Case Study	NSCLC Reversal/Normalization Case Study	
Background	Page 1.	
Case presentation	Page 1.	
Investigations	Page 1; Figure 1, page 2. X-ray, 10/2004, not available, no findings, verbally reported by patient. CT chest 12/01/2005, noted in CT report, 12/07/2011, page 13. X-ray chest, 9/01/2011, page 10. CT chest, 08/03/2011, pages 11-12. CT chest, 12/07/2011, page 13. PET/CT whole body, 03/08/2011, page 14. CT chest, 16/03/12, page 15. CT chest, 12/12/2012, page 16.	
Differential diagnosis	Lesion “metabolically active and should be considered malignant until proven otherwise”, from positive PET/CT 03/08/2011 with ongoing/increasing severity of symptoms (Figure 1). A NSCLC.	
Treatment	Urgent surgical resection recommended by oncologist and GP, noted in GP letter to patient, 05/05/2012, page 17. No conventional oncological treatment received. ECRL treatment, 27/03/2012, noted in letter to Richard Malter, 16/07/2018, page 18, to around July 2013.	
Outcome and follow-up	Patient recovered, weight regained and stable. Neoplasm shrinkage and clinical normalization. Hemoptysis stopped and major improvement in other symptoms. Non-specific, intermittent, residual bronchial discomfort remains with persistent mild to moderate intermittent coughing. Normal functioning and QOL maintained as of September 2020. Periodic follow-up visits for monitoring and treatment to date.	

NSCLC Reversal and Normalization Clinical Case Study

BACKGROUND

Lung cancers are longstanding, serious medical problems.[104] Overall lifespans are seriously shortened: in non-small cell lung cancer (NSCLC) average lifespans from time of diagnoses are approximately 7 months.[106] Symptoms are a cough that won't go away, shortness of breath, weight loss, or coughing up blood (hemoptysis).[120]

SUMMARY CASE PRESENTATION

63yo female exposed to second-hand tobacco smoke for 30 years. Gradually and continually increasing symptoms in number and severity, beginning with a persistent cough in 2004, presented to our clinic on 27/03/2012 with hemoptysis, coughing, bilateral flank and central chest pain, “pneumonia”-like sensations in her lungs, 8-9/10 pain scale, and weight loss of 12kg in the preceding 6-8 months from a previously normal stable 60kg (Figure 1). Lung X-ray in October 2004 and CT scan 12/01/2005 were negative for focal pulmonary lesions. A second X-ray in 19/01/2011 prompted by ongoing clinical symptoms again showed no abnormal radiologic findings. Without a diagnosis and with worsened symptoms a subsequent CT scan was done on 08/03/2011; a new “small focus of peribronchovascular nodularity” and “opacification” of “15mm maximal extent” within the right middle lobe, laterally adjacent to the oblique fissure was found that “was not present at all previously”. This lesion was considered by the reporting radiologist to be most likely “post inflammatory” and suggested that a “follow-up study in 3-6 months may be required to ensure this is decreasing in size rather than increasing”. A 12/07/2011 CT scan again showed this nodule [14mm “greatest transaxial dimension”]. A PET/CT scan (Figure 2) was performed on 03/08/2011 with the radiologist reporting “intense FDG uptake” and that the lesion was “metabolically active and should be considered malignant until proven otherwise”, that is, a diagnosis of a non-small cell lung cancer (NSCLC). The patient’s oncologist verbally reported to the patient that the lesion had a “90%” chance of being a cancer; her oncologist and GP therefore jointly recommended urgent surgical resection else that she would likely “die a horrible death”. The patient pursued alternative care; she received no surgery, chemotherapy nor radiotherapy (through to September 2020). She received twice-weekly intravenous (IV) Vitamin C infusions and ozone autohemotherapy for a six month period from the time of the 03/08/2011 positive PET scan up to the beginning of our care on 27/03/2012 that only marginally improved some of her clinical symptoms, but still leading her independent, integrated medicine medical practitioner provider to also recommend the urgent surgical resection in addition to the patient's oncologist and GP. The follow-up CT scan on 16/03/12 just before commencement of our care, demonstrated lesion “margins remaining irregular”, and “no appreciable interval [dimensional] change” from the previous CT study on 12/07/11, however with the patient experiencing concurrent ongoing clinical symptoms. The final CT chest on 12/12/2012 after approximately 8½ months of ECRL treatments, noting the positive PET on 03/08/2011, reported a “minimally altered in size” “15mm maximal extent” lesion.

INVESTIGATIONS

See Figure 1.
X-ray chest, ??/10/2004, not available, no findings; verbally reported by patient.
CT chest 12/01/2005, noted in CT report, 12/07/2011.
X-ray chest, 9/01/2011.
CT chest, 08/03/2011.
CT chest, 12/07/2011.
PET/CT whole body, 03/08/2011.
CT chest, 16/03/12.
CT chest, 12/12/2012.

