Year 3 Case-based Learning 2024-25

Case 1 Part 1

Facilitator Materials

Key Contributors:

Michael Trimble – Academic Lead for Year 3 CBL

Amy Taylor – ADEPT Fellow 2021-22

Contents

STUDENT MATERIALS

Patient background

Farah Bibi is a 64 year old Muslim woman from Bangladesh. She is a widow and lives with her daughter Aysha Chowdhury and her family. She does not work and English is her second language. Over the past few months she has noticed changes in her bowel habit. She attended her GP who made an outpatient referral, but over the weekend she has become increasingly concerned about worsening diarrhoea. She self-presents to the Emergency Department (ED) accompanied by her daughter.

Outpatient referral

Name: Farah Bibi
Age: 64 years
HCN: 412 035 7027
Address: 14 St Anne's Place, Belfast

Date: 14/09/2022

Time: 1508

Registered GP: Dr C Denniston

GP address: Eastside Medical Practice, Bracton Terrace, Belfast

RED FLAG REFRRAL: GENERAL SURGERY

I would be grateful for your assessment of this 64 year old woman who reports a change in bowel habit for past 3/12. She describes frequent loose stools x4 daily and reports PR bleeding on 2 occasions. No previous attendance at bowel cancer screening. Family history of IBD and colorectal ca. Requires interpreter. qFIT, FBP and haematinics requested today. Many thanks for your ongoing care

PMH

Hypertension

Osteoarthritis (hands)

Repeat medication

Ramipril 10mg MANE x 28

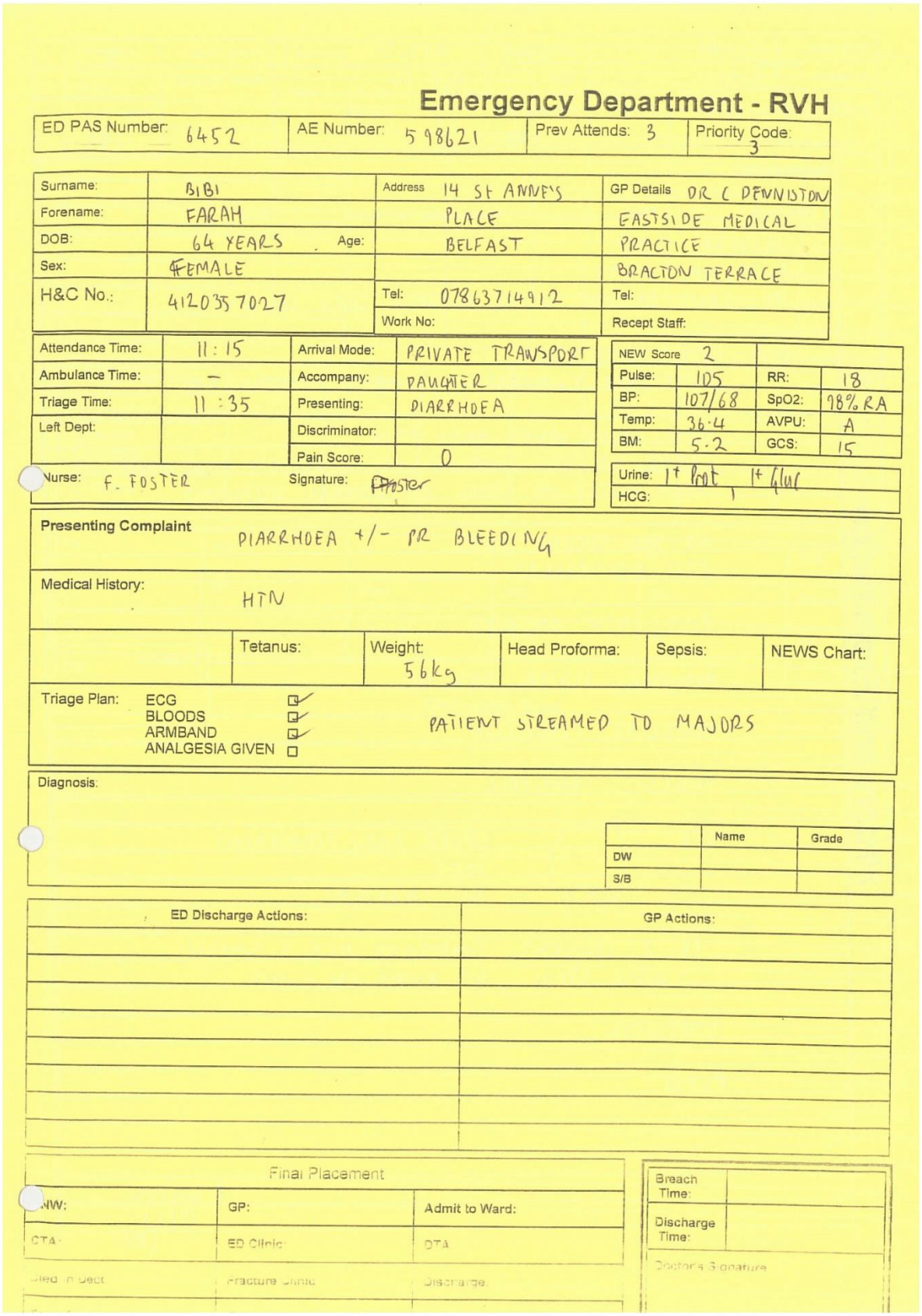
Social

Widow

Smoking DOES NOT SMOKE

Alcohol DOES NOT DRINK ALCOHOL

ED flimsy



Emergency Department - RVH

ED PAS Number: 6452	AE Number: 598621	Prev Attends: 3	Priority Code: 3

Surname:	BIBI	Address 14 ST ANNES	GP Details DR C DENNISTON
Forename:	FARAH	PLACE	EASTSIDE MEDICAL
DOB:	64 YEARS Age:	BELFAST	PRACTICE
Sex:	FEMALE		BRACTON TERRACE
H&C No.:	4120357027	Tel: 07863714912	Tel:
		Work No:	Recept Staff:

