GroupHealth COOPERATIVE

Referral Services
P.O. BOX 34589
SEATTLE WA 98124-1589
GHC-RMLAU01PH5050-12/02

Patient ID : 00215848
Patient DOB : 06/27/39
Authorization: 07340322
Group Number : 0100300
Group Name : PEBB RETIREES WEST

037801

November 16, 2006

IVAN C. DOIG
17277 15TH AVE NW
SEATTLE WA 98177

Referred by :
STEVEN S. GINSBERG
310 15th Ave E
Seattle WA 98112
206-326-3000

Dear Patient:

We have authorized your referral to this consulting specialist. Please call the specialist at 206-288-7222 if a visit has not already been scheduled.

SEATTLE CANCER CARE ALLIANCE
825 EASTLAKE AVE E
PO BOX 19023 MS G1-030
SEATTLE WA 98109-1023

Specialty: ONCOLOGY/HEMATOLOGY

Please note:

- Coverage is authorized for: Consult Only
- PATIENT WITH INDOLENT MYELOMA
- You are approved for 1 visit(s).
- For each visit, you are responsible for a $ 10.00 copayment.
- This referral begins 11/09/06 and ends 02/08/07.
- Authorization is for second opinion only.
- Group Health only covers care and services specifically authorized in advance.
- Please refer to the back of this letter for additional information.

If you need care after this date or require more visits, please contact your referring provider. For questions about this letter, please call 1-888-901-4636 (TTY/TDD 1-800-833-6388 or 711 from 8:00 a.m. to 5:00 p.m., Monday through Friday), or e-mail us at info@ghc.org.

Thank you. We appreciate the opportunity to serve you.

Sincerely,

Your Referral Services Team

cc: SEATTLE CANCER CARE ALLIANCE

AUTHORIZATION FOR PATIENT SERVICES

- Group Health will provide medical coverage subject to the terms and conditions of the patient's certificate of coverage, including any applicable copayments, deductibles, benefit limits or coinsurance.

- The cost of any goods or services listed on the authorization and provided to the patient after his/her medical coverage is no longer in effect will be the responsibility of the patient.

- The cost of any goods or services provided to the patient, which are not listed on the authorization, will not be covered by Group Health.

- Any non-covered services provided to the patient will be billed by Group Health or the provider in accordance with the terms of the agreement between Group Health and the provider.

PATIENT INSTRUCTIONS:

General Care: You must continue to go to your Group Health personal physician or the medical center where your personal physician is located for any additional medical care needs that are not part of the authorization.

Hospital Care: Admissions to any facility for inpatient care or for short stay surgery (including hospitals and freestanding ambulatory surgical centers) are not included in this authorization unless otherwise noted.

Missed/Cancelled Appointments: You will be responsible for any charges resulting from missed or cancelled appointments in accordance with the provider's policy.

Prescriptions, laboratory tests, and x-rays: X-rays, laboratory work and all prescriptions must be obtained at a Group Health medical center or Group Health contracted pharmacy unless otherwise noted. Present this document at the Group Health pharmacy when filling prescriptions ordered by non-Group Health providers. If a prescription is filled elsewhere or the drug is not carried or covered by Group Health, you will be responsible for payment.

ACCOUNT SUMMARY:		
	** Previous balance:	0.00
	New charges:	282.80
	Insurance payments:	137.98-
	Adjustments:	134.82-
	Patient payments:	0.00
	Patient refunds:	0.00
	Insurance refunds:	0.00
	** Account balance:	10.00
Charges pending	Insurance processing:	0.00
	PAYMENT DUE NOW:	10.00

Payment is due. To pay by phone (VISA,MC,AMEX,Discover) or to update your account, please call 206-543-8606 or 1-888-234-5467

Current insurance coverage:
MEDICARE MANAGED CARE-GHC MEDICARE

DATE	DIAGNOSIS PROCEDURE EOB	SERVICE AREA PHYSICIAN NAME DESCRIPTION / ACTIVITY	CHARGES	INSURANCE PAYMENTS	ADJUSTMENTS	PATIENT PAYMENTS	PENDING INSURANCE	++ PATIENT RESPONSIBILITY
		PAMELA SUE BECKER MD						
	273.1	SCCA HEM/ONC CLINIC						
12/06/06	99205	OFFICE/OUTPT VISIT,NEW,LE*	282.80					10.00
12/14/06		Billed to MEDICARE MANAGED CARE						
01/17/07		MEDICARE INS PAYMENT		137.98-				
01/17/07		MEDICARE INS CONTRACT ADJ			134.82-			
		EPR-Applied to patient co-payment- patient responsibility						
		Totals	282.80	137.98-	134.82-	0.00	0.00	10.00

