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OKLAHOMA ONCOLOGY
specialists in the treatment of cancer

INITIAL EVALUATION -- CONFIDENTIAL

Livolsi, Linda

10/30/2012 – TULSA – INITIAL EVALUATION

Linda Livolsi was sent to me by the District Attorney to evaluate her cancers.

CHIEF COMPLAINT: "I only have one cancer, I do not know why the District Attorney keep saying I have two cancers. My thyroid is benign. I only have leukemia."

HISTORY OF PRESENT ILLNESS: The patient is a female who was sent to our office for evaluation of whether or not she could travel for a court date in Las Vegas. She stated to me that she had known me and had seen me in the past while at St. Francis back in 2010 (there are no records that I have ever seen her before). She stated that in March 2010, she required a blood transfusion. She then said that she was hospitalized at St. Francis in July 2010 where she had flu, fevers, weakness, and had been on many antibiotics that did not relieve this. She said that she had leukemia. She said that she was told that she may have had a "preleukemia or a myelodysplastic syndrome." She said, "I saw you and when I called your office for a new patient appointment, they said I needed a primary doctor to refer me," (no records of this). I asked her specifically if she had a bone marrow aspirate and biopsy to confirm her diagnosis and she did not. I was unable to locate any bone marrow aspirate and biopsies in her medical records that diagnosed acute leukemia. She told me that she was diagnosed with acute leukemia in August 2010 on her first trip to MD Anderson. She said that the bone marrow biopsy down there said that she had acute myeloid leukemia, the M2 subtype. When asked if we could gather those records, she said Linda Livolsi is on a "no report" status down there because her sister is trying to get information about her. She stated that while at MD Anderson, she had been diagnosed with AML-M2. She said that she received two cycles of 7 plus 3 induction chemotherapy. She said that her doctor was Dr. Malkin and she said, "I do not have the name of the others two, but one was Oriental." She said that there is a possibility that her acute leukemia arose out of a myelodysplastic syndrome. She said that her leukemia marker became negative. When asked specifically what marker, she was unable to tell me. She said that she was supposed to go to do consolidation chemotherapy in January 2011 but due to other issues that arose, she was not able to. She said that she had a bone marrow in January 2011 at MD Anderson that confirmed her complete remission and she states that since January 2011 without further consolidation chemotherapy, her acute leukemia has been in remission. I did review a bone marrow aspirate and biopsy that was performed at St. John's that revealed no evidence of leukemia. She did not bring any papers from MD Anderson, but she said that she had them at home and she forgot to bring them. She told me that her last trip to MD Anderson was in January 2011 where they confirmed her remission status and she said she is traveling to Houston again in this coming January for further evaluation and confirming her status. She said that she is able to travel to MD Anderson for evaluation.

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HISTORY OF PRESENT ILLNESS (Continued): Today, she is feeling good with the exception of back pain from her "kidney stones," but she has no fevers, chills, sweats, or weight loss right now.

MEDICATIONS: Ibuprofen 800 mg twice a day, Prevacid 24 HR one in the morning, methimazole 5 mg half-tablet once a day (discontinued until further notice), Celexa 60 mg once a day in the morning, torsemide 30 mg two in the morning and one in the afternoon, potassium chloride 20 mEq two times a day, temazepam 30 mg one at bedtime, OxyContin 30 mg one tablet every six hours as needed for breakthrough pain, Flexeril 10 mg one three times a day as needed, Mirapex 0.25 mg one a day, acetaminophen 500 mg two tablets every six hours as needed; stool softener 100 mg two in the morning and two in the evening; Feosol 45 mg tablets eight per day two in the a.m., two at noon, two in the evening, and two at bedtime; B12 1000 mcg two tablets a day; fentanyl 75 mg patch every two days; morphine 15 mg one every six hours; Valium 2 mg one every 12 hours; promethazine with codeine one teaspoon every four hours; numerous vitamins two times a day; Advair Diskus 250/50 mcg dose inhalation one puff two times a day that was the medicine list that she presented to me.

ALLERGIES: Lortab. She said that she had a motor vehicle accident in 1988 and she stopped breathing after taking Lortab. She is allergic to penicillin taken as a child.

PAST MEDICAL HISTORY: Lupus. She said that she was diagnosed with lupus in 2005 at UCLA Medical Center and iron deficiency anemia.

