H: Renal lump - ablated, then lung resection for secondary lung ca. More recently then sepsis after arrythmia issues and the cardiac ablation 3 weeks ago. .
Remaining breathlessness.
came for review of diabetes - last HBA1c raised.
P: Long chat about past year. Lifestyle advice given. Start S/R metformin - sees cardiac nurse Thursday
Review 3-4 weeks - needs lipid profile when HbA1c repeated.
Less cheese!

Medication review done

Sukkarto SR 500mg tablets (Morningside Healthcare Ltd) - 28 tablet - take one daily

16:52 - Surgery: Dr Gail Sanderson (Clinical Practitioner Access Role)

Metformin 500mg modified-release tablets - 28 tablet - take one daily

10:15 - Patient's Home: Elizabeth Corbett (Specialist Nurse Practitioner) @ HDFT - Heart Failure Specialist Nurses

H: Follow up with HFSN
Note recent consult with Dr Parry and decision to treat diabetes with metformin 500mgs od
E: John continues to make progress after his recent AF ablation
Breathing has improved significantly
No longer has to stop walking up the stairs and he has managed to walk further
Sleeing well
Says cough is now 'virtually non existant' and his voice is less hoarse
No peripheral oedema seen
No dizziness and no palpitations
Heart rate is 72 and regular, assuming SR
130 / 60mmHg
O2 sats:96%
Renal function satisfactory

Discussed raised HbA1c and decison to treat, happy to do this
Raised concern over toe nail which has recently come off...
Suggested needs to ask GP to review and will likely be referred to podiatry in light of diabetes
P: As heart failure symptoms much improved now he is in SR to reduce bumetanide to 1.5mgs od instead of 2mgs od
I will review John in a couple of weeks

70 year old male – two consults consecutive days with GP and heart failure specialist nurse

---

H: bilateral elbow pain on hand flexion
E: tender around insertion of hand flexors
D: tendinitis.
P: Concerned that due to haemachromatosis - chat about this and benefit of continuing to abstain from alcohol.

H: long talk about issues around ED. Frustrated that cannot get a solution to the issues. Prospect of caverject not welcome. Unable to source vitaros still
Chat about poor outcome of psychosexual councelling as partner unable to join in.
P: Need to review depression score at next appt. Px given to try and source med elsewhere.

Vitaros 3mg/g cream (Ferring Pharmaceuticals Ltd) - 4 applicator - use as directed

Patient has parkinson's disease

H: ?burn from hot water bottle L lower leg. - but blister (now present 5 days) occured two days after hot water bottle applied.
Aching in l leg - painful around site of ulcer.
No contact with animals, no running in long grass etc.
Fitness instructor
E: 1.5cm diam shallow ulcer L lower leg anteriorly. Sl surrounding erythema but no tracking
D: ulcer ? cause.
P: adv non-a dressings and fresh are. Review if worsening.

Young adult

H: recent D&V - was i/p overnight
E: apyrexial; alert and responsive. Eczema still present. Ears nad.
Abdo sl bloated (dad says usual). Small faecal residue RIGHT IF (not left)
Cardiac sounds easily heard on R chest.
D: D&V with residual constipation
P: Gen adv re fluid intake and continuing to feed. ADv see if worsening (esp floppy, xs vomiting etc.) Considered situs inversus but on reflection think this is the remainder of constipation - adv review in a week to palpate abdo.

Patient has branchio-oculo-facial syndrome; aged 43 weeks

H: request morning after pill - SI yesterday afternoon .
P: counselled about taking, risks etc. See if no period, see if abdo pain.

Ulipristal 30mg tablets - 1 tablet - Take one tablet As a single dose As soon As possible

40 year old female patient with alpha thalassaemia trait and h/o psychosis

---

H: request for COCP to regularise periods. finds 3m helps for a while then pattern becomes chaotic. Asked about early implant change - adv ok to do so and possible helpful to see if periods better controlled.
Vegetarian.
E: 100 / 50mmHg
P: see sos

Gedarel 30microgram/150microgram tablets (Consilient Health Ltd) - 63 tablet - take one tablet every day for twenty one days, have a seven day break (no tablets) before starting the cycle again, one tablet per day for twenty one days

24 yr old female with implanon implant in place

H: old plated # L ankle - sl prominence. No h/o trauma.
E: redness at proximal end of ankle scar with swelling and tenderness.
P: do XR L ankle for lossening etc.

H: pains in fingers of both hands - lasted a couple of weeks. Office work
E: discomfort on ext pollicis longus tendon R
D: tendonitis.
P: adv ice NSAID and review what the cause is.

14:22 - Surgery: Dr Catherine Dixon (Clinical Practitioner Access Role)
XR Ankle Lt Report, Satisfactory, No Further Action: xr unchanged from previous

32 yr old male – consultation and result of XR

The items below all refer to the same patient aged 67 – one face to face consultation, a note after the patient left and the consultant opinion from the next day.

H: acoutsic neuroma 20 years ago - started to be a little unsteady. Finds if gets physically tired makes it worse. Worsening since October time. abnormal sensory feeling across from waist downwards.
E: see previous neuro exam
D: sensory level ? cause
P: A&E said need spine MRI as well as head.
No urgent neuro appts for 12 weeks. Chase up CT scan.

