Plaintiff Name: [redacted]
Date of Incident: 6/8/2020
Date of Death: (if applicable)

[redacted] [redacted] MERIT REVIEW REPORT

FILE DEMOGRAPHICS

Plaintiff Name:	[redacted]	**Attorney:**	
Date of Incident:	6/8/2020	**Defendant MD:**	[redacted], MD
Date of Birth:	3/12/1973	**Defendant Facility**	[redacted] Medical Cente
Occupation:	Disabled	**Marital Status:**	Married

Attorney Questions and Issues to Address:

1. Assess for possible complications from mastectomy and/or MediPort placement.
2. Assess if mastectomy should have been performed.

I. NURSING OPINION REGARDING MERIT:

This case has no merit.

- Regarding the alleged complication in this case of difficulty breathing and new onset need of supplemental oxygen: This allegation is **not** supported by the medical records. She had a history of being a heavy smoker, her pre-operative vital signs showed a low oxygen saturation of 92% on room air with normal levels being 95-100%. During surgery her oxygen saturation dropped to the 83-86% range and dropped as low as 81% near the end of the case. This alleged complication would not have been due to the Mediport placement as she was found to have difficulty breathing and underwent a CT of her chest prior to undergoing the Mediport placement.
- Regarding the alleged unnecessary mastectomy surgery on 6/8/2020: This allegation is **not** supported by the medical records. The pathology results from her excisional biopsy of the right breast on 5/18/20 revealed invasive ductal carcinoma with lobular features, grade 1; ductal carcinoma in situ, solid, cribriform and comedo types, grade II; and microcalcifications associated with invasive tumor. Her tumor was ER/PR and HER2 positive. Invasive ductal carcinoma treatment includes surgical removal of the breast tumor and lymph nodes.[1]

****PLEASE REFER TO CASE STRENGTHS/WEAKNESSES TABLE AND MEDICAL FACT CHRONOLOGY BELOW FOR FURTHER DETAILS.**

[1] Treatment for invasive ductal carcinoma - https://www.breastcancer.org/symptoms/types/idc/treatment

Plaintiff Name: [redacted]
Date of Incident: 6/8/2020
Date of Death: (if applicable)

II. RECOMMENDATIONS FOR EXPERT WITNESSES:

1. **Oncology physician:** Review pathology results and opine regarding the standard of care in treatment for Ms. [redacted] type of breast cancer.
2. **Pulmonologist:** Review Ms. [redacted] history as a heavy smoker, pre-operative, intraoperative and post-operative oxygen saturations, and CT chest findings from 7/9/20 and opine whether her heavy smoking history had an impact on her respiratory status or if there was possible negligence during the surgery.

TRIFECTA'S EXPERT WITNESS LOCATION SERVICE CAN PROCURE/VET ALL RECOMMENDED EXPERTS.

III. MISSING RECORDS/FURTHER RECOMMENDATIONS:

1. No missing records at this time.

IV. CASE STRENGTHS AND WEAKNESSES TABLE:

Issues	Case Strengths	Case Weaknesses	LNC Rationale for Findings
Complications from mastectomy surgery and/or MediPort placement.	She developed difficulty breathing after the mastectomy surgery and new onset need for supplemental oxygen.	She was a heavy smoker, 1-2 packs per day. She had a low oxygen saturation of 92% on room air pre-operatively for the mastectomy surgery. She had low oxygen saturation levels during the entirety of the mastectomy surgery, ranging from 83-86%, and dropping to 81% near the end of the case.	Cigarette smoking has been implicated as an import risk factor for the development of respiratory symptoms.[2]

[2] Cigarette smoking and difficulty breathing - http://europepmc.org/article/PMC/2671519

