CONTAINS PROTECTED HEALTH INFORMATION - HANDLE ACCORDING TO MSKCC POLICY

MEMORIAL HOSPITAL FOR CANCER AND ALLIED DISEASES
OUTPATIENT PROGRESS RECORD

NAME:	LOPEZ ,MAILET	MRN:	████
DATE:	06/06/2008	SERVICE:	MEDMER
ATTENDING:	████	ATT MD NO:	████

INITIAL CONSULTATION

LOCATION: MERCY, ROCKVILLE CENTRE
DIAGNOSIS: Breast cancer. STAGE: IIB.

HISTORY OF PRESENT ILLNESS: The patient is a 34-year-old, premenopausal female, who noted a mass in the upper outer quadrant of her right breast in 02/2008. This was confirmed by her gynecologist, and mammogram demonstrated an asymmetric density in the right upper quadrant corresponding to the palpable area. Bilateral MRI demonstrated a 4cm, abnormal enhancement in the right upper quadrant corresponding to the site of known tumor with a suggestion of muscle infiltration. The left breast was normal.

A PET/CT showed increased uptake in the lateral aspect of the right breast and in the right axilla, but otherwise there were no suspicious areas of metastatic disease. An ultrasound-guided biopsy was performed on 04/10/08 that demonstrated invasive ductal carcinoma, poorly differentiated. On the biopsy, the estrogen receptor was positive, the progesterone receptor was negative, and HER- 2/neu was negative (Mineola Laboratories, specimen # ████). The patient then underwent a right axillary lymph node biopsy that also confirmed invasive ductal carcinoma, NOS type, poorly differentiated, involving fibroadipose tissue, and morphologically similar to the prior specimen (MSK ████ ████).

On 04/25/08, the patient underwent a right lumpectomy that demonstrated invasive ductal carcinoma, NOS type, histologic grade III/III, nuclear grade III/III, measuring 2cm in largest dimension microscopically. Ductal carcinoma in situ was also identified, solid type, with intermediate nuclear grade and minimal necrosis. There was glandular involvement by DCIS. The DCIS constituted less than or equal to 25% of the total tumor mass. Vascular invasion was present. Invasive carcinoma extended to the posterior margin. Skeletal muscle was negative. One out of five level I lymph nodes was positive by carcinoma, and it measured 2.5 cm in diameter. There was perinodal extension, 2mm, and two out of 16 level II lymph nodes were positive for carcinoma. Of note, on this specimen, estrogen receptor stain was 0, progesterone receptor stain was 0, and HER-2/neu was 1+/- (S08-17839). The patient has already had four oocytes harvested through her gynecologist, and one more cycle of harvesting is planned. She is feeling well and recovering from surgery well.

PAST MEDICAL HISTORY: Uterine fibroid recently demonstrated, 4cm. The

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	inguinal regions.
HEART:	Regular rate and rhythm. S1, S2. No murmurs, rubs, or gallops.
LUNGS:	Clear to auscultation and percussion.
ABDOMEN:	Soft, nontender. No hepatosplenomegaly.
EXTREMITIES:	No clubbing, cyanosis, or edema.
NEURO:	Alert and oriented x3. Cranial nerves II-XII intact. 5/5 strength. Sensory is intact.
GYN/RECTAL:	Examination not performed in light of recent normal examinations.
BREASTS:	Right breast is status post lumpectomy. She is healing well from surgery. There is some residual edema, consistent with postoperative changes. In the left, there are some shotty lymph nodes in the left axilla, but no pathological enlargement clinically.

LABORATORY TESTS: 04/18/08: The patient's CBC was normal. PT/PTT normal. Comprehensive panel including liver function tests within normal limits, including hCG.

IMPRESSION/PLAN: This is a premenopausal female with newly diagnosed right breast, stage IIB, invasive ductal carcinoma. The invasive carcinoma measured 2 cm, and there were three positive lymph nodes. A full axillary lymph node dissection was performed. The patient is status post lumpectomy and will require radiation therapy. Of note, the biopsy originally showed an ER positive cancer, but on the complete excision, it was triple negative.

I had an extensive discussion with the patient regarding her risk of relapse that is approximately 50%. For this reason, I have recommended adjuvant chemotherapy with dose- dense Adriamycin and cyclophosphamide for four cycles to be followed by paclitaxel for four cycles. Chemotherapy will be administered in a dose-dense fashion with Neulasta support.

Following chemotherapy, she will receive radiation therapy and then tamoxifen until she enters menopause for at least five years. She has already had four oocytes harvested and a second cycle of harvesting is planned. This will place the patient to begin therapy in 10 weeks postoperatively. I have asked her to have her infertility specialist contact me regarding the need for a second cycle of egg harvesting, depending on the quality of the four eggs which have already been harvested.

I explained that chemotherapy, with her risk of disease relapse, should not be postponed further than this. The side effects of chemotherapy were reviewed in detail which include, but are not limited to alopecia, leukopenia and the risk of infection, anemia, thrombocytopenia,

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permanent congestive heart failure, permanent peripheral neuropathy, risk of hospitalization, death, and rare secondary leukemia. I provided her with written literature regarding the chemotherapy agents, as well as breast cancer.

This was a one and one-half hour discussion with the patient. She expressed an understanding of the discussion and asked very well-educated questions. The patient also has poor venous access and will require MediPort prior to initiation of treatment. Arrangements will be made for this as well as an echocardiogram prior to chemotherapy initiation.

The patient will be set to begin the first week in July or possibly sooner, depending on GYN as above.

DICT: PD 06/06/2008

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