28 November 2022

Dr Sarah Machin
Consultant Gynaecologist
Crest Specialist Centre
21 Carroll Street
PALMERSTON NORTH 4410

cc: *The Doctors*
Tararua Medical Centre
P O Box 98
LEVIN 5540

Dear Sarah

LILLEY, Melanie
108 Kukutauaki Road
R D 5
LEVIN 5575

NHI: EBJ1364
DOB: 01/06/1968
PH: 063679361/0204888803
GP: Tararua Medical

Diagnosis:

1. Myocardial infarction followed by PCI thought to be related to coronary stenosis induced by radiotherapy for non-Hodgkin's lymphoma
2. Non-Hodgkin's lymphoma treated with radiotherapy and chemotherapy in her 20s
3. Intolerance to Atorvastatin (and some degree of non-compliance)
4. Abnormal vaginal bleeding and incontinence

Medications:
Rosuvastatin 5mg daily (SA approved and scripted)
Aspirin 100mg daily

Many thanks for your letter of referral dated 6th September requesting an assessment of this 54 year old lady. As you know, she was diagnosed with non-Hodgkin's lymphoma in her 20s which was treated with radiotherapy and chemotherapy. In her 40s, she developed central chest discomfort and dyspnoea which culminated in a myocardial infarction while residing in the Gold Coast. Angiography demonstrated important coronary stenosis (artery undetermined) and thought to be related to her history for radiotherapy. This was stented. I do have the details of the culprit artery as Melanie did not bring in her discharge summary with her.

For at least two years, she has had some restriction in walking particularly when picking up her pace. She describes a tachycardia and shortness of breath. Immediately following exercise, she is aware of extra or mixed beats representative of ectopy. She also experiences intermittent resting chest discomfort and was seen through Palmerston North Hospital on 6th November 2020. She underwent an exercise test which was negative for coronary ischaemia. In addition a troponin T and ECG remain normal. She was discharged on Atorvastatin 40mg, Bisoprolol and Cilazapril. She cannot recall taking this treatment particularly as she has not tolerated Atorvastatin in the past. Therefore it is unlikely that she ever embarked on the course of treatment that was offered through ED.

Since that time and while on Aspirin only, she has continued to experience exertional dyspnoea and chest tightness, the latter also occurring at times at rest. She feels that her symptoms are similar to that prior to her PCI.

As you have indicated, her father was diagnosed with coronary heart disease at a young age. Melanie does not smoke. She has no other cardiovascular risk factors, blood pressure today 130/80.

Examination was unremarkable.

An ECG today demonstrates sinus rhythm at a rate of 77 beats/minute with no ischaemic changes.

Current labs demonstrate an LDL cholesterol of 3.2mmol/L and historically, her LDL has been consistently above 2.0mmol/L since at least 2016. This would probably be due to the fact that she has really not been taking statins for any length of time.

An exercise test was performed utilising the standard Bruce protocol. Total exercise time was 7.27 minutes. Heartrate increased from 110 beats/minute to 165 beats/minute (99% predicted for age). Blood pressure increased from 124/73 to 154/60. She remained asymptomatic throughout and there were no ischaemic changes or arrythmias. Therefore negative for coronary ischaemia at a high workload.

Opinion and Plan:
First of all, I am pleased to report that Melanie's coronary status is satisfactory with no evidence of coronary ischaemia at a high workload on exercise testing today. However we did notice a rapid heartrate response with exercise which also could be due to her lack of physical fitness.

Melanie needs to be handled as someone who requires secondary prevention given her history for a PCI and in the context of a positive family history for premature coronary disease.

- I have obtained Special Authority for Rosuvastatin and this has been prescribed at Rosuvastatin 5mg daily, starting low due to her history for intolerance on Atorvastatin. Her lipid profile will be checked in three months' time and if her LDL cholesterol is >1.4mmol/L, Rosuvastatin should be increased to 10mg if tolerated. I will leave this in her GP's good hands to follow through.

- It is apparent that she has a brisk heartrate response with exercise and I have introduced Bisoprolol 2.5mg daily to her regime. Her exertional symptoms may be due to a rapid heartrate increase with exercise and therefore Bisoprolol should provide some benefit.

- She needs to remain on Aspirin for life.

- She will get an echocardiogram performed in January to exclude any structural heart disease particularly with respect to her history for radiotherapy.

I have discharged her back to her GP's care and have given her the clearance to proceed with surgery in the future.

