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Side effects of alpha-interferon therapy and impact on health-related quality of life in children with chronic viral hepatitis.

Iorio R, Pensati P, Botta S, Moschella S, Impagliazzo N, Vajro P, Vegnente A.

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BACKGROUND: Interferon (IFN) is standard therapy for chronic viral hepatitis in children. The aim of this study was to evaluate the side effects of alpha-interferon (IFN) in 94 consecutive children (58 males; age range, 3 to 14 years) affected by chronic viral hepatitis treated with different schedules ranging from 3 to 10 MU and from 3 to 12 months, and the impact of this therapy on health-related quality of life. METHODS: Side effects were evaluated with clinical and laboratory examinations and were recorded on a diary card. The health-related quality of life was evaluated with a modified version of the Sickness Impact Profile. RESULTS: All patients experienced at least one adverse reaction to IFN treatment; 80% had more than five side effects.There were no life-threatening reactions. Three children experienced severe reactions (febrile seizure, severe hypertransaminasemia and relapsing episodes of epistaxis, respectively) that required permanent IFN withdrawal. Another child had a febrile seizure requiring temporary IFN withdrawal. In seven children the neutrophil count fell below 1000/mm3 and promptly increased when IFN was temporarily discontinued. The remaining children had mild or moderate clinical and/or laboratory adverse reactions. Age, sex, viral etiology of chronic hepatitis and response to therapy were not significantly associated with the appearance of side effects. The pre-IFN health-related quality of life was good in all children; it deteriorated significantly during IFN therapy and returned to basal standards within 3 months after IFN withdrawal. No patient required suspension of IFN therapy because of worsening of health-related quality of life. CONCLUSION: Children have a low risk of developing severe IFN-induced side effects. Adverse reactions and worsening of health-related quality of life were tolerable and did not seem to be a limiting factor for IFN

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Anton C, **Trifan A**, **Stanciu C**, **Stanciu GO**, **Malgarinos G**.

Faculté de Medicine, 2-éme Clinique Medicale Gastroenterologie, Université de Medicine et Pharmacie Gr. T. Popa.

Interferon alpha (IFN-alpha) is a well-established first-line treatment for chronic viral hepatitis. Side effects of IFN-alpha therapy are common but generally mild and self-limited. Generalized seizures during IFN-alpha therapy are very uncommon and are present in clinical isolated cases and usually in association with high doses of IFN-alpha. In our case a female of 39 years old, seizures have occurred at low doses of IFN-alpha used as therapy for chronic C viral hepatitis. As it comes to our knowledge, till now, there were published only 4 cases of generalized seizures that occurred during treatment with IFN-alpha for chronic C viral hepatitis. The physiopathology of this complication is unknown. Generalized seizures can be reasonable due to IFN-alpha therapy, as long as the patient didn't have any seizure history, or other factors, which can develop seizures. Neurological examination, EEG and brain scan were normal. The recurrence of these seizures was absent stopping IFN-alpha therapy without any other seizure treatment.

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Psychosomatics 43:237-240, June 2002
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Case Report

Neuropsychiatric Complications Associated With Interferon-Alpha-2b Treatment of Malignant Melanoma

Olivia I. Okereke, M.D.

Received July 2, 2001; revised November 13, 2001; accepted December 7, 2001. From the Department of Psychiatry, Massachusetts General Hospital. Address reprint requests to Dr. Okereke, Massachusetts General Hospital, Wang Building-Suite 812, Boston, MA 02114. Copyright (2002 The Academy of Psychosomatic Medicine.

Key Words: Malignant Malinoma • Complications

Malignant melanoma is a common skin neoplasm; it accounts for 3% of all cancers.[1] Each year, approximately 40,000 new cases are diagnosed in the United States. Treatments for this potentially lethal cancer include lesion excision, lymph node dissection, and surgical adjuvant therapy with chemotherapy or with an immunomodulatory agent. [1] More recently, interferon-alpha-2b (IFN-A), an immunomodulatory drug produced by recombinant DNA techniques, has become the agent of choice for patients with resected lesions and a high risk of disease recurrence. [2,3] Unfortunately, a variety of neuropsychiatric side effects can result from use of IFN-A.

This is the case of a 51-year-old man who underwent a course of high-dose intravenous (IV) IFN-A to treat malignant melanoma. During IFN-A therapy, he developed severe depression, which was effectively treated with electroconvulsive therapy (ECT). To the author's knowledge, this is the first such case report. A review of the relevant literature on malignant melanoma, IFN-A, and interferon-related mood disorders and their treatments is provided.

Case Report

Mr. A, a 51-year-old mechanic, was diagnosed with malignant melanoma 1 month after he noted spots of blood on the back of his shirt. Treatment included a wide excision of the lesion and a left axillary node dissection (after a positive sentinel node biopsy). He underwent a course of high-dose IFN-A (20 million units/square meter [MU/m^2] IV five times a week for 4 weeks). After 1 week of IFN-A, Mr. A became depressed. Although he had a history of major depressive disorder (MDD) with a suicide attempt 5 years earlier, obsessive-compulsive disorder (OCD), and posttraumatic stress disorder (PTSD) related to combat experience, his psychiatric symptoms had been stable until interferon administration. After the first week

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of interferon, olanzapine 2.5 mg twice daily was added to his regimen of citalopram 40 mg daily to target his excessive ruminative thoughts. By the end of the fourth week, Mr. A was severely depressed and had intense thoughts of suicide with a plan to drive his car into a bridge abutment; this prompted referral for inpatient psychiatric treatment.

He reported no history of alcohol or substance abuse. Medications on admission included citalopram (40 mg daily), olanzapine (2.5 mg twice daily), a multivitamin (daily), as well as a nonsteroidal anti-inflammatory drug for pain and temazepam for sleep when needed.

Mr. A had a burly physique and appeared in good health. Surgical scars over the back and axillae were the only remarkable findings; there was no evidence of infection. Laboratory studies revealed normal levels of electrolytes and glucose; liver function tests, a complete blood count, and folate and B_{12} levels were also normal. The urinalysis and urine screen for drugs of abuse were unremarkable. Thyroid stimulating hormone (TSH) was elevated at 30.31 μU/mL (normal range: 0.50–5.00 μU/mL). This was rechecked three times at several intervals during Mr. A's hospital course; each value (8.41, 9.30, and 11.40 μU/mL) was elevated. The remainder of the thyroid panel was also repeatedly checked and was within normal limits, except for a slightly decreased free T4 index of 3.6 (normal range: 4.5–10.9) at the time of discharge. Rapid plasma reagin (RPR) test was nonreactive. An electrocardiogram (EKG) revealed mild sinus bradycardia; the EKG was otherwise unremarkable. A chest X ray was normal. Computed tomography (CT) scans of the head, thorax, abdomen, and pelvis (completed 3 months before admission at another hospital) were reportedly normal. The mental status examination revealed depressed mood, anxious and dysphoric affect, obsessive rumination, and suicidal ideation (with a plan), but there was no evidence of homicidal ideation, mania, psychosis, or abnormal cognition.

The initial diagnostic impression was that Mr. A was experiencing a major depressive episode as well as obsessive symptoms. Given the severity of his depression, which had continued to worsen despite ongoing treatment with antidepressant medication, ECT was planned. Four unilateral ECT treatments were performed. Mr. A was continued on citalopram (40 mg/day), his olanzapine dose was decreased (to 2.5 mg/day), and he was given a benzodiazepine as needed for sleep and anxiety. Initiation of thyroid hormone supplementation was not recommended by endocrinology consultants, who suspected that Mr. A's thyroid function abnormalities were interferon related and could be followed as an outpatient.

Mr. A was discharged in good condition; he was without depressed mood, severe anxiety, or suicidal ideation. His outpatient oncology team recommended termination of IFN-A therapy (which had been scheduled to proceed with a maintenance phase of 10 MU/m^2 subcutaneously three times a week for 48 weeks) because of presumed interferon-induced depression and suicidal ideation, and he was followed in the oncology clinic. He received no subsequent immunotherapy or chemotherapy for his melanoma, and there has been no evidence of cancer recurrence.

