Canberra Health Services

Medical - in - Confidence
Gynaecology
(Discharge Summary)

[DoB:] Female
Ph:

First Admitted: 11:00

To: Dr.
Cc: CENTRAL OUTPATIENT CLINICS TCH; TCH CENTRAL OUTPATIENTS
Discharged To: Home

Discharge Date: 16:45
Ward/Location: AN
Discharge Method: Hospital Outpatient Service

Encounter History

Episode	Admission Date	Discharge Date	Episode Type	Discharge Unit	Discharge Doctor	Discharge Destination
			Inpatient Service	Gynaecology		Home

Discharge Location
has been discharged from: The Canberra Hospital

Primary Discharge Diagnosis
Elective admission for apronectomy, total abdominal hysterectomy and bilateral salpingo-oopherectomy for large right adnexal cyst

Additional Diagnosis
High BMI
Under breast candida infection

Complications Treated during this Admission
-

Presenting History & Symptoms (including reason for encounter)
was admitted for elective apronectomy, TAH and BSO.

Past Medical History
1990 - PCOS
1997 - Necrotising fasciitis
2004 - Depression
2004 - HTN
2008 - Fatty liver
2008 - Impaired glucose tolerance
2008 - Metabolic Syndrome
2008 - Sabaceous cyst
2009 - Asthma
2009 - T2DM
2015/16 - Recurrent abdominal cellulitis

Procedures / Operations

· Procedure / Operation: Elective apronectomy, abdominal hysterectomy and bilateral salpingo-oopherectomy, Date: , Notes:
Joint procedure between Gynaecology and Plastic Surgery (Dr / Dr)

Summary of Investigations / Observations

As below

Summary of Management

Procedure as above
Initially monitored in ICU post-procedure
Admitted to Antenatal ward for monitoring
Physiotherapy review for mobility
Endocrine review for BGl control, will follow up as outpatient
Plastics review for progress and drain care, will follow up as outpatient
Gynaecology review for progress, will follow up as outpatient
Regular observations and vitals
Completed course of antibiotics post-procedure
Fungal infection under breasts noted, confirmed on skin swab--recommended topical clotrimazole
Bloods and imaging as below

Discharged home with follow up below

Deceased

-

Pending Results / Investigations for GP to Follow-up

Nil

Ongoing Issues / Recommendations to GP

Dear Doctor,

Thank you for your ongoing care of Ms . We have summarised the key issues from her admission below:

1) Ongoing drain management with community nursing
2) Removal of drain 2 weeks post operatively regardless of drain output
3) Follow up with plastic surgical clinic next Tuesday at 09:50am then further appointment in 3 months time
4) Dressing to remain until Plastics appointment
5) Recommenced on regular oral hypoglycaemics and insulin
6) Gynecology follow up in 8 weeks time
7) Ongoing physiotherapy input as outpatient with preferred physiotherapist
8) Candida infection noted underneath breasts, confirmed on swab--recommended topical clotrimazole
9) Follow up with yourself in 3-5 days to check progress on current regimen
10) If you have any queries please contact Gynaecology at TCH

Kind Regards,

TCH Gynecology

Follow-up Required

· Service Requested: Plastic Surgical Registrar, Organisation: TCH, Clinician's Name: Dr , Appt made: Yes, Patient Advised: Yes, Appt Details: at 09:50 am, Location: Outpatient's department
· Service Requested: Gynaecology follow up, Organisation: TCH, Appt made: No, Patient Advised: No, Appt Details: 8 weeks post operatively , the clinic will be in touch with you with an appointent time

· Service Requested: Plastics Surgical Follow up, Organisation: TCH, Clinician's Name: Dr , Appt made: No, Patient Advised: Yes, Appt Details: Please arrange for 3 months time and send patient the details
· Service Requested: Endocrine clinic, Organisation: TCH, Appt made: Yes, Patient Advised: Yes
· Service Requested: GP, Appt made: No, Patient Advised: Yes, Appt Details: Please follow up with your GP in 3-5 days for post-discharge management

