University College London Hospitals NHS
NHS Foundation Trust

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URGENT FAX

To: Dr Nicholas Norwell **Fax:** GRO-C

From: Dr Stephen Wroe **Date:** 28th June 2006

Re: Patient with CJD **Pages (inc. this one):** 3

o **Urgent** o **For Information** o **Please comment**

Your ref: NPN/EG-KLH/NC/0604067-00

Dr Dr Norwell,

I would be very grateful for your urgent advice about the attached letter on the previously discussed patient with Creutzfeld-Jakob Disease.

I am today on my mobile telephone, GRO-C, and would be very grateful if you were able to call me.

I look forward to hearing from you shortly.

With best wishes.

Yours sincerely,

Dr Stephen Wroe
Consultant Neurologist

DRAFT

MEDICAL – IN CONFIDENCE

Veronica Hamilton-Deeley
HM Coroner
The Coroner's Office
Woodvale
Lewes Road
Brighton BN2 3QB

27th June 2006

Dear Ms Hamilton-Deeley

Re: the late XXXXXXXX your reference VHD/BHT/91/06/INQ

You kindly wrote to my colleague Professor Sebastian Brandner regarding publication of a case report on this patient who was under the care of Dr Wroe and myself at the National Prion Clinic, and said that you would not allow the case report to include autopsy findings until your inquest is completed.

There are issues of public health significance, and approaches to early diagnosis of other individuals at risk of developing variant CJD following exposure to variant CJD-implicated blood transfusion raised by this patient's tragic disease. I had hoped to discuss these issues with you by phone, but your office felt it better I write in the first instance.

This gentleman was the third recorded instance of infection with variant CJD prions occurring in a very small group of individuals who are known to have received transfused blood from a donor who went on to develop variant CJD. He was the first such individual to be diagnosed during life and as such it was possible to obtain much clinical and other diagnostic information that may be of considerable importance in diagnosis of future cases (which in my opinion are very likely to occur). In particular, there were early clinical features that we wish to communicate to clinical colleagues and, most importantly, autopsy demonstrated prion infection of tonsil, a tissue which can be biopsied during life to diagnose variant CJD. There was previously doubt as to whether such a diagnostic test would be useful in patients infected by blood transfusion rather than, as is presumed to be the case in variant CJD acquired from exposure to BSE in the diet, by mouth.

You will appreciate I am sure that these are very important matters, both for other similarly exposed individuals, and also with respect to wider public health issues surrounding the safety of the blood supply. Indeed, the Chief Medical Officer has established a committee, the Variant CJD Clinical Governance Advisory Group, chaired by Sir William Stewart, to advise on management of these issues.

My colleagues and I, with the consent of XXXX and his family, had already submitted a case report to the *Lancet* describing the clinical features and discussing the issues raised to highlight these to the medical and wider public health community. We were in fact

responding to the comments of *Lancet's* peer reviewers when XXXX died. You suggest we might proceed with a limited manuscript excluding the neuropathological findings. With respect, I am not willing to do this as I do not think it would be scientifically appropriate to exclude important findings, known to us at the time of writing, which have a major bearing on the report and its interpretation.

Could I therefore respectfully ask if you might re-consider your decision on publication? While our wish is of course to publish these findings at the earliest opportunity, and we feel a scientific and clinical responsibility to do so, it is likely that some weeks will be required by *Lancet* to consider the substantially revised manuscript incorporating the neuropathological findings. If you did not feel able to alter you decision, would it be acceptable for us to re-submit the manuscript to the journal for further peer review (which is of course a confidential process) on the understanding that the manuscript would not be published until after your inquest date?

Thank you for your consent that my colleague Dr Wroe could communicate the autopsy findings to the family, which he has now done. Could I also ask if I might communicate these findings in confidence to Sir William Stewart's committee? Sir William has asked me to prepare an outline for him on the diagnostic role of tonsil biopsy and the current finding is of key importance in this regard, both for the deliberations of his committee, and for clinical management of future patients.

Thank you for considering these requests. Needless to say, I would be very happy to discuss any of these matters with you by phone in more detail if this would be helpful.

With best wishes

Yours sincerely

John Collinge CBE FRCP FRS
Professor of Neurology

Neuropathology Report

Division of Neuropathology
University College London, Institute of Neurology
The National Hospital for Neurology and Neurosurgery
Queen Square, London WC1N 3BG

NAME: GRO-A
HOSPNO: AP-325
DOB: GRO-A 1974
CLINICAL DG: vCJD
DATE/TIME OF DEATH: GRO-A 2006
DATEOFPM: 24/05/2006

PM NO: GRO-A
AGE/SEX: 32Y M
WARD: MRC PRION UNIT/CORONER
CONSULTANT: DR S WROE

HOUROFDEATH: 07:20hrs
HOUROFPM:

POST MORTEM: GROSS FINDINGS

EXTERNAL APPEARANCES: The patient was a Caucasian man, height 175cm, weight 59kg with slim appearance. No name tag was present on wrist or feet. The skin showed generalised jaundice due to the treatment with quinacrine. There was a scar (25cm) extending from navel towards left and right groin. Facial examination showed isocor and wide pupils. Oral examination revealed natural teeth.

To obtain somatic organs, midline incision on the chest and abdomen was done. Opening of the rib cage and removing of the larynx and pharynx block. Identification of tonsils and asservation of tonsilar tissue. Preparation of the aorta and identification of para-aorta lymph nodes. Asservation of two lymph nodes. Sampling of lung and heart, both were sampled for freezing and formalin fixation. In the abdomen, sampling of liver, spleen, kidney, terminal ileum, and testis. After closure of thorax and abdomen, opening of CNS and skull.

CNS & SKULL: After removing the scalp the skull was removed. Exposure of dura which was soft and showed no abnormalities. The sinuses were patent. Removal of dura and exposure of brain, which showed no abnormalities. No venous congestion, haemorrhage or signs of infection. Removal of the brain, exposure of the skull base, which appeared normal. The ventral aspect of the brain showed normal configuration of the Circle of Willis, no atherosclerosis. Normal configuration of all cranial nerves. Sampling of frontal, parietal, occipital, and temporal lobe. Further samples of midbrain and cerebellum were taken. In addition, sampling of both trigeminal nerves was done. We also sampled 20ml of CSF. In total, circa 100g of brain tissue and 10g of each somatic organ were taken.

CONSENT: Consent was given for retention of representative tissue samples (see consent form) and their use for medical research.

GRO-C
CONSULTANT: S BRANDNER

REPORT DATE: 25/05/2006