Stinson, Emma M

From: Trouton, Heather [redacted]
Sent: 06 June 2017 16:40
To: Carroll, Ronan; Gracey, David
Cc: Haynes, Mark; Weir, Colin; Gishkori, Esther; McKay, Damian
Subject: RE: Problem with outsourced radiology reports

Ronan

We are reviewing all the IS discrepancies with the individual companies. [redacted] Clinical Director has been very involved with David and has put in place a very tight process with regard to the quality of reporting , particularly with regard to prostate MRI which has been raised. In effect , he has allocated his 2 most senior Urology specialist Radiologists to the SHSCT work to ensure a quality service.

I am advised by Denise Newell that the other reported trend is regarding MRI rectum and we are dealing with this in the same way now that this has become apparent.

In general the overall discrepancy rate from the IS is well below the accepted discrepancy rate agreed as reasonable in the radiology industry. That said we will continue to address any quality issues with each provider.

We are currently putting together a paper for the Director and the Chief executive outlining our experience in using the IS in the area of radiology which is relatively new and due to circumstances outside of our control. We will share this with the wider clinical team when available.

Happy to meet with clinical teams to discuss and agree any other actions if that would be helpful
Heather

From: Carroll, Ronan
Sent: 02 June 2017 15:20
To: Trouton, Heather; Gracey, David
Cc: Haynes, Mark; Weir, Colin
Subject: FW: Problem with outsourced radiology reports
Importance: High

Heather/David,
Please see emails. You may already be aware of these pts/reports. Heather recently at our SMT we discussed this i.e. IS reporting discrepancies and had there been anything new incidences.
Maybe we can discuss again at next Tuesdays SMT
Ronan.

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob [redacted]

From: Clayton, Wendy
Sent: 02 June 2017 15:01
To: Carroll, Ronan; Nelson, Amie
Subject: FW: Problem with outsourced radiology reports
Importance: High

Ronan / Amie

See below from Vicki re GI radiology reports back from IS. There were 3 discrepancies at yesterday's MDT. All these reports were reported by the IS.

Regards

Wendy Clayton
Operational Support Lead
ATICS/SEC
Ext: Personal Information redacted by the USI
External number: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI

EX [redacted] if dialling from Avaya phone.
If dialling from old phone please dial Personal Information redacted by the USI

External No. Personal Information redacted by the USI

From: Graham, Vicki
Sent: 02 June 2017 11:43
To: Clayton, Wendy
Cc: Reddick, Fiona; Shannon, Hilda
Subject: FW: Problem with outsourced radiology reports
Importance: High

Hi Wendy,

Just want to bring the below email to your attention from Hilda following MDM yesterday. This is really quite worrying that this is happening. Hilda has also advised me that a letter has been sent on behalf of the team addressing these concerns to the AD and Director round 12th April. To date they have not received a response regarding this.

Regards,

Vicki Graham
Cancer Services Co-ordinator
Red Flag Appointment Office
Tel. No. Personal Information redacted by the USI
Internal Ext: Personal Information redacted by the *(Note: if dialling from the old system please dial* Personal Information redacted by *in front of the extension)*

From: Shannon, Hilda
Sent: 02 June 2017 11:29
To: Graham, Vicki
Subject: Problem with outsourced radiology reports

HI Vicki,

The GI MDT are concerned regarding radiology reports that have been outsourced. We had 3 cases yesterday that the MRI's had been reported wrong.

Please see below names,

Personal Information redacted by the USI

Thanks
Hilda

Upper GI & Colorectal Tracker
Cancer Services
Internal Ext [redacted] (If calling from old system please dial [redacted]3 in front of extension)
External No: Personal Information redacted by the USI

Stinson, Emma M

From: Williams, Marc
Sent: 09 November 2017 11:51
To: Newell, Denise E
Cc: Gracey, David; McConville, Richard; Trouton, Heather
Subject: Irrelevant Information

Personal Information redacted by the USI

Reported as convincing for significant tumour (on 2 occasions) despite the biopsies of Gleason 6.
To me, the appearances are actually convincing for the central zone, which is a normal anatomical structure.

Please see

Personal Information redacted by the USI

The pictures and description in this article may help Personal Information. Figure 1, C and D.

Would Irrelevant Information Redacted by not agree?

The case will be discussed again at the urology MDT today.

Marc

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 22 November 2017 12:35
To: Trouton, Heather; Tariq, S; Wright, Richard
Subject: FW: [redacted] prostate MRI (another discrepancy)

Dear All,

For your consideration, [redacted] may feel it is in their best interests to withdraw their service if I pass this on. Would involvement from urology (Mr Mark Haynes)be appropriate as withdrawal may place this portion of their service at risk?

Regards

David

From: Williams, Marc
Sent: 22 November 2017 11:37
To: Gracey, David
Cc: Trouton, Heather; Tariq, S
Subject: RE: [redacted] prostate MRI (another discrepancy)

David
Thanks.
See my comments in red.
Please feedback to [redacted] if you want.
We should be in NO doubt that the outsourcing of these examinations has caused significant quality issues and prevents the further improvement of our service to the best it can be. We are already ahead of any trust in NI and we could have done better. I worked hard to get us to this position and I can do nothing more now.
Ask any urologist if they are happy with the service.
Managers need to rethink what is happening here. The trust could always try and recruit?

From: Gracey, David
Sent: 22 November 2017 11:08
To: Williams, Marc
Cc: Trouton, Heather; Tariq, S
Subject: FW: [redacted] prostate MRI (another discrepancy)

Marc

[redacted] esponses to the recently raised discrepancies

Regards

David

From: Robin Evans [redacted]
Sent: 21 November 2017 13:57
To: Gracey, David
Cc: Trouton, Heather; Tariq, S; Clinical Governance; Daniel Rose
Subject: RE: [redacted] prostate MRI (another discrepancy)

Dear David,
I have now heard back from the radiologist reporting this study and had the case double read.

I have laid out comments from these responses below as they make some valid points about clinical information, scan technique and quality, inter observer variation and other challenges reporting in this area.

In summary:

1. I can confirm Irrelevant information redacted by radiologists being assigned prostate MRI for reporting attend regular MDTM's.
2. Please continue to feedback discrepancies.
3. I await you instruction as to whether you wish Irrelevant information redacted by to continue reporting these studies for you given the comments in my last email. I can see that you have a significant capacity problem. (easily resolvable)
4. We are developing a PIRAD reporting template.
5. I have assigned a Level 3 discrepancy to this case and the reporting radiologist has the feedback.
6. Please share the content of this email with Dr Williams.

Reporting radiologist comments:
"Answering the referrers queries, yes I go to the urology MDT and have received adequate training in reporting MRI prostates. A single discrepancy is not the grounds for questioning some ones competency (indeed but some discrepancies are so concerning that they question whether someone should be reporting these examinations. For example reporting infiltrated seminal vesicles when it is haemorrhage (Persona l discrepancy) or calling a prostatic abscess that is simply not there (there isn't any restricted diffusion). Some of the interpretations I have seen from Irrelevant information redacted by USI show that some radiologists are not aware of the pitfalls of prostate MRI and report disease that is simply not there). Thankfully this has been addressed to an extent below. There is a difference in the quality of MRI images across the centres and even in best of circumstances most competent of the radiologists make errors (highly variable in frequency). I have regularly reported these examinations for your organisation with no significant issues. Most of radiologists realise that clinical information provided in many instances is not adequate. Medico legally this is not considered a valid argument. (no idea what this refers to) In the absence of interaction with clinicians which is drawback of remote reporting we are left with no option other than to refer to MDTs." And therefore you agree that remote reporting is suboptimal. I agree too Irrelevant information redacted by reports also contain image references that mean nothing to us and images cannot be marked up for biopsy. Remote reporting has reduced the quality of care this trust provides. We now cannot offer a TRUS MRI service without re reading all scans.

Second read comments:
"Clinical details: Poor. What is the patient's PSA / DRE findings. The patient is young so is there a family history.
Images:
Poor quality. Movement artefact and no dynamic contrast images (useful sequence in prostate cancer as focal suspicious enhancement up stages PIRADS 3 lesions to 4 which is suspicious for cancer whilst difuse enhancement leans to prostatitis). The role of contrast is disputed. Various papers show it has no value. It's not required in the vast majority of patients so we don't give it in all patients.

Have they done b1400 sequences?. This is the recommended sequence to assess restriction. No we do b2000. Far better than b1400.
Report: I cannot comment on this as I don't have the patient details.
No comment on technical limitations.
In the absence of contrast images modified PIRADS score should have been utilised and documented as so.
Agreed there is a small focus of low T2 signal within the RT PZ which is low on the ADC images and has features of a 3 (modified score of 3)
There is also a focal low T2 signal seen within the left PZ apex with low ADC signal. This is wedge shaped and thus may be a scar (contrast would be useful to assess this)
The periprostatic free fluid in think is just a rim of the PZ and not fluid. Entirely agree.
Patient has mild to moderate sigmoid diverticulosis (not mentioned in the report).
On the basis of the imaging I would say there is a small modified PIRADS 3/5 nodule in the right PZ and possibly a 3/5 nodule within the left PZ apex/mid gland but as the study is limited correlation with PSA density (17cc prostate)

and DRE is recommended. If PSA trend is concerning then TRUS biopsy however the nodule in the right is small and may be missed." So no evidence of a prostatic abscess then which is what was reported.

Please let me know if there is any more I can do to assist.
BW

Irrelevant information redacted by USI

Hi David,
Please see comments from the referring radiologist.
Registered as a Level 3 discrepancy.

"Referrer: Reported as convincing for significant tumour (on 2 occasions) despite the biopsies of Gleason 6.
To me, the appearances are actually convincing for the central zone, which is a normal anatomical structure.
Irrelevant information redacted by USI The pictures and description in this article may help Persona l . Figure 1, C and D.
Would Irrelevant information redacted by not agree?

Irrelevant information redacted by USI Reporting Radiologist :agree that in retrospect, given the stability of the imaging and reassuring biopsy results, that the perceived abnormal area, although larger in volume than perhaps would be expected, could be normal central zone tissue. I have reflected on this and made a note of this in my portfolio. The paper highlighted by the referrer I have not come across before, thank you for highlighting this."

Agree with this though don't agree that the conclusion can only be drawn with the benefit of retrospect. The appearances are of the central zone on the first MRI. The patient would not have been followed up had I reported this scan. The follow up occurred because of the Irrelevant information redacted by USI report and no radiologist at MDT.

BW

Irrelevant information redacted by USI

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 14 May 2015 21:00
To: Clayton, Wendy
Subject: RE: Urology MDM update

Wendy

Thanks. Looking at the leave diary – Marc is off Thur 28. He does not have leave booked on a Thurs in June or 1st 2 weeks of July.

If it is an issue of day could the meeting be moved? The urologists also meet about non oncology cases one morning per week. Could cases be moved? I will ask that he is not given other departmental duties on a Thur pm.

Next recruitment needs to be for GU (and preferably also GI).

David

From: Clayton, Wendy
Sent: 14 May 2015 15:11
To: Hall, Stephen; Gracey, David; Carroll, Ronan; Robinson, Jeanette
Cc: Graham, Vicki; Reddick, Fiona; McVeigh, Shauna
Subject: Urology MDM update

Hi all

Vicki went to the Urology MDM today, Mr O'Brien was chairing. The team agreed that they are happy for radiology urology cases to be listed for discussion without a Radiologist present if the report is available. However, in specific cases if there is any doubt regarding the radiology result they advised they will defer the case until a Radiologist is present or liaise directly with the Radiologist outside of the MDM.

The urology MDM is on this afternoon 2-5pm, so I will advise tomorrow morning if any cases were deferred and they reason why. Next week's urology MDM is cancelled due to Audit, next meeting scheduled as normal for Thursday, 28th May at 2pm.

Regards

Wendy Clayton
Operational Support Lead
Cancer & Clinical Services / ATICs
Southern Trust

Tel: [redacted]
Mob: [redacted]

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 15 May 2015 09:41
To: Clayton, Wendy
Cc: Hall, Stephen
Subject: RE: Urology MDM update

As far as I am aware non of the new starts are GU trained.

From: Clayton, Wendy
Sent: 14 May 2015 22:13
To: Gracey, David
Subject: Re: Urology MDM update

Thanks, I will let the Tracker know that Dr Williams will be on leave 28the May.

I'm in DHH tomorrow but will come and see you early next week about possible solutions. It will be difficult to move the whole MDM as so many job plans are affected, however, we could talk to the Urologist about an interim solution until the new Radiologists start - do you know if any of the new Radiologists will be attending the Urology MDM or report MRI prostates?

