Stinson, Emma M

From: Reddick, Fiona [redacted]
Sent: 26 January 2017 12:01
To: Gracey, David; Robinson, Jeanette
Cc: Glenny, Sharon; Trouton, Heather
Subject: FW: Radiology at Urology MDM

David/Jeanette

Please see correspondence as below re Dr Mark Williams not being available for Urology MDT until 2nd March.

Can you confirm if this is the case as the Urology MDT is at the point of no longer running.

Can we urgently meet to discuss.

Regards

Fiona

Fiona Reddick
Fiona Reddick
Head of Cancer Services
Southern Health and Social Care Trust
Macmillan Building
[redacted]

From: Glackin, Anthony
Sent: 26 January 2017 10:30
To: Reddick, Fiona; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Cc: McVeigh, Shauna
Subject: RE: Radiology at Urology MDM

Dear Fiona,
please see below, we are at the point of closure.

Can you attend today's Meeting to discuss with those present.

Many thanks

Tony

From: McVeigh, Shauna
Sent: 26 January 2017 10:28
To: Glackin, Anthony; O'Brien, Aidan; Haynes, Mark; ODonoghue, JohnP; Young, Michael
Subject: Radiology at MDM

Hi,

Just to make you aware, I have been advised by Dr Williams that he won't be at MDT until 02 March due to combination of leave and departmental commitments.

Thanks

Shauna

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 26 January 2017 12:14
To: Reddick, Fiona; Robinson, Jeanette
Cc: Glenny, Sharon; Trouton, Heather
Subject: RE: Radiology at Urology MDM

Thurs 9th Feb and thurs 23th Feb Marc is on annual leave, he seems to preferential take the second part of the week of leave – 14 thurs this year most in the last few months. His MDM is protected as much as is possible. He is covering an acute CT list on the Thurs 20th February which is a short staffed week due to half term leave – I will see if this can be changed.

He is available today, 2/3 and 9/3.

Is it possible to discuss radiology cases at another time?

David

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Sent: 26 January 2017 12:01
To: Gracey, David; Robinson, Jeanette
Cc: Glenny, Sharon; Trouton, Heather
Subject: FW: Radiology at Urology MDM

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Shauna

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 08 February 2017 15:24
To: Reddick, Fiona; Robinson, Jeanette
Cc: Glenny, Sharon; Trouton, Heather
Subject: RE: Radiology at Urology MDM

I have cancelled my leave next Thursday to accommodate the urology meeting.

David

From: Reddick, Fiona
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Cc: Glenny, Sharon; Trouton, Heather
Subject: FW: Radiology at Urology MDM

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Shauna

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 08 February 2017 15:31
To: Williams, Marc; Milligan, Aaron
Cc: McSherry, Pauleen; Barr, Jill
Subject: RE: Radiologist Rotas

No plans and solves a problem.

From: Williams, Marc
Sent: 08 February 2017 15:30
To: Gracey, David; Milligan, Aaron
Cc: McSherry, Pauleen; Barr, Jill
Subject: RE: Radiologist Rotas

David
Your leave is more important that the urology MDT but I am happy to do CT or the MDT, whatever is needed.
Marc

From: Gracey, David
Sent: 08 February 2017 15:27
To: Milligan, Aaron
Cc: McSherry, Pauleen; Williams, Marc; Barr, Jill
Subject: RE: Radiologist Rotas

Aaron

I will not take leave next Thursday. This will accommodate the Urology meeting.

Jill would you kindly move this leave day to Monday 6th March.

Patricia – could we do the bone biopsy in the morning [redacted] ?

Thanks to all

David

From: Milligan, Aaron
Sent: 06 February 2017 10:18
To: Baltacioglu, Julia; Barr, Jill; Benson, Vassey; Best, Pauline T; Boyle, Stephanie; Breen, Caoimhe; Breen, Sarah; Clarke, Susan; Clayton, Wendy; Colgan, Fiona; Colvin, Leanne; Crozier, Cathy; Ferguson, Lisa; Forsythe, Grainne; Foy, Ann; Furphy, Lisa; Glendinning, Tracey; Glenny, Sharon; Green, Lynn; Gribben, Ruth; Hamill, Bernadette; Hickey, Aine; Holland, Margaret; Johnston, Christine; Keenan, Marian; Knipe, Joanne; Lavery, Pauline; Lindsay, Gail; Martin, Janet; McBurney, Angela; McCann, Tracey; McDonald, Pat; McEvoy, Yvonne; Mcilkenny, Shauna; McNeill, Paula; McWilliams, Liz; Mitchell, Kathryn L; Moore, Eamer; Murphy, Gemma; Neagle, Heather; Newell, Denise E; OConnor, Josephine; ONeill, Kate; Parks, Emily; Poland, Orla; Reaney, Gillian; Robinson, Ciara; Robinson, Jeanette; Tate, Ann; Thornbury, Rosanne; Toland, Patricia; Ahmad, Munir; Carson, Anne; Conlan, Enda; Gracey, David; James, Barry; Jamison, Michael; Johnston, Dr Linda; McConville, Richard; McGarry, Philip; McSherry, Pauleen; Porter, Simon; Rice, Paul; Williams, Marc; Yarr, Dr Julie; Yousuf, Imran
Subject: RE: Radiologist Rotas

Please find attached the updated weekly rotas for the next 7 weeks.

- 6/2/2017 – **Changed:**
  - Dr Carson is now off all week.
    i. Dr Gracey will now cover will cover Monday AM CAH CT.
    ii. Dr McConville will now cover Tuesday Am CAH CT.
    iii. General Enquiries Tuesday AM is currently uncovered.
  - Dr McSherry is now off Friday PM.
    i. Dr McConville will now cover Friday PM DHH CT (from CAH, in-patients only).
- 13/2/2017 – No changes to last email**:**
  - The confirmed date of out-sourcing of CT On-call from 2200-0900 remains Tuesday 6th of February 2017.
- 20/2/2017 – No changes to last email**:**
  - General Enquires will only be assigned for afternoons only from this point forward.
    i. This will be from 1400 to 1600.
    ii. Enquiries from fellow consultant staff at any time will not be refused.
    iii. The consultant covering CAH CT is **only** available for discussion of inpatient CT requests.
- 27/2/2017 – No changes to last email**:**
- 6/3/2017 – No changes to last email**:**
- 13/3/2017 – **Finalised.** No changes to last email**.**
- 20/3/2017 – **Provisional**:
  - Please inform me of any problems and I will send out the next sets of rotas next Friday.

Please note, these rotas are primarily for the organisation of the CAH main X-ray department, and CT cover in DHH, but may not accurately reflect the Breast radiology service.

Nb. in case you're wondering what the (1) & (2) after the dates on the spread sheets mean, its refers to that consultants 'week 1' or 'week 2' on their job plan, and it is there purely for reference.

If there is anyone else you feel may benefit from being sent these rotas, please let me know and I will add them to the mailing list. If you have any questions or concerns please do not hesitate to contact me.

Aaron Milligan
Consultant Radiologist
Southern HSCT

Stinson, Emma M

From: Williams, Marc [redacted]
Sent: 24 May 2017 14:26
To: Gracey, David
Subject: FW: Urology preview list 25.05.17

45 cases!

From: McVeigh, Shauna
Sent: 24 May 2017 11:24
To: Connolly, Maureen; Dabbous, Marie; Dignam, Paulette; Elliott, Noleen; Glackin, Anthony; Graham, Vicki; Gribben, Trudy; Hanvey, Leanne; Haynes, Mark; Holloway, Janice; Hughes, Paul 2; Jacob, Thomas; joe o'sullivan; Kelly, Wendy; Larkin, Bronagh; Loughran, Teresa; McAuley, Laura; McCartney, Rachel; McClean, Gareth; McCourt, Leanne; McCreesh, Kate; McCrum, Gillian; McMahon, Jenny; McVeigh, Shauna; Moore, SarahM; O'Brien, Aidan; ODonoghue, JohnP; ONeill, Kate; Reid, Stephanie; Robinson, NicolaJ; Shannon, Hilda; Shum, Lin; Topping, Christina; Troughton, Elizabeth; Turkington, Ann E; Tyson, Matthew; Ward, Ann; White, Deborah; Williams, Marc; Young, Michael
Subject: Urology preview list 25.05.17

There will be no lunch this week.

There are 45 cases listed for this week – quite a few had to be deferred.

Urology MDM @ The Southern Trust on 25/05/2017

		Clinical Summary / MDM Update	Notes
[redacted]			
Sex:	**Male**	**CONSULTANT MR HAYNES:** [redacted] **is** [redacted] **years old and presented initially to his GP with some constipation and incidentally was found to have a large left sided renal mass. He went on to have a CT scan which demonstrated a 14cm left renal mass and a 2.5cm right renal mass. In addition there are a number of enlarged lymph nodes in the para-aortic region measuring up to 14mm and also some mild bilateral inguinal/distal external iliac lymphadenopathy. There is no evidence of any visceral/distant metastases. His over renal function is normal. He went on to have a left open radical nephrectomy and para-aortic lymphadenectomy on 14th December 2016. For MDM review and consideration of ongoing management. Left open radical nephrectomy and para-aortic lymphadenectomy, 14.12.16 - Clear cell renal cell carcinoma. Growth pattern - compact, nested, alveolar, tubular cystic. Moderately differentiated, no evidence of sarcomatoid differentiation is seen. Grade III. Tumour**	
DOB:	[redacted]		
Age:	[redacted]		
Hospital Number:	[redacted]		
HCN:	[redacted]		
Consultant	**MR M D HAYNES**		
Diagnosis:	**Renal clear cell carcinoma**		
Stage:			
Reason for Discussion:	**REGIONAL DISCUSSION**		
Target Date			

necrosis - yes , 30 to 40% of total renal tumour. Local Invasion - tumour appears to infiltrate the renal sinus fat and renal capsule however it is clear from Gerota's fascia by 5 mm. Lymphovascular invasion - yes. Margins - 5 mm clear from Gerota's fascia. pT3a. Discussed at Urology MDM 05.01.17. For review with Mr Haynes to arrange a follow up CT. Personal Information redacted by the USI underwent a left open nephrectomy in December 2016 for a T3a N0 renal cancer. He also had a small right sided renal mass. His EGFR is 50. He underwent a follow up CT scan on 25th April 2017. For Central MDM discussion of CT scan with a view to arranging open right partial nephrectomy at Belfast City Hospital.

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 T JACOB**
Diagnosis:	**TCC Bladder invasive**
Stage:	
Reason for Discussion:	**REGIONAL DISCUSSION**
Target Date	

CONSULTANT MR JACOB: This [redacted] year old man suffered multifocal cerebral and cerebellar infarction in 2001, presumably as a consequence of paradoxical embolism associated with a patent foramen ovale, which was subsequently closed percutaneously in 2008 since when he has remained on Aspirin. He has since developed hypertension and diabetes. He reported the onset of hesitancy, a poor urinary flow and a sensation of unsatisfactory voiding in May 2016. He was referred in August 2016 for investigation of biochemical haematuria. He has chronically impaired but stable renal function with a GFR of 58 ml/min. His serum PSA was 1.95 ng/ml. He had pyuria, haematuria and bactiuria on urinary microscopy. He was found to have a dilated right upper urinary tract, an enlarged prostate gland with a volume of 70 ml and a residual volume of 840 ml on ultrasound scanning. He was then found to have tumour surrounding the bladder outlet on flexible cystoscopy on 08 September 2016 when he was catheterised and admitted. On endoscopic assessment under spinal anaesthesia, he was found to have an obstructive prostate gland. There was no suspicion of tumour within the prostatic urethra. He had exophytic tumour of a mixed, solid and papillary appearance involving most of the circumference of the bladder neck and trigone. He had a large, ectopic, right ureteric orifice. All tumour was resected. The prostate resected. TURBT, 12.09.16 - Part 1, Sections reveal multiple pieces of bladder mucosa containing portions of muscularis propria. There is a G3 papillary TCC, HG (WHO 2004). There is no evidence of invasion of the loose connective stoma or of smooth

muscles. There is no lymphovascular invasion. There is in situ urothelial carcinoma present. Part 2, This specimen includes portions of prostatic urethra showing in situ urothelial carcinoma. There are also fragments of prostatic tissue with foci of well differentiated prostatic adenocarcinoma with Gleason pattern 6 (3+3). There is no evidence of perineural invasion. The remaining prostatic tissue shows benign prostatic hyperplasia and active chronic inflammation. Discussed at Urology MDM 22.09.16. Personal Information redacted by the USI **has been found to have high risk, non muscle invasive transitional cell carcinoma of his bladder. Incidental Gleason 6 adenocarcinoma of prostate. His CT urogram results is awaited. For review with Mr O'Brien to organise MRI prostate and pelvis and to offer intravesical BCG and arrange further endoscopic assessment.** Personal Information redacted by the USI **was advised of the pathological diagnoses at review on 11 October 2016 when he reported having nocturia x 1 and improving urinary incontinence requiring the use of two pads daily. An induction course of intravesical BCG was arranged. MRI scanning of his prostate gland in January 2017 was requested. For readmission in February 2017 for Cystoscopy ? TURBT.** Personal Information redacted by the USI **completed a six week course of BCG on 22/11/16 his plan is for MRI scanning of his prostate booked for 19/1/17 and endoscopic reassessment early February as Mr O'Brien may still be off, could this gentleman be discussed at MDM and have his cystoscopy with another consultant. Discussed at Urology MDM 19.01.17.** Personal Information redacted by the USI **will be reviewed in outpatients by Mr Glackin with a view to planning surveillance of his previous high risk non muscle invasive bladder cancer.** Personal Information redacted by the USI **was reviewed by Mr Jacob on 23.03.17, he has had an induction course of BCG (6 weeks) and was due his maintenance therapy in February which has been unfortunately postponed. He had a recent episode of bleeding 12 days post-bladder biopsy and diathermy and was also treated with Ciprofloxacin presuming he had a urinary tract infection but culture and sensitivity from 9th March 2017 showed no growth. He has no LUTS at present. Bladder biopsy, 23.02.17 - Part 1, Histological examination shows two fragments of urinary bladder tissue with short segments of preserved severely dysplastic surface urothelium corresponding to CIS. Part 2, Urothelial carcinoma. Papillary. High-grade (G3). Local invasion - no (pTa). Lymphovascular invasion - no. Adjacent Mucosa - flat carcinoma in situ - yes. Granulomas - no. muscularis propria - not present. Discussed at Urology MDM**