1016 SS11-RE

** Balance represents pending insurance plus patient responsibility
++ Deductibles, co-pays and non-covered by insurance

2/6/07
Wa Mu check
#3554

STATEMENT DATE: 01/27/2007 **ACCOUNT NUMBER:** 20-1538405 **PATIENT NAME:** IVAN DOIG

CURRENT	31-60 DAYS	61-90 DAYS	91-120 DAYS	OVER 120 DAYS
10.00	0.00	0.00	0.00	0.00

PAYMENT DUE
10.00

UW Physicians
P.O. Box 50095
Seattle, WA 98145-5095
206-543-8606
1-888-234-5467
(toll free in Washington state)

IMPORTANT: This statement reflects Physician services only.
You may receive a separate statement for hospital/clinic charges.
Payment of the balance shown is due and payable within 30 days unless prior payment terms have been arranged. See reverse side for more information.

WWW.UWPHYSICIANS.ORG

PAYMENTS RECEIVED AFTER THE STATEMENT DATE WILL APPEAR ON YOUR NEXT STATEMENT

"Who are UW Physicians?"

We are a group of physicians and other health professionals working together to care for patients who come to the University of Washington Medical Center, Harborview Medical Center, Fred Hutchinson Cancer Research Center, UW Physicians Neighborhood Clinics and other sites of practice. We are faculty members of the University of Washington School of Medicine who may be involved in teaching and research as well as providing care to patients.

The billing and collection of fees for your care is the responsibility of UW Physicians. Charges appearing on this statement are not included in any Hospital bill or statement.

Insurance Claim Filing

If you have provided us with complete and accurate information, we will bill your insurance including any insurance that is supplemental to Medicare.

Credit Policy

You will receive a monthly statement if you have a balance due on your account. The patient responsibility shown is due and payable within 30 days unless prior special payment terms have been arranged. Please contact our Business Office at (206) 543-8606 promptly if a payment plan is desired.

Other Information

Please include the patient's name and account number with all payments and correspondence.

Please call (206) 543-8606 if you have any questions or concerns about your account. The purpose of the Administrative Services Office is to serve your needs. Our mailing address for any other correspondence is:

UW Physicians
PO Box 50095
Seattle WA 98145-5095

OUR OFFICE IS OPEN FOR INQUIRIES FROM 9:00AM to 5:00PM MONDAY THROUGH FRIDAY.

Charges appearing on this statement are not included in any Hospital bill or statement.

RETAIN THIS PORTION OF YOUR STATEMENT FOR TAX PURPOSES.

Jan. 4 '07 phone message to Deborah Frieze, Cancer Alliance pharmacist

598-3393

Deborah, hello--

This is Ivan Doig, a Group Health patient whom Dr. Becker and you saw on a second-opinion referral last month on my myeloma case. My Cancer Care Alliance Number is u2 56 39 19, and that last name is spelled D-O-I-G. You kindly invited me to call you on pharmaceutical questions if need be, and I have what I hope are a couple of quick ones.

Dr. Ginsberg at Group Health started me on therapy on January first, 40 mg of Dexamethasone, 200 mg of Thalidomide, and l gram of Warfarin. First question is about the Dexamethasone. I'm finishing up the first pulse of that, and the first three days I was full of pep as you suggested I might be, but on this fourth and last day I'm noticeably more spacy--not too bad, but I can tell things are a little bit off. From your experience with patients, is this likely to be the pattern with all the pulses? It would help me with my planning and decision-making to know the pattern to expect on the rest of the pulses ahead, if there is one. Also, how long does it usually take for a person to come down off the dex after a pulse?

As to the 200 gm of Thalidomide, I've e-mailed the Group Health providers that a rash is showing up on my back. I'm putting Eucerin on it, and asked if that is adequate for now, but I wonder what you think? And bowel movements have shut down. I induced one yesterday with a fleet enema, but figure I'd better resort to laxative/stool softener if nothing moves today. I know it's early in the therapy regimen to do that--think it's okay to start anyway?

Her reply, 5 Jan.:

--If rash spreads to majority of my torso, let 'em know at Gp Health. Meanwhile put hydrocortisone cream on it whether or not it itches. If I have trouble breathing, that's an allergic reaction instead of just a side effect and I should get to the emergency room.

--"periodicity" of dex I've just been through is probably the pattern I can expect; she says people usually crash the day after they're off it.

--take laxative etc. twice a day until I get loose stool, then cut back to once. Don't go more than 3 days (that will be tomorrow) without bowel movement; resort to fleet enema if need be.

--told her my blood draw this morn was **Protime value 11.9** although I had no idea what that meant; she said they were checking to see if I'm ultrasensitive to Coumadin, and that reading shows normal.