Attendance Time:	11:15	Arrival Mode:	PRIVATE TRANSPORT
Ambulance Time:	–	Accompany:	DAUGHTER
Triage Time:	11:35	Presenting:	DIARRHOEA
Left Dept:		Discriminator:	
		Pain Score:	0

Nurse: F. FOSTER Signature: F Foster

NEW Score 2			
Pulse:	105	RR:	18
BP:	107/68	SpO2:	98% RA
Temp:	36.4	AVPU:	A
BM:	5.2	GCS:	15

Urine: 1+ Prot, 1+ Glur
HCG:

Presenting Complaint DIARRHOEA +/- PR BLEEDING

Medical History: HTN

	Tetanus:	Weight: 56kg	Head Proforma:	Sepsis:	NEWS Chart:

Triage Plan: ECG ☑ BLOODS ☑ ARMBAND ☑ ANALGESIA GIVEN ☐ PATIENT STREAMED TO MAJORS

Diagnosis:

	Name	Grade
DW		
S/B		

ED Discharge Actions:	GP Actions:

Final Placement

NW:	GP:	Admit to Ward:
CTA	ED Clinic	DTA
Died in Dept	Fracture Clinic	Discharge

Breach Time:
Discharge Time:
Doctor's Signature

Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

GP: Dr C Denniston, Eastside Medical Practice, Bracton Terrace

Date: 17/09/2022

Attendance time: 11.15

Arrival mode: Private transport

Triage time: 11.35

Accompanied by: Daughter

Priority code: 3

Presenting complaint: diarrhoea +/- PR bleeding

Medical history: HTN

Weight: 56kg

Any allergies to medications? Penicillin - rash

Any blood thinners? No

NEW Score 2	
Pulse: 105	RR: 18
BP: 107/68	SpO2: 98% room air
Temp: 36.4	AVPU: A
BM: 5.2	GCS: 15

Triage plan: ECG, bloods, armband

Patient streamed to majors

Forename:	FARAH	AE Number:	598621	Priority Code:	3
Surname:	BIBI	Dob:	AGE 64	Doctor (Printed)	
Allergies: PENICILLIN - RASH		Anticoagulants: NO	Diabetic: NO	Exam Time:	12.00

History and Examination

~~Assessment:~~

Pain Score_____ Time _____ Re-evaluation Pain Score_____ Time _____

11/9/22 12.00.
R WESTON GPST1
Hx FROM PATIENT USING BIGWORD WITH CONSENT

64 + 3/12 LOOSE STOOL
PROGRESSIVELY WORSE, NOW 6-10 MOTIONS/DAY
TYPE 5-7
SOME VAGUE LOWER ABDO PAIN
THINKS HAS LOST SOME WEIGHT - UNCERTAIN HOW MUCH
BLOOD NOTED IN STOOL ON SEVERAL OCCASIONS

NO NEW RECENT MEDS
POST-MENOPAUSAL

PMH: HTN ON ACEI

Fam Hx: SISTER HAS UC

ALLERGIES: PENICILLIN

DRUGS: RAMIPRIL

O/E  LOWER ABDO TENDERNESS
SOFT
NO GUARDING

PR ✓ CONSENT. CHAPERONE HCA S. SMYTH
- LOOSE STOOL, NO BLOOD ON GLOVE

IMPRESSION:

PLAN:

Chaperone:

R WESTON
RLW
GPST1

Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

History from patient using Bigword with consent

64 year old woman with a 3 month history of loose stool, progressively worse, now 6-10 motions per day, type 5-7. Some vague lower abdominal pain. Thinks might have lost some weight.

Thinks blood in stool on a couple of occasions. No new medications. Post-menopausal.

PMH: hypertension on ACE-i

Sister has ulcerative colitis

Allergy – Penicillin

O/E: Tender lower abdomen but soft and no guarding.

PR loose stool, no blood on glove.

Chaperone HCA S Smyth.

Diagnosis:

Plan:

Signed R Weston

Forename	Surname	DOB	AE Number

Nursing Interventions:

Date & Time	

Skin Assessment: Y/N	CARE BUNDLE
MRSA / C-diff: Y/N	
Venflon inserted by:	
Site / Time:	

Social History	
Lives Alone:	Y/N
Lives With:	
Relatives Present	Y/N
Relatives Aware	Y/N
Contacted by	

Communication

Discharge Observations: Time: Sign:

Pulse:	BP:	RR:	SpO2:	Temp:	AVPU:	New Score:

Next of Kin Details

Name:	AYSHA CHOWDHURY
Relationship:	DAUGHTER
Address:	14 ST ANNE'S PLACE, BELFAST
Mobile:	07713703902

Text:

Next of kin details: Aysha Chowdry, daughter, 14 St Anne's Place, Belfast, 07773703902

Medical Assessment Document

BHSCT Medical Assessment Document

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Patient Name: FARAH BIBI
Address: 14 ST ANNE'S PLACE
DOB: AGE 64 Age: 64
Male/Female: F
Hospital No:
H&C No: 442 035 7027 (or affix label)

Ward: 70
Date of admission: 17.09.2022 Time: 19.45 hrs

Consultant: PROF. A. FROST Admitting Doctor: E. RANSOM Designation: F2

Presenting Complaint

Diarrhoea

History of Presenting Complaint

History taken from patient - support from daughter ± interpretation
3 month hx loose stool, progressively worse, now 6-10 T5-7 motions/24h
Abdo pain - lower abdo, vague, every few days
Weight loss - amount uncertain
Blood noted PR x3 in past
No new meds
No temps
GP sent qFIT test

Past Medical History

HTN
Arthritis

OS18220 1

Text:

BHSCT Medical Assessment Document

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Consultant: Prof. A Frost Admitting Doctor: E Ransom Designation: F2

Date: 16/09/2022

Time: 1945

Presenting Complaint: 3 month history of diarrhoea

History of Presenting Complaint: History taken from patient with interpretation support from daughter

3 month history of loose stool, progressively worse, now 6-10 motions per day, described as type 5-7. Some vague lower abdominal pain every few days. Weight loss, unsure of the amount. Thinks blood in the stool on a few occasions. No new medications. No temperatures. GP has sent a qFIT stool test.