Kind regards,
Yours sincerely

Raffat Shameem
Consultant Cardiologist
RS:sc

Manawatu Heartcare
Crest Hospital Specialist Centre
21 Carroll Street, Box 442
Palmerston North
Ph: 069532498

Transthoracic Echocardiography

Dr Raffat Shameem, MB, ChB, FRACP Cardiologist

Patient Name: LILLEY, Melanie
Address: 108 Kukutauaki Road RD 5 LEVIN 5575
Patient ID: EBJ1364
Date of Birth: 01/06/1968
Sex: Female
Height: 162.0 cm
Weight: 79.0 kg
BSA: 1.84 m²

Exam Date: 20/01/2023
Echocardiographer: Dr Raffat Shameem
Referring Dr: Dr R Shameem, Dr F Haerewa
Referral Reasons: Exercise induced dyspnoea. Radiotherapy for lymphoma at 23 years ? SHD

2D	
Ao asc	2.7 cm
LVOT Diam	1.9 cm
Ao sinus	2.9 cm
Ao st junct	2.7 cm
Ao Arch Diam	2.3 cm
Ao Desc Diam	1.3 cm
IVSd	0.7 cm
LVIDd	4.6 cm
LVIDd Index	2.5 cm/m²
LVPWd	0.7 cm
LVIDs	3.3 cm
LVIDs Index	1.8 cm/m²
EF(Teich)	53 %
%FS	27 %
LA Diam	3.0 cm
G peak SL(APLAX)	-13.4 %
G peak SL(A4C)	-17.1 %
G peak SL(A2C)	-17.4 %
G peak SL(Avg)	-15.9 %

M-Mode	
TAPSE	2.3 cm
Volume / Area	
EF Biplane	64 %
LVEDV MOD BP	110 ml
LVESV MOD BP	40 ml
LVEDV BPi	60 ml/m²
LVESV BPi	22 ml/m²
LAESV(A-L)	64 ml
LAESV Index (A-L)	35 ml/m²
RAESV MOD	51 ml
RAESVi	28 ml/m²
4D	

Doppler	
LVOT Vmax	0.8 m/s
LVOT VTI	20.7 cm
AV Vmax	1.5 m/s
AV maxPG	8.5 mmHg
AV meanPG	5.1 mmHg
DPI	0.60
AVA (VTI)	1.8 cm²
AVAI (VTI)	1.0 cm²/m²
DAo Vmax	1.0 m/s
AR PHT	669 ms
PV Vmax	1.1 m/s
PV maxPG	4.8 mmHg

MV E Vel	1.0 m/s
MV DecT	160 ms
MV A Vel	1.2 m/s
MV E/A Ratio	0.9
MV A Dur	131 ms
Septal E'	0.06 m/s
E/Septal E'	17.77
Lateral E'	0.09 m/s
E/Lateral E'	11.73
RVS'	0.13 m/s

Comments

Rate and rhythm:
Cardiac Chambers - Normal left ventricular size, wall thickness and function. EF biplane 64 %, GLS (GE) [-15.9]%.
No regional wall motion abnormality. Grade 1 diastolic dysfunction with raised LAP.
Right ventricular size and systolic function is normal. TAPSE: 2.3 cm, RVS': 0.13 m/s.
Left atrium is mildly dilated. Right atrial size is normal. Interatrial septum is intact. No thrombus.
Cardiac Valves - Mitral: Normal. Aortic: Mild thickening of the aortic cusps with trivial regurgitation, no stenosis.
Tricuspid: Normal. Pulmonary: Normal. Aortic root is normal. No pericardial effusion. No coarctation.

Diagnosis

Normal LV size and function, EF 64 %
Minor thickening of the aortic valve? radiation effect with trivial regurgitation, no stenosis

No follow up recommended

LFu

Liver Function

Andries DE LANGE

pathlabs

17/03/2023

Lab Result

Bilirubin

6 umol/l (2-24)

Alk Phosphatase

116 U/L (40-120)

GGT

15 U/l (10-35)

ALT

20 U/l (0-45)

AST

30 U/l (10-45)

Total Protein

74 g/L (65-80)

Albumin

38 g/L (32-48)

Lipid Tests
Andries DE LANGE
pathlabs
17/03/2023

Lab Result

Cholesterol
4.0 mmol/L

Triglyceride
0.8 mmol/L

HDL Cholesterol
1.8 mmol/L

Chol/HDL Ratio
2.2

cLDL Cholesterol
1.8 mmol/L

Lipid Comment
A combined CVD risk, of which lipids is one component shc
estimated to guide CVD risk management decisions. If lipid
modifying medication is considered, suggest checking firstl
treatable secondary causes of dyslipidaemia. For further
information on CVD risk and lipid levels please refer to
https://www.health.govt.nz/system/files/documents/publicat
risk-assess ment-and-management-for-primary-care-v2.pdl

HbA

HbA1c

Andries DE LANGE

pathlabs

17/03/2023

Lab Result

HbA1c

38 mmol/mol

***HbA1c measurements may be misleading in cases of haemoglobinopathy,

increased red cell turnover or post transfusion; amongst others.***

In the setting of diagnosis or CV risk screening, this result virtually

excludes diabetes. There is no need to repeat this test until scheduled CVD

risk assessment.