		The CT Chest was done on 7/9/20 and showed bilateral upper lobe dominant groundglass opacity with subsolid nodularity. This CT was done prior to the 7/10/20 Mediport placement ruling out complications from the Mediport placement surgery. Although she saw a pulmonologist, [redacted], MD, on 7/21/20, who indicated the onset of her dyspnea was one month prior to this visit there was no documentation in any of Dr. [redacted] visit notes to indicate she had reported difficulty breathing. [redacted] MD, oncologist, on 10/1/20 indicated she had been non-compliant.	Smoking can cause interstitial lung disease. The most common high-resolution CT findings in RB-ILD are centrilobular nodules, ground-glass opacities.[3]
Alleged unnecessary mastectomy		The treatment of choice for her type of breast cancer was mastectomy and lymph node removal. Of note 2/15 lymph nodes were found to be cancerous.	The pathology results from her excisional biopsy of the right breast on 5/18/20 revealed invasive ductal carcinoma with lobular features, grade 1; ductal carcinoma in situ, solid, cribriform and comedo types, grade II; and microcalcifications associated with invasive tumor. Her tumor was ER/PR and HER2 positive. Invasive ductal carcinoma treatment includes surgical removal of the breast tumor and lymph nodes.

[3] Smoking and ground-glass opacities - https://pubs.rsna.org/doi/pdf/10.1148/rg.285075223

V. CASE SUMMARY:

Ms. [redacted] underwent a screening mammogram on 4/30/20 and was found to have a right breast mass concerning for malignancy. Recommendation was to undergo a right breast biopsy. She saw general surgeon, [redacted] MD, on 5/12/20, for an initial visit and he scheduled her for an excisional biopsy of the right breast on 5/18/20. **Ms. [redacted] underwent the right breast biopsy on 5/18/20** and the **surgical pathology report, on 5/26/20, showed she had invasive ductal carcinoma.** Her tumor was ER/PR/HER-2 positive. She saw Dr. [redacted] for follow up on 6/2/20, and after discussing the findings from the biopsy, **Ms. [redacted] elected to undergo a right modified radical mastectomy.** This surgery was performed on 6/8/20. The medical records from her **pre-operative care showed Ms. [redacted] had a low oxygen saturation of 92% on room air**, with 95-100% being the normal range. During surgery the anesthesia records showed **Ms. [redacted] oxygen saturation level range generally from 83-86% with it dropping to 81% near the end of the case**. Records from her post-operative care showed she had an oxygen saturation initially of 93% on 8 liters of supplemental oxygen. The **pathology results from Ms. [redacted] modified radical mastectomy showed two out of 15 lymph nodes with metastatic carcinoma**. Pathology staging was pT0, pN1a. Ms. [redacted] was again ER/PR/HER-2 positive.

Ms. [redacted] saw Dr. [redacted] post-operatively on 6/12/20 and 6/18/20. No mention was made regarding any difficulty breathing on the part of Ms. [redacted]. On 6/19/20 a communication message indicated Dr. [redacted] started her on an antibiotic, Levaquin, but the message provided no reason for this antibiotic being prescribed.

On 06/24/20 Ms. [redacted] saw oncologist, [redacted] MD, for an initial visit. Her review of systems was positive for fatigue, weakness, and constipation but not for difficulty breathing. Dr. [redacted] indicated she would undergo **CT scans of the chest, abdomen, and pelvis for staging of her cancer treatment**.

On 7/7/20 Ms. [redacted] saw Dr. [redacted] for f/u and again there was no mention of difficulty breathing.

On 7/9/20 Ms. [redacted] underwent the routine staging CT chest which **revealed nonspecific bilateral upper lobe dominant groundglass opacity** with subsolid nodularity which might represent atypical infection. Underlying lesion could not be entirely excluded and should be followed to resolution.

On 7/10/20 Ms. [redacted] underwent an uneventful MediPort placement with Dr. [redacted].

On 7/21/20 she saw [redacted] MD, pulmonologist, who noted Ms. [redacted] recent dyspnea had worsened. **This was the first mention of difficulty breathing in the medical records reviewed**.

Ms. [redacted] underwent a right upper lobe lung biopsy with the 8/28/20 pathology report revealed the bronchial mucosa with focal, mild, chronic inflammation and the alveolated lung tissue with chronic inflammation. **These are changes seen with smoking.** The biopsy was negative for malignancy.

Ms. [redacted] saw oncologist, Dr. [redacted] for f/u on 10/1/20 and he noted she had been non-compliant. On 11/23/20 she saw general surgeon, [redacted] MD for a malfunctioning Mediport. She was to be scheduled for Mediport removal and replacement. A malfunctioning Mediport is not a complication but a known issue which occurs at times.

