Name: Emily A Suess | DOB: 3/4/1980 | MRN: 103592534 | PCP: Deborah S. Singleton, MD

Letter Details

SITEMAN CANCER CENTER

[redacted]

BARNES-JEWISH Hospital MC HealthCare | Washington University in St. Louis Physicians

June 6, 2019

Emily A. Suess

Patient: [redacted]
Date of Birth [redacted]
Date of Visit: **4/22/2019**

To Whom it May Concern:

[redacted] is a 39 y.o. female with diffuse astrocytoma of the pons, medulla and upper cervical cord to the level of C3, WHO grade II, IDH1, R132H mutant, 1p/19q intact by FISH, ATRX retained, status post sub occipital craniotomy with biopsy on 02/09/2017. She was treated with concurrent chemo/radiation with Temodar 75 mg/m² from 03/06/2017 to 04/12/2017. Unfortunately, she did not tolerate high-dose adjuvant Temodar due to suspected drug reaction with eosinophilia and systemic symptoms (DRESS) syndrome. We avoided Temodar afterward, and the patient received CCNU, first cycle on 07/27/2017. She completed 6 cycles of CCNU on 04/11/2018. We are monitoring with serial MRIs which have showed no substantial change to a T2/FLAIR hyperintense expansile mass in the medulla and upper cervical spinal cord consistent with known diffuse astrocytoma. The lesion has not substantially changed dating back to 07/10/2018. Full report also attached.

She states that she has overall been doing fairly well with no new complaints. She continues to have episodes of dizziness, particularly when looking down, as well as migraines. Although her condition is currently stable, she has chronic effects caused by the tumor.

[redacted] has been followed closely by her primary care physician, Dr. [redacted]. Due to the infrequency of office visits required by medical oncology, and the familiarity with [redacted]'s ongoing symptoms by Dr. [redacted], I differ to [redacted] for a determination of disability for [redacted].

If you have questions, please do not hesitate to contact my office at [redacted].

Sincerely,

Medical Oncology

Additional documentation: MRI dated 3/6/19

EXAMINATION: Magnetic resonance imaging (MRI) of the brain and brainstem without and with contrast

HISTORY: 39-year-old woman with diffuse astrocytoma of the medulla and cervical spinal cord.

TECHNIQUE: Multiplanar multi-weighted MRI of the brain and brainstem was performed without and with intravenous contrast using the brain tumor protocol. This included high-resolution T1-weighted images with intravenous contrast and data for perfusion analysis.

Contrast information:
18 mL Dotarem

COMPARISON: 11/05/2018, 07/10/2018

FINDINGS:

There are changes of prior suboccipital craniotomy and C1 laminectomy for spinal cord lesion biopsy.

Redemonstrated is a T2/FLAIR hyperintense nonenhancing expansile lesion within the medulla and cervical spinal cord, which extends from approximately the pontomedullary junction to the mid portion of C2. The most expanded portion of the medulla measures up to 2.8 x 2.5 cm, and is not substantially changed when remeasured on the prior examination in similar fashion. Lesion is also not substantially changed compared to the 07/10/2018 examination.

The superior sagittal sinus demonstrates normal venous flow. The corpus callosum is normal in shape and signal intensity. The posterior fossa is unremarkable. The pituitary and sella are normal.

Diffusion weighted images reveal no hyperintensities to suggest acute cerebral infarction. The ventricles are normal in size and position without evidence of hydrocephalus.

The paranasal sinuses are normal. The visualized portions of the mastoids are unremarkable. The orbits appear normal. Normal flow voids are demonstrated in the carotid arteries and basilar artery.

IMPRESSION:
No substantial change to a T2/FLAIR hyperintense expansile mass in the medulla and upper cervical spinal cord consistent with known

diffuse astrocytoma. The lesion is also not substantially changed dating back to 07/10/2018.

[redacted]

[redacted]