Wilson's Disease Support Group - UK

BRITISH LIVER TRUST

AFFILIATED TO THE BRITISH LIVER TRUST

NEWSLETTER FEBRUARY 2009

Welcome!

The Wilson's Disease Support Group - UK (WDSG-UK) is an all volunteer organisation which strives to promote the wellbeing of patients with Wilson's disease, their families and friends.

The organisation aims to provide informative articles about the nature of the disease, articles written by patients, families and friends, about their experiences of the disease, recent progress in treatment and much more by way of an annual newsletter.

The organisation also aims to promote networking of Wilson's disease patients and their families by helping and encouraging them to correspond with one another.

The organisation also strives to promote a wider awareness of Wilson's disease within the medical profession.

Greetings; seemingly from the arctic!

We have welcomed five new members this year, but have sadly lost one of our first members, James Duncan from Leeds, who died in December. Also, we are sorry to report the death of Dr Hal Dixon of King's College, Cambridge, who has always been a great help and support to the Group.

We had a very successful meeting in Cambridge in June last year and I'd like to take this opportunity to thank everyone who attended, with particular thanks to Drs Walshe and Gillett, Kay, Dr Bill Griffiths and Dr Rupert Purchase for their continued support of the group, not forgetting Jean Barr, a Wilson's parent, who travelled all the way down from Fife to be with us.

In October I attended the Children's Liver Disease Foundation conference which was held at The National Motorcycle Museum near Coventry. It was good to see two of our members there also. Professor Tanner, the EuroWilson coordinator, was one of the speakers and talked about the EuroWilson database and register, with which many of you will be familiar. Professor Nigel Heaton talked about transplants and I was fascinated to learn that the first transplant was carried out over a hundred years ago in China, when a kidney was transplanted into the recipient's thigh and actually worked and produced urine for a short time. Valerie and I also attended The British Liver Trust Support Group conference in Hinckley in November.

We have decided to hold our funny anecdote competition open for another year at Dr Walshe's suggestion, due to a poor response. The woolly mammoth has been sketched and signed by Dr Walshe and he suggests you don your 'woolly thinking caps' and submit entries for him to judge before our meeting in the summer.

Thank you to everyone who enclosed donations with their membership forms in 2008. Our major outgoings include the newsletter, meeting in Cambridge and website maintenance, together with the sum of £334.80 given to Rupert Purchase for his research into synthesizing molybdate and £73.00 spent on two special drinking cups for one of our disabled members in Norwich. Full accounts will be available at our next meeting.

Our aims this year include achieving charitable status, improving our links with the British Liver Trust and increasing our distribution of the newsletter to include more hepatology and neurology clinics within the UK.

Finally, Valerie and I spent a few days in Yorkshire in September, where I discovered that her grip of the public transport system is as loose as her grip of contour lines on ordnance survey maps!

DON'T FORGET to renew your membership...form enclosed. Details of the meeting will be sent to you soon.

Best Wishes to you all for the rest of the year. Linda

IN THIS ISSUE ...

Fundraising in Devon

Once again we would like to thank Sylvia Penny of Torquay for her fundraising efforts for the Group on behalf of her granddaughter, Emma, who was diagnosed with WD at Derriford Hospital, Plymouth, in March 2007 aged 26. On April 17 2008 Sylvia organised a coffee morning and draw at the Victoria Park Methodist Church Hall in Babbacombe, Devon. The event was a resounding success raising £443

Sylvia and granddaughter, Emma

L to R: daughter Amy, Emma, son Thomas, Emma's mum, Sheila, & sister Daisy

Later in the year, on December 20, Sylvia organised another coffee morning and bring and buy sale raising a further £400. A friend of hers, Iris Keay, made a personal donation of £500 bringing the total amount for the year to £1,343. We are indebted to Sylvia and her family and friends for their continued support and tireless fundraising and are delighted to hear of Emma's continuing improvement.

Pupils' Fundraising Concert 2008

Liz Morell

Every summer term, my mother (Barbara Fordham) and I aim to put on a concert featuring our piano, flute and singing pupils. A couple of years ago we took part in the CLIC Sargent 'Pratice-athon' which is an ongoing fundraising project to help raise money for children suffering from cancer and other related illnesses. The children – and a few adults – got sponsorship for practising daily for two weeks culminating in a concert. Last year, we decided that we would hold our concert as usual and that instead of obtaining sponsors, we would have a collection at the end in aid of the Wilson's Disease Support Group.

About 20 pupils took part in a concert lasting an hour and a half, performing a wide variety of music, ranging from Handel to Andrew Lloyd Webber, to a packed audience who all cheered and encouraged their family and friends. My two children, Abby and Jonathan, also took part and they, together with mum and me, wore WDSG t-shirts! We left some leaflets about WD on the seats and I spoke at the beginning of the concert about Wilson's disease and the support group. We also put a photograph of my sister, Joy, on a stand at the front of the church. Joy passed away aged 17 in March 1974 at the Royal Free hospital, just eight weeks after being diagnosed with WD. Joy was a wonderful musician, playing the piano and flute and singing in local choirs. I was diagnosed 2 months after Joy's death and have been visiting the Royal Free regularly ever since. I am pleased to say that I am completely well, having been 'de-coppered' and I have been taking Trientine since 1983, after becoming intolerant to Penicillamine.

We followed the concert with refreshments and put a couple of collection plates on a table. I am delighted to say that we raised £200 in aid of WDSG, which I passed on to Val and Linda asking that the money be used to help Rupert Purchase's drug research.

OUR MEETING AT CRUFC - 8 JUNE 2008

Cambridge Rugby Union Football Club provided the venue for our Support Group meeting last year. Situated on the outskirts of Cambridge within a short distance of junction 12 of the M11, it was easy to reach by car and offered ample parking. The conference room on the first floor, with disabled access, was light and airy and offered magnificent views over sports fields and meadows across to the River Cam.

54 people attended, including members of the medical profession, patients, friends and family. Linda opened the meeting by welcoming us all and outlining the programme of the day's proceedings. Over light refreshments we had the opportunity to mix and chat, renewing old acquaintances and meeting new members. Dr Walshe made himself readily available to all.

