Name: Brett Anderson | DOB: 8/12/1967 | MRN: 3879446 | PCP: Siman Margaret, MD

Progress Notes

Subodh Pandey, MD at 03/03/23 1140

University of Virginia Health System
Outpatient Pulmonary Clinic Note

Patient Name: Michael Brett Anderson
MRN: 3879446
DOB: 8/12/1967
Date of Note: 3/6/2023

HISTORY OF PRESENT ILLNESS

Chief Complaint: Lung Nodule f/u

This is a 55 y.o. male with dyspnea since mid 2021. Initial bronchoscopy had demonstrated an increased percentage of eosinophils, leading to a presumptive diagnosis of chronic eosinophilic pneumonia. He received a trial of corticosteroids, but symptoms did not improve. Despite ongoing immunosuppression with high-dose MMF (1500 mg bid) and steroids (prednisone currently 37.5 mg qd) and antifibrotic therapy with nintedanib, his symptoms continued to progress. He is also on benralizumab (Fasenra, anti-eosinophil antibody). In parallel, he experienced further decline in lung volumes and diffusion capacity, eventually leading to referral for lung transplant evaluation. During w/u he was found to have lung nodule and being referred to me.

Mr. Anderson remains fairly functional despite his underlying lung disease. He tolerates being on room air at rest, but has now been using up to 3-5L of oxygen for activity, which is delivered by a portable concentrator. He tries to stay physically active and walks at least 2-3miles a day, and he regularly goes to the gym to lift weights.

Current ILD therapy:
Prednisone 25mg po tapered from. Ofev. Bactrim ppx. Fasenra last dose (every 8 weeks)

He underwent Nav bronch biopsy and EBUS on 2/27/2023 and is follwoing up to review results.
Since the biopsy still has minimal hemoptysis - specks of blood mixed with phlegm and some sore throat.

PAST MEDICAL & SURGICAL HISTORY

Past Medical History:

Diagnosis	Date
• Hyperlipidemia *per pt report*	
• Hypertension	
• Interstitial lung disease *per pt report*	
• LBBB (left bundle branch block)	
• Mitral valve regurgitation	
• Non Hodgkin's lymphoma *Treated with vincristine, bleomycin, adriamycin, cytoxan, prednisone, and radiation*	1978
• Pulmonary fibrosis *per pt report*	

Past Surgical History:

Procedure	Laterality	Date
• CHG 3D RENDERING W/INTERP & POSTPROCESS SUPERVISION *RADIOLOGY, 3D IMAGING C-ARM; SEIMENS CIOS SPIN performed by Subodh Pandey, MD at UVHE Main OR*	Left	2/27/2023
• NECK SURGERY *nontoxic lymphoma*		1978
• OTHER SURGICAL HISTORY *Face- Basil Cell Carcinoma removal*		01/2022
• PR BRONCHOSCOPY W/CPTR-ASST IMAGE-GUIDED NAVIGATION *NAVIGATION, ION ROBOTIC ASSISTED, (ENB) BRONCHOSCOPY performed by Subodh Pandey, MD at UVHE Main OR*	Left	2/27/2023
• PR BRONCHOSCOPY W/TRANSBRONCHIAL LUNG BX 1 LOBE *BRONCHUS, ION ROBOTIC ASSISTED, BRONCHOSCOPY (RIGID OR FLEXIBLE), WITH TRANSBRONCHIAL LUNG BIOPSY(S), SINGLE LOBE performed by Subodh Pandey, MD at UVHE Main OR*	Left	2/27/2023
• TONSILLECTOMY		
• TURBINATE RESECTION		

ALLERGIES

Allergies

Allergen	Reactions
• Bee Pollen	Other (See Comments)
• Cat Hair Extract	Itching and Other (See Comments)
• Dust Mite Extract *Environmental allergy*	Other (See Comments)
• Mold Extract [Cosamin Ds] *Environmental allergy*	Other (See Comments)
• Molds & Smuts *Other reaction(s): nasal symptoms* *Other reaction(s): nasal symptoms*	Other (See Comments)
• Pollen Extract	Other (See Comments)
• Seasonal	Other (See Comments)