Patient Instructions
Dear ,

On discharge from hospital, please take note of the below plan (agreed on by both the gynaecology and plastic surgical team)
1) Ongoing drain management with community nursing
2) Removal of drain 2 weeks post operatively regardless of drain output
3) Please attend follow up with plastic surgical clinic next at 09:50am
4) Please call Dr clinic for an appointment in 3 months time
5) Keep dressing on until review with plastics registrar next week.
6) You have been recommenced on dapagliflozin and your usual insulin on discharge from hospital. Please continue until your Endocrine outpatient appointment
7) Please attend your gynecology follow up in 8 weeks time (the clinic will call you with an appointment time however, if we do not do so, please contact TCH on 6244 2222 and let us know at the Central Outpatients Department)
8) Please use your prescribed analgesia as required. We encourage you to mobilise and resume normal activities at home
9) No heavy lifting (>5kg or 2 shopping bags per arm) for 4-6 weeks
10) No driving until you are pain free and are able to execute an emergency stop. Please consult your driving insurance company for policy details
11) If you feel acutely unwell for any reason, or notice blood, pus or a spreading redness from your incision site, please seek medical attention urgently – either your GP or return to TCH emergency where we will reassess you
12) Please start a topical anti-fungal (such as 1% clotrimazole, twice daily for 2 weeks) for the yeast infection under your breasts
13) Please follow up with your GP in 3-5 days to monitor your progress

Medications on Admission
- Aldactone, 100mg mane PO
- Metformin XR, 1000mg mane PO
- Micardis, 80mg mane PO
- Setraline, 50mg mane PO
- Forxia, 10mg mane PO
- Vitamin D, 2000IU mane PO
- Cefalexin 500 mg BD
- Lantus 24 units nocte
- Novorapid 4 units at dinner

Complete List of Medications on Discharge
- Aldactone, 100mg mane PO (Supply on Discharge), Supply: Own supply
- Metformin XR, 1000mg mane PO (Supply on Discharge), Supply: Own supply
- Micardis, 80mg mane PO (Supply on Discharge), Supply: Own supply
- Setraline, 50mg mane PO (Supply on Discharge), Supply: Own supply
- Forxia, 10mg mane PO (Supply on Discharge), Supply: Own supply
- Vitamin D, 2000IU mane PO (Supply on Discharge), Supply: Own supply
- Lantus 24 units nocte (Supply on Discharge), Supply: Own supply
- Novorapid 4 units at dinner (Supply on Discharge), Supply: Own supply
- Paracetamol 1 g QID prn (Supply on Discharge), Supply: Own supply
- Ibuprofen 400 mg TDS prn (Supply on Discharge), Supply: Own supply
- Tramadol 50-100 mg QID prn (Supply on Discharge), Supply: Script
- Enoxaparin 80 mg subcut injection daily for four days then cease (Supply on Discharge), Supply: Script
- Movicol 1-2 sachets BD prn (Supply on Discharge), Supply: Own supply
- 1% Clotrimazole topical under breasts BD for 2 weeks (Supply on Discharge), Supply: Own supply

Details of Pre-Inpatient Medications Ceased during this Admission
· Cephalexin 500 mg BD

Adverse Drug Reactions Previously Reported
Drug: Penicillin -class of antibiotic-;;Unknown;

Allergies / Sensitivities
· Substance: Penicillin

Relevant Pathology
Hematology 10:39 : FBC & General Haem
1.)Image : CURRENT REPORT
WCC :* Hypersegmented neutrophils.
RBC :* Polychromasia: mild. * Elliptocytes: some noted.

TOTAL NEUT: is the sum of Neutrophils, Bands, Myelocytes, Metamyelocytes.