30.03.17. Personal Information redacted by the USI has BCG refractory high grade non muscle invasive urothelial cancer of the bladder. Mr Jacob to review in outpatients and recommend radical surgical treatment, arrange a CT CAP, Bone scan and central MDM discussion. Bone scan, 02.05.17 - There is suspicious activity in the left femoral shaft requiring correlation with plain radiographs. Is there any history of Pagets disease? No evidence of metastatic disease elsewhere. CT, 09.05.17 - However no obvious disease extension outside of the urinary bladder is seen. No obvious metastatic disease throughout the chest, clear and bony parts noted. Mild volume of nonspecific mesenteric lymph nodes noted. There is also a few para-aortic lymph nodes present. But this pattern is unchanged since previous scan from 16 September 2016.

	Clinical Summary / MDM Update	Notes
Personal Information redacted by the USI		
Sex:	**Male**	**CONSULTANT MR GLACKIN: This [redacted] year old man was referred with visible haematuria. Bleeding had occurred whilst he was on holiday in Thailand and a CT performed there was reported as showing a right kidney mass. He has a background history of hypertension. He has some hypercholesterolemia and had a bone graft to a left scaphoid fracture a number of years ago. He is a smoker. Digital rectal examination revealed a large round 60-80cc smooth feeling prostate. His blood tests on 14th October revealed normal FBC, U&E and LFTs. His PSA was 3.3ng/ml. Discussed at Urology MDM 29.10.15. This man has been found to have a large right renal tumour. For review by Mr Glackin to arrange laparoscopic nephrectomy following pre operative CT chest. Patient was electively admitted on 27th November for right laparoscopic nephrectomy converted to open for right renal mass. Right kidney mobilised. Ureter mobilised, clipped and divided at iliac level. Kidney further mobilised, specimen split at lower pole with necrotic tumour material typical of TCC spillage. Kidney removed. Washout and removal of all macroscopic tumour material. Pathology showed papillary renal cell carcinoma, type I. Growth pattern, papillary and solid differentiation - moderate Fuhrman nuclear grade NA. Tumour necrosis - yes Local Invasion - no definite infiltration into perirenal or hilar fat identified. Tumour is however seen to infiltrate into urothelial lined renal pelvis Lymphovascular invasion - no Lymph nodes - none identified**
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 cell carcinoma**	
Stage:		
Reason for Discussion:	**REGIONAL DISCUSSION**	
Target Date		

Margins - not assessable due to tumour disruption ureteric margin clear. pT2a Discussed at Urology MDM 10.12.15. [redacted] had a large necrotic papillary RCC type 1. For review with Mr Glackin to advise CT in 3 months. [redacted] has history of pT2a papillary renal cell carcinoma. He had a right laparoscopic converted to open nephrectomy November 2015. Unfortunately his latest CT has shown nodular disease in the aortocaval region and also near the ascending colon. This is thought to represent disease recurrence related to his papillary renal cell carcinoma.

Clinical Summary / MDM Update **Notes**

[redacted]

Sex: Male
DOB: [redacted]
Age: [redacted]
Hospital Number: [redacted]
HCN: [redacted]
Consultant **MR J P O'DONOGHUE**
Diagnosis: **Prostate cancer**
Stage:
Reason for Discussion: **BONE SCAN**
Target Date

CONSULTANT MR O'DONOGHUE: This [redacted] year old gentleman was referred with an elevated PSA of 9.8 and on repeat it remained the same. His MRI prostate has confirmed a suspicious area at the right apex which is suspicious for prostate cancer. He has ongoing shortness of breath and occasional chest discomfort. He is currently on a Beta-blocker and has some postural dizziness. With regards to his lower urinary tract symptoms, he complains of nocturia, frequency, urgency and hesitancy although he reports his stream is fairly good. DRE reveals an enlarged 50-60cc prostate. Examination of the gland, it is slightly irregular with some firm areas which are clinically suspicious. Transrectal prostatic biopsy, 25.04.17 - Within 10 of the 15 prostatic cores biopsies there are infiltrates of Gleason 3+4 and 3+3 adenocarcinoma. This occupies approximately 20% of the overall tissue examined. There is extensive perineural invasion but no lymphovascular extension or extracapsular extension. Discussed at Urology MDM 04.05.17. [redacted] biopsies have shown an intermediate risk prostate cancer, MRI stage rT2N0. Mr O'Donoghue to review in outpatients to arrange an isotope bone scan, assess LUTs and commence ADT with a view to likely subsequent treatment with radiotherapy. [redacted] was commenced on ADT, his IPSS score is 19. Bone scan, 16.05.17 - No evidence of bony metastatic disease. There is degenerative tracer activity at the base of both thumbs and in the cervical spine.

Clinical Summary / MDM Update **Notes**

[redacted]

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:	**PATH POST SURGERY**
Target Date	**28/04/2017**

Clinical Summary / MDM Update **Notes**

Personal Information redacted by the USI

CONSULTANT MR GLACKIN: [redacted] year old gentleman with microscopic haematuria, no other significant health issues. Left probable renal pelvic TCC on CT. Cystoscopy unremarkable. For discussion of cytology, staging imaging and functional renal imaging. Urine cytology showed features that are thought to be malignant, and would be consistent with exfoliation from a transitional cell carcinoma. Patient aware of diagnosis. Discussed at Urology MDM 30.03.17. Personal Information redacted by the USI has a left upper tract abnormality on CT and cytology is consistent with upper tract urothelial cancer. Mr Glackin to review and recommend surgical management with nephrourterectomy. Left laparoscopic nephroureterectomy, 12.05.17 - await pathology.

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:	**CIS**
Stage:	
Reason for Discussion:	**PATH POST SURGERY**
Target Date	

CONSULTANT MR HAYNES: This [redacted] year old man with history of non-visible haematuria. He had a normal ultrasound scan. He describes no lower urinary tract symptoms. EGFR of greater than 60 and a creatinine of 96. He is an insulin dependent diabetic with a history of hypertension. Flexible cystoscopy in May 2015, showed a normal urethra and a small to moderate prostate, and areas of red bladder mucosa. Flexible cystoscopy was repeated in July 2015, again this showed the persistent scattered red patches seen previously. CT urogram was performed and this was normal. Bladder biopsy, 05.08.15 - Histological examination through levels showed carcinoma in-situ within both biopsies. Underlying this there were some Von Brunn's nests with cystitis cystica. Focally the dysplastic epithelium extended down into Von Brunn's nests. Discussed at Urology MDM 27.09.15. Personal Information redacted by the USI recent bladder biopsies have shown carcinoma in situ. For Outpatients review with Mr O'Donoghue to recommend BCG if available. If no BCG available, then intravesical Mitomicin C should be given with follow-up endoscopic surveillance / bladder biopsies under GA in early 2016. Personal Information redacted by the USI was electively admitted for TURBT and Bladder Biopsies. This was undertaken with likely recurrance of CIS noted which was more extensive than previous. A large area of bladder was resected including the bladder neck with samples sent for histology. TURBT, 19.01.16 - Histological examination shows multiple fragments of bladder mucosa in which there is abundant

carcinoma in-situ on a background of cystitis cystica. In addition there is extension of carcinoma in-situ into cystitis cystica related islands of epithelium within the subepithelial tissue. There is one additional small fragment of detached epithelium which is malignant in nature, however this is most likely detached epithelium involved by carcinoma in-situ and it is not felt to represent exophytic transitional cell carcinoma. Fragments of detrusor muscle are present. Bone scan, 26.01.16 - No evidence of bone metastases. CT C/A/P, 27.01.16 - Irregular thickening of the right lateral wall of the urinary bladder, in relation to recent TURBT. No evidence of lymphadenopathy or distant metastases. Discussed at Urology MDM 04.02.16. Personal Information redacted by the USI **biopsies show CIS. He has BCG refractory disease. For assessment with Mr O'Donoghue to consider radical cystectomy.** r Personal Information redacted by **has history of bladder CIS treated with intravesical BCG. He attended for cystoscopy on 07 June 2016, this gentleman had a normal urethra and he had a very red raised area on the right lateral wall of the bladder which I suspect is further treatment. This area was resected and sent for histology. Further tissue was sent from the bladder base including the bladder neck. TURBT, 07.06.16 - Histology shows inflamed and oedematous fragments of bladder mucosa. There is cystitis cystica present and, in areas, the surface contour is slightly irregular but there is no convincing evidence of a well-formed papillary lesion. A small amount of benign detrusor muscle is included in the sample. In some areas the surface urothelium shows marked cytological atypia with disorderly maturation and frequent mitotic figures. The morphological features are consistent with those of carcinoma in-situ (CIS). There is no evidence of invasive urothelial carcinoma in these biopsy fragments. Discussed at Urology MDM 16.06.16.** Personal Information redacted by the USI **bladder biopsies once again demonstrate Carcinoma in situ. He has previously been treated with a course of intravesical MMMC and more recently a course of intravesical BCG. He has previously seen Mr O'Kane to discuss the role of radical cystoprostatectomy. Mr O'Donoghue to review in outpatients and refer to Mr O'Kane for a further discussion regarding radical cystectoprostatectomy.** Personal Information redacted by the USI **was seen by Mr O'Kane and he advised as bladder biopsies had shown no evidence of muscle invasive disease he advised not to proceed to cystectomy and undergo bladder surveillance. In relation to the symptomatic bleeding from the left kidney,**

He had suggested a flexible ureteroscopy and laser plus biopsy if feasible. If not, consideration could be given to proceeding to left nephro-ureterectomy. Personal Information redacted by the USI **had bladder biopsies performed, he also now has TCC at the upper pole of the left kidney. Washings and biopsies were taken and these have been sent as red flag I will get an up to date CTU here in the Southern trust. Can he be discussed at the MDT. RENAL BIOPSY 08.11.16 - Histological examination through levels shows tiny fragments predominantly consisting of blood and fibrin. Floating within these are occasional tiny fragments of urothelium (GATA-3 positive, PAX-8 negative). The cytoplasm of these urothelial cells appears rather cleared. Within the extremely limited material, cytologic atypia is not appreciated and no transitional cell carcinoma has been identified. Given the radiological impression, the features are considered inadequate for diagnosis. BLADDER BIOPSY 08.11.16 - Histological examination through levels shows the fragments to be predominantly composed of inflamed and fibrotic lamina propria with occasional multinucleate giant cells. Only one fragment has surface urothelium and within this there is no significant atypia. There is no CIS or transitional cell carcinoma represented. URETERIC WASHINGS 08.11.16 - Cytology shows individual and clusters of urothelial cells in keeping with an instrumentation sample. No definite high grade urothelial malignancy is identified. Cytology has its limitations in distinguishing a low grade urothelial neoplasm from an instrumentation sample. Correlation with clinical features and other investigations including imaging is advised. 11.11.16 - eGFR 58ml/min. CT Renal 22.11.2016 - A known case of UB TCC, with the current findings of highly suspicious left renal pelvis TCC, with extention to the upper pole renal parenchyma. No lymph nodes or distant metastases. Discussed at Urology MDM 24.11.16** Personal Information redacted by the USI **recent bladder biopsies are benign, previous biopsies had shown BCG refractory CIS. There is an upper tract abnormality on the left consistent with a possible upper tract urothelial cancer. Recent ureteroscopic biopsies and cytology are non diagnostic, but endoscopic appearances are consistent with an upper tract urothelial cancer. For central MDM discussion next week. Discussed at Urology MDM 01.12.16 Needs discussed with patient pros and cons of palliative nephrectomy and potential need of histology prior to surgery.** Personal Information redacted by the USI **had BCG therapy, he was electively admitted on 08 May**

2017 for left laparoscopic nephrouretectomy. Histological examination shows a very friable transitional cell carcinoma. Artefactual tumour is seen within the renal pelvis and blood vessels. Tumour is seen to invade the parenchyma of the kidney making the stage pT3. No CIS is seen within the ureter or renal pelvis.

