

History & Physical
11/10/2007

CC: hoarseness, cough

HPI: 65-year-old African male presents with complaint of cough, hoarseness and occasional SOB with exertion. Walking is no problem, just running a couple of blocks; this is progressing over time, but can mow lawn with push mower without difficulty. Decreased appetite, eating more liquids than solids as he notes food tends to get stuck and begins to cough.

Past Medical History: Right knee problems from basketball, degenerative disk disease in back affecting right shoulder

Past Surgical History: Tonsillectomy

Prevention: Pneumovax 2 years ago at VA

Allergies: None

Medications:

Enalapril

Omeprazole (quit yesterday)

Family History: Diabetes, no cancer or thyroid

Social History: Positive for tobacco 45 years (trying to quit), occasional ETOH (mixed cocktails or wine), no illicit drugs. Immigrant from Nigeria.

Review of Systems: Lost 3 pounds, but no gross weight changes, decreased appetite, no fever, chills, or night sweats. No weakness or fatigue, no palpitations. No vomiting, clear cough, no blood in stool, no black tarry stool, no bowel habit changes. No polyuria or polydypsia.

Physical Examination:

T: 98.5F, BP: 120/89, P: 80, Hgt: 74 in, Wgt: 206lb.

General: Pleasant, hoarse voice

HEENT: PERRL, EOMI, no icterus, TMs obscured by cerumen, nares patent with mild boggyngness, pharynx pink with mild cobblestoning, upper/lower dentures no masses or mucosa changes in cheek or under tongue to palpation.

CVS: RRR

Pulmonary: CTAB no W/R/R

Abdomen: +BS, NT, ND

Skin: No rashes

Lymph: No neck or supraclavicular

Neuro: 2+ brisk biceps, brachioradialis, patellar reflexes bilaterally.

Assessment/Plan:

1. Hoarseness: Patient has ENT appt next week November 15. Patient has 45 pyhx smoking. No lesions in mouth or neck/supraclavicular LAD. Will follow up after ENT if nothing found. Omeprazole did not help. Check TSH.
2. Dysphagia: Could be tumor, zinker's, reflux. Omeprazole did not help. Try famotidine. Consider barium swallow eval if ENT does not find source of problem, but patient desires to wait for this until after consultation with ENT next week. Check CXR PA/Lat today.
3. HTN: Stable. Continue Enalapril, check Na, K+, Cr, Glucose
4. Screening: Patient desires cholesterol screen. He desires PSA after discussion risks, benefits of screening.

Radiology Report
11/10/2007

PA and Lateral Chest X-Ray

Clinical History: Evaluation of cough and hoarseness

Findings:

There is increased opacity in the left hilar region and the region of the AP window. These findings are suspicious for adenopathy or mass. No pleural effusion or pneumothorax is seen. Recommend CT of the chest for further evaluation.

Impression:

Left hilar mass. Recommend CT for further evaluation.

Radiology Report
11/19/2007

Head CT with Contrast

Clinical History: Left vocal cord paralysis, sudden onset. Rule out mass along the vagus and recurrent laryngeal nerve and within the brain.

Technique: 5 mm axial contrast images were obtained. Additional imaging of the neck and chest were obtained at the same time.

No comparisons.

Findings: There is a 1.7 x 2.3 cm enhancing mass within the medial right temporal lobe just inferior to the thalamus and posterior limb of the internal capsule. There is a moderate amount of edema within this lobe. Currently, there is no significant mass effect. Tumor extends toward the mid brain without definite compression of the peduncle or midbrain here.

A second enhancing focus measuring 9 x 13 mm is present within the left parietal lobe near the ventricle. Only minimal edema is seen here. There may be a third focus of enhancement in the inferior left cerebellum. This area is inherently difficult to evaluate due to significant artifact in this region.

Note is made of a prominent cisternal magna. The calvarium appears intact. The mastoid air cells and paranasal sinuses are well aerated.

Impression:

1. Two, or possibly three, enhancing lesions within the brain, highly suspicious for metastatic disease.
2. The largest lesion measures 2.3 cm and is surrounded by a moderate amount of edema. The mass extends to the mid brain without definite evidence of impending herniation.

Radiology Report
11/19/2007

CT of the Neck and Chest:

Clinical History: Sudden onset left vocal cord paralysis. Rule out mass along the course of the vagus and recurrent laryngeal nerve.

Technique: 5 mm axial contrast images were obtained

Findings:

Neck: The glottis is asymmetric in appearance without a discrete mass seen. Findings may be related to patient's known vocal cord paralysis. The remainder of the airways is unremarkable. No mucosal lesions are seen.

There is no significant cervical adenopathy. The parotid and submandibular glands are symmetric in appearance. Thyroid gland is slightly prominent without a discrete mass seen.