CUMULATIVE REPORT

Req No:	P276482	P274767	P278625	P284928	P286776		
Date:							
Time:	04:17	04:14	03:43	10:42	10:39		
Hosp.:	TCH	TCH	TCH	TCH	TCH	Units	Ref Range
BLOOD COUNT							
Hb	110L	93L	82L	92L	90L	g/L	115-160
WCC	14.5H	14.8H	11.0	9.6	9.1	x10^9/L	4.0-11.0
Plat	260	205	200	284	484H	x10^9/L	150-400
RCC	3.64	3.12L	2.76L	3.05L	2.99L	x10^12/L	3.60-5.80
HCT	0.33	0.28L	0.25L	0.28L	0.28L	L/L	0.32-0.47
MCV	90	91	91	92	92	fL	80-96
MCH	30.1	29.9	29.8	30.3	30.2	pg	27.0-33.0
MCHC	332	329	328	329	329	g/L	320-360
RDW	14.9H	15.0H	14.6H	14.9H	14.8H	%	11.0-14.5
White Cell Differential							
Tot Neut	12.14H	11.74H	8.49H	6.45	6.19	x10^9/L	1.8-7.5
Neut	12.14H	11.74H	8.49H	6.45	6.19	x10^9/L	1.8-7.5
Lymph	1.04L	1.36	1.49	2.09	2.46	x10^9/L	1.2-4.0
Mono	1.31H	1.64H	0.90	0.77	0.46	x10^9/L	0.10-1.0
Eos		0.01	0.08	0.23		x10^9/L	0.00-0.7
Baso	0.01	0.04	0.04	0.06		x10^9/L	0.00-0.2

Status: F

Chemistry 10:39 : Routine Chemistry
1.)Image : --

Request No:	P276482	P274767	P278625	P284928	P286776		
Date:							
Time:	04:17	04:14	03:43	10:42	10:39		
Hospital:	TCH	TCH	TCH	TCH	TCH	Units	Ref Range
Fasting:	No			No	No		
Sodium	133L	132L	135	134L	136	mmol/L	135-145
Potassium	4.5	4.7	4.3	4.1	3.8	mmol/L	3.5-5.2

Test						Units	Reference
Chloride	104	103	102	100	100	mmol/L	95-110
Bicarbonate	22	23	27	28	27	mmol/L	22-32
Anion Gap	12	11	10	10	13	mmol/L	8-16
Urea	4.6	7.2	6.0	6.0	3.2L	mmol/L	3.4-9.0
Creatinine	62	67	44L	52	46	umol/L	45-90
Est. of GFR	>90	>90	>90	>90	>90	*	>90
Glucose	15.4H	13.0H	10.4H	12.6H	7.5H	mmol/L	3.5-5.5
Osmol-calc	287	285	286	287	282	mOsm/kg	280-300
Bili Tot.		13				umol/L	2-20
ALT		86H				U/L	<33
ALKP		40				U/L	30-110
New GGT		12				U/L	<56
Protein		53L				g/L	60-80
Albumin	34	30L	28L		31L	g/L	33-50
Globulin		23L				g/L	24-41
Calcium	2.00L	1.99L	2.04L		2.30	mmol/L	2.10-2.60
CorrCalcium	2.12	2.19	2.28		2.48	mmol/L	2.10-2.60
Phosphate	1.03	1.23	0.51L		1.21	mmol/L	0.75-1.50
Magnesium	0.90	0.96	1.01		0.75	mmol/L	0.70-1.10
Haemolysis Index							
Haemolysis	0.06	0.02	0.01	0.05	0.04		

Estimated GFR(CKD-EPI Formula)
eGFR is calculated using creatinine, sex and age of the patient ONLY.
It is less accurate in situations of rapidly changing kidney function,
extremes of body size or age and severe malnutrition.

*GFR units are: mL/min/1.73m2

General Glucose Comment:
The above glucose reference range is valid for FASTING samples on males
or non-pregnant females.
The reference range for RANDOM GLUCOSE is 3.5-7.7 mmol/L.
A RANDOM GLUCOSE >11.0 mmol/L is diagnostic of DM.

Age Related Reference Intervals
Where appropriate, the age-related Reference Interval is quoted for
each analyte. These Reference Intervals are available from the laboratory. Status:
F

Microbiology 09:46 : General MC&S
1.)Image : LAB.NUMBER:
SPECIMEN: SWAB
SITE: UNDER LEFT BREAST FOLD
GRAM STAIN:

Polymorphs	Not seen
Gram positive cocci	++
Gram positive bacilli	+++
Gram negative bacilli	+++

CULTURE:
1. Candida glabrata complex Scanty growth

with a heavy growth of skin type flora including Proteus
mirabilis, Enterococcus faecalis and mixed anaerobes. Status: F