Liver Function
Andries DE LANGE
pathlabs
17/03/2023

Lab Result

Bilirubin
6 umol/l (2-24)

Alk Phosphatase
116 U/L (40-120)

GGT
15 U/l (10-35)

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AST
30 U/l (10-45)

Total Protein
74 g/L (65-80)

Albumin
38 g/L (32-48)

UAc

Uric Acid

Andries DE LANGE

pathlabs

17/03/2023

Lab Result

Uric Acid

0.31 mmol/l (0.16-0.42)

In patients with acute gout the levels may be within the stated population

reference interval for uric acid. Furthermore, the target for patients on

treatment for hyperuricaemia is </= 0.36 mmol/L.

TFu

Thyroid Function

Andries DE LANGE

pathlabs

17/03/2023

Lab Result

TSH

2.33 mU/L (0.27-4.2)

Thyroid range comment

Reference Interval supplied for Thyroid Function Tests is for NON-PREGNANT females only.

Cre

Creatinine

Andries DE LANGE

pathlabs

17/03/2023

Lab Result

Creatinine

73 umol/l (45-90)
2 should not be considered

2 should not be considered

2 should not be considered

abnormal unless there is other evidence of kidney damage, such as

proteinuria or haematuria, when it may represent stage 2 CKD.

Refer www.kidney.org.au

Estimated GFR is only reliable under steady state conditions (stable

creatinine >4 days). Caution should be used in interpretation in

non-Caucasians, extremes of body weight, pregnancy, oedematous subjects,

CBC

Complete Blood ...

Andries DE LANGE

pathlabs

17/03/2023

Lab Result

RBC

4.9 x10'12/L (3.9-5.5)

Haemoglobin

131 g/L (115-155)

PCV

0.42 L/L (0.36-0.47)

MCV

85 fL (80-100)

MCH

27 pg (27-32)

Red Cell Width

13.8 % (11.5-14.5)

Platelet Count

283 x10'9/L (150-400)

WBC

6.9 x10'9/L (4.0-10.0)

Neutrophil

4.3 x10'9/L (2.0-7.5)

MCH

Red Cell Width
13.8 % (11.5-14.5)

Platelet Count
283 x10'9/L (150-400)

WBC
6.9 x10'9/L (4.0-10.0)

Neutrophil
4.3 x10'9/L (2.0-7.5)

Lymphocyte
1.8 x10'9/L (1.2-3.5)

Monocyte
0.5 x10'9/L (0.3-1.0)

Eosinophil
0.2 x10'9/L (0.05-0.4)

Basophil
0.0 x10'9/L (0.0-0.10)

ImmGranulocyte
0.0 x10'9/L (0.0-0.25)

Blood Film
Blood film not examined.

Ōtaki Medical Centre
2 Aotaki Street Otaki, Otaki 5512
Ph: 063648555
Email: admin@otakimedical.co.nz

Please Scan RECEIVED 03 AUG 2022

Melanie Lilley

Patient Name:
NHI Number: EBJ1364
Date of Birth: 01-Jun-1968

Radiology ULTRASOUND

This report is for: N/P F. Haerewa
Referred By:
N/P F. Haerewa

PELVIC ULTRASOUND 27/07/2022 Reference: 1098800
NHI: EBJ1364

INDICATION:
Urinary incontinence. Previous procedure in Australia in 2013.

FINDINGS:
Both kidneys are normal no hydronephrosis.
The urinary bladder appears grossly normal.
Transabdominal and transvaginal scans the pelvis.
The uterus is anteroverted and of normal size measuring approximately
84 x 59 x 38 mm. There is a left sided submucosal fibroid measuring
approximately 40 x 45 x 32 mm.
The endometrium measures approximately 9 mm in thickness which is the
upper limit of normal for this age, no focal endometrial lesion is
seen.
Neither ovary is demonstrated, there is no other evidence of
significant adnexal abnormality and no free fluid is demonstrated

IMPRESSION:
Left sided para uterine fibroid.
Slightly prominent endometrial cavity.
Neither ovary is demonstrated.

