SAR Team
Health Records Department
Glasgow Royal Infirmary Hospital
8 - 16 Alexandra Parade
Glasgow
G31 2ER

NHS
Greater Glasgow and Clyde

MMA Legal Ltd
23 Goodlass Road
Building B
Speke
Liverpool
L24 9HJ

Date: 20th July 2026
Your Ref: 100295
Our Ref: SAR Team /PA
Enquiries To: Patricia
Direct Line: 0141 201 3382
Email: patricia.armstrong3@nhs.scot

Dear Sir/Madam,

Re: Subject Access Request under the General Data Protection Regulation

PATIENT: STEWART MCFARLANE DOB: 09/06/1971

Thank you for your request received in which you seek a copy of your client's personal information.

Your request has been dealt with in line with our requirements under Article 15 of the General Data Protection Regulation and I now attach the following:

GLASGOW ROYAL INFIRMARY & STOBHILL HOSPITAL RECORDS
X-RAY REPORTS

Please be aware that these health records have been reviewed by a clinician and any information identifying or provided by a third party has been removed.

We process personal information to enable us to provide healthcare services for patients; support and manage our employees; to carry out research and clinical trials; maintain our accounts and records and to carry out data matching under the national fraud initiative. We also use CCTV systems for crime prevention.

This personal information can be both clinical and non-clinical in nature and can include

- Patient health records, photographs or radiology images
- Video/telephone recordings, including CCTV images
- Witness statements
- Incident reports
- Complaints files
- Emails

The source of our data includes Patients, General Practitioners, Healthcare, Social and Welfare organisations, Legal representatives and Police forces.

We sometimes need to share the personal information we process with the individual themselves and also with other organisations as listed above. Where this is necessary we are required to comply with all aspects of the General Data Protection Regulation

Where these organisations are based outside Europe we take all appropriate safeguards to protect your information.

Health records are kept for a limited time and this is noted below for your information

- Adult general hospital records – six years after the date of last entry
- Maternity records – 25 years after the birth of the last child
- Children's and young people's records – until the child or young person's 25th birthday.
- Mental health records – 20 years after the date of the last contact

If you have any queries, please do not hesitate to contact me.

If you are unhappy with how your request has been dealt with please contact the NHSGGC Data Protection Officer. Their contact details are noted below:

Data Protection Officer
Information Governance Department
NHS GG&C – 2nd Floor
1 Smithhills Street
Paisley
PA1 1EB
Email: data.protection@ggc.scot.nhs.uk

Yours sincerely

SAR Team

ELECTRONIC PATIENT RECORDS

ALL HOSPITAL RECORDS HELD NHSGGC	☐		
ACS	☐		
BEATSON HOSPITAL	☐		
CANNIESBURN HOSPITAL	☐		
DENTAL HOSPITAL	☐		
GARTNAVEL GENERAL HOSPITAL	☐		
GLASGOW ROYAL INFIRMARY (PODIATRY)	☑		
INVERCLYDE ROYAL HOSPITAL	☐	MATERNITY	☐
NEW VICTORIA ACH	☐		
PRINCESS ROYAL MATERNITY	☐		
QUEEN ELIZABETH UNIVERSITY HOSPITAL	☐	MATERNITY	☐
ROYAL ALEXANDRA HOSPITAL	☐	MATERNITY	☐
ROYAL HOSPITAL FOR CHILDREN	☐		
STOBHILL HOSPITAL	☐		
VALE OF LEVEN	☐	MATERNITY	☐
WEST CARE AMBULATORY HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

BADGERNET	☐
CAREVUE	☐
MEDICAL ILLUSTRATION	☐
METAVISION	☐
PHYSIOTHERAPY	☐
RADIOLOGY	☐
WEST MARC	☐
LABS	☐

Name:	**MCFARLANE, Stewart (Mr)**		Ward:	**Weight**	**Height**
CHI No:	**0906716470**		Hospital:	**BSA:**	
DOB:	09/06/1971 - 55 yr(s) Gender:	Male	Bed:		
Consultant:	GRI Orthotist 3		Room:		

Contacts

Next of Kin

Relation	Contact Type	Surname	Forename	Address Line 1	Town / City	PostCode
HomePhone	MobilePhone	BusinessPhone	DateFrom	DateTo	School	
Parent	Next of Kin	?	?	137 CAUSEWAYSIDE STREET, , GLASGOW		
778 8466		550 0629		17/02/2021		
Parent	Next of Kin	?	?	SA		
		550 0629		17/02/2021		
Wife	Next of Kin	McFarlane	Debbie	32 DALRY STREET	Glasgow	G32 9BL
07880855579	07880855579		03/06/2021			

Alerts

Alerts

Alert	Message	Alert Category	Closed	Date Entered	Expected Review Date	Status
Edit						

Allergies

Allergens

Category	Allergen	Free Text Allergen	Nature of Reaction	Severity	Onset Date and Description	Status
Comments	Edit					

Diagnosis

Diagnosis

Select	Edit	Status	Diagnosis Type	ICD Diagnosis	Symptom	Onset Date
Duration	Last Update User	Last Update Date	Linked Orders	Description	Inactive	CS Report Flag

Problems

Name:	**MCFARLANE, Stewart (Mr)**		Ward:	**Weight**	**Height**
CHI No:	**0906716470**		Hospital:	**BSA:**	
DOB:	09/06/1971 - 55 yr(s) Gender:	Male	Bed:		
Consultant:	GRI Orthotist 3		Room:		

Active Problems

Problem (Snomed)	Laterality	No Known History	Onset Date	Comments	Status

Social History

History - Social

Habit	Onset Date	Duration	Quantity	Last Update Date	Last Update Time	Last Update User
Comments	Edit History	Edit				

Family History

History - Family

Relation	Disease	Body System	System Problem	System Sub-Problem	Comments	Onset Date
Duration	Last Update Date	Last Update Time	Last Update User	Edit		

Surgical History

History - Surgical

Onset Date	Description	Laterality	CommentsDisplay	Last Update User	Last Update Date	Last Update Time
Edit	Last Update Hospital					

Procedures

Procedures

Select	Procedure Date	Last Update Time	Operation Code	Operation	Operation Category	Care Provider
Last Update User	Last Update Hospital	Edit				

ED Procedures

ED Procedures

Name:	**MCFARLANE, Stewart (Mr)**	Ward:		**Weight**	**Height**
CHI No:	**0906716470**	Hospital:		**BSA:**	
DOB:	09/06/1971 - 55 yr(s) Gender: Male	Bed:			
Consultant:	GRI Orthotist 3	Room:			

Select	Request Item	Priority	Request Status	Start Date	Start Time	Episode No
Variance Reason						

Observations

Clinical Notes

All Clinical Notes (This Episode)

Edit	Date	Time	Type	Note	Last Update User	Care Provider
Care Provider Type	Status	Appointment Date	Appointment Time	Episode No		

All Clinical Notes (This Episode)

Floorplan Notes

Floorplan Notes

Text	Date	Time

Questionnaires

Questionnaires

Select	Entered in Error Reason	Text	Significant Answer	Date	Time	User
Create Date	Create Time	Episode Number				
	Orthotic Clinical Record	19/02/2026		19/02/2026	15:40	Hannah Wilson2
19/02/2026	15:40	O0029584644				
	Orthotic Clinical Record	22/01/2026		22/01/2026	10:52	Hannah Wilson2
22/01/2026	10:52	O0029584644				
	MSK Vetting	05/01/2026		05/01/2026	15:18	Kirsty Green
05/01/2026	15:18	O0029584644				

Questionnaires

Orthotic Clinical Record

Status : Authorised

Clinical Working Diagnosis : Rheumatoid Arthritis

Achilles Tendinopathy

Subjective Information : Patient attended Glasgow Royal Infirmary alone for fitting of insoles. Patient reports some benefit from heel raises given at the last appointment

Assessment : Verbal consent obtained. Insoles checked and both contour well to foot shape. 1st ray sinks in correct location. Insoles trimmed to fit footwear. Good fit achieved with trainer inlays removed. Patient reported they felt comfortable

Patient Goals : Reduce achilles pain

Clinical Goals : reduce stress on achilles tendon

Analysis : Insoles fit well and meet the requested specification therefore are suitable for supply

Treatment Plan : Insoles supplied with advice on gradual build up of wear. Patient information supplied with information on how to re access the service

Timeframes : Orthotic input may be required long term

Numeric pain Start : 8

Discharge Status :Discharged

Discharge documentation is complete (letter) :Not required

Orthotic Clinical Record

Orthotic Clinical Record

Status : Authorised

Name:	**MCFARLANE, Stewart (Mr)**	Ward:		**Weight**	**Height**
CHI No:	**0906716470**	Hospital:		**BSA:**	
DOB:	09/06/1971 - 55 yr(s) Gender: Male	Bed:			
Consultant:	GRI Orthotist 3	Room:			

Orthotic Clinical Record

Clinical Working Diagnosis : Rheumatoid Arthritis

Achilles Tendinopathy

Subjective Information : Patient attended Glasgow Royal Infirmary alone for assessment following referral from Rheumatology. Patient was diagnosed with Rheumatoid Arthritis in 2022. Patient complains of pain in medial arches and toes. His main complaint is right achilles pain with standing and walking, no pain at rest. Patient uses slimflex insoles and finds some benefit from these.

Assessment : Verbal consent obtained. Patient indicated to pain at midportion of right achilles. Pain on palpation and with active plantarflexion. Tight in gastrocs, achieving plantargrade but no dorsiflexion range with knees flexed. Pes cavus foot posture. Plantarflexed 1st ray. Retracted toes. Antalgic gait

Patient Goals : Reduce achilles pain

Clinical Goals : reduce stress on achilles tendon

Analysis : As patient has persistent symptoms despite using stock insoles, agreed to try custom insoles. Scans taken for insoles with 5mm heel raises to reduce stress on achilles and 1st ray sinks to accommodate plantarflexed 1st rays.

Treatment Plan : Patient to attend for fitting of insoles. Appointment booked and letter given to patient today. 5mm heel raises supplied for use until custom insoles are ready.

Timeframes : Orthotic input may be required long term

Numeric pain Start : 8

Discharge Status :Episode ongoing

Discharge documentation is complete (letter) :Not required

MSK Vetting

Questionnaire 'QSCXXMSK' is not available for text representation. Please contact your system administrator.

Patient Movements

Name:	**MCFARLANE, Stewart (Mr)**		Ward:	**Weight**	**Height**
CHI No:	**0906716470**		Hospital:	**BSA:**	
DOB:	09/06/1971 - 55 yr(s)	Gender: Male	Bed:		
Consultant:	GRI Orthotist 3		Room:		

Movements List

Embedded Day Case	Ward	Room	Room Type	Bed	Movement Start Date	Movement Start Time
End Date	End Time	Edit	Status		Type	

Encounters

Encounters

StartDate	Start Time	End Date	End Time	Location	Care Provider
22/01/2026	08:52			Orthotics	GRI Orthotist 3
19/02/2026	08:43			Orthotics	GRI Orthotist 3

ELECTRONIC PATIENT RECORDS

ALL HOSPITAL RECORDS HELD NHSGGC	☐		
ACS	☐		
BEATSON HOSPITAL	☐		
CANNIESBURN HOSPITAL	☐		
DENTAL HOSPITAL	☐		
GARTNAVEL GENERAL HOSPITAL	☐		
GLASGOW ROYAL INFIRMARY	☑		
INVERCLYDE ROYAL HOSPITAL	☐	MATERNITY	☐
NEW VICTORIA ACH	☐		
PRINCESS ROYAL MATERNITY	☐		
QUEEN ELIZABETH UNIVERSITY HOSPITAL	☐	MATERNITY	☐
ROYAL ALEXANDRA HOSPITAL	☐	MATERNITY	☐
ROYAL HOSPITAL FOR CHILDREN	☐		
STOBHILL HOSPITAL	☐		
VALE OF LEVEN	☐	MATERNITY	☐
WEST CARE AMBULATORY HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

BADGERNET	☐
CAREVUE	☐
MEDICAL ILLUSTRATION	☐
METAVISION	☐
PHYSIOTHERAPY	☐
RADIOLOGY	☐
WEST MARC	☐

Clinic Letter

NHS Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Main Switchboard:	
Department:	Rheumatology
Contact Tel:	0141 451 5365/0141 451 5384
Enquiries to:	
Letter Date:	03/06/2026
Reference:	NG/VW
Dictated Date:	03/06/2026
Transcribed Date:	12/06/2026

Dear Dr. El Douglas,

Stewart McFarlane; D.O.B: 09 Jun 1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Attendance: Specialty - Rheumatology; Clinic - GRRMRH5-DR MADHOCK RHEUM WEDNESDAY AM FACE TO FACE TO BE BOOKED BY CONS ONLY
Date and Time of Appointment - 03/06/2026 10:30

Follow Up: 27/10/2026 11:00 Rheumatology GRRH-Rheumatology 06/01/2027 09:30 Rheumatology Dr Rajan Madhok

Clinical Comments:
I saw Stewart in clinic today at GRI and we discussed the following:-

1. Rheumatoid arthritis: First seen in June 2022, **strongly CCP positive, and weakly RF positive**. Continues on Methotrexate 7.5mg subcutaneous once weekly (maximum dose tolerated), Sulfasalazine 2g once daily and Hydroxychloroquine 400/200mg alternate days. He has been struggling with his right side of the body particularly his right foot and ankle, and also his hands and this sometimes can affect both hands. He mentioned that he has been struggling with his right ankle particularly over the Achilles area which is quite painful and it is painful when he wakes up in the morning and gets worse as the day goes on as he starts walking or standing for a long time.

On examination I could appreciate his right Achilles area is quite tender and also his MTP squeeze is positive on the right side, and his ankle joint is also tender over the sides. He also mentioned the same over the right hand and his MCP squeeze is also positive although I could not appreciate any active synovitis over the MCP or PIP joints today.

He has been complaining of the same things when seen by my colleague in December and the plan was to maybe think about tendinopathy which I am also suspecting. He has been using Ibuprofen gel and has also got Orthotics for insoles, and is saying that since starting insoles his base of the foot is okay but his Achilles and ankle is still quite painful. He has been using some Codydramol that does help a bit but he does not want to take it long term and as you are already aware he has got one kidney and is very conscious about going for NSAIDs for a long time, and also he may need escalation of treatment so I am going to request an**MRI of his right foot and ankle** to look for any progression or inflammatory changes or tendinopathy. If it is positive he may be escalated to biologics. I have requested this MRI on an urgent basis and requested that can be done as early as possible and as soon as we get the results we will get back to him.

Cardiovascular risk: His blood pressure today is 112/76mmHg and his weight is 73.5kg. His last bloods were relatively stable and we have not changed anything but I think he will need an MRI to rule out tenosynovitis which I am suspecting clinically and then he will be for consideration of biologic or escalation to that.

Yours sincerely,

Dr Numan Ghafoor

ST6 Rheumatology

Electronically Signed: Dr Numan Ghafoor, Doctor

cc.

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Orthotics NPC General – ACUTE STAFF ONLY		**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF		**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Routine
Date of referral 05-Jan-2026 **Date sent** 05-Jan-2026

PATIENT DETAILS

Surname	McFarlane
Forename(s)	Stewart
Title	Mr
Sex	Male
Date of birth	09-Jun-1971
CHI no.	0906716470
Area of Residence	-

Patient's address

32 DALRY STREET
Glasgow
Lanarkshire
G32 9BL

Contact number(s)

Voice: 07504247668
Voice: 07504247668

101038650274G

Unique Care Pathway Number: 101038650274G

REGISTERED GP DETAILS

Name	Dr Douglas		
GMC code	-	GP code	-
Practice name	-		
Practice code	-		

Practice address

Contact number(s)

-

REFERRING HCP DETAILS

HCP Name	DavidMcCarey
HCP code	4422198
HCP Position	Rheumatology - Consultant
Organisation name	Rheumatology Acute North Sector (GGC)
Location code	G159G

Organisation address

SCIGW Virtual Location

Contact number(s)

-

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Pain right foot and ankle

Comment: I would be grateful for review of this gentleman's right foot and ankle. He states he is struggling to walk with pain there and I think there is more of a tendinopathy issue at the achilles,and possibly at both the medial + lateral areas of the foot. I would be grateful for review of this. Yours sincerely Dr James Brock ST7 Rheumatology Please refer to clinic letter

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

No current medications recorded

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

No recent medications recorded

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Consultant

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Referral letter:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Consultant-on-call
Orthotics Department
Glasgow Royal Infirmary

Main Switchboard: 0141 211 4000
Department: Rheumatology
Contact Tel: 0141 451 5384
Enquiries to:
Letter Date: 05/01/2026
Reference: JB/LD
Dictated Date: 03/12/2025
Transcribed Date: 29/12/2025

Dear Orthotics Department,

Stewart McFarlane; D.O.B: 09/06/1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

. would be grateful for review of this gentleman's right foot and ankle. He states he is struggling to walk with pain there and I think there is more of a tendinopathy issue at the achilles and possibly at both the medial + lateral areas of the foot. I would be grateful for review of this.

Yours sincerely

Dr James Brock

ST7 Rheumatology

Please refer to clinic letter

Electronically Signed: Dr James Brock, Doctor

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Main Switchboard:
Department: Rheumatology
Contact Tel: Consultant-on-call Orthotics Department Glasgow Royal Infirmary
Enquiries to:
Letter Date: 03/12/2025
Reference: JB/LD
Dictated Date: 03/12/2025
Transcribed Date: 29/12/2025

Dear Dr. El Douglas,

Stewart McFarlane; D.O.B: 09 Jun 1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Attendance: Specialty - Rheumatology; Clinic - GRRMRH5-DR MADHOCK RHEUM WEDNESDAY AM FACE TO FACE TO BE BOOKED BY CONS ONLY
Date and Time of Appointment - 03/12/2025 10:00

Follow Up: 03/06/2026 10:30 Rheumatology Dr Rajan Madhok

Clinical Comments:
I saw this 54 year old gentleman at rheumatology clinic today problems are as follows:

Rheumatoid arthritis: First seen June 2022, strongly CCP positive, weak RF positive. Continues on Methotrexate 7.5mg subcutaneous once weekly (maximum dose tolerated), Sulfasalazine 2g once daily and Hydroxychloroquine 400/200mg alternate days. Overall things seem relatively well controlled. He does have increasing pain at his right elbow, right ankle and pain mainly of his right hand/can affect both hands. He states he has just noticed pain with no swelling and describes burning pain sensations.

On examination of the right elbow he is tender over the lateral epicondyle in keeping with lateral epicondylitis. He states that he has been struggling to open jars with his right hand properly and therefore he is probably putting strain through the left when he is trying to open things. There is no elbow synovitis. His right hand - there is no synovitis but does feel as though there is mechanical osteoarthritis there. The left hand appears relatively good. His right ankle as well does not show any evidence of synovitis. He describes pain more at the achilles tendon and around the sides of his feet but feels again like a tendinopathy type pain that he is experiencing. Again no swelling was evident there and I overall thought his rheumatoid disease was stable with no evidence of inflammatory disease present.

I have advised Ibuprofen gel and deep heat in the first instance and it would be worthwhile getting orthotics review for him with the right foot and ankle pain as he states at times he struggles to walk long distances. There may be an element of neuropathic pain here as he does have neck and backpain which was the consequence of a road traffic accident approximately five years ago.

Kidney: He only has one kidney and therefore we have to be cautious with NSAID therapy but Ibuprofen gel would be safe.

Blood pressure and weight: 118/83 and 74.4kg.

Bloods were relatively stable I have not made any changes to his medications today and in the first instance we will try conservative measures. If he is having ongoing issues with the right foot ankle hen we can consider MRI to ensure there is no evidence of tenosynovitis but this certainly doesn't seem warranted at present.

Yours sincerely

Dr James Brock

ST7 Rheumatology

Electronically Signed: Dr James Brock, Doctor

cc. 0141 451 5384

MCFARLANE, Stewart (Mr)
BORN 09-Jun-1971 (55y) GENDER Male
CHI 0906716470

Request to GP to prescribe medication

Last updated by James BROCK (James Brock) 7 months ago (v. 1) Show History

Content Restricted	No	Sensitivity	Sensitive
If the information on this form merits further restriction than that of Highly Sensitive, please select **Yes** to apply a Privacy Seal		The information on this form **will** be viewable by health and care providers with the appropriate access permissions	

Date	03-Dec-2025		
Hospital	Glasgow Royal Infirmary	Other	—
Specialty / Service	Rheumatology		
Clinic	Yes	Please Specify	—

Dear Doctor

Your Patient Was Seen

Please Prescribe

Urgent / Routine: Routine - prescription available 48 hours following request

indication: mechanical pain

Additions and Replacements

Product	Dose	Frequency	Current Regime Status	Comments
Ibuprofen gel 5%	1 APP	PRN	Addition	—

Replacements

This medication replaces which should now be stopped: —

Patient advised to collect prescription: Yes

Please Note: A Detailed Letter Will Follow.

Additional Notes / Summary

Additional Notes / Summary: —

When you click to 'Complete' a summary of the the form will be sent electronically to the registered GP practice.

