Southern Health and Social Care Trust

6.0 FINDINGS

assessment is solely dependent on the Urology waiting time- which was a minimum of 42 weeks in 2014. The default management process provides an explanation to why Patient 10's 'Routine' referral letter was not upgraded and why Patient 10 was not seen by the Urology Team until 16 January 2016.

Patient 10 is now recovering from a laparoscopic excision of a papillary renal carcinoma which was done on 30 October 2016. This procedure was superseded by breast surgery in 2016 for breast lobular carcinoma on 14 February 2016. It had been agreed by the Oncology and Urology teams that the breast histology was priority and treatment proceeded in advance of renal surgery.

Relevant members of the Review Team completed a 'look-back' exercise in relation to the remaining 7 other GP letters to establish the patient management and outcome. The Panel can confirm that the other 7 patients have been seen by the Urology Team on or before 26 January 2016, and have not been known to have been exposed to significant harm.

7.0 CONCLUSIONS

The MRI report by Dr 2 on 29 September 2014 as previously discussed, was misleading and was inappropriately condensed. The quality of the information resulted in the evolving right renal cyst being overlooked by Drs 3 and Dr 5.

The SHSCT Radiology Team continuously review and audit the quality and accuracy of their reporting. On this occasion, the MRI report irregularities were not detected until viewed by a Urology Consultant.

All available evidence suggests that Dr 6 did not triage Patient 10's GP referral letter on the week ending 30 October 2014. The default triage management process was initiated which resulted in Patient 10 waiting 64 weeks for Urological assessment.

The Review Panel agree that in relation to Patient 10, the opportunity to upgrade the referral to red flag was lost by the omission of triage, this resulted in a 64 week delay to diagnosis of a suspicious renal mass.

While the remit of this Serious Adverse Incident (SAI) Review was to examine the factors in Patient 10's delayed management of papillary renal cancer. The Review Panel were provided evidence that a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team.

SECTION E – Personal impact/additional information

Please outline the personal impact that the treatment received, which forms the basis of your complaint(s), has had on the patient/deceased patient and provide any additional information which you feel may be of assistance to this Inquiry.

When Dr [Patient's GP] requested the appointment with Urology Department [Patient 10] was not aware of the triage system. The delay in being seen by Urology was not a concern as she had been told the two cysts were nothing to worry about. It was only on receiving The Serious Incident Report that she became aware of the triage system in Urology. She was shocked, angry and disappointed that not only had her appointment not been triaged but 7 other patients in the same week had also not been triaged. She was concerned that this was not therefore a simple mistake and that she had been overlooked but it looked like a systematic failure for patients. The extent of this error certainly undermined her confidence in the entire system for her care. The major concern was, of course, if she had been seen sooner would there have been a better outcome for her i.e. would earlier scans have been ordered and would they have picked up subsequent cancers earlier.

Additional sheets, if needed, can be attached

30-40 Gleason

C

MDM Report from Urology MDM @ The Southern Trust

RE: Mr [Patient 18 redacted] [Personal Information redacted by USI redacted] , HCN:

Contact Tel:

MDM Report from the Urology MDM @ The Southern Trust on 28/07/2011.

Diagnosis	Prostate cancer
Histology	Adenocarcinoma, NOS,
PSA	11.7
Gleason Score	4 + 3 In 3 out of 11 Cores.
Longest Tumour Length	11.00 mm
% Tissue Involved	20
Prostate Volume	57

MDM Update

Dear Dr [Patient's GP redacted]

Diagnosis:Prostate adenocarcinoma, Gleason score 4+3=7

CONSULTANT MR O'BRIEN: [Personal Information redacted by the USI] old patient reviewed for a history of TURP for lower urinary tract symptoms. His PSA following the procedure was elevated and the last PSA in 2008 measured 7.6ng/ml. His Free to Total Ratio was reduced at 11%.
Digital rectal examination revealed a 30-40 gram smooth-feeling prostate.

Repeat PSA of 11.73ng/ml.

Investigations-
Transrectal prostatic biopsy 24.05.11:Pathology reports prostate adenocarcinoma Gleason score 4+3=7. Present in 3/11 cores biopsies with 20% of tissue involvement.

