Christenson, Alan

MRN: 16743072

Loo, Billy Wiseman, MD
Physician
Radiation Oncology

Progress Notes
Signed

Encounter Date: 1/26/2017

Signed

Stanford MEDICINE | Department of Radiation Oncology

Follow Up Visit

Name: Alan Christenson
DOB: 7/21/1936
MRN: 16743072
Address:
197 Via Lantana
Aptos CA 95003-5834
Phone:
408-219-2454 (home) 408-219-2454 (work)

Date: 1/26/2017
Attending Physician: Billy Wiseman Loo, MD

Chu, William Nain-Cheng
Internal Medical Group of Palo Alto 805 El Camino Real Ste B
Palo Alto CA 94301

Dear Doctors,

We had the pleasure of seeing our mutual patient, Mr. Alan Christenson, in routine follow up today, 1/26/2017, in the Department of Radiation Oncology at Stanford Hospital & Clinics.

Identification: Mr. Alan Christenson is a 80 Year-old male with T2b N1 NSCLC (squamous) s/p RML/RLL bilobectomy and LND with 1/51 nodes involved by direct extension and positive margin at the right inferior pulmonary vein s/p adjuvant radiotherapy (60 Gy in 20 fractions, patient declined chemotherapy), completed 6/29/16.

Interval Since Completion of Radiation Therapy: 6 months

Last Clinic Visit: 10/13/16

Interval History: At his last clinic visit, he was doing well, but had headaches. He returned to work and was starting to be active again. CT chest revealed post radiation changes in the RUL and stable bilateral nodules. PET/CT showed resolution of FDG uptake in the right chest.

10/26/16: he had a follow up visit with Dr. Berry he was doing well, but had chronic headaches and Dr. Berry recommended brain MRI to rule out distant metastases.

11/22/16: MRI
1. No evidence of intracranial metastatic disease

1/26/17: CT Chest
1. Size of loculated right pleural effusion is unchanged however there is increased pleural thickening and enhancement with several new locules of gas. Correlate for recent intervention and signs for infection.

2. Decreased opacification in the inferior aspect of the right upper lobe likely evolving radiation changes.

3. Slightly increased size of a solid left upper lobe now measuring 0.4 cm, previously 0.2 cm.

1/26/17: PFTs FVC 51%, FEV1 62% and DLCO 58% of predicted

Today, he feels quite well. His energy is slowly improving from about 50% - 70%. He has some dyspnea on exertion especially after walking up two flights of steps in his home. He continues to have chronic headaches in the middle of the day and is on oxycontin 30mg BID. He denies cough or shortness of breath. He continues to work out 3 times a week with a trainer.
He follows with Dr. Choi for asthma, and a neurologist for neuropathy. He fell twice in December, one fall was mechanical and other was fatigue, there was no LOC. He is in the process of retiring and is looking forward to spending more time with his family.

Review of Systems: As per chronological history of present illness. Otherwise, a comprehensive 14-point review of systems was negative.

Allergies:

Allergies

Allergen	Reactions
• Tetracycline	Rash

Current Medications:

Current Outpatient Prescriptions

Medication	Sig
• ADVAIR HFA 115-21 mcg/actuation HFAA	
• atorvastatin (LIPITOR) 10 mg tablet	take 10 mg by mouth daily
• CALCIUM CARBONATE (TUMS PO)	take by mouth as needed
• DEXILANT 60 mg CpDM	take 60 mg by mouth Every Day
• docusate (COLACE) 100 mg capsule	take 2 Caps by mouth daily
• NASONEX 50 mcg/actuation Spry	
• other drug	B12 injection
• oxyCODONE (OXYCONTIN) 30 mg TR12	take 30 mg by mouth 2 times a day Pain for headache
• rivaroxaban (XARELTO) 20 mg tablet	take 1 Tab by mouth daily with dinner
• SPIRIVA WITH HANDIHALER 18 mcg CpDv	
• tiotropium (SPIRIVA) 18 mcg inhalation capsule	1 Cap by Inhalation route daily

Social History:

Social History

Social History

- Marital status: Widowed
  - Spouse name: N/A
- Number of children: N/A
- Years of education: N/A

Occupational History

- HR consultant
  works 25 hours per week

Social History Main Topics

- Smoking status: Former Smoker
  - Packs/day: 3.00
  - Years: 30.00
  - Quit date: 3/23/1984
- Smokeless tobacco: Never Used
- Alcohol use 8.4 oz/week
  - 14 Glasses of wine per week
    Comment: reports no wine since 4/14-8/5/16
- Drug use: No
- Sexual activity: Not on file

Other Topics	Concern
Military Service	No
Blood Transfusions	No
Caffeine Concern	No
Occupational Exposure	No
Hobby Hazards	No
Sleep Concern	No
Stress Concern	No
Weight Concern	No
Special Diet	No
Back Care	No
Exercise	No
Bike Helmet	No
Seat Belt	Yes
Self-Exams	No

Social History Narrative

Lives alone, support from friends. Sister on east coast who can come out to support patient.