CURRENT MEDICATIONS

Current Outpatient Medications on File Prior to Visit

Medication	Sig	Dispense	Refill
• amlodipine (NORVASC) 5 MG tablet	Take 5 mg by mouth daily.		
• atorvaSTATin (LIPITOR) 40 MG tablet	Take 40 mg by mouth nightly.		
• benralizumab (FASENRA PEN) 30 MG/ML SOAJ	Inject 30 mg into the skin every 8 weeks.		
• fluticasone (FLONASE) 50 MCG/ACT nasal spray	Place 2 sprays into each nostril daily.		
• fluticasone (FLOVENT HFA) 220	Inhale 2 puffs into the		

MCG/ACT inhaler	lungs 2 times daily.		
• Loperamide HCl (IMODIUM PO)	Take by mouth as needed. Taking prn		
• loratadine (CLARITIN) 10 MG tablet	Take 10 mg by mouth daily.		
• magnesium oxide (MAG-OX) 400 MG tablet	Take 400 mg by mouth daily.		
• multiple vitamins w/ minerals (CENTRUM SILVER) CHEW	Take 1 tablet by mouth daily.		
• Multiple Vitamins-Minerals (ZINC PO)	Take 200 mg by mouth Daily.		
• mycophenolate (CELLCEPT) 500 MG tablet	Take 1,500 mg by mouth 2 times daily.		
• nintedanib esylate (OFEV) 150 MG CAPS	Take 150 mg by mouth 2 times daily.		
• omeprazole (PRILOSEC) 40 MG capsule	Take 1 capsule by mouth daily.	90 capsule	3
• ondansetron (ZOFRAN-ODT) 4 MG disintegrating tablet	Take 4 mg by mouth every 8 hours as needed.		
• OXYGEN-HELIUM IN	Inhale into the lungs.		
• Potassium 99 MG TABS	Take 10 mg by mouth daily.		
• predniSONE (DELTASONE) 10 MG tablet	Take 1 tablet by mouth daily. Please take according to the schedule below: 1) Prednisone 40mg (4 tabs) once daily until 12/31 2) Prednisone 30mg (3 tabs) once daily from 1/1/23 to 1/7/23 3) Prednisone 20mg (2 tabs) once daily thereafter (after 1/7/23) (Patient not taking: Reported on 3/3/2023)	60 tablet	3
• sulfamethoxazole-trimethoprim (BACTRIM DS) 800-160 MG per tablet	Take 1 tablet by mouth daily on Monday, Wednesday, and Friday.		
• vitamin D3 (CHOLECALCIFEROL) 25 MCG (1000 UT) TABS	Take 1,000 Units by mouth daily.		
• zoledronic acid (RECLAST) 5 MG/100ML SOLN	Infuse 5 mg into the vein Every year. Last infusion 02/02/2023		

No current facility-administered medications on file prior to visit.

Immunization History:

Immunization History

Administered	Date(s) Administered
• COVID-19 (MODERNA) VACCINE	02/12/2021, 03/18/2021, 11/27/2021, 05/26/2022
• COVID-19 (MODERNA) VACCINE BIVALENT BOOSTER	02/02/2023
• INFLUENZA (FLUCELVAX) VACCINE (CH)	09/29/2022

• Pneumo 20 (Ex: Prevnar 20)	02/09/2023
• Shingrix	09/29/2022
• pneumococcal, unspecified formulation	06/05/2003

FAMILY HISTORY

Family History

Problem	Relation	Age of Onset
• Breast Cancer	Mother	
• Colon Cancer	Maternal Grandmother	
• Lung disease	Neg Hx	
• Autoimmune disease	Neg Hx	

SOCIAL HISTORY

Patient is a life-long non-smoker. No EtOH or illicit drug use. Remote exposure to birds and feathers as a child.
He attends today's visit together with his wife.
Wife has been identified as primary support. Sister from CA potential secondary support.
He used to work as a commercial pilot for United Airlines, but is now on disability.
He lives in Hot Springs, VA and has traveled extensively.