Bone scan 07.07.11:No evidence of bony mets.
MRI 20.07.11:The appearances are suggestive of T2 disease.

MDM Action

Discussed @ Urology MDM 28.07.11. Patient has moderate grade, moderate volume organ confined disease. Will be seen at Day 4 clinic by Mr O'Brien to discuss treatment options. External beam radiation to be advised in first instance. Will not be suitable for brachytherapy due to PSA level, volume of disease and history of previous TUR of prostate.

Radiology

MRI Findings

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
CLINIC LETTER

CONSULTANT UROLOGIST: Mr O'Brien
SECRETARY: Monica McCorry
TELEPHONE: [redacted]

25th July 2012

DR F HOUGHTON
CONSULTANT CLINICAL ONCOLOGY
BELFAST CITY HOSPITAL
LISBURN ROAD
BELFAST

Dear Fionnuala

Re: Patient Name: [redacted]
D.O.B.: [redacted]
Address: [redacted]
Hospital No: **HCN:** [redacted]

I enclose a copy of a recent letter pertaining to this [redacted] old gentleman who initially became our patient in September 2006 following his admission to our department in acute urinary retention requiring catheterisation. On subsequent removal of the catheter, he was found to have a grossly enlarged prostate gland with a volume of 118mls, and who still retained urine, with a residual volume of 242mls. His serum total PSA level at that time was 19.3ng/ml. I was able to facilitate prostatic resection during that inpatient admission. 60g of prostatic tissue were resected. There was no evidence of carcinoma on histological examination of resected tissue. Mr [redacted] had an entirely satisfactorily outcome following prostatic resection. At review in 2007, the only lower urinary tract symptom which persisted was that of occasional nocturia. At review in 2007, he was found to have a serum total PSA level of 7.6ng/ml. That PSA level increased a little to 7.79ng/ml in 2008.

Mr [redacted] returned for review in March 2011, reporting that he remained completely devoid of any lower urinary tract symptoms but was found to have an elevated PSA level of 13.86ng/ml. On rectal examination, he was considered to have a moderately enlarged, and clinically benign, prostate gland. However, in view of the elevated PSA level, Mr [redacted] agreed to proceed with prostatic biopsies which were performed in May 2011, and when he was found to have a prostatic volume of 57.6mls. He was found to have adenocarcinoma of Gleason score 7 present in three of the five cores taken from the right lateral lobe, with no evidence of any carcinoma found in any of the biopsies taken from the left lateral lobe. There was no suspicion of any metastatic disease on radio-isotope bone scanning and there was no suspicion of any extra-capsular disease on MRI scanning.

2.11. Overall care

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.
Areas identified where learning could occur, including areas of good practice, should be included in addition to any potential areas of further investigation.
Please also include any other information that you think is important or relevant.

The patient was not started on proper androgen blockade, but was started on low dose bicalutamide that gave him side effects of AntiAndrogens but no clinical improvement.

He suffered the side effects for over 7 months and wrote to his surgeon and that is when he was referred to Radiotherapy.

There was an explained delay in referring the gentleman to Radiotherapy

Please rate the care received by the patient during this phase as:
5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☒

Section not applicable ☐

2.12. If care was below an acceptable standard, did it lead to harm?

If yes, please provide details and state an action plan

The patient suffered from the side effects of Anti Androgens for a long time unnecessarily, he should have been started on the right dose and referred to Radiotherapy

2.13. If the patient died is it considered more likely than not to have resulted from problems in care delivery or service provision?
If yes, please provide details and state an action plan (consider whether a serious incident investigation is required).

2.14. If a family member, carer, or staff raised concerns, please outline any feedback provided and state who was responsible for providing this feedback. Please state further action required.
If no feedback was provided, please consider how the outcome of this review should be fed back to the relevant people, considering the duty of candour principle.

2.15. Were the patient records adequate for the purpose of the review?	Yes ☒ No ☐

Please outline any difficulties in accessing appropriate information:

Time taken to complete Section 2 of this form (minutes): .....

