Do you have a question about this report? Ask a Question

Christenson, Alan

MRN: 16743072

Office Visit 5/26/2016
Radiation Onc Clinic

Provider: Loo, Billy Wiseman, MD (Radiation Oncology - General)
Primary diagnosis: Squamous cell lung cancer, right (CMS-HCC)
Reason for Visit: New Patient Referral; Referred by Chu, William Nain-Cheng, MD

Progress Notes

Stanford MEDICINE | Department of Radiation Oncology

New Patient Consultation

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: 5/26/2016
Attending Physician: Loo, Billy Wiseman, MD

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

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

Mark Berry, MD

Joel Neil, MD

Dear Doctors,

We had the pleasure of seeing your patient, Mr. Alan Christenson, in consultation today, 5/26/2016, in the Department of Radiation Oncology at Stanford Hospital & Clinics.

Identification: Mr. Alan Christenson is a 79-year-old gentleman with a right lower lobe lung NSCLC (SCC), pathologic stage T2b N1 M0, who had right middle and lower bilobectomy and mediastinal lymph node dissection on 4/15/16 by Dr. Berry with positive vascular margin and 1/51 lymph nodes positive by direct extension. He presents today to discuss adjuvant treatment options.

Chronological History of Present Illness:
Mr. Christenson has a 90 pack year smoking history (quit in 1984) as well as COPD and hyperlipidemia. He presented in January 2016 with cough that developed into hemoptysis by February 2016.

February 25, 2016: Chest x-ray showed abnormal findings in the right lung.

Followup CT chest with IV contrast showed a central right lower lobe mass measuring 55 x 43 mm, extending into the lower part of the bronchus intermedius and right lower lobe bronchus. Several mediastinal nodes were seen, for instance 10 mm in the AP window, 10 mm subcarinal, also 10 mm right hilar node.

March 10, 2016: Dr. Ramsey performed bronchoscopy which showed tumor in the right bronchus intermedius. Bronchoscopic biopsy of the tumor demonstrated squamous cell carcinoma.

March 17, 2016: PET-CT showed SUV of 14.3 in the right lower lobe mass. The mediastinal nodes had no increased FDG avidity above background.

Brain MRI was negative for brain metastases.

April 15, 2016: He had right middle and lower lobectomy and mediastinal lymph node dissection with Dr. Berry. Intraoperatively tumor was noted to be close to the pericardium, so the pericardium was opened to improve the vascular margin. Pathology showed a 5.2 cm squamous cell carcinoma in the right lower lobe with a positive vascular margin. One hilar node was involved by direct extension. 50 other hilar and mediastinal nodes were negative. There was no extracapsular extension.

His hospitalization was complicated by acute delirium and atrial fibrillation. Psychiatry and cardiology were consulted. He was discharged to home on Xarelto and will follow up with cardiology as an outpatient, currently scheduled for 6/6/16.

May 18, 2016: He saw Dr. Berry in follow up, as well as Dr. Neil and Dr. Gensheimer in consultation regarding chemotherapy and radiation therapy, respectively. Dr. Neil outlined three treatment options: 1) Chemo --> chemoradiation, 2) Chemoradiation, and 3) Radiation alone. He favored chemotherapy but was understanding if patient did not want it due to personal concern over toxicity. Dr. Gensheimer, knowing the patient was against chemotherapy, advised radiation therapy alone

Today, he asked to see us for a second opinion regarding radiation treatment. He is still mostly opposed to chemotherapy due to concern over toxicity, but open to radiation therapy if recommended (would prefer shorter treatment time though than recommended 5-6 weeks).

He has recovered well from his surgery ~6 weeks ago. His breathing and SOB with exertion is improving, and he is completely active, working 25 hours a week and also volunteering 10-15 hours a week. He drove himself to the appointment without any issue. He has finished physical therapy. He had a chronic headache over the past month, which he believes is due to stopping his coffee and daily wine intake, which is managed by tramadol. He has started drinking coffee again too which helps.

He has no fevers, chills, night sweats, hemoptysis, cough, SOB at rest, CP, nausea, vomiting, or any other associated symptoms.

