NHS Lothian

Astley Ainslie Hospital
133 Grange Loan
Edinburgh
EH9 2HL
Telephone: 0131 537 9000

Dr Nelson
Mackenzie Medical Centre
20 West Richmond Street
Edinburgh
EH8 9DX

Date: 05/07/2011

Outpatient Clinic Letter

Patient	Cindy McPherson 63/4 Pleasance Edinburgh EH8 9TG	**CHI** **Date of Birth / Age** **UHPI**	**1808721349** 18/08/1972 (38 years) 700047474K
Specialty	Rehabilitation Medical Neurology	**Attendance Date**	20/06/2011
Consultant	Dr Alasdair J FitzGerald		

Dear Dr Nelson

Problems
1)Right basal ganglia haemorrhage, possibly related to amphetamine use March 2010
2)Left upper limb paralysis with left lower limb paresis
3)Neuropathic left shoulder pain - well controlled
4)Previous history of alcohol and drug abuse.

Ms McPherson attended the outpatient clinic on the 20th June. Previously right-handed, she struggles to cope with her left upper limb paralysis. Pain is relatively well controlled with Pregabalin. There was an attempt to switch to Gabapentin to see if this would give better control, but without success. Nevertheless she does not feel the need for additional medication at this stage.

Her main concern was in terms of loss of function. In particular, she has difficulty with lower half dressing, with cooking and with toileting. On the other hand, mobility and balance appear to have improved and she has power grade 4+/5 in her left lower limb with relatively little difference between left and right in many motor groups. She still walks with a slightly hesitant hemiplegic gait. I would think this lady should be aiming for a greater degree of independence at this stage and I will discuss her case with my occupational therapy colleagues to see if this can be achieved.

Incontinence
She describes urinary incontinence on a regular basis. As described, this is a pattern that is suggestive of stress incontinence occurring when coughing or sneezing, or sometimes she notices it when rising from her sofa. She does not describe any problems with urinary frequency or urgency and does not describe any other genitourinary symptoms. This incontinence developed subsequent to her discharge from hospital and I do not think it is neurological in origin. I understand she has been referred to the continence advisory service. It is relevant to note that her bowels are well controlled.

She previously had been wearing a supportive sling for her left upper limb but apparently this is no longer usable and she needs a replacement. I will try and arrange replacement of this as well.

She will be reviewed in the outpatient clinic again in about 3 months' time.

Yours sincerely

Dr Alasdair FitzGerald
Consultant in Neurorehabilitation

NHS Lothian

Astley Ainslie Hospital
Smart Centre
133 Grange Loan
Edinburgh
EH9 2HL

Dr Hepple
Muirhouse Medical Group
Muirhouse Medical Centre
1 Muirhouse Avenue
Edinburgh
EH4 4PL

Date: 10/04/2015

Outpatient Clinic Letter

Patient	Cindy McPherson Flat 2 37 West Pilton Drive Edinburgh EH4 4EY	**CHI** **Date of Birth / Age** **UHPI**	**1808721349** 18/08/1972 (42 years) 700047474K
Specialty	Rehabilitation Medical Neurology	**Attendance Date**	20/03/2015
Consultant	Dr AJ FitzGerald		

Dear Dr Hepple

Problems
1)Right basal ganglia haemorrhage 2010 -
a.possibly secondary to either Amphetamine or alcohol abuse
b.Paretic, non-functioning left upper limb and left lower limb paresis
i.Relative inattention left side
ii.Neuropathic pain left upper limb
iii.Increased tone left extensor hallucis longus
2)Depression

Cindy and her [redacted] were seen in the outpatient clinic on the 20th March. The principal reason for referral was in relation to problems with pain and discomfort in her left side. Before describing management of these there were a couple of issues otherwise that she also was keen to discuss.

Why Not Traumatic Brain Injury?
She was keen to determine why I was so sure that her injury was a haemorrhagic rather than a traumatic brain injury. I explained this was based on CT appearances at the time and the absence of a history of traumatic brain injury at the time. The distribution of her pattern of bleeding was much more consistent with a haemorrhagic brain injury.

She was also keen to determine why I was so sure that her impairments related to the use of Amphetamines or alcohol. I explained that in the absence of any identified vascular abnormality, it would have to be assumed that an arterial bleed was related to hypertension. Alcohol and amphetamine intake can result in hypertension, alcohol doing so on a more gradual basis and Amphetamine doing it in a more acute way. I showed her her imaging from the time and I think she now has a better understanding of her condition.

