1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Doris A. Whitaker

DOB
04/22/1959

AGE/SEX
67 / Female

MRN / PATIENT ID
DAW-6604193

DATE OF SERVICE
11/04/2026

PROVIDER
Samuel Achebe

CREDENTIALS
MD, FCCP (Interventional Pulmonology)

VISIT TYPE
Procedure Planning — same-day indwelling pleural catheter placement

CARE SETTING
Procedure Unit (outpatient)

PRIMARY PULMONOLOGIST, IF APPLICABLE
None

PRIMARY CARE PROVIDER, IF APPLICABLE
Marjorie Lund, MD

REFERRING PROVIDER, IF APPLICABLE
Aisha Rahman, MD (Medical Oncology)

ONCOLOGY CARE TEAM, IF APPLICABLE
Dr. Rahman; breast oncology nurse navigator K. Ortiz

INTERPRETER USED, IF APPLICABLE
Not required

CC CHIEF COMPLAINT

2 PRIMARY CONCERN

"The fluid keeps coming back every two weeks. I can breathe after they drain it, then I'm winded again. I don't want to keep coming in for needles."

S SUBJECTIVE

3 PATIENT-REPORTED HISTORY

3a REASON FOR VISIT & SYMPTOMS

Reason for Interventional Pulmonology Evaluation:

Recurrent symptomatic right malignant pleural effusion — definitive management with a tunneled indwelling pleural catheter (IPC).

Current Respiratory Symptoms:

Dyspnea after half a block or one flight of stairs, worse lying flat (sleeps on 2 pillows). Dry cough. Right chest heaviness. Fatigue. Lost 3 kg in 2 months. No fever, hemoptysis, or stridor.

Lung Nodule / Mass History:

No lung nodules or mass. Small pleural-based nodules on the right on CT (see Imaging).

Cancer Risk and Oncologic Context:

Right breast cancer (ER+/PR+/HER2−), stage IIA in 2019: lumpectomy, radiation, then anastrozole. Recurrence 08/2026 with pleural and bone metastases. Now on letrozole + ribociclib (cycle 3). Never smoker.

Mediastinal / Lymph Node Concern:

Mildly PET-avid right internal mammary node; no mediastinal staging needed — metastatic disease already confirmed by pleural fluid cytology.

Pleural Disease Symptoms:

Three right thoracenteses in 6 weeks (1.4 L, 1.2 L, 1.5 L), each giving marked relief. Effusion returns in 10–14 days. Last tap 10/21, with manometry. No fever or post-procedure infection.

Airway Obstruction / Stenosis Symptoms:

None. Orthopnea attributed to effusion.

Hemoptysis History:

None.

3b PROCEDURAL RISK FACTORS

Prior Pulmonary Procedures:

Three ultrasound-guided thoracenteses (09/2026–10/2026). Third tap: manometry showed opening pressure +8 cmH2O, pressure −6 cmH2O after 1.5 L; lung re-expanded fully on CXR (not trapped). No complications. No pleuroscopy or pleurodesis.

Medication and Anticoagulation History:

Letrozole 2.5 mg daily; ribociclib 600 mg (days 1–21, now day 9). Zoledronic acid monthly. Denosumab not used. No anticoagulants, antiplatelets, or NSAIDs. Acetaminophen as needed. Oncology agrees to continue ribociclib through the procedure.

Medical Risk Factors:

Hypertension; hypothyroidism. Mild neutropenia from ribociclib (ANC 1.3). No heart failure, bleeding disorder, or anesthesia problems.

Oxygen / Ventilatory Support:

No home oxygen. Home SpO2 93–95% at rest, 89–90% walking when the effusion is large.

Smoking / Vaping / Exposure History:

Never smoker. Retired accountant. No asbestos, silica, or TB exposure.

Functional Status and Procedure Tolerance:

ECOG 1. Can sit upright and lie on her left side for the procedure. Tolerated prior taps with local anesthetic only. Lives with husband (Frank), who will learn home drainage; daughter nearby. Husband driving today.