Orthoderm
private medical clinic

OD No: [redacted]
Hospital No: [redacted]

17 November 2020

Mr M D Haynes
Consultant Oncologist
Craigavon Area Hospital
68 Lurgan Road
Craigavon
Co Armagh BT63 5QQ

Dear Mark

Re: Mr [redacted] **- DOB** [redacted]
[redacted]
Tel: [redacted]
[redacted]

Mr [redacted] attended today as part of a waiting list initiative at Orthoderm Private Medical Clinic on behalf of the Southern Trust.

This man had a TURP in 2006, but by 2011 his PSA had gone up and he had a diagnosis of Gleason 4+3, 3/12 cores in June 2011. There was no MDM discussion but he was put on Bicalutamide 50mgs and Tamoxifen. He had some toxicity from that and was referred up some 18 months later for discussion in Belfast and was referred for radical radiotherapy which he completed in 2013 and he has remained well and his current PSA is 0.2. He has no particular urinary symptoms that are bothering him.

I have discharged him from surgical follow-up. You may wish to review the hormone initial management of Mr [redacted]. Many thanks.

Yours sincerely

Mr Patrick Keane
Consultant Urologist

Cc [redacted]

cancer" as indicated by Mr O'Brien right after my emergency prostate operation. Additionally, I was told by the lady consultant that it was she (oncologist) who would decide who would get radiotherapy treatment and not me, the patient. I was somewhat taken aback given the changing diagnosis and differing information that had been given to me over the course of my care. I considered that at this stage my family and I had to do our own research regarding my prostate cancer as we felt that we had been misinformed somewhat about diagnosis and also about treatment options. We were beginning to lose trust in our doctors.

- I was referred by this lady oncologist to the urology services at BCH but I was advised by her from the outset that the BCH urologist would not be taking any action with regard to surgical options and that I would be referred onwards to radiotherapy.
- I attended the appointment with a male urologist at BCH. He confirmed that surgery was not an option for my cancer as the prostate was now too "sticky" because of the hormone treatment that I had received. They referred me for radiotherapy.
- I received radiotherapy treatment from March – April 2013 at BCH.
- Subsequent to the radiotherapy that I received at BCH I developed ongoing side effects of sigmoid colitis, fatigue, ~~prostatitis~~ proctitis, chronic shin pain and double incontinence. These side effects have not improved since my radiation treatment. The combined tiredness, incontinence, ~~foot~~ shin pain and restriction of the food types that I find that I can tolerate has left me with a very much reduced quality of life. Before I was energetic; enjoying walking, holidaying abroad and gardening. Now I am restricted to being able to shop for my own groceries, driving and some light gardening as my energy levels permit. I am restricted to being close to a toilet wherever I go daily
- I am very grateful that I am still alive, however, I believe that my retirement years have been blighted by my treatment for prostate cancer. Although aware of possible side effects of radiotherapy treatment I believe that due to inaccurate and disingenuous information provided to me regarding my condition and treatment options earlier in my treatment pathway, I was unable to make an informed choice. I believe that this led to delayed treatment, thus restricting further options and that this resulted in a poorer treatment outcome for me in general.

Patient 18 [redacted]

Yours sincerely

Patient 18 [redacted]

Personal information redacted by USI

19th September 2016

Corporate Complaints Officer
Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Dear Sir/Madam,

Patient 84
DOB: Personal information redacted by USI
H&C No.: Personal information redacted by USI

I am writing to make an official complaint about the neglect towards myself resulting in my total dissatisfaction on how I have been treated over the past few months.

To give you the background into my situation, I was phoned by a consultant (Mr Puyson I believe) on Friday 25th March 2016 (Good Friday) to say that I had a blockage in my ureter, noticed on a recent CT scan, and that it would be best that I come into hospital as soon as possible to get surgery. I was informed that the Easter weekend would be a good time as there was some capacity to do the surgery as I was on an emergency list. I was obviously a bit alarmed and was in the middle of packing for the Easter weekend away. Of course, I realised the seriousness of my condition so I cancelled my plans and the consultant and I agreed that I would receive a telephone call on the Saturday morning to confirm bed availability. I didn't receive this call and then had to do some chasing myself. The staff currently on weren't aware of the plans for surgery. I eventually got confirmation on Easter Sunday morning to come to hospital for the surgery planned on Monday but when I arrived the staff were surprised as I shouldn't have needed to stay pre-operatively and therefore could have just came to hospital on Monday morning. This is just to highlight the severe lack of communication from the start and the fact that my weekend plans were cancelled unnecessarily. However, in saying all that, what followed is the real reason for this letter.