Caroline Simms, who began the Group with Linda in 2000, then gave a short talk about her personal experience of having a liver transplant back in 2004. She was followed by Rupert Purchase who spoke about trientine, one of the drugs for treating WD patients. An important lesson from his talk was the importance of storing trientine in a refrigerator. For those of you who were absent from the meeting Rupert has written an article highlighting the main points of his talk overleaf.

The in-house caterers provided us with a superb buffet lunch during which Belinda Diggles kindly agreed to run the raffle, which raised £93 towards Group funds. Thank you to everybody who donated prizes, especially Jane Ridley for her many and varied contributions.

After lunch we had a formal question and answer session conducted by Drs Walshe and Gillett, with the help of Dr Bill Griffiths, consultant hepatologist from Addenbrooke's Hospital, Rupert Purchase and Kay, Dr Walshe's former assistant. Patients and their families were invited to ask the panel questions, which proved interesting and useful to us all. Clinic sessions tend to be rushed affairs and it was therefore pleasant to be able to discuss worries and pass comments in a relaxed and convivial atmosphere.

Our thanks go to Belinda's husband, Barry, who took photographs throughout the day, culminating in the group picture below.

Linda introducing the meeting

Dr Walshe, (standing) mingling with patients and their families

The panel of professionals fielding questions

WD Support Group-UK Meeting 2008

Among the speakers at our 2008 meeting, **Rupert Purchase** spoke briefly on some new work carried out in Japan on the bioavailability of trientine dihydrochloride and recounted some advice from a Scottish-based physician about the correct storage conditions for trientine.

It is known that trientine dihydrochloride is poorly absorbed from the gastrointestinal tract and this decreases the amount of the drug that is bioavailable to chelate with cupric ions in the blood. That is why relatively large doses of this chelating agent have to be given to patients. Another complication with trientine is that food can interfere with its absorption. Therefore it is recommended that trientine should be taken on an empty stomach, at least one hour before meals or two hours after meals and at least one hour apart from any other drug, food or milk.

Recent work from Japan offers a possible solution to the interaction of food with trientine. Firstly, the Japanese researchers confirmed the so called "negative effect" that food has on the absorption of trientine. Then they went on to prepare a novel formulation of trientine dihydrochloride in which tablets of the drug were coated with a derivative of cellulose. When tested, it was found that absorption of the trientine was markedly improved in animals fed with these coated tablets. Further work with this formulation is continuing in Japan. If successful, it will make the problem of juggling meal times with work and trying to remember the correct times to take trientine a lot easier.

Professor R G Will, a consultant neurologist who works in Edinburgh, recounted a cautionary story about using trientine in the journal *Practical Neurology* last year. The condition of a Wilson's disease (WD) patient who had used trientine for a number of years started to deteriorate. So much so that another drug for treating WD, British anti-Lewisite, BAL, had to be administered intermittently. This pattern continued for some years, until a simple solution to the patient's problems emerged. The patient's pharmacy had been providing her with about six months' supply of trientine dihydrochloride at a time. Although the patient knew from the instructions for using this drug that it should be stored in her refrigerator, with such a large stock it was not possible to keep it all in this way. Much of the trientine she used had not been stored in a refrigerator. In fact, it was kept in a Welsh dresser near to a radiator — often for weeks at a time.

With these facts in hand, resolution of this problem was swift. The patient was supplied more frequently with trientine, storage of unopened containers at or above room temperature for long periods was therefore no longer necessary and, most importantly, the patient's health recovered.

Clearly, the advice given by the manufacturer for storing trientine dihydrochloride needs to be followed: 'Trientine should be stored at 2-8 °C.' However, the quality of trientine dihydrochloride will not alter significantly if it is kept at room temperature (say 25 °C or below) for several hours at a time — during a working day for example. For other situations, this may not always be the case. A two-week summer holiday in a warm climate will require some thought about the best conditions to store medication, and the advice of a doctor should be sought beforehand.

Wilson's Disease - A Pain in the Backside!

By Verity Longley

I was diagnosed with Wilson's disease in July 2007 aged 22, after developing tremors in my hands, dystonia in my toes, falling over, illegible handwriting and choking on water. I was backpacking around Australia at the time and went to the doctor's about it, but no one there knew what it was. Luckily, on my return to England, I was given a diagnosis straight away.

I started on penicillamine and suffered no ill effects. As the months progressed I got worse, having more trouble swallowing, dystonic hands and wrists and fatigue. In October I went back into hospital and switched to trientine. However, by November I could barely swallow, so was rapidly losing weight and I

was constantly tremoring. Eventually, after struggling to drink even sips of water, I was readmitted into Southampton General Hospital and put on a drip and given a naso-gastric feeding tube. I could only walk with the help of two people; my hands had closed up, no one could understand my speech, I was burning from moving so much … I couldn't even roll myself over in bed.

I was switched back on to penicillamine and it was decided to try that in combination with dimercaprol injections. Dimercaprol was developed during the war to treat metal poisoning, so it can be used to treat Wilson's.

No one at the hospital had used it before, because it is so rarely used, but good results have been reported and it was decided to give it a go. It took two weeks for the hospital to get hold of it, agree funding and get their heads round the unusualness of it. We were constantly reminded each injection cost £45 ... so it had better work!

I was injected three times a day in alternate bum cheeks, first with a local anaesthetic then with dimercaprol. It is very thick and oily and smells absolutely vile. Sometimes it would leak back out and I'd be covered in the smell of it. Also, because I was moving so much whilst having a needle stuck in my buttock, IT HURT A LOT, especially as it is a deep intra-muscular injection. At this stage the anaesthetic did not help. However, we persevered.

Whilst all this was going on, I had a PEG inserted in my stomach for feeding. The dietician spent months developing a copper-free feed for me, as they are non-existent commercially. It had to be mixed up in the neonatal unit with the baby food, and was a combination of fat, protein and carbohydrate. All my vitamins were given as supplements, so for a while I was on 21 different types of medication and supplements a day.

This combination of dimercaprol and a copper-free feed allowed me to go home for a few days at Christmas. I had been suffering from severe mood swings along with everything else, see-sawing between euphoria and tears, but being out of hospital helped. On January 3 I was moved to Snowden Neuro Rehab unit and walked into my room without any help. In two months I had turned around and, although I still had the same problems, I was visibly improving every day. The arrival of me and my dimercaprol confused the new ward as much as the last, but I kept having injections three times a day. By this time my bottom was green from bruising so we had a two week break to give it a rest. My mum had to mix up my feed at home and bring it in every day, as they didn't have the facilities to make it in the hospital. After being in rehab for six weeks, I had started eating meals with the other patients and was soon discharged on only one feed a day, and only then if I hadn't managed to eat enough.