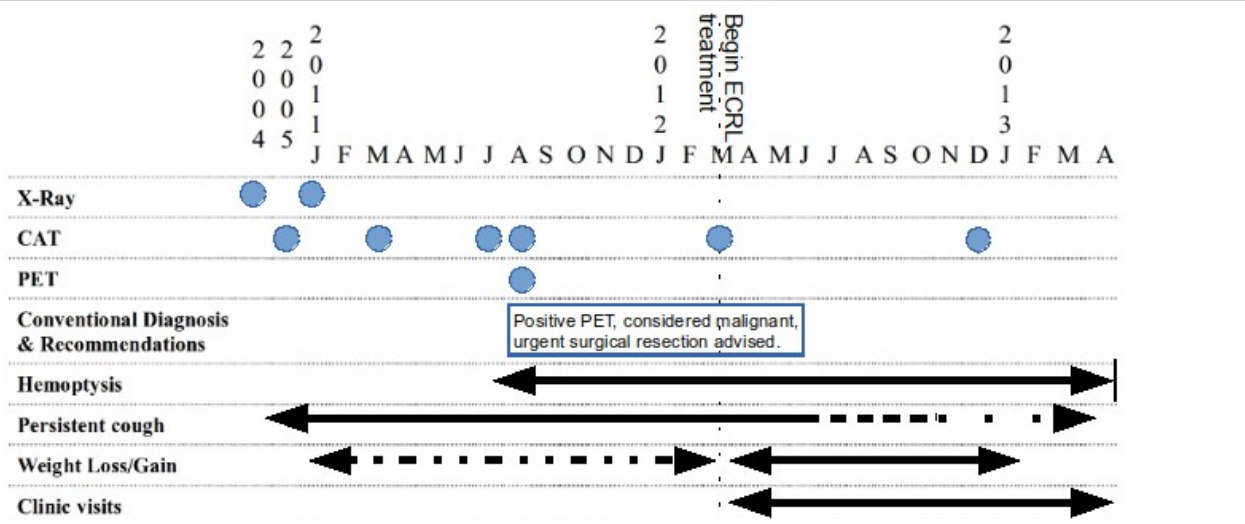

Figure 1: Timeline of clinical and treatment events.
Weight loss/gain is represented by dotted/solid lines. IV Vitamin C infusions and ozone autohemotherapy received by the patient prior to commencement of our care (August-February 2011) not shown (Case Presentation). "Positive PET, considered malignant" box shows period of conventional oncological recommendations. Hemoptysis began and was continuous from July 2011 until ending in April 2013 as shown.

