Patient Name:	GUEST, SUSAN		
Patient Address:	COURADDA, NARRABRI 2390		
D.O.B:	22/01/1959	**Sex at Birth:**	F
Medicare No.:	2292249421	**IHI No.:**	
Lab. Reference:	6371965Z047	**Provider:**	SYDPATH
Addressee:	DR OKWUN OJAH	**Referred by:**	Dr OKWUN OJAH
Date Requested:	1/02/2024	**Date Performed:**	2/02/2024
Date Collected:	2/02/2024	**Complete:**	Final
Specimen:			
Subject(Test Name):	IRON STUDIES		
Clinical Information:			

	Current Result	Previous results for comparison only				
Date:	02/02/24	18/01/24	27/11/23	05/10/23		Reference
Time:	10:10	11:40	10:30	11:30		(for this
Request No.:	6371965	6371139	6368350	6365086	Units	collection)
Iron Studies						
Ferritin serum	233	303 H	242	228	ug/L	30-300
Iron serum	20	28	29	19	umol/L	10-30
Transferrin	1.6 L	1.7 L	1.8 L	1.8 L	g/L	2.0-3.5
Transferrin satn	50	66 H	64 H	42	%	15-50

Tests Pending: Vit B12,EBV Serology,Ross River Virus Serology

Patient Name:	GUEST, SUSAN		
Patient Address:	COURADDA, NARRABRI 2390		
D.O.B:	22/01/1959	**Sex at Birth:**	F
Medicare No.:	2292249421	**IHI No.:**	
Lab. Reference:	6371965S015	**Provider:**	SYDPATH
Addressee:	DR OKWUN OJAH	**Referred by:**	Dr OKWUN OJAH
Date Requested:	1/02/2024	**Date Performed:**	2/02/2024
Date Collected:	2/02/2024	**Complete:**	Final
Specimen:			
Subject(Test Name):	EBV SEROLOGY		
Clinical Information:			

Viral Serology (serum)
EBV VCA IgG Interp Reactive
EBV VCA IgM Interp Reactive

glandular fever

Epstein Barr Virus Comment

These results suggest recent infection with Epstein Barr virus.

Tests Pending: Ross River Virus Serology

ST VINCENT'S PRIVATE HOSPITAL
TOOWOOMBA

HEPATOLOGY GASTROENTEROLOGY

Referring Doctor: Dr Okwun Ojah
Narrabri Medical Centre
110 Tibbereena Street
NARRABRI 2390

Toowoomba Gastroenterology Clinic
Medici Medical Centre
Level 1, Suite 105, 15 Scott Stree
Toowoomba QLD 435
Ph: 07 4639 412

Patient:	**GUEST, SUSAN**	**Patient ID:**	200214
Patient DOB:	22/01/1959	**Procedure Date:**	13/04/2023

COLONOSCOPY REPORT

Examiner:	Dr Robyn Nagel	**Scope:**	
Anaesthetist:	Dr Greg Bond	**Withdrawal (h/m/s):**	

Indication

Abdominal pain, left loin. Surveillance of previous polyps.

Colonoscopy History

A previous colonoscopy was performed on this patient 6 years ago.

Distance & Preparation

The bowel was prepared using split Moviprep.

The preparation was excellent.

Medications administered as per anaesthetist: Fentanyl, Midazolam, Propofol.

Optiflow O2 delivery used.

The colonoscope was inserted to the terminal ileum.

Findings & Interventions

DRE/Perineum

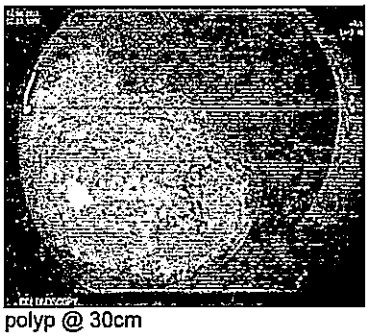
The perineum appeared normal. Digital rectal examination was normal.

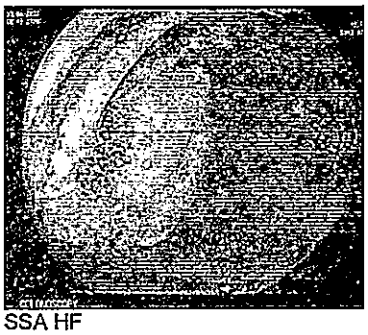
Ileum

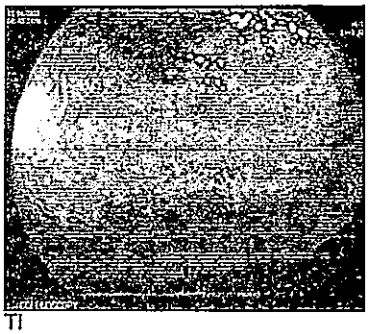
The ileum appeared normal.

