1 Patient Information

1 PATIENT DETAILS

Name
Gerald T. Washington

Date of Service
05/06/2026

DOB
09/03/1961

Provider
Dr. Angela N. Torres, MD — Medical Oncology

Age / Sex
64 / Male

MRN
MO-2025-3317

Visit Type
Chemotherapy Follow-up — Cycle 8, Day 1

Cancer Diagnosis
Metastatic colorectal adenocarcinoma (sigmoid colon primary), KRAS G12D mutant, MSS/MMR-proficient, Stage IV (liver and lung metastases)

Stage
Stage IVB — synchronous hepatic and pulmonary metastases

Treatment Regimen
FOLFIRI (irinotecan + leucovorin + 5-FU) + bevacizumab — Cycle 8 Day 1 today

CC Chief Complaint

2 PRIMARY REASON FOR ENCOUNTER

Mr. Washington presents for Cycle 8, Day 1 of FOLFIRI + bevacizumab. He reports worsening bilateral distal lower extremity numbness and tingling over the past 3 weeks (Grade 2 peripheral neuropathy), increased frequency of loose stools (4–5/day, Grade 2 diarrhea), and significant fatigue. He states: 'The numbness in my feet is getting worse — I'm stumbling sometimes. And the diarrhea is exhausting me.' He also requests review of his most recent CT results, which he understands showed continued response.

S Subjective

3 PATIENT-REPORTED SYMPTOMS & TREATMENT HISTORY

3a CANCER HISTORY / INTERVAL STATUS

Mr. Washington was diagnosed in August 2025 with sigmoid colon adenocarcinoma following an ER presentation for bowel obstruction. Emergency sigmoid colectomy was performed 08/12/2025 — surgical pathology: T4aN2bM1 (liver and lung metastases present at surgery; R0 sigmoid resection). Molecular: KRAS G12D mutant (anti-EGFR therapy not indicated), BRAF wild-type, MSS (MMR-proficient — immunotherapy not indicated), HER2 negative. Staging: Stage IVB. Post-surgical recovery uncomplicated. FOLFIRI + bevacizumab initiated 10/07/2025 per NCCN guidelines for first-line RAS-mutant/MSS metastatic CRC. Most recent CT chest/abdomen/pelvis (04/28/2026 — reviewed today): Partial response — hepatic lesions collectively reduced 32% from baseline; lung nodules stable (now too small to measure). CEA trending down (see labs).

3b SYSTEMIC THERAPY STATUS

Current Regimen
FOLFIRI (irinotecan 180 mg/m², leucovorin 400 mg/m², 5-FU 400 mg/m² bolus + 2400 mg/m² over 46h CI) + bevacizumab 5 mg/kg — Q2 weeks

Cycle Number / Treatment Date
Cycle 8, Day 1 — today 05/06/2026

Dose Modifications
Cycle 6: Irinotecan reduced to 150 mg/m² (80% dose) due to Grade 3 diarrhea — maintained at 80% since. 5-FU continuous infusion maintained at 100%.

Missed Treatments / Delays
Cycle 7 delayed 1 week (04/22 → 04/29) due to ANC 0.9 — G-CSF not used; held for count recovery. No missed cycles.

3c TREATMENT-RELATED SYMPTOMS

1. Peripheral neuropathy (primary concern): Bilateral distal lower extremity numbness and tingling — worsening over past 3 weeks. Rated 5/10 intensity. Now affecting gait (stumbling on uneven surfaces, one near-fall last week). Symptoms present at rest and worse with activity. Hands mildly involved — reports difficulty buttoning shirts. CTCAE Grade 2 (moderate — limiting instrumental ADLs). No pain component. This is 5-FU/irinotecan-related, not oxaliplatin-related (no oxaliplatin in current regimen — neuropathy may be related to prior oxaliplatin if used, but this patient has not received oxaliplatin; etiology under evaluation). 2. Diarrhea: 4–5 loose/watery stools per day over the past 2 weeks (CTCAE Grade 2). Associated with cramping. No blood in stool. No fever. Managed partially with loperamide 4 mg after each loose stool, maximum 16 mg/day — partially effective (reducing to 3–4 episodes/day). 3. Fatigue: Severe — 3/10 energy level. Unable to complete light household activities without resting. Sleep 10–11 hours/day. 4. Nausea: Mild — 1–2 episodes/day post-infusion Day 1, resolving by Day 3–4. Ondansetron 8 mg and prochlorperazine effective. 5. Alopecia: Moderate — wearing cap; cosmetically bothersome but patient is coping. 6. Appetite: Reduced — eating 1–2 meals/day; unintentional weight loss 8 lbs since treatment initiation.