Mr. A continued to have a stable mood until 15 months later, when he was readmitted to an inpatient psychiatric facility for a recurrence of depressive symptoms with suicidal ideation in the setting of 3 months of alcohol abuse. The medical workup included a brain magnetic resonance imaging (MRI) study with and without gadolinium contrast; there was no evidence of metastasis. Physical examination and contrast-enhanced chest CT similarly showed no evidence of melanoma recurrence. The remainder of the comprehensive laboratory workup was unremarkable except for an elevated TSH of 20.45 μU/mL. This was rechecked the next day, and the value remained elevated at 19.22 μU/mL with normal thyroid indices. Given the patient's prior response, consultation for ECT was obtained. However, the consultants chose not to proceed with ECT because Mr. A's symptoms were not severe enough during this hospitalization. In fact, Mr. A's mood stabilized quickly with milieu support, alcohol detoxification, and small medication adjustments, and he has since remained in good condition.

Discussion

With the incidence of melanoma rising more rapidly than any other form of cancer, malignant melanoma now represents 3% of all cancers. [1] The American Cancer Society has estimated that 41,600 new cases of melanoma were diagnosed in the United States in 1998 alone; the U.S. lifetime disease risk for melanoma

has increased sharply from 1/1,500 persons in 1935 to (an estimated) 1/75 persons in 2000. [1]

Surgical excision remains the principal treatment for primary melanoma; treatment for regional metastasis includes additional surgery, lymph node dissection, and regional chemotherapy limb perfusion. Adjuvant therapies include radiation, chemotherapy, and administration of biologic response modifiers (e.g., interferons and interleukins). As a result of the protocol titled Eastern Cooperative Oncology Group (ECOG) 1684, high-dose IFN-A emerged as the agent of choice for surgical adjuvant therapy in melanoma patients meeting specific criteria (i.e., [1] American Joint Commission on Cancer stage IIB or III melanoma, [2] absence of disease after surgical excision, [3] high risk for recurrence). [1,4] In these patients, IFN-A increased the median time to relapse, improved the estimated 5-year relapse-free survival rate (37% vs. 26% observation controls), and lengthened the estimated 5-year overall survival rate (46% vs. 37%). [4] ECOG 1684 established the following regimen for high-dose IFN-A in malignant melanoma: 4 weeks of 20 MU/m^2 of body surface area administered IV five times per week, followed by 48 weeks of 10 MU/ m^2 SC three times per week.

As interferons (immunomodulatory proteins with antimicrobial and antitumor properties) have been increasingly used in the treatment of melanoma and other diseases (e.g., chronic hepatitis B and C, AIDS-related Kaposi's sarcoma, hairy cell leukemias, and non-Hodgkin's lymphoma), awareness of their central nervous system (CNS) side effects has grown. [5] These effects can be grouped into two categories: early-onset constitutional reactions (e.g., fever, flulike symptoms, and malaise) after treatment initiation and late-onset reactions following sustained treatment. [5] Psychiatric complications include depression, anxiety, mania, and suicidal ideation; neurologic and neuropsychiatric complications include headaches, visual changes, paresthesias, hyperkinesia, decreased attention and concentration, and impairments in visual scanning, verbal memory, executive function, and motor control. [5,6] In addition, Greenberg and colleagues[3] described a syndrome of mood instability associated with IFN-A. This syndrome included unipolar depression, mania, and mixed affective states (either with or without psychotic features). Overall, 40% of interferon-treated melanoma patients report depressed mood; 8% endorse severe depression with functional impairment or suicidal ideation. [2,3] Attempted and completed suicides have been reported as adverse events to the Food and Drug Administration.[7]

The mechanisms by which interferon, which is similar in structure and function to adrenocorticotropic hormone and beta-endorphin, causes neuropsychiatric effects are unclear. IFN-A does not cross the blood-brain barrier, so its effects likely derive from indirect actions on the CNS. Proposed etiologies include direct stimulation or inhibition of the hypothalamic-pituitary axis, interferon-induced changes in thyroid function, indirect effects of IFN-A on the opioid receptor system, interferon-mediated alterations in neurotransmitter (e.g., serotonin, norepinephrine, and dopamine) levels, and toxic effects of secondary cytokines (e.g., interleukin-1). [6]

This case (Mr. A) provides an opportunity to consider the complex potential etiologies of his depression. Possibilities include recurrence of his primary mood disorder, depression secondary to CNS infiltration of his melanoma, depression secondary to the complications of treatment (interferon-induced vs. secondary to interferon-related hypothyroidism), and a reactive depression associated with having cancer. [6]

Mr. A's depression could have represented a recurrence of MDD that was completely independent of interferon therapy. However, the temporal relationship between IFN-A initiation and his development of mood symptoms suggests an interferon-induced recurrence of depression. Furthermore, the intensity of dysphoria was new to Mr. A and not consistent with prior episodes.

Since malignant melanoma is known to metastasize to the brain, this complication could have caused Mr. A's depression. The clinical literature reveals an estimated incidence of CNS metastases of 6%–11% (36%–54% in autopsy series). [8] CNS sites of involvement in order of frequency are as follows: cerebrum, usually the frontal lobe (no hemispheric preference), > cerebellum > base of brain > spinal cord. [9] Herald symptoms of CNS metastases include headaches, motor and sensory problems, psychological changes, and seizures. [9] As a Stage III patient, Mr. A underwent an extent-of-disease workup (including CTs of the head, chest, abdomen, and pelvis) that was unremarkable by report, and the inpatient psychiatry team was

satisfied with this evaluation. Unfortunately, since repeat brain imaging was not completed, CNS involvement could not be definitively excluded during the first hospitalization; a subsequent admission revealed no evidence of melanoma recurrence. The possibility of CNS metastasis underscores the importance of comprehensive workups, including head imaging and detailed neurologic examination. This has special significance in ECT, where increases in intracranial pressure due to space-occupying lesions could cause serious complications.

Another important factor was Mr. A's elevated thyroid stimulating hormone; it is unclear to what degree his thyroid abnormalities contributed to his mood changes. Although the increase in his TSH was presumed to be due to IFN-A treatment (since it fell rapidly following withdrawal of IFN-A), no baseline values were available for comparison. Furthermore, Mr. A's subsequent thyroid testing revealed an elevated TSH (with normal thyroid indices) 15 months after the termination of IFN-A. Thus, a causal relationship between interferon therapy and hypothyroidism cannot be clearly established in this case. The role of thyroid changes in the high incidence of depression among interferon-treated melanoma patients is difficult to discern. Trask and co-workers[5] noted that among studies reporting psychiatric side effects of IFN-A, only three studies mentioned any tests of thyroid function. The role of thyroid hormone augmentation in the treatment of depressed patients like Mr. A requires further inquiry.

Finally, while the temporal relationship between the start of interferon therapy and the onset of depressive symptoms suggests causality, it is also possible that Mr. A suffered from a reactive depression. In fact, depressed mood is commonly reported in patients before the initiation of any cancer treatment, [6] and it is thought to be precipitated by the stress of a life-threatening diagnosis.

Fortunately, Mr. A's depression, regardless of its etiology, responded to ECT. An established treatment for severe mood disorders for decades, ECT is considered safe and effective, and it is indicated in cases involving a serious risk of suicide. [10] Furthermore, "not a single controlled trial has shown another form of treatment to be superior to ECT in the short-term management of severe depressions." [11,12] In the case of Mr. A, ECT's impact may have been lifesaving. However, it is unclear how the patient might have responded to discontinuation of IFN-A alone. Case reports suggest that patients can either improve, remain unchanged, or become worse following the discontinuation of interferon. [3,13]

The occurrence of depression with suicidal ideation is felt to limit interferon treatment; in fact, the development of suicidal ideation is recognized as an absolute contraindication to continued therapy with IFN-A. [2] In our case, Mr. A's scheduled course of 48 weeks of subcutaneous IFN-A was terminated for this reason. In a case described by Ademmer and associates, [14] a patient treated with the IFN-A and ribavirin combination for hepatitis C made a suicide attempt while on an inpatient psychiatry unit; the treatment team chose to discontinue interferon because of the suicidal behavior. However, the authors concede that the literature is limited and does not provide consistent guidance on whether or when to stop interferon following the emergence of depressive symptoms. [14]

The presence of an effective and rapidly acting antidepressant treatment for interferon-induced depression not only would reduce the risks associated with depression and suicidal ideation but also would allow patients to continue treatment that can greatly improve prognosis. ECT should be considered such a treatment, but its role in the therapy of interferon-induced mood disorders requires further investigation. One may wonder if maintenance ECT could be an option for patients who are at high risk not only for fatal melanoma recurrences but also for depression and suicidal behavior while on interferon. While it was possible for Mr. A to be rechallenged with IFN-A and treated for depression with additional courses of ECT or other antidepressants, his outpatient oncology team elected to avoid the risk of another interferon-induced suicidal episode and discontinued IFN-A.

