Document Type: Medical Record - Routine Physical Exam
Date of Service: January 20, 2005

[Harmony Health Clinic - *Logo: A stylized green leaf over interlocking circles*]
Patient Name: John Doe
Date of Birth: 01/15/1970

SUBJECTIVE:
Patient reports feeling generally well. No specific complaints. Denies fever, chills, new aches, or pains.

OBJECTIVE:

- **Vitals:** BP: 125/80 mmHg, HR: 72 bpm, Temp: 98.6°F, Respiration Rate: 16 bpm.
- **Physical Exam:** General: Appears well, no acute distress. HEENT: Normocephalic, atraumatic. Lungs: Clear to auscultation bilaterally. Heart: Regular rate and rhythm, no murmurs. Abdomen: Soft, non-tender, non-distended, normoactive bowel sounds. Extremities: No edema, full range of motion. Skin: Warm, dry, intact.

ASSESSMENT:
Healthy male, age 35. Routine health maintenance. Elevated cholesterol noted, to be monitored.

PLAN:

1. Continue healthy lifestyle, emphasizing heart-healthy diet and regular exercise.
2. Follow up in 1 year for next annual physical.
3. Discuss cholesterol management if levels persist or rise.

LAB RESULTS (Attached):

- **Lab Date:** 01/18/2005 (Performed by Unity Diagnostics Lab)
- **Lipid Panel:**
    - Total Cholesterol: 220 mg/dL (High - *Reference Range: <200 mg/dL*)
    - LDL: 140 mg/dL (High - *Reference Range: <100 mg/dL*)
    - HDL: 50 mg/dL (Good)
    - Triglycerides: 100 mg/dL (Normal)
- **Complete Blood Count (CBC):** All within normal limits.
- **Basic Metabolic Panel (BMP):** All within normal limits.
- **Urinalysis:** Negative.

Physician Signature:
Dr. Evelyn Reed, MD
January 25, 2005

Document Type: Medical Record - Hypertension Diagnosis
Date of Service: March 15, 2010

[Harmony Health Clinic - *Logo: A stylized green leaf over interlocking circles*]
Patient Name: John Doe
Date of Birth: 01/15/1970

SUBJECTIVE:
Patient reports recurrent dull headaches over the past 3 months, primarily in the temporal region, occasionally accompanied by mild dizziness. Headaches occur 2-3 times per week, rated 4/10 intensity. Denies vision changes, chest pain, or shortness of breath.

OBJECTIVE:

- **Vitals:** BP: 155/95 mmHg (initial), 150/92 mmHg (repeat after 5 min rest). HR: 80 bpm, RR: 16 bpm, Temp: 98.6°F.
- **Physical Exam:** HEENT: Pupils equal, round, reactive to light and accommodation. Fundoscopic exam normal. Lungs: Clear. Heart: Regular rate and rhythm, no S3/S4, no murmurs. Abdomen: Soft, non-tender. Extremities: No edema. Neurological: Grossly intact, no focal deficits.

ASSESSMENT:
Essential Hypertension (ICD-10: I10). New diagnosis. Elevated blood pressure on multiple occasions. Headaches likely related to hypertension. Patient's cholesterol remains mildly elevated.

PLAN:

1. Initiate Lisinopril 10mg daily by mouth.
2. Provide patient with educational materials on low-sodium diet (DASH diet) and cardiovascular health. Referral to clinic nutritionist offered.
3. Strongly encourage regular aerobic exercise (e.g., brisk walking for 30 minutes, 5 times per week).
4. Instruct patient on proper technique for home blood pressure monitoring; patient to record and bring readings to next visit.
5. Follow up in 4 weeks for blood pressure check, review of home readings, and medication adjustment as needed.

