

## Discharge Summary

Date of Admission: 02/08/2007

Date of Discharge: 02/25/2007

Discharge Diagnosis: Perforated sigmoid adenocarcinoma with involvement of the bladder

Brief History and Hospital Course: The patient is a 56-year-old male admitted with melena and weakness. The patient was noted to be markedly anemic. The patient had melena, urinary urgency and weakness. The patient was admitted and recommended continuing Levaquin. Esophagogastroduodenoscopy was benign. A colonoscopy revealed an obstructing lesion in the sigmoid colon which was biopsied. The patient was given a transfusion at this point. The patient was scheduled for a colectomy. He underwent a preoperative ureteral stent. The patient had no kidney on the left side. A right stent was placed. An exploratory laparotomy was performed and a colectomy and colostomy were performed. The patient had an obstructing lesion with a perforation sealed off against the bladder. Frozen sections suggested this to be a neuroendocrine tumor. An undescended left testicle was also found along the left psoas. This was sacrificed. Multiple frozen sections of the friable tissue against the bladder were sent and read as benign.

Postoperatively, the patient did reasonably well. A nasogastric tube was left. A Foley catheter was left, and a drain was left in place as well. The patient was started on total parenteral nutrition and broad-spectrum antibiotics. The patient was treated for his ileus, and his nasogastric tube was removed on postoperative day #3. The cultures from the abscess against his bladder were *Escherichia coli* which were treated with antibiotics. The Jackson-Pratt drain was removed. At this point, the pathology report came back showing adenocarcinoma which was felt to be colonic and definitely not neuroendocrine. However, the bladder biopsies which were initially read as normal came back on permanent as positive. Summary was stage III colon cancer involving the bladder wall. He recommended adjuvant chemotherapy after removal of a portion of the bladder was performed. The patient was taken on 02/17/2007 for a subtotal cystectomy with bladder augmentation without difficulty. Postoperatively the patient continued to do well. He had a suprapubic catheter and an indwelling Foley. The drains were also left. The patient was continued on total parenteral nutrition and treated for his leukocytosis and anemia. The ostomy nurse was consulted for teaching. The patient developed a temperature up to 103. His central line was removed, and a new line was placed. The patient was started on vancomycin for a nosocomial line infection, possible Methicillin-resistant *Staphylococcus aureus*. This eventually came back sensitive, and he was placed on Ancef. The wicks were removed from his incision on 02/21/2007. He had good bowel function, and his diet was slowly advanced. By later in that same week, two areas of his incision were opened and packed due to superficial wound infections. By 02/25/2007, the patient was doing well. He was tolerating food by mouth. The Foley catheter was removed.

Discharge Medications: The patient was discharged home with Keflex and Percocet.

Consultation  
02/08/2007

Reason for Consultation: Urinary tract infection, elevated prostate specific antigen

History of Present Illness: 56-year-old white male with a 2-week history of urinary frequency, urgency, some suprapubic and penile discomfort, nocturia, increasing to 3-4 times, some rectal pressure and a sense of incomplete emptying. He has also had some intermittent visible blood in his stool and now some melena. He was noted to have an abnormal urinalysis, PSA, and low blood count. He was admitted directly today for a positive GI bleed. The patient has no prior urologic history, no history of UTIs, prostatitis, etc.

Past Medical History: None

Past Surgical History: Herniorrhaphy at age 5

Medications: None

Allergies: Penicillin

Social History: No tobacco, no ETOH

Family History: Negative

Physical Examination: Vital signs: Currently stable. General: Alert, comfortable. Abdomen: Soft, nontender, no masses. Flanks nontender. Genitalia: Unremarkable, no evidence of infection. Rectal: Deferred; it was just performed showing positive melena.

Laboratory Data: On 02/07/2007, white count 12.5, hematocrit 29, urinalysis 12 red cells per high power field, 37 white cells, and moderate bacteria. PSA is 8.6. Laboratory data from 02/08/2007: Creatinine 0.9, hematocrit 26, white cell count 10.5, and a urinalysis 25-50 white cells, 0-2 red cells, few bacteria

Assessment:

1. Gastrointestinal bleed
2. Prostatitis with positive urinary symptoms
3. Positive urinalysis and secondary prostate specific antigen elevation

Plan:

1. Will check culture and sensitivity
2. Start IV Levaquin and then convert to by mouth Levaquin
3. Will follow while the patient is in the hospital
4. The patient should follow up with me in 2 months' time for repeat PSA and DRE examination.
5. I suspect that the prostate specific antigen will subsequently normalize.