Effective treatment of interferon-induced psychiatric symptoms has been achieved with tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), psychostimulants, opioid-antagonists, and anxiolytics. [5,6] In addition, Greenberg and associates[3] reported the successful use of gabapentin for interferon-related mood instability in four patients with melanoma. To date, there have been no published controlled trials of antidepressant treatments that follow the initiation of IFN-A. [6]

Recently, Musselman and co-workers[15] published a randomized, double-blinded, placebo-controlled trial of paroxetine as prophylactic treatment for interferon-induced depression in patients receiving high-dose interferon for malignant melanoma. Significant findings in the paroxetine group included reduced incidence of major depression, decreased severity of mood symptoms when they did occur, and decreased likelihood of IFN-A discontinuation due to depressive symptoms. [15] Furthermore, the study found that baseline mood and anxiety ratings were predictive of depression and anxiety scores in the placebo group after IFN-A administration; [15] Capuron and Ravaud[16] have shown similar findings. These studies point to the importance of careful screening and prevention. Effective screening methods could play a critical role in identifying those at risk for severe depression.

Conclusion

The incidence of malignant melanoma is rapidly rising. As a result, more individuals will receive state-of-the-art immunomodulatory treatments (e.g., IFN-A). Since neuropsychiatric complications of this treatment are prevalent, we need to remain vigilant for their manifestations. Mr. A's case provides a compelling example of the neuropsychiatric symptoms associated with IFN-A therapy and presents a strategy for reviewing the differential diagnosis and treatment alternatives. Systematic study of preventive treatments as well as interventions for IFN-A psychiatric side effects is required. If we can diagnose and treat IFN-A psychiatric complications in a timely and effective fashion, we will be providing a valuable and lifesaving service.

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[Seizures during interferon alpha therapy: three cases in dermatology]

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Legroux-Crespel E, Lafaye S, Mahé E, Picard-Dahan C, Crickx B, Sassolas B, Descamps V.

Service de Dermatologie, Groupe Hospitalier Bichat-Claude Bernard, Paris.

INTRODUCTION: Interferon alpha has many side effects. Among them the risk of occurrence of seizures is not well known by dermatologists. We report three cases of seizures that occurred in patients treated with interferon alpha in two dermatological diseases: mycosis fungoides and melanoma. OBSERVATIONS: A 68 year-old man, treated for mycosis fungoides, and two men aged 47 and 52 years, treated for melanoma, were under interferon alpha. After 11 months, 3 weeks and 9.5 months, respectively, the three patients had seizures without any past history of epilepsy. Anamnesis and assessment of each patient (brain CT, biological results) suggested the responsibility of interferon alpha. After withdrawal of the treatment, no relapse was observed after 3 months, 6 months and 1 year later, respectively. DISCUSSION: Seizures during treatment with interferon alpha have already been reported. According to the series their prevalence would be of 1 to 4 p. 100. Their pathophysiology is not well known, but apparently interferon alpha lowers the epileptogenic threshold by affecting the central nervous system either directly or through cytokines or neuromediators. The risk of occurrence of seizures must be known by the prescribing physician who must systematically search for past history of epilepsy or risk factors for seizures. This rare but existing side effect raises the problem of information to be supplied to the patient by the prescribing physician.

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Interferon Therapy in Patient With History of Seizures?

Question

Is a past or current history of seizures/epilepsy a contraindication to the use of interferon (IFN), pegylated or not, for the treatment of hepatitis?

Alvaro Gonzalez-Koch, MD

Response from Roshan Shrestha, MD
Assistant Professor of Medicine, Associate Director of Transplant Hepatology, Medical Director, Liver Transplantation Program University of North Carolina, Chapel Hill,. NC.

A history of seizures or epilepsy is a relative contraindication to the treatment of hepatitis C virus (HCV) infection with IFN. However, an individual with a history of a seizure disorder who (1) has been on antiseizure therapy without any episodes of recurrent seizure activity within the past 1-2 years, (2) has been followed by a neurologist, and (3) has a favorable HCV genotype with active disease by both laboratory and liver histology could be considered for treatment with IFN. The patient should be counseled about the possibility of seizures during treatment, despite being on antiseizure medication with therapeutic levels. However, if there is ongoing seizure disorder, the patient should not be considered for IFN therapy.

Posted 06/27/2003

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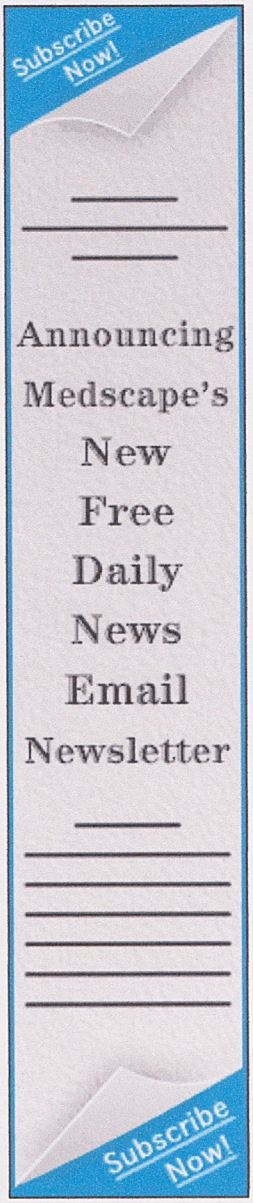

Interferon - Research + Literature
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D ADVERSE EFFECTS

A review article (Quesada) concluded that with alfa interferons, doses of 1-9 MU are generally well tolerated, but doses of 18-36 MU yield moderate to severe toxicity. Doses greater than 36 MU can induce significant toxicity and significantly alter the performance status of the patient. Side effects can be minimized by administering ***interferon at bedtime***.

The most common adverse effect is ***flu-like syndrome*** consisting of fever, chills, fatigue, myalgias, anorexia and headache. These effects are transient, dose-related and reversible within 72 hours of cessation of treatment. Acetaminophen 500-1000 mg (10 mg/kg/dose for children) given 30 minutes before administration of interferon and q4h after alleviates the flu-like symptoms. Chills and rigors can be managed with meperidine 50 mg IV (1 mg/kg/dose in children) or chlorpromazine 25-50 mg IM before dose. Tolerance to the flu-like syndrome develops over several months on continued dosing. There are data to suggest that symptoms may be less pronounced if the interferon is given as a continuous infusion over a prolonged period of time such as 12-18 hours.

The significance of developing ***neutralizing antibodies*** to interferon remains controversial. The incidence of antibody formation to interferon alpha is approximately 0-10% but may be as high as 38% in patients with renal cell cancer. The issue of neutralizing antibodies has clinical relevance since patients have been described who lose their response to therapy after the formation of antibodies.

Elevation in liver function tests occur frequently, especially at doses greater than 10 MU daily, but generally decrease despite continued treatment and return to pre-existing levels within two weeks following cessation of treatment. Severe toxicity and liver failure can occur rarely.

The ***CNS toxicity*** is dose related and generally reversible, but resolution may take up to three weeks. Emotional and/or psychiatric problems have been reported in patients receiving >20 MU/m^2. At doses ≥100 MU, marked lethargy, confusion, dysphagia and overall mental and motor slowing occurs. Rarely, seizures have occurred at high doses. Suicidal ideation has been reported; interferon should be discontinued.

Cardiovascular adverse events, especially arrhythmias, are correlated with pre-existing cardiac dysfunction and prior cardiotoxic therapy. Hypotension may occur during, or up to two days after, interferon therapy. Patients should be adequately hydrated during therapy.

Adverse reactions to the ***intralesional administration*** of interferon are common (80%, severe 9%), but mild to moderate in severity, transient and rapidly reversible, usually within 24 hours. The most common reactions are flu-like symptoms and local reactions such as pruritis, paresthesia, swelling or pain.

