file in CNS.

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To: DR RR JAMIESON
BRIDGETON HEALTH CENTRE
201 ABERCROMBY STREET
GLASGOW

G40 2DA

Admission date: 20/11/2003
Discharge date: 20/11/2003
Consultant: Dr Alastair MacGilchrist

Ward: SLTU

Our reference: CB/CJC

Name: **VICTOR TAMBURRINI**

Address: 284E LONDON ROAD
GLASGOW
G40 1PT

Number: 620109706M
CHI no:
D.O.B.: 27/04/1957

LIVER /
ICD LSA 1200990000

No Complications

8 December 2003

READMITTED - 25.11.03
DISCHARGED - 26.11.03

DIAGNOSIS -

1. Orthotopic liver transplant for hepatitis C and alcohol October 2002
2. Subsequent bile leak and anastomotic stricture common bile duct
3. ? hepatic arterty stenosis
4. Hypertension
5. Cirrhosis and recurrent hepatitis C on repeat biopsy
6. Persistent biliary stricture on recent MRCP

Mr Tamburrini was readmitted electively firstly for MR angiogram and MRCP and then subsequently for ultrasound guided liver biopsy.

You will be familiar with his previous history.

He was readmitted electively for MR angiogram and MRCP because of ongoing abnormal liver function tests.

Her MRA and MRCP showed the hepatic artery, although tortuous, had no focal stricture. The MRCP showed similar appearances to the biliary tree compared to the previous ERCP with calibre change at the level of the anastomosis. There was no evidence of dilatation of the donor biliary tree and no evidence of intra hepatic dilatation, however on previous ERCPs this has also been the case. In addition, a new finding was of multiple upper abdominal fluid collections which had developed since the previous MR study. The nature of these collections were

not certain. We discussed these at our x-ray meeting today and a consensus on the cause of these was not obtained.

In view of the findings above he was then admitted for ultrasound guided liver biopsy. The ultrasound indicated these collections of fluids in the sub hepatic area but no evidence of general ascites. The portal vein flow appeared slow, however the vein was patent and the hepatic artery flow was prominent. A liver biopsy was carried out and unfortunately this has shown the presence of established cirrhosis with evidence of recurrent and active hepatitis C infection.

This is obviously disappointing given the short period of time since Mr Tamburrini had his liver transplant.

After significant discussion with our radiological and surgical colleagues, we have decided to proceed to repeat ERCP and stenting across the anastomotic stricture to try and improve his biliary drainage and see if this improves his liver function tests. In addition we will repeat his HCV RNA and if this shows significant activity then we would consider anti viral treatment. In addition it has been noted that he is HCV genotype 1A.

He is due to be reviewed in the transplant clinic on the 4th December and a further letter will follow at that time.

With kind regards

Yours sincerely

Dr C Blair
Registrar to Dr Alastair MacGilchrist

Copy to: Dr A Stanley
Consultant Physician
Royal Infirmary
GLASGOW