NHS DISCHARGE SUMMARY (FICTIONAL)

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MERSEYSIDE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

Department of Neurology
The Walton Centre for Neurology and Neurosurgery
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Tel: 0151 525 3611

NHS Number: 123 456 7890
Hospital Number: WC78901

GP: Dr. Anish Sharma
Waterloo Primary Care Centre
22 Crosby Road South
Liverpool L22 1RQ

PATIENT DETAILS

Name: THOMPSON, Robert
DOB: 17/11/1976 (48 years)
Address: 14 Mersey View, Liverpool L3 4AT

DISCHARGE SUMMARY

Date of Admission: 16 February 2025
Date of Discharge: 24 February 2025
Consultant: Professor David Wilson, Consultant Neurologist
Discharging Doctor: Dr. Sophie Evans, Specialty Registrar

DIAGNOSIS

1. Secondary progressive multiple sclerosis with acute deterioration
2. Aspiration pneumonia
3. Dysphagia
4. Neurogenic bladder with catheter-associated UTI

PRESENTING COMPLAINT

Mr. Thompson was admitted via A&E with acute worsening of speech, swallowing difficulties, and increased lethargy over 48 hours.

HISTORY OF PRESENTING COMPLAINT

Mr. Thompson has a 15-year history of multiple sclerosis, initially presenting with transient sensory symptoms in 2010. He was diagnosed with relapsing-remitting MS and commenced on beta-interferon. His disease converted to secondary progressive MS in 2020. He has been wheelchair-dependent since 2022.

Two days prior to admission, his wife noted progressive slurring of speech and difficulty swallowing, with episodes of coughing while drinking. On the day of admission, he became increasingly lethargic with a low-grade fever. Upon arrival to A&E, he was tachypnoeic with oxygen saturations of 92% on room air.

His disease-modifying therapy was changed from interferon to siponimod in 2021. However, this was discontinued 6 months ago due to progressive liver function abnormalities and concern about lack of efficacy in his advanced disease state.

PAST MEDICAL HISTORY

- Secondary progressive multiple sclerosis (transitioned from RRMS in 2020)
- Neurogenic bladder (indwelling catheter since 2023)
- Spasticity and contractures
- Recurrent aspiration pneumonia (previous admission November 2024)
- Stage 2 pressure ulcer sacrum (healing)
- Depression and anxiety
- Previous cholecystectomy (2015)

MEDICATIONS ON ADMISSION

1. Baclofen 25mg TDS
2. Tizanidine 2mg nocte
3. Pregabalin 150mg BD
4. Fluoxetine 40mg OD
5. Oxybutynin 5mg BD
6. Docusate sodium 100mg BD
7. Vitamin D 4000 IU OD
8. Calcium carbonate 1.25g OD
9. Omeprazole 20mg OD
10. Paracetamol 1g QDS PRN
11. Codeine phosphate 30mg QDS PRN

ALLERGIES

Tramadol (causes confusion)

SOCIAL HISTORY

Lives with wife (main carer) in adapted ground-floor flat. Package of care with carers visiting twice daily for personal care. Full wheelchair user. Previously worked as a civil engineer until 2021. Non-smoker. Occasional alcohol.

INVESTIGATIONS

Blood Tests: - WCC: 14.2 x10^9/L (↑) - Neutrophils: 12.1 x10^9/L (↑) - Hb: 118 g/L - Platelets: 324 x10^9/L - CRP: 87 mg/L (↑) - Sodium: 133 mmol/L (↓) - Potassium: 4.2 mmol/L - Urea: 8.7 mmol/L (↑) - Creatinine: 98 umol/L - eGFR: 75 mL/min - ALT: 32 U/L - ALP: 104 U/L - Albumin: 32 g/L (↓)

Microbiology: - Blood cultures: No growth after 5 days - Urine culture: >10^5 cfu/mL E. coli (sensitive to nitrofurantoin, trimethoprim) - Sputum culture: Mixed respiratory flora, no predominant pathogen

Imaging: - Chest X-ray (16/02/2025): Right lower zone consolidation consistent with aspiration pneumonia - CT Head (16/02/2025): Multiple periventricular white matter lesions consistent with demyelination. No acute changes. Mild generalised atrophy. - MRI Brain and Cervical Spine (18/02/2025): Extensive demyelinating lesions throughout the periventricular regions, brainstem, and upper cervical cord. No new or enhancing lesions. Progressive atrophy compared to previous imaging (09/2023).