After three-and-a-half months in hospital I went home, with my mum having to continue with my injections. I was a bit unsure about this at first, because there is only a small area you can jab without hitting nerves, but she was very good at it and we got into a routine. In the end I could only handle one injection a day as my bottom was so sore and hard from bruising. As my tremors stopped the injections hurt less, because I was able to keep still. After two six-week courses with numerous breaks I had had 180 injections and these finished on April 1 2008.The dimercaprol without doubt cured me, because I could now eat and walk and everything was so much better. I had my PEG removed in May.

Now, in September 2008, fifteen months after this started, I consider myself almost fully recovered. People who did not see me at my worst don't really believe what happened when I tell them, because I recovered so fast they don't believe how bad it was. The dystonia in one of my fingers developed into a problem with the tendons, but with constant splinting is finally almost normal. My speech has got a lot better; it's not perfect but you can't really tell. I can't write very well still and I have been attending a work rehabilitation service that has built my stamina back up. I'm now going to university this month to study occupational therapy, because my experiences have made me want to help others going through similar things.

I was asked to write this because of my unusual treatment. I personally think that dimercaprol should be given to all Wilson's disease sufferers, where appropriate because, as I have proved, the old fashioned treatments are sometimes the best! It wasn't much fun but I soon saw the benefits and am now grateful to Drs Walshe and Dr Gillett for their support which has led to my speedy recovery.

The Story of Dimercaprol and its Use for Treating Wilson's Disease

By Dr Godfrey Gillett

Introduction

On the previous two pages Verity Longley describes her battle with Wilson's disease and how treatment helped. One of the drugs she used was dimercaprol or British Anti-Lewisite. Dr John Walshe wrote an article about this drug in a previous newsletter which is well worth looking up (www.wilsonsdisease.org.uk/documents/WDSG_Newsletter_vol4issue1.pdf).

I shall go over some of that ground and mention some further points. The reason for this is partly for my benefit, so as to have a further item on the WDSG-UK website to refer doctors and patients to in future.

Discovery

Dimercaprol was a drug discovered in Oxford during the Second World War as an antidote to the war gas Lewisite (www.atsdr.cdc.gov/substances/toxsubstance.asp?toxid=190). This arsenical vesicant, the "dew of death", was first synthesised in 1904 and developed in the United States towards the end of the First World War by a chemical warfare research unit led by a Captain Lewis.

There are unconfirmed rumours that Lewisite was used by Japan against Chinese troops in the 1930s. It was feared that it could be used in future conflicts, and in 1939 the Ministry of Supply in the UK commissioned a research group at Oxford to find antidotes to chemical warfare agents, including Lewisite. This successful UK research which resulted in a drug to counteract the effects of Lewisite is recognised by an alternative name for dimercaprol, British Anti-Lewisite (BAL).

The story of the discovery of dimercaprol is described in a fascinating article by one of the principal researchers of the Oxford group, Dr Lloyd Stocken, who died in his late 90's in 2008 ("A contribution to chemical defence in World War II", Margery G. Ord and Lloyd A. Stocken, *Trends in Biochemical Sciences*, 2000;25,5:253-256, doi:10.1016/S0968-0004(00)01578-4).

The development and clinical applications of the drug are discussed in another readable article ("British Anti-Lewisite (dimercaprol): An amazing history", Joel A. Vilensky and Kent Redman, *Annals of Emergency Medicine*, 2003;41,3:378-383, doi:10.1067/mem.2003.72).

Therapeutic uses of dimercaprol

Arsenic poisoning. Fortunately, dimercaprol was not needed as an antidote to Lewisite during WW2 and was rapidly exploited in medicine, initially as an ointment in industrial arsenical accidents and, given intra-muscularly, to counter some of the side-effects of arsenical drugs used in the treatment of syphilis.

Heavy metal toxicity. It was soon found to increase the urinary excretion of some heavy metals, e.g. mercury and gold, and was used successfully to treat mercury bichloride ingestion and the toxic effects of gold salts used in rheumatoid arthritis. Its use for treating Wilson's disease was suggested by Professor J. N. Cumings in his seminal 1948 article ("The copper and iron content of brain and liver in the normal and in hepatolenticular degeneration", *Brain* 1948;71:410-415, doi:10.1093/brain/71.4.410) on the basis of a serendipitous observation by B. M. Mandelbrote *et al.* (Brain 1948;71:212-228, doi:10.1093/brain/71.2.212).

Wilson's disease. The increase in copper excretion in Wilson's patients was subsequently demonstrated by Cumings and others (H. Porter, D. Denny-Brown). As Dr Walshe mentions in his WDSG article, dimercaprol was effective treatment for some but not all Wilson's patients and the beneficial effect tended to wear off. It was one such patient under the care of Professor Denny-Brown in Boston, Massachusetts whom Dr Charles Davidson was asked to see (while Dr Walshe was a Fulbright Fellow in his unit) who proved the clinical inspiration to Dr Walshe to consider penicillamine for the treatment of Wilson's.

Penicillamine (and later trientine, tetrathiomolybdate, and zinc salts) became the principal drugs used in Wilson's from 1956 onwards. But in the late 1970s, Professors Herb Scheinberg and Irmin Sternlieb, the pioneers of Wilson's disease investigation and treatment in the USA, discovered that dimercaprol in combination with penicillamine could help

lamine could help patients with neurological Wilson's especially where there was marked dystonia or rigidity. Dystonia is the term used to describe involuntary, sustained contractions of muscle where agonist and antagonist groups contract together and there is overflow of contraction into adjacent muscles. They discuss the treatment of this type of 'desperately ill' patient in their comprehensive textbook, (dedicated to Dr Walshe) "Wilson's Disease", (Major Problems in Internal Medicine, vol. 23, WB Saunders 1984, pp 145-8, ISBN-13 9780721679532).