Microbiology 09:46 : General MC&S
1.)Image : LAB.NUMBER:
SPECIMEN: SWAB
SITE: UNDER RIGHT BREAST FOLD
GRAM STAIN:

Polymorphs	Scanty
Gram positive cocci	++
Gram positive bacilli	+
Gram negative bacilli	+

CULTURE:
1. Candida glabrata complex Scanty growth

with a heavy growth of skin type flora including Proteus mirabilis, Enterococcus faecalis and mixed anaerobes. Status: F

Chemistry 10:42 : Special Chemistry
1.)Image : Request No: P250846 P056753 P284932

Date:					
Time:	12:30	08:40	10:42	Units	Ref Range
GLYCAEMIC CONTROL MONITORING-(Venous Whole Blood)					
HbA1c (%)	9.0H	9.6	8.0	%	(See below)
HbA1c (IFCC)	75	81	64	mmol/mol	(See below)
Glucose	12.9	10.9	12.6	mmol/L	

The analytical method of HbA1c measurement remains unchanged. The two units can be inter-converted according to the table below.

mmol/mol	%	mmol/mol	%	mmol/mol	%	mmol/mol	%
35	5.4	55	7.2	75	9.0	100	11.3
40	5.8	60	7.6	80	9.5	110	12.2
45	6.3	65	8.1	85	9.9	120	13.1
50	6.7	70	8.6	90	10.4	130	14.0

Clinical Significance:
HbA1c > 6.4% (>46 mmol/mol)is consistent with diabetes mellitus.
Reference: D'Embden et al MJA 2015;203:89-90

HbA1c < 7.1% (< 54 mmol/mol) demonstrates satisfactory glycaemic control.
HbA1c targets should be individualised for particular patient groups to achieve the best outcome.
Reference: Diabetes Australia and the NHMRC, 2009

Glycated haemoglobin may be underestimated in cases of reduced red cell survival (eg Haemolysis), some haemoglobinopathies and thalassaemia. Status: F

Microbiology 16:16 : Catheter Tip MC&S
1.)Image : LAB.NUMBER:
SPECIMEN: TIP
SITE: LEFT IJ CENTRAL VENOUS CATHETER

CULTURE:
No microbial growth after 48 hours incubation. Status: F

Immunology 13:36 : ACTH/Cortisol/Renin
1.)Image : -Cumulative
Report--

Request No:	P292374	P274767	P243793		
Date:					
Time:	08:30	04:14	13:36	Units	Ref Interval
ACTH/Cortisol Studies (Plasma/Serum)					
Cortisol	386	402	393	see table	

Cortisol ADULT Reference Interval
100 - 540 nmol/L (before 10am)
80 - 480 nmol/L (after 5pm) Status: F

Surgical Pathology 16:00 : Anatomical Pathology
1.)Image : Lab #: 2019T014916

NATURE OF SPECIMEN
UTERUS, FALLOPIAN TUBES AND OVARIES

HISTORY
Subtotal hysterectomy. Right adnexal lesion (indication). Omental biopsy.

MACROSCOPIC DESCRIPTION
A. "UTERUS, FALLOPIAN TUBES + OVARIES"
A subtotal hysterectomy specimen with the uterus (fundus and body) transected at the lower uterine segment, 62mm mid fundus to point of transection, 56mm medial to lateral by 45mm anterior to posterior. Attached bilateral ovaries and attached distal portions of the fallopian tubes (without the fimbriated ends). Also received is a separate ?fimbriated end of a fallopian tube and paratubal cyst and a separate fragment of ?fallopian tube. Combined specimen weight 285 grams.

The endometrium measures up to 2mm in thickness and is macroscopically unremarkable. The myometrium measures up to 22mm in thickness and is coarsely trabeculated.

The right ovary is 89x65x45mm. The external surface is shiny and smooth, slightly bosselated. The ovary is largely replaced by a multilocular cyst, with the locules ranging from 10-62mm in dimension. One locule contains a solid protuberance approximately 18x10x10mm, the remainder of the locule containing small papillary excrescences covering an area of approximately 10mm. Elsewhere the cyst wall on average is approximately 2mm thick within smooth internal surface. The cyst contains a clear slightly yellow tinged serous fluid.