Because the toxicity of high-dose interferon can be severely debilitating in ***patients with AIDS-related Kaposi's sarcoma***, it is advisable to escalate dose levels slowly in 3 MU/m^2 increments over several weeks and to immediately reduce doses by 50% when serious toxicity is encountered.

W Date: 8/18/08

Father's Notes Post my Seizure

ANTI-SEIZURE MEDS: Keppra
Topamax
Lamictal
Trileptal

INTERFERON alpha-2b Schering Corp. (Intron A)

Hi dose → 20 MU/m² 5x/wk 4 wks
Lo " → 10 MU/m² 3x/wk 48 wks

CHANCE MEL ↓ BY ___ & W/1 MO hi-dose?

CHANCE MEL ↓ BY ___ & W/11 MO lo-dose?

SEIZURE DUE HI-DOSE OR THE LO-DOSE?
NO WAY TO TELL (MORALES 8/18/08)

IF KEEP KEPPRA & RESTART IFN, CHANCE MORE SEIZURES?

OTHER SIDE EFFECTS IFN PERMANENT OR STOP WHEN STOP IFN (e.g. MEMORY PROBLEMS)?

→ Per Morales (8/18/08), 10 → 20% More people survive 5 yrs if go thru entire IFN treatment.

Per Herzog (4/21/08) – IF ADULT 50% CHANCE RECURRENCE, INT ↓ TO ABOUT 20%. SOME DRS THINK BETTER W/KIDS

UT M.D. Anderson Cancer Center
Radiology Print by ALONZO, HEATHER R. at 8/15/2008 8:37:59 AM

744652 - BODIN, JEFFREY T 11yo M 05/22/1997 (133.5cm 27.6kg BSA: 1.01m² 06/05/08)

MRI, BRAIN W&W/O CONTRAST 4/22/2008 1:59:00 PM
Accession: 6794686

FULL RESULT:
Examination: MRI of the brain with and without contrast, 04/22/2008.

Clinical History: This is a 10-year-old male with melanoma, rule out metastasis.

Comparison: None.

Findings: There is no abnormal intracranial enhancement or susceptibility signal abnormality to suggest metastasis. There is increased FLAIR hyperintense signal in the sulci of the bilateral cerebral hemispheres likely related to supplemental oxygenation under sedation for MRI scanning in this pediatric patient. There is no acute intracranial finding. There is no significant mass effect, hydrocephalus, or extra-axial collection. The major intracranial flow voids are patent. The globes and orbits are unremarkable. There is circumferential mucosal thickening of the bilateral maxillary sinuses containing air-fluid levels. There is mucosal thickening of the ethmoid air cells and bilateral sphenoid sinuses. The calvarial bone marrow demonstrates no focal abnormalities to suggest osseous metastasis.

IMPRESSION:
1. No evidence for intracranial metastasis.
2. Paranasal sinus disease with fluid levels in the bilateral maxillary sinuses. In the appropriate clinical setting, this may represent acute sinusitis.

11745 - KWON, MICHAEL
SIGNED BY: 11745 - KWON, MICHAEL 4/24/2008 11:41:00 AM

Children's Hospital

Patient Name	BODIN,JEFFREY	**Patient ID**	0445573
Birth Date	05/22/1997	**Sex**	M
Age	11 Year	**Exam Status**	APPROVED
Exam Procedure	MRI BRAIN W/O & W/CON	**Modality**	MR
Study Time	08/08/2008 02:20:56	**Image Count**	246

Diagnostic Report(Radiologists : ARCEMENT, CHRIS)

MR BRAIN WITH AND WITHOUT:

There is a small focus of T2 hyperintensity in the right peritrigonal white matter. There is no associated mass effect or or contrast enhancement. The remainder of the brain and ventricular size is within normal limits.

IMPRESSION: SMALL NON-SPECIFIC FOCUS OF T2 HYPERINTENSITY IN THE RIGHT PERITRIGONAL WHITE MATTER, OTHERWISE NORMAL STUDY.

From: "Joseph Hajjar" <jdhajjar@gmail.com>
Subject: **Re: Jeffrey's MRI today**
Date: August 12, 2008 7:38:07 PM CDT
To: "Bodin E-mail" <mljscomp@bellsouth.net>
Reply-To: jdhajjar@gmail.com

Almost certainly nothing to worry about. The report is quite brief but seems to describe a "small" area of increased water content in a small portion of the white matter of the brain. We see this everyday and do not know why these areas are there. In adults they are even termed UBOs "unidentified bright objects) and are often seen in "normal" brains. The theories why one tiny area of brain are different in water content ranges from migraine headaches to tiny strokes to development variants to the brain equivalent of birthmark. Regardless of the theory these finding are usually meaningless. If we see 4 or 5 of them we may recommend a follow up exam to make sure they are not a very early manifestation of a disease process like tiny strokes. I bet that you and I have two or three of them in our brains (best not to look). The same finding was likely present on the study at MD anderson but they did not mention it.

If you want me to look at the exam you can request a cdrom copy of the mri exam and have them mail it to you or pick it up the next time you are there but it sound like a nothing to worry about.

How is everything else?

Joe

On Tue, Aug 12, 2008 at 6:17 PM, Bodin E-mail <mljscomp@bellsouth.net> wrote:

Joe:

Last Friday, Jeffrey had an MRI of the brain done at Children's. The report is attached. Doctor told her nothing to worry about, and no indication of melanoma. But Linda never got a good explanation for what this might be. Doctor said could have been present on MRI done at MD Anderson earlier in year (we don't have that report). We're going to talk to the people in Houston, but do you know what this report is saying? Thanks. Mark

CHILDREN'S HOSPITAL
200 Henry Clay Avenue – New Orleans, LA 70118

REPORT OF ELECTROENCEPHALOGRAPHY

NAME:	BODIN, JEFFREY	**AGE:**	11 YEARS
HOSPITAL NO:	24306318	**MED. REC. NO.:**	445573
EXAM DATE:	08/12/08	**EEG NO.:**	08-637

REFERRING PHYSICIAN: Dr. Morales, Dr. Tilton

MEDICATIONS: Interferon, Keppra.

HISTORY: This is an 11-year old with a history of melanoma. The patient had a reported seizure.

DESCRIPTION: The waking background is characterized by a 10-Hz occipital rhythm that is medium amplitude symmetric and which attenuates with eye opening. Lower voltage faster frequencies are more prominent over anterior head regions. Hyperventilation produces a small amount of background slowing. Hyperventilation is aborted because the patient complains of light-headedness. There is intermittent theta to delta slowing, which is sharply contoured over the left mid to posterior temporal area with some involvement of the left central area and the left frontal area as well (T3-T5 +/- C3-F7). Photic stimulation produces no further abnormalities. There are no clear epileptiform discharges although slowing is often sharply contoured.

IMPRESSION: This is a mildly abnormal electroencephalogram due to the presence of intermittent focal slowing over the left temporal head region.

SHANNON MCGUIRE, M.D.
DD: 08/12/08 DT: 08/13/08
Cc: Dr. Morales
Dr. Tilton

W Date: 8/18/08

Father's Notes Post my Seizure

ANTI-SEIZURE MEDS: Keppra
Topamax
Lamictal
Trileptal

INTERFERON alpha-2b Schering Corp. (Intron A)

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Per Herzog (4/21/08) – IF ADULT 50% CHANCE RECURRENCE, INT ↓ TO ABOUT 20%. SOME DRS THINK BETTER W/KIDS

ST TAMMANY PARISH HOSPITAL

1202 SOUTH TYLER STREET, COVINGTON, LA 70433

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NAME:	BODIN, JEFFREY
SEX:	M
LOCATION:	
MR#:	28-07-19
PHYSICIAN:	SHERRI CASEY 71107 Hwy 21 Suite 1 Covington, LA 70433 (985) 893-2580

PT PHONE:	985-845-0969
DATE OF BIRTH:	05/22/1997
AGE:	11Y
DATE OF EXAM:	02/16/2009
ORD# / FC:	90002 / B
ADM NO:	000377557483
PT CLASS / TYPE:	O / P
ADM DATE:	02/16/2009

Final Report

ACCESSION #: 1791895

Clinical History: 172.9 - SKIN MAL MELANOMA NOS -

MRI BRAIN W/WO CONTRAST - 02/16/2009 metastatic melanoma

RESULT: MRI of the brain

70553

Indication: Headaches, malignant melanoma, rule out metastases

Technique: Sequences performed included axial and sagittal T1 weighted, axial T2 weighted, axial FLAIR, axial proton density, and axial ADC and diffusion weighted images.