The regime which they found to work was a combination of adequate nutrition (by nasogastric tube), high-dose penicillamine (2 g/d) and dimercaprol. Dimercaprol is poorly soluble in water so has to be dissolved in oil, which is peanut (arachis) oil in the preparations available in the USA and UK. Oily injections cannot be given intravenously and have to be given into muscle. This is very painful (as Verity found) and the injections are given daily for at least a month. The dimercaprol dose they recommend is 300 mg daily, five days a week for one to two months. Then a break for a week or two, and repeated, if there has been clinical improvement. Patients understandably get fed up with the course and doctors have to be flexible (e.g. allowing earlier breaks). Dr John Walshe and Dr N. A. R. Munro used this combination to treat a severely affected patient at the Middlesex Hospital who made a remarkable recovery (*Archives of Neurology*, 1995;52:10-11). It has been used occasionally since, usually when recommended by Dr Walshe to the patient's neurologist.

Formulations of dimercaprol

The dimercaprol used in the USA is made by Akorn Inc. (www.akorn.com) and is supplied as a 3 ml vial containing 300 mg. This is convenient for Wilson's treatment since it is one or two injections of the contents of one vial daily. Unfortunately, the preparation available in the UK from Sovereign Medical (www.amdipharm.com) is half this strength, 50 mg/ml, 2 ml vial. This means that patients in this country have to have twice the number of injections (since you can't reasonably give 6 ml as a single intramuscular injection). I've drawn this to the attention of the Drug Information pharmacists in Sheffield and we hope that it may be possible to import some of the more concentrated Akorn product for use in the UK.

Wouldn't it be much easier if the drug could be given intravenously, into a vein? Cambridge Professors R.A. McCance and his colleague E. M. Widdowson evidently thought so, and published their studies of the use of "BAL-Intrav" in the journal *Nature* in 1946 (doi:10.1038/157837a0). BAL-Intrav is dithioglycerol glucoside in a 25% solution and human volunteers were able to tolerate doses of up to 1 g. It causes a significant urinary excretion of copper, as least in sheep (the next paper in that issue of *Nature*, by Dr L. W. McDonald, doi:10.1038/157837b0). These very early reports were not exploited in the treatment of Wilson's patients and dithioglycerol glucoside isn't currently available. Perhaps it should be.

Another way of making drugs which are only soluble in oil suitable for intravenous injection is to make an emulsion. This technology is well-developed and several lipid-soluble drugs are supplied in this way. These include diazepam, the sedative, muscle-relaxant and hypnotic ('Diazemuls') and the short-acting anaesthetic agent, propofol. Preparing the emulsion is like making mayonnaise, only instead of using egg yolk, manufacturers get the water, drug and oil to mix using purified egg phosphatide (among other ingredients).

What we don't know, of course, is whether by making the dimercaprol more water-soluble or water-miscible, it may lose some or all of its beneficial effects in getting copper out of the brain (a very fatty structure) or of protecting the brain from the arsenical-like actions of copper. But we can only try and see.

A successful outcome for Verity

Congratulations to Verity for putting up with two courses: the excellent outcome must be due to her determination to get well in addition to the drugs. I suspect that an important aspect of successful treatment of poorly patients is to ensure that they get adequate nutrition and maintain their weight. Verity's dietitians in Southampton, Sarah Deacon and Nadine Hodgson, rose to that challenge and laboured to produce a copper-free feed that could be given first through the nasogastric tube and then through the percutaneous enteral gastrostomy or PEG. I hope that they will describe this in an article in a dietetic journal and maybe write a summary for us.

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February 2009

with thanks to Dr Rupert Purchase for his helpful comments and careful copy-editing of this article.

… WHY I GOT THE NEEDLE!

Aubrey Morris ©

Hullo, again! I don't flatter myself that any of you remember a single word of what I wrote last time, so I'll begin by recapping. I was 41 when, in September 1969, I was admitted to Dean Street Neurological Hospital, in central London, with a severe tremor, having previously lived an active life with no symptoms. I was diagnosed with Wilson's disease in December of that year and prescribed 500mg per day of penicillamine, which was deemed to be the maximum safe dose. In 1970, I caught a hospital bug, which attacked my left kidney and very nearly killed me. When the paraphernalia which had been set up to deal with this crisis was dismantled, no one noticed that the end of my catheter had snapped off and been left in my bladder. Subsequently, a stone formed around this foreign object. Before I could have the operation to crush the stone, I went out of my mind and did various crazy things. The stone was eventually disposed of at the Middlesex and I returned to Dean Street, where in December I pointed out to the consultant in charge that after a whole year on penicillamine I was no better (or worse). In reply, he said that he had arranged for a Wilson's specialist to see me. That turned out to be our very own Dr Walshe.

When Dr Parsons-Smith had said to me, "If we're very lucky, he'll take you back with him to his hospital," he had not known that luck would have nothing to do with it. Dr Walshe, already the country's leading (if not only) expert in Wilson's, was in fact extremely keen to make a close study of as many victims as he could find and thus broaden his knowledge of an illness that presented itself in so many varied and baffling forms.

I was put on the train at Liverpool Street station to Cambridge at the end of February in 1971, accompanied by a lad from the Channel Islands called Hayden Tostevin and his father. Hayden's elder brother had died of Wilson's, which did not necessarily mean that he had it himself, and he was going for tests. On the journey Mr Tostevin regaled me with a harrowing account of Tostevin major's last days, which raised my morale no end.

Once I was installed in Addenbrooke's Hospital (Old Addenbrooke's, that is, in Trumpington Street) Dr Walshe cast his eye over my medical notes and observed that I was doped up to the eyeballs with Valium. He didn't approve of tranquillisers and stopped the medication, whereupon the result was fairly catastrophic. I went to pieces completely and started to moan, "When is it going to stop? Will it never stop?" I had been shaking continuously, remember, for a whole year since I was diagnosed and for nearly a year before that. Dr Walshe realised that he had perhaps acted hastily and restored my dosage. And he sat by my bedside, talking to me, for a whole hour until I had calmed down. No other doctor, in my experience, would have done that - he would have told a nurse to keep an eye on me and gone away - and here was this eminent man acting in this unassuming, humane way. I have never forgotten it.

