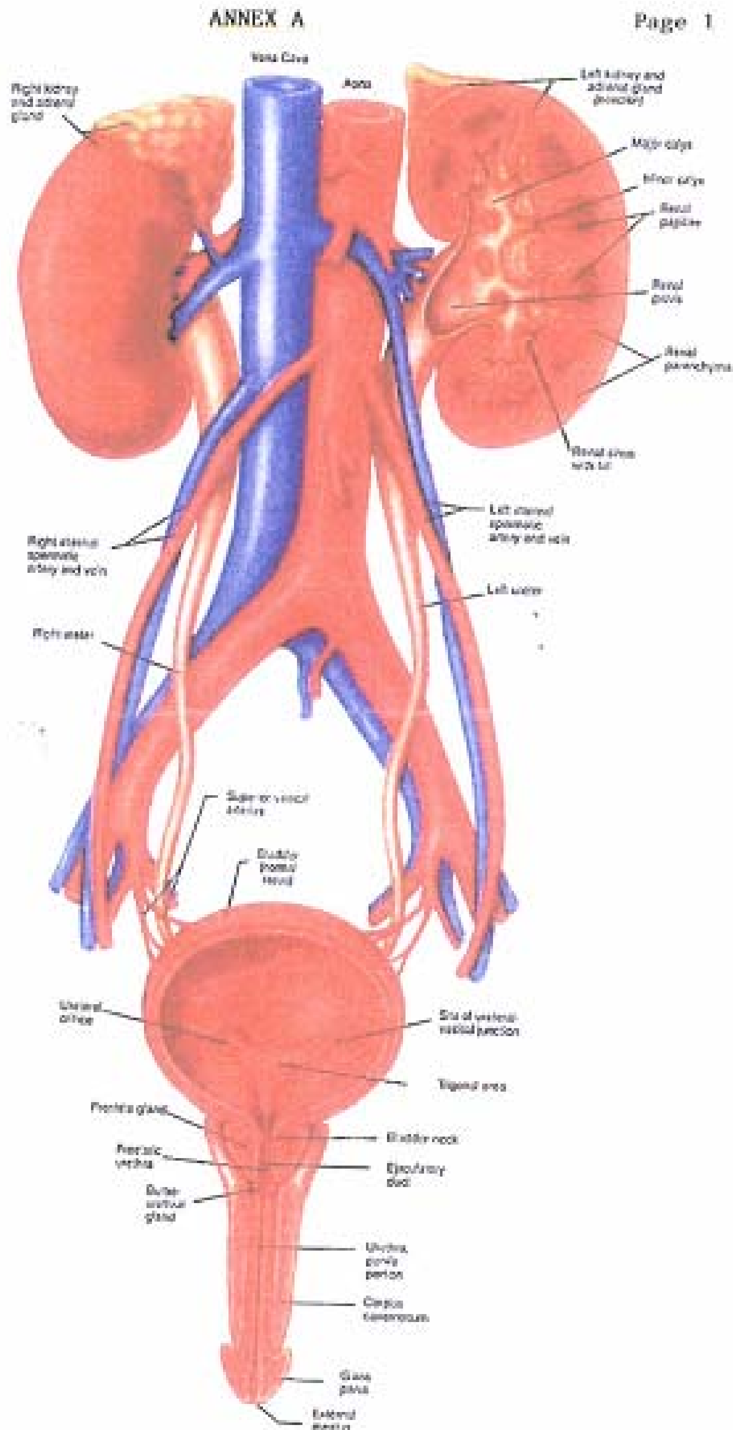
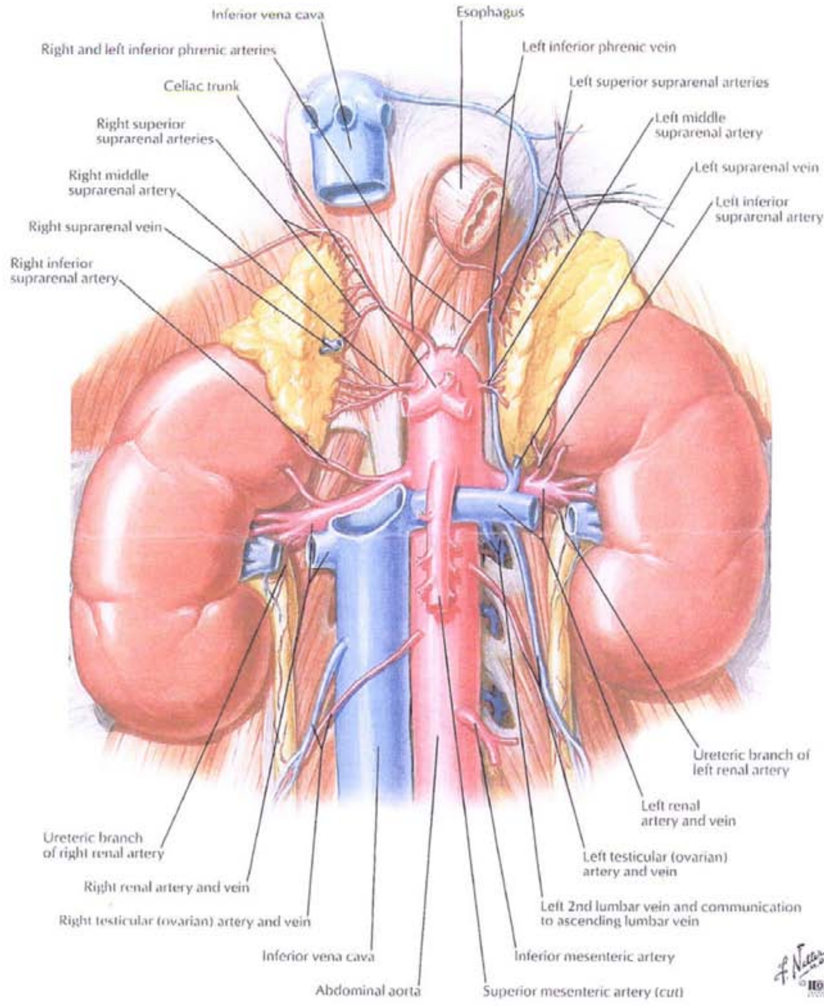
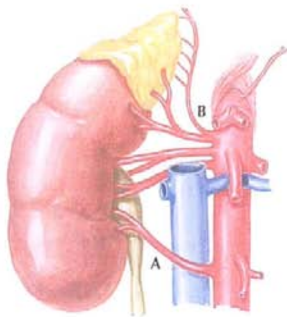
Surender Singh s/o Jagdish Singh and another (administrators of the estate of Narindar Kaur d/o Sarwan Singh) v Li Man Kay and others
[2009] SGHC 168

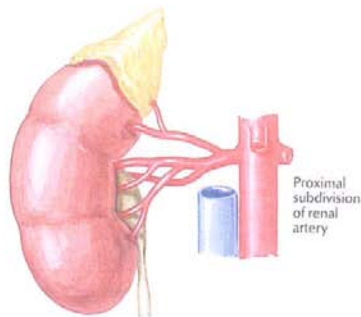


Renal Artery and Vein In Situ



Variations in Renal Artery and Vein

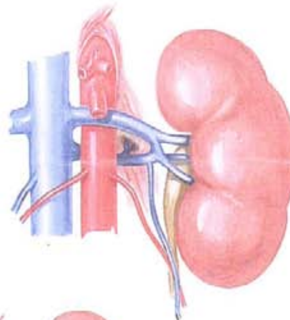




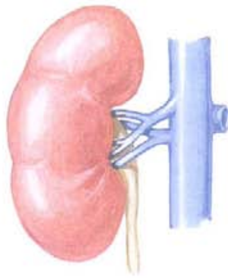
Proximal subdivision of renal artery

A Low accessory right renal artery may pass anterior to inferior vena cava instead of posterior to it

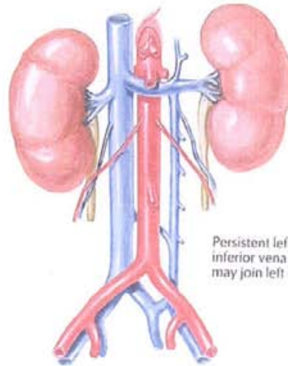
B Inferior phrenic artery with superior suprarenal arteries may arise from renal artery (middle suprarenal artery absent)



Double left renal vein may form ring around abdominal aorta



Multiple renal veins



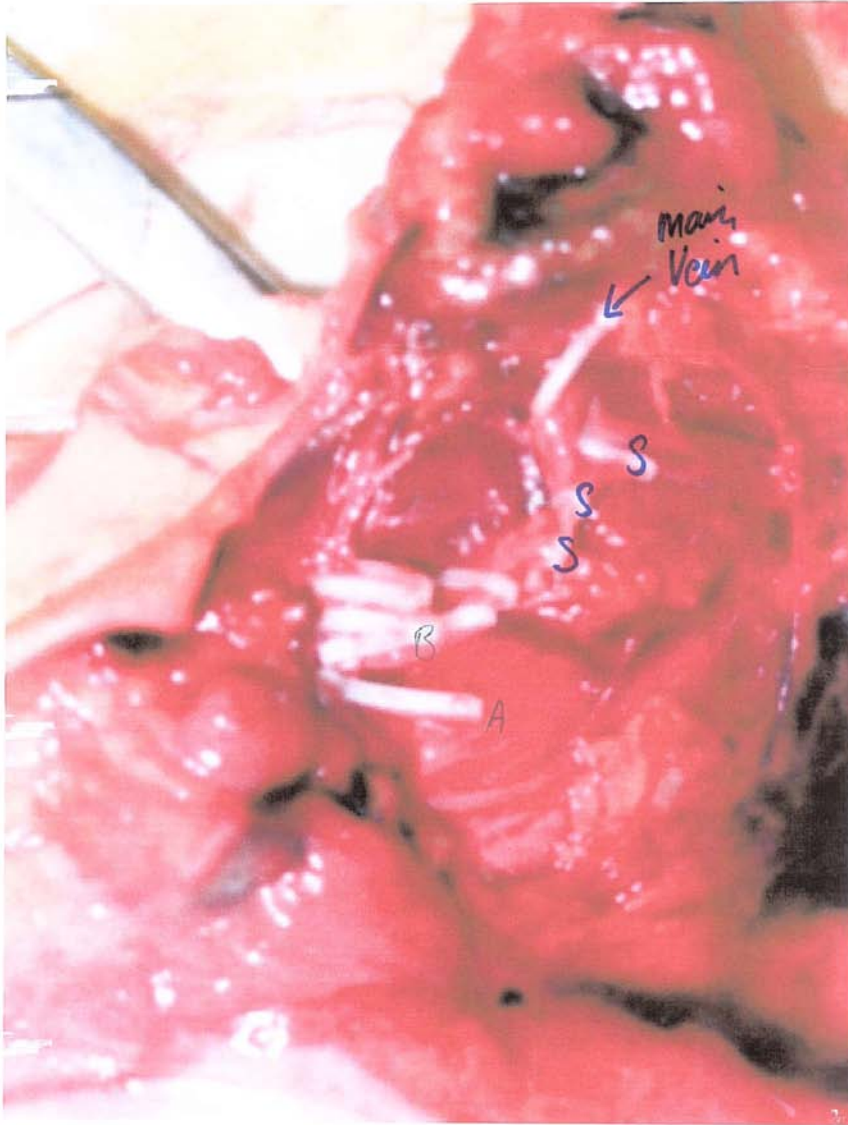
Persistent left inferior vena cava may join left renal vein

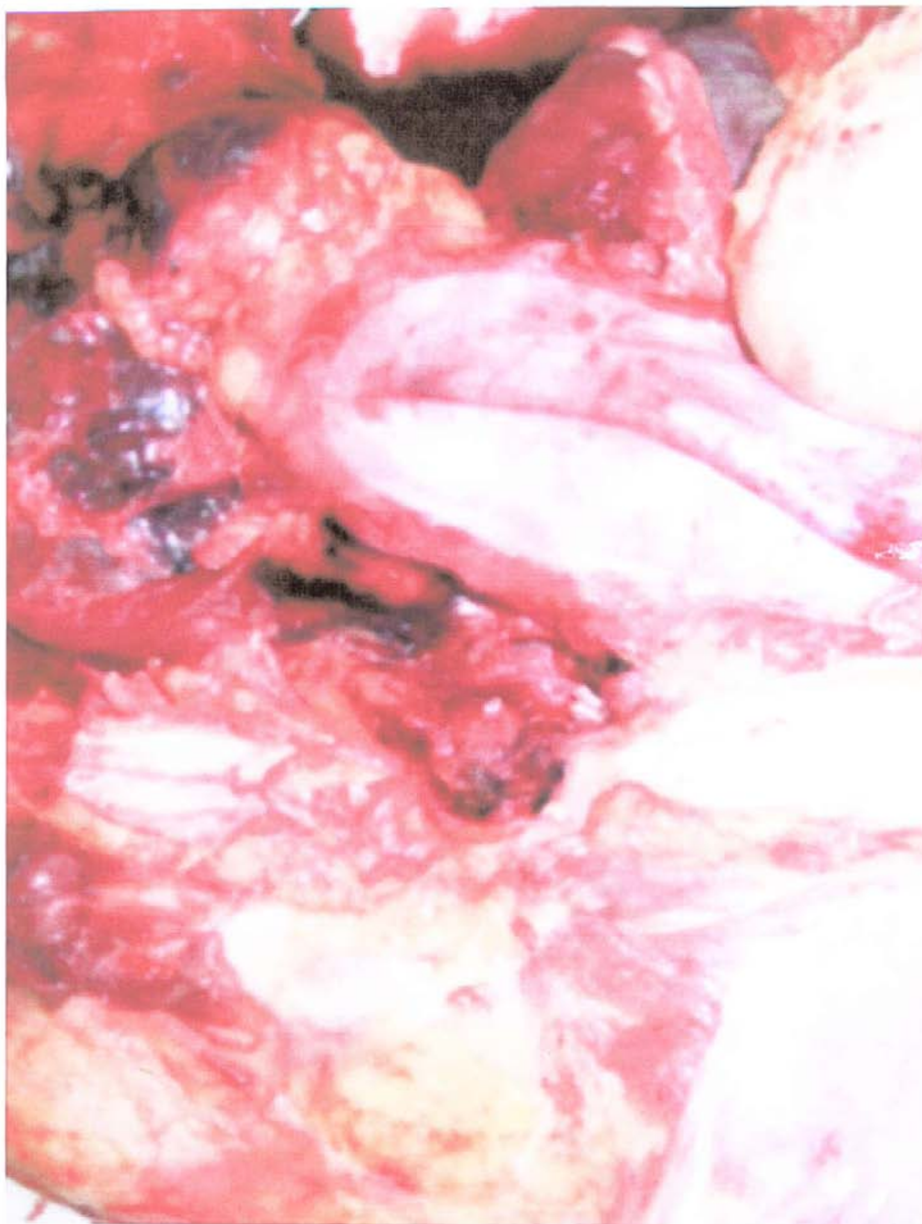
F. Netter ©ICON

ANNEX B

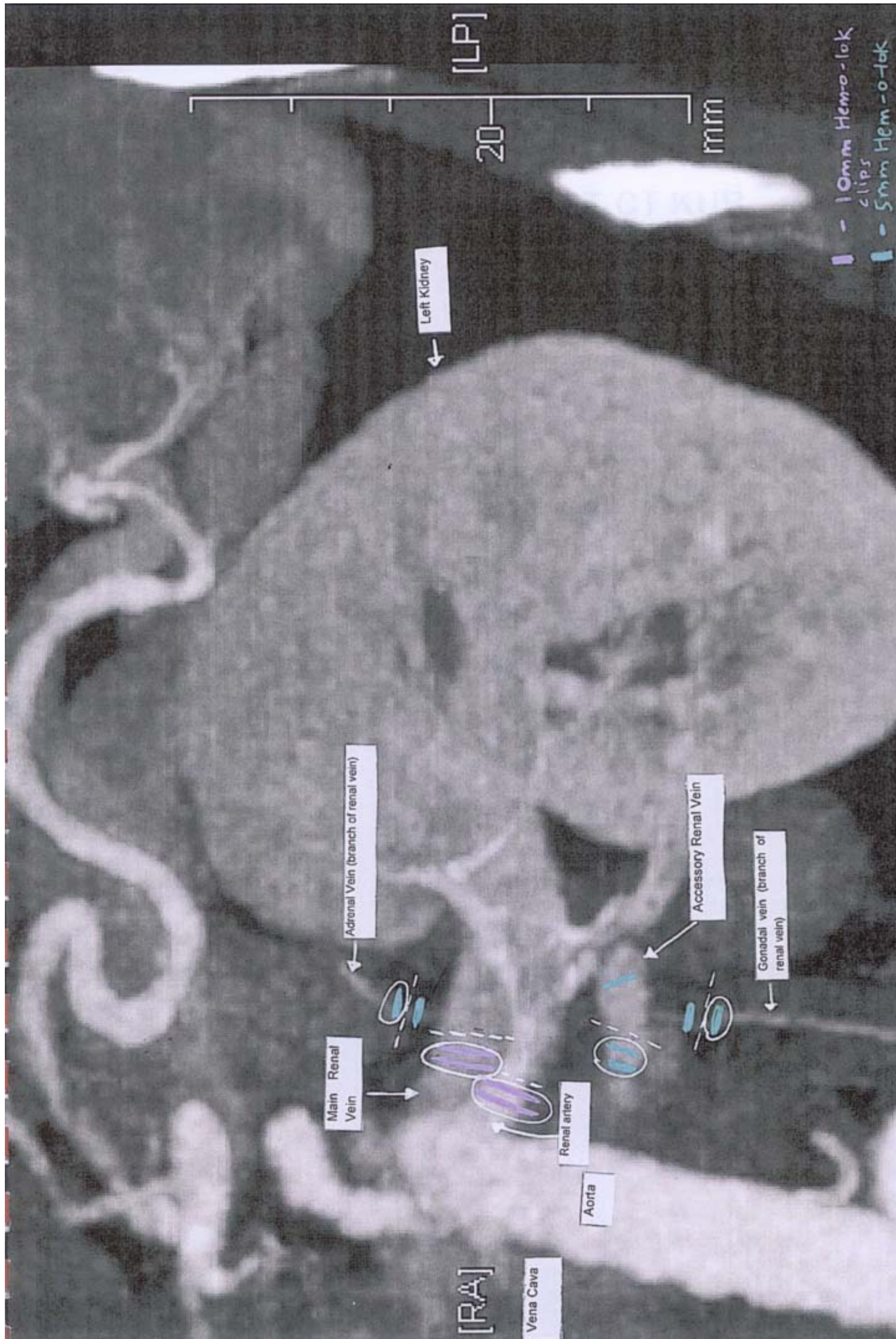
5 mm M

10 mm L


main
Vein
S
S
S
B
A



ANNEX D



ANNEX E

PLOPERPT-01 National University Hospital
Original OPERATION REPORT [Operation 1 of 1]

MRN:	SJ7213342	Account:	155011148100	
Name:	NARINDAR KAUR D/O SARWAN SINGH	Sex/Race/Birth:	F/X/07-02-1972	
Dept/Ward/Room/Bed:	32/WD43/ /24			
Enter Date/Time	16-02-2005 08:30	Exit Date/Time	16-02-2005 12:00	
First Surgeon	05025C	LI MAN KAY	Medical Service	109
Second Surgeon	02864I	DAVID TERRENCE CONSIGLIERE		
Visiting Consultant				
Assistant 1	07161G	CHONG KIAN TAI		
Assistant 2				
Assistant 3				
Principal Anaesthetist	06681H	NG HUEY PING		
Assistant				
Date/Time Op Started	16-02-2005 08:55	Completed	16-02-2005 11:50	
Nature of Operation	Medical	Theatre No	OR03	
Priority of Operation	Elective	Type of Anaesthesia	GA	
Surgical Code	SLG018K	KIDNEY,VARIOUS LESIONS,NEPHRECTOMY (LAPAROSCOPIC/MINIMAL ACCESS)		
Surgical Table	5A			
Summary of Operation	Hand-assisted laparoscopic left donor nephrectomy			
Post-Op Diagnosis1	V594	KIDNEY DONORS		
Post-Op Diagnosis2				
Post-Op Diagnosis3				

Findings Normal left kidney with single renal artery and vein

Operative Procedures

GA, cleaned and draped
Lower midline incision through previous abd scar deepened into peritoneum.
Adhesiolysis to left hypochondrium
Lap disc, 10 mm ports x 2 inserted
Pneumoperitoneum.
Dissection through white line of Todd to left kidney
Left ureter identified and traced proximally to renal hilum.
Harmonic scarpel to remove Gerota's fascia from left kidney
Left renal artery and vein identified. Left ureter identidied and transected near bladder base.
Left renal vein and its branch clamped with hemolock first and transected, before similar procedure for left renal artery.
Left kidney removed
Benchwork to start cold HTK infusion x 10 min and trim renal artery and vein
-Warm ischemic time: 1 min 30 sec
-Cold ischemic time: starts at 11.00 am

National University Hospital
5 Lower Kent Ridge Road, Singapore 119074
Tel: 6779 5555 Fax: 6779 5678

ANNEX F

DRUG ALLERGY > ASPRIN

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SPONGES / SHARPS / SUTURES COUNT SHEET

	TYPES OF COUNT	INITIAL COUNT	ADDITIONAL	FIRST COUNT	ADDITIONAL	SECOND COUNT	ADDITIONAL	FINAL COUNT
SPONGES	Lahey Swab							
	Tonsil Strips							
	Raytex Gauze	10		10				10
	Penny Towel	5	5	10				10
	Patties							
SHARPS	Blades	2		2				2
	Loose Needles							
	Inj Needles	2		2				2
SUTURES	Atraumatic Sutures	3	2	5				5
OTHERS	Diathermy Tip	2		2				2
	Surgikos	1		1				1
SCRUB NURSE		Chuk H		Chua KH				ChuaKH
CIRCULATOR		May		Carol LV				May

OTS-FORM-OEN-003

HOSPITAL INPATIENT DISCHARGE SUMMARY

NATIONAL UNIVERSITY HOSPITAL - HOSPITAL INPATIENT DISCHARGE SUMMARY

[illegible]

CLINICAL SUMMARY

NAME : NARINDAR KAUR D/O SARWAN SINGH		HRN : SJ7213342	ACCT : 155011148100	
Sex :Female	DOB :07/02/1972	RACE :Others	FEE :Subsidised	PATIENT TYPE : I
ADDRESS : Blk 699,HOUGANG STREET 52, #10-09,Singapore - 530699 (O)91463135				
Printed Date: 16/02/2005	Printed Time: 19:36:57	Admit: 15/02/2005	Disch. Date: 16/02/2005	Disch. Time: 17:17

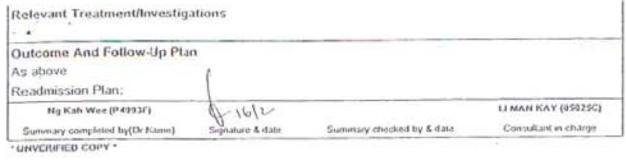
CLINICAL SUMMARY

History And Physical Findings

33/Indian/Female:
K/C:
1. Asthma: since childhood, last attack last year, never needed intubation or ICU admission
2. Known drug allergy to aspirin

Patient is adm for elective operation of:
Living related donation of Left kidney to husband
CT ANGIOGRAM OF RENAL ARTERIES AND POST CT KUB
Axial sections were obtained with intravenous contrast. The images were reconstructed into axial and coronal MIP images.
B[illegible] kidneys show no renal parenchymal abnormality. There is one renal artery and one renal vein su[illegible]lying each kidney. No intrinsic abnormality is seen in the renal arteries or veins. No accessory renal arteries seen.
There is early extra hilar branching of both the right and left renal arteries. On the right, the bifurcation is 1.2cm from the ostium whereas it is 1.1cm on the left. The lumbar veins, adrenal vessels, renal capsular arteries and gonadal vessels are not identified.
Post CT KUB shows no significant abnormality within and outside the urinary tract although the mid and distal right ureter are not seen on this image. An intrauterine contraceptive device is noted.
Patient is well pre-operatively and has no symptoms of URTI or fever
Patient underwent renal transplant- harvets on 16/02/2005
Patient was well post operatively in the recovery room and was sent up to ward
Post operatively, patient was reviewed in the ward
Patient was well and alert, vitals signs were atable at 120/70mmHg for BP and HR of 70bpm
Patient was not in pain and comfortable
Heart: S1S2
Lungs: clear, good air entry bilaterally
Abdomen: soft, non tender, BS+, dressing is clean, drain is minimal
Calves supple
Patient was put on hourly parameters and kept NBM and on IV Drip
Analgesia as prn
Patient was found to be unresponsive at 1615hrs by staff nurse and house officer was informed
H[illegible] was 10.8
On arrival of house officer: patient was noted to be unresponsive to pain stimulus, cold clammy, BP was unrecordable
Heart: S1S2 no murmurs, lungs: air entry equal bilaterally
Bp could not be recorded, pulse weak and bradycardic
Resus trolley was pushed into cubicle and ECG leads connected
Code Blue was activated and resuscitation was started.
With arrival of Code Blue team, patient was noted to be apneoic and bradycardic
PR: 40bpm, ventilation was started, airway clear
Atropine 1.2 mg given
Post intubation, pateitn became asystolic, CPR initiated
Rhythm converted to PEA, strated aggressive resuscitation with IV adrenaline, IV vasopressin, IV NaHCO3 and IV CaCl2
Multiple attempts to get IV access via right subclavian and right internal jugular and right and left femoral vein. Unsuccessful with nil flash back
Left subclavian line was inserted afetr multiple attempts, rhythm continue to be in PEA despite resuscitation
PEA persistent with no signs of cardiac output
Intracardiac adrenaline was administered by A/Prof Lee KH
Decision was made to call off resuscitation at 1710hrs in view of failure return of spontaneous circulations afetr 50mins
Seen by Consultant Mr David Consigliere, agreed with above management
Patient is pronounced deceased at ~~1717~~hrs 1714 Dr Dean Chia
Coroner's case

HOSPITAL INPATIENT DISCHARGE SUMMARY



Relevant Treatment/Investigations

Outcome And Follow-Up Plan

As above

Readmission Plan:

Ng Kah Wee (P4993F)	16/2		LI MAN KAY (05025C)
Summary completed by(Dr Name)	Signature & date	Summary checked by & date	Consultant in charge

* UNVERIFIED COPY *

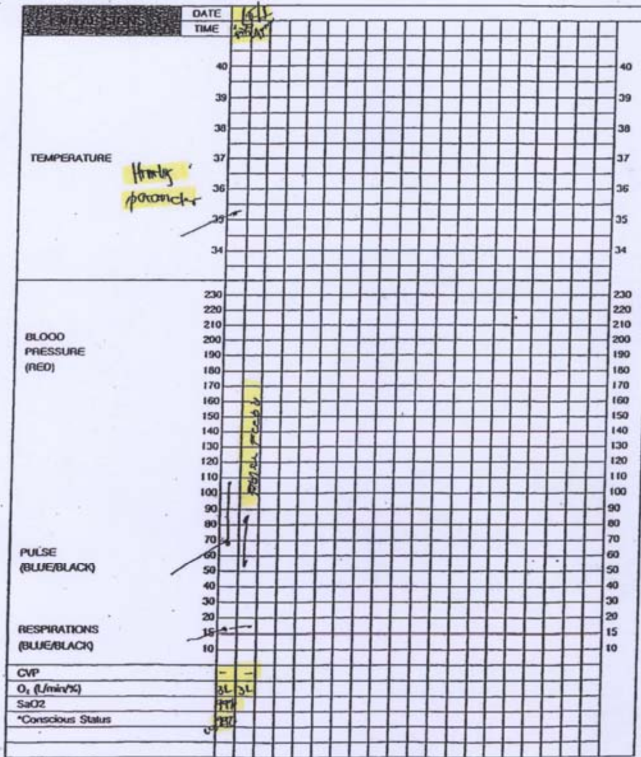
ANNEX H

F1-46

National University Hospital
5 Lower Kent Ridge Road, Singapore 119074
Tel 6779 5555 Fax 6779 5678

OBSERVATION CHART	UNIT	WARD	BED
		43	24

IP
DA



Legend : C = Conscious S = Sedated D = Drowsy U = Unconscious

*Note : * Use the Neurological Observation Chart for more detail assessment of patient's neurological status.*