VI. MEDICAL HISTORY AT TIME OF INCIDENT

Height/Weight: 5'11" / 290 pounds

Pertinent Medical History: Heavy smoker, Bronchitis, hypertension, hyperlipidemia, anxiety, depression, chronic back pain, ovarian cysts, gout, tachycardia, ulcers, GERD. She was on disability due to back pain.

Pertinent Surgical History: Oophorectomy, Appendectomy.

Medications at time of Incident:

1. Gabapentin 800 mg 3 times daily for nerve pain.
2. Ultram 50 mg every 6 hours for pain.
3. Linzess 145 mcg capsule before 1st meal of the day for chronic constipation.
4. Omeprazole 40 mg daily before a meal for reflux.
5. Paxil 40 mg daily for depression.

Co-Morbidities:

1. She was obese, 5'11" and weighing 290 pounds

2. Heavy smoker of cigarettes, 1-2 packs per day.

3. History of bronchitis.

4. Family history of lung, liver and colon cancer.

VII. MEDICAL FACT CHRONOLOGY TIMELINE:

Medical Fact Chronology Timeline

Date/ Time	Page	Provider	Event/Outcome
4/30/20	PMC, PDF 282-283	[redacted] Medical Center [redacted] MD Radiologist	**IMAGING STUDY:** Mammogram Diagnostic Bilateral w/TOMO **IND:** Screening **IMP:** Right breast retroareolar mass concerning for malignancy. BIRADS 4. Suspicious. **RECOMMENDATION:** Right breast biopsy.
5/12/20	PMC, PDF 67-69	[redacted] Medical Center [redacted] MD General Surgeon	**OFFICE VISIT:** **CC:** Breast lump **HPI:** Breast lump to right breast, onset 2 months ago. **ROS:** Negative, including negative for any type of discharge from breast, breast asymmetry, breast dimpling, nipple retraction, breast pain. **ASSESSMENT:** Lump in the right breast. 47 y/o female presents with mammogram showing BIRADS-4 (suspicious). **PLAN:** Scheduled for excisional biopsy of right breast mass on Monday (5/18/20).
5/18/20	PMC, PDF 315	[redacted] Medical Center [redacted] MD	**OPERATIVE REPORT** **PROC:** Excisional biopsy of right breast. **IND:** This is a 47 year-old white female who knows there is palpable mass of the right breast including areola. The mammogram was done and came back positive with BI-RADS 4.

Plaintiff Name: [redacted]
Date of Incident: 6/8/2020
Date of Death: (if applicable)

Medical Fact Chronology Timeline

Date/ Time	Page	Provider	Event/Outcome
		General Surgeon	**Pre-Op. DX:** Right breast mass. BI-RADS 4. **Post-Op. DX:** Right breast mass. BI-RADS 4. **Specimen:** Right breast mass.
5/26/20	PMC, PDF 270-271	[redacted] Medical Center [redacted] D.O. Pathologist	**SURGICAL PATHOLOGY REPORT** **PROCEDURE DATE:** 5/18/20 **RECEIVED DATE:** 5/19/20 **SIGN OUT DATE:** 5/26/20 **DIAGNOSIS:** Right breast, Excisional Biopsy: - Invasive ductal carcinoma with lobular features, grade 1; margins negative. See comment. - Ductal carcinoma in situ, solid, cribriform and comedo types, grade II; margins negative. - Microcalcifications associated with invasive tumor. **COMMENTS:** Tumor Site: Retroareolar region. Tumor Size: Greatest dimension: 26 mm; Additional dimensions: 20 mm. Histologic Grade: Glandular/tubular differentiation: Score 2. Nuclear pleomorphism: Score 2. Mitotic score: Score 1. Overall grade: Grade I. Tumor Focality: Single focus of invasive carcinoma. Ductal Carcinoma in Situ: Present, negative for extensive intraductal component. Size (Extent) of DCIS: 9 x 7 mm. Architectural Patterns: Solid, cribriform and comedo. Nuclear Grade: Grade II (intermediate). Necrosis: Present, central. Lobular Carcinoma in Situ: Not identified. Tumor Extension: Invasive carcinoma directly invades into the dermis without skin ulceration. Margins: Invasive carcinoma margins: Uninvolved by invasive carcinoma.

