Digestive Diseases Directorate
Stobhill Hospital

Department of General Surgery

Mr K Robertson
Upper GI & Laparoscopic Surgeon

133 Balornock Road
Balornock Road
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Direct Line: 0141 201 3770
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KR/SS

Dictated: 09.05.03
Typed : 15.05.03

Dr F Harris
Springburn Health Centre
200 Springburn Way
GLASGOW
G21 1TR

Dear Dr Harris

EILEEN O'HARA, DOB 09.10.30, UNIT NO 093961
56 MENZIES ROAD, GLASGOW, G21 3LY

Admission:		26.03.03
Discharge:		07.05.03 (Died)
Pathology:	1	Severe acute pancreatitis
	2	Gallstones
	3	Hepatic failure secondary to hepatitis C
	4	Cardiac failure
	5	MVR
	6	? Bacterial Endocarditis
Management:	1	ERCP (X 3)
	2	Intravenous antibiotics
	3	Cardiology/ Gastro-enterology

This pleasant lady clearly had a number of problems. She was initially admitted under Mr McMahon with chiefly epigastric pain and vomiting. Apparently some days prior to her admission she had a similar episode at which time her amylase was in excess of 700. On this occasion it was nearly 1200. An ultrasound suggested a complex 6cm collection in the region of the head of the pancreas and in addition cholelithiasis. She then became pyrexial to 38° and Mr McMahon asked if I might become involved in her care. Since her liver function tests were marginally abnormal and there was a history of minimal alcohol intake the likely diagnosis was that of gallstone acute pancreatitis. We initially tried to manage her conservatively and reduce her INR which had creeped up to 6. CT of her abdomen was performed and showed marked changes of acute pancreatitis but no obvious necrosis or local complication. At this stage her condition seemed to stabilise which left us the choice of considering laparoscopic cholecystectomy or ERCP and endoscopic sphincterotomy.

Our anaesthetist felt that it would be inappropriate to provide general anaesthesia since they were concerned that she would be difficult or impossible to wean from the ventilator. In light of this she proceeded to ERCP and endoscopic sphincterotomy. For reasons of anatomy and duodenal oedema from her pancreatitis this was a particularly difficult procedure and required 3 separate endoscopy procedures to ensure that her bile duct was clear of any stones.

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At the last of these however we were able to confirm clear duct system. Although this was a difficult time for Eileen during which she intermittently became pyrexial, she seemed to be making slow progress. We had asked for cardiological input and also input from the Gastro-enterologist in light of her decompensated cardiac and hepatic failure, however, generally they were happy with her progress. She continued to generally improve although her multiple medical problems meant that she was never truly getting out of the bit.

Although her pancreatitis now seemed resolved and a risk of subsequent attacks was hopefully excluded by her sphincterotomy she continued to provide us with numerous medical problems. She developed a tense abdomen with marked sites which I think probably reflected a combination of decompensated hepatic and cardiac failure along with a degree of hypoalbuminia from her acute illness. Again cardiological and gastro-enterological help was received. With modifications in her medication she seemed to improve but she had marked lower limb oedemia particularly sever below the knee. This resulted in a cellulitis of the right leg which caused a pyrexia. This seemed to respond to intravenous antibiotics but may have been the cause of a bacteraemia that could have in turn caused her suspected bacterial endocarditis.

She again became decompensated in a cardiological sense, she was transferred to the CCU after a number of medical and ITU reviews. Initially, she seemed to improve with further modifications of her medication, unfortunately, she then deteriorated once more and died at approximately 10pm on 07.05.03.

I am sorry to have to inform you of this death, although, hop that the above helps outline the events leading to it. If there is a blessing for this poor lady, it must be that she managed to attend the wedding of her son the weekend before her death. She had expressed that this was very important to her and at least in this regard we were able to help her.

Yours sincerely

Mr K Robertson MD FRCS
Upper Gastro-intestinal and Laparoscopic Surgeon