[redacted] Sex: M
Visit date: [redacted]
Ambulatory Notes/Results

[redacted]

Visit Summary

Reason for Visit

Follow-up

Diagnoses

	Codes	Comments
Malignant neoplasm of sigmoid colon (HCC) - Primary	C18.7	
Aphasia	R47.01	
Cerebrovascular accident (CVA) due to stenosis of left carotid artery (HCC)	I63.232	
Hemiparesis affecting dominant side as late effect of stroke (HCC)	I69.359	
Malignant neoplasm of colon, unspecified part of colon (HCC)	C18.9	

Vital Signs - Last Recorded

Most recent update: [redacted] 11:06 AM

BP	Pulse	Temp	Resp	Wt
115/70 (BP Location: LUE, BP Position: sitting, BP Cuff Size: Reg)	50	36.6 °C (97.8 °F) (Skin probe)	20	87.1 kg (192 lb)

SpO2	BMI	Smoking Status
96%	26.04 kg/m²	Former Smoker

Progress Notes

[redacted] at [redacted] **11:15 AM**

Author Type: Physician Status: Signed

DIAGNOSIS:
1. Adenocarcinoma of the sigmoid colon s/p robotic assisted low anterior resection, [redacted] Pretreatment CEA 3.7)
2. pT3, pN1a, M1, G2, R0.
3. Liver metastasis s/p CT-guided liver biopsy, [redacted]

GENOMIC DATA:
NGS-CARIS, HER2 negative, MMR-p, PD-L1 negatve, NTRK1/2/3 Negative, BRAF fusion not detected.

SECONDARY DIAGNOSIS:
1. CVA with aphasia/hemiparesis
2. Right intertrochanteric hip fracture status post short cephalomedullary implant, [redacted]

Progress Notes (continued)

[redacted] at [redacted] 11:15 AM (continued)

INTERVAL HISTORY:
Patient is a 78 years old elderly gentleman with past medical history of coronary artery disease, polymyalgia rheumatica, expressive aphasia/right hemiparesis from previous CVA. Patient required hospitalization on [redacted] after a fall with a right intratrochanteric hip fracture. Patient was also found to have anemia and some rectal bleed. Initially patient was seen by [redacted] on [redacted] day prior to this hip surgery, and advised colonoscopy down the road. Patient underwent short cephalomedullary implant, [redacted] for right intertrochanteric hip fracture. Patient was discharged on [redacted] to [redacted] on Eliquis. Subsequently patient was found to have bright red blood per rectum as well as coffee-ground loose stool. Patient was readmitted on [redacted] On [redacted] EGD was normal. On [redacted] patient underwent colonoscopy with [redacted] which revealed rectosigmoid mass and the pathology came back as adenocarcinoma, grade 1–2, p–MMR. Pre surgery CEA was 3.7.
CT abdomen pelvis with contrast, [redacted] revealed possible mass in the sigmoid colon. Hypodense lesion in the right hepatic lobe measuring 1.2 cm. CT chest with contrast on [redacted] essentially negative. On [redacted] MRI of the abdomen with and without contrast revealed, there are several small lesions in the liver favoring cyst. There is a hepatic lesion in segment 6 of the liver characteristic strongly favor focus of metastatic deposit.
On [redacted] patient underwent robotic assisted low anterior resection with robotic splenic flexure mobilization by [redacted]. Tumor was identified in the sigmoid colon above the peritoneum. Intraoperatively, the liver lesion was not identified on the surface. Path number S21–7773, grade 2 colonic adenocarcinoma measuring 5.5 cm, tumor invades into the pericolonic soft tissue. No lymphovascular or perineural invasion identified. All resection margins including radial, proximal and distal were not involved. 22 lymph nodes were removed and one was positive for metastatic deposit. The tumor arising within the tubulovillous adenoma with high-grade dysplasia., pT3 N1a MX G2 R0.
On [redacted] patient underwent CT-guided core biopsy of the liver mass. Pathology came back metastatic adenocarcinoma, morphology consistent with metastatic colorectal adenocarcinoma.
Final stage,pT3 N1a M1 G2 R0.
Patient was subsequently transferred to nursing home on [redacted]
Patient underwent PET CT scan on [redacted] @ [redacted] PET scan revealed no significant FDG avidity in the anastomotic site. The biopsy-proven metastatic to the hepatic segment 6 also lacks FDG avidity. There is no regional or distant lymphadenopathy or solid organ or osseous metastasis.
NGS-CARIS, HER2 negative, MMR-p, PD-L1 negatve, NTRK1/2/3 Negative, BRAF fusion not detected.
In the office today his questionnaires are reviewed.