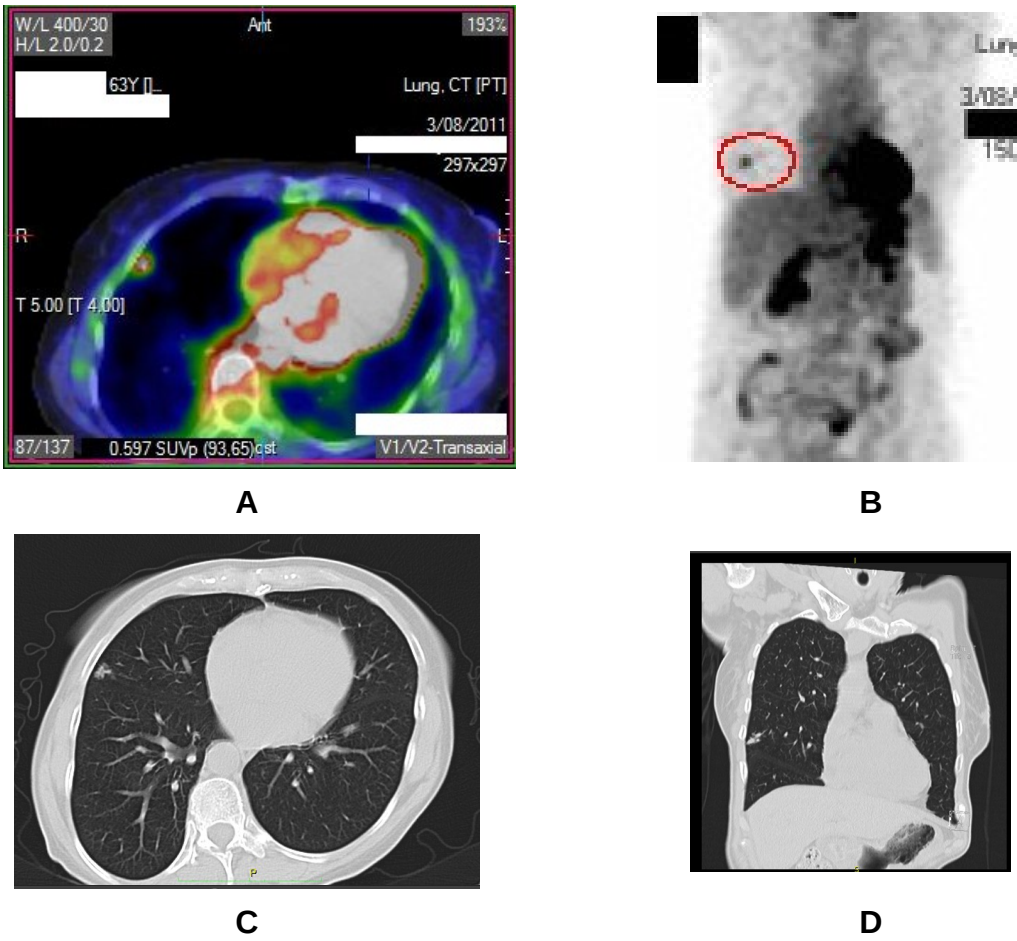

Figure 2. NSCLC images in transverse and coronal planes, A & B: CT/PET 03/08/2011, C & D: CT 16/03/2012.

ANALYSIS OF RADIOGRAPHIC DATA

In any CT scan planar image sequence, the dimensional measurement resolution of a visible lesion is the slice interval ('section width') and is a significant[51] parameter in all measurements made in any single (planar) study and in comparisons between studies

performed with the same or differing slice intervals. To maximize accuracy from the radiographic data, we made a tri-planar chronological dimension and volume dynamics comparison assessment of the lesion from the radiographic image sequences of the three CT studies (12/07/2011, 27/03/2012, 12/12/2012). For maximum accuracy, we retrieved the actual slice interval and image position data from the CT scanner generated electronic data file of each digitized image (slice) in each planar sequence in each CT study. The resulting data conclusively shows increasing dimensions and volume of the NSCLC prior to our treatments (12/07/2011→27/03/2012); and then decreasing dimensions and volume of the NSCLC concurrent with our treatments (27/03/2012→12/12/12), with concomitant markedly decreasing and disappearing clinical symptoms (Table 2, Figures 3, 4).

Study date	Plane of image sequence	Slice interval (SI) recorded/ (actual)	Slice position of lesion appearance **[A]**	Slice position of lesion disappearance **[B]**	Sectional visualized dimension $\mathbf{D_{secvis}}$=**[A]**-**[B]**	Total maximum possible dimension measurement errors $\mathbf{DME_{sum}}$ at **[A]** plus **[B]** = $\mathbf{DME_{max}}$+$\mathbf{DME_{max}}$	Maximum possible dimension value $\mathbf{D_{secvis}}$+$\mathbf{DME_{sum}}$
12-07-2011	Transverse	5.5	114.25	124.4	10.15	4.5+0	14.65
12-07-2011	Coronal	5	24.5	34.5	10	4+0	14
12-07-2011	Sagittal	5	101.4	116.4	15	4+0	19
16-03-2012	Transverse	1/(0.7)	173.5	188.2	14.7 (known)	0+0	14.7 (known)
			← 21 slices →				
16-03-2012	Coronal	3.3/(3.25)	152.6	139.6	13	2.3+0	15.3
16-03-2012	Sagittal	4.6	102.5	120.8	18.3 (known)	0+0	18.3 (known)
27-03-2012	Beginning of ECRL treatments						
12-12-12	Transverse	1	178.9	191.9	13 (known)	0+0	13 (known)
12-12-12	Coronal	4	45.43	53.69	8.26	3+0	11.26
12-12-12	Sagittal	Same contrast study not performed; radiologist reported measurement.			15	-	15

Table 2: Lesion planar dimensions and volume extreme change possibilities computed using sectional visualized dimensions and study slice interval resolution resulting min/max possible measurement errors.
The sectional visualized dimension $D_{\mathbf{secvis}}$ is the reconstruction of the lesion from radiographic images in the anatomical plane perpendicular to the plane of the radiography study slice sequence. For transverse plane slice sequences, $D_{\mathbf{secvis}}$ is in the superior-inferior (caudal-cephalic) plane. For the coronal plane slice sequences, $D_{\mathbf{secvis}}$ is in the anterior-posterior (coronal) plane. For the sagittal plane slice sequences, $D_{\mathbf{secvis}}$ is in the transverse (axial) plane. For the tri-planar image sequences of each of the three CT studies (12/07/2011, 16/03/2012, 12/12/2012), [A] and [B] are the extreme positions of the images wherein the lesion appears and disappears, and D_{secvis} is given by [A]-[B]. Where the slice interval (SI) in a planar sequence in a study was larger than the ideal reference slice interval (resolution) of 1mm, meaning that the lesion might have extended beyond polar D_{secvis} positions [A] and/or [B] to an unknown extent up to a maximum of the resolution (SI) of study, the maximum possible dimension under-measurement error DME_{max} for both [A] and [B] is SI-1mm. The maximum sum possible under-measurement error DME_{sum} at the two extremities of the opposite poles of the lesion in any plane is thus given by DME_{max}+DME_{max}. To reduce uncertainty to zero wherever possible, DME_{max}=0 was assigned when two dimensional digital tape measure software measurement of the lesion at positions [A] and/or [B] was ≤ 1mm x 1mm showing the actual extremity of the pole(s) of the lesion in that plane. Across the period covering the three sequential CT scans, for each of the tri-planar dimension and volume histories of the lesion, using combinations of the D_{secvis} and the computed DME_{sum} values—from 0 to their maxima, the extreme planar dimension and volume change possibilities were graphed as, (a) the sequence of tri-planar dimensions and volumes (smallest to largest values) that maximally show that the lesion grew in size despite ECRL treatments, (b) the sequence of tri-planar dimensions and volumes (largest to smallest values) that maximally show that the lesion shrunk in size with ECRL treatments, and (c) the sequence of tri-planar dimensions and volumes (closest set of values) that maximally show that the lesion was stable and minimally changed in size (Figure 3).

