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My Family Suffered Cancer

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Personal history and reason for inquiry:

It is a woman of 63 years, allergy to beta-Lactam and quinolone. Smoker of 50 packages per year

- Moderate chronic obstructive pulmonary disease.
- Anxious and depressive disorder.
- Nephrolithiasis with episodes of colic of repetition.
- Episode of upper gastrointestinal bleeding from gastric ulcer.

Treatment with Zolpidem, diazepam and metered demand.

Go to the emergency room for evaluation by picture of shortness of breath and fever of 38 degrees for 3 days of evolution. It also concerns presenting progressive weight loss with constitutional picture and pain level left hemithorax which has increased in the last three days from 6 months ago.

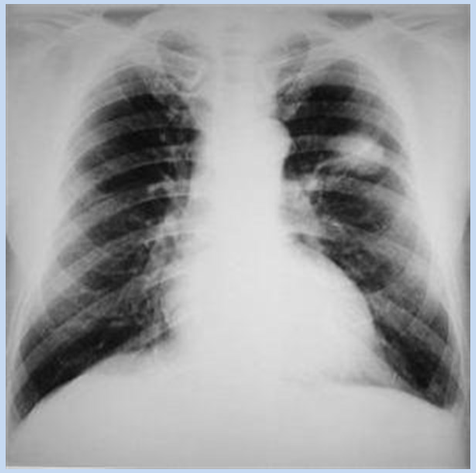
They include family history: father and mother die from lung cancer, a brother passed away from lung cancer and a sister suffers from renal carcinoma.

Physical examination:

General State regular, conscious and collaborator. Well hydrated and eupneica at rest. Blood pressure: 110/70 FC: 100 BPM. 95% baseline O2 saturation.

- Cardiac auscultation: Rhythmic and regular (100 BPM). Not audible murmurs.
- Respiratory auscultation: Absence of vesicular murmur in 3/4 parts of left lung.
- Abdomen: tender, depressible, not painful.

Lower extremities edema without signs of thrombosis.



Complementary tests:

- Analytical income: hemogram and normal biochemistry, highlights only PCR 55
- Chest x-ray: image of white left lung with deviation to the left Mediastinal.
- ECG: RS at 100 BPM. Unaltered driving or the Repolarization.

Evolution:

The patient enters in charge of Pneumology Department where the study is completed:

- Bronchoscopy: objective in bronchial tree left progressive closure of the BPI in "chicken ass" light leaving in the distal area a minimum light that does not pass the bronchoscope but yes biopsy forceps taking 5 samples. Compatible with carcinoma biopsy.
- CT of the chest: findings compatible with pulmonary neoplasm locally advanced (7 x 6 x 6 cm) with lymph nodes metastases subcarinales and aortopulmonary window. Hiperinsuflacion buffer right hemithorax.

Conclusions:

The clinical judgment of the patient was T4 N2 pulmonary Carcinoma with probable post obstructive Pneumonitis. Both active smoking of the patient along with the clinic's weight loss and constitutional picture, Dyspnea and chest pain, spontaneous and family history were not enough so that the patient consult with more advance. We must make stress to patients with a family history of cancer, consult early before the appearance of clinical symptoms or signs.