PORTSMOUTH
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=> Mulb A (141)

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Dr V Banks
Consultant in Old Age Psychiatry
Gosport War Memorial Hospital
Bury Road
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please file

Code A

Dear Vicky

WARD VISIT - MULBERRY A, GWMH
ARTHUR CUNNINGHAM, DOB Code A
HA: ALVERSTOKE HOUSE NURSING HOME, SOMERVELL CLOSE, GOSPORT

Mr Cunningham was reviewed on Mulberry A on 27 July at Dr Child's request as he wished the dose of Levodopa to be increased. I visited at 8.45 am and he was at the breakfast table with two other gentlemen, was observed to be eating his porridge on his own, subsequently buttered his toast which he was able to swallow without any obvious dysphagia, or bradykinesia.

Mr Cunningham has not been observed to have any particular day-time stiffness, but I note from his medical notes that there has been some stiffness at night although this seems to be improving. Clinically he had mild cogwheel rigidity in the left upper limb, a tremor on the left more than the right, was not dystonic, dysphonia as before, but there was no evidence of any stuttering or freezing. The dose of Levodopa had been reduced as he had problems with severe postural hypotension, hallucinations and dystonia on a higher dose.

Investigations early last week confirm normal renal function with a very low serum albumin of 26. However, a couple of days later (22 July) his urea has risen to 11, creatinine 101, electrolytes are normal and the albumin is spuriously raised at 47. Thyroid function tests are normal. His white count remains low but stable at 2.9, haemoglobin is normal at 14, MCV 93.5 and platelets stable around 100. ESR is 18.

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I do not feel that further action need be taken about his neutropenia and thrombocytopenia but feel that he will need weekly full blood counts for the present. I feel his fluid input should be increased, aiming for 2 litres a day. I have also mentioned him to Ruth Deverill, Speech and Language Therapist so that his swallow could be formally assessed as he may benefit from thickened fluids rather than thin fluids if this is difficult. I feel that his present dose of Co-careldopa 110 should be maintained at 5 a day, but if night-time stiffness is still a problem towards the end of the week I would suggest that this is increased to Co-careldopa CR 250 at 10.00 pm and the 110 omitted. If this does cause more problems with hallucinations the dose will need to be reduced back again.

Overall Mr Cunningham's parkinson's disease is no worse and his transfers continue to be difficult mostly due to an old war injury which has resulted in considerable weakness of the pelvic girdle.

I would be happy to review him as appropriate.

With best wishes.

Yours sincerely

Code A

Dr A Lord FRCP
Consultant Physician in Geriatrics