Past Medical History: Hypertension, arthritis

Family History

Sister had Ulcerative Colitis diagnosed age 52

Social History

Baseline mobility

Nursing Home ☐ Residential Home ☐ Own Home ☑

Carers Yes ☐ Frequency ...../day No ☑ Driving Yes ☐ No ☑

Smoking Yes ☐ ..... pack years No ☑ Ex-smoker ☐

Alcohol Screening – AUDIT-C Score

Questions	Scoring system					Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many standard drinks of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more drinks if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total	0

does not drink alcohol

Score ≥ 4 women – offer brief advice
Score ≥ 5 men – offer brief advice
Score ≥ 8 - on-line referral to alcohol liaison nurse (http://belk2dev01.belfasttrust.local/alnurse/SitePages/Home.aspx)

Brief advice offered Yes ☐ No ☑ Referred to ALN Yes ☐ No ☑

Are you using any drug which is not prescribed by your doctor? Yes ☐ Specify drugs ..... No ☑

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Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Family History: Sister with ulcerative colitis diagnosed age 52

Social History: Non-smoker.

Alcohol Screening: Does not drink.

No use of drugs not prescribed.

ALLERGY STATUS	
Medicine/substance	Type of reaction
Penicillin	?Rash as a child

OR No Known Allergies ☐ (please tick)
Signature _____ Date _____

Patient Name: FARAH QIBI
Hospital No: 412 035 702 7
DOB AGE 64
H&C No: 412 035 702 7 (or affix label)

VTE risk assessment form filled out ? (Yes) No

Has patient any special dispensing arrangements? e.g. weekly dispensing (Please state)

Drug Name	Dose	Frequency	Source Used	Medical staff Medication action					Pharmacist
				Continue	Hold	Stop	Change	Reason	Issues
RAMIPRIL	10 mg	MANE	ECR						

Warfarin Yes ☐ No ☑
Indication .....
Dose .....

NOAC Yes ☐ No ☑
Indication .....
Drug ..... Dose .....

Insulin Yes ☐ No ☑
Insulin .....
Dose .....

Home O2
Yes ☐ No ☑

Doctors signature ECR Print name: E. RAMSIM Date: 11.09.22

Pharmacist signature

Print:

Further action required? e.g. phone GP Yes (No)
Comments_____

Pharmacist comments

A medication is unreconciled if it is omitted from the kardex or if the dose, strength or frequency prescribed differ from what the patient was taking preadmission without a documented explanation.

TO ENSURE RECONCILIATION OF MEDICINES PLEASE REFER TO THIS FORM AT DISCHARGE ALONG WITH MEDICATION KARDEX

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Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Allergy Status: Possibly had rash with penicillin as a child

Medication: Ramipril 10mg mane

Systematic Questioning

Cardiovascular system:

Nil of note

Respiratory system:

Gastrointestinal system:

Genitourinary system:

Central nervous system:

Locomotor system:

Cognitive history :	History of confusion	Yes ☐	No ☐
	Known diagnosis of dementia	Yes ☐	No ☐
	Known to memory service	Yes ☐	No ☐
	Recent change in cognition	Yes ☐	No ☐

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Text:

Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Systemic Questioning: Nil of note

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Patient Name: FARAH BIBI
Hospital No:
DOB AGE 64
H&C No: 412 035 7027 (or affix label)

Observations on admission

Respiratory rate: 17	Sats: 98% RA	Room Air/% O2	Pulse: 108
BP: 98/52	A/V/P/U: A		Temp: 36.6
Capillary blood glucose: 5.0		Weight: 56kg	Height: 170cm

Glasgow Coma Scale

Eyes
4 = Open spontaneously
3 = Open to speech
2 = Open to pain
1 = Never open

Best Verbal Response
5 = Orientated
4 = Confused
3 = Inappropriate words
2 = Incomprehensible sounds
1 = Silent

Best Motor Response
6 = Obeys commands
5 = Localises pain
4 = Flexion withdrawal
3 = Abnormal flexion
2 = Extension to pain
1 = No response

GCS = 15 /15

AMTS = 10/10

Abbreviated Mental Test Score (*Tick Correct Answer*)

Age	Yes ☑ No ☐
Time (*nearest hour*)	Yes ☑ No ☐
Name of Hospital (*Memorise 42 West Street*)	Yes ☑ No ☐
Recognise person (*e.g. Doctor & Nurse*)	Yes ☑ No ☐
Year	Yes ☑ No ☐
Name of P.M/Queen	Yes ☑ No ☐
Date of birth	Yes ☑ No ☐
Dates of WW2	Yes ☑ No ☐
Count 20-1	Yes ☑ No ☐
Recall 42 West St	Yes ☑ No ☐

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General Examination

Confused - Yes ☐ No ☑

looks ill
Mucous membranes dry

Cardiovascular Examination

Heart rate Tachy 108 Heart Rhythm Regular JVP ↔

Pulses - Carotid Radial Femoral

Heart Sounds/Murmur 1+11+0

Oedema – Sacral
Leg/ankle Nil oedema

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Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Observations on admission:

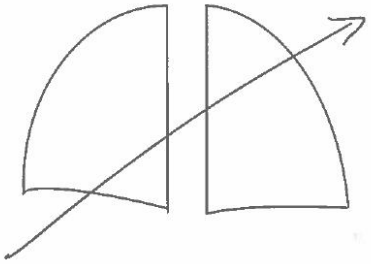
RR: 17	SpO2: 98% room air	Pulse: 108
BP: 98/52	AVPU: A	Temp: 36.6
BM: 5.0	Weight: 56kg	Height: 170cm
GCS: 15	AMT: 10	

