

# CLINIC LETTER

Dr AP BHASI  
SHREWSBURY ROAD HLTH CTR  
LONDON  
E7 8QP

The Royal London Hospital  
Whitechapel Road  
London E1 1FR

Mr JIALIN YANG  
Flat 48 Cornwell House  
13 Ron Leighton Way  
LONDON  
E6 1EQ

NHS no:717-887-1857  
MRN:10542590  
Sex: Male  
DOB: 06-MAR-1985

Date: 07-FEB-2024

Clinic: RNJ Clinic 3 RLH  
Clinic Date: 07-FEB-2024  
Next Clinic:

**Consultant: Janet Dearden; Hepatology Service**

Dear Jialin,

**Problem List:**

1. Solitary Hepatic Metastasis (Adenocarcinoma) of Unknown Primary
  - referred due to weight loss and dysphagia
  - OGD and CTCAP unremarkable except for presume haemangioma of liver
  - in view of previous hepatitis C, MRI liver arranged which was concerning for malignancy
  - biopsy 24/1 confirms metastatic adenocarcinoma, possible lung or GI primary

**Previous Medical History:**

Spontaneous Pneumothorax  
Hepatitis C (cleared)

**Family History:**

Father - Lung Cancer

**Social History:**

Data Analyst  
Lives alone  
PS 0  
Ex-smoker

**Recent Investigations:**

CTCAP Oct 2023 - The oesophagus is not dilated. No oesophageal mass. No thoracic lymph node enlargement. No pleural effusion. A 3-mm nodule posteriorly in the left lower lobe is likely a benign intrapulmonary lymph node. Within segment 4b of the liver there is a 9-mm hypodensity, difficult to characterise but likely a haemangioma. The remaining solid organs are normal. There is faecal loading in the colon. Allowing for the unprepared nature of the study there is no colonic mass. No aggressive bone lesion.

Targeted Liver Biopsy Jan 2024 - moderately differentiated adenocarcinoma

Thank you for attending clinic today. I saw you in conjunction with Dr Dearden (Consultant Hepatologist) and Jenny Crone (Hepatology Nurse Specialist). We re-capped the events which had led to your attendance in clinic today. You had symptoms of weight loss and dysphagia which were investigated with a CT chest/abdomen/pelvis and a gastroscopy. These were normal except for a small liver lesion which was presumed to be a haemangioma. In view of your previous history of

hepatitis C, an MRI liver was performed which was less reassuring. You have since undergone a targeted liver biopsy and discussion in our multidisciplinary team meeting (MDT) and I was sorry to report the biopsy has confirmed this to be cancer. It is not a primary liver cancer and has spread from somewhere else within the body, possibly lung or lower gastrointestinal tract.

Our priority is to try and identify the primary. You have no symptoms to suggest either a lung or lower GI primary. We have therefore arranged for an urgent PET-CT scan. Further tests may be required beyond this. We are hopeful that you will have operable disease but we need more information before we can provide any information regarding treatment options and prognosis.

We have provided you with our contact details and we will proactively call you tomorrow and keep you updated as and when results come back.

Outcome / Plan:

PET-CT - booked for 9/2/24

Yours sincerely,

**Dr Michael Hewitt**  
Hepatology Registrar to  
Dr Yiannis Kallis and Dr Janet Dearden  
Consultant Hepatologists  
Secretary Tel: 020 359 43500 / 43400

Email: [bartshealth.hepatology.services@nhs.net](mailto:bartshealth.hepatology.services@nhs.net)

**Electronically Signed By: Michael Hewitt, Clinical Practitioner Access Role**

# Cancer

## CLINIC LETTER

Dr AP BHASI	The Royal London Hospital
SHREWSBURY ROAD HLTH CTR	Whitechapel Road
LONDON	London E1 1FR
E7 8QP	

Mr JIALIN YANG	NHS no: 717-887-1857	Date: 15-FEB-2024
Flat 48 Cornwell House 13 Ron Leighton Way	MRN: 10542590 Sex: Male	Clinic: RNJ Clinic 3 RLH
LONDON E6 1EQ	DOB: 06-MAR-1985	Clinic Date: 14-FEB-2024
		Next Clinic:

