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**Referral Information**

Patient:

Status: Class: Diagnosis:

 [610333821)

Authorized
Outgoing

L59.8,Y84.2 (ICD-10-CM) - Radiation necrosis of skin and subcutaneous C77.5 (ICD-10-CM) - Metastasis to obturator lymph node (CMS/HCC) E10.9 (ICD-10-CM) - Type 1 diabetes mellitus without complication (CMS/HCC)

SC Radiation Therapy Center ­Encinitas

Radiation necrosis of skin

subcutaneous

Metastasis to obturator lymph node

(CMS/HCC)

Type 1 diabetes mellitus without

complication (CMS/HCC)

TCMC Hyperbaric oxygen department. Woman with complicated oncologic history. Developed osteonecrosis of the right pelvis and responded well to HBO at UCSD. Had further XRT to a loft obturator node and has developed osteonecrosis of the left pelvis. UCSD is unable to treat again at this time. Please see, advise and treat.

Thank you,

Anuradha Koka

 **Office Visit** 9/16/2019 Provider: Anuradha Koka, MD (Radiation Oncology)

Scripps Clinic Radiation Primary diagnosis; Squamous cell carcinoma of anal canal (CMS/HCC)

Therapy Center - Encinitas Reason for Visit: Referred by Melissa Kathleen Wolinski, DO

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| 10/3/2019 | Salvatore John Pacella, MD, FACS Scripps Clinic Del Mar Plastic Surgery,SCDM Del Mar |
|  |  |

 George Eugene Dailey HI, MD Scripps Clinic Anderson Medical

Pavilion Diabetes and Endocrinology,

SI-ILJ

.

**Progress *Notes*** Anuradha Koka, MD (Physician) • Radiation Oncology

REASON FOR VISIT:

Diagnosis Plan

1. **Squamous cell carcinoma of anal canal
(CPAS/HCC)**
2. **Radiation necrosis of skin and
subcutaneous**
3. **Metastasis to obturator lymph node
(CMS/HCC)**
4. **Type 1 diabetes mellitus without
complication (CMS/HCC)**

Dear Jon and Sabina,

Liza is well known to you both. She was diagnosed in 1998 with a squamous cell carcinoma of the rectum. She was treated with AP-PA field, 1.8 Gy to 41.4 Gy with concurrent mitomycin C and 5-FU, followed by an AP resection, including right pelvic sidewall resection and

coccygectomy. She had severe complications and ultimately went on to require a Koch pouch, which is permanent.

In June 2014, Elizabeth was found to have an anal verge lesion, which turned out to be biopsy-proven squamous cell carcinoma. She saw myself and Dr. Wallach. She underwent resection C**?"1** of the tumor on 07/08/2014 by Dr. Worsey and a 2.2 x 1.5 cm squamous cell carcinoma was found. It was poorly differentiated with invasion into the submucosa. Margins were uninvoive4 with the closest being the distal margin at 0.5 cm. PET-CT on June 11, 2014, showed abnormal FDG activity in a right inguinal node measuring 1.5 cm with 1.8 cm hypermetabolic lesion in the posterior aspect of the Koch pouch. Dr. Worsey felt this was not disease. The anal verge had no residual findings.

I then treated with radiation therapy with very modified fields to the anal cancer and treated the inguinal nodes and the anal verge only. The anal verge final dose was 37.2 Gy, given that she was treated with concurrent mitomycin C and 5-FU. Shortly after the start of treatment, she had significant complications with difficulty voiding from the Kock pouch and elevated LFTs. She was admitted and once her symptoms had improved, she was discharged home. I then modified the radiation therapy field even further **and** completed 25.2 Gy in 1.8 Gy fractions to

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 Encounter Date: 09/16/2019

the right perianal tissue and bilateral inguinal nodes, with further modification to 34.2 Gy and took the final dose to the right groin with electron beam to 46.2 Gy and a total to the right groin at 56.2 Gy. The left groin received a total of 37.2 Gy and the perianal scar received a total of 37.2 Gy.

