NHS Lothian

Royal Infirmary of Edinburgh
Outpatient Department 3
51 Little France Crescent
Edinburgh
EH16 4SA

Cardiology

Dr Craig
Dalkeith Road Medical Practice
145 Dalkeith Road
Edinburgh
EH16 5HQ

Date: 12/03/2021

Outpatient Clinic Letter

Patient	Colin Day 27s Findhorn Place Edinburgh EH9 2NY	**CHI** **Date of Birth / Age** **UHPI**	**2704610150** 27/04/1961 (59 years) 700793490X
Attendance Date	12/02/2021		
Consultant	Prof Nicholas L Mills		

Dear Dr Craig

I reviewed Mr Day today after a referral for a 72 hour tape. He recently had a stroke in 2020 and he was seen at Wishaw General Hospital for this. Today his blood pressure was 128/91 and a heart rate of 89. He describes no symptoms of palpitations currently and his heart rate was regular on palpation. His ECG was unremarkable. He did say that for a number of years now he does intermittently get palpitations that pass quite quickly but he doesn't recall when he last had these because he has just got used to them. He doesn't drive. I have arranged for him to have an out patient 72 hourtape which has been fitted today and will write to you with the results. Otherwise we have discharged him from clinic. Many thanks.

Yours sincerely

Dr Ryan Wereski
Cardiology Research Fellow
(BM5/3)

NHS Lothian

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Outpatient Department 3
51 Little France Crescent
Edinburgh
EH16 4SA

Cardiology

Dr Craig
Dalkeith Road Medical Practice
145 Dalkeith Road
Edinburgh
EH16 5HQ

Date: 25/03/2021

Outpatient Clinic Letter

Patient	Colin Day 27s Findhorn Place Edinburgh EH9 2NY	**CHI** **Date of Birth / Age** **UHPI**	**2704610150** 27/04/1961 (59 years) 700793490X
Attendance Date	12/02/2021		
Consultant	Prof Nicholas L Mills		

Dear Dr Craig

This 59-year-old man was referred by Wishaw Hospital to the service for Holter monitoring following a lacunar stroke. This was conducted on 12th February and he completed 72 hours of monitoring. He was in sinus rhythm throughout, with an average heart rate of 73 beats per minute (range 54-102 beats per minute). He had no symptoms and there were no abnormal rhythm disturbances. I hope this is of some reassurance.

With best wishes

Yours sincerely

Professor Nicholas Mills
Consultant Cardiologist
Secretary: 0131 242 1847
NLM/KR

NHS Lothian

Ambulatory Care

Western General Hospital

Dr Wright
Dalkeith Road Medical Practice
Salisbury Court
102 St Leonards Street
Edinburgh
EH8 9RD

Date: 27/12/2023

Outpatient Clinic Letter

Patient	Colin Day 27s Findhorn Place Edinburgh EH9 2NY	**CHI** **Date of Birth / Age** **UHPI**	**2704610150** 27/04/1961 (62 years) 700793490X
Attendance Date	22/12/2023		
Consultant	SDEC New Clinic		

Dear Dr Wright

SDEC Review - Rebecca Woodfield (Consultant), K Vickneson (IMT1)

Presenting Problems:
1. Dizziness - likely postural hypotension

Action for GP
1. Uptitrate atorvastatin to 80mg OD
2. Please wean amitriptyline dose given that he has dry mouth and has a high anticholinergic burden
3. Please reduce bisoprolol dose in the first instance and possibly down-titrate isosorbide mononitrate if tolerated
4. If ongoing peripheral vertigo-like dizziness despite the above changes, consider referral to ENT for assessment of peripheral-like dizziness

Mr Day returned to SDEC clinic today for a CT scan follwong a presentation of dizziness. This showed that he has no new acute intracranial pathology but there were multiple new established bilateral basal gangalia lacunaes that were new from his scan since 2020.

The stroke team were called to review Mr Day.