**Consultant: Janet Dearden; Hepatology Service**

Dear Jalin,

### Problem List:

1. Metastatic Adenocarcinoma of Unknown Primary
  - referred due to weight loss and dysphagia
  - OGD and CTCAP unremarkable except for presume haemangioma of liver, symptoms resolved
  - in view of previous hepatitis C, MRI liver arranged which was concerning for malignancy
  - biopsy 24/1 confirms metastatic adenocarcinoma, possible lung or GI primary
  - PET scan 9/2 - multiple hepatic metastases, further tracer uptake in sigmoid colon

### Previous Medical History:

Spontaneous Pneumothorax  
Hepatitis C (cleared)

### Family History:

## Father - Lung Cancer

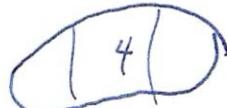
### Social History:

Data Analyst

Lives alone

PS 0

Ex-smoker



### Recent Investigations:

CTCAP Oct 2023 - The oesophagus is not dilated. No oesophageal mass. No thoracic lymph node enlargement. No pleural effusion. A 3-mm nodule posteriorly in the left lower lobe is likely a benign intrapulmonary lymph node. Within segment 4b of the liver there is a 9-mm hypodensity, difficult to characterise but likely a haemangioma. The remaining solid organs are normal. There is faecal loading in the colon. Allowing for the unprepared nature of the study there is no colonic mass. No aggressive bone lesion.

Targeted Liver Biopsy Jan 2024 - moderately differentiated adenocarcinoma

PET CT Feb 2024 - There are at least seven metabolically active lesions throughout both lobes of the liver which are suspicious for hepatic metastases. The focus of uptake within the sigmoid colon could represent bowel spasm, however a colonoscopy is advised to rule out a primary colorectal malignancy. There is no metabolically active disease identified elsewhere.

### Progress:

Thank you for attending clinic today. I reviewed you with our CNS Joy present. I was extremely sorry to report that the PET scan had demonstrated multiple sites of tracer uptake within the liver, suggestive of more extensive liver metastases than previously thought. This unfortunately makes your cancer non-operable and incurable. We are still trying to identify the primary site and the PET scan has suggested a possible area in the sigmoid colon which we will visualise directly via a colonoscopy which has since been scheduled for this coming Saturday. You will have some additional bloods as requested by the

oncology team, alongside a repeat CT chest/abdomen/pelvis to formally re-stage your disease given the progression we have seen on the PET.

We discussed how systemic therapy with chemotherapy will be the likely way forwards and our oncologists are aware of your case and will see you as soon as we have sufficient information regarding the underlying primary diagnosis.

Outcome / Plan:

Repeat Bloods  
CT Chest / Abdomen / Pelvis  
Colonoscopy

Yours sincerely,

**Dr Michael Hewitt**  
Hepatology Registrar to  
Dr Yiannis Kallis and Dr Janet Dearden  
Consultant Hepatologists  
Secretary Tel: 020 359 43500 / 43400  
Email: bartshealth.hepatology.services@nhs.net

**Outpatient Phlebotomy Booking**

The blood test services at The Royal London & Mile End Hospitals are changing from a walk-in service to an appointment-only system. Patients will need to book an appointment online at:

**[www.bartshealth.nhs.uk/phlebotomy](http://www.bartshealth.nhs.uk/phlebotomy)**

If patients do not have access to the internet they can book an appointment by calling Central Appointments on 020 7767 3200.

**Electronically Signed By: Michael Hewitt, Clinical Practitioner Access Role**

# CLINIC LETTER

Barts Health NHS Trust

Dr AP BHASI  
SHREWSBURY ROAD HLTH CTR  
LONDON  
E7 8QP

The Royal London Hospital  
Whitechapel Road  
London E1 1FR

Mr JIALIN YANG  
Flat 48 Cornwell House  
13 Ron Leighton Way  
LONDON  
E6 1EQ

NHS no: 717-887-1857  
MRN: 10542590  
Sex: Male  
DOB: 06-MAR-1985

Date: 27-OCT-2023

Clinic: RNJClinic 5 RLH  
Clinic Date: 27-OCT-2023  
Next Clinic:

## Consultant: Michael Glynn; Gastroenterology Service

Dear Jialin,

### Problem:

2WW referral for dysphagia and weight loss

### Investigations:

Gastroscopy Sept 2023: non-erosive gastritis, CLO negative

CT TAP Oct 2023: The oesophagus is not dilated. No oesophageal mass. No thoracic lymph node enlargement. No pleural effusion. A 3-mm nodule posteriorly in the left lower lobe is likely a benign intrapulmonary lymph node. Within segment 4b of the liver there is a 9-mm hypodensity, difficult to characterise but likely a haemangioma. The remaining solid organs are normal. There is faecal loading in the colon. Allowing for the unprepared nature of the study there is no colonic mass. No aggressive bone lesion.

### Clinic Review:

It was a pleasure to see you in a face-to-face consultation in 2WW Gastroenterology clinic.

You had an acute 1 month history of some difficulty in swallowing and associated epigastric pain when eating. You reduced your oral intake as a result of the pain and then lost about 4kg in weight. There was no associated vomiting, haematemesis or change in bowel habit. You are otherwise well. You have since started an acid suppressant medication and your symptoms have improved, and you have re-gained 1kg and indeed to day you were very well and completely symptom free.

Your medical history is significant for previous pneumothorax and treated Hepatitis C. You were born in Shanghai and have lived here for 5 years. You are an ex-smoker, do not use drugs and drink 2 units of alcohol per week. You live alone and work as a data analyst.

I explained we will get an MRI scan of the liver to confirm a benign haemangioma and review you again with the results.

Yours sincerely,

Dr Sarah Faloon MRCP  
Gastroenterology Registrar  
Secretary Tel: 020 359 43500 / 43400  
Email: [bartshealth.gastroenterologyservices@nhs.net](mailto:bartshealth.gastroenterologyservices@nhs.net)

# Endoscopy and Bronchoscopy Department

The Royal London Hospital - Direct Line: +44 (0)20 359 43600

Barts Health NHS Trust

## Gastroscopy Report

Patient MRN: 10542590

Date: 27/09/2023

Biopsy Nurse: Sheila Marie Arjona

Patient Name: Mr JIALIN YANG

Time: 13:46

Nurse 2: Sarah Kaye Trinidad

Date of Birth: 06/03/1985

Gastroscope: GIF-XQ260 - 2522295

Nurse 3:

NHS Number: 7178871857

Independent Endoscopist: Mr Benidick

Requested by: BHASI A

GP: Dr BHASI A

Batallones

SHREWSBURY ROAD HLTH CTR,

Assistant:

SHREWSBURY ROAD, FOREST GATE LONDON

Trainee: Emma Routledge

N E7 8QP

Patient Source: Outpatient urgent

### Indication

Procedure Intention: Diagnosis

Dysphagia.

Weight loss.

### Comorbidity

None.

### Medication

ASA Status 1 (healthy).

Xylocaine - Throat spray.

### Extent of Exam

The endoscope was introduced to: the 2nd part of duodenum.

The extent of examination was reached by the trainee.

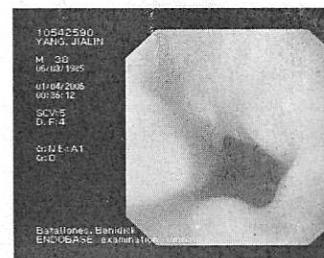
The procedure was not limited and the intended extent of examination was reached.

### Findings

**OESOPHAGUS:** The oesophagus appeared normal.

**STOMACH:** There was mild non-bleeding erythematous gastritis in the lower body of the stomach & the incisura & the antrum.

**DUODENUM:** The duodenal cap and second part appeared normal.



1. Lower oesophagus

### Diagnosis

Gastritis - non-erosive.

**Procedures:** No therapeutic procedures performed.

**Adverse Events:** There were no complications during the procedure.

**Specimens** No biopsies taken.

**Urease (CLO) Test** A biopsy urease (CLO test) test was performed. The result was negative.

**Aftercare:** Return to referring Dr. Follow up in gastro clinic.

**Cancer Pathway:** Cancer not found but further investigations required - continue on pathway.

### Additional Comments

2WW referral for dysphagia and ongoing weight loss.