Physician Signature:
Dr. Evelyn Reed, MD
March 16, 2010

Document Type: Gastroenterology Report - Ulcerative Colitis Diagnosis
Date of Service: August 22, 2012

[Riverside Gastroenterology & Endoscopy Center - *Logo: A winding blue river icon*]
Patient Name: John Doe
Date of Birth: 01/15/1970

CONSULTATION NOTE (August 1, 2012):

- **Referring Physician:** Dr. Evelyn Reed
- **Reason for Consult:** Chronic abdominal pain, diarrhea, and unintended weight loss. Patient reports symptoms for approximately 6 months: diffuse cramping abdominal pain (rated 5-7/10), 4-6 loose bowel movements per day, occasionally bloody or with mucus. Has lost 10 lbs over 3 months without intentional dieting.
- **Review of Systems:** Reports significant fatigue. Denies fever, chills, night sweats, joint pain, or rashes.
- **Physical Exam:** General: Appears fatigued. Abdomen: Soft, mildly distended, diffuse tenderness on deep palpation, particularly in the lower left quadrant. No rebound tenderness or guarding. Bowel sounds hyperactive. Rectal exam: Mild tenderness, no palpable masses, occult blood positive.
- **Impression:** Clinical picture highly suggestive of Inflammatory Bowel Disease (IBD), specifically Ulcerative Colitis given bloody diarrhea and left-sided abdominal pain.
- **Plan:** Discussed need for diagnostic colonoscopy with biopsies. Patient consented. Scheduled for August 22, 2012.

COLONOSCOPY REPORT (August 22, 2012):

- **Procedure:** Complete Colonoscopy to Cecum.
- **Sedation:** Moderate sedation (Midazolam 2mg, Fentanyl 50mcg).
- **Findings:**
    - **Rectum:** Severe erythema, diffuse friability, spontaneous bleeding on scope insertion, widespread shallow ulcerations, complete loss of normal vascular pattern.
    - **Sigmoid Colon:** Moderate erythema and friability with patchy ulcerations, loss of vascular pattern.
    - **Descending Colon:** Mild, focal areas of erythema, otherwise unremarkable.
    - **Transverse Colon, Ascending Colon, Cecum, Terminal Ileum:** Normal mucosa.
    - **Biopsies:** Multiple biopsies taken from affected rectal and sigmoid segments.
-

- **Impression:** Endoscopic findings consistent with active Ulcerative Colitis, involving the rectum and sigmoid colon (Proctosigmoiditis).

PATHOLOGY REPORT (Unity Diagnostics Lab - August 29, 2012 - Attached):

- **Specimen:** Biopsies from Rectum and Sigmoid Colon.
- **Gross Description:** Multiple fragments of tan-pink tissue, up to 0.3 cm.
- **Microscopic Description:** Sections show colonic mucosa with severe active inflammation, diffuse crypt architectural distortion, marked cryptitis, and crypt abscesses. Goblet cell depletion is prominent. Lamina propria shows increased chronic inflammatory cells (lymphocytes, plasma cells). No granulomas.
- **Diagnosis:** Active chronic colitis with features consistent with Ulcerative Colitis. No dysplasia or malignancy identified.

PLAN:

1. Diagnosis confirmed: Ulcerative Colitis (Proctosigmoiditis).
2. Initiate Mesalamine (oral: Lialda 2.4g BID; rectal suppositories: Canasa 1000mg nightly).
3. Patient provided with dietary recommendations for IBD.
4. Schedule follow-up appointment in 6 weeks to assess clinical response to therapy and discuss long-term management.

Physician Signature:
Dr. Samuel Chen, MD (Gastroenterologist)
September 1, 2012

Document Type: Hospital Discharge Summary - Acute Kidney Injury
Admission Date: November 5, 2014
Discharge Date: November 8, 2014

[Metropolitan General Hospital - *Logo: A blue cross within a shield*]
Patient Name: John Doe
Date of Birth: 01/15/1970
Medical Record Number: MJ19700115

ADMITTING DIAGNOSIS:
Acute Kidney Injury.