Medical Fact Chronology Timeline

Date/ Time	Page	Provider	Event/Outcome
			Distance from closest margin: Invasive tumor is 0.6 mm from the anterior/superior margin. DCIS margin: Uninvolved by DCIS. Regional Lymph nodes: No lymph nodes submitted or found. Treatment Effect: No known presurgical therapy. Lymphovascular invasion: Not identified. Pathologic Staging: Primary tumor: pT2a. Regional Lymph Nodes: pNX Distant metastases: Not applicable. Microcalcifications: Present in invasive tumor. **BREAST BIOMARKER TESTS RESULTS** Estrogen Receptor (ER): Positive 100%. Progesterone Receptor (PR): Positive, 90%. HER2 (by Immunohistochemistry): Positive, 60%. KI-67: Proliferation index 5%
6/2/20	PMC, PDF 73-76	[redacted] Medical Center [redacted] MD General Surgeon	**OFFICE VISIT** **CC:** Post-op **HPI:** The patient reports incisional pain. Diagnosis is right breast excision biopsy: Invasive ductal carcinoma with lobular features, grade 1; margins negative. Ductal carcinoma in situ, solid, cribriform and comedo types, grade II; margins negative. Microcalcifications associated with invasive tumor. **ROS:** Negative. **ASSESSMENT:** 47 year-old s/p excisional biopsy of right breast mass 5/18/20. Pathology discussed with patient was positive for invasive ductal carcinoma. **PLAN: After discussing with pt she has elected to undergo right MRM on Monday.**
6/8/20 0830	PMC2, PDF 242	[redacted] Medical Center [redacted] RN	**PRE-OP VITAL SIGNS** BP 145/86, Temp 98.1, Heart rate 104, Respirations 22, **Oxygen Saturation 92% on Room Air.**

Plaintiff Name: [redacted]
Date of Incident: 6/8/2020
Date of Death: (if applicable)

Medical Fact Chronology Timeline

Date/ Time	Page	Provider	Event/Outcome
6/8/20	PMC2, PDF 242	[redacted] Medical Center [redacted] MD General Surgeon	**OPERATIVE REPORT** **PROC:** Right modified radical mastectomy **IND:** This is a 47- year- old white female, who noticed appearance of palpable mass in the area of right breast . Excisional biopsy was performed , which came back positive for invasive adenocarcinoma. The patient is going to the operating room for right modified radical mastectomy. **Pre-Op. DX:** Right breast cancer. **Post-Op. DX:** Right breast cancer. **Specimen:** Right breast and right axillary lymph nodes.
6/8/20	PMC2, PDF 214, 216, 212	[redacted] Medical Center [redacted] D.O. Anesthesiologist [redacted] CRNA Anesthetist	**ANESTHESIA RECORD** **SpO2:** During surgery her oxygen saturation dropped and stayed generally in the 83-86% range. **It dropped as low as 81% near the end of the case** *(the scan is of poor quality and the times are illegible)*. **FINAL ANESTHESIA DATA:** BP 145/84, Pulse rate 102, Resp rate 20, Temp 100 degrees, **% O2 'Sat 94% on 6L O2.**
6/8/20 1043 - 1113	PMC2, PDF 269	[redacted] Medical Center [redacted] RN	**POST ANESTHESIA CARE VITAL SIGNS** 10:43: Oxygen Saturation 93% on 8 LPM O2. 10:58: Oxygen Saturation 93% on 4 LPM O2 per nasal cannula. 11:13: Oxygen Saturation 93% on 4 LPM O2 per nasal cannula.
6/10/20	PMC, PDF 269-271	[redacted] Labs [redacted] MD, F.C.A. P. Pathologist	**SURGICAL PATHOLOGY REPORT** **DIAGNOSIS:** BREAST, MASTECTOMY - WITH REGIONAL LYMPH NODES, RIGHT: Benign breast with procedure-related changes and no residual invasive carcinoma. **Two out of 15 lymph nodes with metastatic carcinoma** (2/15). **TYPE OF SPECIMENIPROCEDURE**: Total mastectomy Specimen laterality: Right Tumor size: No residual Invasive carcinoma Histologic type of invasive carcinoma: No residual invasive carcinoma

