Radiology Report
08/10/2007

Left Breast Ultrasound

Real time scanning of the left breast demonstrates an irregular solid lesion in the 12 o'clock position which measures 5.4 x 5.5 cm. There is a second larger multilobulated lesion in the 1 to 2 o'clock position measuring 33.3 x 21.0 mm. Scattered microcalcifications in this lesion are seen. There is also overlying skin thickening to 6.6 mm.

Impression:
1. Left breast carcinoma with satellite lesion
2. Ultrasound BIRADS 5

Radiology Report
08/10/2007

Bilateral Mammography with Craniocaudal and Oblique Lateral Views, with Second Look Analysis

Static imaging of both breasts demonstrates a spiculated mass in the left breast 1 to 2 o'clock position measuring 50 x 35 mm. There are extensions to the skin surface. Skin thickening is present. There are scattered microcalcifications within this mass.

Correlation with ultrasound demonstrates an irregular solid mass in the 12 o'clock position measuring 5.4 x 3.9 mm, and a second irregular, lobulated and spiculated mass in the 1 to 2 o'clock position which measures 33.3 x 21.0 mm. Three are scattered microcalcifications in this lesion. There is also overlying skin thickening to 6.6 mm. No cystic lesions are identified.

Impression:
1. Spiculated mass in the left breast 1 o 2 o'clock position with a satellite lesion at 12 o'clock, presumed carcinoma
2. BIRADS 5, suggest biopsy

BIRADS 0: Need additional imaging evaluation.
BIRADS 1: Negative.
BIRADS 2: Benign finding.
BIRADS 3: Probably benign finding. Short-term interval follow-up is recommended
BIRADS 4: Suspicious abnormality. Biopsy is recommended.
BIRADS 5: Highly suggestive of malignancy. Biopsy if recommended.
BIRADS 6: Biopsy-proven malignancy.

Radiology Report
08/10/2007

Chest, PA and Lateral

Heart size and mediastinal structures are normal. There are bullous lesions in the apices. No pulmonary nodules or effusions are seen. Bony thorax normal.

Impression: Bullous emphysema

Progress Notes

08/11/2007: HPI: See full History & Physical exam for details. Impression/Plan: The patient to be added for left modified radical mastectomy next few days.

08/18/2007: Surgery 08/18/2007 @ 7:30 am – Left modified radical mastectomy

08/22/2007:
S: The patient says she is still a bit sore and uses the Vicodin 5 to 10 mg.
O: On physical exam, the flaps are clean and healthy and sutures are removed. Staples left in. The medial JP output has shrunk down to about 35 for the last day, and it was removed. Pathology shows six to twelve positive lymph nodes and multicentric tumor.
A: In all doing well.
P: Vicodin 7.5 mg given #30. The medial JP drain was removed. Recheck here three days in anticipation of removal of the axillary drain. Will get patient in to see physician in the next week or two.

08/25/2007:
S: The patient has no complaints today. The JP output is 90 mL in the last twenty-four hours.
O: The flaps look flat and healthy, and every other staple is removed. There may be a bit of seroma at the medial corner.
A: All in all doing well.
P: I believe I will leave the JP drain in since the output is significant. Recheck here four days. I will also get her in to see physician.

08/29/2007:
S: The patient has had a good bit of left chest wall pain last evening. Otherwise doing well.
O: On physical exam, there is a medial corner seroma. The JP drainage output is nil and it was removed. The remaining staples are removed. The seroma was aspirated of 30 mL of thin bloody fluid, and it disappeared.
A: Postop pain and seroma.
P: We will increase Lorcet to Percocet #30. To see physicians. Recheck here two weeks for probable re-aspiration and follow-up.

09/12/2007:
S: The patient is doing much better and has no complaints today.
O: On physical exam, the wound is well-healed. I cannot palpate a medial corner seroma anymore. Range of motion is improved too, nearly equal to the right side.
A: Satisfactory course.
P: Mastectomy bra prescription given. To see physicians. Recheck here three months.

