of post transfusion jaundice. In view of her mildly deranged transaminases she will require a liver biopsy and trial of Interferon therapy. We will discuss this with her when we see her in the Clinic on 21st December 1993. Discharge medication nil.

Yours sincerely

D K GEORGE
Registrar

GENERAL PRACTITIONERS NAME and ADDRESS

COPY PAGE

Dr McGill
Health Centre
138-144 Windmillhill Street
Motherwell

RIR/RS/515326M

8th November 1993

Dear Dr McGill,

Eileen Dyson GRO-C /55)
GRO-C

Thank you for your letter about this patient whom I saw at my Clinic today. She gives a complex history starting in 1980 with abdominal pain and swelling which was intermittent since then and became worse in 1988 during her first pregnancy. At that time she was in Monklands Hospital and had a haematemesis in January 1989 and was found to have portal hypertension, the cause of this seems to have been unclear. Since then she has had frequent abdominal pains and in January 1992 had a cholecystectomy followed by acute pancreatitis and since then bouts of sub acute or chronic pancreatic insufficiency presenting with pain, tiredness and diarrhoea. She drinks only slightly, but alcohol induces pain, she does not smoke. There was no clinical anaemia, nor oedema on examination and no obvious weight loss, but abdominal examination showed wide spread generalised tenderness and the spleen was palpable. There is no ascites. It is clear that we need to try to get to the bottom of the portal hypertension and the possible sub acute or chronic pancreatitis. For this reason I have arranged to admit her as soon as possible to my Ward for further investigations to be performed.

Yours sincerely

R I RUSSELL
MD PhD FRCP

COPY PAGE

GASTROENTEROLOGY

Royal Infirmary
16 Alexandra Parade
Glasgow G31 2ER

Dr A J Morris's Liver Clinic

Switchboard 0141 211 4000
Direct Dial
Fax Number

• Glasgow Royal Infirmary •
• Glasgow Royal Maternity Hospital •
• Cannicsburn Hospital •
• Lightburn Hospital • Belvidere Hospital •

Dr Kerr
Motherwell Health Centre
138-144 Windmillhill Street
MOTHERWELL
ML1 1TB

AJM/SKP/515326M

Dict: 8 June 1998
Typed: 12 June 1998

Dear Dr Kerr

Eileen Dyson GRO-C .58)
GRO-C

Diagnoses:
1 Chronic hepatitis C
2 Previous portal vein thrombosis
3 Previous pancreatitis

Mrs Dyson was seen with her husband in the Liver Clinic this afternoon. She wished to discuss further the question of an ERCP given that her HIDA scan was normal. In fact the reason for her ERCP was to try and delineate whether she had structural changes of chronic pancreatitis. I agreed with her suggestion that this would not materially affect her management at present and for this reason we have decided to defer the test given her natural anxieties about side effects of the procedure. In addition, she was not keen to have endoscopy and as she has had no bleeding for 10 years I do not feel we should pursue this by means of primary prophylaxis by identifying current varicele status and allowing this primary pharmacological prophylaxis unless her planned liver biopsy shows advanced hepatitis C liver disease.

Our main discussion today therefore was around liver biopsy and we discussed its potential side effects and complications. She had a liver biopsy in 1994 and certainly had referred shoulder tip pain. In principal the reason for this test is to establish whether the disease has progressed, particularly as we would probably not treat her if she had very mild liver disease but would strongly pursue treatment should she have progressed in any way towards fibrosis or cirrhosis.

She has had further discussions with our nurse specialist this afternoon and she will return for a liver biopsy when she has decided on/

CONSULTANT A J MORRIS GASTROENTEROLOGY

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST
84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000 Ext. WITN3362002

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
11.11.98.	11.11.98.	32	GRO-C 58.	515326

DISPOSAL: HOME

FOLLOW UP: LIVER CLINIC

NAME AND ADDRESS:

Eileen Dyson

GRO-C

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS

		I.S.C. CODE
1.	CHRONIC HEPATITIS C	
2.		
3.		
4.		
5.		
6.		

DISTRIBUTION OF LETTERS

Dr Kerr
Motherwell H C
138-144 Windmillhill Street
MOTHERWELL
ML1

OPERATION	CODE
1. LIVER BIOPSY	
2.	
3.	

HM/EH Dictated 13.11.98.
Typed 16.11.98.

This patient attended for a liver biopsy. This was carried out with standards aseptic technique. Two smallish cores were obtained on two passes through the liver with true cut needle.

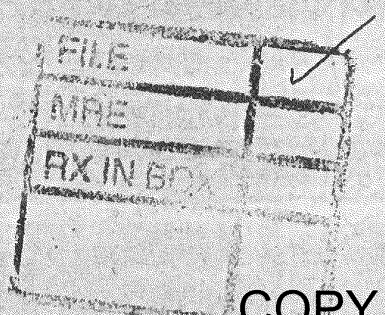
Histology is awaited. She suffered no ill effects from her procedure and will be followed up in the clinic.

GRO-C

HELEN MACKIE
Specialist Registrar in Gastroenterology

GRO-C

A J MORRIS
Consultant Gastroenterologist



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File Note re Eileen Dyson GRO-C 58

Notes Review

Unfortunately Monklands and Glasgow Royal Infirmary notes have been destroyed and, therefore, the Wishaw notes are all that remain.