Chat with you next week.

Kind regards

Wendy Clayton
Operational Support Lead
Cancer + Clinical Services/ATICs
Southern Trust
Mob: [redacted]

From: Gracey, David
Sent: Thursday, May 14, 2015 08:59 PM
To: Clayton, Wendy
Subject: RE: Urology MDM update

Wendy

Thanks. Looking at the leave diary – Marc is off Thur 28. He does not have leave booked on a Thurs in June or 1st 2 weeks of July.

If it is an issue of day could the meeting be moved? The urologists also meet about non oncology cases one morning per week. Could cases be moved? I will ask that he is not given other departmental duties on a Thur pm.

Next recruitment needs to be for GU (and preferably also GI).

David

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To: Hall, Stephen; Gracey, David; Carroll, Ronan; Robinson, Jeanette
Cc: Graham, Vicki; Reddick, Fiona; McVeigh, Shauna
Subject: Urology MDM update

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Regards

Wendy Clayton
Operational Support Lead
Cancer & Clinical Services / ATICs
Southern Trust

Tel: Personal Information redacted by the USI
Mob: [redacted]

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 27 April 2016 14:58
To: Williams, Marc; O'Brien, Aidan
Subject: RE: Urology MDT

I have requested AMD and senior management input. I will be in touch in due course.

From: Williams, Marc
Sent: 27 April 2016 11:14
To: O'Brien, Aidan
Cc: Gracey, David
Subject: Urology MDT

Dear Aidan,
I am, with immediate effect, resigning as lead radiologist for the urology MDT.
Marc

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 27 April 2016 11:53
To: McAllister, Charlie
Subject: AMD assistance

Charlie

Heather Trouton said that you would be very happy to lend me some assistance if required.

The Urology MDM has been an on going issue. Following one radiologist leaving and the suspension of another, this MDM lies with a sole radiologist, Dr Marc Williams. He has found the work load onerous and feels the MDM is poorly organised. In contrast Urology have issues with his attendance, which I believe has been escalated by Aiden to Richard.

Today after additions to the clinic Marc has emailed to say he is resigning as Urology lead. Given that there is no other Radiologist with Urology expertise this leaves the service unmanageable.

Could I discuss options for taking this forward.

David

Dr David Gracey, FRCR
Consultant Radiologist, Clinical Director of Radiology

[redacted]
[redacted] (office)

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 27 April 2016 12:27
To: Trouton, Heather
Subject: FW: AMD assistance

For you information.

Marc has been asking for a job plan review, I believe primarily to ensure he can do waiting lists, but he reduced some time ago to a 4 day week (Mon to Thurs) which he is unwilling to give up. Given current pressures I have not yet addressed this.

Urology MDM has been an on going issue, as Thursday is a not infrequent leave day for him. I can also understand his frustration though as the MDM list is very long and due to the way it is presented runs to many pages.

I will try and speak to you soon.

David

From: Gracey, David
Sent: 27 April 2016 11:53
To: McAllister, Charlie
Subject: AMD assistance

Charlie

Heather Trouton said that you would be very happy to lend me some assistance if required.

The Urology MDM has been an on going issue. Following one radiologist leaving and the suspension of another, this MDM lies with a sole radiologist, Dr Marc Williams. He has found the work load onerous and feels the MDM is poorly organised. In contrast Urology have issues with his attendance, which I believe has been escalated by Aiden to Richard.

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Could I discuss options for taking this forward.

David

Dr David Gracey, FRCR
Consultant Radiologist, Clinical Director of Radiology

[redacted]
[redacted] (office)

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 26 April 2016 13:40
To: Williams, Marc
Subject: RE: Urology preview list 28.04.16

I'm meeting with Richard Wright next week and see if there is a way to address. I know Aidan was bending his ear over it too. I'm not a fan of prose.

From: Williams, Marc
Sent: 26 April 2016 13:37
To: Gracey, David
Subject: FW: Urology preview list 28.04.16

This week, *only* 27 pages to go through.

From: McVeigh, Shauna
Sent: 26 April 2016 12:37
To: Brown, Robin; Campbell, Dolores; Connolly, Maureen; Cummings, Ursula; Dabbous, Marie; Davies, Caroline L; Dignam, Paulette; Dr Sai Jonnada; Elliott, Noleen; Glackin, Anthony; Graham, Vicki; Hanvey, Leanne; Haynes, Mark; Holloway, Janice; Jolyne OHare; Kelly, Wendy; Larkin, Bronagh; Loughran, Teresa; McCartney, Rachel; McClean, Gareth; McClure, Mark; McConville, Richard; McCreesh, Kate; McMahon, Jenny; McVeigh, Gerry; McVeigh, Shauna; Mukhtar, Bashir; O'Brien, Aidan; ODonoghue, JohnP; ONeill, Kate; Reid, Stephanie; Robinson, NicolaJ; Shah, Rajeev; Shannon, Hilda; Sheridan, Patrick; Suresh, Ram; Topping, Christina; Troughton, Elizabeth; Turkington, Ann E; Tyson, Matthew; Ward, Ann; White, Deborah; Williams, Marc; Young, Michael
Subject: Urology preview list 28.04.16

Lunch is to be confirmed.

Urology MDM @ The Southern Trust on 28/04/2016

		Clinical Summary / MDM Update	Notes
[redacted]			
Sex: Male		**CONSULTANT MR SURESH: This** [redacted] **gentleman was living in** [redacted] **and had a few episodes of gross haematuria with mild right loin pain since February 2016. He underwent TURBT in** [redacted] **the operation notes says - 'There was a large bladder mass occupying the posterior and lateral wall and trigone & right UO. Incomplete resection due to infiltration into bladder wall'. Histology – High grade invasive urothelial carcinoma with giant cell features and necrosis. Tumour cells are immunoreactive with CK-7, p63, patchy Uroplakin III but negative with PAX-8 and PSA. Deeper cut- high grade invasive carcinoma, highlighted by pankeratin stain. He was advised radical cystectomy and he has now moved to the UK to have further treatment. The CDs of CT**	
DOB: [redacted]			
Age: [redacted]			
Hospital Number:	[redacted]		
HCN:	[redacted]		
Consultant	**DR K SURESH**		
Diagnosis:			
Stage:			
Reason for Discussion:	**PATH REGIONAL DISCUSSION / POST SURGERY**		

Target Date	**02/06/2016**	**abdomen & chest have been handed over to PACS office for downloading onto our system. Seen in the clinic on 11/4/16. Examination of abdomen & external genitalia were normal. DRE showed a benign feeling prostate, with a probable mass above the prostate. He has been provisionally wait listed for Bimanual examination, TURBT +- ureteric stenting, prostatic urethral biopsies to be done on 22/4/16. Requested CT chest and bone scan, apart from arranging baseline blood tests. CT, 21.04.16 - No thoracic metastasis seen. Discussed at Urology MDM 14.04.16. Defer until patient has had surgery performed which is planned for 22 April 2016. Staging scans have been requested. Underwent TURBT on 22/4/16. Prior bimanual examination showed a large mobile mass in the right side of pelvis. Cystoscopy showed small non occlusive prostate. There was a large solid tumour with areas of necrosis in the trigone extending to right lateral wall. Neither UO was clearly seen, even after TURBT. Await pathology.**

	Clinical Summary / MDM Update	**Notes**
Personal Information redacted by the USI		
Sex: Male	**CONSULTANT MR SURESH:** Personal Information redacted by the USI **man who had a laparoscopic right radical nephrectomy performed on 30th November 2012. Pathology reported Fuhrman grade II, pT1b renal cell carcinoma. Chronic kidney disease with an eGFR of 36 in February 2014. CT C/A/P, 28.03.13 - The lung changes were likely infective/inflammatory however follow up CT of the chest suggested in three months time. The left adrenal gland was enlarged but unchanged since the previous examination. Discussed @ Urology MDM, 03.04.14. This gentleman has been found to have a small nodule in the lower lobe of his left lung, and which has increased since previous scanning in March 2013. For review by Mr Suresh, to request a CT of chest in September 2014, and will be for subsequent MDM discussion. Attended for review on 07.04.14 and was found to be keeping well without any bothersome problems. His EGFR was 36. CT Chest, 30.09.14 - Small lung nodules within the chest - has increased very marginally in size(mms) from previous scan February 2014. Findings not in keeping with significant progression from previous scan. Discussed @ Urology MDM, 23.10.14. Review of the gentleman's CT of Chest shows no significant progression of lung nodules.** Personal Information **will require a further CT of Chest/Abdomen and Pelvis in**	
DOB: Personal Information redacted by the USI		
Age: Personal		
Hospital Number: Personal Information redacted by the USI		
HCN: Personal Information redacted by the USI		
Consultant	**DR K SURESH**	
Diagnosis:	**Renal clear cell carcinoma**	
Stage:		
Reason for Discussion:	**REGIONAL DISCUSSION**	
Target Date		

March 2015. Mr Suresh will inform patient of findings. Personal Information eGFR has decreased from 34 to 27 on 9th June 2015. He had follow up CT chest , abdomen & pelvis on 02.06.15. To discuss the imagings. CT C/A/P, 02.06.15 - Slight increase in size of nodule within the left lower lobe. Again this requires surveillance. The possibility of a primary lung lesion is unlikely but not excluded. At just over 1 cm consideration might be given to PET CT to assess FDG activity. Discussed at Urology MDM 25.06.15. This gentleman has an enlarging left lung nodule which may represent metastatic disease relating to his previous kidney cancer. For referral to lung MDT to advise on further management. For review with Mr Suresh. Personal Information was reviewed in clinic on 05th February 2016, he was due to have a wedge resection of his LUL performed by Mr Sidhu. This was performed on 03rd February, Histology of paraffin sections from the nodule shows a deposit of clear cell adenocarcinoma, consistent with a metastasis from the previously diagnosed renal cell carcinoma. The remaining lung parenchyma is unremarkable and the stapled margin is tumour free. For discussion of his metastatic renal cell carcinoma. Discussed at Urology MDM 18.02.16. For review with Mr Suresh to advise of management plan and onwards referral to Oncology. Personal Information was reviewed in clinic on 04 April 2016 and was referred to Belfast City Hospital for treatment of his metastatic renal cell carcinoma. Belfast has asked for this patient to be added for MDM discussion as he is not known to Dr Hurwitz.

	Clinical Summary / MDM Update	Notes
Personal Information redacted by the USI		
Sex: Male	CONSULTANT MR SURESH: This Personal Information redacted by the USI gentleman had TRUS and biopsies in Ulster independent clinic on 2010, which showed Ca prostate in the right lobe with Gleason score 3+3 in 2/14 cores. His bone scan was clear and he has been on active surveillance. His PSA has gone up from 8.1ng/ml in May 2015 to 11.1ng/ml and then on rechecking has dropped slightly to 9.5ng/ml. From a urological point of view he has been asymptomatic without any lower urinary tract symptoms. He has not had any UTI or haematuria. Co morbidities - Laparoscopic converted to open cholecystectomy in November 2012, complicated by biliary leak, managed by biliary stenting. AKI, mild asthma, hypertension, severe depression and alcohol abuse. DRE showed a small benign feeling prostate. His MRI	
DOB: Personal Information redacted by the USI		
Age: Personal		
Hospital Number: Personal Information redacted by the USI		
HCN: Personal Information redacted by the USI		
Consultant DR K SURESH		
Diagnosis: Prostate cancer		
Stage:		
Reason for Discussion: REGIONAL DISCUSSION		
Target Date		

prostate done in December 2015 was suggestive of tumour in right apex and therefore he had repeat TRUS and biopsies on 16/2/16. Twenty cores of biopsies were taken. Transrectal prostatic biopsy, 16.02.16 - Prostatic adenocarcinoma is present in a total of 15/20 of the cores. The Gleason score is 3+4 = 7. The longest continuous length of tumour is 5.5 mm. Discussed at Urology MDM 03.03.16. Personal Information redacted by the USI **surveillance prostate biopsies have shown progression in grade and volume of his prostate cancer which remains organ confined on surveillance MRI. Mr Suresh to review in outpatients, discuss recommendation of a switch to a radical treatment and arrange a bone scan and subsequent MDM discussion. Reviewed in the clinic on 11/3/16. Requested bone scan. Written to chest physician as his follow up CT scan done in February 2016 has shown slight increase in the incidentally found 5 mm lung nodule. To discuss after the bone scan. Bone scan, 08.04.16 - There is linear increased tracer uptake lying across the lower lumbar spine at the L4-A5 level. No recent plain film evaluation of this region has been performed. However CT scanning of the chest in February 2016 has demonstrated multiple thoracic vertebral collapse and wedging and the uptake within the lower spine may represent a more acute vertebral body collapse. Elsewhere, the distribution of tracer is unremarkable. Discussed at Urology MDM 14.04.16.** Personal Information redacted by the USI **has intermediate risk, prostate cancer. He has a lesion in his lumbar spine which requires plain film for clarification. The other abnormalities indicate chest trauma. For review with Mr Suresh to recommend active treatment for prostate cancer. In November 2015,** Personal Information redacted by the USI **fell off a ladder from 5 feet and sustained multiple rib fractures. He has not had the X ray lumbar spine yet, but, arranged this to be done (25/4/16). Discussed the options of Radical prostatectomy or External beam radiotherapy.** Personal Information redacted by the USI **was very anxious and he could not make a decision, but he is happy to see both the surgeon and oncologist. For direct referral to surgeon and oncologist, provided X ray is clear.**

