NUR Handover Note SGH-AM [Charted Location: W55A-0003-05] [Authored: 21-Jun-2025 14:51]- for Visit: 6725340463D, *Complete, Revised, Signed in Full, General*

Situation:

• **Shift Type**	AM
• **Care Level**	GW

Background:

• **Past Medical History**	1. Invasive carcinoma of breast, Desc: 3290542017 : Invasive carcinoma of breast 2. Distortion of breast, Desc: 476155018 : Distortion of breast Basis of Staging=Pending Basis of Staging=Pending Basis of Staging=Pending 3. Keratosis pilaris
• **Diagnosis**	1. Urticaria, Onset: 20/6/2025
• **Presenting Complaints**	===Demographics=== 57 year-old Chinese female Post menopausal PS: ECOG 0 DA to celecoxib Non smoker, non drinker Divorced with 1 daughter lives with daughter not working FMHx: mother breast ca 70s ===Past Medical History=== Onco Hx 1. Right breast Stage IV pT2(43mm)N2a(5/14)M1(L axilla LN+ve) G2 IDC - ER+(95%), PR+(10%), HER2 2+, FISH-ve - Dx Mar25 - s/p R SMAC + contralateral risk reducing L SM + SLNBx 23/5/25 -> R breast pT2(43mm)N2a(5/14) -> L breast - no in-situ/invasive Ca, 1mi/2 LN -> same morphology + immunoprofile as R breast Past Medical History/Past Surgical History: 1. GERD 2.lumbar spondylosis 3. Uterine fibroids s/p laparotomy myomectomy on 20/3/15 last seen by DMO 16/6/25 -urticarial rash noted, persistent despite antihistamine, given TCU Derm -letrozole stopped

===History of Presenting Complaint===
1. persistent itchy rash x1 week
affecting face, body, limbs
worsening past 2 days
a/w facial swelling and bilat LL swelling
taking antihistamines but not improving
no voice changes

previously on letrozole from 10/4/25-12/6/25
-forgot to take since 12/6/25, then DMO told her to stop since 16/6/25
no new medications
allergic to celecoxib (rash)
no recent ingestion of analgesia/NSAIDs
no known food allergy

2. tactile fever x few days
did not measure temperature at home
a/w dry throat

3. chest tightness since Monday
central chest
on/off
not related to exertion
a/w SOB
no diaphoresis
no orthopnea
no reduced ET

no abdo pain
BO normal
no diarrhea
no vomiting
no urinary symptoms
no urinary frequency, no dysuria/hematuria

<Hx revisited>
Bilateral feet rash and itch started 12/6
says spread up bilateral LL
initially involved centre of bilateral palms, then started to affect proximal UL
Involvement of trunk (chest, back, abdo) started at midpoint between 12/6 and now
Now involving face and eyes
Itchy++++
No diarrhoea
No tongue or lip swelling

SOBOE and chest tightness started 2 days ago
Would feel very tired when trying to shower
no diaphoresis
Worried about new occurence of rash; was previously

well before breast ca diagnosis

===Examination===
vitals stable, afebrile

alert, nontoxic
not in respi distress
speaking in sentences
no stridor
no periorbital swelling
generalized urticaria over face, trunk, upper and lower limbs
mild periorbital and perioral swelling
H S1S2
L clear, no wheeze, no creps
A SNT
calves supple, bilat pedal edema over mid shins
Wound over R breast clean not particularly

===Progress in Emergency===
IV hydrocort 200mg once
IM Diphenhydramine 25mg
PO Paracet once

===Initial Ix===
Trop flat
K 3.4
CRP 69.5
NTproBNP 648
Hb 11.1 (baseline 12s)
TW 5.13 Plt 364
CXR nil consolidations or pleural effusions
ECG - NAD

===Issues/Impression===
1. urticaria for further investigation ?paraneoplastic
-may not be allergy as pt already had urticaria for 1 week, no obvious trigger, no new meds
- not improving with hydrocort or diphenhydramine
2. raised CRP and tactile fever- however, no clear source of infection
3. nonspecific chest discomfort and SOB - CXR clear, no lung infection, not overloaded, no ACS
4. b/g breast cancer

===Plan===
<Nursing>
Vitals Q4 hourly
Monitor IO
Allow diet

CBG TDS + 10pm x1/7 off if NAD

<Ix>
Trace CXR report

<Mx>
Mist KCl once
IV diphenhydramine
Telfast 180mg BD regular
Hold off IV abx for now as no clear source of infection
KIV refer DER cm

<Medication Changes>
Med recon
- Restart all old medications

<Discharge Plans>

Assessment:

- **Vital Signs**

Parameters charted in Vital Signs Flowsheet from 20/06/25 06:00 to 21/06/25 14:57:

21/06/2025 09:15:00	**Temperature (deg.C):** 36.9 (36-36.9) **Blood Pressure (NIBP) (mmHg):** 109/73 (99-125/53-75) **Blood Pressure (NIBP) mean:** 84.8 (84.8-84.8) **Heart Rate (beats/min):** 73 (67-76) **SpO2 (%):** 98 (98-100) **Respiration (breaths/min):** 18 (17-18) **Pain Score A:** 0 (0-0) **NEWS:** 1 (Low Risk)

- **Nursing Problems List** — Comfort

Progress Note:

- **Nursing Progress Notes** — Patient alert and conscious. For home today.
Discharge documents given and explained to patient.
Patient collected discharge medications on her own.
IV plug removed, nil redness or swelling seen. RFID removed.
Went home herself.
x1 suture on left leg in situ, opsite dressing dry and intact. Additional dressing supplies given to her and patient was taught on how to change dressing herself if needed. Explained to patient to remove dressing and expose suture after 48hours and apply tetracycline ointment on suture site after off dressing.

Taught patient to watch for signs of infection.
Discharge call card given to patient. Instructed if any reactions at home can call back the ward level immediately within 7 days of discharge.
needs attended to

Electronic Signatures:
Liang Xingyi (Nurse) (Signed 21-Jun-2025 14:58)
Authored: *Assessment*
Co-Signer: *Situation, Background, Assessment*
Valerie Tan Kai Lin (Nurse) (Signed 21-Jun-2025 14:54)
Authored: *Situation, Background, Assessment*

Last Updated: *21-Jun-2025 14:58 by Liang Xingyi (Nurse)*