Findings:

There is no abnormal enhancement or focal brain parenchymal abnormality evident. Normal enhancement of the pituitary is incidentally noted. Diffusion images demonstrate no acute ischemia. The ventricles and sulci are not enlarged. There is no intracranial hemorrhage, mass or mass effect. The posterior fossa is unremarkable. There is no abnormality of the cerebellum, brainstem or cerebellopontine angles. The sella and optic chiasm are within normal limits. The paranasal sinuses and mastoid air cells are clear.

IMPRESSION:

1. No focal brain parenchymal abnormality or abnormal enhancement.

Interpreting Physician: JOSEPH PERDIGAO M.D.
Transcribed by / Date: PSC on Feb 16 2009 3:23P
Approved Electronically by / Date: PERDIGAO M.D., JOSEPH Feb 16 2009 3:23P
Distribution: SHERRI CASEY
SHERRI CASEY

Name: Jeffrey Bodin | DOB: 5/22/1997 | MRN: 2592229 | PCP: Lauren S Elder, MD

MRI BRAIN W/WO CONTRAST - Details

Study Result

Impression

Normal MRI of the brain with and without gadolinium

Electronically signed by: JOSEPH HAJJAR MD
Date: 10/06/16
Time: 14:58

Narrative

Pre-and post gadolinium (4 cc of Gadovist) images were obtained through the brain. Comparison is made to the previous examination performed 07/14/2014. The brain ventricles appear normal. There is no evidence of mass effect or midline shift. No abnormal extra-axial collections are seen. There is no evidence of restricted diffusion and there is no evidence of abnormal enhancement. Flow voids are seen in the expected locations of the carotid and vertebrobasilar systems.

Images

Click here to view images

Component Results

There is no component information for this result.

General Information

Ordered by Diane K Africk, MD

Resulted on 10/06/2016 2:58 PM

Result Status: Final result

This test result has been released by an automatic process.

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To scan

Jeffrey Bodin

Male, 22 y.o., 5/22/1997
MRN: 1002548110
Phone: 985-520-4713 (W)

PCP: Chno Zzzprovider, MD
Primary Cvg: AETNA BETTER...

NEXT APPT
With Neurology (Monica Noya Santana, MD) 05/27/2020 at 2:30 PM

EEG Awake and Drowsy

Order: 115217182

Status: Final result Visible to patient: No (Not Released) Dx: Grand mal seizure; Narcolepsy due to ...

Details

Narrative
Maxwell Harris Levy, MD 9/4/2019 10:36 AM
Procedure: Routine Outpatient EEG

Clinical information:
Grand mal sz, Narcolepsy due to underlying condition with
cataplexy x 10 years -sz on Sunday - since CA treatment. not
sleep deprived.

Referring Diagnosis:
Seizures

Medications:
Current Outpatient Medications on File Prior to Encounter
Medication Sig Dispense Refill
• AFLURIA QUAD 2018-2019, PF, 60 mcg/0.5 mL Syrg ADM 0.5ML IM UTD
0
• azelastine (ASTELIN) 137 mcg (0.1 %) nasal spray 1 spray by
Nasal route 2 (two) times daily
• azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry 1 spray
by Nasal route daily
• buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet Take 300 mg by
mouth daily
• dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet
Take 30 mg by mouth 3 (three) times daily
• dextroamphetamine-amphetamine (ADDERALL) 30 mg Tab per tablet
TK ONE T PO TID FOR 30 DAYS 0
• fexofenadine (ALLEGRA) 180 MG tablet Take 180 mg by mouth daily

• fluticasone (FLONASE) 50 mcg/actuation nasal

Jeffrey Bodin
Male, 22 y.o., 5/22/1997
MRN: 1002548110
Phone: 985-520-4713 (W)

PCP: Chno Zzzprovider, MD
Primary Cvg: AETNA BETTER...

NEXT APPT
With Neurology (Monica Noya Santana, MD) 05/27/2020 at 2:30 PM

spray USE ONE
SPRAY IEN ONCE D 1
• montelukast (SINGULAIR) 10 mg tablet Take 10 mg by mouth daily

• naproxen sodium (ALEVE) 220 MG tablet Take 1,000 mg by mouth 2
(two) times daily with meals
• neomycin-polymyxin-hydrocortisone (CORTISPORIN) 3.5-10,000-1 mg/mL-unit/mL-% otic suspension Place 3 drops into both ears 5
(five) times daily
• olopatadine 0.2 % Drop 1 drop

No current facility-administered medications on file prior to
encounter.

Technique:
Digital EEG was recorded in the EEG laboratory on an alert
and coherent patient. Recording of EEG, time-locked video, and
single-channel EKG was performed with the Natus XLTek EEG
machine. Electrodes were placed on the scalp according to the
International 10-20 System. The record was reviewed using the
Natus Neuroworks EEG software. Default settings: digital filter
bandpass of 1-70 Hz, and 60-Hz notch, sensitivity setting of 7
uV/mm, and time base of 30 mm/s. When necessary, the settings
were adjusted during the review process. The patient was awake or
asleep during the study. Activation consisted of hyperventilation.

EEG Findings:
· Waking background activity: bisymmetric 11-Hz alpha rhythm;
posteriorly dominant, medium amplitude, well organized, reactive
to eye opening.

Jeffrey Bodin
Male, 22 y.o., 5/22/1997
MRN: 1002548110
Phone: 985-520-4713 (W)

PCP: Chno Zzzprovider, MD
Primary Cvg: AETNA BETTER...

NEXT APPT
With Neurology (Monica Noya Santana, MD)
05/27/2020 at 2:30 PM

· Sleep background activity: bisymmetric central theta activity,
vertex waves, sleep spindles, and K complexes.
· No epileptiform activity.
· No abnormalities with hyperventilation.

Interpretation:
Normal awake and sleeping EEG

Interpreting Fellow/Resident: Maxwell Levy MD
Interpreting Faculty/Staff: Piotr Olejniczak MD

Last Resulted: 09/04/19 10:30

Order Details | View Encounter | Lab and Collection Details | Routing | Result History

Routing History

Priority	Sent On	From	To	Message Type
	9/4/2019 1:15 PM	Piotr W. Olejniczak, MD	Piotr W. Olejniczak, MD	Results

9/19/19
Nerve Conduction Study

LSUHSC-NO NEUROLOGY
EMG LABORATORY
478 S Johnson St, 5th Floor
New Orleans, LA 70112
504-412-1517

Full Name: Jeffrey Bodin
Patient ID: 2327610
Gender: Male
Date of Birth: 5/22/1997

Visit Date: 9/19/2019 11:17
Age: 22 Years 3 Months Old
Examining Physician: Michael P. Charlet, M.D.
Referring Physician: Dr. Joseph Gonzales

Patient History: 22 y/o M with malignant melanoma. Patient states a history of polyneuropathy after treatment for melanoma. Currently patient complaining of pain and numbness in bilateral arms and legs. On neurological examination, strength is normal. Deep tendon reflexes are symmetrical.

Findings: NCS were performed on the right upper and bilateral lower extremities and were normal. EMG of bilateral upper and lower extremities was normal.

Impression: Normal study without significant evidence of polyneuropathy or radiculopathy

Thank you for this consultation.

M. Charlet

Michael P. Charlet, M.D.

