1 Patient Information

1 PATIENT DETAILS

Name
Diane L. Forsythe

Date of Service
05/06/2026

DOB
03/11/1974

Provider
Dr. Kevin R. Nwosu, MD, FACS — Surgical Oncology

Age / Sex
52 / Female

MRN
SO-2026-0984

Visit Type
Pre-Operative Consultation

Cancer Diagnosis
Invasive ductal carcinoma (IDC), left breast, ER+/PR+/HER2-, Grade 2, Stage IIB (T2N1M0)

Surgical Site / Planned Procedure
Left breast — left partial mastectomy (lumpectomy) + left sentinel lymph node biopsy (SLNB); planned for 05/20/2026

CC Chief Complaint

2 PRIMARY REASON FOR ENCOUNTER

Pre-operative surgical consultation for planned left partial mastectomy and sentinel lymph node biopsy. Ms. Forsythe completed 6 months of neoadjuvant letrozole therapy (initiated 11/2025) with partial radiographic response and now presents for definitive surgical planning and consent. She states: 'I just want to get this surgery done and move forward. I understand the plan and I'm ready.'

S Subjective

3 PATIENT-REPORTED SYMPTOMS & SURGICAL HISTORY

3a CANCER HISTORY / INTERVAL STATUS

Ms. Forsythe was diagnosed in October 2025 following self-detection of a left breast lump. Core needle biopsy confirmed invasive ductal carcinoma: ER 95% positive, PR 80% positive, HER2 negative (IHC 1+, FISH ratio 1.4), Ki-67 18%, Grade 2. Staging: T2N1M0, Stage IIB — ultrasound-guided biopsy of the left axillary level I lymph node confirmed metastatic carcinoma. No distant metastases on staging CT chest/abdomen/pelvis and bone scan. She was enrolled in a neoadjuvant endocrine therapy approach (letrozole 2.5 mg PO daily x6 months) per multidisciplinary tumor board recommendation given ER-rich, HER2-negative tumor biology and patient preference to attempt tumor downstaging. Pre-neoadjuvant MRI (10/2025): left breast primary 3.1 cm, left axillary level I LN 1.8 cm. Post-neoadjuvant MRI (04/2026): left breast primary 2.0 cm (35% reduction), left axillary LN 1.2 cm (33% reduction) — partial response, residual disease present. MDT decision: proceed with partial mastectomy + SLNB.

3b SURGICAL HISTORY / PROCEDURE STATUS

Prior Oncologic Surgery
None — this is her first breast cancer surgery

Date of Procedure / Post-Op Day
Planned: 05/20/2026 (pre-operative visit today)

Other Relevant Surgical History
Right knee arthroscopy 2019 (no anesthesia complications). Laparoscopic appendectomy 2007. C-section x1 (2002, uneventful).

3c CURRENT SYMPTOMS

She reports no significant breast pain at rest. She notes mild tenderness at the left breast lump site with direct palpation (3/10). No nipple discharge, skin changes, or new breast symptoms. No axillary pain or swelling. She reports mild arthralgia of the bilateral hands and wrists — well-known side effect of aromatase inhibitor therapy; rated 3/10 severity, managed with ibuprofen PRN. Letrozole-associated hot flashes occurring 4–6 times daily, moderate severity. No dyspnea, chest pain, fever, or neurologic symptoms. She reports appropriate fatigue (4/10) which she attributes to letrozole therapy. No new lymphadenopathy noticed by patient.

3d WOUND / INCISION CONCERNS

No prior breast surgical wounds. Pre-operative skin is intact bilaterally with no ulceration, peau d'orange, nipple retraction, or skin tethering. Patient has no current wound concerns. She was instructed to avoid shaving the left axilla for 2 weeks prior to surgery (SLNB site prep protocol).

3e FUNCTIONAL STATUS

Ms. Forsythe is a practicing attorney (litigation partner). She works full-time and reports no significant functional limitation from her cancer diagnosis or treatment. She exercises regularly (pilates and cycling). She lives with her husband and two adult children. She is emotionally prepared for surgery. She has arranged 2 weeks of post-operative leave from work. She has a caregiver (her husband) identified for the immediate post-operative period. Nutritional status: well-nourished; BMI 24.8. No significant weight change on letrozole.

3f PERTINENT NEGATIVES

Denies fever, chills, or signs of infection. Denies uncontrolled pain. Denies new or worsening shortness of breath, chest pain, or hemoptysis. Denies new bone pain, headache, or visual changes (no distant metastasis concern). Denies bleeding abnormalities or anticoagulant use. Denies recent DVT or PE history. Denies allergy to surgical prep solutions (Betadine, Chlorhexidine). Denies tobacco or alcohol use.

O Objective

4 MEASURABLE & OBSERVED FINDINGS

V VITAL SIGNS

Temperature
98.1°F

Blood Pressure
118/74 mmHg

Heart Rate
68 bpm

Respiratory Rate
14 breaths/min

Oxygen Saturation
99% on room air

Weight
142 lbs (64.5 kg) — stable on letrozole

Pain Score
3/10 at left breast lump site; 0/10 elsewhere

Performance Status
ECOG 0 — fully active

4a PHYSICAL EXAMINATION

General Appearance
Well-appearing, well-nourished female in no acute distress. Alert and engaged. Professionally dressed.