	Clinical Summary / MDM Update	Notes
Personal Information redacted by the USI		
Sex: Male **DOB:** Personal Information redacted by the USI **Age:** Personal	**CONSULTANT MR HAYNES: This** Personal Information redacted by the USI **man was referred with rising PSA. It was 4.88 in January 2013, 4.86 in June 2014, 5.58 in January 2015, 7.07 in May 2015 and 6.09 in September**	

Hospital Number:	Personal Information redacted by the USI
HCN:	Personal Information redacted by the USI
Consultant	**MR M D HAYNES**
Diagnosis:	**Prostate cancer**
Stage:	
Reason for Discussion:	**CT CT**
Target Date	

2015. He has no bothersome urinary symptoms. MRI, 07.01.16 - Probable tumour in the left apex to mid gland peripheral zone. The degree of capsular contact is in itself significant but there is also possible capsular irregularity which may represent very early extracapsular extension of tumour. No lymphadenopathy or definite pelvic bone metastasis. If tumour is proven in the left apex to mid gland peripheral zone, staging is probably T3a N0 M0. Transrectal prostatic biopsy, 08.02.16 - Histological examination shows Gleason 4+3, prostatic adenocarcinoma, involving 8 of 16 cores and predominantly within the left mid zone and apex. Within the cores from the left mid zone and apex, admixed with the acinar type adenocarcinoma there is also relatively conspicuous intraductal (large duct) prostatic adenocarcinoma which while containing focal necrosis, is not formally graded. Tumour occupies approximately 15% of the examined material with a longest confluent tumour length of 10 mm. There is perineural invasion but no lymphovascular invasion or extracapsular extension has been identified. Discussed at Urology MDM 25.02.16. Personal Information redacted by the USI **prostate biopsies confirm a High risk Gleason 4+3=7 prostate cancer. For OP review with Mr Haynes to arrange a bone scan and subsequent MDM discussion. This gentleman attended clinic on 1st March and was advised of his diagnosis of prostate cancer. For MDM review of bone scan and follow up with Mr Haynes. Bone scan, 14.03.16 - A small focal area of uptake overlying the anterior aspect of the right fourth rib is assumed to be related to simple trauma but again plain film evaluation should be considered. Discussed at Urology MDM 24.03.16.** Personal Information **has a high risk prostate cancer. There is an area of increased uptake on the bone scan in the right 4th rib which may be related to trauma. Mr Haynes to contact** Personal Information **, if there is a history of previous rib injury. If no history of trauma then Mr Haynes to arrange a chest X-Ray followed by a CT Chest if the Chest X ray is inconclusive. If there is a history of previous trauma Mr Haynes to recommend radical treatment with radical surgery or ADT + EBRT. This gentleman has what would appear radiologically to be a locally advanced prostate cancer with no pelvic nodal disease. His bone scan has shown a single area of hot spot in relation to the right 4th rib. He does not have any history of trauma. Further imaging has been arranged. For MDM review prior to subsequent outpatient follow up with Mr Haynes. CT,**

19.04.16 - Nonspecific focal sclerosis in the posterior cortex of right fourth rib anteriorly.

Clinical Summary / MDM Update	Notes

Personal Information redacted by the USI

Sex: Female	
DOB: Personal Information redacted by the USI	
Age: [redacted]	
Hospital Number: Personal Information redacted by the USI	
HCN: [redacted]	
Consultant	**MR RJ BROWN**
Diagnosis:	**TCC Bladder pTa Grade 2**
Stage:	
Reason for Discussion:	**PATH BLADDER BIOPSY**
Target Date	

CONSULTANT MR BROWN: [redacted] year old lady who had been referred with visible painful haematuria, dysuria and loin pain. Medical history of diabetes and hypertension. She had a stroke in 2014. She has only one kidney. Flexible cystoscopy showed - single right UO. Patch of papillary TCC just beyond right UO, Significant cystocoele. CTU was performed and this had shown no abnormalities. Urine cytology was negative for malignant cells. Bladder biopsy, 06.04.16 - Transitional cell carcinoma. Papillary, WHO grade II. pTa lYMPHOVASCULAR INVASION - not seen. Flat carcinoma in situ - none present for assessment. Granulomas - not seen muscularis propria - absent. Further Comments - Histology shows a fragmenting superficial biopsy consistent with sampling from a papillary transitional cell carcinoma of WHO grade II.

Clinical Summary / MDM Update	Notes

Personal Information redacted by the USI

Sex: Female	
DOB: Personal Information redacted by the USI	
Age: [redacted]	
Hospital Number: Personal Information redacted by the USI	
HCN: [redacted]	
Consultant	**DR K SURESH**
Diagnosis:	**TCC Bladder invasive**
Stage:	
Reason for Discussion:	**CT PATH CYSTOSCOPY / CT**
Target Date	

CONSULTANT MR SURESH: This [redacted] year old lady was seen in the clinic on 23/11/15 for noticing blood in toilet tissues over the previous 3 weeks. She has not had any UTI nor definite gross haematuria. On flexible cystoscopy, there were diffuse changes of radiotherapy apart from a small "lesion" in the posterior wall of bladder. Her eGFR was >60 in July 2015 but has dropped to 53. CT urogram showed dilated right ureter up to VUJ. She had local excision followed by chemo-radiotherapy for ca cervix in 2004. Underwent Cystoscopy under GA on 16/12/2015. Bimanual examination showed short vaginal shelf, but no mass. There were diffuse radiotherapy changes in bladder and a few unstable areas. There was a small (2 cm) nodule lateral to the right UO. Right UO appeared very tight, but admitted the semi-rigid ureteroscope. The impression was that of stricture due to radiotherapy and there was no tumour. Proximally the whole ureter and pelvicalyceal system was dilated. 6 Fr ureteric stent was placed in. The bladder tumour was resected and the unstable areas biopsied. Bladder wall appeared thin. Bladder biopsy, 16.12.15 - Part 1, Histological examination through levels with the aid of

immunohistochemical staining shows mucosal oedema and background chronic active inflammation with mild blood vessel wall thickening possibly related to previous radiotherapy. In 2 of the tissue fragments there is also surface urothelial full thickness dysplasia in keeping with carcinoma in situ (CK20 positive) and one of these fragments also contains a small focus of invasive transitional cell carcinoma seen predominantly as small cohesive groups and single cells overall regarded as pT1 grade III TCC. Part 2, Histological examination through levels shows fragments of bladder mucosa demonstrating background inflammatory changes similar to those described above. Part 3, Histological examination shows fibrofatty connective tissue and detrusor muscle with no evidence of invasive tumour. Discussed at Urology MDM 24.12.15. Personal Information redacted by the USI has high risk non-muscle invasive bladder cancer, pT1 grade 3 with cis. For review with Mr Suresh to discuss BCG therapy with an early repeat cystoscopy +/- TURBT versus primary cystectomy. On reviewing in the clinic in January 2016. Personal Information redacted by the USI opted to have BCG instillations, rather than cystectomy. She completed the six weeks course of BCG. Check cystoscopy was done on 13/4/2016. Bimanual examination showed short vaginal shelf and some' thickening' in the pelvis. There was solid tumour in the trigone extending to the region of left UO. The left UO was seen only resection and this was stented. The right stent was replaced with a new one. Histology shows focally necrotic fragments of urinary bladder mucosa with structures of Grade 3 transitional cell carcinoma. Detrusor muscle is present in the biopsy but with no evidence of invasion. CT C/A/P, 20.04.16 - Bony changes within the pelvis may be secondary to previous radiotherapy. No abdominal or pelvic lymphadenopathy or evidence of metastatic disease.

Clinical Summary / MDM Update **Notes**

Personal Information redacted by the USI

Sex: Male
DOB: Personal Information redacted by the USI
Age: [redacted]
Hospital Number: Personal Information redacted by the USI
HCN: Personal Information redacted by the USI
Consultant MR M D HAYNES
Diagnosis:

CONSULTANT MR GLACKIN: This [redacted] year old gentleman was found to have Gleason 7 prostate cancer in late 2015. Staging investigations in Lancashire showed a T2N0M0 prostate cancer. He requires complete review of his histology and imaging. For completeness I have requested up to date MRI and bone scan. His current PSA is 19.0ng/ml, his initial PSA was 18.5ng/ml in November 2015. MRI, 05.04.16 - Limited examination as a result of significant

Stage:	
Reason for Discussion:	**MRI BONE SCAN**
Target Date	**17/05/2016**

artefact from pelvic metal work. The lack of diffusion weighted imaging does not allow for accurate assessment of tumour within the peripheral zone. The appearances are probably of organ confined disease with no evidence of abdominal or pelvic lymphadenopathy or skeletal metastasis in the pelvis or lumbar spine. Bone scan, 18.04.16 - The bone scan appearances are felt to be broadly unremarkable. No convincing evidence to suggest underlying osteoblastic metastasis.

Clinical Summary / MDM Update **Notes**

Personal Information redacted by the USI

Sex:	**Female**
DOB:	Personal Information redacted by the USI
Age:	[redacted]
Hospital Number:	Personal Information redacted by the USI
HCN:	Personal Information redacted by the USI
Consultant	**MR M D HAYNES**
Diagnosis:	
Stage:	
Reason for Discussion:	**CT**
Target Date	

CONSULTANT MR HAYNES: This [redacted] year old lady presented to the General Surgeons with microscopic anaemia. OGD and colonoscopy were performed which were normal. She subsequently underwent a CT of the chest, abdomen and pelvis which revealed a 4.4cm enhancing left renal mass. She has subsequently undergone a DMSA renogram and bone scan. For MDM review of all images regarding ongoing management.

Clinical Summary / MDM Update **Notes**

Personal Information redacted by the USI

Sex:	**Male**
DOB:	Personal Information redacted by the USI
Age:	[redacted]
Hospital Number:	Personal Information redacted by the USI
HCN:	Personal Information redacted by the USI
Consultant	**MR J P O'DONOGHUE**
Diagnosis:	
Stage:	
Reason for Discussion:	**ULTRASOUND TESTES**
Target Date	**02/06/2016**

CONSULTANT MR O'DONOGHUE: [redacted] year old gentleman who was referred with scrotal swelling of his right hemiscrotum. He has Downs syndrome. On examination he has a huge swelling of his right hemiscrotum which looks like a chronic hydrocele. He has had an ultrasound of his testes and this showed an inhomogeneous right testicle and bilateral microlithiasis. Ultrasound testes was repeated on 19 April 2016 - 1. Large right hydrocele. 2. Large heterogeneous right testis with microlithiasis. Differential diagnosis would include a diffusely infiltrative tumour. Correlation with tumour markers and Urology MDM discussion required. Tumour markers were taken and these were normal.