Thank you for this consultation.

Operative Report  
02/09/2007

Operative Procedure: Esophagogastroduodenoscopy

Indications: Melenic stool and anemia

Anesthesia: Versed 4 milligrams, fentanyl 100 micrograms were given IV in titrated doses prior to and during the procedure

Monitoring: Continuous oxygen, pulse oximetry, telemetry and Dinamap

Procedure: After informed consent, the patient was placed in the left lateral decubitus position. The Olympus CFV-160 endoscope was introduced into the mouth and advanced carefully under direct visualization through the esophagus, stomach and into the duodenum. It was advanced to the second portion and withdrawn.

Findings:

1. There is no bleeding anywhere.
2. The duodenal bulb and second portion was normal.
3. The antrum was normal. It was carefully inspected and there was no evidence of bleeding site anywhere.
4. The distal esophagus showed erosive esophagitis. The exam was otherwise unremarkable. The endoscope was introduced into the second portion and 1-1/2 ounces of Fleet's Phospho-Soda was placed and put in the portion of the duodenum. The patient tolerated this well, and was taken to recovery in good condition.

Impression: No evidence of ulcer disease, rule out lower GI source of bleeding.

Plan: We will do this with colonoscopy tomorrow.

Consultation  
02/10/2007

Reason for Consultation: Obstructing mass in the sigmoid colon

Impression: Suspect cancer

Plan: Agree with CT scan, bowel prep, and proceed with surgical resection

History of Present Illness: The patient is a 56-year-old male with a 2-month history of malaise and generalized abdominal discomfort. The patient was anemic. He had melena. He had a colonoscopy today which showed an obstructing mass in the distal sigmoid colon.

Past Medical History: The patient's past medical history includes hernia repair at the age of 5

Social History: He drinks occasionally, but does not smoke

Medications: He denies any current medications

Allergies: Penicillin

Review of Systems: He denies shortness of breath, chest pain, or dyspnea on exertion. He does have an elevated PSA.

Physical Examination: Vital signs: Pulse is 96, respiratory rate 20, blood pressure 133/74, 94% room air sat. Head and Neck: No carotid bruits. Chest: Clear to auscultation. Heart: Regular rate and rhythm. Abdomen: Soft, nondistended, nontender. The patient has a fullness in the left abdomen. He has no hepatosplenomegaly.

Laboratory Data: TSH is 2.06. Culture is normal of the urine. His chemistry is essentially normal. His white count is 13,000, hemoglobin as of this morning was 7.8, hematocrit 24.4. He received 2 units of blood earlier today.

Discussion: The patient is a 56-year-old with anemia and an obstructing mass. I suspect cancer. At this point, the patient needs surgery. If the CT scan shows any urologic involvement we will ask his urologist to help, otherwise complete his bowel prep tonight, get hemoglobin greater than 9, proceed with surgery tomorrow.

Operative Report  
02/10/2007

Procedure: Colonoscopy, shortened to sigmoidoscopy because of obstruction colon lesion

Anesthesia: Versed 4 milligrams, fentanyl 125 micrograms were given IV in titrated doses prior to and during the procedure

Monitoring: Continuous oxygen, pulse oximetry, telemetry and Dinamap

Procedure: After informed consent, the patient was placed in the left lateral decubitus position. The Olympus CFV-160 was advanced but could not be passed through a loop of sigmoid at about 20 cm. He has a large fungating mass. Biopsies are obtained. The endoscope was removed. The patient did well.

Impression: Obstructing sigmoid cancer

Plan: The bowel has already been prepped, will get a CT of the abdomen and pelvis, surgical consultation and hopefully deter urgent surgery.