Mr Day complains of dizziness on looking down to the floor and bending down. These episodes are very intermittent and last for a few seconds to minutes before it resolves. he first noticed this about 10 days ago. On further questioning, he describes having these light-headed and dizzy episodes in the morning, especially when getting out of bed and standing up before it quickly resolves when he is in the hallway. He has not had any falls or syncopal episodes secondary to this. He described a similar episode of intermittent dizziness earlier this year which lasted for a week and then completely resolved.

Medications reviewed today:
Clopidogrel 75mg once daily - advised to withhold am.

Bisoprolol 3.75mg once daily
Atorvastatin 40mg at night
Amitriptyline 25mg at night
Fluoxetine 20mg at night
Co-codamol 30mg/500mg - 1 to 2 tabs every 4-6 hrs prn
Allopurinol 300mg once daily
Isosorbide Mononitrate 20mg bd

On examination today, he did not have any nystagmus. The Dix-Hallpike test for posterior canal BPPV was negative. There was evidence of residual right hand spasticity. He walks with one stick with no evidence of ataxia. His BP on lying down was 154/87mmHg and on standing up, did drop to144/84mmHg, but he was asymptomatic. We were unable to reproduce his dizzy episodes on examination today

We explained to Colin that he has not had a stroke. He would benefit from an increase in his atorvastatin dose. His clinical presentation is in keeping with a postural drop, which intermittent symptomatic dizzy episodes that quickly resolves. We had some discussions with a plan to reduce his bisoprolol dose in the first instance and as a second line reducing his isosorbide mononitrate if tolerated (his last anginal episode has been for a few years and has had no recent anginal episode). He is also using amitriptyline for pain and we discussed that given its high anticholinergic burden (he is currently complaining of a very dry mouth because of this), it increases his risk of postural symptoms, falls and cognitive dysfunction in the long term. Mr Day might benefit from weaning his amitriptyline dose and ultimately stopping it, if he does not get any benefit from this. If the above measures fail, then he would benefit from an ENT referral for formal assessment of BPPV.

We have discharged him from SDEC clinic today.

Yours sincerely
Keeran Vickneson
IMT1; on behalf of the stroke team
SDEC
WGH

Any queries please contact 0131 537 2116

NHS Lothian

Liberton Hospital
Day Hospital
113 Lasswade Road
Edinburgh
EH16 6UB

Medicine of the Elderly

Dr Cockburn
Dalkeith Road Medical Practice
Salisbury Court
102 St Leonards Street
Edinburgh
EH8 9RD

Date: 13/10/2025

Outpatient Clinic Letter

Patient	Colin Day 27s Findhorn Place Edinburgh EH9 2NY	**CHI** **Date of Birth / Age** **UHPI**	**2704610150** 27/04/1961 (64 years) 700793490X
Attendance Date	07/10/2025		
Consultant	LIB Day Hospital Consultant		

Dear Dr Cockburn

INTEGRATED OLDER PEOPLE'S SERVICE (IOPS)

DATE OF ASSESSMENT: 07/10/25
LOCATION: Liberton Day Hospital
CONSULTANT: Andrew Coull

ACTIVE PROBLEMS AND DIAGNOSES:
1. Falls likely multifactorial; previous lacunar infarct, previous ETOH xs, polypharmacy, R foot drop
2. Likely idiopathic leg cramps
3. Likely BPH
4. Low vitamin D
5. Clinical Frailty Score: 4

CHANGES TO MEDICATIONS:
Commence Colecalciferol 400 units OD

SIGNIFICANT INVESTIGATION RESULTS:
Bloods: Hb 149, WCC 6.6, Na 143, K 4.8, eGFR >60, adj calcium 2.3, phosphate 0.72, magnesium 0.87, TFT NAD, Vit D 3, PSA 1.9, ESR 21, HbA1c 41

SUGGESTED ACTIONS FOR GP:
Please update KIS with DNACPR and Hospital at Home updates.
Consider trialling quinine on alternate days for leg cramps
Consider starting tamsulosin or finasteride for BPH voiding symptoms if ongoing issues with LUTS

ANTICIPATORY CARE PLANNING:
ACP has not previously been discussed and you have not arranged a Power of Attorney.