Clinical Summary / MDM Update **Notes**

Personal Information redacted by the USI

Sex:	**Male**
DOB:	Personal Information redacted by the USI
Age:	[redacted]
Hospital Number:	Personal Information redacted by the USI
HCN:	Personal Information redacted by the USI
Consultant	**MR A.J GLACKIN**
Diagnosis:	**Prostate cancer**
Stage:	**N0**
Reason for Discussion:	**PATH TRUSB**
Target Date	

CONSULTANT MR GLACKIN: [redacted] year old man who has had longstanding intermittent testicular discomfort but more recently he has also noted perineal discomfort particularly when sitting which has been associated with episodes of mild dysuria. On review of his lower urinary tract symptoms he reported that his flow was satisfactory. He felt that he was emptying his bladder well. On most days his urinary frequency was not unduly troublesome but when his symptoms were present related to his perineal discomfort his frequency increased to at least two hourly. He had nocturia 0-1. He did not report any visible haematuria. His PSA was 5.7ng/ml on 28th August 2013. It was previously 6.4ng/ml on 13th August 2013 and 7.90ng/ml on 6th January 2014. Digital rectal examination showed a smooth benign feeling enlarged prostate. Transrectal prostatic biopsy, 05.02.14 - Prostatic adenocarcinoma of Gleason score 3 + 3 = 6, was present in 3 of 12 cores with a maximum tumour length of 2 mm. The tumour occupied less than 2% of the total tissue volume. IVP and ultrasound performed on 14.02.14. Discussed @ Urology MDM, 20.02.14. This gentleman has been found to have prostatic adenocarcinoma on recent prostatic biopsies. There is also a possibility he may have renal calculi. For histology review, to arrange an MRI of prostate and CT of urinary tract and subsequent MDM discussion. Attended histology clinic on 03.03.14, MRI of prostate and CT Urinary tract were requested. CT Urinary tract, 24.03.14 - There is a focal solitary 9 mm calculus at the cortical medullary junction of the upper pole of the right kidney, but no hydronephrosis or cortical scar. The left ureter is difficult to clearly visualise in its distal and middle thirds, but no obvious ureteral calculi. No bladder calculi. Multiple extensive calcified phleboliths in both sides of the pelvis. MRI prostate, 30.04.14 - The features are consistent with gland confined disease. Likely stage T2c N0. Discussed @ Urology MDM, 01.05.14. There was no evidence of any extra-capsular disease on recent MRI scanning. CT urinary tract has also confirmed the presence of a right renal calculus. For review by Mr Glackin, to arrange ESWL for the right renal stone. The patient is suitable for all treatment modalities for his prostate cancer, but may be advised that active surveillance is entirely appropriate in the first instance. Personal Information redacted by the USI was reviewed at clinic following MDM discussion and he was happy to pursue with active surveillance with 3 monthly checks of his PSA and repeat biopsy in February 2015. Personal Information redacted by the USI was

reviewed at clinic on 12th May 2015, His PSA has risen recently to 9.5ng/ml. His PSA at the time of presentation in February 2014 was 7.9ng/ml. We have discussed the possibility of proceeding to MRI versus TRUS biopsy. Personal Information redacted by the USI would prefer to have an MRI and then targeted biopsies later if necessary. His most recent PSA was 10.07ng/ml on 15th June 2015. MRI, 25.08.15 - Patient movement causes significant image degradation. No definite significant prostate tumour is seen. Discussed at Urology MDM 03.09.15. Personal Information redacted by the USI MRI has not identified any prostatic tumour. He remains suitable for active surveillance for low volume, Gleason 6 prostate cancer. For review by Mr Glackin. Personal Information redacted by the USI has remained on surveillance for his Gleason 6, prostate cancer diagnosed in February 2014. His PSA has been creeping up, since July of last year his PSA level has been 10ng/ml and this has been confirmed again on 1st March 2016. His current level of PSA is out of keeping with the volume of his prostate and even though his MRI from August did not show any identifiable tumour I think it would be worthwhile considering a repeat TRUS biopsy to ensure that we haven't overlooked any high grade disease. Transrectal prostatic biopsy, 20.04.16 - await pathology.

Clinical Summary / MDM Update **Notes**

Personal Information redacted by the USI

Sex: Male
DOB: Personal Information redacted by the USI
Age: [redacted]
Hospital Number: Personal Information redacted by the USI
HCN: Personal Information redacted by the USI
Consultant
Diagnosis:
Stage:
Reason for Discussion: **FURTHER MANAGEMENT**
Target Date

[redacted] year old gentleman who has recently been diagnosed with a low rectal tumour. On his staging MRI he was noted to have an abnormality of his prostate with associated iliac lymphadenopathy. The radiologist felt that this represented a separate prostatic tumour. Mr Epanomeritakis is making arrangements for Personal Information redacted by the USI to have formal anaesthetic assessment for consideration of abdominal perineal resection rectum and I would be grateful for your advice with regards to the management of his prostate problem. He has had his PSA checked in February of this year and it was very raised, up to 116. He has had a previous history of successful renal transplant 24 years' ago.

Clinical Summary / MDM Update **Notes**

Personal Information redacted by the USI

Sex: Male
DOB: Personal Information redacted by the USI

CONSULTANT MR SURESH: [redacted] year old man with a PSA of 10.61ng/ml. Personal Information redacted by the USI had minimally bothersome lower urinary tract symptoms. Did

Age:	[redacted]
Hospital Number:	Personal Information redacted by the USI
HCN:	Personal Information redacted by the USI
Consultant	**MR AJAY PAHUJA**
Diagnosis:	**Prostate cancer**
Stage:	**T2 N0**
Reason for Discussion:	**MRI BONE SCAN**
Target Date	

not report any dysuria or haematuria. His IPSS score was 6/35, his quality of life score was 2/6. History of COPD and hypertension. Ultrasound urinary tract - right kidney may be congenitally absent. Left kidney was hypertrophied measuring 13.5cm but was otherwise unremarkable. Bladder emptying was satisfactory. Prostate volume was estimated at 40cc. Flow rate was normal the q-max of 17ml/sec. Digital rectal exam demonstrated a firm prostate particularly at the right base. Felt suspicious. Transrectal prostatic biopsy, 18.12.13- Prostatic adenocarcinoma of Gleason score 3+3=6 was present in 3 of 12 cores with maximum tumour into 1 mm. The tumour occupied less than 2% of the total tissue volume. Discussed @ Urology MDM, 02.01.14. This gentleman has been found to have prostatic adenocarcinoma, of Gleason score 6, on recent prostatic biopsies. For histology review, to request staging MRI and bone scanning, and will be for subsequent MDM discussion. Attended histology clinic on 06.01.14. Staging MRI and bone scanning requested. Bone scan, 17.01.14 - No evidence of bony metastasis. MRI Prostate, 29.01.14 - T2 N0. Discussed @ Urology MDM, 06.02.14. This gentleman's staging investigations for prostate cancer indicate that he has low-risk organ-confined disease. The bone scan supports the ultrasound findings that the right kidney is absent. To be reviewed by Mr Suresh. To be offered all treatment options for his prostate cancer. Personal Information redacted by the USI was reviewed in clinic in March 2014, all options were discussed with him and he preferred active surveillance. His PSA has remained fairly stable, it was 10.45 ng/ml in December 2015. Transrectal prostatic biopsy, 02.02.16 - Maximum length of tumour 5 mm. Gleason score 3+4=7, number of cores involved 5/17. Overall tumour volume 2%. Lymphovascular invasion- no. Perineural invasion - not seen. Extraprostatic extension - no. Discussed at Urology MDM 11.02.16. Mr Donnelly has been found to have intermediate risk prostate cancer. For review with Mr Suresh to organise staging MRI and bone scan and for further MDM discussion. Requested bone scan and MRI. To discuss after the reports of the imagings. Bone scan, 09.03.16 - No convincing evidence of osteoblastic metastasis but there are features suggestive of degenerative change within the cervical and lumbar spine with further degenerative features around the shoulders, elbows and wrists. MRI, 19.04.16 - No radiological evidence of a significant prostate

tumour. The appearances are of organ confined disease.

Clinical Summary / MDM Update	Notes
Personal Information redacted by the USI	

Sex: Male		**CONSULTANT MR O'DONOGHUE: This [redacted] year old man was admitted from South West Acute Hospital with a right testicular tumour on a background of a previous right orchidopexy. His alpha-feta protein was greater than 6000. I performed the orchidectomy through the old right inguinal incision and the procedure was extremely difficult. The tissues were very scarred and there was possible involvement of the cord as it was very indurated. It was globulated and quite extensive and there was a large necrotic area with some tumour spillage. Eventually got the tumour out and took the cord as high as possible. The wound was irrigated with saline and was closed in the standard fashion with absorbable sutures. Right radical orchidectomy, 19.04.16 - await pathology. CT C/A/P, 21.04.16 - Few inguinal lymph nodes bilaterally perhaps of reactive in nature requiring USS/MRI verification. Induration & inflammatory stranding at Right inguinal area as post-recent-op. Liver, kidneys, spleen, pancreas & adrenals appear unremarkable. Urology MDM discussion is advisable for further investigation as PET-CT & management**
DOB: [redacted]		
Age: [redacted]		
Hospital Number:	Personal Information redacted by the USI	
HCN:	Personal Information redacted by the USI	
Consultant		
Diagnosis:		
Stage:		
Reason for Discussion:	**PATH POST SURGERY / ULTRASOUND**	
Target Date		

Clinical Summary / MDM Update	Notes
Personal Information redacted by the USI	

Sex: Female		**CONSULTANT MR SURESH: This [redacted] year old lady was referred by nephrology due to deteriorating eGFR from 38 to 18 over the last couple of years. Initial ultrasound scan showed bilateral hydronephrosis with CT urinary tract showing dilated ureters up to the VUJ. She was admitted to hospital on 1st April 2016, and the bladder was catheterised but there was only very slight improvement in her renal biochemistry. MAG-3 renogram was suggestive of obstruction at the VUJ on both sides. She underwent GA cystoscopy on 15th April 2016. Bimanual examination showed no mass nor any prolapse. On DRE there was soft faecal loading. Cystoscopy showed very small bladder capacity of just 100mls with extensive edema all over the bladder. The left UO was wide open. On table cystogram showed brisk grade 4 reflux on the left side even with just 50mls of contrast in the**
DOB: Personal Information redacted by the USI		
Age: [redacted]		
Hospital Number:	Personal Information redacted by the USI	
HCN:	Personal Information redacted by the USI	
Consultant	**DR K SURESH**	
Diagnosis:		
Stage:		
Reason for Discussion:	**PATH CYSTOSCOPY**	
Target Date		

bladder. There was no reflux on the right side. Semi-rigid ureteroscopy showed very dilated ureter on the left side up to PUJ without any evidence of distal obstruction. However on the right side the intramural ureter was right with proximally dilated ureter. Right ureter was stented. Though there was no obvious bladder tumour the bladder wall was widely resected after right ureteric stenting. TURBT, 15.04.16 - await pathology.

	Clinical Summary / MDM Update	Notes
Personal Information redacted by the USI		
Sex: Female **DOB:** Personal Information redacted by the USI **Age:** [redacted] **Hospital Number:** Personal Information redacted by the USI **HCN:** Personal Information redacted by the USI **Consultant** DR K SURESH **Diagnosis:** **Stage:** **Reason for Discussion:** CT **Target Date**	**CONSULTANT MR SURESH: This [redacted] year old lady was admitted on 13/12/2015 under physician with features of right pyelonephritis. Apart from previous hysterectomy for endometriosis and cholecystectomy, nothing to note on past medical history. CT urogram showed 3.8 cm right renal lesion with features of PUJ obstruction. Her fever settled with antibiotics. eGFR dropped to 41. She underwent right ureteric stenting on 18/12/2015. Preliminary retrograde pyelogram showed kinking at the PUJ, consistent with chronic PUJ obstruction. Attempted semi-rigid ureteroscopy, but the scope could not be advanced beyond pelvic brim. CT Chest 21.12.15 - No pulmonary metastasis. Discussed at Urology MDM 24.12.15. Defer for radiology input. Mr Suresh to consider MAG3. Discussed at Urology MDM 07.01.16. Personal Information redacted by the USI requires a follow up CT in 3 months and a DMSA. For review with Mr Suresh. She has been scheduled to attend for DMSA renogram 09 May 2016. CT renal, 06.04.16 - Mass lesion in the right kidney is unchanged in size, and highly suspicious for RCC.**	

	Clinical Summary / MDM Update	Notes
Personal Information redacted by the USI		
Sex: Male **DOB:** Personal Information redacted by the USI **Age:** [redacted] **Hospital Number:** [redacted] **HCN:** Personal Information redacted by the USI **Consultant** MR J P O'DONOGHUE **Diagnosis:** Prostate cancer **Stage:** **Reason for Discussion:** BONE SCAN	**CONSULTANT MR O'DONOGHUE: This [redacted] year old man with rising PSA whilst on Finasteride, seen in clinic on 10th November 2015. PSA on 2nd April 2015 was 5.09ng/ml, on the 16th April was 5.73ng/ml, June 2015 was 6.30ng/ml, July 2015 was 6.09ng/ml and October 2015 was 8.76ng/ml. Symptom wise, he has been bothered by new onset nocturia of 1 to 2 times. Reduced stream for some time but no intermittency, some hesitancy but does feel like he fully empties his bladder. No frequency or urgency. He has had no new back pain. Heavy smoker. No known family history of prostatic carcinoma. Patient medical history includes**	

