	Date	Clinical Notes
→	12/03/19	WR [redacted]
Age	09:15	
URINE Protein		
Sugar		
Acetone		Pt feels well - sitting out
WEIGHT		~40ml serous fluid in drain.
kg.		Has been walking around ward
		Plan
→		→ Remove drain today.
Age		→ Re-commence warfarin - 4mg daily as per pt.
URINE Protein		→ continue clexane until INR in
Sugar		
Acetone		range.
WEIGHT		→ (FU) once INR in range
kg.		
		[redacted]
		FU.
→		
Age	12/3/19	[redacted]
URINE Protein		Hb 95 · CRP 52
Sugar		Plt 291
Acetone		WCC 8·96 INR 1·0
WEIGHT		U+E Na 137
kg.		K 4·6
		Cl 97
		urea 4·7
		SCr 120
		eGfr 50.
→		
Age	13/03/19	WR [redacted]
URINE Protein		
Sugar		
Acetone		Pt Feels well at present
WEIGHT		No new issues
kg.	Plan	
	1)	FU INR, liase with consultant to see if can be managed
	2)	FU

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

[redacted]

NOTES

When used for in-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		
Age		[redacted]
URINE Protein		
Sugar		
Acetone		FBP
WEIGHT		Hb: 97
kg.		WCC: 16.7 (8.96)
		Plt: 361
		CRP: 57.78
→		U+E
Age		Na 134
URINE Protein		K+: 4.8
Sugar		creat 123
Acetone		eGFR 49
WEIGHT		
kg.		
→	13/03/19	[redacted]
Age		Retrospective note
URINE Protein		- Temp Spike @ 12.00
Sugar		
Acetone	News: 2	- Pt otherwise well
WEIGHT		- Denies infective symptoms
kg.		
		SN7
	Plan	1) CXR ☐, MSSU ☐
		2) C/O Tazocin 4.5g TDS

	Date	Clinical Notes
→		
Age		[redacted]
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.	14/3/19	CXR. [redacted]
	09.45	
		post nephrectomy
→		- temp spike last night none since
Age	NEWS 0	- pt. not at bedside
URINE Protein	apyrexic	
Sugar		
Acetone	since 12 oclock	plan - CT abdomen + pelvis
WEIGHT		- D/W micro
kg.		- referral to MPT
		[redacted]
→		
Age	14/03/19.	[redacted]
URINE Protein	16:50.	
Sugar		
Acetone		CRP 179.
WEIGHT		INR 1.2. Na 134 K+ 4.5.
kg.		Hb 87 (97) Cl 99
		Plt 346 urea 6.1
		WCC 12.8 scr 138
		eGFR 42.
→		Phone call received from microbiology who advised 3 different bacteria have grown from blood cultures - significance will be known tomorrow. They advised: → continue Tazocin. → if deteriorates add gentamicin. → Re-contact tomorrow.
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		
		[redacted]

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Personal Information redacted by the USI

[redacted]

NOTES

When used for in-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→	29/03/19	CAOBUD - MR O'BRIEN
Age		
URINE Protein		VERY WELL
Sugar		
Acetone		PLAN
WEIGHT		
kg.		
		• CT - CAP IN JUNE '19
→		• REVIEW JULY 2019
Age		Personal Information redacted by USI
URINE Protein		[redacted]
Sugar		
Acetone		
WEIGHT		
kg.		
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Personal Information redacted by the USI

NOTES

When used for in-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→	30/10/19	Personal Information redacted by the USI
Age	hoo	
URINE Protein		Telephone call from Nicole
Sugar		Pharmist ? reason for change from
Acetone		apixaban to edoxaban.
WEIGHT		
kg.		
	–	Notes retrieved
	–	changed in ALL on admission
→	–	Notes retrieved from clinic letter
Age		from Dr Personal Information redacted by the USI no mention
URINE Protein		of edoxaban
Sugar		
Acetone	–	renal function now @ baseline.
WEIGHT		
kg.	–	Diuresed well, asked switch back
		to apixaban.
		Personal Information redacted by USI
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		

LPC 03/08/021

WPH000134

	Date	Clinical Notes
→	31/10/19	WR [redacted]
Age	09:55	– Hx noted. Admitted from clinic with
URINE Protein		AKI / ↓Hb.
Sugar		– Renal function back to baseline; egfr = 41(55)
Acetone		furosemide / irbesartan withheld.
WEIGHT		– Note ECHO reviews. Denies SOB. Minimal
kg.		peripheral leg oedema.
		– Hb = 94 ↔. Vit B12/folate (N).
→		Iron (N).
Age		
URINE Protein		
Sugar		
Acetone		MS 1 + 11 + 0.
WEIGHT		[redacted]
kg.		
		Plan/ – Stop furosemide; aware to see GP
→		if ↑SOB / leg swelling.
		– Restart irbesartan @ 150mg
Age		OD + GP to monitor BP.
URINE Protein		– Continue apixaban as per
Sugar		pre-admission
Acetone		– No need for USS kidneys as
WEIGHT		renal function recovered
kg.		[redacted]
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by the USI
E mail: Personal Information redacted by the USI
Secretary: Mrs N. Elliott

Personal Information redacted by USI

Dear DR [redacted]

Re: Patient Name: Personal Information redacted by USI
D.O.B.:
Address:
Hospital No:

I last wrote to you regarding this Personal Information year old man who had an open right radical nephrectomy performed earlier that month for renal cell carcinoma infiltrative of his right renal vein. I arranged for him to have a further CT scan of his chest, abdomen and pelvis performed on the 17th of June 2019 when there was no definitive evidence of any disease recurrence or progression.

I am aware that you more recently referred Personal Information redac to the Department of Cardiology at Craigavon Area Hospital as he had become increasingly dyspnoeic and fatigued. He was found to be quite anaemic with a haemoglobin of 80g/L and his global renal function had also deteriorated somewhat, his glomerular filtration rate having decreased to 35mls/min. I am aware that he was admitted to the Department of Cardiology following consultation with Dr [redacted], Consultant Cardiologist. Nephrotoxic medication was withheld. He was hydrated intravenously. Irbesartan was reintroduced at 75mgs daily upon his discharge on the 31st of October 2019, but I gather that the daily dose of Irbesartan has since been increased to 150mgs daily due to worsening hypertension.

I have had the opportunity of speaking with his daughter by telephone, she advising that her father was keeping somewhat better than he had been in recent months. I am aware that he has been prescribed Ferrous Fumarate. However, in addition, I do believe that he would benefit from being prescribed Folic Acid 5mgs to be taken once daily for a period of 3 months, particularly as he was found to be folic deficient in October 2019, and presumably still remains anaemic. Therefore, I would be grateful if you would issue a prescription for Folic Acid 5mgs to be taken once daily for a period of 3 months, and I have asked Personal Information redac to collect a prescription from your practice.

I have requested the Department of Radiology at South Tyrone Hospital to arrange a further appointment for Personal Information redac to have CT scanning of his chest,

Personal Information redacted by the USI

Southern Health and Social Care Trust

28/10/19

CHART LJB

Personal Information redacted by USI

[redacted]

Dear colleague.

I saw this man today. He had (R) nephrectomy for renal cell carcinoma earlier this year. Hb ~~was~~ has fallen to 80 and renal function has deteriorated - eGFR falling. I have advised stopping apixaban and renal toxic agents [IRBESARTAN, FRUSEMIDE.

Impression 1) dehydration, ~~was~~
2) deterioration in renal function
3) Blood loss →

Personal Information redacted by the USI

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

CARDIOLOGY DEPARTMENT
Craigavon Area Hospital
Lurgan Road
Portadown, Co Armagh,
BT63 5QQ
Secretary: Personal Information redacted by the USI
Telephone:
Consultant:

30/10/19

Personal Information redacted by the USI

Dear Personal Information redacted by the USI

Re: Patient Name: Personal Information redacted by USI
D.O.B.:
Address:
Hospital No: Personal Information redacted by USI **H&C No:** Personal Information redacted by USI

I reviewed Personal Information redacted by USI who attended today with his daughter. He has had an eventful year with right nephrectomy carried out under Mr Aidan O'Brien for renal cell carcinoma in March 2019.