General Examination: Looks ill, dry mucous membranes

Cardiovascular Examination: HS I + II + nil, JVP not visible, no oedema

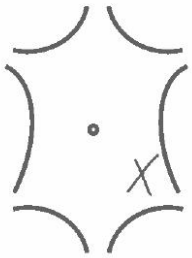
Respiratory Examination

Trachea	Central
Expansion	Equal
Percussion	Resonant bilaterally
Auscultation	Breath sounds vesicular
PEFR	



Gastrointestinal Examination

Liver	Abdo soft
Spleen	Mild tenderness LIF
Kidneys	No guarding
Masses	°mass
Hernia	°organomegaly BS+
Rectal Examination	As per ED – loose stool on glove, no blood



Central/Peripheral Nervous System Examination

CNS

Moving arms + legs
Not formally assessed

PNS

Other Relevant Examination

Nil

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Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Respiratory Examination:	Trachea central, expansion equal, resonant to percussion, breath sounds vesicular, nil added
Gastrointestinal Examination:	Abdomen soft, mild tenderness LIF but no guarding, no mass or organomegaly, BS active

Central/Peripheral Nervous System Examination: Not formally assessed

Other relevant examination: Nil

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Patient Name: FARAH BIBI
Hospital No:
DOB AGE 64
H&C No: 412 035 7027 (or affix label)

Diagnosis +/- Differential

Management Plan

Problem list:

Plan:

DNAR form completed (if appropriate) ☐
Oxygen prescribed on medicine kardex (if required) ☐
Risk Assessment for Venous Thromboembolism completed on medicine kardex ☑

Signature of Doctor ER **Name of Doctor** F.RANSOM

Date: 17/9/22 **Time:** 20:45 **Designation:** F2 **GMC No:** 7189897 **Pager No:** 6040

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Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Diagnosis / Differential:

Management Plan:

Problem list:

Plan:

Signed E Ransom, FY1, 16/9/22, 20:45, pager #1234

Initial Investigations & Results on Admission

FBC			U+E			LFT		
	Current	Baseline		Current	Baseline		Current	Baseline
Hb	90		Na	136		Bilirubin	13	
MCV	70		K	4·1		ALP	58	
Wcc	12·3		Cl	95		AST	15	
Plat	449		Co2	23		ALT	9	
			Urea	2·5		GGT	27	
			Creat	47		Albumin	40	
			eGFR	>60				

Coagulation		Miscellaneous		ABG		
					Time	Time
PT	11	Glucose				
APTT	30	ESR		pH		
Fib	2	CRP	45	pCO_2		
INR		Amylase	110	pO_2		
D-Dimer		Calcium		HCO_3		
		Magnesium		BE		
		Phosphate		Lactate		
		TnT (Time)		FiO_2		
		TnT (Time)				

Paracetamol Hours after ingestion Salicylate Alcohol	
X-Rays/CT Relevant findings	
Urinalysis	1+ Prot, 1+ Gluc
ECG	Sinus tachy
Other	

ACUTE KIDNEY INJURY RISK ASSESSMENT

Risk Factor	Tick if present
Baseline eGFR<60 ml/min	
Age > 60 years	✓
Sepsis (or serious infection)	
Systolic BP <100mmHg	✓
Evidence of hypovolaemia	✓
Urinary Tract symptoms	
Receiving IV contrast	
Diabetes, Heart failure, Liver disease	

If 1 or more risk factor present, the patient is at risk of developing kidney injury and you **MUST:**

Action	Achieved? (Tick)
1. Restore an effective BP	✓
2. Review all drugs (stop or adjust dose)	✓
3. Treat sepsis	

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Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Initial Investigations & Results on Admission:

FBC	**U+E**	**LFT**
Hb 90	Na 136	Bilirubin 13
MCV 70	K 4.1	ALP 58
WCC 12.3	Cl 95	AST 15
PLTs 449	CO2 23	ALT 9
	Urea 2.5	GGT 27
	Creat 47	Albumin 40
	eGFR >60	

Coagulation	**Miscellaneous**	**ABG**
PT 11	Glucose	Ca
APTT 30	ESR	Adj. Ca
Fib 2	CRP 45	Mg
INR	Amylase 110	PO4
D-dimer		
Troponin (time)		
Troponin (time)		

X-Ray	
Urinalysis	1+ Protein; 1+ Glucose
ECG	Sinus rhythm, 110bpm
Other	

Investigations

Blood work

412 035 7027 BIBI, Farah (Female / 64 years)

Complete Blood Count

Number	1	Ref. Range (Units)
Collected	16-Sep 2022 12:00	
Signed		
Source	BHSCT	
HGB	* 90	115-150 (g/L)
HCT	* 0.29	0.40-0.54 (L/L)
WBC	*12.3	4.0-10.0 (x 10^9/L)
PLT	449	150-450 (x 10^9/L)
RBC	* 3.1	3.8-5.8 (x 10^{12}/L)
MCV	* 70	76-100 (fL)
MCHC	* 301	320-360 (g/L)
MCH	* 25	27-32 (pg)
NEUT	*8.5	2.0-7.5 (x 10^9/L)
LYMPH	1.9	1.0-3.5 (x 10^9/L)
MONO	0.3	0.2-0.8 (x 10^9/L)
EOSIN	0.06	0.04-0.4 (x 10^9/L)
BASO	0.01	0.01-0.1 (x 10^9/L)

* Denotes abnormal result

Iron Profile

Number	1	Ref. Range (Units)
Collected	16-Sep 2022 12:00	
Signed		
Source	BHSCT	
Serum iron	* 4.0	5.83-34.5 (µmol/L)
Transferrin	3.6	2.0-3.6 (g/L)
Ferritin	* 15	30-400 (µg/L)
Transferrin saturation	* 18	23-50 (%)

* Denotes abnormal result

Blood Film

Number	1	Ref. Range (Units)
Collected	16-Sep 2022 12:00	
Signed		
Source	BHSCT	
Findings	Anisocytosis, poikilocytosis. Microcytic, hypochromic red cells. Pencil cells present. White cells and platelets normal.	