SEATTLE
CANCER CARE
ALLIANCE

Fred Hutchinson Cancer Research Center
UW Medicine
Children's Hospital and Regional Medical Center

December 6, 2006

Steven Ginsberg, MD
Group Health Central Specialty Center
201 16th Ave E.
Seattle, WA 98112

Re: DOIG, IVAN
U2563919

Dear Dr. Ginsberg:

Thank you very much for requesting consultation for your delightful patient, Mr. Ivan Doig, for a second opinion regarding his multiple myeloma.

I will now review his history for our records.

As you know, he is a 67-year-old gentleman who you have followed for a history of monoclonal gammopathy of uncertain significance.

Patient describes that about 6 years ago he underwent a general physical examination, when Dr. Kato noted anemia with hematocrit 36. He describes that he was then referred to you for evaluation. At that time, you made a diagnosis of monoclonal gammopathy of undetermined significance. He describes that he was followed by you initially about every 3 months for a couple of years. He then describes that he was followed every 6 months during the third year and thereafter.

On 08/13/2004, when you evaluated him, you noted a white blood count of 2.8, hemoglobin 11.9, hematocrit 36, MCV 97, platelet count 224,000, serum monoclonal protein 0.5 grams per deciliter, serum creatinine 1, and calcium 9.5. On 02/24/2004, you note that he had an IgA lambda monoclonal gammopathy of undetermined significance. At that time, white blood count 2.7, hemoglobin 12.3, hematocrit 37, platelet count 230,000. 24-hour urine monoclonal protein was 48 mg with monoclonal serum protein 0.4 grams per deciliter. Serum creatinine 1.1, calcium 10, albumin

4.8, and on 02/25/2005 white blood count 3.2, hemoglobin 12.8, hematocrit 38, platelet count 238,000, serum monoclonal protein 0.6. Serum monoclonal protein then rose to 1.2 grams per deciliter in April 2006.

In April 2006, you described that the patient had a 5-year history of monoclonal gammopathy of undetermined significance and that a bone marrow aspiration showed 30% bone marrow plasmacytosis, as well as rise in the monoclonal protein initially to 1.2 grams per deciliter in April and then 2.1 grams per deciliter in August 2006. On 03/30/2006, the 24-hour urine showed 442 mg per 24 hours and the serum monoclonal protein was 1.3 grams per deciliter. On 11/20/2006, the urine monoclonal protein was 623 mg per 24 hours. Other data noted on 11/08/2006, hematocrit 37, creatinine 0.9, monoclonal protein 2.7 grams per deciliter.

At that date in November, you discussed initiation of pamidronate and initiation of therapy for myeloma with either thalidomide, dexamethasone with or without melphalan and possibly a randomized trial of thalidomide and dexamethasone.

Patient had a serum beta2-microglobulin of 1.6, quantitative immunoglobulins in April 2006 including IgG of 295, IgM 26, IgA 2607.

The cytogenetics showed loss of Y chromosome in 6 out of 20 cells.

Skeletal survey showed no lytic lesions.

PAST MEDICAL HISTORY
Significant for arthroscopy of both knees.

FAMILY HISTORY
Significant for father dying at age 70 with emphysema, mother dying in her 30s with asthma.

SOCIAL HISTORY
Patient is married and is here with his wife today. They have no children. He has no history of chemical radiation exposure. He grew up in Montana. No history of cigarette smoking. Regarding alcohol intake, he has a couple of drinks per night.

CURRENT MEDICATIONS
1. Clobetasol propionate cream 0.05% for red spots of Grover syndrome of back and buttocks.
2. Temazepam 2 to 3 x per week for insomnia.
3. Glucosamine 1500 mg and chondroitin sulfate 1200 mg 2 tablets daily since arthroscopy 7 to 8 years ago.

ALLERGIES

NO KNOWN DRUG ALLERGIES.

REVIEW OF SYSTEMS
Patient has had no history of weight loss, no fevers, sweats, or chills. He wears eyeglasses, has had no new visual changes. No ear, nose or throat symptoms. No shortness of breath, chest pain, nausea, vomiting, or diarrhea. No urinary symptoms. No bone or joint pain. No skin rash. No headache, no dizziness, no numbness or weakness. No thyroid condition, no diabetes, no bleeding or bruising.

PHYSICAL EXAMINATION
GENERAL APPEARANCE: Well appearing in no acute distress. VITAL SIGNS: Temperature 97.2, heart rate 78, BP 138/68, weight 70.9 kg, height 172 cm. HEENT: Normocephalic, atraumatic. Pupils equal, round, reactive to light and accommodation. Extraocular movements intact. Oropharynx is without lesions or exudate. NECK: Supple. CHEST Clear to percussion and ascultation. CARDIAC Regular in rate and rhythm. ABDOMEN: Nontender, without palpable masses or hepatosplenomegaly. EXTREMITIES: Full range of motion, without clubbing, cyanosis, or edema. No petechiae. NEUROLOGIC: Cranial nerves II-XII grossly intact. Gait is normal. MENTAL STATUS: Alert and oriented times three. Mood is normal. NODES: There are no palpable cervical, supraclavicular, axillary, or inguinal lymph nodes. Performance status 0.

