NAME:	MARYLU ENG	MRN#:	243-12-3456
ADDRESS:			
456 BEACH DRIVE		ACCT#:	11224466
XRAY, VA 22180		DOB:	01/01/1964

SSN# 999-93-9993

RACE: U

SEX: F

RELIGION: SDA

MARITAL STATUS: S

MANAGING MD: DR. D. CHEST

DIAGNOSIS: C34.1

PATIENT PHONE# 555-333-1114

EMPLOYER: NOT EMPLOYED

EMPLOYER ADDRESS: NOT EMPLY'D

INSURANCE PROVIDER: MEDICAID

GROUP #:

SURGERY CONSULTATION
10/16/2006

I am seeing this patient in preparation for her planned right thoracotomy and right upper lobectomy to be performed on 10/20/2006. She is a pleasant 42-year-old woman who was found to have a nodule in her right upper lobe. Biopsy was positive for non-small cell lung carcinoma on 09/15/2006. Her FEV1 is 1.76 which is 70% of predicted and her DLCO was 65% of predicted. She had a PET scan which showed uptake in the nodule in the right upper lobe and then what was thought to be gastrohepatic ligament and external iliac lymph nodes. CT scan of her abdomen showed no evidence of masses of lymph nodes in these regions. She underwent a cardiac stress test today and we are awaiting the results. Her lesion is quite peripheral. I am happy to report that she stopped smoking approximately two months ago and has done well with this.

PAST MEDICAL HISTORY: She has a history of hypertension, diabetes mellitus and arthritis.

MEDICATIONS: Glucotrol 5 mg daily, Accupril 40 mg daily, Toprol XL 400 mg daily, Hyzaar 20 mg per 12.5 mg twice daily, Prilosec 20 mg daily, Skelaxin 200 mg twice daily, vitamin B6, amitriptyline 50 mg nightly, aspirin 81 mg, vitamin C, multivitamin, vitamin E, and albuterol.

ALLERGIES: None

PHYSICAL EXAMINATION: Temperature 36.8, pulse 72, respirations 20, blood pressure 183/86, saturations 96% on room air, weight is 96.2 kilograms which is up 5.4 kilograms from 07/21/06. She appears well. She has no supraclavicular or cervical adenopathy. Her breath sounds are slightly wheezy bilaterally. Heart: Regular rate and rhythm. Abdomen: Soft, nontender, nondistended.

IMPRESSION AND PLAN: Patient has a small peripheral adenocarcinoma of the right upper lobe and will undergo right thoracotomy, right upper lobectomy on 10/20/06. She has done very well with her smoking cessation.

DISCHARGE SUMMARY
10/23/2006

PROCEDURES: Flexible bronchoscopy, right thoracotomy, right upper lobe resection, and lymphadenectomy.

ADMISSION DIAGNOSES:
1. Right upper lobe nodule, adenocarcinoma
2. Hypertension
3. Diabetes
4. Arthritis

DISCHARGE DIAGNOSES:
1. Right upper lobe nodule, adenocarcinoma
2. Hypertension
3. Diabetes
4. Arthritis

HISTORY: This is a 42-year-old female that was recently diagnosed with adenocarcinoma.

PAST MEDICAL HISTORY: As noted above

PAST SURGICAL HISTORY: Cervical fusion

ALLERGIES: None

MEDICATIONS PRIOR TO ADMISSION: Glucotrol 5 mg daily, Accupril 40 mg daily, Toprol XL 400 mg daily, Hyzaar 20 mg per 12.5 mg twice daily, Prilosec 20 mg daily, Skelaxin 200 mg twice daily, vitamin B6, amitriptyline 50 mg nightly, aspirin 81 mg, vitamin C, multivitamin, vitamin E, and albuterol.

SOCIAL HISTORY: The patient lives alone in an apartment and has a son that lives within driving distance. She quit smoking two months prior to surgery and has a 40 pk-yr history.

PHYSICAL EXAMINATION: Her vital signs are stable. She has no adenopathy. Mediastinoscopy incision is well healed. Breath sounds are clear to auscultation. Heart sounds regular rate and rhythm. No murmur, rub or gallop appreciated. Bowel sounds are present. Soft, nontender, and obese abdomen. She has no palpable masses. She has good peripheral pulses.

HOSPITAL COURSE: She underwent the above procedure on 10/20/06. She was hemodynamically stable, but did experience postoperative pain and she was referred to the pain service where she received pain control with an epidural. On postoperative day #1, her chest tube was put to water seal and the patient was ambulating with physical therapy. The patient did experience some nausea with the epidural which was relieved with Benadryl and Reglan. The patient's chest tube and epidural were removed on 10/22.06, postoperative day #2. The patient

was then started on oral pain medication and was weaned from her oxygen. She needs OxyContin and oxycodone to control her pain. On 10/23/06, she was very comfortable with no further nausea or pain and was ready for discharge.

DISCHARGE INSTRUCTIONS: Postoperative instructions were given to the patient and she was instructed to follow a diabetic diet. She was asked to follow physical therapy instructions for postoperative activity. She was also given a prescription for rolling walker and hospital bed as she has had some difficulty ambulating and getting out of bed with her arthritis, cervical fusion and some weakness postoperatively. She was also instructed that she would receive a home health nurse that would see her. The patient was also instructed that she has an appointment in 2 weeks. She is to have a chest x-ray done at 10:30 and her appointment with the surgeon is at 11:30 that same day.

DISCHARGE MEDICATIONS: Metoprolol 50 mg twice a day, Accupril 40 mg once daily, Xanax 0.5 mg twice a day, OxyContin 20 mg twice a day, Glucotrol 5 mg once daily, Prilosec 20 mg once daily, Colace 100 mg twice a day, Skelaxin as she was taking at home, Reglan 10 mg 4 times a day, and oxycodone 5 mg 1-2 tablets by mouth every 4 hours as needed for pain.

OPERATIVE/PROCEDURE REPORT
10/20/2006

PREOPERATIVE DIAGNOSIS: Right upper lobe adenocarcinoma.

POSTOPERATIVE DIAGNOSIS: Right upper lobe adenocarcinoma.

PROCEDURE: Right thoracotomy, right upper lobectomy, mediastinal lymphadenectomy.

ANESTHESIA: General.

ESTIMATED BLOOD LOSS: 100 cubic centimeters.

INDICATIONS: This 42-year-old woman was found to have a nodule in her right upper lobe. This was biopsied and was positive for adenocarcinoma. She underwent bronchoscopy and mediastinoscopy and there was no evidence of endobronchial lesions or mediastinal lymph node metastasis. She now requires right upper lobectomy. She quit smoking two months ago.

FINDINGS: During thoracotomy, there were no pleural, pericardial or diaphragmatic abnormalities. The mass was palpated in the posterior segment of the right upper lobe and was approximately 1.5 cm in diameter and firm. There was some puckering of the pleural surface on the fissural side, overlying the nodule. There was no pleural effusion. All lymph nodes visualized were small to moderate in size and anthracotic.

A frozen section of the #7 lymph node was sent and was negative for metastasis. The bronchial margin was also negative for tumor.

PROCEDURE: The patient was taken to the operating room and was placed under general anesthesia in the supine position. Double-lumen endotracheal tube was placed. The patient was then placed into the left lateral decubitus position and well padded. The right chest was prepped and draped aseptically. A right posterolateral thoracotomy was performed in the sixth intercostals space. The latissimus dorsi muscle was divided, but the serratus was spared. A small portion of the seventh rib was removed posteriorly. After opening the chest, exploration was performed and described above.

The inferior pulmonary ligament was divided with electrocauterization and a small anthracotic lymph node in the inferior pulmonary ligament was removed and was sent for permanent section. Dissection continued along the posterior hilum to the inferior pulmonary vein and the subcarinal lymph node station was encountered. The subcarinal lymph nodes were dissected and sent for permanent section.

The dissection then continued anteriorly and superiorly until the truncus anterior pulmonary artery and the upper and middle pulmonary veins could be visualized. The upper pulmonary vein was dissected from the surrounding tissue until it could be encircled easily with a 2-0 silk tie. The truncus anterior was then dissected carefully until free circumferentially.

The fissure was then inspected and the branch to the basilar segments was easily visualized and this was dissected proximally. The right middle lobe artery was visualized as was a superior segmental artery. More proximal to this, another superior segmental artery was visualized, but no posterior ascending branch was visualized. Careful dissection was performed in the posterior portion of the major fissure.

A window was created between the junction of the right upper lobe bronchus and the bronchus intermedius until this fissure could be completed with multiple fires of a GIA stapler. After this was performed, a very posterior and high posterior ascending branch was seen coming off the artery, just above the first superior segmental branch. It was dissected until it could be encircled easily with a clamp.

A separate incision was made for the chest tube anteriorly. An endovascular staple was placed through this and the posterior ascending branch of the artery was divided. The truncus anterior was then divided with an endovascular stapler and the superior pulmonary vein was then divided. A small anthracotic lymph node, which had been between the superior pulmonary vein and the truncus anterior, was then dissected.

A window was then created from the fissure above the middle pulmonary artery through the minor fissure. This was divided with a GIA stapler to separate the upper and middle lobes. Some lymphatic tissue and lymph nodes around the right upper lobe bronchus were then dissected until it was free. It was clamped with a TA-30 stapler and there was easy inflation of the middle and lower lobes. The stapler was fired and the bronchus was divided distally. It was sent for frozen section and was negative for tumor.

The pleural cavity was filled with warm water and pressure at 30 cm revealed a very small leak from the midportion of the bronchus. The whole bronchus was then re-closed, leaving the staples intact with interrupted sutures of 4-0 Vicryl. The bronchial stump was again tested and there was no evidence of leak at 30 cm of water pressure. Hemostasis was good.

The right lower paratracheal lymph node station was dissected and only one small lymph node in this area was visualized and removed for permanent section along with some fibroadipose tissue. The inferior portion of the periphrenic fat was grasped and injected with 0.25% Marcaine. Tisseel glue was used to seal over the staple lines and the raw surface areas of the lung. A 28 French chest tube was placed through the anterior chest tube hole and secured with a suture.

The chest was then closed with figure-of-8 #1 Vicryl sutures around the ribs. The lung was inflated and filled the space. The muscle was closed with 0 Vicryl, subcutaneous tissues with 2-0 Vicryl and the skin with 4-0 subcuticular Vicryl. Benzoin and Steri-Strips were placed.

The patient tolerated the procedure well. There were no complications. All counts were correct at the end of the case.

PATHOLOGY REPORT
10/20/2006

CLINICAL HISTORY: 42-year-old female with history of lung cancer.

SPECIMEN(S) RECEIVED:
A: Lymph node 7
B: Right upper lobe bronchial margin
C: Lymph node 7
D: Lymph node 9
E: Lymph node R4

DIAGNOSIS:
A. Lymph node, 7, excision – no significant pathologic changes.
B. Lung, right upper lobe, lobectomy – adenocarcinoma, moderately differentiated.

Size – 1.0 x 1.0 x 0.6 cm.
Bronchial Margin – Negative.
Visceral Pleural Invasion – Not present.
Lymph/Vascular Invasion – Not present.
Extension Outside of Lung – Not present.
Remainder of Lung – Focal bronchiolitis.

Peribronchial lymph nodes (4), excision – no significant pathologic changes.

PT1 N0 MX

C. Lymph node, 7, excision – no significant pathologic changes.
D. Lymph node, 9, excision – no significant pathologic changes.
E. Lymph node R4, excision – no significant pathologic changes.

INTRAOPERATIVE CONSULTATION: FSA. Lymph node Number 7 – no tumor seen. Reactive lymph node.

GROSS DESCRIPTION: The specimen is received in five parts.

Part A is received in formalin labeled with the patient's name and "lymph node number 7". It consists of a lymph node measuring 1.5 x 0.8 x 0.2 cm. Cut sections reveal pink-tan tissue. The specimen is submitted for frozen section and the remainder is totally submitted in one cassette.

Part B is received in formalin labeled with the patient's name and "right upper lobe bronchial margin". It consists of a right upper lobe measuring 10.0 x 8.0 x 4.0 cm and weighing 120 grams with bronchial margin remnant measuring 0.5 cm in length by 0.9 cm in diameter. The pleural surface appears grossly unremarkable with two stapled surgical margins measuring 5.0 cm and 3.0 cm in length. Cross sections reveal a white firm nodular lesion measuring 1.0 x 1.0 x 0.6 cm. Present 0.2 cm from the pleura and 5.0 cm from the bronchial margin. The remainder of the lung

parenchyma is grossly unremarkable. Close to the bronchial margin there are four lymph nodes varying in size from 0.3 cm to 0.5 cm. Representative sections are submitted as follows:
B1-2 -tumor
B3 -uninvolved parenchyma.
B4 -vascular margin.
B5 -lymph nodes.
B6 -remaining of frozen section of bronchial margin.

Part C is received in formalin labeled with the patient's name and "lymph node number 7". It consists of multiple pieces of red-tan soft tissue measuring in aggregate 2.0 x 1.0 x 0.5 cm and varying size from 0.3 cm to 1.2 cm. Totally submitted in two cassettes.

Part D is received in formalin labeled with the patient's name and "lymph node number 9". It consists of one irregular piece of tissue measuring 2.0 x 1.0 x 0.6 cm. It is bisected. Another piece of brown soft tissue measuring 1.0 x 0.5 x 0.3 cm. The specimen is totally submitted in one cassette.

Part E is received in formalin labeled with the patient's name and "R4 lymph node". It consists of four pieces of modeled yellow to dark soft tissue varying in size from 0.3 cm to 0.6 cm and measuring in aggregate 1.0 x 0.6 x 0.3 cm. Totally submitted in one cassette.

RADIOLOGY REPORT
10/20/2006

EXAM: Chest Frontal Port

HISTORY: A 42-year-old female status post right thoracotomy and right upper lobe resection.

TECHNIQUE: A frontal view of the chest was obtained and compared with 7/30/06.

FINDINGS: There is a new right-sided chest tube. There is volume loss on the right from a right upper lobectomy. There is a tiny right pneumothorax. The lungs are otherwise clear. There is a plate over the lower cervical spine

IMPRESSION: Right-sided chest tube with tiny right apical pneumothorax status post right upper lobectomy.

RADIOLOGY REPORT
10/21/2006

EXAM: Chest Frontal Port

Chest, Frontal Portable, 10/21/06:

CLINICAL HISTORY: The patient is a 42-year-old female status post right thoracotomy with a right chest tube to water seal.

INDICATION: Assess for pneumothorax.

TECHNIQUE: Chest, one view portable. 60-degree AP upright portable film 10/21/06 at 1309 hours.

FINDINGS: Compared to films 10/20/06. Again seen is the single right chest tube in place. There is increased density in the right lung base most consistent with atelectasis. No definite pneumothorax is seen on the right. Some tubing overlies the very apex. Epidural anesthesia catheter is still seen in place. There is a poor inspiratory effort.

IMPRESSION: Increased density in the right lung base most consistent with atelectasis. No definite evidence of pneumothorax after right upper lobectomy.

RADIOLOGY REPORT
10/22/2006

EXAM: Chest Front/Lat

Chest, Frontal and Lateral, 10/22/06:

CLINICAL HISTORY: The patient is a 42-year-old female status post chest tube removal.

INDICATION: Assess for pneumothorax.

TECHNIQUE: Chest, two views. PA and lateral chest on 10/22/06 at 1157 hours.

FINDINGS: Compared to films on 10/21/06, the single right chest tube has been removed. There is evidence of an apical and anterior pneumothorax. An air-fluid level is seen in the anterior pleural space on the lateral film. There is bibasilar linear atelectasis. Surgical clips are noted in the right hilum. The abnormal contour of the right cardiac border is unchanged. In the lower cervical spine, posterior plating devices are seen.

IMPRESSION: Right chest tube removed with evidence of a small right apical and anterior hydropneumothorax.

MEMORIAL HOSPITAL - PATIENT IDENTIFICATION Acsn # |______/_________|

|_____Eng__________________Marylu_______________________________|_____|_____|_____|
Patient Last Name **First Name** **MI** Prefix Suffix

|_______________________| |_999___ - _93__ - _9993____| |_243-12-3456_____|
Maiden Name/Alias SocSec# MR #

Address |_456 Beach Drive____| **County** |_______|

City/**St**|__Xray_______________|_VA__| Zip + 4|22180_|_____| Area Code/Phone #|555__/_333_-_1114_|

PT PERSONAL INFO **Birthdate** |_01__/_01__/_1964__| **Age**|_43__| **Birth Loc** |_999__|

Sex |_2___| **Race** |_99_| **Hisp Orig** |_9__| **Race#2-5** |_99_| |_99_| |_99_| |99__| **Insurance** |_31____|

Spouse Last Name/First Name |_____________________|_______________________|

Occup |____________________________| Indus|____|

Comments

SECONDARY CONTACT Phone |_______/_______-_________| Relation |______|

|_______________________________________| |_______________________________________| |____|
Last Name First Name MI

Address |____|

City|____| St|_______| Zip+4|________________|___________|

DIAGNOSIS IDENTIFICATION **Seq #** |_00__|

Site |_____Right Upper Lobe Lung________________________| Site code |_C341_____|

Histology |_______Adenocarcinoma, md_________________________| Hist code |__8140___|

Behavior |_3___| **Grade** |__2__| Coding Sys Site |CCC| Morph |CCC| Conv flag |CCC|

Laterality |_1_| **Dx Confirm** |_1__| **Rpt Src** |_8_| Casef Src |_20_| Class/Case |_1____|

Supporting Text9/15/06-RUL Lung bx-non-small cell ca. 10/20/06-RUL lobectomy w/ mediastinal LNS-adenoca md, 1.0cm in size, Peribronchial LNS (4) neg for ca. Surgical margins neg.

DATE INIT DX |_09_/_15_/_06_| Admit |____/____/____| D/C |____/____/____|

DX EXT OF DIS CS Tumor Sz (mm) |_01__| **CS Extension** |_10__| CS T Eval |______|

#LN exam |_04__| #LN + |_00__| **CS LN** |_00__| CS N Eval |______|

CS Ver 1st |_______| CS Ver Latest |_______| **CS Mets** |_00__| CS M Eval |______|

CS SS Factors **#1** |_____| #2 |______| **#3** |_____| #4 |_____| #5 |_____| #6 |_____|
C38.4 only C619 only

Sum Stage |_1__| Version |CCC| Derived |CCC|

PT |_____| N |_____| M |_____| Stage |_____| Descrip |____| Staged By |_____| **AJCC Ed** |CCC|

cT |_____| N |_____| M |_____| Stage |_____| Descrip |____| Staged By |_____|

Staging Descrip ____

Date First Course of Treatment |_10___/_20___/__06___| Date Init Rx |_10___/_20___/_06___|

Surgery

Date|10__/_20_/_06_| Surg Prim Site |_33_____| Scope LN |_5__| Other|_0__| Reason No Surg |_0__|

Date|____/____/____| Surg Prim Site |______| Scope LN |_____| Other|_____| Reason No Surg |_____|

Date|____/____/____| Surg Prim Site |______| Scope LN |_____| Other|_____| Reason No Surg |_____|

OTHER TREATMENT

Date |____/____/____| Radiation Sum |_____| Surg/Rad Seq |_______| Reg Rad Rx Modal |_______|

Date |____/____/____| Chemotherapy Sum |____|

Date |____/____/____| Hormone Sum |____|

Date |____/____/____| BRM Sum |____| Other Rx Sum |____| Transpl/Endocr Sum |____|

PHYS SEQ
N = _______________________________

M = _______________________________ Ref From ___________________________________

R = _______________________________ Add ___________________________________

F = _______________________________ Ref To ___________________________________

2 = _______________________________ Add ___________________________________

3 = _______________________________ Comments: ______________________________

PT STATUS Date Last Contact |_10_/_22__/_06__| Vital Stat |_1__| CA Status |_1__| FU Source |_0__|

COD (ICD) |_______| ICD Revision |______|

OVERRIDE FLAGS
Age/Site/Morph |CCC| SeqNo/Dx Conf |CCC| Site/Lat/SeqNo |CCC| Site/Type |CCC| Histol |CCC|

Rept Source |CCC| Ill-def Site |CCC| Leuk,Lymph |CCC| Site/Beh |CCC| Site/Lat/Morph |CCC|

Additional Data
Census Tract |CCC| Cen Cod Sys |CCC| Cen Year |CCC| Cen Tr Cert |CCC|

NHIA Hisp Orig |CCC| IHS link |CCC| Comp Ethn |CCC| Comp Ethn Src |CCC|

Rec Type |CCC| Unique Pt ID |CCC| Reg ID |CCC| NAACCR Rec Ver |CCC|

KEY Data items in **Bold** are required fields Other data items are optional or “advanced surveillance”
|ccc| computed field, no manual input Shaded are optional non-NPCR items