Pathology Report
08/11/2007

Gross Description:
Specimen is received in formalin, labeled with the patient's name, designated as "right breast mass" and consists of two white-yellow cores of fibrous rubbery tissue measuring up to 2.5 x 0.2 cm, entirely submitted in 1 cassette. Sections are taken on several slides as follows:
Slides 1, 3, 5 placed on white slides cut at 3 microns, stained for H&P
Slides 2, 4, 6, 7 are placed on blue positive slides for possible special staining.

Microscopic Description:
These are well taken cores that show extensive replacement by nests and cords of malignant epithelial cells with inconspicuous mitoses, abundant fibroblastic proliferation and colloidal type collagen. The cells have an intermediate nuclear grade. There is an in-situ cribriform component. There is retraction artifact making difficult to evaluate whether there is true vascular space invasion. I do not see any unequivocal vascular space invasion.

Final Diagnosis:
Breast, right breast core biopsies (clinically a mass): Infiltrating ductal carcinoma with extensive fibrosis and hyalinization.

1. Histologic Grade (SBR):	II
2. In-Situ Component:	DCIS, cribriform type with intermediate nuclear grade without necrosis
3. Vascular Space Invasion:	Not definitely identified
4. Predictive/Prognosis Factors:	
Estrogen Receptors:	> 95% (ER/PR positive)
Progesterone Receptors:	Positive (> 95%)
HER-2/neu:	1+ (indicates borderline overexpression)
Ki-67:	> 25% (indicates high proliferative rate)

History & Physical
08/18/2007

Chief Complaint: Lump in left breast

History of Present Illness: Discovered by patient 6 months ago; slowing growing; no pain or nipple discharge

Past Medical History: TAH 1976

Social History: 1 ppd x 40 years smoking history. ETOH: rare.

Family History: Father w/prostate cancer.

Allergies: PCA

Physical Examination:
General: Normal
Plump white female NAD approximately 5 cm hard mass inverted nipple left breast – needle biopsy to be done.

Impression: CA left breast

Plan: Left modified radical mastectomy

Operative Report
08/18/2007

Preoperative Diagnosis: Carcinoma left breast

Postoperative Diagnosis: Same

Operative Procedure: Left modified radical mastectomy

Estimated Blood Loss: Nil

Condition on Completion of Surgery: Patient was sent to the recovery room doing well, no complications

Findings: There was a large, about 5 cm tumor in the left central breast with nipple inversion, and a separate hard tumor in the upper medial breast about 1 cm in diameter, suggesting a new primary or perhaps intransit metastases. The low axilla showed a palpable hard lymph node, and as dissection proceeded, there were multiple hard lymph nodes up to level 2.

Procedure: After suitable level of general endotracheal anesthesia was reached and a left subscapular pad was placed, the arm was abducted 90 degrees the left breast was prepped and draped in the usual sterile fashion for a modified mastectomy. A marking pen was used to delineate a transverse oriented ellipse, as well as the extent of dissection inferiorly, superiorly, laterally, and medially. The superior incision was made and a superior flap developed to clavicle using knife for skin and cutting current of Bovie for dissection of the flaps. Similarly, an inferior flag was developed to the rectus. Dissection proceeded laterally to the latissimus dorsi and medially to the sternum, and the breast was swung from the medial to lateral direction, taking the pectoral fascia as well as some of the muscle beneath the tumor. The lateral border of pectoralis major was cleared with sharp dissection and intercostal brachial nerve sacrificed between clips. There was hard tumor masses palpated in the axillary tissue, and I sacrificed the medial pectoral nerve and vessels between clips. Reaching up under the pectoralis minor, I commenced the dissection downward by clamping, dividing and ligating with #2-0 Vicryl the highest axillary contents, that is, to the top of level 2. The axillary vein was cleared by taking its tributaries between clamps, tied with #2-0 Vicryl. The serratus muscle was cleaned off s well as subscapular muscle. In this bundle the long thoracic nerve was dissected away and placed back against the serratus anterior. The subscapular vessels were sacrificed by dividing them between clamps, tied with #2-0 Vicryl, and the thoracodorsal nerve was carefully preserved throughout. The axillary contents were further swept inferiorly, and finally handed away. The nerve remained intact to simulation of the muscles.