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Pathology Report  
02/10/2007

Clinical History: Rule out carcinoma

Specimen:  
Sigmoid mass biopsies

Gross Description:  
The specimen is labeled with the patient's name and "sigmoid mass biopsies." Received in formalin are several blood-stained tan tissues, 0.6 x 0.6 x 0.2 cm together.

Final Diagnosis:  
Sigmoid colon, biopsy: Villous adenoma with at least focal high-grade dysplasia

Comment: Adenocarcinoma cannot be completely excluded in the superficial biopsy

Operative Report  
02/11/2007

Preoperative Diagnosis: Probable colon cancer, possible attachment to bladder

Postoperative Diagnosis: Probable colon cancer, possible attachment to bladder.  
Neuroendocrine bladder tumor.

Anesthesia: General

Procedure: Cystoscopy, right ureteral catheter placement and subsequent left intra-abdominal testis orchiectomy and posterior bladder wall excision and biopsy

Procedure: After the induction of general anesthesia, the patient was placed in dorsal lithotomy position, prepped and draped in usual sterile fashion. A 22-French cystoscope was passed through the urethra into the bladder. The urethra and prostate were unremarkable. The bladder demonstrated a right ureteral orifice very close to the bladder neck. The posterior bladder wall was significantly edematous with no obvious frank tumor but a 4 cm by 4 cm area of thickened bladder wall with edema cobblestoning. No left ureteral orifice could be found. The patient was given indigo carmine and blue efflux was only from the right known ureteral orifice. Patient was an absent left kidney on CT scan. A stent was placed in the right ureter, that being a 5-French whistle tip catheter, a Foley catheter was placed to gravity drainage and the stent was placed within the catheter. He then began the abdominal portion of the case and called me back to the room as expected to inspect the bladder. He then removed a very large sigmoid colon mass with good margins on both sides. There appeared to be thickened inflammatory reaction stuck to the posterior bladder. He also had found a left undescended testis. Family admitted the patient had a history of a left undescended testis unable to be found surgically as a child. Examination of the scrotum intraoperatively demonstrated an absent left testis and a normal right testis. The left testis appears very small and atrophic and we cross-clamped the cord and doubly ligated it with an 0 Vicryl tie and removed for specimen. The posterior bladder was inspected and it was exceptionally thickened and mass-like. The bladder itself was freely movable. One could palpate the right ureteral stent well away from this area. There was necrosis and inflammation of the fat with whitish nodularity. The necrotic area was biopsied, the whitish nodularity was biopsied. I reviewed the case with the pathologist personally and he felt that this was not involved with neuroendocrine tumor and there was no evidence of any malignancy on the bladder biopsies, despite the marked appearance intraoperatively. For this reason, we opted against any cystectomy. I did not feel even a partial cystectomy was indicated. I reviewed with the family the findings extensively and then returned to the operating room and performed deeper excision of the necrotic area where the colon had been adherent to the posterior bladder. The bladder was then filled with saline and there was no leak. It was still watertight with no through and through excision. At this point, no further surgery on the bladder was anticipated unless permanent sections on the biopsies we just performed returned positive for malignancy, we may return and perform a cystectomy; partial versus total and a urinary diversion. Certainly this can be at a later date and hopefully as expected on the biopsies that they are benign.

Operative Report  
02/11/2007

Preoperative Diagnosis: Obstruction mass sigmoid colon

Postoperative Diagnosis:

1. Obstructing neuroendocrine mass in the sigmoid colon
2. Abscess to bladder
3. Absent left kidney
4. Undescended left testicle in the abdominal cavity

Procedure:

1. Preoperative ureteral stent
2. Exploratory laparotomy
3. Sigmoid colectomy with end colostomy and Hartmann's procedure
4. Biopsy of bladder
5. Biopsy of left iliac lymph node
6. Additional biopsy of bladder
7. Removal of undescended testicle

Anesthesia: General endotracheal

Estimated Blood Loss: 100 cc

Specimen:

1. Sigmoid colon
2. Multiple biopsies from the bladder
3. Biopsy of undescended testicle and the testicle itself
4. A biopsy of lymph node

Drains: Foley catheter, nasogastric tube and right lower quadrant drain

History: The patient is a 56-year-old male who was admitted with anemia and chronic pain. The patient had a colonoscopy showing an obstructing mass at approximately 35 cm. CT scan showed obstruction at this area. It appeared to be above the bladder. There was no direct involvement into the bladder after I discussed the case. It was noted on CT scan that the patient had an absent left kidney. The ureteral stents were planned. The patient had a cystoscopy and ureteral stent on the right placed. There was no orifice on the left. There was edema and inflammation of the dome of the bladder but no direct cancer involvement.