Family History:

Sister — breast cancer at 52. No lung disease or clotting disorder.

Pertinent Negatives:

Denies hemoptysis, rest dyspnea, chest pain, syncope, fever, leg swelling, or stridor.

ROS INTERVENTIONAL PULMONOLOGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Dyspnea, cough, wheezing, chest tightness, sputum production, or hemoptysis
Positive — exertional dyspnea, dry cough, chest heaviness.

Chest pain, pleuritic pain, orthopnea, exercise intolerance, or oxygen desaturation
Positive — orthopnea, exercise intolerance, exertional desaturation to 89%.

Fever, chills, night sweats, weight loss, fatigue, or infection symptoms
Positive — fatigue, 3 kg weight loss. No fever.

Hoarseness, stridor, choking, secretion retention, or airway obstruction symptoms
Negative.

Pleural catheter pain, drainage change, leakage, redness, swelling, or infection symptoms
Not applicable — no catheter yet.

Bleeding tendency, anticoagulant use, bruising, thrombocytopenia, or prior procedure bleeding
Negative. Platelets normal.

Sedation/anesthesia complications, difficult airway history, or inability to lie flat
Can lie flat only briefly — procedure done semi-upright, lateral decubitus.

Anxiety, cancer-related distress, procedural concerns, or functional limitation
Positive — worried about living with a catheter; wants fewer hospital visits.

O OBJECTIVE

5 CARDIOPULMONARY EXAMINATION

5a VITALS

TEMPERATURE	BLOOD PRESSURE	HEART RATE
98.0 °F	132/76 mmHg	96 bpm
RESPIRATORY RATE	**OXYGEN SATURATION**	**OXYGEN FLOW RATE, IF APPLICABLE**
22 /min	93% RA	None
HEIGHT	**WEIGHT**	**BMI**
162 cm	61.4 kg	23.4
PAIN SCORE, IF APPLICABLE	**PERFORMANCE STATUS, IF APPLICABLE**	
2/10 (R chest)	ECOG 1	

5b EXAMINATION

General Appearance:

Alert, mildly dyspneic, speaks in full sentences. Slightly increased work of breathing when supine. Walks independently.

Head / Neck / Airway:

Mallampati II. Trachea shifted slightly to the left. No stridor or cervical lymphadenopathy.

Cardiovascular:

Regular, mildly tachycardic. No murmur. No JVD or edema.

Pulmonary:

Absent breath sounds and stony dullness over the right lower two-thirds. Clear on the left. No wheeze or rub.

Chest Wall / Pleural Catheter Site, if applicable:

Pre-procedure: prior thoracentesis sites in the R posterior axillary line healed. Well-healed R breast lumpectomy scar; mild post-radiation skin change over the R breast — catheter tunnel planned below this area.

Abdomen:

Soft, non-tender. No ascites or hepatomegaly.

Extremities:

No edema, clubbing, or calf tenderness.

Skin:

Left chest port, clean. R breast radiation change as above. No rash.

Neurologic:

Alert and oriented ×3. Has capacity; consented herself.

IM IMAGING / LESION ASSESSMENT

6 PROCEDURE-PLANNING IMAGING

IMAGING MODALITY AND DATE

CT chest with contrast 10/14/2026; CXR and bedside ultrasound today

INDICATION FOR IMAGING

Recurrent effusion; restaging

LUNG NODULE/MASS SIZE, LOCATION, AND BRONCHUS SIGN IF AVAILABLE

None

SOLID, SUBSOLID, GROUND-GLASS, CAVITARY, CALCIFIED, OR SPICULATED FEATURES

Not applicable

GROWTH TREND AND COMPARISON TO PRIOR IMAGING

Effusion refilled to two-thirds of hemithorax since 10/21 tap

PET AVIDITY AND SUV IF AVAILABLE

PET 08/2026: R pleural SUV 6.2; T8 and L2 bone lesions

MEDIASTINAL OR HILAR LYMPH NODE STATIONS INVOLVED

None; R internal mammary node 9 mm

PLEURAL EFFUSION SIZE, LATERALITY, LOCULATION, PLEURAL THICKENING, OR PLEURAL NODULARITY

Large R free-flowing effusion; no loculation; nodular R pleural thickening up to 6 mm

