# Mentor Assessment 1

**Name of Mentor:** Dr. John Mansour

**Profession:** Surgical Oncologist

**Location:** U.T.S.W. Harold C. Simmons Comprehensive Cancer Center

**Date of Visit:** December 20, 2017

**Time:** 8:45 A.M. - 5:00 P.M.

**Assessment:**

Over winter break I was given the opportunity to spend an entire day at the surgical oncology clinic with Dr. Mansour and his P.A. We saw a variety of cases, and most of them were incredibly interesting and were cancers I was unfamiliar with.

The first case I saw was a gastric cancer. This patient had a subtotal gastrectomy from the pyloric sphincter, or the valve that releases food into the duodenum of the small intestine from the stomach. The second patient we saw had a posterior neck mass, which was subdural and quite large. Dr. Mansour allowed me to palpate this neck mass, and showed me how to feel the boundaries of the mass. I was very interested by this experience, and I was incredibly excited that Dr. Mansour gave me an opportunity to be very hands-on with the patients.

The third case I saw was a patient who had renal cell carcinoma, which Dr. Mansour had previously removed. The surgery was complex and removed large areas of the gastrointestinal tracts, including areas of the colon, pancreas, a small portion of the diaphragm, and a total resection of the kidney. The tumor had not metastasized, however Dr. Mansour had to remove such extensive portions to ensure that the surgical margins were negative. When we saw this patient in clinic, he was healing quite well after his surgery, and I watched as Dr. Mansour removed his clips, which are the surgical staples used to seal the wound after a surgery.

The fourth case was introduced both an organ and a cancer that I was not aware existed. This patient had ampullary cancer, which is a rare form of cancer. I learned, both from Dr. Mansour and some research on the side, that the ampulla of Vater is formed by the junction of the bile duct and pancreatic duct. This is where the digestive juices are secreted into the duodenum. Ampullary cancer, for an unknown reason, tends to be less aggressive than pancreatic cancer itself and has a tendency to behave better following treatment. The patient had a pancreatoduodenectomy to remove the cancer, and was doing incredibly well when I saw her with Dr. Mansour. She was ready to have both her clips and feeding tube removed, which I was able to observe. I was incredibly grateful that Dr. Mansour allowed me to observe small procedures such as these because it gives me a hands-on approach to my learning, and it gives

me an idea of what patients have to endure after such an intense surgery, such as a whipple or total gastrectomy.

One of the last cases we saw was a particularly interesting case. This patient had an incredibly large hemangioma, which is benign tumor composed of blood vessels, which makes them very difficult to remove. This patient had previously had renal cell carcinoma, which was treated by a nephrectomy of the kidney with the tumor. Her original scans showed smaller hemangiomas throughout the liver, however a PET scan with contrast showed what seemed to be metastases from the renal cell carcinoma. Dr. Mansour wasn't sure which scan was correct, so he decided to present the case at the GIDOT (Gastrointestinal Disease Oriented Team) conference the next day to get the opinion of the radiologists in the department.

Overall, I found my day at the clinic to be incredibly informational. I learned a lot, not only about various forms of cancer, but also about dealing with patients, reading scans, and post-operative care. Each time I go down to clinic, I learn something new about how to be a compassionate doctor and how to help your patients through the difficult times. I also am given incredible opportunities to learn hands-on and talk to patients.