Neuropathic Pain
She continues to have left upper and lower limb neuropathic pain which is constant with no aggravating or relieving factors. She did not appear to express any pain behaviour during the consultation. She currently uses Pregabalin and Tramadol and Ibuprofen as required for pain control. She is aware that being on Lisinopril for hypertension is a relative contraindication to Ibuprofen and that having asthma is also a relative contraindication. In addition to medications listed above she also takes Mirtazapine and Paracetamol.

On examination she has increased tone, in particular in elbow flexors with a mid-range catch pattern followed by increased tone on further attempted extension. She also in her finger flexors has limiting extension of her DIP joints by 30 degrees and with increased

tone at her PIP joints and MCP joints throughout range of movement. There does not appear to be any limitation of movement in her thumb on her left. She appears to have normal sensation on formal testing but I am aware of previous history of sensory inattention. It's difficult to know what to recommend as further analgesia in this instance. Given that she did not appear particularly distressed during this clinic appointment I did not feel that adding in further medication would be appropriate.

Spasticity
She has increased tone in her left extensor hallucis longus, resulting in what is described as a hitch-hiker's toe such that her left great toe tends to be cocked up. She also describes curling of other toes but this is possibly a secondary adjustment to the abnormal positioning of her EHL. Certainly there did not appear to be any significant change in tone in flexors or extensors of her other toes. Examination of her left lower limb otherwise did not demonstrate any significant impairments other than mild hemiparesis as noted before with normal tone and normal sensation. She walks with a circumducting gait either unsupported or using a crutch.

Botulinum toxin (Xeomin 30 units, Batch no 475353, per 0.6 mls normal saline injected under EMG guidance) to her left extensor hallucis longus should reduce problems in relation to tone in this particular muscle group. I will arrange for her to be reviewed again in 3 months' time to see whether further repeat injection will be appropriate.

Yours sincerely

Alasdair FitzGerald,
Consultant

NHS Lothian

St John's Hospital at Howden
Outpatient Department 4
Howden Road West
Livingston
West Lothian EH54 6PP

Dr Wild
East Calder Medical Practice
East Calder Health Centre
147 Main Street
East Calder
EH53 0EW

Date: 04/12/2017

Outpatient Clinic Letter

Patient	Cindy McPherson 10 Mansefield Place East Calder Livingston EH53 0PP	**CHI** **Date of Birth / Age** **UHPI**	**1808721349** 18/08/1972 (45 years) 700047474K
Specialty	Haematology	**Attendance Date**	02/12/2017
Consultant	Dr Robbie C McNeil		

Dear Dr Wild

Thank you for your letter of the 23rd of November regarding this 45 year old lady. I note that she has a mild neutrophilia and monocytosis. I note that she is also a smoker. Her blood film morphology from mid November showed an increased white cell count and some reactive lymphocytes.

I think in the absence of any clinical concern about lymphadenopathy or hepatosplenomegaly then no further investigations are required. We can see neutrophilia in the context of smokers. I note that LDH is normal and CRP is 9. I hope this is reassuring. I have not appointed her to clinic at present but I would be happy to discuss further if needs be.

Yours sincerely

Dr Robbie McNeil
Consultant Haematologist
GMC 6148133

RMcN/DMG

NHS Lothian - Referral Letter

Referral To	St John's Hospital Diabetes - Type 2 Education (DESMOND) LI TYPE 2 Education (Desmond)
Urgency of referral	Routine
Date of referral	19/07/2021
Date submitted	19/07/2021
UCPN	101023885176C

PATIENT DETAILS

CHI number:	1808721349
Name:	Miss Cindy McPherson
Date of birth:	18/08/1972
Sex:	Female

Contact Details

10 Mansefield Place
East Calder
Livingston
EH53 0PP

Voice (Mobile) : 07496 726 576

REFERRING PRACTITIONER DETAILS

Name:	Dr. Paul McMurtrie (GMC: 6151464)
Practice:	East Calder Medical Practice (78024)
Phone:	Voice : 01506 882882

Practice address

East Calder Health Centre
147 Main Street
East Calder
EH53 0EW

CLINICAL INFORMATION

Reason for Referral: t2dm
Main Referral Text: New patient with T2DM

Investigations

Description	Result	Date
Current BP :	128/85	
Recent HDL/LDL/Cholesterol :	0.9/2.1/4.2	
Recent HbA1c :	76	
Date of diagnosis :	2021-07-09	