Additional Investigations: - SALT assessment (18/02/2025): Moderate oropharyngeal dysphagia. Unsafe for thin fluids. Able to manage soft moist diet with supervision. Silent aspiration observed on videofluoroscopy.

HOSPITAL COURSE

Mr. Thompson was admitted with aspiration pneumonia and urinary tract infection complicating his underlying secondary progressive MS. He was commenced on IV co-amoxiclav and IV fluids. His indwelling catheter was changed. Within 48 hours, he showed clinical improvement with reduced fever and improved respiratory status.

Neurology team assessment determined that his acute deterioration was primarily related to infection rather than MS disease activity. MRI showed no new or active lesions.

Speech and Language Therapy assessed his swallowing and implemented modified diet recommendations. Dietetics provided guidance on nutritional supplementation.

Physiotherapy provided chest physiotherapy and maintaining range of motion exercises. Occupational Therapy assessed seating and pressure care needs.

The MS Specialist Nurse reviewed his symptom management regimen and adjusted medications for optimal symptom control.

The patient and his wife were counselled regarding disease progression and advanced care planning.

DISCHARGE PLAN

Medications on Discharge: 1. Baclofen 25mg TDS (unchanged) 2. Tizanidine 4mg nocte (↑ from 2mg) 3. Pregabalin 150mg BD (unchanged) 4. Fluoxetine 40mg OD (unchanged) 5. Oxybutynin 5mg BD (unchanged) 6. Docusate sodium 100mg BD (unchanged) 7. Vitamin D 4000 IU OD (unchanged) 8. Calcium carbonate 1.25g OD (unchanged) 9. Omeprazole 20mg OD (unchanged) 10. Paracetamol 1g QDS PRN (unchanged) 11. Codeine phosphate 30mg QDS PRN (unchanged) 12. Nitrofurantoin 50mg nocte (NEW - prophylactic dose for 3 months) 13. Metoclopramide 10mg TDS PRN (NEW - for nausea)

Clinical Management Plan: 1. Complete 7-day course of oral co-amoxiclav 625mg TDS (5 days remaining) 2. Continue thickened fluids and soft moist diet as per SALT recommendations 3. District Nurse referral for catheter care and pressure area management 4. Increased package of care to 3 times daily visits

Follow-up Arrangements: 1. Community MS Nurse: Home visit booked for 03/03/2025 2. Community SALT: Review in 2 weeks 3. Neurology outpatient clinic: 6 weeks (appointment to be sent) 4. GP review: 1 week

Equipment and Adaptations: 1. Hospital bed arranged for home installation (28/02/2025) 2. Pressure-relieving mattress provided 3. New wheelchair cushion provided

INFORMATION PROVIDED TO PATIENT/CARER

The patient and his wife have been informed about: - The nature of his recent deterioration and management plan - Warning signs that would necessitate urgent medical attention - Management of dysphagia and modified diet instructions - Medication changes and side effects to monitor - Contact details for MS Specialist Nurse and community teams - Advanced care planning discussions initiated

ADDITIONAL INFORMATION FOR GP

Mr. Thompson's disease has shown significant progression over the past year with increasing bulbar symptoms. We have discussed with the patient and family that his MS has entered an advanced stage. The MS team has initiated conversations about advance care planning, but further discussions in the community setting would be beneficial.

We have not restarted disease-modifying therapy given the advanced secondary progressive nature of his condition and previous adverse effects. Palliative approach to symptom management is now the focus of care.

Please consider referral to community palliative care team for ongoing support with symptom management and advance care planning.

If you have any questions or concerns, please contact our MS Specialist Nurse team on 0151 525 3611 ext. 4778.

Yours sincerely,

Dr. Sophie Evans
Specialty Registrar in Neurology
GMC No: 7654321

Countersigned by:

Professor David Wilson
Consultant Neurologist
GMC No: 4567890

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