AIRWAY NARROWING, OBSTRUCTION, ENDOBRONCHIAL LESION, STENOSIS, OR TRACHEOBRONCHOMALACIA FINDINGS

None; no endobronchial obstruction

EMPHYSEMA, FIBROSIS, BRONCHIECTASIS, PNEUMOTHORAX, ATELECTASIS, OR INFILTRATES

R lower lobe compressive atelectasis; no pneumothorax

PROCEDURAL TARGET FEASIBILITY AND LIMITATIONS

Ultrasound: large anechoic pocket, 7 cm depth, R 7th ICS mid-axillary line; no septations; diaphragm moves well

NEED FOR CT CHEST, PET/CT, ULTRASOUND, BRONCHOSCOPY, BIOPSY, THORACENTESIS, PLEUROSCOPY, OR SURGICAL REFERRAL

IPC today; no pleuroscopy needed — cytology already diagnostic

PRA PROCEDURE RISK / PRE-PROCEDURE ASSESSMENT

7 READINESS & SAFETY REVIEW

PLANNED PROCEDURE AND INDICATION

Tunneled R IPC — recurrent symptomatic malignant effusion, expandable lung

DIAGNOSTIC OR THERAPEUTIC GOAL

Therapeutic: symptom control, fewer visits, possible spontaneous pleurodesis

CONSENT STATUS

Written consent signed; teach-back done

ANTICOAGULANT/ANTIPLATELET MANAGEMENT

None to hold

BLEEDING RISK AND PLATELET/COAGULATION STATUS

Low — platelets 214, INR 1.0

OXYGEN REQUIREMENT AND RESPIRATORY RESERVE

Room air; adequate reserve

SEDATION/ANESTHESIA RISK

Local anesthesia only; no sedation

DIFFICULT AIRWAY RISK

Low

ABILITY TO LIE FLAT

Limited — semi-recumbent left lateral position

CARDIAC RISK FACTORS

Hypertension, controlled

PULMONARY HYPERTENSION RISK

None known

INFECTION RISK

Mild neutropenia (ANC 1.3) — sterile technique stressed

PREGNANCY STATUS WHEN RELEVANT

Not applicable (postmenopausal)

ALLERGIES TO ANESTHETICS, LATEX, CHLORHEXIDINE, IODINE, ADHESIVES, OR ANTIBIOTICS

Adhesive tape — skin irritation; use silicone dressing

NPO STATUS IF APPLICABLE

Not required (local only)

TRANSPORTATION AND POST-SEDATION SUPPORT

Husband driving

ALTERNATIVES DISCUSSED AND SHARED DECISION-MAKING

Talc pleurodesis (by pleuroscopy or slurry), repeat taps, combined IPC + talc. Patient chose IPC alone to stay out of the hospital

PR PROCEDURES PERFORMED, IF APPLICABLE

8 INTERVENTIONAL PULMONOLOGY PROCEDURES

Right tunneled indwelling pleural catheter placement (15.5 Fr), 10:20–10:52. Indication: recurrent symptomatic malignant pleural effusion with expandable lung. Written consent; timeout done. Local anesthesia only: 1% lidocaine, 18 mL. Real-time ultrasound guidance; entry R 7th ICS, mid-axillary line. Full sterile technique. Seldinger method with peel-away sheath; 5 cm subcutaneous tunnel running anterior-inferior; cuff 1 cm inside the exit site. One pass.

Drained 1,200 mL of straw-colored, serosanguinous fluid by vacuum bottle; stopped for chest tightness. Two sutures placed (incision closed; exit site anchored). Silicone dressing. Minimal blood loss. Tolerated well. No complications.