ONCOLOGY HISTORY:
1 # Patient is a 78 years old elderly gentleman with past medical history of coronary artery disease, polymyalgia rheumatica, expressive aphasia/right hemiparesis from previous CVA.

2 # Patient required hospitalization on [redacted] after a fall with a right intratrochanteric hip fracture. Patient was also found to have anemia and some rectal bleed. Initially patient was seen by [redacted] on [redacted] day prior to this hip surgery, and advised colonoscopy down the road.

3 # Patient underwent short cephalomedullary implant, [redacted] for right intertrochanteric hip fracture. Patient was discharged on [redacted] to [redacted] on Eliquis.

4 # Subsequently patient was found to have bright red blood per rectum as well as coffee-ground loose stool. Patient was readmitted on [redacted]

Progress Notes (continued)

[redacted] at [redacted] 11:15 AM (continued)

5 # On [redacted] EGD was normal.

6 # On [redacted] patient underwent colonoscopy with [redacted] which revealed rectosigmoid mass and the pathology came back as adenocarcinoma, grade 1–2, p–MMR. Pre surgery CEA was 3.7.

7 # CT abdomen pelvis with contrast, [redacted] revealed possible mass in the sigmoid colon. Hypodense lesion in the right hepatic lobe measuring 1.2 cm.

8 # CT chest with contrast on [redacted] essentially negative.

9 # On [redacted] MRI of the abdomen with and without contrast revealed, there are several small lesions in the liver favoring cyst. There is a hepatic lesion in segment 6 of the liver characteristic strongly favor focus of metastatic deposit.

10 # On [redacted] patient underwent robotic assisted low anterior resection with robotic splenic flexure mobilization by [redacted]. Tumor was identified in the sigmoid colon above the peritoneum. Intraoperatively, the liver lesion was not identified on the surface.

11 # Path number S21–7773, grade 2 colonic adenocarcinoma measuring 5.5 cm, tumor invades into the pericolonic soft tissue. No lymphovascular or perineural invasion identified. All resection margins including radial, proximal and distal were not involved. 22 lymph nodes were removed and one was positive for metastatic deposit. The tumor arising within the tubulovillous adenoma with high-grade dysplasia., pT3 N1a M0 G2 R0.

12 # On [redacted] patient underwent CT-guided core biopsy of the liver mass. Pathology came back metastatic adenocarcinoma, morphology consistent with metastatic colorectal adenocarcinoma.

13 # Final stage, **pT3 pN1a M1 G2 R0.**

14 # PET CT scan on [redacted] @ [redacted] PET scan revealed no significant FDG avidity in the anastomotic site. The biopsy-proven metastatic to the hepatic segment 6 also lacks FDG avidity. There is no regional or distant lymphadenopathy or solid organ or osseous metastasis.

15 # NGS-CARIS, HER2 negative, MMR-p, PD-L1 negatve, NTRK1/2/3 Negative, BRAF fusion not detected. (not enough tissue)

ALLERGIES:
No Known Allergies

CURRENT MEDICATIONS:

Current Outpatient Medications:
- acetaminophen (TYLENOL ARTHRITIS) 650 MG CR tablet, Take 1,300 mg by mouth every 8 (eight) hours as needed for Pain. , Disp: , Rfl:
- atorvastatin (LIPITOR) 40 MG tablet, Take 1 tablet by mouth daily., Disp: 30 tablet, Rfl: 0
- calcium-vitamin D (OSCAL-500) 500-200 MG-UNIT per tablet, Take 1 tablet by mouth 3 (three) times daily.,

Progress Notes (continued)

[redacted] at [redacted] 11:15 AM (continued)

Disp: , Rfl:
- FLUoxetine (PROZAC) 20 MG capsule, TAKE 1 CAPSULE BY MOUTH DAILY., Disp: 90 capsule, Rfl: 3
- tamsulosin HCl (FLOMAX) 0.4 MG capsule, TAKE 1 CAPSULE BY MOUTH EVERY DAY, Disp: 90 capsule, Rfl: 3

PAST MEDICAL HISTORY:
The patient has a past medical history of Generalized osteoarthrosis, involving multiple sites, High cholesterol, Polymyalgia rheumatica (HCC), Pure hypercholesterolemia, and Stroke (HCC) (2015). Expressive aphasia and right hemiparesis from previous CVA.

