The Lothian University
Hospitals NHS Trust

NHS
Lothian

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

0439157

To: DR JAMIESON
BRIDGETON HEALTH CENTRE
201 ABERCROMBY STREET
GLASGOW

G40 3DA

Admission date: 25/02/2002
Discharge date: 02/03/2002
Consultant: Dr Alastair MacGilchrist

Ward: SLTU

Our reference: HD/CJC

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

5 March 2002

FAO AJS

DIAGNOSIS -

1. Hepatitis C
2. Excessive alcohol
3. Rising AFP

MEDICATIONS -

Frusemide 40 mg od
Spironolactone 100 mg od

This gentleman was admitted to the Liver Transplant Unit for assessment for liver transplantation. The story goes back to the 1980s where he had where he had surgery for burns and received plasma. In 1998 he presented to Glasgow Royal Infirmary with right breast swelling and a history of alcohol excess was noted. The following year he had bilateral subcutaneous mastectomies and he had a blood transfusion. In 2000 he had admission with abdominal pain and a raised amylase and he was thought to have alcohol induced pancreatitis and was advised to abstain from alcohol. In June of last year he presented to his GP with peripheral oedema and abnormal LFTs. He was referred to Glasgow Royal Infirmary and found to be hepatitis C positive. He was seen in the out patient clinic and advised on several occasions to abstain from alcohol. It was noted gradually that his AFP had risen and in January of this year his AFP had risen to 449. He underwent an MRI scan, CT scan, abdominal ultrasound scan and no focal lesion was seen.

Regarding his alcohol history he was drinking 100 units a week of wine and beer for the last 8 years. He had managed to be abstinent for about 6 weeks in November, December of last year but had relapsed at Christmas time. Currently he is drinking 5 to 6 units per week.

Past medical history - as above. He is married with no children. Is a non smoker and works as a barman.

On examination he was pale, icteric and dehydrated. He was afebrile and had mild peripheral oedema. His heart sounds were pure and his chest was clear. Abdomen showed a little ascites and testicular examination was normal.

Blood tests showed Hb 142, wcc 5.2, platelets 77, prothrombin 17, sodium 134, potassium 3.9, urea 3.8, creatinine 93, bilirubin 65, ALT 146, alk phos 240, GGT 110, albumin 24, glucose 4.6, AFP 359. Blood group AB positive. Pa02 15.49, PaC02 4.54. Urinary sodium 251. Creatinine clearance 79 mls/min. His endoscopy two grade 1 varices. Chest x-ray was normal and his doppler ultrasound scan showed a normal portal vein and no focal lesions. His hepatic vein was also patent. CT scan abdomen and thorax were normal with no abnormality seen. ECG was also normal. Pulmonary function tests showed FEV1 3.97, FVC 4.74. Bacteriology showed an E coli urine infection for which he was commenced on a week's course of Trimethoprim 200 mg bd. Virology showed him to be CMV positive, HIV, hepatitis B negative and hepatitis C positive. His dentition was good.

He also underwent a laparoscopic ultrasound scan which showed a cirrhotic liver and no obvious tumour. He had a biopsy of his liver at the same time, the result of which is still awaited. As we are still highly suspicious of a tumour which has not been located on multiple imaging. He underwent a lopoidal angiogram. This was performed by Dr Redhead on the 1st March. Hepatic angiogram was performed and gastric varices were noted. 10 mls of lopoidal were introduced into all hepatic arteries. He will have a follow up CT scan on the 21st of 28th March as an out patient.

He was seen by the psychiatrist who felt that he was beginning to understand the problems related to his alcohol and recognising that it was hard to remain abstinent. It was felt that any decision to transplant him should be delayed until he had had an opportunity to maintain abstinence with support. Dr Jauker, Consultant Psychiatrist for the East End of Glasgow was contacted and the patient will be seen by the community alcohol relapse prevention psychiatric nurse.

His case was discussed at the transplant meeting. As he was still drinking it was felt that he was not a suitable candidate for transplantation. Currently we have no evidence that he has a hepatoma apart from a raised AFP. We will await the result of his lopoidal CT scan in a month's time. If this is positive for hepatoma then we will re discuss his situation, however if it is negative then there will be no indication for transplantation at the present time.

Yours sincerely

Helen D. Dallal

Dr Helen Dallal
Specialist Registrar to Dr Alastair MacGilchrist

Copy to: Dr A J Stanley
Consultant Physician
Royal Infirmary
GLASGOW