WASHINGTON HOSPITAL CENTER
CONSULTATION

PATIENT: Walker, Samantha
ADMISSION DATE: 02/12/2002
DISCHARGE DATE: 03/12/2002
DATE OF SERVICE: 03/01/2002
ATTENDING PHYSICIAN: PAUL H. SUGARBAKER, M.D.

MEDICAL RECORD NO.: 238-17-23
DOB: [redacted]
SSN:

DATE OF BIRTH: 02/12/1970

SOCIAL SECURITY: 267348605

REASON FOR CONSULTATION: Consideration for systemic chemotherapy in this patient with a known appendiceal mucinous adenocarcinoma, ~~with~~ accompanying peritoneal carcinomatosis.

HISTORY OF PRESENT ILLNESS: This 32-year-old, white female, advertising business person from Canada, was examined at the request of Dr. Sugarbaker for evaluation and treatment of her well-differentiated mucinous adenocarcinoma of the primary appendix, accompanying peritoneal carcinomatosis.

IMPRESSIONS: Well-differentiated mucinous adenocarcinoma, appendix primary, associated with peritoneal carcinomatosis, status post CC1 cytoreduction (thus residual tumor less than 2.5 mm) on 02/13/2002 with HIIC (heated intraoperative intraperitoneal chemotherapy with mitomycin C 60 mg for 90 minutes) followed by EPIC (early postoperative intraoperative chemotherapy with 5-FU 1,040 mg per day for five consecutive days from 02/14/2002 through 02/18/2002 through the Tenckhoff catheter) now recovering uneventfully. No significant preoperative weight loss and fully ambulatory with a good performance status prior to surgery here. Preoperative tumor marker increased only with CA19-9 to 124.9 (normal less than 15.8) on 02/12/2002 has decreased to 53.2 on 02/23/2002. Other tumor markers including CEA and CA-125 were not significantly elevated, thus not useful for follow-up.

PAST MEDICAL HISTORY: Initial appendectomy for "acute appendicitis" on 11/07/2001 which demonstrated well-differentiated mucin-producing adenocarcinoma of the appendix followed by exploratory laparotomy on 12/11/2001 for biopsy only and then came to this institution for a second opinion.

Multifactorial anemia with the hemoglobin and hematocrit of 10.4/30.5 (MCV 92.9) associated with a WBC of 8.0 and platelet count of 423,000, most likely anemia, surgical blood loss and concurrent anemia of chronic disease accompanied with reactive thrombocytosis, all from 02/25/2002. Seriously doubtful for hemolysis and/or nutritional anemia.

HEALTH SURVEILLANCE: This previously healthy lady, nonsmoker, nondrinker was admitted here on 02/13/2002 for elective cytoreduction. Benign left breast lump at age 21.

Copy for DAL YOO, MD

3/11/02

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ALLERGIES: Penicillin.

FAMILY HISTORY: No family history of appendix or colorectal cancer, but father with a history of prostate cancer at age 61. Mother with a skin cancer in the past, but alive and well at age 61.

DISPOSITION AND RECOMMENDATIONS
1. In light of well-differentiated grading of the tumor, negative lymph node status (17 out of 17 negative including one high colic node)and most importantly, CC1 cytoreduction with HIIC and EPIC as described above, I would not recommend additional systemic chemotherapy such as Saltz regimen (CPT-11 5-FU leucovorin) at this time for this patient. In stead, I would like to recommend a close surveillance follow-up with the tumor marker, especially CA19-9 every three months plus a CAT scan of the chest, abdomen and pelvis with and without contrast every six months for the first two years and then perhaps less frequently thereafter. I was not able to find any evidence of "signet ring" adenocarcinoma histology report anywhere from her original appendectomy surgery or recent cytoreduction here on 02/13/2002.

2. Should her anemia get worse and should she become symptomatic from the anemia such as increasing generalized weakness and easy fatigability, etc., then consider anemia workup with a CBC, reticulocyte count, direct Coombs, serum ferritin, B12, folic acid and serum erythropoietin level first to see whether the patient would be a candidate for erythropoietin treatment (40,000 units subcutaneous weekly for four weeks initially, if no contraindication exists).