Colon

There were 10 flat polyps in the ascending colon (15mm, x1) and the sigmoid colon (size of the largest: 20mm, x8), with a typical adenomatous (sessile serrated) appearance. The 30cm site was injected with 6mL of Gelofusine. A single clip was applied at the HF as a precaution against bleeding.


polyp @ 30cm


SSA HF


TI

Summary

Colonic polyp(s).

Follow-Up

A repeat colonoscopy is recommended in 3 years.

Follow up in my private rooms in 6 weeks.

Copies To: St Vincent's Hospital
Item no: 32222, 32229

ST VINCENT'S PRIVATE HOSPITAL
TOOWOOMBA

HEPATOLOGY GASTROENTEROLOG

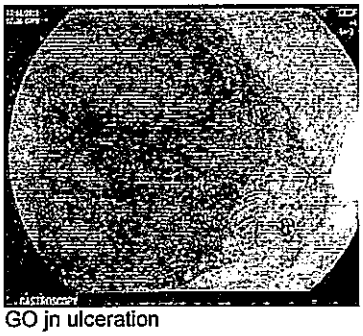
Referring Doctor: Dr Okwun Ojah
Narrabri Medical Centre
110 Tibbereena Street
NARRABRI 2390

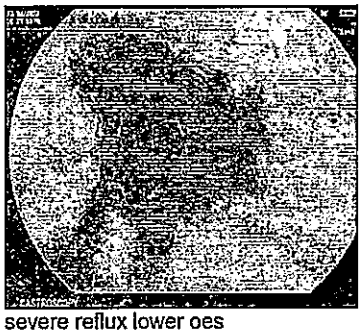
Toowoomba Gastroenterology Clini
Medici Medical Centr
Level 1, Suite 105, 15 Scott Stre
Toowoomba QLD 435
Ph: 07 4639 412

Patient:	**GUEST**, SUSAN	**Patient ID:**	200214
Patient DOB:	22/01/1959	**Procedure Date:**	13/04/2023

GASTROSCOPY REPORT

Examiner:	Dr Robyn Nagel	**Scope:**	
Anaesthetist:	Dr Greg Bond	**Withdrawal (h/m/s):**	


GO jn ulceration


severe reflux lower oes

Indication

Abdominal pain - left upper loin.

Distance & Preparation

The endoscope was inserted to the third part of the duodenum without difficulty. Medications administered as per anaesthetist: Fentanyl, Midazolam, Propofol. Optiflow O2 delivery used.

Findings & Interventions

Oesophagus

Gastro-oesophageal junction situated at 38cm. There was a 2cm hiatus hernia present. There was severe, erosive reflux oesophagitis in the lower third of the oesophagus and the region of the gastro-oesophageal junction.

Stomach

The stomach appeared normal. Biopsies were taken from the antrum.

Duodenum

The duodenum appeared normal. Biopsies were taken from the 2nd part of the duodenum. Tissue sent for disaccharidases testing and histology.

Summary

Hiatus hernia.

Severe reflux oesophagitis.

Instructions

Commence Nexium 20mg b.d. as planned.

Follow-Up

Follow up in my private rooms in 8 weeks.

Copies To: St Vincent's Hospital

MBS Codes: 30473.

QUEENSLAND X-RAY PTY LTD ABN 40 094 502 208
St. Vincents Toowoomba, TOOWOOMBA, QLD, 4350
Telephone : 07 4659 4500 Facsimile : 07 4659 4550

Friday, 16 June 2023

DR NANDANA ERATHNA ERATHNAGE
SUITE 4
159 MAITLAND STREET
NARRABRI NSW 2390

RE: MS SUSAN GUEST (22/01/1959)
COURADDA
NARRABRI NSW 2390

Patient ID : QXR2182719
Service Date : 14/06/2023
Dept :
UR No :
Episode ID : SVH20254604

EPID:
nca/sgl1

MRI THORACIC AND LUMBOSACRAL SPINE

History: Left sided thoracic wall pain ?nerve impingement.