Target Date	**T2DM, hypertension, COPD, Severe IHD with NSTEMI in 2007 for which he had coronary stents inserted and further stenting 2008, duodenal ulcer, CKD stage 3 and rheumatoid and osteoarthritis. On Rivaroxaban. High BMI. DRE 40cc, firm. Baseline Creatinine ~ 120, eGFR 50 and stable. High bleeding risk so underwent MR prostate 7/1/2015. MRI, 07.01.16 - Images are degraded by movement. Probable tumour within the peripheral zone of the right mid to gland base. There is a small volume of reduced T2 and ADC signal change extending from the right gland base into the medial aspect of the right seminal vesicle which is asymmetrical with the left. The appearances are suspicious for a small volume of seminal vesicular infiltration by tumour, if tumour is proven on biopsy at the right base of the gland. No lymphadenopathy or bone metastasis is seen in the visualised skeleton. Discussed at Urology MDM 21.01.16. Recent MRI scanning has indicated the presence of probable tumour involving the right posterior peripheral zone. For review by Mr O'Donoghue to advise targeted biopsies following withdrawal of Apixaban. Transrectal prostatic biopsy, 14.03.16 - Maximum length of tumour 7 mm. Gleason score 3+4=7, number of cores involved 7/18. Overall tumour volume 14%. Lymphovascular invasion no. Perineural invasion yes. Extraprostatic extension: no Discussed at Urology MDM 24.03.16. Personal Information redacted by the USI prostate biopsies have confirmed Gleason 3+4=7 prostate cancer which is felt to be locally advanced (T3b) with no evidence of metastatic disease on MRI. For outpatients review with Mr O'Donoghue to arrange a bone scan to complete staging and commence ADT with a view to addition of radical radiotherapy if the bone scan is clear. For subsequent MDM discussion after bone scan. Bone scan, 19.04.16 - In addition there is mid and lower thoracic and mid lumbar patchy tracer uptake. The spinal pattern of uptake is relatively low grade, also likely to reflect degenerative change. A small focal area of tracer uptake is also projected over the posterior left tenth rib. This may represent simple fracture formation but correlation with plain film should be considered in the first instance. (If the patient is symptomatic, cross-sectional imaging of the spine and ribs would be indicated).**

Personal Information redacted by the USI	**Clinical Summary / MDM Update**	**Notes**

Sex:	**Male**
DOB:	Personal Information redacted by the USI
Age:	[redacted]
Hospital Number:	Personal Information redacted by the USI
HCN:	Personal Information redacted by the USI
Consultant	**DR K SURESH**
Diagnosis:	
Stage:	
Reason for Discussion:	**PATH MRI TRUSB /MRI**
Target Date	

CONSULTANT MR SURESH: This [redacted] year old gentleman was seen in the clinic on 16/2/16 for mild LUTS in the form of nocturia of just once per night, with IPSS score of 9 & QoL score of 2. His PSA was persistently high at 15, in the absence of any UTI. DRE showed benign feeling prostate. Patient medical history includes, type2 diabetes and hypertension. Following MRI scan, he underwent TRUS and biopsy on 19/4/16. 18 cores were taken. Await pathology.

Clinical Summary / MDM Update **Notes**

Personal Information redacted by the USI

Sex:	**Male**
DOB:	Personal Information redacted by the USI
Age:	**62**
Hospital Number:	Personal Information redacted by the USI
HCN:	Personal Information redacted by the USI
Consultant	**RM BROWN**
Diagnosis:	
Stage:	
Reason for Discussion:	**CT CT**
Target Date	**26/05/2016**

CONSULTANT MR BROWN: [redacted] year old man referred with single episode of frank painless haematuria. No dysuria/frequency. He is an ex-smoker. Flexible cystoscopy was performed this was normal, urine cytology had reported no abnormal cells. His renal function was normal when checked in March 2016. CTU, 20.04.16 - .5 cm welldefined mass lesion in the left kidney showing smooth mass effect on the pelvicalyceal system. The differential diagnosis inlcude oncocytoma and carcinoma. MDT discussion advised.

Clinical Summary / MDM Update **Notes**

Personal Information redacted by the USI

Sex:	**Male**
DOB:	Personal Information redacted by the USI
Age:	[redacted]
Hospital Number:	Personal Information redacted by the USI
HCN:	Personal Information redacted by the USI
Consultant	**MR M D HAYNES**
Diagnosis:	**TCC Bladder invasive**
Stage:	
Reason for Discussion:	**PATH CYSTOSCOPY, BLADDER WASHINGS & BIOPSIES**
Target Date	

CONSULTANT MR HAYNES: This [redacted] year old man was seen at the clinic, he had frank haematuria with dysuria, treated with antibiotics and asymptomatic since. No previous history of urinary symptoms. Ex-smoker. His PSA was 1.24 on 19th August 2015. Cystoscopy showed multifocal TCC base and right lateral recess. He has been added to WL for TURBT, this has been scheduled for 29th September 2015. CTU, 16.09.15 - Thick walled urinary bladder and protruding mass in the base. Slightly dilated right ureter. Personal Information redacted by the USI was electively admitted on 29th September 2015 for TURBT. Multifocal tumours on the posterior wall, extending on to the right dlateral wall. Histological examination shows fragments derived from a papillary transitional cell carcinoma. For the most part the tumour has Grade II cytology and is non-invasive however in one area there is marked

cytologic atypia consistent with Grade III transitional cell carcinoma and in this area there is also evidence of invasion (pT1) fragments of muscularis propria are present but not involved and there is no lymphovascular or perineural invasion identified. Discussed at Urology MDM 08.10.15. Personal Information redacted by the USI has high risk non-muscle invasive bladder cancer. For review with Mr Brown and to refer to Mr Haynes for further early cystoscopy. This gentleman underwent a re-resection TURBT on 23rd November. At cystoscopy there was an area of slough over the right lateral wall with some adjacent red areas which extended to the neck of the bladder. A deep resection of previous resection sites and adjacent urothelium was performed. For pathology review at MDM prior to subsequent outpatient follow up with Mr Haynes. Histological examination shows fragments of bladder mucosa within which there is patchy background inflammation. No evidence of transitional cell carcinoma is seen. In several areas there is however full thickness epithelial dysplasia in keeping with CIS/carcinoma in situ. Discussed at Urology MDM 03.12.15. For review with Mr Haynes to discuss BCG and primary cystectomy. This gentleman has completed his 6 week induction of BCG and underwent check cystoscopy , bladder washings and bladder biopsies on 22nd April 2016. Endoscopically his bladder is clear. For pathology/cytology review. If no recurrence of bladder cancer would plan for Mr Keenan to continue with maintenance BCG and subsequent endoscopic surveillance. Await pathology.

Clinical Summary / MDM Update **Notes**

Personal Information redacted by the USI

Sex: Male
DOB: Personal Information redacted by the USI
Age: [redacted]
Hospital Number: Personal Information redacted by the USI
HCN: [redacted]
Consultant MR A.J GLACKIN
Diagnosis:
Stage:
Reason for Discussion: CT CT RENAL
Target Date 02/06/2016

CONSULTANT MR GLACKIN: [redacted] is [redacted] years of age and recently diagnosed with hypertension. An ultrasound examination in February identified a possible left upper pole septated renal cyst. Personal Information redacted by the USI went on to have a CT renal on 25th March 2016. He has no other significant medical history. There is no family history of renal disease. For discussion of imaging and further management please.

Clinical Summary / MDM Update **Notes**

Personal Information redacted by the USI

Sex:	**Male**
DOB:	Personal Information redacted by the USI
Age:	[redacted]
Hospital Number:	Personal Information redacted by the USI
HCN:	Personal Information redacted by the USI
Consultant	
Diagnosis:	**Prostate cancer**
Stage:	
Reason for Discussion:	**PATH FURTHER MANAGEMENT**
Target Date	

Consultant Mr Young: [redacted] year old referred by GP complaining of urgency and reduced urinary stream for a few months. Occassional blood, was positive on urinalysis. PSA of 7.11, on oral Prednisolone for polymyalgia rheumatica past several months. Flexible cystoscopy was performed 16.07.10 which revealed gross haematuria. Endoscopy examination revealed patchy haemorrhages in the distal urethra, no mucosal lesion, no stricture. Ultrasound performed 12.04.10 reports irregular 2cm solid lesion upper pole right kidney. CT Abdomen performed 26.04.10 reports- 1-Right upper pole renal lesion-probable renal cell carcinoma. 2-Bilateral atrophic renal change. 3-No evidence of metastatic disease. CT kidneys performed 20.05.10- Right upper pole renal mass lesion likely RCC No evidence of distant metastasis. Enlargement of the prostate with a consequent thick wall urinary bladder. Mild thickening noted in the proximal part of the transverse colon which could be inflammatory. Bone scan 24.05.10 -There is no evidence of bony mets. Transrectal prostatic biopsy, 27.07.10-Prostate adenocarcinoma, Gleason score 3+4=7. 5% tissue involvement. MRI 08.09.10-Incomplete examination. An axial T1 sequence is needed to assess for pelvic adenopathy and I will arrange for the patient to be recalled. CT Abdomen 21.10.10-The upper pole lesion in the right kidney has increased in size and measures 3.7 cm. Appearance in keeping with RCC. Discussed @ Urology MDM 28.10.10. Has appointment to see Mr Young on 29.10.10 and to be booked for CT scan in 6 months with Mr Young. [redacted] Personal Information redacted by the USI has remained on active surveillance for his prostate cancer. He is currently on Casodex. His PSA has been under reasonable control, but it is starting to rise. I was going to start him on the LHRH agonists however the main issue for discussion is his right renal tumour. This was measured at 4cm several years ago and has remained static, until his last recent scan where it has increased in size to 7cm. We had turned him down for surgery before because of a significant deterioration in his renal function; this was probably due to the creatinine clearance alteration by Trimethoprim however when we came round to offer him surgery again he wasn't keen to proceed and decided on an observational approach. This we have been doing since 2012.

His eGFR was 47 in January 2016. For discussion for further management.

Personal Information redacted by the USI	Clinical Summary / MDM Update	Notes
Sex: Male **DOB:** Personal Information redacted by the USI **Age: 82** **Hospital Number:** Personal Information redacted by the USI **HCN:** Personal Information redacted by the USI **Consultant** MR A.J GLACKIN **Diagnosis:** Prostate cancer **Stage:** **Reason for Discussion:** MRI BONE SCAN **Target Date**	**CONSULTANT MR GLACKIN: This [redacted] year old man with a PSA of 7.7 ng/ml reports that his urinary symptoms are quite reasonable. His flow most of the time is pretty good except first thing in the morning. He passes urine 2-3 hourly during the day. He doesn't report any nocturia. Occasionally he has some slight urgency. Digital rectal exam demonstrates 2 nodules on the prostate, 1 at the right mid zone and the other from the left base extending to left mid zone. His PSA was rechecked and it was 8.3 ng/ml on 01 February 2016. He proceeded to TRUS biopsy. Transrectal prostatic biopsy, 02.03.16 - Prostatic adenocarcinoma of Gleason score 4+3=7, is present in 4 of 12 cores (all cores present in the left side) with a maximum tumour length of 5 mm. The tumour occupies 10% of the total tissue submitted. The possibility of pattern 5 has been considered in Part 6, as there is debris within the lumen of a few glands. However on balance this is not felt to represent true necrosis, and hence not pattern 5. Discussed at Urology MDM 17.03.16. Personal Information redacted by the USI has been found to have intermediate risk, prostatic carcinoma on recent biopsies. For review by Mr. Glackin to request a bone scan and MRI scan of prostate, followed by further MDM discussion. Bone scan, 12.04.16 - There is some degenerative tracer activity anteriorly in the lumbar spine at the lumbosacral junction. No evidence of osteoblastic metastatic disease. MRI, 13.04.16 - Probable bulky left-sided peripheral zone tumour. Likely extracapsular extension based on capsular irregularity in the left mid to base of the gland and the extent of capsular contact. rT3a N0 M0. 4cm abdominal aortic aneurysm.**	

