Burzynski CLINIC
First, Do Not Harm!

9432 Katy Freeway, Suite 200, Houston, TX 77055
Phone: 713-335-5697 Fax: 713-935-0649

History and Physical

002849
Siegel, Mary J.
09-Oct-09

CHIEF COMPLAINTS: The patient is a 59-year-old Caucasian female accompanied by her husband, who presents to our office for a follow-up evaluation, stating that she continues to be symptom-free and is feeling very well. The patient is able to carry on normal activity with no complaints and no evidence of disease.

HISTORY OF PRESENT ILLNESS: This patient was in very good health until February, 1991 when she was diagnosed with small cleaved cell, Non-Hodgkin's lymphoma. She came under our care on April 3, 1992. Initially her treatment program included administration of Antineoplaston A10 and AS2-1 capsules in the dose range of 0.13 g/kg/day of A10 and 0.22 g/kg/day of AS2-1. On April 6, 1992 a low dose of alpha-interferon was added to the treatment (1.2 MU s.c. q.o.d.). On November 16, 1992, oral Antineoplastons were discontinued and the patient began taking Antineoplaston A10 and AS2-1 intravenous infusions administered through a subclavian venous catheter via an ambulatory infusion pump, receiving 1.5 g/kg/day of A10 and 0.3 g/kg/day of AS2-1. The treatment resulted in complete response, as documented by physical examinations, CT scan, and bone marrow biopsy of November 16, 1993. Antineoplaston infusions and alpha-interferon were discontinued on May 3, 1994. On May 18, 1994, the patient began taking Antineoplaston AS2-1 capsules 0.25 g/kg/day, which were discontinued on July 26, 1995. Approximately two years later after her complete response was documented and four months after discontinuation of treatment, the CT scan of October 19, 1995 was suspicious for small lymph nodes in the neck indicating recurrence. The patient restarted the treatment with Antineoplaston AS2-1 and A10 capsules, on November 7, 1995, which resulted in disappearance of the enlarged lymph nodes in the neck by physical examination and CT scan of March 7, 1996.

On April 29, 1996, the patient was admitted to the study for administration of PO Antineoplaston A10 and AS2-1 according to Protocol CAN-1. The daily dose of Antineoplaston A10 was gradually increased to 0.23g/kg/day and AS2-1 to 0.29g/kg/day, which were discontinued on November 22, 2004.

PAST MEDICAL HISTORY: Non-contributory.

PAST SURGICAL HISTORY:
1. Resection of the benign cyst from bilateral breasts.

GYNECOLOGICAL HISTORY: P3 G3 AB0.

History and Physical

002849
Siegel, Mary J.
09-Oct-09

ALLERGIES: No known drug allergies.

MEDICATIONS: No prescription medications only nutritional supplements.

FAMILY HISTORY: Father died in 2003 secondary to leukemia, one brother died in 2003 due to esophageal cancer, one sister and a brother are both in good health.

SOCIAL HISTORY: She is married with three children, has one grandson and works full-time.

HABITS: She denies smoking, alcohol consumption or the use of illicit drugs

REVIEW OF SYSTEMS: She continues to be symptom-free. She denies headaches, problems hearing, vision difficulty, blurred or double vision, shortness of breath, chest pain, palpitation, paroxysmal nocturnal dyspnea, orthopnea, chronic cough, hemoptysis, abdominal pain, nausea, vomiting, diarrhea, constipation, melena, dysuria, frequency, pain with urination, seizure or syncopal episodes.

PHYSICAL EXAMINATION:

GENERAL: The patient, who presents with her husband, is in no apparent distress, cooperative to examination, happy mood, and alert and oriented x4.

VITAL SIGNS: Wt: 123 pounds. BP: 114/69. Heart rate: 80 per min/rhythm regular. Respiration rate: 20 per min. T: 97.1°F. Pulse ox: 98%.

SKIN: Warm and moist without lesions. No jaundice.

HEAD: Atraumatic. Normocephalic. There was no temporal muscle wasting. There was a right temple subcutaneous nodule of approximately 2 mm in size that was freely mobile, non-tender, non-erythematous, and most likely cystic in nature.

EYES: Pupils were equal, round, and reactive to light. Extraocular muscles were intact. Sclerae were anicteric.

EARS: Tympanic membranes were intact with good light reflex bilaterally.

NOSE: Septum was midline without polyps or ulcers. Nasal mucosa was non-erythematous without postnasal drip.

MOUTH AND THROAT: Good dentition. No buccal lesions. Pharynx was non-erythematous without tonsil enlargement or exudate.

NECK: Supple without masses or thyromegaly. There was no JVD. Carotids were 2+ bilaterally without bruit.

PERIPHERAL LYMPH NODES: There were no palpable cervical, supraclavicular, axillary, or inguinal lymph nodes.

CHEST: Chest moves symmetrically with respiration.

LUNGS: Clear to auscultation and percussion.

CARDIOVASCULAR EXAMINATION: S1 and S2 normal, without S3, S4, or murmur. Regular rate and rhythm.

ABDOMEN: Soft, non-tender. There were no masses or hepatosplenomegaly. There was no guarding or rebound. Positive bowel sounds.

GU/RECTAL: Deferred.

EXTREMITIES: There was no clubbing, cyanosis, or edema. Radial and dorsalis pedis pulses equal and strong bilaterally.

NEUROLOGICAL EXAMINATION: The patient was alert and oriented x4. Cranial nerves II-XII were intact. Motor strength grossly intact throughout.

KARNOFSKY PERFORMANCE STATUS: 100.

IMPRESSION:
Non-Hodgkin's Lymphoma, Small Cleaved Cell, low grade, Stage IV - in remission.

TREATMENT PLAN:
1. She will have a profile I, VEGF, EGFR and HER-2 receptor.
2. She will repeat the CT of the neck, chest, abdomen and pelvis since the last radiographic

studies were performed on May 22, 2007.

PM ADDENDUM: We received the results of the blood test collected this morning, which were clinically significant for trace hematuria; therefore, the patient once again was recommended to consult a urologist for this matter. She was previously consulted by a urologist, who stated that he could not find any reason for her microscopic hematuria.

MD/MT: BS/mc AM/mw

Alejandro Marquis, M.D.