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 J P O'DONOGHUE **Diagnosis:** **Stage:** **Reason for Discussion:** CT **Target Date** 28/06/2017	**CONSULTANT MR O'DONOGHUE: This [redacted] year old gentleman had a pain in his right thigh for a year. An x-ray of his right hip showed a few small lucent areas in the inferior pubic ramus. Subsequent bone scan showed no evidence of metastasis. A single PSA from 14th March came back at 38.08. It was repeated and on 09 May it was 40.36ng/ml. He tells me he has a good flow of urine. He denies hesitancy and he has no storage symptoms. Personal Information redacted by the USI has a significant past medical history including several myocardial infarcts, congestive heart failure and angina. He has had appendicectomy in the past. On digital rectal examination he has a malignant feeling prostate. CT, 19.05.17 - History of prostatic CA noted. No convincing metastasis. Small sub centimetre left common iliac node, not felt to be significant.**	

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 D HAYNES **Diagnosis:** Prostate cancer **Stage:** **Reason for Discussion:** PATH TRUSB **Target Date**	**CONSULTANT MR HAYNES: [redacted] year old man who initially presented with a proven e-coli urinary tract infection and a raised PSA which remained persistently elevated. Initial biopsies showed a single focus of Gleason 3+3=6 prostate cancer. Subsequent staging suggested a left apical abnormality measuring 9mm. There was no cancer detected in his left apical biopsy. Given the potential for an under sampled area a targeted biopsy of the left apex has been performed. For MDM review of targeted biopsy pathology with a view to treatment recommendation. Transrectal prostatic biopsy, 18.02.15 - Prostatic adenocarcinoma of Gleason score 3+3 = 6 is present in 3 of 16 cores (all cores are from the left apex). The maximum tumour length is <1 mm. The tumour occupies <1% of the total tissue submitted. Discussed @ Urology MDM 05.03.15. Personal Information redacted by the USI' targeted prostate biopsies have found low risk prostate cancer. Suitable for all options but active surveillance is recommended. Personal Information redacted by the USI has remained on**	

active surveillance he had an MRI performed in January 2017 which was satisfactory. However his PSA was 5.96ng/ml in April 2017. Transrectal prostatic biopsy, 16.05.17 - 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	MR M D HAYNES
Diagnosis:	Benign
Stage:	
Reason for Discussion:	PATH TRUSB
Target Date	

CONSULTANT MR HAYNES: This [redacted] year old man was seen at clinic, his PSA had been gradually rising over the last 3 years. His PSA in October 2012 was 7.7ng/ml, May 2013 8.55ng/ml, October 2014 12.08ng/ml and in September of this year it was 16.29ng/ml. He has a history of two prostatic biopsies transrectally in 2011 and 2012, the first revealing a suspicion of Gleason 6 but the repeat biopsy revealing no neoplasm. He has had no associated urinary symptoms. Past medical history includes hypertension and high cholesterol. He is an ex smoker. Examination revealed a soft non-tender abdomen with no masses. Digital rectal examination revealed a firm, smooth 30cc prostate. MRI, 26.10.15 - There is probable tumour within the anterior transition zone of the mid to base of the gland with significant contact of the anterior margin of the gland but no gross evidence of extra-capsular extension. No lymphadenopathy or bone metastasis is seen in the visualised skeleton. Pancreatic findings, as described. Pancreatic tumour markers and CT of the pancreas are recommended. Please arrange for referral of the patient to the upper GI MDT with a view to endoscopic ultrasound and aspiration of the larger pancreatic lesion. Discussed at Urology MDM 12.11.15. Personal Information redacted by the USI MRI has suggested an anterior prostatic abnormality and a pancreatic abnormality. For outpatient review with Mr Suresh to arrange Ca 19-9, referral to Upper GI surgeons and consideration of targeted biopsies. TRUS and biopsy performed on 14/12/15. Prostate measured 65 cc. There was a focal hard area in the left lobe. 18 cores were taken, including the extra cores from anterior zone. Transrectal prostatic biopsy, 14.12.15- There are foci suggestive of prostatic intraepithelial neoplasia in the cores from the right base (part 1). Immunohistochemical staining for Racemase is negative in these foci however this remains the probable diagnosis. There is also a patchy chronic inflammatory cell infiltrate and focal areas of atrophy within the cores. No tumour is identified. Discussed at Urology MDM 24.12.15. Personal Information redacted by the USI prostate biopsies indicate probable high grade PIN but no

evidence of adenocarcinoma. For review with Mr Suresh to recommend PSA monitoring and an early repeat MRI if PSA is rising. Personal Information redacted by the USI has remained on active surveillance, he had an MRI performed in April 2017 which was satisfactory. His PSA has been increasing and it was 17.47ng/ml in April 2017. Transrectal prostatic biopsy, 16.05.17 - Within 2 of the 12 prostatic core biopsies there are infiltrates of Gleason 3+3 adenocarcinoma. It occupies approximately 8% of the overall tissue examined. The maximum length of the tumour is 3.7 mm. There is no perineural invasion, lymphovascular invasion or extracapsular extension.

	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 T JACOB**	
Diagnosis:	**Bladder tumour**	
Stage:		
Reason for Discussion:	**PATH POST SURGERY**	
Target Date		

CONSULTANT MR JACOB: This [redacted] year old gentleman was referred with multiple episodes of frank haematuria. He is an ex-smoker of approximately 10 years with a history of hypertension and hypercholesterolemia. Flexible cystoscopy showed extensive TCC on the left lateral wall of his bladder. His left UO was not visualised. CTU, 15.03.17 - Discussion at urological MDT meeting, Red Flag cystoscopy and follow-up non-contrast CT abdomen and pelvis 3 months would be suggested. TURBT, 12.04.17 - Urothelial carcinoma Growth pattern - Infiltrative, solid. High grade (G3). Local invasion - yes (pT1). Lymphovascular invasion - yes. Adjacent mucosa - flat carcinoma in situ - yes. Granulomas - no. Muscularis propria - represented within few fragments, no unequivocal invasion is seen. Discussed at Urology MDM 20.04.17. Personal Information redacted by the USI has high grade pT1 TCC with CIS and LVI. He should be seen in clinic where arrangements can be made for an induction course of BCG. He should have a CT abdomen in 3 months to reassess the mesenteric panniculitis. Mr Jacob reviewed [redacted] Personal Information redacted by the USI and he wishes to bring him back for a redo TURBT, to obtain further deeper samples and also to try and clear the residual tumour that is still in situ. His left ureteric orifice, though resected, had still residual TCC within and was resected as far possible. Prior to an induction course of BCG. Discussed at Urology MDM 04.05.17. Personal Information redacted by the USI has a high risk non muscle invasive urothelial cancer of the bladder. For a FU CT Chest Abdomen and Pelvis to reassess the para-aortic borderline lymph nodes and subsequent re-resection / completion TURBT

and MDM discussion. [redacted] was admitted for re resection TURBT on 11 May 2017, on this occasion we resected as far deep as possible and all of the residual tumour has been resected. Histology showed - Urothelial carcinoma. Infiltrative, high grade (G3) Local invasion - yes (pT1). Lymphovascular invasion - no. Adjacent mucosa - flat carcinoma in situ - yes. Granulomas: No. Muscularis propria - represented within few fragments, mostly necrotic, clear of tumour. CT Chest, 18.05.17 - No thoracic metastasis.

[redacted]	Clinical Summary / MDM Update	Notes
Sex: Male **DOB:** [redacted] **Age:** [redacted] **Hospital Number:** [redacted] **HCN:** [redacted] **Consultant** MR J P O'DONOGHUE **Diagnosis:** Prostate cancer **Stage:** **Reason for Discussion:** MRI BONE SCAN **Target Date**	**CONSULTANT MR O'DONOGHUE: [redacted] year old gentleman with LUTS and raised PSA of 31 ng/ml in February 2017. He has some frequency, nocturia and dribbling. Patient medical history of gout, HTN, renal calculi, obesity. DRE revealed an abnormal prostate, clinically T3 disease. Transrectal prostatic biopsy, 14.03.17 - Maximum length of tumour - 10 mm. Gleason score 4+4=8, number of cores involved 8/15. Overall tumour volume: 27% Lymphovascular invasion: not seen Perineural invasion: yes Extraprostatic extension: no Discussed at Urology MDM 23.03.17. [redacted] has a high grade prostate cancer. Mr O'Donoghue to review in outpatients, commence ADT and arrange staging with an MRI and bone scan with subsequent MDM discussion. [redacted] was commenced on ADT. Bone scan, 14.04.17 - The pattern of uptake is not convincing of osteoblastic metastasis. MRI, 03.05.17 - Equivocal (PIRADS 3) signal change within the right apical peripheral zone and right anterior transition zone. The histology results are noted. There is no definite evidence of extracapsular disease. Large bowel diverticula disease. Thick-walled sigmoid colon. Direct visualisation should be considered. rT2a N0 M0.**	

[redacted]	Clinical Summary / MDM Update	Notes
Sex: Male **DOB:** [redacted] **Age:** [redacted] **Hospital Number:** [redacted] **HCN:** [redacted]	**CONSULTANT MR O'DONOGHUE: This [redacted] year old gentleman has minimal lower urinary symptoms. His PSA was 4.36ng/ml in February 2017, 6.01ng/ml in March and 4.68ng/ml in April. He had a normal DRE. MRI, 30.04.17 - Hypertrophic prostate No malignant focus demonstrated. Transrectal prostatic biopsy, 17.05.17 - Histological examination of all cores**	

Consultant	**MR J P O'DONOGHUE**
Diagnosis:	**Benign**
Stage:	
Reason for Discussion:	**PATH MRI TRUSB**
Target Date	

shows benign prostatic ducts and acini. In areas there is a chronic inflammatory cell infiltrate. There is no PIN or adenocarcinoma.

Clinical Summary / MDM Update **Notes**

Patient 11

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:	**BONE SCAN**
Target Date	**21/10/2016**

CONSULTANT MR HAYNES: This [redacted] year old gentleman who has had a two year history of frequency of urination and some stinging inside which is relieved by urination. He also feels he has intermittent incomplete emptying. His PSA in July 2016 was 5.6ng/ml and January 2017 5.5 ng/ml. On PR examination the base was smooth but I was unable to access the top of the prostate. He underwent flow and post void residual which showed a post void residual of 7mls and a maximum flow of 16.2mls. MRI, 27.02.17 - T2, N0, M0 left peripheral zone carcinoma. (Assumed ilial lesion to be benign but bone scintigraphy recommended). Transrectal prostatic biopsy, 04.04.17 - Within 7 of the 19 prostatic core biopsies there are infiltrates of Gleason 3+3 adenocarcinoma. This occupies approximately 20% of the overall tissue examined. There is perineural invasion but no lymphovascular invasion of extracapsular extension. Discussed at Urology MDM 20.04.17. Patient 11 **to be seen in clinic for a discussion of all treatment options including AS. Should have a bone scan as recommended on MRI 27.02.17. Bone scan, 18.05.17 - No evidence of bony metastatic disease. Bilateral hip replacements noted.**

Clinical Summary / MDM Update **Notes**

Personal Information redacted by the USI

Sex:	**Male**
DOB:	Personal Information redacted by the USI
Age:	**81**
Hospital Number:	Personal Information redacted by the USI
HCN:	Personal Information redacted by the USI
Consultant	**MR M D HAYNES**
Diagnosis:	**Carcinoma of penis**
Stage:	

CONSULTANT MR HAYNES: This [redacted] year old man was admitted in July 2014 with a penile trauma. He had increasing LUTS with some haematuria. Fell onto top of fence while trying to cross with a step ladder. Full force of body landed on penis. Marked phimosis on examination. Warfarin held and taken to theatre on 15.07.14 for circumcision & biopsy of glans penis. Pathology reported - Part 1 - foreskin biopsy, Histology showed features of a well differentiated squamous cell carcinoma