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Type 2 diabetes mellitus			09/07/2021	09/07/2021
Pure hypercholesterolaemia			09/10/2019	09/10/2019
Anxiety states			19/09/2017	19/09/2017
Constipation			22/08/2017	22/08/2017
Gastro-oesophageal reflux			26/04/2016	26/04/2016
Constipation			06/09/2013	06/09/2013
Incontinence of urine			06/09/2013	06/09/2013
Hospital acquired pneumonia			06/09/2013	06/09/2013
[V]Behavioural problems			06/09/2013	06/09/2013
Head injury			06/09/2013	06/09/2013
Overdose of drug			06/09/2013	06/09/2013
Hair loss			06/09/2013	06/09/2013
Neuropathic pain		left shoulder	06/09/2013	06/09/2013
Intracerebral haemorrhage		L hemiplegia	15/03/2010	15/03/2010
Child abuse NEC		told GP that she had been sexually abused as a child. was ref for counsellling.	01/01/2002	01/01/2002
Breast abscess		non obstetric	26/07/2001	26/07/2001
Backache			17/09/1998	17/09/1998
[X]Depressive episode			25/02/1998	25/02/1998

Drug dependence	DHC amphetamines	11/09/1995	11/09/1995
Acute pyelonephritis		20/06/1995	20/06/1995
Cellulitis and abscess of trunk		06/06/1995	06/06/1995
Psoriasis NOS		01/02/1993	01/02/1993
Asthma		22/05/1992	22/05/1992
Closed fracture of one or more phalanges of foot		13/07/1983	13/07/1983

Past procedures (High and Medium Priority)

Procedure	Comment	Modifier	Date Performed	Date Recorded
Dental clearance NEC			03/11/2016	03/11/2016
Craniotomy	evacuation of haematoma		15/03/2010	15/03/2010

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Atorvastatin Tablets 20 mg	28 TABLET	ONE TO BE TAKEN EACH DAY		01/10/2019		21/06/2021
Mirtazapine Tablets 30 mg	28 TABLET	1 AT NIGHT		02/04/2019		21/06/2021
Zerobase Cream 11 %	500 GRAM	APPLY AS OFTEN AS REQUIRED AND/OR USE AS SOAP SUBSTITUTE		16/01/2019		07/09/2020
Pregabalin Capsules 200 mg	90 capsule	ONE TO BE TAKEN THREE TIMES PER DAY		22/08/2018		21/06/2021
Folic Acid Tablets 5 mg	28 TABLET	1 OD		14/11/2017		21/06/2021
Salbutamol Cfc-free inhaler 100 micrograms/puff	2 INHALER	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY		06/02/2017		21/06/2021
Fostair Cfc-free inhaler 100 micrograms + 6 micrograms/dose	2 INHALER	ONE OR TWO DOSES TO BE INHALED TWICE DAILY		11/01/2017		21/06/2021
Tramadol Hydrochloride M/R capsules 100 mg	60 capsule	ONE TO BE TAKEN TWICE A DAY		06/12/2016		21/06/2021
Lisinopril Tablets 10 mg	28 TABLET	ONE TO BE TAKEN EACH DAY		11/12/2015		21/06/2021
Paracetamol Tablets 500 mg	200 tablet	ONE OR TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)		11/12/2015		21/06/2021
Lansoprazole Capsules (Gastro-Resistant) 30 mg	28 CAPSULE	ONE TO BE TAKEN EACH DAY		11/12/2015		21/06/2021

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Clotrimazole Cream and Pessary 2 % + 500 mg	1 pack	TO BE USED AS DIRECTED		08/07/2021		08/07/2021
Trimethoprim Tablets 200 mg	6 TABLET	ONE TO BE TAKEN TWICE A DAY FOR 3 DAYS (WOMEN) OR 7 DAYS (MEN)		02/07/2021		02/07/2021

Clinical warnings

Allergies

Description	Comment	Modifier	Start Date	Recorded Date
Adverse reaction to Penicillins			01/01/1975	01/01/1975

Additional information

Patient Weight in Kilograms:113

Patient Blood Pressure (Systolic):128

Patient Blood Pressure (Diastolic):85

Smoking history (Screening):Ex smoker	Date Recorded:07 Dec 2020
Smoking history (Encounters):Ex smoker	Date Recorded:07-Dec-2020
Alcohol history (Screening):Alcohol consumption, 0 units/week	Date Recorded:10 Sep 2019
Alcohol history (Encounters):Alcohol consumption, 0 units/week	Date Recorded:10-Sep-2019

NHS Lothian

Neurorehabilitation

Astley Ainslie Hospital

Dr Lough
East Calder Medical Practice
East Calder Health Centre
147 Main Street
East Calder
EH53 0EW

Date: 15/10/2024

Outpatient Clinic Letter

Patient	Cindy McPherson 10 Mansefield Place East Calder Livingston EH53 0PP	**CHI** **Date of Birth / Age** **UHPI**	**1808721349** 18/08/1972 (52 years) 700047474K
Attendance Date	10/10/2024		
Consultant	Spasticity MDT		

Dear Dr Lough

Spasticity Management Service Telephone Appointment

Date of assessment: 10/10/24

Diagnosis:
Stroke 2010 Intracerebral haemorrhage, left sided weakness.
Type 2 DM

It was a pleasure to speak to Ms McPherson on the telephone today. She is keen to consider the role of botulinum toxin to try and flatten her toes when walking as she experiences pain.