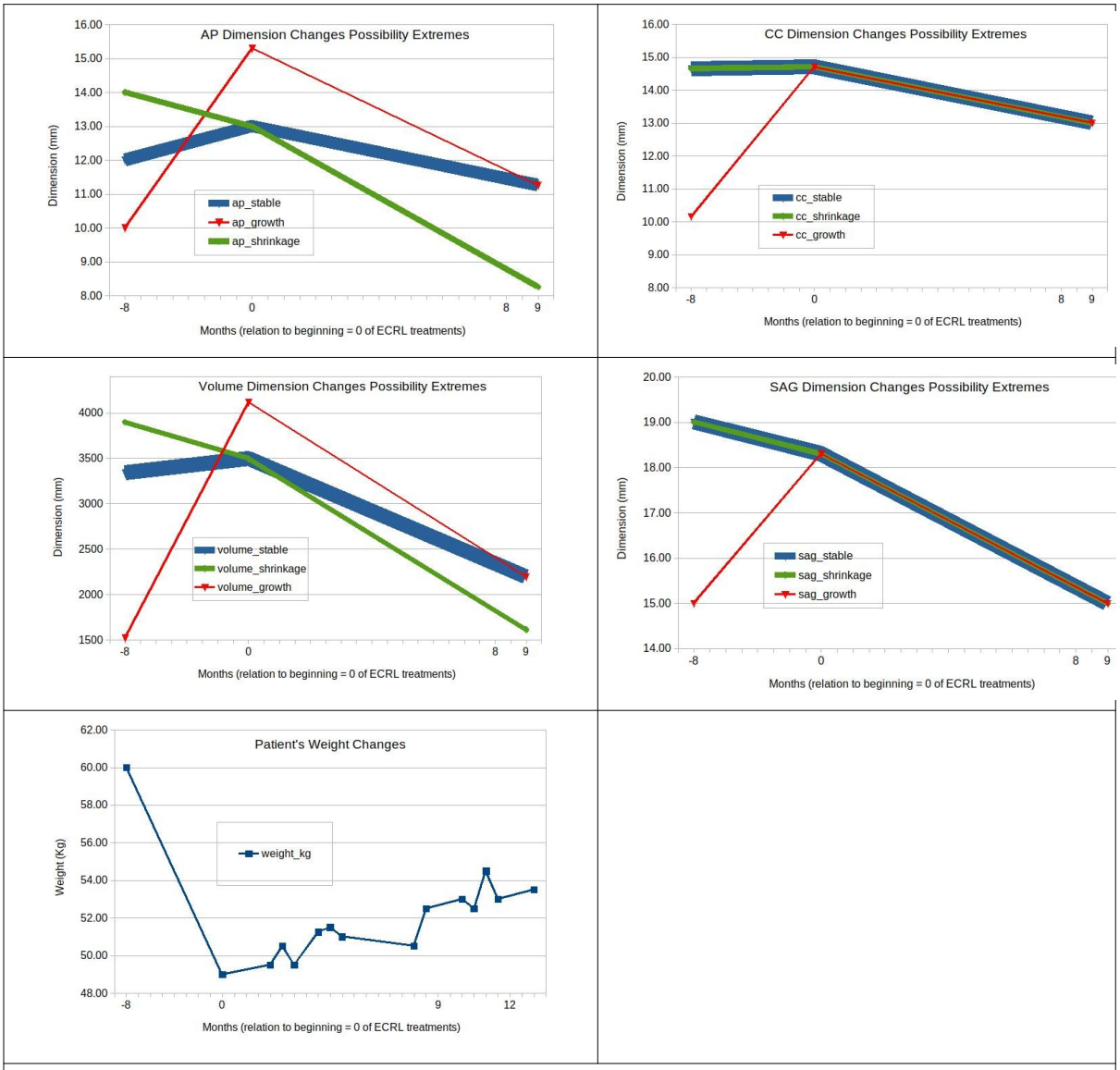

Figure 3: Lesion planar dimension and volume dynamics with concurrent weight loss and gain. Clockwise, anterior-posterior (AP), caudal-cephalic (CC), sagittal (SAG), and Volume extreme possible dynamics (Table 2) are traced. Concurrent patient's weight loss and re-gain is also shown bottom left.