In terms of previous cardiology history I note that in 2014 he was noted to have atrial fibrillation. He was anticoagulated and had DC Conversions. An echocardiogram showed normal LV function. Left atrium was dilated. He reverted to atrial fibrillation. He has changed to NOAC (Apixaban 2.5mg bd) more recently.

Since the urological surgery he has reported low energy. His Hb prior to surgery was 132. It has fallen to variable levels but most recently it was around 80 which likely accounts for his fatigue. His iron indices were low with ferritin at 12 on 7th of October. Indices tending towards macrocytic. Also of concern he has a deterioration in renal function which was previously normal. Most recent renal function shows a EGFR of 35 22nd of October.

On examination he appears pale and clinically dehydrated. Pulse 90 irregular. BP 110/70. Two heart sounds and no murmurs. Chest was clear.

ECG showed atrial fibrillation with control of ventricular response.

I reviewed his medications which include Apixaban, Irbesartan and Furosemide.

I note that a BNP is elevated on recent measurements. His previous echo showed normal LV function.

There are multiple medical issues on-going including dehydration, anaemia, deteriorating renal function and possible new onset heart failure. In the circumstances I felt the safest thing to do was to admit for work up. He may require transfusion and IV fluids. I have indicated that he should discontinue Apixaban and nephrotoxic ie: Furosemide and Irbesartan for the interim.

If his renal function does not recover he may need to change to Warfarin in view of his age.

[redacted]
Irrelevant information redacted by the USI

Yours sincerely,

Dictated but not signed by

[redacted]
Consultant Cardiologist
Personal Information redacted by the USI

Date Dictated: 28/10/19	Date Typed: 30/10/19 ED

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by the USI
E mail: Personal Information redacted by the USI
Secretary: Mrs N. Elliott

Personal Information redacted by the USI

Dear DR Personal Information redacted by the

Re: Patient Name: Personal Information redacted by USI
D.O.B.:
Address:
Hospital No: Personal Information redacted by USI **HCN:** Personal Information redacted by USI

Date/Time of Clinic: 29/03/19	**Follow Up:** Review July 2019

I last wrote to you in February 2019 when I arranged for Personal Information redacted by USI to be admitted to our department on Wednesday the 6th of March 2019 when he underwent open right radical nephrectomy that day. His inpatient stay was prolonged by the development of a bacteraemia due to Enterobacter on the 13th of March 2019. After initial intravenous antibiotic therapy using Gentamycin and Tazocin, he was indeed fit for discharge on the 17th of March 2019 to remain on Ciprofloxacin for a further period of 1 week.

I reviewed Personal Information redacted by USI on the 29th of March 2019 when I was absolutely delighted to find him keeping so well. He has had a remarkable postoperative recovery for a man of his age. I was able to advise him that histopathological examination of the resected right kidney confirmed the presence of a large, clear cell, renal cell carcinoma measuring 11cms in diameter, invasive of the renal vein, but without any evidence of resection margin involvement. Such a large renal cell carcinoma with venous and lymphovascular infiltration much be accompanied by a significant risk of occult microscopic disease. To this end, I have requested a further CT scan of his chest, abdomen and pelvis to be performed during June 2019, and I hope to review him with the report in July 2019.

Yours sincerely

Dictated but not signed by

Personal Information redacted by USI

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 12/04/19	**Date Typed:** 17/04/19-NE

Personal Information redacted by the USI

CRAIGAVON CELLULAR PATHOLOGY

Surname [redacted] Source **CRAIGAVON AREA HOSPITAL**
Forename Consultant **MR A O'BRIEN**
Hosp. No.
DOB/Sex **Male** Ward/GP **WARD 1 WEST (ELECTIVE) CRAIGAVON AREA HOSPITAL**
Address BT70 1QS **68 LURGAN ROAD PORTADOWN BT63 5QQ**

1 5 MAR 2019

Specimen **KIDNEY RESECTION** [redacted]

CLINICAL DETAILS

Radical nephrectomy for renal tumour.

SPECIMEN – Right kidney.

PATHOLOGIST'S REPORT

GROSS DESCRIPTION

NATURE OF SPECIMEN:	Right radical nephrectomy.
ADRENAL GLAND:	Absent.
LYMPH NODES:	Absent.
IVC THROMBUS:	No
TUMOUR FOCALITY:	Large and unifocal.
TUMOUR DIMENSION:	110 mm.
TUMOUR EXTENT:	Grossly into major veins (present in proximal renal vein) – see comments
TUMOUR TYPE:	Clear cell renal cell carcinoma.
WHO/ISUP TUMOUR GRADE:	Predominantly Grade II with some Grade III.
SARCOMATOID MORPHOLOGY:	Not identified.

Reported by: [redacted]
Date of Specimen : 06 Mar 2019
Date of report print : 13 Mar 2019

Sample Number: **19K03651**

CRAIGAVON CELLULAR PATHOLOGY

Surname	Personal Information redacted by USI	Source	CRAIGAVON AREA HOSPITAL
Forename		Consultant	MR A O'BRIEN
Hosp. No.			
DOB/Sex	Male	Ward/GP	WARD 1 WEST (ELECTIVE)
Address		Personal Information redacted by USI	CRAIGAVON AREA HOSPITAL
			68 LURGAN ROAD
			PORTADOWN BT63 5QQ

Specimen **KIDNEY RESECTION**

RHABDOID MORPHOLOGY:	Not identified.
TUMOUR NECROSIS:	Not identified.
PERINEPHRIC FAT INVASION:	No.
INVASION BEYOND GEROTAS FASCIA:	No.
RIGHT RENAL SINUS INVASION:	Not identified.
TUMOUR PRESENT IN MAJOR VEINS:	Microscopically confirmed - see comments
LYMPHOVASCULAR INVASION:	Yes – intratumoural.
TUMOUR INVOLVES PELVICALYCEAL SYSTEM:	No.
RESECTION MARGIN STATUS:	Not involved.
CO-EXISTING PATHOLOGY IN NON-NEOPLASTIC KIDNEY:	None identified.
pTNM STAGE (UICC8):	pT3a – tumour extends into the renal vein.

Comments:
Gross examination showed a large tumour deposit bulging into the proximal renal vein corresponding to the appearances identified on MRI. Microscopic examination of this area confirms the tumour nodule though it is harder to appreciate this is renal vein

Reported by: Personal Information redacted by the USI
Date of Specimen : 06 Mar 2019
Date of report print : 13 Mar 2019
Sample Number: 19K03651

CRAIGAVON CELLULAR PATHOLOGY

Surname	Personal Information redacted by USI	Source	CRAIGAVON AREA HOSPITAL
Forename		Consultant	MR A O'BRIEN
Hosp. No.			
DOB/Sex	Male	Ward/GP	WARD 1 WEST (ELECTIVE)
Address		Personal Information redac	CRAIGAVON AREA HOSPITAL
			68 LURGAN ROAD
			PORTADOWN BT63 5QQ

Specimen **KIDNEY RESECTION**

involvement (Block B) but on balance it is felt to be proximal vein involvement in keeping with a pT3a tumour.