REVIEW OF SYSTEMS

Pertinent ROS noted in the HPI and all other systems are negative.

PHYSICAL EXAMINATION

Vitals: Visit Vitals

BP	134/89 (BP Location: Right arm, Patient Position: Sitting, BP Cuff Size: Adult)
Pulse	85
Temp	36.5 °C (97.7 °F) (Oral)
Resp	16
Ht	1.778 m (5' 10")
Wt	83.9 kg (185 lb)
SpO2	97%
BMI	26.54 kg/m²

GENERAL: NAD, orientated, and breathing comfortably
EYES: Pupils equal, round, and reactive to light
HENT: Moist mucosa, normal oral cavity on inspection
CARDS: RRR without GMR
PULM: scattered crackles at bases
GI: Soft, NTND, hypoactive bowel sounds
SKIN: No acute pathological rashes or findings
NEURO: Cranial nerves grossly intact, good, uniform strength in all limbs, no focal findings
LYMPHATIC: No cervical chain lymphadenopathy

LABS/STUDIES

Lab Results

Component	Value	Date
CREATININE	0.9	02/09/2023
BUN	21	02/09/2023
NA	138	02/09/2023
K	4.9 (H)	02/09/2023
CL	103	02/09/2023
CO2	24	02/09/2023
MG	2.1	02/09/2023
AST	28	02/09/2023

Lab Results

Component	Value	Date
WBC	10.83	02/09/2023
HGB	13.9 (L)	02/09/2023
HCT	42.1	02/09/2023
MCV	103.7 (H)	02/09/2023
PLT	325	02/09/2023
INR	0.9	02/09/2023
PTT	23.9 (L)	02/09/2023

No components found for: ABG

Diagnostic Studies

Diagnostic imaging results were personally reviewed and by me today on this visit.

LEFT HEART CATH 2018

CONCLUSION:
1. Minimal nonobstructive coronary atherosclerosis involving the distal right coronary artery and mid left anterior descending artery with no stenosis greater than 5%-10%.
2. Normal left ventricular systolic function (ejection fraction of 55%-60%) without any regional wall motion abnormalities.
3. Normal left ventricular filling pressure.

PLAN:
The patient may benefit from statin therapy for primary prevention. He does not require any revascularization at this time. I think his stress test appears to be a false positive. He will undergo standard postprocedure care and continue the risk factor management and modification.

Dictated By: Zeshan A Rana, MD (HUB)

JOB# 090440/812797207
Authenticated by Zeshan A Rana, MD On 11/06/2018 03:18:53 PM

Pulmonary Function Tests:

PFT Results	Latest Ref Rng & Units	1/23/2023
FVC	L	2.45
FVC % pred	%	50
FEV1	L	2.21
FEV1 % pred	%	58
FEV1/FVC	%	90
FEF25-75%	L/SEC	3.96
FEF25-75% pred	%	120
DLCO	ML/MIN/MMHG	9.59
TLC	L	3.45
RV	L	0.87
FRC	L	2.12
RAW	CMH2O/L/S	0.54

Post Test Comments: Spirometry results repeatable, acceptable, and usable.
DLCO repeatable and acceptable. IVC 90% or greater than best FVC. DLCO not corrected for Hb.
Lung Volumes and RAW repeatable and acceptable.

6 MIN. WALK=	Oxygen/Liters	SaO2 Begin Exertion	SaO2 With Exertion	Meters walked
	RA	92%	86%	50m
	2L	95%	92%	244m

Before and After exercise: Dyspnea Borg score: .5 and .5 ; Heart Rate: 102 and 98 ; Blood Pressure: 127/76 and 135/92
TOTAL METERS WALKED IN 6 MINUTES = 244m SaO2 improved with 2L liters oxygen. SaO2 at rest on room air = 92% Pt wore mask for the entire walk test.
Pt answered no to all COVID screening questions. Temp = 98.1

PET CT 1/5/2023

1. Left lower lobe superior segment mass-like consolidation with increased FDG uptake, SUV max 5.5. Finding is concerning for malignancy, though infection remains a differential consideration given slightly decreased size and the patient's background airspace disease. Short-term follow-up chest CT is recommended.