3. Although chemo prevention data is unavailable for primary appendiceal tumor, we discussed at length about some of the ongoing clinical trials for colorectal chemo prevention protocol including nonsteroidal anti-inflammatory drugs such as aspirin or Celebrex, estrogen replacement therapy, selenium, calcium and folic acid supplementation, all discussed. Estrogen replacement therapy was the main topic and I told her that I do not know of any data that estrogen replacement therapy increases the risk of recurrent appendix cancer.

Continue psychosocial support and nutritional counseling as she slowly and progressively recovers uneventfully from the 02/13/2002 cytoreduction surgery.

CLINICAL BACKGROUND: This is a 32-year-old, white female Canadian, advertising specialist, who was well up until 11/07/2001 when she was operated on for her "acute

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appendicitis" which identified a well-differentiated mucin producing adenocarcinoma of the appendix. Subsequently, she underwent another exploratory laparotomy on 12/11/2001 after a CAT scan 11/10/2001 identified peritoneal seeding. Exploratory laparotomy only resulted in biopsy, confirming again well-differentiated mucinous adenocarcinoma with a peritoneal carcinomatosis, therefore came to see Dr. Sugarbaker for a second opinion concerning surgical and other treatment options.

On 02/13/2002, she underwent the exploratory laparotomy here at which time CC1 cytoreduction was performed including greater and lesser omentectomy, excision of the abdominal wall tumor, cholecystectomy, pelvic peritonectomy, total abdominal hysterectomy with bilateral salpingo-oophorectomy, right colectomy with ileocolic anastomosis, left colectomy with a low stapled colorectal anastomosis, plus HIIC followed by EPIC as described above. This extensive CC1 cytoreduction surgery lasted for six and a half hours, but without any major complications and healing well thus far. Hematology oncology consult was requested for consideration of the systemic chemotherapy in this unique clinical setting.

Pertinent physical exam at this time shows an alert and oriented, delightful lady who asked highly informative and challenging questions throughout in the presence of her husband at the bedside who was equally informed extremely well on the topic. Conjunctiva appears moderately pale due to anemia, but no scleral icterus. No significant lymphadenopathy around the neck, axilla or groin. Thyroid is in the midline without nodules or goiter. No supraclavicular mass. Chest clear anteriorly. Heart: Normal sinus rhythm. Abdomen shows a nicely healing midline incisional scar. Still, three Jackson-Pratt drains in place without any bleeding or infection at the site of drainage. No palpable hepatosplenomegaly or any palpable mass. No pitting edema or ecchymosis throughout the extremities. No calf muscle tenderness. No focal or lateralizing neurologic deficit.

Most recent pertinent laboratory data from 06/27/2002 showed hemoglobin and hematocrit 11.7/34.4 (MCV 94.4, LVC 5.7, platelet count 548,000. Random glucose 106, BUN and creatinine 15/0.5. Normal electrolytes. Calcium low at 8.3, phosphorus 4.8 (normal 2.2 to 4.4), magnesium normal at 1.4. Liver function profile also on 02/27/2002 showed a normal bilirubin of 0.2, but alkaline phosphatase slightly increased to 145 (normal 38 to 126), AST 47 (normal 10 to 42), ALT 89 (normal 0 to 42), total protein 5.7 with an albumin of 2.8. CA19-9 decreased from a preoperative level of 124.7 on 01/12/2002 (normal less than 15.8) to 53.2 on 02/23/2002. Urinalysis on 02/25/2002 was completely negative, except for 7 WBCs per high power field and many bacteria. Urine culture however on 02/27/2002 showed greater than

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100,000 enterococcus and sensitivity is currently pending.

A CAT scan of the chest on 02/15/2002 demonstrated new bilateral pleural effusion and bibasilar consolidation, but no evidence of pulmonary embolism while postoperative anticipated tiny free intraperitoneal air was observed.

Preoperative EKG on 02/12/2002 showed normal sinus rhythm with a ventricular rate of 60 per minute.

Thank you very much for this interesting consult opportunity and will follow as needed.

DICTATED BY DAL YOO, MD

SIGNATURE OF CONSULTING PHYSICIAN _____ DATE 3/12/02
DAL YOO, M.D.

cc: PAUL H SUGARBAKER, MD
DAL YOO, MD
SR:mdi: mdi
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T: 03/02/2002 4:09 P
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