Clinician Details

Name	James Brock
Clinician Details Role	Doctor
Professional Registration Number	7334349
Contact Details	james.brock2@nhs.scot

MCFARLANE, Stewart (Mr)
BORN 09 June 1971 (55y) GENDER Male
CHI 0906716470

Outlook

Re: Patient Query

From Rheumatology Advice, Gri <ggc.gri.rheumatologyadvice@nhs.scot>
Date Mon 31/03/2025 15:07
To Katie MacDonald <katie.macdonald5@nhs.scot>
Cc gp46131clinical (Crail Medical Practice) <ggc.gp46131clinical@nhs.scot>

Hi Katie

Can you please ask the patient to withhold his MTX until his rash has cleared. Once it has then he is ok to restart

His bloods were ok from Saturday so he wouldn't require further monitoring

kind regards
Karen Deans CNS/DCN

Rheumatology Clinical Nurse Specialists, Centre for Rheumatic Diseases, Glasgow Royal Infirmary. ***Please note the email service is for Primary care only. Patients should contact us on the advice line. Telephone number 0141 451 5384***

From: Katie MacDonald <katie.macdonald5@nhs.scot>
Sent: 31 March 2025 14:57
To: Rheumatology Advice, Gri <ggc.gri.rheumatologyadvice@nhs.scot>
Cc: gp46131clinical (Crail Medical Practice) <ggc.gp46131clinical@nhs.scot>
Subject: Patient Query

Good afternoon,

I am emailing you regarding the below patient.
SM 0906716470.

Stewart presented to GRI on Saturday past as per NHS24 guidance after he came out in a rash across his chest, then lips, hands, and legs. He said it was blotchy and felt swollen/inflamed. I have not seen the patient F2F so not sure what it actually looks like. They had advised he stop his terbinafine (started 6 weeks ago) as they felt this could be the cause. Since stopping his rash has not cleared up at all. He is due in for NPT bloods tomorrow although his bloods from Saturday were staisfactory. Would you consider an interruption to treatment? He usually takes his MTX dose on a Tuesday.

I have copied in the practice as I am on annual leave later this week. Any help is highly appreciated.

Kind Regards,

Katie

Foundation Pharmacist
North East Locality, Glasgow City HSCP
Pavillion 4
Glasgow Business Park

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 31/03/2025

Consultant: Dr Alan Davidson

El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
Glasgow
G31 4UW

Dear El Douglas

Re: **McFarlane Stewart** DOB: **09/06/1971** CHI: **0906716470**
32 DALRY STREET
Glasgow G32 9BL

Attended on: **29/03/2025 at 14:37 hrs.** Departed on: **29/03/2025 at 19:59 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
NHS24 REFERRAL ED DIRECT-RASH- 1 HOUR

Nursing Assessment:
NEWS 0. RASH. Pt had itchy eyes yesterday and then broke out in rash, blotches all over body. Taken own antihistamine to nil relief. Nil known allergies. Nil airway concerns. States feeling fine otherwise, slight headache.

Investigations in ED:
1. Full Blood Count **2. CRP** **3. Urea and Electrolytes**
4. LFT **5. Coagulation screen**

Diagnosis:

Diagnosis	Side	Site
Rash and Other Nonspecific Skin Eruption		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:
53 yo rash to chest back and legs. Systemically well. Multiple red raised rash to these areas. Bloods unremarkable discharged. Contacted later and advised to stop terbinafine that he was recently prescribed as this could be causing his symptoms

Followup :
Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Cara Chotai
Doctor

Copies to:
1. El Douglas (GP)
School Address:

CHI: 0906716470

Glasgow Royal Infirmary

T8

Total Att: 7

12 Mth Att: 0

Title: **MR**

MCFARLANE **Stewart**

DOB **09/06/1971** Age: **53y** Sex: **Male**

32 DALRY STREET

Glasgow
Lanarkshire
G32 9BL
07504247668

Next of kin: **MCFARLANE, Debbie**
Relationship: **Wife**
07880855579

GP: **El Douglas**
0141 554 3199

Attendance Date: **29/03/2025** Arrival Time: **14:37**

Registration Time: **14:37** Date of Incident: **29/03/2025**

Major Incident Desc:

Reason for Attendance: **NHS24 REFERRAL ED DIRECT-RASH- 1 HOUR**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **29/03/2025 15:17** Nurse name: **Nurse Mary ONeil2**

Temp	**36.5**	C
HR	**84**	bpm
BP	**123/88**	mmHg
MAP	**99.67**	mmHg
RR	**17**	bpm
SpO2	**98**	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	**4**
Motor	**6**
Verbal	**5**
Total	**15**

Pupils: Right		Pupils: Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **NEWS 0. RASH. Pt had itchy eyes yesterday and then broke out in rash, blotches all over body. Taken own antihistamine to nil relief. Nil known allergies. Nil airway concerns. States feeling fine otherwise, slight headache.**

0906716470 09/06/1971 MCFARLANE Stewart
0906716470 09/06/1971 MCFARLANE Stewart
0906716470 09/06/1971 MCFARLANE Stewart
0906716470 09/06/1971 MCFARLANE Stewart
0906716470 09/06/1971 MCFARLANE Stewart

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	Clinical Notes

Seen By CARA CHOTAI — Time Seen

53 ♂ presents c rash.
feeling well. Nil other symptoms.
Itchy eyes/swelling yesterday
Today developed widespread rash over chest back + thighs.
Took anti-histamine nil effect.
Red, raised bumps, tender, not particularly itchy.
Systemically well.
Hasn't spread particularly since attend ED.

PMHx.
RH - on methotrexate

O/E.
Temp 36.5 HR 123/88 HR 84. RR 17 Sats 98%.
Chest clear
HS 1+1+0 Pulse reg
SNT.

Blanching rash
to chest, thighs, back.
mildly tender
not itchy
raised red, pink

WCC 6-1 CRP 5
UTEs ⓝ
Neut 3-2 Plt 446
LFTs ⓝ

Imp Unclear cause
no concerning features
d/w Dr Bell bloods as on MTx - normal.
After d/c saw on Terbinafine ?cause
- advised stop this. Worsening advice

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By
29/3	CHLORPHENAMINE	4mg	PO	1755		

Case No 7588921 **Case Active** 29/03/2025 13:28 **Case Type** Direct Referral ED

Patient Stewart Mcfarlane **Sex** M **D.O.B** 09/06/1971 **Age** 53 years

Current Address
32 Dalry Street Glasgow

G32 9BL

Home Address (if currently not at home)

Current Phone: 07504 247668 **Home Phone:** **CHI:** 0906716470

Case Origin **Callers Name** Stewart **Callers Tel:**

Own Doctor

Surgery Crail Medical Practice

NHS24 Received By Katriona Bain (Call Taker Si) ()

NHS24 Triage By Katriona Bain (Call Taker Si) ()

NHS24 Triage Start 13:30

NHS24 Triage End 14:00

NHS24 Outcome AEP

NHS24 Reported Condition
RASH- 1 HOUR

NHS24 Recorded Allergies

NHS24 Recorded Medications

NHS24 Recorded Medical History

NHS24 Clinical Summary
Clinical summary created by: Katriona Bain (Call Taker Si) () [29/03/2025 14:03:40]
Reason for call: RASH- 1 HOUR
29:03:2025 13:29:56 BAINK.. INFLAMED RASH ON EYES LIPS LEGS AND CHEST. WORST ON CHEST. EYES HAVE BEEN ITCHY FOR THE LAST FEW DAYS.-..
29:03:2025 13:58:42 ERSKINEV.. WORSENING RED, RAISED, BUMPY, ITCHY RASH SPREADING TO MORE AREAS - RASH OVER CHEST, NECK, FACE, KNEES HANDS, TOP LIP SWOLLEN, BOTH EYES PUFFY RED AND WATERY. RASH HOT TO TOUCH . NO KNOWN ALLERGIES... HAS TAKEN ANTIHISTIMINE DURING CALL. BREATHING FEELS HEAVIER - NO AUDIBLE WHEEZE, SPEAKING IN FULL SENTENCES. NO CHANGE TO MEDICATION. HX OF ARTHRISTIS. OUTCOME : A&E ASAP..
Outcome: Patient advised to go to A&E

NHS24 Disposition
Accident & Emergency (ASAP)

NHS24 NUrse Comments

Reported Condition **Received By** **Received**

TAS Assessment **Assessed By** **TAS Assess Start** **TAS Assess End**

Consultation **Consult By** **Consult Start** **Consult End**

Examination Details **Clinical Codes**

Diagnosis

Treatment

Prescriptions

Follow-up(s)

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Main Switchboard:	
Department:	Rheumatology
Contact Tel:	0141 451 5369/0141 451 5384
Enquiries to:	Kim.Suares@nhs.scot
Letter Date:	27/11/2024
Reference:	DMcC/KS
Dictated Date:	27/11/2024
Transcribed Date:	28/11/2024

Dear Dr. El Douglas,

Stewart McFarlane; D.O.B: 09 Jun 1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Attendance: Specialty - Rheumatology; Clinic - GRRMRH5-DR MADHOCK RHEUM WEDNESDAY AM FACE TO FACE TO BE BOOKED BY CONS ONLY
Date and Time of Appointment - 27/11/2024 11:00

Requested Out-patient Investigations:
None.

Follow Up: 03/12/2025 10:00 Rheumatology Dr Rajan Madhok

Medication Note:
Methotrexate 7.5mg subcut weekly, folic acid 5mg daily except for day of methotrexate, sulfasalazine 2g per day, hydroxychloroquine 400/200mg on alternate days, paracetamol/dihydrocodeine, cyclizine, atorvastatin.

Clinical Comments:
I reviewed this 53 year old gentleman in the rheumatology clinic today. Problems are as follows;

1. Rheumatoid arthritis: First seen June 2022 with mild synovitis in the wrists, rheumatoid factor weakly positive, CCP strongly positive. Continues on methotrexate at low dose 7.5mg subcut weekly (which is his maximum tolerated dose) along with sulfasalazine 2g per day and hydroxychloroquine 400/200mg on alternate days. His inflammatory joint disease is now well controlled. He has pain around the base of the thumbs where he has known osteoarthritis and some intermittent discomfort in the right foot when he has been up on his feet all day. There is no active synovitis and I have suggested that he continue on current treatment. We will see him for review again in a year's time.

2. Previous weight loss: This has fully stabilised and his weight has increased over the last year from 67.6kgs to 70.9kgs.

3. Back pain: This is a consequence of a road traffic accident around four years ago.

4. Cardiovascular risk: I am unsure of his smoking status. Blood pressure was 114/81. He continues on atorvastatin.

Yours sincerely

Dr David McCarey

Consultant Rheumatologist

Electronically Signed: Dr David McCarey, Consultant

cc.

Re: Assistance needed with patient

Rheumatology Advice, Gri <Rheumatologyadvice.gri@ggc.scot.nhs.uk>
Fri 15/03/2024 14:47
To:Hutton, Ann <ann.hutton2@ggc.scot.nhs.uk>

Hi Roz,

Thanks for the update.

We are due to see him on 27/03/24.

Kind regards

Anne

Rheumatology Clinical Nurse Specialists, Centre for Rheumatic Diseases, Glasgow Royal Infirmary. ***Please note the email service is for Primary care only. Patients should contact us on the advice line. Telephone number 0141 451 5384***

From: Hutton, Ann <ann.hutton2@ggc.scot.nhs.uk>
Sent: 15 March 2024 10:28
To: Rheumatology Advice, Gri <Rheumatologyadvice.gri@ggc.scot.nhs.uk>
Subject: Assistance needed with patient

Dear Rheumatology,

Re: Stewart Mcfarlane CHI: 0906716470

This patient is missing quite a few of his Metoject doses due to nausea. Only ordered 8 injections since Christmas. We've started him on cyclizine to see if this helps. He has been taking his folic acid.
Kind regards

Roz

Ann Roslyn (Roz) Hutton
Senior Pharmacist (Primary Care)
North East Locality, Glasgow City HSCP Primary Care Pharmacy Team
Building 2, Templeton Business Centre
62 Templeton Street
Glasgow
G40 1DA
Primary Contact - 0797 759 5653
Secondary Contact - PharmacyHubNE@ggc.scot.nhs.uk Telephone: 0141 201 3073

Lightburn Medical Centre: Mon pm & Wed
Crail Medical Practice: Tues, Thurs & Fri am

He mahi te ataa noho, e kii ana te wheke

Letter to Patient:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Main Switchboard: 0141 211 4000
Department: Rheumatology
Contact Tel: 0141 451 5369/0141 451 5384
Enquiries to:

Stewart McFarlane
32 DALRY STREET
Glasgow
Lanarkshire
G32 9BL

Letter Date: 29/09/2023
Reference: CG/JD
Dictated Date: 27/09/2023
Transcribed Date: 29/09/2023

Dear Mr McFarlane,

It was a great pleasure to meet you today in clinic.

Just to go over the sulfasalazine.

This is a tablet which you take every day while you continue to take the hydroxychloroquine and also the methotrexate injections which are once a week.

The sulfasalazine will start with a low dose and build up. Please start taking 1 tablet a day for the first week, and for the second week take 2 tablets a day, for the third week take 3 tablets a day, and for the fourth week take 4 tablets a day. The continue with 4 tablets a day long term.

You can spread these out however much you like, but you will probably find it is easier by the time you are taking 4 tablets to be taking 2 with your breakfast and 2 with your dinner.

If you get any rashes on sulfasalazine please stop it straight away and let us know.

Please arrange with your doctor to get your bloods every 2 weeks until you are on a stable dose, then at 2 weeks, 6 weeks, 3 months and 3 monthly.

Please let us know if you have any problems.

Yours sincerely

Dr Catriona Grigor

Consultant Rheumatologist

Electronically Signed: Dr Catriona Grigor, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Main Switchboard:	
Department:	Rheumatology
Contact Tel:	0141 451 5369/0141 451 5384
Enquiries to:	
Letter Date:	27/09/2023
Reference:	CG/JD
Dictated Date:	27/09/2023
Transcribed Date:	29/09/2023

Dear Dr. El Douglas,

Stewart McFarlane; D.O.B: 09 Jun 1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Attendance: Specialty - Rheumatology; Clinic - GRRMRH5-DR MADHOCK RHEUM WEDNESDAY AM FACE TO FACE TO BE BOOKED BY CONS ONLY
Date and Time of Appointment - 27/09/2023 10:15

Follow Up: 27/03/2024 09:45 Rheumatology face to face

Medication Note:
Methotrexate subcut to reduce to 7.5mg once a week, omeprazole 20mg, hydroxychloroquine 200/400mg on alternate days, folic acid 5mg 6 days a week, atorvastatin 20mg

Clinical Comments:

I reviewed this gentleman today at the rheumatology clinic. He has the following problems:

1. Rheumatoid arthritis: First seen June 2022 with mild synovitis in his wrists, CCP 286, rheumatoid factor 39. He was commenced on hydroxychloroquine at that point and had good improvement with IM Kenalog and I think had an ultrasound of his feet which did not show synovitis, but this was in September. However, he had ongoing pain and he was started on methotrexate in August of last year.

He struggled with oral methotrexate and switched to subcut. He felt better on subcut, but still felt really groggy for 2 days after taking it and so I reduced him to 10mg once a week. His grogginess has improved with the reduction of the dose to 10mg, however, he still feels quite groggy on a Wednesday having taken it on a Tuesday, so I have suggested we reduce to 7.5mg which is the smallest dose we can give subcut I think.

He remains on hydroxychloroquine and gets his eyes checked regularly.

He is feeling that his joints are not as good, particularly his right big toe, although he does not describe anything suggestive of gout, there is no particular swelling, but he does have metatarsalgia. There was nothing to suggest gout on examination. He also has pain in his wrists. It was difficult to know if there was definite synovitis and there is certainly nothing to suggest that we should be escalating to biologic, but I wonder whether he might benefit from adding a bit of sulfasalazine.

As we are reducing his methotrexate I think we should continue the hydroxychloroquine and add sulfasalazine EN 500mg a day, increasing by 500mg per day per week to a target dose of 2g. I would be grateful if you could check his bloods every 2 weeks until he is on a stable dose then at 2 weeks, 6 weeks, 3 months and then 3 monthly.

I have arranged to follow him up in 6 months' time.

2. Previous weight loss: His weight has now stabilised at 67.6kg which is what it was in April.

3. Back pain: This is following a road traffic accident about 3 years ago, he has not worked since. I have spoken to him today again about the benefits of back strengthening exercises and keeping active.

4. BP 121/76

Yours sincerely

Dr Catriona Grigor

Consultant Rheumatologist

Electronically Signed: Dr Catriona Grigor, Consultant

cc.

NHS
Greater Glasgow and Clyde

0906716470
MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

The patient attended Rheum Clinic at GRI

Hospital on 27/9/2023 and I would advise a change to drug therapy from

to

or additional therapy of

as detailed below. Full letter to follow.

Additional Comments: please reduce Methotrexate to 7.5 s/c once per week and add

DRUG (print)	DOSE	FREQUENCY	DURATION / REVIEW DATE
Sulphasalazine EN	500	1/d	
increase by 500	1/d	/week to	
target dose	2gm		

Yours Sincerely

Signature:

Name (print) Grade: Ext. No:

bloods eg 2 weeks until on stable dose then at 2 weeks / 6 weeks / 3 months

White copy to - G.P. Pink copy - *File this copy in Case Records*

00545 GGC0004

+ 3 months Thanks Catherine Gracie CNS

Letter to Patient:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Stewart McFarlane
32 DALRY STREET
Glasgow
Lanarkshire
G32 9BL

Main Switchboard:	0141 211 4000
Department:	Rheumatology
Contact Tel:	0141 451 5370
Enquiries to:	
Letter Date:	27/04/2023
Reference:	CG/LS
Dictated Date:	21/04/2023
Transcribed Date:	24/04/2023

Dear Mr McFarlane ,

It was really nice to see you in clinic today. As promised this is a letter to let you know exactly what it is I wish you to be taking.

I would like you to take a reduced dose of Methotrexate, so that's 10mg once per week as an injection. I would like you to restart the Hydroxychloroquine and I would like you to take two/ one tablets on alternate days, so for example two tablets on Monday, one on Tuesday, two on Wednesday, one on Thursday etc.

As you know it is important that you go to get your eyes checked at your opticians every year or at least every two years. It is important that you arrange this through your own opticians. We look forward to seeing you back at clinic.

Yours Sincerely,

Dr Catriona Grigor

Consultant Rheumatologist

Electronically Signed: Dr Catriona Grigor, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Main Switchboard:	
Department:	Rheumatology
Contact Tel:	0141 355 1514
Enquiries to:	
Letter Date:	21/04/2023
Reference:	CG/LS
Dictated Date:	21/04/2023
Transcribed Date:	24/04/2023

Dear Dr. El Douglas,

Stewart McFarlane; D.O.B: 09 Jun 1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Attendance: Specialty - Rheumatology; Clinic - GREACRH0-EARLY ARTHRITIS CLINIC FRIDAY PM
Date and Time of Appointment - 21/04/2023 14:15

Follow Up: 27/09/2023 10:15 Rheumatology Dr Rajan Madhok

Medication Note:
Methotrexate sub cut to reduce to 10mg once per week, Hydroxychloroquine 400/200mg on alternate days to restart, Omeprazole 20mg, Folic acid 5mg six days a week.

Clinical Comments:
I reviewed this gentleman today at the rheumatology clinic, he has the following problems;

Rheumatoid arthritis: Symptom onset early 2022, first seen June 2022 with mild synovitis in his wrists, CCP 286, rheumatoid factor 39. He was commenced on Hydroxychloroquine at that point and had a good improvement with IM Kenalog and I think had an ultrasound of his feet which did not necessarily show synovitis in his feet in September, but he had ongoing pain and he was therefore started on Methotrexate in August of last year. He struggled with the oral Methotrexate and switched to sub cut. Side effects are much better on sub cut but he still feels really groggy and sick for a couple of days after taking it which is not really ideal so I have asked him to reduce the Methotrexate to 10mg once a week.

He had been on Hydroxychloroquine and he is unsure why this was stopped but he has not had a repeat prescription since September and I think we should restart this especially as we are reducing the Methotrexate. I would be grateful if you could commence him on Hydroxychloroquine 200/400mg

on alternate days and I have reinforced today that he needs to get his eyes checked at his optician every year or two.

He is still getting some pain in his hands and feet, although he does feel that the insoles that he now has are helpful. There was no evidence of synovitis today.

I have arranged follow up for him in around six months' time and he can now come to our routine follow up clinic.

Weight loss: His weight has now stabilised. When I last weighed him in November it was 67.5 and today he is 67.3kg. As you know he has had a normal endoscopy and negative Q-Fit and no evidence of malignancy on a CT chest abdo and pelvis.

Back Pain: This is following a road traffic accident a couple of years ago and he has not worked since. I have spoken today about the fact that I think it would be beneficial for him from a mental health and a physical health point of view to see if he can walk more and also see if he can get back to work. He has always done manual jobs, which would not be appropriate now but it might be possible for him to get some voluntary work or a non manual job and he is going to look into this.

Follow up: Six months face to face Wednesday morning.

Yours Sincerely,

Dr Catriona Grigor

Consultant Rheumatologist

Electronically Signed: Dr Catriona Grigor, Consultant

cc.

NHS
Greater Glasgow and Clyde

0906716470
MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

The patient attended Rheum Clinic at GM

Hospital on 21/4/2023 and I would advise a change to drug therapy from

to

or additional therapy of

as detailed below. Full letter to follow.

Additional Comments: please reduce Methotrexate to 10g/week and re-start Hydroxychloroquine 400g/200g on alt days

DRUG (print)	DOSE	FREQUENCY	DURATION / REVIEW DATE

Thanks

Yours Sincerely

A Thomas
GMedSci

Signature:

Name (print) Grade: Ext. No:

White copy to - G.P. Pink copy - *File this copy in Case Records*

00545 GGC0004

CENTRE FOR RHEUMATIC DISEASES TELEPHONE ADVICE LINE

Mcol
Date of call: 30.1.23 **Time of call:** 14:23

Date 1: 30.1.23 **Time Call returned** 16:34
2: **Time Call returned**

Caller Name: Stuart McFarlane

CHI: 0906716470 **DOB:**

Tel: 07504247668

Diagnosis:
Reason for call:
Received my injections & need app

Action taken:
- ☐Advice given
- ☐Onward referral (to :_____)
- ☐Urgent CNS appointment (for: _____)
- ☐Appointment made/changed _____)
- ☐Homecare service contacted
- ☐Prescription arranged
- ☐Advised to attend primary care / A&E/ Other_____)
- ☐Passed to on call doctor (who: _____)
- ☐Consultant informed (who :_____)
- ☐OPD appointment rearranged

Comments:
App arranged for 1/2/23 for education & practice. Will also need to collect a sharps bin.

