DEPARTMENT OF HAEMATOLOGY
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Consultants:
Dr Isobel D Walker
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Dr I D Walker's Haematology Clinic
Wednesday 5 September 2001

LMCL/LB/0439157V

20 September 2001

Dr A J Stanley
Consultant
Gastroenterology Department
GRI

Dear Dr Stanley

Victor Tamburrini – 27.4.57
284E London Road, Glasgow G40 1PT

I would be grateful if you could see this 44 year old gentleman who I have discovered is Hepatitis C positive.

He was referred simultaneously to Haematology and Medical Clinic in June of this year. He was referred to Haematology from the Department of Oral Medicine where he attended for oral ulcerations. They noted there that he has a macrocytosis with mild eosinophilia and a reticulocytosis. Around the same time his GP referred him to the Medical Out Patient Department to deranged LFTs and leg oedema.

When I saw him there were no other complaints. He did tell me that he drank in excess of 20 units per week and worked as a barman. He has obviously drunk this amount for some time.

On examination he did in fact have a mouth ulcer. I thought I could probably just feel the edge of his liver. He had a petechial rash on his legs and there was pitting oedema to mid calf. There was no evidence of any lymphadenopathy.

His blood showed a bilirubin of 116, AST of 206, AlT 104, alkaline phosphatase 614, gamma GT 83, albumin of 24. I had asked for an LDH, but unfortunately this was not done. His white cell count was 7.3 x 10^9/l; haemoglobin 14.9 g/dl; platelets 84 x 10^9/l; ESR 8 mm/hr; reticulocytes 14 x 10^9/l; B12 1148 pg/ml; serum folate 11.9 ng/ml; ferritin 209 ug/l; MCV 112; PT 19; APTT 50; TCT 26; fibrinogen 1.9.

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GLASGOW ROYAL INFIRMARY University N.H.S. Trust
AUSPICE CÆLO

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I was therefore suspicious that his haematology related to liver disease. I have also checked his thyroid function as this can cause macrocytosis, however the results of this are still outstanding. I have also looked for haemolysis. Unfortunately I do not have the result of an LDH as yet. His bilirubin appears to be elevated because of his liver function. His haptoglobin is reduced, however this can also be reduced in liver disease and his DCT is very weakly positive and retic count slightly elevated. At the time I suspected his oedema was due to hyperalbuminaemia and this was obviously confirmed with an albumin of 24.

To assess his liver status further I have arranged for him to have an abdominal ultrasound, although this has not happened yet. I checked his autoantibody screen including smooth muscle and anti-mitochondrial antibody, both of these are negative. His Hep B surface antigen is negative. His HCV PCR was positive and Hepatitis C screen reactive. His AFP is elevated at 78 and hCG normal at less than 2. He also has polyclonal immunoglobulins.

I am almost certain that all his haematology relates to his liver problems.

At present I have just got the result of his Hepatitis serology and have not had a chance to let him know this yet. I spoke with Sister Neilson today who suggested that I write to you and arrange to see him back at our Clinic to let him know the results of these tests sooner than planned. She also let me know that I could contact her on her page at this time and she would give him some information and a time to come and see her. I would be grateful for further advice and assessment of this patient.

I am sending him an appointment for Haematology Clinic for Wednesday 26 September to discuss things further.

Yours sincerely

Dr Lorna McLintock
Specialist Registrar

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