Witness Name: Dr Pooja Khanna
Statement No.: WITN3816001
Exhibits: Nil
Dated: 8th October 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR POOJA KHANNA

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 4 September 2019.

I, Dr Pooja Khanna, will say as follows: -

Section 1: Introduction

1. I confirm my personal details, as follow:

   Dr Pooja Khanna
   Luton and Dunstable University Hospital,
   Lewsey Road
   Luton & Dunstable Hospital LU4 0DZ

   DOB: GRO-C 1976

   Qualifications: BSc, MBBS, MRCP

2. I am a Consultant Hepatologist and Gastroenterologist and I have been working at the Luton and Dunstable University Hospital since March 2013. I currently work as a Consultant Hepatologist, Consultant Gastroenterologist and General Internal Medical Consultant. My role involves seeing patients with liver disease, both as inpatients and outpatients including those with Hepatitis C Virus (HCV), hepatitis B, alcohol related liver disease and non-alcohol related fatty liver disease. I liaise with Addenbrooke's Hospital for complex cases that either require transfer to tertiary care centre or transplant assessment. I also look after in-patients with Gastroenterological

disorders and General Medical in-patients. I am a member of BASL British Association of the Study of Liver and EASL (European Association of Study of Liver).

Section 2: Responses to criticism of W2000

3. My first ever consultation with witness W2000 was on May 2015. I was aware that she had been found to be Hepatitis C positive as part of a panel of fertility tests and thus referred to the Hepatology Department. I remember the consultation well, she attended with both her partner and her mother. I was informed that her mother had been infected with Hepatitis C as a consequence of blood transfusion. She had been told in the past that she had been tested for Hepatitis C and that she was negative. She had sought medical attention from her GP a few times and asked to be tested for Hepatitis C but was not tested for this. The consultation was clearly emotionally difficult for the patient. She was very tearful during this and upset about not having been tested before. I had to be very sensitive around issues of acquisition and transmission of hepatitis C. We explored issues of routes of transmission of Hepatitis C including tattoos, piercings and injection of drugs but concluded that it was likely she acquired it through vertical transmission.

4. I can assure the Inquiry that it is my usual practice to discuss the routes of transmission of Hepatitis C, discuss how the patient may have acquired it, discuss the possibility of transmitting it to others and also go through the Natural history of the virus and consequences of infection. I usually counsel monogamous heterosexual people in long-term relationships about the low risk of transmitting the infection to their partners especially if they are HIV negative and not indulging in sexual practices that increases the risk of exposure to blood. The the main focus of my consultation, however, is establishing state of Liver disease (level of fibrosis, presence of decompensation, discussing the need for biopsy and its complications) and discussing treatment options. The patient is then shortly afterwards seen by the Viral Hepatitis nurse specialist who takes the patient over in more detail about routes of transmission, discusses means to reduce risk of transmission to others and side effects of treatments and timelines. It was unfortunate that the Viral Hepatitis Nurse Specialist appointment did not happen in a timely fashion for this patient as shortly afterwards our Nurse specialist left the hospital and it was several months before a replacement started.

5. As mentioned earlier, this was a very emotionally difficult consultation for the patient. She was very upset at having been diagnosed this late in life after having acquired it vertically. A lot of the consultation was spent discussing why she was told she had a negative test and that she had been seeking medical help for a variety of symptoms for a while but was never tested for HCV.

6. For my part, I tried to establish the extent of liver damage as a consequence of chronic infection. But my priority at this consultation was to reassure the patient that, no matter what the stage of fibrosis was, she had credible treatment options available to her both at that time in point, and in the future. I also understood that her priority was both clearing the virus and clearing the virus in a timely fashion so as to proceed with fertility treatment.

7. We discussed the fact that we needed to establish the state of underlying Liver disease by means of a Liver Biopsy, but I was reassured by her normal platelet count and thought she was unlikely to be cirrhotic. I discussed treatment options with her, should she not have cirrhosis. I told her she could carry on with fertility treatment, and if she were to get pregnant, she could then either defer treatment until after the birth, or wait until we were able to eliminate the virus before seeking fertility treatment. The risk of transmission to the baby would have been 5%. At the time she came to see me, she had yet to be seen by the Fertility Department. We thus agreed that I would go ahead and book the biopsy and then we would go over treatment options in more detail at the subsequent appointment. The standard waiting list for biopsy was 3-5 months at the time and I arranged to see her in 4 months. I was concerned that she was so obviously distressed and did not want her to leave the clinic without being reassured to some extent that whatever the state of the underlying Liver disease, we would have options to treat her and would do our best to eliminate the infection.

8. On 3 November 2015, when she came back to see me for her review, her liver biopsy had not yet taken place. It was, as I did explain, perhaps an error on my part, that her liver biopsy had not taken place. I have had numerous occasions in the past when I have made a request for something on IT and that request has somehow not been transmitted to the Radiology Department. It may well also be an error on my part, in that the biopsy just somehow got missed to be booked. The usual waiting list for a biopsy is around about 3-4 months at the very least. When I saw her in clinic and realised that the biopsy had not taken place, I ensured that I got it booked it

urgently, and explained to the radiology department that there was an error on my part and asked that they kindly help me rectify this by giving her an urgent slot. It is my belief that this error on my part resulted in a small delay in the treatment pathway for the patient, and I recognise that the delay though small was significant to the patient and for that I am very sorry

9. It is not the case that I did not see any urgency in her having treatment. However, from a liver point of view the urgency of treatment and prioritisation of treatment is determined by whether or not the patient has cirrhosis (scarring or fibrosis) and decompensation of cirrhosis (failure of the liver as a consequence of cirrhosis). The architecture of the liver was essentially normal on her liver biopsy, i.e. there was no underlying cirrhosis, and hence from a liver point of view there was not an absolute urgency for her to be treated for Hepatitis C. The urgency was determined by how she wanted to proceed with fertility treatment which was entirely understandable. She was clear that she wanted to clear the Hepatitis infection prior to seeking fertility treatment. I did inform her at this point that the risk of transmission to the baby was 5% should she decide to proceed with fertility treatment prior to treating infection. However, as she acquired the infection via vertical transmission, this was not an acceptable risk to her, which was entirely understandable.