Reason for Discussion:	**FURTHER MANAGEMENT**	**which extended to the peripheral margin of excision and is 1.5 mm from the deep margin of excision of this biopsy. Part 2, foreskin - features of a well differentiated squamous cell carcinoma which was present at the peripheral margin of excision and is 3.1 mm from the deep margin of excision. On the basis of this specimen, the pathological stage was at least pT2. Part 3 - biopsy of glans penis - features of a moderately differentiated squamous cell carcinoma. Discussed @ Urology MDM, 07.08.14. This gentleman has been found to have a squamous cell carcinoma of his penile foreskin and of glans, incompletely resected and requiring partial penectomy. He will be readmitted in near future for further surgery. Electively admitted on 26.08.14 for partial penectomy. Pathology reports a moderately differentiated keratinising squamous cell carcinoma which has a non-cohesive pattern of invasion. Both lymphovascular and perineural invasion are identified. There are areas of full thickness dysplasia adjacent to the tumour, towards the sulcus. There is marked inflammation within the urethral mucosa along with possible mild dysplasia. Perineural invasion is identified within the limit block of the corpus spongiosum. The foreskin margin is clear. Stage pT2 Nx Mx. CT A/P, 17.09.14 - The cause for his bilateral leg swelling is not apparent. USS, 19.09.14- No echogenic thrombus was seen. Discussed @ Urology MDM, 25.09.14. Pathological examination of** Personal Information redacted by the USI **partial penectomy has revealed an invasive squamous cell carcinoma with perineural invasion extending the length of spongiosum, to involve resection margin. For review by Mr Haynes, for clinical observation and repeated cross sectional imaging in three months' time.** Personal Information redacted by the USI **has continued on follow up for his previously moderately differentiated T2 penile carcinoma for which he underwent a partial penectomy. At last clinic review there were no clinical signs of recurrence and a CT scan in April 2016 was reported as satisfactory. Unfortunately on his most recent CT scan he now has some right sided lymph nodes which may be consistent with nodal metastases. For review of imaging and outpatient review with Mr Haynes. Discussed at Urology MDM 18.05.17. Await update from spinal meeting as discussed with Dr Lyons.**
Target Date		

Clinical Summary / MDM Update **Notes**

Patient 10

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:	**Renal cell carcinoma**
Stage:	
Reason for Discussion:	**CT**
Target Date	

CONSULTANT MR HAYNES: This [redacted] year old lady underwent her partial nephrectomy for her complex renal cyst on 31st October 2016. She has history of adenocarcinoma of sigmoid colon in 2010 and breast cancer in 2013 with recurrence in February 2016. For pathology review at MDM and subsequent outpatient follow up with Mr Haynes. Right laparoscopic partial nephrectomy, 31/10/16 - Papillary renal cell carcinoma (type II). Differentiation. Fuhrman nuclear grade III. Tumour necrosis. No although there is extensive cystic change. Local invasion. pT1a. Lymphovascular invasion. No lymph nodes. None submitted Margins. Surgical margin-0.2 mm pT1aNx Further Comments - As above, the tumour is predominantly encapsulated and within the fibrous rim there is conspicuous dystrophic calcification. Psammomatous calcification is however not appreciated within the tumour although there are extensive foamy macrophages within papillary cores. Much of the tumour exhibits oncocytic like change but in areas the cytoplasm is more clear. While the well circumscribed component of the tumour is relatively well clear of the surgical margin, a nodule infiltrates into the renal parenchyma and extends to 0.2 mm from the inked surgical margin. Discussed at Urology MDM 10.11.16. Patient 10 recent partial nephrectomy pathology shows a T1a Papillary type 2 , grade 3 renal cancer with negative margins. Mr Haynes to review in outpatients and arrange a follow-up CT in 6 months. Patient 10 has had her first follow up CT scan following her partial nephrectomy for renal cancer. For MDM review of radiology. CT, 11/04/17 - No lung mets. No liver mets. Stable left axillary appearances.

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 A.J GLACKIN**
Diagnosis:	
Stage:	
Reason for Discussion:	**PATH POST SURGERY**

CONSULTANT MR GLACKIN: [redacted] year old lady has recently been detected to have haematuria with multiple recurrent UTI's since January of this year. On each occasion this has grown an e-coli. CT 29/03/17 - Substantial bladder lesion. Consider pelvic MRI to clarify the relationship between the lesion and the vagina/cervix and rule out invasion of these structures. Bilateral complex ovarian cysts. Tumour markers 11/04/17 CA125 - 32, CA19-9 - 151, CEA - 10. TURBT 12.05.17 - Histological examination shows multiple fragments of tissue extensively infiltrated by tumour demonstrating features

Target Date	**20/04/2017**	**suggestive of B-cell non-Hodgkin's lymphoma. This case has been forwarded to Dr L Venkatraman, Consultant Haematopathologist, RVH, for reporting. Histology showed - WHO CATEGORY. B-cell neoplasm - extra nodal MALT / marginal zone lymphoma. Nodular and diffuse; reactive follicles present, no lymphoepithelial lesions (LEL).**

Personal Information redacted by the USI		**Clinical Summary / MDM Update**	**Notes**
Sex: Male		**CONSULTANT MR GLACKIN: This [redacted] year old gentleman was found to have an incidental complex renal cyst on CT renal. He had had an ultrasound performed which identified a 2cm complex cyst in the left kidney. He was referred with an elevated PSA which was 8.51ng/ml in March 2017. He has a past medical history of being an ex-smoker and GORD and a right total hip replacement and right inguinal hernia repair**	
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:	**CT**		
Target Date			

Personal Information redacted by the USI		**Clinical Summary / MDM Update**	**Notes**
Sex: Male		**CONSULTANT MR HAYNES: This [redacted] year old gentleman moved from Personal Information redacted by to Northern Ireland in 2015. He suffered a stroke in 2015. He provided images which have indicated that he had suffered a left hemispheric infarct. The patient has not been able to advise whether he had any stenting , embolization or other surgical procedure performed at that time. He also related that he had had a left renal cyst aspirated several years previously. He was reported to have a left renal, upper pole cyst, measuring 3.7 cm in diameter, with a solid component, septation and mural calcification on ultrasound scanning in April 2016. At review in June 2016, he was asymptomatic. His renal function was normal. Renal CT scan on hold for the moment until the outcome of the CT brain is known. Discussed at Urology MDM 04.08.16. This gentleman has a complex left renal cyst which requires further assessment. For review with Mr Suresh to request patient to obtain details of vascular intervention in Personal information in 2015, in order to determine whether renal MRI scanning is possible. CT Brain 22.11.16 - No**	
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:	**MRI**		
Target Date			

intracranial coiling or convincing stenting. No metallic foreign body. Discussed @ Urology MDM, 01.12.16 Personal Information has a complex renal cyst and requires an MRI to further characterise this Mr Haynes to arrange MRI and subsequent MDM review. Personal Information redacted by the USI has a Bosniak 2F left renal cyst. An MRI scan has been arranged to further characterise this. For radiology review. Mr Haynes to write with ongoing management plan. MRI, 28.04.17 - Left upper pole renal cyst with some internal septation and architecture suggesting previous intervention but no sinister findings on MRI.

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 T JACOB **Diagnosis:** **Stage:** **Reason for Discussion:** ULTRASOUND **Target Date**	**CONSULTANT MR JACOB: This [redacted] year old gentleman presented with vague left scrotal discomfort in October 2016 to his GP who found a normal testicular examination but organised a routine USS to ensure no abnormality. Ultrasound, 09.02.17 - There is however a small left sided varicocele present. However, significantly there is a 5 mm smooth rounded solid mass present within the left testis. This is obviously not the mass that the patient presented with. Although it is smooth and outline measuring just 5 mm. The left kidney appears normal. His HCG was 0.1, AFP was 1.5, LDH was 185, and his eGFR was >60. This gentleman was advised that an orchidectomy may be required for diagnosis but in light of the absence of bloods and the homogenous features of the lump on USS it would be best discussed at MDT before confirming a way forward. Discussed at Urology MDM 16.03.17. Review of imaging is satisfactory for repeat ultrasound in 3 months. Mr Jacobs to advise the patient. In light of Personal Information redacted by the USI mass being palpable, for rediscussion at MDT to ask does he need re-imaged sooner? and I also wish to know if a surgical biopsy of this lesion is warranted? Discussed at Urology MDM 18.05.17. Defer for radiology.**	

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 GLACKIN: [redacted] year old man referred with increasing PSA during investigations related to lymphadenopathy. On reviewing his PSA trend it was 6ng/ml in July 2011, 6.15ng/ml in August 2013 and most recently 8.5ng/ml in June 2014 with a free to**	

Consultant	**MR A.J GLACKIN**
Diagnosis:	**Prostate cancer**
Stage:	**T2 N0**
Reason for Discussion:	**MRI**
Target Date	

total ratio of 12%. There is no family history of prostate cancer. Cardiac stent placed in September 2006 at Belfast City Hospital. He has had a cholestectomy in the past. CT neck, chest, abdomen and pelvis, 9.1.14 - showed stable lymphadenopathy. Results showed a single sclerotic focus on the left side of the pubic symphysis. There are no other sclerotic areas on the scan. Ultrasound 20.8.14 showed a prostate measuring 64cc with calcification. TRUSB, 15.12.14 - Adenocarcinoma gleason 3+3 = 6, in 2 out of 12 needle cores (left base and left apex). The longest single length measuring 2 mm in length. The overall percentage volume involved is 3%. Discussed @ Urology MDM 8.1.15. [redacted] **prostate biopsies have shown a low risk prostate cancer. His CT has suggested a sclerotic lesion in the left pubic ramus which is not likely to be related to his prostate cancer. For OP review with Mr Glackin and for MRI prostate and subsequent MDM discussion. MRI, 05.04.15 - The appearance is suggestive of cancer prostate stage T2 N0. Discussed at Urology MDM 14.05.15.** [redacted] **has organ confined low risk prostate cancer. For review with Mr Glackin to advise active surveillance.** [redacted] **has remained on active surveillance for his Gleason 6 prostate cancer. He was reviewed on 08th December 2015, it was noted that his PSA had risen to 11.3ng/ml on 19th November 2015. It had then fallen to 9.5ng/ml by 4th December 2015. His PSA was rechecked and it was 9.80 ng/ml in January 2016. Transrectal prostatic biopsy, 27.01.16 - Histological examination of parts 1 to 6 shows foci of PIN. The history of previous diagnosis of prostatic adenocarcinoma is noted, and there are multiple foci within all cores where the presence of bland tumour has been considered. Immunohistochemistry has therefore been extensively applied, and it shows the majority of these areas to contain at least a focal myoepithelial layer and hence not represent adenocarcinoma. Within Part 3 there is a small collection of glands, which although not appearing markedly atypical, do lack a myoepithelial layer. These probably are benign glands, however overall they are considered to be an atypical small acinar proliferation (ASAP). Discussed @ Urology MDM, 11.02.16.** [redacted] **recent prostate biopsies have not found any definite prostate cancer. He remains suitable for active surveillance.** [redacted] **remains suitable for prostate cancer active surveillance. As a precaution I am going to repeat his MRI scan and for further MDM**

discussion. MRI, 08.03.16 - The examination is degraded by patient movement and may also be affected by post biopsy artefact. Indeterminate and reduced T2 and ADC signal change in the left peripheral zone is minimally more prominent than on the previous examination. No gross evidence of extracapsular extension. The appearances continue to be of organ confined disease. Discussed at Urology MDM 07.04.16. [redacted] MRI does not show any radiological evidence of progression of his prostate cancer and ongoing surveillance is recommended with repeat MRI / consideration of targeted surveillance biopsies in early 2017 or earlier if his PSA is rising. MRI, 12.03.17 - No definite radiological evidence of a significant prostate tumour. No evidence to suggest disease progression.

	Clinical Summary / MDM Update	Notes
[redacted]		
Sex:	**Male**	**CONSULTANT MR GLACKIN: [redacted] year old gentleman had a left laparoscopic radical nephrectomy in September 2011 under the care of Mr Akhtar for a pT1a renal cell carcinoma. On subsequent imaging he has been found to have some cysts in the right kidney. There is a cyst at the lower pole anteromedially which requires review at the MDT. CT 01/03/17 - The right renal cysts are unchanged from previous imaging. The right lower pole lesions would seem to represent hyperdense cysts and do not appear sinister.**
DOB:	[redacted]	
Age:	[redacted]	
Hospital Number:	[redacted]	
HCN:	[redacted]	
Consultant	**MR A.J GLACKIN**	
Diagnosis:	**Renal cell carcinoma**	
Stage:		
Reason for Discussion:	**CT**	
Target Date		

	Clinical Summary / MDM Update	Notes
[redacted]		
Sex:	[redacted]	**CONSULTANT MR JACOB: This [redacted] year old gentleman was referred with raised PSA findings, it was 13.9ng/ml on 30th January 2017. His initial PSA from April 2013 was slightly raised at 5.6ng/ml, 10.9ng/ml in January 2016 and 11.2ng/ml in March 2016. He has on-going LUTS mainly nocturia. In his background history he has had an arthroscopy of his left knee, suffers with vertigo and has had a left sided varicocele ligation in the past. Of note there is no family history of prostate cancer. His prostate is moderately enlarged measuring about 40-60cc with slight firmness and palpable nodules within**
DOB:	[redacted]	
Age:	[redacted]	
Hospital Number:	[redacted]	
HCN:	[redacted]	
Consultant	**MR T JACOB**	
Diagnosis:	**Benign**	
Stage:		
Reason for Discussion:	**PATH MRI TRUSB**	
Target Date		

the mid zones of both lobes. MRI, 04.05.17 - No definite evidence of prostate malignancy. Transrectal prostatic biopsy, 16.05.17 - Histological examination of all cores through levels shows prostatic glands and stroma in which there is patchy chronic active inflammation but no PIN or invasive malignancy.

