

Patient MR# 666602
Patient Name: Sally Swift

GYN Advanced Case #2
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Radiology Report
01/05/2007

Chest PA and Lat Routine

Reason for Exam: Shortness of breath

Two views, without any previous films, show a somewhat poor inspiratory effort with some blunting at the left CP angle. I don't see any discrete focal pulmonary infiltrate. The cardiomeastinal silhouettes are within normal limits of size. The bony structures show some mild degenerative-appearing changes.

Impression: Some blunting at the left CP angle

Pathology Report
01/10/2007

Clinical History: 79 y/o female with pelvic mass and ascites, polyp uterus – please evaluate for malignancy.

Specimen:

- A. Right tube and ovary
- B. Uterus, left tube and ovary
- C. Liver biopsy
- D. Abdominal wall adhesion
- E. Omentum
- F. Peritoneal implants
- G. Oomphalectomy

Gross Description:

A. Received fresh labeled Patient and “right tube and ovary” is a 75.2 gram fallopian tube with ovary. The 6.5 x 0.5 cm pink tan intact fallopian tube segment is distally dilated to 0.9 cm in greatest dimension. Sectioning reveals the dilated area to be a cyst filled with straw colored fluid. A single 0.3 cm yellow tan firm nodule is present on the outer surface of the fallopian tube. The 6.4 x 4 x 2 cm ovary is yellow tan and covered by yellow tan soft tissue. The outer surface of the ovary is inked blue and the specimen is serially sectioned to reveal a cystic yellow tan softened cut surface. The largest of the cysts measures 3 cm in greatest dimension and has a pink tan smooth lining. Representative sections are submitted for frozen sectioning and subsequently placed in AFS1. Representative permanent sections are submitted in A1 – A8.

- A1 Fallopian tube to include cyst (3)
- A2 Parovarian soft tissue (2)
- A3-8 Representative sections of ovary to include inked edges. (1)

B. Received fresh labeled Patient and “uterus, left tube and ovary” is a previously incised uterus with attached cervix, left fallopian tube and ovary and segment of right fallopian tube. The uterus is divided into left and right halves. The serosa is pink tan with numerous yellow tan firm nodules on both the right and left halves. Ectocervix is not grossly appreciated. The endocervical canal is yellow tan and rugose. The 5.7 x 1.5 x 0.1 cm pink tan endometrium has two polypoid yellow tan masses measuring 2 and 1.8 cm in greatest dimension. Adjacent to one of these masses is a 0.8 cm plaque-like lesion. One polyp and the plaque-like lesion are submitted for frozen section and subsequently placed in BFS1 and BFS2 respectively. Also present are approximately three submucosal white whorled pink tan modules measuring up to 3 cm in greatest dimension. The myometrium is pink tan and smooth. Multiple (>10) white whorled homogeneous nodules are noted measuring up to 7.2 cm in greatest dimension. The majority of these nodules are firm and calcified.

The left fallopian tube and ovary weigh 13 grams. The 3.5 x 0.3 cm purple gray fallopian tube segment is intact. There is a single 0.6 cm clear fluid filled cyst present. Adherent to the

fallopian tube and ovary are multiple yellow tan nodules. The cut surface of these nodules is yellow tan and firm. The 2 x 1.5 x 0.3 cm slightly lobulated yellow tan ovary has a 0.3 cm peripheral cyst. The 4.2 x 0.5 cm purple pink segment of right fallopian tube is without fimbriae. Present on the outer surface are multiple white tan firm nodules. Representative sections are submitted as follows.

- B1 9 to 3 o'clock cervix (black ink) (2)
- B2 Serosal nodules (2)
- B3 Left superior endomyometrium
- B4 Left mid endomyometrium to include submucosal nodule (2)
- B5 Left lower uterine segment (1)
- B6 Right superior endomyometrium to include intramural nodules and polyp (1)
- B7 Right mid endomyometrium (1)
- B8 Right lower uterine segment
- B9, 10 Representative sections of intramural nodules (3, 2)
- B11 Representative section of largest intramural nodule (2)
- B12 Left fallopian tube and ovary
- B13 Right fallopian tube

C. Received fresh labeled Patient and "liver biopsy" is a single 0.6 x 0.2 cm brown tan needle core. The specimen is submitted in toto for frozen sectioning and subsequently placed in CFS1.