12:52 - Surgery: Dr Kathryn McCready (Clinical Practitioner Access Role)
Neutrophil count 2.02 10^9/L [1.8 - 8]
Mean cell haemoglobin concentration 33.4 g/dL [32 - 37]
Red blood cell distribution width 13.6 % [10 - 16]
Eosinophil count - observation 0.2 10^9/L [0.04 - 0.5]
Monocyte count - observation 0.43 10^9/L [0.3 - 0.9]
Lymphocyte count 1.71 10^9/L [1 - 4]
Basophil count 0 10^9/L [0 - 0.1]
Mean cell haemoglobin level 30.9 pg [27 - 32]
Total white blood count 4.4 10^9/L [3.6 - 11]
Haemoglobin concentration 14.1 g/dL [12 - 16]
Full blood count
Platelet count - observation 174 10^9/L [140 - 425]
Mean cell volume 92.3 fL [81 - 101]
Haematocrit 0.422 [0.37 - 0.49]
Red blood cell count 4.57 10^12/L [3.8 - 5.8]
Full blood count Report, Normal, No Further Action

Serum alkaline phosphatase level 65 iu/L [35 - 105]
Serum total bilirubin level 7 umol/L [0 - 21]
Liver function tests
Serum alanine aminotransferase level 21 iu/L [7 - 33]
Urea and electrolytes
If the patient is of Afro-Caribbean origin
multiply eGFR by 1.159
Serum TSH level 2.55 miu/L [0.2 - 4.2]
Serum albumin level 45 g/L [35 - 50]
Serum folate level 6.9 ng/ml [3.9 - 27]
*in cases of renal disease Serum Folate
may be unreliable
Please note as of 9/12/16 due to a kit reformulation a
new folate reference range is in use.
Serum urea level 7.4 mmol/L [2.8 - 8.1]
Serum sodium level 144 mmol/L [133 - 146]
Serum potassium level 4.6 mmol/L [3.5 - 5.3]
Serum creatinine level 69 umol/L [45 - 84]
Serum C reactive protein level < 1 mg/L [< 5]
Serum vitamin B12 level 305 ng/L [180 - 630]
eGFR using creatinine (CKD-EPI) per 1.73 square metres 79 mL/min
Serum C reactive protein level;Serum folate level;Liver function tests;Serum TSH level;Urea and electrolytes;Serum vitamin B12 level;AKI Alert Report, Normal, No Further Action

P: As agreed with patient I spoke to radiology at HGH - . Describing the disparate neuro symptoms to him he said that the patient needs to see a neurologist before they would undertake more scanning. Pt does have head ct appt on Monday.

Email to send to neurology secretary . @nhs.net from my nhs.net account:

Thank you for considering this referral a urgent. The patient is aware that I am trying to expedite the appointment.
Anne has a PH of acoustic neuroma removal 1997 (+ post op CSF leak and meningitis) and excision of C5/6 disc for spondylosis and myelopathy in 2008. She is fiercely independent and lives alone. Over the last 3-4 weeks she has become increasingly unsteady on her feet, needing to hold on to furniture and is now using sticks. She reports pain across her neck and down her back when she coughs or sneezes. She has no headache or vertigo. She has no bowel or bladder dysfunction.
She has been seen in primary care and in HGH A&E. Examination only reveals reduced pin prick sensation around the mid abdomen, without loss of power or reflexes. She has an ataxic gait.
A colleague discussed the case with the neurologist who has organised a CT head for this coming Monday. The doctors in A&E have suggested that she should have a full spine MRI. Dr today is understandably unwilling to organise this without neurological assessment. I feel concerned about this lady and hope an early appointment can be offered.

Investigation:
MRI spine

Diagnosis:
Suspected cervical myeloradiculopathy

Thank you for referring who is a sixty seven year old, retired teaching assistant who attended with her daughter. I note she had a left sided acoustic neuroma removed in 1997 and also had surgery to the C5/6 disc in London in 2008 (it sounds like she may have had a radiculopathy).

About four weeks ago she had difficulties walking which has been gradually getting worse, in other words it was not of sudden onset. She has also noticed some numbness around her torso and left leg.
She feels the left leg is weaker than the right but her arms are not quite as strong as they were. She also describes a pain shooting from her left shoulder down into the elbow. She has not described any new bladder or bowel symptoms. If she flexes her neck this seems to help her symptoms and sometimes when she coughs she gets a sudden shock spreading down her legs.

She does not describe any dizziness or vertigo.

She is on Duloxetine. She is an ex-smoker and drinks no alcohol. She does not drive. On examination she had mild spasticity in both legs and some mild weakness throughout the left leg. Her reflexes were globally brisk, although the plantar responses were downgoing. She reported some patchy alteration to sensation in her lower back but there was no definite sensory level.

Impression:
The symptoms sound suggestive of a cervical myeloradiculopathy, probably due to degeneration and the
previous neck problems would also favour this diagnosis. I note she has had an urgent CT scan of the
brain booked for next week but that is not required. I have requested an urgent MRI scan of her cervical and thoracic spine. If this shows cord compression then she was keen to get referred to a surgeon and I will write to the neurosurgery department in Leeds.

If she has any clear worsening of her symptoms pending the scan then we might need to expedite the
scan and referral.

For this stage I have not arranged follow up.