DIAGNOSIS
RIGHT KIDNEY
NEPHRECTOMY
CLEAR CELL RENAL CELL CARCINOMA

Electronically authorised by
Personal Information redacted by the USI
Date:- 13/03/19
Personal Information redacted by the USI

Reported by: Personal Information redacted by the USI
Date of Specimen : 06 Mar 2019
Date of report print : 13 Mar 2019
Sample Number: 19K03651

Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by the USI
E mail: Personal Information redacted by the USI
Secretary: Mrs N. Elliott

25/02/19

CONFIDENTIAL

Personal Information redacted by USI

HCN: Personal Information redacted by USI

Dear Personal Information redacted by USI

I was pleased to have the opportunity of reviewing you once again on 19th February 2019. I write to confirm that I have arranged for you to be admitted to our department, on Wednesday 6th March 2019 for right radical nephrectomy that day. You will receive formal notification of your admission before then. You will be expected to arrive at the Elective Admissions Ward, Ward 1 West, at 8am that day. I would be grateful if you would ensure that you arrive anytime after 7.30am and no later than 8am, just in case any further blood tests need to be performed prior to surgery. It is critically important that you do not have anything to eat or drink after midnight the night before.

I also write to confirm that I have advised that you continue to take Warfarin as usual up until and including Thursday 28th February 2019. You should not take any Warfarin thereafter. I have written to your family doctor, Personal Information redacted by the USI requesting that the Practice Nurse administer Enoxaparin subcutaneously, 60mg on Monday 4th March 2019 and 40mg on Tuesday 5th March 2019. I have also requested that the Practice Nurse repeat your INR on Tuesday 5th March 2019.

When you receive this letter, I would be grateful if you would contact Personal Information redacted by the USI to arrange those appointments with the Practice Nurse on Monday 4th March and Tuesday 5th March. I look forward to meeting you again following your forthcoming admission.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Personal Information redacted by USI

Personal Information redacted by the USI

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by the USI
E mail: Personal Information redacted by the USI
Secretary: Mrs N. Elliott

Personal Information redacted by the USI
CONSULTANT ANAETHETIST
CRAIGAVON AREA HOSPITAL

Dear Personal Information redacted by USI

Re: Patient Name: Personal Information redacted by USI
D.O.B.:
Address:
Hospital No: Personal Information redacted by USI **HCN:** Personal Information redacted by USI

I enclose a copy of a further letter addressed to the family doctor of this 88 year old man who's perioperative risk you recently assessed. Upon further review on 19th February 2019, it was evident that Personal Information redacted by the USI was particularly keen to proceed with surgery, even though he had a reasonable appreciation of the risks which accompany such significant surgical intervention in a man of his age. I have arranged for him to be admitted on Wednesday 6th March 2019 for open right radical nephrectomy.

I would be grateful if it were possible for a bed in Intensive Care or in the High Dependency Unit to be reserved for his immediate post-operative care.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated:	**Date Typed:** 25/02/19

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by the USI
E mail: Personal Information redacted by the USI
Secretary: Mrs N. Elliott

Personal Information redacted by the USI

Re: Patient Name: Personal Information redacted by USI
D.O.B.:
Address:
Hospital No: Personal Information redacted by USI HCN:

Date/Time of Clinic: 19/02/19	Follow Up: Admission 6th March 2019

I wrote to you in January 2019 when I arranged for Personal Information redacted by USI to have radioisotope renography performed on 5th February 2019, and when his right renal differential function was reported to be 37%. He then had MRI scanning of his inferior vena cava performed on 7th February 2019. Though it demonstrated that tumour had probably infiltrated along the right renal vein, it was reassuring to find that it had not reached the inferior vena cava.

Personal Information redacted by USI also had further echocardiography performed on 7th February 2019. The dominant finding was that his left atrium is severely dilated, and with a capacity of 92ml. It is disconcerting that there has been evidence of progressive left atrial dilatation, even though there has been evidence of only mild mitral regurgitation, normal left ventricular systolic function and no evidence of any aortic valvular stenosis. Apart from left atrial dilatation, there was no evidence of any other significant valvular or ventricular dysfunction.

Personal Information redacted by USI then attended for cardiopulmonary exercise testing on 8th February 2019, when it was not possible to proceed with testing due to arthritis in his right knee rather than because of the Personal Information redacted by the USI. In any case, Personal Information redacted by USI advised that right radical nephrectomy would be accompanied by significant risk of mortality of the order of 10 to 18%, and of morbidity of the order of 70 to 80%.

I reviewed Personal Information redacted by USI accompanied by his daughters, on 19th February 2019, when they had concluded that he was not going to be offered any prospect of surgical intervention. They had interpreted the calculated risk of mortality and morbidity as absolutely contraindicating surgical intervention. I advised that it was possible to proceed with right radical nephrectomy, though I also did

Personal Information redacted by the USI

emphasize the risks that accompanied surgery. [redacted] was particularly keen to proceed with surgery. It was evident that this was his overriding preference. His dominant concern was that surgery could be complicated by some severely disabling complications such as cerebral infarction. His daughters were also relieved to learn that surgical intervention remained a prospect.

I have therefore arranged for [redacted] to be admitted to our department on Wednesday 6th March 2019 for open right radical nephrectomy. I have advised [redacted] not to take any Warfarin after Thursday 28th February 2019. I would be grateful if your practice nurse would administer Enoxaparin 60mg subcutaneously on Monday 4th March 2019 and Enoxaparin 40mg subcutaneously on Tuesday 5th March 2019. I would also be grateful if she could repeat his INR on Tuesday 5th March 2019. I would be grateful and am appreciative of your assistance in this regard.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

CC. DR RAYMOND MCKEE
CONSULTANT ANAETHETIST
CRAIGAVON AREA HOSPITAL

Date Dictated: 24/02/19	**Date Typed:** 25/02/19 – SM

Southern Health and Social Care Trust

Preoperative Assessment Clinic
Craigavon Area Hospital
Department of Anaesthetics
68 Lurgan Road
Portadown
BT63 5QQ

Tel: 028 37565167

Anaesthetics, Theatres
Intensive Care Services

Predicted Perioperative Risk:
P-POSSUM 30-Day Mortality: **10-18%**
30 Day Morbidity: **70-80%**

8th February 2019

Mr A O'Brien
Consultant Urologist
Craigavon Area Hospital

Dear Aidan

Re: **Name:** Personal Information redacted by USI
DOB:
Address:
Hospital No: Personal Information redacted by USI **HCN:** Personal Information redacted by USI

I saw Personal Information redacted by USI this morning, accompanied by 2 of his Pers daughters. He is currently being considered for a nephrectomy for a large right sided renal tumour.

He is Personal Information redacted by USI with his main health issues to date being cardiac. He has known hypertension (on irbesartan), and atrial fibrillation (maintained on bisoprolol and warfarinised). There is a history of a failed DC cardioversion. Most recent echocardiogram (7th February 2019) shows mild-moderate tricuspid regurgitation, biatrial dilation (with his left atrium severely dilated), preserved systolic function but evidence of diastolic cardiac dysfunction (which would be in keeping with his hypertension).

[redacted] has no respiratory problems, and remains active. He lives independently, and continues to garden, including grass cutting. He would become dyspnoeic on climbing stairs. There is no clear suggestion in his history to suggest overt cardiac defeat. He has had a previous Personal Information redacted by the USI following trauma, and also suffers from arthritis in his right knee.

I had hoped to perform CPX testing on him today, however the limited flexion available in his arthritic knee meant we were unable to proceed, and the attempted test was essentially non-diagnostic. He did become fairly dyspnoeic early into cycling, however it is difficult to read too much into that, as there was ongoing discomfort from his arthritic knee.

Despite his remaining active and independent, such a procedure does have significant associated risk. I have discussed this with him in detail, specifically discussing the mortality and morbidity figures quoted above. Major concerns outlined were CVA, MI, development of heart failure requiring ongoing treatment, pneumonia, DVT, PE, and other infective problems. The possibility of his not being as well able to manage independently following surgery has also been raised.

I have explained that given the risk profile here, he would need level 2 / HDU care post-operatively. His daughters seemed to grasp the significance of this, however, certainly on discussion today Personal Information redacted by USI seemed to be keen to actively consider surgery. I have explained that you would plan to review him following all his investigations and discuss this all in the round, including any other options which may be available.