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** **Diagnosis:** Prostate cancer **Stage:** **Reason for Discussion:** PATH MRI TRUSB **Target Date** 24/05/2017	**CONSULTANT MR GLACKIN: This [redacted] year old gentleman was referred with an elevated PSA in November 2015 it was 7.1ng/ml, in June 2016 it was 9.16ng/ml and then in March 2017 it was 11.82ng/ml. He describes poor flow with some urgency and frequency and passing urine overnight. He has a past medical history of Type II diabetes and hypertension and he had a cardiac stent put in 2 years ago. He also has known respiratory fibrosis. On PR I was unable to locate the top of the prostate but could not feel any gross abnormalities and a prostate size of 30cc. MRI, 06.05.17 - Signal change in the posterolateral peripheral zone and anterior transition zone of the right mid gland is equivocal (PIRADS 3). Targeted biopsies of the right mid gland peripheral zone are recommended in the first instance. If tumour should be present, there is possible capsular infliltration in the posterolateral peripheral zone of the right mid gland but no gross evidence of extra-capulsar extension. Transrectal prostatic biopsy, 17.05.17 - Prostatic adenocarcinoma of Gleason score 3 + 4 = 7, is present in 8 of 17 histological cores with a maximum tumour length of 6 mm. The tumour occupies approximately 8 % of the total tissue volume.**	

Personal Information redacted by the USI	Clinical Summary / MDM Update	Notes
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 A.J GLACKIN **Diagnosis:** TCC Bladder pTa Grade 2 **Stage:**	**CONSULTANT MR GLACKIN: [redacted] year old lady with persistent non-visible hamaturia associated with symptoms of UTI. Episode of frank haematuria one month ago, now settled. Dysuria and frequency. No abdominal pain. Smoker. US 06.02.17 showed a bladder mass and 1.5 cm cyst at lower pole of right kidney. CT Urogram 20.02.17 - No evidence of renal tract calcification of the unenhanced study. Large soft tissue mass right-sided bladder, approximate 3.8 cm in diameter. Both kidneys have a normal post contrast appearance, normal enhancement, simple cyst in the right. This lady had a 3cm**	

Reason for Discussion:	**CT PATH POST SURGERY**	**papillary bladder mass resected on 19th May 2017. For discussion of histology and also review of her CT urogram and CT chest. She has some small chest nodules which may require further imaging follow up. Part 1, Histological examination shows numerous fragments derived from an inflamed papillary transitional cell carcinoma. For the most part I would regard the tumour as grade 2-low-grade however focally there is sufficient atypia and a few more mitoses to warrant designation as grade 2-high-grade. No definite invasion into the lamina propria is seen (pTa). Part 2, Histological examination shows fragments of tumour similar to those described above. There is no invasion into the lamina propria seen and while small fragments of muscularis propria are present these are also not involved.**
Target Date		

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:	**Prostate cancer**
Stage:	
Reason for Discussion:	**MRI IMAGING REVIEW**
Target Date	**18/02/2017**

CONSULTANT MR HAYNES: This [redacted] year old gentleman was found to have an elevated PSA at 16.2 ng/ml. An MSU at the time was negative and he has no bothersome urinary symptoms. Clinically his prostate is benign feeling. I have discussed the implications of a single elevated PSA. His PSA was repeated and it was 15.25 ng/ml. MRI, 03.02.17 - Small but suspicious focus within the right peripheral zone of the prostate (series 5 image 11). On histologic confirmation, disease appears organ confined T2c N0. Transrectal prostatic biopsy, 14.03.17 - Within 7 of 13 prostatic core biopsies there are infiltrates of Gleason 3+ 4 adenocarcinoma. This occupies approximately 20-25% of the overall examined material. There is perineural invasion but no lymphovascular invasion or extracapsular extension. Discussed at Urology MDM 23.03.17. Personal Information redacted by the USI **has an intermediate risk prostate cancer. Mr Haynes to review in outpatients, arrange a bone scan and for subsequent MDM discussion.** Personal Information redacted by the USI **has been advised of the diagnosis of an intermediate risk prostate cancer. He has no lower urinary tract symptoms. His prostate measured 42cc on TRUS. His presenting PSA was 15 and on MRI scan staged as T2c N0. A bone scan has been arranged to complete his staging. For MDM review with bone scan and outpatient follow up with Mr Haynes. Bone scan, 03.05.17 - No convincing evidence of bony metastatic disease. Focal activity in relation to the right femoral head is likely degenerative but should be correlated**

with the MR findings. Discussed at Urology MDM 18.05.17. Defer for radiology.

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 D HAYNES **Diagnosis:** Prostate cancer **Stage:** **Reason for Discussion:** BONE SCAN **Target Date**	**CONSULTANT MR HAYNES:** Personal Information redacted by the USI **presents having been found to have enlarged pelvic nodes on a CT scan and a raised PSA at 209 ng/ml. The peripheral zone of his prostate does not feel overtly malignant however on TRUS he has a significant anterior hypoechoic lesion which is extending in an extra prostatic/seminal vesicle region. This was biopsied in the cores of the left base. In addition a standard template of biopsies was performed. He has been commenced on Bicalutamide and a bone scan has been arranged to complete his staging. For review of radiology and pathology and subsequent follow up with Mr Haynes. Transrectal prostatic biopsy, 26.04.17 -Within 13 of 13 prostatic core biopsies there are infiltrates of Gleason 4+3 adenocarcinoma. This occupies approximately 75-80% of the overall examined material. There is perineural invasion and extracapsular extension but no lymphovascular invasion. Discussed at Urology MDM 04.05.17.** Personal Information redacted by the USI **has metastatic prostate cancer and has been commenced on ADT. For Review with Mr Haynes after bone scan and for consideration of referral to oncology. Bone scan, 15.05.17 - There is focal tracer activity in the distal right femur and in the skull vault on the right side suspicious for metastatic disease. Plain film correlation required.**	

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 D HAYNES **Diagnosis:** Prostate cancer **Stage:** **Reason for Discussion:** PATH TRUSB **Target Date**	**CONSULTANT MR HAYNES: This** [redacted] **year old gentleman who complains of nocturia x3 overnight and poor flow. He also describes some terminal dribbling. No hesitancy, urgency or haematuria. He does feel intermittently that he does not completely empty his bladder. On PR he had a reasonably smooth feeling prostate. PSA most recently was 22ng/ml increased from 16.4ng/ml in September 2016. Post void residual was 5mls. MRI, 06.03.17 - Benign prostatic hypertrophy is noted. There is no pelvic lymphadenopathy, involvement of seminal vesicles or prostatic invasion to suggest a malignancy. Transrectal prostatic biopsy, 16.05.17 - Prostatic adenocarcinoma of overall Gleason score 3 + 4 = 7 is present in 2 of 12**	

clinical cores with a maximum tumour length of 1.9 mm. The tumour occupies less than 2% of the total tissue volume.

	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: Prostate cancer Stage: Reason for Discussion: MRI BONE SCAN Target Date	CONSULTANT MR HAYNES: [redacted] year old gentleman with an elevated PSA. He has some mild lower urinary tract symptoms which are not overly troublesome. His recent PSA was significantly elevated at 42ng/ml. He is otherwise fit and well, has had no recent weight loss and has no family history of prostate cancer. Digital rectal examination revealed an enlarged 50-60cc prostate with suspicious feeling left lateral lobe. Transrectal prostatoic biopsy, 27.03.17 - Prostatic adenocarcinoma of Gleason score 4 + 3 = 7, is present in 14 of 15 cores with a maximum tumour length of 11mm. The tumour occupies approximately 40% of the total tissue volume. Discussed at Urology MDM 06.04.17. [redacted] Personal Information redacted by the USI has a high risk prostate cancer. Mr Haynes to review in outpatients, commence ADT, arrange staging with an MRI and bone scan and subsequent MDM review. Personal Information redacted by the USI was commenced on ADT, CT bone scan and MRI have been requested and will be discussed at MDT. MRI, 03.05.17 - Post biopsy examination. The appearances are suspicious for tumour in the posterior peripheral zone of the left mid gland to base with early extension into the left seminal vesicle. No pelvic lymphadenopathy or skeletal metastasis in the pelvis or lumbar spine. rT3b N0 M0. Bone scan, 05.05.17 - No evidence of bony metastatic disease.	

	Clinical Summary / MDM Update	Notes
Patient 7 [redacted]		
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 O'BRIEN Diagnosis: Stage: Reason for Discussion: MRI Target Date	CONSULTANT MR O'BRIEN: This [redacted] year old man was found to have a small left renal lesion when he had ultrasound scanning performed in May 2016 in the assessment of a chronically elevated, hepatic transaminase level. On Renal CT scanning in June 2016, he was found to have a mildly enhancing lesion within the anterior cortex of the lower pole of the left kidney. It measured 2.5 cms in diameter. It mildly enhanced by approximately 30 Hu. Ct scanning also reported the presence of subcentimeter, left mesenteric lymphadenopathy, raising the possibility of lymphoma. It was noted at review on 19 July 2016 that the patient had an unproven	

diagnosis of sarcoidosis in 1983, and suffered a myocardial infarct in 2003 when he had coronary arterial stenting performed. He was advised of the finding. He was advised that the location of the lesion did not lend itself to biopsy free of risk. He has had a staging CT scan arranged for 21 July 2016. He was content to pursue management by active surveillance if considered appropriate. For MDM discussion. Discussed at Urology MDM 28.07.16. Patient 7 has a small renal mass which is suitable for active surveillance. In addition there is some mesenteric lymphadenopathy which requires follow-up. For review with Mr O'Brien to arrange surveillance CT in 4 months to assess mesenteric nodes and renal mass. Patient 7 has had his follow up CT performed which suggests MDM discussion, as it shows a slight increase in his left lower pole RCC by a few mm but stable mesenteric lymph nodes as seen previous. I wish to discuss his further management in light of the very slight increase of the lesion as this wasn't amenable to biopsies as it is anteromedial placed. Discussed at Urology MDM 19.01.17. [redacted] Patient 7 repeat CT shows minimal change in the left renal mass and no changes in the mesenteric appearances which are not felt to be significant. A follow-up MR kidneys is recommended and Mr Haynes will arrange this. MRI 08.05.17 - Some sequences are degraded by patient movement. Allowing for comparison with a different modality, there is no change in size of a left renal lesion since December 2016. The lesion is non specific and may represent a papillary renal cell carcinoma. Discussed at Urology MDM 18.05.17. Defer for radiology.

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 YOUNG**
Diagnosis:	
Stage:	
Reason for Discussion:	**MRI**
Target Date	

CONSULTANT MR YOUNG: This [redacted] year old gentleman presented with an elevated PSA which was 11 ng/ml. He has large prostate gland verging on 100cc, PR examination showed it is indeed large but smooth in texture. His micturitional flow is fairly good. MRI, 05.03.17 - Abnormal indeterminate signal in right peripheral zone. Although there is no restriction, focus of malignancy cannot be excluded. You may wish to correlate with tissue biopsy. Discussed at Urology MDM 18.05.17. Defer for radiology.