Chest: There is a large necrotic and nodal mass within the mediastinum centered within the AP window. The mass measures up to 7.5 x 8.5 cm here. The mass is contiguous with nodes within the superior left hilum, extending into the parenchyma. Within the left upper lobe, there may be one or two small nodules measuring less than 1 cm, which are somewhat ill-defined and could be post-obstructive inflammatory foci rather than satellite lesions.

Necrotic nodes are also seen within the subcarinal and right paratracheal regions as well as within both hila. The subcarinal mass measures 6.7 x 3.2 cm. A 2.5 x 2.8 cm right paratracheal node is seen.

There are no significant pericardial or pleural effusions. No parenchymal lesions are seen within the right lung and left lower lobe.

Images through the upper abdomen demonstrate normal appearance of the liver. Please note that the inferior tip of the liver is not included on this examination. There is a necrotic right adrenal mass measuring 5.9 x 4.1 cm which is suspicious for metastatic disease. In addition, there is a band of abnormal tissue in Morrison's pouch, interposed between the right kidney and liver. This is suspicious for tumor implant possibly along the liver capsule but probably not subcapsular in location.

The left adrenal gland is normal. The visualized portions of the spleen, pancreas and kidneys are unremarkable. The inferior aspect of all of these organs are not included on this exam. No suspicious osseous lesions are identified on this screening modality.

Additional findings in the chest include the concentric narrowing of the distal left pulmonary artery, secondary to encasing lymph node. Some narrowing of the upper and lower lobe bronchi on the left are also mildly narrowed.

Impression:

1. Massive mediastinal and hilar adenopathy, consistent with metastatic disease. A primary lesion is not identified, although bronchogenic carcinoma is a consideration.
2. Concentric narrowing of the left main pulmonary artery
3. 5.9 cm right adrenal mass suspicious for metastatic disease
4. Probable tumor implant within Morrison's pouch, as described above
5. One or two small nodular densities within the left upper lobe which may represent post obstructive inflammatory foci. Small satellite lesions are not excluded.
6. Asymmetry of the glottis, as described above. Findings may be related to patient's known vocal cord paralysis. No discrete lesion is seen within the neck.

The above findings were discussed with doctors at the time of this dictation on November 23, 2007.

Bronchoscopy Report
11/30/2007

Preoperative Diagnosis: Left hilar mass and extensive mediastinal adenopathy, rule out primary bronchogenic carcinoma with brain metastasis.

Postoperative Diagnosis: Fungating, friable endobronchial lesion almost completely occluded the upper lobe bronchus, secondary carina widened.

Procedure: Per nasal fiberoptic bronchoscopy, bronchioalveolar lavage and biopsy of the left upper lobe endobronchial lesion.

Anesthesia: Local Xylocaine

Sedation: None

Procedure: After anesthetizing the nose, nasopharynx and oropharynx, the fiberoptic bronchoscope was introduced per nasally. The vocal cords were seen to adduct normally on phonation and were anesthetized by direct instillation of Xylocaine.

The bronchoscope was then advanced into the trachea, which appeared central with normal mucosal characteristics. The carina was sharp and moved normally on respiration. The right main bronchus, right upper lobe, middle lobe and lower lobe segmental anatomy were normal. No endobronchial lesions were seen.

The left main bronchus was patent; however, the upper division showed an endobronchial fungating friable lesion occluding the left upper lobe bronchus. The lingula was compressed from extrinsic compression but patent. The left lower lobe was also patent.

Multiple biopsies of this suspicious-looking mass were taken and submitted for cytology and cell block studies in addition to AFB and fungal smears and cultures.

The patient tolerated the procedure well. No immediate complications were encountered. Tissue was submitted for histology. An oncology referral was made.

Pathology Report
11/30/2007

Specimen:
LUL Bx. Primary lung Ca suspected.

Gross Description:
Received in formalin labeled "Patient" is a somewhat polypoid fragment of tan mucosal tissue measuring 0.7 x 0.6 x 0.3 cm, as well as four fragments of tan soft tissue aggregating to 0.6 x 0.2 x 0.1 cm. The larger fragment is bisected and submitted in block 1. (X-0) Two cassettes.

Final Diagnosis:
Left upper lobe of lung, biopsy: Findings consistent with a small cell carcinoma

Note: Doctor notified by voice mail on 12/02/2007.

Source
Bronchial Alveolar Lavage

Final Diagnosis:
Bronchial alveolar lavage, cytology: Negative for malignancy.
Note: Please refer to the concurrent lung biopsy specimen for additional information.

Consultation
12/02/2007

Reason for Consultation: Probable metastatic lung cancer.