Mild erythematous gastritis with no sinister abnormality, remainder of GI tract appeared unremarkable. CLO test negative



2. Fundus in retroflexion

### PLAN:

GP to continue standard dsoe PPI

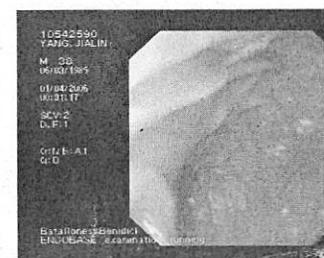
Urgent CT TAP to investigate weight loss futher

Follow up in Gastro Clinic to review results.

### Electronically signed by:

Mr Benidick Batallones. Clinical Endoscopist

Dr Emma Routledge. IMT3 Gastroenterology



3. Second stage of duodenu

Dr BHASI A  
SHREWSBURY ROAD HLTH CTR, SHREWSBURY ROAD,  
FOREST GATE  
LONDON  
E7 8QP

4.

Discharge by:  
Discharge Nurse:  
Outcome:  
Discharging Ward: RNJ RLH DSU

# Summary

## Diagnosis

No ranking:

24-Jan-2024 Abdominal pain (Confirmed) - Presented On: 24-Jan-2024

## Procedures

None

## Clinical summary

Patient has attended for a liver biopsy in segment 4b liver lesion. US guided biopsy of liver lesion using 18 guage x 2 core biopsies using the biopince needle. No bleeding post procedure. Samples sent for histopathology. Patient can go home after 4 hours, if no pain, haemodynamically stable and eating / drinking/ mobilising.

## Follow up plans

Follow up requested: HPB MDM discussion

Time frame: 2 weeks

## Outpatient appointment

Please contact the central appointments team as soon as possible if:

You have not received your clinic or outpatient follow up on the time that was agreed upon discharge from hospital or

You need to cancel or change an outpatient appointment

For The Royal London Hospital, Mile End Hospital or St Bartholomew's Hospital (non-cardiac patients) call: 020 7767 3200

For cardiac patients, contact Barts Heart Centre on: 0207 480 4602

For Newham Hospital call: 020 7476 4000

For Whipps Cross Hospital call: 020 8535 6768

Follow up Barts

Health appointment required: Yes

## Safety alerts

None

Result title: Inpatient Discharge Summary

Performed by: Mohamed , Leyla Abdillahi on 24 January 2024 11:33 GMT

Verified by: Mohamed , Leyla Abdillahi on 24 January 2024 11:33 GMT

Printed by: Ege , Myles Orion Cenas

Printed on: 24/Jan/2024 12:17 GMT

Page2 of 4

# Endoscopy and Bronchoscopy Department

The Royal London Hospital - Direct Line: +44 (0)20 359 43600

Barts Health NHS Trust

## Colonoscopy Report

Patient MRN: 10542590  
Patient Name: Mr Jialin Yang  
Date of Birth: 06/03/1985  
NHS Number: 7178871857  
GP: Dr A BHASI  
SHREWSBURY ROAD HLTH CTR,  
SHREWSBURY ROAD, FOREST GATE LONDON Trainee:  
N E7 8QP

Date: 17/02/2024

Time: 09:58

Colonoscope: CF-HQ290L - 2852708

Independent Endoscopist: Dr SHAMEER MEHTA

Assistant:

Biopsy Nurse:

Nurse 2: Ofelia Luarca

Nurse 3: ENRICO BAMBAO

Requested by: Michael Hewitt

Patient Source: Outpatient urgent

Procedure Intention: Diagnosis

### Medication

Midazolam - iv: 4 mg.

Fentanyl - iv: 100 mcg.

Buscopan - iv: 10 mg.

### Bowel Prep:

Bowel cleansing agent: Moviprep. Quality: Good - >90% of mucosa seen, mostly liquid stool, significant suctioning needed for adequate visualisation.

### Indication

Abnormality on CT / barium.

### Comorbidity

None.

ASA Status 1 (healthy).

### Extent of Exam

The extent of examination was reached by the independent endoscopist.

The endoscope was introduced to the caecum. The withdrawal time was 25 mins.

The intended extent of examination was reached.

### Findings

TERMINAL ILEUM: The terminal ileum was not entered.