D. Received without fixative labeled Patient and "abdominal wall adhesions" is a 4.5 x 2 x 0.3 cm piece of glistening, slightly nodular pink tissue. Sectioned and entirely submitted. M/2

E. Received fresh labeled Patient and "omentum" is a 21 x 11.5 x 2.5 cm aggregate of firm flat tan tissue pieces. Cut surfaces are uniform pale tan to yellow. Representative sections are submitted. 2/2

F. Received in formalin labeled Patient and "peritoneal implant" is a 1 x 1 x 0.2 cm aggregate of tan to pale yellow tissue which is entirely submitted. M/1

G. Received without fixative labeled Patient is a 2.8 x 2.8 x 2 cm ovoid piece of brown skin with a central 1.6 x 1.3 cm brown umbilicus. The margins are inked. There is a 2 x 1.8 x 1 cm firm pale tan mass deep to the skin. Representative sections are submitted. 2/2

Frozen Section Diagnosis:

AFS1. Right Ovary: Serous papillary carcinoma.

BFS1 and 2. Endometrium: Endometrioid adenocarcinoma, not invasive into myometrium on frozen, arising in endometrial polyp: Cytologically different from right ovarian cancer.

CFS1. Liver Biopsy: Metastatic carcinoma, as discussed.

Final Diagnosis:

- A. Right ovary and fallopian tube, right salpingo-oophorectomy: Right ovary: Serous carcinoma, high grade (6.4 cm) with lymphovascular invasion, surface involvement, and paratubal and tubo-ovarian soft tissue implants. Fallopian tube with distal hydrosalpinx.
- B. Uterus and left adnexa, hysterectomy and left salpingo-oophorectomy: Cervix: Negative for dysplasia or carcinoma. Endometrium: Endometrioid adenocarcinoma (2 cm), FIGO grade II, arising and confined within an endometrial polyp (T1a), without myometrial invasion; background of cystic atrophy; additional benign (flat) endometrial polyp. Myometrium: Lymphovascular involvement by serous carcinoma; focal adenomyosis. Serosa: Implants of metastatic serous carcinoma. Left fallopian tube: Serosal implants of serous carcinoma. Left ovary: Endosalpingiosis.
- C. Liver, core biopsy: Metastatic serous carcinoma, see comment.
- D. Abdominal wall adhesion: Metastatic serous carcinoma.
- E. Omentum, biopsies: Metastatic serous carcinoma.
- F. Peritoneal implants, biopsies: Metastatic serous carcinoma.
- G. Skin and soft tissue, umbilectomy: Dermal soft tissue and intralymphatic metastatic serous carcinoma.

Comment:

C. It cannot histologically be determined whether this represents a capsular implant or intraparenchymal lesion.

CAP Surgical Pathology Cancer Case Summary:

Ovary: Oophorectomy, salpingo-oophorectomy, subtotal oophorectomy or removal of tumor in fragments, hysterectomy with salpingo-oophorectomy

MACROSCOPIC

Specimen Type (check all that apply)

- Right oophorectomy
- Left oophorectomy
- Right salpingo-oophorectomy
- Left salpingo-oophorectomy
- Subtotal right oophorectomy
- Subtotal left oophorectomy
- Removal of tumor in fragments
- Hysterectomy with salpingo-oophorectomy
- Omentectomy
- Other (specify): _____
- Not specified

Tumor Site

Right ovary: Parenchymal growth; Growth on surface
Left ovary: Uninvolved

Specimen Integrity (specify side): Intact

Tumor Size:
Dimension: 6.4 x 4 x 2 cm.

MICROSCOPIC
Histologic Type (check all that apply): Serous, carcinoma

Histologic Grade: G3: Poorly differentiated

Extent of Invasion

Primary Tumor (T): T3: Tumor involves 1 or both ovaries with microscopically confirmed peritoneal metastasis outside the pelvis (including liver capsule metastasis) and/or regional lymph node metastasis.

T3a: Microscopic peritoneal metastasis beyond pelvis

T3b: Macroscopic peritoneal metastasis beyond pelvis 2 cm or less in greatest dimension.

T3c: Peritoneal metastasis beyond pelvis more than 2 cm in greatest dimension and/or regional lymph node metastasis.

*T3 Stages a-c Will require intraoperative, surgical designation or upstage to IV based on location of liver metastasis.

Note: If pleural effusion is present, there must be positive cytology to assign a case to Stage IV. Parenchymal liver metastasis is classified as Stage IV.

Regional Lymph Nodes (N): NX: Cannot be assessed

Distant Metastasis (M): M1: Distant metastasis

Specify site(s), if known: Liver surgical correlation required as to capsular or parenchymal metastasis.

Summary of organs/tissue microscopically involved by tumor (check all that apply)

One ovary

Both ovaries

Omentum

Uterus

Peritoneum

Other organs/tissues

Specify all: liver

Venous/Lymphatic (large/small vessel) Invasion: Present

Additional Pathologic Findings: Endosalpingiosis

Comment: Also incidental grade II endometrioid adenocarcinoma of the endometrium, confined to an endometrial polyp, without myometrial invasion (T1a).