Physical Examination:

VITAL SIGNS:

Visit Vitals

BP	145/68
Pulse	99
Temp	36.7 °C (98.1 °F) (Oral)
Resp	18
Ht	1.88 m (6' 2.02")
Wt	83.9 kg (185 lb)
SpO2	98%
BMI	23.74 kg/m2

GENERAL: Well-appearing, well-developed, in no acute distress. ECOG Performance Status 1: Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.
HEENT: Normocephalic/Atraumatic. Moist mucous membranes.
LYMPH NODES: There is no palpable cervical, supraclavicular, infraclavicular, or axillary lymphadenopathy.
BACK: Spine non-tender to palpation.
PULMONARY: Normal respiratory effort. Clear to auscultation bilaterally.
CARDIOVASCULAR: Heart is regular rate and rhythm with no murmurs, rubs, or gallops.
ABDOMEN: Normally active bowel sounds. Soft, non-tender, non-distended. No hepatosplenomegaly.
EXTREMITIES: No cyanosis, clubbing, or edema.
SKIN: Clear with no rashes or other visible lesions.
NEUROLOGICAL: Cranial nerves II-XII intact. Sensation to light touch is preserved throughout. Strength is 5/5 throughout. Gait is grossly normal.
PSYCH: Appropriate mood and affect. Speech with regular rate, rhythm and tone.

Laboratory:

Lab Results

Basename	Value	Date
WBC	7.2	04/23/2016
HGB	10.2 (L)	04/23/2016
HCT	32.7 (L)	04/23/2016
PLT	428 (H)	04/23/2016

Lab Results

Basename	Value	Date
NA	142	09/12/2016
K	4.0	09/12/2016
CL	106	09/12/2016
CO2	29	09/12/2016
BUN	14	09/12/2016
CR	0.7	01/26/2017
GLU	129	10/13/2016
CA	9.1	09/12/2016

Imaging: We personally reviewed the imaging and agree with the impressions as described above. There is a relatively stable right sided effusion which appears somewhat loculated with new air fluid levels or gas bubbles. There are also multiple stable bilateral pulmonary nodules, with a slight increase in a LUL nodule.

Impression and Plan:
In summary, Mr. Alan Christenson is a 80 Year-old male with T2b N1 NSCLC (squamous) s/p RML/RLL bilobectomy and LND with 1/51 nodes involved by direct extension and positive margin at the right inferior pulmonary vein s/p adjuvant radiotherapy (60 Gy in 20 fractions, patient declined chemotherapy), completed 6/29/16.

Mr. Christenson is 6 months from the completion of treatment and is improving clinically. He has a number of falls in December which may be related to fatigue in the setting of oxycontin use. He is working out more and feels like his energy is improving and we are happy with his clinical improvement.

Review of his imaging shows a stable right sided effusion with gas bubbles, however he is completely asymptomatic and we are inclined to continue to observe. We have asked him to contact us if he develops fevers, chills or any signs of an infection as we would be concerned about a bronchopulmonary fistula or an empyema.

He is otherwise well and we would like to see him in follow up in 3 moths with a repeat CT scan. There is a 4mm nodule in the LUL that is too small to intervene upon at the moment, but we want to pay particular attention to on serial scans.

Mr. Alan Christenson asked appropriate questions, which were answered completely to his satisfaction. He knows he can contact us at any point with any additional questions or concerns.

Plan
- Follow up in 3 months with repeat CT thorax.
-

Future Appointments

	Provider	Department	Center
3/22/2017 1:00 PM	Zei, Paul Cameron	Cardiovascular Med	
4/26/2017 3:00 PM	Berry, Mark Francis	Thoracic Oncology	CCA

Thank you for allowing us the privilege of participating in the care of Mr. Alan Christenson. Please feel free to contact us with any questions or concerns.

Sincerely,

Chika Rebecca Nwachukwu, MD
Department of Radiation Oncology, Resident

Teaching Physician Attestation
I saw and examined the patient and discussed the management with the resident physician/fellow.

I reviewed the resident/fellow's note, made the appropriate edits, and agree with the documented findings and plan of care.

Billy W. Loo, Jr., M.D., Ph.D.
Associate Professor and Thoracic Radiation Oncology Program Leader
Department of Radiation Oncology & Stanford Cancer Institute, Stanford University School of Medicine

Notes for this encounter will NOT be shared with the patient in MyHealth.

Electronically signed by Loo, Billy Wiseman, MD at 2/6/2017 11:01 AM

Office Visit
on 1/26/2017

This note has not been shared with the patient via Myhealth Shared Notes.