9/19/19
Nerve Con Study

Jeffrey Bodin 2327610 9/19/2019 11:17

Sensory NCS

Nerve / Sites	Rec. Site	Onset Lat ms	Peak Lat ms	NP Amp µV	Segments	Distance cm	Velocity m/s
R Median, Ulnar - Digital Antidromic							
Median Wrist	D2	2.19	3.07	69.3	Median Wrist - D2	13	59
Median Wrist	D3	2.19	3.02	56.0	Median Wrist - D3	13	59
Median Wrist	Palm	1.51	1.98	65.6	Median Wrist - Palm	8	53
Ulnar Wrist	D5	2.29	3.18	42.7	Ulnar Wrist - D5	11.5	50
R Radial - Anatomical snuff box (Forearm)							
Forearm	Wrist	1.88	2.55	42.1	Forearm - Wrist	10	53
R Medial antebrachial cutaneous - Forearm (Elbow)							
Elbow	Forearm	2.19	2.71	13.6	Elbow - Forearm	12	55
R Sural - Ankle (Calf)							
Calf	Ankle	3.49	4.27	18.5	Calf - Ankle	14	40
L Sural - Ankle (Calf)							
Calf	Ankle	3.54	4.32	17.9	Calf - Ankle	14	40

Motor NCS

Nerve / Sites	Muscle	Latency ms	Amplitude mV	Amp % %	Duration ms	Area mVms	Segments	Distance cm	Lat Diff ms	Velocity m/s
R Median - APB										
Wrist	APB	3.02	12.8	100	6.98	54.7	Wrist - APB	7		
Elbow	APB	7.45	12.1	94.8	7.34	55.0	Elbow - Wrist	26.2	4.43	59
R Ulnar - ADM										
Wrist	ADM	2.76	11.1	100	7.55	54.0	Wrist - ADM	7		
B.Elbow	ADM	6.30	11.5	103	8.18	52.1	B.Elbow - Wrist	20	3.54	56
A.Elbow	ADM	8.59	11.4	102	8.02	51.9	A.Elbow - B.Elbow	14	2.29	61
R Peroneal - EDB										
Ankle	EDB	5.52	6.1	100	8.39	29.1	Ankle - EDB	8		
Fib head	EDB	13.49	6.0	99.1	8.85	30.8	Fib head - Ankle	35	7.97	44
Pop fossa	EDB	15.83	6.6	110	8.65	32.4	Pop fossa - Fib head	9.5	2.34	41
L Peroneal - EDB										
Ankle	EDB	4.32	7.2	100	7.24	30.0	Ankle - EDB	8		
Fib head	EDB	11.77	7.5	104	7.19	29.8	Fib head - Ankle	33.5	7.45	45
Pop fossa	EDB	13.23	8.4	116	7.14	32.7	Pop fossa - Fib head	7	1.46	48
R Tibial - AH										
Ankle	AH	4.69	15.9	100	8.02	70.7	Ankle - AH	8		
Pop fossa	AH	13.18	13.8	86.6	8.80	71.0	Pop fossa - Ankle	39	8.49	46
L Tibial - AH										
Ankle	AH	4.43	19.4	100	7.71	61.4	Ankle - AH	8		
Pop fossa	AH	12.71	17.4	89.7	8.44	63.9	Pop fossa - Ankle	38.5	8.28	46

H Reflex

Nerve	H Lat ms
L Tibial - Soleus	30.00
R Tibial - Soleus	29.95

9/19/19
Nerve Con Study

EMG

EMG Summary Table										
	Spontaneous				MUP Recruitment					
Muscle	Fib	PSW	Fasc	Other	#	Rate	Polys	Dur	Amp	Effort
L. Biceps brachii	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
L. Triceps brachii	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
L. Pronator teres	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
L. Extensor digitorum communis	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
L. First dorsal interosseous	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
L. Abductor pollicis brevis	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
R. Biceps brachii	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
R. Triceps brachii	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
R. Pronator teres	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
R. Extensor digitorum communis	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
R. First dorsal interosseous	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
R. Abductor pollicis brevis	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
R. Tibialis anterior	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
R. Gastrocnemius	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
R. Vastus medialis	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
R. Extensor hallucis longus	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
R. Tibialis posterior	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
L. Tibialis anterior	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
L. Gastrocnemius	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
L. Vastus medialis	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
L. Extensor hallucis longus	None	None	None	.	Normal	Normal	None	Normal	Normal	Max
L. Tibialis posterior	None	None	None	.	Normal	Normal	None	Normal	Normal	Max

LSU Healthcare Network

Campus Multispecialty Clinic 5th Floor
478 South Johnson St Floor 5
New Orleans, LA 70112
(504) 412-1517
(504) 412-1538

Patient: JEFFREY BODIN
528 BEAU CHENE DR
MANDEVILLE, LA 70471

Home: (985) 520-4713
Work:

EMRN: 2327610
Age/DOB: 23 05/22/1997
Encounter Date: 04/20/2020

Reason For Visit

Follow-up visit for seizure disorder care. This telemedicine visit was initiated by the provider using a Zoom video-capable platform that was offered to the patient, even if the visit ended up being an audio only call. If it was determined that an in-person physical examination or a higher level of care was indicated or if other diagnostic testing was needed, the patient was referred to the appropriate resources. The patient verbally consented to this telemedicine visit due to restrictions of the COVID-19 pandemic, after all questions were answered.

History of Present Illness

Handedness: right handed
Seizure Onset:09/2008
Last Seizure: 02/28/2020
Seizure frequency: previous seizure in 12/2020
Seizure intervention: not on antiseizure medication
Etiology, Seizure type, or Epilepsy syndrome: NOS, NES?; shaking upon waking up
Querying and Intervention for side effects of anti-seizure therapy: N/A
Personalized Epilepsy Safety Issue and Education provided:
Screening for Psychiatric or Behavioral Health Disorders:
Counseling for Women of Childbearing Potential with epilepsy:
Referral to Comprehensive Epilepsy Center: N/a
Quality of life assessment: Done

Allergies

1. Latex Gloves

Current Meds

Medication Name	Instruction
24HR Allergy Relief 180 MG Oral Tablet	TAKE 1 TABLET DAILY
Amphetamine-Dextroamphet ER 30 MG Oral Capsule Extended Release 24 Hour	TAKE 3 CAPSULE DAILY
Azelastine HCl - 0.1 % Nasal Solution	USE 1 SPRAY IN EACH NOSTRIL TWICE DAILY
buPROPion HCl ER (XL) 300 MG Oral Tablet Extended Release 24 Hour	TAKE 1 TABLET DAILY.

Fluticasone Propionate 50 MCG/ACT Nasal Suspension	USE 2 SPRAYS IN EACH NOSTRIL ONCE DAILY
Montelukast Sodium 10 MG Oral Tablet	TAKE 1 TABLET AT BEDTIME.
Sunosi 75 MG Oral Tablet	

Review of Systems

Constitutional no weight loss, no fever; continuing treatment for myeloma
Respiratory negative
CV negative
Eyes negative
GI negative
ENT negative
Skin left leg scar(myeloma surgery)
GU negative
Musculoskeletal post dislocation surgery
Hematologic Myeloma on remission
Neurologic left leg diminished tactile sensory
Endocrine negative
Allergic seasonal allergies. Latex allergy

Sleep Issues:negative

Chronic Medical Issues: myeloma, narcolepsy, seizure disorder

Employment/School: N/A

Recent Stressors: Covid pandemic

Results/Data

EMG (Dr. Charlet 9/19/2019): normal study (claimed polyneuropathy post melanoma therapy)
EEG (UMC 9/4/2019): 11 Hz alpha rhythm when awake; normal awake and sleep
EEG Reviewed (Ochsner 9/19/2018) : normal EEG with the patient awake and asleep
MRI of Brain Reviewed (without and with contrast 10/06/2016): normal MRI of the brain with and without gadolinium
MSLT (MD Anderson Houston 8/5/2016): mean sleep onset latency 5.9 minutes. 4 SOREMPs

Physical Exam

Appearance not in acute distress - as per zoom video and patient report
Orientation oriented x 3.
Memory intact
Attn Span/Concentration intact
Language fluent
Fundi wnl
Visual Field wnl
EOM (Nystagmus?) negative
Muscle Strength 5/5 all extremities, but right shoulder 3/5
Muscle Tone wnl
Sensation intact, but left leg diminished.
Reflexes reduced ankle reflexes b/l, no clonus
Coordination intact finger-nose
Gait and Station wnl.

Assessment

Epilepsy Note

Patient: JEFFREY BODIN EMRN: 2327610
Encounter: Apr 20 2020 11:30AM

1. Intractable epilepsy without status epilepticus, unspecified epilepsy type (G40.919)
2. Narcolepsy (G47.419)

Could not assess in person outside of video zoom assessment and patient report. No significant interval change as compared to the previous visit.
~~Could not assess in person outside of video zoom assessment. No significant interval change~~

Discussed

Spent greater than 15 minutes face to face: greater than 50 % in counseling or Coordination of care

Plan

1. The patient needs inpatient Video-EEG monitoring - would perform as soon as Covid-19 pandemic emergency status would allow elective procedures
2. RTC after monitoring or if emergency

Education

State laws regarding driving have been reviewed with the patient.
Counseling has been provided about risks of seizures including SUDEP as well as risk with anti-epileptic therapy.