LABORATORY DATA
As described above with 24 hour urine collection 11/16/2006 showing Bence Jones proteins 1623 mg per 24 hours. Most recent monoclonal protein 2.7 grams per deciliter.

Addendum: Bone marrow FISH negative for deletion 13.

SUMMARY
This 67-year-old gentleman presents with a history of monoclonal protein dating back to 2001, with relative stability or slow rise until this year, when there has been a more rapid rise in serum monoclonal protein, as well as nearly a four-fold increase in the urinary excretion of Bence Jones protein. At the present time, his serum creatinine has remained within normal limits at 0.94 as of approximately 1 month ago.

The patient's most recent serum beta2-microglobulin was 1.6 on 04/20/2006 and this would be consistent with stage I myeloma. Patient's cytogenetics show only deletion Y in 6 of 20 cells which could be related to age, and FISH was negative for deletion 13.

The patient has had long-standing mild anemia and long-standing mild leukopenia as well.

At this time, my impression is that the patient with a history of monoclonal gammopathy of uncertain significance,is no longer is exhibiting smoldering myeloma. His monoclonal protein is rising and he may currently now have what is described as indolent myeloma, as he has no obvious symptoms.

He does not yet have any of the classic indications for therapy, namely there is no hypercalcemia, no renal failure, no change in mild anemia for the past 5 years, and no bone lesions by skeletal survey. Bone marrow survey by MRI might be more sensitive for detection of myeloma. However, patient is also completely asymptomatic.

I am most concerned with the nearly four-fold rise in the excretion of monoclonal protein in the urine, because this could lead to renal failure, and in fact I have seen rapid development of renal failure in some patients. I recommend continued close monitoring and believe the patient will soon need therapy (i.e.-within the next 1-3 months).

I had a long discussion with the patient and his wife regarding treatment options. At the present time, there are options such as the combination of thalidomide and dexamethasone, which has over a 70% response rate. We discussed the side effects of thalidomide, and also discussed that in older patients, a combination of thalidomide with melphalan and prednisone exhibited progression-free survival of 68% at 2 years. I also described lenalidomide and dexamethasone was being investigated in randomized study, SWOG 0232, and gave the patient the consent form for this study. I noted that Group Health was also a site for this trial.

We discussed the side effects of lenalidomide and the results of the study of lenalidomide and dexamethasone in relapsed patients, with anticipated good response rate in up front patients.

We also discussed a new combination study by the Aptium Oncology network for previously untreated patients being conducte here and at other sites, consisting of multiple drugs, including cyclophosphamide, thalidomide, bortezomib and dexamethasone, and gave a copy of the consent form to the patient.

We also discussed autologous stem cell transplant, tandem autologous stem cell transplants and tandem autologous followed by minimum myeloablative allogeneic stem cell transplant. I presented an overview of the procedures for transplant, including mobilization chemotherapy with growth factor, followed by apheresis collection of peripheral blood stem cells, followed by high dose melphalan, then intravenous infusion of thawed stem cells. I indicated that the timing of the auto transplant would be to follow an initial period of therapy to maximal response (i.e. monoclonal protein down to 0.5 or less, and improvement in urinary excretion of monoclonal protein). Serum free light chain may be helpful in following his response.

I agree with your plans of intiating biphosphonate therapy, as it has enhanced response to treatment, minimized bone mineral loss, although it has been associated with osteonecrosis of the jaw. This latter potential side effect has occurred less in patients on pamidronate then zoledronate.

I indicated that Vitamin B6 100 mg po bid may minimize the neuropathy side effects of drugs such as thalidomide.
Because of the potential for thrombosis on a combination of thalidomide and dexamethasone (15% incidence), I usually anticoagulate with coumadin. The pharmacist here assisted me by presenting information on thalidomide and anticoagulation. The SWOG 0232 protocol uses full dose aspirin, but the data suggest an incidence of thrombosis of 14% with lenalidomide and dexamethasone.

I recommended that the FISH analysis be performed on his bone marrow cytogenetics, and have added the result to the Lab Data above.

Thank you for allowing us to participate in the care of your patient. Please telephone me should have any questions.