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
• docusate (COLACE) 250 mg capsule	take 250 mg by mouth 2 times a day
• HYDROmorphone (DILAUDID) 2 mg tablet	take 1-2 Tabs by mouth every 4 hours as needed
• melatonin 3 mg tablet	take 2 Tabs by mouth every bedtime
• NASONEX 50 mcg/actuation Spry	
• other drug	B12 injection
• rivaroxaban (XARELTO) 20 mg tablet	take 1 Tab by mouth daily with dinner
• SPIRIVA WITH HANDIHALER 18 mcg CpDv	
• tamsulosin (FLOMAX) 0.4 mg capsule	take 1 Cap by mouth daily
• tiotropium (SPIRIVA) 18 mcg inhalation capsule	1 Cap by Inhalation route daily
• traMADol (ULTRAM) 50 mg tablet	take 2 Tabs by mouth every 8 hours as needed for Pain (take 1 to 2 tabs as needed for pain)

Past Medical History:

Past Medical History

Diagnosis	Date
• Asthma	
• Erythema	
• Esophageal disorder *Mild nonspecific dysmotility*	
• Gastroesophageal reflux disease	
• High cholesterol	
• Hypertension	
• Insomnia *Some degress, currently being treated with Ambien*	
• Lung cancer (HCC)	
• Nasal congestion *Allergies*	
• Neuropathy	
• Obstructive sleep apnea *Moderate--no cpap*	
• Sinusitis *Recurrent*	
• Throat pain *Chronic*	

Past Surgical History:

Past Surgical History

Procedure	Laterality	Date
• Hx other surgical history *Fundal plication*		
• Endoscopy procedure *Fiberoptic*		
• Hip total joint replacement cemented		
• Flexible bronchoscopy, mediastinoscopy, right vats, right thoracotomy, right bi-lobectomy *Performed by Berry, Mark Francis, MD at STANFORD HOSPITAL MAIN OR.*	Right	4/15/2016

- Mediastinoscopy with biopsy and frozen section — Right — 4/15/2016
  Performed by Berry, Mark Francis, MD at STANFORD HOSPITAL MAIN OR.
- Thoracotomy — Right — 4/15/2016
  Performed by Berry, Mark Francis, MD at STANFORD HOSPITAL MAIN OR.
- Bronchoscopy with endo bronchial ultrasound — Bilateral — 3/10/2016
  Performed by Sung, Arthur Wai, MD at STANFORD HOSPITAL ENDOSCOPY.
- Colonoscopy with or without brushing — N/A — 4/2/2009
  Performed by Shields, David Stanley, MD at STANFORD HOSPITAL ENDOSCOPY.

Family Medical History:

Family History

Problem	Relation	Age of Onset
Cancer	Mother	
Heart Attack	Father	
Cancer	Sister	

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
- 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	137/71
• Pulse	115
• Temp	36.6 °C (97.9 °F) (Oral)
• Resp	18
• Ht	1.88 m (6' 2.02")
• Wt	86.1 kg (189 lb 13.1 oz)
• SpO2	98%
• BMI	24.36 kg/m2

GENERAL: Well-appearing, well-developed, in no acute distress. ECOG 1.
HEENT: Normocephalic/Atraumatic. Pupils are equally round and reactive to light. Sclera anicteric. Moist mucous membranes. Normal oral cavity and oropharynx.
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 on the left, decrease air movement on the right.
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 grossly intact.
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	138	04/24/2016
K	4.3	04/24/2016
CL	104	04/24/2016
CO2	26	04/24/2016
BUN	20	04/24/2016
CR	0.77	04/24/2016
GLU	151 (H)	04/24/2016
CA	8.5	04/24/2016

Imaging: We personally reviewed the imaging and agree with the impressions as described above.

CXR from 2/25/16 shows loss of heart contour on the right in PA, on lateral retrocardiac mass seen.

CT from 2/25/16 shows a central RLL lung mass ~5x4 cm involving the lower part of the bronchus intermedius and obliterating the majority of the RLL bronchus. The mass is wrapping around the

inferior pulmonary vein and abutting the pericardium. There are visible mediastinal (levels 4R, 7) and hilar lymph nodes that appear ~1 cm in size.

PET/CT from 3/17/16 shows large hypermetabolic RLL lung mass without FDG-avidity of suspicious lymph nodes.

Impression and Plan:
In summary, Mr. Alan Christenson is a 79-year-old gentleman with a right lower lobe lung NSCLC (SCC), stage IIB, pT2b pN1 cM0, who had right middle and lower bilobectomy and mediastinal lymph node dissection on 4/15/16 by Dr. Berry with positive vascular margin and 1/51 lymph nodes positive by direct extension. He presents today to discuss adjuvant treatment options.