HPI: 65-year-old man with long history of tobacco smoking who developed a sore throat and hoarse voice in 8/2007. He was treated with antibiotic for 3 weeks without resolution. He then had ENT evaluation on 11/15 which showed a paralyzed left vocal cord. A chest x-ray showed a left hilar mass, and a chest CT confirmed a mediastinal mass and massive hilar lymphadenopathy, along with left adrenal mass. He underwent a bronchoscopy which revealed a LUL endobronchial lesion, biopsy was done, and final pathology is pending.

He also developed numbness and weakness affecting his left side.

His head CT showed a 1.7 x 2.3 cm enhancing mass within the medial right temporal lobe just inferior to the thalamus and posterior limb of the internal capsule, a second enhancing focus measuring 9 x 12 mm within the left parietal lobe near the ventricle, and possibly a third focus of enhancement in the inferior left cerebellum, no mass effect or midline shift. He was started on dexamethasone with improvement of his symptoms.

He denies any headache or other neurological deficits.

He has a cough that is dry. He has no pain or shortness of breath.

PMH/PSH: HTN

Medications: Enalapril and Dexamethasone

Family History: Noncontributory

Social History: Smoke 1 ppd for 40 years, stopped 2 weeks ago, drink 2 drinks a day.

PE:

Ht 74 inches

Wt: 200 lbs

BP: 138/78

HEENT: Anicteric, no lymphadenopathy

Back No paraspinal tenderness

Lung Clear

Heart RRR, no murmur, rub or gallop

Abdomen soft, active bowel sounds, non tender, no organomegaly

Extremities No edema

Neuro Left pronator drift, DTR brisk, L>R

Assessment/Plan:

Probable lung cancer with metastases to adrenal gland, brain. Discussed with patient, his wife and daughters that treatment goal now is palliative and not curative. Treatment options are systemic chemotherapy or supportive, hospice care alone. He wishes to proceed with palliative systemic therapy.

For now, he needs radiation therapy for his brain mets; will refer. I also recommended physical therapy, but he feels that he does not need it now.

Once radiation therapy is complete, we can proceed with chemotherapy. Plan is to start treatment in a month.

Consultation
01/16/2008

Radiation Oncology Treatment Summary

Diagnosis: Patient is a 65-year-old male with metastatic small cell lung cancer. He was diagnosed by trans-bronchial biopsy on 11/30/2007. These symptoms responded moderately to high dose steroids. He has now completed a course of radiation therapy.

Treatment Intent: Palliative

Treatment Summary: Patient was treated to his whole brain using parallel opposed lateral fields. A total dose of 30 Gy given in 10 equal treatments of 3 Gy each given 5 days per week was administered over 14 elapsed days. Treatment commenced on 12/13/2007 and was completed on 12/27/2007.

Overall, he tolerated treatment and continued to gradually improve neurologically.

Disposition: The patient will follow up with me in approximately one month. He is receiving ongoing chemotherapy under the supervision of doctor. The patient and family have been given detailed instructions on how to taper his steroids.

History & Physical
02/15/2008

Chief Complaint/Reason for Admission: Diarrhea and dehydration

History of Present Illness: This is a 65-year-old man who was diagnosed with small-cell lung cancer, extensive stage, in November of 2007 who was treated. The patient was found to have brain and adrenal gland metastases at the time of diagnosis. He was treated with one cycle of chemotherapy with carboplatin and VP-16, followed by radiation to his brain, followed by two more cycles of chemotherapy with carboplatin and VP-16. The patient developed anemia after his first cycle with therapy and was hospitalized on February 8, 2008 for blood transfusion.

The patient was discharged on February 9, 2008. He became constipated at home and was given milk of magnesia with which he developed diarrhea. The patient's diarrhea resolved on its own but then he became constipated again and was seen in the emergency department on Saturday, February 11, 2008. He was given an enema which resolved his constipation. However, for the past four days, the patient has had diarrhea with frequent and loose bowel movements. He also developed excoriation of his perianal area which caused him to have severe pain.

He denied any abdominal pain. He is able to tolerate some p.o. without nausea or vomiting.

He denied any worsening back pain or loss of control of his bladder.

Past Medical History significant for:

1. Small-cell lung cancer.
2. Hypertension.

Current Medications: At home:

1. Enalapril 10 mg once a day
2. Procrit 40,000 units a week.
3. Ativan as needed
4. Compazine as needed

Allergies: The patient has no known drug allergies

Family History: Noncontributory

Abdomen: Soft, nontender

Rectal: Loose stool and excoriated perianal area

Extremities: No edema

Laboratory Data: Laboratories that were done yesterday show a WBC of 8.2. Hemoglobin 10.8. The patient has 58% neutrophils. Liver enzymes are normal. Serum creatinine 1.0.

Assessment and Plan: The patient is a 65-year-old with small-cell lung cancer extensive stage. The patient is due for chemotherapy today but given his current condition, we will hold chemotherapy.