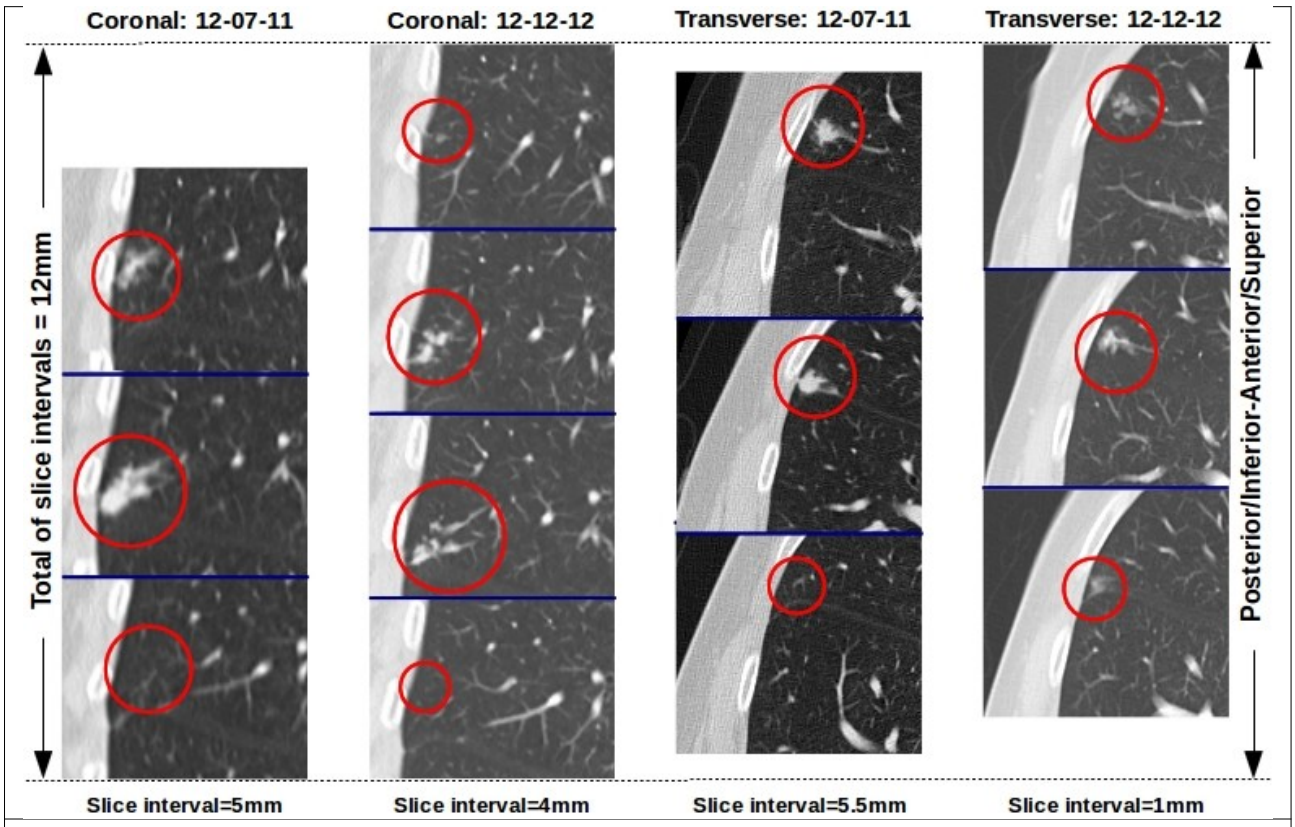

Figure 4: **Image sequence comparison between 27/03/2012 and 12/12/12 CT studies.**
Images are scanned directly from plates without modification and shown extremely near to same scale only due to scanning variations. The CT sequences were begun at slightly varying anatomical planar starting positions: images are aligned vertically corresponding to their relative anatomical planar positions.

DIFFERENTIAL DIAGNOSIS

Lesion “metabolically active and should be considered malignant until proven otherwise”, from positive PET 03/08/2011 with increasing severity of symptoms (Figure 1). A NSCLC.

TREATMENT

No conventional oncological treatment. ECRL treatment begun 27/03/2012 and was continuous to around July 2013.

OUTCOME AND FOLLOW-UP

This patient's NSCLC has achieved conventionally perceived remission without recurrence for approximately 9 years to the time of this publication from the date of diagnosis, as determined jointly by clinical assays, resolved signs and symptoms, and correlated shrinking on radiographic studies. This gradual long-term outcome is neither spontaneous nor miraculous (i.e., not unexplained), shown by our chronologically corresponding close clinical tracking of these assays and analyses. Correlating with the course of our care, the patient steadily regained and has maintained her weight (less than the previous 60Kg as a result of changing to a plant-based organic whole food diet recommended by us) following the previous rapid weight loss of 12Kg in 6-8 months prior to her first ECRL visit; her pain has decreased substantially; hemoptysis stopped and has not returned (Figures 1, 3). The patient's overall clinical condition has largely returned to normal; her QOL has also been nicely maintained and back to her normal condition of over 16 years ago, before the probable NSCLC-related clinical symptoms began. The patient is alive and well as of September 2020, and has lived to see the birth of her many grandchildren.