After the surgery by Mr O'Brien, I was told that the blockage had been removed (although the stone escaped back up to the kidney) and that I did have a lot of stones in both kidneys and a stent was placed in the right ureter. I understood the logic for a stent and I was informed that it will be uncomfortable at first and that I may feel the urgency to pass urine a bit more frequently as the stent protrudes inside the bladder slightly. I was informed that the stent should be removed in 6 weeks' time. I felt that this was fine and that this would be good timing for my pre-booked holiday at the end of May.

Unfortunately, from the beginning I had persistent pain with the stent at the tip of my penis particularly when passing urine, and I was passing fresh red blood post exercise and had severe urgency and severe frequency. This clearly had a major impact on my life both at home and in work. I was on regular Ibuprofen and Paracetamol to alleviate the pain but the pain was not being controlled. I was worried about my severe signs and symptoms so I contacted Mr O'Brien's secretary and asked could I speak to him or a member of his team for some medical advice and to discuss the symptoms I was

SECTION C – Details of concerns raised/complaints reported

1.	Please provide full details of any concerns and/or complaints raised by you, specifying the nature of those concerns in as much detail as possible.

I submitted a formal complaint letter to the Corporate Complaints Officer on the 19th September 2016.

I was notified by Mr O'Brien via Mr Tyson to come into for admission to CAH on Easter Sunday 27th March 2016 as I needed to be admitted to have a ureteroscopy performed as an emergency. When I arrived at the ward, they were not expecting me, this hadn't been communicated to them. A minor thing overall, but it was an inconvenience as it was Easter Sunday and I was away for the weekend, so I had to cut things short.

The operation was undertaken on Monday 28th March 2016 and I had a stent inserted, this is where my main complaint lies. As admitted by the hospital later on 1st December 2016, in a response to my complaint letter, a stent inserted should have this removed and have an ureteroscopic lithotripsy performed four to six weeks later. I didn't get this stent removed until 10th August, nearly 5 months later. During these 5 months I was in excruciating pain throughout, right from the start, particularly when passing urine. I was passing fresh blood post exercise and had severe urgency and severe frequency. It was very disruptive to my home and work life. I had to bear the pain for so long and take painkillers all the time, likely putting more strain on my kidneys.

I only got this stent removed because I was so ill and had to get admitted via A&E on 6th August 2016. I had a very nasty bacteria in my urine that produced Extended-Spectrum Beta-Lactamases (ESBLSs). To remove this infection, I needed different kinds of strong anti-biotics. I was fearful of septicaemia at this point. I also learnt at this time from a further CT scan that a stone was still in my ureter and it lay next to the stent. The stent removal went well thankfully as I was warned about a risk of damage during its removal as it had been in there for that length of time. However, while I was discharged on 14th August I was re-admitted on 17th August. I felt poorly since I was discharged, so I visited my GP, who sent me straight to A&E. I was then transferred to 3 South, with query Sepsis, and I was on another anti-biotic for 7 days. The anti-biotic was an even stronger one named Meropenum. Finally, I was discharged on 24th August 2016.

The stent not only worsened the kidney stone blockage issue I was originally admitted for, but it was also causing extreme pain while inserted, and it then caused me to become really ill by causing infections. It should have been removed much sooner as was recommended and known but I continued to get fobbed off by Mr O'Brien via his secretary. I phoned many times to speak to him.

I feel there was a definite breach of duty of care to me. The staff including the different consultants during my unnecessary stays were excellent but Mr O'Brien

SECTION C – Details of concerns raised/complaints reported

1. Please provide full details of any concerns and/or complaints raised by you, specifying the nature of those concerns in as much detail as possible.