With best regards,

Pamela Sue Becker, MD, PhD

Electronically Reviewed/Signed On: 12/26/06 at 06:24

Pamela Sue Becker, MD, PhD
Attending, Dept of Medicine/Hematology
Box 357710
Seattle, WA

cc: Steven S Ginsberg, MD
Group Health Central Specialty Center
201 16th Ave E.
Seattle, WA 98112

Ivan Doig
17277 - 15th Avenue NW
Seattle, WA 98177

PSB/AMM
DD:12/08/06
TD:12/08/06

28076-***

Dec. 6 '06

"Second opinion" session with Dr. Pamela Becker @ Seattle Cancer Care Alliance

This became a quite encyclopedic session of nearly two hours, with the main result that Dr. B concurs with Dr. Ginsberg that treatment should begin soon; at least twice she stipulated possible kidney damage ahead if the protein 'light chains' keep increasing.

Carol, much the better notekeeper while I tried to juggle listening, fathoming, scrawling, and asking occasional questions, did the following accurate summary as soon as we got home:

"Both Drs. B & G agree that you should start treatment soon, with B a bit more urgent because she's concerned about possible kidney damage. Even so, she said 'You don't need to start this week.'

"Both agree that you should start with Thal-Dex, unless the chromosone analysis mandates something more aggressive. The 4-medicine combo is the most aggressive."

"Both think you should go ahead with the (pamidronate) injections to strengthen your bones, which may also have other positive effects (unspecified).

"Both think you're in general good health and at the beginning states of myeloma. In addition, you feel well. B's brief exam of you turned up nothing to be concerned about.

"Of the average, she said longevity from the point of diagnosis is about 3.5 years, can be extended by at least 2 years, and with some of the new drugs and new techniques, more beyond that. Since you are in good health and starting treatment earlier than average (no symptoms yet), that seems a definite upside. Further, she said that new drugs, and new treatments using older drugs, provide 'plenty of options.'"

Dr. B said she would also be sending me a written report summarizing the session, and so my ensuing notes here are medical details gleaned from her parsing of my case and the current state of treatments, rather than another comprehensive summing up:

--my Beta 2 microglobulin readings are "not high," and so she categorizes my myeloma in Stage 1 at indolent. On the other hand, the IgA monoclonal protein reading is high enough --"in the mid-2s"--it means treatment should be started.

--the four criteria used to decide whether to start treatment are acronymed **CRAB**:

Calcium: my readings are in acceptable range

Renal (kidney function): my creatinine readings so far have not changed out of acceptable range, but given the light chains being inflicted on the kidneys by the spiking protein, she said the creatinine reading "might bump." (The potential damage scenario as she explained it: excessive protein urinary excretions hurt the kidneys, and I've had a fourfold increase in those protein light chains.

Anemia: she cited my current reading as 12.4, so I take this to be the hemoglobin count on my latest test result sheet; this is in acceptable range, but she said it could go down to l0 or 11, which would be below range.

Wt 156 w/sheer jacket off bld pressure 138/68 (after more than an hr in waiting rm)

Bone lessions: no sign of any on the last test done

In short, my interpretation is that she finds two areas of immediate concern out of four, with the kidney damage prospect the most indicative toward treatment soon.

She then went through "new drug studies" with us, of which she said there are "4 or 5." She gave me the consent forms on two of these now in clinical trials, which have the details I won't go into here. Instead here are some points gleaned as she connected the drug regimens to stem cell transplant:

--on average, stem cell transplant can extend by 2 years the average survival of 3.5 years from time of diagnosis of myeloma. She does have some patients alive after "9-10 years."

--the 2-year average of remission after transplant has been extended to 5 years in some cases where a second "mini" transplant was done. This can either be with a person's own stem cells (autologous) or from a donor (allogenic). Cancer centers do have a bank of donor cells, and the success rate from unrelated donor is actually higher (50%) than from one's own second round of stem cells (40%) because the donor cells may have some immune system benefit still in them.

<u>Induction therapy drugs and drugs in clinical tests</u>: as I understood it, the central point here is that my protein reading, now 2.7 grams, must be brought down to .5 grams before stem cell transplant.

As to how aggressive the chemotherapy needs to be to achieve this (and I think for another indicator of how far my myeloma has advanced), she wants a Y chromosome analysis to see how much "deletion" there has been. The bone marrow test done by Dr. G in April indicates "less than 75%," which could simply be age-related, but she wants a more sophisticated measurement called a **FISH** analysis, and will talk to Dr. G about that.

add Thal- dosage add Dex "pulses"

**--Her basic chemotherapy approach is to use the Thalidomide-dexamethasone combination first; if the person can't tolerate, say, the finger-and-toes numbness, she would switch them to Revlimid. She has 5 patients in the Revlimid clinical trial, and while the results are still double-blinded, she has seen the protein level go down so quickly in some of them she feels sure they're getting the Revlimid instead of the placebo.