Personal Information redacted by the USI	Clinical Summary / MDM Update	Notes
Sex: Male **DOB:** Personal Information redacted by the USI **Age:** [redacted] **Hospital Number:** Personal Information redacted by the USI **HCN:** Personal Information redacted by the USI **Consultant** MR M YOUNG	**CONSULTANT MR SURESH: This [redacted] year old man underwent glansectomy in November 2011, under the care of Mr Young and the histology showed moderate grade squamous cell carcinoma (pT1). Subsequently, he had bilateral modified groin dissection in March 2012 and the histology showed only reactive lymphnodes. Discussed @ Urology MDM 22.03.12. Patient is to be reviewed by Mr Young to be informed of**	

Diagnosis:	**Carcinoma of penis**	**pathology results post surgery. Follow up CT scan is to be performed in 3-6 months time. On reviewing him in the clinic in March 2016, there were no signs of any local recurrence. The urinary meatus appeared adequate without any stenosis. There was a discreet 1cm right inguinal lymph node but it was noted even on the previous scans. To discuss the follow up CT scan. CT A/P, 06.04.16 - No interval changes seen.**
Stage:		
Reason for Discussion:	**CT**	
Target Date		

	Clinical Summary / MDM Update	**Notes**
Personal Information redacted by the USI		

Sex: Female	
DOB: Personal Information redacted by the USI	
Age: [redacted]	
Hospital Number: Personal Information redacted by the USI	
HCN: Personal Information redacted by the USI	
Consultant	**MR M D HAYNES**
Diagnosis:	**TCC Bladder invasive**
Stage:	
Reason for Discussion:	**PATH POST SURGERY**
Target Date	

CONSULTANT MR HAYNES: This [redacted] year old lady presented with visible haematuria in January 2016. She was treated for a possible episode of left sided pyelonephritis and on her non contrast CT there is certainly evidence in keeping with this. Her eGFR was 46 in January 2016 but was normal when checked in February. She was found to have multifocal TCC at flexible cystoscopy. Her urine MSU was negative on 20/01/16. Past medical history of hypertension and is a smoker of 15 a day. CT urogram was performed on 10th February 2016, this had shown , small 1 cm enhancing lesion upper pole right kidney - potentially representative of small RCC. TURBT, 02.03.16 - Histological examination shows fragments of bladder mucosa with surface papillary urothelial/transitional cell carcinoma of WHO grade III. Focal areas of infiltration into subepithelial tissue are however also noted and the tumour is regarded as stage is pT1. No detrusor muscle fragments are present. Discussed at Urology MDM 10.03.16. [redacted] Personal Information redacted by the USI has a high risk non muscle invasive bladder cancer. Mr Haynes has arranged an early re-resection for this. She also has a small renal mass which will require surveillance in the first instance with a CT Renal in August 2016. This lady was admitted on 18th April for her re-resection of her bladder tumour. On the left lateral wall of bladder there was papillary recurrences around the site of previous resection. This entire area was resected to muscle to achieve complete resection. For pathology review at MDM prior to subsequent outpatient follow up with Mr Haynes. TURBT, 18.04.16 - Histology shows a small residual WHO Grade III transitional cell carcinoma with no invasion into the sub-epithelium (pTa). In addition, one of the fragments with the help of immunohistochemistry shows features of CIS. Fragments of muscle are identified and these are not infiltrated by tumour.

Clinical Summary / MDM Update	Notes

Personal Information redacted by the USI

Sex: Male	
DOB: Personal Information redacted by the USI	
Age: [redacted]	
Hospital Number: Personal Information redacted by the USI	
HCN: Personal Information redacted by the USI	
Consultant	**DR FIONNAULA HOUGHTON**
Diagnosis:	**Prostate cancer**
Stage:	
Reason for Discussion:	**IMAGING**
Target Date	

CONSULTANT DR O'HARE: [redacted] year old man with a PSA of 19.86ng/ml on 15th March 2013. Positive bone scan (left pubic ramus and bilateral intertrochanteric regions). [redacted] Personal Information redacted by the USI is asymptomatic from a urinary tract perspective. There is no family history of prostate cancer. He is complaining of pain in his left hemi pelvis. His PSA in December 2011 was 3ng/ml. His IPSS score was 1/35, his quality of life score was 1/6, his flow rate was excellent with a Q-max 35ml/sec. His dipstick urinalysis was clear. Ultrasound examination of his urinary tract was satisfactory. His prostate volume was 44cc. Digital rectal examination showed that the right lobe was very hard and the left lobe was smooth. Transrectal prostatic biopsy 16.04.13: Histology reports prostatic carcinoma, Gleason score 4+3=7, present in 3/11 cores with maximum tumour length of 4mm and 4% of tissue involved. Discussed @ Urology MDM 25.04.13. Personal Information redacted by the USI has been found to have Gleason 7 adenocarcinoma of prostate on biopsies. He will be reviewed at histology clinic. CT abdomen and pelvis is to be requested to clarify the abnormality noted in his pelvis on bone scan which was performed on 13.03.13. CT Abdomen & Pelvis 03.05.13: 1. Bony metastases as described. 2. No solid abdominal organ metastases. Discussed @ Urology MDM 23.05.13. CT scanning has confirmed that this gentleman has skeletal metastatic disease. For review by Mr Pahuja on 29.05.13 to advise androgen deprivation and referral for palliative radiotherapy. Personal Information redacted by the USI has remained under review in Belfast City Hospital with oncology. He has metastatic prostate cancer with bony mets. His most recent PSA was 6.56 ng/ml on 12 April 2016. For MDM discussion with imaging. CT, 02.02.16 - Progressive skeletal metastases.

Clinical Summary / MDM Update	Notes

Personal Information redacted by the USI

Sex: Male	
DOB: Personal Information redacted by the USI	
Age: [redacted]	
Hospital Number: Personal Information redacted by the USI	
HCN: [redacted]	

CONSULTANT MR O'BRIEN: This Personal Informa year old man was found to have Gleason 6 adenocarcinoma in one core from apex of right lateral lobe of prostate in 2006 when PSA was 7.1ng/ml. Staged T1/T2 NO MO. Referred to Oncology then. Patient opted for active surveillance, but failed to return for review after 2007. PSA levels had remained reasonably stable since: 7.7 in 2007,

Consultant	**MR A O'BRIEN**
Diagnosis:	**Prostate cancer**
Stage:	**T2 N0**
Reason for Discussion:	**MRI**
Target Date	

7.92 in 2010, 8.79 in 2011, and increasing to 9.52 in September 2012. Referred by GP. Only LUTS was nocturia x 0-3. Erectile function normal. Transrectal prostatic biopsy, 27.11.12 - Prostatic adenocarcinoma, Gleason score 3+4=7 with a maximum tumour length of 2 mm, present in 2/10 cores. Tumour involved 2% of tissue. Discussed @ Urology MDM 06.12.12. For histology review to be informed of pathology results. Staging MRI to be requested. Histology results are to be reviewed at will be rediscussed at the MDM 13.12.12. Discussed @ Urology MDM 13.12.12. Patient will be reviewed at a Histology clinic to be informed of results. Staging MRI to be requested. Will be rediscussed with results. MRI Prostate, 22.01.13 - The appearance was in keeping with cancer prostate stage T2 N0. Discussed @ Urology MDM 31.01.13. There was no evidence of any extracapsular disease on recent MRI scanning. For review by Mr O'Brien. To be advised that all management options remain appropriate, including active surveillance. Attended for review on 01.03.13. PSA 12.03 February 2013. Found to be keeping well, opted for continued surveillance. PSA repeated. To have PSA levels 3 monthly. Review July 2013. Patient remained very well when reviewed on 03 October 2014. He reported no LUTS and normal erectile function which he wished to maintain. Most recent PSA was 11.3 in May 2014. PSA repeated. Oct 2014: 11.36. GFR >60. Patient agreed to have biopsies repeated. Transrectal prostatic biopsy, 22.10.14 - Prostatic adenocarcinoma of overall Gleason sum score 3+4 =7 is present in 3 of 12 cores with a maximum tumour length of 4 mm. The tumour occupies <10% of total tissue submitted. Discussed @ Urology MDM, 30.10.14. There has been pathological evidence of progression of prostatic carcinoma on recent prostatic biopsies, in that carcinoma of Gleason 3+4 was found in 3 cores, and with an increase in maximum tumour length to 4 mms. For histology review, to arrange bone scan and MRI prostate and for subsequent MDM discussion. NM Bone Scan 14.11.14: No evidence of bony metastasis. NM Bone Thorax 14.11.14: No significant abnormal uptake. MRI Pelvis/Prostate/Spine/Abdomen 4.2.15: Stage T2N0 right base. Discussed @ Urology MDM 12.2.15. Personal Information redacted by the USI **MRI indicates organ confined disease at the right base of prostate, his histology shows disease progression. For review with Mr O'Brien to discuss treatment of all options for management of organ confined prostate cancer. Patient remained well at review on 20 February 2015,**

and preferred to remain on active surveillance. PSA repeated. Agreed to have PSA levels repeated every six months. For remote review by CNS with the agreement that he would be restaged by MRI scanning followed by further prostatic biopsies if and when serum PSA levels reached 15 ngs/ml. Patient well at review on 19 March 2016. PSA 12.84 ngs/ml. Awaiting MRI scan. For review April 2016. MRI, 31.03.16 - Prostatic CA stage T2N0. The disease is organ confined.

Personal Information redacted by the USI	Clinical Summary / MDM Update	Notes
Sex: Male DOB: Personal Information redacted by the USI Age: [redacted] Hospital Number: Personal Information redacted by the USI HCN: Personal Information redacted by the USI Consultant: MR A.J GLACKIN Diagnosis: Stage: Reason for Discussion: MRI Target Date: 22/05/2016	CONSULTANT MR GLACKIN: [redacted] year old gentleman with a rising PSA, it was 4.18 ng/ml in 2014, 6.55 ng/ml in December 2015 and 7.09 ng/ml in March 2016. He reports some occasional urinary frequency but is not particularly bothered by lower urinary tract symptoms. DRE, showed a small prostate which felt abnormal on the left lobe indicative of T2a disease. He would have proceeded to TRUS biopsy at clinic but his blood pressure was raised at 183/97 and 190/104. MRI, 20.04.16 - Probable tumour within the peripheral zone of the left apex to mid gland with extension to the capsule. Possible early extracapsular extension in the left mid gland posterolaterally. rT3a N0 (if tumour is proven).	

Personal Information redacted by the USI	Clinical Summary / MDM Update	Notes
Sex: Male DOB: Personal Information redacted by the USI Age: [redacted] Hospital Number: Personal Information redacted by the USI HCN: Personal Information redacted by the USI Consultant: DR K SURESH Diagnosis: Prostate cancer Stage: Reason for Discussion: PATH MRI TRUSB / MRI Target Date	CONSULTANT MR SURESH: This [redacted] year old gentleman was seen in the clinic on 17/11/15 for mild LUTS over the last year (nocturia twice per night and trivial stress leak which happens when he has full bladder). Examination of the abdomen was difficult due to obesity. DRE was again difficult but it showed a benign feeling prostate. His uro-flow showed a satisfactory Q-max of 18mls/sec leaving no residual. Patient medical history obesity (120 kilos), on Methotrexate and prednisolone for polymyalgia rheumatica and hypertension. His PSA was 3.3 in January 2015, went up slightly to 3.8 in October 2015 and to 4.2 in January 2016. Therefore, after MRI scan, he underwent TRUS & Bx on 18/4/16. Prostate measured 40cc, felt benign and 16 cores taken with Gentamycin cover. MRI, 04.02.16 - Possible, but not definite, tumour in the peripheral zone of the left mid gland with capsular thickening, suggesting capsular	

infiltration if tumour is present. No gross evidence of extracapuslar extension. No lymphadenopathy or bone metastasis is seen in the pelvis. If tumour is present, radiological staging is probably T2a N0. Transrectal prostatic biopsy, 18.04.16 - Prostatic adenocarcinoma is present in a total of 3 out of 17 identified cores. The Gleason score is 3+6=6. The longest continuous length of tumour is 3 mm. Overall tumour involves <5% of the submitted tissue. No perineural invasion is identified.