PAST SURGICAL HISTORY:
The patient has a past surgical history that includes Other surgical history; Other surgical history; Other surgical history; Other surgical history; Other surgical history; Other surgical history; Fracture surgery; Thromboendarterectomy; and Carpal tunnel release (12/2016).

FAMILY HISTORY:
family history includes Heart disease in his father and mother; Stroke in his mother.

SOCIAL HISTORY:
The patient reports that he quit smoking about 32 years ago. He has a 15.00 pack-year smoking history. He has never used smokeless tobacco. He reports that he does not drink alcohol and does not use drugs.

ONCOLOGY REVIEW OF SYSTEMS
Pain - 0
Nausea/Vomiting - 0
Fatigue/Tiredness - 0
Loss of Appetite - 0
Constipation - 0
Diarrhea - 0
Mouth Sores - 0
Numbness/Tingling - 0
Distress/Stress - 0
Quality of life: Good/2
ECOG Status: 2

REVIEW OF SYSTEMS:
CONSTITUTIONAL: Denies any fever, chills, night sweats, or any weight loss.
HEENT: Denies any headache, vertigo, dizziness, diplopia, photophobia, sore throat, difficulty in swallowing.
RESPIRATORY: Denies any cough, sputum production, hemoptysis.
CARDIOVASCULAR: Denies any chest pain, orthopnea, PND.
GI: Denies any nausea, vomiting, constipation, diarrhea, hematochezia, or melena.
GU: Denies any frequency, urgency, dysuria, hematuria, or flank pain.
MUSCULOSKELETAL: No bony pain.
CNS: Denies seizure activity. History of CVA with right hemiparesis and expressive aphasia.

PHYSICAL EXAMINTION:
BP 115/70 (BP Location: LUE, BP Position: sitting, BP Cuff Size: Reg) | Pulse 50 | Temp 36.6 °C (97.8 °F) (Skin probe) | Resp 20 | Wt 87.1 kg (192 lb) | SpO2 96% | BMI 26.04 kg/m²

Progress Notes (continued)

[redacted] at [redacted] 11:15 AM (continued)

GENERAL: The patient is a 78 y.o. female.
SKIN: Warm and moist. No bruises, ecchymosis, or any petechiae.
HEAD: Normocephalic, atraumatic.
EYES: PERRLA. EOM full. Conjunctivae pink. Sclerae anicteric.
OROPHARYNGEAL EXAM: Unremarkable for any mucositis or thrush.
NECK: Supple without any JVD, bruit, or thyromegaly.
LYMPHATIC SYSTEM: No palpable lymphadenopathy in cervical, supraclavicular, infraclavicular, axillary, or inguinal areas.
RESPIRATORY: Chest is clear to percussion and auscultation.
CARDIOVASCULAR: Unremarkable for any gallop or murmur.
ABDOMEN: Soft, nontender, without any organomegaly. Bowel sounds are positive.
EXTREMITIES: No cyanosis, clubbing, or edema.
CNS exam: The patient is alert and oriented x 3. Cranial nerves are grossly intact. Expressive aphasia. Right hemiparesis.
MUSCULOSKELETAL: Unremarkable for any point tenderness.

LABS:

Lab Results

Component	Value	Date
WBC	5.4	[redacted]
RBC	4.18 (L)	
HGB	13.1 (L)	
HCT	42.6	
MCV	101.9 (H)	
MCH	31.3	
MCHC	30.8 (L)	
RDW	13.9	
PLT	236	
MPV	9.6	
LYMPHS	1.5	
EOSABS	0.4	
BASOSABS	0.0	

Lab Results

Component	Value	Date
GLU	72	[redacted]
GLUF	84	

Lab Results

Component	Value	Date
BUN	25	[redacted]
CREAT	1.4	
CREATININE	1.4	
GFREST	47 (L)	

Lab Results

Component	Value	Date

Progress Notes (continued)

[redacted] at [redacted] 11:15 AM (continued)

