CM Results Viewer

last refresh: 12:58

Report for Daly, Colleen (MRN: 0290970)

Results List Select All Tests Check 10 on All Selected

Check 10 on Selected Components for CTS ABD-PELVIS W CONTRAST

TEST: CTS ABD-PELVIS W CONTRAST

Collected Date & Time: 08/27/13 12:13

Result Name	Results	Units	Reference Range
CTR ABD-PELVIS W CONTRAST	(..)		

CT CHEST, ABDOMEN AND PELVIS, AUGUST 27, 2013

CLINICAL INDICATION- Breast cancer. Pulmonary nodule.

TECHNIQUE- Multiple axial CT images of the abdomen and pelvis are obtained from the lung bases to the level of the adrenal glands following 99 cc Omnipaque 350 intravenously. Oral contrast was also administered. Coronal reformatted images were generated from the axial data.

COMPARISON- None.

FINDINGS- There is a 5 mm pulmonary nodule in the left lower lobe series 3, image 38. There is a 5 mm pulmonary nodule right middle lobe series 3, image 43. There is nodular density right middle lobe series 2, image 38 which measures approximately 3 mm. No other pulmonary nodules are appreciated.

There is nodularity in the left lobe of the thyroid gland. There is no axillary, mediastinal or hilar lymphadenopathy. There is no pleural or pericardial effusion. Heart and great vessels enhance normally.

ABDOMEN- The liver enhances homogeneously. No focal hepatic mass is appreciated. the gallbladder has been surgically removed. The pancreas enhances normally. There is no intra or extrahepatic biliary dilatation. There is no splenomegaly. Bilateral adrenal glands are within normal limits. The kidneys enhance bilaterally. There is no hydronephrosis, renal mass or stone. There is no acute inflammatory change of bowel in the abdomen.

PELVIS- The bladder is distended and thinned wall. There are numerous hypoattenuating densities within the uterus. The right ovary is prominent. There is no gross adnexal mass. There is no pelvic lymphadenopathy or free fluid. There is colonic diverticula with no CT evidence of diverticulitis.

Numerous lytic lesions are identified within the spine. This includes a lytic lesion associated with the left aspect of the left 5th thoracic vertebral body measuring 1.4 x 1.5 cm, series 2, image 29. There is a lucency in the right lateral aspect of the 6th thoracic vertebral body measuring a centimeter in diameter, series 2, image 33. In the T7 vertebral body, series 2, image 38, there is a 1.0 x 1.0 cm lytic lesion. At T11 there is a lytic lesion right aspect of the thoracic vertebral body, series 2, image 42 which measures 1.1 x .8 cm. There are two lytic lesions at T12, series 2, image 52, one anteriorly and one left aspect of the posterior vertebral body which measures 1 cm. The more anterior lesion measures 1.1 cm. There is a lytic lesion at L1 anteriorly, series 2, image 58 which measures 1.2 cm in diameter. A lytic lesion identified in the L1 vertebral body, series 2, image 61 with a corduroy type appearance which measures 9 mm. In the L2 vertebral body there is subtle lucency series 2, image 72, which measure approximately 4 mm. At L2, image 74 there is a 6 mm lucency. The L5 vertebral body demonstrates a few lucencies most prominent, series 2, image 93 which measures approximately 6 mm. Within the sacrum, series 2, image 97 there is a lytic lesion which measures 1.1 cm in diameter. There is an area of sclerosis in the right sacrum, series 2, image 99, which measures 1.3 cm in diameter.

IMPRESSION-

Right middle lobe and left lower lobe nodular densities which are non-specific. Recommend direct comparison with prior outside imaging.

Additionally a smaller nodular density seen in the right middle lobe which is also non-specific. Recommend comparison with outside studies to entirely exclude metastatic disease.

No thoracic, abdominal or pelvic lymphadenopathy.

Numerous osseous lesions in the axial skeletonworrisome for metastasis. Consider whole body bone scan for further evaluation.

Numerous masses within the uterus which are non-specific and may be related to uterine myoma.

Prominent right ovary. No definitive mass is appreciated. However, consider evaluation with pelvic ultrasound to exclude underlying mass.

Colonic diverticulosis. No CT evidence of diverticulitis.

Preliminary findings were discussed with Dr. Langella at 3-18 p.m., August 27, 2013.

This is a preliminary report unless designated "FINAL" at the bottom of the report and authenticated by the interpreting physician.