	Clinical Summary / MDM Update	Notes
Personal Information redacted by the USI		
Sex: Male	**CONSULTANT MR YOUNG: Personal Informa year old man who has had venesection for hemochromatosis. Overall he is fairly content with his micturitional habit. CT scans have been clear for stones however he has an increasing PSA. Transrectal prostatic biopsy, 11.02.14 - Prostatic adenocarcinoma of Gleason score 3+3 was present in 4 of 12 cores with a maximum length of 4 mm. The tumour occupied <10% of the total tissue submitted. Discussed @ Urology MDM, 27.02.14. This gentleman has been found to have prostatic carcinoma on recent prostatic biopsies. For histology review, to request staging MRI of prostate and will be for subsequent MDM discussion. Attended histology clinic on 06.03.14 and MRI of prostate was requested. MRI Prostate, 01.05.14 - Features consistent with gland-confined disease. Stage T2c, N0. Discussed @ Urology MDM, 08.05.14. There was no suspicion of any extra-capsular disease on MRI scanning. For review by Mr Young, to advise patient that he is eligible for all treatment modalities with curative intent. Active surveillance is a management option, though prostatic biopsies require repeating in one year's time. Personal Information redacted by the USI has remained on active surveillance for his Gleason 6, prostate carcinoma. He was reviewed in clinic February 2016, his renal function has deteriorated, his eGFR was 13 and he was offered a renal transplant but declined as he was due prostate assessment. Trus biopsy was carried out 01 March 2016, his prostate measured 21.9 cc on transrectal ultrasound scan. Transrectal prostatic biopsy, 01.03.16 - Prostatic adenocarcinoma of Gleason score 3 + 4 = 7, is present in 8 of 10 cores (left and right side of prostate) with a maximum tumour length of 3.5 mm. The tumour occupies approximately 10% of the tissue. The vast majority of the tumour is Gleason pattern 3**	
DOB: Personal Information redacted by the USI		
Age: [redacted]		
Hospital Number: Personal Information redacted by the USI		
HCN: Personal Information redacted by the USI		
Consultant MR M YOUNG		
Diagnosis: Prostate cancer		
Stage: T2c N0		
Reason for Discussion: MRI BONE SCAN		
Target Date		

with only a limited amount of pattern 4. Discussed at Urology MDM 10.03.16. Mr Personal Information surveillance prostate biopsies show progression in grade and volume of prostate cancer which is now intermediate risk. Mr Young to review in outpatients and arrange up to date staging with an MRI and Bone scan and subsequent MDM discussion. Bone scan, 24.03.16 - There is degenerative tracer activity at both wrists and knees. Tracer activity in the lower cervical spine is also likely to be degenerative but plain film correlation is required. No convincing evidence of osteoblastic metastases. MRI, 12.04.16 - Reduced T2 signal change in the peripheral zone is non specific, particularly given the recent biopsy and resultant haemorrhage. No definite radiological evidence of a significant prostate tumour. The appearances suggest organ confined disease.

	Clinical Summary / MDM Update	Notes
Personal Information redacted by the USI		
Sex:	**Male**	
DOB:	Personal Information redacted by the USI	
Age:	[redacted]	
Hospital Number:	Personal Information redacted by the USI	
HCN:	Personal Information redacted by the USI	
Consultant	**MR A.J GLACKIN**	
Diagnosis:	**Renal clear cell carcinoma**	
Stage:		
Reason for Discussion:	**CT**	
Target Date		

CONSULTANT MR GLACKIN: [redacted]year old man with a 4.5cm right midpole renal mass noted incidentally on CT of chest and upper abdomen 8th January 2014. Personal Information redacted by the USI was asymptomatic regarding his kidney. He has had recent investigations at 352 for haemoptysis and cough which were clear. Personal Information redacted by the USI has a history of ankylosing spondylitis but has no other significant health issues. His U&E on 6th January 2014 was normal. CT C/A/P, 08.01.14 - Images imported. Bone scan, 24.02.14 - No definite evidence of metastatic disease skull vault changes as described please assess. DMSA - 04.03.14 - Split renal function was slightly abnormal as right kidney was contributing about 43% of the total renal function while the left one contributed about 57%. Discussed @ Urology MDM, 13.03.14. For review by Mr Glackin to discuss open partial nephrectomy V's Laparoscopic radical nephrectomy. Electively admitted on 16.05.14 for right radical nephrectomy. Pathology reports clear cell adenocarcinoma, Fuhrman Grade II. Margins - 5 mm to the edge of perinephric fat. Stage pT1b. Discussed @ Urology MDM, 29.05.14. This gentleman has had a right renal cell carcinoma removed at right radical nephrectomy performed on 16.05.14. For review by Mr Glackin, to request a CT of chest, abdomen and pelvis in November 2014, and will be for subsequent review. Personal Information redacted by the USI appears to have a slight enlargement of 2 lymph nodes found on

follow up CT, which requires discussion at the meeting. He had an open nephrectomy for pT1 Fuhrman grade 2 right sided renal cell carcinoma in May 2014.

Personal Information redacted by the USI	Clinical Summary / MDM Update	Notes
Sex: Male DOB: Personal Information redacted by the USI Age: [redacted] Hospital Number: Personal Information redacted by the USI HCN: Personal Information redacted by the USI Consultant RM BROWN Diagnosis: Stage: Reason for Discussion: CT RENAL CT Target Date	CONSULTANT MR BROWN: This [redacted] year old man was referred with persistent non visible haemtauria. He has a history of lymphoma, but is under no treatment at present. He is on Warfarin his recent PSA and GFR was normal. He is an ex smoker. Digital rectal examination revealed a moderately enlarged smooth prostate. CTU, 14.10.15 - . Small enhancing lesion at upper pole of right kidney concerning for RCC. Urology MDT referral recommended. Flexible cystoscopy was performed and this showed tiny TCC beside right ureteric orifice. Discussed at Urology MDM 29.10.15. This man has been found to have a small right renal tumour, suitable for surveillance in the first instance. For review by Mr Brown to arrange resection of bladder tumour and to request a renal CT scan to be done in April 2016 and for subsequent MDM discussion. Bladder biopsy, 19.11.15 - Histological examination of the specimen shows a somewhat cauterised, fragmentary urothelium overlying a benign looking, spindle celled lesion within the superficial muscularis propria. Some of the cells within the lesion appear epithelioid with slipper shaped nuclei, but the lesion overall is not in keeping with a granuloma. Discussed at Urology MDM 03.12.15. Personal Information redacted by the USI bladder lesion is benign. For ongoing follow up of renal lesion with CT in April 2016. Personal Information redacted by the USI has had his follow up CT renal. Lesion in right kidney shows enhancement but no increase in size.	

Personal Information redacted by the USI	Clinical Summary / MDM Update	Notes
Sex: Male DOB: Personal Information redacted by the USI Age: [redacted] Hospital Number: Personal Information redacted by the USI HCN: Personal Information redacted by the USI Consultant DR K SURESH Diagnosis: Stage:	CONSULTANT MR SURESH: This [redacted] year old gentleman, after assessment in the clinic on 19/4/16, underwent TRUS and biopsy on the same day due to rising PSA from 3.8 to 4.3 in the last six months. DRE showed hard left apex (T2). He has no bothersome LUTS, but he has been having PSA surveillance, as his father died of prostate cancer in his early seventies. He underwent coronary stentings in RVH in 2009 and requested the details of the stent. Transrectal prostatic biopsy, 19.04.16 - await pathology.	

Reason for Discussion:	**PATH TRUSB**
Target Date	**31/05/2016**

	Clinical Summary / MDM Update	**Notes**
Personal Information redacted by the USI		
Sex: Male	**CONSULTANT MR SURESH: This [redacted] year old gentleman presented with urinary retention in November 2015 and abnormal DRE (T2 ca prostate) & PSA of 11. TRUS biopsy on 25/11/15 showed adenocarcinoma with Gleason score of 4+5 in 11/13 cores and he has been on ADT since January 2016. He underwent channel TURP on 11/3/16. MRI and bone scan are consistent with metastasis in the pelvic bones (rT3b N0 M1b) He has been referred to oncologist. His echo has showed severe mitral regurgitation and the cardiologist has asked our opinion regarding the prognosis to decide about the valve replacement.**	
DOB: Personal Information redacted by the USI		
Age: [redacted]		
Hospital Number: Personal Information redacted by the USI		
HCN: Personal Information redacted by the USI		
Consultant	**DR K SURESH**	
Diagnosis:	**Prostate cancer**	
Stage:		
Reason for Discussion:	**FURTHER MANAGEMENT**	
Target Date		

	Clinical Summary / MDM Update	**Notes**
Personal Information redacted by the USI		
Sex: Female	**CONSULTANT MR GLACKIN: This [redacted] year old lady was admitted to ICU Craigavon on 15th January 2016 with confusion, dehydration, hypotension and severe AKI (eGFR 6 from baseline 50). Diagnosed with E coli urosepsis, she made an excellent recovery with medical management. Ultrasound KUB on 18th January revealed an 8cm left renal mass. CT C/A/P, 28th January - confirmed an 8.5cm x 7cm left mid-pole renal tumour. No evidence of pulmonary or nodal metastases. The patient denies any loin pain, recurrent UTIs or visible haematuria. Has had unintentional weight loss over the last 6 years. On examination she was comfortable, BP well controlled and no palpable masses. She has severe thoracolumbar spondylosis and kyphosis so that her face is essentially parallel to the ground when standing. Hb 98, plts 398, Hct 0.299, creat 104, eGFR 44, Ca 2.20, ALP 152. Patient medical history includes IHD, NSTEMI 1998 + 2012, EF 55% 2012, CKD 3, HTN, OA. She is on Aspirin + Clopidogrel. Lifelong non-smoker and no EtOH. Discussed at Urology MDM 11.02.16. This lady has a left sided renal tumour. For review with Mr Glackin to organise bone scan, DMSA and assess appropriateness for surgery. Bone scan, 29.02.16 - No evidence of osteoblastic bony metastatic disease. Left laparoscopic nephrectomy, 08.04.16 - Clear cell**	
DOB: Personal Information redacted by the USI		
Age: [redacted]		
Hospital Number: Personal Information redacted by the USI		
HCN: Personal Information redacted by the USI		
Consultant	**MR A.J GLACKIN**	
Diagnosis:	**Renal clear cell carcinoma**	
Stage:		
Reason for Discussion:	**PATH POST SURGERY**	
Target Date		

adenocarcinoma. Fuhrman nuclear grade II. Tumour necrosis - no. Local invasion. pT2a Lymphovascular invasion - yes-tumour is seen within relatively large calibre but non-muscularised vascular channels adjacent to the tumour in blocks taken to include the renal hilum. These vessels were not grossly apparent. Lymph nodes - none submitted/identified Margins. Gerotas fascia - 12 mm. pT2a.

Clinical Summary / MDM Update **Notes**

Personal Information redacted by the USI

Sex: Female
DOB: Personal Information redacted by the USI
Age: [redacted]
Hospital Number: Personal Information redacted by the USI
HCN: Personal Information redacted by the USI
Consultant MR J P O'DONOGHUE
Diagnosis:
Stage:
Reason for Discussion: CT BONE SCAN
Target Date

CONSULTANT MR O'DONOGHUE: This [redacted] year old lady who has a history of recurrent urinary tract infections. She had several urinary tract infections particularly around the time she had her hip replaced back in August 2015. Her eGFR is >60 and creatinine of 79. She tells me her flow is intermittently good and bad and she describes storage type symptoms. She passes urine 2 or 3 times during the day and once or twice at night. On examination she is somewhat immobile consistent with her recent total hip replacement. She has had a flexible cystoscopy and that showed red vulva and the urethra looked alright. The bladder mucosa was very reddened in patches with a considerable amount of slough obscuring the views. Her eGFR was normal. Bladder biopsy, 16.02.16 - Overall, the features are of a poorly differentiated carcinoma arising in a background of squamous metaplasia. The morphological features along with the immunohistochemical staining pattern are, while not totally specific, in keeping with poorly differentiated squamous cell carcinoma. Discussed at Urology MDM 10.03.16. Personal Information redacted by the USI **has a squamous cancer of the bladder. Mr O'Donoghue to arrange staging with a CT Chest abdomen and pelvis, Bone scan, assess suitability for radical cystectomy and for subsequent central MDM discussion.** Personal Information redacted by the USI **was reviewed in the clinic and surgery was discussed, she certainly is reasonably fit and I am sure would be a candidate in spite of her advanced years for cystectomy. Bone scan, 04.04.16 - Increased tracer uptake within the mid and lower lumbar spine is of uncertain significance and may reflect degenerative processes but up to date plain film evaluation or cross-sectional imaging is advised. CT C/A/P, 19.04.16 - 1. No definite metastatic disease. Bladder wall thickening likely represents the primary lesion. 2. A couple of small pulmonary**

nodules are nonspecific and may be followed up with subsequent imaging.