Signatures

Electronically signed by : PIOTR OLEJNICZAK, M.D.; Physician Apr 21 2020 8:50AM CST (Author)
Electronically signed by : PIOTR OLEJNICZAK, M.D.; Physician May 12 2020 8:16AM CST (Author)

LSU Health
Healthcare Network

Campus Multispecialty Clinic 5th Floor
478 South Johnson St Floor 5
New Orleans, LA 70112
(504) 412-1517
(504) 412-1538

Patient: JEFFREY BODIN
528 BEAU CHENE DR
MANDEVILLE, LA 70471

Home: (985) 520-4713
Work:

EMRN: 2327610
Age/DOB: 23 05/22/1997
Encounter Date: 09/28/2020

Reason For Visit

Follow-up visit for seizure disorder care and narcolepsy. Former patient of Dr. Caroline Barton co-managed with another neurologist. Patient presents today for follow up. He has history of seizures but he is not on any AED. He states that last time he had a GTC seizure was in 2016. He reports multiples episodes of lack of awareness and like "mild seizure events" where he does not loss consciousness. Patient also has narcolepsy w/o cataplexy, he is taking amphetamine-dextroamphetamine ER (prescribed by another neurologist) which helps with his daytime symptoms. Patient states that he has being able to gain some weight and do more important stuffs since he is on this medication. He visit another neurologist (specialist in sleep medicine) for this last complaint.
Patient asked about his pending EMU admission to localized/characterize his seizure like activity.

History of Present Illness

Handedness: right handed
Seizure Onset:09/2008
Last Seizure: Poorly defined frequent auras. Last GTC seizure was in February of 2016. Last "small" seizure was in February of 2020
Seizure frequency: previous seizures in 12/2020; 02/28/2020
Seizure intervention: not on antiseizure medication
Etiology, Seizure type, or Epilepsy syndrome: NOS, NES?; shaking upon waking up
Querying and Intervention for side effects of anti-seizure therapy: N/A
Personalized Epilepsy Safety Issue and Education provided:
Screening for Psychiatric or Behavioral Health Disorders:
Counseling for Women of Childbearing Potential with epilepsy:
Referral to Comprehensive Epilepsy Center: N/a
Quality of life assessment: Done

Allergies

1. Latex Gloves

Current Meds

Medication Name	Instruction
24HR Allergy Relief 180 MG Oral Tablet	TAKE 1 TABLET DAILY
Amphetamine-Dextroamphet ER 30 MG Oral Capsule Extended Release 24 Hour	TAKE 3 CAPSULE DAILY

Azelastine HCl - 0.1 % Nasal Solution	USE 1 SPRAY IN EACH NOSTRIL TWICE DAILY
buPROPion HCl ER (XL) 300 MG Oral Tablet Extended Release 24 Hour	TAKE 1 TABLET DAILY.
Fluticasone Propionate 50 MCG/ACT Nasal Suspension	USE 2 SPRAYS IN EACH NOSTRIL ONCE DAILY
Montelukast Sodium 10 MG Oral Tablet	TAKE 1 TABLET AT BEDTIME.
Sunosi 75 MG Oral Tablet	

Review of Systems

Constitutional no weight loss, no fever; continuing treatment for myeloma
Respiratory negative
CV negative
Eyes negative
GI negative
ENT negative
Skin left leg scar(myeloma surgery)
GU negative
Musculoskeletal post dislocation surgery
Hematologic Myeloma on remission
Neurologic left leg diminished tactile sensory
Endocrine negative
Allergic seasonal allergies. Latex allergy

Sleep Issues:negative

Chronic Medical Issues: myeloma, narcolepsy, seizure disorder

Employment/School: N/A

Recent Stressors: Covid pandemic

Results/Data

EMG (Dr. Charlet 9/19/2019): normal study (claimed polyneuropathy post melanoma therapy)
EEG (UMC 9/4/2019): 11 Hz alpha rhythm when awake; normal awake and sleep
EEG Reviewed (Ochsner 9/19/2018) : normal EEG with the patient awake and asleep
MRI of Brain Reviewed (without and with contrast 10/06/2016): normal MRI of the brain with and without gadolinium
MSLT (MD Anderson Houston 8/5/2016): mean sleep onset latency 5.9 minutes. 4 SOREMPs

~~Constitutional no weight loss, no fever; continuing treatment for myeloma~~
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~~Sleep Issues:negative~~

~~Chronic Medical Issues: myeloma, narcolepsy, seizure disorder~~

~~Employment/School: N/A~~

~~Recent Stressors: Covid pandemic~~

Vitals

Adult Vital Signs

	Recorded: 28Sep2020 10:21AM
Height	5 ft 7 in
Weight	98 lb 12.8 oz
BMI Calculated	15.47
BSA Calculated	1.5
Systolic	111, Sitting
Diastolic	78, Sitting
Heart Rate	91
Pulse Quality	Normal
Pain Scale	0

Physical Exam

Appearance not in acute distress, mildly anxious.
Orientation oriented x 3.
Memory intact
Attn Span/Concentration intact
Language fluent
Fundi wnl
Visual Field wnl
EOM (Nystagmus?) negative
Muscle Strength 5/5 all extremities, but right shoulder 3/5
Muscle Tone wnl
Sensation intact, but left leg diminished.
Reflexes reduced ankle reflexes b/l, no clonus
Coordination intact finger-nose
Gait and Station wnl.

Assessment

1. Intractable epilepsy without status epilepticus, unspecified epilepsy type (G40.919)
2. Narcolepsy (G47.419)

Discussed

Spent greater than 25 minutes face to face: greater than 50 % in counseling or Coordination of care

Plan

1. Educated about medication side effect
2. Epworth sleepiness scale applied today (score 24 w/o medication and 0 with medication)
3. Would refer for inpatient/observation (off AED meds already) Video-EEG monitoring for frequent persistent auras/focal seizures to establish need for therapy
4. Follow up in 3 months

~~1. Educated abut medication side effect~~
~~2. Epworth sleepiness scale applied today (score 24 w/o medication and 0 with medication)~~
~~3. Would refer for inpatient/observation (off AED meds already) Video-EEG monitoring for frequent persistent auras/focal seizures to establish need for therapy~~
~~4. Follow up in 3 months~~

Education

State laws regarding driving have been reviewed with the patient.
Counseling has been provided about risks of seizures including SUDEP as well as risk with anti-epileptic therapy.

Attending Note

I have performed a history and physical exam on Mr. JEFFREY BODIN with Dr. Losada and discussed the management of the patient with the resident. I reviewed the resident's note and agree with the documented findings and plan of care and I have indicated above.

Signatures

Electronically signed by : PIOTR OLEJNICZAK, M.D.; Physician Sep 28 2020 12:18PM CST (Co-author)
Electronically signed by : PIOTR OLEJNICZAK, M.D.; Physician Oct 13 2020 11:03AM CST (Author)

AETNA BETTER HEALTH® OF LOUISIANA
Prior authorization form

Phone: 1-855-242-0802
Fax: 1-844-227-9205

Date of Request: 10 /15/2020

For urgent requests (required within 24 hours), call Aetna Better Health of Louisiana at 1-855-242-0802

MEMBER INFORMATION

Name: BODIN,JEFFREY ID Number 5794038645696
Date of Birth: 05/22/1997 Physician Name: DR. PIOTR OLEJNICZAK
Other Insurance: N/A Gender (circle one): F **M**

REQUESTING PHYSICIAN OR PROVIDER INFORMATION

Referring Provider / Requesting Provider
Name: DR. PIOTR OLEJNICZAK
Address: 2000 Canal St New Orleans LA 70112
Telephone #: 504-702-4800 ext 0328
Fax #: 504-962-6484
Specialty: Neurology
National Provider Identification (NPI): 1942221965
Contact Person: Tamara Landry

Place of Service or Facility Name
Name: University Medical Center New Orleans
Address: 2000 Canal St New Orleans LA 70112
Telephone #: 504-702-3000
Fax #: 504-962-6484
Specialty: ACUTE CARE FACILITY
National Provider Identification (NPI): 1568403111
Contact Person: Tamara Landry

