Patient which she received wide local excision

Patient X is a 75-year-old female retired council worker who presented to her GP in January 2017 with symptoms of increased urinary frequency, mild lower abdominal pain and burning when passing urine. Patient X had been experiencing these symptoms for several days and had presented to the GP on 3 occasions over the proceeding 6 months with similar symptoms. Patient X had not experienced any recent weight loss, PV bleeding or systemic symptoms. Patient X has a past medical history of breast cancer for which she received wide local excision and radiotherapy combination treatment in 2011. Tamoxifen therapy was not used at any stage.

In addition, patient X underwent a right-sided hip replacement in 2012 after a fractured neck of femur secondary to osteoporosis. Patient X also has high blood pressure and had an appendectomy as a teenager. Currently, patient X takes losartan, alendronic acid, cholecalciferol, anastrozole and latanoprost. Patient X is gravida 3 para 2+1, with both deliveries being vaginal and the most recent occurring 45 years ago. Patient X used HRT during her early fifties for 4 years, and has never used the oral contraceptive pill. All patient X’s smears have been normal with her previous being aged 70. Patient X became menopausal aged 53, with menarche around aged 14. Patient X lives at home along with her husband, is usually mobile and is a non-smoker/non-drinker.

On examination, patient X’s abdomen was soft with some tenderness in the suprapubic area. There was absence of distension, masses and organomegaly. The GP diagnosed patient X with a UTI, and due to the recurrence of UTI’s, subsequently organised an ultrasound scan of the abdomen, which revealed possible urinary retention. A referral to Urology at

Royal Shrewsbury Hospital was made and a postvoid scan revealed residual urine and confirmed urinary retention. Self-catheterisation was advised for patient X, which she found particularly unpleasant.

Patient X began to develop mild abdominal pain in the absence of active UTI’s. A gynaecological referral was made and transvaginal ultrasound scanning revealed a fluid filled cyst with no solid components, lymphadenopathy, ascites or bony lesions. A CT scan confirmed a midline pelvic cyst of around 12cm. CA-125 levels were measured at 10U/ml. Initially, patient X was anxious that her cyst might be related to her previous breast cancer.

The option of a laparotomy for hysterectomy with bilateral salpingo-oophorectomy was discussed with patient X, and she had concerns surrounding the post-operative complications and recovery that would happen as a result. One nurse involved with patient X’s care gave the patient her telephone number to discuss any concerns she might have and this helped reduce patient X’s anxiety. Patient X was initially due to undergo surgery on 2/1/2018; her operation was the final of the days list and was cancelled due to the preceding operations running over.

On 16/1/2018 patient X underwent a total abdominal hysterectomy, bilateral salpingo-oophorectomy and omental biopsy. On 19/1/2018 patient X was discharged on a 28-day course of prophylactic tinzaparin with a follow up dependent on the biopsy results.