2. Diffusely increased FDG uptake throughout the skeletal muscle, which may be secondary to prednisone use per chart review.

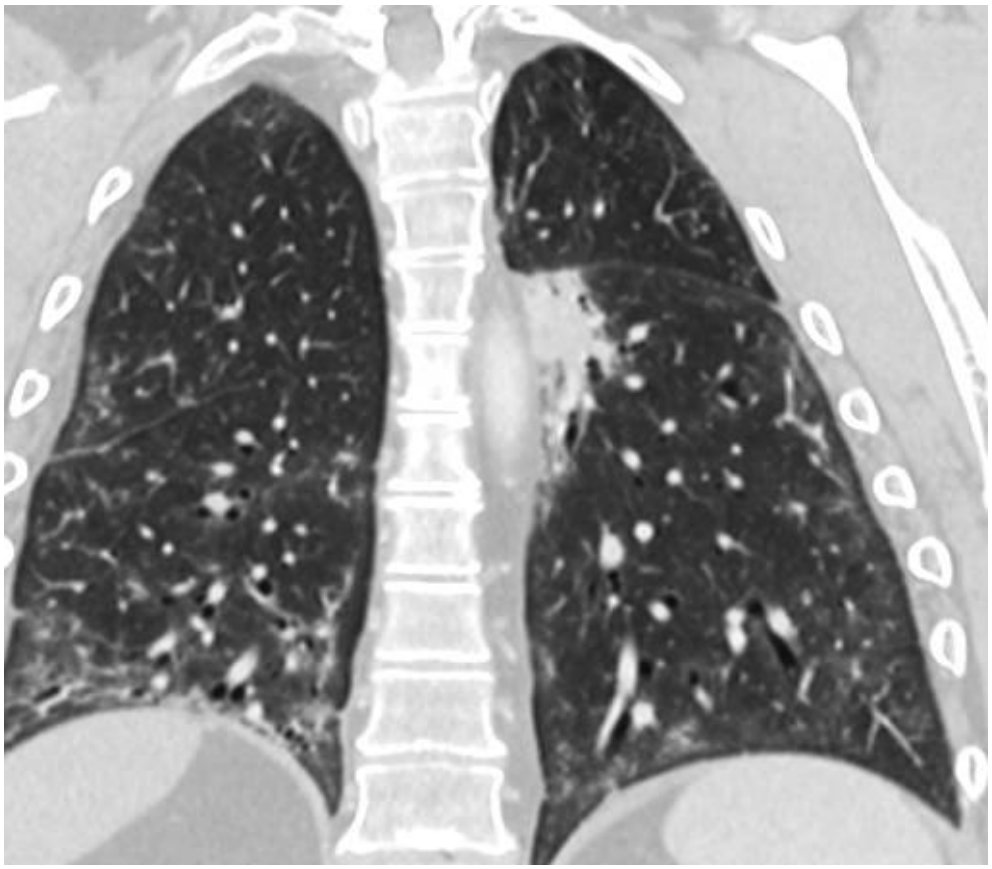
3. Grossly stable basilar predominant ground glass opacities in keeping with history of interstitial lung disease, better evaluated on prior chest CT.

CT chest 2/9/2023

1. Persistent heterogeneous region of consolidation in the superior segment of the left lower lobe which demonstrated FDG uptake on January 5, 2023. Given its persistence since August 15, 2022 and possible slight interval growth, neoplasm deserves consideration. If bronchoscopy is contemplated, this can likely be reached via superior a subsegmental bronchus extending from the left lower lobe superior segmental bronchus.