The wound was thoroughly irrigated with saline and suctioned clean. Two Jackson-Pratt drains were placed, one in the axilla and one over the pectoralis major, and bought out separately inferior to the incision and attached to skin with #2-0 silk. The skin was coapted with several interrupted vertical mattress #3-0 nylon and staples, and gauze was placed over the wound and drain sponges, followed by wide paper tape. Patient was sent to the recovery room doing well, no complications.

Pathology Report
08/18/2007

Specimen:
Left breast tissue

Gross Description:
Received labeled left breast tissue is a portion of left breast including skin and underlying adipose tissue with dimensions of 21.5 x 18 x 7 cm. The ellipse of skin has overall dimensions of 21 x 12.4 cm. The nipple is inverted. 1.5 cm from the nipple there is a 4 x 3.5 x 2.5 cm palpable mass. The mass grossly appears to extend to the skin surface. 7 c from the first mass there is a secondary mass 1.5 x 2.5 x 2 cm. The first tumor is 5 cm from the deep resection margin. On sectioning of what appears to be an axillary tail there are sixteen possible lymph nodes identified up to 1.2 cm in diameter. Several of these lymph nodes appear to be grossly involved by tumor. The secondary lesion identified in the breast which is close to the apparent axillary tail may actually be an involved lymph node rather than a secondary tumor site. Sections are submitted as follows: 1. Nipple, 2 & 3. Tissue directly beneath nipple, 4. Deep resection margin, 5-8. Random sections of the four quadrants. 9. Deep resection margin of primary tumor. 10-13. Random sections of tumor including skin. 14-15. Secondary tumor. 16-23. Possible lymph nodes. 23 blocks

Microscopic Description: Breast

Breast – excision less than total mastectomy (includes wire-guided localization excisions), total mastectomy, modified radical mastectomy, radical mastectomy

Macroscopic:

Specimen Type:	Mastectomy
Lymph Node Sampling:	Axillary dissection
Specimen Size:	21.5 cm
Laterality:	Left
Tumor Site:	Not specified

Microscopic:

Size of Invasive Component:	4 and 2.5 cm
Histologic Type:	Invasive ductal carcinoma
Tubule Formation:	Moderate 10% to 75% (score: 2)
Nuclear Pleomorphism:	Moderate increase in size (score: 2)
Mitotic Count:	6 to 10 mitoses per 10 HPF (score: 2)
Total Nottingham Score:	Grade II: 6-7 points

Primary Tumor (pT):	pT2: Tumor more than 2.0 cm but not more than 5.0 cm in greatest dimension
Regional Lymph Nodes (pN):	pN2a: Metastasis in 4 to 9 axillary lymph nodes (at least 1 tumor deposit greater than 2.0 mm)

Distant Metastasis (pM): pMX: Cannot be assessed
Margins: Margins uninvolved by invasive carcinoma
Venous/Lymphatic (Large/Small Vessel) Invasion (V/L): Present
Microcalcifications: Present in both tumor and non-neoplastic tissue
Additional Pathologic Changes: Fibrocystic changes

Final Diagnosis:
Invasive ductal carcinoma, intermediate to high-grade, multicentric. The large lesion measures 4 cm in greatest dimension and is 1.5 cm from the nipple region and involves microscopically skin of breast without definitive dermal lymphatic involvement.

The surgical resection margins of this lesion are free of tumor.

A second lesion which is 7 cm from the first lesion measures 2.5 cm in greatest dimension and is in the axillary tail region.

The surgical resection margins of the second lesion are also free of tumor.

Both lesions show extensive perineural invasion as well as lymphatic invasion.

There is a minimal ductal in-situ component.

Metastatic carcinoma in six of eleven axillary lymph nodes (6/11).

Consultation
09/14/2007

Dear Dr.

I had the pleasure of seeing your patient in my Radiation Oncology Clinic today. Please allow me to review her history and physical below for our records.