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: TCC Bladder invasive

Stage:

Reason for Discussion: PATH BLADDER BIOPSIES

Target Date

CONSULTANT MR O'DONOGHUE: [redacted] year old man who presented initially with a 6 month history of intermittent episodes of painless frank haematuria. PSA was normal. He is on Alfuzosin for management of his blood pressure and is also taking Warfarin for atrial flutter that occurred after a triple bypass 5 years ago. He has a past medical history of MI, cholesterol, hypertension and COPD. He is an ex-smoker of 40 cigarettes per day quitting 5 years ago at the time of his heart surgery. He had an ultrasound scan in July 2014 that was normal. His MSSUs have been clear aside from blood. Flexible cystoscopy showed a suspicious lesion on the left lateral wall just adjacent to his left ureteric orifice, this is suspicious of solid TCC and it did appear to be slightly bleeding. CT Chest/CT Urogram, 10.03.15 - 1) Thick walled urinary bladder. 2) Cardiomegaly. Discussed at MDM 19.3.15. Personal Information redacted by the USI TURBT has shown High grade T1 urothelial cancer with adjacent CIS. His upper tracts are clear on CT Urogram. For outpatient review with Mr O'Donoghue to recommend early re-resection TURBT to include prostatic urethral biopsies. Personal Information redacted by the USI was electively admitted for bladder biopsies and redo TURBT on 2nd June 2015. Discussed at Urology MDM 30.07.15. This man has been found to have persistent carcinoma in situ on further, recent bladder mucosa biopsies. For review by Mr O'Donoghue to advise intravesical BCG followed by re admission in November 2015 endoscopic re assessment. Patient was electively admitted on 18th November 2015 for TURBT. At cystoscopy this gentleman had a normal urethra and a moderate sized prostate. There was an area of redness around the previous resection site on the right lateral wall and a lesion on the dome of the bladder. Discussed at Urology MDM 24.12.15. [redacted] Personal Information redacted by the USI bladder biopsies are benign. Mr O'Donoghue to arrange maintenance BCG and surveillance cystoscopy. Bladder biopsy, 23.03.16 - Histological examination through levels shows multiple fragments of normal bladder mucosa. There is no evidence of CIS or transitional cell carcinoma. CT Urogram 14.11.16 - Comparison made with previous examination of 10/03/2015. Findings. No renal or ureteric calculus seen. There are no obstructive changes on either side. Urinary bladder is thick walled. Liver, gallbladder,

spleen and pancreas appear normal. Atherosclerotic calcification of the aorta and its branches seen. Small bilateral inguinal hernia sac seen containing fats. Marked degenerative changes seen in the spine at L2/3, L4/5 and L5/1 levels. There is mild scoliosis with convexity to the left side. Thick walled urinary bladder. BLADDER BIOPSY 15.11.16 - Histology shows urothelium and underlying subepithelial tissue which is congested, oedematous and contains a mild chronic inflammatory infiltrate. A fragment of muscularis propria is also identified. There are no granulomas and there is no in situ or invasive malignancy. Discussed @ Urology MDM, 24.11.16 Personal Information redacted by the USI recent recent bladder biopsies are benign. Mr O'Donoghue to recommend ongoing maintenance BCG and ongoing endoscopic surveillance. [redacted] Personal Information redacted by the USI has a previous pT1 G3 with CIS bladder tumour. He has also had a full course of BCG in the past. He was admitted for bladder mapping/biopsies on 10.05.17. Histology shows unremarkable bladder mucosal biopsies. There is no CIS or urothelial carcinoma and there is no significant inflammatory cell infiltrate.

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: **Benign**
Stage:
Reason for Discussion: **PATH TURP**
Target Date

CONSULTANT MR HAYNES: This [redacted] year old gentleman with high pressure urinary retention was admitted on 15th May. He had red patches at base of diverticulum with copious debris. Cold cup biopsies of bladder mucosa were taken. CT urogram in March 2017 was unremarkable. PSA in December 2017 was 1.07 ng/ml. For discussion of result of bladder biopsy. Bladder biopsy, 15.05.17 - Part 1, Histological examination through levels shows a fragment of bladder mucosa within which there is a severe mixed chronic active inflammatory cell infiltrate of the lamina propria with extensive denudation of the surface urothelium. The minimal amount of urothelium present shows probable reactive changes. The histological features are suggestive of marked inflammatory changes. Part 2, Histology shows prostatic parenchyma with benign nodular hyperplasia and patchy chronic active inflammation. There is no evidence of malignancy.

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 T JACOB**
Diagnosis:	**TCC Bladder invasive**
Stage:	
Reason for Discussion:	**PATH POST SURGERY**
Target Date	

CONSULTANT MR JACOB: This [redacted] year old gentleman was admitted on 11th May through our A&E department when he presented further to a collapse at home with central abdominal pain. Querying a AAA they had performed a CT of his abdomen and pelvis and an incidental finding of a bladder lesion was made with slightly decreased function of his left kidney. A AAA has been ruled out on the scans. Initially flexible cystoscopy revealed an extensive bladder TCC which appeared solid and extensive involving all of his left lateral wall, dome, bladder base and the left bladder neck. He had a formal TURBT on 16 May 2017, the mass was palpable bimanually and is mobile. Histological examination shows extensive grade 3 transitional cell carcinoma which is seen to infiltrate fragments of muscularis propria (at least pT2a). Focal lymphovascular invasion is seen.

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:	**CT**
Target Date	**08/06/2017**

CONSULTANT MR O'DONOGHUE: This [redacted] year old gentleman had a single episode of frank haematuria. A CT urogram was performed and identified a 3.3cm lesion in the upper pole of his left kidney but no other gross abnormalities. Flexible cystoscopy revealed no abnormalities within the urethra, prostate or bladder. His eGFR is 43.

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:	**Prostate cancer**
Stage:	

CONSULTANT MR HAYNES: [redacted] year old man who presented with a PSA of 3.55 and a clinically benign feeling prostate gland. He underwent TRUS biopsies which he found extremely uncomfortable and could only tolerate 7 biopsies – 5 on right, 2 from left base. Biopsies showed gleason 3+3=6 prostate cancer in the cores from the left base with a maximal tumour length of 4.5mm in these cores. The MRI has shown a large area of abnormality in the left lobe, much of which has not been biopsied. Personal Information redacted by the USI has a long history of bowel problems with frequent urgent motions 2-3 times per day. He also has

Reason for Discussion:	**MRI**
Target Date	

low back problems. For MDM discussion of treatment options. Personal Information redacted by the USI is keen to proceed to a curative treatment and has a preference for surgical treatment. Discussed at Urology MDM 23.04.15. Personal Information redacted by the USI bowel and back complaints are relevant to his optimal treatment choice for treatment of his prostate cancer with possible prostate apical margin involvement noted on MRI. For direct referral to regional MDM by Mr Haynes. Discussed at Urology MDM 14.05.15. Refer to BCH surgeons for consideration. Refer to oncology for radiotherapy opinion. Mr O'Brien to arrange referral. Personal Information redacted by the USI is on surveillance for a low risk prostate cancer diagnosed in 2015. He only tolerated 7 biopsy cores and had significant prostatitis symptoms afterwards. His initial MRI suggested a large area of restricted diffusion on the left which was out of keeping with his biopsies and PSA. After discussion he went on to have follow-up MRI scans and this area resolved. His PSA has remained low with his November 2016 level being 2.92, albeit this is a slight rise from his preceeding 2 readings which were 2.6 (August 2016) and 2.2 (May 2016), he is due a further PSA. For review of imaging and subsequent OP FU with Mr Haynes.

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	
Diagnosis:	**TCC Bladder pTa Grade 2**
Stage:	**Ta**
Reason for Discussion:	**PATH BLADDER BIOPSY**
Target Date	

CONSULTANT MR HUGHES: [redacted] year old lady with frank painless haematuria. CT urogram in December 2014 showed filling defects in the region of the left vesical ureteral junction and correlation with results of cystoscopy is needed. TURBT 15.12.14 - Histology shows structures of superficial, Grade 2 transitional cell carcinoma. Fragments of detrusor muscle are present with no evidence of invasion. pTa. Discussed @ Urology MDM 15.1.15. Personal Information redacted by the USI recent bladder biopsy has shown TCC in Gleason II, pTa. To be reviewed by Mr Brown. To arrange flexible cystoscopy in 3 months (March 2015). [redacted] Personal Information redacted by the has history of pTa GII TCC December 2014. Irregular area biopsied 12 April 2017. Histological examination shows two fragments of bladder mucosa. One fragment shows thickening of urothelium without any evidence of dysplasia or CIS. The other fragment is slightly distorted with a detached tangentially cut fragment of hyperplastic urothelium with a fine fibrovascular core exhibiting mild to moderate cytonuclear atypia. A definite papilla is identified on further levels. There is no evidence of lamina propria

invasion. These findings are in keeping with tiny low-grade (G2) TCC.

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** **Diagnosis:** **Stage:** **Reason for Discussion:** **Target Date**	**MR M D HAYNES** **PATH RENAL BIOPSY**	**CONSULTANT MR HAYNES: [redacted] year old man with an incidental finding of a 2cm indeterminate lesion of left kidney on ultrasound scan in September 2012. Left flexible ureteroscopy 20th June 2014 –Small smooth bulge in midpole calyx - no malignancy. He has mild learning difficulties. Not keen for percutaneous biopsy of renal lesion. CT 16.02.15, 1) Stable appearance of the left renal mass lesion. 2) Thick walled urinary bladder and mild projection of the the median lobe into the urinary bladder. Discussed at Urology MDM 12.03.15. Personal Information redacted by the USI indeterminate renal lesion is unchanged sinec July 2013. For review by Mr Suresh to recommend Renal CT scanning in 1 years' time. Personal Information redacted by the USI left renal mass has increased in size on recent imaging. Due to its unusual location for it to be an RCC I have requested a biopsy of this prior to proceeding to treatment which would entail a laparoscopic nephrectomy. A previous ureteroscopy and urinary cytology were negative. For pathology and radiology review and subsequent follow up with Mr Haynes. CT, 22.02.17 - Slow growing left renal mass. Ultrasound guided biopsy, 11.05.17 - The morphology along with the immunoprofile is in keeping with eosinophilic renal cell carcinoma, possibly chromophobe carcinoma. Definitive subtyping will be done on resection specimen.**	

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** **Diagnosis:** **Stage:** **Reason for Discussion:** **Target Date**	**MR M D HAYNES** **Prostate cancer** **CT ONCOLOGY DISCUSSION**	**CONSULTANT MR HAYNES: This [redacted] year old gentleman presented initially to his GP with significant storage urinary symptoms and symptoms consistent with prostatitis. There was some improvement with Ciprofloxacin but these have not resolved completely. His PSA was found to be elevated at 50 and then 54 on repeat. Clinically he has an abnormal prostate consistent with locally advanced prostate cancer. TRUS biopsies of the prostate were performed. For pathology review and subsequent follow up with Mr Haynes. Transrectal prostatic biopsy, 29.12.16 - In summary prostatic adenocarcinoma of Gleason score 4+5=9 is present in a total of 6 out of the 12 cores and involves all 6 cores from the right**	

side of the prostate. The longest continuous length of tumour is 14 mm. Possible extracapsular extension is present and perineural invasion is seen. Overall tumour involves approximately 30% of the tissue submitted. Bone scan 31.01.17 - No evidence of bony metastatic disease. MRI 10.02.17 - Probable bulky right-sided prostate tumour with a wide capsular contact and early infiltration into the right seminal vesicle. A 7.5 mm right pelvic node is of indeterminate significance. rT3b N0 (but indeterminate 7mm right pelvic node) M0. Discussed at Urology MDM 02.03.17. [redacted] Personal Information redacted by the USI has a high risk locally advanced, non metastatic prostate cancer. Mr Haynes to review in outpatients, commence androgen deprivation therapy, arrange a CT Chest and refer for EBRT. Personal Information redacted by the USI is on ADT for a high risk prostate cancer and has been referred for consideration of radiotherapy. A CT chest was arranged which has shown multiple lung nodules for Radiology review / oncology discussion (had oncology OPA 17th May).

	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 M YOUNG **Diagnosis:** Prostate cancer **Stage:** **Reason for Discussion:** MRI **Target Date**	**CONSULTANT MR YOUNG:** [redacted] **year old gentle man with low risk, organ confined prostate cancer. His MRI showed some abnormalities in the kidneys felt to represent either parapelvic cysts or PUJ obstruction. At review** Personal Information redacted by the USI **has a rising PSA despite the active surveillance; Feb 2016 - 4.6 ng/ml, Feb 2017 - 9.7ng/ml.** [redacted] Personal Information redacted by the **is keen to change tact now from the active surveillance policy to a treatment plan. MRI 29/04/17 - No definite prostate tumour is identified.**	

	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	**CONSULTANT MR GLACKIN:** [redacted] **year old gentleman who was originally referred with bothersome lower urinary tract symptoms. He recently reported haematuria. An abnormality of the mucosa of the distal urethra was noted at flexible cystoscopy, there is a palpable mass in the distal urethra. The urethra mucosa is suspicious of tumour. His remaining urethra,**	

Diagnosis:	**Other**
Stage:	**pT3**
Reason for Discussion:	**PATH LYMPH NODE RESECTION**
Target Date	

prostate and bladder mucosa are normal. He has some bladder trabeculation secondary to outflow obstruction. Staging Ct was requested and has identified an enlarged right inguinal lympnode. Admitted on 15/7/2016 for cystoscopy and urethral biopsy and excision of right inguinal lymphnode. Part 1, Histology shows structures of a moderately differentiated squamous cell carcinoma. Part 2, Histology shows features of metastatic squamous cell carcinoma. Discussed at Regional MDM 27.10.16 - Pathology has reported penis/urethra squamous cell carcinoma. CT has shown bilateral groin nodes. Has results clinic arranged. For CT PET then re-discuss and consider bilateral nodal dissection. CT PET 18.11.16 - Solitary FDG avid left groin node. No evidence of FDG avid disease outside the pelvis CT Chest Abdo & Pel 29.03.17 - There is an enlarged left inguinal node measuring 1.8 cm in the short axis. No other suspicious mass lesion or lymphadenopathy. Discussed at Urology MDM 04.05.17. Personal Information redacted by the USI **has an enlarged left inguinal lymph node. Mr Glackin to recommend a left inguinal lymphadenectomy. Left inguinal lynph node,12.05.17 - Histology of the largest lymph node as well as one of two smaller lymph nodes (2 out of total 3 lymph nodes) shows features of metastatic squamous cell carcinoma.**

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:	
Stage:	
Reason for Discussion:	**PATH POST SURGERY**
Target Date	**28/05/2017**

