NAME: IMA COLONEL
ADDRESS:
10 MANOR AVENUE
CEA, NV 34567

MRN#: 241-12-3456
ACCT#: 11224400
DOB: 11/01/1930

SSN# 999-91-9991

RACE: B

SEX: F
RELIGION: ATHE
MARITAL STATUS: S

MANAGING MD: DR. C. CATH
DIAGNOSIS: C18.3
PATIENT PHONE# 555-333-1112

EMPLOYER: HSPD BANK

EMPLOYER ADDRESS: CEA, NV

INSURANCE PROVIDER: MEDICARE W/HMO
GROUP #: 999-91-9991

PATHOLOGY REPORT

SOURCE:
A. Esophagus, NOS (esophageal biopsy at 36 cm)
B. Colon, NOS (proximal ascending colon biopsy)

PROCEDURE: Gross and Micro/2, alcian blue, control slide, colon, biopsy, esophagus, biopsy

Pre-op Diagnosis: ABD pain.
Post-op Diagnosis: Barretts; Mass
Surgical Procedure: EGD and colonoscopy

DIAGNOSIS:
A. Esophageal biopsy at 36 cm: Chronically inflamed gastric cardiac type mucosa. No goblet cell metaplasia or glandular dysplasia seen in H&E or Alcian blue stains.
B. Biopsy mass proximal ascending colon: Moderately differentiated, papillary and invasive adenocarcinoma.

GROSS DESCRIPTION:
A. Received in formalin, labeled esoph biopsy 36 cm, are two soft, irregular, tan tissue fragment(s), 0.2 x 0.2 x 0.2 cm and 0.4 x 0.2 x 0.2 cm each. An Alcian blue special stain is performed. The specimen is entirely processed in one cassette(S).
B. Received in formalin, labeled proximal ascending colon biopsy, are three soft, irregular, tan tissue fragment(S), averaging 0.3 x 0.2 x 0.2 cm. The specimen is entirely processed in one cassette(S).

DISCHARGE SUMMARY

FINAL DIAGNOSIS:
1. Right colon cancer
2. Cholelithiasis
3. Incarcerated parastomal hernia

ADMITTING DIAGNOSIS:
1. Right colon cancer
2. Cholelithiasis
3. Incarcerated parastomal hernia

PRINCIPAL PROCEDURES:
Partial right colectomy, primary repair of incarcerated parastomal hernia, open cholecystectomy.

CLINICAL COURSE:
The patient was admitted through same day surgery, prepared for, and taken to the operating room where the above named procedure was performed without difficulty. Postoperatively, she initially did well and was transferred to the surgical floor. She had no postoperative symptoms or signs of infection and had the usual resolution of a postoperative ileus. She was tolerating activity and diet well and only had difficulty with some brief supraventricular tachycardia which intermittently initially converted to atrial fibrillation. With aggressive medical management, she was converted back into sinus rhythm and her medications were adjusted appropriately. Then in physical and occupational therapy, she had a spontaneous event with altered level of consciousness which was felt to represent a transient neurologic event. She had a very profound initial change in her neurologic examination and was transferred to the intensive care unit. Neurology consultation was obtained, and she was evaluated with CT scan as well as MRI scan and appropriate vascular studies. Neurologically, she then responded very nicely and regained her preoperative level of consciousness. She progressed and was transferred to the regular surgical floor. She again tolerated a diet and was progressing well in physical therapy. She was thought by therapy to be a good candidate for the rehab center. She was transferred to the rehab unit in stable condition.

HISTORY & PHYSICAL

CHIEF COMPLAINT: Colon cancer

HISTORY OF PRESENT ILLNESS:
The patient is a 76-year-old female who recently underwent colonoscopy for the evaluation of anemia which revealed a cecal carcinoma. The patient also underwent CT scan evaluation which showed cholelithiasis and a parastomal hernia. She was actually aware of the parastomal hernia and states it occurred relatively soon after her previous surgery.

PAST MEDICAL HISTORY:
She has chronic essential hypertension and urinary tract infections.

MEDICATIONS: Iron

ALLERGIES: No known drug allergies

SOCIAL HISTORY: The patient has no significant history of ethanol or tobacco use.

FAMILY HISTORY: Positive for coronary artery disease but negative for hypertension, diabetes and cancer.

REVIEW OF SYSTEMS: The patient denies any recent illnesses.
HEENT: Head, the patent denies headaches. Eyes-The patient wears glasses and denies any acute visual changes. Ears-Patient is hard of hearing and wears hearing aids. Nose-Patient denies rhinorrhea. Throat-Patient denies sore throat.
Neurologic: Patient denies dizziness or history of syncope, seizures, strokes or amaurosis fugax.
Respiratory: Patient has mild exertional dyspnea although none at rest. She denies orthopnea, cough or history of hemoptysis.
Cardiovascular: Patient denies chest pain, pressure, squeezing, heaviness or tightness. She does have occasional palpitations.
Breasts: The patient denies new or changing masses, skin changes, nipple discharge, or significant mastalgia.
Gastrointestinal: The patient denies nausea, vomiting, diarrhea, constipation, hematochezia, melena or heartburn. Her stools are dark since taking iron. She irrigates her colostomy every morning.
Genitourinary: The patient denies dysuria or hematuria or any change in her chronic 2x per night nocturia.

PHYSICAL EXAMINATION:
General Appearance: Temperature 98.7, heart rate 64, respirations 12, blood pressure 144/66. She is a well developed, thin 76-year-old white female in no acute distress.
HEENT: Head is normocephalic, atraumatic. Eyes-Pupils are equal, round and reactive to light. Extraocular motions are intact. Sclerae are anicteric. Nose and throat are clear. She has upper and lower dentures.

Neck: Supple and nontender with no JVD, carotid bruits, adenopathy, thyromegaly or thyroid nodularity.
Back: No costovertebral angle tenderness.
Chest: Symmetric. Respirations are clear to auscultation throughout.
Cardiovascular: S1 and S2, regular rate and rhythm without rubs, gallops, or murmurs.
Abdomen: Flat, soft and non tender with no hepatosplenomegaly or fluid wave. She does have a palpable, minimally tender, soft, right lower quadrant mass and an obvious peristomal hernia. There is a midline scar.
Extremities: Trace edema on left side worse than right. Pulses are palpable. Range of motion is intact.
Neurologic: The patient is alert and oriented times three. Cranial nerves II-XII are grossly intact. There are no obvious focal, motor or sensory deficits.
Integument: Cool, dry and without focal lesions.
Lymphatics: There is no evidence of cervical, supraclavicular or inguinal adenopathy.

Impression:
1. Cecal cancer
2. Parastomal hernia with small bowel incarceration
3. Cholelithiasis.

Plan: Partial right colectomy, repair of incarcerated parastomal hernia. Possible cholecystectomy.

OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Cecal cancer, cholelithiasis, incarcerated peristomal hernia.

POSTOPERATIVE DIAGNOSIS: Cecal cancer, cholelithiasis, incarcerated peristomal hernia.

OPERATION: Right hemicolectomy, cholecystectomy, primary repair of peristomal hernia

ANESTHESIA: General endotracheal anesthesia

INDICATIONS: The patient is an 76-year-old white female recently diagnosed with cecal cancer causing anemia. She is also known to have cholelithiasis and a large peristomal hernia from her left sided colostomy with incarcerated small bowel loops. She presents for surgery on that basis.

PROCEDURE: The patient was brought to the operating room suite and placed on the operating room table in the supine position. After the adequate induction of general endotracheal anesthesia, she was prepped and draped in the usual sterile fashion. The abdomen was opened in the midline using a scalpel #10 blade. Adequate hemostasis was easily achieved using Bovie electrocautery. Bovie was used to dissect through the thin subcutaneous tissue and through the atrophic fascia in the midline. Previous Prolene sutures were removed. Lysis of adhesions was performed to free up the small bowel loops, the omentum, and the colon from all of the dense adhesions to the anterior abdominal wall. The abdomen was explored showing no evidence of wide spread metastatic disease. The colon tumor was in the mid ascending colon and it was easily palpable. The right colon was reflected from its lateral peritoneal attachments along the white line of Toldt using Bovie electrocautery. The terminal ileum was transected using a GI-75 stapler. The transverse colon was transected to the right of the middle colic vessels also using a GI-75 stapler. The right mesocolon was divided using standard clamp, cut and tie technique with 2-0 Vicryl ties. The right colon vessels were taken proximally. The right ureter was visualized and kept well posterior. The duodenum was also kept well posterior. The specimen was sent to pathology for examination.

Next, the cholecystectomy was performed by taking the gallbladder adhesions down using Bovie electrocautery. After the adhesions were taken down, the gallbladder was dissected from a dome down direction using Bovie electrocautery. The cystic artery and cystic duct were individually ligated with 2-0 Vicryl and divided. The specimen was sent to pathology for examination.

Reanastomosis was then performed in standard side to side functional end to end fashion between the remaining ileum and the transverse colon using a GIA-75 stapler. The open end was closed using a linear 60 stapler. The anastomosis was reinforced at the angle of Sorrows and along the end of the crotch using Lemberting seromuscular sutures of 3-0 silk. The mesenteric defect was closed using running simple locked 2-0 Vicryl. Perfect hemostasis was noted. Next, the large peristomal hernia was dissected circumferentially using Bovie electrocautery as well as sharp dissection. The multiple loops of small bowel that were adhesed within the hernia sac and adhesed to the end of the colon were taken down. The portion of the hernia sac that reflected along the parietal peritonium was excised. The visceral peritoneal level was not completely

dissected due to fear of injury to the atrophic appearing colon. The defect was then repaired using a running simple locked suture of #0 Prolene. The mesocolon was also tacked to the abdominal wall using 3-0 Vicryl. Perfect hemostasis was noted. The abdomen was copiously irrigated with sterile saline solution. Adequate hemostasis was noted. The position of the nasogastric tube was confirmed within the stomach. The abdomen was then closed in layers. A running simple suture of #1 looped PDS was intermittently reinforced with figure of eight sutures of #0 Prolene. After excellent approximation of fascial edges was complete, the subcutaneous space was copiously irrigated with sterile saline solution. Adequate hemostasis was noted. The subcutaneous tissue was reapproximated with 2-0 Vicryl. The skin incision was closed using staples. After excellent approximation of skin edges was complete, the wound was cleansed with sterile saline solution. A dry sterile dressing was placed in addition to a coloscopy appliance. The patient tolerated the procedure well with insignificant blood loss and was transferred postoperatively to the recovery area in stable condition. All sponge, instrument and needle counts were correct times two at the conclusion of the case.

PATHOLOGY REPORT

SPECIMEN: Gallbladder, small bowel, hernia sac

SURGICAL PROCEDURE: Right hemicolectomy, repair parastomal hernia, cholecystectomy

DIAGNOSIS:
Gallbladder, small bowel, and hernia sac:
Right colon: Hemicolectomy including cecum, ascending and proximal transverse colon and portion of terminal ileum:
Cecum with moderately well differentiated colonic adenocarcinoma invading into the muscularis propria with focal mucinous features (less than 10%) with foci of poorly differentiated adenocarcinoma (20%) and numerous foci of angiolymphatic invasion with 13 negative lymph nodes and negative margins (proximal, distal, and circumferential).
Unremarkable bowel trimmings.

Gallbladder: Chronic cholecystitis with cholelithiasis

Hernia sac: Focally degenerated fibrofatty and fibrocollagenous tissue with a mesothelial lining consistent with hernia sac.

Gross Description:
Received in formalin labeled gallbladder, small bowel, hernia sac, is first a 4.8 x 2.7 x 1.3 cm gallbladder having a 0.5 x 0.4 cm diameter cystic duct and no adjacent cystic duct lymph node. The serosa is congested gray purple with scattered petechia and focal green staining of the serosa. The lumen contains a residual amount of green to yellow brown semi viscid bile and a single, finely granular, intact 1.0 x 0.7 x 0.7 cm cholelith demonstrating a crystalline, centrally green brown to peripherally black core. The mucosa is velvety, amber to red brown and without gross lesions. The wall thickness averages 0.2 cm.

Second received, is a 6.0 x 2.0 x 0.3 cm saccular portion of pink amber to yellow brown focally bile stained fibromembranous and fibrofatty soft tissue having a smooth gray pink lining without gross lesions. Additionally, there is a 17.5 x 2.7 x 0.7 cm roughly rectangular sheet of yellow amber lobulated omental fat, which demonstrates no gross lesions on palpation or sectioning at half centimeter intervals.

Third received, is a 19.5 cm right hemicolectomy specimen consisting of 2.5 cm of terminal ileum, cecum without an identifiable appendix, ascending, and proximal transverse colon with moderate amounts of mesenteric, and pericolic fat and small amount of omental fat. Within the cecum/proximal ascending colon, is a palpable 7.0 cm mass. The specimen is opened revealing a well circumscribed 6.5 x 3.6 x 2.0 cm red brown polypoid exophytic tumor, measuring 2.0 cm distal to the ileocecal valve. The adjacent colonic mucosa is pink tan and partially flattened, but still maintaining the typical mucosal plicated pattern. No additional gross mucosal lesions are identified. Sectioning through the tumor does grossly show involvement to the underlying muscularis with focal extension into the adjacent mesenteric/pericolic fat, which contains 13 pink to gray tan lymph nodes varying from 0.3 to 0.7 cm.

Lastly received, is a 3.0 x 2.8 x 0.8 cm annular portion of brown, congested, and focally hemorrhagic mucosa lined rubbery soft tissue, consistent with bowel trimmings. Gross photographs are taken. Representative sections are processed in fourteen cassettes.

SECTION SUMMARY:
A1-Gallbladder
A2-Hernia sac and omental fat
A3-Hemicolectomy margins
A4-Ileocecal valve
A5-6-Sections from tumor and adjacent mucosa to include circumferential margin
A7-Tumor and adjacent proximal mucosa
A8-Tumor and adjacent distal mucosa
A9-Representative distal mucosa away from the tumor
A10-Lymph nodes from apex of mesenteric root
A11-Lymph nodes progressing along the mesenteric root toward the colon
A12-13-Peritumoral lymph nodes
A14-Bowel trimmings

MICROSCOPIC DESCRIPTION:
Microscopy performed.

CHECKLIST
Checklist for colo-rectal tumors.

T2 N0 MX
Type: Adenocarcinoma
Location: Cecum
Histologic grade: 2 with foci of grade 3 (20%)
Tumor size: 6.5 x 3.6 x 2.0cm
Depth of invasion/modified Dukes Stage (Astler-Coller, 1954): B1: involves muscularis propria (not penetrated)

Margins: Free

Checklist:
Accompanying polyp(S): no
Peritumoral angiolymphatic invasion: yes
Extramural venous invasion: No
Perineural invasion: no
Conspicuous peritumoral lymphocytic response: no
Perforation: no
Lymph node(S): 0 positive nodes of a total of 13 nodes

GASTROENTEROLOGY REPORT

INDICATION(S): Anemia

POSTPROCEDURE DIAGNOSIS:
1. Large ulcerated mass occupying 2/3 of the luminal circumference, fungating. Multiple biopsies obtained from the proximal ascending colon.
2. Diverticulosis moderate severity
3. Status post sigmoid resection with colostomy

PROCEDURE TECHNIQUE:
Informed consent was obtained after explaining the indications, the risks including perforation, bleeding, phlebitis, and medication reaction.

MEDICATIONS: The patient was presecated for upper endoscopy

The Olympus video colonoscope was advanced to the cecum, which was identified by the ileocecal valve, appendiceal orifice and the cecal strap. There was a large fungating mass ulcerated with mild oozing occupying 2.3 of the luminal circumference in the proximal ascending colon. Multiple biopsies were obtained. Diverticular disease of the distal colon was noted. The patient tolerated the procedure without any complications.

RECOMMENDATIONS:
Follow up biopsy results
CT of the abdomen and pelvis
CEA level
Further recommendations accordingly

MEMORIAL HOSPITAL - PATIENT IDENTIFICATION Acsn # |_____/_____|

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

|_____| |_999__ - _91_ - __9991___| |___241-12-3456_____|
Maiden Name/Alias SocSec# MR #

Address |_____10 Manor Avenue_____| **County** |_____|

City/**St**|____Cea_____|_NV__| Zip + 4|_34567_|_____| Area Code/Phone #|_555_/_333_-_1112__|

PT PERSONAL INFO **Birthdate** |_11_/_01__/_1930___| **Age**|_76_____| **Birth Loc** |_999____|

Sex |_2_| **Race** | 02__| **Hisp Orig** |_9__| **Race#2-5** |_88_| |_88_| |_88_| |_88_| **Insurance** |_61_____|

Spouse Last Name/First Name |_____|_____|

Occup |___nr_____| Indus|___Banking_____|

Comments

SECONDARY CONTACT Phone |_____/_____-_____| Relation |_____|

|_____| |_____| |____|
Last Name First Name MI

Address |_____|

City|_____| St|_____| Zip+4|_____|_____|

DIAGNOSIS IDENTIFICATION **Seq #** |_00__|

Site |_____Colon Cecum_____| Site code |___C180_____|

Histology |_____Adenocarcinoma_____| Hist code |_8140_____|

Behavior |__3___| **Grade** |___2__| Coding Sys Site |ccc| Morph |ccc| Conv flag |ccc|

Laterality |_0__| **Dx Confirm** |_1__| **Rpt Src** |_8__| Casef Src |_20___| Class/Case |__1__|

Supporting Text-Rt hemicolectomy mod well diff adenoca of the cecum measuring 6.5cm in size invading into but not through the muscularis propria. Thirteen pericolonic lymph nodes neg for ca.

DATE INIT DX |99_/99/_99| Admit |____/____/____| D/C |____/____/____|

DX EXT OF DIS CS Tumor Sz (mm) |_065 **CS Extension |_20__|** CS T Eval |_____|

#LN exam |_13__| #LN + |_00__| **CS LN |_00__|** CS N Eval |_____|

CS Ver 1st |_____| CS Ver Latest |_____| **CS Mets |_00__|** CS M Eval |_____|

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

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 |_99___/_99___/___99__| Date Init Rx |__99__/__99__/_99____|

Surgery

Date|_99_/_99_/_99_| Surg Prim Site |_40__| 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 |_99__/_99/_99__| Vital Stat |_1__| CA Status |_1__| FU Source |_9___|

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