(A side effect of Revlimid, however, is that it lowers the blood count and therefore worse infection are possible. She says it has less neuropathy--the numbing--but evidently the same frequency of blood clotting as other treatments, 15%.)

--There is another clinical trial by what's called the Aptium Group, as C and I understood it more aggressive than Revlimid, using the intravenous drug Velcade in combination with Thalidomide, dexamethasone and cyclophosphamide. Results have indicated 80-90% response, with 25% of that complete remission.

In short, the logical path for me seems to be to try the Thalidomide-dexamethasone approach to induction therapy, then if it turns out something more aggressive is needed to bring the protein level down to .5, the Revlimid clinical test would be available to me through Group Health, the Velcade +3 clinical test would be available through SCCA but Group Health would have to be "talked to" to let me participate. + Coumadin

**from C's notes, see dosage amounts on next page

MORE

***Thalidomide and dexamethasone: Dr. B's pharmacist Deborah Frieze went over these basics with us:

Thalidomide possible side effects:

--finger and toe numbness as noted earlier by Dr. B; Deborah said this is dose dependent, and they back off on the dosage if tingling starts.

--constipation; stool softeners are advised.

--drowsiness; the advice therefore is to take Thalidomide at night.

Because of the birth defects history, Thalidomide has a bunch of protocols. I can't see that any of them would impact me, but just for the record:

--patient must register with the Thalidomide company, agreeing among others things not to father any children. She says registration is a phone process taking 30 minutes or so.

--similarly there's a monthly telephone survey the patient must do, vowing again to abide by the protocols.

--a new prescription is needed for each new supply of Thalidomide, i.e. there are no refills.

** dexamethasone possible side effects:

--sleeplessness

--mood change: could make me "peppy, even aggressive"

--blood sugar goes up

--weight gain; she's seen "20-30 pounds" on some patients. Along with this is possibility of "moonface" (medical term is "cushinoid").

In essence, dexamethasone is a more powerful prednisone (a corticosteroid).

CCA
~~SAAC~~ has Thal-dex patients take the blood-thinner Coumadin. At the start of therapy, they draw blood twice a week to figure out the proper Coumadin dose. It "interacts" with other medications such as antibiotics (and even aspirin), so both the Coumadin and what else you take has to be watched.

--Deborah mentioned that Coumadin users should avoid food with vitamin K, and when I asked for examples and she said "green leafy vegetables," C and I groaned. She then said the dose could be worked around our salad habit, the important thing was consistency of diet, i.e. don't eat vitamin K food if you haven't been.

***Thalidomide dosage Dr. B uses is 50 mg for 2 wks, 100 mg for 2 wks, 200 mg for 2 wks.

**Deborah said dexamethasone is given in 'pulses' of 4 days on, 4 days off, to minimize weight gain.

MORE

Two last stray points from Dr. B:

--I am to avoid "black mold" (such as really moldy leaves) because the spores can linger and cause a problem in the stem cell transplant.

--on my question about possible permanent side effects of any of this on mental acuity, she said the donor transplant process chemotherapy can disrupt thinking ability in some patients. On the other hand, she said, it might make me "more creative."

Summary Dr. Pam Becker. Dec. 6, 2006.

Both Drs. B. and G. agree that you should ~~xxx~~ start treatment soon, with B. a bit more urgent because she's concerned about possible kidney damage. Even so, she said, "You don't need to start this week."

Both agree that you should start with Thal-Dex, unless the chromosome ~~x~~ analysis mandates something more aggressive. the 4-medicine combo is the most aggressive.

Both think you should go ahead with the injections to strengthen your bones, which may also have other positive effects (unspecified).

Both think you're in general good health, and at the beginning stages of myeloma. In addition, you feel well. B's brief exam of you turned up nothing to be concerned about.

Of the averages, she said ~~that~~ longevity from the point of diagnosis ~~is~~ is about 3½ years, can be extended by at least 2 years, and with some of the new drugs and new techniques, more beyond that. Since you are in good health and are starting treatment earlier than average (no symptoms yet), that seems a definite upside. Further, she said that new drugs, and new treatments using older drugs, provide "plenty of options."

①

Beta 2 not high / Stage I

now indolent

IGA - mid-2 1, start therapy

C calcium
R enal (creatinine) might bump
A nemia (12.4 10/11 ↓ anemia
Bone lesions

urinary xallers hurt kidneys
(4 fold light chain increase)

albumin "pretty good" (normal)

bone marrow / 30%

soon

1 g - 1.6 g in urine

---

from diagnosis ave s.r.l 3 1/2 yrs - extend y txtmt
2 yrs y stem cells
- some alive 9-10 yrs

4-5 new drug studies / Revlimid
Velcade

2nd transplant / mini
- from donor (can be unrelated)
5-yr survival: 50% ↘ 40%

2 yrs of remission ave. after transplant

Thal/dex (Thal forms)

S
T
E
P
S

dizziness & somnolence
neuro prob common - back down dose (150-200 g. best)

(2).