A portion of the attached right fallopian tube measures 22x4mm, the fimbriated end is not visualised. The separate fragment of ?fimbriated end of a fallopian tube measures 15x14x4mm, with an attached unilocular

cyst, with a shiny and smooth external surface, cyst wall <1mm thick, smoothly lined surface containing clear serous fluid, 38x28x25mm.

The left ovary is 37x28x18mm. The ovary is multicystic, the external surface is shiny and smooth, the cut surface reveals multiple cysts ranging from 4-23mm in maximal dimension. The cyst lining is shiny and smooth with the wall on average 2mm thick. There is a solid area spanning approximately 15mm, ?residual ovarian parenchyma.

The attached left fallopian tube is 48x5mm, the fimbriated end is not macroscopically visualised.

The separate tubal structure ?fallopian tube is 50x5mm, no fimbriated end is visualised.

KEY TO BLOCKS
-1-2 = Representative sections of the endomyometrium and serosa
-3-8 = Sections of right ovary showing solid areas and papillary excrescences
-9-10 = Right ovarian cyst wall
-11 = Representative sections of right fallopian tube
-12-15 = Representative sections of left ovary showing multiple locules and solid area
-16 = Representative sections of left fallopian tube
-17 = ?Separate fimbriated end
-18 = Representative sections of cyst attached to separate fimbriated end of fallopian tube, ?paratubal cyst
-19 = Representative sections of separate tubal structure ?fallopian tube 19-N

B. "OMENTAL BIOPSY"
Two fragments of fatty tissue, 330x292x35mm. The tissue largely consists of fatty tissue. There is an area of white, firm, poorly defined fibrous tissue, ?fat necrosis, approximately 18mm across. There are interspersed firm fibrous bands.

KEY TO BLOCKS
-1-3 = Firm fibrous white tissue ?fat necrosis
-4-5 = Representative sections of fatty tissue 5-5 (SH)

MICROSCOPIC
A. "UTERUS, FALLOPIAN TUBES + OVARIES"
The sections of uterus show proliferative phase endometrium with slightly coiled mitotically active glands; there is no evidence of hyperplasia, polyp formation, atypia or malignancy. The myometrium is unremarkable as is the uterine serosa.

The right ovary contains a multiloculated serous cystadenomafibroma. Most of the cyst locules are lined by a single layer of flattened cuboidal epithelium. One locule shows broad papilliform infoldings in the wall with focal smaller papilliform tufts (A5, A7). The epithelium is one cell thick with ciliation. No crowding, multilayering or atypia is seen. This region of papilliform hyperplasia involves well below 10% of the overall surface of the cystic lesion. On the surface of the ovary are multifocal deposits of psammomatous calcification associated with small numbers of residual papillary epithelial structures, surrounded by fibrosis (eg A5). There are consistent with desmoplastic non-invasive implants.

The right fallopian tube shows a benign paratubal cyst with no

evidence of atypical epithelial proliferation.

The left fallopian tube appears unremarkable.

The left ovary also contains a smaller multiloculated serous cystadenoma as well as a follicular cyst. No papillary formations are are evident. Scattered calcific deposits are seen beneath the surface of the ovary, but no associated epithelial elements are identified.

Comment: The presence of very focal mild papillary proliferation with the serous ovarian cystic lesion is consistent with classification as a "serous cystadenomafibroma with focal epithelial proliferation", falling short of the >10% papillary proliferation required for a diagnosis of serous borderline tumour. The psammomatous desmoplastic non-invasive papillary "implants" on the surface of the right ovary are similar to those demonstrated on the peritoneal surface (see Specimen B below), and these are known to be frequently correlated in serous borderline tumours.

B. "OMENTAL BIOPSY"
Sections show fibrofatty tissue with scattered collections of psammomatous calcifications associated with a few residual papillary epithelial nests surrounded by fibrosis. These appear to be located on the peritoneal surface although the tissue is folded. The epithelial cells show mild nuclear atypia with nucleolar prominence. The amount of desmoplastic stroma exceeds the epithelial component. Destructive invasion of the fatty tissue is not seen.

These deposits are consistent with desmoplastic non-invasive papillary implants.