REFERRAL / AUTHORIZATION INFORMATION

Problem / Diagnosis (ICD-9 Code(s)): G40.919/ Medically Intractable Epilepsy; G47.419/ Narcolepsy

Procedure / Test Requested (CPT Code(s)): 95720, 95716 Video-EEG monitoring in the Inpatient Epilepsy Monitoring Unit

Date of Appointment or Service: 10/26/20-10/29/20 Number of Visits Required: 3 days

Type of Procedure (circle one): **Inpatient** Outpatient In Office

Other Clinical Information - Include clinical notes, lab and X-ray reports, etc. (For procedures, please attach additional pages as necessary.): Please see attached

Problem List

- Melanoma in situ of left lower leg
- Migraine-cluster headache syndrome
- Peripheral neuropathy
- Inflammatory neuropathy
- Bilateral impacted cerumen

Health Maintenance

05/22/1999	Annual Wellness	?
09/01/2020	Influenza Vaccine	
11/05/2029	Tetanus-Diphtheria-Pertusis (DTap-Tdap-Td) (9 - Td)	
05/22/2062	Pneumococcal Vaccine: 65+ Years (1 of 2 - PCV13)	

Tobacco History

Smoking Status	Never Smoker
Smokeless Tobacco Status	Never Used

Medical History

2016	Clinical trial participant
02/15/2015	Narcolepsy
Date Unknown	Cancer
Date Unknown	Dislocated shoulder
Date Unknown	Melanoma in situ of left lower leg
Date Unknown	Migraine-cluster headache syndrome
Date Unknown	Migraines
Date Unknown	Peripheral neuropathy
Date Unknown	Prematurity
Date Unknown	Seasonal allergies
Date Unknown	Seizure syndrome

Surgical History

Surgical History

2015	Wisdom tooth extraction
Date Unknown	Adenoidectomy w/ myringotomy and tubes
Date Unknown	Appendectomy
Date Unknown	dislocated shoulder [Other] (Right)
Date Unknown	gum graft [Other]
Date Unknown	melanoma excision [Other]
Date Unknown	Tonsillectomy

Care Team and Communications

PCPs	Type
Callie Anne Linden, MD	General

Other Patient Care Team Members	Relationship
Laura Conway Williams, MD	Attending
Ashley Lena Weiss, DO	Consulting Physician
Dana Marie Leblanc, MD	Pediatrician
Curry Antoine, CNA	Not specified
Dominique R Banks, MA	Medical Assistant
Carolyn Haley, RN	Registered Nurse
Elizabeth Aronson, RN	Registered Nurse

Recipients of Past 2 Communications

Office Visit - 8/31/2018

Children's Hospital Dermatology	8/31/2018	Mail
Chno Zzzprovider, MD	8/31/2018	Mail

Sep 25 — Telephone with Derm - Stevens, J

Vitals from encounters over the past 365 days

	9/29/20	8/27/20
BP	112/91 !	--
Pulse	83	--
Resp	16	--
Temp	97.6 °F (36.4 °C)	97.7 °F (36.5 °C)
Temp src	Temporal	Temporal
SpO2	--	--
Weight	45.2 kg (99 lb 9.6 oz)	45.1 kg (99 lb 6.4 oz)
Height	1.702 m (5' 7")	1.715 m (5' 7.5")
Pain Score	0	--

Allergies

Lactose Nausea And Vomiting, Diarrhea

Latex Rash

Medications

Outpatient Medications

AFLURIA QUAD 2018-2019, PF, 60 mcg/0.5 mL Syrg

azelastine (ASTELIN) 137 mcg (0.1 %) nasal spray

dextroamphetamine-amphetamine (ADDERALL) 30 mg Tab per tablet

fexofenadine (ALLEGRA) 180 MG tablet

fluticasone (FLONASE) 50 mcg/actuation nasal spray

montelukast (SINGULAIR) 10 mg tablet

Clinic-Administered Medications

lidocaine (PF) (XYLOCAINE) 10 mg/mL (1 %) injection 2 mL

lidocaine (PF) (XYLOCAINE) 10 mg/mL (1 %) injection 2 mL

triamcinolone acetonide (KENALOG-40) 40 mg/mL injection 40 mg

triamcinolone acetonide (KENALOG-40) 40 mg/mL injection 80 mg

triamcinolone acetonide (KENALOG-40) 40 mg/mL injection 80 mg

Preferred Pharmacies

WALGREENS DRUG STORE #05382 - MANDEVILLE, LA - 4330 985-674-2551
HIGHWAY 22 AT SEC OF ACCESS ROAD & HWY 22 985-674-5334

Immunizations/Injections

DTaP 6/8/2001, 11/24/1998, 11/21/1997, . . .

HPV (Gardasil-4) 5/20/2013, 7/19/2011, 5/18/2011

Hepatitis A, Pediatric/Adolescent 11/27/2007, 4/18/2007

Hepatitis B, Pediatric/Adolescent 2/26/1998, 6/26/1997, 5/27/1997

Hib Unspecified 8/25/1998, 11/21/1997, 9/23/1997, . . .

INFLUENZA, SEASONAL, INJECTABLE, (PF) 11/16/2017

IPV 6/8/2001, 8/25/1998, 9/23/1997, . . .

Influenza, Injectable, MDCK, Preservative Free, Quadrivalent 11/5/2019

Influenza, Seasonal, Injectable 11/25/2013, 11/25/2013, 9/16/2010, . . .

Influenza, Unspecified 11/16/2017, 9/16/2010, 9/9/2009, . . .

Influenza, injectable, quadrivalent, preservative free 10/5/2016, 11/4/2015

MMR 6/8/2001, 5/26/1998

Meningococcal MCV4P 5/26/2015, 5/18/2009

Pneumococcal Conjugate PCV 12/15/2000

Pneumococcal Conjugate PCV 13 2/19/2015

Pneumococcal Polysaccharide PPSV 23 11/5/2019

TST-PPD intradermal 11/4/2015, 5/20/2013, 5/17/2013

Tdap 11/5/2019, 7/14/2015, 5/18/2009

Varicella 5/10/2007, 5/26/1998

Mr. **Jeffrey Bodin** is a 23-year-old man with history of medically intractable epilepsy since 09/2008. The patient continues to experience frequent daily sensory events/seizures which he describes as auras. In addition to the auras, the patient has had longer and more pronounced episodes with alteration of awareness which occur every several months. Last generalized tonic-clonic convulsion occurred in 2016. The routine EEG from 09/04/20219 did not capture evidence of epileptiform activity, similar to previous EEG studies. MRI of the brain from 10/06/2016 was normal as well. Patient's quality of life has suffered from intractable seizures and side effects of medications. Due to perceived lack of anti-epileptic drugs (AEDs) efficacy and their side effect profile which include potential interactions with his other medications, the patient has been refusing to be re-challenged with AEDs. Secondary generalized convulsions pose a direct risk of death from SUDEP (sudden unexpected death in epilepsy). The co-morbidities include multiple myeloma treated at MD Anderson and narcolepsy objectively verified among others by the multiple sleep latency test (MSLT). The allergies include latex gloves.

Diagnosis: G40.919 Medically intractable epilepsy, undetermined if focal or generalized
G47.419 Narcolepsy

The patient suffers from medically intractable epilepsy. In order to record representative seizures to allow their precise localization and classification, she needs inpatient Video-EEG monitoring with scalp electrodes primarily to guide future therapy, be it pharmacological or surgical. If the seizures turn out to be non-epileptic (e.g related to sleep/wake phenomena with narcolepsy), the therapy will need to change as well and the patient may not need anti-epileptic medications. The patient will be admitted to the Epilepsy Monitoring Unit at the University Medical Center in New Orleans on 10/26/2020. Because of the possibility of uncontrolled seizures, the patient will be equipped with an IV access for administration of rescue medications if necessary. If no seizures will be captured on the day of admission, the seizure activation protocol will be implemented. It includes overnight sleep deprivation followed in the morning by photic stimulation, hyperventilation and physical exercise. After recording sufficient number of representative events allowing appropriate diagnosis to guide future therapy, the patient, if medically stable, will be discharged home with recommendation to follow with Dr. Olejniczak at the LSUHN Epilepsy Clinic in New Orleans

Piotr Olejniczak, MD
Diplomat, ABPN with subspecialty in Epilepsy