Sunrise Oncology Partners

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233 Spring Street
New York, NY 10013
P: (212) 123-1223
F: (212) 123-1224

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

Date: **05/01/2018**
Date Of Birth: **08/29/1960**

INITIAL CONSULTATION

Chief Complaint
Mrs. Elizabeth Mott is a very pleasant 57 y/o woman who recently felt a lump on her left breast with reddish coloration for which she went for evaluation to her PCP. He immediately ordered a mammogram which showed an abnormal area of her breast at the 12:00 position. She had a biopsy of this, revealing invasive ductal carcinoma, and subsequent workup by PET/CT revealed metastasis to bone and liver, as well as significant adenopathy. She has been referred to us for evaluation. She denies any family history of breast or ovarian cancer. She is without personal history of cancer of any kind. She reports history of anxiety and hypothyroidism. Patient is here to discuss stage IV breast cancer diagnosis and options for systemic therapy.

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. Denies history of tobacco or drug 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, glass of wine, weekly.

Family History
Reviewed. No family history of breast cancer. Her father has a history of colon polyps.

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

Review Of Systems
Constitutional Symptoms: Patient reports: no 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 5/1/2018 09:17:00 AM: Height=66in, Weight=155lb, Pulse=74, SystolicBP=122, DiastolicBP=68

Physical Exam
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 5/1/2018: Sodium=135 mmol/L, Potassium=**2.9** 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

Imaging Results
Radiology results were reviewed and discussed with the patient, including 4/2018- MRI Brain - no metastasis- deep white matter change s 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
I have discussed with the patient the diagnosis, prognosis and natural history of metastatic breast cancer. I have discussed the incurable nature of the disease and the palliative nature of treatment. I have discussed the rational for treatment in patients like her with stage IV, ER/PR positive, HER-2/neu positive breast cancer. We have discussed pertinent trials with regard to Herceptin therapy as well as addition of Perjeta, possible side effects and complications, and management of those. I have reviewed NCCN guidelines with the patient. After doing this, patient expressed understanding and is agreeable to pursue TH and Perjeta in standard doses.

Recommendation/Plan
Time spent with patient was 90 minutes. Over half the time was spent counseling and coordinating care, which included the following:
Arranged patient treatment education. OV in 1 week to start therapy.
Reviewed with patient treatment side effects.
Supportive measures reviewed.
All questions answered.

Fax to: John Wilson, MD; Neena Sangha, MD MPH

Electronically signed: S. Wu MD
DATE May 1, 2018
TIME 10:46AM
Shannon Wu, M.D.