

**MIL-\*\*\*, DORIS F**

SSN: 000-01-1406

DOB: 4/26/1933

MRN: E002035313

Date Registered: 8/13/2013

Treating Physician: THOMPSON, J SPENCER

Requesting Physician: MANNEL, ROBERT

Primary ICD9: 182.0 - Malignant Neoplasm - Carcinoma  
Endometrium - Myometrium

Secondary ICD9:

Treatment Start Date: 8/26/2013

Last Treatment Date: 8/28/2013

Treatments Completed: 3

Treatments Estimated: 25

**Weekly Progress Note - 8/28/2013****Dosage**

PLANNED TOTAL IMRT DOSE : 4500cGy

AREA : PELVIS TD

TOTAL DOSE : 480

**Nature of the Presenting Problem**

CHIEF COMPLAINT : Endometrial adenocarcinoma, postoperative.

HISTORY OF PRESENT ILLNESS : 80 year old female who presented with a seven month history of abnormal vaginal bleeding. The patient was seen by her physician, whom performed an ultrasound and biopsy. The pathology report noted a mixed mullerian tumor. The patient met with Dr Mannel and was staged with a pelvic CT scan and chest Xray on 6/11/2013, which confirmed a uterine mass and did not show any pelvic lymphadenopathy or evidence of metastatic disease. She discussed her treatment options and underwent a transvaginal hysterectomy and BSO on 7/11/2013. The pathology of the surgical specimen reported a FIGO Grade III endometrial adenocarcinoma invading over 50% of the myometrium, LVSI+ and extending to the cervical stroma. Due to her pathologic features, the patient was recommended postoperative radiation as adjuvant therapy. She arrives today to discuss her treatment options.

LOCATION OF PROBLEM : Genitourinary

STAGING : T2 N0 M0, Stage II.

GYNECOLOGY ONCOLOGY PROTOCOL : This patient has been enrolled in a special randomized protocol study RTOG 1203.

PATIENT ENTERED ON PROTOCOL : This patient has been enrolled in a special randomized protocol study designed to utilize pooled data to answer specific clinical outcome questions. The patient has signed consent to be part of this protocol study, and has all of the risks and benefits of participation in the study explained in complete detail. The patient understands the purpose of this trial study and accepts the consequences of participation in the study. The patient has had adequate time to ask all pertinent questions related to participation and accepts the parameters of the study as it has been explained to them.

PATIENT LOCATION : This patient is an outpatient.

**Pain**

The patient reports no pain without the use of pain medication. Patient states the pain is completely relieved by medication. No pain intervention at this time.

**Allergies/Medications/Chemo**

GENERAL EVALUATION DRUG ALLERGIES : The patient has no known drug allergies.

ALLERGIES : No Known Drug Allergies.

OUTSIDE MEDICATIONS : tramadol (tramadol) tablet 50 mg : 1 tablet by mouth as directed as needed for pain

Synthroid (levothyroxine) tablet 100 mcg : 1 tablet by mouth once a day

multivitamin (multivitamin) tablet : 1 tablet by mouth once a day

Senokot-S (sennosides-docusate sodium) tablet 8.6-50 mg : 1 tablet by mouth twice a day

Norco (hydrocodone-acetaminophen) tablet 5-325 mg : 1-2 tablet by mouth every six hours as needed for pain  
Lyrica (pregabalin) capsule 50 mg : 2 capsule by mouth three times a day  
Zocor (simvastatin) tablet 20 mg : 1 tablet by mouth at bedtime  
Aggrenox (dipyridamole-aspirin) capsule, ER multiphase 12 hr 200-25 mg : 1 capsule by mouth twice a day  
Calcium Citrate + D (calcium citrate-vitamin d3) tablet 315-200 mg-unit : 3 tablet by mouth once a day  
acetaminophen-codeine (acetaminophen-codeine) tablet 300-15 mg : 1 tablet by mouth every six hours as needed for pain  
Tenex (guanfacine) tablet 2 mg : 1 tablet by mouth at bedtime

## Review of Systems

No problems reported at this time

## Performance Indicators

QUALITY OF LIFE ASSESSMENT : Many factors have been considered including the patient's own personal assessment and a weighted average of these factors assigns the patient an age and treatment status adjusted quality of life factor of 90.

KARNOFSKY PERFORMANCE SCALE : 90% - Can perform normal activities, minor signs of disease.

ECOG PERFORMANCE SCALE : 1 - Symptomatic but completely ambulatory (Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature.).

HISTORY OF FALLING : The patient has not fallen during the present evaluation period and has no recent history of physiological falls.

MEDICAL DIAGNOSIS : The patient has multiple medical diagnoses listed for this encounter.

INTRAVENOUS THERAPY : The patient does not have an active intravenous access.

GAIT : The patient walks without losing balance but steps may be short and shuffling.

MENTAL STATUS : Using a combination of the patient's self-assessment with interpretation by the nursing staff, the patient's mental status is rated at normal.

TOTAL MORSE FALL RISK ASSESSMENT : The total Morse Fall Risk Assessment for this patient is 35. The Morse fall scale is a method of assessing a patient's likelihood of falling utilizing six variables. The Morse fall scale has been shown to have predictive validity and interrater reliability. A score of 24 or less indicates minimal to no risk of fall. A score of 25 to 50 indicates a low risk of fall and requires implementation of fall prevention interventions. A score of greater than 50 indicates a high risk of fall and requires close supervision and fall prevention interventions.

## Medical Decision Making

CHEST XRAY : Nt relevant.

RESULTS CT PELVIS : Uterine mass noted.

RESULTS CT ABDOMEN : No metastatic disease reported.

RESULT OF CT OF THE CHEST : Not performed.

OXYGEN SATURATION : The patient's O2 sat today is 92 %.

SIGNED INFORMED CONSENT : A diagnoses specific signed informed consent has been obtained and is scanned into the electronic record.

CLINICAL SUMMARY PROVIDED : A clinical summary of this office visit was provided to the patient at their request.

## Social History

The patient did not graduate from high school. The patient is retired. The patient's primary occupation is listed as: Waitress. The patient has never served in the military. The patient admits to limited exercise at this time. No reports of exposure to hazardous materials at work. The patient is widowed. The patient lives at home. The patient lives alone. The patient denies ever using controlled substances. Substance Abuse History: No history of substance abuse is reported. The patient gives a history of tobacco usage at the maximum level of: cigarettes, 1 pack daily. The patient started utilizing tobacco products at the age of 18. Patient has recently quit utilizing tobacco in any form. Smoking cessation counseling was done. Approximately 3 minutes were spent advising the patient of the risks of continued use of any tobacco products. We discussed the interrelationship of the use of tobacco and the occurrence of cancer. We spoke of the increased reactions from the radiation therapy treatment caused by continuing to smoke. I provided the patient with our basic smoking cessation educational materials. We briefly discussed the various methods available to help the patient quit smoking. smoked at least 100 cigarettes during his/her lifetime but does not currently smoke and The patient does not utilize alcohol in any significant amount.

## Under Beam Technical Factors

WEEKLY CHART REVIEW : Weekly chart review was completed on this patient. Documentation and appropriate signatures were found to be correct for all procedures being performed.

WEEKLY PHYSICS REVIEW : All physics factors of the patient's chart have been checked and found to be correct as

prescribed. All basic dosimetry and isodose plans have been compared to the original prescription and recording on the log page and found to be correct.

PORT FILM REVIEW : Port films were reviewed this week and all films were found to be in full agreement with the simulation films as they were initially established for these portals. No corrections were necessary.

ISODOSE PLANS : Isodose plan on this patient has been previously approved for treatment and no further evaluation is necessary.

DOSIMETRY CALCULATIONS : All conventional dosimetry calculations have been checked and are found to be in full agreement with the initial prescription as written. The monitor units and the backup time have been compared and are correct as initially prescribed.

STEREOSCOPIC LOCALIZATION : A definable and reproduceable structure can be seen and localized to determine the isocenter of treatment.

### Under Beam Treatment Related Factors

RESPONSE TO TREATMENT : The patient's tumor cannot be clinically assessed.

### Under Beam Physical Exam - Prog Note

GENERAL EVALUATION CONSTITUTIONAL : Alert and oriented. In no acute distress.

### Advanced Directives

HEALTHCARE PROXY : It is unknown if the patient has appointed a healthcare proxy.

LIVING WILL : It is unknown if the patient has a Living Will.

ADVISED OF LIVING WILL INFORMATION : Advising the patient about the availability of information regarding Living Wills was not applicable in this situation.

ADVISED OF HEALTHCARE PROXY INFORMATION : Advising the patient about Healthcare Proxy information was not applicable in this situation.

ADVISED RIGHT TO RESUSCITATION DECISION : Advising the patient about information regarding the right to have a resuscitation decision was not applicable in this situation.

### Recommendation of Therapy - Prog Note

CONTINUE AS PLANNED : The patient's treatment is to continue as planned.

### Clinical Comments

CLINICAL COMMENTS : Patient enrolled into RTOG 1203 and randomized to the IMRT arm. She will receive 4500cGy to pelvis and HDR 600x2 to the vaginal surface as a boost.

8/28/2013 Fraction 3/25

Patient seen for routine OTV. She is tolerating her treatment well and reports no side effects at this time. The plan is to continue as scheduled.

Physician's Signature : \_\_\_\_\_



Electronically signed by J SPENCER THOMPSON, MD on 8/30/2013 at 2:39

This clinical service was performed in conjunction with the Radiation Oncology resident. I reviewed the resident's note, and I agree with the assessment and plan. I was present for and participated in the history taking, physical examination and discussion of management options with the patient.

### Save History

Signature : \_\_\_\_\_

Reviewed and modified by ROBERTO SABATER, MD on  
8/28/2013 at 6:47 PM

Signature : \_\_\_\_\_

Reviewed and modified by J SPENCER THOMPSON, MD  
on  
8/30/2013 at 2:39 PM

Name: MIL-\*\*\*, DORIS F

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