ST. MAR[illegible] HOSPITAL AND MEDICAL CENTER
450 STAN[illegible]ST • SAN FRANCISCO CA 94117 • 415 668-1000

KENNETT, Teresa
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Drs. J. [redacted]
MR #: 50 92 93

HISTORY & PHYSICAL

DATE OF ADMISSION: 7/17/84

HISTORY OF PRESENT ILLNESS: The patient is a 35-year-old white female who is three months post partum. Delivery was normal vaginal delivery without complications. Three weeks after delivery the patient noticed an asymmetrical bulging over the subumbilical area. This area was minimally tender and there was a noticeable mass present. She then went to see her general practitioner, Dr. Schofferman, who proceeded to watch the mass closely. He then referred her to Dr. Clarke, and in May, the patient underwent an ultrasound, which showed some small, rounded cyst-like structures. It was felt at this time that these structures may have been of uterine involvement and the patient was again to be watched closely. Throughout this time, the patient reported being in good health. She had no difficulty with bowel movements or urination. She denied any fever, chills, night sweats, nausea or vomiting. Appetite had been normal.

Over the course of the next few weeks, this ill-defined mass began to enlarge and became more noticeable. Ultrasound done on 7/16/84 showed there to be profoundly perisacral, periaortic and mesenteric nodes. CT scan of the abdomen done on 7/16/84 showed there to be massively enlarged periaortic and mesenteric nodes displacing the bowel. The patient also had a barium enema done back in May that was normal.

The patient gives a history of recent gynecological exam that was unremarkable. Throughout this course, the patient's only complaints have been slight left lower quadrant discomfort and some lower back pain.

MEDICATIONS: None.

ALLERGIES: The patient was allergic to penicillin, causing a rash, and has a history of extrinsic allergies.

PAST MEDICAL HISTORY: In 1972, the patient had a Fallopian cyst removal. In 1974, the patient had a kidney infection, treated with IV antibiotics, resolved without complications.

SOCIAL HISTORY: Smoking history: None. Alcohol: Occasionally. Employment: As a neighborhood administrator.

FAMILY HISTORY: There is a negative history of cancer. Grandfather died at age 69 of a myocardial infarction. No history of diabetes.

REVIEW OF SYSTEMS:
HEENT: No headache, dizziness, or visual disturbances.
Lungs: No shortness of breath, cough or hemoptysis.
Heart: No chest pains, palpitations.
Abdomen: See above.
Genitourinary: No hematuria or dysuria.

PHYSICAL EXAMINATION:

General: The patient is a well-nourished female, in no apparent distress.

Vital signs: Pulse 72. B/P and temperature still pending.

Skin: Without rashes or lesions.Warm and dry color and turgor2

HEENT: Eyes: Pupils equal, round and reactive to light and extraocular movements are intact. Sclera is anicteric. Nose and throat: Pink mucosa without exudates or erythema.

Neck: Supple. Thyroid not palpable.

Nodes: Cervical, submandibular, axillary, and inguinal nodes not palpable.

Lungs: Clear to auscultation and percussion.

Heart: Normal S1 and S2. There is a Grade II/VI systolic murmur heard best along the left sternal border. No S3 or S4.

Abdomen: The patient has normal bowel sounds. Liver and spleen are not palpable. Abdomen is soft. There is a large, palpable mass extending from just under the xiphoid process to just above the suprapubic area. This mass is approximately 5 cm in width, minimally tender and able to be moved across the abdomen slightly. The mass is also very firm.

Rectal: The patient reported this as recently being done by Dr. Clarke, and requested it to be deferred. Reportedly unremarkable per patient.

Extremities: No clubbing, cyanosis or edema.

Neurologic: The patient is alert, oriented times 3. Cranial nerves II-XII are intact. Motor and sensory are grossly intact. Deep tendon reflexes are +2 and symmetrical.

Pulses: Carotid pulses are full and of normal upstroke without bruit. Femoral, dorsal pedis and posterior tibial are normal without bruit.

LABORATORY DATA: Pending.

CHEST X-RAY: No active pulmonary disease.

EKG: Pending.

ASSESSMENT: The patient is a 35-year-old patient with obvious abdominal mass. Ultrasound and CT findings most compatible with non-Hodgkin's lymphoma. The patient has no systemic complaints.

PLAN: Will rule out non-Hodgkin's lymphoma. Scheduled for exploratory laparotomy with excision of nodes in the AM.

FP/ss
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[redacted] M.D.