BR BRONCHOSCOPY / EBUS DOCUMENTATION, IF PERFORMED

9 BRONCHOSCOPY FINDINGS

Not performed — not indicated. CT shows no endobronchial obstruction, and diagnosis is already confirmed by fluid cytology.

PL PLEURAL PROCEDURE DOCUMENTATION, IF PERFORMED

10 PLEURAL INTERVENTION FINDINGS

LATERALITY AND INDICATION

Right — recurrent malignant effusion

ULTRASOUND FINDINGS AND FLUID POCKET ASSESSMENT

Large anechoic, free-flowing; 7 cm pocket; no septations

FLUID VOLUME REMOVED

1,200 mL

FLUID APPEARANCE

Straw-colored to lightly serosanguinous

PLEURAL MANOMETRY IF USED

Not today (done 10/21: expandable lung)

SYMPTOMS DURING DRAINAGE

Chest tightness at 1,200 mL — drainage stopped

SAMPLES SENT

Cytology, cell count, LDH, protein, glucose

POST-PROCEDURE LUNG EXPANSION

Near-complete re-expansion on CXR

PNEUMOTHORAX ASSESSMENT

No pneumothorax on CXR or ultrasound sliding

CATHETER PLACEMENT DETAILS IF APPLICABLE

15.5 Fr tunneled IPC, R 7th ICS; tip posterior-basal

DRAINAGE INSTRUCTIONS AND SUPPLIES

Drain every other day, up to 1,000 mL; vacuum bottles ordered

COMPLICATIONS IF ANY

None

FOLLOW-UP IMAGING AND LAB PLAN

CXR at 2 weeks; cytology review

L LABORATORY AND DIAGNOSTIC RESULTS

11 REVIEWED & ORDERED

Pathology / Cytology:

Pleural fluid cytology 09/08/2026: metastatic carcinoma consistent with breast primary (GATA3+, ER+ 90%, HER2 1+). Today's cytology pending.

Microbiology:

Pleural fluid cultures (09/2026, 10/2026): no growth.

Pleural Fluid Studies:

10/21 fluid: exudate (protein 4.6 g/dL, fluid/serum ratio 0.70; LDH 412 U/L). Glucose 88 mg/dL. pH 7.38. Nucleated cells 1,450 (lymphocytes 72%). Today's studies pending.

Pre-Procedure Labs:

11/02/2026: WBC 3.1, ANC 1.3, Hb 11.6, platelets 214. INR 1.0. Cr 0.8. Albumin 3.5.

Imaging:

Pre-procedure CXR: large R effusion, mediastinal shift to the left. Post-procedure CXR: catheter well placed, near-complete lung re-expansion, small residual effusion, no pneumothorax. CT and PET as above.

Pulmonary / Cardiac Testing:

EKG 08/2026 (ribociclib baseline): NSR, QTc 438. Echo 08/2026: LVEF 60%, no pericardial effusion.

Prior Records Reviewed:

Oncology notes (Dr. Rahman), three thoracentesis reports with manometry, cytology reports, CT and PET reports, and medication list.

A ASSESSMENT

12 INTERVENTIONAL PULMONOLOGY INTERPRETATION

1) Recurrent symptomatic right malignant pleural effusion from metastatic ER+ breast cancer, confirmed by cytology. Refills quickly (three taps in 6 weeks). 2) The lung is expandable on manometry and CXR, so she is a candidate for IPC or talc pleurodesis. After shared decision-making she chose an outpatient IPC; spontaneous pleurodesis is expected in about 40–50% over 2–3 months, particularly with endocrine and CDK4/6 response. 3) Differential for the recurrence (heart failure, infection, trapped lung) has been excluded. 4) IPC placed today without complications; lung re-expanded and no pneumothorax. 5) Risk factors: mild neutropenia from ribociclib raises the risk of catheter infection (about 5%) — needs strict aseptic home drainage. Radiation skin over the R breast was avoided in tunnel placement. 6) No bronchoscopy, EBUS, or further biopsy needed. Discharge home today.

P PLAN

13 MANAGEMENT BY PROBLEM

Lung nodule or mass plan

Not applicable. Restaging imaging per oncology.