DIAGNOSIS
A. UTERUS, FALLOPIAN TUBES + OVARIES:
- RIGHT OVARIAN MULTILOCULATED 9CM SEROUS CYSTADENOFIBROMA WITH FOCAL EPITHELIAL PROLIFERATION
- NON-INVASIVE DESMOPLASTIC PSAMMOMATOUS IMPLANTS ON RIGHT OVARIAN SURFACE
- BENIGN PARATUBAL CYST ADJACENT TO RIGHT FALLOPIAN TUBE
- LEFT OVARIAN SMALL MULTILOCULATED SEROUS CYSTADENOMA

B. OMENTAL BIOPSY:
- NON-INVASIVE DESMOPLASTIC PAPILLARY IMPLANTS WITH PSAMMOMATOUS CALCIFICATIONS

Reported by Dr
Phone: (02) 5124 8350 Status: F

Blood Bank 14:00 : Blood Transfusion
1.)Image : BLOOD GROUP: O Rh(D) Positive

ANTIBODY SCREEN: Negative

UNIT AVAILABILITY
The Blood Units listed are available for transfusion to the patient nominated above. The listed units will be allocated for a maximum of 72hours from the time of specimen collection. Exceptions to this 72 hour rule will be noted in the General Comments Section below.

TRANSFUSION COMMENTS
The units listed are compatible with this patient.

UNIT NUMBER	PRODUCT	BLOOD GROUP
2652877	Packed Cells	O Rh(D) Positive

SPECIAL TRANSFUSION INSTRUCTIONS
.

GENERAL COMMENT
Insufficient information has been provided regarding the patient's transfusion history. Therefore, this specimen will be held for 72 hours from the time of collection. Status: F

Relevant Diagnostic Imaging

Chest- Mobile [XR] 01:26
1.)Chest- Mobile [XR] :
URN:
Clinical History D2 post apronectomy + TAH + BSO for fibroid/bleeding. Morning bloods and CXR please Technique AP Mobile CXR Comparison AP Mobile CXR 31/7/19 Findings The cardiomediastinal contour is unchanged allowing for rotational differences. The right sided central line is unchanged in position. There is a small left sided pleural effusion. There is minimal interval improvement in the left basal collapse consolidation with small residual opacity evident in the left lung base laterally. There is a right basal atelectasis. There is blunting of the both pleural recess is suggesting a degree of small pleural effusion.
Status: Final
Preliminary Reading Doctor: ; Authorising Doctor: ;

Chest- Mobile [XR] 08:34
1.)Chest- Mobile [XR] :
URN:
Clinical History D2 post-extubation desaturation ?collapse Comparison Note is made of the plain radiograph dated 29/07/2019 Findings The patient is rotated to the left. A central line terminates within the proximal SVC. There is a vertically oriented linear retrocardiac opacity. The left hemidiaphragm is effaced. This may represent partial lobar collapse. The upper zones demonstrate improved aeration when compared with previous study. The heart is not enlarged. Conclusion Ongoing Left basal collapse/consolidation.
Status: Final
Preliminary Reading Doctor: Authorising Doctor: ;

Chest- Mobile [XR] 20:15
1.)Chest- Mobile [XR] :
URN:
Clinical History 50 year old F post op apronectomy + hysterectomy + salpingectomyarrival to icu post-opAssess CVC and ETT position Comparison Comparison is made with the previous chest radiograph dated 20/11/2015. Conclusion The ETT tube terminates 5mm from the carina. The right IJ CVC tip projects over the SVC. The patient is slightly rotated to the right. There is left basal collapse/consolidation. There is blunting of the left costophrenic recess consistent with a small effusion.
Status: Final
Preliminary Reading Doctor: Authorising Doctor: ;

Clinician: **Signature:**
For Consultant: **Date:** 16:07

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Health Information Service 5124 2124 **GP Liaison phone** 5124 4183 **GP Liaison fax** 5124 5935

Sent via Healthlink to Dr

Canberra Hospital and Health Services
PO Box 11 Woden
ACT 2606

URN:
Patient Name:
DOB:
Episode ID:

Discharge Summary CC List Transmission History:

Transmission To:

Transmission To:

List of Recipients:

Name	Suburb	Phone	Fax	HealthLink Address	Del via HealthLink	Primary Contact