10. We discussed her treatment options, which were as follow:
    i) Directly acting Antiviral (DAA) Sofosbuvir (Sof) + Ribavirin(Rib). These essentially involved taking oral tablets which act on the life cycle of the virus to stop it replicating thus eliminate the virus. The duration of treatment would be 3 months. Success rates for her Genotype (subtype of virus) would have been 90-95%.
    ii) Pegylated Interferon (PEG-IFN) and Ribavarin. This involved daily tablets taken in conjunction with a weekly injection. The success rate of treatment was 80-90%. It has considerably more side effects than the first treatment option including fatigue and flu-like symptoms. This treatment regimen is usually given for 24 weeks but could be shortened to 16 weeks if the virus was undetectable at 4 weeks on a blood test.

11. We were hoping to give her option 1, which is what she made it clear to us she preferred. However, at the time option 1 was not available to patients with Genotype 2 HCV infection who did not have cirrhosis i.e. significant fibrosis/scarring of the Liver. DAA's were limited to use in patients with significant scarring or cirrhosis of the

Liver and for other subtypes of the virus. We had hoped that it would become available very soon for those in her position, but had no information from NHS England when exactly this would be so or whether this would definitely be the case. Treatment algorithms were determined by NHS England on a National basis and not by individual clinicians, and treatment decisions were discussed on a local level with other Hepatologists and nurse specialists. We based our treatment decision at the time on the only treatment option available to us.

12. The third choice would have been to wait for the newer Directly Acting Antivirals to become available and continue with Fertility treatment in the interim. But as we were unclear of exactly when this would be, we elected to treat her on grounds that, in the unlikely event that she did not respond (response rates for her Genotype, non-cirrhotic female would have been in the region of 80-90%), we could then use the DAA's as and when they became available. We were hoping that we could give her a shorter course of treatment of 16 weeks, if she had been an early responder. There was at the time a considerable waiting list for treatment at the Luton and Dunstable Hospital as our viral Hepatitis nurse led treatment service had only just recommenced. We put her on top of that list. This was based on clinical and humanitarian judgement that timing of treatment was important. At the same time, we did also have cirrhotic decompensated patients who were awaiting treatment with DAA's who had to be prioritised for this treatment. I explained to her in Clinic with the nurse specialist that at the time option 1 was not available for use in patients like herself as directed by NHS England and that she was being prioritised for treatment with Peg-IFN and Ribavarin, which was the only clinical decision in our hands. I did also explain that the difference in the efficacy rates for both treatment options for patients with her particular sub type of the virus was marginal.

13. I apologise for the fact that my letter dated 21 February 2016 reads "unfortunately the patient does not have cirrhosis." That is not how I meant for the statement to be read. What I was trying to get across was the fact that because she did not have cirrhosis, unfortunately we did not have access to the newer acting directly acting anti-viral agents which at that time and point were only available to those with decompensated cirrhosis on a named patient basis as directed by NHS England. It was not in our hands to be able to offer her the shorter, more efficacious treatment the first time around.

14. From the time she came to see me in April 2015 to when she commenced her first course of treatment was 9 months. This was due to establishing state of underlying Liver disease, recommencement of the viral Hepatitis nurse Led service and arranging Homecare delivery. Unfortunately, she could not be shortened to 16 weeks of PEG-IFN+Rib and she relapsed three months post cessation of treatment. She was then given the DAA's shortly afterwards and finished treatment in April 2018. As I have explained, the choice of the treatment first time round was dictated by guidelines.

15. It has never been the case that I just assumed she was fat and lazy. Whilst I was amazed and pleased at how well, fit and in general good health she appeared to be in August 2018, that was not a reflection in any way of me having thought she was just fat and lazy at her prior clinic appointments. I had previously encouraged her to lose weight as it would have improved her chances of responding to PEG-IFN and Rib treatment and also because she had been asked to lose weight by the fertility team prior to commencing Fertility treatment. There was no judgement on my part, this was medical advice. I am sorry that she felt that I was judging her.

16. When I saw her in August 2018, she seemed happier in herself. She voiced concerns that the medical Faculty, including me, had not taken her concerns seriously. I apologised for that, and explained that it was never my intention to make her feel that we did not hear her concerns. I was simply following guidelines.

17. In my review in August 2018, I had offered to see her again in a year time but unfortunately there is currently a long waiting list for follow up appointments and patients are being seen up to 3-4 months later than intended. I have put on extra clinics to help mitigate this but the situation is out of my hands as demand currently far outweighs capacity. However, we did arrange for a repeat HCV RNA test which was negative and the results were communicated to her via text with the hope that we would see her again in clinic soon.

18. I have accessed her Hepatology medical records held at Luton and Dunstable Hospital from April 2015 to date to produce this statement.

Section 3: Other Issues

19. There are no other issues that I wish to address in this statement.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 8th Oct 2019