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Professor Peter Hayes
Liver Transplant Unit
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Dear Professor Hayes

EILEEN DYSON GRO-C *58)*
GRO-C

I would be very grateful for any advice you may have in the further management of Mrs Dyson. You may remember we discussed her briefly on the 'phone a few weeks ago. I wondered whether she might be a candidate for TIPPS.

She has a rather long and complex history. When she was pregnant around 1980 she required blood transfusion. Following this she became jaundiced. It subsequently transpired that she had acquired hepatitis C infection. In 1998 she underwent liver biopsy in the Royal Infirmary in Glasgow. This showed only minimal active hepatitis. Her first problems started in 1989 when she was admitted as an emergency to Monklands Hospital with a massive haematemesis and subsequently underwent laparotomy. She was found to be bleeding from gastric varices. Subsequent investigations showed cavernous transformation at the portal vein and portal vein thrombosis. Doppler scan at that time suggested the blood flow was into the liver. Shortly after this she developed abdominal pain and abnormal LFT's. An ultrasound showed gall stones/.....

stones. She underwent cholecystectomy and then sphincterotomy of the common bile duct. The cystic duct was not possible to dissect at the time of cholecystectomy due to abnormal dilated veins.

Since that time she has had problems with recurrent abdominal pain which has always been treated as her flare-ups of chronic pancreatitis and she normally manages to treat this with Pethidine.

I was asked to see her in 2000. She was initially referred by her GP for gastroscopy but it was felt this was not appropriate and I was asked to see her. Her LFT's have only ever been only very mildly disturbed. I arranged a CT scan to assess her pancreas at that time. This showed no significant abnormality in the pancreas but did show extensive venous collaterals. In 2004 she was having a lot of trouble with pain. I suggested bringing her up for gastroscopy but she declined at that time. She remained hepatitis C PCR positive.

At the beginning of this year she was admitted with much more severe abdominal pain. She was noted to be jaundiced at that time. Ultrasound showed a dilated common bile duct and splenomegaly. MR cholangiogram showed a dilated extra hepatic common bile duct. The intra-hepatic duct appeared slightly prominent and irregular. There were multiple prominent vessels in the peri-pancreatic region and splenic hilum. Intra-hepatic ducts were thought to be slightly irregular and the possibility of sclerosing cholangitis was raised.

Mrs Dyson was readmitted at the beginning of February with acute cholangitis. Blood cultures were positive. She was started on antibiotics and seemed to settle. I proceeded to ERCP. This showed a smooth stricture in the lower common bile duct. The ducts proximal to this appear to be normal. A balloon catheter was passed down the duct but no stones were extracted. I saw her at the beginning of August. At that time she was having more pain and she thought she had been jaundiced over the previous week. I brought her in for a further ERCP. Again the stricture was identified and on this occasion I put in a 7cm 10F stent. Following this she has kept extremely well. She has had no pain whatsoever although it is still early days. I reviewed her films with one of our radiologists. They thought that the stricture may be because of the large number of collaterals wrapped around the/.....

the common bile duct and the porta-hepatis causing obstruction. There did not seem to be any evidence of chronic pancreatitis or any mass lesion.

Obviously the stent is controlling her symptoms. However I wonder if a better form of longterm management might be a TIPPS or whether you think that even some form of shunt surgery might be reasonable under the circumstances. I enclose copies of her various CT's, ERCP's and MRCP's. I would be very interested in your thoughts on how we could help her.

Yours sincerely

R W CROFTON
Consultant Physician & Gastroenterologist