My first admission to Addenbrooke's lasted three weeks, and I don't remember much about it. Moreover, I must be careful in what I write, because I have met some of you who were there at about the same time (or even earlier) and will be able to pounce on my mistakes. If you were 16 to 23 in 1971, then you are 53 to 60 now, and that covers many who are reading this. I recall that Dr Walshe worked from a shed outside the hospital, at the front of the building (I thought this an odd position, as any "extras" are usually at the back). I was introduced to his right-hand woman, Kay Gibbs, and he also at this time had a nurse who, alas, had a club foot. I particularly remember a machine that he called his "typewriter", because it made the clacking sound of a typewriter, as it travelled to and fro across one's body to produce an image of one's liver in a series of dots. It must long ago have been replaced by something more sophisticated. And then, of course, there was the elephant. He drew one on my tummy with a felt-tip (I don't know how this has become dubbed a "woolly mammoth" - I'm sure that he meant it to be an elephant.)

At the end of his tests and calculations, Dr Walshe concluded that the 500mg a day of penicillamine I had been taking was just enough to flush out my daily intake of copper and not to make any inroads on the accumulated copper of 42 years. That was why I had got neither better nor worse. He returned me to Dean Street with instructions that I should have 500mg three times a day. This was, of course, a potentially toxic dose, but with his experience of other Wilson's patients (which the Dean Street doctors didn't have) Dr Walshe knew that it could actually be tolerated. No doubt, all of us who are on penicillamine are aware that our regular check-ups are concerned as much with monitoring the side-effects of the drug as with how well the disease itself is being controlled.

We are all unlucky to have Wilson's disease, but I am lucky to tolerate penicillamine very well. Once my dosage was increased, the improvement was spectacular, and I was soon sent home - with a supply of tablets.

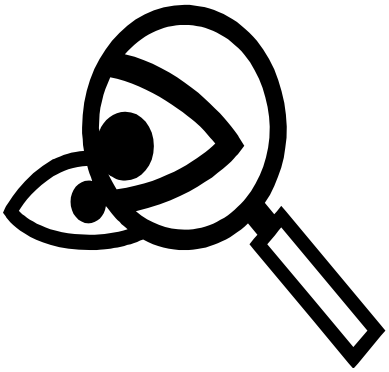
I was back again at Addenbrooke's for a fortnight, six months later, and Dr Walshe was well pleased. At the end of my stay, I took the opportunity to let the hospital's urological department crush another stone which had appeared in my bladder. Both Drs Walshe and Gillett have told me that bladder stones are "quite common" in Wilson's patients and seem to imply that mine were thus inevitable. However, I have the cheek to disagree with the experts. I reason that I would not have had my first stone, had it not been for Dean Street's carelessness in leaving a catheter-end inside my bladder to form a nucleus for the deposits, and I think each subsequent stone had for its nucleus a tiny fragment of the crushed previous one.

Some of you, I suppose, have had the same operation. Under a general anaesthetic, the surgeon pushes up one's urethra and into the bladder not only a cystoscope but some sort of crushing implement. Once the stone is crushed, it is suctioned out. Before my second stone op, I asked if I might be given it as a souvenir. I still have it, crushed, in one of those little bottles used for urine samples, and it fills half the bottle. Having a thing like that bouncing around inside one would obviously be painful. But the point is this**: it is not** crushed to powder but to tiny pieces, and it is easy to see how, in the whooshing-out, a fragment could remain in the urethra and fall back into the bladder to start another stone. My previous op at the Middlesex had been bloody because my urethra was not wide enough to accommodate the instruments and they had had to pare it away. I had bled for days after, the urine in my catheter-bag being blood red. All that blood (I imagine) would have impaired the surgeon's vision, and I began to feel the new stone only a couple of weeks later. Anyway, this stone was disposed of at Addenbrooke's, in October 1971, only ten months after the previous one. After that, Dr Walshe said he would not need to see me again for a whole year.

In 1972, he required me only for a 3-day check-up. Having stopped my penicillamine a couple of days before, as instructed, I settled in on Sunday afternoon. On the Monday, I began a 24-hour urine collection and went to see the eye surgeon, Mr Cairns, who looked at my KF rings through a slit-lamp. On Tuesday, after being given a test dose of penicillamine, I gave blood and urine samples alternately every two hours. On Wednesday, while awaiting the lab results, Dr Walshe investigated anything else that claimed his attention (I recall hanging around a lot in the X-ray department). This was to be the routine of all my subsequent visits (thereafter, every two years) and one with which all of you who were under Dr Walshe's care at the time will be familiar. Normally, one would go home on the Thursday morning , but in 1972 I stayed to have my third stone crushed.

My fourth stone was dealt with in 1974, by which time Addenbrooke's had closed, New Addenbrooke's had opened on the outskirts of the town and I had a different surgeon - a gentleman from the Middle East. They are good at surgery, are the Arabs. He came to my bedside, on the day before, to get me to sign the usual form of consent. He glanced briefly at my private parts, and then our eyes met. He could tell what I was thinking and I could tell that he could tell. I am Jewish, you see. But he had the last laugh - he did a perfect job and I have never since been troubled with stones.

New Addenbrooke's acquired a scanner, and going for a brain scan became part of the routine. This enabled Dr Walshe to see whether the copper deposits in my brain were diminishing. One year, he murmured, "You've lost a lot of neurons." I wasn't bothered - in the context of 20 billion, "a lot" is not really much!



At the end of 1980, I succumbed to pneumonia so severe that it brought about heart failure, but that's another story. I made a good recovery from both and have no need of a heart pacemaker.

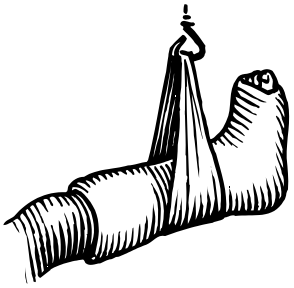
At last came the day when Mr Cairns declared: "I can't see any rings." This patient doesn't have Wilson's." "That's right," chortled Dr Walshe. "We've decoppered him!"

Way back in 1969, when I had been admitted to Dean Street, routine hospital checks had shown me to have high blood pressure, and I had been taking Aldomet (methyldopa) for it since. Nevertheless my bp remained on the high side, sometimes worryingly (though not dangerously) so. In 1984, Dr Walshe noted that I had a low potassium level, and low potassium usually accompanies high sodium. Sodium, or salt (which is sodium chloride), is of course bad for bp. He wondered whether I might benefit from a low-sodium diet. The hospital's hypertension expert (who shall be nameless) offered to take me under her wing and experiment.