TMF-mw

LOCATION- PED

Read By- TANYA FIELDS MD

☑	Read By	TANYA FIELDS MD
☑	Released By	TANYA FIELDS

Other Clinicians who have viewed this Result in Portal or Rounding

Results List Select All Tests Check 10 on All Selected

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Electronic Medical Interpretation

REPORT

THERMOGRAPHY.

EMI Inc.
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Ronald I Blum
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Israel Posner
MD

John Ward
MD

Karen Pendleton
MD

John Bartone
MD

Ken Fernandez-Taylor
MD

Thomas Hudson
MD

Patient: Colleen Daly
Date of Birth: 03/29/1951
Patient ID: 156007
Referring Practitioner: self referred
Reported By: Bryan Cotton MD

Scan Date: 10/8/2013
Report Ref: 290467
Report Type: ROI + Breast
Thermographer: Janique Cook

All normal protocols were observed

HISTORY AND SUBJECTIVE COMPLAINTS:

Previous surgeries include: breast reduction in 2003; tubal ligation in 1981; gall bladder removal in 2003. Ms. Daly was diagnosed with invasive lobular breast cancer in the right breast in August 2013. Sharp pain in the right breast prompted her visit to the doctor and a biopsy confirmed breast cancer. Initially her right breast become very hard, pointed down, and the nipple inverted. Since she began taking Chinese herbs since her diagnosis her breast has softened, returned to almost normal shape, and the nipple is coming out. She has no current pain or symptoms in the right breast. She does however experience and aching pain on the left lateral side of the rib area below the left axilla and just past the left breast. Lying on back or on left side aggravates the pain. Standing relieves it. She feels indigestion may have triggered the pain. She currently experiences constipation, indigestion, and burping despite being on a very healthy diet.

Small tumors were also detected in her spine via CT scan in August 2013. The report reads:

There is a lucency in the right lateral aspect of the 6th thoracic vertebral body measuring a centimeter in diameter. In the T7 vertebral body there is 1.0 x1.0 cm lytic lesion. At T11 there is a lytic lesion right aspect of the thoracic vertebral body which measures 1.1 x.8 cm. There are two lytic lesions at T12, one anteriorly and one left aspect of the posterior vertebral body which measures 1cm. The more anterior lesion measures 1.1 cm. There is a lytic lesion at L1 anteriorly which measures 1.2 cm. A lytic lesion identified in the L1 vertebral body with a corduroy type appearance which measures 9mm. In the L2 vertebral body there is a subtle lucency which measure proximately 4mm. At L2 there is a 6 mm lucency. The L5 vertebral body demonstrates a few lucencies most prominent which measures approximately 6 mm. Within the sacrum there is a lytic lesion which measures 1.1 cm. There is an area of sclerosis in the right sacrum, which measures 1.3 cm.

Impression:

Right middle lobe and left lower lobe nodular densities which are non specific. Additionally a smaller nodular density seen in the right middle lobe is also non specific. Recommend comparison with outside studies to entirely exclude metastatic disease. No thoracic, abdominal, or pelvic lymphadenopathy. Numerous osseous lesions in the axial skeleton worrisome for metastasis. Consider whole body bone scan for further evaluation. Numerous masses within the uterus which are non specific and may be related to uterine myoma. Prominent right ovary. No definitive mass is appreciated. Consider evaluation with pelvic ultrasound to exclude underlying mass. Colonic diverticulosis. No CT evidence of diverticulitis.

She's had a tarlov cyst at the tip of her sacrum for many years. She took bio identical hormones for 10 years but stopped when she was diagnosed. She feels better than ever since she's made major dietary improvements and taking herbs since her diagnosis.

To Delamiers 6 pages
FAXED
10-24-13

follow-up t .nal study in 3 months should be part of a c. prehensive testing panel.

At high Risk (Suspicious)
This represents a high risk of confirming malignant breast disease. Benign processes or personal variant are very unlikely. Urgent clinical correlation is indicated with a comprehensive panel of testing and evaluation with all possible alacrity. A follow-up thermal study in 3 months should be a part of this evaluation.

Previously Confirmed Malignancy
This represents a current diagnosis of malignant pathology in the patients history. Thermography will not show any cancers from a structural or pathological perspective. It will show positive physiological findings in 83% of malignancy (specificity), leaving 17% of cancers that present as thermographically silent due to the type of pathology, long term cancer which the body has accommodated or encapsulation and age of patient. The utility for including thermography as an adjunctive screening test in previously confirmed malignancy is for the establishment of a baseline and detection of any physiological change over time, correlation with other tests and the monitoring of response to treatment. Breast thermography screening is an adjunctive test to mammography, ultrasound and MRI and is a specialized physiological test designed to detect angiogenesis, hyperthermia from nitric oxide, estrogen dominance, lymph abnormality and inflammatory processes including inflammatory breast disease, all of which cannot be detected with structural tests. Follow-up and interval screening of less than 12 months should be determined by patients healthcare professional as considered appropriate.

