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

Christenson, Alan

MRN: 16743072

Office Visit 10/13/2016
Radiation Onc Clinic

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

Progress Notes

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: 10/13/2016
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

William Nain-Cheng Chu, MD
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, 10/13/2016, 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: 3 months

Last Clinic Visit:
6/29/16: At the completion of radiotherapy.

Interval History:
9/12/16: Seen in arrhythmia clinic with plan to stay on anticoagulation.

10/131/6: CT thorax showed
1. Status post right middle and lower lobectomies with parenchymal opacification along inferior aspect of remaining right upper lobe presumably representing postradiation changes.

2. New, nonspecific 2 mm nodule in left upper lobe.

3. Remainder of previously noted nodules are stable.

PET/CT showed
1. Resolved FDG uptake in the right chest.
2. Mild decreased uptake in FDG avid right upper lobe lung nodule
3. No new FDG avid lymphadenopathy or distant metastasis.

Today, he is most bothered by bilateral shoulder and hip soreness. He has starting working out again and returned to work as well. He has been having headaches which have responded to massage therapy. He is taking probiotics for constipation. Appetite is normal and weight is stable. Denies fever, chills, headaches, shortness of breath, chest pain, nausea, emesis, constipation, diarrhea, and dysuria.

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
• ciprofloxacin HCl (CIPRO) 500 mg tablet	take 500 mg by mouth
• 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 2 mg by mouth
• minocycline (DYNACIN) 100 mg tablet	take 100 mg by mouth
• 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 50 mg by mouth

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: There were no vitals taken for this visit.
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. Pupils are equally round and reactive to light. Sclera anicteric. 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. Decreased at right base.
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. 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	0.9	10/13/2016
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.

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.

Symptomatically, Mr. Christenson is doing well. His bilateral shoulder and hip pain is likely musculoskeletal and degenerative in etiology with exacerbation by resuming exercise. There is no evidence of metastatic disease at these sites. Radiographically, Mr. Christenson has no evidence of recurrent or progressive disease.

We would like to see Mr. Christenson in 3 months with CT thorax.

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
- CT thorax in 3 months

Future Appointments

	Provider	Department	Center
10/13/2016 10:00 AM	SOUTH BAY 1 PET CT ROOM 1	South Bay Radiology First Floor	CCSB
10/13/2016 12:10 PM	SOUTH BAY 1 CT ROOM	South Bay Radiology First Floor	CCSB
10/13/2016 3:30 PM	Loo, Billy Wiseman	Radiation Onc Clinic	CCA

10/26/2016 1:00 PM	Berry, Mark Francis	Thoracic Oncology	CCA
3/22/2017 1:00 PM	Zei, Paul Cameron	Cardiovascular Med	

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,

Nicolas Demetrios Prionas, 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.

Other Notes

All notes

Instructions

Follow up with Dr Billy Loo in 3 months with a new CT and Pulmonary Function Tests prior to the visit.

Please make your follow up appointment today when you leave the clinic.
Please call radiology to schedule the imaging appointment - 650.723.6855 option 1

After Visit Summary (Printed 10/13/2016)

Additional Documentation

Vitals:	BP 135/69 Pulse 90 Temp 36.7 °C (98.1 °F) (Oral) Ht 1.88 m (6' 2.02") Wt 86.9 kg (191 lb 9.3 oz) SpO2 99% BMI 24.59 kg/m² BSA 2.13 m²
Flowsheets:	Vital Signs
Encounter Info:	Billing Info, History, Allergies, Detailed Report, Vitals, Reviewed This Encounter, Quality Measure Details

Orders Placed

None

Medication Changes

None

Visit Diagnoses

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

  Status post radiation therapy R Hilum (60/20) 6/29/16

Level of Service

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