Urology Consultation Report
01/13/2007

Reason for Consultation: Mild acute renal failure, creatinine going from 0.8 to 0.9, elevation of BUN going from 16 to 22 with oliguria, presenting intravascularly volume depleted and hypoalbuminemia with hyponcotic pressure.

History of Present Illness: The patient is a 79-year-old African American female currently status post exploratory laparotomy for stage IV ovarian carcinoma, now with complete disorientation. The daughter is in the room. Apparently in the postop period she started experiencing oliguria, slight increase both in BUN and creatinine. The patient had also evidence of mild metabolic alkalosis with bicarb of 29, potassium 3.9, albumen 2.0, white count 17.1. Confusion and disorientation following the postop period on multiple medications, evidence of probable protein malnourishment. Was on a diuretic therapy at home along with ace therapy. CT which was completed showed evidence of intra-abdominal mass. CA-125 level was 1,580 previous to intervention.

No previous history of renal insufficiency or difficulty in urinating.

Past Medical History: Anemia, hypertensive disease, degenerative joint disease, questionable history of seizure with absent attacks time four over the past two to three years and bilateral glaucoma.

Past Surgical History: Cataract surgery bilaterally

Allergies: None

Current Medications: At home include Vit, Xalatan and Cosopt eyedrops. Currently include Pepcid, Capozide which was discontinued, her eyedrops, Milk of Magnesia, Dilaudid, Reglan, Compazine, Ativan, Vistaril, Toradol, lactated ringers.

Social History: She is widowed, living with family. Negative for alcohol, tobacco or substance abuse.

Review of Systems: The patient is not able to answer any questions. No obvious respiratory distress. Status post abdominal surgery with some guarding present.

Physical Examination:

Vital Signs: BP 157/91, pulse 126, respirations 20, weight 139.9, temperature 99.2.

HEENT: Temporal wasting is present. Arcus senilis is present. Oral mucosa not visualized. No facial edema is present.

Neck: No neck vein distention. Upstroke appears equal.

Lungs: Equal breath sounds. Good expansion. No rhonchi or rales.

COR: PMI in the left sternal border, tachycardic. Regular rate. No S3 is present.

Abdomen: Status post exploratory laparotomy with dressing. No rebound is present. Tender.

Extremities: Atrophic. Decreased muscle mass. No flank or sacral edema. No peripheral edema. Distal pulses decreased intensity. Moving all extremities.

Neurological: No focal findings. The patient is disoriented times three.

Laboratory Data:

Creatinine 0.8, progressing to 0.9, BUN 16, progressing to 22. Bicarb 29, sodium 141. White count 17.1, hemoglobin 12.1, albumen 20.

Impression:

79-year-old African American female with evidence of oliguria, mild acute renal failure, probably secondary to intravascular volume depletion with hyponcotic pressure and low albumen. Status post exploratory laparotomy for ovarian carcinoma, stage IV, change in mentation, probably secondary to medication, evidence of protein malnourishment with hypoalbuminemia.

Plan:

At this point would suggest a bolus with colloids, IV albumin, saline. Continue with aggressive resuscitation. I will convert to a nonoliguric state with single dose of diuretic. Change Foley catheter. Rule out possibility of obstruction. Suggest to discontinue all nonsteroidal therapy including Toradol. Discontinue Reglan, Compazine, Pepcid, Ativan, Dilaudid. These may cause change in mentation. Will follow up labs.

Will follow along with you. Thanks for allowing me to participate in the care of your patient.

Pulmonary Consultation Report
01/13/2007

This is a 79-year-old African American female who was admitted to the hospital on the 10th for exploratory lap, transabdominal hysterectomy, BSO, omentectomy, and debulking of a Stage IV ovarian cancer. The patient has been unstable since her procedure and has become oliguric. She has also had hypokalemia as well as delirium and diarrhea. This evening she has become progressively more short of breath. She has required an increase in her FI02 and her chest x-ray suggested worsening densities at both bases. For these reasons I was asked to see her.

Past Medical History: Is remarkable for absence attacks. She has generalized osteoarthritis, hypertension, and problems with anemia. She also has glaucoma.

Social History: She lives at home with her family. She does not smoke or drink alcohol.

Present Medications: Protonix 40 mg po q d, Darvocet one or two po q6 hours prn. The patient has gotten repeated boluses of ringer's lactate and albumin a total of 2 liters bolus fluids over the past two days as well as 300 cc of 25% albumin in an IV fluid rate of 90 cc an hour. She is also on Reglan.

