Figure 4 – Demonstrating the SEP Diagnostic Falsification

The tests were carried out according to procedure but the diagnostic findings are a huge deviation from the data in the findings, its a diagnostic falsification. A single glace at the data and the graph in of the SEPs would determine underlying pathology or clinical effect.

But lets demonstrate how:

Factual:

Referral: VEP or SSEP delay?

Optic neuropathy? Also has sensory symptoms with few signs.

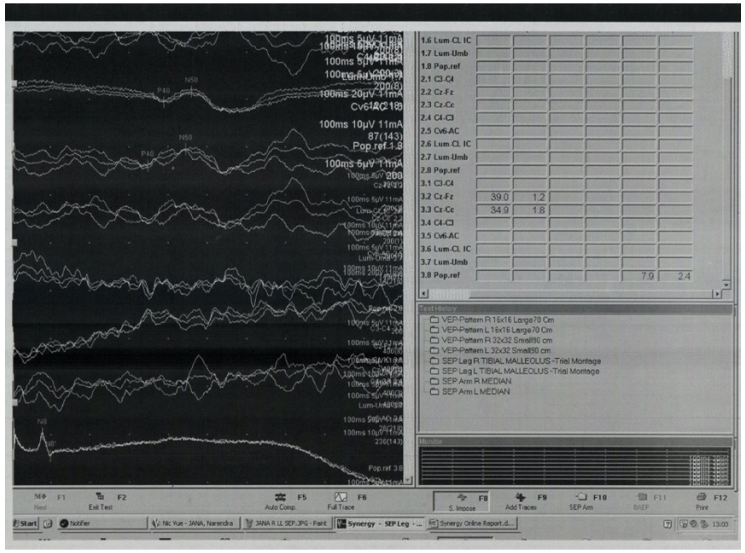
Findings:

VEPs waveforms are well-formed, with normal latencies for both large and small checks, bilaterally.

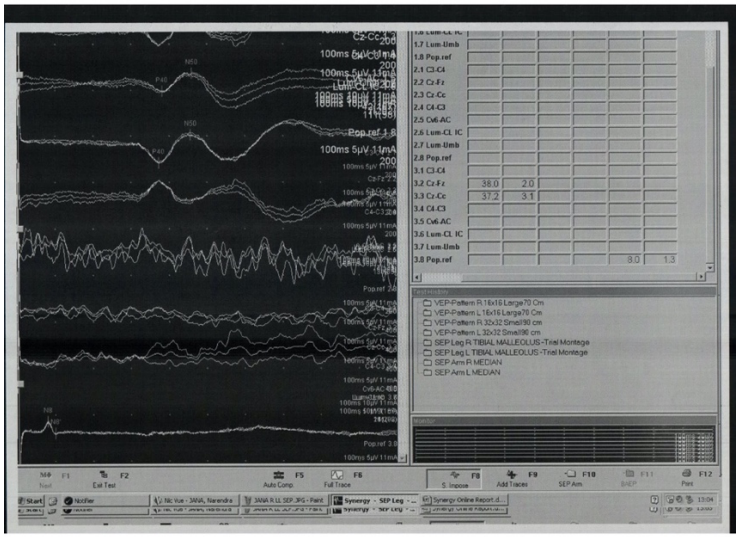
SSEPs waveforms are well-formed, with normal latencies for both upper and lower limbs.

Dr. Catania's statement is that the "SSEPs waveforms are well-formed, with normal latencies for upper and lower limbs."

The two graphs of the tibial (leg) SEP are given below:



I. Left tibial (leg) SEP.



II. Right tibial (leg) SEP.

Any medical textbook that was ever written about sensory evoked potentials in history could be referenced to negate Dr. Catania's statement, if you have graph I. in a medical test you will undoubtedly have multiple sclerosis or a neurodegenerative condition. The right tibial (leg) SEP (graph II.) is a normal or passable SEP, but the left (graph I.) is a gross malformation.
The below examples are from well known medical texts used in medical school (common to medical students).