He has met with his surgeon Dr. Berry after surgery, who discussed adjuvant treatment options and referred him to see Dr. Neal in medical oncology and Dr. Gensheimer in radiation oncology. He had discussed chemotherapy with Dr. Neal and is leaning away from this due to concern about toxicities, and also discussed radiation therapy with Dr. Gensheimer but came in today for a second opinion on radiation therapy.

We explained to Mr. Christenson that standard of care treatment recommendation for his stage IIB NSCLC with positive margin is adjuvant chemotherapy and radiation therapy. He has two indications for chemotherapy, which include his large tumor size (>4 cm) and positive lymph node. His indication for radiation therapy is the positive margin. However, we discussed that his case is unique, as he only had 1/51 lymph nodes that was involved with disease and it was through direct extension. Furthermore, the size indication for chemotherapy is not as strong as true lymph node disease, so the recommendation for adjuvant chemotherapy is not as definitive, and should be balance with the risks and patient's personal preference. However, he did have a true positive vascular margin despite Dr. Berry's best attempt to dissect around the inferior pulmonary vein, and pre-operative imaging shows the tumor wrapping around the inferior pulmonary vein and abutting the pericardium, thus we would more strongly recommend adjuvant radiation therapy in order to prevent local tumor recurrence.

With respect to radiation, we recommend treating the area of positive margin and post-operative bed/stump to a total dose of 60 Gy in 20 fractions over the course of 4 weeks using a Rapid Arc technique. Rapid Arc VMAT (volume-modulated arc therapy), a special form of IMRT (intensity-modulated radiation therapy), will be required in order to conformally treat our target while avoiding nearby organs at risk, principally nearby vessels, heart, uninvolved lung, spinal cord, liver, and kidney. Prior to commencing treatment, a 4D PET/CT simulation scan with contrast will be performed in order to accurately delineate our targets of radiation therapy. Radiation treatment will begin ~1-2 weeks following simulation scan, and occur once daily, Monday through Friday.

We explained all these recommendations in detail, including the rationale, technique, and potential short and long-term side effects of radiation treatment, which may include, but are not limited to, fatigue, cough, esophagitis, radiation pneumonitis which if occurs happens a few months after completing radiation treatment and may require treatment with steroids, and a small risk of more severe injury to nearby vessels, airways, heart, and spinal cord.

Mr. Alan Christenson asked appropriate questions, which were answered completely to his satisfaction. Written informed consent was obtained and placed in the chart. He knows he can contact us at any point with any additional questions or concerns.

<u>Plan</u>
- Adjuvant radiation treatment alone (no chemo) once daily for ~20 fractions over the course of ~4 weeks
- 4D PET/CT simulation scan with contrast tomorrow (5/27) at 12:30 pm, with daily radiation treatment starting ~1-2 weeks later

Future Appointments

Date	Time	Provider	Department	Center
5/27/2016	12:30 PM	Loo, Billy Wiseman, MD	RADTHER	radonc

5/27/2016	1:30 PM	Loo, Billy Wiseman, MD	RADTHER	radonc
5/27/2016	2:30 PM	Loo, Billy Wiseman, MD	RADTHER	radonc
6/6/2016	2:30 PM	Tsiperfal, Angela, NP	CVMED2	None
10/13/2016	12:00 PM	SOUTH BAY 1 CT ROOM	CCSBRA1	CCSB
10/19/2016	1:00 PM	Berry, Mark Francis, MD	THRON	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,

Kiran Achut Kumar, 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

Other Notes

All notes

Instructions

SUMMARY OF YOUR RADIATION ONCOLOGY CONSULTATION

Dr. Billy Loo is recommending Radiation Alone.

LAB WORK

CC AVS (Printed 5/26/2016)

Additional Documentation

Vitals:	BP 137/71 Pulse 115 Temp 36.6 °C (97.9 °F) (Oral) Resp 18 Ht 1.88 m (6' 2.02") Wt 86.1 kg (189 lb 13.1 oz) SpO2 98% BMI 24.36 kg/m² BSA 2.12 m²
Flowsheets:	Vital Signs, All Vitals
Encounter Info:	Billing Info, History, Allergies, Detailed Report, Vitals, Reviewed This Encounter, Quality Measure Details

New Media

Scan on 5/27/2016 11:17 AM by Bernard, Rhonda: Radiation Oncology

Orders Placed

None

Medication Changes

+ sucralfate 1 g Oral EVERY 6 HOURS

Visit Diagnoses

- Squamous cell lung cancer, right (CMS-HCC)

Level of Service

Level of Service	Modifiers
EVAL/MGMT OF EST PATIENT LEVEL 3 [99213]	Gc [GC]

Log History

LOS History