Preferred place of care:
Discussed what should happen if you were to become unwell and you would like to remain at home if possible. You would also be appropriate to consider intervention by the Hospital at home team.

Who is around to support?
No package of care.

DNACPR:
Not previously been discussed however on further discussion today you stated a DNACPR form aligns with your wishes. Therefore, I have completed and signed a DNACPR form today and provided you with the red form to keep.

Power of Attorney:
You have not discussed Power of Attorney. I have provided you with leaflets on POA for further information.

FOLLOW UP:
PT and OT review
Nil further medical follow up required

DETAILS OF ASSESSMENT:
It was a pleasure to meet Colin in Clinic today. He was referred by his GP due to worsening falls, reduced mobility, and ongoing leg cramps.

Falls
Colin mobilises with a stick and a three-wheel walker at baseline. He reported a fall three weeks ago when he dropped his keys upon entering his house. As he bent forward to pick them up, he fell forwards and bruised his right side. He has also experienced occasional trips on the carpet at home. He feels he tends to rush and struggles to pace himself.

Despite these issues, Colin remains independent with outdoor activities and continues to do his own shopping, which involves walking uphill. He had a previous fall a few years ago with a head strike, though he did not require hospital admission. He has never been admitted to hospital due to a fall.

He describes symptoms suggestive of orthostatic hypotension but denies any episodes of syncope.
He is due to have his eyes tested and is planning to attend.

Cognition
There are no concerns regarding Colins memory.

Pain
Colin experiences ongoing nocturnal leg cramps, primarily in the right calf and foot, which worsen when lying in bed. Relief is achieved by standing on cold surfaces and stretching. These cramps have persisted for several years without significant change and have recently started affecting the left calf as well. The cramps are not neuropathic and only occur when lying down, either in bed or on the couch. He does not experience pain while mobilising and reports no altered sensation in his toes or feet.

His GP has trialled quinine over the past few years, which Colin felt helped with the cramps. However, he experienced side effects, including a tendency to veer left while walking. He stopped quinine two weeks ago and has since noticed an improvement in his gait.

He reports chronic lumbar spine pain without neuropathic or sciatic features and no saddle anaesthesia. Colin has PRN Co-codamol 30/500mg (2 capsules TDS), which he mainly takes for back pain, though he finds it ineffective for both his back and calf pain.

He has a history of gout in both feet but has had no further episodes since starting allopurinol.

Continence
Colin reports no issues with bladder or bowel control. He experiences nocturia 34 times per night and drinks water throughout the night. He has difficulty initiating voiding, a weak flow, and incomplete bladder emptying.
He drinks sugar-free fizzy juice and sugar-free, caffeine-free Red Bull. He does not consume tea or coffee.

Nutrition
Colin has a poor appetite and diet. He uses an air fryer to prepare meals such as chicken burgers, potatoes, battered fish, or fish fingers. He rarely eats vegetables or fruit. He believes he has lost some weight recently and has been trying to reduce his intake of cakes and crisps.

Mood
Colin used to travel to London every two months to visit family but has not done so in the past 18 months due to a lack of motivation. He reports poor sleep and stays on his phone until 3 a.m. Although he has tried leaving his phone in the living room, he ends up using his tablet instead. He denies any suicidal thoughts.

PAST MEDICAL HISTORY:
R lacunar CVA 2021 with residual R sided weakness
IHD
Gout
Depression
ETOH xs

CURRENT MEDICATIONS:
Folic acid 5mg OD
ISMN 20mg BD
Fluoxetine 20 mg OD
Clopidogrel 75 mg OD
Bisoprolol 3.75 mg OD
Allopurinol 300 mg OD
Atorvastain 80 mg OD
Quinine 200 mg nocte stopped 2 weeks ago
Co-codamol 30 mg/500mg PRN

ALLERGIES: NKDA

SOCIAL HISTORY:
Lives alone
Package of Care/Support: Nil POC
Smoking history: Ex-smoker
Alcohol History: Prev ETOH xs, has only 2-3 beers once a year
Mobilises with stick and 3 wheel walker
Currently drives

EXAMINATION:

Obs: News: 0 Temp 36.2, P 81, RR 21, Sat 96% on A
SBP 156/90 -> 146/68 -> 148/64 -> 166/67

Weight 96.3Kg
Height 168cm

Cardio: HS 1+2+0, good radial pulse. Regular
Reps: Vesicular BS B/L
Neuro: GCS 15. PEARL CN II+XII intact.
Tone: Increased tone RUL
Power: 4-/5 R U+LL
Reflexes: Normal knee and R biceps reflex. Unable to illicit L biceps reflex
Sensation: Normal
Mobile with: Stick
Stamping R foot gait

PHYSIOTHERAPY REVIEW
Our Team plan to review you.

OCCUPATIONAL THERAPY REVIEW
Our Team plan to conduct a home review with you.

DISCUSSION/ MANAGEMENT PLAN:
It was a pleasure to meet Colin in Clinic today. His primary concern is longstanding nocturnal leg cramps, which he has experienced over several years. These cramps have remained stable without any recent worsening. He denies symptoms suggestive of claudication or deep vein thrombosis. The cramps are relieved by stretching and the overall presentation is consistent with idiopathic leg cramps.

In terms of mobility, Colin reports no significant changes since his stroke in 2021. He previously experienced veering to the left while walking, which resolved after discontinuing quinine and Amitriptyline. His mobility issues are likely multifactorial, related to his prior stroke, a history of alcohol use and polypharmacy. On examination, his gait is notable for a stamping right foot. Sensation is intact, and there is slightly reduced power on the left side, consistent with his stroke history. No other neurological abnormalities were identified. He will be reviewed by the physiotherapy and occupational therapy teams.

Colin also reports postural symptoms. Lifestyle advice was provided, along with an information leaflet on postural hypotension.

Regarding his leg cramps, Colin may consider re-trying quinine on alternate days to assess for benefit. If ineffective, over-the-counter magnesium supplements or B vitaminsboth of which have shown benefit in some individualscould be trialled. Unfortunately, there are no further pharmacological options available. Given that he experiences good relief with stretching, he should continue this as a first-line strategy.

Additionally, Colin reports urinary symptoms suggestive of benign prostatic hyperplasia (BPH). A PSA test was performed today, yielding a reassuring result of 1.4. If symptoms persist or worsen, medical management with Tamsulosin or Finasteride could be considered. However, it is important to note that Tamsulosin may exacerbate his postural symptoms.

Yours sincerely,

Name: Dr Christine Orr
Designation: Clinical Fellow

Case discussed and letter checked by Dr Andrew Coull

The Integrated Older People's Service is based at Liberton Hospital, Lasswade Road, Edinburgh, EH16 6UB.

In case of enquiries please contact the Medical Secretaries on 0131 536 7830/7872

NHS Lothian

Ambulatory Care

Western General Hospital

Dr Cockburn
Dalkeith Road Medical Practice
Salisbury Court
102 St Leonards Street
Edinburgh
EH8 9RD

Date: 27/10/2025

Outpatient Clinic Letter

Patient	Colin Day 27s Findhorn Place Edinburgh EH9 2NY	**CHI** **Date of Birth / Age** **UHPI**	**2704610150** 27/04/1961 (64 years) 700793490X
Attendance Date	24/10/2025		
Consultant	SDEC New Clinic		

Dear Dr Cockburn

Stevenson SDEC Cons

64 yom

Referral with central chest pain.
Patient reports that 3 days prior developed sharp central chest pain and felt unwell when out shopping. No radiation of pain and no associated symptoms. Got a taxi home and took his normal medications. Reports then sleeping for a number of hours and, on awakening, felt well.
Nil since. No other exertional chest pain episodes.
Has had symptoms of an upper respiratory tract infection recently which are now improving.
Otherwise well.