This is a pleasant 56-year-old white female who apparently had a mass in the 12 o'clock position of the left breast for about six months and ultimately caused an inverted nipple on that side. Mammogram revealed a spiculated mass in the left breast at the one to two o'clock position with some extension to the skin with thickening present. There were scattered microcalcifications within the mass. Ultrasound correlation revealed an irregular solid mass in the 12 o'clock position measuring 52 x 39 mm and a second irregular lobulated and spiculated mass in the one to two o'clock position measuring 3.3 x 2.1 cm. There were scattered microcalcifications in that lesion and there was also overlying skin thickening. The patient had a biopsy performed which revealed a 4.0 x 3.5 x 2.5 cm mass in the area of the nipple with the mass grossly extending to involve the skin surface and microscopically involving skin but with no dermal lymphatic invasion. There was a second 1.5 x 2.5 x 2.0 cm mass involving the axillary tail that was either another lesion with a multicentric presentation or a replaced axillary lymph node that was low lying – the primary tumor was grade 2-3 and there was marked lymphovascular invasion and perineural invasion present. Axillary resection revealed six of eleven axillary lymph nodes positive not including the axillary tail lesion. All surgical resections were negative. The tumor was ER/PR positive and HER-2/neu 1+ positive on immunohistochemistry – K167 showed a poorly differentiated tumor. The patient has done well following her surgery and is referred for consideration of further workup and treatment options.

Past Medical History: Total abdominal hysterectomy

Current Medication: Lomab as needed Allergies: Penicillin causes a rash.

Family History: Father had prostate cancer

Social History: The patient is married with two children and four grandchildren. She is a housewife. Hobbies include crafts including flower arrangements. She has smoked one ppd for 40 years. No alcohol use.

Review of Systems: Her Karnofsky performance status is 100. Her chief complaint is breast cancer. She has been doing well following her surgery and moving her arm well. She has no weight loss. No new aches or pains. She eats about one to two servings of fruits and vegetables a day. She has been sleeping poorly since her diagnosis due to anxiety. She does very little in the way of exercise.

Physical Examination: This is a well-developed, well-nourished white female in no acute distress. There is no palpable adenopathy in the right side of the neck or supraclavicular region.

Heart regular. Lungs clear. Abdomen benign. Examination of the right breast reveals no dominant mass or associated nodes. The left chest wall shows no significant nodularity of induration and the scar that is well healed extends from near midline over the axillary region. There are no dominant areas of nodularity or induration. Extremities are without edema. She does have some what appears to be vascular darkening changes in bilateral feet and apparently has seen her general physician concerning this and had been told she had some vascular insufficiency. Neurologically, nonfocal. No palpable bony tenderness throughout.

Assessment and Plan: 56-year-old white female with T2 pN2a MX infiltrating ductal carcinoma of the breast status post mastectomy with negative margins – tumor is ER/PR positive and HER-2 negative by immunohistochemistry with only 1+ uptake and doe have extensive lymphovascular invasion as well as perineural invasion. I have spoken with her physician and she will see the patient and order a PET CT for further staging and almost certainly treat the patient with systemic chemotherapy and assuming that she does not have any evidence of distal metastatic disease then she will be a candidate for post mastectomy radiotherapy as well following chemotherapy. Following radiation, she will then have an antiestrogen. I have explained the various risks and benefits of radiotherapy and generally talked with her about the way that this precedes and the general course of cancer treatment. I have made some general lifestyle nutritional recommendations including smoking cessation and we have given some informational handouts concerning this. She will return to follow-up with us following her chemotherapy.

Thank you for your referral of this patient and for the opportunity to participate in her care. Hopefully, our combined efforts will result in significant long-term control of her disease.

Oncology Consultation
09/26/2007

Reason for Referral: Breast cancer

Subjective: Patient is a delightful 56-year-old lady who said that she had noticed an enlarging breast mass for a year and a half. She had not been receiving regular mammography but did present to Imaging without doctor's referral. The mammogram and ultrasound on 08/10/2007 showed a spiculated mass in the left breast at the 1 o'clock to 2 o'clock position with satellite lesion at the 12 o'clock position. The size was 5.4 cm x 3.3 cm, also suspicious on ultrasound. The ultrasound further noted overlying skin thickening to 6.6 mm. She was referred. She had a positive biopsy and then had a left modified radical mastectomy. On note it was said to be a 5 cm central tumor with nipple inversion and separate hard mass in the upper medial breast at approximately 1 cm in diameter with low palpable hard lymph nodes in the axilla. She comes in today to discuss adjuvant therapy.