In June 2015 she was found to have a right obturator side wall node which was PET positive. She declined standard treatment. She chose alternative approaches. By February 2017 she was having pain in the right groin with limitation to range of motion. PET/CT on September 21, 2017 showed this node had increased in size. It measured 2.4 cm. I requested a repeat MRI which was performed at San Diego imaging and showed a 4.5 x 2.1 x 3.9 cm right obturator node which had invaded into the right supra-acetabular iliac bone as well as involvement of the anterior obturator intemus muscle on the right.

At this point Liza eventually agreed to have radiation therapy. We proceeded with a very tight SBRT approach with rapid fall off of dose medially where bowel was adjacent to the node. Once this plan was generated it was felt to be reasonable to proceed with SBRT.

Liza underwent SBRT to the right obturator node and right medial acetabular wall between November 20, 2017 and November 28, 2017. She received 700 cGy x5 to a total of 3500 cGy.

On February 27, 2018 Liza had a PET/CT which showed moderate improvement of the right pelvic sidewall malignancy. I did not see her that day in follow-up as she had the flu.

On May 4, 2018 Liza had a repeat PET/CT There was continued improvement of the avidity in the right pelvic node. The right iliac bone was stable. Mild activity was noted in the right supraclavicular soft tissues consistent with a recent Mohs surgery. There was no other abnormal hypermetabolic activity.

In June 2018, Elizabeth was admitted to Scripps Memorial La Jolla for right pelvic pain. Workup eventually led to a diagnosis of osteonecrosis of the right iliac bone with significant edema. This responded to hyperbaric oxygen and she was able to be tapered off steroid which significantly worsened her type 1 diabetes. Pain level decreased but she still has pain.

On the June 21, 2018 CT there was a mild 1.3 cm node in the left pelvic sidewall with slight PET activity in May 2018. Repeat MRI of the pelvis on September 26, 2018 showed a left pelvic sidewall nodule with enhancement. PET/CT on October 1, 2018 showed

hypermetabolic activity in this left pelvic sidewall node with an SUV of 6.8. The right pelvic area of adenopathy had no hypermetabolic activity consistent with necrosis.

After discussion of her options, I did recommend SBRT to the left pelvic sidewall node while it ***e***

was fairly small and it was not involving the left pelvic bone. After careful counseling Liza

agreed to proceed with treatment, She received 700 cGy x5 fractions to a total of 3500 cGy

which she completed October 31, 2018 and is here for a 5-month follow-up visit.

Liza has had admissions recently for small bowel obstruction and stenosis of the Kook pouch. Dr. Worsey has been managing this. He has now recommended she meet with Dr. Walter Coyle for GI evaluation. She is waiting for the breath test prior to her appointment with him in April. Her appetite is good but she is unable to eat as she has significant abdominal pain.

She continues with pain in the right groin and also tells me she has just generalized pain. She is eating very small amounts and has actually dropped from 125 pounds to 108 pounds. She is weak. She gets it at the most 200 cal/day and this is challenging as she is a type 1 diabetic.

Bactrim for recent UTI as she has had to self catheterize since the hospitalization.

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**July 19th 2019**

I had requested a repeat PET/CT but her insurance denied this. Therefore on July 2 Liza had a CT of the chest abdomen and pelvis. A 1.5 cm nodule was thought to be either within the anterior gallbladder are abutting it. Multiple lung nodules in the dependent right lower lobe most likely thought to be infection or aspiration related. Malignancy was less likely.

**On July 12, 2019** an abdominal ultrasound showed no suspicious findings. The 1.5 cm nodule seen on CT abutting the gallbladder was not identified by ultrasound.