I have attached the letter of compliant (dated 05/12/16) forwarded to Governance ~~office~~ which details the main areas of concern / Complaint raised by Mr [Patient 16] family. The subsequent SAI report details the sequence of events and Mr O'Brien and his colleagues are interlinked within the Compliant.

The main concern I have is the lack of response from Mr O'Brien to numerous letters from Consultant Oncologists and Consultant Surgeons alongside numerous phonecalls from [Patient 16] and his family regarding the problems he was encountering because of a stent which was in place for 15 months when guidance on good practice suggests that they should only remain in place for up to 6 months. The outcome of this was a range of complications which resulted in sepsis and the requirement for a nephrostomy tube. Furthermore the lack of Consistent Care and attention by Dr O'Brien to be continued and impacted on the treatment options available to my father on account of delays in stent removal and insertion.

(See overleaf)

Continued at PAT-000154.

SECTION D - Details of concerns held but NOT raised/reported

1. Please provide full details of any concerns you held at the relevant time specifying the nature of those concerns in as much detail as possible.

My father had [redacted] which resulted in years of involvement with various departments across most of the hospitals in Northern Ireland. He advised us, his family, that the lack of consistent care provided by Mr O'Brien in the Urology Department in Craigavon Area Hospital was the worst he had ever encountered. He described one particular incident on 31.03.15 when he was advised to attend for admission for insertion of a stent. Upon arrival at the designated time he was advised that he was not on the list for the procedure and following on was only admitted after a number of hours waiting for the issue to be resolved.

2. Please explain why you did not raise your concern(s) at the time and state if there was something that prevented you from raising your concern(s).

We were grateful for the care my father received over the years and did not want to formalise our concerns at an earlier stage of our involvement with Mr O'Brien and the Urology Department in case it had an impact on the patient/consultant relationship. My father found Mr O'Brien to be arrogant and dismissive in his dealings with him.

PAT-000037

Personal information redacted by USI

[redacted]

Christine A Smith, QC
Urology Services Inquiry
1 Bradford Court
Belfast
BT8 6RB

17th March 2022

Dear Ms Smith,

I have received your letter of 10th inst. together with the Terms of Reference for the Inquiry.

I am enclosing the replies to the questionnaire. As my late wife Patient 10 had a complex medical history in the 10 years prior to her death I am enclosing a short summary of Patient 10's medical history leading to her contact with Urology Department – Appendix 1 to the Questionnaire.

I am also enclosing a copy of a Serious Adverse Incident Report (The Report) dated 16/3/2017 – Appendix 2. You will note from The Report that there were other serious errors made in Patient 10's treatment. The Report is only sent to you to show you the context in which Patient 10 had contact with the Urology Department. Under the terms of your inquiry I do not expect any investigation or comment on the other non-urological matters contained in The Report.

Patient 10 and I attended at Craigavon Area Hospital on 10/4/2017 to discuss and examine The Report. We confirmed we were taking no further action, legal or otherwise. We were assured at that meeting that the Trust had already initiated procedures to address the serious failings outlined in The Report.

For ease of reading The Report I outline below the relevant doctor and surgeons' names referred to in The Report. The names I have left out relate to non-urological matters. I have only included Me Hewitts, Dr Patient's GP and Mr Haynes' names as they are not associated with any errors in The Report.

THE REPORT

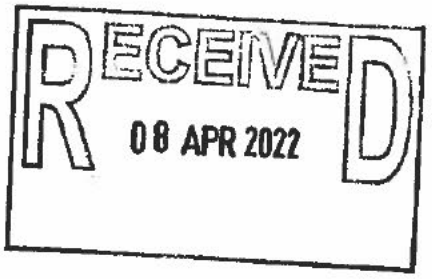
DR 1 - Mr G Hewitt – Bowel Surgeon

DR 5 – Dr Patient's GP – Patient 10's G.P. requested the appointment on 1/11/2014 in Urology

DR 6 – Mr Aidan O'Brien – Urologist on call who should have triaged the appointment requested by DR 5 (Dr Patient's GP) on 1/11/2014

Ref [redacted] D.O.B [redacted]

[redacted]



28 March 2022

Urology Services Inquiry

1 Bradford Court

Belfast

BT6RB

With reference to your letter of 10th March 2022, I apologise for the delay in replying.