Past Medical History: She had a total abdominal hysterectomy in 1976 for endometriosis at the age of 26. She is gravida 2, para 2, with two children aged 37and 30, both sons.

Review of Systems: She has chronic bronchitis and sinusitis with purulent sputum. She is having some sinus congestion and dyspnea on exertion now. She denies chest pain or other pain and has been feeling well and eating well. She has been extremely anxious recently.

Current Medications: Hydrocodone 7.5, Advil, Sudafed, aspirin

Allergies: Penicillin which cause a rash

Family History: Positive for father who died with prostate cancer, a mother who is living with a diagnosis of diabetes. She has a total of six sisters. One of the older ones has had several coronary artery bypass grafts. The other ones are healthy. She has a second cousin with breast cancer but no other malignancy in the family.

Social History: Positive for smoking one to two packs of cigarettes a day for many years. She currently smokes one pack of cigarettes a day. She is retired from the carpet industry and currently does crafts. She is married and accompanied by her husband.

Physical Examination:
General: She is alert, healthy and quite pleasant. She is very emotionally distraught and cries throughout the time together. She also is coughing, hoarse and has a very congested cough. She seemed short of breath at rest.
Vital Signs: Height 65.5", weight 172, blood pressure 162/96, pulse 94, respirations 16, temperature 67.
HEENT: Edentulous mouth with no other abnormalities.
Lymph Nodes: There is no peripheral lymph adenopathy.
Breasts: Left modified radical mastectomy scars well healed with no abnormalities.

Chest: Shows COPD changes without wheezes but prolonged expiratory phase. There are no rales or rhonchi.
Cardiovascular: Unremarkable with a regular rat, and rhythm.
Abdomen: Soft, and nontender without organomegaly or masses.
Extremities: Unremarkable without edema.

Laboratory/Radiology/Pathology: Chest x-ray on 08/10/2007 was unremarkable. The biopsy done on 08/16/2007 shows infiltrating ductal carcinoma grade II with an in situ component, strongly positive estrogen and progesterone receptor, negative HER-2 neu. She went on and had the modified radical mastectomy on 08/18/2007. It showed invasive ductal carcinoma intermediate to high grade, multi-centric. The largest lesion was 4 cm and microscopically involves the skin of the breast without definitive dermal lymphatic involvement. The smaller mass is 2.5 cm in the axillary tail region. There were clear margins, extensive perineural invasion as well as lymphatic invasion, minimal ductal in situ component and metastatic carcinoma in 6 of 11 axillary lymph nodes. The pathologist notes that several of the lymph nodes appear to be grossly involved with tumor and the smaller mass could possibly be an involved lymph node other than a second primary. He also mentions that the mass grossly appear to extend to the skin's surface. The lab has just come back showing chemistry profile with a glucose elevated at 112, a high SGPT of 56 and a high LDH of 225. CBC is normal.

Assessment:
1. Possible multifocal left breast cancer with the largest lesion measuring 4 cm representing a pT2 pN2a, invasive ductal carcinoma intermediate to high grade with 6 positive of 11 axillary lymph nodes, a second breast mass measuring 2.5 cm either representing a lymph node or a second primary, ER/PR positive, HER-2 neu negative, status post modified radical mastectomy on 08/18/2007.
2. Acute and chronic bronchitis presentably due to cigarette smoking.

Medical Decision Making: I would like to get a PET scan to rule out any metastatic disease before we start chemotherapy. I also have a MUGA heart scan scheduled for Friday of this week with a follow-up visit Friday afternoon to try to make a final decision about what to do. She had I had a long discussion about this presentation. I tried to be as positive as possible and emphasize that the adjuvant therapy is prophylactic treatment for the possibility of micrometastatic disease with a purpose primarily of increasing the cure rate. We also briefly discussed the possibility of the AC-T chemotherapy regimen which is aggressive and causes hair loss, nausea, etc. but deferred any decision about chemotherapy pending the results of the PET and the MUGA heart scan. We went over the ACS-NCCN booklet in detail and she was sent home with that material to read.