Electrolyte Profile

Number	1	Ref. Range (Units)
Collected	16-Sep 2022 12:00	
Signed		
Source	BHSCT	
Sodium	136	136-145 (mmol/L)
Potassium	4.1	3.5-5.3 (mmol/L)
Chloride	95	95-108 (mmol/L)
CO2	23	22-29 (mmol/L)
Urea	2.5	2.5-7.8 (mmol/L)
Creatinine	47	45-84 (µmol/L)
eGFR	>60	<60 (mL/min/1.73m^2)

Liver Profile

Number	1	Ref. Range (Units)
Collected	16-Sep 2022 12:00	
Signed		
Source	BHSCT	
T. Bilirubin	13	<21 (µmol/L)
ALP	58	30-130 (U/L)
AST	15	<32 (U/L)
GGT	27	6-42 (U/L)
ALT	9	<33 (U/L)
Albumin	40	35-50 mg/L

Coagulation Screen

Number	1	Ref. Range (Units)
Collected	16-Sep 2022 12:00	
Signed		
Source	BHSCT	
PT	11	10-12 (seconds)
APTT	30	22-41 (seconds)
Fibrinogen	2	1.5-4.0 (g/dL)

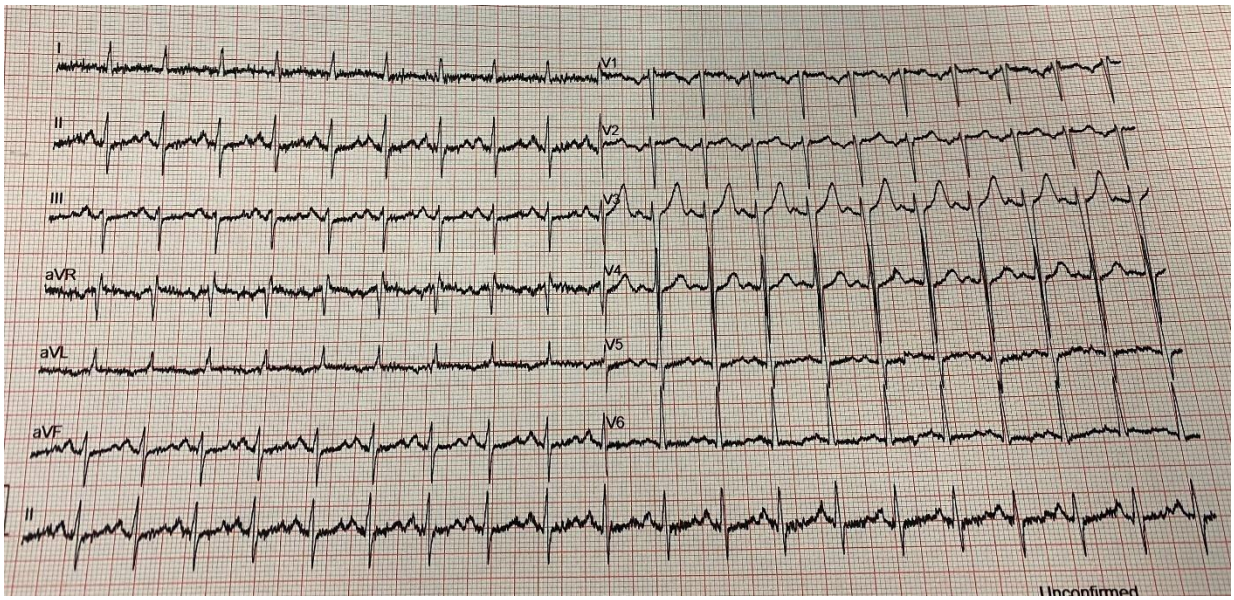
Amylase

Number	1	Ref. Range (Units)
Collected	16-Sep 2022 12:00	
Signed		
Source	BHSCT	
Amylase	110	< 220 (U/L)