Medical Fact Chronology Timeline

Date/ Time	Page	Provider	Event/Outcome
			... Regional lymph nodes involved by tumor cells: Number of lymph nodes with macrometastases: 2 Number of lymph nodes.wi.th micrometastases: 0. Number of lymph nodes with isolated tumor cells: 0. Size of largest metastatic deposit: 4 mm. Extranodal extension: Not identified. Total number of lymph nodes examined: 15. ... AJCC Pathologic Staging: pT0, pN1a. Estrogen Receptor by IHC: Positive 100%. Progesterone Receptor by IHC: Positive 90%. HER-2/NEU Oncoprotein Status by IHC: Positive score 3+, Ki67 is 5%. **CLINICAL HISTORY:** Breast cancer. **SPECIMENT RECEIVED:** Breast, mastectomy – with regional lymph nodes, right.
6/12/20	PMC, PDF 78-81	[redacted] Medical Center [redacted] MD General Surgeon	**OFFICE VISIT** **CC:** Post-op. **HPI:** The patient reports incisional pain. the pain scale is 5/10. The patient is not using pain medication and reports no complications with the wound. Had breast mastectomy 6/8/20. **ROS:** Negative, including negative for dyspnea or any other respiratory issues. **ASSESSMENT:** Lump in the right breast, s/p right MRM 4 days ago, Recovering well. No complaints. Postop, wound is healing with primary intention. Still substantial amount of fluid from JP drains. **PLAN:** F/u next week.
6/18/20	PMC, PDF 83-87	[redacted] Medical Center [redacted] MD General Surgeon	**OFFICE VISIT** **CC:** Post-op. **HPI:** The patient reports incisional pain. the pain scale is 2/10. Indwelling device includes JP x 2. No s/s of infection present. **ROS**: Negative, including negative for dyspnea or any other respiratory issues. **ASSESSMENT:** Lump in the right breast, s/p right MRM. Postop wound is healing with primary intention. JP drains removed.

Plaintiff Name: [redacted]
Date of Incident: 6/8/2020
Date of Death: (if applicable)

Medical Fact Chronology Timeline

Date/ Time	Page	Provider	Event/Outcome
			Pathology: 2 of 15 LNs are positive. **PLAN:** F/u with Dr.[redacted] for possible chemotherapy. F/u with me in 2 weeks for stapes removal and possible MediPort placement.
6/19/20 1504	PMC, PDF 88	[redacted] Medical Center [redacted] MD General Surgeon	**COMMUNICATION MESSAGE** Dr.[redacted] called in an order for Levaquin to the pharmacy. No reason was given for this order.
6/22/20 1504	PMC, PDF 89	[redacted] Medical Center [redacted] MD General Surgeon	**COMMUNICATION MESSAGE** Ms.[redacted] called to state she had concerns about swelling under both drain sites removed at her last office visit. Dr.[redacted] instructed her to take Motrin 800 mg every 3-4 hours as needed and report to clinic on 6/23/20.
6/24/20	PMC, PDF 99-105	[redacted] Medical Center [redacted] MD Oncologist	**CC:** Post-op. **HPI:** Pt referred by Dr[redacted] for consideration of adjuvant chemotherapy. Pt wasn't getting routine mammograms, however around March she started to feel rt sided nipple changes that got worse and eventually had a mammogram done in 4/2020 that showed a **rt breast mass. This was biopsied 5/18/20, found to be invasive ductal carcinoma, Grade 1, 2.6 cm, margins negative, ER(+) 100%, PR(+) 90%, Her2 (+)by IHC +3, Ki-67 5%.** Pt eventually had a rt modified radical mastectomy 6/10/20 by Dr[redacted] that showed no residual invasive carcinoma but did show **2/15 LN involved with metastatic carcinoma**, largest spot was 4mm. No ECE. There was no LVI, no dermal LVI. There was a DCIS in the bx, but none in the mastectomy specimen. **ROS:** Positive for fatigue, weakness and constipation. **ASSESSMENT:** Cancer of right female breast. 47 yr. old post-menopausal female pt (last menstrual period was 2 yrs ago) with no routine mammograms and is currently diagnosed with a

Plaintiff Name: [redacted]
Date of Incident: 6/8/2020
Date of Death: (if applicable)