PMH: previous stroke, IHD

O/E:
appears well
chest clear
HS I+II

ECG: SR - nil acute

bloods: normal, incl troponin 6

CXR nad

Imp: non-cardiac chest pain ?GORD related ?secondary to recent LRTI

Plan: home with advice

Typed by:
Dr A Stevenson
Consultant Physician
SDEC

Any enquiries please contact 0131 537 2137 or 0131 537 1938

NHS Lothian

Liberton Hospital
113 Lasswade Road
Edinburgh
EH16 6UB

Medicine of the Elderly

Dr Cockburn
Dalkeith Road Medical Practice
Salisbury Court
102 St Leonards Street
Edinburgh
EH8 9RD

Date: 12/11/2025

Outpatient Clinic Letter

Patient	Colin Day 27s Findhorn Place Edinburgh EH9 2NY	**CHI** **Date of Birth / Age** **UHPI**	**2704610150** 27/04/1961 (64 years) 700793490X
Attendance Date			
Consultant	LIB Day Hospital Consultant		

Dear Dr Cockburn

Physiotherapy discharge summary

Reason for referral: reduced mobility
Impression: Patient is independent with ADL's, he presents with functional movements of all limbs, he is independent with mobility and balance. He follows his own exercise routine at home for strengthening of weakness on R hand side secondary to stroke.
Treatment: Initial assessment, HEP reviewed, declined e=referral to exercise community
Outcome: Self-management and discharged

Andreza Sangalli B6PT
0131 536 7880

NHS Lothian

Liberton Hospital
Day Hospital
113 Lasswade Road
Edinburgh
EH16 6UB

Medicine of the Elderly

Dr Cockburn
Dalkeith Road Medical Practice
Salisbury Court
102 St Leonards Street
Edinburgh
EH8 9RD

Date: 16/12/2025

Outpatient Clinic Letter

Patient	Colin Day 27s Findhorn Place Edinburgh EH9 2NY	**CHI** **Date of Birth / Age** **UHPI**	**2704610150** 27/04/1961 (64 years) 700793490X
Attendance Date	07/10/2025		
Consultant	LIB Day Hospital Consultant		

Dear Dr Cockburn

INTEGRATED OLDER PEOPLE'S SERVICE (IOPS)

DATE OF UPDATE: 16/12/2025
DATE OF PREVIOUS ASSESSMENT: 07/10/25
CONSULTANT: DR ANDREW COULL

ACTIVE PROBLEMS AND DIAGNOSES:
1. Falls with impaired balance with previous stroke, previous alcohol excess, polypharmacy and right footdrop
2. Probable idiopathic leg cramps
3. Probable benign prostatic hypertrophy
4. Low vitamin D
5. CLINICAL FRAILTY SCALE:4

MEDICAL UPDATE
I see Mr Day attended SDEC on 24th October 2025 with non-cardiac chest pain and there was a question whether this might be gastro-oesophageal refllux or secondary to a recent chest infection. Recent blood tests on 10th December were all normal apart from an albumin of 35. A urine was negative and a chest x-ray was clear.

PHYSIOTHERAPY
You will have received a discharge summary from our Physio team who had seen Mr Day because of reduced mobility. He was independent with activities of daily living and presented with functional movement of all four limbs and was independent with mobility and balance and he has his own exercise regime and a home exercise programme.

OCCUPATIONAL THERAPY

Our team visited Mr Day on 28th October. He was independent in activities of daily living. There was some recommendations made around falls prevention. A free standing toilet frame was trialled to improve safety and independence of toilet transfers. A horizontal grab rail was declined. Further information was provided on a key safe.

ANTICIPATORY CARE PLANNING:
He was happy to consider Hospital at Home Team for suitable intercurrent illness. A DNA CPR form was completed at the previous assessment and he was given it to keep. He was provided with information leaflets on the Power of Attorney.

SUGGESTED ACTIONS FOR GP
Thank you for updating the KIS with a DNACPR and Hospital at Home updates.
You may wish to trial Quinine on alternate days for leg cramps.
Please consider starting Tamsulosin or Finasteride or both for BPH voiding symptoms if ongoing issues with lower urinary tract symptoms.
Thank you for commencing cholecalciferol.

FOLLOW UP
Discharged to GP.

