**Radiation Oncology Report**

DIAGNOSIS: STAGE IV, T4, N1, M0 SQUAMOUS CELL CARCINOMA OF THE OROPHARNYX. RADIATION TREATMENT WAS COMPLETED 10/2/99

Patient: John Doe  
SSN: 455-51-7704

Dear Dr. X:

INTERVAL HISTORY: Mr. John Doe returned yesterday. It has been a month since he was last seen here. He is status post osteonecrosis of his right mandible. He has seen Dr. X. He has had some of the exposed bone removed. He has been feeling a lot better since then. Very little pain remains. Last night when he was eating popcorn, he developed some swelling and discomfort over his right cheek. I told him that his salivary gland probably was swollen. He is having no difficulties swallowing. He is eating garnishes, breakfast with protein enhancers, and some soft foods. His weight has dropped about 2-1/2 pounds since last month. No other complaints or problems were offered; no suggestion of a new primary.

PHYSICAL EXAMINATION: Weight 244-1/2 pounds. Mr. Doe appears about the same as the last time I saw him. He is in no apparent distress. Neck was supple without lymph nodes. Lungs were clear to auscultation bilaterally. Inspection of oral cavity and oropharnyx shows he has some small area of exposed bone in the right posterior mandible. There are two separate areas of some bridging of the gingiva covering partially over those areas. It is smooth to feel. I do not feel any rough edges or jagged edges. View of the thyroid scope, supraglottic and glottic structures are readily visualized. They appeared to be normal. The oropharnyx is also visible and palpably normal.

IMPRESSION:  
1. No evidence of disease recurrence.  
2. Osteonecrosis of the right mandible.

PLAN: I will ask Mr. Doe to return to see me in one month. If he continues to heal, that would be great. If there is some delay in his healing, our concern for progression is osteonecrosis. I think he should have hyperbaric oxygen. Once again, thank you very much for allowing us to participate in Mr. Doe's oncology care.

Oncology Follow-up and Initial Consultations

HISTORY: The patient is seen today in anticipation of beginning his fifth cycle of adjuvant 5-FU and leucovorin chemotherapy for node-negative colon cancer. He continues to tolerate chemotherapy without significant toxicity. His only complaint is of mild nausea at the time of administration of each 5-FU treatment. This lasts a brief time. It is not relieved completely with Compazine. Otherwise he is feeling well. Appetite is normal and weight is stable. ECOG performance status remains 0. He has had no mouth sores, diarrhea or other significant toxicity from chemotherapy. He has noted areas of darkening on his palms and soles as well as just proximal to his nails. These are not associated with discomfort. He also questioned about a slight pruritic rash on his left ankle. The patient also reports that he has had occasional right-sided abdominal discomfort. Presently he is not experiencing pain. In addition, he has been experiencing some right scapular discomfort over the last week. He believes this is muscular although he does not recall having injured himself. There has been no significant change in the last week.

PHYSICAL EXAMINATION: Reveals a well-appearing gentleman. Weight is 75.6 kg, up 1.2 kg from last visit. Blood pressure is 140/78. Pulse is 68 and regular. HEENT examination is grossly unremarkable. There is no palpable peripheral adenopathy. Lung and cardiac examinations are normal. There is no tenderness to palpation or obvious mass noted on evaluation of the posterior chest wall on the right. Abdomen is soft and nontender without evidence of organomegaly or mass. Extremities are without edema. There is slight hyperpigmentation of the palms and soles consistent with 5-FU effect. In addition, there is mild stasis dermatitis of the left ankle with some mild scaling.

LABORATORY AND X-RAY DATA: White blood count 4.1 with absolute neutrophil count of 2100, hematocrit 41% and platelet count 207,000. Serum chemistries including liver enzymes are all within normal limits except for borderline elevated AST of 38 and ALT of 72. CEA level from \_\_\_\_\_\_\_\_\_\_\_ was less than 0.5.

IMPRESSION/PLAN: The patient continues to tolerate adjuvant chemotherapy with reasonable toxicity. He will proceed on with cycle number five today, once again consisting of 5-FU 425 mg/m2 IV given daily x5 days along with leucovorin 20 mg/m2 IV. I will see him back in 4 weeks in anticipation of beginning his sixth and final month of chemotherapy treatment. I suspect that his hyperpigmentation on the palms and soles is related to 5-FU. I have suggested that he consider topical hydrocortisone cream for the rash on his left ankle. The significance of the right shoulder discomfort is unclear. Examination is unrevealing and given the fact that his symptoms have been present for only 1 week and are not escalating, I have recommended continued observation. If however there is persistence of symptoms or worsening then further evaluation will be undertaken.

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Dear Doctor:

Your patient was seen today for followup of stage II right colon cancer for which he has now completed 6 months of adjuvant 5-FU and leucovorin chemotherapy. Two weeks ago he was evaluated for complaint of several days of tarry, black stools. There was no associated abdominal pain, dyspepsia, nausea or vomiting. At the time that he was seen in the office, rectal examination was performed and stool was guaiac negative. In addition, he was given stool guaiac cards to have done at home and these likewise were negative for presence of blood. He has had complete resolution of the symptoms and has had no recurrence. Presently, bowel movements are regular and he is without abdominal discomfort. He continues to have mild orthostatic lightheadedness. There has been no progression of symptoms. Appetite is normal. Weight has been stable recently, although he has gained in excess of 30 pounds since starting chemotherapy treatments. He has slight fatigue with an ECOG performance status of 0. He notes no respiratory symptoms other than for some mild shortness of breath with exertion. He has no anginal-type symptoms.