PROCEDURE:
This patient was examined with digital infrared thermal imaging to identify thermal findings which may suggest abnormal physiology.

Thermography is a physiologic test, which demonstrates thermal patterns in skin temperature that may be normal or which may indicate disease or other abnormality. If abnormal heat patterns are identified relating to a specific region of interest or function, clinical correlation and further investigation may be necessary to assist your health care provider in diagnosis and treatment.

Thermal imaging is an adjunctive test, which contributes to the process of differential diagnosis, and is not independently diagnostic of pathology.

Breast thermography is a way of monitoring breast health over time. Every woman has a unique thermal pattern that should not change over time, like a fingerprint. The purpose of the two initial breast studies (usually obtained three months apart) is to establish the baseline pattern for each patient to which all future thermograms are compared to monitor stability. With continued breast health, the thermograms remain identical to the initial study. Changes may be identified on follow up studies that could represent physiological differences within the breast that warrant further investigation.

The ability to interpret the first breast study is limited since there are no previous images for comparison.

This exam is an adjunctive diagnostic procedure and all interpretive findings must be clinically correlated. DITI is not a substitute for mammography.

PROTOCOLS:
The thermographer certifies that this exam was conducted under standard and clinically acceptable protocols.

PATIENT HISTORY:

DALY, COLLEEN M. 03/29/1951
Office/Outpatient Visit
Visit Date: Fri, Oct 18, 2013 12:20 pm
Provider: Rosa Langella, M.D. (Supervisor: Rosa Langella, M.D.; Assistant: Misty Davis)
Location: North Georgia Breast Center

Electronically signed by Rosa Langella, M.D. on 10/18/2013 05:07:23 PM
Printed on 10/18/2013 at 5:07 pm.

SUBJECTIVE:

CC: slight back/rib soreness

HPI: This is a 62 year old female who who was recently diagnosed with metastatic right breast cancer to her spine and is persuing non traditional treatment. She presents today to discuss how she is doing and her latest physical/medical developments.

She no long is taking the aromatase inhibitor as of 2-3 weeks ago because of the side effects (hot flashes and sleep disturbances). She has been able to completely come off of the hormone replacement therapy, however.

She continues to have some rib cage pain bilaterally at the level just below her breasts. The pain in her mid thoracic spine has just about gone away.Other than some "reflux" symptoms she denies any new systemic complaints. She denies any new masses, skin changes, and nipple discharge.

ROS:
CONSTITUTIONAL: Negative for fatigue, unintentional weight gain and unintentional weight loss.
EYES: Negative for blurred vision.
E/N/T: Negative for diminished hearing.
CARDIOVASCULAR: Negative for chest pain and dizziness.
RESPIRATORY: Negative for dyspnea.
GASTROINTESTINAL: Positive for **acid reflux symptoms (she has contacted a gastroenterologist for an endoscopy) and belching**.
GENITOURINARY: Negative for frequent UTI's.
MUSCULOSKELETAL: Positive for **slight mid back soreness, some bilateral rib pain below level of her breasts**.
INTEGUMENTARY/BREAST: Positive for **performance of self breast exams**. Negative for breast mass, skin changes of breast, breast tenderness or nipple discharge.
NEUROLOGICAL: Negative for ataxia and headaches.
ENDOCRINE: Positive for **hot flashes (infrequent)**.
ALLERGIC/IMMUNOLOGIC: Negative for frequent URI-type illnesses.
PSYCHIATRIC: Negative for anxiety, depression and feelings of stress.

Past Medical History / Family History / Social History:
Past Medical History:

GYNECOLOGICAL HISTORY:
G4 P2 Ab2
Menarche occurred at age 16.
Menopause at age 51.
Last mammogram was 04/2011

BREAST CANCER HISTORY:

STAGE iV, T3N1M==>bone, invasive lobular. Right breast cancer in the LIQ dx by us core. diagnosed on 08/2013 (PATHOLOGY===> 5.5 cm by MRI, low grade, low risk oncotype, ER/PR >90/>90% pos, HER-2 neu negative) followed by antihormonal rx ---> Arimadex continued for a total of 4-5 weeks (discontinued this due to intolerable side effects.).