Yours sincerely,

DR ANDREW COULL
CONSULTANT PHYSICIAN

letter to patient and GP

AC/G2dictated/gmc

The Integrated Older People's Service is based at Liberton Hospital, Lasswade Road, Edinburgh, EH16 6UB.

In case of enquiries please contact the Medical Secretaries on 0131 536 7830/7872

NHS Lothian

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Flexible Cystoscopy

Dr Cockburn
Dalkeith Road Medical Practice
Salisbury Court
102 St Leonards Street
Edinburgh
EH8 9RD

Date: 26/02/2026

Outpatient Clinic Letter

Patient	Colin Day 27s Findhorn Place Edinburgh EH9 2NY	**CHI** **Date of Birth / Age** **UHPI**	**2704610150** 27/04/1961 (64 years) 700793490X
Attendance Date	11/02/2026		
Consultant	DPU - One Stop Clinic 1		

Dear Dr Cockburn

JB/LN
Diagnosis
Visible haematuria

Procedure:
Flexible cystoscopy abandoned
Plan
1. GA cystoscopy
2. Ultrasound urinary tract

Many thanks for your referral of this 64-year-old gentleman with an episode of visible haematuria. He also complains of nocturia, but this seems to be triggered by drinking quite a lot fluid overnight to alleviate a dry throat. Past history was well documented from his recent attendance at Liberton Hospital.
Kidney function was normal. PSA was in the normal range at 1.9 g/L. Urine culture was negative.

The patient was unable to tolerate the instillation of Instillagel and the flexible cystoscopy was therefore abandoned. He has a slightly tight foreskin, but the meatus was easily visible.

We agreed to list him for a general anaesthetic cystoscopy. We discussed the main risks of the procedure including the anaesthetic. I have also requested an ultrasound of his urinary tract.

Kind regards

Yours sincerely

James Blackmur

Mr James Blackmur
FRCSEd(Urol) PhD
Consultant Urologist, NHS Lothian
Honorary Clinical Senior Lecturer, University of Edinburgh
0131 537 3943 (secretary)

letter to GP
copy letter to patient

NHS Lothian

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Urology

Dr Cockburn
Dalkeith Road Medical Practice
Salisbury Court
102 St Leonards Street
Edinburgh
EH8 9RD

Date: 08/04/2026

Outpatient Clinic Letter

Patient	Colin Day 27s Findhorn Place Edinburgh EH9 2NY	**CHI** **Date of Birth / Age** **UHPI**	**2704610150** 27/04/1961 (64 years) 700793490X
Attendance Date			
Consultant	Urology Cancer MDM		

Dear Dr Cockburn

Urology Multidisciplinary Meeting Patient Summary 01/04/2026

Consultant: Dr James P Blackmur
Referring Doctor: James Blackmur

PRESENTATION NARRATIVE
SCAN REVIEW: Yes
PATH REVIEW: No
GENERAL DISCUSSION: Yes R Kidney

WHO/ECOG Status: 0
Latest Biochemistry: eGFR: 91 Crea: >60

64M. Visible haematuria. Flexi cysto abandoned due to pain. GA Cysto requested. US 9cm R renal mass. CT not yet reported, but 9cm R renal mass, with what looks like renal vein invasion. PHx Falls with impaired balance and previous stroke, previous alcohol excess, polypharmacy and right footdrop.

MDT review of CT.

RADIOLOGICAL INVESTIGATIONS/STAGING
Investigation: Ultrasound
Investigation Date: 17/03/2026
Investigation Result: Right solid renal mass. CT staging assessment is advised

Investigation: CT Chest Abdo/Pelvis
Investigation Date: 25/03/2026

Investigation Result: Right renal tumour. Staging is T3b (IVC) N1 M1 (v likely lung)

MDM MANAGEMENT PLAN, COMMENTS AND ANY OTHER RELEVANT INFORMATION
Date: 01/04/2026 To arrange CT Head and to proceed with renal biopsy then review in MDT.