Procedure: At this point in lithotomy position, the patient was prepped and draped in the usual fashion. A midline incision was made to the right of the umbilicus and down to the symphysis pubis. Bovie cautery was used to incise through subcutaneous tissue. The anterior fascia was opened and the peritoneum entered. Upon entering the abdomen, the sigmoid colon was densely adherent to the bladder. This was taken down sharply. Immediately there was a large amount of

pus seen between the colon and bladder. This was immediately cultured. At this point, the colon was immobilized along the white line of Toldt. The bladder was quite hard. The sigmoid colon was transected with a GIA-75 approximately 10 cm proximal to the mass. The mesentery of this area of the colon was clamped and tied with 0 Vicryl. Additional bleeders were controlled with figure-of-eight 3-0 stick tie. This was taken down approximately 10 cm below the mass. The colon was transected and this was sent for frozen section to determine whether this was a cancer or inflammatory change from diverticulitis. A hard mass from the bladder was sent down for frozen section as well. At this point, the left ureter could be visualized. An undescended left testicle was viewed. This was biopsied to confirm its origin. After confirmation of the undescended testicle, an orchiectomy was performed on the left side. At this point, multiple other biopsies were taken of the bladder. At this point, the pathology of the colon appeared to be neuroendocrine tumor originating in the colon. The biopsies of the bladder after numerous biopsies all came back inflammatory change. Based on this, a cystectomy was not performed. The abdomen was copiously irrigated. A 19-French drain was placed through a stab wound to the right of the incision and left behind the dome of the bladder. The bladder was distended with approximately 300 cc of fluid with no sign of leak. At this point, a lymph node in the left iliac area had been biopsied. The liver was explored and there was no metastasis seen. The appendix and remaining colon appeared normal, as did the small bowel. At this point, once hemostasis had been confirmed and the mesentery was hemostatic, a colostomy was planned due to the gross pus seen. An orifice was made by retracting the skin with a Kocher clamp and making the circular incision with a 15 blade. This was dissected down to the fascia which was opened in a cruciate fashion. This was spread using a muscle spreading technique to accommodate 2 fingers. At this point, a Babcock was used to grab the proximal colon and bring out through the skin. This was secured internally with 3-0 Vicryl. At this point, omentum was brought down overlying the incision. Two pieces of Seprafilm were placed. Please note that Prolene sutures were placed on the Hartmann's pouch to make this easier to find. At this point, the fascia was closed with running #1 looped PDS suture. The skin was copiously irrigated and closed with skin staples and Telfa wicks were placed in between the staples. At this point, an occlusive dressing was placed on both the incision and drain after suturing the drain with 2-0 silk. The colostomy was matured at this point by excising the stable line with cautery and using 3-0 Vicryl suture to mature the colostomy. The colostomy was widely patent. There was no bleeding seen. An ostomy bag was placed. The findings were discussed. The patient was extubated postoperatively. A nasogastric tube, Foley catheter and Jackson-Pratt drain were left in place. At this point, the patient will be kept on a PCA, antibiotics and await the final pathology.

Pathology Report  
02/11/2007

Clinical History: Obstructing mass sigmoid colon attached to bladder

Gross Description:

1. -Specimen #1 is labeled with the patient's name and "colon mass". Received fresh is a 3.4 x 1.7 x 1.5 cm rubbery, mass with a smooth surface which may represent peritoneal surface. A representative cross-section is frozen.
2. -Specimen #2 is labeled with the patient's name and "sigmoid colon – suture marks distal margin". Received fresh is a colon segment 19 cm long by 8 cm diameter. A suture marks the distal margin as indicated. A large circumferential 7.5 x 6.5 cm ulcerated tumor involves colon mucosa 4 cm from the distal mucosal margin and 8.5 cm from the proximal mucosal margin. Gross tumor invades through muscularis and deeply into pericolic fat. The total tumor thickness is 1.7 cm. Over the tumor, there is questionable gross tumor involving the outer pericolic fat serosa/mesothelium. The remaining colon mucosa shows a 0.6 cm sessile tan polyp. There are multiple pericolic lymph nodes candidates from 0.2 cm to 0.8 cm.
3. -Specimen #3 is labeled with the patient's name and "left pelvic mass – possible undescended testicle left". Received fresh is a 1 x 0.5 x 0.4 cm tan, soft irregular fragment. A portion is selected for frozen section.
4. Specimen #4 is labeled with the patient's name and "exterior – posterior bladder wall". Received fresh is a 2.4 x 1.5 x 1.5 cm dark, purple and tan mass. A portion is selected for frozen section.
5. Specimen #5 is labeled with the patient's name and "exterior-posterior bladder wall". Received fresh is a 1.4 x 0.9 x 0.5 cm tan irregular rubbery tissue. A portion is selected for frozen section.
6. -Specimen #6 is labeled with the patient's name and "bladder". Received in formalin are four irregular pieces of rubbery to firm yellow-gray-tan tissue 3 x 2.5 x 2.cm together.
7. Specimen #7 is labeled with the patient's name and "undescended left testicle". Received in formalin is a 3 x 1.5 x 1.2 cm rubbery, tan tissue compatible with testicle.
8. -Specimen #8 is labeled with the patient's name and "left node left pelvic". Received in formalin is a 1.3 x 1 x 0.8 cm rubbery, yellow-tan tissue. Bisected.

Intraoperative Consultation Diagnosis:

1. Frozen Section #1 Diagnosis: Soft tissue, urinary bladder, biopsy: Fibrosis and inflammation. No carcinoma identified.
2. -Frozen Section #2 Diagnosis: Sigmoid colon, resection: Neuroendocrine neoplasm, favor large cell neuroendocrine carcinoma.
3. Frozen Section #3 Diagnosis: Pelvis, biopsy: Sclerotic tubules consistent with atrophic testis.
4. Frozen Section #4 Diagnosis: Soft tissue, exterior-posterior bladder wall, biopsy: Soft tissue with inflammation. No carcinoma identified.
5. Frozen Section #5 Diagnosis: Soft tissue, exterior-posterior bladder wall, biopsy: Inflammation and fibrous tissue. No carcinoma identified.

Slide Index:

1A	Frozen section #1 cryoblock, colon mass
1B-E	Entire remaining colon
2A	Frozen section #2 cryoblock, sigmoid colon tumor
2B	Sigmoid colon, shaved proximal mucosal margin
2C	Sigmoid colon, shaved distal mucosal margin
2D	Sigmoid colon, perpendicular sections shows tumor approaching outer pericolic serosa/mesothelium (inked blue)
2E-H	Sigmoid colon, selected tumor
2I	Sigmoid colon, entire small mucosal polyp
2J-M	Sigmoid colon, pericolic lymph node candidates
2N-Q	Sigmoid colon, additional blocks pericolic lymph node candidates
3A	Frozen section #3 cryoblock, left pelvis mass
3B	Entire remaining left pelvic mass
4A	Frozen section #4 cryoblock, exterior-posterior bladder wall
4B-C	Entire remaining exterior-posterior bladder wall
5A	Frozen section #5 cryoblock, exterior-posterior bladder wall
5B	Entire remaining exterior-posterior bladder wall
6A-H	Entire bladder tissue
7A-E	Entire undescended left testicle
8A	Entire lymph node left pelvic

Final Diagnosis:

1. Inflamed fibrofatty tissue showing focal involvement by adenocarcinoma, see comment – specimen submitted as “colon mass” (excisional biopsy)
2. Sigmoid colon (segmental resection) showing:
  - a. -Ulcerated, moderately to poorly differentiated adenocarcinoma, 7.5 x 6.5 x 1.7 cm, invading through the muscularis propria to involve the serosa and pericolic fat
  - b. Margin status:
    - i. Proximal and distal margins free of tumor
    - ii. Inked outer pericolic/radial margin positive for adenocarcinoma
  - c. Small tubular adenoma
  - d. Metastatic adenocarcinoma present in two of twenty pericolic lymph nodes (+2/20)
3. Sclerotic seminiferous tubules with absent spermatogenesis consistent with a portion of an atrophic testis – left pelvis mass, possible undescended testicle left (biopsy)
4. -Inflamed fibrofatty tissue showing involvement by adenocarcinoma, see comment – exterior, posterior bladder wall (excisional biopsy)
5. Fibrofatty tissue showing fibrosis and patchy chronic inflammation; malignancy not identified – exterior, posterior bladder wall (excisional biopsy)
6. Severely inflamed fibrofatty tissue showing involvement by adenocarcinoma – bladder (excision)
7. -Atrophic testicle with absent spermatogenesis consistent with an undescended testicle – undescended left testicle (orchietomy)
8. Benign lymph node showing no evidence of metastatic carcinoma (0/1) – left pelvic lymph node (biopsy)

Comment:

The sigmoid colon segmental resection shows a large ulcerated moderate to poorly differentiated adenocarcinoma extending through the muscular propria to involve the serosa and pericolic fat. Although the possibility of a neuroendocrine carcinoma was considered at the time of frozen section, immunostains for neuroendocrine markers (Chromogranin and Synaptophysin) were negative. Thus, the tumor is felt to be a colon adenocarcinoma with some areas that are only poorly differentiated. The outer pericolic/radial margin is positive for tumor.

The specimen labeled "colon mass" (specimen #1) and the exterior/posterior bladder wall (specimen #4) do show areas of involvement by a similar appearing adenocarcinoma. The tumor is present in portions of tissue not sampled at the time of frozen section. Adenocarcinoma is also seen in the specimen labeled "bladder" (specimen #6).

The undescended left testicle shows atrophic testicular tissue without evidence of neoplasia.

A block of the colon tumor will be sent to Genzyme Impath Laboratory for EGFR assay and a supplemental report will be issued.

Pathologic Staging:

T4	Tumor directly invades other organs or structures, and/or perforates the visceral peritoneum
N1	Metastasis in one to three regional lymph nodes
MX	Distant metastasis cannot be assessed
Stage Grouping	IIIB T4      N1      M0

02/11/2007    CEA 13.6

Pathology Report  
02/11/2007

Genzyme Impath Report

Body site: Colon  
Specimen received: 1 paraffin

Therapeutic Analysis

Antibody/Test: EGFR pharmDx  
Marker For: Epidermal Growth Factor Receptor  
Results: Positive 1+

Comments:

The EGFR pharmDx is FDA approved for use with formalin, PenFix, and Bouin's fixed tissues.

EGFR pharmDx is a trademark of DakoCytomation. EGFR pharmDx is an FDA approved test used as an aid in identifying colorectal cancer patients eligible for treatment with ERBITUX (Cetuximab). Reference ranges for this test in other cancer types are not approved at this time.

EGFR Negative: Absence of specific membrane staining within the tumor

EGFR Positive: Positive (1+) staining is defined as an IHC staining of tumor cell membranes above background level

Staining Intensity: 1+, 2+, 3+  
% of tumor cell staining: greater than or equal to 1%

Consultation  
02/15/2007

Reason for Consultation: Adjuvant treatment recommendations concerning T4 adenocarcinoma of the sigmoid colon

History of Present Illness: This is a previously healthy 56-year-old male who has been suffering from symptoms of both urinary urgency and rectal urgency for the past several weeks. He had noted both melena and bright red blood per rectum. He was seen by his primary care physician and evaluated. Performed an EGD that revealed no evidence of any source of bleeding. He then underwent a colonoscopy that showed an obstructing lesion of the sigmoid colon. He had a preoperative CEA of 13.6 and underwent a transfusion. He underwent a sigmoid colectomy with an end colostomy. He also had a urethral stent placed and urology was involved. He had an undescended testicle removed and as noted to have a left kidney. He recovered with an expected ileus. Unfortunately, he had evidence of a very low albumin of 1.6 and was started on total parenteral nutrition. The surgical pathology results revealed that he had gross involvement of his bladder. The decision was made that the patient would undergo a cystectomy with the urinary diversion scheduled for 02/17/2007.