Medical Fact Chronology Timeline

Date/ Time	Page	Provider	Event/Outcome
			T2, N1a invasive ductal carcinoma, right breast, Grade 1, Ki-67 5%, ER(+) 100%, PR(+) 90%, Her2 (+) +3 IHC. S/p modified radical mastectomy 6/10/20. Negative margins. No PNI, no LVI, no dermal LVI. 2/15 LN involved . Largest spot 4 mm ECE. Currently healing from sx. Drains just removed. **PLAN:** Pt will need adjuvant for her Stage 2b, triple(+), IDC. This will be in form of AC followed by TPH. We will wait for her to be healed and cleared from sx to start chemo (currently planned for 7/13/20) -Staging scans given her Her2 positivity and LN involvement and this will be in form of CT c/a/p and Bone scan. ... -Pt will see Dr [redacted] on the 7th and I will see her on the 8th and if cleared from sx will start chemo on the 13th after port is placed.
7/7/20	PMC, PDF 92-	[redacted] Medical Center [redacted] MD General Surgeon	**OFFICE VISIT** **CC:** Post-op **HPI:** The status of the patient is improved. The patient reports pain. The pain scale is 2/10. Pertinent negative include all respiratory type symptoms. **ROS:** Negative except for lymphadenopathy. **ASSESSMENT:** Cancer of right female breast. S/p right MRM. -Postoperative wound is healing with primary intention. No signs or symptoms of infection. **PLAN:** Scheduled pt for MediPort placement on Friday (7/10/20).
7/9/20	PMC, PDF 98	[redacted] Medical Center [redacted] MD Radiology	**CT CHEST W+W/O CONTRAST** **IND:** Malignant neoplasm of unsp site of right female breast. **IMP:** 1. Nonspecific bilateral upper lobe dominant groundglass opacity with subsolid nodularity may represent atypical infection. Underlying lesion cannot be entirely excluded and should be followed to resolution. 2. Large right anterior chest wall fluid collection extending from the axilla to the breast tissue likely postoperative seroma.

Plaintiff Name: [redacted]
Date of Incident: 6/8/2020
Date of Death: (if applicable)

Medical Fact Chronology Timeline

Date/ Time	Page	Provider	Event/Outcome
			3. Mediastinal lymphadenopathy is nonspecific given lung findings and may represent reactive adenopathy; however, metastatic enlargement cannot be entirely excluded , attention to be paid on follow-up.
7/10/20	PMC, PDF 425-426	[redacted] Medical Center [redacted] MD General Surgeon	**OPERATIVE REPORT** **PROC:** MediPort Placement. **IND:** This is well known to me, 47-year-old white female, who was diagnosed with breast cancer. Modified radical mastectomy was performed. Today, the patient is going to the operating room for Mediport placement. **Pre-Op. DX:** Breast cancer. **Post-Op. DX:** Breast cancer.
7/21/20	PMC, PDF 112-119	[redacted] Medical Center [redacted] MD Pulmonary Disease	**OFFICE VISIT** **CC:** Dyspnea. **HPI: Onset of symptoms was 1 month ago. Recently the dyspnea has worsened.** The dyspnea lasts (length) varies. Symptoms are debilitating. Symptom is aggravated by activities of daily living, mod activity (e.g. climbing stairs) and mild activity (e.g. walking). Denies relieving factors. Associated symptoms include fatigue. Pertinent negatives include anxiety, chest pressure/discomfort, chills, dry cough, excessive sputum, fever, hemoptysis ... pleuritic pain, productive cough, purulent sputum, stridor, substernal chest pain, thromboembolic events. **ROS:** Negative. **ASSESSMENT:** Interstitial pulmonary disease, unspecified. Patient has **new onset need for oxygen therapy of unclear reasons.** CT scan is showing bilateral pulmonary infiltrates. **Shortness of breath all started about the time she had a mastectomy on June 8.** She has not had chemotherapy or radiation therapy apparently. **During surgery she was reported to have dropped oxygen saturation.** She says she has not been the same since. She does report coughing up some green sputum. She did have antibiotics at some point. **PLAN:**