Please note that the MDT is acting in an advisory role and its recommendations are based on the information available at the time of the meeting. As always, the patient, who may not be aware of the proposed plan, should decide with their treating clinician what is right for them. The responsibility of the patient remains with the referring clinician until seen in the OPD or otherwise stated

On behalf of Urology Multi Disciplinary Team

NHS Lothian

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Urology

Dr Cockburn
Dalkeith Road Medical Practice
Salisbury Court
102 St Leonards Street
Edinburgh
EH8 9RD

Date: 25/05/2026

Outpatient Clinic Letter

Patient	Colin Day 27s Findhorn Place Edinburgh EH9 2NY	**CHI** **Date of Birth / Age** **UHPI**	**2704610150** 27/04/1961 (65 years) 700793490X
Attendance Date	24/04/2026		
Consultant	Dr James P Blackmur		

Dear Dr Cockburn

JB/LN

Diagnosis:
10 cm right renal mass cT3b N1 M1 likely lung mets

Plan
Has renal biopsy and oncology appointment planned

Is very nice to see you again in clinic. Although we discussed your scan results over the phone, the purpose of this appointment was to go back over these and answer any further questions. You initially presented with visible blood in the urine and underwent a camera inspection of your bladder which was abandoned due to pain. We had initially planned for you to have a general anaesthetic camera inspection of your bladder, but I think this is no longer required given the mass identified in your kidney. The ultrasound and then subsequent CT identified a 10 cm mass in the kidney. We reviewed the images together.

I explained that this mass is highly likely to represent a kidney cancer. This appears to have spread locally to some of the lymph nodes and along the vein draining the kidney into the main vein draining blood back to your heart. There were also some nodules in your lungs which likely represent spread of cancer there as well. Reassuringly the CT of your head showed no evidence of spread there.

You are generally relatively fit and active. You do your own cooking, cleaning and shopping. You use a wheeler and walk with stick following your previous stroke in 2021. You have some minor right sided weakness from this, but manage stairs without breathlessness. You have been driving back and forth to London to visit your daughter who had a baby recently. You stopped your Clopidogrel to allow the biopsy to take place next week. Your overall kidney function was normal.

We had a discussion again about kidney cancer. We discussed the possible treatment avenues, which include managing conservatively, medical anticancer treatment provided by the oncologists or the possible roles of surgery. While surgery can cure cancer that remains within the kidney, where it has spread elsewhere the main benefit would come from medical anti-cancer therapy. You are due to meet with Dr Stares who will discuss this in more detail.

After the appointment you met with our specialist cancer nurse Louise Ross and we checked blood tests. If you have any further questions please get in touch with Louise or my secretary.

Kind regards

Yours sincerely

James Blackmur

Mr James Blackmur
FRCSEd(Urol) PhD
Consultant Urologist, NHS Lothian
Honorary Clinical Senior Lecturer, University of Edinburgh
0131 537 3943 (secretary)

To patient

Copy GP Electronically.

cc Dr Stares Consultant Oncologist WGH

Louise Ross, Specialist Nurse In Urology WGH

NHS Lothian

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Medical Oncology

Dr Cockburn
Dalkeith Road Medical Practice
Salisbury Court
102 St Leonards Street
Edinburgh
EH8 9RD

Date: 28/05/2026

Outpatient Clinic Letter

Patient	Colin Day 27s Findhorn Place Edinburgh EH9 2NY	**CHI** **Date of Birth / Age** **UHPI**	**2704610150** 27/04/1961 (65 years) 700793490X
Attendance Date	19/05/2026		
Consultant	Dr Mark Stares		

Dear Dr Cockburn

Diagnosis: metastatic clear cell renal cell carcinoma (lung, primary in-situ (pT3b)), Intermediate IMDC Risk

Treatment: nil to date

Background: This 65 year old gentleman presented with a short history of haemtauria. Investigations have found a large, 10cm, right renal mass with direct extension past the renal vein into the IVC. There are small likely lung metastases. Colin tells me he feels well from these changes. He is, perhaps, a little more tired. The haematuria has settled.

I note he has multiple comorbidities. There is an excellent review by the medicine of the elderly team dated 13/10/2025 on TRAK. Colin gets about with a stick or frame and does his own shopping. He has had some falls and has been experiencing cramps in his right calf. I do not think these are related to mRCC. His clinical frailty score is 4.