I did not take to the woman at all. She put me on a drug called spironolactone, which made me develop female breasts - something I could well have done without. On my last day in hospital, she arrived at my bedside with a string of medical students in tow and began to lecture them not on blood pressure but, to my astonishment, on Wilson's disease. Having told them about KF rings, she peered into my eyes with a pencil torch to look at mine,

and then invited the students to do likewise. Some immediately said they saw the rings. Others had more difficulty (since I had none). "You're not looking properly," said the expert, pulling my cheek this way and that. "Here, hold the torch slanting, like this!" One by one, she bullied them into agreeing that they saw the rings. I was so outraged by this that I said loudly: "Mr Cairns says I have no rings!" I shouldn't have done it, and Madam was furious. She got her revenge by instructing a nurse to put pupil-dilating drops in my eyes. There was absolutely no purpose in this, since I was discharged an hour later, but of course with blurred vision all the way home. To give her her due, she finally recommended me to switch from methyldopa to nifedipine, and this has proved effective. My bp is now 138/75 - not bad for an 80-year-old.

Dr Walshe retired in September 1987, and all of his patients were left in limbo. Nearly a year later came the good news that he had been invited to run an outpatients' clinic at the Middlesex. The 3-day routine would be compressed into a one-hour session and, because that was less reliable, he would see me more often, ie annually. I was delighted, since it would mean no more travelling to Cambridge. In 1995, my daily dose of penicillamine was reduced to 1000mg. In 2000, Dr Walshe finally bowed out, and Dr Godfrey Gillett took over. In 2001 (when I was 73) I was knocked down on a crossing by a hit-and-run driver who went through a red light, and I suffered a broken leg and lost three pints of blood from a gashed head - but, again, that's another story.



Dr Gillett had attended Dr Walshe's clinics as an observer for a number of years before taking the helm. A nicer man, it would be hard to find. With a string of letters after his name, he bears his knowledge modestly and with charm and is a worthy successor to his illustrious predecessor. I think that, compared with some of you, I have had an easy time of it, my Wilson's being relatively straightforward. At any rate, at 80 I'm still here. I guess I'm a survivor.

British Liver Trust Support Group Conference

November 1st – 2nd 2008

By Valerie

Linda and I were invited to represent the Wilson's Disease Support Group at the British Liver Trust conference which was held in Hinckley, Leicestershire, at the end of last year. It was the second such meeting that the Trust had organized, but the first that Linda and I had attended.

The idea of the conference was to bring together various liver disease support groups from across the UK, so that ideas could be exchanged on improving the day to day running of our Groups, reaching new members, fundraising and increasing our profile among the medical profession. There were twenty-six different support groups represented at the conference, an increase of eleven from the previous year, out of a total of fifty-five known to the Trust.

The British Liver Trust is a registered charity which exists to improve the lives of adults suffering from over one hundred forms of liver disease and is the only national organization in the UK to do so. It was started by Professor Sheila Sherlock and a group of eminent hepatologists in 1988 with the aim of providing information, patient support and funding research for all forms of liver disease.

It leads the way in increased understanding and better services for liver patients. In achieving its aims of education, support and research, the Trust has taken on a wide ranging role encompassing lobbying, fundraising, raising awareness in the media and working with support groups across the country.

Recently it has been involved in preparing leaflets about different liver diseases and has published one about Wilson's disease, explaining in simple terms the nature of the illness, giving accurate advice and helping to deal with fear, confusion and distress experienced by sufferers and those closest to them. By clicking on to the Trust's logo on the homepage of our website (www.wilsonsdisease.org.uk) their website can be accessed and the leaflet either downloaded directly or alternatively requested by telephone from their offices. The leaflet is free to patients.

Richard Hall, who organized the conference, has been the Trust's Support Group Co-ordinator since February 2008. He chaired the meeting and introduced the following speakers:

Alison Rogers, who is the Chief Executive and Company Secretary and joined the Trust back in 1992. She supports a staff of twenty and has gained funding of £1m for liver disease research;

Dr Toby Delahooke, who is a consultant hepatologist from Leicester Royal Infirmary. He spoke about the management of chronic liver diseases and mentioned about non-invasive alternatives to liver biopsies, where appropriate, including an Enhanced Liver Fibrosis test and the use of the FibroScan. The FibroScan is a medical device which is a painless alternative to liver biopsy for evaluating the stage of liver fibrosis;

Gordon Cave, who is a liver transplant recipient and the chairman of the Royal Victoria Hospital Liver Support Group in Belfast. He talked of his experiences within the Group, which is composed of patients from all over Northern Ireland. He and members of his Group often attend clinics to advise and reassure patients based on their own experiences. His Group has raised in excess of £1m in one year to fund a FibroScan machine at the hospital; and

Kate Birch, who is a nurse and BSc graduate in nursing studies and 'mans' the telephone helpline at the Trust's Headquarters in Ringwood, Hampshire, five days a week from 0900 to 1700. She is available during these hours to speak to liver disease patients and their families who ring up for advice and support. Calls to the helpline have increased fivefold in the past two years.

On the Sunday morning the Support Group representatives had a choice of three group discussions to attend. The topics covered were **online support**, **community fundraising** and **building group memberships**. Linda and I attended the group memberships discussion, which seemed to be the most popular. It was hosted jointly by **Gordon Cave** and **Ruth Parfitt**. Ruth is a retired medical professional and is herself a transplant recipient. She has been involved with the Trust since its inception. The group discussion was lively and informative and many suggestions were put forward. The main recommendation was for Groups to push for greater awareness among consultants and hospital clinics, so that patients could make use of all the benefits that the groups offer.

With other representatives at dinner

It proved to be a very productive weekend and highly profitable to network with other Groups. Although Wilson's disease is one of the rarer liver conditions, it is by no means the rarest and for me, the conference underlined the need for us to join forces, raise our profile and work together with the British Liver Trust for the good of all patients affected by liver disease.