I hope this is of some benefit in helping plan his future course. If there is anything else you want to know here, please let me know.

Yours sincerely

Personal Information redacted by the USI
Consultant in Anaesthesia and Intensive Care Medicine

Please remember these scores are a ***prediction*** of morbidity and mortality and the scores tend to slightly overpredict in the low-risk group and at the extremes of age.

MDM Report from Urology MDM @ The Southern Trust

RE: Personal Information redacted by USI

Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

Contact Tel:

~~O'Brien office~~ ASP Took notes after clinic 18/01/19

Noleen Elliott await Res

MDM Report from the Urology MDM @ The Southern Trust on 17/01/2019.

MDM Update

CONSULTANT MR O'BRIEN: This Personal Information year old man has remained on Warfarin since 2012 when he was found to have fast atrial fibrillation and left bundle branch block. DC conversion in 2014 did not succeed in permanent restoration of sinus rhythm. Taking Bisoprolol 7.5 mg daily has maintained controlled atrial fibrillation since. Echocardiography in 2015 confirmed a LVEF of 55%, mild mitral valvular regurgitation, moderate left atrial dilatation and mild right ventricular dilatation. He was discharged from cardilogical review in 2015.

He presented to the Emergency Department on 12 December 2018 following the onset of visible haematuria. His GFR was 57 ml/min. A CT Chest and CT Urogram were performed on 04 January 2019. The heart was reported to be enlarged. One pretracheal lymph node had a diameter of 12 mm and there was one small intrapulmonary lymph node related to the horizontal fissure. He was found to have a large, right renal tumour mass with a craniocaudal diameter of 15 cm. The right renal vein appeared to be distended, and in continuity with the cranial pole of the tumour.

An outpatient consultation on 18 January 2019 has been arranged.

MDM Action

Discussed at Urology MDM 17.01.19. Personal Information redacted by USI has a large right renal tumour with no definite evidence of metastatic disease. For review by Mr O'Brien on 18 January 2019.

Radiology

. **Findings**

MDM Report from Urology MDM @ The Southern Trust

RE: Personal Information redacted by USI
Personal Information redacted by the USI
DOB: Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI
Contact Tel: Personal Information redacted by USI

Latest Findings from CT performed on 04/01/2019
04/01/2019 12:36 CT Urogram, Author: Personal Information redacted by USI

04/01/2019 12:36 CT Chest with contrast, Author: Personal Information redacted by USI

Indication: Frank haematuria. Anticoagulated.

Technique: A dual phase CT urogram was performed. A delayed phase volume scan of the chest was subsequently performed following the abdominal findings.

Findings: There is very large heterogeneously enhancing right renal tumour. This arises from the lower pole and extends over 14.6 cm in maximal diameter. This has a low density necrotic appearing centre, and contains several small areas of calcification.

Incidental note made of a small simple cyst at the upper pole of right kidney. The left renal cortex enhances normally.

The presence or absence of tumour extension into the right renal vein is difficult to exclude on these phases of examination. A small fleck of calcification within the inferior vena cava immediately adjacent to the left renal vein however should be viewed with suspicion, and a dedicated multi phase CT scan of the kidneys would be worth considering after MDT discussion. There appears to a solitary right renal artery.

The ureters and left pelvocaliceal systems enhance normally with no soft tissue filling defects, back pressure change or calculi.

The heart is enlarged. A lower pretracheal lymph node is mildly enlarged measuring up to 12 mm in short axis. There is no size significant lymphadenopathy elsewhere within the scan range. Incidental note is made of a small intrapulmonary lymph node related to the horizontal fissure. Overall, no definite evidence of lung metastasis.

A couple of sub centimetre low density lesions in the liver are too small to accurately characterise, but are most suggestive of cysts. The adrenal glands and spleen and pancreas are unremarkable.

The aorta has normal calibre, there is no destructive osseous lesion.

Conclusion: 14.6 cm right renal tumour. No definite evidence of metastatic disease, but there is an isolated mildly enlarged mediastinal lymph node, and subtle evidence of right renal vein invasion.

Report marked for urgent communication.

MDM Report from Urology MDM @ The Southern Trust

RE:	Personal Information redacted by USI
Contact Tel:	

Urology MDM @ The Southern Trust

[redacted]

RE: [redacted]

DOB: [redacted] Hospital Number [redacted], HCN: [redacted]

Dear Dr [redacted]

This patient was discussed at the Urology MDM @ The Southern Trust

On 17/01/2019.

MDM Update:

CONSULTANT MR O'BRIEN: This [redacted] year old man has remained on Warfarin since 2012 when he was found to have fast atrial fibrillation and left bundle branch block. DC conversion in 2014 did not succeed in permanent restoration of sinus rhythm. Taking Bisoprolol 7.5 mg daily has maintained controlled atrial fibrillation since. Echocardiography in 2015 confirmed a LVEF of 55%, [redacted]d mitral valvular regurgitation, moderate left atrial dilatation and mild right ventricular dilatation. He was discharged from cardilogical review in 2015.

He presented to the Emergency Department on 12 December 2018 following the onset of visible haematuria. His GFR was 57 ml/min. A CT Chest and CT Urogram were performed on 04 January 2019. The heart was reported to be enlarged. One pretracheal lymph node had a diameter of 12 mm and there was one small intrapulmonary lymph node related to the horizontal fissure. He was found to have a large, right renal tumour mass with a craniocaudal diameter of 15 cm. The right renal vein appeared to be distended, and in continuity with the cranial pole of the tumour.

An outpatient consultation on 18 January 2019 has been arranged.

MDM Plan:

Discussed at Urology MDM 17.01.19. [redacted] has a large right renal tumour with no definite evidence of metastatic disease. For review by Mr O'Brien on 18 January 2019.

If you have any queries or require further information, please do not hesitate to contact us.

Yours sincerely,

Urology MDM @ The Southern Trust

[redacted]

RE: Mr [redacted]
[redacted]
DOB: [redacted] Hospital Number: [redacted], HCN: [redacted]

Dear Dr [redacted]

This patient was discussed at the Urology MDM @ The Southern Trust
On 14/02/2019.

MDM Update:

Urology MDM @ The Southern Trust

Personal Information redacted by USI

RE: Mr Personal Information redacted by USI

Personal Information redacted by USI

DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

CONSULTANT MR O'BRIEN: This Personal Inform year old man has remained on Warfarin since 2012 when he was found to have fast atrial fibrillation and left bundle branch block. DC conversion did not succeed in permanent restoration of sinus rhythm. He has remained in controlled atrial fibrillation on Bisoprolol 7.5 mg daily since. On ECHO in 2016, he was reported to have a LVEF of 55 %, mild mitral regurgitation, severe biatrial dilatation and mild tricuspid regurgitation. When repeated in February 2018, the biatrial dilatation was reported to be moderate in severity. The remaining parameters remained unchanged. He was discharged from cardiac review in 2018.

He presented to the Emergency Department on 12 December 2018 following the onset of visible haematuria. His GFR was 57 ml/min. A CT Chest and CT Urogram were performed on 04 January 2019. The heart was reported to be enlarged. One pretracheal lymph node had a diameter of 12 mm and there was one small intrapulmonary lymph node related to the horizontal fissure. He was found to have a large, right renal tumour mass with a craniocaudal diameter of 15 cm. The right renal vein appeared to be distended, and in continuity with the cranial pole of the tumour.

An outpatient consultation on 18 January 2019 has been arranged.

Discussed at Urology MDM 17.01.19. Per has a large right renal tumour with no definite evidence of metastatic disease. For review by Mr O'Brien on 18 January 2019.

was advised of the reported CT findings at review on 18 January 2019. It was then additionally appreciated that he had suffered a Personal Information redacted by the USI many years previously, resulting in a through Personal Information redacted by the USI Personal Information redacted by the USI since. His daughters advised that their father was very active, and had been cutting hedges one day previously. MRI scanning of his inferior vena cava was requested. A renogram was requested to quantify left renal differential function.