BREAST IMAGING HISTORY

MAMMOGRAM
The patient's most recent mammo was on 08/14/2013. It was performed by PMH.
BIRADS VI, BIOPSY PROVEN CANCER

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BREAST MRI
08/2013 showed > 5cm mass in the LIQ of the right breast. Possible right axillary lymph node involvement.

Surgical History:

Cholecystectomy and
PTCA (Coronary Angioplasty)
Bilateral Breast Reductions 2004

Family History: denies ovarian, breast, colon, uterine, and pancreatic

Social History:
Retired (senior care)
Marital Status: Married
Children: 2 children 5 step-children

Tobacco/Alcohol/Supplements:

Tobacco: She has never smoked.

Supplements: Patient admits to use of "pharmaceutical grade" given to her by her healer.

Allergies:
Morphine Sulfate:

Current Medications:
Dexilant (formerly Kapidex) 60mg Capsules, Delayed Release Take 1 capsule(s) by mouth daily

OBJECTIVE:

Vitals:

Current: 10/18/2013 12:26:25 PM
Ht: 5 ft, 4 in; Wt: 150 lbs; BMI: 25.7
T: 97.6 F (oral); BP: 113/79 mm Hg (right arm, sitting); P: 76 bpm

Exams:

GENERAL: alone in exam room; well nourished; thin build; well groomed; no apparent distress
EYES: no icterus noted
E/N/T: Hearing Screen: grossly normal; Oropharynx: normal mucosa; ;
NECK: thyroid exam: nonpalpable:
RESPIRATORY: normal respiratory rate and pattern with no distress;
CARDIOVASCULAR: no pedal edema;
BREASTS: The patient's right breast is much softer than at our last exam
GASTROINTESTINAL: abdomen nontender; soft and flat
LYMPHATIC: no enlargement of cervical nodes; no supraclavicular, suboccipital, periauricular or other nodes;
MUSCULOSKELETAL: Upper extremity ROM Normal
SKIN: no ulcerations, lesions or rashes
NEUROLOGIC: cranial nerves: grossly normal;
PSYCHIATRIC: Orientation: alert; Mood/Affect: appropriate; Insight/Judgment: fair insight;

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Location: North Georgia Breast Center

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Printed on 10/18/2013 at 5:07 pm.

PROCEDURES:

BREAST ULTRASOUND:

This patient was imaged in real-time using 2-D imaging and a 15 mHz linear transducer. The patient's right breast was scanned. The area of tissue plan disruptiion is not obvious on todays ultrasound.. No other nodularities, tissue plane disruptions or other abnormal findings noted.

IMPRESSION:

1. Right brest cancer, which was difficult to see by US on the last exam, is no longer visible on today's US after a month's worth of antihormonal therapy.
BIRADS VI, BIOPSY PROVEN CANCER.

ASSESSMENT:

1. This is a 62 year old female with Invasive Lobular carcinoma of the right LIQ breast and spinal mets to the mid and lower thoracic vertebrae (T7-9, T11-12) as well as nearly every lumbar vertebra by CT. She has a few questionable areas in her lungs, sacrum, and thyroid gland as well. She says that the lung and sacral lesions are old.
2. The patient has been reticent to standard medical treatment since her diagnosis. But, she did agree to coming off of her hormone replacement and start an Aromatase Inhibitor. She is still not at all interested in seeing a medical oncologist.
3. After just over one month of the Arimadex, the patient had some symptomatic relief of her back pain as well as softening of her right breast. However she had to stop the Arimadex due to side effects.
4. She could not tolerate the aromatase inhibitor (Arimadex) for more than 4-5 weeks due to the severe hot flashes and therefore stopped 2-3 weeks ago.. Today we discussed again that there were multiple other medications she could try that may not be as difficult for her. She is not interested and would like to continue to peruse the non traditional treatment.
6. She and I discussed in detail where the metastatic disease appeared to be. We also discussed the dangers of metastatic disease again including progression into other organ systems, spinal and other fractures.
7. Of note she is having some GI complaints and is planning to have an upper endoscopy for this.
6. She will follow up with me for repeat full body CT scans and a bone density in December per her request.
8. I emphasized to her that she should contact me sooner if she should change her mind about the anti hormonal or a medical oncology consult. She assured me that she would think about this and let me know.

ADDENDUMS:

Addendum: 10/18/2013 05:07 PM - Langella, Rosa L

Visit Note Faxed to:
GALAMBOS, MICHAEL R (Gastroenterology); Number (706)253-7342
JAGO, KENNETH (Family Practice); Number (770)720-3454

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