Wilson's Disease Support Group UK - Website Update

When did you last log on to our website www.wilsonsdisease.org.uk

It has now been up and running for over a year. Do take the opportunity to have a look at it and send any comments or suggestions to linda.hart37@ntlworld.com

The 2008 newsletter has now been posted on the site. You will also see the addition of the British Liver Trust logo on our homepage. By clicking on to it, you will gain access to their website, which is also worth a look around.

Don't forget to download the Trust's information pamphlet about Wilson's disease, which is a very good read!

LINDA'S STORY

By Linda Asher

Hello all! My name is Linda Asher and I was diagnosed with Wilson's disease in 1957 at the age of 13. I am now 64, so I have had the condition for 51 years.

My symptoms were shaky hands, slight slurring of speech and tiredness. I was at grammar school when these symptoms occurred and it was thought that there was too much pressure at school which was causing the condition. I was top at maths, physics and chemistry and art. I always wanted to be the top of the class and worked very hard to achieve this. I loved studying, but unfortunately I found it impossible to write since my hands were so shaky, so I missed a lot of schoolwork because I was in and out of hospital for checkups. I remember my friends writing my notes for me since there were no computers in those days.

My GP referred me to St George's Hospital at Hyde Park Corner (which is now the Lanesborough House Hotel), and I can still remember waiting to see the consultant. The consultant's name was Dr Victor Roseneau, who was a young man at the time; he studied my eyes with a magnifier, and detected the Kaiser Fleisher 'rings', from which he deduced that I had Wilson's disease. I feel very lucky that this doctor was aware of this very rare condition, and if it was not for him and the treatment he recommended, I possibly would not be here today!! I believe that I was one of the first people in the UK to be diagnosed with this condition.

He put me on a course of 'penicillamine', which at that time was in capsule form. I was informed that this capsule had only recently been developed, and was costing the hospital 1% of their drugs' cost!!. I am now taking three a day (750 mg), and go for checkups at the Royal Free Hospital three to four times a year.

It was several years before I started feeling better, and not so shaky. During this period I attended occupational therapy courses; I was so bad at first and was unable even to hold a glass of water without it spilling. I can also remember having to write my name on a blackboard in front of a room full of student doctors who were studying this condition: as you can well imagine the result was very poor.

I have only just found out two years ago, after attending a fifty year reunion at my old grammar school in Richmond, that the class was informed before I arrived that they were to expect a pupil who was not very well, and they were to look after her and help with notes etc. I had always wondered why they were so kind to me!

Despite my condition I have a passion for painting and have been painting for over thirty years; very often I have to hold the brush with two hands. I have completed a seven year 'OCA' (open college of the arts) course, and have obtained a diploma and will be receiving my BA degree in September. I am pleased to say that I have sold quite a few of my pictures, and have had a few commissions.

I have been married for over forty years, and have two married sons who each have two sons. My twin brother, however, has a married daughter who has two daughters, so I do have an excuse to buy pretty dresses. My twin is twenty-five minutes older than me. Thankfully he did not inherit the condition and is in perfect health.

I have attempted to contact Dr. V Roseneau, but despite all my searches I am unable to locate him. There is a possibility that he may be living in the USA, and if anyone has any information on him would they please let me know.

WAS YORKSHIRE READY!?

By Linda

We spent four days in a small village near Pickering, North Yorkshire, last September. It was gloriously sunny, late summer weather, a huge improvement on what we had for our jaunt in Derbyshire in November 2007!

Our first day was spent exploring the moors and Pickering, which is a busy market town in North Yorkshire and is also the starting point for the N Yorks Moors Railway, a steam railway running to Whitby through the Moors National Park. On the following day we drove to Whitby, not of course by the most direct route. We stopped off at Grosmont where there is a beautifully kept, straight out of the 1960's railway station, complete with ladies' and gents' waiting rooms and the best station buffet we had ever seen. We drove on to find ourselves on a single track road and heading steeply downhill, assuming that what goes down must come up! After about two miles of descent - disaster! When we reached the bottom we were confronted by a ford, almost a foot deep, and we could still be there today had it not been for a helpful farmer with a tractor whom we spotted on the other side. He kindly agreed to help us, steer us across and we arrived in Whitby craving comfort food – which happened to be fish 'n' chips from the famed Magpie café. Incidentally, our idea of cooking that week consisted of either piercing film lids and popping ready meals in the microwave or buying 'pub grub!' Whitby is a fascinating place, steeped in history and smugglers tales and we went on to spend a happy afternoon there.

The second day we were lucky enough to arrive in Goathland when Heartbeat (the TV series) was being filmed on the main street. It was interesting to watch, but it must become incredibly boring for the actors having to do take after take for just one shot. The policeman must have ridden up and down the road on his old BSA motorbike at least twenty times (mind you I did manage to get my picture taken with him!)

We decided to do a coastal walk on the final day. Val had planned out our route and modes of transport, so we set off bright and early to catch the steam train from Pickering to Whitby; it was a wonderful never to be forgotten journey. On arriving in Whitby we headed up the 199 steps to the Abbey from the harbour, every tenth step being marked with a brass disc displaying a Roman numeral. The Abbey and churchyard were the inspiration for Bram Stoker's Dracula Tales. Our walk was to be part of the coastal section of The Cleveland Way, which itself is 109 miles long and runs from Helmsley to Filey. The views along the way were breathtaking and we felt all was well with the world. We were hoping to get as far as Ravenscar then get a scenic route bus back to Pickering, but we soon realised this plan was a little over ambitious, so we stopped at Robin Hood's Bay. Alas, no bus service to Pickering existed, so instead we took one to Scarborough only to find we had a two hour wait before a connection to Pickering, where we had left the car. It was just as well we didn't continue walking to Ravenscar as there were no buses at all from there! I ragged Val mercilessly.

We managed to find a pub quiz one evening (which seems to have become a habit now.) This year we excelled and came second! However, we believe our rightful winning position was usurped, as the team that came first were constantly sending text messages to pals for answers! Nevertheless we won the princely sum of £6.50 and were given a pie and peas supper for our trouble.

All in all a grand week out!

Whitby Abbey

Valerie - 'nuff said!

'ello 'ello 'ello...trouble again!
The 'policeman' from Heartbeat

The steam train from Pickering to Whitby

Being Diagnosed with Wilson's Disease

By Jane Ridley

It was April 1977 and I had just been diagnosed with Wilson's disease and admitted to ward D5 at Addenbrooke's Hospital Cambridge, under the care of Dr Walshe and his assistant, Kay Gibbs. It was a lengthy stay because I was very ill, during which time I had numerous tests before they could get me stable enough to cope when I went home.