A comparative analysis of ECHO performed in 2016 and 2018 indicated that the biatrial dilatation of 2016 may have been better reported as mild in severity, but that there had been increased dilatation by 2018, considered to be moderate in severity. A further ECHO was requested. CPEX assessment was requested and agreed.

MDM Plan:

Urology MDM @ The Southern Trust

Personal Information redacted by USI

RE: Personal Information redacted by USI

DOB: Personal Information redacted by USI Hospital Number: [redacted], HCN: Personal Information redacted by USI

Discussed at Urology MDM 14.02.19. Personal Information redacted by USI imaging indicates a large right renal lesion with right renal vein involvement but no involvement of the IVC. Pre op assessment indicates high risk for mortality and morbidity in the post-operative period. For review with Mr O'Brien to discuss with patient and family if surgery is in his best interest.

If you have any queries or require further information, please do not hesitate to contact us.

Yours sincerely,

Chairman of Urology MDM

Personal Information redacted by the USI

Consultant Urologist

MDM Report from Urology MDM @ The Southern Trust

Noleen Elliott - Awaiting Results

RE: Personal Information redacted by USI

Personal Information redacted by USI

DOB Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

Contact Tel: Personal Information redacted by USI

MDM Report from the Urology MDM @ The Southern Trust on 14/03/2019.

Diagnosis	Renal clear cell carcinoma
Histology	Clear cell adenocarcinoma, NOS,
Laterality:	right

MDM Update

MDM Report from Urology MDM @ The Southern Trust

RE: Personal Information redacted by the USI

DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

Contact Tel: Personal Information redacted by USI

Latest Findings from CT performed on 04/01/2019
04/01/2019 12:36 CT Urogram, Author: Personal Information redacted by USI

04/01/2019 12:36 CT Chest with contrast, Author: Personal Information redacted by USI

Indication: Frank haematuria. Anticoagulated.

Technique: A dual phase CT urogram was performed. A delayed phase volume scan of the chest was subsequently performed following the abdominal findings.

Findings: There is very large heterogeneously enhancing right renal tumour. This arises from the lower pole and extends over 14.6 cm in maximal diameter. This has a low density necrotic appearing centre, and contains several small areas of calcification.

Incidental note made of a small simple cyst at the upper pole of right kidney. The left renal cortex enhances normally.

The presence or absence of tumour extension into the right renal vein is difficult to exclude on these phases of examination. A small fleck of calcification within the inferior vena cava immediately adjacent to the left renal vein however should be viewed with suspicion, and a dedicated multi phase CT scan of the kidneys would be worth considering after MDT discussion. There appears to a solitary right renal artery.

The ureters and left pelvocaliceal systems enhance normally with no soft tissue filling defects, back pressure change or calculi.

The heart is enlarged. A lower pretracheal lymph node is mildly enlarged measuring up to 12 mm in short axis. There is no size significant lymphadenopathy elsewhere within the scan range. Incidental note is made of a small intrapulmonary lymph node related to the horizontal fissure. Overall, no definite evidence of lung metastasis.

A couple of sub centimetre low density lesions in the liver are too small to accurately characterise, but are most suggestive of cysts. The adrenal glands and spleen and pancreas are unremarkable.

The aorta has normal calibre, there is no destructive osseous lesion.

Conclusion: 14.6 cm right renal tumour. No definite evidence of metastatic disease, but there is an isolated mildly enlarged mediastinal lymph node, and subtle evidence of right renal vein invasion.

Report marked for urgent communication.

Urology MDM @ The Southern Trust

DR [redacted]

[redacted]

RE: [redacted]

DOB: [redacted] Hospital Number [redacted], HCN: [redacted]

Dear Dr [redacted]

This patient was discussed at the Urology MDM @ The Southern Trust
On 14/03/2019.

Diagnosis: Renal clear cell carcinoma

MDM Update:

Urology MDM @ The Southern Trust

Irrelevant information redacted by the USI

Personal Information redacted by USI

RE: Personal Information redacted by USI

Personal Information redacted by USI

DOB Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: al Information redacted by USI

MDM Plan:

Discussed at Urology MDM 14.03.19. Personal Information redacted by USI has a high risk Clear Cell Renal Cell Carcinoma. For review with Mr O'Brien to arrange CT in 3 months.

If you have any queries or require further information, please do not hesitate to contact us.

Yours sincerely,

Chairman of Urology MDM

Southern Health and Social Care Trust

Craigavon Area Hospital, Lurgan Road, Portadown, Craigavon, County Armagh, BT63 5QQ
Tel: 028 3861 3674/2952

Ward Tel:

Notes Copy

Personal Information redacted by USI

Personal Information redacted by USI

Date: 17/03/2019 17:08
Discharge Id: 560312
Version: 17

505

Dear Personal Information redacted by USI

DISCHARGE NOTIFICATION

The patient was admitted under the care of **MR A O'BRIEN** (specialty: **UROLOGY(C)**) into **3 SOUTH ELECTIVE WARD** Ward at **CRAIGAVON AREA HOSPITAL** on **06/03/2019 08:00:00** and discharged on **17/03/2019**.

Forenames: Personal Information redacted by USI
Surname:
D.O.B:
Hospital No:
NHS No:
Gender: Male
Ward: 3 SOUTH ELECTIVE WARD

Address: Personal Information redacted by USI

Admission Reason

Right radical nephrectomy for RCC

Principle Discharge Diagnosis

Right radical nephrectomy

Operations/Procedures/Radiology

TUMOUR TYPE: Clear cell renal cell carcinoma.

WHO/ISUP TUMOUR GRADE: Predominantly Grade II with some Grade III.

pTNM STAGE (UICC8): pT3a - tumour extends into the renal vein.

Comments:
Gross examination showed a large tumour deposit bulging into the proximal renal vein corresponding to the appearances identified on MRI. Microscopic examination of this area confirms the tumour nodule though it is harder to appreciate this is renal vein involvement (Block B) but on balance it is felt to be proximal vein involvement in keeping with a pT3a tumour.

Additional Information for GP

Changes to Medications - Start/Stop

See discharge prescription below for medication changes

Clinical Information/Comments

This [redacted] year old man was admitted electively for a radical nephrectomy for suspected renal cell carcinoma. He was t/f to ICU post op for inotropic support. He was later transfered to the ward.

He developed Enterobacter aerogenes +ve BC. On micro advice he was continued on tazocin + ciprofloxacin. He is to be discharged on a 7 day course of ciprofloxacin.

Histology confirmed renal cell carcinoma

He is to be followed up by Mr O'Brien.

INR subtherapeutic, on pharmacy discussion to be discharged on prophylactic clexane.

Many thanks

Did the patient receive a blood transfusion?

No

Allergies Patient has no known allergies

Discharge Date 17/03/2019 **Discharge Time**

Arrangements For Follow-Up

Please CC Mr O'Brien, for OP follow up following MDM results

Further Detailed Discharge Letter To Follow: No

Awaiting Further Results: Yes

Awaited Results

MDM results

Patient Aware Of Diagnosis: Yes

Other Management Information For GP

Anticoagulation Therapy

Anticoagulant Therapy was commenced prior to this Admission.