Findings: Thoracic vertebral alignment is satisfactory. No acute fracture or subluxation. Bone marrow signal intensity is preserved.
No focal bone abnormality. The intervertebral discs appear preserved.
No intervertebral disc herniation. The thoracic spinal cord is intact with no cord compression. No significant nerve root impingement.
Facet joints appear intact.
Lumbar vertebral alignment satisfactory. No acute fracture or subluxation. Bone marrow signal intensity is normal. No focal bone abnormality. Upper lumbar intervertebral disc are preserved.
L4/5 level: Intervertebral disc height reduction with disc desiccation and posterolateral disc herniation with moderate neuroforaminal narrowing potential impingement of the exiting L4 nerve root. Bilateral facet joint arthropathy.
L5/S1 level: Intervertebral disc height reduction with posterolateral disc herniation with moderate neuroforaminal narrowing potential impingement of the exiting L5 nerve root. Bilateral facet joint arthropathy.
Sacroiliac joints are intact except for degenerative changes.
Pre and paravertebral soft tissues unremarkable.

Conclusion: No significant abnormality of the thoracic spine. The thoracic spinal cord and the nerve roots are intact. Degenerative lumbar intervertebral disc changes mainly at L4/5 and L5/S1 level with discogenic exiting neuroforaminal narrowing and nerve root impingement.

Dr Nishani Atapattu
Queensland X-Ray

IRD

Hunter Imaging (incorporating Coast Medical, Castlereagh Imaging and Cardio-Vascular Centre)

12/09/2023

DR OKWUN OJAH
110 TIBEREENA STREET
NARRABRI NSW 2390

Phone: (02)67922949
Fax:

MRS SUSAN GUEST (22/01/1959)
COURADDA
NARRABRI NSW 2390
EPID:

Service Date: 11/09/2023
Patient Id: HIG167086
Episode No: TAM6028363

MR RIGHT KNEE

Clinical History:
Recent fall with pain in the medial joint

Findings:
The ACL and PCL are intact.

Horizontal tear seen affecting posterior horn body of the medial meniscus with meniscal extrusion in medial gutter. Grade 1 sprain of medial collateral ligament is seen. There is evidence of the deep fissuring of the articular cartilage along the central weight-bearing surface of the medial tibial and femoral condyles.

There is evidence of full-thickness articular cartilage defect measuring 6.4 mm along the medial aspect of the lateral femoral condyles involving the posterior aspect. Deep fissuring also seen along the lateral tibial condyles. The lateral meniscus and the lateral collateral ligaments are intact.

The proximal tibiofibular joint appears normal.
The popliteal neurovascular structures appear normal.

Deep cartilage fissuring along the inferior aspect of the trochlea seen with the associated subarticular oedema in the central trochlea.. Quadriceps and patellar tendons are normal.

Minor suprapatellar joint effusion is seen. An intact popliteal cyst is seen measuring 53 x 8 mm in size..

CONCLUSION:

1. Deep cartilage thinning suggestive of advanced chondromalacia as described.
2. Horizontal tear of the posterior horn and body of the medial meniscus and grade 1 sprain of medial collateral ligament.
3. Minor suprapatellar effusion and intact Baker's cyst.

MR RIGHT ANKLE

Clinical History:
Recent injury with discomfort right ankle

Findings:
Advanced chondromalacia along the tibiotalar joint with a full-thickness cartilage loss. Subarticular cystic change oedema seen in the tailor dome as well as in the tibial articular surface. No joint effusion is seen. The subtalar and midfoot joints are normal. Hindfoot alignment is normal.

Advanced changes seen in the tarsometatarsal joints predominant affecting 3rd 4th and 5th TMT joints with subarticular cystic changes.

The syndesmotic ligaments are intact. Thickening of the calcaneofibular ligament and anterior talofibular ligament suggest sequelae of prior tear. No acute tear is seen. Posterior talofibular ligament is intact.. Deltoid ligament complex and spring ligament are intact.

A longitudinal split tear is seen of the peroneus brevis tendon starting just of the level of the tip of the lateral malleolus. It extends for a length of approximately 4.5 cm and reunites before the insertion. Peroneus longus tendon is intact. Minimal oedema seen in the peroneal tendon sheath.

There is evidence of fluid in the posterior tendon sheath. Tendon is intact., the anterior extensor tendons are unremarkable.

Achilles tendon and plantar fascia are intact. Sinus tarsi retains normal fat signal.

CONCLUSION:

1. Osteoarthritis change involving the ankle joint as well as the 3rd, 4th and 5th tarsometatarsal joints.
2. Longitudinal split tear of the peroneus brevis tendon
3. Tibialis posterior tenosynovitis.

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Hunter Imaging (incorporating Coast Medical, Castlereagh Imaging and Cardio-Vascular Centre)

4. No acute ligamentous tear. Sequela of old tear of the anterior talofibular and calcaneofibular ligaments.

Dr. Mudit Gupta

report electronically authorised by Dr Mudit Gupta

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