Interpretation of the patient's outcome is secondarily supported by the radiologist's report on the last CT scan on 12/12/2012, that contrary to conventional expectations (prognosis),

“no effusion, new pulmonary lesions or evidence of lymphadenopathy” was seen, and that the “16mm in maximum transverse dimension” “well defined peripheral peribronchovascular nodules” “when compared to the prior report” “minimally altered in size. Findings are non-specific. This may still represent chronic endobronchial infection or may be neoplastic such as bronchoalveolar carcinoma”. Given the 9 year (2004-2013) history (Figure 1) of the patient's symptoms, and the eventual radiographic appearance of the lesion, it is highly improbable that this lesion was caused by just inflammation (Case Presentation) and so was almost certainly a neoplasm, which was conventionally conceived and described as cancerous (i.e., malignant) by the patient’s oncologist from the positive PET on 03/08/2011. Thus, here where conventional oncological treatment was declined and not received, and after unsuccessful treatment with IV Vitamin C, clinical and symptomatic neoplasm normalization is seen, completely oppositely to what usually happens in lung cancer cases (Background).

Furthermore, our detailed assessment of three sequential CT scan studies (Table 2, Figures 3, 4) shows decreased tri-planar lesion dimensions (AP: 4.0-4.7mm, CC: 1.7mm, SAG: 3.3mm) and volume (~1.9cm^3) over a 9 month period. NSCLCs do not usually decrease in size even with slow or near horizontal growth curves, and if so very minimally (maximum 1-2mm planar) and/or not by more than 1mm simultaneously in more than one plane[45].

The patient has remaining, non-specific, intermittent, residual bronchial discomfort, with intermittent coughing, possibly due to the radiologically noted “atelectasis or scarring left lung base with mild traction bronchiectasis” (CT 12/12/2012) representing small fibrotic masses mechanically impacting free pain nerve endings. The patient has also had cardiovascular monitoring for left sided chest pain, and since presented with occasional non lung neoplasm related issues.

REFERENCES

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.
17.
18.
19.
20.
21.
22.
23.

45. Lindell RM, Hartman TE, Swensen SJ, Jett JR, Midthun DE, Mandrekar JN. 5-year lung cancer screening experience: growth curves of 18 lung cancers compared to histologic type, CT attenuation, stage, survival, and size. Chest. 2009 Dec;136(6):1586-95.

51. Assessing the effect of CT slice interval on unidimensional, bidimensional and volumetric measurements of solid tumours. Tan Y, Guo P, Mann H, Marley SE, Juanita Scott ML, Schwartz LH, Ghiorghiu DC, Zhao B. Cancer Imaging. 2012 Oct 31;12:497-505.

http://www.cancer.net/cancer-types/lung-cancer/statistics Accessed 9/22/20

Wao H, Mhaskar R, Kumar A, Miladinovic B, Djulbegovic B. Survival of patients with non-small cell lung cancer without treatment: a systematic review and meta-analysis. Syst Rev. 2013 Feb 4;2:10. doi: 10.1186/2046-4053-2-10.

120. https://www.mayoclinic.org/diseases-conditions/lung-cancer/symptoms-causes/syc-20374620?utm_source=Google&utm_medium=abstract&utm_content=Non-small-cell-lung-cancer&utm_campaign=Knowledge-panel Accessed 9/22/20

This information is current as of 07/11/2011 [redacted]

Reason For Study

Study Comments

Patient Name
[redacted] **MRS.**

Patient ID
[redacted]

Patient Sex
F

Age
063Y

Patient Birth Date
[redacted]

Modality
CR

Status
[redacted]

Accession Number
[redacted]

Study Date
20110119

Study Time
[redacted]

Referring Physician
[redacted]

Performing Physician

Study Description
Chest X-Ray

Institution
[redacted] **Hospital**

Department
[redacted] **Hospital**

Patient Report

Patient Details

Name	Patient ID	Sex	Date of Birth
[redacted] MRS.	[redacted]	F	[redacted]

Result Details

Status
APPROVED

Author
Virtual IPO

Impressions
Not Available

Body
CHEST X-RAY

CLINICAL NOTES:
Chest pain.

FINDINGS:
There is a
thoracic scoliosis convex to the right. Heart, mediastinum and
hilar
contours are otherwise normal. Lungs are clear. No pleural or chest
wall thickening is
seen. No pneumothorax. No free air is seen under the
diaphragm.

