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NHS Trust

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Dr M A Roland
Consultant Physician

Clinic: 29 December 2006
Typed: 2 January 2007

MAR/GW/G102024/424 888 7452

Dr K Madhava
Consultant in Clinical Oncology
Portsmouth Oncology Centre

Dear Mady

Re: James **RIPLEY** d.o.b. Code A
Code A

Please see the attached complex summary of this gentleman's case. He has essentially been diagnosed as having epithelioid malignant mesothelioma. He has been discussed previously in the MDT. He has a poor functional status and would not be a candidate for aggressive management but I would be grateful if you would consider assessing him briefly to be considered for drain site radiotherapy.

The date of thoracoscopy was 21/11/06.

Many thanks indeed for your kind help with his continued care.

Yours sincerely,

M A Roland
Consultant Respiratory Physician

c.c. Cari Winter, Ward Manager, F4, QAH

G102024 James RIPLEY

CT showed bilateral pleural plaques, large right pleural effusion with no definite pleural nodularity, no obvious mediastinal adenopathy. He went on to have medical thoracoscopy on 21/11/06 performed by Drs Brims and Chauhan, which showed multiple pleural plaques and diffuse nodularity of the visceral and parietal pleura, 4 litres of fluid were drained, biopsies were taken and talc pleurodesis was performed with good effect.

The biopsies confirmed a diagnosis of epithelioid malignant mesothelioma, which was explained at some length by one of our Registrars, Martha Scott, to Mrs Ripley on 29/11/06 (the first day that histology had been completely confirmed). In the intervening period, Mr Ripley had become hypotensive and septic with this being attributed to a hospital acquired pneumonia and was treated effectively for this with Cefuroxime and Vancomycin.

During the course of his admission he was intermittently very confused and on 28/11/06 had an episode where he tried to pull his own catheter out, breaking it in the urethra and with forceps being required to remove the remaining part of the catheter.

CRP climbed to 446 at its peak, down to 204 by time of discharge. Albumen dipped to 11 at its zenith, climbing to 13 at discharge. Hb fell from 12.7 to 8.6 during the admission but creatinine recovered to 88 by the time of discharge (sodium 140, potassium 3.7, urea 2.0).

In view of his persistent confusion, a CT scan of the brain was performed which showed no intracranial haemorrhage or space occupying lesion but areas of low attenuation in the left sub-insular (external capsule) suggestive of infarcts/small vessel disease. This seemed to fit with a picture of multi-infarct confusional state with a further step-wise decline precipitated by his concurrent severe illness.

We had planned, once he was recovering more fully from his hospital acquired pneumonia, for Mr Ripley to be transferred to Gosport War Memorial for a period of more controlled rehabilitation and recuperation whilst an appropriate package of care could be put in place for him at home.

A referral was made to the Care of the Elderly physicians to assess him to see if this would be possible but he lost patience with being in hospital, as I believe did his wife, and he was taken home by her on 4th December.

I believe that pressure sores were found on the buttocks at discharge which was not clearly documented in any of his notes whilst an inpatient and I plan to make enquiries about how this could be the case from the senior nursing staff on our ward.

Since home, he has had trouble with persistent severe oral Candida and soreness, profound anorexia and fatigue only taking 5 Fortisips a day for nourishment. He, I believe, has had two courses of antibiotics although it is not entirely clear what these were for (wife states for poor oral hygiene but this would seem surprising).

G102024 James RIPLEY

I saw him in clinic today and I think he had rallied since I spoke to you last week and was sitting comfortably in the chair. He is apparently spending much of the day now in a reclining chair and not in his bed. He describes his breathing as not too bad, he denies any pain, he has a persistently poor appetite as described. Apparently the district nurse is happy with the recovery of his pressure areas and is dressing this area once a week (previously twice a week).

He still has significant coating and discolouration of his tongue, which he denies as being sore. With his weight loss through the recent illness his dentures are fitting poorly. He has no peripheral oedema, good breath sounds audible in the right lung now suggesting no significant re-accumulation of his effusion. I believe there are twice daily carers coming into the home now to help with washing and dressing and that he has also been seen by the Palliative Care team based at Countess Mountbatten.

I suspect that he may benefit from day hospital assessment in view of his new cognitive disability as well as his weakened physical state and would recommend that you consider referring him to the Medicine for Older People service to be assessed for day hospital review.

I am happy to make this referral myself but I have been counselled that I should offer the opportunity to make these referrals to yourself if you prefer to do so. I hope through this Care of the Elderly assessment that a decision can be made as to what, if any, input may be required from the psycho-geriatric team at this time.

I am also going to refer him to Dr Madhava, one of our consultant clinical oncologists, to assess him for drain site radiotherapy. I have explained to them that drain site radiotherapy is not an active treatment for his mesothelioma but merely a preventative measure to try and stop the tumour growing through the previous drain site. I have explained that chemotherapy is not indicated due to his poor functional status and poor response rates associated with mesothelioma, and that he is not fit for surgery. I have checked an up to date screen of bloods from clinic today, ensuring that the results will be copied to you and plan to review him initially in 2 months with repeat chest X-ray on arrival, although would be happy to see him sooner if symptoms deteriorated in the intervening period.

Yours sincerely,

M A Roland
Consultant Respiratory Physician

c.c. Anne Moylan, Lung Nurse Specialist, QAH
Dr K Madhava, Consultant Clinical Oncologist, SMH