Allergies: She has no known drug allergies

Physical Examination:

Vital Signs: Her respiratory rate is 36, blood pressure 120/67, pulse 118. She is afebrile.

HEENT: Remarkable for an NG tube in place.

Neck: No bruits. No JVD.

Lungs: Auscultation reveals no breath sounds in both bases, rare crackles, no wheezing

Heart: Regular tachycardia. No clear gallop or murmur.

Abdomen: Distended. No bowel sounds are heard to this examiner.

Extremities: No edema

Neurological: The patient is confused but follows most commands

Laboratory/X-ray:

Chest x-ray shows bilateral lower lobe densities the left greater than the right. There is a hazy density of the left base and very likely a pleural effusion bilaterally left greater than right. The diaphragms are very high. There was a small pleural effusion on her baseline chest x-ray. Lab work is remarkable for potassium of 3.5, BUN 20, creatinine 0.8. Arterial blood gasses yesterday revealed a pH of 7.46, CO2 40, and CACO2 of 63 on room air, hemoglobin 12.2, and white count 13.9.

Impression:

Respiratory insufficiency secondary to severe atelectasis, elevation of the diaphragms from abdominal distention, and bilateral pleural effusion.

Plan:

We will try to mobilize her pleural fluids by giving her diuretics along with albumin to increase her oncotic pressure. She will also have increased supplemental oxygen, inhaled bronchodilators, and decompression of the abdomen. She may well require mechanical ventilation and her overall prognosis, I am afraid, is poor.

I appreciate the opportunity of seeing this patient in consultation.

Pathology Report
01/15/2007

Clinical History:

Lt pleural effusion, enlarged fibroid uterus with possible (rt) adnexal mass + CA-125 suggest gyn malignancy.

Specimen:

Pleural Fluid

Gross Description:

Pleural Fluid: 700 cc, fresh, red, foamy, mucoid, cloudy

Microscopic Description:

Microscopic examination is performed. The special stain controls react appropriately.

Final Diagnosis:

Pleural fluid, left (thoracentesis): Atypical cells present. Features consistent with markedly reactive mesothelial cells.

Comment:

Mucicarmine stain is negative. Immunohistochemical studies show the atypical cells exhibit immunoreactivity for calretinin and cytokeratin 5/6; they are negative for CEA.

Medical Oncology Consultation Report
01/17/2007

Reason for Consultation: Stage IV ovarian carcinoma status post maximum debulking, needing chemotherapy.

History of Present Illness: Patient is a pleasant 79-year-old female admitted after she was referred for evaluation of a pelvic mass and ascites, etc. She underwent exploratory laparotomy, debulking on the 10th. Apparently she has diffuse metastatic disease. She is currently being seen by doctor for what I am presuming is malignant pleural effusions although I cannot find any path reports to confirm that. Her hospital course has been complicated by delirium, altered mental status, and renal insufficiency. Today she is doing well. She had chest tube placed. Doctor is concerned that her pleural effusions would continue to drain, and the chest tube may not be able to be pulled at all without introducing some systemic therapy.

This morning she feels fairly well. She is breathing much better. She can ambulate with some difficulty. Her appetite is poor. All things considered, she seems to be progressing in a positive fashion albeit somewhat slowly.

Past Medical History: Osteoarthritis, hypertension, glaucoma

Social History: No tobacco or alcohol history

Current Medications: Lovenox, Lasix, Protonix, Rocephin, p.r.n. Dilaudid.

Family History: Noncontributory

Allergies: None

Review of Systems: As noted above, otherwise unremarkable except for the anticipated postoperative complaints.

Physical Exam:

Vitals: Stable. She is afebrile.

General: No acute distress

HEENT: Oropharynx moist

Neck: Supple

Nodes: No palpable cervical, supraclavicular, or axillary nodes appreciated

Heart: S1 and S2. Regular rate and rhythm.

Lungs: Clear anteriorly with some crackles in the bases. There is a chest tube on the left.

Abdomen: Soft. Midline incision appears to be healing well. There are positive bowel sounds. She has no real tenderness other than expected postoperative complaints. No rebound or guarding. Positive bowel sounds.

Extremities: Bilateral SCDs are present.

Neuro: She is alert and appears to be oriented. No gross focal findings.

Labs:

CBC done on the 16th reveals a normal white count, hemoglobin 14.5. She has been transfused after drop in hemoglobin to 9.2, platelets 275. Chemistries reveal some mild hypernatremia with BUN of 10 and creatinine 0.8. Liver function all normal.

Impression: Stage IV ovarian carcinoma with presumed malignant pleural effusion requiring chest tube placement.