Signed: McDonald. **Print: Moira McDonald**

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Main Switchboard:	
Department:	Rheumatology
Contact Tel:	0141 451 5370
Enquiries to:	
Letter Date:	20/01/2023
Reference:	CW/LD
Dictated Date:	20/01/2023
Transcribed Date:	24/01/2023

Dear Dr. El Douglas,

Stewart McFarlane; D.O.B: 09 Jun 1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Attendance: Specialty - Rheumatology; Clinic - GRSSRH0-DR SAUNDERS AND DR GRIGOR COMBINED EARLY ARTHRITIS FRI PM
Date and Time of Appointment - 20/01/2023 14:15

Follow Up: 21/04/2023 14:15 Rheumatology Dr Sarah Saunders

Clinical Comments:
I reviewed this 51 year old gentleman in the clinic today. We discussed the following:

Rheumatoid arthritis: Symptom onset about 10 months ago. He was seen in June with inflammatory joint symptoms in his hands and feet, early morning stiffness and mild synovitis around his ulnar styloid at both wrists and likely synovitis in his right mid foot. He is seropositive for rheumatoid factor and anti-CCP antibodies. He made a good clinical improvement with intramuscular Kenalog. He responded well to Methotrexate but has been struggling with significant nauseous post dose. At his last appointment his dose was reduced to 15mg. This reduction in dose doesn't seem to have affected his joint symptoms but it's also not improved his nausea.

He describes some occasional discomfort in his right hand but there was no synovitis on exam today and he has a good range of movement. He's seen our physiotherapist for exercises for his hands and feet. He also continues on Hydroxychloroquine 400mg. I've suggested that we switch him to subcutaneous Methotrexate which can help with the GI side effects. He's happy to do this. **I'd suggest changing him to 15mg methotrexate subcut (Metoject) weekly**. He knows to get in contact with us via the helpline once he has his prescription and we'll arrange to bring him up for some teaching on how to administer it and provision of a sharps bin.

Weight loss, nauseous and anemia: This was a problem at his last appointment and symptoms have been present for a few months. He felt like he'd lost probably about a stone and a half, had gone off his food, had early satiety and some nausea. He's had a qFit which was negative, a normal endoscopy and no evidence of malignancy on a CT chest abdomen and pelvis. He still has ongoing symptoms of poor appetite and early satiety. Weight in clinic today was 66.8kgs which is just slightly less than when he was seen in November. He's an ex-smoker. It will be interesting to see if his symptoms improve with the change to subcutaneous Methotrexate. We'll keep an eye on his weight when he next comes back.

Back pain: He's waiting an MRI for this following a road traffic accident a couple of years ago. It wasn't discussed today.

Follow-up: 3 months.

Yours sincerely

Dr Claire Wood

ST7 Rheumatology

Electronically Signed: Dr Claire Wood, Doctor

cc.

MCFARLANE, Stewart (Mr)
BORN 09-Jun-1971 (55y) GENDER Male
CHI 0906716470

Request to GP to prescribe medication

Last updated by Claire WOOD (Claire Wood) 3.5 years ago (v. 1) Show History

Content Restricted	No	Sensitivity	Sensitive
If the information on this form merits further restriction than that of Highly Sensitive, please select **Yes** to apply a Privacy Seal		The information on this form **will** be viewable by health and care providers with the appropriate access permissions	

Date	20-Jan-2023		
Hospital	Glasgow Royal Infirmary	Other	—
Specialty / Service	Rheumatology		
Clinic	Yes	Please Specify	—

Clinician Details

Name	Claire Wood
ClinicianDetailsRole	Doctor
Professional Registration Number	7411267
Contact Details	Claire.Wood@ggc.scot.nhs.uk

Dear Doctor

Your Patient Was Seen

Please Prescribe

Urgent / Routine: Routine - prescription available 48 hours following request

indication: —

Additions and Replacements

Product	Dose	Frequency	Current Regime Status	Comments
Methotrexate subcutaneous (Metoject)	15mg	Weekly	Amendment	Please change from oral to subcutaneous MTX

Replacements

This medication replaces which should now be stopped: —

Patient advised to collect prescription: Yes

Please Note: A Detailed Letter Will Follow.

Additional Notes / Summary

MCFARLANE, Stewart (Mr)

Additional Notes / Summary

DOB 09-Jun-1971 (55y) GENDER Male

CHI 0906716470

When you click to 'Complete' a summary of the the form will be sent electronically to the registered GP practice.

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Rheumatology
Contact Tel: 0141 451 5369
Enquiries to:

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Letter Date: 21/12/2022
Reference: CG/CB
Dictated Date: 21/12/2022
Transcribed Date: 29/12/2022

Dear Dr. El Douglas,

Stewart McFarlane; D.O.B: 09 Jun 1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Attendance: Specialty - Rheumatology; Clinic - GRGCRH6-GENERAL RHEUM CONS WEDNESDAY PM
Date and Time of Appointment - 21/12/2022 16:15

Follow Up: 20/01/2023 14:15 Rheumatology

Clinical Comments:
I had a brief telephone consultation with this gentleman today to let him know the result of his CT abdomen, thorax and pelvis. I have copied the result below but essentially this shows no radiological evidence of malignancy and he was relieved to hear this. Follow up is as previously arranged.

Yours sincerely

Dr Catriona Grigor

Consultant Rheumatologist

There is no size significant supraclavicular, axillary or mediastinal adenopathy. Pleural spaces are clear. Within limits of the study there is no major central PE. Thyroid gland and oesophagus are unremarkable.

Trachea and main-stem bronchi are within normal limits. Hypostatic density is seen posteriorly. Lungs are clear of any concerning nodule or consolidation.

No concerning parenchymal lesion liver. There is no dilatation of biliary radicles. Gallbladder is distended with clear bile. Solitary left kidney noted. Rest of the visualised solid upper abdominal organs are unremarkable.

Stomach is partially distended. There is no size significant upper abdominal, retroperitoneal or pelvic adenopathy.

Urinary bladder is distended. Unprepared bowel shows faecal residue. No obstructing lesion is seen in unprepared colon. There is no pericolic adenopathy or free fluid.

No destructive bony lesion is seen.

Conclusion: No radiological evidence of malignancy noted.

Report Date : 18/12/2022

Reporting Consultant: Dr Nirmali Dutta. Consultant Radiologist

Electronically Signed: Dr Catriona Grigor, Consultant

cc.

NHS
Greater Glasgow and Clyde

0906716470
MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

The patient attended Rheum Clinic at GR

Hospital on 4/11/2022 and I would advise a change to drug therapy from

to

or additional therapy of

as detailed below. Full letter to follow.

Additional Comments: please reduce Methotrexate to 15g/week

DRUG (print)	DOSE	FREQUENCY	DURATION / REVIEW DATE

also has angry anaemia

please check a q fit

Thanks

Yours Sincerely

Signature:

Name (print) Grade: Ext. No:

Catriona
Graham
Cons

White copy to - *G.P.* Pink copy - *File this copy in Case Records*

00545 GGC0004

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Rheumatology
0141 451 5369/0141 451 5384

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Main Switchboard:
Department:
Contact Tel:
Enquiries to:
Letter Date: 04/11/2022
Reference: CG/JD
Dictated Date: 04/11/2022
Transcribed Date: 08/11/2022

Dear Dr. El Douglas,

Stewart McFarlane; D.O.B: 09 Jun 1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Attendance: Specialty - Rheumatology; Clinic - GRSSRH0-DR SAUNDERS AND DR GRIGOR COMBINED EARLY ARTHRITIS FRI PM
Date and Time of Appointment - 04/11/2022 15:05

Follow Up: 20/01/2023 14:15 Rheumatology

Medication Note:
Methotrexate to reduce to 15mg once per week, folic acid 5mg, paracetamol and dihydrocodeine, hydroxychloroquine 200mg bd, atorvastatin 20mg

Clinical Comments:
I reviewed this gentleman today at the rheumatology clinic. He has the following problems:

1. Rheumatoid arthritis: Symptom onset around eight months ago, he was seen in June with inflammatory joint symptoms in the small joints of his hands and feet and early morning stiffness lasting around an hour. When he was first seen he had mild synovitis around his ulnar styloid in both wrists with slightly reduced power grip and tender MTPs with likely synovitis in his right midfoot.

He is rheumatoid factor and CCP positive and had a good clinical improvement with IM Kenalog given in June from the point of view of his hands, but the pain in his feet persisted. He was commenced on methotrexate and subsequently had an ultrasound of his feet which did not show inflammation and he was referred to John Tougher Specialist Podiatrist. Unfortunately he got confused with his appointments and did not attend his face to face appointment with podiatry, but he has spoken to them and they are going to send out another appointment and he knows how important it is to go and see them.

His methotrexate had been increased to 20mg, but unfortunately he feels a bit rubbish after taking the methotrexate and this is worse on the higher dose.

There was no evidence of synovitis today. I have asked him to reduce the methotrexate back to 15mg to see how he feels and we will review him in a couple of months.

2. Weight loss, nausea, anaemia: Over the last few months he has had anaemia which yesterday was a haemoglobin of 120 with increased platelets of 443 in association with weight loss. He thinks he has lost about 1 ½ stone, he has gone off his food, his appetite is poor, he has nausea, possibly some shortness of breath.

I would be grateful if you could check a qFIT. I have referred him for endoscopy and a CT chest, abdomen and pelvis to exclude malignancy. I have also requested a CRP (13) and serum iron.(17).His weight today was 67.5kg.

3. Back pain: I believe he is awaiting an MRI for investigation of back pain following from a road traffic accident a couple of years ago. We did not discuss this today.

Yours sincerely

Dr Catriona Grigor

Consultant Rheumatologist

Electronically Signed: Dr Catriona Grigor, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Rheumatology
0141 451 5369/0141 451 5384

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Main Switchboard:	
Department:	Rheumatology
Contact Tel:	0141 451 5369/0141 451 5384
Enquiries to:	
Letter Date:	04/11/2022
Reference:	CG/JD
Dictated Date:	04/11/2022
Transcribed Date:	08/11/2022

Dear Dr. El Douglas,

Stewart McFarlane; D.O.B: 09 Jun 1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Attendance: Specialty - Rheumatology; Clinic - GRSSRH0-DR SAUNDERS AND DR GRIGOR COMBINED EARLY ARTHRITIS FRI PM
Date and Time of Appointment - 04/11/2022 15:05

Follow Up: 20/01/2023 14:15 Rheumatology

Medication Note:
Methotrexate to reduce to 15mg once per week, folic acid 5mg, paracetamol and dihydrocodeine, hydroxychloroquine 200mg bd, atorvastatin 20mg

Clinical Comments:
I reviewed this gentleman today at the rheumatology clinic. He has the following problems:

1. **Rheumatoid arthritis:** Symptom onset around eight months ago, he was seen in June with inflammatory joint symptoms in the small joints of his hands and feet and early morning stiffness lasting around an hour. When he was first seen he had mild synovitis around his ulnar styloid in both wrists with slightly reduced power grip and tender MTPs with likely synovitis in his right midfoot.

He is rheumatoid factor and CCP positive and had a good clinical improvement with IM Kenalog given in June from the point of view of his hands, but the pain in his feet persisted. He was commenced on methotrexate and subsequently had an ultrasound of his feet which did not show inflammation and he was referred to John Tougher Specialist Podiatrist. Unfortunately he got confused with his appointments and did not attend his face to face appointment with podiatry, but he has spoken to them and they are going to send out another appointment and he knows how important it is to go and see them.

His methotrexate had been increased to 20mg, but unfortunately he feels a bit rubbish after taking the methotrexate and this is worse on the higher dose.

There was no evidence of synovitis today. I have asked him to reduce the methotrexate back to 15mg to see how he feels and we will review him in a couple of months.

2. Weight loss, nausea, anaemia: Over the last few months he has had anaemia which yesterday was a haemoglobin of 120 with increased platelets of 443 in association with weight loss. He thinks he has lost about 1 ½ stone, he has gone off his food, his appetite is poor, he has nausea, possibly some shortness of breath.

I would be grateful if you could check a qFIT. I have referred him for endoscopy and a CT chest, abdomen and pelvis to exclude malignancy. I have also requested a CRP (13) and serum iron.(17).His weight today was 67.5kg.

3. Back pain: I believe he is awaiting an MRI for investigation of back pain following from a road traffic accident a couple of years ago. We did not discuss this today.

Yours sincerely

Dr Catriona Grigor

Consultant Rheumatologist

Electronically Signed: Dr Catriona Grigor, Consultant

cc.

Generic general letter:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Main Switchboard: 0141 211 4000
Department: Rheumatology
Contact Tel: 0141 451 5384
Enquiries to:
Letter Date: 05/10/2022
Reference: CW/JD
Dictated Date: 28/09/2022
Transcribed Date: 04/10/2022

To Whom It May Concern

Dear Sir/Madam,

Stewart McFarlane; D.O.B: 09/06/1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Stewart attends the Rheumatology clinic at Glasgow Royal Infirmary with a new diagnosis of Rheumatoid arthritis. Symptom onset six months ago and first seen in the Centre for Rheumatic Diseases in June 2022.

His onset of disease had presented with bilateral, symmetrical inflammatory arthritis affecting wrists, ankles and MTP joints and had also presented with very painful feet. Unfortunately at this time his feet are still very limiting and affecting his mobility. He is awaiting a specialist podiatry appointment at the Queen Elizabeth University Hospital.

At this present time his Rheumatoid disease is not fully under control and he continues to attend the early arthritis clinic, currently six weekly. Hopefully this will improve as we get his disease under control.

Rheumatoid arthritis is an autoimmune disorder which can be unpredictable in nature and patients can suffer flare ups from time to time requiring steroids.

Yours faithfully

Nurse Cora Winters

Rheumatology Clinical Nurse Specialist

Electronically Signed: Nurse Cora Winters, Nurse

cc. Stewart McFarlane
32 Dalry Street
Glasgow
G32 9BL

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Rheumatology
Contact Tel: 0141 451 5384
Enquiries to:

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Letter Date: 16/09/2022
Reference: CW/RM
Dictated Date: 16/09/2022
Transcribed Date: 23/09/2022

Dear Dr. El Douglas,

Stewart McFarlane; D.O.B: 09 Jun 1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Attendance: Specialty - Rheumatology; Clinic - GRSSRH0-DR SAUNDERS AND DR GRIGOR COMBINED EARLY ARTHRITIS FRI PM
Date and Time of Appointment - 16/09/2022 15:55

Follow Up: 04/11/2022 15:05 Rheumatology Dr Sarah Saunders

Medication Note:
15mg Methotrexate to increase up to 20mg one day per week, Folic Acid 5mg daily except Methotrexate day, Hydroxychloroquine 200mg bd, Atorvastatin 20mg one daily, Codydramol 20/500 as required.

Clinical Comments:
I have reviewed Stewart in clinic this afternoon. Issues are as follows:

1. Rheumatoid arthritis : Symptom onset six months ago, first seen CRD June 2022, rheumatoid factor and CCP antibody positive. ESR at presentation 77, CRP 75 and x-rays non erosive.

Mr McFarlane had presented with bilateral symmetrical inflammatory arthritis affecting wrists, ankles and MTP joints. He had a good clinical improvement with IM Kenalog given in June in relation to his hands but he is still struggling at present with pain in both feet. The pain is not limited to any particular time of day and seems to be present throughout the day and is limiting his mobility.

On examination, I could not feel any particular hand joint swollen although fingers were extremely stiff and tight generally, both shoulders tender. His main complaint remains both feet and I believe he has been referred to Specialist Podiatrist John Tougher for review.

2. Back pain : He is awaiting an MRI scan for investigation of back pain following on from a road traffic accident a couple of years ago. This is unfortunately still causing Stewart quite a bit of pain.

He works in the building trade as an asbestos remover but has not worked since his back injury.

Weight = 66.8kg. Thankyou for your continued help with blood monitoring and I note bloods are satisfactory.

I have requested a six week follow up consultation and Stewart has the nurse advice line should he need us in between times.

Yours sincerely

Cora Winters

Rheumatology Nurse Specialist

Electronically Signed: Nurse Cora Winters, Nurse

cc.

NHS
Greater Glasgow and Clyde

0906716470
MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

The patient attended Rheumatology Clinic at GRI

Hospital on 16/9/22 and I would advise a change to drug therapy from

_____ to _____

or additional therapy of _____

as detailed below. Full letter to follow.

Additional Comments: _____

DRUG (print)	DOSE	FREQUENCY	DURATION / REVIEW DATE
methotrexate	20mg	one day per week	3/12

Yours Sincerely

Signature: Written

Name (print) CARA WATTERS Grade: 6 Ext. No: (0141) 451 5384

White copy to - *G.P.* Pink copy - *File this copy in Case Records*

00545 GGC0004

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Main Switchboard:	
Department:	Respiratory Department
Contact Tel:	0141 201 3831
Enquiries to:	Fiona.maclellan@ggc.scot.nhs.uk
Letter Date:	15/08/2022
Reference:	GWC/FM
Dictated Date:	15/08/2022
Transcribed Date:	15/08/2022

Dear Dr. El Douglas,

tewart McFarlane; D.O.B: 09 Jun 1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Attendance: Specialty - Respiratory Medicine; Clinic - GRGCRE1-DR CHALMERS TEMP ILD MON AM - NO OVERBOOKINGS ON CLINIC UNLESS AUTHORISED BY DR CHALMERS
Date and Time of Appointment - 15/08/2022 10:50

Clinical Comments:
Dear Doctor,

Problems:
1. Rheumatoid arthritis now on Methotrexate
2. Previous minor interstitial change on CT scan has now resolved
3. Road traffic accident with back pain
4. Solidary left kidney
5. Ex-smoker
6. Avian exposure (No evidence of hypersensitivity pneumonitis)

I contacted Mr McFarlane by telephone on 15/08/2022. I was pleased to inform him that the minor interstitial change seen on previous imaging have now resolved.

He was recently started on Methotrexate but I have no concerns about this beyond the obvious need to monitor for any new symptoms since Methotrexate induced pneumonitis is a rare condition.

Yours sincerely,

Dr George W Chalmers

Consultant Respiratory Physician

Electronically Signed: Dr George Chalmers, Consultant

cc.

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑ NURSING ☐

Please tick ✔ appropriate directorate

0906716470
MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

Date & Time		Signature, Print Name & Designation
15/8/22		
	Sig.	
	RA – MRI (rec'd).	
	[illegible]	
	RTA. [illegible]	
	[illegible]	
	[illegible]	
	[illegible]	
	[illegible]	
	–	
		(A)

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Main Switchboard:
Department: Rheumatology
Contact Tel: 0141 451 5370 / 0141 451 5384
Enquiries to: carrie.macneil@ggc.scot.nhs.uk
Letter Date: 01/08/2022
Reference: SS/JD
Dictated Date: 01/08/2022
Transcribed Date: 02/08/2022

Dear Dr. El Douglas,

tewart McFarlane; D.O.B: 09 Jun 1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Attendance: Specialty - Rheumatology; Clinic - GRSSRH0-DR SAUNDERS AND DR GRIGOR COMBINED EARLY ARTHRITIS FRI PM TIMESHIFT
Date and Time of Appointment - 01/08/2022 11:40

Requested Out-patient Investigations:
None performed today

Medication Note:
As noted

Clinical Comments:
I reviewed this 51-year-old gentleman in the rheumatoid clinic where we discussed the following:

1. Rheumatoid arthritis: Symptom onset six months ago, first seen CRD June 2022, rheumatoid factor and CCP antibody positive, ESR at presentation 77mm/hr, CRP 75mg/L. X-rays non-erosive.

Mr McFarlane presented with a bilateral, symmetrical inflammatory arthritis affecting wrists, ankles and MTP joints. He seems to have had quite a good clinical improvement with IM Kenalog given in June in relation to his hands, but he is struggling with pain in the MTP joints bilaterally and in both ankles. Foot pain is particularly severe first thing in the morning and is limiting his mobility.

On examination today he had striking metatarsalgia in the 1st MTP joint, but also the 5th, 4th and 3rd MTP joints in both feet. He also had a slightly high arch which is not a new feature. He had pain in the medial aspect of his ankles, but no evidence of ankle synovitis clinically.

I have gone through with him the diagnosis of rheumatoid arthritis and I have given him written information regarding that. I am optimistic that the pain in his feet is inflammatory, I am referring him to my physiotherapy colleagues for a further assessment, as there may be orthotic intervention that might be helpful for him or if his intramuscular steroid is not helpful then targeted injections may be. However I am hopeful that on appropriate disease modifying therapy things will improve.

I would be grateful if you would commence him on methotrexate 15mg once weekly with folic acid 5mg daily except the day of methotrexate. Thank you for carrying out blood monitoring, as per the near patient testing protocol.

He should continue on the hydroxychloroquine which was already started. We can always pull back on that if he gets a good response to methotrexate.

I am arranging for him to be seen in the clinic in six weeks from now at which point we will aim to escalate his methotrexate to 20mg once weekly.

2. Respiratory: He has an appointment for lung function tests. He has very minor fibrotic scarring on a previous high resolution CT scan of chest, but Dr Chalmers is happy that we progress with his methotrexate.

3. Back pain: He is awaiting an MRI scan for investigation of back pain following on from a road traffic accident a couple of years ago.