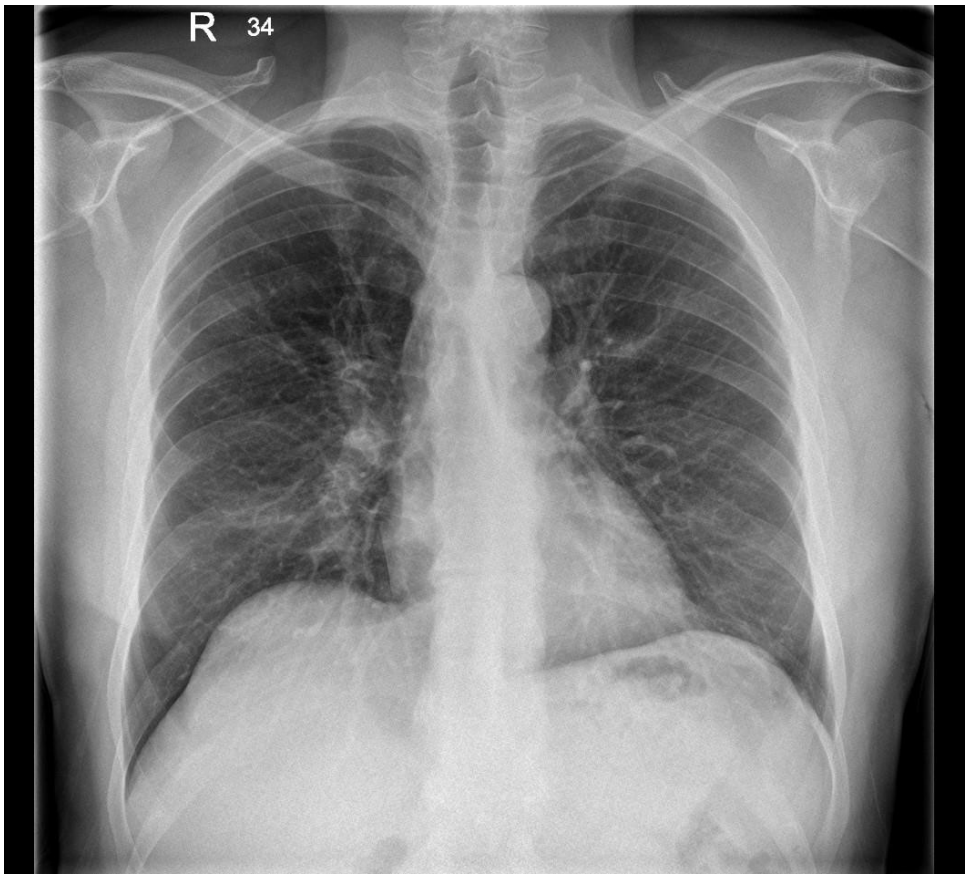
CRP

Number	1	Ref. Range (Units)
Collected	16-Sep 2022 12:00	
Signed		
Source	BHSCT	
C reactive protein (CRP)	45	<5 (mg/L)

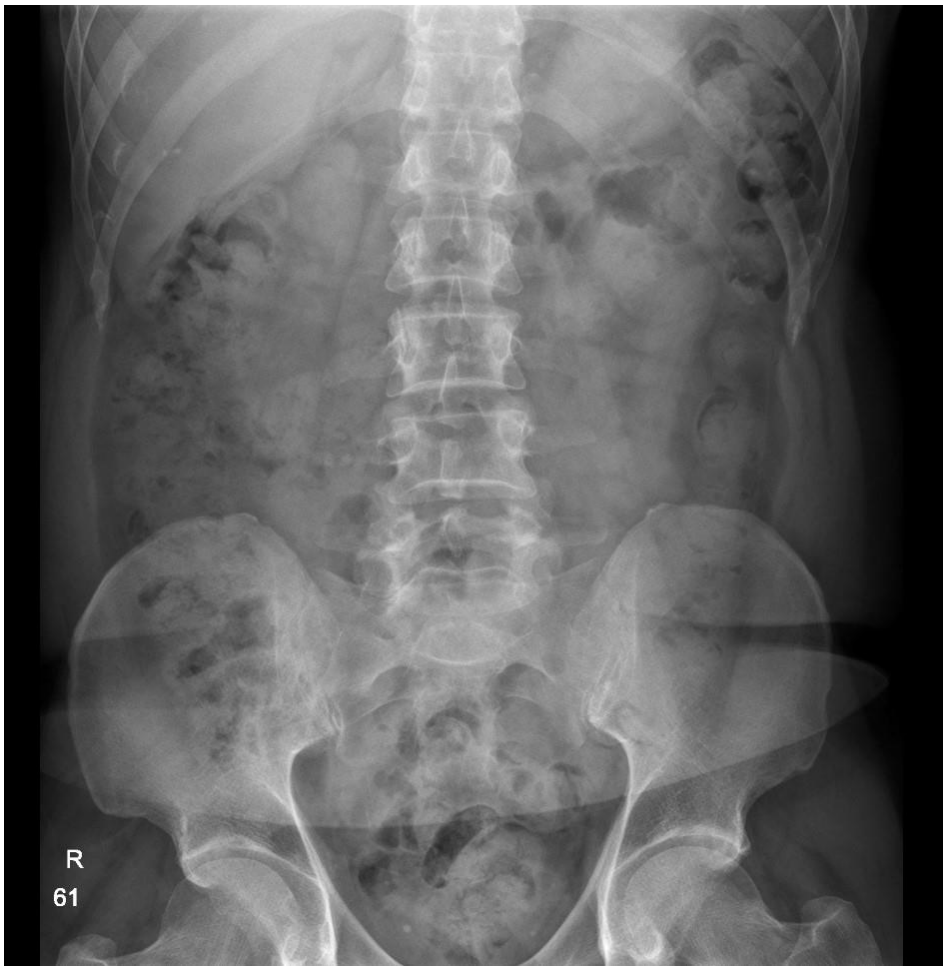
ECG



Chest X-ray



Abdominal X-ray



ADDITIONAL FACILITATOR MATERIALS

Post-Take Ward Round

Post-Take Ward Round / Outcome Focused Management Plan

Consultant: P. Gullet Ward: 7D Date: 18.9.22 Time: 09.40

Presenting Problem List

Altered bowel habit / Bloody diarrhoea / dehydration

Focused Examination Findings / Clinical Assessment

RR 18 SaO_2 97% (RA) Pulse 104 BP 96/51 Temp 37°C

- History taken using interpreter ī consent
- Progressive hx loose stool over 3/12, initially intermittent, now more frequent
- Passing 15-7 bowel motions 8-10 x/day now
- Some vague intermittent abdo pain
- ↓ appetite for weeks.
- Weight loss, unsure of amount
- Several episodes of PR bleeding - fresh red, mixed in with stool, none on wiping.
- No recent travel. No infectious contacts.
- GP sent gastro - result awaited
- Family hx: Sister UC dx age 52, brother colon cancer RIP age 56
- Social hx: Independent of ADLs - PS 0. Does not drive. Widow. Lives ī daughter

O/E

Abdo soft on superficial palpation
Some lower abdo / LIF discomfort on deep palpation
No masses
Bowel sounds normal

