REASON FOR CONSULTATION: , I was asked by Dr. X to see the patient in regard to his likely recurrent brain tumor.,HISTORY OF PRESENT ILLNESS: , The patient was admitted for symptoms that sounded like postictal state. He was initially taken to Hospital. CT showed edema and slight midline shift, and therefore he was transferred here. He has been seen by Hospitalists Service. He has not had a recurrent seizure. Electroencephalogram shows slowing. MRI of the brain shows large inhomogeneous infiltrating right frontotemporal neoplasm surrounding the right middle cerebral artery. There is inhomogeneous uptake consistent with potential necrosis. He also has had a SPECT image of his brain, consistent with neoplasm, suggesting relatively high-grade neoplasm. The patient was diagnosed with a brain tumor in 1999. All details are still not available to us. He underwent a biopsy by Dr. Y. One of the notes suggested that this was a glioma, likely an oligodendroglioma, pending a second opinion at Clinic. That is not available on the chart as I dictate.,After discussion of treatment issues with radiation therapist and Dr. Z (medical oncologist), the decision was made to treat him primarily with radiation alone. He tolerated that reasonably well. His wife says it's been several years since he had a scan. His behavior had not been changed, until it changed as noted earlier in this summary.,PAST MEDICAL HISTORY: , He has had a lumbar fusion. I believe he's had heart disease. Mental status changes are either due to the tumor or other psychiatric problems.,SOCIAL HISTORY:, He is living with his wife, next door to one of his

children. He has been disabled since 2001, due to the back problems.,REVIEW OF SYSTEMS: , No headaches or vision issues. Ongoing heart problems, without complaints. No weakness, numbness or tingling, except that related to his chronic neck pain. No history of endocrine problems. He has nocturia and urinary frequency.,PHYSICAL EXAMINATION: , Blood pressure 146/91, pulse 76. Normal conjunctivae. Ears, nose, throat normal. Neck is supple. Chest clear. Heart tones normal. Abdomen soft. Positive bowel sounds. No hepatosplenomegaly. No adenopathy in the neck, supraclavicular or axillary regions. Neurologically alert. Cranial nerves are intact. Strength is 5/5 throughout.,LABORATORY WORK: , White blood count 10.4, hemoglobin 16, platelets not noted. Sodium 137, calcium 9.1.,IMPRESSION AND PLAN:, Likely recurrent low-grade tumor, possibly evolved to a higher grade, given the MRI and SPECT findings. Dr. X's note suggests discussing the situation in the tumor board on Wednesday. He is stable enough. The pause in his care would not jeopardize his current status. It would be helpful to get old films and pathology from Abbott Northwestern. However, he likely will need a re-biopsy, as he is highly suspicious for recurrent tumor and radiation necrosis. Optimizing his treatment would probably be helped by knowing his current grade of tumor.