4. Social: He works in the building trade as an asbestos remover, but has not worked since his back injury.

Yours sincerely

Dr Sarah Saunders

Consultant Rheumatologist

Electronically Signed: Dr Sarah Saunders, Consultant

cc.

NHS
Greater Glasgow and Clyde

Patient label

0906716470
MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

The patient attended [illegible] Clinic at [illegible]

Hospital on [illegible] and I would advise a change to drug therapy from

[illegible] to [illegible]

or additional therapy of [illegible]

[illegible]

as detailed below. Full letter to follow.

Additional Comments: [illegible]

DRUG (print)	DOSE	FREQUENCY	DURATION / REVIEW DATE

Yours Sincerely

Signature: [illegible]

Name (print) [illegible] Grade: [illegible] Ext. No: [illegible]

White copy to - *G.P.* Pink copy - *File this copy in Case Records*

00545 GGC0004

McFarlane Stewart CHI: 0906716470

Clinical letter - Others:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Dr David MCarey
Consultant Rheumatologist
Rheumatology Department
Glasgow Royal Infirmary

Main Switchboard: 0141 211 4000
Department: Respiratory
Contact Tel: 0141 201 3831
Enquiries to: Fiona.maclellan@ggc.scot.nhs.uk
Letter Date: 13/07/2022
Reference: GWC/FM
Dictated Date: 06/07/2022
Transcribed Date: 08/07/2022

Dear Dr McCarey,

Stewart McFarlane; D.O.B: 09/06/1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Thank you for your letter regarding Mr McFarlane. As you have anticipated I would have no concerns about him starting on Methotrexate for his recent diagnosed rheumatoid arthritis. The absence of interstitial lung disease on his CT scan from June is reassuring.

Yours sincerely,

Dr George W Chalmers

Consultant Respiratory Physician

Electronically Signed: Dr George Chalmers, Consultant

cc. Dr Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Clinical letter - Others:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Dr George Chalmers
Respiratory Consultant
Respiratory Department
Outpatient Area A Queen Elizabeth Building
Glasgow Royal Infirmary
84 Castle St
G4 0SF

Main Switchboard: 0141 211 4000
Department: Rheumatology
Contact Tel: 0141 355 1050
Enquiries to: Lauren Scott
Letter Date: 23/06/2022
Reference: DM/LS
Dictated Date: 16/06/2022
Transcribed Date: 20/06/2022

Dear George,

Stewart McFarlane; D.O.B: 09/06/1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

This gentleman appears to be evolving rheumatoid arthritis. My assumption would be that you would be happy for us to give him Methotrexate if required but I just thought I should check in case you had any objection. Many thanks in anticipation of your opinion.

Yours sincerely,

Dr David McCarey

Consultant Rheumatologist

P.S. I see that his most recent HRCT has now been reported and shows no significant ILD. Clearly this is reassuring. **DMcC 23.6.22**

ENC: Clinic letter 16 06 22

Electronically Signed: Dr David McCarey, Consultant

cc.

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Rheumatology GGC General Referral or Advice	—	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	—	**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Urgent
Date of referral 26-Apr-2022 **Date sent** 26-Apr-2022

PATIENT DETAILS

Surname	Mcfarlane
Forename(s)	Stewart
Title	Mr
Sex	Male
Date of birth	09-Jun-1971
CHI no.	0906716470
Area of Residence	-

Patient's address

32 Dalry Street
GLASGOW
G32 9BL

Contact number(s)

Voice: 07504247668

101026160565H | Unique Care Pathway Number: 101026160565H

REGISTERED GP DETAILS

Name	Dr Emma Douglas		
GMC code	6128501	GP code	01171
Practice name	Crail Medical Practice		
Practice code	46131		

Practice address

Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Contact number(s)

Voice: 0141 554 3199
Facsimile: 0141 551 9950
E-mail: ggc.gp46131clinical@nhs.scot

REFERRING GP DETAILS

Name	Dr. Emma Douglas		
GMC code	6128501	GP code	01171
Practice name	Crail Medical Practice (46131)		
Practice code	46131		

Practice address

245 Tollcross Road
Glasgow
G31 4UW

Contact number(s)

Voice: 0141 554 3199

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: pain and stiffness in joints

Comment: Dear doctor, I would be grateful of your review of this 50 year old gentleman who is currently undergoing investigations by the respiratory teams for possible interstitial lung disease. He presented recently with increasing pain and stiffness in the small joints of both hands. He feels that it is worse across the knuckles. He denies any specific redness or swelling but does describe significant morning stiffness in his hands. He is taking co-dydramol for long standing back pain and is find this beneficial for his hand as well. His blood tests have shown a slightly raised rheumatoid factor on two separate occasions initially in January it was 43 and more recently it was 39. He also has a raised ESR and mildly raised platelets. He had his ANA checked by the respiratory team and it was moderately positive with 1/6.40 homogenous pattern. I have arrange for some x-rays of his hands to see if there is any specific changes in the joints. Given his history and the blood results I wonder if this could be an inflammatory arthritis and would be grateful for you expert input.

Yours sincerely

Dr Morgan

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Chronic kidney disease stage 1	CKD stage 1/2	26-Feb-2021	26-Feb-2021
Renal agenesis, unspecified	solitary left kidney	18-Feb-2021	18-Feb-2021
Iritis - acute	-	05-Aug-2009	05-Aug-2009
Bite of nonvenomous snakes and lizards	Left upper limb	21-Nov-2008	21-Nov-2008
[X]Mild depression	-	21-Jan-2005	21-Jan-2005
Generalised anxiety disorder	with panic symptoms due to social/ financial problems+++	17-Dec-2004	17-Dec-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Paracetamol And Dihydrocodeine Tablets 500 mg + 20 mg	112	112 tablet	ONE OR TWO TO BE TAKEN EVERY 4-6 HOURS WHEN REQUIRED (NO MORE THAN 8 IN 24 HOURS)	-	12-Apr-2022	12-Apr-2022
Atorvastatin Tablets 20 mg	56	56 tablet	ONE TO BE TAKEN EACH DAY	-	15-Mar-2021	02-Jul-2021

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Omeprazole Capsules (Gastro-Resistant) 20 mg	28	28 capsule	ONE TO BE TAKEN EACH DAY	-	12-Apr-2022	12-Apr-2022
Promethazine Hydrochloride Tablets 25 mg	28	28 tablet	ONE AT NIGHT	-	06-Dec-2021	06-Dec-2021
Macrogol Compound Oral Powder	30	30 sachet	ONE TWICE DAILY	-	03-Nov-2021	

(sachets) NPF Sugar Free						06-Dec-2021
Co-Dydramol 10/500 Tablets	100	100 tablet	ONE OR TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)	-	16-Jul-2021	23-Mar-2022

Blood Pressure

Date Recorded	Systolic	Diastolic
08-Mar-2021	110	82
27-Nov-2015	126	88
01-Nov-2004	134	90

Body Measurements

Date Recorded	Height	Weight	BMI
08-Mar-2021	-	71.5	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex smoker:		08-Mar-2021
Cigarette smoker 6 Cigarettes/day :	pain left ear for 3 days has had URTI left ear nad, imp eust tibe dysfxn adv given	01-Feb-2016
Cigarette smoker :		06-Mar-2013
Current smoker:	Smoker$$ Status.clm - Repeat after an Interval	01-Nov-2004
Alcohol consumption, 0 units/week:		08-Mar-2021
Light drinker - 1-2u/day:	Alcohol Intake$$.clm - Repeat after an Interval	01-Nov-2004

Clinical warnings

Additional Support Needs
No known ASN requirements

Additional relevant information
Administrative information
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Referred By:Referring GP
Electronic Attachment Present:No

Social circumstances
Ethnic Origin: (White) British

Signature of referring doctor (or other professional) **Date**

Clinical letter - GP: Discharge

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Physiotherapy
Contact Tel: 0141 232 1562
Enquiries to: Stuart Burgon
Letter Date: 19/01/2022
Reference:
Dictated Date: 19/01/2022
Transcribed Date: 19/01/2022

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Dear Dr Douglas,

Stewart McFarlane; D.O.B: 09/06/1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

GP Action Required: NIL

Presenting Condition: Lx and Cx pain

Physiotherapy Comments:

Onset and Mechanism of injury - RTA 14/02/21

Diagnosis -Soft tissue injury related to RTA

Treatment -Gentle ROM and strengthening programme

Further Info -No red flags/Neurology or signs or CES.

Discharge Outcome:

The patient cancelled review appointment(s) with no further contact.

This patient has now been discharged from our care.

Yours sincerely

Stuart Burgon

Band 6 Physiotherapist

Electronically Signed: ,

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Main Switchboard: 0141 211 4000
Department: Respiratory Department
Contact Tel: 0141 201 3831
Enquiries to: suzy.brown@ggc.scot.nhs.uk
Letter Date: 11/01/2022
Reference: GWC/SB
Dictated Date: 11/01/2022
Transcribed Date: 12/01/2022

Dear Dr. El Douglas,

Stewart McFarlane; D.O.B: 09 Jun 1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Attendance: Specialty - Respiratory Medicine; Clinic - GRGCRE4-DR CHALMERS/WRIGHT ILD TUE PM
Date and Time of Appointment - 11/01/2022 14:45

Follow Up: Dr Chalmers Clinic - 12/07/2022 @ 14:00

Clinical Comments:
Problems:

1. Possible minor fibrotic change on CT.
2. Probable COVID-19 infection 2020.
3. Road traffic accident with back pain.
4. Solitary left kidney.
5. Ex-smoker.
6. Avian exposure (pet parrot at home).

Thank you for referring Mr McFarlane whom I saw at clinic on 11/01/2022. He reports breathlessness on exertion going back about a year or more and has to stop on walking on level ground after a few hundred yards. He can manage three flights of stairs but is breathless thereafter.

He has a history of avian exposure as he has had a pet parrot at home for about 25 years although the pattern of abnormality seen on CT is perhaps not typical of hypersensitivity pneumonitis. More obvious on the scan is some fairly subtle lower zone reticular change consistent with early fibrosis but which could be dependent changes. I have requested a prone CT scan along with inspiratory and expiratory images to assess for any trapping in relation to possible hypersensitivity. I have also

checked an avian antibody but would update this with a specific antibody for parrot antigen if the test is even mildly positive. He will have outpatient lung function tests and echocardiography.

I explained to him that he has evidence of minor change on CT which requires follow up. At present there is no specific diagnosis or treatment but hopefully investigations will clarify this over time.

Yours sincerely

Dr George W Chalmers

Consultant Respiratory Physician

Electronically Signed: Dr George Chalmers, Consultant

cc.

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑ NURSING ☐

Please tick ✔ appropriate directorate

0906716470
MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

Date & Time		Signature, Print Name & Designation
11/2/22	50 yr. ♂	
	CT - min bruised.	
	following ⓒ imaging	
	COVID - 2020.	HR.
	2020 RTA 2021	Phone CT
	ex smoker	
	2020 1 yr A	
	head and - 100 yds	
	? fractured nose	anaesth ☐
	° Cyclo. ° Cannula	
		full PPE ☐
	Pmhx Dx SH	ECHO ☐
	fractured analgesia co smoker 1yr	
	° alcoholic	
	lives with bro.	
	25 anaesthetic removal 2yr	
	pets - 2 dogs - 1 female 25° yr	
	Chest W	
	° clubbing.	

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments
Respiratory Medicine - 25112021 Results 563974
Respiratory Medicine - 17102021 Results 558742

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Respiratory Medicine GGC General Referral or Advice	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	——	**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Urgent
Date of referral 01-Dec-2021 **Date sent** 01-Dec-2021

PATIENT DETAILS

Surname	Mcfarlane
Forename(s)	Stewart
Title	Mr
Sex	Male
Date of birth	09-Jun-1971
CHI no.	0906716470
Area of Residence	-

Patient's address
32 Dalry Street
GLASGOW
G32 9BL
Contact number(s)
Voice: 07504247668

1010250040347 Unique Care Pathway Number: 1010250040347

REGISTERED GP DETAILS

Name	Dr Emma Douglas		
GMC code	6128501	GP code	01171
Practice name	Crail Medical Practice		
Practice code	46131		

Practice address
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW
Contact number(s)
Voice: 0141 554 3199
Facsimile: 0141 551 9950
E-mail: ggc.gp46131clinical@nhs.scot

REFERRING GP DETAILS

Name	Dr. Wendy Killin		
GMC code	7020263	GP code	01155
Practice name	Crail Medical Practice (46131)		

Practice address
245 Tollcross Road
Glasgow
G31 4UW
Contact number(s)

Practice code	46131	Voice: 0141 554 3199

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: complaining of feeling breathless on very short distances which was unlike him

Comment: Dear Doctor,

I wonder if you would be kind enough to review Stewart. He is a 50 year old gentleman who has had fatigue for many months. He has a background diagnosis of CKD stage 1 due to having a solitary left kidney.

I spoke to him at the beginning of October and he said that he had, had some weight loss. He had a smoking history from the age of 15 until 2 years ago. He was complaining of feeling breathless on very short distances which was unlike him. He had COVID in 2020 and also had a car accident in February 2021 and he put some of his symptoms down to these issues. A chest x-ray was normal and a CT Scan of his chest was carried and enclosed. He has also been referred for spirometry and we started him on a Salbutamol Inhaler for probable COPD.

The CT Scan has come back a possible interstitial lung disease and I would appreciate your assessment with regards to his on going symptoms.

Thank you and kind regards

Doctor Killin

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Chronic kidney disease stage 1	CKD stage 1/2	26-Feb-2021	26-Feb-2021
Renal agenesis, unspecified	solitary left kidney	18-Feb-2021	18-Feb-2021
Iritis - acute	-	05-Aug-2009	05-Aug-2009
Bite of nonvenomous snakes and lizards	Left upper limb	21-Nov-2008	21-Nov-2008
[X]Mild depression	-	21-Jan-2005	21-Jan-2005
Generalised anxiety disorder	with panic symptoms due to social/ financial problems+++	17-Dec-2004	17-Dec-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Co-Dydramol 10/500 Tablets	100	100 tablet	ONE OR TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)	-	16-Jul-2021	25-Nov-2021
Atorvastatin Tablets 20 mg	56	56 tablet	ONE TO BE TAKEN EACH DAY	-	15-Mar-2021	02-Jul-2021

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Macrogol Compound Oral Powder (sachets) NPF Sugar Free	30	30 sachet	ONE TWICE DAILY	-	03-Nov-2021	03-Nov-2021
Salbutamol Cfc-free inhaler 100 micrograms/puff	1	1 INHALER	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	03-Nov-2021	03-Nov-2021

Peptac Liquid (peppermint)	500	500 ML	10-20ML TO BE TAKEN AFTER MEALS AND AT BEDTIME	-	07-Oct-2021	07-Oct-2021
Ibuprofen Gel 5 %	50	50 GRAM (S)	APPLY TO THE AFFECTED AREA UP TO THREE TIMES A DAY	-	16-Jul-2021	16-Jul-2021
Co-Codamol 30/500 Tablets	50	50 TABLET	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)	-	14-Jun-2021	02-Jul-2021

Blood Pressure

Date Recorded	Systolic	Diastolic
08-Mar-2021	110	82
27-Nov-2015	126	88
01-Nov-2004	134	90

Body Measurements

Date Recorded	Height	Weight	BMI
08-Mar-2021	-	71.5	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex smoker:		08-Mar-2021
Cigarette smoker 6 Cigarettes/day :	pain left ear for 3 days has had URTI left ear nad, imp eust tibe dysfxn adv given	01-Feb-2016
Cigarette smoker :		06-Mar-2013
Current smoker:	Smoker$$ Status.clm - Repeat after an Interval	01-Nov-2004
Alcohol consumption, 0 units/week:		08-Mar-2021
Light drinker - 1-2u/day:	Alcohol Intake$$.clm - Repeat after an Interval	01-Nov-2004

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:Yes

Social circumstances

Ethnic Origin: (White) British

Respiratory Medicine - 25112021 Results 563974

Respiratory Medicine - 17102021 Results 558742

Signature of referring doctor (or other professional) **Date**

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Main Switchboard: 0141 211 4000
Department: Urology
Contact Tel: 0141 201 3617
Enquiries to: sharon.napier@ggc.scot.nhs.uk
Letter Date: 15/06/2021
Reference: SM/SN
Dictated Date: 05/06/2021
Transcribed Date: 07/06/2021

Dear Dr. El Douglas,

Stewart McFarlane; D.O.B: 09/06/1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Admission: Specialty - Urology; Ward - GRIWD69D GRI Ward 69 Urology Diagnostic Centre Consultant - Mr Simon Morton; Date of Admission - 05/06/2021
Date of Discharge - 05/06/2021; Discharged to - Private Residence - no additional detail added

Clinical Comments:

Summary

Non visible haematuria

Solitary left kidney

Thank you for referring Mr McFarlane who I reviewed at my flexible cystoscopy clinic this afternoon. This was regards to persistent non visible haematuria. I note he was in a RTA earlier this year and a CT scan upon admission identified he has been born with a congenital absent right kidney and the left kidney was satisfactory. There were no ureteric abnormalities.

I carried out a flexible cystoscopy with informed verbal consent and he was aware of the main risks of pain, infection or bleeding. This identified a normal urethra, non occlusive prostate and no intravesical abnormalities. The urothelium was healthy. I have discharged Mr McFarlane.

Yours sincerely

Mr Simon Morton

Consultant Urological Surgeon

Electronically Signed: Mr Simon Morton, Consultant

cc.

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 03/06/2021

Consultant: Dr Donogh Maguire

El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
Glasgow
G31 4UW

Dear El Douglas

Re: **McFarlane Stewart** DOB: **09/06/1971** CHI: **0906716470**
32 DALRY STREET
Glasgow G32 9BL

Attended on: **03/06/2021 at 06:51 hrs.** Departed on: **03/06/2021 at 09:05 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
chest pain

Nursing Assessment:
CENTRAL CHEST PAIN radiating into back. Sudden onset 0500 this am. No cardiac history. Hx CKD. Deneis covid.

Investigations in ED:

1. Coagulation screen	**2. Urea and Electrolytes**	**3. Glucose**
4. LFT	**5. CRP**	**6. Chol / Triglyceride**
7. Full Blood Count	**8. Troponin I hs**	**9. XR Chest**

Diagnosis:

Diagnosis	Side	Site
Other Chest Pain		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Stewart attended ED with chest pain. He did not have any acute ECG changes. His Trop-I was <4 and PERC rule 0. He was systemically well. Stewart went home with strict worsening advice.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Thomas Fenwick2
Doctor

Copies to:

1. El Douglas (GP)

School Address:

CHI: 0906716470

Glasgow Royal Infirmary

Total Att: 6

12 Mth Att: 1

Title: **MR**

MCFARLANE **Stewart**

DOB **09/06/1971** Age: **49y** Sex: **Male**

32 DALRY STREET

Glasgow
Lanarkshire
G32 9BL
07504247668

Next of kin: **MCFARLANE, Debbie**
Relationship: **Wife**
07880855579

GP: **El Douglas**
0141 554 3199

Attendance Date: **03/06/2021** Arrival Time: **06:51**

Registration Time: **06:51** Date of Incident: **03/06/2021**

Major Incident Desc:

Reason for Attendance: **chest pain**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **0** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **03/06/2021 06:55** Nurse name: **Nurse Paige Cairns**

Temp	**36.2**	C
HR	**70**	bpm
BP	**138/104**	mmHg
MAP	**115.33**	mmHg
RR	**17**	bpm
SpO2	**100**	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils Right		Pupils Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **"CENTRAL CHEST PAIN radiating into back. Sudden onset 0500 this am. No cardiac history. Hx CKD. Deneis covid. "**

0906716470 09/06/1971 MCFARLANE Stewart
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0906716470 09/06/1971 MCFARLANE Stewart

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	**Clinical Notes**	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

0906716470
MCFARLANE Stewart M
32 DALRY STREET 09/06/1971
Glasgow, Lanarkshire
G32 9BL

Initial Investigations Ordered

FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

Date 3/6/21 Time 0730 Name MacRae Grade CDF Specialty GM

PC// chest pain

HPC// woke up @ 5am with sudden onset heavy chest pain 10/10
↳ non-radiating
↳ now 2/10
↳ felt SOB with pain
↳ NO sweatiness / clamminess / lightheadedness
Has had 2 other episodes of severe chest tightness / heaviness in the last 4 days, first one came in the afternoon after having an electric shock from an exposed wire 4/7 previously
- other episode in the evening 2/7 ago
- in between time has had a constant 2/10 tightness in chest

PMH// Solitary kidney
CKD 3/2
Anxiety

FHx// Mum - MI.

For the last few months has been ~~experiencing~~ experiencing some sharp R side chest pain on deep inspiration and over the last 6/12 has been experiencing ↑ breathlessness gets breathless walking 20 minutes to school with his son and sometimes has to stop to rest.
Did a 2hr walk 3 weeks ago and took 2-3 days to recover
No cough / fever / abdominal pain

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number

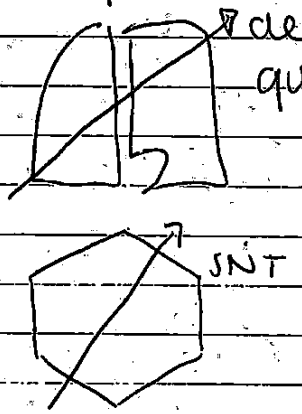
or affix label

Clinical Notes

Involved in RTC February 2021 and had (L) side neck pain and back pain since - on co-codamol.

O/E// HR 70
BP 138/104
RR 17
SpO2 100%
temp 36.2°C

HS pure



Causes - SNT
- nil peripheral oedema

Imp// ?MSK ?ACS ?PE ?cause.

Plan// 1) Bloods
2) CXR
3) ECG
4) If Bloods reassuring and CXR normal then (H)

J. FENWICK (PY2)

NEWS = 0.