Electronically Signed By:

Dr. [redacted]
[redacted]

This information is current as of 07/11/2011 [redacted]

Reason For Study

Study Comments

Patient Name
[redacted] **MRS.**

Patient ID
[redacted]

Patient Sex
F

Age
063Y

Patient Birth Date
[redacted]

Modality
CT

Status
[redacted]

Accession Number
[redacted]

Study Date
20110308

Study Time
[redacted]

Referring Physician
[redacted]

Performing Physician

Study Description
CT of the Chest and HRCT - Without Contrast

Institution
[redacted] **Hospital**

Department
[redacted] **Hospital**

Patient Report

Patient Details

Name	Patient ID	Sex	Date of Birth
[redacted] MRS.	[redacted]	F	[redacted]

Result Details

Status
APPROVED

Author
[redacted]

Impressions
Not Available

Body
CT CHEST:

Clinical Notes:
Follow-up rib nodule. Passive smoker.

Report:
The small sclerotic focus within the left posterolateral 6th rib is
unchanged from the previous imaging: given the lack of interval change this
is most likely a bone island in the absence of any known underlying
malignancy. No other bone lesion is shown.
Broadbased thoracic scoliosis
concave to the left.
Within the right middle lobe laterally adjacent to the oblique fissure is a
small focus of peribronchovascular nodularity: at this site and this
distribution this is most likely post inflammatory and was not present at
all previously. A follow-up study in 3-6 months may be required to ensure
this is decreasing in size rather than increasing.
There is no pleural fluid on the non-contrast imaging. There is no
mediastinal lymphadenopathy.

[redacted]

There is minor scarring/atelectasis left lung base posteriorly similar to
the previous imaging and could be post inflammatory in nature.

Opinion:
Stable left rib lesion ?bone island. There is new nodular opacification
right middle lobe over a 15mm maximal extent ?post inflammatory: a
follow-up in 3-6 months to ensure resolution may be of value.

Reported by: Dr [redacted]

[redacted]

Radiology

[redacted]

12th July 2011

Dr [redacted]

Folio: [redacted]
Order:
UR Number:
Typist [redacted]
Exam Date:12th July 2011

[redacted]

Re: Mrs [redacted] - DOB: [redacted]

CT CHEST

Clinical Notes: Passive smoker. New right middle lobe nodule. Sclerotic left rib lesion. ? malignancy ? infection.

Findings: Post contrast scanning has been undertaken from the thoracic inlet to the level of the adrenal glands. Reference is made to previous report dated 12/1/2005.

There is no significant axillary lymphadenopathy. There is no mediastinal nor hilar lymphadenopathy present.

Within the right middle lobe, extending to abut the horizontal fissure, an irregular density is noted which measures 1.4 x 0.7 cm in greatest transaxial dimension. There is a linear component more medially with the appearance being more in keeping with focal scarring. A direct comparison with more recent imaging would be desirable to assess if there has been any serial change in this finding. By reference to the previous report dated 12/1/2005, this was not present at that time. No other focal pulmonary pathology is identified. Minor scarring present at the left base.

A single sclerotic focus is noted involving the lateral aspect of the left 5th rib, the margins are smooth and there is no evidence of bony destruction nor expansion. The features appear non aggressive. However correlation with recent bone scan would be desirable.

Both adrenal glands are normal. Cystic lesion within the spleen is identified which by reference to the previous report from 2005 appears stable and most likely represents a cyst.

[redacted]

Incidental note made of marked thoracic scoliosis convex to the right side.

Comment: An irregular density within the right middle lobe has some features suggesting that this is focal scarring rather than a discrete nodule, however direct comparison with more recent imaging would be desirable to determine if there has been any serial change in this finding. Alternatively consideration for a PET scan should be given for further characterisation.

Dr [redacted]
Verified Tue 12/07/2011 [redacted] am

[redacted]

Department of Nuclear Medicine & Centre for PET

Prof [redacted]
Prof
Dr
Dr
Dr
Dr
Dr
Dr

Surname [redacted] **First Name** [redacted] **UR** [redacted]
D.O.B [redacted] **Age** 63 **Sex** Female
Dr [redacted]
Study FDG PET/CT WHOLE BODY STUDY **Date** 3 Aug 2011 **Series** 1
Report To [redacted] **Cc:** MEDICAL RECORDS
Fax [redacted] Dr [redacted]

Report CLINICAL HISTORY
63 year old lady presents for assessment of a solitary right middle lobe lesion in a context of passive smoking and hemoptysis.

PROCEDURE
Following IV administration of 385 MBq F-18 FDG, emission tomographic images of the body were acquired from base of skull to upper thighs. Low-dose, non-contrast CT was performed for attenuation correction and anatomical correlation. The patient's diagnostic CT performed at [redacted] on 12/07/2011 is not available for correlation, but reference is made with the written report. The blood glucose level is 6.7 mmol/L.

REPORT
There is intense FDG activity in the small right middle lobe pulmonary nodule seen on low dose CT today.

There are no FDG avid lesions elsewhere in the pulmonary hila, mediastinum, or elsewhere in the neck, chest, abdomen, pelvis or axial skeleton. In particular, there is no abnormal FDG uptake in the left 5th rib and spleen at the location of the lesions described on the diagnostic CT.

CONCLUSION
The right middle lobe pulmonary nodule is metabolically active and should be considered malignant until proven otherwise. No other metabolic lesion is detected to suggest locoregional tumour spread or distant metastatic disease.