Ms McPherson explained that her toes are in a curled position most of the time. If her toenails are long they can dig into her toe pads. She sees a private podiatrist every 6-12months when she can afford it and her friend helps with nail care at other times. She can manually straighten her toes but they re-curl when she removes the stretch. Her toes can rub together and can cause pressure but she denies any skin breakdown. When walking she experiences pain on weight bearing surfaces of her curled toes after a few steps. She has no pain at rest. She thinks her toes are straighter when she has been smoking cannabis. She describes her left great toe as 'sticking up all the time. When she was an inpatient in 2010, she was given Botulinum toxin to her Extensor Hallus Longus muscle for this and found this helpful. She expressed that her striated great toe doesnt cause any problems. She was wondering if repeat toxin would be helpful.

Impression:
It is likely that Ms McPherson has contracture of her toes that will not be helped with Botulinum toxin but the only way to know for certain is to carry out an assessment.

Follow-up:

Ms McPherson has agreed to attend an outpatient clinic appointment at the AAH for further assessment. I will also ask a podiatry colleague their advice and consider if toe spacers would be worth considering.

Yours sincerely

e-signed

Dr Alyson Nelson
Consultant in Rehabilitation Medicine
and
Irene Nicol
Specialist Nurse, Spasticity Management Service.

Cc
Ms McPherson, 10 Mansefield Place, East Calder, EH53 0PP
Olivia Martin, specialist podiatrist, emailed 15/10/24

NHS Lothian

Astley Ainslie Hospital
133 Grange Loan
Edinburgh
EH9 2HL

Neurorehabilitation

Dr Lough
East Calder Medical Practice
East Calder Health Centre
147 Main Street
East Calder
EH53 0EW

Date: 09/01/2025

Outpatient Clinic Letter

Patient	Cindy McPherson 10 Mansefield Place East Calder Livingston EH53 0PP	**CHI** **Date of Birth / Age** **UHPI**	**1808721349** 18/08/1972 (52 years) 700047474K
Attendance Date	08/01/2025		
Consultant	Dr Alyson J Nelson		

Dear Dr Lough

Spasticity Management Clinic - 08/01/25

Present in Clinic- Cindy, Dr A Nelson, Dr I Aneela (registrar), Mathew Diment (Podiatrist).

After speaking to Cindy on the telephone in October I arranged a joint appointment with podiatry today to further assess her foot issue and find the best way forward. I'm grateful to Mathew for attending today.

Diagnosis:
ICH - Stroke 2010 with left sided weakness
Type 2 Diabetes

Recommendations:
1. Issued by podiatry with insole to support MT heads
2. Self treatment of fungal toe infection - written guidance given
3. No indication for botulinum toxin

Follow up:
1. Discharge from Spasticity Management Service
2. Cindy will be reviewed in local podiatry clinic in West Lothian by Matthew

Most of the history was obtained on speaking to Cindy on the telephone in October. She confirmed that this has been a problem since the stroke in 2010. She has tried something between her toes in the past and she found it painful. She informed us that she was given a pair of slippers at Christmas which she has found really helpful as they are cushioned.

Assessment today:
Evidence of fungal toe (tinea pedis) infection in toe spaces of left foot. Light touch sensation appears intact in feet with no evidence of peripheral neuropathy, although slightly reduced sensation in S1 dermatonal distribution on the left.

Left foot:
The toes tend to claw (at MTJ) with some rubbing noted on the dorsum of toes and lateral border of little toe. The great toe is slightly turned in position (valgus). Her great toe can stick up (busy EHL) but settles well in standing and doesn't appear to be a significant issue. The toes passively easily come out to neutral with no significant loss of range. In barefoot stance she has reasonable foot contact, normal arches and toes relax onto the floor.

Matthew issued Cindy with insoles with support at MT heads. She walked in the corridor and found it comfortable and felt it may be helpful. Matthew will follow her up in a local podiatry clinic to consider if toe spacers would be required or if the insoles are sufficient.

There is no indication for botulinum toxin injections following assessment and I'm hopeful that her pain when walking can be improved with supportive measures. I have not arranged further follow up in the spasticity management clinic.

Yours sincerely

e-signed

Dr Alyson Nelson
Consultant in Rehabilitation Medicine

CC
Matthew Diment, MSK Specialist Podiatrist
Cindy McPherson, 10 Mansefield Place, East Calder, EH53 0PP