PERC = 0

Trop-I < 4. Other bloods acceptable.

Have d/w ED Cons (Dr Taylor), agrees could go (D).

Strict worsening advice given.

Glasgow Royal Infirmary
Emergency Department

0906716470
MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

Clinical Notes

Date	Time	Name	Grade	Speciality

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number

or affix label

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC			Na			Bil			FiO_2		
Hb			K			ALT			H^+		
Plat			Cl			AST			$PaCO_2$		
Neut			Ur			GGT			PaO_2		
DD			Creat			A phos			Bic		
PT			eGFR			Alb			BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP			Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

mi • 287967 Version 1_0 • GGC0226

(16) StEWART MCFARLANE

NEWS 2 Key	1	2	3

0906716470
MCFARLANE
Stewart M
32 DALRY STREET 09/06/1971
Glasgow, Lanarkshire
G32 9BL

Date	1/11	[illegible]			
Time	11.00	06:08	55:47		

A + B Respirations Breaths/min

				Range	Score
				≥25	3
				21-24	2
	•	•	12	12-20	0
				9-11	1
				≤8	3

A + B SpO2 Scale 1 Oxygen saturation (%)

				Range	Score
	97	100	99	≥96	0
				94-95	1
				92-93	2
				≤91	3

SpO2 Scale 2
Oxygen saturation (%)
Use Scale 2 if target range is 88-92% e.g. in chronic hypertcapnic respiratory failure
Only use scale 2 under direction of qualified clinician

Range	Score
≥97 on O2	3
95-96% on O2	2
93-94% on O2	1
≥93 on air	0
88-92	0
86-87	1
84-85	2
≤83	3

Air or oxygen?

				Range	Score
	A	A	✓	Air (A) or O2 device*	0
				O2 L/min 2	2

C Blood Pressure mmHg (Score uses systolic BP only)

				Range	Score
				≥220	3
				201-219	0
				181-200	0
				161-180	0
				141-160	0
	↑	^		121-140	0
				111-120	0
		v	105	101-110	1
				91-100	2
				81-90	3
	↓		71	71-80	3
				61-70	3
				51-60	3
				≤50	3

C Pulse Beats/min

				Range	Score
				≥131	3
				121-130	2
				111-120	2
				101-110	1
				91-100	1
				81-90	0
	•			71-80	0
		•		61-70	0
			54	51-60	0
				41-50	1
				31-40	3
				≤30	3

D
Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.

				Range	Score
	•	•	✓	A Alert	0
				C New Confusion	3
				V Verbal	3
				P Pressure	3
				U Unresponsive	3

E Temperature

				Range	Score
				≥39	2
				38.1-39.0	1
				37.1-38.0	0
	•	•	36.2	36.1-37.0	0
				35.1-36.0	1
				≤35.0	3

NEWS Total	0	0	1
Blood glucose	7.0		
Pain / function score	0/4		0
Time Pt last passed urine	10.20		
Fluid balance chart indicated Y/N	N		
GCS indicated Y/N	N		N
Time NEWS due	23.00		
Escalation of care Y/N	N		N
Initials	AB	TR	[illegible]

Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RM	Reservoir Mask (Emergency use only)

0906716470
MCFARLANE
Stewart M
32 DALRY STREET 09/06/1971
Glasgow, Lanarkshire
G32 9BL

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE

A Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.

C Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.

E Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

HSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

0906718470
MCFARLANE
Stewart
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL
M
09/06/1971

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY:	
Date:	Date:	

Document all actions and Interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed.....

Medical: .....

Date: .....

Glasgow Coma Scale

Date:
Time: 11/1 11.00

Eyes Y E S: Spontaneously 4 · To sound 3 · To pressure 2 · None 1 · Not testable NT

Endotracheal tube or tracheostomy = NT

Verbal V E R B A L: Oriented 5 · Confused 4 · Words 3 · Sounds 2 · None 1 · Not testable NT

Always record the best response

Motor M O T O R: Obeys command 6 · Localising pressure 5 · Normal flexion 4 · Abnormal flexion 3 · Extension 2 · None 1 · Not testable NT

TOTAL: 15

Right size: P U P I L S 4
Right reaction: +
Left size: 4
Left reaction: +

Record right (R) and left (L) separately if there is a difference between the two sides

Arms A R M S: Normal power · Mild weakness · Severe weakness · Some flexion · Extension · No response

Record right (R) and left (L) separately if there is a difference between the two sides

Legs L E G S: Normal power · Mild weakness · Severe weakness · Some flexion · Extension · No response

Pupil Reaction and size: S = sluggish, + = reaction, - = no reaction, C = eyes closed

Pupil Size (mm): 1 2 3 4 5 6 7 8

Pain Function Score

A	No limitations, activity unrestricted by pain or settles quickly
B	Mild limitations, mild activity restrictions
C	Moderate limitations, attempts but reluctant to continue because of pain. **Seek Advice**
D	Severe limitations, unable to or refuse to perform because of pain. **Urgent Review Required**

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

No Pain	Mild Pain			Moderate Pain		Severe Pain			
0	1	2	3	4	5	6	7	8	9	10

Affix Patient ID

mi • 316654 v5.1 • GGC0264

16

Emergency Department Nursing Documentation

Presenting Complaint - CCP

Date: 03/06/21 Time: 0655

0906716470
MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print) WENDY LESLEY

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - 0 (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☑	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☐ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☑ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/(N)
		Adult Support and Protection	Y/(N)

Urinalysis

Leucocytes	☐	Nitrites	☐	Protein	☐	Blood	☐
Ketones	☐	Glucose	☐	PH		S.G.	
MSSU / CSU	☐	Toxiclogy	☐				
HCG	☐	+VE	☐	-VE	☐	Strip No -	

Screening Tools
(Please tick/circle when completed)

SEPSIS RISK? / SIRS Criteria 2 or more	Y/(N)	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/(N)	If NOT WHY? - (details) NOT REQD	(NO)
GMAWS	Y/(N)	Date - 03/06/21 Time - 0704 Signature -	

4AT

AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score /12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	**F**unctional impairment (new or worsening) eg difficulty with self care		
R	**R**esident in a care home?		
A	**A**ltered mental state such as acute confusion or dementia use the 4AT		
I	**I**mmobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	**L**ikely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) **Pressure Damage** Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	**Date**	**Location of Redness/Ulcers**	**Grade of Ulcer**	
2) **Mobility**	Does the person require assistance?	Y/N				
3) **Continence**		Y/N	5) **Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?		Y/N
4) **Nutrition**		Y/N	6) **Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS		Y/N

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

0906716470
MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire el
G32 9BL

At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	NO

Pause for Transfer / Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge	☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward	☐	Always	
GGC RED BAG - with patient	☐	Always	
Name Band	☐	Always	
Nursing Screening Tools completed	☐	Always	
Bed requested, SBAR COMPLETE	☐	☐	
NEWS chart	☐	Always	
Prescriptions / Charts signed — Infusions	☐	☐	
Cannula	☐	☐	
Notes: medical notes, GP letter, PRF	☐	☐	
Patients requiring analgesia: sufficient	☐	☐	
Belongings (including patients medication)	☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.	☐	☐	
Print Name Sign -			

Nursing Notes

Date and Time		Print Name and Signature
03/06/21 0704	Patient presents with Central Chest pain radiating into back. Sudden onset 0700 this am. No cardiac history. Awaiting review/plan.	

Nursing Notes

0906716470
MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

Date and Time		

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Urology GGC General Referral		**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF		**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Urgent - Suspected Cancer
Date of referral 20-May-2021 **Date sent** 20-May-2021

PATIENT DETAILS

Surname	Mcfarlane
Forename(s)	Stewart
Title	Mr
Sex	Male
Date of birth	09-Jun-1971
CHI no.	0906716470
Area of Residence	-

Patient's address

32 Dalry Street
GLASGOW
G32 9BL

Contact number(s)

Voice: 07504247668

1010234005903

Unique Care Pathway Number: 1010234005903

REGISTERED GP DETAILS

Name	Dr Emma Douglas		
GMC code	6128501	GP code	01171
Practice name	Crail Medical Practice		
Practice code	46131		

Practice address

Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Contact number(s)

Voice: 0141 554 3199
Facsimile: 0141 551 9950
E-mail: GG-UHB.gp46131clinical@nhs.net

REFERRING GP DETAILS

Name	Dr. Wendy Killin		
GMC code	7020263	GP code	01155
Practice name	Crail Medical Practice (46131)		
Practice code	46131		

Practice address

245 Tollcross Road
Glasgow
G31 4UW

Contact number(s)

Voice: 0141 554 3199

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: non visible haematuria

Comment: Dear Doctor,

I wonder if you would be kind enough to assess Mr McFarlane. He is 49 year old gentleman with non visible haematuria that has persisted since March. In March he had a urine dip which was +blood, in April he had a trace/+blood and in May he has had +blood.

His investigations started in ooh when he attended on the 29th March with some feeling of fatigue and told by his friends that he wasn't looking right. This was on the background of having a car accident 6 weeks previous which he attended A&E for. He had a CT Scan at that time which showed he had a single kidney. He has been under renal review and they have discharged him although he is coded with CKD stage 1/2 due to his structural abnormality, however his eGFR is normal and his blood pressure is also normal. He has had continued back pain following the road traffic accident and is to see a Physiotherapist next week.

He is concerned about the on going non visible haematuria and wonders what the cause is given his new renal diagnosis. He would be most appreciative as would I if you could investigate this for him.

He is an ex smoker with no other urinary symptoms.

Thank you and kind regards

Doctor Killin

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Chronic kidney disease stage 1	CKD stage 1/2	26-Feb-2021	26-Feb-2021
Renal agenesis, unspecified	solitary left kidney	18-Feb-2021	18-Feb-2021
Iritis - acute	-	05-Aug-2009	05-Aug-2009
Bite of nonvenomous snakes and lizards	Left upper limb	21-Nov-2008	21-Nov-2008
[X]Mild depression	-	21-Jan-2005	21-Jan-2005
Generalised anxiety disorder	with panic symptoms due to social/ financial problems+++	17-Dec-2004	17-Dec-2004

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Atorvastatin Tablets 20 mg	56	56 tablet	ONE TO BE TAKEN EACH DAY	-	15-Mar-2021	16-Mar-2021

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Co-Codamol 30/500 Tablets	56	56 tablet	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)	-	11-Mar-2021	29-Apr-2021
Co-Codamol 30/500 Tablets	56	56 tablet	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 8 IN 24 HOURS)	-	23-Feb-2021	23-Feb-2021

Blood Pressure

Date Recorded	Systolic	Diastolic
08-Mar-2021	110	82
27-Nov-2015	126	88
01-Nov-2004	134	90

Body Measurements

Date Recorded	Height	Weight	BMI
08-Mar-2021	-	71.5	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex smoker:		08-Mar-2021
Cigarette smoker 6 Cigarettes/day :	pain left ear for 3 days has had URTI left ear nad, imp eust tibe dysfxn adv given	01-Feb-2016
Cigarette smoker :		06-Mar-2013
Current smoker:	Smoker$$ Status.clm - Repeat after an Interval	01-Nov-2004
Alcohol consumption, 0 units/week:		08-Mar-2021
Light drinker - 1-2u/day:	Alcohol Intake$$.clm - Repeat after an Interval	01-Nov-2004

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) British

Signature of referring doctor (or other professional) **Date**

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 18/02/2021

Consultant: Dr Colin Bell

EI Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
Glasgow
G31 4UW

Dear EI Douglas

Re: **McFarlane Stewart** DOB: **09/06/1971** CHI: **0906716470**
32 DALRY STREET
Glasgow G32 9BL

Attended on: **18/02/2021 at 17:50 hrs.** Departed on: **18/02/2021 at 21:45 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
RTC, chest pain - NO FT

Nursing Assessment:
RTC. News . Passenger in RTC 5/7 Ago. travelling approx. 60mph, van hit ice and flipped onto side. no airbag deployment. R sided neck and Chest pain since. CP radiating into back. Denies COVID19 symptoms. cat 2 due to MOI.

Investigations in ED:

1. Urea and Electrolytes	**2. Troponin I hs**	**3. CRP**
4. LFT	**5. Full Blood Count**	**6. XR Chest**
7. D - Dimer	**8. Coagulation screen**	**9. CT Aorta thoracic with contrast**
10. CT Aorta thoracic	**11. SARS-CoV-2 (ED/IP use) (COVID-19)**	**12. SARS-CoV-2 (ED/IP use) (COVID-19)**

Diagnosis:

Diagnosis	Side	Site
Chest Pain, Unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Attended with chest pain following RTC. Troponin and D-Dimer normal. ECG showed no ST elevation. CT aorta performed due to trauma history and showed normal aorta and no cause for pain. Incidental finding of solitary left kidney. Patient had normal U&E and no known FH of renal disease. We would ask if referral to renal could be made to ask if they would want any follow up or if any routine monitoring is required with regards to this. His pain settled and he was well in department so he was discharged with strict worsening statement.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Claire Marletta
Doctor

Copies to:

1. El Douglas (GP)

School Address:

CHI: 0906716470

Glasgow Royal Infirmary

(7)

Total Att: 5

12 Mth Att: 0

Title: MR

MCFARLANE **Stewart**

DOB **09/06/1971** Age: **49y** Sex: **Male**

32 DALRY STREET
Glasgow
Lanarkshire
G32 9BL
07504247668

Next of kin: **MCFARLANE, Debbie**
Relationship: **Wife**
07504247668

GP: **El Douglas**
0141 554 3199

Attendance Date: **18/02/2021** Arrival Time: **17:50**

Registration Time: **17:50** Date of Incident: **18/02/2021**

Major Incident Desc:

Reason for Attendance: **RTC, chest pain - NO FT**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **2** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **18/02/2021 18:00** Nurse name: **Nurse Catriona McQuade**

Temp	**36.4**	C
HR	**115**	bpm
BP	**163/111**	mmHg
MAP	**128.33**	mmHg
RR	**18**	bpm
SpO2	**99**	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	**4**
Motor	**6**
Verbal	**5**
Total	**15**

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **"RTC. News . Passenger in RTC 5/7 Ago. travelling approx. 60mph, van hit ice and flipped onto side. no airbag deployment. R sided neck and Chest pain since. CP radiating into back. Denies COVID19 symptoms. cat 2 due to MOI. "**

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	**Clinical Notes**	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By
18/2/21	Morphine	~~4mg~~ 10mg	IV	19:05		
18/2/21	Ondansetron	4mg	IV	19:05		

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

0906716470
MCFARLANE
Stewart M
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Initial Investigations Ordered										
FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

Date	Time	Name	Grade	Speciality
18/2/21	18:30	Dr C. McGetta	ST3	EM

PC Chest pain

HPC RTC Sunday
Passenger in van.
Travelling ~60mph
Slid on ice/snow.
Van flipped onto side landing on driver side
Slid unknown distance & landed on ditch.
Airbags not deployed
He was wearing seatbelt. Took it off to get out & fell onto driver side.
Needed help from passerbye to get out.
No medical attention sought at time
Felt tired for ~48°. Upset & anxious & not sleeping.
Right sided neck pain.

This am ~03:00am woke up from sleep with central chest pain radiating to back
Sudden onset but gradually ↑ severity.
7/10 at present. Never been 10/10.
No nausea. Not sweaty. Not SOB.
Pain is pleuritic & worse when lying sitting forward. No chest pain at time.

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number

or affix label

Clinical Notes [redacted]

Date | Time | Name | Grade | Specialty

of injury No history similar time

No recent immobility, long travel, dehydration

No PMH
Normally fit + well
No regular medication NKDA.
Non-smoker No alcohol excess
Lives wife & son. Works full time

O/E A-Patient
B- Equal air entry. Equal expansion.
No flail segment. RR 18 Spo2 99%
C- HS 1+1+0 BP 163/111 HR 115
Peripheral. CR<2
D- GCS 15/15
E- Calfs SNT. No swelling
Abdo SNT. T=36.4.
Tender sternal area. No rib tenderness
No external bruising chest. No seat belt sign.
No c-spine pain + normal ROM neck.

Impression
Unlikely bony injury.
Concern may be unrelated to trauma - cardiac or PE vs delayed presentation of traumatic injury

(P) ECG - No ST elevation to suggest acute infarct
CXR - no pneumothorax
Bloods incl trop & D-Dimer - normal.
CT aorta.

Glasgow Royal Infirmary
Emergency Department

Patient Name
0906716470
MCFARLANE M
Stewart 09/06/1971

Clinical Notes

Date	Time	Name	Grade	Speciality

Analgesia - resolved pain
BP both arms - 20 difference.

J. Hall
7/4/10/26

CT - No dissection/cause pain
Solitary left kidney noted as incidental finding

Patient feeling well. Pain resolved.
Worsening cause excluded:
Home
Strict worsening statement

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number

or affix label

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC			Na			Bil			FiO_2		
Hb			K			ALT			H^+		
Plat			Cl			AST			$PaCO_2$		
Neut			Ur			GGT			PaO_2		
DD			Creat			A phos			Bic		
PT			eGFR			Alb			BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP			Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

mi • 287967 Version 1_0 • GGC0226

Emergency Department Nursing Documentation

KA CP

Presenting Complaint -

Date: 18/2/21 Time: 1815

0906716470
MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print)

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☐	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☐
GGC RED BAG - with patient	☐		
12 Lead ECG	☐	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☐ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☐ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis

Leucocytes	☐	Nitrites	☐	Protein	☐	Blood	☐
Ketones	☐	Glucose	☐	PH		S.G.	
MSSU / CSU	☐	Toxiclogy	☐				
HCG	☐	+VE	☐	-VE	☐	Strip No -	

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details) N/a.	NO
GMAWS	Y/N	Date - 18/2/21 Time - 1815 Signature -	

4AT	
AMT	Correct
Age	
Date of Birth	
Place	
Current year	

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score

/12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	**F**unctional impairment (new or worsening) eg difficulty with self care		
R	**R**esident in a care home?		
A	**A**ltered mental state such as acute confusion or dementia use the 4AT		
I	**I**mmobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	**L**ikely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	**Date**	**Location of Redness/Ulcers**	**Grade of Ulcer**
2) Mobility	Does the person require assistance?	Y/N			
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?	Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS	Y/N

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

0906716470
MCFARLANE M
Stewart 09/06/1971
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G32 9BL

ph Label

At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	NO

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
	Cannula	☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes		
Date and Time		Print Name and Signature
18/2 1935	In Cubicle awaits r/v Under r/v - IV antiemetic + analgesia as prescribed. Has returned from XRAY. Awaiting results ———	

Nursing Notes

Date and Time		Print Name and Signature

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(7)

NEWS 2 Key	1	2	3

Stewart McFarlane

Date			1/11	1/12				
Time			11.00	17 58	19 10	19 35	19 48	
A + B Respirations Breaths/min	≥25	3						
	21-24	2						
	12-20	0	•	•	•	•	•	
	9-11	1						
	≤8	3						
A + B SpO2 Scale 1 Oxygen saturation (%)	≥96	0	97	99	98	98	98	
	94-95	1						
	92-93	2						
	≤91	3						
SpO2 Scale 2. Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure	≥97 on O2	3						
	95-96% on O2	2						
	93-94% on O2	1						
	≥93 on air	0						
	88-92	0						
Only use scale 2 under direction of qualified clinician	86-87	1						
	84-85	2						
	≤83	3						
Air or oxygen?	Air (A) or O2 device*	0	A	A	A	A	A	
	O2 L/min 2	2						POST MORPHINE
C Blood Pressure mmHg (Score uses systolic BP only)	≥220	3						
	201-219	0			R	L		
	181-200	0		15[illegible]				
	161-180	0		^				
	141-160	0			^			
	121-140	0	↑			^	^	
	111-120	0		v 11[illegible]				
	101-110	1			v			
	91-100	2						
	81-90	3						
	71-80	3	↓			v	v	
	61-70	3						
	51-60	3						
	≤50	3						
C Pulse Beats/min	≥131	3						
	121-130	2						
	111-120	2		•				
	101-110	1						
	91-100	1			•	•	•	
	81-90	0						
	71-80	0	•					
	61-70	0						
	51-60	0						
	41-50	1						
	31-40	3						
	≤30	3						
D Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.	A Alert	0	•	•	•	•	•	
	C New Confusion	3						
	V Verbal	3						
	P Pressure	3						
	U Unresponsive	3						
E Temperature	≥39	2						
	38.1-39.0	1						
	37.1-38.0	0						
	36.1-37.0	0	•	•	•	•	•	
	35.1-36.0	1						
	≤35.0	3						
NEWS Total			0	1	1	1	1	
Blood glucose			7.0			NM	NM	
Pain / function score			0A			10	10	
Time Pt last passed urine			10.20			?	?	
Fluid balance chart indicated Y/N			N			N	N	
GCS indicated Y/N			N			N	N	
Time NEWS due			23.00					
Escalation of care Y/N			N		[illegible]	N	N	
Initials			AB		JB	[illegible]	[illegible]	

Affix Patient ID

Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RM	Reservoir Mask (Emergency use only)

0906716470
MCFARLANE
Stewart
32 DALRY STREET
Glasgow, Lanarkshire
09/06/1971 M
G32 9BL

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE

A Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.

C Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.

E Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

0906716470
MCFARLANE
Stewart M
32 DALRY STREET 09/06/1971
Glasgow, Lanarkshire
G32 9BL

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y ☐ N ☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY:	
Date:	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed...

Medical:..

Date:...