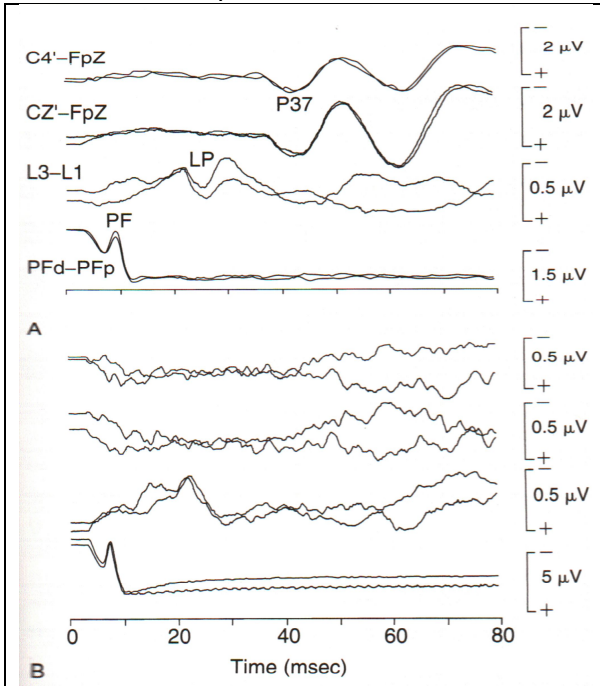


FIGURE 25-10 ■ **A**, Normal response recorded over the popliteal fossa, the scalp, and the spine with stimulation of the right tibial nerve at the ankle. A well-marked potential is recorded over the nerve at the popliteal fossa between the distal and the proximal electrodes (PFd and PFp), and a lumbar potential (LP) is recorded between the third and the first lumbar vertebrae (L3–L1). A positivity is seen at Cz′ and the contralateral scalp area (C4′) with reference to Fpz. **B**, Somatosensory evoked potential to right tibial nerve stimulation in a patient with definite multiple sclerosis. An initial potential is recorded over the nerve in the popliteal fossa and over the lumbar spine, but no response can be identified over the scalp.

Chapter 26, Somatosensory Evoked Potentials,
"Electrodiagnosis in Clinical Neurology" by Michael J. Aminoff

Graph B in the left textbook example is similar to Graph I. in my diagnostic data. Same test, same malformations.
Graph I. in my test undoubtedly indicates a neurodegenerative process.

Graph A. in the textbook example is much healthier, clear peaks and troughs similar to Graph II. of my passable right tibial SEP.

III. Left median (arm) SEP

IV. Right median (arm) SEP

The graphs to the right are what a normal median nerve somatosensory SEP looks like:
Clear well defined peaks and troughs. The N20 usually has a well defined curve with a large amplitude.

Normal Response

Figure 14-1 shows a normal median nerve somatosensory evoked potential. The montage may differ among laboratories, but the same waveforms are identified. Refer to the figure during this discussion.

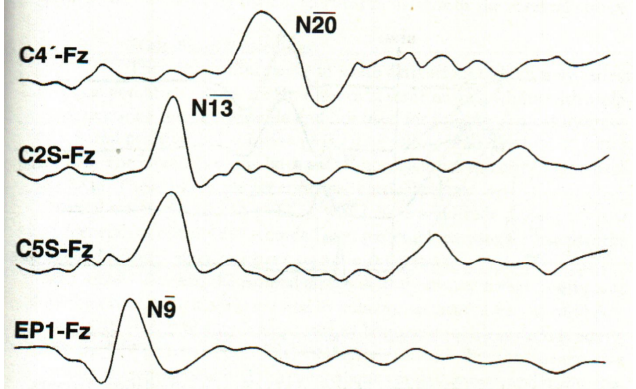


Figure 14-1 Normal median SEP. Stimulation of the left median nerve at the wrist produces clavicular (*bottom* trace), cervical (*middle two* traces), and scalp potentials (*top* trace).

"Spehlmann's Evoked Potential Primer" – Karl E. Misulis and Toufic Fakhoury

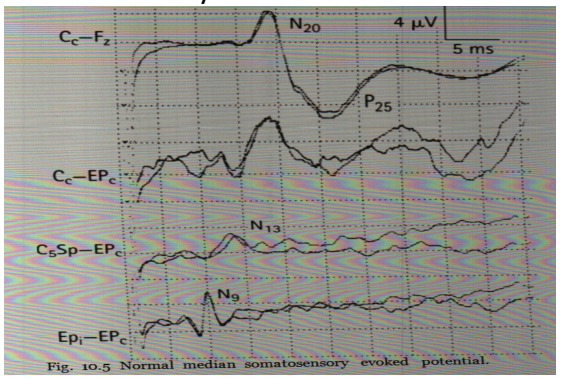


Fig. 10.5 Normal median somatosensory evoked potential.