CONSULTANT MR GLACKIN: This [redacted] **year old gentleman had visible haematuria occurring intermittently x 6-7 months. He does not describe any dysuria. Past medical history of type II diabetes and hypertension. His CT urogram showed a 3.5cm tumour on the left side of his bladder. There is some dilatation of the left ureter. His EGFR was greater than 60 on 1st March 2017. Flexible cystoscopy confirmed that there is a necrotic papillary tumour overlying the region of the left ureteric orifice. The remainder of the bladder is clear.** Personal Information redacted by the USI **had his bladder tumour resected. His left UO was involved. The tissue was sent for histology.** [redacted] Personal Information redacted by the **will recover on the ward over the weekend. If his urine is clear he will have Mitomycin C. His histology results will be reviewed at the MDT. 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	**MR J P O'DONOGHUE**
Diagnosis:	**Prostate cancer**
Stage:	
Reason for Discussion:	**PATH TRUSB**
Target Date	

CONSULTANT MR O'DONOGHUE: This [redacted] year old man who had a PSA of 6.26 in September 2015, on 29th September it was 5.19 and on 26th October it was 6.12. He has no storage type symptoms. On digital rectal examination he had a 30-40 gram prostate with nodules on the right and left lobe. Transrectal prostatic biopsy, 02.11.15 - Histological examination shows prostate adenocarcinoma, Gleason 3+4 involving 7 of 12 cores, (3 right and 4 left). The vast majority of the tumour is pattern 3 but focally there is sufficient fusion to warrant designation as pattern 4. Tumour occupies a total of approximately 4% of the examined material while the longest length of confluent tumour is 3.5 mm. No definite perineural invasion has been identified and there is no lymphovascular invasion or evidence of extracapsular extension. Discussed at Urology MDM 12.11.15. Personal Information redacted by the USI' prostate biopsies have shown intermediate risk prostate cancer. For outpatient review with Mr O'Donoghue to arrange an MRI and subsequent MDM discussion. MRI, 04.01.16 - No definite significiant prostate tumour is identified. No pelvic or peri-aortic lymphadenopathy. No bone metastasis is seen in the visualised skeleton. The appearances are of organ confined disease. Discussed at Urology MDM 14.01.16. For review with Mr O'Donoghue to advise treatment with curative intent. Personal Information redacted by the USI i has remained under active surveillance for his organ confined prostate cancer. His most recent MRI of prostate in January 2017 showed no radiological evidence to suggest disease progression. His most recent PSA on 3rd May 2017 was 7.43 and in January 2017 it was 6.48. His prostate volume measured 19cc. Transrectal prostatic biopsy, 15.05.17 - Prostatic adenocarcinoma is present in 9 of 14 cores (predominantly left lobe). The vast majority of the tumour is Gleason pattern 3 but focally there is sufficient fusion (Part 3-right apex) and to warrant designation as pattern 4. The Gleason score is therefore 3+4 =7. The longest confluent length of tumour is 2.8 mm and overall tumour occupies approximately 8% of the examined material. There is perineural invasion but no lymphovascular invasion. Tumour is seen extremely close to adipose tissue but definite extracapsular extension has not been identified.

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 T JACOB**
Diagnosis:	**TCC Bladder pTa Grade 2**
Stage:	
Reason for Discussion:	**PATH POST SURGERY**
Target Date	

CONSULTANT MR JACOB: This [redacted] year old lady in her past history has had bilateral lung transplants for interstitial fibrosis in 2005. She was initially diagnosed with pTa G2 bladder TCC in Birmingham in 2013 and has had 1 or 2 recurrences since. Most recent flexible cystoscopic surveillance bladder tumour check picked up a couple of small areas of recurrence which we have biopsied using the cold cut biopsy forceps and the bases have been diathermised. Bladder biopsies, 10.05.17 - Urothelial (transitional cell) carcinoma. Papillary. WHO 1973 - Grade II. WHO/ISUP: 2004 - low grade. pTa - non-invasive papillary tumour. Lymphovascular invasion - absent. CIS - Absent.

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:	**CT BONE SCAN**
Target Date	**24/05/2017**

CONSULTANT MR O'DONOGHUE: [redacted] year old gentleman who was referred with a PSA of 29.24ng/ml. He describes lower urinary tract symptoms with increased frequency, some urgency, incomplete emptying, hesitancy and terminal dribbling but denies haematuria or urinary tract infections. He has a baseline renal function of EGFR of 39. On PR he has a firm right lobe of prostate. Bone scan, 04.05.17 - No evidence of bony metastatic disease. CT Chest Abdo & Pel 09.05.17 - No CT evidence of metastatic malignancy.

Clinical Summary / MDM Update **Notes**

Personal Information redacted by the USI

Sex:	**Female**
DOB:	Personal Information redacted by the USI
Age:	**61**
Hospital Number:	Personal Information redacted by the USI
HCN:	Personal Information redacted by the USI
Consultant	**MR M YOUNG**
Diagnosis:	**TCC Bladder pTa Grade 2**
Stage:	
Reason for Discussion:	**PATH POST SURGERY**
Target Date	

CONSULTANT MR YOUNG: [redacted] year old lady with incidental finding of mass within her bladder. Cystoscopy and TURBT 09/05/2017 1.5cm papillary lesion overlying right UO. Complete resection and post-operative single dose Mitomycin C. For discussion with histopathology. TURBT, 09.05.17 - Histological examination shows material derived from a grade 2 (low-grade) transitional cell carcinoma. There is no invasion into the underlying lamina propria (pTa). Fragments containing relatively thick muscle bundles with intervening fibrous tissue are present and these are felt to represent muscularis propria from around the ureteric orifice. These muscle fibres are not involved by tumour.

Stinson, Emma M

From: Trouton, Heather
Sent: 20 June 2017 13:12
To: Williams, Marc; Gracey, David; Hogan, Martina; Newell, Denise E; McConville, Richard
Subject: RE: discrepancy

Marc

Thanks for raising. You will be aware of the one to one work that David has done with the Clinical Director of Irrelevant Information and the undertaking that he has given to allocate his 2 most senior Urology experienced radiologists to our scans .

However , as already suggested and to eradicate the need for any MRI prostate examinations to be sent to Irrelevant Information Redacted, I would ask that you work with David and Martina to review your job plan to enable you report on the relatively small number required each week in house and in core time. This may make as you say , a huge difference to patient management and local patient care and of course the MDT.

Heather

From: Williams, Marc
Sent: 15 June 2017 10:59
To: Trouton, Heather; McConville, Richard; Gracey, David; Hogan, Martina; Newell, Denise E
Subject: discrepancy

Personal Information redacted by the USI
MRI prostate 31/3/17
Suspicious left perirectal node. Ax T1 22/40, sag T2 22/30. In the context of locally advanced ca prostate.
Not reported.

2 explanations: Irrelevant Information consistently don't give the examination adequate time to report it properly or they don't know what they are doing.

These things actually matter to the patient and to the MDT. They make a huge difference to patient management and the rate of serious discrepancies is **appalling.**

Stinson, Emma M

From: Trouton, Heather [redacted]
Sent: 25 September 2017 11:57
To: Tariq, S; Gracey, David
Cc: Reddick, Fiona
Subject: FW: Urology MDT documents for Peer Review Self-assessment
Attachments: image001.jpg; image002.png

Dr Tariq and David

Can you please see below?

It would be my view that we need to review the rota to see if Marc can be released to cover the MDT as this is essential.

What do you think?

Heather

-----Original Message-----
From: Reddick, Fiona
Sent: 25 September 2017 08:46
To: Trouton, Heather
Cc: Glenny, Sharon
Subject: Fw: Urology MDT documents for Peer Review Self-assessment

Heather,

Can we discuss the below email at our 1:1 later.

Regards

Fiona

Sent from my BlackBerry 10 smartphone.
Original Message
From: Glackin, Anthony [redacted]
Sent: Friday, 22 September 2017 14:57
To: Convery, Rory; Reddick, Fiona
Cc: Corrigan, Martina; Haynes, Mark
Subject: FW: Urology MDT documents for Peer Review Self-assessment

Dear Rory and Fiona,
We are now in the position with no radiologist to attend the Urology MDT until the 9th November. This is an untenable position and if we cannot obtain cover then we may need to suspend the MDT. I am available today and next week to discuss in person.

Kind regards

Tony

Anthony J Glackin MD FRCSI(Urol)
Consultant Urologist
SHSCT

Secretary: Elizabeth Troughton Personal Information redacted by the USI

-----Original Message-----
From: Williams, Marc
Sent: 22 September 2017 13:29
To: McVeigh, Shauna; Glackin, Anthony
Subject: Re: Urology MDT documents for Peer Review Self-assessment

Dear Tony and Shauna
I cannot make the MDT and the AGM on 26 October as I have to cover CT on the afternoon of Wednesday 25th October and I therefore have no prep time. I need 3-4 hours for MDT prep and there is no other time I can fit it in.
Because of general enquiries similarly taking up the MDT prep time I will not be there on 28 September, 5 October, and 19th October. I am on leave on 12th October and the 2nd November. I won't therefore be at MDT until 9th November. I appreciate this leaves you in dire straights (?) but it's not my doing. I cover what I am told to. Without general enquiries or the need to cover CT, I would be there every week except when I am on leave. On a positive note, if I leave, you presumably wouldn't have any radiology cover at all and this is always a possibility given how things are in radiology at the moment.
Marc

> On 22 Sep 2017, at 12:07, McVeigh, Shauna Personal Information redacted by the USI wrote:
>
> Hi
>
> Please see below email.
>
> Thanks
>
> Shauna
>
> From: Haughey, Mary
> Sent: 22 September 2017 08:23
> To: McVeigh, Shauna
> Cc: Glackin, Anthony
> Subject: FW: Urology MDT documents for Peer Review Self-assessment
> Importance: High
>
> Good morning Shauna
> Tony asked if you could circulate the attached Urology MDT documents, which have been prepared for the peer review self-assessment process, to the Urology MDT members please?
> The documents are as follows:

>
> 1. Urology self-assessment report
> 2. Urology self-assessment matrix
> 3. Urology MDT Operational Policy
> 4. Urology MDT Annual Report 2016
> 5. Urology MDT Workplan 2016/17
> The documents will be uploaded on Friday 29th September 2017.
> Many thanks
>
> Regards
>
> Mary
>
> Mary Haughey
> Macmillan Cancer Service Improvement Lead
> [Description: Description: SHSCTmainlogo] Craigavon Area Hospital
> Tel: Personal Information redacted by the USI; Mob: Personal Information redacted by the USI
> Internal Ext: Personal Information redacted by the USI (Note: if dialling from the old system please dial
> Personal Information redacted by in front of the extension) [cid:image001.png@01D2892B.9D88C130]
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> <image001.jpg>
> <image002.png>
> <Self Assessment Peer Review Report Sept2017.pdf> <Urology
> Self-Assessment matrix 2016.xml> <Urology Cancer MDT Operational
> Policy Final May2017.pdf> <Urology MDT Annual Report 2016 .pdf>
> <Southern Urology MDT Workplan 2016-17.pdf>

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 22 November 2017 15:50
To: Tariq, S
Subject: RE: Meeting you

I will try but I am covering acute CT. I think it would be worth chatting with Ronan Carroll about the breast service before if you have not previously had the opportunity.

I had an informal chat with Mark Haynes today regarding MRI. Tony Glackin is the Urology MDT lead who's opinion may also be worth considering.

David

From: Tariq, S
Sent: 22 November 2017 15:48
To: Gracey, David; Trouton, Heather
Subject: Meeting you

David I am meeting Linda at 12 tomorrow to review her job plan. Are you coming to that meeting? Can three of us meet afterwards between 1 and 330 to discuss few things that have come up.

Shahid

Stinson, Emma M

From: Trouton, Heather [redacted]
Sent: 06 February 2018 17:16
To: Tariq, S; Yousuf, Imran; Gracey, David
Subject: Urology radiology

Dear All

At the regional Cancer performance meeting yesterday , we were asked again regarding any plans to address the single handed Urology radiologist that often causes understandable delays in the urology cancer pathway from a diagnostics perspective.

I advised that when we were able to recruit to increase the team as a whole we planned to train someone in Urology.

Can we please look at that again? This is raised at every cancer meeting and I think we will need to be seen to take some tangible action.

What do you think?

Heather

Mrs Heather Trouton
Interim Executive Director of Nursing, Midwives and AHP's
Assistant Director Of Acute Services - Cancer and Clinical Services
Southern Health and Social Care Trust
TEL: [redacted]
Mobile: [redacted]
Email: [redacted]

Internal with new AVAYA phone: [redacted]
Internal with old Legacy Phone: [redacted]

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 21 February 2017 16:30
To: OConnor, Josephine
Cc: Robinson, Jeanette
Subject: RE:

No.

This needs to be communicated to the referrers and discussed with urology first.

I will discuss with urology.

