PHYSICIANS COPY

Holy Cross Hospital

Operated by
Sisters of the Holy Cross
1045 East 1st South
Salt Lake City, Utah 84102

[illegible] | A.W. MIDDLETON, JR., M.D. | 2068 | 2290382

DATE OF ADMISSION: 4/4/76

DATE OF DISCHARGE: 4/14/76

The patient is a 7 year old boy who was found to have nonfunction of right kidney on intravenous pyelography following an episode of gross painless total hematuria. The left upper tract was entirely normal on pyelography. The previous retrograde pyelograms had demonstrated marked distortion of the collecting structures of the right kidney with a large mass where the kidney parenchyma should be located with the calices splayed around it.

Laboratory data:
Urinalysis showed 35 to 40 red blood cells per hpf and 5 to 10 white cells per hpf. CBC within normal limits except for hematocrit of 38.7. Protime was 100%.

6 channel SMA within normal limits. 12 channel SMA within normal limits except for alkaline phosphatase of 196 and LDH of 253.

Urinary VMA was 2.0 mg./mg. with normal being .5 to 4.0.

Postoperatively creatinine was .9 and hematocrit was 36.8. The CBC and platelet count remained within normal limits through the day prior to discharge.

Course in hospital:
On April 5th the patient was taken for selective bilateral renal angiograms and these revealedan entirely normal left kidney and vascular system but a typical Wilm's tumor on the right replacing essentially all but a rim of parenchyma on the top and a rim of parenchyma on the bottom poles of the right kidney. A vena cavogram was done and this showed a poorly defined filling defect just at the junction with the right renal vein which was somewhat suggestive of the possibility of tumor spread into the cava.

A mechanical bowel prep was accomplished and the patient was taken to the operating room on April 7th where a radical right nephrectomy and lymph adenectomy were performed. There was no evidence of spread outside of the kidney itself, with nothing into the renal vein or vena cava and no spread from the kidney into contiguous structures. We completely mobilized the left kidney and it was entirely normal.

Actinomycin in the appropriate dose had been given just prior to surgery and was continued throughout the patient's postoperative period. In addition, once the diagnosis was confirmed, he was given a course of Vincristin.

The postoperative period has been completely unremarkable. The patient has remained afebrile. The skin clips were removed on the second postoperative day and steri-strips were placed across the wound. Nasogastric tube was removed on the second postoperative day and diet was advanced thereafter without any problems.

(continued)

☐ History ☐ Physical ☐ Operative ☒ Discharge Summary ☐