Blood results seen	Yes / No / NA	Relevant findings: microcytic anaemia
ECG reviewed	Yes / No / NA	Relevant findings: sinus Tachycardia
Radiology reviewed	Yes / No / NA	Relevant findings: normal CXR / AXR
Urinalysis	Yes / No / NA	Relevant findings
Capillary blood glucose	Yes / No / NA	Relevant findings
Cannula, catheters necessary?	Yes / No / NA	Checked Cannulae
Dementia	Yes / No / Don't know	
Delirium	Yes / No / Don't know	Delirium risk – high/low
Drug chart reviewed	Yes / No	Chart labelled/allergies/antibiotic duration and indication/VTE prophylaxis/oxygen prescription

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Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Post-Take ward Round / Outcome Focused Management Plan

Consultant: Dr Peter Gullet Ward: 7D Date: 18/09/2022 Time: 0940

Presenting Problem List: Altered bowel habit / bloody diarrhoea / dehydration

Focused examination Findings / Clinical Assessment:

RR: 18 SaO2: 97% (RA) Pulse: 104 BP: 96/51 Temp: 37.0^{0}C

History taken using interpreter with consent

Progressive history of loose stool over 3 months, initially intermittent, now more frequent. Passing T5-7 bowel motions 8-10x per day now. Some vague intermittent abdominal pain. Reduced appetite for weeks. Weight loss, unsure of amount.

Several episodes of passing blood PR. The blood is fresh red and mixed in with the stool. None on the toilet paper. No recent travel. No infectious contacts.

FHx: Sister ulcerative colitis diagnosed aged 52; brother colon cancer diagnosed aged 56

GP has sent a qFIT test, result awaited.

Independent of ADLs – Performance status 0. Does not drive. Widow. Lives with daughter.

O/E Abdomen soft on superficial palpation with some lower abdominal / LIF discomfort on deep palpation. No masses. Bowel sounds normal.

Blood results seen – Yes (microcytic anaemia)

ECG reviewed – Yes (sinus tachycardia)

Radiology reviewed – Yes (Normal CXR and AXR)

Urinalysis - Yes

Capillary blood glucose - Yes

Cannula/catheters necessary?- Yes

Dementia – No

Delirium – No

Drug chart reviewed - Yes

HSC Belfast Health and Social Care Trust
caring supporting improving together

Patient Name: Farah Bibi
Hospital No:
DOB Age 64
H&C No: 412 035 1027 (or affix label)

Clinical Impression / Working Diagnosis

? Inflammatory bowel disease
? Colorectal cancer
? Infectious colitis

Plan

Investigations and Treatment

Problem list: Bloody diarrhoea
Anaemia
↑WCC +CRP ? infection v. inflammation
Weight loss

Management plan: Stool for O+S + C. Diff
Stool chart
Faecal calprotectin
Bloods (TTG, TFTs)
CXR ✓
AXR ✓
Venous blood gas
ECG ✓

IVF
Prophylactic clexane
Hold ramipril
Dietician r/v
Red flag OP colonoscopy ☑ Reg

OPALS referral	Yes ☐	No ☐	Dietitian referral	Yes ☑	No ☐
Physiotherapy referral	Yes ☐	No ☐	Podiatry referral	Yes ☐	No ☐
OT referral	Yes ☐	No ☐	AUDIT-C completed	Yes ☐	No ☐
Social worker referral	Yes ☐	No ☐	Specialist Nurse referral	Yes ☐	No ☐
SALT referral	Yes ☐	No ☐	Other specialty referral	Yes ☐	No ☐

Criteria For Discharge

Resuscitation Status

CPR status	For full CPR ☑	DNAR form completed ☐
Ceiling of care	All including ICU/critical care ☑	Ward-based ☐
Triage to *(circle)*	**EDD**	
Acute Medicine / Respiratory Gastroenterology / Hepatology Endocrinology / Cardiology Care of the Elderly / Oncology Surgery / Other _____	3/7	**Signature** D. Devine **Name** David Devine **Designation** SHO **GMC No.** 7666132

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Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Clinical impression/working diagnosis:	Inflammatory bowel disease; Colorectal cancer; Infectious colitis
Problem list:	Bloody diarrhoea; Anaemia; WCC and CRP raised ?inflammation/infection; Weight loss
Management Plan:	Stool for O&S and c.diff, stool chart, faecal calprotectin, bloods (TTG, TFTs), CXR, AXR, venous blood gas, ECG, IVF, prophylactic clexane, hold ramipril, dietician. Red flag outpatient colonoscopy EDD 3 days