Contact details of Clinical Team normally responsible for monitoring INR:

GP

Reasons For Anticoagulation Therapy:

Atrial fibrillation

INR Target:

2.50 (range: 2.00 - 3.00)

Duration of oral anticoagulant therapy required:

Long Term

INR Test Results:

INR Test Date	INR Test Value	Warfarin Dose
12/03/2019	1	5mg
13/03/2019	1	6mg
14/03/2019	1.2	Held (Procedure)
15/03/2019	0	5mg
16/03/2019	1.2	5mg

Dose until next INR test	**5mg**
Next INR test appointment	**19/03/2019**

Other information:

Yellow Book Completed?:

Yes

Patient educated / For existing patients education confirmed?:

Yes

Patient has anticoagulant therapy pack?:

Yes

Discharge Prescription: (POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

Drug	Dose	Frequency	Days	Route	GP

					Continue?
Admission drugs (unamended)					
WARFARIN Tablets	As per INR	When Required	-	Oral	Yes
BISOPROLOL Tablets	5mg	Twice Daily	-	Oral	Yes
IRBESARTAN Tablets	150mg	Each Morning	-	Oral	Yes
Drugs prescribed since admission					
CIPROFLOXACIN Tablets	750mg	Twice Daily	5	Oral	No
ENOXAPARIN Pre-filled Syringe	40mg	Each Night	until INR greater than 2	Subcutaneous	Review
(Additional Info: Amber List Medicine\ 2 days supplied on d/c. Warfarin clinic to supply further doses if needed please)					
Admission drugs (amended)					

Stopped Medication: (POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

Drug	Dose	Frequency	Days	Route
Admission drugs (stopped)				

Authorised Forms

Form	Authorised By	Date/Time
Adult Clinical Details (Elective-CMPM)	Personal Information redacted by the USI	17/03/2019 11:5
Anticoagulant Therapy	Personal Information redacted by the USI	17/03/2019 11:5

Prescribing Clinician: Personal Information redacted by the USI **Bleep No:** Personal Information redacted by the

81/CA 51

OPERATION NOTES

Affix Label

Personal Information redacted by the USI

WIT-925

HOSPITAL: CRAIGAVON AREA

Operations Performed	Date
RIGHT RADICAL NEPHRECTOMY	06 MARCH 2019
Surgeon: AIDAN O'BRIEN	Anaesthe: Personal Information redacted by the USI
Assistant: KEN HIGH	Sister: AIDAN CULLEN
Incision	Blood
Findings	Drains
	Packs

PROCEDURE

RIGHT FLANK INCISION, RESECTING 11D OF SEVENTH RIB

LARGE RIGHT RENAL TUMOUR MASS EXTENDING TO RIGHT HEMIPELVIS

SINGLE RIGHT RENAL ARTERY & VEIN

RIGHT RADICAL NEPHRECTOMY PERFORMED

2 OF ROBINSON'S DRAIN

CLOSURE: LAYERED MUSCULAR USING

0/1 LOOP PDS x 2

3/0 SUBCUTICULAR MONOCRYL

LISTED FOR MDM

Personal Information redacted by USI

WPH000378 Revised 03/13

MRV Inferior vena cava

Patient ID	Personal Information redacted by USI	**Patient Name**	Personal Information redacted by USI Personal Information redacted by USI
Sex	Male	**Date Of Birth**	
Time Performed	07-Feb-2019 14:30	**Time Reported**	11-Feb-2019 14:32
Requested by	Aidan O'Brien	**Requested from**	Urology Outpatients Craigavon
Order Number	NIRSCR0026229785	**Status**	Final

Report Fi

07/02/2019 15:03 MRV Inferior vena cava, Author: Personal Information redacted by the USI

Image quality suboptimal, due to patient movement.

Large, 14 cm mass in the right kidney.
There is likely tumour in the right renal vein.
Over a distance of 1.7 cm, the vein is clear of thrombus before it joins the IVC.

Clinical Info From Order Fin

This Person al Inform year old man has a large right renal tumour which may be distending the right renal vein and may be extending to IVC.
Discussed with Dr. Personal Information redacted by the US
Patients wears a Personal Information redacted by the USI years ago.
Patient may be contacted at Personal Information redacted by USI

Priority: Red Flag
Pacemaker / implanted cardiac device leads?: No
Intra-cranial clips or shunts?: No
Surgery involving implants to eyes or ears?: No
Ever had metal fragments in eyes or skin?: No
Surgery involving implants to the heart?: No
Surgery involving implants to the head?: No
Surgery involving implants to the abdomen?: No
Any other implants eg endoscopic clips, stents, neurostimulators etc?: No
Is the patient pregnant?: No
Method of transport: Walking
oes the patient have a known infection status?: No
Does the patient have a disability?: Physical
Is the patient diabetic?: No
Does patient have any of the following contrast risk factors; Over 70 years of age, renal impairment, diabetes, CHF, myeloma, chemotherapy or nephrotoxic drugs?: Yes
Renal function information: eGFR
eGFR value? Failure to provide required information when applicable may cause a delay due to requests being returned: 57 ml/min
eGFR date: 12 December 2018
Referral status: NHS
Referrer grade: Consultant
Referrer name: Aidan O'Brien
Referrer contact / bleep detail: Personal Information redacted by the USI

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
OUTPATIENT LETTER
Telephone: Personal Information redacted by the USI
E mail: Personal Information redacted by the USI
Secretary: Mrs N. Elliott

Personal Information redacted by the USI

Dear Personal Information redacted by the USI

Re: Patient Name: Personal Information redacted by USI
D.O.B.:
Address:
Hospital No: Personal Information redacted by USI **HCN:** Personal Information redacted by USI

Date/Time of Clinic: 18/01/19	**Follow Up:** Awaiting results – echocardiogram/PFT's/MRI/renography

I write to you regarding this Persona l Informat year old man who presented to the Emergency Department at Craigavon Area Hospital on 12th December 2018 following the onset of visible haematuria earlier that day. He reported some associated low back pain. Otherwise, he appeared well. There was no indication of any urinary infection, and he was then referred to our department for further assessment.

I arranged for Personal Information redacted by USI to have a CT scan of his chest, and a CT urogram performed on 4th January 2019. The dominant finding was that of a large, enhancing, right renal tumour, measuring some 15cm in diameter. The tumour certainly arose from the lower pole of the right kidney, and appeared to have a necrotic centre. More importantly, the cranial pole of the tumour appeared to directly extend into the right renal vein, causing distension of the vein. It was not possible to determine whether tumour additionally extended to the lumen of the inferior vena cava. However, the presence of punctate calcification within the caval lumen would raise the index of suspicion that there may be extension of tumour into the lumen of the inferior vena cava.

Otherwise, he was reported to have a mildly enlarged, lower, pre-tracheal, lymph node measuring 1.2cm in short axis. Apart from the additional presence of a small, intrapulmonary lymph node related to the horizontal fissure, there was no definite evidence of any pulmonary or mediastinal metastatic disease. There were a couple of lesions of low density within his liver, and which were too small to accurately characterise but which were probably simple hepatic cysts.

I met [redacted], accompanied by his two daughters, on Friday 18th January 2019. It was then that I appreciated that [redacted] had an [redacted], through his left knee joint, as a consequence of sustaining a [redacted] whilst [redacted] many years ago. He has worn a [redacted] ever since. Nevertheless, his two daughters advised that he has remained very active indeed, and had been out cutting hedges in recent days.

I noted that [redacted] had been found to have fast atrial fibrillation accompanied by left bundle branch block, in 2012, since when he has remained anti-coagulated on Warfarin. DC conversion failed to permanently maintain sinus rhythm in 2014. I gather that he has remained in controlled atrial fibrillation on Bisoprolol 7.5mg daily since.

I reviewed the reports of echocardiography performed in 2016 and again in February 2018. He does not have any evidence of stenotic valvular disease. He was indeed reported to have mild regurgitation of his aortic, mitral and tricuspid valves. Left ventricular function was maintained with an ejection fraction of 55%. He was reported to have severe dilatation of both atria in 2016, and modest dilatation of both atria in February 2018. Since then, I have had the opportunity of reviewing these two cardiograms with an echocardiographer who indicated that the degree of atrial dilatation in 2016 may probably have been better described as mild in severity. Nevertheless, there has been an increase in the degree of atrial dilatation, it more appropriately being described indeed as moderate in February 2018. In any case, a further echo will be arranged in the near future.