Medical Fact Chronology Timeline

Date/ Time	Page	Provider	Event/Outcome
			She has bilateral pulmonary infiltrates I will schedule for bronchoscopy, bronchoalveolar lavage and possible transbronchial biopsy on 07/24/2020. She had a 6-minute walk and she has required oxygen therapy. We will plan for bronchoscopy on 7/24/2020.
8/28/20	PMC, PDF 187	[redacted] Medical Center [redacted] DO Pathologist	**SURGICAL PATHOLOGY REPORT** **DIAGNOSIS:** Lung, Right Upper Lobe, Biopsy: -Bronchial mucosa with focal, **mild, chronic inflammation.** -Alveolated lung tissue with **chronic inflammation** and pigmented alveolar macrophages. -Negative for malignancy .
10/1/20	PMC, PDF 140 -	[redacted] Medical Center [redacted] MD Oncology	**OFFICE VISIT** **CC:** Breast cancer follow up. **HPI:** The initial visit date was 06/24/2020. The patient reports a performance level of 90% (Karnofsky Performance Scale). Performance status is scored as a 1. The patient is restricted in some physical activity but is able to perform normal activities with effort. Today pt is feeling much better and looking much better. **She is no longer on oxygen.** She is saturating with room air. **She feels she is back to her normal self.** She had a BRONCH done 8/28/20. From what I have seen there was no evidence of malignancy or infection. However I will still discuss with Dr [redacted]. **ROS:** Positive for weakness, constipation and back pain. **ASSESSMENT:** Cancer of right female breast. ... CT C/A/P and bone scans 7/2020 with no e/o mets. It showed b/I infiltrates for which chemo was held. Referred to pulm. Planned for bronc but pt did not come due to being sick ... Today pt is feeling much better and looking much better. She is no longer on oxygen. She is saturating with room air. She feels she is back to her normal self. She had a BRONCH done 8/28/20. From what I have seen there was no evidence of malignancy or infection. However I will still discuss with Dr [redacted].

Medical Fact Chronology Timeline			
Date/ Time	**Page**	**Provider**	**Event/Outcome**
			Pt lost multiple f/u appts. **Pt has been non-compliant**. **PLAN:** -Re-imaging now in form of CT c/a/p and Bone Scan ASAP. - If the images show no evidence of metastatic disease we will need to start our adjuvant chemo ASAP. -I will discuss re -imaging and final BROCH findings with Dr. [redacted] /pulmonary and if all clear we will go ahead and start chemo. ...
11/23/20	PMC2, PDF 127-	[redacted] Medical Center [redacted] MD General Surgeon	**OFFICE VISIT** **CC:** Malfunctioning Mediport **HPI:** The symptoms began 1 year ago, are mild and occur randomly. The location is chest wall. The patient is a 47-year-old female who I am asked to see in consultation for malfunctioning Mediport. The Mediport has been malfunctioning and will not aspirate blood. Today she reports mild pain at the Mediport site and mild pain at the mastectomy site. **ROS:** Negative. **ASSESSMENT:** Cancer of right female breast. **PLAN:** The patient will be schedule for Mediport removal and replacement. Her procedure has been schedule for December 10, 2020.

***** At attorney request, Trifecta Legal Nurse Consulting can provide a more extensive, detailed medical chronology (with or without opinions) for use as an attorney study tool and roadmap for any experts for this case.**

VIII. RECORDS REVIEWED:

1. [redacted] Medical Center – DOS 4/30/2020 – 11/23/2020: General surgeon, pulmonologist and oncologist office visit, operative reports, lab results, pathology reports, diagnostic testing.

2. [redacted] Medical Center – DOS 6/8/2020 – 6/10/2020, 8/28/2020 – 1/12/2021: Operative reports, perioperative and anesthesia records, pre-op records, office visits, diagnostic studies, lab results.

