

Radiology Report  
07/20/2007

Bone Scan

Clinical History: 74-year-old white woman with MRI done for back pain and states extensive marrow signal heterogeneity. Follow-up bone scan recommended.

Findings:

Dose: Tc 99m HDP 19.4 mCi

Anterior and posterior whole body images were obtained approximately 3 hours after injection of the radiotracer. Numerous foci of abnormal increased radiotracer accumulation are present. Lesions are identified involving the upper and mid thoracic spine, at the approximate levels of T1, T5, and T7. Less intense but abnormal increased radiotracer accumulation is also seen near the left 9<sup>th</sup> costovertebral junction and along the lateral aspect of the 8<sup>th</sup> left rib. Increased radiotracer accumulation is also identified along the superior endplate of the 4<sup>th</sup> lumbar vertebra.

Evaluation of the bony pelvis shows rather intense abnormal increased radiotracer accumulation along the posteromedial left ilium and to a lesser extent, the medial right iliac wing. Additional abnormalities are seen within the mid and lower sacrum, the left ischium, and the left acetabulum. Abnormal radiotracer accumulation is seen involving the proximal one-third of the left femoral shaft and the intertrochanteric region of the right femur.

There is mildly increased periarticular activity involving both shoulders, the base of both thumbs, small joints of the left hand, both elbows.

Renal activity is symmetric and physiologic.

Impression:

Numerous abnormalities are identified within the spine, bony pelvis, and proximal femora. There has been no reported trauma to any of these regions. Findings are considered highly suspicious of widespread metastatic bone disease. Possibilities would include metastases from breast, colon, or renal cell cancer. Mild arthritic changes are identified within several peripheral joints and the lumbar spine. Action required. Results were called to the office of doctor (voice mail message was left).

History & Physical  
07/21/2007

Patient is seen in f/u to her bone scan done yesterday. She was found to have multiple changes in the spine, bony pelvis and proximal left femur that are suspicious for metastatic bone disease. She has no known primary and had normal mammogram done within the past few months.

She was seen initially for lumbosacral radiculopathy in 4/07. She was referred to PT and felt that patient's progress is poor. A MRI was done and no discrete bulge/herniation was seen but there was some increased marrow signal.

She is taking Norco and a prednisone taper currently. She is having some relief of the leg pain but worsening leg strength, using walker.

She has history of DM type II (diet controlled), HTM and hypothyroidism.

PE: 128/76, BMI 23, WT 125 lbs, afebrile

CXR: Right hilar abnormality

A/P

1. Abnormal bone scan with highly probable bone mets, abnormal chest x-ray: have called for a rapid read on the x-ray, labs today and will call heme onc for advice on best way to f/u. Will order Endocet for pain, ongoing bowel regimen.
2. DMII: Discussed Prednisone effects
3. HTN: Stable

Radiology Report  
07/21/2007

Chest (Digital)

Impression: Right upper lobe right hilar mass

These findings were discussed with doctor prior to this dictation on the July 21, 2007. The patient will be recalled for a CT of the chest and abdomen.

History: MRI and bone scan positive for metastatic appearance. No known primary at this time.

Findings: There is a 3.5 cm mass within or adjacent to the superior right hilum within the upper lobe. No other lesions are identified. The left lung is clear. No discrete osseous lesions are identified despite the stated history. There is a subtle erosive quality of the distal clavicles which may or may not be clinically significant.

Outpatient Consultation:  
07/25/2007

Reason for Consultation: The patient is a 74-year-old woman with probable metastatic cancer.

History of Present Illness: The patient has a long history of osteoarthritis but around April or May began having more severe pain with a sciatica type pattern into the left leg. Physical therapy and other modalities were not helpful and then a bone scan on July 20 showed probable metastatic disease in the first thoracic, fifth thoracic, seventh thoracic vertebrae, in the eighth rib, in the fourth lumbar vertebra and in the left ileus and left acetabulum in the pelvis. No tissue diagnosis has yet been obtained. The patient is awaiting appointments to be seen in pulmonary and have a CT scan and other studies. She has also lost some weight of about 10 pounds. There have also been some complaints of shortness of breath and also a chest x-ray has shown a right hilar mass. She is not a smoker but says she was exposed to lots of second-hand smoke in her years.

Current Medications: Endocet, prednisone added recently and has helped with the pain control, thyroid, lisinopril, Dyazide, atenolol, lovastatin, Ogen.

Allergies: None known

Past Medical History: Diabetes mellitus type 2, high blood pressure, hypothyroidism, degenerative joint disease, elevated lipids.

Social History: Her husband died in 2004. She is a retired accountant. She was exposed to second-hand smoke before she was married.