I have also requested cardiopulmonary exercise testing which may be compromised in view of [redacted], though I have been advised that having had an [redacted] does not necessarily contraindicate cardiopulmonary exercise testing.

[redacted] has had mild recent impairment of global renal function, with a glomerular filtration rate of 57ml per minute in December 2018. It would appear that his left kidney is probably contributing the greater part of his global renal function. I have requested radioisotope renography in order to quantify left renal differential function.

I had the impression on meeting [redacted] that he may not be keen on surgical intervention. However, I persuaded him not to rush to any conclusions in that regard until we have had the opportunity of completing staging and operability of the tumour, and until a qualitative and quantitative assessment has been made of operative risks. In any case, in the interim, his further management will be discussed once again when the reports of MRI scanning of his inferior vena cava and renography are available.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 18/01/19	**Date Typed:** 28/01/19 – [redacted]

[redacted]

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by the USI
E mail: Personal Information redacted by the USI
Secretary: Mrs N. Elliott

28/01/19

CONFIDENTIAL

Personal Information redacted by the USI

HCN: Personal Information redacted by USI

Dear Personal Information redacted by

I was pleased to have the opportunity of meeting you, accompanied by your daughters, on Friday 18th January 2019. Since then, I have had the opportunity of discussing the usefulness of further scans with my colleagues. It has been agreed that it would certainly be most useful for you to have an MRI scan performed in order to determine whether there is any extensive involvement of major vessels in your abdomen by the tumour arising from your right kidney. You will receive an appointment to attend the MRI department at Craigavon Area Hospital in the near future.

I have also requested a radioisotope renogram in order to quantify the function of your left kidney, in order to be able to advise you of the likely remaining kidney function, if you were to have your right kidney removed. You will also receive a letter of appointment to attend the Department of Radiology at Craigavon Area Hospital to have that renogram performed.

I have also had the opportunity of reviewing echocardiograms that you have had done of your heart in 2016, and again more recently in February 2018. The Department of Cardiology will arrange a further appointment for you to attend to have a further echo performed in the near future.

Personal Information redacted by the USI

Lastly, I have also shared your history with my colleagues in anaesthesia, and who have kindly agreed to arrange a consultation for you, in order to further assess the risks posed by significant surgery. You will receive that appointment as well.

When all of that has been conducted, I will arrange a further review appointment for you when I will discuss with you the views of my colleagues, and when hopefully you will be enabled to arrive at an informed decision regarding your further management.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Radiology Report

South Tyrone Hospital
South Tyrone Hospital
Carland Road
BT71 4AU

Tel.:
Fax: 02887713498

9 JAN 2019

Personal Information redacted by USI

Report recipient
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Date of birth Personal Information redacted by USI

Request no. NIRSST0021939099

Ref. clinician O'Brien, Aidan

Request date 23/12/2018 17:41:00

Referral source
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Requested examination(s) CT Urogram

Clinical details
This man has had visible haematuria.
He is anticoagulated with Warfarin because of atrial fibrillation.
He has had an Personal Information redacted by the USI.
His sister died of metastatic renal cell carcinoma.
Please advise his daughter Personal Information redacted by USI of the date and time of his appointment, as she will bring him to the appointment.
Personal Information redacted by USI

Priority: Red Flag
Is the patient female and of child bearing age (11-55)?: No
Irradiated area between diaphragm / upper femora?: Yes
Does patient have any of the following contrast risk factors; Over 70 years of age, renal impairment, diabetes, CHF, myeloma, chemotherapy or nephrotoxic drugs?: Yes
Renal function information: eGFR
eGFR value? Failure to provide required information when applicable may cause a delay due to requests being returned: 57 ml/min
eGFR date: 12 December 2018
Does the patient have a known infection status?: No
Does the patient have a disability?: Physical
Is the patient diabetic?: No
Method of transport: Chair
Referral status: NHS
Referrer name: Aidan O'Brien
Referrer grade: Consultant
Referrer contact / bleep detail: Personal Information redacted by the USI

Radiology Report

South Tyrone Hospital
South Tyrone Hospital
Tel.:
Fax: 02887713498

Carland Road

BT71 4AU

Irrelevant information redacted by the USI

Personal Information redacted by USI

Report recipient
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Date of birth Personal Information redacted by USI

Request no. NIRSST0021939099

Reason for referral
To assess anatomy of urinary tract

Author: Personal Information redacted by the U
Authorized by: Personal Information redacted by the
Prel. Sign:

Document date: 07/01/2019
Secretary: Personal Information redacted by the
Sign.datum:

04/01/2019 12:36 CT Urogram, Author: Personal Information redacted by the USI

04/01/2019 12:36 CT Chest with contrast, Author: Personal Information redacted by the USI

Indication: Frank haematuria. Anticoagulated.

Technique: A dual phase CT urogram was performed. A delayed phase volume scan of the chest was subsequently performed following the abdominal findings.

Findings: There is very large heterogeneously enhancing right renal tumour. This arises from the lower pole and extends over 14.6 cm in maximal diameter. This has a low density necrotic appearing centre, and contains several small areas of calcification.

Incidental note made of a small simple cyst at the upper pole of right kidney. The left renal cortex enhances normally.

The presence or absence of tumour extension into the right renal vein is difficult to exclude on these phases of examination. A small fleck of calcification within the inferior vena cava immediately adjacent to the left renal vein however should be viewed with suspicion, and a dedicated multi phase CT scan of the kidneys would be worth considering after MDT discussion. There ap-

Radiology Report

South Tyrone Hospital
South Tyrone Hospital
Tel.:
Fax: 02887713498

Carland Road

BT71 4AU

Personal Information redacted by USI

Report recipient
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Date of birth Personal Information redacted by USI

Request no. NIRSST0021939099

pears to a solitary right renal artery.

The ureters and left pelvocaliceal systems enhance normally with no soft tissue filling defects, back pressure change or calculi.

The heart is enlarged. A lower pretracheal lymph node is mildly enlarged measuring up to 12 mm in short axis. There is no size significant lymphadenopathy elsewhere within the scan range. Incidental note is made of a small intrapulmonary lymph node related to the horizontal fissure. Overall, no definite evidence of lung metastasis.

A couple of sub centimetre low density lesions in the liver are too small to accurately characterise, but are most suggestive of cysts. The adrenal glands and spleen and pancreas are unremarkable.

The aorta has normal calibre, there is no destructive osseous lesion.

Conclusion: 14.6 cm right renal tumour. No definite evidence of metastatic disease, but there is an isolated mildly enlarged mediastinal lymph node, and subtle evidence of right renal vein invasion.

Report marked for urgent communication.

Patient ID	Personal Information redacted by the USI	**Patient Name**	Personal Information redacted by the USI
Sex	Male	**Date Of Birth**	
Time Performed	04-Jan-2019 11:35	**Time Reported**	07-Jan-2019 20:39
Requested by	Aidan O'Brien	**Requested from**	Urology Outpatients Craigavon
Order Number	NIRSST0026085771	**Status**	Final

Report Final

04/01/2019 12:36 CT Urogram, Author: Personal Information redacted by the USI

04/01/2019 12:36 CT Chest with contrast, Author: Personal Information redacted by the USI

Indication: Frank haematuria. Anticoagulated.

Technique: A dual phase CT urogram was performed. A delayed phase volume scan of the chest was subsequently performed following the abdominal findings.

Findings: There is very large heterogeneously enhancing right renal tumour. This arises from the lower pole and extends over 14.6 cm in maximal diameter. This has a low density necrotic appearing centre, and contains several small areas of calcification.

Incidental note made of a small simple cyst at the upper pole of right kidney. The left renal cortex enhances normally.

The presence or absence of tumour extension into the right renal vein is difficult to exclude on these phases of examination. A small fleck of calcification within the inferior vena cava immediately adjacent to the left renal vein however should be viewed with suspicion, and a dedicated multi phase CT scan of the kidneys would be worth considering after MDT discussion. There appears to a solitary right renal artery.

