**Patient:** Richard Coleman (DOB 1952-06-06)  
**Medical Record Number:** 672915  
**Date of Admission:** 2025-03-21  
**Date of Discharge:** 2025-03-30  
**Admitting Physician:** Dr. A. Mehta (Nephrology)  
**Consulting Physician:** Dr. S. Washington (Hematology/Oncology), Dr. J. Park (Urology)

**Discharge Diagnosis: Relapsed Follicular Lymphoma with Postrenal Acute Kidney Injury due to Retroperitoneal Lymphadenopathy, Status Post Bilateral Ureteral Double J Stent Placement**

**1. Detailed Oncological Diagnosis:**

Primary Diagnosis: Follicular Lymphoma, Grade 2  
Date of Initial Diagnosis: 2023-04-18  
Current Status: First relapse after 17-month remission

Histology:

* Initial diagnosis: Left inguinal lymph node excisional biopsy (2023-04-12)
* Histology showed follicular lymphoma, Grade 2, with a predominantly follicular growth pattern (>75%)
* Immunohistochemistry: CD20+, CD10+, BCL2+, BCL6+, CD3- (scattered T-cells), CD5-, cyclin D1-
* Ki-67 proliferation index: 25%

Molecular/Genetic:

* FISH: t(14;18)(q32;q21) BCL2-IGH rearrangement positive
* Next-generation sequencing: CREBBP mutation, KMT2D mutation

Current Staging (at relapse):

* PET/CT (2025-03-22): Multiple FDG-avid lymph nodes above and below the diaphragm [Cervical: Right-sided, up to 1.8 cm, SUVmax 5.9, Axillary: Left-sided, up to 2.1 cm, SUVmax 6.6, Mediastinal: Multiple, up to 2.5 cm, SUVmax 7.4, Retroperitoneal: Extensive conglomerate of lymph nodes surrounding the aorta, IVC, and bilateral ureters at the level of L3-L5, measuring 7.2 × 5.8 cm, causing hydronephrosis, SUVmax 11.5, Mesenteric: Multiple, up to 2.3 cm, SUVmax 6.9, Iliac: Bilateral, up to 3.2 cm, SUVmax 8.4, Inguinal: Bilateral, up to 2.4 cm, SUVmax 7.1]
* Bone marrow biopsy (2025-03-24): Positive for paratrabecular involvement by follicular lymphoma (approximately 15% of cellularity)
* Ann Arbor Stage: Stage III
* FLIPI score: 5 (High risk - Age >60, Stage III, Hgb <12 g/dL, >4 nodal sites, elevated LDH)

**2. Current Treatment:**

Postrenal AKI

* double J ureteral stents on 2025-03-21
* Rituximab 375 mg/m² IV on 2025-03-28

**3. History of Oncological Treatment:**

Initial Therapy (2023-05 to 2023-10):

* Regimen: BR (bendamustine, rituximab)
  + Bendamustine 90 mg/m² IV Days 1-2
  + Rituximab 375 mg/m² IV Day 1
  + 28-day cycle × 6 cycles
* Tolerated well with Grade 2 neutropenia (nadir ANC 1.0 × 10⁹/L)
* No dose reductions or delays required
* Complete metabolic response achieved (negative PET/CT on 2023-11-10)

Maintenance Therapy (2023-11 to 2024-10):

* Rituximab 375 mg/m² IV every 2 months (stopped after 1 year due to patient’s wish)
* Remained in complete remission until surveillance PET/CT on 2025-03-10 showed relapse

**4. Comorbidities:**

* Hypertension (diagnosed 2015, managed with medication)
* Coronary artery disease (status post stenting of LAD 2019)
* Chronic kidney disease stage G2 (baseline eGFR 65 mL/min/1.73m², creatinine 1.1 mg/dL as of 2025-02-02)
* GERD
* Benign prostatic hyperplasia
* Hyperlipidemia

**5. Physical Exam at Admission:**

General: 72-year-old male, alert and oriented, appearing fatigued and uncomfortable

Vitals: BP 168/94 mmHg, HR 88 bpm, RR 20/min, Temp 37.2°C, SpO2 96% on room air, Weight 84 kg, Height 178 cm

HEENT: Normocephalic, atraumatic. No scleral icterus. Mucous membranes slightly dry.