Thal cont.

clotting / add patients cumidin

SW Oncology / Revlimid trial

- advtges: less neuropathy
  same clotting (15%)
- protein went dn quickly

[5 patient basis]
drugs

- trial 7 4, Aptium
- Velcade
-

dex toxic to lymphocytes (+ potent prednisone)

Revlimid side effect: lowers bld count (worse infections?)
" dec patients

+ny Thal-dex 1st; numbness; go to Rev

Bortezomid (Velcade) (pen) (other 3 reg; medicare)
- i-venus

80-90% response w/ Thal/dex

4th drug cycle

25% complete remission

protein reading 2.7 → .5 goal / then transplant
6-12 mo probably come back up

Aptium: acts Erinberg

③

abnormalities
chromo 13 / poor prognosis
^
FISH needed /

—

Thal / register w/ co. / 30 min. or so
- mo'ly telephone survey
- new prescriptn ev. mo.

3 side effects:
- numbness (dose dependent)
- tingling, back of
- constipation (stool softeners)
- drowsiness (take @ nt)

dex - 4-day pulses (4 days on, 4 off)
main side effects
- sleeplessness
- mood change (peppy, aggsve
- bld sugar goes up
- wt gain (20-30#)
(cushinoid: moon face from steroids)

coumadin: 1x/wk bld draws @ start to figure dose
- interacts w/ other medication: (such as antibiotics)
- vit K: green leafy vegs (dose cumadn around it)
- diet consistency + important

(4)

deletion of Y chromo
~~#~~ less than 75% / age related?

- donor transplant : can disrupt thinking ability

- away from moldy places
  - dead leaves / black mold

C: both begin, B + than B
- " Pandrita
- agree on Thal / dex

Dec. 6 '06

Questions for Dr.Becker:

1. Do you agree with Dr. Ginsberg that I should have treatment now?

   --If so, what treatment would you recommend?

   kidney function

   --Are there other treatment options I should consider?

   --Since I am currently feeling fine and functioning as well as ever in my daily work as a writer, to what extent would I be putting myself at greater risk in the long run by waiting on treatment?

2. Dr. Ginsberg says I am in a "gray area," the myeloma either smoldering or indolent, but the continuing rise in the protein counts bothers him. Is there any realistic likelihood the protein counts, without treatment, might cease spiking and leave me in this present condition for a span of, say, a few years?

3. Induction therapy and possible side effects: I'm a writer of fiction, an activity that takes all the mental acuity I have. Are there any potential side effects in the chemotherapy regimen that could permanently alter my intellectual ability or my ability to concentrate?

   --From what I've been able to read on this topic of side effects, the possible severity of side effects increases when dexamethasone is used in combination with Thalidomide--as, I gather, does their rate of effectiveness. Is there a reasonable treatment scenario that would start with Thalidomide alone and add dexamethasone if results were not satisfactory?

   -- Dr. Ginsberg is inclined to include a one-year regimen of Pamidronate infusions along with the main course of treatment. Would you?

   yes w/ Bp 100 mg / every day

4. The stem cell transplant possibility:

   --What is the success rate of a treatment sequence of Thalidomide-dexamethasone induction therapy and stem cell transplantation?

   12 mo remission

   --What is the measure of "success" in this treatment, in terms of a "Treatment Outcome" chart I've seen on the Myeloma Research Foundation website which, for instance, defines "Very good partial response" as "Greater than 90% decrease in M protein."

   --If remission is achieved, how long is that likely to last?

   2 yrs ~~after~~

   remiss 3 1/2 yr

   ~ 7% mortality

   risk factor/ mortality rate?

Dec. 6 '06

Questions for Dr.Becker:

1. Do you agree with Dr. Ginsberg that I should have treatment now?

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   -- Dr. Ginsberg is inclined to include a one-year regimen of Pamidronate infusions along with the main course of treatment. Would you?

   yes
   w.t BC 100 mg / (thirty day)

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   12 mo remission

   --What is the measure of "success" in this treatment, in terms of a "Treatment Outcome" chart I've seen on the Myeloma Research Foundation website which, for instance, defines "Very good partial response" as "Greater than 90% decrease in M protein."

   --If remission is achieved, how long is that likely to last?