I also treated her bronchitis. I failed to mention above that she did have an O2 sat of 91% to 92% resting. She was given an albuterol inhaler. Ativan 1 mg for anxiety, a Medrol dose pack to start after the PET scan tomorrow with Zantac and 1 gave her a Z-pac.

Radiology Report
09/27/2007

PET/CT Fusion Scan

Indications: Left breast cancer with modified radical mastectomy, for staging

Comparison Studies: Consult 09-14-2007, pathology 08-22-2007, lab mammography report 08-10-2007.

Injection: 13.9 mCi FDG right hand; Blood Glucose 112; uptake time 65 minutes

CT Findings: The patient has had a modified left radical mastectomy with 1eft axillary node dissection. The patient has also had a previous hysterectomy. There is a right paratracheal lymph node which measures 9 mm in long axis, and lies approximately 15 mm above the carina. There are subpulmonic blebs and bullae in the lung parenchyma. No soft tissue masses in the lung parenchyma are seen. No hilar adenopathy is seen. There are diverticula present in the sigmoid colon.

PET Findings: There is diffuse activity over the left chest wall and into the left axilla with SUV's ranging between 1.4 and 2.1. No focal increased activity over the left chest wall or in the left axillary is seen. There is no increased activity in the internal mammary chains of nodes or in the supraclavicular region.. Cervical nodes are also normal appearing.

However, there is a single node with intense increased activity in the right paratracheal region, the node described in the CT findings, with an SUV of 5.1. No other nodes in the mediastinum, and no focal soft tissue nodules in the lung parenchyma are seen.

The liver, spleen, retroperitoneal, and pelvic lymph nodes show normal activity. There is no abnormal uptake and activity in the bones.

Pertinent Negatives: No evidence of liver, cervical node, supraclavicular, or internal mammary nodal activity. No evidence of bony or liver metastases.

Impression:
CT Findings:

1. Status post-modified radical mastectomy on the left with axillary node dissection
2. Sigmoid diverticulosis

PET Findings:

1. Diffuse low-level activity over the left chest wall and left axilla, normal findings post-surgery
2. Single mediastinal node with focal increased activity SUV 5.1 in the right paratracheal region without associated nodes, and with no evidence of lung mass; however, suspicious for a single node distant metastasis

Comment: Consider mediastinoscopy with node sampling to differentiate a single inflammatory

node vs. a single nodal metastasis.

Radiology Report
09/29/2007

Cardiac study, MUGA, using 28.0 MCI 99M technetium pertechnetate

Dynamic imaging of the left ventricle following intravenous injection radionuclide demonstrates a normal global ejection fraction of 58%. There is normal contractility of all segments of the left ventricle. Wall motion study is normal.

Impression: Normal left ventricular function, ejection fraction 58%

Oncology Consultation
09/29/2007

Subjective: Patient comes in today to make a final decision about her chemotherapy. She presented with a T2, N2a, grade II left breast cancer probably multifocal treated with left modified radical mastectomy on 08/18/2007. She comes back today after having a PET and MUGA heart scan.

Objective: Weight is 170, blood pressure 150/87, pulse 102, respirations 20, temperature 97.6. She is alert and in no acute distress. She was not reexamined.

Laboratory/Radiology/Pathology: The PET CT scan does show a single right mediastinal lymph node that is positive with an SUV of 5.1. It is in the right peritracheal region but the other areas are completely normal. The MUGA heart scan report is not available but the physician tells me that the ejection fraction is normal.

Assessment:
pT2, pN2a grade II breast cancer, possibly multifocal with a 4 cm large mass and 6 positive lymph nodes out of 11, status post left modified radical mastectomy 08/18/2007 with positive ER/PR and negative HER-2 neu, PET scan with a single right mediastinal lymph node of uncertain etiology.

