The Lothian University
Hospitals NHS Trust

NHS
Lothian

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

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

G40 2DA

Admission date: 26/10/2002
Discharge date: 15/11/2002
Consultant: Dr Alastair MacGilchrist

Ward: SLTU

Our reference: KLN/JF

Name: **VICTOR TAMBURRINI**

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

Address: 284E LONDON ROAD
GLASGOW
G40 1PT

LIVER / Cirrhosis with portal hypertension
Orthotopic liver transpl. + caval preservation
ICD LSA 1203240000

Date of operation 26/10/2002

No Complications

13 December 2002

DIAGNOSIS:

1. Liver transplant for alcoholic liver cirrhosis and hepatitis C infection - 26.10.02
2. Previously high AFP but no hepatoma found in explanted liver
3. E-coli spontaneous bacterial peritonitis
4. Acute renal impairment post liver transplant recovered with conservative management

Mr Tamburrini was admitted to the Scottish Liver Transplantation Unit less than 24 hours post discharge when a suitable liver became available for him. He underwent liver transplant on the 26th October 2002.

The surgery was performed without event but he spiked a temperature at 38 immediately post operatively. He was given IV Cefotaxime 2gms and IV Amoxycillin for 7 days. Both his peri operative and post operative cultures were negative. He developed renal impairment day one post surgery although his urine output remained satisfactory. He was transferred to the high dependency unit of the Liver Transplant Unit on the 28th October 2002. Ultrasound doppler performed on the same day showed good portal vein and hepatic artery signals.

His drain output remained very high post transplant with more than 3 litres per day until 6 days post surgery. We were unable to start him on Frusemide in view of the renal impairment. With tight contol of his input of output fluid management, his ascites and peripheral oedema were managable and reducing. He had a repeat ultrasound doppler on the 6th November 2002 which showed a right pleural effusion with patent portal vein, inferior vena cava and hepatic artery.

Mr Tamburrini continued to do well and improved further except for some low grade

temperatures but no clinical evidence of sepsis. He was allowed to go home on the 15th November 2002 and we will review him again on the 19th November 2002. Just prior to discharge his urine culture showed intermittent growth of enterococcus which was sensitive to Amoxycillin.

His latest blood tests showed urea 7.8, creatinine 99, sodium 139, potassium 4.5, bilirubin 20, ALT 83, ALT 83, ALP 831, GGT 691, albumin 20, calcium 1.85, phosphate 1.38, Tacrolimus level 7, haemoglobin 99, white cell count 11.9, platelets 188 and PT 9 seconds.

MEDICATIONS ON DISCHARGE:

Azathioprine 75mg od
Prednisolone 20mg od
Tacrolimus 1mg bd
Tramadol 50mg qid
Paracetamol 1gm prn
Ranitidine 150mg bd
Cotrimoxazole 480mg
Fluconazole 100mg od
Amoxycillin 250mg 3 times daily for 5 days

Discharged to Home.

Dr K L Ng
Specialist Registrar to Dr Alastair MacGilchrist

Copy to: Dr A Stanley
Consultant Physician
Royal Infirmary
Glasgow