REASON FOR ADMISSION:
Nausea, vomiting, and decreased urine output. Patient presented to the Emergency Department with 2 days of severe gastroenteritis symptoms (6 episodes of non-bloody emesis, 8-10 episodes of watery diarrhea) and marked fatigue. Reports minimal oral intake during this period.

HISTORY OF PRESENT ILLNESS:
Patient's home medications include Lisinopril 10mg daily for hypertension and Mesalamine for Ulcerative Colitis. Unaware of medication-related kidney risks in setting of dehydration.

PAST MEDICAL HISTORY:

- Hypertension
- Ulcerative Colitis
- Hyperlipidemia

SIGNIFICANT HOSPITAL FINDINGS:

- **Labs (upon admission, 11/05/2014 - Metro Labs):**
    - Creatinine: 3.2 mg/dL (baseline known by PCP to be approximately 1.0-1.1 mg/dL)
    - BUN: 45 mg/dL
    - Potassium: 5.5 mEq/L
    - Sodium: 130 mEq/L
-
- **Labs (upon discharge, 11/08/2014 - Metro Labs):**
    - Creatinine: 1.8 mg/dL
    - BUN: 25 mg/dL
    - Potassium: 4.2 mEq/L
    - Sodium: 138 mEq/L
-

HOSPITAL COURSE:
Patient admitted to internal medicine service. Aggressive intravenous fluid resuscitation initiated (Normal Saline). Lisinopril held temporarily. Electrolytes and renal function monitored closely. Patient's gastroenteritis symptoms resolved within 24 hours. Kidney function showed progressive improvement. Cardiology consultation obtained to review medication given AKI, recommended resuming Lisinopril at a lower dose after discharge.

DISCHARGE DIAGNOSIS:

1. Acute Kidney Injury, likely pre-renal, secondary to severe dehydration in the setting of gastroenteritis and concurrent ACE inhibitor use.
2. Dehydration.
3. Gastroenteritis (resolved).

DISCHARGE MEDICATIONS:

- Lisinopril 5mg daily (restart)
- Mesalamine 2.4g BID (continue)
- Multivitamin daily

DISCHARGE INSTRUCTIONS:

1. Strict adherence to oral fluid intake; avoid dehydration, especially during illness or warm weather.
2. Monitor urine output and symptoms of recurring gastroenteritis or kidney issues.
3. Avoid NSAIDs (ibuprofen, naproxen).
4. Follow up with PCP (Dr. Evelyn Reed) in 1 week for repeat labs (BMP, Creatinine, Electrolytes) and blood pressure check.
5. Follow up with Gastroenterology (Dr. Samuel Chen) as scheduled.

Physician Signature:
Dr. Laura Miller, MD (Hospitalist)
November 8, 2014

Document Type: Endocrinology Report - Hypothyroidism Diagnosis
Date of Service: May 10, 2016

[Summit Endocrine Associates - *Logo: A stylized mountain peak*]
Patient Name: John Doe
Date of Birth: 01/15/1970

REASON FOR CONSULT:
Patient referred by Dr. Evelyn Reed for evaluation of suspected hypothyroidism. Patient reports persistent, profound fatigue that is not relieved by sleep, unexplained weight gain of 15 lbs over the past 6-8 months despite no change in diet/exercise, chronic constipation (now 2-3 bowel movements per week, previously daily), and increased sensitivity to cold. Also reports some hair thinning and dry skin.

REVIEW OF SYSTEMS:
Denies palpitations, tremors, anxiety, or heat intolerance. Endorses "brain fog" and decreased concentration.

OBJECTIVE:

- **Vitals:** BP: 130/85 mmHg, HR: 58 bpm, RR: 14 bpm, Temp: 97.4°F. Weight: 195 lbs (from 180 lbs 8 months prior).
- **Physical Exam:** General: Appears tired. Skin: Dry, cool to touch. Hair: Mildly sparse, brittle. Neck: Thyroid gland diffusely enlarged, firm, non-tender to palpation (estimated 30-40g). Extremities: No edema. Neurological: Reflexes normal, no focal deficits.