Glasgow Coma Scale

Pupil Reaction and size: s = sluggish, + = reaction, - = no reaction, c = eyes closed

Pupil Size (mm): 1 2 3 4 5 6 7 8

Date:
Time:

EYES (Eyes closed by swelling = NT): 4 Spontaneously, 3 To sound, 2 To pressure, 1 None, NT Non testable

VERBAL (Endotracheal tube or tracheostomy = NT): 5 Orientated, 4 Confused, 3 Words, 2 Sounds, 1 None, NT Non testable

MOTOR (Always record the best response): 6 Obeys command, 5 Localising pressure, 4 Normal flexion, 3 Abnormal flexion, 2 Extension, 1 None, NT Non testable

TOTAL

PUPILS: Right size, Right reaction, Left size, Left reaction

ARMS (Record right (R) and left (L) separately if there is a difference between the two sides): Normal power, Mild weakness, Severe weakness, Spastic flexion, Extension, No response

LEGS (Record right (R) and left (L) separately if there is a difference between the two sides): Normal power, Mild weakness, Severe weakness, Spastic flexion, Extension, No response

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

No Pain	Mild Pain			Moderate Pain			Severe Pain			
0	1	2	3	4	5	6	7	8	9	10

Pain Function Score

A	No limitations, activity unrestricted by pain or settles quickly
B	Mild limitations, mild activity restrictions
C	Moderate limitations, attempts but reluctant to continue because of pain. Seek Advice
D	Severe limitations, unable to or refuse to perform because of pain. Urgent Review Required

MI • 316654 v5.1 • GGC0264

0906716470
MCFARLANE
Stewart M
32 DALRY STREET 09/06/1971
Glasgow, Lanarkshire
G32 9BL

Previous Patient Notes for Rheumatology (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		**Outpatient Note**
Date/Time: 08-Feb-2023 11:16	**Created By:** Staff Nurse - Jayne Pitcairn	**Role:** Nurse - GGC
Specialty: Rheumatology	**Organisation:**	Sensitive
Note:		
Stewart attended clinic for MTX S/C pen training. Good technique and happy to self administer own MTX as per prescription. Self administered with no issues, no complaints offered. Sharps bin given to take away.		

Patient Note		**Outpatient Note**
Date/Time: 01-Feb-2023 09:09	**Created By:** Staff Nurse - Jayne Pitcairn	**Role:** Nurse - GGC
Specialty: Rheumatology	**Organisation:**	Sensitive
Note:		
Stewart cancelled clinic appointment today as has no child care. Reappointed for 08/02/23.		

AHP Rheumatology / Musculoskeletal Ultrasound

Hospital- Glasgow Royal Infirmary

NHS Greater Glasgow and Clyde

0906716470
MCFARLANE Stewart M
09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

DATE OF EXAMINATION 12/9/2022

REGION OF EXAMINATION: (1) ankle + foot
(2) Talonavicular jt -
(3) Subtalar jt -
(4) mid foot -
(5) fore foot -

The above named patient consented to MSK Ultrasound scan.
Risks and benefits of scan were discussed with patient prior to gaining consent

Presenting Condition: New Inflamm Arthropathy involving hindfoot + foot.

CONSULTANT:

Musculoskeletal examination: (1) Talocrural joints - no joint effusion. good joint space - no doppler enhancement -
(2) Talonavicular (R) - small osteophyte changes. Good joint space - no doppler.

DESCRIPTION:
(3) STJ - no inflammation.
(4) mid foot - no inflammation (5) fore foot MTPJs no inflammation -

CONCLUSION: Regular Podiatry specialist Rheumatology input - Refer to John Taylor Spec Podiatrist @ QEUH. for specialist Podiatry Rheumatology -

CONSULTANT AHP SONOGRAPHER: Dr Mhairi Brandon

Mhairi Brandon (Rheumatology Consultant/MSK Sonographer)

Centre for Rheumatic Diseases
Rheumatology Day Ward
Centre Block
Glasgow Royal Infirmary
84 Castle Street
G4 0SF
Reception Tel: 0141 451 5385
Advice Line: 0141 451 5384

NHS
Greater Glasgow and Clyde

AHP RAPID REPORT

Patient Label:

0906716470
MCFARLANE
Stewart M
32 DALRY STREET 09/06/1971
Glasgow, Lanarkshire
G32 9BL

General Practitioner Label:

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Date: 12/12/2022

Consultant: Dr Sanders.

New Patient: ☑

Return Patient: ☐

Condition / Problems:
New ? Arthropathy — Bilateral foot pain
mid foot ? lateral border of foot (metat)

Day Patient Treatment: MSUS scan. feet.

Current Medication: Escalating methotrexate currently 4/52.

Summary: MSUS Scan.
Speak. Rheum - Podiatry Referral to
John Taylor Bd Spe. Podiatrist BELM.

Follow Up: Clinic 16/9/2023

Signature: ..... **Designation:** Consultant

PRINT NAME: Ulrike Bremner. MSK Sonographer

MCFARLANE, STEWART ID: 0906716470 3-Jun-2021 0:12:57 GLASGOW ROYAL INFIRMARY ED

9-Jun-1971
Male

Vent. rate 59
PR interval 152
QRS duration 108 ms
QT/QTc 432/427 ms
P-R-T axes 41 5 55

Sinus bradycardia
Septal infarct, age undetermined
Abnormal ECG

Loc: 20f

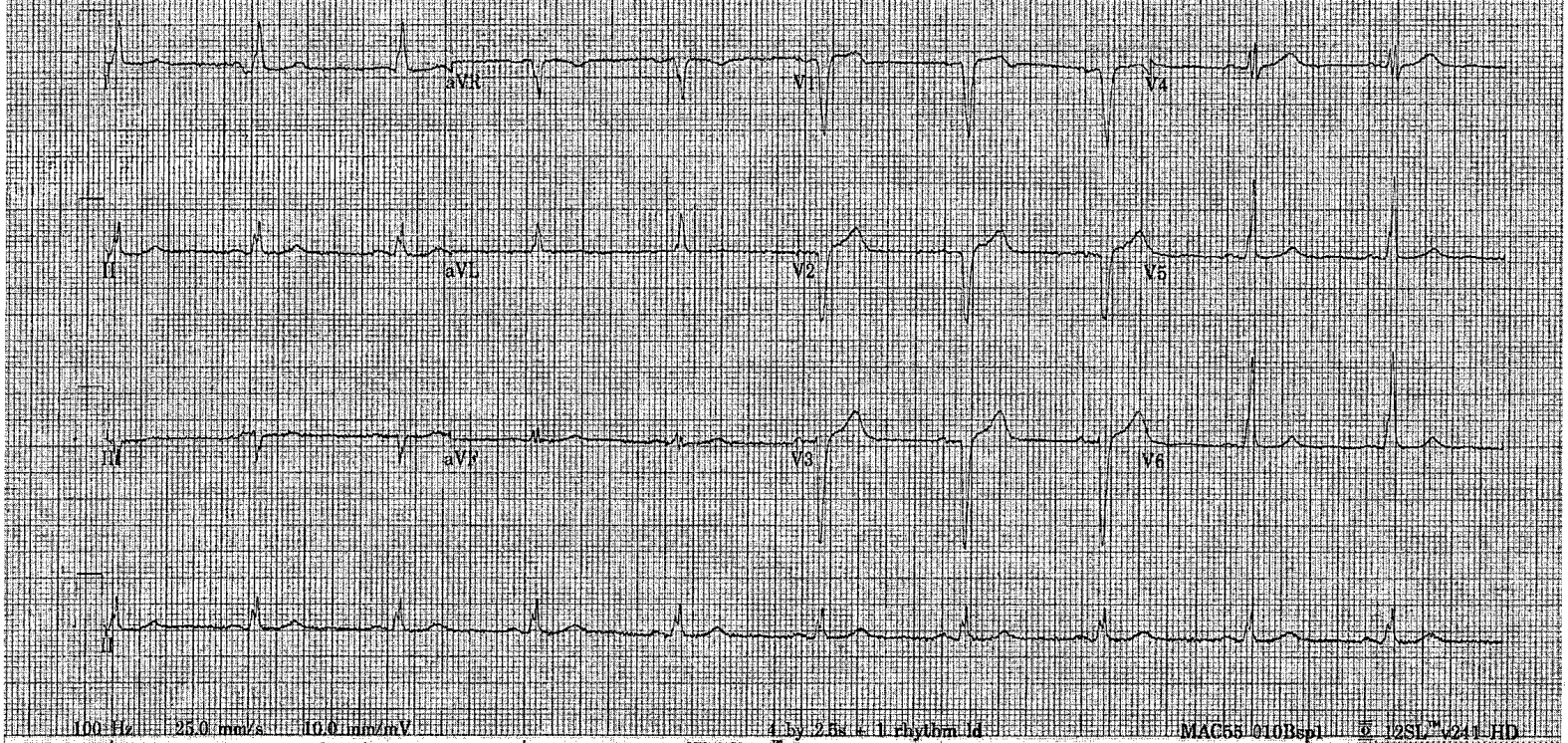
Technician:

Referred by:

Unconfirmed

COMMENTS:

0906716470 M
MCFARLANE 09/06/1971
Stewart
32 DALRY STREET
Glasgow, Lanarkshire G32 9BL



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm Id MAC55 010Bsp1 S 12SL™ v241 HD

MCFARLANE, STEWART ID: 090671647 18-Feb-2021 19:06:42 GLASGOW ROYAL INFIRMARY ED

9 Jun 1971
Male

Loc: 201

Technician:

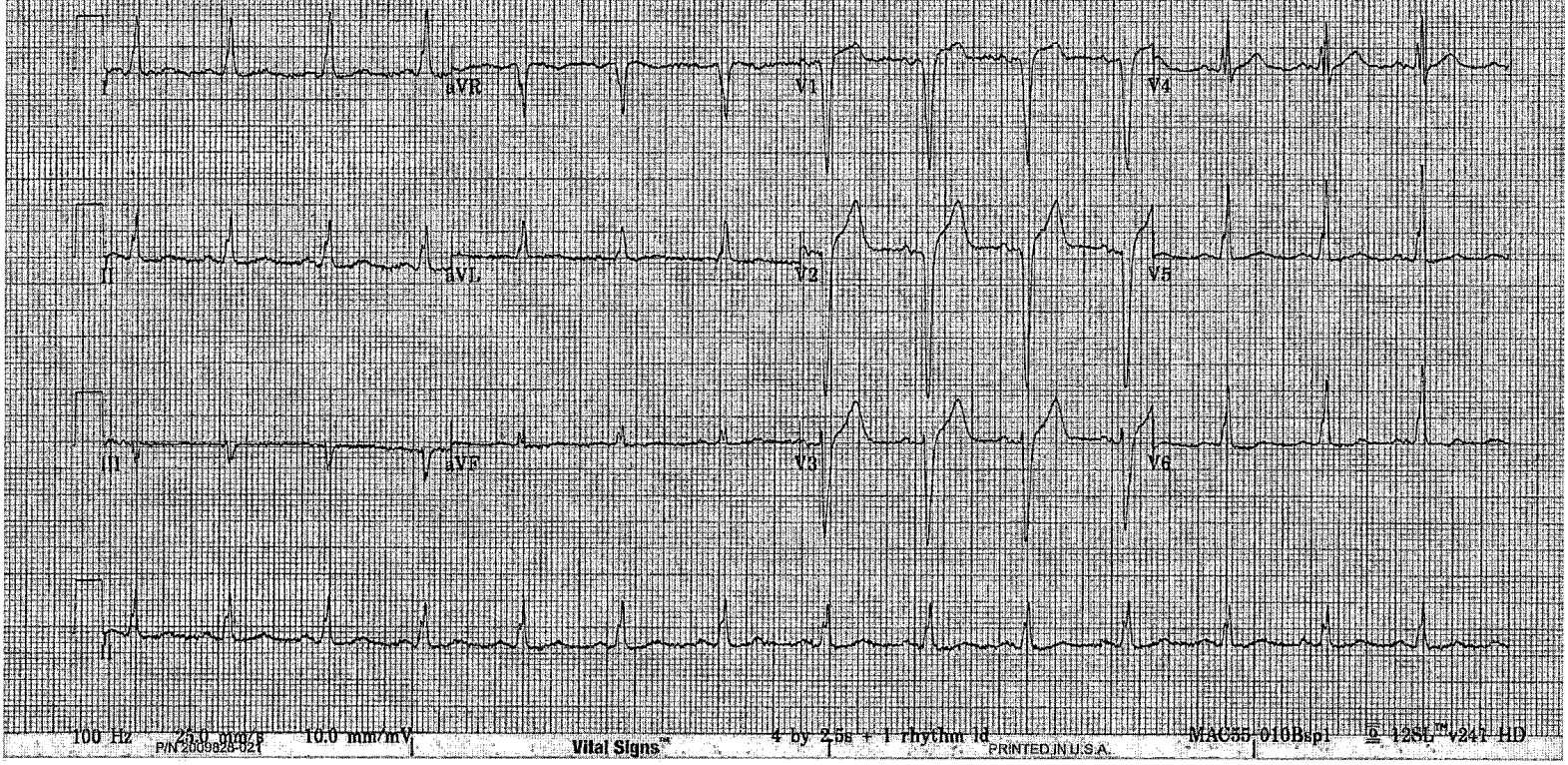
Vent. rate	85	
PR interval	148	ms
QRS duration	112	ms
QT/QTc	376/447	ms
P-R-T axes	44 12 32	

Normal sinus rhythm
Minimal voltage criteria for LVH, may be normal variant
Septal infarct, age undetermined
Abnormal ECG

0906716470
MCFARLANE M
Stewart 09/06/1971

Referred by: Unconfirmed

COMMENTS:



100 Hz 25.0 mm/s 10.0 mm/mV Vital Signs™ 4 by 2.5s + 1 rhythm id MAC55 010Bsp1 12SL™ v241 HD

P/N 2009828-021 PRINTED IN U.S.A.

Department of Respiratory Medicine
Glasgow Royal Infirmary
Pulmonary Function Report

NHS
Greater Glasgow and Clyde

CHI:	0906716470				
Last Name:	McFarlane	Height:	164 cm	Physician:	Dr Chalmers
First Name:	Stewart	Weight:	68.6 kg	Ward:	GRI Lab 1
Date of Birth:	09/06/1971	BMI:	26 kg/m²	Smoking status:	Ex-Smoker
Age:	51 Years	Race:	Caucasian	Smoking pk-yrs:	10
Gender:	male	Pred. Module:	GLI_ECCS	Physiologist:	Lennon R
Visit date:	17/11/2022	Referral reason:	ILD		

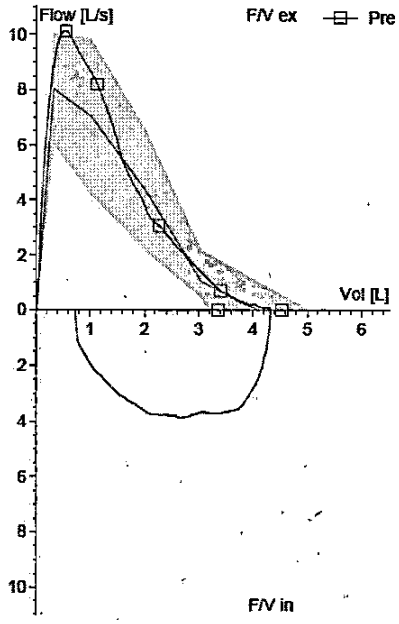
SR Range Normal +/- 1.64 to 1.64 Mild +/- 1.65 to 2.50 Moderate +/- 2.51 to 3.50 Severe +/- >3.50

Spirometry

		Pred	Best Pre	% Pred	SR	SR Graph Pre	Best Post	% Pred	SR	% Chg
FVC	L	4.07	4.52	111	0.83					
FEV 1	L	3.25	3.36	103	0.25					
FEV 1 % FVC	%	80	74	93	-0.87					
FEV 1 % VC MAX	%	80	74	93	-0.87					
PEF	L/s	8.03	10.10	126	1.71					
FMEF 75/25	L/s	3.06	2.33	76	-0.78					

Bodyplethysmography

		Pred	Best	% Pred	SR	SR Graph Pre
FRCpleth	L	2.79	2.71	97 %	-0.13	
TLC	L	5.99	6.06	101 %	0.11	
VC	L	4.44	4.58	103 %	0.26	
IC	L	3.20	3.35	105 %	0.29	
ERV	L	1.09	1.23	113 %	0.29	
RV	L	1.59	1.48	93 %	-0.27	
RV % TLC	%	26	24	93 %	-0.32	
FRCpl% TLC	%	55	45	82 %	-1.46	



Transfer Factor

		Pred	Meas	% Pred	SR	SR Graph Pre
Hb	g(Hb)/dL		12.00			
DLCO_SB	mmol/(min*kPa)	8.28	7.02	85	-1.02	
DLCOcSB	mmol/(min*kPa)	8.28	7.64	92	-0.50	
VA_SB	L	5.44	5.84	107	0.61	
KCO_SB	mmol/(min*kPa*L)	1.53	1.20	78	-1.55	
KCOc_SB	mmol/(min*kPa*L)	1.53	1.31	85	-1.03	

		Meas
SpO2	%	98

Comments

Results are accurate and reproducible. Nil inahlers.

Dynamic lung volumes are normal, no airflow obstruction.
Static lung volumes are normal.
Transfer factor is within normal limits. VA normal, KCO when corrected for [Hb] is normal.

Corrected for [Hb] 12.0 g/dL from 03/11/2022.

Reported: R Lennon
Verified: L Speake

CT Thorax abdomen pelvis with contrast

Performed	09-Dec-2022 15:48	Received	18-Dec-2022 11:13
Reported	18-Dec-2022 11:11	Order Number	G107H39019345
Status	Final	Source System	MiSys

CT Thorax abdomen pelvis with contrast Final
Stewart McFarlane
Clinical History :
RA. Weight loss 1.5 stone over last few months without trying. Nausea, loss of appetite. Anaemia since June. Ferritin difficult to interpret in context of inflammatory joint disease. ? Malignancy?
PLease do Urgently, suspicion of cancer. Ex smoker 5 years. Some SOB Thanks

Date of Examination: 9 December 2022
Name of Procedure and Technique: CT chest, abdomen and pelvis with contrast
Findings:
There is no size significant supraclavicular, axillary or mediastinal adenopathy. Pleural spaces are clear. Within limits of the study there is no major central PE. Thyroid gland and oesophagus are unremarkable.
Trachea and main-stem bronchi are within normal limits. Hypostatic density is seen posteriorly. Lungs are clear of any concerning nodule or consolidation.
No concerning parenchymal lesion liver. There is no dilatation of biliary radicles. Gallbladder is distended with clear bile. Solitary left kidney noted. Rest of the visualised solid upper abdominal organs are unremarkable.
Stomach is partially distended. There is no size significant upper abdominal, retroperitoneal or pelvic adenopathy.
Urinary bladder is distended. Unprepared bowel shows faecal residue. No obstructing lesion is seen in unprepared colon. There is no pericolic adenopathy or free fluid.
No destructive bony lesion is seen.
Conclusion: No radiological evidence of malignancy noted.
Report Date : 18/12/2022
Reporting Consultant: Dr Nirmali Dutta. Consultant Radiologist,
GMC: 7121593 Medica Reporting Ltd

Reported by: Dr Nirmali Dutta
Verified by: Dr Nirmali Dutta

XR Foot Rt

Performed	06-Jul-2022 18:08	Received	11-Jul-2022 06:44
Reported	11-Jul-2022 06:42	Order Number	G107H38612302
Status	Final	Source System	MiSys

XR Foot Lt Final
Stewart McFarlane
Clinical History :

RA ?erosive change

XR Foot Lt :
There is no significant erosive change.

XR Foot Rt :
There is no significant erosive change.

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly

CT Chest high resolution

Performed	08-Jun-2022 16:22	Received	16-Jun-2022 17:13
Reported	16-Jun-2022 17:11	Order Number	G107H38026330
Status	Final	Source System	MiSys

CT Chest high resolution Final
Stewart McFarlane
Clinical History :

Prone scans please and insp/expiratory images. Minor fibrotic change but more limiting SoB - has a parrot - exclude HP. Basal reticular change ?? dependent

CT Chest high resolution :

Volume acquisition in prone position.
There are no stigmata of H-P.
No active parenchymal lung disease or any significant ILD demonstrated. No suspicious nodules seen.
No evidence of thoracic lymphadenopathy.

Solitary left kidney noted.

Reported by: Dr Michal Gronski
Verified by: Dr Michal Gronski

XR Hand Rt

Performed	20-May-2022 10:17	Received	22-May-2022 08:44
Reported	22-May-2022 08:42	Order Number	G107H38330976
Status	Final	Source System	MiSys

XR Hand Lt Final
Stewart McFarlane
Clinical History :

under Ix for fibrotic lung disease. now c/o bilateral pain in hands mostly affecting PIPJs. early morning stiffness. ?any erosive changes. Note RhF mildly positive in Jan with positive ANA titre. update inflammatory bloods. heartburn - ?h pylori

under Ix for fibrotic lung disease. now c/o bilateral pain in hands mostly affecting PIPJs. early morning stiffness. ?any erosive changes. Note RhF mildly positive in Jan with positive ANA titre. update inflammatory bloods. heartburn - ?h pylori

XR Hand Lt :
See hand both report

XR Hand Rt :
See hand both report

XR Hand Both :
There are early/minor degenerative changes affecting the majority of the D I.P. joints plus both thumbs CMC joints.
There is no significant erosive change.

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly

XR Hand Lt

Performed	20-May-2022 10:17	Received	22-May-2022 08:44
Reported	22-May-2022 08:42	Order Number	G107H38330975
Status	Final	Source System	MiSys

XR Hand Lt Final
Stewart McFarlane
Clinical History :

under lx for fibrotic lung disease. now c/o bilateral pain in hands mostly affecting PIPJs. early morning stiffness. ?any erosive changes. Note RhF mildly positive in Jan with positive ANA titre. update inflammatory bloods. heartburn - ?h pylori

under lx for fibrotic lung disease. now c/o bilateral pain in hands mostly affecting PIPJs. early morning stiffness. ?any erosive changes. Note RhF mildly positive in Jan with positive ANA titre. update inflammatory bloods. heartburn - ?h pylori

XR Hand Lt :
See hand both report

XR Hand Rt :
See hand both report

XR Hand Both :
There are early/minor degenerative changes affecting the majority of the D I.P. joints plus both thumbs CMC joints.
There is no significant erosive change.

