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29 April 2010

MEDICAL REPORT

Re: Miss Tracy-Ann LOGAN, dob: 27.04.1978
c/o 6 Fenton Close, London SW9 0ST

Further to my initial medical report Tracy-Ann Logan was admitted for further evaluation as a patient at The National Hospital for Neurology & Neurosurgery, Queen Square, London, on the 14th of April 2010.

The earlier history outlined in my initial report was entirely suggestive of neuromyelitis optica.

The additional investigations we did as an in-patient supported this diagnosis.

The MRI brain scan showed a solitary periventricular lesion abutting the trigone of the left lateral ventricle, but otherwise the intracranial appearances were normal, and there was no pathological enhancement. There was swelling and diffuse patches of signal abnormality on the cervical cord extending from C1 to C5/6 with several foci of more well defined higher T2 weighted signals suggestive of some cystic change. Post Gadolinium there is some faint patchy enhancement extending over these levels.

CSF examination did not show any oligoclonal bands and none in the serum.

Routine blood tests including renal function, electrolytes and full blood count were normal. ALT was very slightly elevated compatible with fibrin therapy.

CSF protein was minimally elevated at 0.5 (normal range 0.13-0.40). CSF microscopy was unremarkable. Coagulation screen: minimally elevated Prothrombin time at 14 (10-12). INR, APTT2 and TT2 were normal. C-reactive protein was normal at 2.3. Thyroid function was normal. CSF white cell count was normal at 1 and ANCA was negative. Aquaporin antibodies are awaited.

Visual evoked responses showed absent responses from the right eye. Potentials from the left centre and both hemisurrounds in the left were absent. The responses from the left whole field were reasonable well formed but of markedly increased latency in keeping with a demyelinating optic neuropathy.

The above investigations are consistent with a diagnosis of neuromyelitis optica. The aquaporin antibody test positive (Aquaporin 4) consistent with the diagnosis of neuromyelitis

optica which is autoimmune in basis.

Treatment recommendations:

She has only recently achieved a treatment dose of Azathioprine and we consider that she should continue on Prednisolone 50mgs a day and Azathioprine 200mgs a day for the next 6 weeks. We would then recommend a cautious steady reduction of Prednisolone by 5mgs every 10 days but maintaining the Azathioprine dose of 200mgs.

If the commencement of reduction of Prednisolone results in a relapse, or if she has a relapse in the next 6 weeks while she is maintained on Azathioprine and Prednisolone, then I our recommendation would be to refer her for a trial of intravenous immunoglobulin (IVIg). The dose of intravenous immunoglobulin will be 0.4 grams per kilogram per day for 5 days. If this seemed to be effective then one could continue with IVIg regularly as guided by symptoms.

If the IVIg was ineffective then consideration to a trial of Rituximab, if ineffective then Mitozantrone should be considered. Her other medications are unchanged and our list is in the attached discharge summary. Copies of all the medical reports that are mentioned in this report are attached.

In addition I am attaching a copy of the consultation with my colleague, Dr Paul Jarman, while the patient was on the ward.

Thank you for referring this patient.

I would be happy to advise as required.

She will benefit from continuing physiotherapy on her return home this week.

With best wishes and kind regards.

Yours faithfully,

Dictated but unsigned to avoid delay.
Professor Michael G Hanna BSc (Hons) FRCP MD
Consultant Neurologist and Professor in Clinical Neurology

Encs.

Copies to:

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