3d MEDICATION / SUPPORTIVE CARE RESPONSE

Loperamide 4 mg PRN (up to 16 mg/day): Partially effective — diarrhea Grade 2 persisting. Ondansetron 8 mg PO Q8h on Day 1–2 post-infusion: effective for nausea. Prochlorperazine 10 mg PRN: used 1–2x/cycle. Methylphenidate 5 mg PO QAM (trial for cancer-related fatigue, started Cycle 5): Minimal benefit reported — considering discontinuation. Vitamin B6 100 mg PO daily (neuropathy prophylaxis): inadequate response to prevent neuropathy progression. Omeprazole 20 mg daily: ongoing GI protection. Lorazepam 0.5 mg PO PRN: used rarely for anticipatory nausea.

3e FUNCTIONAL STATUS

Mr. Washington is a retired postal supervisor. Lives at home with his wife in Baltimore. He was ECOG 1 at treatment initiation — now functioning at ECOG 2 due to neuropathy and fatigue. He uses the handrail consistently on stairs. He has stopped driving in the evenings due to foot numbness. He is no longer able to walk his dog independently due to stumbling risk. His wife is supportive and present for today's appointment. He is on medical disability. Nutrition: 1–2 meals/day; 8 lb weight loss since treatment start. Dietitian referral was placed 2 cycles ago — patient attended once then did not follow through.

3f PERTINENT NEGATIVES

Denies fever (home temperature this AM 98.4°F). Denies oral mucositis or mouth sores at this time. Denies chest pain or dyspnea (bevacizumab monitoring). Denies hematuria, hemoptysis, or rectal bleeding. Denies wound healing issues (no active wounds; colostomy not present — J-pouch not yet performed). Denies confusion or focal neurologic symptoms beyond neuropathy. Denies DVT symptoms (no calf pain, no leg swelling — bevacizumab thrombotic risk). Denies uncontrolled pain. Denies rash or skin breakdown.

O Objective

4 MEASURABLE & OBSERVED FINDINGS

V VITAL SIGNS

Temperature
98.2°F

Blood Pressure
138/84 mmHg (mildly elevated — bevacizumab-related hypertension monitoring)

Heart Rate
76 bpm

Respiratory Rate
16 breaths/min

Oxygen Saturation
98% on room air

Weight
181 lbs (82.3 kg) — down 8 lbs from 189 lbs at treatment start

Pain Score
2/10 (mild discomfort from neuropathy and cramping)

Performance Status
ECOG 2 — ambulatory, up >50% of waking hours; limited self-care in some domains

4a PHYSICAL EXAMINATION

General Appearance
Tired-appearing, thin male. Alert, cooperative. Cap worn for alopecia. Ambulates with mild cautious gait due to foot numbness — steady, no assistive device.

HEENT / Oral Mucosa
Oropharynx: clear, no mucositis, no thrush. Lips intact. No jaundice. No periorbital edema.

Lymph Nodes
No palpable cervical, supraclavicular, axillary, or inguinal lymphadenopathy.

Cardiovascular
Regular rate and rhythm. BP 138/84 (elevated from 122/76 at Cycle 1 — bevacizumab-associated hypertension, grade 1). No murmurs, JVD, or edema.

Respiratory
Clear to auscultation bilaterally. No wheezes, crackles, or pleural rub. No dyspnea at rest.

Abdomen
Well-healed midline laparotomy scar from sigmoid colectomy. Soft, mild right upper quadrant fullness on deep palpation (hepatomegaly, liver lesions). Non-tender. Normoactive bowel sounds. No ascites.

Skin
Mild alopecia. No hand-foot syndrome. No rash. Port site (right chest infraclavicular) intact, non-tender, no surrounding erythema.

Neurological
Alert and oriented x4. CN II–XII intact. Motor strength 5/5 all extremities. Sensation: Diminished to light touch and vibration at bilateral feet and ankles bilaterally (stocking distribution). 10g monofilament: absent bilaterally at plantar great toes. Romberg: positive (sways with eyes closed). DTRs: ankle reflexes 1+ bilaterally (reduced). Gait: slightly cautious, wide-based stance; no frank ataxia.

Musculoskeletal
No synovitis or joint effusions. Bilateral hand grip mildly reduced on testing — consistent with early sensorimotor neuropathy.