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly

XR Hand Both

Performed	20-May-2022 10:17	Received	22-May-2022 08:44
Reported	22-May-2022 08:42	Order Number	G107H38457253
Status	Final	Source System	MiSys

XR Hand Lt Final
Stewart McFarlane
Clinical History :

under Ix for fibrotic lung disease. now c/o bilateral pain in hands mostly affecting PIPJs. early morning stiffness. ?any erosive changes. Note RhF mildly positive in Jan with positive ANA titre. update inflammatory bloods. heartburn - ?h pylori

under Ix for fibrotic lung disease. now c/o bilateral pain in hands mostly affecting PIPJs. early morning stiffness. ?any erosive changes. Note RhF mildly positive in Jan with positive ANA titre. update inflammatory bloods. heartburn - ?h pylori

XR Hand Lt :
See hand both report

XR Hand Rt :
See hand both report

XR Hand Both :
There are early/minor degenerative changes affecting the majority of the D I.P. joints plus both thumbs CMC joints.
There is no significant erosive change.

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly

CT Thorax

Performed	25-Nov-2021 08:37	Received	25-Nov-2021 14:43
Reported	25-Nov-2021 14:41	Order Number	G107H37813236
Status	Final	Source System	MiSys

CT Thorax Final
Stewart McFarlane
Clinical History :

Has the patient had a recent chest X-ray? : Yes
Unexplained and persistent (more than six weeks) CTRL click to select all that apply : Dyspnoea,Loss of appetite,Weight loss
Persistent Haemoptysis in smokers/ex-smokers over 40 years of age? : No
New or not previously documented finger clubbing? : No
Persistent or recurring chest infection? : No
Is the patient a Smoker/Ex Smoker? : Yes
** pt has solitary kidney but normal GFR ** utd UE to be done on mon 8th. fatigue, SOB partic on exertion, new weight loss, loss of appetite. prev worked 7 days week as builder, now has to lie down after school drop off. stopped smoking 2y ago, prev smoked since age 15. ? underlying lung ca

CT Thorax :
A noncontrast scan of thorax performed. Comparison is made to previous study of 18/02/2021.

There is no evidence of parenchymal mass lesion. There is minor paraseptal emphysema at the apices and an ill defined subpleural reticular abnormality at both bases. While this may well be dependent in nature there is also some prominence of the airways in this region and the possibility of an early interstitial lung disease should be considered given the patient's presentation.
No size significant mediastinal, hilar or supraclavicular lymphadenopathy, allowing for the noncontrast nature of the study. Satisfactory cardiac appearances.
Unremarkable appearance of the partly included solid abdominal organs including the upper pole of the solitary left kidney.
Slightly striated appearance of the T7 vertebral body is likely haemangioma.

Opinion: No parenchymal mass identified. Ill-defined subpleural reticular abnormality, interstitial lung disease requires exclusion given presentation. Respiratory opinion and prone CT advised.

Reported by: Dr Laura Thomson
Verified by: Dr Laura Thomson

XR Chest

Performed	17-Oct-2021 14:16	Received	18-Oct-2021 06:51
Reported	18-Oct-2021 06:49	Order Number	G107H37731385
Status	Final	Source System	MiSys

XR Chest Final
Stewart McFarlane
Clinical History :

URGENT PLS fatigue, post likely covid infection, some weight loss, ex-smoker ? underlying lung pathology

XR Chest :
The heart is not enlarged. The lungs are clear of active disease. No significant focal lung lesion identified

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly

XR Chest

Performed	03-Jun-2021 07:40	Received	04-Jun-2021 11:10
Reported	04-Jun-2021 11:08	Order Number	G107H37314626
Status	Final	Source System	MiSys

XR Chest Final
Stewart McFarlane
Clinical History :

woke up with sudden onset chest pain this morning with shortness of breath, has been having increasing SOB over the last 6 months ?PE ?malignancy ?failure

XR Chest :
The heart is not enlarged, mediastinal contours within normal limits. No focal active pulmonary pathology demonstrated.

Reported by: Dr Abdullah Al-Adhami
Verified by: Dr Abdullah Al-Adhami

CT Aorta thoracic with contrast

Performed	18-Feb-2021 20:15	Received	19-Feb-2021 08:44
Reported	19-Feb-2021 08:42	Order Number	G107H36981028
Status	Final	Source System	MiSys

CT Aorta thoracic with contrast Final
Stewart McFarlane
Clinical History :
Significant RTC 4 days ago- 60mph, van flipped and landed off road in ditch. Attends today with sudden onset severe chest pain radiating to back. Woke him up from sleep. Hypertensive on examination. No CXR changes. CT aorta to exclude delayed presentation of dissection/traumatic injury
differential systolic BP in upper limbs and ongoing pain. troponin negative, ECG normal.
) on 18-Feb-2021 at 19:45)

CT Aorta thoracic with contrast :
Comparison to chest radiograph acquired earlier the same day, and ultrasound dated 27/05/2019.

Motion artefact through the lung bases and upper abdomen secondary to breathing.

No evidence of acute aortic syndrome, specifically no dissection.
The ascending thoracic aorta measures 4 cm which is just within normal limits.

There is a tiny linear focus of hypoattenuation arising from the posterior aspect of the ascending thoracic aorta which correlates with the fleck of calcification on the unenhanced acquisition. This is not thought to represent an acute pathology, more likely artefact/small branching vessel (see key image). Fleck of calcification at the aortic isthmus.

No pneumothorax or pneumomediastinum. Allowing for breathing motion artefact in the lungs demonstrate dependent change with no convincing focal consolidation.
Mild emphysematous change. No thoracic lymphadenopathy.

Breathing artefact obscures bony detail of the ribs, however no convincing evidence of fracture or bony injury.

The abdominal aorta is normal calibre with patent branching vessels - I note solitary left renal artery arising from the aorta.
Incidentally the right kidney is absent with no abnormality in the right renal bed. Normal adrenal glands.
The left kidney is enlarged, measuring 12 cm in maximal length, with the appearance of crossed fused ectopia. No hydronephrosis. No abnormality of the solitary left ureter.

The liver, gallbladder, biliary tree, pancreas and spleen are normal.
No gross abnormality of the unprepared bowel.
Incidental high riding caecum in the subhepatic position within normal appendix.
No free fluid. Nonspecific subcentimetre mesenteric nodes in the upper abdomen.

Symmetrical sclerosis of both ilium adjacent to the sacroiliac joints are noted. No abnormality of the sacroiliac joints. This may represent degenerative change.

Conclusion:
Negative examination for acute aortic syndrome. Bony thorax is intact.
Incidental solitary left kidney as described.

Discussed with referring A&E doctor at time of reporting.

Consultant review:
Agree with above.

CT aorta thoracic :
See above.

Reported by: Dr Leanne Alexander (SpR) and Dr Abdullah Al-Adhami
Verified by: Dr Abdullah Al-Adhami

CT aorta thoracic

Performed	18-Feb-2021 20:15	Received	19-Feb-2021 08:44
Reported	19-Feb-2021 08:42	Order Number	G107H36981057
Status	Final	Source System	MiSys

CT Aorta thoracic with contrast Final
Stewart McFarlane
Clinical History :
Significant RTC 4 days ago- 60mph, van flipped and landed off road in ditch. Attends today with sudden onset severe chest pain radiating to back. Woke him up from sleep. Hypertensive on examination. No CXR changes. CT aorta to exclude delayed presentation of dissection/traumatic injury
differential systolic BP in upper limbs and ongoing pain. troponin negative, ECG normal.
) on 18-Feb-2021 at 19:45)

CT Aorta thoracic with contrast :
Comparison to chest radiograph acquired earlier the same day, and ultrasound dated 27/05/2019.

Motion artefact through the lung bases and upper abdomen secondary to breathing.

No evidence of acute aortic syndrome, specifically no dissection.
The ascending thoracic aorta measures 4 cm which is just within normal limits.

There is a tiny linear focus of hypoattenuation arising from the posterior aspect of the ascending thoracic aorta which correlates with the fleck of calcification on the unenhanced acquisition. This is not thought to represent an acute pathology, more likely artefact/small branching vessel (see key image). Fleck of calcification at the aortic isthmus.

No pneumothorax or pneumomediastinum. Allowing for breathing motion artefact in the lungs demonstrate dependent change with no convincing focal consolidation.
Mild emphysematous change. No thoracic lymphadenopathy.

Breathing artefact obscures bony detail of the ribs, however no convincing evidence of fracture or bony injury.

The abdominal aorta is normal calibre with patent branching vessels - I note solitary left renal artery arising from the aorta.
Incidentally the right kidney is absent with no abnormality in the right renal bed. Normal adrenal glands.
The left kidney is enlarged, measuring 12 cm in maximal length, with the appearance of crossed fused ectopia. No hydronephrosis. No abnormality of the solitary left ureter.

The liver, gallbladder, biliary tree, pancreas and spleen are normal.
No gross abnormality of the unprepared bowel.
Incidental high riding caecum in the subhepatic position within normal appendix.
No free fluid. Nonspecific subcentimetre mesenteric nodes in the upper abdomen.

Symmetrical sclerosis of both ilium adjacent to the sacroiliac joints are noted. No abnormality of the sacroiliac joints. This may represent degenerative change.

Conclusion:
Negative examination for acute aortic syndrome. Bony thorax is intact.
Incidental solitary left kidney as described.

Discussed with referring A&E doctor at time of reporting.

Consultant review:
Agree with above.

CT aorta thoracic :
See above.

Reported by: Dr Leanne Alexander (SpR) and Dr Abdullah Al-Adhami
Verified by: Dr Abdullah Al-Adhami

XR Chest

Performed	18-Feb-2021 18:35	Received	19-Feb-2021 13:44
Reported	19-Feb-2021 13:42	Order Number	G107H36980951
Status	Final	Source System	MiSys

XR Chest Final
Stewart McFarlane
Clinical History :

chest pain and SOB following trauma ? evidence pneumothorax

XR Chest :
The heart is not enlarged. The lungs are clear. No pneumothorax.

Reported by: Dr Gregory O'Neill
Verified by: Dr Gregory O'Neill

US Testes

Performed	27-May-2019 11:38	Received	27-May-2019 12:20
Reported	27-May-2019 12:18	Order Number	G107H34995724
Status	Final	Source System	MiSys

US Testes Final
Stewart McFarlane
Clinical History :

?left testicular lump. smooth cyst like. also tired poor appte

US Testes :
Both testes are normal in size, shape and echo texture. The right measures 4.6 cm and the left measures 4.6 cm.
There is a 9 mm cyst within the left epididymal head. Also noted is a small 2 mm cyst in the mid left testis anteriorly.
A small hydrocele and slightly dilated veins are seen on the left.
There is a 7 mm cyst in the right epididymal head. Right epididymal body and tail are not well visualised.

Examination reported by Tina Wilson, locum sonographer.

Reported by: Tina Wilson (locum Sonographer)
Verified by: Tina Wilson (locum Sonographer)

ELECTRONIC PATIENT RECORDS

ALL HOSPITAL RECORDS HELD NHSGGC	☐		
ACS	☐		
BEATSON HOSPITAL	☐		
CANNIESBURN HOSPITAL	☐		
DENTAL HOSPITAL	☐		
GARTNAVEL GENERAL HOSPITAL	☐		
GLASGOW ROYAL INFIRMARY	☐		
INVERCLYDE ROYAL HOSPITAL	☐	MATERNITY	☐
NEW VICTORIA ACH	☐		
PRINCESS ROYAL MATERNITY	☐		
QUEEN ELIZABETH UNIVERSITY HOSPITAL	☐	MATERNITY	☐
ROYAL ALEXANDRA HOSPITAL	☐	MATERNITY	☐
ROYAL HOSPITAL FOR CHILDREN	☐		
STOBHILL HOSPITAL	☒		
VALE OF LEVEN	☐	MATERNITY	☐
WEST CARE AMBULATORY HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

BADGERNET	☐
CAREVUE	☐
MEDICAL ILLUSTRATION	☐
METAVISION	☐
PHYSIOTHERAPY	☐
RADIOLOGY	☐
WEST MARC	☐

Letter to Patient:

NHS
Greater Glasgow and Clyde

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW
Main Switchboard: 0141 201 3000
Department: General Surgery
Contact Tel: 0141 355 1368
Enquiries to: Fiona.beck@ggc.scot.nhs.uk

Letter Date: 17/01/2023
Reference: FB/MO
Dictated Date: 09/01/2023
Transcribed Date: 16/01/2023

Stewart McFarlane
32 DALRY STREET
Glasgow
Lanarkshire
G32 9BL

Dear Mr McFarlane,

I now have the results of the biopsies obtained at your endoscopy on 14th November. These show normal small bowel mucosa. Rheumatology follow up is already in place.

Yours sincerely

Fiona Beck

Nurse Endoscopist

Electronically Signed: Nurse Fiona Beck, Consultant

cc. Dr E Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

NHS Greater Glasgow and Clyde

Endoscopy Care Plan

0906716470
MCFARLANE
Stewart
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL
F
M
09/06/1971

Date: 14/11/22 Consultant / Endoscopist: Dr Beck

Patient liked to be known as: .....

Procedure

Gastroscopy	☑	E.R.C.P	☐	EBUS	☐
Colonoscopy	☐	E.U.S	☐	Enteroscopy	☐
Sigmoidoscopy	☐	Bronchoscopy	☐	Thoracoscopy	☐

Discharge Arrangements

Name of Escort /contact DEBORAH	**Escort Required** Yes ☐ No ☐	**Overnight supervision arranged** Yes ☐ No ☐
Relationship Wife	**Escort to be contacted** Yes ☑ No ☐	**Overnight stay in ward** Yes ☐ No ☐
Contact tel no 07880855579		

Have you received Patient Information and understood it: Yes ☑ No ☐

Medical History and Pre Procedure check

Condition	Yes	No	Details
Diabetes		✓	Type 1 ☐ Type 2 ☐
Angina/ Ischaemic heart Disease		✓	
Hypertension		✓	
Myocardial Infarction		✓	Date:
Artificial valves		✓	
Pacemaker		✓	
CABG		✓	
Coronary artery stent		✓	
Stroke/TIA		✓	
Asthma		✓	
COPD		✓	
Epilepsy		✓	
Liver disease		✓	
Arthritis	✓		
Orthopaedic implants		✓	Specify:
Glaucoma		✓	
Anaemia	✓		
Recent surgery		✓	
Previous endoscopy		✓	
CJD/VCJD risk		✓	
Other			

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MCFARLANE M
Stewart 09/06/1971
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Glasgow, Lanarkshire
G32 9BL

Presenting complaint	Yes	No	Detail other illness or complaint
Reflux			
Dysphagia			
Barretts			
Oesphageal/Gastric Varices			
Gastric ulcer			
Altered bowel habit			
PR bleeding			
Crohns disease			
Ulcerative colitis			
Surveillance colonoscopy			
Screening programme			
Other:	✓		Weight loss, anaemia

Mobility Assessment

Independent Yes ☑ No ☐ If No, complete all questions

Aids and/ or assistance required Yes ☐ No ☐

Walking stick ☐ Zimmer ☐ Wheelchair ☐ Other ☐ Specify .....

Sight impairment Yes ☐ No ☑ if yes specify .....

Communication Needs (answer only applicable question)

Hearing impairment Yes ☐ No ☑

Hearing aid Yes ☐ No ☑ right ear ☐ left ear ☐ both ears ☐

Sign Interpreter required Yes ☐ No ☐

Lip reads Yes ☐ No ☐

Interpreter Required Yes ☐ No ☐ Language .....

Interpreter present Yes ☐ No ☐

Relative / friend present Yes ☐ No ☐

The use of relatives and friends as interpreters is discouraged unless it is the patient's choice to use them.

Learning Disability Yes ☐ No ☐ Carer present Yes ☐ No ☐

Dementia Yes ☐ No ☐ Incapacity form completed Yes ☐ No ☐

Current Medication (list below and tick those taken today)

Folic Acid					
Hydroxychloroquine					
Dihydrocodeine					
Methotrexate					

ANTICOAGULANT THERAPY Yes ☐ No ☑ If yes current medication .....

When was this medication last taken Specify .....

INR Result .....

0906716470
MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

T 36·4

Admission Observations

BP 126/76 Pulse 73 Oxygen Saturation 97% (A)

BM (if applicable) N/A Respirations (if applicable) Reg

Fasted since 22:00 last night

Bowel Prep	Klean Prep	Moviprep	Picolax	Enema / home	Enema / dept	Other
No of sachets						
Result- Good / Poor		N/A				

Patient Requests

Throat Spray ☑ IV Sedation ☐ No Sedation ☐ Not Applicable ☐

IV Cannulation

R Hand	L Hand	R Arm	L Arm	Other	Time	Inserted by (please print)

Dentures removed (if applicable) Yes ☐ No ☐ upper plate

Crowns Yes ☐ No ☐ upper ☐ lower ☐ front ☐ back ☐ R side ☐ L side ☐

Bridgework Yes ☐ No ☐ upper ☐ lower ☐ front ☐ back ☐ R side ☐ L side ☐

Identiband details checked Yes ☑ No ☐

Consent form signed Yes ☑ No ☐

Consent form countersigned Yes ☑ No ☐

Underwear removed (if applicable) Yes ☐ No ☑ N/A

Jewellery removed Yes ☐ No ☑

ALLERGIES Yes ☐ if yes detail below No ☑

Details NKDA

Name of Admission Nurse (Print) APATTON

Signature of Admission Nurse [signature]

Patient's Declaration

I have read and understood the warnings regarding the after effects of sedation.

Patient's signature .....

0906716470
P MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

Intra Procedure

Endoscopist (print) ..... S. Beck .....

Endoscopy Room Nurses (print) ..... Key Balmer .....

Surgical Pause carried out Yes ☑ No ☐

Medication Administered Pre, Intra and Post Procedure

Drug	Yes	No	Time	Dose	Route	Given/Sign/Dr/Nurse
Xylocaine spray	✓		1428	10 puffs	T	
Midazolam				mg	IV	
Midazolam				mg		
Midazolam				mg		
Pethidine				mg		
Pethidine				mg		
Pethidine				mg		
Fentanyl				mcg		
Fentanyl				mcg		
Fentanyl				mcg		
Buscopan				mg		
Buscopan				mg		
Buscopan				mg		
Antibiotics						
				mg		
				mg		
				mg		
Reversal Agents						
				mg		
				mg		
Local anaesthetic						
				mg		
				mg		
Other						
Botox				mg		
Prescribed by.....						

Endoscopist Signature.....

Start Time ..... 1429 ..... Finish Time .....

Patient position Left Lateral ☑ Supine ☐ Prone ☐ All ☐

Oxygen therapy Yes ☐ No ☑ nasal sponge ☐ cannula ☐ mask ☐ rate .....

PEN-EG29-I10- Sn: K110923 Prod Id: 54130
ID- 5055476420000762 11/11/2022
Stobhill Hospital EXPIRES: 11/11/2022 16:19

0906716470
MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

Observations during procedure

Time						
Pulse						
SpO2						
BP						
Resps						

Procedure (please tick all relevant)

Gastroscopy	✓	Biopsy	✓	Varices		Adrenaline	
Colonoscopy		Hot Biopsy		Gastric Ulcer		Spot Dye	
Sigmoidoscopy		Snare Polypectomy		Duodenal Ulcer		Indigo Carmine	
E.R.C.P.		Balloon dilatation		Oesophagus		Gelofusine	
E.U.S		Injection		Duodenum	✓	Normal Saline	
Bronchoscopy		Laser		Biliary		Haemospray	
E.B.U.S		Heater Probe		Pancreatic			
Thoracoscopy		Endo clip		Haemorrhoids			
Enteroscopy		Insertion of Stent		Rectum			
		EMR		Sigmoid			
		PEG		Descending			
		Needle Aspiration		Splenic flexure			
		Brushings		Transverse			
		Washings		Hepatic flexure			
		Banding		Ascending			
		Insert of NJ tube		Caecum			
		Gastric Pacing Wire		Terminal Ileum			

Other .....

Sedation score	Tick	Comfort Score	Tick
Asleep		None, resting comfortably	
Drowsy		One or two episodes of mild discomfort, well tolerated	
Awake	✓	More than two episodes of discomfort, adequately tolerated.	
		Significant discomfort experienced several times	
		Extreme discomfort frequently during procedure	

Comments

Specimens Yes ☑ No ☐

Pathology ☑ No of pots ..... H pylori test ☑ bacteriology ☐ cytology ☐ mytology ☐

0906716470
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P Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

Diathermy Yes ☐ No ☑ Type mono ☐ Argon ☐

Site of diathermy pad leg ☐ back ☐ R side ☐ L side ☐ Upper ☐ Lower ☐

Other .....

Condition of skin post diathermy normal ☐ other ☐ comment below

.....

Recovery Room Instructions (if applicable)

Oxygen 4 litres per minute if SpO2 drops below 95% ☐

Oxygen 4 litres per minute until fully awake ☐

Oxygen ..... per minute via .....until ..... ☐

Normal Diet ☑ Fluids only ☐ Soft Diet ☐ Nil orally till further medical instructions ☐

To be seen by endoscopist before discharge ☐

Further Instructions ..... NBM 1458 .....

.....

Endoscopy Room Nurse Signature ..... Lynne Key .....