Discussion and Recommendations:

I had an extensive discussion with patient and her daughter-in-law regarding the use of chemotherapy this soon after surgery. In my opinion, if the opinion of doctor is that her pleural effusions will remain stable once the chest tube has been pulled, then I would wait on systemic chemotherapy because of concerns over delayed wound healing, dehiscence, etc. If there is concern over continued effusions and chest tube drainage, then we could consider systemic chemotherapy at this point. The chances are overwhelming that it will induce a response that will ultimately abate these effusions. However, again, as I relayed to the family and patient, the benefits would have to be weighed against the attendant risks as outlined above. I will confer with doctor and get back with the family regarding the possibility of systemic chemotherapy at this point approximately one week postoperative from her major surgery.

GI Consultation Report
01/23/2007

Chief Complaint: Nausea and vomiting

History of Present Illness: The patient is a 79-year-old lady who was admitted to the hospital here for surgery. She was found to have an abdominal mass and was brought here to have the surgery done. She had an exploratory laparotomy, total hysterectomy, umbilical reconstruction, and a liver biopsy. This was done on January 10, 2007. She states she has been having nausea and vomiting, due to the nausea. She feels full after just a few bites. She states she feels like it is sticking in the epigastric area when she eats anything. She states she has vomited once before surgery, however, has not had any recently. She does complain of frequent heartburn and acid reflux symptoms. She states her bowel movements are usually 2 times a day, however, since the hospitalized, they have been 3 to 4 times a day. She has had some diarrhea and intermittent watery stools. She denies any abdominal pain other than a little incisional pain postop. She does complain of dyspnea. She does have a chest tube in place for a pleural effusion on the left side. Her diagnosis after surgery was ovarian cancer, colonoscopy a year or so ago, which was normal. She was started on chemotherapy on Thursday. She had a KUB done on January 14, 2007, which showed no evidence of obstruction.

Laboratory Data:

Her labs are currently sodium 143, potassium 3.7, glucose 103, BUN 5, creatinine 0.7. Bilirubin was 2.9 and is now 1.2, alkaline phosphatase 72 up to 110, AST 40 up to 47, ALT 30 up to 34. CEA 28.9, CA-125 is 256, albumin 2, total protein 4.5, TSH 0.91, white cell count 11.2, hemoglobin 11.9, MCV 92.5, and platelets 207,000, PT 13.6, INR 1.02, and PTT 28.9.

Past Medical History: Osteoarthritis, hypertension, glaucoma, ovarian cancer with metastasis, and anemia

Past Surgical History: Exploratory laparotomy along with hysterectomy, umbilical reconstruction, liver biopsy, and tumor debulking. She has also had a cataract surgery in addition to that.

Family History: Noncontributory

Social History: Denies any smoking, ETOH, or illicit drug use

Medications: As per the chart

Allergies: No known drug allergies

Review of Systems: As stated above in the HPI.

Physical Examination

Vital Signs: Vital signs are stable and she is afebrile. Her heart rate is a little elevated at 111.

General: An elderly African American female who in no acute distress at this time.
HEENT: Normocephalic.
Eyes: Conjunctivae pink. Sclerae anicteric.
Ears: No gross abnormalities.
Nose: No gross abnormalities.
Neck: Supple. Trachea midline. No thyromegaly.
Throat: Mucous membranes moist and pink. Tongue is midline.
Lymph: No cervical or supraclavicular lymphadenopathy.
Lungs: Diminished bilateral lung base. No wheezing, rales, or rhonchi.
Cardiac: S1, S2 regular rhythm. The right is somewhat tachycardic. No murmurs, rubs, or gallops. No peripheral edema.
Abdomen: Positive bowel sounds in all quadrants. Abdomen is soft and mildly tender in all quadrants. No guarding or rebound. No organomegaly, masses, or ascites are noted. She is somewhat distended and does have midline abdominal incision from the epigastric area to the suprapubic area, which appears to be healing well. There is no drainage.
GU: No CVA or suprapubic tenderness.
Rectal: Deferred.
Musculoskeletal: Good range of motion.
Derm: No cyanosis, jaundice, or rashes.
Neuro: Awake, alert and oriented x3.

Impression: Stage 4 ovarian cancer with nausea and vomiting. Questionable obstructive versus nonobstructive. Differential includes medications, chemotherapy, pancreatitis. (This is most likely in the absence of abdominal pain). Peptic ulcer disease, biliary.

Plan:

We will obtain upper GI series and small bowel follow through.
We will increase PPI to twice a day.
We will add Reglan.
Pending results of above. The patient may need an upper GI endoscopy.