I am replying under heading (a) in your Terms of Reference. I do not have a full record of dates of my treatment but I have made a chronological list of what I experienced while in the care of Southern Health and Social Care Trust and Mr O'Brien together with the dates that I can remember.

- I was admitted to CAH in 2006 in emergency, unable to urinate with an enlarged prostate gland. I was operated on by Mr O'Brien to clear the blockage. After the operation Mr O'Brien informed me that there was "absolutely no trace of cancer".
- Some time passed and I was surprised to receive, out of the blue, an appointment for the Urology Department in CAH. I was examined in the presence of Mr O'Brien and biopsies were advised. I was later told that the biopsy results indicated that I had prostate cancer.
- I received an appointment with Mr O' Brien and he prescribed Bicalutamide and Tamoxifen and I was told on this occasion by Mr O'Brien that I would be receiving radiation treatment.
- After a further duration of time had passed, I was reviewed once more in an appointment with Mr O'Brien. I was told on this occasion that I would not be receiving radiotherapy. The reason provided for this decision by Mr O'Brien was that because of my age I would find it too tiring to travel to BCH daily for 7 weeks. I was shocked by the news and said nothing.
- Over this review period with MrO'Brien, I found it difficult to get an appointment with him and this added to the anxiety and stress that I was experiencing in dealing with my diagnosis. We explained this to him at one of the appointments and he gave us his personal card for private treatment. We accepted the card but did not choose to follow this option.
- After consideration and discussion with family members I wrote a letter of complaint to Mr O'Brien dated 24 May 2012. (copy attached). I appealed for radiation treatment as hormone therapy was giving me a poor quality of life – I was depressed and I could not imagine living like this for the rest of my life. I received a reply from Mr O'Brien dated 25 July 2012 (copy attached), in which he informed me that an appointment with oncology was being arranged.
- I had a further review appointment with Mr O'Brien in August 2012.
- I had my first appointment with a lady Oncologist in CAH. The lady consultant told me that I had cancer from the very outset of my prostate symptoms and not " absolutely no trace of

24th May 2012

Mr A. O'Brien F.R.C.S.

Urology Department

Craigavon Hospital

68 Lurgan Road

Portadown

BT63 5QQ

Dear Mr O'Brien

Re: Patient 18 Personal information redacted by USI

DOB: Personal Information redacted by USI HCN no. Personal Information redacted by USI

I am aware that you are processing a letter regarding my treatment. However, although this has not yet been received, I feel I have to state my wishes.

Until the 27th April 2012 I have been on Bicalutamide. The side effects I experienced were: fatigue, headache, dizziness, depression, loss of strength, forgetfulness, lack of appetite (resulting in unhealthy eating), weight gain.

As a result of this treatment I was only able to walk slowly for a short distance and could not do much more than sit in an arm chair. I persevered with the treatment for 7 ½ months as I was informed at my first consultation that I would be treated with radiotherapy when my PSA count came down.

At my consultation on the 27th April 2012 I was told that the referral for radiotherapy would mean travelling to Belfast City Hospital every day of the week for 7 weeks and that this was very tiring. However, it was also pointed out that that this would mean getting the tiredness over and done with. It was then suggested that I should go on to what I believe is Intermittent Hormone Therapy and quality of life was also mentioned.

Apart from the side effects mentioned above, I could potentially develop muscle loss, bone thinning, risk of heart disease and insulin - dependent diabetes. I understand that this treatment could continue but only as long as it continues to work. It can take 6-9 months or sometimes longer for the side effects to wear off. The longer you are on the treatment, the shorter the interval between treatments becomes. In these circumstances I cannot foresee quality of life with this treatment. There is also no cure.

I understand that radiotherapy is used for treating men with prostate cancer that is localised or worse and is as effective at treating this as surgery to remove the prostate. The only disadvantage mentioned on the 27th April was the tiredness. We

I have initiated a degree of androgen blockade by prescribing Bicalutamide 50mg daily. I also prescribed Tamoxifen 10mg daily, in order to prevent gynaecomastia. I have arranged to review him at my clinic at the Thorndale Unit in January 2012. I have written to Mr Patient 18, asking him to have his serum PSA repeated by your practice nurse during December 2011, and so that a result will be available when he returns for review. He may require an increased dose of Bicalutamide, in order to achieve a satisfactory biochemical response prior to considering proceeding to radical radiotherapy.