L Lab & Imaging Results

5 REVIEWED DATA

5a LABORATORY STUDIES

Today's pre-cycle CBC: WBC 5.8, ANC 3.4 (adequate — no neutropenia), Hgb 10.8 (anemia — mild, down from 12.1 at Cycle 1), Plt 218 — adequate for bevacizumab and chemotherapy. CMP: Na 137, K 3.8, Cr 0.9 (GFR 88 — adequate for bevacizumab), total bilirubin 0.8, AST 42 (mildly elevated), ALT 38, alk phos 128 (mildly elevated — hepatic metastases); albumin 3.2 (low — nutritional depletion). Electrolytes: Mg 1.8, phosphate 2.9 — borderline; Mg supplement continued. Tumor markers: CEA 48 ng/mL (down from 210 ng/mL at diagnosis, 95 ng/mL at Cycle 4, 48 today — sustained response). CA 19-9: 210 U/mL (down from 840 at diagnosis). No coagulation testing required today (bevacizumab — no active anticoagulation).

5b IMAGING STUDIES

CT chest/abdomen/pelvis with contrast (04/28/2026 — reviewed with radiology and patient today): Liver: 5 hepatic metastases visible; aggregate maximum diameter 6.8 cm (down from 10.2 cm at Cycle 4 CT — 32% reduction; partial response per RECIST 1.1 criteria). Largest lesion: right lobe segment VI, 2.4 cm (down from 3.8 cm). Lungs: 3 small pulmonary nodules, now all <6 mm and below threshold for measurement — stable to decreased. No new lesions in liver, lung, peritoneum, or other sites. No lymphadenopathy. No ascites. No bowel obstruction. Assessment: Continued partial response — treatment efficacy confirmed. Next staging CT planned at Cycle 12 (approximately 8/2026).

5c PATHOLOGY / MOLECULAR RESULTS

Surgical pathology (08/2025): Sigmoid colon adenocarcinoma, moderately differentiated (Grade 2). pT4aN2bM1 (23 lymph nodes positive/31 examined). Margins: R0 (proximal and distal margins negative). Molecular (Foundation One CDx, 09/2025): KRAS G12D mutation detected. BRAF V600E: wild-type. MSI status: MSS (microsatellite stable). HER2: Not amplified. TMB: 4 mut/Mb (low). PD-L1: <1% (not a checkpoint inhibitor candidate). NTRK fusion: Not detected. RET: Not detected. No targetable alterations beyond VEGF pathway (bevacizumab).

5d TREATMENT MONITORING DATA

Response assessment: Partial response confirmed (RECIST 1.1) at Cycle 8. Treatment-emergent adverse events to date: Grade 3 diarrhea Cycle 6 (irinotecan dose reduced to 80%); Grade 1 hypertension (bevacizumab) managed with lisinopril; Grade 2 peripheral neuropathy (progressive, under review); Grade 1 alopecia; Grade 2 fatigue; Grade 1 nausea (well-controlled). No Grade 4 toxicities. No treatment interruptions for toxicity beyond the 1-week delay at Cycle 7 (ANC recovery).

A Assessment

6 MEDICAL ONCOLOGY CLINICAL INTERPRETATION

Mr. Gerald Washington is a 64-year-old male with Stage IVB KRAS-mutant, MSS metastatic colorectal adenocarcinoma currently achieving a confirmed partial response (32% hepatic lesion reduction, CEA trending down 77% from baseline) on FOLFIRI + bevacizumab Cycle 8. Treatment is demonstrably effective and should continue. Two primary toxicity concerns are escalating and require active management today: (1) Grade 2 peripheral neuropathy — progressive worsening with gait instability and near-fall risk. This is an atypical toxicity for FOLFIRI (not typically associated with severe neuropathy); differential includes unrecognized pre-existing condition, alternative etiology (metabolic, vascular), or cumulative 5-FU neurotoxicity. Neurology consultation and EMG/NCS are indicated to clarify etiology and guide further management. Neuropathy is not yet dose-limiting but is approaching functional threshold. (2) Grade 2 diarrhea — persisting despite loperamide; irinotecan dose is already reduced to 80% from prior Grade 3 event. Further dose reduction may be necessary if no improvement with budesonide. Bevacizumab-associated hypertension is Grade 1 — monitored and managed. Anemia (Hgb 10.8) is not transfusion-requiring but contributing to fatigue. Weight loss of 8 lbs with albumin 3.2 indicates nutritional depletion requiring urgent re-engagement with dietitian. ECOG performance status is declining (1→2) — this trend must be monitored closely; progression to ECOG 3 would prompt a treatment strategy reassessment.