1989 admitted to Monklands Hospital with haematemesis, laparotomy for uncontrolled bleeding from gastric varices and bleeding gastric varix oversewn. Subsequent investigations suggested cavenous malformation of the portal vein and portal vein thrombosis. Repeat Doppler ultrasound in 1991 suggested flow of blood in the dilated vessels around the porta hepatis and in forward direction of flow.

Contracted Hep C as a result of blood transfusion.

Subsequently developed problems with abdominal pain with abnormal liver function tests. An ultrasound scan showed stones in gallbladder. Cholecystectomy performed in Monklands in 1992 and subsequent sphincterotomy of common bile duct because of retained stone in cystic duct. Cystic duct not able to be dissected out at the time of cholestectomy due to abnormal dilated veins.

1992 Open cholescystectomy.

One week post operatively acute pancreatitis.

Subsequent documented admission to Monklands Hospital with documented chronic pancreatitis.

1993 current problems with right upper quadrant and epigastric pain, intermittent abdominal distension, intermittent diarrhoea with occasional loose and pale stools.

Investigations in 1993 full blood count normal. Ferritin normal. Bilirubin 10, alk phos 200, ALT 72, gamma GT 52. Copper studies normal. Doppler ultrasound multiple collateral vessels in the porta hepatis, but portal vein appeared patent as her right and middle hepatic veins. CT scan of abdomen showed extensive varices in the epigastrium and splenic hilum. Pancreas swollen to about twice the normal size, but no mass lesion or fluid collection, pseudo cyst, ascites or calcification. Normal spleen. Hepatitis B surface antigen negative. Upper GI endoscopy negative.

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She was found to be Hepatitis C positive at that time and subsequent liver biopsies showed changes of chronic persistent hepatitis, but no active hepatitis.

1994 tripsyn level, LUNDH test normal. Fat absorption normal reflecting normal pancreatic function. November 1994 abdominal pain resolved.

January 1998 re-referred to liver clinic symptoms related to chronic fatigue and intermittent episodes of abdominal pain. Liver function tests normal. Ultrasound scan cavenous transformation of the portal vein. Gross splenomegaly.

March 1998 HIDA scan normal.

"In view of the doubt as to whether she has chronic pancreatitis we will proceed to ERCP to try and clarify". ERCP then deferred due to patient concern about side effects of the procedure.

November 1998 repeat liver biopsy – minimal active hepatitis and no evidence of cirrhosis. No significant progression since 1994.

August 1999 significantly troubled by abdominal pain and general fatigue. Sharp abdominal pain worse after food.

May 2000 seen by Dr Crofton "fairly constant right sided abdominal pain which goes away completely about one day a week. Her other pain is left sided pain that goes through to the back which comes on every two to three months. It starts as a low grade pain for about three weeks culminating in very severe pain which lasts for several days associated with nausea and vomiting. She has learned to field these acute attacks with analgesia including Kapake and Pethadine. "Liver function tests normal.

December 2000 CT scan extensive venous collateralisation on the left of the spleen, but no evidence of pancreatic calcification or pseudo cysts.

2001 – 2006 ongoing abdominal pain, fatigue, mildly abnormal liver function tests.

January 2007 admitted with abdominal pain and jaundice. Bilirubin 73, ALT 112, alk phos 318, gamma GT 263, albumin 31. CRP 156. Ultrasound scan – common bile duct is not dilated, spleen is large, gallbladder has been removed. Pancreas could not be well visualised, but no features in upper abdomen.

February 2007 MRCP – no extra hepatic dilatation and no evidence of intra duct calculus. Proximal intra hepatic biliary tree appears slightly prominent with somewhat irregular in calibre. Multiple prominent vessels in the peri pancreatic area and splenic hilum. The spleen is moderately enlarged. The appearances suggest portal hypertension ?PSC.

February 2007 further admission with abdominal pain and jaundice. Bilirubin 34, ALT 247, alk phos 559, gamma GT 309, bilirubin rising to 198. Repeat ultrasound shows CBD 0.65 cm. Pancreatic head normal. No other abnormality seen.

ERCP March 07 ampulla cannulated, previous sphincterotomy noted. "There appears to be a stricture in the lower common bile duct. The ducts proximal to this appear to be normal in appearance. A free filling defect was noted. Balloon catheter passed in the duct, but did not produce any stones and the defects were probably air bubbles. Comment LFT's improving.

Admitted on holiday in France in July 2007 with fever, jaundice. ERCP in August demonstrated a short tight stricture in the lower common bile duct and a 7 cm stent was inserted.

MRI in France.

This resulted in resolution of jaundice and pain. Discussions with radiologists "it is possible the stricture is due to a large portal vein collateral obstructing the bowel duct which could be treated with intra hepatic shunt".

Letter to Professor Hayes in November 2007 with discussion about TIPSS. Comment from Professor Hayes was that TIPSS was not going to be possible technically as the portal vein was largely thrombosed. Surgical shunt thought to be difficult because the extent of the thrombosis including the splenic vein. Conservative approach to treatment suggested. If further clinical episodes occur and require further stenting the least aggressive surgical option may be hepato jejunostomy. In the meantime commenced on Carvedilol to reduce portal pressure.

January 08 replacement of the bilary stent because of abdominal pain and jaundice. 10 cm stent inserted.

Unable to tolerate Carvedilol at 6.25 dose, tolerate 3.125 mg.

July 2008 recurrence of jaundice. Normal intra hepatic ducts, extra hepatic stricture. Further stent inserted.

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September 2008 abdominal pain and abnormal liver function tests.
Normal intra hepatic ducts metal stent 6 cm inserted.

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