   2 yrs ~~after~~
   possible 3'/— yrs

   ~ 7% mortality

SEATTLE CANCER CARE ALLIANCE

Fred Hutchinson Cancer Research Center
UW Medicine
Children's Hospital & Regional Medical Center

November 28, 2006

Dear Mr. Doig:

Welcome to the Seattle Cancer Care Alliance (SCCA). Our outpatient services are provided here at the SCCA building. Inpatient services such as surgery are provided at the University of Washington Medical Center (UWMC). A map with driving directions is included. It is important that you note the date, time and **location** of your appointments as indicated below. If you have appointments scheduled at both facilities, we do provide a shuttle between them. Patient parking is available in the SCCA garage. The cost is up to $4.00 per day with validation.

I have scheduled the following appointments for you:

Date	Time	Provider	Location
December 6, 2006	12:30 pm	Registration Appointment	SCCA 1st Floor
December 6, 2006	1:00 pm	Dr. Becker	SCCA 4th Floor

Please take a few moments to review the enclosed information, as it contains important information about our facility, including billing information.

If you are continuing your treatment here, you will have a Clinical Nurse Coordinator who will monitor your care and facilitate communication with your doctor. You will meet your Clinical Nurse Coordinator during your appointment.

Further, if you require future appointments with us, your Team Coordinator, **Sarah**, will schedule them. **Sarah** can be reached at **(206) 288-6917.**

****Also, enclosed with this letter is a Medication History Form that needs to be filled out and brought to your appointment.****

If you have any other questions, or need to cancel/change ***this*** appointment, please contact me directly at **(206) 288-1260**.

We look forward to meeting you.

Sincerely,

Aileen Imperial
Patient Care Coordinator

SEATTLE CANCER CARE ALLIANCE

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UW Medicine
Children's Hospital and Regional Medical Center

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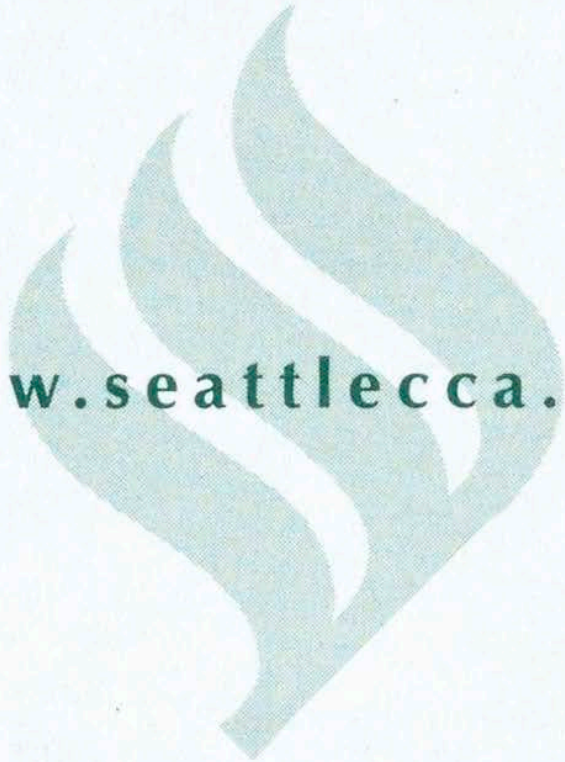
Janice →



www.seattlecca.org

SEATTLE
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ALLIANCE

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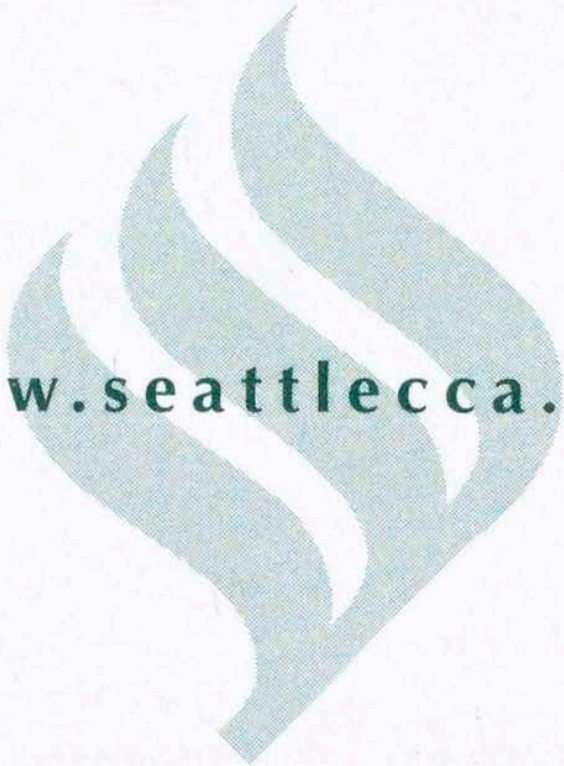

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