From: OConnor, Josephine
Sent: 21 February 2017 16:25
To: Gracey, David
Cc: Robinson, Jeanette
Subject: FW:

Before I implement this change can your run your eye over it and approve please. see emails from Marc below

I will tell the sonographers to "NO APPROVAL" requests for US for Gross Haematuria and say 'Ultrasound is not the investigation of choice for macroscopic haematuria. A urology referral is recommended'.

I will get the Approval Guidelines and Protocols updated.
Will take a while to feed into the system as loads are probably already appointed and approved.

Josephine

Josephine O'Connor
Principal Lead Sonographer
Southern Trust
Craigavon Area Hospital
[redacted]

From: OConnor, Josephine
Sent: 15 February 2017 14:49
To: Williams, Marc
Subject: RE:

Perfect for GP referrals , what about ward and outpatient referrals? Can't really tell them urology referral

Josephine O'Connor
Principal Lead Sonographer
Southern Trust
Craigavon Area Hospital
[redacted]

From: Williams, Marc
Sent: 15 February 2017 14:29
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This should prevent any requests for CTU from GPs.

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Can GP's request CT urogram or do we need to tell GPs to refer to Urology?

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Personal Information redacted by the USI

From: Williams, Marc
Sent: 15 February 2017 13:25
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Subject:

Josephine

In an effort to provide some improvement to our service which is currently a free for all I would suggest the following:

Adult patients with gross haematuria do not require ultrasound. The investigation that is needed is a CT urogram (via a urology referral) which many patients get anyway.

An example is Personal Information redacted by the USI: the patient had an US then a CT which is not good practice. The GP should not have referred the patient for it and we should not have done it.

In some instances, there is a question about bladder emptying in patients with haematuria and ultrasound is fine for this purpose but as a first line investigation for gross haematuria in an adult, it is not needed.

I am happy for you to write this into your protocols.

We can deal with renal calculi and microscopic haematuria another time if you should do wish (?) as this is more of a grey area.

Marc

Stinson, Emma M

From: Williams, Marc [redacted]
Sent: 21 February 2017 19:02
To: Gracey, David; Haynes, Mark
Cc: Robinson, Jeanette; OConnor, Josephine; Trouton, Heather; Hogan, Martina; Barron, Caroline
Subject: RE: Macroscopic haematuria

David

You will notice that GPs send patients with macroscopic haematuria for US and refer to urology at the same time. The urologists then request CT urography. I admit that some patients are at lower risk but age in itself is not the discriminator. Perhaps if you add all in all the various risk factors for TCC you could stratify a real low risk group but is there any evidence for this approach? NICE guidelines are just that and are regularly wrong (the unprovoked DVT pathway for example). So in my view, patients with macroscopic haematuria of any age (not associated with UTI) require the most definitive investigation we have. The urologists regularly refer patients in this age group.

GPs should not have direct access to CT urography for so many reasons. The service will be abused and I find the reports result in endless calls for interpretations. Furthermore, would a GP know how to interpret a negative test and what needs to be done? (no).

That's my view point and I don't mind what is implemented. I well appreciate that I have no real decision making ability and never have had.

Marc

From: Gracey, David
Sent: 21 February 2017 17:55
To: Williams, Marc; Haynes, Mark
Cc: Robinson, Jeanette; OConnor, Josephine; Trouton, Heather; Hogan, Martina; Barron, Caroline
Subject: Macroscopic haematuria

Marc

Thanks for your input. Have the changes been discussed with urology as this will undoubtedly significantly increase their number of Red Flag referrals? Do we have an idea of how many referrals we receive per month which will instead be redirected to urology? My understanding is that there is still a role for US in the younger lower risk group (NICE Guidance 12, 2015 – cancer pathway if over 45 yrs with macroscopic haematuria without UTI, or persistent or recurrent haematuria post UTI treatment). Would we still accept urgent ultrasound requests for the lower risk group or should these also be first assessed by urology?

If agreed with urology can we disseminate to the GPs prior to implementing please. Denise has contact details for the practice managers. There is currently no GP AMD whom I am aware off, but I will see what other avenues are available for dissemination.

In the longer term is there a role for direct GP access for CT urograms, under strict guidelines?

Thanks

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We can deal with renal calculi and microscopic haematuria another time if you should do wish (?) as this is more of a grey area.

Marc

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 21 February 2017 17:59
To: Barron, Caroline
Subject: FW: Macroscopic haematuria

Caroline

Have the Trust committed to NG12?

Thanks

David

From: Gracey, David
Sent: 21 February 2017 17:55
To: Williams, Marc; Haynes, Mark
Cc: Robinson, Jeanette; OConnor, Josephine; Trouton, Heather; Hogan, Martina; Barron, Caroline
Subject: Macroscopic haematuria

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Marc

Stinson, Emma M

From: Young, Michael [redacted]
Sent: 22 November 2017 11:40
To: Gracey, David; Hampton, Gareth; Tyson, Matthew
Cc: Corrigan, Martina
Subject: FW: renal colic pathway version 3

I believe Gareth is discussing this at A/E meeting today
I appreciate other Radiologists view.
I don't think we are too far away from an agreed pathway.
The NICE guidance I believe is for GPs so a quicker turn around in A/E would be better.
Whether it is 16 or 18 yr for the 'child' pathway is up for discussion - I personally still think this will end up as a discussion / assessment between A/E and urology before a scan is done, but radiology will have to agree to the choice of scan the clinicians involved are requesting, as the patient is in front of them and there are often finer nuances on clinical examination that are not put on the xray form.
We are discussing all of this at our Urology dept meeting tomorrow as well, so there is a clear focus on this topic at present. I'm hoping for this to be signed off by 1.12.17 !!!

MY

From: Tyson, Matthew
Sent: 20 November 2017 14:05
To: Young, Michael
Subject: RE: renal colic pathway version 3

Afternoon

Following a review of the comments below,

a. Pathway was devised to relate to up to date recommendations (see Dr Gracey email 17Nov/17… i Refer8)
b. The NICE guidelines commented on are for general practice. They do not relate to a patient in A+E, or risk stratify once on presentation, such as infection, renal function.
c. For stones identified on CT and to be referred to stone MDT (and not admitted) an x-ray KUB (if NOT clearly seen on CT scout film) would be useful for follow-up
d. Comment re. uss for <18 years, this would be against recommendations, but we could change to <18years have an USS, then review in 1 year all those needing an USS.. how many went on to have a CT?

From: Young, Michael
Sent: 17 November 2017 17:31
To: Gracey, David
Cc: Hampton, Gareth; Tyson, Matthew
Subject: RE: renal colic pathway version 3

1/ The pathway is advice to A/e staff on how to best investigate patients with suspected urinary tract stones no matter what their age.
2/ Timing of scan has only been noted in specific areas which are very important ie single kidney AKI and infection
3/ to date other patients, which covers those in the below noted categories, I understand have returned to A/E the following day for their CT. I thought this was an agreed protocol? – whether it is the next day to two is fine by me however …..

4/ however a point for A/E out of this will be that a referral to the STC will not be accepted until there is a proven stone.
5/ This pathway is for A/E to follow – I don't quite understand the comparison of the ages given below. This pathway as stated is if the A/E staff regard the patient as having a urinary tract stone then this is the path to take.
6/ I would think 'local policy' should prevail on this one.

7/ a further slight addition I would put in to this pathway would be – if CT KUB does define a stone then a plain abdominal film should be taken immediately after the CT' (The reason is how do we follow up the pts stone passage?)
MY

From: Gracey, David
Sent: 17 November 2017 14:34
To: Young, Michael
Subject: FW: renal colic pathway version 3

Further comments. You may wish to discuss at the urology MDT.

From: Williams, Marc
Sent: 17 November 2017 14:31
To: McConville, Richard
Cc: Gracey, David; Carson, Anne; Conlan, Enda; James, Barry; Johnston, Dr Linda; Khan, Sana; McGarry, Philip; McKeown, Ciara; Milligan, Aaron; McSherry, Pauleen; Porter, Simon; Rice, Paul; Yarr, Dr Julie; Yousuf, Imran
Subject: Re: renal colic pathway version 3

This pathway doesn't allow junior staff in particular to assess the pre test probability of a patient having a calculus ie a 50 year old with loin pain and visible haematuria vs a 20 year old female with no haematuria. I won't be agreeing to scan children (<18) with CT.
I said this at directorate. I do not agree with the pathway.

On 17 Nov 2017, at 10:51, McConville, Richard [redacted] wrote:

> If the patient becomes pain free with analgesia, what is the time frame for imaging with ctkub? From the nice guidance, within 7 days would seem reasonable.
>
> If the person has become asymptomatic or pain is controlled with simple analgesics, arrange urgent hospital referral so that diagnostic investigations (such as non-contrast helical computed tomography) can be done to confirm the diagnosis and to assess the likelihood of spontaneous stone passage.
> ◦This should usually be done within 7 days of the onset of symptoms, or depending on local policy.
>
> ---
>
> **From:** Gracey, David
> **Sent:** 17 November 2017 10:31
> **To:** Carson, Anne; Conlan, Enda; Gracey, David; James, Barry; Johnston, Dr Linda; Khan, Sana; McConville, Richard; McGarry, Philip; McKeown, Ciara; Milligan, Aaron; McSherry, Pauleen; Porter, Simon; Rice, Paul; Williams, Marc; Yarr, Dr Julie; Yousuf, Imran
> **Subject:** FW: renal colic pathway version 3
>
> Revisions following discussion at prior Division meeting.
>
> Imaging is in keeping with iRefer 8. Any further comments/suggestions?
>
> ---
>
> **From:** Young, Michael
> **Sent:** 16 November 2017 12:25

To: Hampton, Gareth; Gracey, David
Subject: FW: renal colic pathway version 3

Gareth and David

We've had further thoughts on the ureteric stone investigation and colic pathway. Its more streamlined yet contains all the information we had before.

Are you content the way this is now?

MY

From: Tyson, Matthew
Sent: 16 November 2017 10:55
To: Young, Michael
Subject: FW: renal colic pathway version 3

From: Tyson, Matthew
Sent: 16 November 2017 10:54
To: McAuley, Laura
Subject: renal colic pathway version 3

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 23 February 2017 16:42
To: OConnor, Josephine
Subject: RE:

Could we get an idea of how many referrals from GPs for the last 2 to 3 months?

Thanks

David

From: OConnor, Josephine
Sent: 21 February 2017 16:25
To: Gracey, David
Cc: Robinson, Jeanette
Subject: FW:

Before I implement this change can your run your eye over it and approve please. see emails from Marc below

I will tell the sonographers to "NO APPROVAL" requests for US for Gross Haematuria and say 'Ultrasound is not the investigation of choice for macroscopic haematuria. A urology referral is recommended'.

I will get the Approval Guidelines and Protocols updated.
Will take a while to feed into the system as loads are probably already appointed and approved.

Josephine

Josephine O'Connor
Principal Lead Sonographer
Southern Trust
Craigavon Area Hospital
[redacted]

From: OConnor, Josephine
Sent: 15 February 2017 14:49
To: Williams, Marc
Subject: RE:

Perfect for GP referrals , what about ward and outpatient referrals? Can't really tell them urology referral

Josephine O'Connor
Principal Lead Sonographer
Southern Trust
Craigavon Area Hospital
[redacted]

From: Williams, Marc
Sent: 15 February 2017 14:29
To: OConnor, Josephine
Subject: RE:

Patients with macroscopic haematuria should be on a red flag referral pathway. Any imaging is requested by the urologists.
It may be worthwhile therefore making your comment something like:

'Ultrasound is not the investigation of choice for macroscopic haematuria. A urology referral is recommended'.

This should prevent any requests for CTU from GPs.

Marc

From: OConnor, Josephine
Sent: 15 February 2017 14:25
To: Williams, Marc
Subject: RE:

Happy with that Marc will get the Approval Guidelines and Protocols updated and implemented.
Will take a while to feed into the system as loads are probably already appointed and approved.

I will tell the sonographers to "NO APPROVAL" them and say "Ultrasound not indicated for Gross Haematuria, CT urogram required examination"

Can GP's request CT urogram or do we need to tell GPs to refer to Urology?

Josephine

Josephine O'Connor
Principal Lead Sonographer
Southern Trust
Craigavon Area Hospital
Personal Information redacted by the USI

From: Williams, Marc
Sent: 15 February 2017 13:25
To: OConnor, Josephine
Subject:

Josephine

In an effort to provide some improvement to our service which is currently a free for all I would suggest the following:

Adult patients with gross haematuria do not require ultrasound. The investigation that is needed is a CT urogram (via a urology referral) which many patients get anyway.

An example is Personal Information redacted by the USI: the patient had an US then a CT which is not good practice. The GP should not have referred the patient for it and we should not have done it.

In some instances, there is a question about bladder emptying in patients with haematuria and ultrasound is fine for this purpose but as a first line investigation for gross haematuria in an adult, it is not needed.

I am happy for you to write this into your protocols.

We can deal with renal calculi and microscopic haematuria another time if you should do wish (?) as this is more of a grey area.

Marc