The ureters and left pelvocaliceal systems enhance normally with no soft tissue filling defects, back pressure change or calculi.

The heart is enlarged. A lower pretracheal lymph node is mildly enlarged measuring up to 12 mm in short axis. There is no size significant lymphadenopathy elsewhere within the scan range. Incidental note is made of a small intrapulmonary lymph node related to the horizontal fissure. Overall, no definite evidence of lung metastasis.

A couple of sub centimetre low density lesions in the liver are too small to accurately characterise, but are most suggestive of cysts. The adrenal glands and spleen and pancreas are unremarkable.

The aorta has normal calibre, there is no destructive osseous lesion.

Conclusion: 14.6 cm right renal tumour. No definite evidence of metastatic disease, but there is an isolated mildly enlarged mediastinal lymph node, and subtle evidence of right renal vein invasion.

Report marked for urgent communication.

Clinical Info From Order Final

This man has had visible haematuria.
He is anticoagulated with Warfarin because of atrial fibrillation.
He has had an Personal Information redacted by the USI.
His sister died of metastatic renal cell carcinoma.

Patient ID	Personal Information redacted by the USI	**Patient Name**	Personal Information redacted by the USI
Sex	Male	**Date Of Birth**	
Time Performed	04-Jan-2019 11:35	**Time Reported**	07-Jan-2019 20:39
Requested by	Aidan O'Brien	**Requested from**	Urology Outpatients Craigavon
Order Number	NIRSST0026085771	**Status**	Final

Please advise his daughter; Personal Information redacte of the date and time of his appointment, as she will bring him to the appointment.
Personal Information may be contacted at Personal Information redacted by

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Priority: Red Flag
Is the patient female and of child bearing age (11-55)?: No
Irradiated area between diaphragm / upper femora?: Yes
Does patient have any of the following contrast risk factors; Over 70 years of age, renal impairment, diabetes, CHF, myeloma, chemotherapy or nephrotoxic drugs?: Yes
Renal function information: eGFR
eGFR value? Failure to provide required information when applicable may cause a delay due to requests being returned: 57 ml/min
eGFR date: 12 December 2018
Does the patient have a known infection status?: No
Does the patient have a disability?: Physical
Is the patient diabetic?: No
Method of transport: Chair
Referral status: NHS
Referrer name: Aidan O'Brien
Referrer grade: Consultant
Referrer contact / bleep detail: Personal Information redacted by the USI

UROLOGY RED FLAG TRIAGE SHEEET

PATIENT NAME: Personal Information redacted by USI

HOSPITAL NO: Personal Information redacted by USI

HCN: Personal Information redacted by USI

AM 13.12.18

RED FLAG ✓	TRUS
UPGRADE RED FLAG	FLEX. C/U ✓
URGENT	FLOW RATE
ROUTINE	ULTRASOUND ✓
OTHER	
VIRTUAL	

-none reqd - Scan Tracks emailed

C20B410

18/01

rf.appointment

From: AEreception
Sent: 13 December 2018 05:44
To: rf.appointment
Subject: Red Flag referral
Attachments: SKM_284e18121306480.pdf

Please find Red Flag Haematuria referral for [redacted] Personal information redacted by USI

Many thanks,

Christine P.

From: noreply@southerntrust.hscni.net [mailto:noreply@southerntrust.hscni.net]
Sent: 13 December 2018 06:49
To: AEreception
Subject: Message from KM_284e

HCN Personal Information redacted by USI Surname Personal Information redacted by USI Forename Personal Information redacted by USI Dob Personal Information redacted by USI

AE Number Personal Information redacted by USI

GP Personal Information redacted by USI

GP TEL

Diagnosis

1. haematuria ? uti

2.

3.

Investigations and Results

NAD 136 WCC 12

ED Discharge Plan

ABX . Review Haematuria clinic

Patient to attend GP re:

Referred to Specialty Time

Admission Agreed By: DTA Time

Grade of Doctor

Patient to make appt with GP

Prescription (Medicines on discharge)

Medicine	Dose	Route	Frequency	Duration	Signature	Supply required	Supply Checked by	Given by	Quantity
TRIMETHOPRIM	200 mg	po	BD	7 days	Personal Information redacted by USI		TA	Personal Information redacted by USI	

FINAL PLACEMENT

Personal Information redacted by USI

Admit to ward	ED Review	other hospital OPD	Sign Personal Information redacted by USI
CDU	Fracture Clinic	Did not wait/refuses Rx	Grade SHO
TNF to OH	CBYL	Psych. Assess	Died in ED	CTMA	Breach Time 02:41
Home	ED Physio		Absconded		Exam Finish Time 0210
OPD Red flags haematuria. Emailed 13-12-18					Departure Time

Discharge OBS

P	BP	RESP	TEMP	SPO2	GCS	CR	BM
86	155/75		37	96	15/15		

Transport booked Time booked Ref if NIAS

IV Cannula removed Advice leaflet given UNOCINI complete

CBYL given GP letter given Patient property returned

Breach Time 02:41

Time left department 02:35 Signature Nurse Personal Information redacted by USI

FBP U&E CRP LFT's Cardiac Coag, D-dimer Troponin VBG Toxscreen Amylase Other: Time: Sign: INR 2310 EL

EM AL MENT

af

Er nscni.net

AE Number Personal Information redacted by USI HCN Personal Information redacted by USI Priority Code 3

Personal Information redacted by the USI

Age Per

Sex M MS W

Occ. RETIRED

Casenote Personal Information redacted by USI Mobile/Other Personal Information redacted by USI

Arrival Date/Time 12/12/2018 22:41

Arrival Mode PR Incident Type NT

Source of Referral Out Of Hours

Accompanied By

NOK Personal Information redacted by USI

Home Personal Information redacted by USI Work: Personal Information redacted by USI

Patient at risk of leaving Yes/No

Presenting Complaint ?UTI (ON WARFARIN) REQUESTING INR TEST

Prev Episodes 02 / 01

Triage Date/Time 12/12/2018 22:53

Breach Time 02:41

Nurse: Personal Information redacted by USI

Tetanus Status: NOT REQUIRED

Booster Given Yes/No

Adult Safeguarding Concerns Yes/No

Social Work Involvement? Current/Past/None/Not Applicable

Special Needs No Special Needs

Presentation URINARY PROBLEMS

Discriminator FRANK HAEMATURIA

Triage Text NOTICED URINE RED THIS AM WITH SOME POSSIBLE CLOTS ALSO LOWER BACK PAIN

Medication

Anti-Coagulant WARFARIN On Anti-Coagulant

Allergies NKDA

Signature

Pulse	B/P	RR	PFR	Temp	SaO2	GCS	CRT	BM	PERL	AVPU
76	170/89	18		37	96	15				A

Visual Acuity Right Eye Left Eye

Urine

Pregnancy Test

Weight

ECG required yes/no (< 10 minutes cardiac)

History MRSA CDIFF

Patient Location GREEN AREA

Pain Score 6

Time 22:53

Category 3 Infection

Commenced on NEWS/CNS/PEWS chart Yes No Signature

Nursing Assessment

MENTAL STATE	Yes	No	WASHING AND DRESSING	Yes	No	SOCIAL HISTORY	Yes	No
Alert and Orientated			Independent			Lives Alone		
Confused			Help Required			Lives With		
Agitated			Full Assistance Required			Relatives Present		
Aggressive			Pressure Areas Checked			Aware		
Drowsy			Commode required			Contacted by		
Trolley Sides in Situ			Pad Changed					
MOBILITY			FEEDING AND DIET			Relative Contact Number		
Independent			Dietary Requirements					
Walk with Help			Dentures top			Patient updated at regular intervals		
Walk with Aids			bottom			Yes		No

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