Physical examination reveals a well appearing gentleman. Weight is 118.1 kg, unchanged from last visit. Blood pressure is 120/70. Pulse is 78 and regular. HEENT examination is grossly unremarkable. There is no palpable peripheral adenopathy. Lung and cardiac examinations are unremarkable. Abdomen is obese. No definite organomegaly or mass is identified. There is no tenderness to palpation. Extremities are without edema.

White blood count is 5.3 with absolute neutrophil count of 2500, hematocrit is 43% and platelet count is 246,000. Serum chemistries are notable for glucose of 159. Liver enzymes are all within normal limits. CEA level is 1.6.

The patient has now successfully completed adjuvant chemotherapy with no definite evidence of disease recurrence. The significance of his recent black stools is unclear. Although this may have represented a brief episode of bleeding, he had no decline in his hematocrit and stool evaluation was negative for the presence of blood. I have recommended that we continue to observe this for now. He will be due for a colonoscopy in early \_\_\_\_\_\_\_\_\_\_\_\_ since that will be 1 year out from initial diagnosis and surgery. However, if symptoms recur then we may need to consider having him evaluated sooner. I will see him back in followup in 3 months for reassessment.

Once again I thank you for allowing me the opportunity to take part in the care of this pleasant gentleman. Please do not hesitate to contact me if you have additional questions or concerns regarding his management.

Sincerely,

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Dear Doctor:

I had the pleasure of seeing your patient today to review treatment plans for recently diagnosed adenocarcinoma of the rectum. As you are aware, his initial consultation was done by Dr. \_\_\_\_\_\_. After further discussion with you it was decided that the patient would be offered 5-FU-based chemotherapy concurrently with radiation for treatment of an invasive adenocarcinoma of the rectum with close and possibly involved resection margin. The patient was set to start infusional 5-FU chemotherapy today but he inadvertently pulled his PICC line partially out this past weekend. In addition, he has had questions about the mode of delivery and duration of the chemotherapy treatments in relation to the radiation treatments. He has started his radiation treatments as of today.

The patient reports no significant change in his health since his initial visit. Currently he averages 1-2 formed bowel movements daily. He is overall feeling well. Appetite is normal and weight is stable. He denies any respiratory or other gastrointestinal symptoms.

Physical examination reveals a well appearing gentleman. HEENT examination is grossly unremarkable. There is no palpable peripheral adenopathy. Lung and cardiac examinations are normal except for slight bronchial breath sounds at the left base. Abdomen is soft and nontender with no definite evidence of organomegaly or mass. There is an old surgical scar present from his previous appendectomy. Extremities are without edema. There is a PICC line present in the proximal left arm. There is a fair amount of tubing present consistent with the line having been partially removed. There is a fine scaly-type rash over his anterior chest, which the patient states he typically gets this time of year and has been diagnosed in the past as a fungal infection.

White blood count 7.3 with absolute neutrophil count of 4900, hematocrit 47% and platelet count 211,000. Serum chemistries including liver enzymes are all within normal limits except for a borderline elevated glucose of 125.

I have had a lengthy discussion with the patient and his wife regarding the rationale for administering chemotherapy in addition to radiation for the treatment of his recently diagnosed rectal cancer. I have explained to him that at the present time, it is unclear whether he has any residual cancer. Unfortunately, without performing additional surgery, there is no way to determine whether residual carcinoma exists. In an effort to preserve rectal function, radiation has been initiated. I have also explained to him that there has not been a randomized trial performed to determine whether the addition of chemotherapy improved outcome beyond radiation alone. In the absence of such information, I do not feel it unreasonable to treat with chemotherapy since we typically treat rectal tumors with radiation and 5-FU chemotherapy. In addition, as you are aware several centers including \_\_\_\_\_\_\_\_\_\_\_ General Hospital have recommended that chemotherapy be added to radiation under these circumstances. The patient has asked about the frequency of the administration of the chemotherapy. Initially, he was under the understanding that treatment would be given on the first and last week of radiation treatments. I explained that bolus 5-FU either alone or with leucovorin could be considered and that this would be administered on the first and last week of treatment. However, the more typical treatment to be given concurrently with radiation would be continuous infusion of low dose 5-FU. This would be administered throughout the duration of radiation treatments. As you are aware, other centers including \_\_\_\_\_\_\_\_\_\_\_\_\_\_ General Hospital are using the continuous infusion approach with radiation treatments. The potential toxicities of treatment including but not limited to nausea and vomiting, mucositis, diarrhea, fatigue, and myelosuppression with possible increased risk of infection were reviewed. The patient has given consent to proceed on with treatments. Given the fact that the PICC line is currently not functioning, we will hold on initiating treatment until the PICC line is replaced. This will be done tomorrow afternoon. I will plan to start chemotherapy on the morning of \_\_\_\_\_\_\_\_\_\_. Instead of a 5-day infusion this week, we will only go for 3 days. However, beginning next week he will receive 5-FU by continuous infusion daily x5 days each week. Dose will consist of 5-FU 225 mg/m2 per 24 hours administered by a continuous IV infusion. We have contacted the radiologist who placed the PICC line. At his request, the present PICC line has been left in place rather than removing it.

I thank you for allowing me the opportunity to take part in the care of this pleasant gentleman. Please do not hesitate to contact me if you have additional questions or concerns regarding his management.

Sincerely,