Neck: Palpable right cervical lymphadenopathy, non-tender, mobile, largest approximately 1.5 cm

Cardiovascular: Regular rate and rhythm, S1/S2 normal, no murmurs, rubs, or gallops

Respiratory: Clear to auscultation bilaterally, no wheezes, rhonchi, or crackles

Abdomen: Distended, moderate diffuse tenderness more pronounced in bilateral costovertebral angles and flanks. No guarding or rebound. Bowel sounds hypoactive. No hepatosplenomegaly appreciated on palpation.

Musculoskeletal: No joint swelling or tenderness. Normal range of motion.

Neurological: Alert and oriented x3. Cranial nerves II-XII intact. Motor strength 5/5 in all extremities. Sensory intact. Reflexes 2+ and symmetric.

Skin: Pale, mild turgor, mild bilateral lower extremity edema to mid-shin.

Lymphatics: Palpable lymphadenopathy in right cervical, left axillary, and bilateral inguinal regions, non-tender, mobile.

**6. Epicrisis:**

Mr. Coleman is a 72-year-old male with a history of follicular lymphoma who presented with oliguria, bilateral flank pain, lower extremity edema, and fatigue. Laboratory studies revealed severe acute kidney injury with creatinine of 6.2 mg/dL (baseline 1.1 mg/dL).

Renal ultrasound and CT abdomen/pelvis demonstrated severe bilateral hydronephrosis due to extensive retroperitoneal lymphadenopathy, consistent with relapsed lymphoma. PET/CT showed lymphoma with widespread nodal involvement above and below the diaphragm. CT-guided biopsy confirmed relapsed follicular lymphoma.

The patient underwent cystoscopy with bilateral retrograde pyelogram and placement of bilateral double J ureteral stents on 2025-03-21. Following decompression, he experienced significant post-obstructive diuresis with urine output averaging 3-4 L/day. Serial creatinine measurements improved from 6.2 mg/dL to 2.1 mg/dL at discharge.

Bone marrow biopsy confirmed marrow involvement by follicular lymphoma. Hematology/Oncology established a treatment plan for Rituximab/Lenalidomide as second-line therapy once renal function stabilizes. Supportive care included IV fluids, electrolyte management, and pain control with continued improvement in renal parameters.

After negative hepatitis/HIV serology, Rituximab was applied on 2025-03-28. Lenalidomide will be initiated once renal function has sufficiently recovered.

The patient was deemed stable for discharge with close outpatient follow-up with Nephrology, Urology, and Hematology/Oncology.

**7. Medication at Discharge:**

* Amlodipine 10 mg PO daily (for hypertension)
* Lisinopril 5 mg PO daily (dose reduced from pre-admission 20 mg due to renal function)
* Valacyclovir 500 mg PO daily (herpes prophylaxis)
* Atorvastatin 40 mg PO daily (for hyperlipidemia)
* Aspirin 81 mg PO daily (for CAD)
* Allopurinol 200 mg PO daily (for tumor lysis syndrome prophylaxis, dose adjusted for renal function)
* Pantoprazole 40 mg PO daily (for GERD)
* Tamsulosin 0.4 mg PO daily (for BPH)
* Acetaminophen 650 mg PO Q6H PRN pain
* Oxycodone 5 mg PO Q6H PRN moderate-severe pain (max 20 mg/24 hours)
* Ondansetron 4 mg PO Q8H PRN nausea
* Docusate sodium 100 mg PO BID (stool softener)
* Potassium chloride 20 mEq PO daily (for ongoing mild hypokalemia due to post-obstructive diuresis)
* Magnesium oxide 400 mg PO BID (for ongoing mild hypomagnesemia due to post-obstructive diuresis)

Medications Held/Discontinued:

* Furosemide (held due to post-obstructive diuresis)

**8. Further Procedure / Follow-up:**

Nephrology Follow-up:

* Appointment with Dr. A. Mehta in 2 days (2025-04-01)
* Laboratory monitoring: CBC, CMP, magnesium, phosphorus every 3 days for 2 weeks, then weekly
* Fluid intake goal: Minimum 2.5-3 liters daily to maintain adequate hydration during post-obstructive phase
* Daily weight monitoring to assess fluid status