P Plan

7 ONCOLOGY MANAGEMENT

7a SYSTEMIC THERAPY PLAN

Proceed with Cycle 8 today — chemotherapy cleared based on: ANC 3.4 (adequate), Hgb 10.8 (acceptable), Plt 218 (adequate), Cr 0.9 (GFR 88 — adequate for bevacizumab). Regimen: FOLFIRI at current 80% irinotecan dose + bevacizumab 5 mg/kg — no further dose reduction today. Pre-medications: Ondansetron 8 mg IV + dexamethasone 8 mg IV + atropine 0.25 mg IV (pre-irinotecan) per protocol. 5-FU pump: To be disconnected in 46 hours (05/08/2026 AM) at infusion clinic.

7b SUPPORTIVE MEDICATIONS & SYMPTOM CONTROL

Diarrhea: Add oral budesonide 9 mg PO daily x2 weeks (irinotecan-associated late diarrhea management); continue loperamide PRN. If Grade 3 recurs, will reduce irinotecan to 60% or consider FOLFOX switch. Neuropathy: Add duloxetine 30 mg PO daily x1 week then 60 mg daily (ASCO-recommended for chemotherapy-induced neuropathy). Continue Vitamin B6. Physical therapy referral for fall prevention and balance training. Hypertension: Increase lisinopril from 5 mg to 10 mg PO daily (BP 138/84 today — CTCAE Grade 1 bevacizumab hypertension; target <130/80). Anemia: No transfusion at this time (Hgb 10.8, no cardiopulmonary symptoms); repeat CBC Cycle 9 — transfuse if symptomatic or Hgb <8. Fatigue: Discontinue methylphenidate (minimal benefit); initiate structured exercise counseling. Magnesium: Increase oral Mg oxide to 800 mg PO BID.

7c LABS, IMAGING & MONITORING

CBC and CMP pre-Cycle 9 (05/19/2026). CEA and CA 19-9 with Cycle 9 labs. EMG/NCS ordered today — neurology referral placed (Dr. Harold Greene, MD — Neurology; appointment requested within 2 weeks). Next staging CT at Cycle 12 (~08/2026). Monitor BP at each visit (bevacizumab). Coagulation studies if any bleeding symptoms.

7d REFERRALS & COORDINATION

Neurology: EMG/NCS and consultation for peripheral neuropathy workup — Dr. Harold Greene, MD; referral placed today. Nutrition/Dietitian: Urgent re-referral — patient to attend at least 3 sessions; dietitian Keisha Brown, RD, notified. High-calorie, high-protein diet counseling, consider oral nutritional supplements (Ensure High Protein or Boost VHC — 2 cans/day). Physical Therapy: Fall prevention program and balance training — referral placed. Social Work: Referral for functional decline support and caregiver resource navigation (wife's support needs assessment). Surgical Oncology: Discussion of hepatic resection candidacy to be revisited after 3–4 more cycles if continued response — referral to hepatobiliary surgery deferred pending further tumor downstaging.

7e PATIENT EDUCATION

1. Reviewed CT results with patient and wife — confirmed partial response, explained significance of CEA decline. Patient expressed relief and continued motivation. 2. Neuropathy: Counseled on fall risk — no walking on uneven surfaces without supervision; non-slip footwear; handrail use mandatory; no driving after dark. 3. Diarrhea: Reviewed budesonide use; loperamide protocol reinforced; hydration instructions (64 oz clear fluids/day). 4. When to call: Fever >100.4°F, blood in stool, uncontrolled diarrhea (>6 stools/day despite loperamide), chest pain, sudden neurologic change, any wound or port site concerns. 5. Nutritional urgency discussed — weight loss and albumin level explained; patient committed to returning to dietitian.

F Follow-Up

8 REASSESSMENT PLAN

Next Visit & Purpose

Cycle 9 Day 1: 05/20/2026. Reassess: diarrhea grade (budesonide response), neuropathy (duloxetine benefit, EMG/NCS results), BP (lisinopril adjustment), weight, ECOG status, and pre-cycle labs. EMG/NCS results expected by 05/20/2026. Dietitian visit: 05/12/2026 (confirmed). PT: First visit 05/14/2026.

TIME DOCUMENTATION & BILLING

Total Time
52 minutes

E/M Level
99215 — Established patient, high complexity

Counseling / Coordination Time
25 minutes

Basis for Billing
Medical Decision Making — High Complexity

Primary ICD-10
C18.7 — Malignant neoplasm of sigmoid colon

Secondary ICD-10
C78.7 — Secondary malignant neoplasm of liver; C78.01 — Secondary malignant neoplasm of right lung; G62.0 — Drug-induced polyneuropathy; K59.1 — Functional diarrhea; D64.9 — Anemia, unspecified

PHYSICIAN NAME, MD	SPECIALTY: MEDICAL ONCOLOGY	DATE	TIME
Angela N. Torres, MD	MD — Medical Oncology, Board Certified	05/06/2026	9:45 AM