Medical Decision Making: I would like to be aggressive with her and treat her with adjuvant chemotherapy hoping that single lymph node is an inflammatory lymph node. I have explained the options and she agrees to be aggressive with the AC-T regimen. We went back over the rationale for aggressive adjuvant therapy and I did chemotherapy teaching for the AC part of the treatment which will either be dose dense or q3 weeks depending on how it is tolerated. She was given a chemotherapy folder and drug sheets and we went over them. She was also given an appointment for Monday for the first treatment and two weeks later to see me and consider the next treatment. She was given multiple prescriptions. She requested a refill of Hydrocodone 7.5 and I gave her Compazine 10 mg, Phenergan 25 mg rectal suppositories, Decadron 4 mg three times a day for two days, twice a day on third day, once on the fourth day with Zantac starting the day following each of the AC treatments, and Zofran 8 mg three times a day for three days every six to eight hours as needed for nausea. I did fail to mention that she is responding to the pulmonary treatment with less shortness of breath and congestion.

Oncology Consultation
11/21/2007

Subjective: Patient came in with a high-risk breast cancer T2, N2, and a possible mediastinal lymph node metastasis on PET scan earlier this fall. She took one cycle of AC chemotherapy on 10/02/2007 and then refused to come back. She has since talked to her physician and received a letter from me and is now back to consider more treatment. She says she not want to take anymore of the AC regimen because she continues to not feel well and was very nauseated for three weeks. She did not throw up; however, she is afraid not to treat the cancer and wants to discuss treatment once again.

Objective: Weight is 172, blood pressure 162/95, pulse 102, respirations 24, temperature 97.4. The patient is alert and in no acute distress. HEENT examination is unremarkable. There is no peripheral lymphadenopathy. The left chest wall is clear. Cardiovascular examination is unremarkable. Abdomen is soft and non-tender without organomegaly or masses. Extremities are unremarkable. CBC was not repeated today.

Assessment: T2, N2, M+? ductal carcinoma of the left breast treated with left modified radical mastectomy and one cycle of AC chemotherapy. ER/PR positive with negative HER-2.

Medical Decision Making: I decided to give her the TAC regimen without the A and did chemotherapy teaching for Taxotere. She was also given a prescription for the standard Decadron dosage with each dose of Taxotere. She has all her other medications and also regularly takes Zantac. She was scheduled for 11/30/2007 to restart chemotherapy. I will try once again to do it dose-dense with Neulasta. Discussed her case and we would like to be aggressive and treat her as if she is receiving adjuvant therapy since the PET scan finding may be an inflammatory lymph node rather than metastatic disease. I would like to hold off on chest wall radiation therapy until she is finished four, or preferably six cycles, of Taxotere based therapy.

Oncology Consultation
12/19/2007

Subjective: Patient called in complaining of extremely sore feet so she was seen without an appointment. She has taken two cycles of Taxotere at 80 mg/m2 on 11/30 and 12/14. I had been attempting to do dose dense chemotherapy on her but she refused the Adriamycin/Cytoxan treatment and did not come back for several months. She did well with the first cycle of Taxotere but said several days ago her feet started getting worse. She denies any pain elsewhere but her hands are also dry. She has had a mild stomatitis. Appetite is okay and she is eating and she denied any fever or chills.

Objective: She was not able to stand up for her weight. Blood pressure 128/83, pulse 106, respirations 20, temperature 97. The patient is alert and in no acute distress. HEENT examination shows some oral candidiasis. Her hands are red, dry and peeling a little bit. Her feet are quite remarkable in that they are red particularly on the soles and she seems to have large blisters forming on some of the weight bearing calluses bilaterally.

Laboratory/Radiology/Pathology: White count is 3.2, hematocrit is 44.6, platelets are 226,000

Assessment: Severe hand/foot syndrome is a patient who is on Taxotere and Cytoxan after refusing Adriamycin therapy for a T2, N2, possibly metastatic breast cancer (to a right mediastinal lymph node on PET scan).

Medical Decision Making: So far, I have been unable to find hand/foot syndrome mentioned with Taxotere and I certainly would not expect to see such toxicity with an 80 mg/m2 dose. At any rate, she was given pain medications and nystatin oral solution and we will follow her closely. Of course, chemotherapy will be held and I will probably not give her any further Taxotere.