Nuclear Medicine Registrar Dr [redacted]
Physician in Nuclear Medicine Dr [redacted]

Final **Report Date** 3 August 2011 [redacted]

[redacted]

Birthdate: [redacted] Sex: F Medicare Number: [redacted]
Your Reference: Lab Reference: [redacted]
Addressee: Dr [redacted] Referred by: Dr [redacted]
Name of Test: CT CHEST
Requested: 16/03/2012 Collected: 16/03/2012 Reported: 16/03/2012
Laboratory: [redacted] Victoria

[redacted]

16th March 2012

Dr [redacted]

Typist:
Exam Date:16th March 2012

[redacted]

Re: Mrs DOB: [redacted]

CT CHEST

Clinical History: ? change right mid zonal lesion previously described on CT scan of July 2011.

Technique: Non-contrast multislice volumetric acquisition with multiplanar reconstructions through the chest from the lung apices to the renal hila. The examination has been directly compared with that of July 2011.

Findings: The mid/lower zonal lesion lying in relationship to the minor fissure on the right peripherally is unchanged. It's margins remain irregular, and there is some associated distortion of the adjacent fissure, compatible with fibrosis. The lungs are otherwise free of recent focal pathology and the pleural spaces are clear. There are no signs of significant mediastinal or hilar lymphadenopathy. Calibre of the trachea and main bronchi is normal. No evidence of retrocrural or upper abdominal retroperitoneal lymphadenopathy was seen. The adrenal glands have a normal appearance.

Conclusion: There has been no appreciable interval change when compared with the previous examination. A follow up scan is suggested in twelve months time to ensure ongoing stability.

12 December 2012

[redacted]

Dr [redacted]

Visit Number: [redacted]
DOB: [redacted]

Examination Date: 12/12/2012
ot3

RE: Mrs [redacted]

CT SCAN - CHEST

Clinical Notes
Right peripheral lung lesion for further evaluation. Positive previous PET scan 2011 as stated verbally by the refferer. (Despite the clinical request stating negative PET scan). For further evaluation.

Technique
CT scan from thoracic inlet to ischial tuberosities post arterial phase IV contrast. Multiplanar reformats. Radiation dose reduction techniques were utilised.

Findings
Correlation made with previous CT chest report dated 08/03/2011 and 16/03/2012. No direct imaging available for comparison.

Peripheral peribronchovascular subpleural nodules at the lateral basal aspect right middle lobe extending to the minor fissure measuring 16mm in maximum transverse dimension. No surrounding ground-glass attenuation. This correlates to the area described previously, at this time measuring 15mm maximal extent. No further pulmonary lesions. Atelectasis or scarring left lung base with mild traction bronchiectasis. No effusions.

Severe thoracic scoliosis results in distortion to the mediastinal contour. No mediastinal or hilar lymphadenopathy based on size criteria.
No adrenal lesion. Remaining visualised upper abdominal viscera unremarkable.

8mm well-sclerotic focus posterior left sixth rib most in keeping with a benign bone island (series 8084, image 42). No suspicious osseous lesion.

Comments
1. Well defined peribronchovascular nodules located peripherally within the lateral basal aspect right middle lobe. When compared to the prior report, this has minimally altered in size. Findings are nonspecific. This still may represent chronic endobronchial infection ormay be neoplastic such as bronchoalveolar carcinoma. No effusion, new pulmonary lesions or evidence of lymphadenopathy.

(contd ...)

2. Atelectasis or scarring left lung base with mild traction bronchiectasis.
3. Well defined subcentimeter sclerotic lesion posterior left sixth rib most in keeping with a benign bone island.

Dr [redacted]
Electronically signed 12/12/2012 [redacted]

[redacted]

Dr. [redacted]

[redacted]

05/05/2012

Re: Mrs [redacted]

Dear [redacted]

We are obviuosly thinking about you and worried about you at the clinic and I was thinking about you again the last week . If the main issue is fear of surgery and fear of the pain after surgery would you consider seeing a pyschologist for free , that we would arrange funding for to look at this fear? The psychologist we have at clinic has done special training in the field on cancer and its effect on how we feel.
Please see [redacted] or me if you able to discuss this more please .

Yours sincerely

[redacted]

[redacted] [redacted]

Richard Malter

ElectroMedicine Sp

Suite 4 / 20 Clarendon Street

Frankston

VIC 3199

Phone @ Rooms : 03 97811889

Re:Ms [redacted]

[redacted]

[redacted]

Dr [redacted]

16/07/2018 [redacted]

Dear Richard,

Thank you for seeing [redacted] age 70 yrs , whom I consulted for the following medical condition. I understand that she is being treated by yourself since 2012. It would be great if we can have some record of her management plan. She is applying for a carer allowance.

I did recently suggest a **Stress Echo** to assess her for e/o coronary artery disease.

I also reprint for your information, the relevant past History, allergies and current medications.

Past History:

	Lung cancer
23/05/2016	Asthma