Appendix 3: Long Discharge Letter (911 words)

Patient:	Mr Harry Charles
Admitted:	14 Jun 2011
Discharged:	22 Jul 2011
LOS:	39 days
D/C Reason:	Care Complete (Clinician's Decision)
D/C Destination:	Private Residence – Self Caring
Specialty:	General Surgery
Consultant:	Mr Jon Smith

Principal Diagnoses: (responsible for admission)

- Anaemia
- Carcinoma of the Colon

Other Conditions / Problems: (active conditions / problems during this admission)

- Asthma
- Hypertension – poor control
- Osteoarthritis
- Type 2 Diabetes

Significant Past Problems and Procedures:

- Appendicectomy
- Cholecystectomy
- Glaucoma
- Panic Attack(s)

History:

Mr. Charles 69-year-old man referred by GP with low Hb of 55. Poor historian. Patient had "flu" 2 weeks ago, since then ongoing cough, dizziness, shortness of breath, pounding in ears and lethargy. Nil chest pain.

Findings on admission:

CVS: loud systolic murmur
Resp: chest clear
Abdo: NAD

Interpreted Summary of Significant Results:

On admission:	FBP:	Hb 54, WBC 7.60, Pits 403
	UEC:	Na 139, K 4.0, HC03 24, Urea 4.3, Cr57 Iron 2, Ferritin 6
	LFT:	Tp 79, Alb 41, Glob 38, Bil 5, ALT 30, ALP 85, GGT 25
	COAG:	APTT 23.4, Fibrinogen 4.3
	B12andfolate-NAD	
Prior to discharge:	Hb 113, MCV 70, MCH v22.8, WCC 8.5, PLT 358. UEC: NAD	

Gastroscopy 17/6/11: Normal gastroscopy

Colonoscopy 17/6/11:

Conclusion: Sigmoid colon stricture

A malignant stricture is the most likely cause and histology of biopsies taken are awaited. If malignancy is confirmed then a staging CT and referral to the colorectal surgical team is recommended. Otherwise, please liaise with Gastroenterology team for further management.

Conclusion: Microscopic and Histopathology:

A. Duodenal biopsy: Within normal limits.

B. Sigmoid colon mass: Moderately differentiated adenocarcinoma. The extent of invasion cannot be assessed on these fragments.
C. CT whole body 20/6/11

Presumably the strictured, ulcerated region demonstrated on colonoscopy corresponds to the abnormality at the hepatic flexure. If this proves to be neoplastic then no definite evidence of metastatic disease is demonstrated in the thorax, abdomen or pelvis.

Conclusion: CXR 14/6/11
There are many possible causes for a reticulo-nodular pattern and a more detailed history is needed. However, in view of the possible basal lung mass, lymphangitis carcinomatosa must be considered. CT scanning is suggested if clinically appropriate.

Conclusion: CT Chest 17/6/11
No evidence of pulmonary mass or interstitial lung thickening. Other causes for the anaemia should be sought, such as bowel pathology. A small 9mm left thyroid nodule. Follow-up with U/S is suggested if clinically appropriate.

Conclusion: CT Colonogram 24/6/11
Suboptimal distension however other than the stenosing sigmoid lesion no other more proximal lesion is identified. In particular the area of the hepatic flexure previously queried is demonstrated to be normal.

Conclusion: CTPA 28/6/11
Sub-segmental right upper lobe PE. Patchy bi-basal ground glass shadowing is nonspecific, no consolidation.

Clinical Management:
Admitted to AAU for observation and management:

1. Pt given Packed cells
   - Iron transfusion given
   - Hb improved to 54->113 (18/6/11)
   - Biopsy report of sigmoid as above, (moderately differentiated adenocarcinoma)
   - CT whole body – no evidence of metastasis
   - Pt asymptomatic and obs stable
2. Transferred care to general surgery team (21/6/11)
3. CT colonography performed
4. Patient consented for anterior resection
5. The day prior to surgery he became SOB and had pleuritic chest pain - Pt had developed a PE. Started on a heparin infusion
6. Patient had an IVC filter placed and then received an anterior resection on the 30/6/11
7. Started on therapeutic Clexane post operatively
8. Patient was quite slow to mobilise post operatively. Also very anxious in nature. He was seen by allied health (OT, PT, SW) who feel that he is able to manage at home independently
9. Infusaport placed (11/7/11) for future chemotherapy – medical oncology outpatient appointment booked for 28th July
10. Discussion with haematologist prior to discharge – felt that therapeutic clexane more appropriate than Warfarin in PE associated with active malignancy. He believed that he should be on this (currently 70mg BD) for at least 6 months from when cancer free. He also feels that the need IVC filter can be reviewed in the near future (2-3 months time)
11. Discharged with therapeutic Clexane to be performed by HITH nurses

Social Issues:
Lives alone at home and is normally independent with activities of daily living. Assistance with gardening and cleaning. Still drives.

Instructions to GP:
Thank you for ongoing care and management. At this stage, all colorectal and medical oncology outpatient follow-up appointments made. Please ensure that follow-up of Clexane and IVC filter occur. At this stage he has a script for 6 months of therapeutic Clexane with him. Could GP please review regarding the left thyroid nodule. BP on day of appointment consultation: 170mmHg/98mmHg. Pulse: 90bpm

Information to Patient:

1. Follow-up with medical oncology on the 28/7/11
2. Follow-up with general surgery clinics in 4 and 12 weeks time
3. Will need review of need for IVC filter at approximately 2-3 months
4. Will need to continue with therapeutic clexane for approximately 6 months from when deemed cancer free

Discharge Medications:

Medication	Dosage	Reason(s)	Special Instructions
Budesonide Turbuhaler 400 mcg	2 puffs mane 2 puffs nocte	Asthma	
Cosopt Eye Drops	1 drop each eye mane 1 drop each eye nocte	Glaucoma	
Gliclazide Modified Release Tablets 30mg	1 mane	Type 2 diabetes	
Metformin hydrochloride Tablets 500mg	1 mane 1 lunch 1 nocte	Type 2 diabetes	
Ramipril Capsules 10mg	1 mane	Hypertension	
Terbutaline sulphate Turbohaler 500mcg	1 puff prn	Asthma	500mcg QID PRN
Xalacom Eye Drops	1 drop each eye bedtime	Glaucoma	