Greendale Medical Practice
14 High Street, Greendale, GR4 1AB
Tel: 01632 960001 | Email: admin.greendale@medclinic.net

Date: 26 February 2026

To:
Dr. Simon Thorne
Consultant Hepatologist
Department of Hepatology
Greendale General Hospital
Trust Way, Greendale, GR1 8QH

URGENT REFERRAL: 2-WEEK WAIT (SUSPECTED HEPATOBILIARY MALIGNANCY)

Patient Details:

Name:	Mr. Arthur Shelby
DOB:	12/04/1958 (Age: 67)
Gender:	Male
NHS Number:	123 456 7890
Address:	88 Willow Road, Greendale, GR4 2XY
Contact:	07700 900123

Dear Dr. Thorne,

Presenting Complaint:

I would be grateful for your urgent specialist assessment of Mr. Shelby, a 67-year-old gentleman who presents with highly concerning constitutional symptoms, including an unintentional weight loss of 6.5 kg over the past six weeks, progressive debilitating fatigue, and a persistent, dull, poorly localized ache in his right upper quadrant (RUQ) radiating to his right scapula.

History of Presenting Complaint:

Mr. Shelby first noted mild RUQ discomfort approximately two months ago, which he initially attributed to indigestion. However, the pain has become persistent, non-colicky, and is exacerbated by large meals. Over the last month, he has developed profound early satiety and generalized lethargy. He denies any overt jaundice, pruritus, dark urine, or pale stools. There is no history of hematemesis, melaena, or recent changes in bowel habit. He has no known prior history of chronic liver disease, viral hepatitis, or significant alcohol use. His WHO Performance Status (ECOG) is currently 1.

Relevant Medical History:

- Type 2 Diabetes Mellitus (Diagnosed 2012, well-controlled, most recent HbA1c 48 mmol/mol).
- Essential Hypertension (Diagnosed 2015).
- Benign Prostatic Hyperplasia (BPH).
- Routine NHS Bowel Cancer Screening colonoscopy in 2024 was entirely unremarkable.

Medication History:

- Metformin 1g BD (Adherent, well-tolerated)
- Ramipril 5mg OD
- Tamsulosin 400mcg OD
- No over-the-counter supplements or herbal remedies.

- No known drug allergies.

Alcohol, Smoking, and Social History:

Mr. Shelby is a retired postman who lives with his wife in a two-story house. He is functionally independent but notes his recent fatigue has stopped his daily walks. He is a lifelong non-smoker. His alcohol intake is minimal, averaging 2–4 units of beer per month. He has no history of blood transfusions, intravenous drug use, tattoos, or occupational exposure to known hepatotoxins or industrial chemicals.

Examination Findings:

On examination today, Mr. Shelby appears chronically fatigued and slightly cachectic. BMI is 24.2 kg/m^2 (down from his baseline of 26.5 kg/m^2). Vitals: BP 135/82 mmHg, HR 78 bpm, Temp 36.8°C, SpO_2 98% on room air.

There is no scleral icterus, pallor, or cervical/supraclavicular lymphadenopathy (Troisier's sign is negative). Cardiorespiratory examination is unremarkable.

Abdominal examination reveals a flat abdomen with no visible distension or caput medusae. Upon palpation, there is moderate tenderness in the RUQ. A firm, nodular, and irregular liver edge is easily palpable approximately 4 cm below the right costal margin. Total liver span to percussion is enlarged at 16 cm. Murphy's sign is negative. Spleen is not palpable. There is no clinically detectable ascites (shifting dullness negative) and no peripheral stigmata of chronic liver disease (no spider naevi, palmar erythema, or asterixis).

Investigation Results:

Laboratory Findings (Drawn 24/02/2026):

- Bilirubin: 28 μmol/L (Ref: <21) [Mildly elevated]
- ALP: 345 U/L (Ref: 30–130) [Markedly elevated]
- ALT: 58 U/L (Ref: 0–40)
- AST: 62 U/L (Ref: 0–40)
- GGT: 210 U/L (Ref: 10–71)
- Albumin: 36 g/L (Ref: 35–50)
- FBC: Hb 112 g/L (Normocytic, MCV 88 fL), WCC 6.2×10^9/L, Platelets 210×10^9/L
- Coagulation: INR 1.0, PT 12.1s
- Renal profile & Electrolytes: Unremarkable.
- Tumour Markers: Alpha-fetoprotein (AFP): 485 kU/L (Ref: <5.8). CEA and CA 19-9 are pending.

Imaging (Urgent GP Direct Access Abdominal Ultrasound – 25/02/2026):

Report summary: "The liver is enlarged with mildly coarse echotexture. A large, 4.8 cm solid, heterogeneous, predominantly hypoechoic mass is visualized in the right hepatic lobe (Segment VI/VII) with irregular, ill-defined margins and internal vascularity on colour Doppler. The main portal vein is patent with normal hepatopetal flow. No intra- or extra-hepatic biliary ductal dilatation. Gallbladder is unremarkable. No ascites or splenomegaly. Conclusion: Highly suspicious for primary hepatocellular carcinoma or solitary metastasis."

Provisional Diagnosis:

Suspected Hepatocellular Carcinoma (HCC), given the solid irregular mass, marked ALP/GGT elevation, raised AFP, and constitutional symptoms.

Reason for Referral:

I am referring Mr. Shelby under the 2-Week Wait (Suspected Cancer) pathway. Given the ultrasound findings and significantly elevated AFP, he requires urgent hepatology review, triphasic cross-sectional imaging (CT/MRI Liver), and discussion at your Hepatobiliary MDT. I have explicitly counselled the patient and his wife regarding the suspected malignant nature of this referral, and they understand the urgency of the upcoming hospital appointments.

Yours sincerely,

Dr. Alice Pendelton, MRCGP
General Practitioner
Greendale Medical Practice