CA	10.1	[redacted]
AST	13	
BILITOT	0.4	
ALT	13	
ALBUMIN	3.7	
ALKPHOS	88	
PROT	7.7	
NA	141	
K	4.1	
CL	101	
CO2	28.5	

Iron Study
Lab Results

Component	Value	Date
IRON	39 (L)	[redacted]
TRANSFERRIN	204	
TIBC	255 (L)	
IRONSAT	15.3	

Lab Results

Component	Value	Date
VITB12BL	801	[redacted]

Lab Results

Component	Value	Date
FOLATE	7.5	[redacted]

Lab Results

Component	Value	Date
CEA	3.4	[redacted]

NGS-CARIS, HER2 negative, MMR-p, PD-L1 negatve, NTRK1/2/3 Negative, BRAF fusion not detected.

ASSESSMENT AND PLAN:
Patient is an elderly gentleman with the multiple comorbidities and compromised performance status due to previous CVA and recent right hip fracture. Patient has multiple issues.

1. pT3, pN1a, M1, G2, R0 with CEA 3.7. Patient initially presented after a GI bleed while on Eliquis. Colonoscopy with biopsy confirmed a mass in the rectosigmoid area. Metastatic work-up revealed liver lesion and multiple bilateral hepatic cysts. Patient underwent low anterior resection on [redacted] Intraoperatively no liver lesion was identified on the hepatic surface. It was staged as T3 N1aMX. Subsequently patient underwent CT-guided biopsy of the suspicious liver lesion which confirmed metastatic deposit. Patient has metastatic colorectal carcinoma with liver only disease.
Patient underwent PET CT scan on [redacted] @ [redacted] PET scan revealed no significant FDG avidity in the anastomotic site. The biopsy-proven metastatic to the hepatic segment 6 also lacks FDG avidity. There is no regional or distant lymphadenopathy or solid organ or osseous metastasis.
NGS-CARIS, HER2 negative, MMR-p, PD-L1 negatve, NTRK1/2/3 Negative, BRAF fusion not detected.

Progress Notes (continued)

[redacted] at [redacted] 11:15 AM (continued)

Apparently there was not enough tissue to do the complete NGS panel.
Overall patient has low disease burden with isolated liver lesion only. PET scan was read out negative. Liver lesion can be treated with liver directed therapy like radiofrequency ablation or microwave ablation. Given the patient's compromised performance status with multiple comorbidities, we are not sure if liver resection would be an ideal therapy.

Patient will clearly need systemic therapy. I believe we would recommend a systemic therapy then follow-up with the liver directed therapy. Initial biopsy shows MMR proficient. NGS-CARIS, HER2 negative, MMR-p, PD-L1 negatve, NTRK1/2/3 Negative, BRAF fusion not detected. Apparently there was not enough tissue to do the complete NGS panel.

Recommending systemic chemotherapy with modified FOLFOX plus minus bevacizumab. In the meantime I will try to get proper NGS panel on: Specimen. We should have plenty of tissue to run NGS panel. Unfortunately liver biopsy did not have enough tissue to run the complete NGS panel. It may change the treatment plan down the road. So far we are recommending initiation of systemic chemotherapy with modified FOLFOX plus minus bevacizumab. Rationale, risk, benefit and side effects were reviewed. We are also recommending Infuse-a-Port placement.
We will refer him back to [redacted] for the consideration of port placement.
Patient will come back to see me in couple of weeks.

2. Anemia. There is an evidence of iron deficiency. Folate is also low normal. May consider intravenous iron infusion. Also initiate folic acid 1 mg daily.

3. Right intertrochanteric hip fracture status post short cephalomedullary implant, [redacted] Patient is following orthopedics.

I had a very detailed and comprehensive discussion with the patient and family. Our discussion lasted more than an hour today.

Please send a copy to
[redacted]

Electronically signed by [redacted] on [redacted] 9:26 PM

History & Physicals

No notes of this type exist for this encounter.

Telephone Encounter

Reason for Call

Follow-up

All Results

All Results (continued)

No results found

Your Updated Medication List

Accurate as of [redacted] **11:59 PM.** Always use your most recent med list.

acetaminophen 650 MG CR tablet
Commonly known as: TYLENOL ARTHRITIS

calcium-vitamin D 500-200 MG-UNIT per tablet
Commonly known as: OSCAL-500

END OF REPORT