Mediastinal lymphadenopathy plan

Not applicable — stage IV disease already established.

Bronchoscopy plan

None planned.

Pleural effusion plan

IPC placed. No further taps. Review today's fluid studies. If output stays high at 6 weeks, consider talc through the IPC to speed pleurodesis.

Indwelling pleural catheter plan

Home health nurse for the first two drains, then husband (trained and observed today with teach-back). Drain every other day, up to 1,000 mL; stop for chest pain or cough. Keep a drainage log. Dressing change with each drain; silicone dressing due to adhesive sensitivity. Supplies ordered through DME (vacuum bottles ×30/month). Sutures out at 7–10 days. Remove the catheter after 3 drains in a row under 50 mL with no fluid on ultrasound.

Airway obstruction or stenosis plan

Not applicable.

Hemoptysis plan

Not applicable.

Pneumothorax plan

No pneumothorax. Return for sudden chest pain or dyspnea.

Post-procedure plan

Discharge after 1 h observation. Acetaminophen as needed for site pain. No submerging the site (baths, swimming). Showering allowed with dressing covered. Continue letrozole and ribociclib without interruption. Oncology to watch ANC.

Smoking cessation and risk reduction plan

Not applicable — never smoker.

Referral and care coordination plan

Procedure note and plan sent to Dr. Rahman and the nurse navigator. Home health referral placed. DME supply order sent. Offered outpatient palliative care for symptom support — patient will think about it.

Patient education

Written IPC care guide and drainage log provided. Call for fever above 100.4 °F, redness or pus at the site, cloudy fluid, catheter damage or leak, or a sudden drop in drainage with worse breathing. Seek emergency care for severe chest pain or sudden severe dyspnea.

F FOLLOW-UP

14 NEXT STEPS

Phone call in 48 h (first home drain). Clinic in 10 days for suture removal and site check. Clinic visit with CXR and pleural ultrasound at 6 weeks to review the drainage log and assess for pleurodesis. Cytology results to oncology in 3–5 days. Urgent return precautions as above.

TB TIME DOCUMENTATION & BILLING

15 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT
55 minutes (excluding procedure time)

PROCEDURE COUNSELING TIME
15 minutes

IMAGING REVIEW TIME
8 minutes

PROCEDURE TIME, IF APPLICABLE
32 minutes

PLEURAL CATHETER COUNSELING TIME, IF APPLICABLE
20 minutes (patient + husband)

CARE COORDINATION TIME

RECORDS REVIEW TIME, IF APPLICABLE

7 minutes	5 minutes

15a BILLING CONSIDERATIONS — E/M / INTERVENTIONAL PULMONOLOGY CODING

E/M LEVEL

Not separately billed — decision for procedure made at the 10/21 visit

BRONCHOSCOPY CODE(S), IF APPLICABLE	EBUS / BIOPSY CODE(S), IF APPLICABLE
Not applicable	Not applicable

THORACENTESIS / CHEST TUBE / PLEURAL PROCEDURE CODE(S), IF APPLICABLE

32550 — tunneled indwelling pleural catheter insertion

AIRWAY INTERVENTION CODE(S), IF APPLICABLE	IMAGING GUIDANCE CODE(S), IF APPLICABLE
Not applicable	76942 — ultrasound guidance

BASIS FOR BILLING

Procedure-based

ICD-10 DIAGNOSIS CODES

J91.0 — Malignant pleural effusion

[SECONDARY NODULE / MASS / PLEURAL / AIRWAY / PROCEDURE DIAGNOSIS CODE(S), IF APPLICABLE]

C78.2 — Secondary malignant neoplasm of pleura; C50.911 — Malignant neoplasm of right female breast, unspecified site; Z17.0 — Estrogen receptor positive status; C79.51 — Secondary malignant neoplasm of bone

SO SIGNATURE

16 PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY
Samuel Achebe	MD, FCCP	Interventional Pulmonology

DATE	TIME
11/04/2026	11:40