PMHx: lacunar CVA in 2021 with residual right sided weakness, IHD, gout, depression, ETOH excess.

DHx: folic acid, ISMN, fluoxetine, clopidogrel, bisoprolol, allopurinol, atorvastatin. NKDA

SHx: lives alone, independent of activities of daily living, performance status 1. Occasional alcohol, ex-smoker

Discussion: I met with Colin in the clinic today. He was a little unsure of the diagnosis of metastatic renal cancer, but recalled conversations with my urology colleagues. He told me that his short term memory was poor. We went through his investigations and I have explained that he has a large right side renal cancer, which biopsy has confirmed is a renal carcinoma. There appear to be lung metastases on his CT staging scans. The urology team had therefore asked him to come and see me about further treatment options.

I note that the nodules seen in Colins lungs are very small, and are unlikely to be causing any symptoms. Overall, now that the haematuria has settled, he feels well in himself. His baseline bloods all came back within appropriate limits.

We discussed treatment options here. My first suggestion would be to simply keep an eye on Colin and repeat his scans in June. This would tell us how the lung metastases are changing. I note his co-morbidities and these do impact on any of our treatment options. Depending on the results of the CT scans I may re-discuss his case with my urology colleagues to consider a cytoreductive nephrectomy. We may also opt to continue with surveillance. Systemic therapy is likely to be more challenging, with some relative contraindications to my treatments. However, it is appropriate to continue follow-up here.

I will arrange to see Colin again with the results of his CT scans. I also introduced him to our CNS team today.

Yours sincerely

E Signed by Dr Mark Stares

Dr Mark Stares
Consultant Medical Oncologist

MS/MQ

NHS Lothian

Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Urology

Dr Cockburn
Dalkeith Road Medical Practice
Salisbury Court
102 St Leonards Street
Edinburgh
EH8 9RD

Date: 01/06/2026

Outpatient Clinic Letter

Patient	Colin Day 27s Findhorn Place Edinburgh EH9 2NY	**CHI** **Date of Birth / Age** **UHPI**	**2704610150** 27/04/1961 (65 years) 700793490X
Attendance Date			
Consultant	Urology Cancer MDM		

Dear Dr Cockburn

Urology Multidisciplinary Meeting Patient Summary 27/05/2026

Consultant: Dr James P Blackmur
Referring Doctor: On path list

PRESENTATION NARRATIVE
SCAN REVIEW: Yes
PATH REVIEW: Yes
GENERAL DISCUSSION: Yes R Kidney

WHO/ECOG Status: 0
Latest Biochemistry: eGFR: 91 Crea: >60

64M. Visible haematuria. Flexi cysto abandoned due to pain. GA Cysto requested. US 9cm R renal mass. CT not yet reported, but 9cm R renal mass, with what looks like renal vein invasion. PHx Falls with impaired balance and previous stroke, previous alcohol excess, polypharmacy and right footdrop.MDT review of CT.

PATH: Core biopsy right renal mass-Clear cell RCC, Grade 2

RADIOLOGICAL INVESTIGATIONS/STAGING
Investigation: Ultrasound
Investigation Date: 17/03/2026
Investigation Result: Right solid renal mass. CT staging assessment is advised

Investigation: CT Chest Abdo/Pelvis
Investigation Date: 25/03/2026

Investigation Result: Right renal tumour. Staging is T3b (IVC) N1 M1 (v likely lung)

Biospy: Renal
Biopsy Date: 29/04/2026

MDM MANAGEMENT PLAN, COMMENTS AND ANY OTHER RELEVANT INFORMATION
Date: 27/05/2026 Oncology follow-up in place with Dr M Stares.

Please note that the MDT is acting in an advisory role and its recommendations are based on the information available at the time of the meeting. As always, the patient, who may not be aware of the proposed plan, should decide with their treating clinician what is right for them. The responsibility of the patient remains with the referring clinician until seen in the OPD or otherwise stated

On behalf of Urology Multi Disciplinary Team