EDINBURGH ROYAL INFIRMARY NHS TRUST DISCHARGE SUMMARY COPY FOR GENERAL PRACTITIONER

~~ROYAL INFIRMARY NHS TRUST~~ 31/10/95

Hospital :

To: Dr HILL
LANARK HC
SOUTH VENNEL
LANARK

Date of admission: 03/11/95

Date of discharge:

Ward: SLTU*RIE

Consultant: DR MACGILCHRIST

Surname: BLACK

Forenames: DAVID

Number: 0105371564

Address: 1 ST.TEILING,, LANARK,

Date of Birth: 01/05/37

Principal Diagnosis
HEPATITIS C CIRRHOSIS WITH ASCITES AND OESOPHAGEAL

Other Conditions
VARICES D070.5/A573.1

789.5 A456.2

HAEMOPHILIA A. 286.0

PORTAL HYPERTENSION. 572.3

GALLSTONES 574.2

Principal Operation

Date of Operation / /

Other Operations

External cause of injury

PM / no PM Tumour Type

Histological Verification of Tumour Verified/not Verified

History - Rev Black aged 58 was admitted for liver transplant assessment. There is a long history of haemophilia A diagnosed when he was five years old with factor 8 levels around 3 - 7% He was subsequently diagnosed as having non A, non B chronic liver disease (later ascertained to be hepatitis C) when he presented with an upper GI bleed in 1989. Endoscopy showed oesophageal varices which were injected and there were no further episodes of upper GI bleed. The main problems that this patient had to face were ascites, currently controlled on Amiloride 15 mg om and Frusemide 40 mg om, and increasing fatigue which he finds is hampering his ability to work at a level he was previously accustomed to.

Drugs on Admission - Amiloride 15 mg om
Frusemide 40 mg om
Vitamin B 6 15 mg bd
Ranitidine 150 mg bd
Potassium Chloride 600 mg om

No known allergies.

Family history - 2 uncles had haemophilia, his mother and one of two daughters are carriers and one of his grandsons is a haemophiliac.

Social History - he is a minister involved in the third world. He does not drink alcohol or smoke.

Examination - the patient was comfortable and exhibited a few spider naevi in

DISCHARGE SUMMARY CONTINUATION SHEET

NAME REV DAVID BLACK **NUMBER**

the upper arms. Cardiovascularly - respiratory examination was normal. In the abdomen ascites was demonstrable but was soft and non tender. Neurological examination was normal and the patient was not encephalopathic.

Investigations - Hb 120, wcc 3.9, platelets 52, PT 15.9/12. Electrolytes normal. Liver function - biliburin 31, ALT 64, GGT 95, ALP 176, albumin 24, calcium and phosphate normal. Thyroid function normal. Blood gases normal. Caeruloplasmin 256, ferritin 70 normal, and 24 hour urinary total protein less than 0.3 g/l. Alpha feta protein 7. Ascitic fluid - white cell count 520/cumm, 95% lymphocytes, no organisms seen or cultures, autoantibodies negative. Viral assays showed CMV positive, varicella zoster positive, EIA for antibody to hepatitis C positive and negative for hepatitis B and HIV. The patient's blood group is O negative. Chest x-ray was normal with heart size at upper limit of normal. Ultrasound of the abdomen showed a very shrunken cirrhotic liver with generalised ascites and splenomegaly at 15 cm. Gallstones were seen. Common bile duct normal. Pancreas and kidneys were normal. Portal vein had hepatopetal flow which was reduced at 0.15 m/sec and hepatic arteries were patent. ECG was normal and pulmonary function tests showed ventilatory capacity with normal range but overall gas transfer even after correction for Hb is mildly reduced. The 2-D echocardiogram showed good left ventricular function and a trivial mitral regurgitation.

Reverend Black was discussed for assessment by the multidisciplinary team and it was felt that currently his liver function and his quality of life are such that he does not require liver transplantation at the present moment. He will be returned to Dr MacKenzie for his regular follow-up to monitor progress of his liver condition with the option of liver transplantation still open to him some time in the future. He was also given an appointment to come back to the Clinic for review in three months' time.

Yours sincerely

HOCK FOONG LUI
Registrar

c.c Dr J F MacKenzie, Consultant Physician, Royal Infirmary, Glasgow
Professor G D O Lowe, Haemophilia Centre, Royal Infirmary, Glasgow

HFJ/CJC/15th November 1995
(Dict. 13.11.95)