My speech had become slurred and I could only take a few steps at a time before I became exhausted. I was so weak; my left hand had become bent and rigid and I could not use my fingers at all. To this day I only have movement in my thumb on my left hand. I had lost co-ordination in my right hand and had to learn to use it again, which I did, in time.

It's there that I met the *dragon* of ward D5, the ward sister! I cannot remember her name, but she was very strict and she seemed to take a dislike towards me.

At meal times, when I needed a little help cutting up food or opening sandwich packs, I would press the call button for a nurse or someone to help, but no one ever came. When I asked why I was not getting any help, a member of staff told me it was because I needed to learn to do it by myself and that it was therapy for me, even though I could not hold a fork in my left hand. I happened to mention this to Dr Walshe one day, when he popped up to see me at lunchtime and he helped me to cut up my food. From then on Dr Walshe or Kay made a point of coming up to the ward at meal times to assist me in either cutting up food or opening sandwich packs. The *dragon* did not like them doing this for me and used to give me funny looks after they had gone.

I had lost a lot of weight and needed to build myself up again. If my knights in shining armour (white coats) had not helped me, I may have starved to death, because the *dragon* and her staff did not seem to care. Why do some people have to be horrible to others when they are sick? I thought nurses were meant to be caring.

I would like to thank Dr Walshe and Kay for all their help and for getting me better, otherwise I would not be here today.

I will never forget the first of my many stays on ward D5.

Labour Question Time?

By Joan Smith

In the early 60s Wilson's disease was relatively unknown and treatment was new. Rules regarding prescription fees were often misunderstood and some patients received free prescriptions whilst others were being asked to pay.

The Cambridge Conservative MP was persuaded to raise the issue during Prime Ministers Questions in parliament of the then Labour government led by the Right Hon. Harold Wilson.

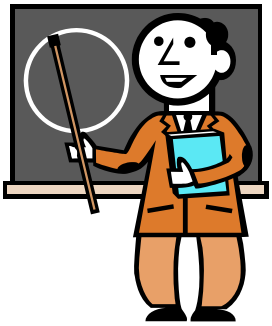
The MP rose to his feet and began… "A constituent of mine is suffering from Wilson's disease which until recently was incurable…" The ensuing uproar of laughter and catcalls drowned out the voice of the MP such that he was unable to continue. Despite the MP's protestations that he was making a serious point, the speaker admonished and sanctioned him for making a facetious remark!

It was much later that Hansard was re-written to show that the question had indeed been genuine.

Mistaken Identity!

By Joan Smith

Hospital doctors were baffled by my illness when one elderly consultant, who had spent his whole career in paediatrics, remembered a lecture he had attended some forty years earlier whilst an undergraduate at Cambridge. The lecture was given by Sir Francis Walshe: the subject…a disease he wasn't ever expecting to come across called Wilson's disease.



The consultant decided to phone Addenbrooke's Hospital in the hope that he may find someone who may have some information. He explained his dilemma to a receptionist and mentioned his memory of the lecture. The chap was stunned when the receptionist quickly replied, "Yes, I'll put you through to Dr Walshe"… And when an incredibly young male voice spoke he almost fell off his chair…he knew the good doctor was a superb physician...but to have discovered the secret of everlasting youth…now that was worthy of utter reverence!

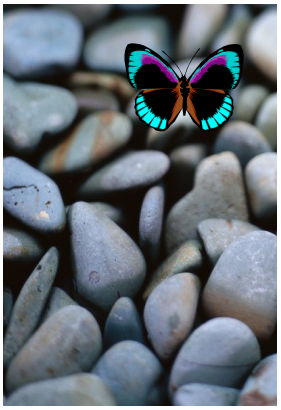
It was well into the conversation when it gradually emerged that he was talking to Dr John Walshe, whose father had given the lecture some forty years earlier!

THE EXAMPLE

Here's an example from a butterfly,
that on a rough hard rock
happy can lie,
friendless and all alone
on this unsweetened stone.

Now let my bed be hard, no care take I,
I'll make my joy like this small butterfly
Whose happy heart has power
to make a stone a flower .

W H Davies



James Duncan died 12 December 2008 aged 33.

James joined the group when it was formed and we have such fond memories of meeting him at our first ever meeting at the Peacock Inn in Nottingham in 2000.

Our deepest sympathy goes to James' family and friends for their very sad and tragic loss.

We are grateful to James' parents for holding a collection in aid of WDSG-UK at his funeral raising a generous £193.03 towards group funds.

* * * * *

Dr Hal Dixon died 30 July 2008 aged 80.

Hal will long be remembered by us, not only for his brilliance and academic achievements, but also for being a very kind, friendly and approachable human being, who arranged two of our support group meetings in the Beves room at King's College Cambridge in 2004 and 2006 and afterwards conducted a guided tour of the Chapel and Fellows' garden for all interested parties.

We will always be indebted to him for suggesting the use of trientine as a suitable non-toxic chelating agent for Wilson's disease.

Valerie and I attended the memorial service for him at King's College Chapel on 18 October 2008. It was a glorious sunny Autumn day and the chapel was full to capacity with family, colleagues and friends. It was a beautiful and moving service and we felt privileged to be there.

Wilsons Disease Support Group UK

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Dr John Walshe -	Honorary president, medical expert and world authority on Wilson's disease.
Dr Godfrey Gillett -	Group adviser, honorary member
Dr James Dooley -	Group adviser, honorary member
Black Cat Websites -	Webmaster.

WDSG-UK

Tell others about the WDSG-UK

Please tell others whom you may know who have WD, who might benefit from the support group and what we are doing.

Inform your family, friends, consultant physicians, GP surgery, local MPs about WDSG-UK

The more people who know about us, the more we can promote a better awareness of Wilson's disease within the community and the better the chance of early diagnosis of WD for future WD patients.

If more copies of this newsletter or patients & families' correspondence list are required, please contact:
Linda Hart
36 Audley Drive, Lenton Abbey, Beeston, Nottingham. NG9 2SF.

We're on the web
www.wilsonsdisease.org.uk