2. No significant change otherwise in the diffuse heterogeneous ground-glass opacities, peribronchovascular abnormalities, bronchiectasis and centrilobular ground-glass nodules. Differential considerations include nonspecific interstitial pneumonitis, multifocal organizing pneumonia and atypical interstitial lung disease such as CTD-ILD or chronic hypersensitivity pneumonitis.

3. No pathologic enlargement of mediastinal or hilar lymph nodes



Bronch results

FINAL DIAGNOSIS AND ATTENDING SIGNATURE

A. LUNG, LEFT LOWER LOBE MASS, ROBOTIC-NAVIGATIONAL FINE NEEDLE ASPIRATION WITH CELL BLOCK:
ADENOCARCINOMA. (See comment.)

B. LUNG, LEFT LOWER LOBE MASS, TRANSBRONCHIAL ROBOTIC-NAVIGATIONAL BIOPSY:
ADENOCARCINOMA. (See comment.)

C. LYMPH NODE, STATION 11L, ENDOBRONCHIAL ULTRASOUND-GUIDED FINE NEEDLE ASPIRATION WITH CELL BLOCK:
METASTATIC ADENOCARCINOMA.

The PD-L1 TPS is negative (<1%).
NGS pending

FLUIDS	
Total Cells, BAL	02/27/23 110,000
Alveolar Macrophage	02/27/23 91
Cilliated Cell	02/27/23 4
Neutrophil, Fluid	02/27/23 4
Lymphocyte, Fluid	02/27/23 1
Pathologist Review	02/27/23 See C...

FINAL DIAGNOSIS AND ATTENDING SIGNATURE
A. LUNG, LEFT LOWER LOBE, BIOPSY:
BRONCHIAL MUCOSA AND ALVEOLATED TISSUE WITH FOCAL FIBROSIS. (See comment.)

ASSESSMENT & PLAN

		ICD-10-CM	ICD-9-CM	
1.	**Adenocarcinoma of left lung**	**C34.92**	**162.9**	**Ambulatory referral to Hematology Oncology**

2. ILD - Chronic eoisinophilic Pneumonia vs NSIP
3. Nonhodkin lymphoma 1978 - s/p neck surgery, chemo/rads

- AdenoCa of left lung - T1cN1M0 - IIB
- He has fairly progressive ILD despite medical therapy (Prednisone 25mg po tapering; Ofev; Bactrim ppx; Fasenra)
- PFT 2021(FVC of 65%, FEV1 of 71%, and DLCO of 68%) have declined over time, PFT 1/2023 - FVC 2.45L(50%); FEV1 2.21(58%) and DLCO 33%. However his overall performance status remains good - he is fairly active - walks at least 2-3miles a day, and he regularly goes to the gym to lift weights.
- Management of Lung Cancer/ILD will be complicated and will need to discuss care in next tumor board 3/7/2023 - while surgical option would have been best option in terms of re-lisitng for txp, his overall pulmonary function, location of tumor and N1 ds may be a barrier. Radiation would be less favored given his fibrotic disease and N1 ds. He likley will need considertaiton of adjuvant therapy given N1 ds.

His biopsy from LLL ant/lat basal segment (different area from nodule) for ILD characterization show fibrotic area, pending further review; Envisia genomic classifier sent and pending; Fluid differential was bland - no eosinophilia; BAL cultures negative

Return to Clinic: pending tumor board discussion on 3/7/2023

I spent 45 min reviewing chart, discussing and co-ordinating care.

Electronic Signature:
Subodh Pandey, MD
Assistant Professor of Medicine
Pulmonary and Critical Care Medicine
University of Virginia Medical Center

CC: Siman Margaret, MD

Addendum:

Tumor board recs 3/7/2023:
Given N1 ds – will not be a segmentectomy candidate; DLCO too low to consider lobectomy
Will likely need systemic therapy – Chemo/targeted therapy if mutation driver positive (genomics pending)
Also recommended to refer to all three specialities – Thoracic Sx, Rad onc, Medical Onc for discussion
MRI head
Recommendations discussed with patient today