LAB RESULTS (Attached, from Unity Diagnostics Lab - dated 05/05/2016):

- **Thyroid Stimulating Hormone (TSH):** 8.5 mIU/L (High - *Reference Range: 0.4-4.0 mIU/L*)
- **Free T4:** 0.7 ng/dL (Low - *Reference Range: 0.8-1.8 ng/dL*)
- **Thyroid Peroxidase Antibodies (TPOAb):** Positive (250 IU/mL - *Reference Range: <35 IU/mL*)
- **Thyroglobulin Antibodies:** Negative.
- **CBC, CMP:** Within normal limits.

ASSESSMENT:
Primary Hypothyroidism, new diagnosis. Given positive TPO antibodies and clinical presentation, most consistent with Hashimoto's Thyroiditis.

PLAN:

1. Initiate Levothyroxine 50 mcg daily by mouth, instructed to take on an empty stomach first thing in the morning, at least 30-60 minutes before food, coffee, or other medications (especially calcium/iron supplements).
2. Provided patient with detailed educational materials on hypothyroidism and Levothyroxine administration.
3. Recheck TSH and Free T4 in 6-8 weeks to assess response and adjust dosage.
4. Schedule follow-up appointment with endocrinology in 3 months.

Physician Signature:
Dr. Sophia Chang, MD (Endocrinologist)
May 12, 2016

Document Type: PCP Progress Note - Elevated Liver Enzymes
Date of Service: July 25, 2017

[Harmony Health Clinic - *Logo: A stylized green leaf over interlocking circles*]
Patient Name: John Doe
Date of Birth: 01/15/1970

SUBJECTIVE:
Patient reports no new symptoms. Follow-up on routine annual blood work which showed elevated liver enzymes. Denies jaundice, dark urine, light stools, or new abdominal pain. Reports maintaining current medication regimen for hypertension, ulcerative colitis, and hypothyroidism. Patient states social alcohol intake is infrequent, approximately 1-2 drinks per month, no binge drinking.

OBJECTIVE:

- **Vitals:** BP: 128/82 mmHg, HR: 70 bpm, Temp: 98.4°F.
- **Physical Exam:** General: Appears well. Abdomen: Soft, non-tender, non-distended. No hepatomegaly (liver not palpable below costal margin). Skin and sclera anicteric. No stigmata of chronic liver disease.

LAB RESULTS (Attached, from Unity Diagnostics Lab - dated 07/20/2017):

- **Liver Function Panel:**
    - AST (Aspartate Aminotransferase): 55 U/L (High - *Reference Range: 10-40 U/L*)
    - ALT (Alanine Aminotransferase): 60 U/L (High - *Reference Range: 7-56 U/L*)
    - Alkaline Phosphatase: 90 U/L (Normal - *Reference Range: 40-129 U/L*)
    - Total Bilirubin: 0.8 mg/dL (Normal - *Reference Range: 0.2-1.2 mg/dL*)
    - Albumin: 4.2 g/dL (Normal - *Reference Range: 3.5-5.0 g/dL*)
-
- **Other Labs:** CBC, BMP, TSH, Free T4 - all stable on current medications. Viral hepatitis panel (Hep B surface antigen, Hep C antibody) from 2010 was negative.

ASSESSMENT:
Elevated liver transaminases (AST/ALT), mild elevation, etiology currently unclear. Given prior normal labs, considering non-alcoholic fatty liver disease (NAFLD) or potential medication effect as possible contributors, though no recent medication changes. Patient denies significant alcohol use.

PLAN:

1. Order Abdominal Ultrasound to evaluate liver parenchyma and rule out structural abnormalities, fatty liver, or biliary pathology.

