The Lothian University
Hospitals NHS Trust

NHS
Lothian

Royal Infirmary of Edinburgh
Lauriston Place, Edinburgh, EH3 9YW. Telephone: 0131 536 1000

17/12/02

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

G40 2DA

Admission date: 19/11/2002
Discharge date: 13/12/2002
Consultant: Dr Alastair MacGilchrist

Ward: SLTU

Our reference: JG/JF

Name: **VICTOR TAMBURRINI**

Number: 2704571796
CHI no:
D.O.B.: 27/04/1957

Address: 284E LONDON ROAD
GLASGOW
G40 1PT

LIVER /
ICD LSA 1200990000

No Complications

14 December 2002

DIAGNOSIS:

1. Bile leak
2. Liver transplant for hepatitis C and alcohol induced cirrhosis - 26.10.02

MEDICATIONS:

Tacrolimus 0.5 mane and 1mg nocte
Azathioprine 75mg od
Ranitidine 150mg bd
Cotrimoxazole 480mg mane
Fluconazole 100mg mane
Tramadol 50mg qds
Prednisolone 10mg mane
Fortijuice 200mls bd
Liquigen 30mls qds
Paracetamol 1gm qds

FOLLOW-UP: Liver Transplant Unit - 17th December 2002 (possible re-admission on the 30th December 2002)

This 45 year old man was admitted around 4 weeks after liver transplant with pleuritic right lower chest/right upper quadrant abdominal pain. He had otherwise been well.

Examination revealed a temperature of 37.1. Chest was clear and there was some right upper quadrant tenderness and some right lower lateral rib tenderness.

Blood tests showed haemoglobin 91, white cell count 13.5 with a neutrophilia and

platelets 115. Prothrombin time was 10/9. Bilirubin 29, ALT 96, ALP 72 and GGT 639. Ascitic tap was performed which showed 6,400 white cells and 200 red cells and a few pseudomonas aeruginosa which were sensitive to Ceftazidime and Meropenem. Protein was 22 and glucose 6.4. Ultrasound showed free fluid within the abdomen especially in the right upper quadrant. He was started on IV Ciprofloxacin and Augmentin which was subsequently changed to Ceftazidime when the culture results came back. Subsequently his condition and white count started to improve with the pain and temperature settling. Subsequent ultrasound and CT showed bi-lobe collection in the upper abdomen inferior to the liver and a drain was inserted under ultrasound guidance. The bilirubin content of repeat aspirates was 80 with a serum level of 17 and therefore this was suggestive of a biliary leak.

His antibiotics were discontinued after one week. Unfortunately he became febrile again and was changed to IV Meropenem after repeat culture. ERCP was performed which revealed a leak at the anastomosis and a stent was inserted. Unfortunately he developed a post ERCP pancreatitis with abdominal pain, nausea and vomiting and an amylase of 2,000. This settled with analgesia and conservative measures over the next 48 hours.

He continued to drain large amounts and was reviewed by the surgeons who feel that the stent may not be long enough. Unfortunately repeat ERCP is likely to cause further pancreatitis. He may, therefore, need to be re-admitted for re-do of the anastomosis.

During the few days before discharge, the drain volumes began to decrease. Repeat ultrasound showed that the collection was smaller (7cm x 5cm x 2cm). The drain was positioned within the collection. He will be continued in the Transplant Unit and may need to return on the 30th December 2002 for re-do anastomosis if his biliary leak has not settled.

Discharged to Home.

Dr Josephine Grace
Staff Grade to Dr Alastair MacGilchrist

Copy to: Dr A Stanley
Consultant Physician
Royal Infirmary
Glasgow