Review of Systems: About a 10 pound weight loss in recent months. Some coughing and wheezing but no hemoptysis, no shortness of breath. She has had some abdominal pains on the left side of the abdomen. The pain is primarily in the left hip radiating down to the left leg and is aggravated by standing.

Family History: Two uncles and an aunt had lung cancer but they were all heavy smokers. Mother died of diabetes and father's medical history is unknown.

Habits: No cigarettes, no alcohol

Physical Examination:

General: Pleasant woman in a wheelchair, appears younger than her age

HEENT: Sclerae anicteric. No oral lesions.

Neck: Supple, no jugular venous distention

Lymph Nodes: Lymph nodes normal in neck, armpits and groin

Lungs: Clear to auscultation and percussion. No wheezes or rhonchi appreciated. Breasts: No masses.

Cardiac: Normal S1-S2. No murmurs or gallops.

Abdomen: Bowel sounds present. Somewhat protuberant on the lower abdomen but no masses or ascites appreciated. The patient has to be examined sitting in her wheelchair because of her leg pain.

Extremities: No edema

Neurologic: Intact

Laboratory Data:

Alkaline phosphatase 170, creatinine 0.8, white blood cell count 9.7, hemoglobin 11.8, platelet count 491,000. Bone scan results given above. MR scan of the lumbosacral spine showed marrow. Mammogram was normal April 2007. Chest x-ray July 21 showed a right hilar mass although it has not been read by the radiologist.

Assessment: Evidence of metastatic cancer, primary unknown. Tissue diagnosis not yet made.

Recommendations: The patient needs pathology urgently before any further treatment can be done. I agree with the plans for the CT scan and for the pulmonary consultation. I also made a referral for CT guided needle biopsy of the chest mass. I gave her a prescription for morphine but she says at present the Percocet is working well enough for her pain. We have scheduled a repeat appointment in 10-14 days, at which time hopefully her pathology report will be ready.

Thank you for this referral and I will follow with you.

Radiology Report  
07/26/2007

CT Chest (Digital)

History:

Right upper lobe/hilar mass seen on plain films with history of positive bone scan, question lung primary.

Findings:

Scans at lung windows show a large mass at the junction of the posterior mid right upper lobe crossing into the superior segment right lower lobe with spiculated borders measuring approximately 4.1 x 3.4 cm. This crosses the level of the proximal right upper lobe bronchus. Some atelectasis is noted peripherally. Contrast is noted entering from the right side. Scans at soft tissue windows show normal vascular structures. A few small pretracheal nodes are identified measuring 5 mm or less in size. There is noted to be a pretracheal/carinal nodal collection measuring up to 2 cm in size with multiple small aortopulmonary window nodes measuring 5 mm or less in size.

The previously noted right upper lobe/lower lobe mass extends to the superior hilum.

A few small axillary lymph nodes are identified.

The heart is normal in size.

The liver, spleen, and pancreas are normal in appearance. Nodule in the right adrenal gland is noted measuring approximately 17 x 12 mm. Left adrenal gland is normal in size.

The kidneys show normal function and are of normal size without evidence of hydronephrosis. Extrarenal pelves are noted bilaterally.

The aorta and inferior vena cava are normal in caliber. The gallbladder is visualized and there are no stones. The common bile duct in the region of the head of the pancreas measures 1 cm. There is no evidence of intrahepatic biliary dilatation.

There is no evidence of retroperitoneal or mesenteric adenopathy. Moderate stool is noted in the colon adjacent to the ileocecal valve. Scan is complete to the top of the pelvis. There is normal bifurcation of iliac vessels without evidence of adenopathy to the level visualized.

Impressions:

1. Findings consistent with primary tumor right upper lung zone crossing the major fissure measuring 4.1 cm in maximum dimension.
2. Hilar adenopathy as described with the largest node measuring approximately 2 cm in size in the precarinal region.
3. Apparent nodule right adrenal gland, which may be a metastatic nodule.
4. Common bile duct measures 10 mm without evidence of obstructing lesions or intrahepatic dilatation.

Pathology Report  
08/04/2007

Clinical History: Right lung hilar mass, fine needle aspiration. Metastatic disease on bone scan, severe pain. Right hilar mass on CXR. 2 direct smears and 2 cell block H&E slides prepared for evaluation.

Specimen:  
Lung, Right, FNA

Final Diagnosis:  
Lung, right, fine needle aspiration: Malignant cells present. Non small cell carcinoma; favor poorly differentiated adenocarcinoma.

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Oncology Note  
08/08/2007

Stage 4 Lung Cancer  
Biopsy showed PD adenocarcinoma  
Still having pain, and cough  
o- wheelchair  
cbc and creat good  
a – Stage 4 adenocarcinoma lung  
p- Start carbo-taxol-Avastin  
RTC 3 weeks