2. Counsel patient again on strict moderation of alcohol intake and importance of healthy diet/weight management.
3. Review all current medications for potential hepatotoxicity (Lisinopril, Mesalamine, Levothyroxine generally low risk).
4. Recheck liver enzymes in 3 months with follow-up visit after ultrasound results.

IMAGING REPORT (Metropolitan General Radiology - Abdominal Ultrasound - Attached, dated 08/01/2017):

- **Study:** Ultrasound Abdomen, Complete.
- **Findings:** Liver normal in size, echotexture, and contour. No focal lesions. No evidence of hepatic steatosis. Gallbladder, bile ducts, spleen, kidneys, pancreas all unremarkable.
- **Impression:** Normal abdominal ultrasound. No evidence of intrinsic liver disease, mass, or biliary obstruction.

Physician Signature:
Dr. Evelyn Reed, MD
August 10, 2017

Document Type: Oncology Report - Testicular Cancer Diagnosis & Orchiectomy
Date of Service: February 18, 2019 (Surgery Date)

[Citywide Cancer Center - *Logo: A stylized ribbon with a star*]
Patient Name: John Doe
Date of Birth: 01/15/1970
Medical Record Number: MJ19700115

UROLOGY CONSULTATION NOTE (February 1, 2019 - Dr. Marcus Thorne, Urologist):

- **Reason for Consult:** Patient referred by Dr. Evelyn Reed for evaluation of painless swelling of the right testicle. Patient noticed a firm lump about 2 months ago, which has gradually increased in size. Denies pain, fever, or trauma.
- **Physical Exam:** General: Appears well. Genitalia: Scrotum reveals a firm, non-tender, irregular mass within the right testicle, measuring approximately 2.5 x 2.0 cm. Transillumination negative. Left testicle normal. Epididymis and spermatic cords non-tender.
- **Impression:** Right testicular mass, highly suspicious for malignancy.
- **Plan:** Urgent scrotal ultrasound and serum tumor markers (AFP, HCG, LDH). Patient consented to potential orchiectomy if malignancy confirmed.

SCROTAL ULTRASOUND REPORT (Metropolitan General Radiology - February 5, 2019 - Attached):

- **Study:** Ultrasound Scrotum.
- **Findings:** Right testicle demonstrates a well-defined, heterogeneous hypoechoic mass measuring 2.5 x 2.0 x 1.8 cm within the parenchyma. Increased color Doppler flow within the mass. No associated hydrocele or epididymitis. Left testicle is normal.
- **Impression:** Right testicular mass, highly suspicious for malignancy. Recommend further workup including tumor markers and urologic consultation.

TUMOR MARKERS (Unity Diagnostics Lab - February 5, 2019 - Attached):

- Alpha-Fetoprotein (AFP): 3.5 ng/mL (Normal - *Reference Range: <8.1 ng/mL*)
- Beta-Human Chorionic Gonadotropin (HCG): <2 mIU/mL (Normal - *Reference Range: <2 mIU/mL*)
- Lactate Dehydrogenase (LDH): 280 U/L (Mildly Elevated - *Reference Range: 140-280 U/L*)

OPERATIVE REPORT (February 18, 2019 - Right Radical Inguinal Orchiectomy - Dr. Marcus Thorne):

- **Procedure:** Right radical inguinal orchiectomy.
- **Anesthesia:** General Anesthesia.
- **Findings:** Standard inguinal incision made. Spermatic cord ligated at internal ring. Right testicle, epididymis, and spermatic cord delivered. A firm, whitish, homogenous mass was palpable within the testicle. Specimen sent to pathology.
- **Complications:** None. Estimated blood loss: Minimal.
- **Postoperative Diagnosis:** Right testicular mass, suspicious for malignancy.

PATHOLOGY REPORT (Citywide Cancer Center Pathology - February 25, 2019 - Attached):

- **Specimen:** Right testicle, orchiectomy.
- **Gross Description:** Testicular parenchyma with a firm, solid, tan-white, homogenous mass measuring 2.5 x 2.0 x 1.8 cm. Appears well-circumscribed.
- **Microscopic Description:** Histological sections reveal sheets of large, uniform cells with distinct cell borders, abundant clear-to-glycogen-rich cytoplasm, and central round nuclei with prominent nucleoli. Extensive lymphocytic infiltration in the stroma. Numerous mitotic figures present. No evidence of vascular or lymphatic invasion. Tunica albuginea intact. Spermatic cord margin free of tumor.
- **Diagnosis:** Seminoma, classic type, limited to the testis (pT1). Tumor size 2.5 cm. No lymphovascular invasion. No involvement of epididymis or spermatic cord margin.

ONCOLOGY CONSULTATION NOTE (March 10, 2019 - Dr. Sarah Jenkins, Oncologist):

- **Referring Physician:** Dr. Marcus Thorne
- **Diagnosis:** Stage I Seminoma (pT1N0M0) of the right testicle.
- **Discussion:** Patient counseled on diagnosis, excellent prognosis for Stage I seminoma, and available management options: active surveillance, one cycle of adjuvant carboplatin chemotherapy, or adjuvant radiation therapy. Risks and benefits of each option were discussed in detail.
- **Plan:** After careful consideration, patient expresses a strong preference for active surveillance. Baseline CT chest/abdomen/pelvis ordered for staging. Regular follow-up with serial tumor markers (LDH) and imaging (CT scans) at prescribed intervals.

Physician Signatures:
Dr. Marcus Thorne, MD (Urologist)

Dr. Sarah Jenkins, MD (Oncologist)
March 12, 2019

Document Type: Rheumatology Report - Fibromyalgia Diagnosis
Date of Service: September 10, 2020

[Joint & Spine Wellness Center - *Logo: A stylized human spine icon*]
Patient Name: John Doe
Date of Birth: 01/15/1970

REASON FOR CONSULT:
Patient referred by Dr. Evelyn Reed for evaluation of chronic widespread pain, profound fatigue, and cognitive difficulties that have been ongoing for approximately 18 months. Patient describes pain as a constant, dull ache, rated 6-8/10, affecting neck, shoulders, upper and lower back, hips, and knees. Pain is worsened by activity, stress, and lack of sleep. Fatigue is debilitating and unrefreshing; patient wakes up feeling exhausted despite adequate sleep duration. Reports "brain fog," difficulty with memory, and concentration. Numerous prior evaluations by PCP and Neurology (Dr. Alana Sharma, Neurologist, records reviewed - no specific neurological disease found) ruled out other conditions.

REVIEW OF SYSTEMS:
Endorses headaches, restless sleep, irritable bowel symptoms (consistent with his Ulcerative Colitis, but new patterns of abdominal discomfort), and anxiety. Denies objective joint swelling, fevers, rashes, muscle weakness, or numbness/tingling (beyond generalized discomfort).

OBJECTIVE:

- **Vitals:** BP: 126/80 mmHg, HR: 75 bpm, Temp: 98.2°F.
- **Physical Exam:**
    - **General:** Appears tired, moves cautiously.
    - **Musculoskeletal:** Diffuse tenderness to palpation in multiple classic fibromyalgia tender points. Positive findings in all 18 specified sites (bilateral occiput, low cervical, trapezius, supraspinatus, second rib, lateral epicondyle, gluteal, greater trochanter, knee). Pain elicited is disproportionate to pressure applied. No objective joint swelling, warmth, or erythema. Full active and passive range of motion in all major joints.
    - **Neurological:** Cranial nerves II-XII intact. Motor strength 5/5 throughout. Sensation intact to light touch, pinprick, vibration. Deep tendon reflexes 2+ and symmetric. No pathological reflexes.
    - **Mental Status:** Appears oriented, but reports difficulty with attention during conversation.
-

LAB RESULTS (Attached, from prior workup 2019-2020, all within normal limits):

- ESR (Erythrocyte Sedimentation Rate)
- CRP (C-Reactive Protein)

- ANA (Antinuclear Antibody)
- Rheumatoid Factor
- TSH, Free T4 (stable on Levothyroxine)
- Vitamin D
- CBC, CMP
- Creatine Kinase (CK)

ASSESSMENT:
Fibromyalgia (ICD-10: M79.7). Patient meets the 2010 American College of Rheumatology diagnostic criteria for fibromyalgia based on a widespread pain index of 19/19 and a symptom severity scale of 10/12, with symptoms present for greater than 3 months and other potential conditions (e.g., inflammatory arthritis, thyroid dysfunction) adequately ruled out by prior workup.

PLAN:

1. **Education:** Provided comprehensive education regarding fibromyalgia, emphasizing it is a chronic, but manageable, pain disorder, and a multidisciplinary approach is key.
2. **Medication:** Initiate Amitriptyline 25mg nightly. Advised to take 1-2 hours before bedtime, starting at a lower dose if needed due to potential sedation.
3. **Referrals:**
    - Physical Therapy (Focus: gentle stretching, aquatic therapy, posture, activity pacing).
    - Cognitive Behavioral Therapy (CBT) for chronic pain management, stress reduction, and sleep hygiene.
    - Pain Management Clinic for adjunctive therapies if needed.
4.
5. **Lifestyle:** Strongly encourage regular, low-impact aerobic exercise (e.g., walking, swimming, tai chi). Discussed importance of stress reduction techniques (mindfulness, meditation).
6. **Follow Up:** Return to rheumatology in 2 months to assess medication response, progress with therapies, and symptom management.

Physician Signature:
Dr. David Kim, MD (Rheumatologist)
September 15, 2020

Document Type: Radiology Report - Cancer Surveillance CT Scan
Date of Scan: April 15, 2022

[Metropolitan General Radiology - *Logo: A blue cross within a shield*]
Patient Name: John Doe
Date of Birth: 01/15/1970
Medical Record Number: MJ19700115

STUDY:
CT Abdomen and Pelvis with Intravenous Contrast.

CLINICAL INDICATION:
Testicular cancer surveillance, Stage I Seminoma. Status post right radical inguinal orchiectomy (February 2019). Follow-up imaging as per oncology protocol.

REFERRING PHYSICIAN:
Dr. Sarah Jenkins (Oncologist)

COMPARISON:
Prior CT Abdomen/Pelvis dated April 20, 2021 (Accession: MG210420CT).

FINDINGS:

- **Lymph Nodes:** No evidence of abdominal, retroperitoneal, or pelvic lymphadenopathy. All lymph nodes identified are stable and within normal limits, unchanged from prior study.
- **Liver:** Normal in size, contour, and homogeneous attenuation. No focal hepatic lesions.
- **Spleen:** Normal size (10.5 cm craniocaudal dimension) and homogeneous appearance.
- **Pancreas:** Unremarkable, no masses or dilatation of the pancreatic duct.
- **Kidneys:** Both kidneys appear normal in size and exhibit normal enhancement. Right kidney demonstrates mild compensatory hypertrophy, stable from prior. No hydronephrosis or stones.
- **Adrenal Glands:** Normal configuration bilaterally. No adrenal masses.
- **Gastrointestinal Tract:** No evidence of bowel obstruction, inflammatory changes, or wall thickening. Bowel loops are non-dilated.
- **Vascular Structures:** Aorta and major vascular structures appear patent and without evidence of aneurysm or dissection.
- **Bones:** Visualized osseous structures demonstrate no suspicious lytic or blastic lesions.
- **Remaining Testicle:** Left testicle normal in appearance.

IMPRESSION:
No evidence of recurrent or metastatic disease. Findings are stable compared to the prior examination from April 20, 2021. Continued surveillance as per oncology protocol recommended.

Radiologist Signature:
Dr. Robert Lee, MD (Attending Radiologist)
April 16, 2022