PAST SURGICAL HISTORY: C-sections in April 15, 2003 and a C-section in May 03, 2005. She had gastric bypass surgery in 1997. She had hernia surgery in 1997. She had a kidney stent placed in 2011 by Dr. Cole Davis and Dr. John Forrest. She had a total vaginal hysterectomy due to uterine tumors that were benign at St. Johns by Dr. Terry Zanovich. She had a tonsillectomy at age 5.

SOCIAL HISTORY: She is married. She has two children, a son age 9 and a daughter age 7. She has three stepchildren. She has been a smoker for the past five years. She denies alcohol consumption. She says that she is unemployed at present. She worked as a financial consultant.

FAMILY HISTORY: Mother died in 1997 at age 44 from a brain aneurysm. Father died in 2004 at an unknown age from small cell cancer. She is from Cleveland, Oklahoma. She has one brother age 38 who lives in Tulsa, one sister age 41 who lives in Tulsa. She said there is a family history of diabetes also.

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REVIEW OF SYSTEMS:

General:	She says that she has fevers daily. She says she spends most of her time in bed, has chills all the time and pain constantly.
HEENT:	She does not wear glasses. She denies hearing problems.
Pulmonary:	She denies asthma, but she says she has chronic bronchitis and she says that she has been coughing up blood. She says this is due to tumors in her lungs and she is being evaluated by a doctor at Mercy Hospital in Oklahoma City (chest x-ray was completely normal today). She had pneumonia at age 19 and in 2006.
Cardiovascular:	She said that she had a dilated cardiomyopathy where her ejection fraction went down to 27% when she was pregnant with her daughter. She stated that she recently had an ejection fraction done at St. Francis Heart Hospital and the ejection fraction was 64%. She says that she gets intermittent swelling and can gain between 8 and 15 pounds of fluid per day, but this goes away over night. She has occasional dyspnea and occasional chest heaviness.
Gastrointestinal:	She has dysphagia to solids. The food gets stuck at the lower part of her esophagus and she says she has to vomit it up. She says it is worse with meat. She also has diarrhea.
Genitourinary:	She says she has kidney infections and chronic kidney stones and issues with urinary retention.
Neurologic:	She says she has a seizure disorder. She was evaluated in UCLA for a seizure disorder and her lupus. She wonders if she has a genetic brain aneurysm. She has frequent headaches. She occasionally is numb. She has no weakness. No speech changes.
Gynecologic:	Gravida 6, para 2. She said she had four miscarriages prior to 20 weeks. She has irregular menses, says her menarche is age 13, menopause was age 42.
Dermatologic:	She says that her skin gets discolored frequently and has occasionally has red lines on it.
Endocrine:	She says she does not have thyroid cancer. She has four growths around her thyroid and has thyroid problems but not cancer.
Psychiatric:	She says she is not depressed but she has a feeling of anxiety.
Musculoskeletal:	She says she was diagnosed with lupus in 2005.

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PHYSICAL EXAMINATION:

General:	Her weight was 101.8 kg. Her blood pressure was 138/82. Her pulse was 83. She is 5 feet 7 inches. Her oxygenation was 99% and her temperature was 36.4. She was well developed and well nourished female who kept moving around on her chair stating that she was having back pain from kidney stones. I asked her if she wanted to go to her urologist for this who offices across the street and she said no I will be all right.
Neck:	There was no palpable adenopathy.
Lungs:	Her lungs were clear.
Heart:	Regular rate and rhythm.
Abdomen:	Soft. Bowel sounds are present and active without organomegaly.
Extremities:	Without edema.

LABORATORY DATA: I did a complete blood count, a normal white blood cell count with a normal differential. Her hemoglobin was 13.2, which was normal. Her platelet count was 254,000, which was normal. Her chemistry panel revealed potassium of 3.4 with the normal range of 3.5 to 5.5 and a creatinine of 1.18 with a normal range of 0.5 to 1.0. Her liver enzymes were normal as was the rest of her chemistry panel.

ASSESSMENT AND PLAN: Acute myeloid leukemia, no evidence of disease. I have absolutely no source documentation to prove that she ever had acute myeloid leukemia. There are no abnormalities on her present bone marrow biopsies that revealed either acute myeloid leukemia or an antecedent hematologic disorder. It is my opinion from her stated history of acute myeloid leukemia that she is able to travel. She is indeed intending to travel to Houston in January for evaluation of her leukemia.

Thank you for asking me to see her and if I can provide you with additional information, please do not hesitate to contact me.

Joseph P. Lynch, M.D.

JPL/MS2/VN1/CA

DD: 11/20/12
DT: 11/20/12