Triage to GI

For full CPR

Signed D Devine IMT1

STUDENT MATERIALS

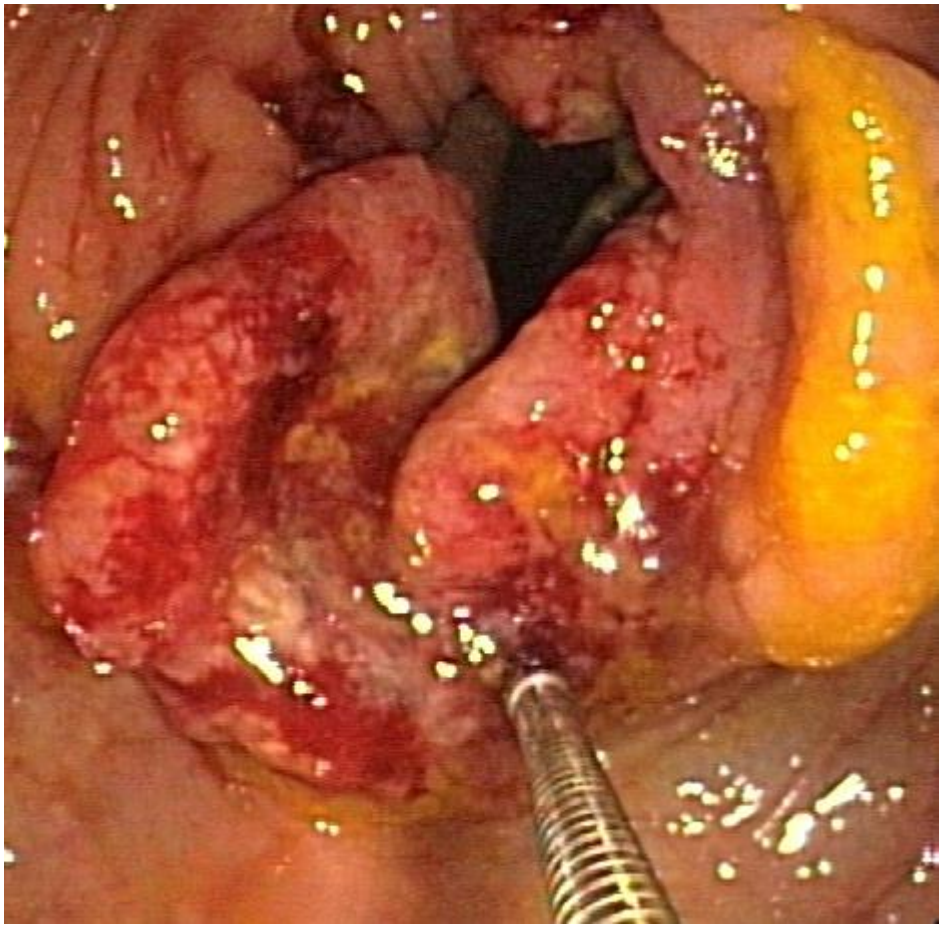
Outpatient investigations after discharge

Following a short inpatient stay, the patient is discharged for some outpatient investigations. The results are shown below.

Endoscopy report

Colonoscopy image

412 035 7027 BIBI, Farah (Female / 64 years)



Colonoscopy report

COLONOSCOPY REPORT

Name:	Farah Bibi	**Date of Birth:**	Age 64
H&C:	412 035 7027	**Address:**	14 St Anne's Place
Case note:	RV 93/2996354		Edgestow

Procedure Date: 28th September 2022

GP:	Dr Camilla Denniston	**Status:**	Outpatient
	Eastside Medical Practice	**Hospital:**	Royal Victoria Hospital
	Bracton Terrace	**Referring Consultant:**	Dr Peter Gullet

Indications
Diarrhoea; PR bleeding

Consultant/Endoscopist

List consultant:	Leona Maguire
Endoscopist:	Leona Maguire
Nurses:	Samuel Ryder
	Georgia Hall

Report
Bowel preparation with 4L KleanPrep was satisfactory
A digital rectal examination was performed
The colonoscope was inserted via the anus to the caecum
The scope was retroflexed in the rectum
Large polypoidal lesion partially obstructing the lumen, visible in the proximal ascending colon/caecum
x8 biopsies taken from lesion
Diverticulosis in descending colon

Instrument: 25142066

Premedication

Midazolam (IV)	3mg
Fentanyl (IV)	50mcg

Diagnoses
Malignant tumour and diverticvulosis

Follow up
Referral to oncology MDM

Advice/Comments
Moderate diverticular disease.
Large tumour in ascending colon / caecum. Partially obstructing the luminal view. Not possible to identify caecal landmarks or IC valve. x8 biopsies of the tumour taken
Will require CT chest, abdomen and pelvis as red flag for staging. Will also require MDM discussion

Dr Leona Maguire

Consultant Gastroenterologist

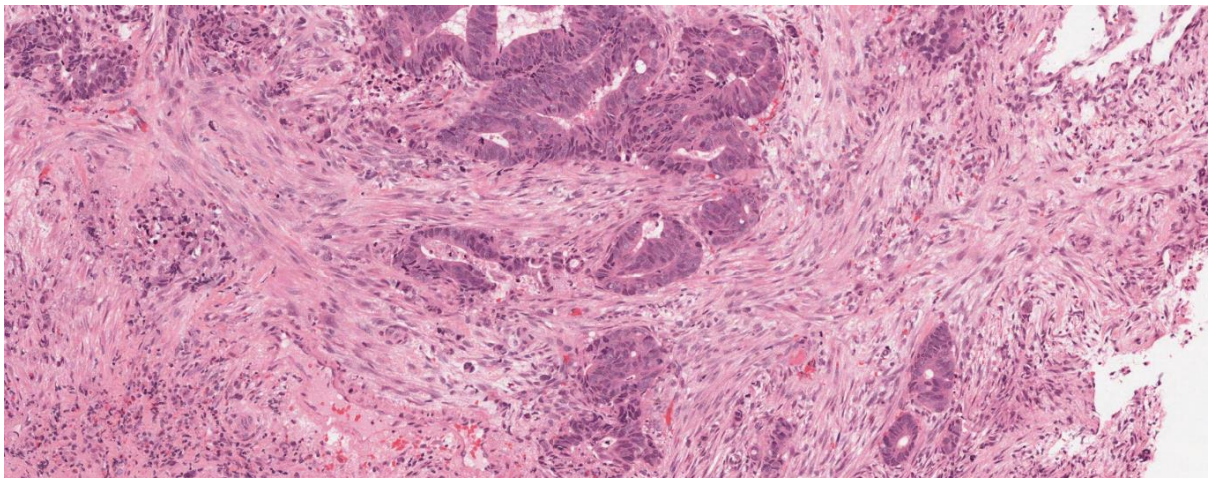
c.c. Dr Peter Gullet, Royal Victoria Hospital

Histopathology

412 035 7027 BIBI, Farah (Female / 64 years)

Caecal biopsies.

The specimen consists of multiple pieces of tissue.



Click HERE to view digital slide

Histology shows an invasive tumour. The cells are epithelial and form glandular structures. Overall, the appearances are in keeping with an adenocarcinoma.

DIAGNOSIS

CAECUM
ADENOCARCINOMA