Sunrise Oncology Partners

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Patient Name: **Mott, Elizabeth**
Patient Number: **12345678**

Date: **08/28/2018**
Date Of Birth: **08/29/1960**

FOLLOW UP VISIT

Chief Complaint
Mrs. Mott is a 57 year old woman who was diagnosed with breast cancer in April 2018. She was found to have extensive bone metastases, adenopathy and hepatic lesions. Tumor was biopsied showing ER positive, PR positive, Her2 amplified breast cancer. Started paclitaxel, trastuzumab and pertuzumab 5/8/18. Added zolendronic acid. Completed four cycles of TH and pertuzumab. Here for cycle five. While she reports increased anxiety since her last visit, Elizabeth is excited for her birthday tomorrow. Husband and sister are present for today's visit.

Ongoing Treatment Events

Date	Type	Details	Outcome	Comment
5/1/2018	Other Therapies	Synthroid 175 mcg tablet	Active	
5/1/2018	Other Therapies	Zoloft 50 mg tablet	Active	

Allergies
No known allergies have been entered for this patient.

Medical and Surgical History
Hypothyroidism. Mild anxiety.

Date	Type	ICD-9	ICD-10	Problem	Comment	Status

Date	Type	Details	Outcome	Comment
	Surgery	Tonsillectomy		1960s

Social History
Patient is married. No history of tobacco use. Mrs. Mott reports the following support system: lives with family. Her diet consists of regular meals. She indicates her daily activity level as: daily activities.

Alcohol Use Yes, Weekly.

Family History
Reviewed and unchanged.

Gyn History
Menarche at the age of 12. LMP more than 10 years ago.

Review Of Systems
Constitutional Symptoms: Patient reports: mild fatigue, no weakness, no weight loss, no fevers, no chills, no diaphoresis, no night sweats , no hot flashes. exertional dyspnea, no cough
Eyes: Patient offers no eye complaints.
Gastrointestinal: Patient offers no gastrointestinal complaints. no nausea, no vomiting, no dysphagia, no abdominal pain, no diarrhea, no constipation
Musculoskeletal: bone pain, no back pain, no arthralgia
Integumentary: Patient reports: no rash, no pruritis, no skin lesions, no dry skin

Neurological: Patient reports: no headache, no peripheral neuropathy, no focal weakness, no tremor, no altered consciousness, n o seizures, no speech impairment, no dizziness. no paralysis, nervousness,

Vital Signs
Vitals on 8/28/18 11:03:00 AM: Height=66in, Weight=155lb, Pulse=74, SystolicBP=122, DiastolicBP=68

Physical
General: Patient appears: well developed and well nourished, No alopecia noted.
Eyes: No scleral icterus, and/or pallor. Conjunctiva clear. EOMs intact. Pupils equal and reactive to light.
Cardiovascular: Heart with regular rate and rhythm. Normal S1 and S2. S3, S4 No gallop. No rubs or clicks. No bruits. Pedal pulses present.
Chest: Clear no rales/rhonchi. No dullness to percussion. No wheezing. Chest wall expansion normal. No chest wall tenderness. No stridor.
Abdomen: Soft. Non-tender. Non-distended. No palpable masses. No ascites. No hepatosplenomegaly. Bowel sounds present in all quadrants. No hernia.
Hematologic/
Lymphatic: No cervical lymphadenopathy. No supraclavicular lymphadenopathy. No axillary lymphadenopathy. No inguinal lymphadenopathy. No petechiae. No ecchymosis.
Skin: No rashes. No lesions. Extremities appear normal. No evidence of cyanosis. No edema. No clubbing present.
Neurologic: Alert and oriented. Normal speech. Cranial nerves in tact.
Genitourinary: Examination deferred.
Rectal: Examination deferred.
Gynecological: Examination deferred.

Laboratory Results
Lab results on 8/28/2018: Sodium=135 mmol/L, Potassium=4.2 mmol/L, CO2=31 mmol/L, Chloride=99 mmol/L, Glucose=84 mg/dL, Calcium=9.0 mg/dL, BUN=14 mg/dL, Creat=1.1 mg/dL, Alk Phos=45 U/L, ALT=21 U/L, AST=23 U/L, Total Bili=0.9 mg/dL, Albumin=3.7g dL, Total Protein=7.5 g/dL. WBC=4.1 x10E3/uL, RBC=4.63 x10E6/uL, HGB=9.9 g/dL, HCT=31.4%, MCV=68 fL, MCH=21.4 pg, MCHC=31.5 g/dL, RDW=16.1 %, Plat=179 x10E3/uL, ANC=2.8 x10E3/uL, Lymph#=1.0 x10E3/uL, MONO#=0.2 x10E3/uL, BASO#=0.1 x10E3/uL, EOS#=0.1 x10E3/uL, MONO%=5 %, BASO%=1 %, EOS%=1 %, Neut%=68 %

Imaging Results
Radiology results were reviewed and discussed with the patient, including 4/2018- MRI Brain no metastasis deep white matter changes suggestive of inflammatory process. PET/CT - left breast mass; diffuse bone metastases; liver lesions suspicious for metastatic breast cancer.

Primary Dx
198.5 - Secondary malignant neoplasm of bone and bone marrow, Diagnosed Apr 2018
174.9 - Malignant neoplasm of breast (female), unspecified site, Diagnosed Apr 2018

Assessment
Stage 4 ER HER2 positive breast cancer with bone and liver metastases. Patient had a negative brain MRI. Testing of tumor demonstrates ER+ PR+. HER2neu equivocal on IHC. FISH positive. Completed four cycles of TH plus pertuzumab with response. CT CAP last month showed interval decrease in size of liver lesions, stable bone metastases. Next imaging in 6 to 8 weeks. Tolerating treatment well overall, mild fatigue. Proceed with C5.

Recommendation/Plan
Time spent with patient was 25 minutes. Over half the time was spent counseling and coordinating care, which included the following:
Arranged patient treatment education.
Reviewed with patient treatment side effects.
Supportive measures reviewed.
Cont Taxol, Herceptin and Perjeta.
All questions answered.

Electronically signed: S. Wu MD
DATE Aug 28, 2018
TIME 11:45AM
Shannon Wu, M.D.