Urology Follow-up:

* Appointment with Dr. J. Park in 2 weeks (2025-04-14)
* Double J stent management:
  + Stents to remain in place for approximately 3 months or until sufficient tumor regression
  + Monitoring for stent-related complications (dysuria, hematuria)
  + Anticipate stent exchange at 3 months if ongoing ureteral compression
* Renal ultrasound scheduled for 2025-04-14 to reassess hydronephrosis# Discharge Summary

Hematology/Oncology Follow-up:

* Appointment with Dr. S. Washington on 2025-04-03 for Rituximab d8
* Plan to initiate Lenalidomide 10 mg once creatinine improves to <1.8 mg/dL (anticipated start date 2025-04-08)
* Consider PCP prophylaxis
* Laboratory monitoring for tumor lysis: CBC, CMP, LDH, uric acid, phosphorus, calcium every 3 days until chemotherapy initiated, then per standard protocol

Imaging:

* Renal ultrasound in 2 weeks (2025-04-14) to reassess hydronephrosis
* PET/CT after 3 cycles of Rituximab/Lenalidomide

Patient Education:

* Double J stent care and potential symptoms (urinary frequency, urgency, mild hematuria, flank pain with urination)
* Symptoms requiring urgent medical attention:
  + Fever ≥38.0°C
  + Severe flank pain
  + Significant decrease in urine output
  + Gross hematuria
  + Increasing lower extremity edema
  + Shortness of breath
* Fluid intake requirements: minimum 10-12 cups (2.5-3 L) of fluid daily
* Importance of medication adherence and follow-up appointments

**9. Lab Values (Excerpt):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Parameter** | **Admission (2025-03-21)** | **Discharge (2025-03-30)** | **Units** | **Reference Range** |
| WBC | 7.6 | 7.2 | x10^9/L | 4.0-11.0 |
| Hemoglobin | 10.2 | 10.8 | g/dL | 13.5-17.5 (M) |
| Platelets | 212 | 225 | x10^9/L | 150-400 |
| Creatinine | 6.2 | 2.1 | mg/dL | 0.7-1.3 |
| eGFR | 9 | 32 | mL/min/1.73m² | >60 |
| BUN | 72 | 38 | mg/dL | 7-20 |
| Sodium | 133 | 136 | mmol/L | 135-145 |
| Potassium | 5.8 | 3.6 | mmol/L | 3.5-5.0 |
| Chloride | 100 | 104 | mmol/L | 98-107 |
| Bicarbonate | 17 | 22 | mmol/L | 22-29 |
| Calcium | 8.3 | 8.7 | mg/dL | 8.6-10.2 |
| Phosphorus | 6.4 | 4.1 | mg/dL | 2.5-4.5 |
| Magnesium | 1.6 | 1.7 | mg/dL | 1.8-2.4 |
| Albumin | 3.3 | 3.5 | g/dL | 3.5-5.0 |
| Total Protein | 8.5 | 8.2 | g/dL | 6.0-8.3 |
| AST | 30 | 28 | U/L | 10-40 |
| ALT | 34 | 32 | U/L | 7-56 |
| Alk Phos | 105 | 98 | U/L | 45-115 |
| Total Bilirubin | 0.9 | 0.8 | mg/dL | 0.1-1.2 |
| LDH | 395 | 350 | U/L | 135-225 |
| Uric Acid | 8.2 | 6.1 | mg/dL | 3.5-7.2 (M) |
| Beta-2 Microglobulin | 9.2 | 6.4 | mg/L | <2.7 |
| Glucose | 102 | 98 | mg/dL | 70-99 |
| HbA1c | - | - | % | <5.7 |
| Urinalysis | Specific gravity 1.022, Protein 2+, Blood 1+, WBC 5-10/hpf, RBC 5-10/hpf, Granular casts present | Specific gravity 1.012, Protein 1+, Blood 1+, WBC 0-5/hpf, RBC 2-5/hpf, No casts | - | - |

Electronically Signed By:  
Dr. A. Mehta (Nephrology)  
Date/Time: 2025-03-30 16:15

Dr. S. Washington (Hematology/Oncology)  
Date/Time: 2025-03-30 15:30

Dr. J. Park (Urology)  
Date/Time: 2025-03-30 14:45