COLON: Polyps - see Polyp Findings. (4 polyps seen).

ANUS: The anus was normal.

### Polyp Findings:

#### Polyp Findings

There was a 3 mm sessile, surface type IIIL - tubular or round pit polyp identified in the sigmoid. The polyp was raised with a submucosal injection of indigo carmine, The polyp was removed by cold snare (removed en bloc), retrieved. The polyp was not tattooed. The polyp was sent for histology in pot number 1. The therapeutic procedure was completed by the endoscopist.

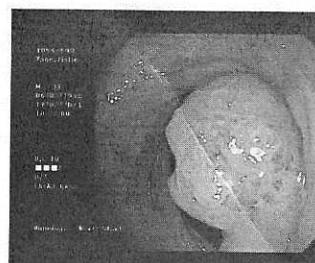
There was a 2 mm sessile, surface type IIIS - tubular or round pit polyp identified in the transverse colon. The polyp was removed by cold snare (removed en bloc), retrieved. The polyp was not tattooed. The polyp was sent for histology in pot number 2. The therapeutic procedure was completed by the endoscopist.

There was a 3 mm, sessile polyp identified in the descending colon. The polyp was removed by cold snare (removed en bloc), retrieved. The polyp was not tattooed. The polyp was sent for histology in pot number 3. The therapeutic procedure was completed by the endoscopist.

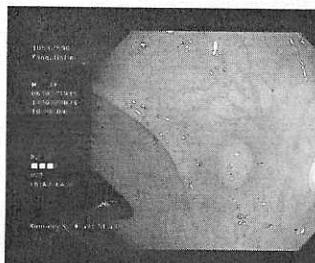
There was a 18 mm, subpedunculated polyp identified in the sigmoid. The polyp was raised with a submucosal injection of indigo carmine, The polyp was (polypectomy not performed) - not removed (reason: See report comment), not retrieved.. The polyp was not tattooed. The polyp was not sent for histology. The therapeutic procedure was completed by the endoscopist.

### Diagnosis

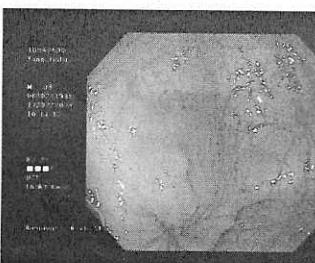
Dr A BHASI  
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FOREST GATE  
LONDON  
E7 8QP



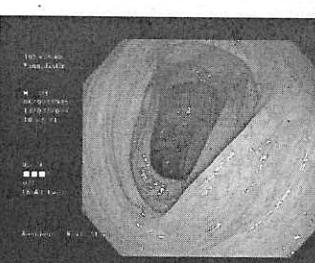
1. Polyp



2. Polyp



3. Polyp



4. Ascending colon

# **Endoscopy and Bronchoscopy Department**

The Royal London Hospital - Direct Line: +44 (0)20 359 43600

**Polyp/s.**

**Procedures:**

Polyp removal - Polypectomy (see polyp findings).

**Adverse Events:**

There were no complications during the procedure.

**Specimens**

Polyp specimen taken - see polyp findings.

No biopsies taken.

**After care**

Follow up in 1 weeks.

**Cancer Pathway**

Cancer not found but further investigations required - continue on pathway.

**Additional Comments**

Three small sessile polyps removed with cold snare as described (sigmoid, transverse and descending colon).

There was an 18mm polyp within the sigmoid at 25cm which presumably accounts for the PET findings. Initially there appeared to be a stalk but actually the polyp looked subpedunculated. The pit pattern was slightly irregular in one area en face, and there was a slight depression on the luminal aspect. The polyp lifted well on the distal aspect but less well on the proximal aspect. Proceeded to snare but there followed quite significant contact bleeding which obscured views so I could not confidently identify the position of the snare. Procedure abandoned, patient placed in recovery and brought back at the end of the morning list to reassess.

Unfortunately stool and clot still could not be washed off.

We will rebook as a sigmoidoscopy with full bowel prep next week for good views and reassessment of this polyp which will obviously be key to next steps of Jialin's management.

**Electronically signed by:**

Dr SHAMEER MEHTA

Consultant Gastroenterologist