Yours sincerely

Dictated but not signed by

Mr Aidan O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 16/09/11	**Date Typed:** 16/09/11 SC

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
CLINIC LETTER

CONSULTANT UROLOGIST: Mr O'Brien
SECRETARY: Monica McCorry
TELEPHONE: Personal information redacted by USI

Patient's GP
Personal information redacted by USI

Dear DR Patient's GP

Re: Patient Name: MR Patient 18
D.O.B.: Personal Information redacted by USI
Address: Personal information redacted by USI
Hospital No: **HCN:** Personal information redacted by USI

Further to my letter of 16th September 2011, I write to advise you that I next reviewed Mr Patient 18 on 27th April 2012, when I found him to have suffered significantly from the adverse effects of androgen blockade. He reported that he suffered particularly from fatigue, anergia and sleep dysfunction. I was pleased to note that his serum total PSA level had decreased to 2.68ng/ml by December 2011 and further to 2.55ng/ml by March 2012. However, the adverse effects of androgen blockade had had a severely negative impact upon his quality of life and to the extent that I advised him to discontinue taking both Bicalutamide and Tamoxifen.

I also availed of the opportunity then of discussing further management options with him. I advised him that he would probably be dissuaded from considering radical surgery, in view of his age and in view of him previously having his prostate resected in 2006. Brachytherapy would probably not be offered in view of the prostatic volume of 57.6mls on ultrasound scanning in 2011, his serum total PSA levels having been greater than 10ng/ml and also because of previous prostatic resection. Radical radiotherapy does still remain an attractive option. Lastly, some consideration was given to the prospect of intermittent androgen blockade.

Patient 18 subsequently wrote to me on 24th May 2012 particularly to emphasise the severe adverse toxicity due to Bicalutamide, including fatigue, headache, dizziness, depression, loss of strength, forgetfulness, loss of appetite and weight gain. For all of these reasons, he was pleased to have androgen blockade discontinued, and eloquently expressed the view that he did not wish to have any further androgen blockade at any time in the future. Equally eloquently and rationally, he asserted that he wishes to proceed with radical radiotherapy.

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
OUTPATIENT LETTER

Telephone: [redacted]
Fax:
Email: [redacted]
Secretary: **Mrs M McCorry**

16 September 2011

DR [redacted]
[redacted]

Dear DR [redacted]

Re: Patient Name: MR [redacted]
D.O.B.: [redacted]
Address: [redacted]
Hospital No: [redacted] **HCN:** [redacted]

Date/Time of Clinic: 09/09/11	**Follow Up:** REV JAN 2012
Procedure (if applicable)	

Further to the letter of 23 June 2011 from Mr Thwaini, I write to advise you that there was no evidence of any skeletal metastatic disease, when [redacted] had radio-isotope bone scanning performed on 7 July 2011. Moreover, there was no evidence of extracapsular disease on MRI scanning performed on 20 July 2011.

When I reviewed Mr [redacted] on 9 September 2011, I found him to be keeping very well indeed. He remains almost completely devoid of any lower urinary tract symptoms, only occasionally having to rise at night to pass urine. I found his serum total PSA level that day to be 11.71ng/ml.

It is interesting to note that Mr [redacted] had a serum total PSA of 19.3ng/ml in 2006, and just prior to having his prostate resected then following an admission in acute urinary retention necessitating catheterisation. There was no evidence of any prostatic carcinoma on histological examination of resected tissue then. His serum total PSA level subsequently fell to 7.6ng/ml in 2007. This value should be regarded as the relevant baseline, from which to estimated PSA velocity and doubling time. His PSA level had increased significantly to 13.86ng/ml by March 2011, resulting in a doubling time of approximately 5 years. It is somewhat reassuring to note that his serum total PSA level has fallen a little, spontaneously, to 11.71ng/ml by 9 September 2011.