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 02 May 2016 20:51
To: Muldrew, Angela
Cc: Williams, Marc; Haynes, Mark; Graham, Vicki; McVeigh, Shauna
Subject: Re: Urology MDM

I can attend on any of the below

Kind regards

David

Sent from my iPad

On 29 Apr 2016, at 14:31, Muldrew, Angela [redacted] wrote:

> Hi
>
> Following the recent issues that have been raised regarding the Urology MDM we thought it would be useful to meet up to talk these through. Could you please advise of you availability for the below dates?
>
> Monday 9th May @ 11.00am
> Wednesday 11th May @ 1.00pm
> Tuesday 17th May @ 1.00pm
>
> Regards
>
> *Angela Muldrew*
> *RISOH Implementation Officer*
> *Cancer Services*
> *Tel. No.* [redacted]

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 02 May 2016 20:55
To: Williams, Marc
Subject: Re: Urology MDM

You have no booked patients for the below dates and times. Please displace work to attend.

As per my prior email reply your job plan has been escalated to AMD. I am meeting with the MD on Wednesday and the Urology MDM will be discussed due to issues raised by both Radiology and Urology. I will let you know the outcomes of both in person.

David

Sent from my iPad

On 2 May 2016, at 15:19, Williams, Marc [redacted] wrote:

> I am not available at any of these times as I have clinical commitments. I am also unsure as to the value of discussion unless this is to address my job plan or the trusts efforts to recruit and it's presumably not. Meeting to discuss MDT add ons is not a good use of time.
>
> I will, from now on, be working to my job plan: I have 2 hours of prep time per week in the job plan. The first hour is supposed to be for the urology Thursday morning meeting. This leaves approximately 1 hour of prep for the MDT (for a meeting that lasts upto 3 hours). Once this hour ends, I won't be spending any more time preparing nor providing radiology input into cases that I have not prepared for. I will ensure that the MDT chair knows which cases won't have any input that week.
>
> I have been asking for extra preparation time for the urology MDT but there is no indication whatsoever that this will be provided and I have been asking for perhaps 9 months. An email I sent last week was unanswered which is most unfortunate.
>
> A new GU job has been advertised which has 2 hours of prep time for the MDT in it. I don't get this.
>
> I remain unclear and confused as to why I should have to fight to get time to do the job I am asked to. I have been trying, by giving up my free time, to provide radiology input to the whole of the MDT but as I have said, this will not continue indefinitely.
>
> I have also started looking for alternative employment and am considering taking locum work to bridge the gap.
>
> Marc

From: Muldrew, Angela
Sent: 29 April 2016 14:32
To: Gracey, David; Williams, Marc; Haynes, Mark
Cc: Graham, Vicki; McVeigh, Shauna
Subject: Urology MDM

Hi

Following the recent issues that have been raised regarding the Urology MDM we thought it would be useful to meet up to talk these through. Could you please advise of you availability for the below dates?

Monday 9th May @ 11.00am
Wednesday 11th May @ 1.00pm
Tuesday 17th May @ 1.00pm

Regards

Angela Muldrew
RISOH Implementation Officer
Cancer Services
Tel. No. Personal Information redacted by the USI

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 09 May 2016 13:04
To: ANGELA.muldrew [redacted]; Graham, Vicki; McVeigh, Shauna; Haynes, Mark
Subject: RE: Radiological Presence at Urology MDM

Apologies I was unable to attend due to last minute commitments but I have discussed with Marc and Aiden since.

I believe the meeting was useful.

Regards

David

From: O'Brien, Aidan
Sent: 09 May 2016 10:48
To: Gracey, David
Cc: ANGELA. [redacted]; Graham, Vicki; McVeigh, Shauna; Haynes, Mark
Subject: FW: Radiological Presence at Urology MDM

David,

I am concerned to learn that a meeting is scheduled for 11 am today to discuss the above, without my having been advised or invited to attend, and whilst still awaiting a response to my email of 20 March 2016.
I am about to operate and will probably not be able to attend.
I am fully supportive of Marc Williams in this regard.
To have two hours allocated in a Job Plan to prepare for two uroradiological meetings per week, one of which is MDM, is woefully inadequate.
To have two hours allocated in a Job Plan to prepare for up to 50 cases per week is no derisory as to not require any further comment.
I do believe that the failure to allocate adequate time to enable a radiologist to prepare adequately for MDM when such preparation is mandatory, has now resulted in an existential threat to Southern Trust Urological MDT.
I do believe that this needs to be addressed in a positive manner to facilitate and bolster MDM rather than undermine it.
These are my thoughts which essentially remain unchanged from previously,

Aidan.

From: O'Brien, Aidan
Sent: 20 March 2016 09:03
To: Gracey, David
Cc: Carroll, Ronan; Reddick, Fiona; Haughey, Mary; Young, Michael; Glackin, Anthony; Haynes, Mark; Suresh, Ram; ODonoghue, JohnP; Convery, Rory
Subject: Radiological Presence at Urology MDM

Dear David,

I take this opportunity of writing to you regarding the presence of a radiologist at Urology MDM.
Radiological input into any MDM is not only crucial to the multidisciplinary discussion of each patient, but it is compulsory.
We have had a properly constituted Urology MDM since April 2010.
During the earlier years, the greater problem had been to have the input of an oncologist at each MDM.

That has been resolved in that we have had a clinical oncologist video-link from Belfast, and a medical oncologist present on site, these past two years.
However, the issue of radiological input remains unresolved.

Having considered this issue at length, and having experienced and participated in repeated attempts over the years to have the issue resolved, I believe that the core issue is that the Department of Radiology has never acknowledged or accepted that radiological membership of MDT and presence at MDM are both compulsory.
This is in marked contrast to the Department of Pathology which has ensured that a pathologist is present at almost all MDMs.
We urologists have had to suspend all other elective activities to accommodate MDM.

I wish to emphasise that we greatly value the expertise and experience of the only radiologist who does attend MDM.
However, we find the lack of commitment to ensure attendance at the majority of meetings unacceptable.
If not resolved with immediacy, this issue poses an existential threat to our MDM which we may be forced to terminate.

I do appreciate how difficult it can be to resolve some longstanding issues.
However, having participated in Peer Review here and elsewhere, the issue here is as I have found it elsewhere.
That is, each and every MDM must have a radiologist present!

I intend to discuss this issue with the Medical Director when I meet with him on Friday 01 April 2016.
It would be helpful if this issue could be satisfactorily addressed by then.

I attach the Quoracy Spreadsheet 2014 and the Peer Review Report 2015, as requested,

Thank you,

Aidan.

Stinson, Emma M

From: Gracey, David <Personal Information redacted by the USI
Sent: 23 September 2016 13:41
To: Glenny, Sharon
Cc: Trouton, Heather; Robinson, Jeanette
Subject: RE: Urology escalation - Patient 113 Personal Information redacted by the USI

Discuss with radiology outside of the meeting

From: Glenny, Sharon
Sent: 23 September 2016 13:34
To: Gracey, David
Cc: Trouton, Heather; Robinson, Jeanette
Subject: FW: Urology escalation - Patient 113 Personal Information redacted by the USI

Hi David

Please see urology escalation below – same situation as previous patient, patient deferred x 3 from MDM discussion due to requirement for radiology opinion. Any suggestions?

Sharon

From: McVeigh, Shauna
Sent: 23 September 2016 12:42
To: Glenny, Sharon
Cc: Graham, Vicki
Subject: Urology escalation - Patient 113 Personal Information redacted by the USI

Hi,

Please see escalation of patient that is currently on day 49 of her pathway and remains a suspect cancer patient. She had a CT performed which is suspicious for renal cancer. She has been discussed at MDM and was listed for virtual MDM 15.09.16, no outcome could be made – deferred for radiology. Was listed for MDM 22.09.16 no outcome was made as need radiology opinion. She has been deferred until 06.10.16 – day 62 as we done have a radiology present until then.

She most likely will require a date for surgery following this.

Patient 113 Personal Information redacted by the USI
CAHE Personal Information redacted by the

Day	Date	Event
5	20/06/2016	First Seen at Craigavon
9	24/06/2016	Await clinic outcome from 20.06.16 - CTU reports - Bozniak type 4 cyst in relation to the lower pole of the left kidney highly suspicious of neoplasia. Report fast tracked to GP
9	24/06/2016	Renal DMSA has been appointed for 28.06.16.
28	13/07/2016	Patient for MDM discussion 21.07.16 - clinical summary provided by Mr O'Brien.
36	21/07/2016	MDM Action : Discussed at Urology MDM 21.07.16. This lady has been found to have a left renal cystic tumour. For review by Mr O'Brien to discuss management options, either active surveillance or laparoscopic left radical nephrectomy pending the outcome of more recent cardiac assessment.
37	02/08/2016	Patient's review has been booked for 22.08.16 - it was patients choice to be reviewed in SWAH so can add an adjustment to reflect this. Management options to be discussed at review.
39	23/08/2016	Patient attended review 22.08.16 - await clinic letter.

39 31/08/2016 Will email Mr O'Brien to see how this lady will be proceeding, as she may require a date for surgery and she could be at high risk of breaching if cancer is confirmed.
39 06/09/2016 Patient had renal CT performed on 05.09.16 - needed further cardiac investigations to ensure she would be fit for surgery. Can add adjustment to reflect this. Will list for MDM 15.09.16 with CT report.
41 15/09/2016 MDM Action : Discussed at Urology MDM 15.09.16. Defer for radiology.
48 22/09/2016 MDM Action : Discussed at Urology MDM 22.09.16. Defer for radiology discussion.

Thanks

Shauna

Shauna Mcveigh
Cancer tracker / MDT Co-ordinator
Extension - Personal Information redacted by

Stinson, Emma M

From: McVeigh, Shauna [redacted]
Sent: 16 January 2017 11:02
To: Reddick, Fiona; Convery, Rory; Boyd, Kathryn; Gracey, David; Campbell, Dolores; Ciara Lyons; Connolly, Maureen; Cummings, Ursula; Dabbous, Marie; Dignam, Paulette; Dr Sai Jonnada; Elliott, Noleen; Glackin, Anthony; Graham, Vicki; Hanvey, Leanne; Haynes, Mark; Holloway, Janice; Jacob, Thomas; Jolyne OHare; Kelly, Wendy; Larkin, Bronagh; Loughran, Teresa; McCartney, Rachel; McClean, Gareth; McConville, Richard; McCreesh, Kate; McMahon, Jenny; McVeigh, Shauna; Moore, SarahM; O'Brien, Aidan; ODonoghue, JohnP; ONeill, Kate; Reid, Stephanie; Robinson, NicolaJ; Shah, Rajeev; Shannon, Hilda; Sheridan, Patrick; Topping, Christina; Troughton, Elizabeth; Turkington, Ann E; Tyson, Matthew; Ward, Ann; White, Deborah; Williams, Marc; Young, Michael
Subject: Urology MDM minutes 12.01.17
Attachments: Urology MDM minutes 12.01.17.doc

Hi

Please find attached Urology MDM minutes 12.01.17.

Thanks

Shauna

MDT UROLOGY CANCER MEETING
THURSDAY 12 January 2017
VENUE: TUTORIAL ROOM 1, MEC

PRESENT
Mr Glackin (Chair), Mr Haynes, Mr O'Donoghue, Mr Brown, Mr Tyson, Mr Curry, Dr McClean, Stephanie Reid, Kate O'Neill & Shauna McVeigh.

MINUTES

1. **APOLOGIES**
Mr O'Brien, Mr Young, Dr Williams, Dr Lyons, Dr O'Hare

2. **MINUTES OF LAST MEETING**
E-mailed to the Urology MDM circulation list on 06 January 2016.

3. **PRESENTATION OF CASES**
Meeting started @ 2:15pm meeting finished @ 3:35pm
39 cases were listed to be discussed.
Belfast City linked in.

4. **A.O.B**
Mr Glackin is the new MDT lead. The Urologists present expressed concern that the meetings are not quorate, due to absence of radiology and clinical oncology. This issue has been discussed previously with Professor O'Sullivan Consultant Clinical Oncologist and Dr Gracey (CD for Radiology at SHSCT).

If the meeting is not quorate at the beginning of the MDM, it will not go forward, and if this happens for more than half of the MDM's then future meetings will be cancelled and alternative arrangements sought.

5. **DATE OF TIME OF NEXT MEETING**
The next meeting is to take place at 2.15 pm on **Thursday 19 January 2016,** Tutorial Room 1, MEC, CAH, Ennis Room, Belfast & DHH.