IX. GLOSSARY OF TERMS/ABBREVIATIONS/DEFINITIONS:

- **AC followed by TPH**: Adriamycin® + Cyclo-phospha-mide / TPH: Taxol® + Herceptin® + Pertuzumab – Chemotherapy Regimen for Breast Cancer - early stage.
- **Adjuvant chemotherapy**: Chemotherapy administered after surgery.
- **Alveolated lung tissue**: Alveolar are the smallest air sac in the lungs and is where the exchange of oxygen and carbon dioxide takes place.
- **Areola**: Circular area around the nipple
- **BI-RADS-4: A BI-RADS 4 lesion under the breast imaging:** Reporting and data system refers to a suspicious abnormality. BI-RADS 4 lesions may not have the characteristic morphology of breast cancer but have a definite probability of being malignant. A biopsy is recommended for these lesions.
- **CT c/a/p:** CT scan of chest, abdomen, pelvis.
- **DCIS:** Ductal carcinoma in situ; an uncontrolled growth of cells within the breast ducts. It's noninvasive, meaning it hasn't grown into the breast tissue outside of the ducts.
- **Ductal carcinoma in situ, solid, cribriform and comedo types, grade II:** Cribriform is usually a low grade carcinoma; comedo type is a high grade subtype of ductal carcinoma in situ.
- **Dyspnea**: Difficulty breathing.
- **ECE**: Extracapsular extension, extending outside
- **E/O**: Evidence of.
- **Estrogen Receptor (ER)**: Positive 100%:
- **F/u**: Follow up.
- **Groundglass opacity (lungs):** Ground-glass opacity is defined as increased pulmonary opacity without obscuration of underlying bronchial and vascular margins. It may been seen in interstitial lung disease.
- **Hemoptysis**: Coughing up blood.
- **HER2 (by Immunohistochemistry)**: Positive, 60%:
- **IDC:** Invasive ductal carcinoma.
- **Invasive ductal carcinoma with lobular features, grade 1:** A type of breast cancer that begins in the milk-producing glands of the breast.
- **JP drain:** Jackson-Pratt drain.
- **Karnofsky Performance Scale:** The Karnofsky Performance Scale Index allows patients to be classified as to their functional impairment.
- **KI-67:** Proliferation index 5%: Ki67 is a special stain that gives a sense to the level of aggression of a tumor.
- **LN:** Lymph nodes.

- **LVI**: Lymphovascular invasion, breast cancer cells invading the blood stream.
- **Lymphadenopathy**: Large or swollen lymph nodes.
- **Mediport:** A small medical appliance surgically installed beneath the skin. A plastic tube (catheter) connects the port to a vein to deliver medicine, blood products, nutrients, or fluids into the bloodstream.
- **Microcalcifications associated with invasive tumor:** Microcalcification is a common feature of both invasive and in situ malignancy.
- **Micrometastases:** Any of the foci of tumor cells invisible to the naked eye or by routine imaging techniques but may be seen using microscopy with special stains or antibodies or by other laboratory techniques.
- **MRM**: Modified radical mastectomy, a procedure that involves removal of the entire breast — including the skin, breast tissue, areola, and nipple — along with most of the axillary (armpit) lymph nodes.
- **Oxygen Saturation**: The amount of oxygen bound to hemoglobin in the blood, expressed as a percentage. Normal is 95-100% without supplemental oxygen.
- **Pleuritic pain:** Sudden and intense sharp, stabbing, or burning pain in the chest when inhaling and exhaling.
- **Primary tumor - pT2a:** Cancer with tumor size more than 2.0 cm, but not more than 5.0 cm in greatest dimension.
- **Progesterone Receptor (PR):** Positive, 90%: Breast cancer with progesterone receptors.
- **RB-ILD: Respiratory Bronchitis-Inflammatory Lung Disease:** Bronchitis is inflammation of the lining of your bronchial tubes; Inflammatory lung disease is inflammation of the lungs caused by the immune system reacting to infection, irritation or injury.
- **S/S:** Signs/symptoms.
- **SX:** Surgery.
- **Stridor**: Noisy, high-pitched breathing sound.
- **Thromboembolic event:** Formation of a clot in a blood vessel that breaks loose and is carried by the blood stream to obstruct another vessel.

Plaintiff Name: [redacted]
Date of Incident: 6/8/2020
Date of Death: (if applicable)

Thank you kindly for this referral. These conclusions and recommendations have been based on those documents currently on file and previously submitted. Should further information become available, this should be reviewed by Trifecta Legal Nurse Consulting to determine content and relationship to the case.

Respectfully Submitted,

Trifecta Legal Nurse Consulting
[redacted]
Contributing Legal Nurse Specialist: [redacted] RN, BSN