Radiologist: Dr J. Graham

This examination was performed at Horowhenua X-ray, Horowhenua Health
Centre.

Ordering Provider: F HAEREWA
Patient GP:
Laboratory: brwayrad
Observation Date: 27-Jul-2022

Dr Sarah Machin

MBChB, FRANZCOG

Obstetrician & Gynaecologist (NZMC No. 31953)

P.O. Box 442 PALMERSTON NORTH,
Tel: (06) 953 2498 Fax: (06) 953 2494
Private Rooms: Crest Specialist Centre, 21 Carroll Street Palmerston North

Date of Clinic: 6 September 2022

NOT KNOWN @ HCP

Ms F E Haerewa
Horowhenua Community Practice
PO Box 50
LEVIN

Dear Fay

Re: Melanie Jane Lilley NHI: EBJ1364

Thank you for referring this lovely 54-year old with urinary incontinence. On further questioning today, this is not her main concern.

As you know, she had a TVT inserted in 2013 in Australia to manage stress urinary incontinence. At the same time, she had resection of a submucosal fibroid and insertion of a Mirena. She was amenorrhoeic with the Mirena which was removed 2-3 months ago, since then having erratic and heavy bleeding. She has not had any obvious menopausal symptoms. Smears are normal and up to date.

She does not really have any leakage at present but describes frequency and urgency, with occasional incomplete emptying. Melanie is para 3, all vaginal deliveries. She has an extensive past history including non-Hodgkins lymphoma in her 20s which was treated with radiotherapy and chemotherapy. In her 40s, she had an MI and has a stent in place. She has previously had an appendectomy. She is currently only taking Aspirin.

Recently from a cardiac perspective, Melanie is concerned there is something wrong and feels her heart is always racing, and after exertion feels almost needs to re-set itself. On occasion, she feels short of breath but she has no chest pain. She is keen to see a Cardiologist and is happy to go privately for this. I have therefore referred her to my colleagues today.

The USS you kindly arranged showed a 9mm endometrium and a 4 x 4.5 x 3.5cm fibroid. It is unclear from the images and report whether this is submucosal or not.

On examination, Melanie has a normal BMI. Her abdomen was soft and non-tender with no palpable masses. Gynaecological examination revealed no prolapse and no visible mesh. The uterus was anteverted and bulky and a pipelle biopsy was taken.

In summary, we need to exclude any endometrial pathology causing Melanie's recent bleeding. I am going to review her USS in terms of the location of her fibroid at our MDT meeting.

I have referred her to Cardiology and following all this, I will review her and plan ongoing management of her bladder symptoms.

Thank you for your referral.

Dr Sarah Machin

MBChB, FRANZCOG

Obstetrician & Gynaecologist (NZMC No. 31953)

P.O. Box 442 PALMERSTON NORTH,
Tel: (06) 953 2498 Fax: (06) 953 2494
Private Rooms: Crest Specialist Centre, 21 Carroll Street Palmerston North

Date of Clinic: 14 March 2023

Tararua Medical Centre
538 Queen Street East
Levin 5510

20 MAR 2023

Dear Doctor

Re: **LILLEY, Melanie Jane** NHI: **EBJ1364**

It was lovely to see Melanie today. She recently had an episode of very heavy bleeding, passing huge clots for 5 days. Prior to this, she had persistent light bleeding. The heavy bleeding has now stopped.

Her second issue is urinary urgency and occasional urge incontinence. She needs to get up multiple times during the night to void. She never feels she empties her bladder fully. She has no stress incontinence. She drinks lots of tea but has tried stopping this or switching to green tea which has not helped her urgency. Her smears are normal and up to date. She has recently seen Dr Shameem and has been cleared from a Cardiology perspective.

In terms of her new bleeding, I think she needs a repeat USS so I have requested this via Broadway Radiology. Regarding her urinary symptoms, we discussed lifestyle modification and the difference between urge and stress urinary incontinence. Due to her history of a prior tape and incomplete bladder emptying, I think she needs urodynamics prior to commencing an anticholinergic. Melanie does not have medical insurance and the cost of this in the private sector is prohibitive so I have referred her to the public system. Should she be found to have to wait for a long time, she may re-contact us and I will arrange for these to be done privately.

Best wishes

Yours sincerely

Sarah Machin

Dr Sarah Machin
Consultant Gynaecologist
Electronically sighted and confirmed