Surgical Site / Incision
No prior breast surgical scars. Left breast skin intact — no erythema, peau d'orange, skin tethering, or satellite nodules. No nipple retraction or discharge.

Skin / Wound
Bilateral breast skin intact. No rashes or lesions. No radiation changes (pre-treatment). Left axilla: intact skin, no hair — patient shaved recently, to be re-instructed to avoid for SLNB.

Lymph Nodes
Left axilla: Single palpable firm rounded node approximately 1.5 cm — reduced from 1.8 cm at diagnosis. Mobile, non-tender. No right axillary, supraclavicular, or infraclavicular lymphadenopathy.

Cardiovascular
Regular rate and rhythm. No murmurs. Peripheral pulses intact.

Respiratory
Clear to auscultation bilaterally. No wheeze, crackles, or friction rub.

Abdomen
Soft, non-tender, non-distended. Well-healed laparoscopic scar RLQ (appendectomy). No hepatomegaly.

Neurological
Alert and oriented x4. No focal deficits. No arm swelling or lymphedema.

Musculoskeletal
Full bilateral upper extremity ROM. Mild bilateral finger joint tenderness on direct palpation — consistent with AI arthralgia. No joint effusions or deformities.

Breast Exam (Primary Focus)
Left breast: Firm, non-tender mass at 10 o'clock position, 3 cm from nipple, approximately 2.0 x 1.8 cm on palpation (consistent with post-neoadjuvant MRI measurement). Overlying skin mobile and uninvolved. No palpable satellite lesions. Nipple: No discharge, no retraction. Right breast: No palpable masses, no skin changes, nipple intact.

L Lab & Imaging Results

5 REVIEWED DATA

5a LABORATORY STUDIES

Pre-operative labs (drawn today): CBC: WBC 6.8, Hgb 12.9, Plt 244 — all WNL, adequate for surgery. CMP: Cr 0.8, LFTs normal, electrolytes WNL. Coagulation: PT/INR 1.0, aPTT 28 sec — normal. Type and Screen: Drawn (O+, antibody screen negative). Tumor markers (04/2026): CA 27.29: 48 U/mL (mildly elevated above normal <38; monitoring for post-treatment trending). CEA: 1.8 ng/mL (normal). Bone turnover markers: not indicated given bone scan negative at staging.

5b IMAGING STUDIES

Breast MRI with contrast — Post-neoadjuvant (04/2026): Left breast: Enhancing mass at 10 o'clock, 2.0 x 1.7 cm (down from 3.1 x 2.8 cm pre-neoadjuvant — partial response). No skin or chest wall involvement. Suspicious left axillary LN 1.2 cm (down from 1.8 cm). No new lesions. Right breast: No suspicious enhancement or masses. Diagnostic mammogram (04/2026): Left breast mass with irregular margins at 10 o'clock — partially obscured by dense parenchyma; correlates with MRI. Right breast: Heterogeneously dense, no masses or suspicious calcifications. Staging CT chest/abdomen/pelvis (10/2025): No pulmonary nodules, no hepatic lesions, no retroperitoneal adenopathy. Bone scan (10/2025): No skeletal metastases.

5c PATHOLOGY RESULTS

Core needle biopsy — left breast (10/15/2025): Invasive ductal carcinoma, Grade 2 (Nottingham score 6/9: tubule formation 3, nuclear grade 2, mitotic rate 1). ER: 95% (Allred 8/8), PR: 80% (Allred 7/8), HER2: 1+ by IHC (FISH ratio 1.4 — not amplified). Ki-67: 18%. Core needle biopsy — left axillary level I LN (10/20/2025): Metastatic carcinoma consistent with breast primary; ER positive. Oncotype DX (breast recurrence score): 18 (intermediate risk — neoadjuvant endocrine therapy approach supported; no neoadjuvant chemotherapy recommended per tumor board).

5d OTHER DIAGNOSTICS

EKG (today, pre-operative): Normal sinus rhythm; no ST/T wave changes; no conduction abnormalities. Cardiac risk: ASA Class II (well-controlled hypertension, no cardiac history). Pre-operative anesthesia consultation requested — scheduled 05/12/2026 with Dr. Karen Wu, MD (Anesthesiology). No pulmonary evaluation required (no respiratory history, ECOG 0, non-smoker).

A Assessment

6 SURGICAL ONCOLOGY CLINICAL INTERPRETATION

Ms. Diane Forsythe is a 52-year-old woman with Stage IIB (T2N1M0), Grade 2, ER+/PR+/HER2- invasive ductal carcinoma of the left breast who has completed 6 months of neoadjuvant letrozole with confirmed partial response (35% reduction in primary tumor; 33% LN reduction). She is an excellent surgical candidate for left partial mastectomy (lumpectomy) with left sentinel lymph node biopsy. Surgical candidacy: ECOG 0, no significant comorbidities, excellent cardiopulmonary reserve, adequate pre-operative labs, and cooperative with surgical planning. Tumor characteristics are favorable for breast conservation — post-neoadjuvant primary 2.0 cm with sufficient predicted margin-to-breast ratio for oncologically adequate resection and acceptable cosmetic outcome. She understands and accepts the possibility of mastectomy if surgical margins are positive on final pathology. Post-operative adjuvant plan (per MDT): Adjuvant radiation therapy to left breast (consultation with Dr. Sarah Park, Radiation Oncology, pending surgery); continued adjuvant endocrine therapy with letrozole x10 years total (or 5 years letrozole then switch to tamoxifen based on menopausal status reassessment). No adjuvant chemotherapy indicated based on Oncotype DX score 18 and T2N1 staging per TAILORx/RxPONDER trial data for this patient profile.