I ordered an MRI of the pelvis and her primary care physician ordered an MRl of the lumbar spine. She was on her way to have these done yesterday when pain which had started in the left leg approximately 2 weeks ago significantly worsened. She called our office and we advised her to go to the emergency room. These MR1s were done yesterday. L-spine MRI showed degenerative changes and some mild disc findings but no spinal or foramina! stenosis and no evidence of metastatic disease. The pelvic MRI showed patchy intramuscular edema involving the lower posterior paraspinous muscles, the pelvic muscles and the abductor muscle of the hips. There was a serpentine abnormal STIR signal within the iliac bones bilaterally felt to be nonspecific. I reviewed the images of both studies and there is persistent change in the right iliac bone with less edema. No suspicious findings of the pelvic bones on the left.

Liza tells me the pain in the left side is quite severe. She has Roxicodone which she takes as needed. However, narcotics then affect her intestines and the function of the Koch pouch. Fortunately her Cl symptoms had been settling down and she had been getting in better nutrition. She has gained some weight. Right chronic pain is stable at 2 out of 10. Pain on the left side moves around her left leg. There appears to be pain in the left buttock. There is some radicular component to this pain.

Review of symptoms:

Appetite is better. No dizziness. No shortness of breath no cough. No fevers no chills. No nausea or vomiting. No significant abdominal pain. Increased abdominal motility particularly at night. Fortunately, she is gaining some weight.

**September 19th 2019**

Pain in the left leg is 7/10. No further hyperbaric oxygen has been given. Currently taking Norco q 4 hours. Decided not to use fentanyl patch as worried about side effects. She has low energy. Stool is fairly liquid and despite drinking lots of liquids she **has been** having weekly hydration with electrolytes through Dr. Wallach. Denies headaches. Some dizziness. Has nausea usually at night but no vomiting. Occasional crampy abdominal pain which is better than it used to be. She has no shortness of breath or cough. Urination has been challenging and she has been self-catheterizing. She believes she did see Dr. Kashefi in the past for a urologic opinion.

Dr. Anderson from UCSD has been helping with hyperbaric oxygen. When I last spoke with him, he thought it was possible to give some more hyperbaric oxygen for the left osteonecrosis although this is challenging from an insurance perspective\_ As yet, Liza has not yet had any further hyperbaric oxygen.

 Encounter Date: Sept 16, 2019

PHYSICAL EXAMINATION:

I have a pleasant female seen on her own. She is alert and orientated and in no obvious

distress.

CHEST: is clear to A&P.

[CVS. SH](http://CVS.SH) S1S2 without MRG/RRR.

ABDOMEN: is soft and without organomegaly,

SPINE: is without tenderness.

ADENOPATHY: There is no cervical, supraclavicular nor inguinal adenopathy bilaterally.

EXTREMITIES: are without cyanosis, clubbing, anemia, edema or jaundice.

MUSCULOSKELETAL: No significant bony tenderness in the right and left groins. Straight leg

raising causes pain left side greater than right. In fact she cannot raise her left leg off the

exam table,

INVESTIGATIONS:

I have reviewed images and reports from of *the* studies discussed above and the findings are as mentioned. Last MRI was July 31, 2019 of the left hip and the radiologist's interpretation was that the changes might be related to developing infarct/osteonecrosis on the left as there was edema extending into the left iliac bone.

IMPRESSIONS:

I believe that Elizabeth is radiographically NED. However, now has significant left leg pain thought to be secondary to osteonecrosis. Pain is controlled with Norco which she is needing every 4 hours and gabapentin. She does not want to stay on Norco long-term\_ I believe Dr. Anderson has been trying to obtain insurance authorization for further hyperbaric oxygen treatments as she had a full course for right pelvic osteonecrosis and now has new left pelvic osteonecrosis.

Type I diabetic.

I will place a referral to palliative care to help with chronic pain management. Continue with hydration with electrolytes per Dr. Wallach's recommendation.

I appreciate the opportunity of being involved in Elizabeth's care, If I can be of any further help please do not hesitate to contact me.

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| Squamous cell carcinoma of anal canal (CMS/HCC) 021,1 Radiation necrosis of skin and subcutaneous 159.8, Y84.2 Metastasis to obturator lymph node (CMS/MCC) C77.5 Type 1 diabetes mellitus without complication (CMS/HCC) E10.9 |  |