"Clinical Neurophysiology" – UK Misra and J Kalita

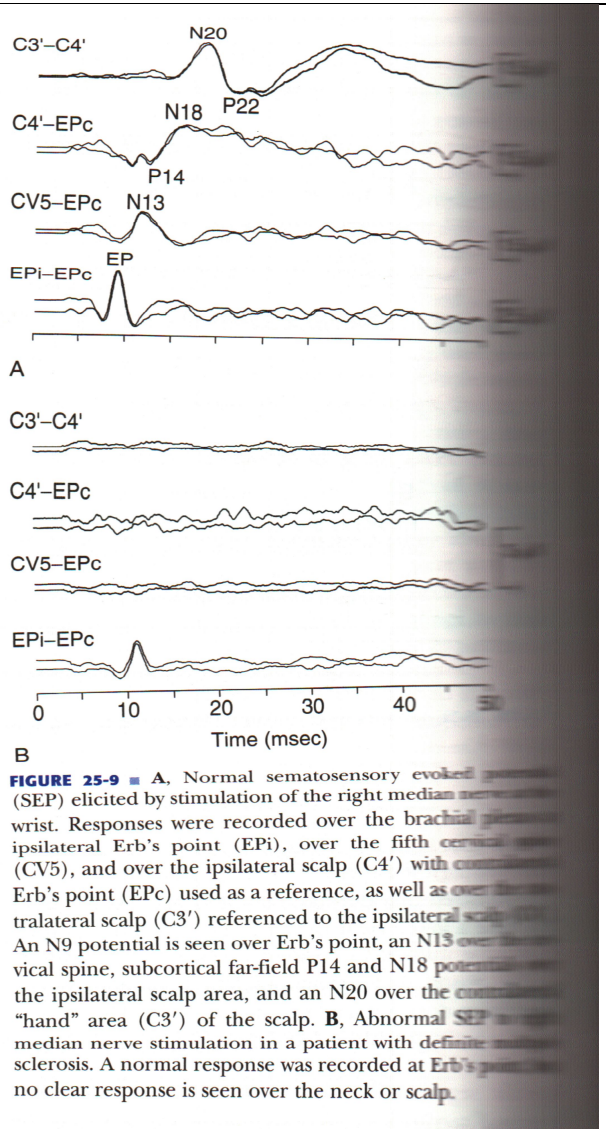


FIGURE 25-9 ■ **A**, Normal sematosensory evoked (SEP) elicited by stimulation of the right median wrist. Responses were recorded over the brachial ipsilateral Erb's point (EPi), over the fifth cervical (CV5), and over the ipsilateral scalp (C4′) with Erb's point (EPc) used as a reference, as well as tralateral scalp (C3′) referenced to the ipsilateral An N9 potential is seen over Erb's point, an N13 vical spine, subcortical far-field P14 and N18 the ipsilateral scalp area, and an N20 over the "hand" area (C3′) of the scalp. **B**, Abnormal median nerve stimulation in a patient with sclerosis. A normal response was recorded at Erb's no clear response is seen over the neck or scalp.

Graph B in the left textbook example is similar to Graph III. in my diagnostic data, though my graphs have slightly more defined peaks.
The nearly flat line and reduced amplitude for N20 in Graph III. indicates a neurodegenerative process, attenuation and reduced amplitude indicate neurodegeneration. Its not like the normal response in the Figure 14-1 in "Spehlmann's Evoked Potential Primer" or Graph A.

Graph A. in the textbook example is much healthier, clear peaks and troughs similar to Graph IV. of my passable right median SEP.

These graphs only occur in CNS neurodegenerative disorders:

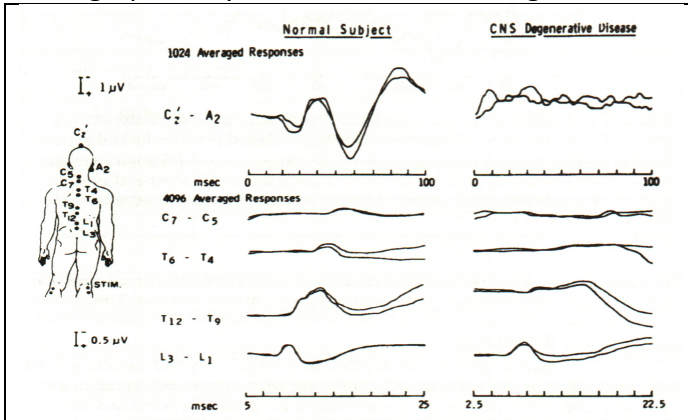


Figure 17-8 Peroneal SEP in a child with a neurodegenerative disease. Peroneal SEP is recorded in response to stimulation near the knee. Left traces are from a normal subject. Right traces are from the patient. The potentials are lost in higher electrode derivations and not detectable at the scalp. (Reprinted with permission from Cracco et al. *EEE Clin Neurophysiol.* 1980;49:437.)

"Spehlmann's Evoked Potential Primer" – Karl E. Misulis and Toufic Fakhoury

Low amplitude scalp responses and malformed graphs are the hallmark of neurodegeneration seen in SEPs.

The SEP test data does reflect that there are lesions in the cervical column even according to Dr. Trip's own statement in the appointment that "VEPs/SEPs aren't used to describe latency, though useful [since latency changes often due to vacillations in inflammation]. They are used to determine damage (lesions) from former inflammatory periods." In the NHS VEP/SEPs aren't done more then once according to Dr. Trip.

Any person with an educated background that has the ability to read a medical text book and an overabundance of clinical history could deconstruct the falsification in this case. (Explained in documents **Figure 5/6**)

Dr. Catania's statement that the "SSEPs waveforms are well-formed, with normal latencies for upper and lower limbs" is easily shown to be false. The waveforms are definitely not well formed and indicate a neurodegenerative condition.

But this is only with the hospital's medical record/diagnostic data, what happens if other data and surrounding diagnostics are considered? Dr. Catania becomes medically impossible to defend.

Figure 5 goes into detail with a small sample of surrounding diagnostic data that negates Dr. Catania.