P Plan

7 SURGICAL ONCOLOGY MANAGEMENT

7a SURGICAL PLAN

Procedure: Left partial mastectomy (lumpectomy) + left sentinel lymph node biopsy (SLNB) using dual-tracer technique (Tc-99m sulfur colloid + isosulfan blue dye). Timing: 05/20/2026 at 7:30 AM — confirmed OR booking at Memorial Surgical Center. Wire/seed localization: RadioSeed (I-125 seed) localization to be placed by radiology on 05/19/2026 at 2:00 PM (pre-operative day). Laterality confirmed: LEFT. Pre-operative skin marking to be performed by Dr. Nwosu on the day of surgery. If intraoperative frozen section of SLNB demonstrates macro-metastasis (>2mm), proceed to complete axillary lymph node dissection (ALND) per pre-consent discussion.

7b ADDITIONAL WORKUP

No additional imaging or staging workup required — complete staging confirmed negative for distant metastases. Genetic counseling referral placed (BRCA1/2 and expanded panel) — patient is 52 with breast cancer, meets criteria per NCCN guidelines. Appointment scheduled with genetics 05/15/2026. No biopsy of contralateral breast indicated — MRI right breast negative.

7c POST-OPERATIVE CARE

Wound care: Dry dressing to incision x48h, then leave open to air. No drain anticipated for partial mastectomy. SLNB site: Steri-strips to axillary incision. Activity restriction: No lifting >5 lbs with left arm for 2 weeks; no driving for 24–48h post-anesthesia. Pain management: Acetaminophen 500mg PO Q6h scheduled + ibuprofen 400mg PO Q8h PRN for first 48h. Opioid prescription only if pain uncontrolled on above regimen — minimize opioid use. Arm exercises: Begin gentle shoulder pendulum exercises POD1 per written handout provided today to prevent stiffness.

7d COORDINATION & REFERRALS

Radiation Oncology: Post-operative referral to Dr. Sarah Park, MD — adjuvant whole-breast radiation (anticipated start 4–6 weeks post-op). Medical Oncology: Continued follow-up with Dr. Emily Chen, MD — adjuvant endocrine therapy management. Genetics: BRCA counseling 05/15/2026. Anesthesiology pre-op: Dr. Karen Wu, MD — 05/12/2026. Radiology: RadioSeed localization 05/19/2026 2:00 PM. Pathology: Intraoperative frozen section of SLNB + permanent sections of lumpectomy specimen (margin assessment, ER/PR/HER2 confirmation on residual disease).

7e PATIENT EDUCATION

Extensive surgical consent discussion today (45 minutes): Risks (bleeding, infection, seroma, hematoma, poor cosmesis, arm numbness/lymphedema from SLNB, positive margins requiring re-excision or mastectomy, anesthesia risks). Benefits (local disease control, breast conservation, staging information). Alternatives (mastectomy — declined by patient after discussion). Expected recovery: 2 weeks limited activity, return to office work 2–3 weeks post-op. Patient verbalized understanding and signed informed consent. She was given written pre-operative instructions including NPO after midnight 05/19, medication hold instructions (hold ibuprofen 7 days pre-op), and arrival time 6:00 AM 05/20.

F Follow-Up

8 REASSESSMENT PLAN

Post-Operative Follow-Up Schedule

1-week post-op wound check: 05/27/2026. 2-week post-op pathology review visit: 06/03/2026 — final surgical pathology, margins, LN status, residual tumor stage (ypT/N). Radiation oncology consultation to be scheduled at 2-week visit. Adjuvant endocrine therapy continuation confirmed at 2-week visit. Lymphedema surveillance at each visit per SLNB protocol.

TIME DOCUMENTATION & BILLING

Total Time
65 minutes

E/M Level
99205 — New patient, high complexity

Counseling / Coordination Time
45 minutes (surgical consent + coordination)

Basis for Billing
Medical Decision Making — High Complexity

Primary ICD-10
C50.912 — Malignant neoplasm of unspecified site of left female breast

Secondary ICD-10
C77.3 — Secondary malignant neoplasm of axilla and upper limb lymph nodes; Z79.811 — Long-term use of aromatase inhibitor; Z80.3 — Family history of malignant neoplasm of breast

PHYSICIAN NAME, MD	SPECIALTY: SURGICAL ONCOLOGY	DATE	TIME
Kevin R. Nwosu, MD, FACS	MD, FACS — Breast Surgical Oncology	05/06/2026	2:00 PM