

(259)

BUNDABERG BASE HOSPITAL

Patient Identification:

Deceased patient (08.01.04)

BUNDABERG HOSPITAL	SEX	UR NO
GRAVE	M	130224
JAMES ASHTON		

HEALTH RECORDS VOLUME 2

QHB.0004.0091.00388


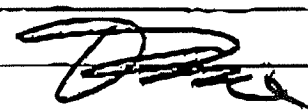
HOSPITAL

SUNDBERG HOSPITAL
GRAVE
JAMES ASHTON

SEX
M

CR NO
130224

OUTPATIENT NOTES

DATE	PROGRESS NOTES
27 AUG 2003	SURGICAL WARD REVIEW
	Patient well. 73.6 Kg.
	Good appetite
	Struggling to keep food down well.
	Swallowing well, no aspiration.
	Plan - NG tube out
	Review 4/59
	
	N. FORDRINGS
23 SEP 2003	SURGICAL WARD REVIEW
	- Well post aeromyotomy.
	- wt. gain.
	- for speech RN today.
	- minimal feelings of aspiration.
	- off G-tube now - BSC's good
	curly mess - Zantac
	- G-tube
	- Lipen
	① - letter to Dr. Pratt
	- MV 5000 3/12
	

SPECIALIST OUTPATIENT NOTES

DATE	PROGRESS NOTES
19 NOV 2003	SURGICAL WARD REVIEW
	63yo ♂ transhiatal oesophagectomy +
	partial gastrectomy
	(Mets - pericardium, LN)
	<u>Complicated by</u> - Vocal cord paralysis
	- Respiratory failure
	- AMI
	- Peritonitis
	has seen Dr Pratt - Palliative chemotherapy
	offered.
	- Considering - most likely <u>not</u>
	liver Mets found.
	Ongoing weight loss
	Some difficulties with food at times - liquid + solids
	Abdo pain - discomfort mainly.
	long discussion w James & wife in prognosis
	(incl time of expectancy ^{expectancy} given) options for end of
	life. Reassurance for quality of life.
	Suggest liquid high energy / protein drinks.
	P: R/V 9/12 - or anytime.
	: Services offered to entire family when
	they desire / need.
	Naden MD

**DIVISION OF ONCOLOGY
BUNDABERG SUB CENTRE
BUNDABERG BASE HOSPITAL
ADMINISTRATION SHEET**

FILE COPY

31 October 2003

**RE: James GRAVE
DOB: 22.12.39**

UR 130224

Referred by Dr Patel's team to consider adjuvant chemotherapy after resection of an oesophageal adenocarcinoma. 6/6/03 trans hiatal oesophagectomy and partial gastrectomy OG junction with gross metastases pericardium and oesophageal lymph nodes. Difficult post operative course, pleural effusion on the left side requiring transfer to Mater Adult's Hospital ICU. Left vocal cord paralysis, thyroplasty, 9/14 lymph node metastases, focal involvement gastric serosa. Past history ischaemic heart disease, CABG 1996, hypertension, type II diabetes, occlusion left internal carotid artery.

He has noticed a lump across the left superior part of his scar and an ultrasound undertaken to investigate this arranged by his LMO at Agnes Waters shows ~~no~~ multiple liver metastases. Currently he has continued to lose weight and is otherwise minimally symptomatic. Liver function tests earlier this month were normal. The utility of palliative chemotherapy in this circumstances is relatively modest and I have discussed with him the potential toxicities. I have given him written information books to consider. He is not keen to rush into any decisions about this matter at present. If he wished to consider this further I would be happy to discuss with him whenever needed.

**Gary Pratt
Radiation Oncologist**

Dictated but not read by Dr Pratt (e-mailed to Dr Pratt 3.11.03)

Copy: Dr J Patel Director of Surgery BBH
Agnes Coast Medical Centre



QHB.0004.0091.00407

Department of Medical Services
 Bundaberg Health Service District
 Bundaberg Base Hospital
 PO Box 34
 BUNDABERG 4670125

QRI Appt
 31/10/03
 1.00

FILE COPY

Telephone No: 4150 2213
 Fax No: 4150 2219

DR/ns

DEPARTMENT OF SURGERY

27 September 2003

Dr G Pratt
 Oncologist
 Bundaberg Base Hospital
 PO Box 34
 BUNDABERG 4670

Dear Dr Pratt

RE: James GRAVE
 DOB: 22.12.39

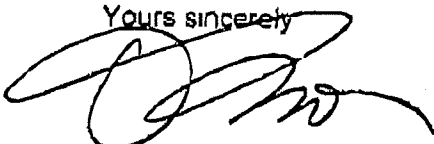
UR: 130224

Thank you for seeing this 63 year old gentleman for consideration of chemotherapy following resection of an oesophageal adenocarcinoma.

He was seen initially on 22 April following a two month history of dysphagia. An OGD soon after showed a fungating cancer at the gastro-oesophageal junction. On 8 June 03 he underwent a transhiatal oesophagectomy and partial gastrectomy and at the time of surgery it was noted that the adenocarcinoma was involving the gastro-oesophageal junction with gross metastases to the pericardium and the oesophageal lymph nodes. He had a difficult post-operative course with pleural effusion on the left side and difficult weaning from ventilation. He was transferred down to the Mater Adults Hospital ICU on 20 June 2003 and was extubated on 25 June. Post extubation there was recurrent aspirations, and ENT review on 27 June showed left vocal cord paralysis. He had a thyroplasty on 2 July and this improved voice quality and cough reflex. However he was still judged at risk for aspiration and after a long speech pathology involvement in his care he was discharged from Bundaberg Hospital on 27 August and is now on a normal diet. Histology of the oesophageal cancer showed an adenocarcinoma of the gastro-oesophageal junction, with invasion through full thickness of muscularis propria but no definite circumferential oesophageal margin. There were lymph node metastases (9/14), focal involvement of the gastric serosa but margins were clear. Prior to this hospitalisation he has had episodes of ischaemic heart disease requiring CABG in 1996, hypertension and type II diabetes. He also has a total occlusion of left internal carotid artery.

I would be pleased if you could have a talk with this gentleman about his options and any altered prognosis which chemotherapy would achieve.

Yours sincerely



David Risson
 JHO-Surgery

QHB.0004.0091.00408

Department of Medical Services
Bundaberg Health Service District
Bundaberg Base Hospital
PO Box 34
BUNDABERG 4670125

FILE COPY

Telephone No: 4150 2213
Fax No: 4150 2219

NL/ns

DEPARTMENT OF SURGERY

19 November 2003

Dr K Corbett
Agnes Coast Medical Centre
PO Box 151
AGNES WATER 4677

Dear Dr Corbett

RE: James GRAVE
DOB: 22.12.39

UR 130224

I reviewed James in Surgical Outpatients today for routine follow up after his trans hiatal oesophagectomy and partial gastrectomy. I understand that an ultrasound was organised which found multiple liver mets. Mr Grave has seen Dr Pratt who offered palliative chemotherapy if he desired. At this point in time Mr Grave is considering his options.

Mr Grave states that he has some ongoing weight loss and difficulties with swallowing food both liquid and solid intermittently. He does give some history of abdominal discomfort but nothing too disturbing.

Mr Grave and his wife had a lot of questions in regards to life expectancy and pain management issues that may occur. I had a long discussion with them with regards to this but unfortunately as you know I was unable to give them any definite time period.

We will review Mr Grave again in three months. I have offered services to Mr Grave and his entire family any time that they desire.

If you have any further concerns please do not hesitate to contact us.

Yours sincerely

Nadeen Low
Surgical PHO

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