Past Medical History: Otherwise noncontributory. He has no evidence of hypertension, coronary artery disease or diabetes. He has a history of an elevated PSA level.

Medications: He was on no medications prior to this admission to the hospital. He is currently on prophylactic dose of Lovenox, Levaquin, Flagyl, Prevacid and TPN. He is also as needed pain medication and antiemetics.

Allergies: Penicillin results in severe swelling

Social History: The patient is married and has one stepson. He does not smoke and he only occasionally drinks alcohol.

Family History: Significant for an aunt that had breast cancer, but otherwise, there is no evidence of malignant colon cancer in the family.

Review of Systems: He has not had any fevers, chills, night sweats. He has had about a 10-pound weight loss. He has not had any difficulty with headaches, swallowing, chest pain, shortness of breath, abdominal discomfort, abdominal cramping, back pain, swelling. He has had some problems with diarrhea, and of course, all of which is mentioned in the history, and of course, difficulty with urination. Remainder of review of systems is negative.

Physical Examination:

General: Thin and normal-appearing male

Vital Signs: Blood pressure is 154/80, pulse oximeter is 94% on room air, respiratory rate is 18 and nonlabored, pulse rate is 80 and regular, temperature is 98 degrees.

HEENT: Eyes are anicteric with no evidence of scleral injection. Pupils are equally round and reactive to light. Mouth and oropharynx reveal no evidence of any exudate or erythema. He has moist mucous membranes.

Lungs: Decreased breath sounds bilaterally. There are no rales noted.

Heart: Regular rate and rhythm with no murmurs, rubs, gallops. He has good 2+ peripheral pulses.

Abdomen: Tender. He had a dry dressing over his laparotomy incision. Hepatomegaly and splenomegaly were not assessed. He is passing flatus.

Extremities: No cyanosis, clubbing or edema. He is wearing TED hose.

Laboratory Data: CT scans were reviewed. Present creatinine is 0.8. BUN is 7, albumin is 1.6, ALTs are normal. Magnesium 2.4. Hemoglobin is 8.3, MCV of 70, platelet count is 513,000, his white count is improving. CT scan done on 2/10/2007 reveals evidence of bowel wall thickening of the sigmoid colon. There is an enlarged prostate gland. Liver is normal. No pulmonary nodules were noted in the lung bases. A 3.3 cm mass anterior to the rectum and posterior to the bladder was noted. No other evidence of lymphadenopathy was seen.

Assessment: Probable Stage III adenocarcinoma with neuroendocrine feature of the sigmoid colon with invasion of the bladder.

Plan: I would recommend and concur that a cystectomy would be the best approach to remove any residual disease, and this should be done in a timely manner. We would recommend 6 months of adjuvant chemotherapy with infusional 5-FU, Leucovorin and Oxaliplatin on an every 2-week basis. We will monitor his kidney function since he only has a single kidney. We may substitute oxaliplatin for irinotecan. I believe he does have a substantial risk of relapse. I spoke with the family for approximately 40 minutes.

Pathology Report  
02/17/2007

Clinical History: Colon cancer with invading bladder. Possible stage 3 adenocarcinoma. ? cancer or inflammation.

Gross Description:

Specimen #1 is labeled "bladder mucosa". Received fresh for frozen section analysis is a 2 x 0.7 x 0.3 cm rubbery pink-white tissue. The specimen is entirely submitted for frozen diagnosis as FS-1A.

Specimen #2 is labeled "bladder wall suture marking: blue – anterior; white – left; black – right, nothing posterior". Received fresh for frozen section analysis is an irregular to square rubbery slightly firm tissue, 11.5 x 10.4 x 4.9 cm. Orientation is previously indicated. At the posterior surface there is a bulging soft to rubbery nodular red-tan circumscribed area, 4.7 x 4.1 cm. The tissue surrounding this area is focally ragged with attached fat. The surface opposite the posterior surface is predominantly erythematous, red-tan-whit with gray-white adhesions. At this surface there is a depressed defect, which is ragged red-brown and is 4 x 2.5 x 1 cm. This surface is interpreted to be a serosal surface. The margins are inked as follows: Anterior – blue, right – black, left – yellow, posterior – green. Shaved sections are submitted for frozen analysis as follows: FS-2A – anterior, FS-2B – right, FS-2C – left, FS-2D – posterior.