Recovery care

Post endoscopy observations

Time										
Blood pressure										
Pulse										
O2 Saturation										
Respiratory Rate										
Sedation score										
Pain score										
Oxygen										
IV Cannula										
BM										
Nurse initials										

Pain score 0 = no pain, 1 = minimal, 2 = mild, 3 = moderate, 4 = severe

Sedation score A - Asleep 0 - Alert 1 - Responds to verbal command

2 - Responds to painful stimuli 3 - Unresponsive

0906716470
MCFARLANE
Stewart
32 DALRY STREET
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M
09/06/1971

Nurses notes

14/11/22 In recovery 1430hrs Lt Groin SV

R/Room at 1445pm.
Uneventful recovery SN to ward

0906716470
MCFARLANE
Stewart
32 DALRY STREET
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G32 9BL
M
09/06/1971

Discharge Criteria	Yes	No
Stable vital signs	☑	☐
Alert and Orientated	☑	☐
Pain score is 2 or below	☑	☐
Diet and fluids taken	☑	☐
IV Cannula removed	☑	☐
Received written instructions regarding sedation	☑	☐
Received verbal and written aftercare instructions	☑	☐
Patient Advice Leaflet given (if applicable)	☑	☐

MBM th'll 1458

Received Endoscopy Report/ Patient letter Yes ☑ No ☐

If no

Verbal report by endoscopist ☐

Follow up appointment indicated on report Yes ☐ No ☑

Follow up appointment (if given in department) .....time .....

Comments..... follow up arranged .....

.....

.....

I confirm patient is satisfactory for discharge

Print Name ..... H Donnelly ..... Signature ..... H Donnelly .....

Discharged at ..... 1445 ..... to care of ..... wife .....

Irregular discharge Reason .....

.....

Patients' Signature ..... Nurses Signature .....

Consent Form

Patient agreement to endoscopic investigation or treatment

0906716470
MCFARLANE M
Stewart 09/06/1971
32 DALRY STREET
Glasgow, Lanarkshire
G32 9BL

Name of Procedure

Gastroscopy: Endoscopy: Oesophago-gastro-duodenoscopy

Inspection of the upper gastrointestinal tract with a flexible endoscope (with or without biopsy and photography)

Biopsy specimens will be retained.

Statement of Patient

You have the right to change your mind at any time, including after you have signed this form.

I have read and understood the information in this booklet including the benefits and any risks.

I agree to the procedure described in this booklet and on the form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however have appropriate experience.

Where a trainee performs this examination, this will be undertaken under supervision by a fully qualified practitioner.

I understand that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.

I would like to have: **local anaesthetic throat spray** ☑
or sedation ☐ (Please tick box)

Have you ever been notified that you are at an increased risk of CJD or VCJD for public health purposes?

☐ Yes ☑ No

Consent Signature **Please Use Black Ink**

Signed: [signature] **Date:** 14/11/2022

Name (print in capitals): STEWART MCFARLANE

Please sign here if you refuse to consent to the emergency administration of blood or blood products.

Signed: _____ **Date:** _____

Staff Only

Confirmation of consent (to be completed by a health care professional when the patient is admitted for the procedure)

I have confirmed that the patient understands what the procedure involves including any risks.

I have confirmed that the patient has no further questions and wishes the procedure to go ahead.

Signed: [signature] **Date:** 14/11/22

Name (print in capitals): APATTON

Job Title: SIN

Gastroscopy report

Performed	14-Nov-2022 14:23	Received	14-Nov-2022 14:38
Reported	14-Nov-2022 14:38	Order Number	UNI256480-0906716470
Status	Final	Source System	MasterLab

UGI G1 Final

NHS Greater Glasgow and Clyde
GASTROSCOPY REPORT

Name:	**Stewart MCFARLANE (M)**	Address:	**32 Dalry Street**
Date of birth:	**09/06/1971**		**Glasgow**
NHS No:	**0906716470**		**Lanarkshire**
Case Note No:	**0906716470**		**G32 9BL**
GP:	**DOUGLAS, EMMA**	Procedure date:	**14th November 2022 (14:**
	Crail Medical Practice	Priority:	**Elective**
	245 Tollcross Road	Hospital:	**GRI**
	Glasgow	Ward:	**(none)**
	G31 4UW	Referring Cons:	**Dr C Grigor (Rheumatolog**

Indications
Anaemia, nausea and/or vomiting, weight loss and reduced appetite.
Clinically important comments: Awaiting CT CAP.

Consultant/Endo
F

Inst
SC
Disposat

Premed
Xylocaine (Spra

Report
The scope was retroflexed in the stomach.
The procedure was completed successfully to D2.
Apparent mucosal junction at 39cm from the incisors. The whole upper gastro-intestinal tract was normal.

Site a: Antrum
Specimens: Result of urease test proved negative for Helicobacter pylori.
Site b: Second part
Specimens: 4x biopsy.

Advice/Comments
CLO TEST NEGATIVE

Follow up
Awaiting pathology results. Follow up already arranged.

Fiona Beck
Nurse Endoscopist

Produced by Unisoft's GI Reporting Tool Compiled on 14/11/202

Clinic Letter

NHS
Greater Glasgow and Clyde

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW
0141 201 3000

Dr. El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Main Switchboard:
Department: Rheumatology
Contact Tel: 0141 355 1050
Enquiries to:
Letter Date: 16/06/2022
Reference: DM/LS
Dictated Date: 16/06/2022
Transcribed Date: 20/06/2022

Dear Dr. El Douglas,

Stewart McFarlane; D.O.B: 09 Jun 1971; CHI: 0906716470
32 DALRY STREET, Glasgow, Lanarkshire, G32 9BL

Attendance: Specialty - Rheumatology; Clinic - STDMRH4-RHEUM ACH DR D MCCAREY TUESDAY PM TIMESHIFT
Date and Time of Appointment - 16/06/2022 15:00

Clinical Comments:
Many thanks indeed for referring this fifty one year old gentleman to rheumatology for assessment. His problems were as follows;

Likely rheumatoid arthritis: Over the last few months he has developed inflammatory joint symptoms in the small joints of the hands and feet. He describes significant morning stiffness lasting around an hour. He finds that his wrists swell up and he has difficulty with tasks requiring power grip strength. In the last couple of weeks his symptoms have been worse in the feet than in the hands.

On examination he appeared systemically well and was of slim build. Musculoskeletal examination revealed mild synovitis around the ulnar styloid in both wrists with slightly reduced power grip strength. He was tender on a few of the small joints of the hands but no definite synovitis in MCPs. Elbows and shoulders move freely. Lower limb examination revealed positive metatarsal squeeze and likely synovitis in the right mid foot. There were no extraarticular features of rheumatic disease, chest was clear to oscitation.

I have explained to Mr McFarlane that in view of his symptoms, signs and weakly positive rheumatoid factor that I think it is highly likely that he has rheumatoid arthritis. For completeness I have arranged to update bloods including inflammatory markers, CCP antibodies and I have also arranged for a BBV screen as low level rheumatoid factor and mild inflammatory joint symptoms can be associated

with viral hepatitis. I have arranged for him to receive 80mgs intramuscular Kenalog today with a view to settling his symptoms in the short term. I have given him written information on rheumatoid arthritis and on Hydroxychloroquine and would be grateful if you could start him on Hydroxychloroquine 200mgs bd. I have explained the need for annual review with an optician.

I have written to my colleague Dr Sarah Saunders asking if she could arrange for follow up in August in the early RA clinic at GRI. I have also written to Dr George Chalmers asking if he would be happy with us proceeding to Methotrexate should this be clinically indicated.

Chest: He has ongoing follow up with Dr Chalmers for minor fibrotic change on CT. He had probable COVID infection in 2020. He has mild shortness of breath on exertion. I note that he has a parrot at home and he also works as an Asbestos removal operative.

Solitary kidney: This was discovered incidentally on a scan. His eGFR is >60.

Social: He stopped smoking two years ago and drinks little alcohol. Works as an asbestos removal operative.

Investigations: Full blood count, ESR, biochemistry CRP (CRP 75, ESR 77), CCP antibodies, HIV/ Hep B/Hep C screen, X-Rays of feet.

Summary medication: Naproxen, Codydramol, Omeprazole, suggest Hydroxychloroquine 200mgs bd, given 80mgs IM Kenalog today 16 06 22

Follow up: To be arranged at early RA clinic at Glasgow Royal Infirmary.

Yours Sincerely,

Dr David McCarey

Consultant Rheumatologist

Electronically Signed: Dr David McCarey, Consultant

cc. Dr Sarah Saunders
Consultant Rheumatologist
Rheumatology Department

Glasgow Royal Infirmary
84 Castle Street
G4 0SF

Dr George Chalmers
Respiratory Consultant
Respiratory Department
Outpatient Area A Queen Elizabeth Building
Glasgow Royal Infirmary
84 Castle St
G4 0SF

NHS Greater Glasgow and Clyde
Renal Services

Stobhill ACH
Renal Dialysis Unit
Ground Floor
GLASGOW G21 3UW
0141 355 1677/8

BLUE TEAM

e-mail: ggc.renalservices@nhs.scot

NHS
Greater Glasgow and Clyde

Our Ref: gl904086.txt gl904086.txt CD/SB

Dictated: 26/02/2021
Typed: 26/02/2021

Stewart McFarlane	**CHI number** **0906716470**
32 DALRY STREET, GLASGOW, G32 9BL	**Date of birth** **09/06/1971**

Dr Carys Morrison
Crail Medical Practice
245 Tollcross Road
GLASGOW
G31 4UW

Dear Dr Morrison

Thank you for your referral letter regarding this 49 year old gentleman who was found to have a solitary left kidney following a road traffic accident.

I note that his CT with contrast showed an enlarged left kidney measuring 12 cm with the appearance of cross fused ectopia, no hydronephrosis and no abnormality of the solid left ureter. The right kidney was absent with no abnormality in the right renal bed and there was a solitary left renal artery rising from the aorta. It would therefore appear that he has a congenital renal agenesis on the right with a solitary left kidney with appropriate compensatory hypertrophy.

I note that he has well preserved renal function with a creatinine of 72 with an eGFR greater than 60. Blood pressure in 2015 was 126/88 and you comment his blood pressure was slightly elevated on arrival to A&E but settled with analgesia and remained with acceptable limits.

In summary therefore, he has a single functioning kidney with excellent renal function, no history of hypertension and has what appears to be renal agenesis on the right with appropriate compensatory hypertrophy on the left.

By definition, he has stage 1 / 2 CKD due to the structural renal abnormality. I do not think he requires renal out-patient review. Data from patients that donate kidneys as live transplant donors suggest there is an increase incidence of hypertension in the long term and a proportion can develop proteinuria. As a result it would seem reasonable for him to have an annual review in primary care to review his blood pressure, dipstick urinalysis and renal function. This would fit with CKD Guidelines. There would be an argument that if his parameters remain normal over a period of time then the frequency of this could be reduced to every couple of years.

I hope this information is of help and would be happy to discuss his case further as required.

Yours sincerely

Dr Chris Deighan

Consultant Nephrologist

Renal Medicine
133 Balornock Road
Glasgow
G21 3UW

25/02/2021

Dr El Douglas
Crail Medical Practice
245 Tollcross Road
Glasgow
G31 4UW

Dear Dr El Douglas

Patient Name: Stewart McFarlane
CHI Number: 0906716470
Referral Date: 25/02/2021

Thank you for your referral.

No renal OP appt required. Full letter to follow

Yours sincerely

Dr Christopher Deighan

User ID Christopher Deighan

SCGC Opwl Rem Ref Hosp Req V1

Duodenal Biopsy

Performed	14-Nov-2022 14:35	Received	15-Nov-2022 15:45
Reported	04-Jan-2023 15:32	Order Number	D,22.0075327.X
Status	Final	Source System	Telepath

Pathology Final

NHS GREATER GLASGOW AND CLYDE
PATHOLOGY DEPARTMENT ENQUIRIES TO: 0141-354-9487 (89487)

Date collected: 14.11.2022
Date received : 15.11.2022 Date reported: 04.01.2023

Reporting Pathologist : Elizabeth Mallon
Consultant Pathologist: Elizabeth Mallon

DUODENAL BIOPSY

CLINICAL HISTORY:
Weight loss, nausea and reduced appetite.

Normal endoscopy.

MACRO:
The specimen consists of 3 fragments, the largest 6mm.

MICROSCOPY:
Sections show normal duodenal mucosa.

Dr E A Mallon (Consultant)
Dictated: 03/01/23 Typed: 04/01/23 AM

McFarlane, Stewart ID:0906716470 10-MAY-2022 10:49:42 GREATER GLASGOW SITE-STCRE ROUTINE RECORD

09-JUN-1971 (50 yr)
Male

Room:
Loc:401

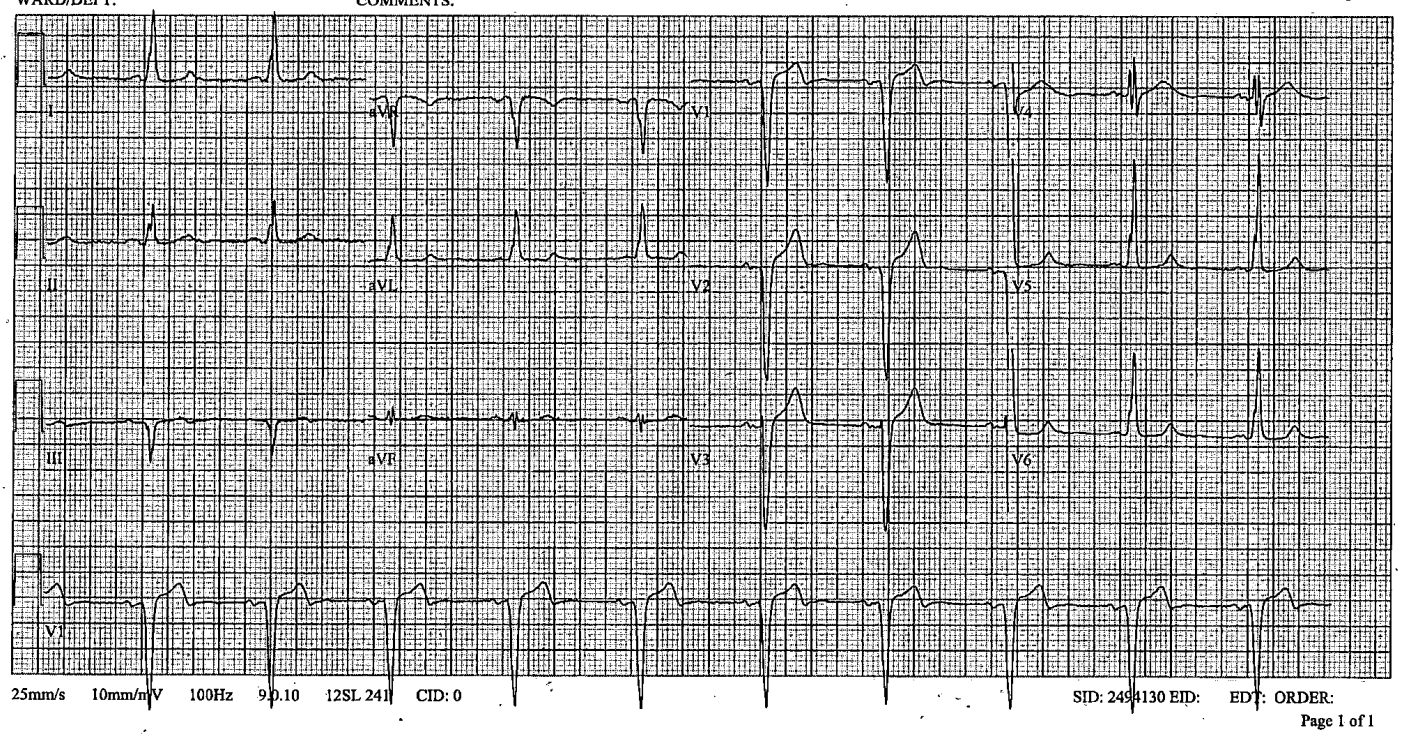
Vent. rate	63	BPM
PR interval	142	ms
QRS duration	116	ms
QT/QTc	426/435	ms
P-R-T axes	51 2	41

Normal sinus rhythm
Left ventricular hypertrophy with QRS widening
Cannot rule out Septal infarct , age undetermined
Abnormal ECG

Technician: 259
Test ind:

Unconfirmed

WARD/DEPT: COMMENTS:



25mm/s 10mm/mV 100Hz 9.0.10 12SL 241 CID: 0 SID: 2454130 EID: EDT: ORDER:

Stobhill Hospital
Echocardiogram Report

NHS Greater Glasgow and Clyde

Patient Name **McFarlane, Stewart** Date of Birth **09/06/1971** Patient Id **0906716470** Sex **Referred from** Respiratory	Date of Exam **10/05/2022** Sonographer **Rebecca McGrath** Ref. Doc **Dr Chalmers** Ward/Dept. **Indication:** ?PAP

2D		M-Mode		Doppler	
IVSd	1.0 cm	TAPSE	2.1 cm	LVOT Vmax	1.0 m/s
LVIDd	4.6 cm	IVC exp	1.7 cm	LVOT Vmean	0.6 m/s
LVIDd Index	2.6 cm/m²	IVC Insp	0.7 cm	LVOT maxPG	4 mmHg
EDV(Teich)	98 ml	IVC collapse	59 %	LVOT meanPG	2 mmHg
LVPWd	1.0 cm			LVOT Env.TI	314.0 m s
LVd Mass	179.0 g			LVOT VTI	19.7 cm
LVd Mass Index	101.1 g/m²			LVSV Dopp	72 ml
LVd Mass (ASE)	154.7 g			LVSI Dopp	40.5 ml/m²
LVd Mass Ind (ASE)	87.4 g/m²			AV Vmax	1.3 m/s
RWT	0.43			AV Vmean	0.9 m/s
RV basal	3.8 cm			AV maxPG	6 mmHg
RV mid	2.9 cm			AV meanPG	4 mmHg
RV length	7.4 cm			AV Env.TI	281.6 m s
LVOT Diam	2.2 cm			AV VTI	26.3 cm
Ao Diam SVals	3.2 cm			AV/LVOT	1.3
SOV Indexed	0.0 cm/m			AVA Vmax	2.81 cm²
Ao Diam STub	3.2 cm			AV EOA I Vmax	1.59 cm²/m²
				AVA (VTI)	2.73 cm²

Print Date: 10/05/2022

Ao Diam STub Indexed	0.0 cm/m
Ao Asc Diam	3.4 cm
LVLd A4C	9.2 cm
LVEDV MOD A4C	134.2 ml
LVLs A4C	6.7 cm
LVESV MOD A4C	47.8 ml
LVEF MOD A4C	64 %
SV MOD A4C	86.35 ml
LVLd A2C	8.4 cm
LVEDV MOD A2C	117.2 ml
LVLs A2C	7.2 cm
LVESV MOD A2C	46.4 ml
LVEF MOD A2C	60.42 %
SV MOD A2C	70.84 ml
EF Biplane	63 %
LVEDV MOD BP	131 ml
LVESV MOD BP	48 ml
SV Biplane	82 ml
LVEDVInd MOD BP	73.75 ml/m²
LVESVInd MOD BP	27.35 ml/m²
LA Area	14.7 cm²
RA Area	8.7 cm²

AV/LVOT	1.34
DVI	0.75
MV E Vel	0.6 m/s
MV DecT	176 m s
MV Dec Slope	3.3 m/s²
MV A Vel	0.5 m/s
MV E/A Ratio	1.2
MV PHT	51 m s
MVA By PHT	4.3 cm²
E' Sept	5.0 cm/s
E' Lat	7.1 cm/s
E' Avg	6.1 cm/s
E/E' Avg	9.5
MV Vmax	0.5 m/s
MV maxPG	1 mmHg
MV meanPG	1 mmHg
MV VTI	18.9 cm
MVA cont	3.8 cm²
VTI MV/LVOT	1.0
MVA (VTI)	3.80 cm²
VTI MV/LVOT	1.0
PV Vmax	0.8 m/s
PV maxPG	3 mmHg
TR Vmax	2.2 m/s
TR maxPG	19 mmHg

Echo Summary

ECG - Sinus rhythm.

Left Ventricle - appears undilated with no LVH. Septal bounce noted due to wide QRS complex. Overall normal LV systolic function. Ejection fraction by Simpsons biplane: 63%.

Left Atrium - Undilated.

E/E' Ratio - Normal range.

Right Ventricle - Undilated with normal systolic contraction. TAPSE: 2.1cm.

Right Atrium - Undilated.

IAS - Appears intact. No obvious colour flow across the atrial septum.

Mitral Valve - appears mildly thickened with good leaflet mobility. Mild MR.

Aortic Valve - Impression of Tri-leaflet AV with good cusp separation. No obvious stenosis. No significant gradient across the valve. Trace AR.

Aortic Root - Proximal ascending aorta measures upper limit of normal when indexed to height [Indexed @ 2cm]. Normal aortic arch appearance.

Pulmonary Valve - Difficult to clearly image PV. Trace PR.

Tricuspid Valve - appearance of good leaflet mobility. Trace TR. Estimated PASP @

19mmHg+RAP.

IVC - Undilated and collapse on inspiration.

Conclusion

Undilated LV with no LVH and normal systolic function.
Undilated RV with normal function.
Proximal ascending aorta measures upper limit of normal when indexed to height.
Mild MR.
PASP within normal limits.

Reported By: R. McGrath

XR Foot Lt

Performed	06-Jul-2022 18:08	Received	11-Jul-2022 06:44
Reported	11-Jul-2022 06:42	Order Number	G207H38561123
Status	Final	Source System	MiSys

XR Foot Lt Final
Stewart McFarlane
Clinical History :

RA ?erosive change

XR Foot Lt :
There is no significant erosive change.

XR Foot Rt :
There is no significant erosive change.

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly