

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:

Initial Evaluation - 8/14/2013**Problem**

PROBLEM : Endometrial adenocarcinoma, postoperative.

HISTORY OF PRESENT ILLNESS, OVERVIEW : 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

SEVERITY OF PAIN : No pain is reported.

SEVERITY OF BLEEDING : No longer experiencing bleeding.

SEVERITY OF DIFFICULTY BREATHING : None

SEVERITY OF DIFFICULTY SWALLOWING : The patient denies any problems with dysphagia.

ORIGIN OF CONSULTATION : Dr. Mannal originated this consultation.

INITIAL DIAGNOSIS : Uterine adenocarcinoma.

SOURCE OF PATIENT INFORMATION : Information contained in this evaluation was obtained from the patient and old records.

REASON FOR TODAY'S APPOINTMENT : New Cancer Problem.

PATIENT LOCATION : This patient is an outpatient.

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.

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

CONSENT FOR RADIATION TREATMENT : Consent form to treat the patient with radiation therapy was signed.

Past History

Yes, The current cancer site(s) is Uterus. The patient has had no previous malignancies. The patient has had the following surgeries in the past D&C, Hysterectomy and Knee Replacement, Right. The patient reports the following hospitalizations: Surgery of Any Type. The patient has not received chemotherapy. The patient denies receiving chemotherapy in the past.,. The patient has had no previous radiation therapy in any form for any condition. The patient reports having in the past or currently experiencing Arthritis, Hemorrhoids, Hypertension, Stroke and Thyroid Disease.

Allergies/Medications/Chemo

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
PRESCRIPTION WRITTEN : No prescriptions were submitted at this encounter.
MEDICATION RECONCILIATION : Medication reconciliation was performed.
CURRENT MEDS, DOSAGES, FREQUENCY, ROUTE DOCUMENTED 18 AND OLDER : List of current medications, including prescription, over-the-counter, herbals, vitamin/mineral/dietary nutritional supplements documented, including drug name, dosage, frequency and route.

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. Pain severity quantified; no pain present. A plan of care for pain was not documented, reason not otherwise specified, including any use of opioids, non-opioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.

Family History

SPOUSE/PARTNER : The spouse is deceased.
NUMBER OF CHILDREN : 4
CHILD NUMBER 1 STATUS : The patient's child number 1 is living and well.
CHILD NUMBER 2 STATUS : The patient's child number 2 is living and well.
CHILD NUMBER 3 STATUS : The patient's child number 3 is living and well.
CHILD NUMBER 4 STATUS : The patient's child number 4 is living and well.
FATHER'S STATUS : Dead of unknown causes.
MOTHER'S STATUS : Dead of unknown causes.
NUMBER OF BROTHERS : The patient has 8 brothers.
NUMBER OF SISTERS : The patient has 1 sisters.

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, Patient screened for tobacco use, identified as a tobacco user and received tobacco cessation counseling. The patient does not utilize alcohol in any significant amount. Patient screened and identified as an alcohol non-user.

Review of Systems

The patient has experienced a loss in weight over the past three months. Weight has decreased 32 pounds. The patient attributes the weight change to cancer. The patient is noting normal energy levels at this time. None reported. No reports of difficulty going to sleep. The patient denies difficulty maintaining sleep. No blurred vision is reported. The patient wears glasses. No history of glaucoma is reported. There is a history of bilateral cataracts. The patient is not blind. Both eyes are present. There is no report of decreased visual acuity. The patient has had a problem related to hearing, with decreased acuity. The patient does not wear hearing aids. No reports of ringing or buzzing in the ears. The patient denies any problems with sense of smell. The patient has a full set of dentures. The patient has no teeth. The patient has no bleeding at the present time. The patient can eat normal foods without any problems. The patient denies difficulty in

swallowing. The patient is not complaining of any swallowing obstruction symptoms at the present time. The patient gives no recent history of hoarseness or voice change. The patient reports a history of hypertension. No reports of heart attack. No reports of stroke. The patient reports no history of angina. No pace maker is reported. A history of pedal edema is reported. The nails are within normal limits. The patient reports no respiratory symptoms. No cough is noted or reported. The patient is experiencing no hemoptysis at the present time. No dyspnea is reported. The patient is experiencing no obstruction at the present time. The patient is not receiving oxygen at this time. The patient reports a history of a chronic cough. No reports of nausea. No vomiting is reported. No reports of appetite loss. No reports of dyspepsia. The patient is experiencing no hematemesis at the present time. The patient has no jaundice at this time. The patient has no complaints of diarrhea at this time. No reports of constipation. No reports of a change in size, color or shape of stools. No blood in the stool is reported. No reports of bowel incontinence. Menarche occurred at age 13. The patient reports a history of regular menstrual periods. The patient is currently experiencing menopausal symptomatology. The patient went through a surgical menopause following a hysterectomy. The patient has had 4 pregnancies. The patient reports 4 live births. The patient's first pregnancy was experienced at age 16. The patient reports a history of 0 miscarriages. See the present illness for the patient's history of vaginal bleeding. The patient had a hysterectomy for a malignancy of the uterus. The patient gives a history of having received the following hormones in the past: None Taken. She currently utilizes no form of birth control. Upon urinating, the patient reports feeling the bladder has fully emptied. No complaints of urinary frequency are reported. There are no reports of dysuria. No complaints of urinary urgency are reported. No episodes of nocturia are reported. The patient denies urinary incontinence. The patient denies any hematuria. No vaginal discharge reported. She is not on any type of hormone manipulation. She is not on any type of hormone manipulation. Surgical wounds healing well. The patient is able to work but with some restrictions of activity. The patient denies having arthritis. No weakness is reported. No balance difficulty is noted or reported. The patient uses wheelchair today assistive device. This patient is at risk for fall. The patient requires limited assistance with activities of daily living. The patient has no headache at the present time. The patient has no paralysis at the present time. No reports of numbness or tingling in toes or fingers. The patient denies experiencing seizures. There are no reports of vertigo. The patient denies any episodes of syncope. No reports of recent or sudden memory loss that did not return. Yes, due to fatigue. Patient is having no psychiatric problems and is requiring no therapy 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.

Physical Examination

GENERAL APPEARANCE : This patient is moderately obese.

AGE : 80 years

RACE : White

ETHNICITY : Not Hispanic or Latino.

PREFERRED LANGUAGE : English

GENDER : Female

STATUS : The patient is in no acute distress.

SYSTOLIC BLOOD PRESSURE SITTING : 108

DIASTOLIC BLOOD PRESSURE SITTING : 53

The patient's temperature is 97.1 degrees Fahrenheit.

The patient's pulse while sitting is 65 .

The patient's respirations are 20 .
OXYGEN SATURATION : The patient's O2 sat today is 95 %.
WEIGHT : The patient's weight today is 126.5 lbs.
HEIGHT, INCHES : 60
HEIGHT, FEET & INCHES : 5 Ft 0 Inches.
BODY MASS INDEX : The body mass index today measures at 24.7 .
NUTRITIONAL STATUS : Nutritional status is stable at this time and the weight is stable.
COSMETIC RESULTS : The patient has post surgical changes.
GENERAL EVALUATION EYES : Glasses present.
GENERAL EVALUATION EARS : Normal externally.
GENERAL EVALUATION NOSE : Normal externally.
GENERAL EVALUATION ORAL CAVITY : Full dentures.
SPEECH : The patient's speech is normal.
AIRWAY OBSTRUCTION : There is no evidence of airway obstruction or lesion blocking the airway.
NECK : No JVD
CHEST, ASSESSMENT RESPIRATORY EFFORT : Chest examination shows a completely normal evaluation. Chest expansion is normal. No shortness of breath is noted.
LUNGS, AUSCULTATION : Lungs are clear to auscultation. No rales or rhonchi are heard. Breath sounds are normal.
CARDIAC : The heart has a regular rate and rhythm. murmur.
VENOUS SYSTEM : No abnormalities or venous distension is noted centrally or peripherally.
GENERAL EVALUATION BREAST FEMALE : Breast examination is not relevant to the present illness.
ABDOMEN : No abdominal masses were palpated. The abdomen is soft, nontender and non distended.
BOWEL SOUNDS : Bowels sounds are present and normal to auscultation.
EXTERNAL GENITALIA, FEMALE : Examination of the external genitalia is found to be completely within normal limits with no masses, ulcerations or surgical deformities noted.
PELVIC EXAM : Parametrial area without masses on binannual exam.
VAGINAL EXAMINATION : Moist mucosa without exudates.
CERVIX : The cervix is surgically absent.
UTERUS : Pelvic exam reveals the uterus to be surgically absent.
OVARIES : Examination of the adnexal areas reveals both ovaries to be surgically absent.
BLADDER : The bladder area is nontender. Palpation of the suprapubic area fails to reveal any significant tenderness.
DIGITAL RECTAL EXAMINATION, GYN : Digital rectal exam was done in conjunction with the remainder of the patient's examination. The exam was completely within normal limits without any abnormal findings being palpable within the anus, rectum or rectal lumen. The sidewalls were soft and smooth. No extra luminal masses could be felt.
GENERAL EVALUATION SKIN : Surgical scars healing well.
EXTREMITY EDEMA : Bilateral ankle edema.
NAILS/DIGITS : The nails are within normal limits.
UPPER EXTREMITY, RIGHT : Examination of the right arm reveals normal configuration without atrophy or lesions.
UPPER EXTREMITY, LEFT : Examination of the left arm reveals normal configuration without atrophy or lesions.
LOWER EXTREMITY, RIGHT : Examination of the right lower extremity reveals normal configuration without atrophy or lesions.
LOWER EXTREMITY, LEFT : Examination of the left lower extremity reveals normal configuration without atrophy or lesions.
GAIT/STATION : In wheelchair, not evaluated.
PSYCHIATRIC : Psychological examination of the patient reveals that the patient is well oriented and appears to be functioning with good insight and judgment. During the interview process, the patient was able to ask intelligent questions and understood the answers.
MENTATION : The patient is functioning with good insight and judgment, and is able to ask intelligent questions and fully understands the answers.
ORIENTATION : The patient is oriented to time, place and person.
AFFECT : No signs of anxiety or agitation were noted.

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

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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.

ADVANCE CARE PLANNING DISCUSSED AND DOCUMENTED : Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record.

Clinical Quality Measures

BMI AND PLAN : Calculated BMI within normal parameters and documented.

PREVENTIVE CARE AND SCREENING: FLU IMMUNIZATION : The patient is 6 months of age or older.

Physician Quality Reporting System Smoke

TOBACCO USAGE : The patient currently smokes tobacco.

TOBACCO USE ASSESSED : Tobacco use assessment has been done for this patient.

CESSATION COUNSELING : Tobacco use cessation intervention counseling was performed.

CURRENT TOBACCO USAGE : Current use of smoking tobacco is reported by the patient.

Medical Decision Making: Patient Type

COORDINATION OF CARE : This patient was seen by us as a consult-only and a full report will be delivered to the requesting physician and further care will be coordinated through the requesting physician. The requesting physician has personally contacted me about this case as a new patient consultation. I have informed the requesting physician regarding my recommendations for treatment. These recommendations were made prior to instituting any form of therapy. Minimal diagnostic testing and determination of acceptable geometry for therapy may have been done to better formulate my opinion regarding the applicability of definitive therapy for this condition. The requesting physician is in agreement with my findings, and I have prepared this written document outlining my findings and recommendations regarding this case.

At the conclusion of my workup, and/or appropriate therapy, I agree to return the total care of this case to the original requesting physician.

I may wish to continue to visit with this patient at a later time as a measure of outcome analysis of my care of this case. The requesting physician agrees to this follow up.

Medical Decision Making: Data Review

CHEST XRAY : Nt relevant.

KUB X-RAY : Not performed.

RESULT OF MRI OF THE CHEST : Not performed.

RESULT OF MRI OF THE ABDOMEN : Not performed.

RESULT OF MRI OF THE PELVIS : Not performed.

OTHER MRI RESULTS : Not performed.

RESULT OF CT OF THE CHEST : Not performed.

RESULTS CT ABDOMEN : No metastatic disease reported.

RESULTS CT PELVIS : Uterine mass noted.

GENERAL EVALUATION ULTRASOUND : Report not available.

OXYGEN SATURATION : The patient's O2 sat today is 95 %.

HISTOLOGY OF UTERINE TUMOR : The patient's pathology report indicates the tumor is an adenocarcinoma.

DIFFERENTIATION OF TUMOR HISTOLOGY : The patient's tumor was indicated as being poorly differentiated.

LYMPHVASCULAR INVASION : The patient's pathology report indicated lymph-vascular invasion.

NEURO-VASCULAR OF INVOLVEMENT : The patient's pathology report indicated neuro-vascular invasion.

EXTRANODAL SPREAD : The patient's pathology report did not indicate extra nodal spread.

RESECTION MARGINS : The pathology report indicates that the resection margins were clear.

LYMPH NODE STATUS : No lymph nodes were resected at this time.

DISCUSSION OF RESULTS : The test results of diagnostic radiology examinations have been reviewed with the performing physician and the information is utilized to aide in my decision making process. The test results of pathological evaluation of the patient's tumor have been reviewed with the performing physician and the information is utilized to aide in my decision making process.

Medical Decision Making: Risk of Complications/Morbidity/Mortality

The risks and benefits to be associated with the proposed course of radiation therapy have been fully explained to the

patient and the patient's family. They completely understand the need for the treatment and accept the therapy as it has been outlined. There is low risk of systemic complications resulting from treatment. There is low risk of developing local area complications from treatment. There is moderate risk of morbidity (severe local complications) resulting from treatment. There is low risk of mortality (death) resulting from treatment. There is moderate risk of mortality (death) resulting from the patient's disease if untreated. There is low risk of mortality (death) resulting from another disease. The patient was counseled extensively regarding the risks and benefits to be associated with the proposed course of radiation therapy and fully understands the treatment as it has been explained. The patient fully understands the risks and accepts the treatment as it has been outlined. Alternative forms of treatment have been discussed with the patient and the patient understands and accepts radiation therapy as the preferred treatment of choice. Alternatives include surgical intervention (to be discussed with neurosurgical service on 7/15/2011), radiation therapy, and/or embolization. The patient is fully able to understand the need for the radiation therapy and accepts the treatment as it has been outlined.

Medical Decision Making: Diagnosis or Management Options

182.0, T2 N0 M0, Stage II. See the patient's past history for co-morbid conditions. The patient's general health is improving. In relation to the present illness, the patient's condition is stable. No referral for consultation is needed at this time. The prognosis on this patient is good considering all factors of the disease. 81 year old female with FIGO II Grade III, LVSI+, >50% invasion adenocarcinoma of the uterus status post hysterectomy. Due to her high risk features and positive cervical stromal involvement, the patient was recommended adjuvant radiation treatments. After discussing her options, she decided to be enrolled in the RTOG 1203 protocol. She arrived today to discuss her radiation treatments. The role of radiation as an adjuvant form of therapy, its risks and benefits and known short and long term toxicities were discussed with the patient and her family. They were allowed time to ask questions and were satisfied with the answers provided. The patient agreed to proceed with treatment and signed an informed consent note. She then underwent CT simulation.

Her treatment was randomized to IMRT and, per declaration, will be stratified to 4500cGy to the pelvis with HDR Vaginal cuff brachytherapy (600cGy x 2 prescribed to the vaginal surface). The patient will begin treatment. A diagnoses specific signed informed consent has been obtained and is scanned into the electronic record. American Joint Committee on Cancer (AJCC) stage documented and reviewed. A clinical summary of this office visit was provided to the patient at their request.

Time

TIME SPENT : Approximately 60 minutes was spent by me in the direct clinical care of this patient. Over 50% of this time was spent in the process of counseling and coordination of care, to include face to face time with the patient and/or family members present.

Transition of Care Summary

TRANSITIONED/REFERRED TO ANOTHER SETTING/PROVIDER : This patient was not transferred to another setting of care or referred to another provider of care.

NOT RELEASED EXPLANATION : The patient will not be transitioned to another care provider at this time.

DATA RELEASED EXPLANATION : Transition of care summary documents were converted to PDF files and e-mailed to the referring physician at the patient's request.

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.

Physician's Signature : _____



Electronically signed by J SPENCER THOMPSON, MD on 8/26/2013 at 5:31


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
8/20/2013 at 3:56 PM

Signature : _____



Reviewed and modified by J SPENCER THOMPSON, MD
on
8/26/2013 at 5:31 PM