On sectioning, the nodular described posterior surface is consistent with bladder mucosa. The bladder mucosa is edematous. The bladder wall is markedly firm, pink-whit and thickened up to 1.7 cm. The bladder wall abuts the serosal defect. The surrounding fat is focally indurated and edematous. No discrete lymph nodes are identified grossly.

Specimen #3 is labeled "extra posterior margin of bladder wall". Received in formalin is an elongate focally ragged red-tan tissue, 3.3 x 1.5 x 0.8 cm. One surface is ragged, red-tan and consistent with mucosa. The opposing surface is smooth and erythematous consistent with serosa. The specimen is serially sectioned.

Intraoperative Consultation Diagnosis:

Frozen Section #1 Diagnosis: Bladder mucosa: Edematous transitional mucosa.

Frozen Section #2 Diagnosis: Bladder wall shaved margin with true margin face up in cryoblock: FS-2A (anterior): Benign. FS-2B (right): Benign. FS-2C (left): Benign. FS-2D (posterior): Benign.

Slide Index:

- 1A Cryoblock bladder mucosa
- 2A Cryoblock shaved section anterior margin
- 2B Cryoblock shaved section right margin
- 2C Cryoblock shaved section left margin
- 2D Cryoblock shaved section posterior margin
- 2E-G Perpendicular sections to include bladder mucosa, wall and serosal defect

2H Bladder wall  
2I Bladder mucosa  
2J-Z Entire remaining serosal defect  
3A-E Entire extra-posterior margin of bladder wall

Final Diagnosis:

1. Bladder mucosa: Transitional cell mucosa with chronic inflammation and marked edema
2. Bladder wall: Portion of bladder with suture material and associated reaction. Surgical margins of excision negative for carcinoma
3. Extra posterior margin of bladder wall: Fibrovascular connective tissue without evidence of malignancy

Comment:

The defect area in the main resection specimen (specimen #2) was extensively sampled in a total of 34 blocks. Previous excision site was identified as with chronic inflammation. Residual adenocarcinoma, however, was not seen.

Patient MR# 123456  
Patient Name: John Corona

Colorectal Advanced Case #1  
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Progress Note  
03/01/2007

56-year-old married white male

POS Family history of cancer  
NEG Tobacco  
POS Alcohol

03/01/2007 given FOLFOX

Consultation  
10/05/2007

Diagnosis: Advanced colon cancer involving the bladder with a nonhealing wound in 2 areas despite aggressive local wound therapy.

Procedure: Excision and closure of nonclosing wound

History of Present Illness: The patient is a delightful 57-year-old male with presentation of obstructing colon mass and severe anemia. The patient underwent a colectomy with augmentation and colostomy. The patient has had 2 nonhealing areas on his abdominal wall which have failed to close despite aggressive local therapy for the last 5-6 months. The patient has completed his chemotherapy approximately 1 month ago. Despite this, these areas still do not close.

Past Medical History: Metastatic colon cancer. He had a hernia repair in 1953.

Medications: No medications

Allergies: Penicillin

Social History: He does not smoke but drinks occasionally. He denies recreational drugs.

Family History: Positive for an uncle with liver and lung cancer, father with hypertension

Review of Systems: He denies headache, blurred vision, chest pain, shortness of breath, diarrhea, constipation, dysuria, hematuria, melena.

Physical Examination:

Head and Neck: Within normal limits

Chest: Clear to auscultation

Heart: Regular rate and rhythm

Abdomen: Soft, nondistended. Well-healed ostomy which is functioning. There are 2 punctate areas, one just below the umbilicus and one in the suprapubic area which are approximately 5 mm wide and approximately 8-12 mm deep. The most inferior one has chronic granulation tissue. The other one shows early granulation tissue.

Recommendations: At this point, I do not feel packing these will be beneficial to the patient. I recommend excising these areas in an attempt to close primarily.