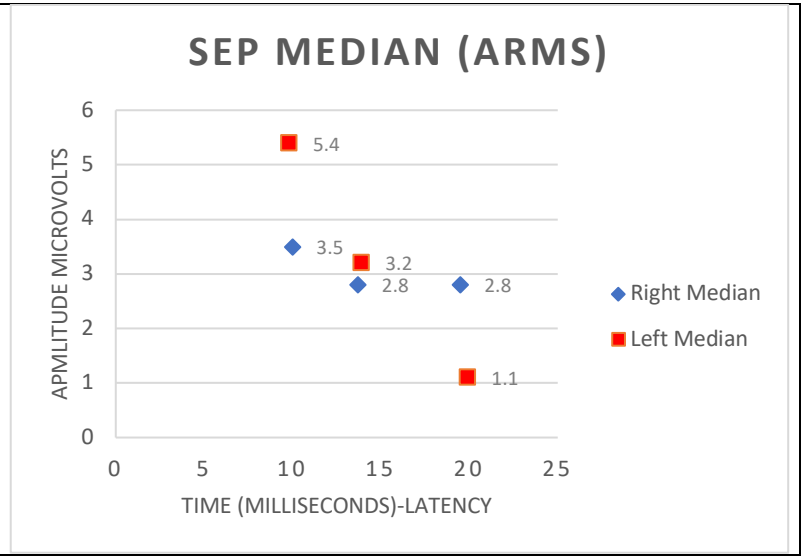
Name: Narendra Jana
NHS Number: 721 602 5954
Email (preferred): realn@mykolab.com
Cell: 07541106744
Cell: 17812235780 (US)

For Dr. Anand Trip,
Data and conclusions about the SEP and VEP:

Arms

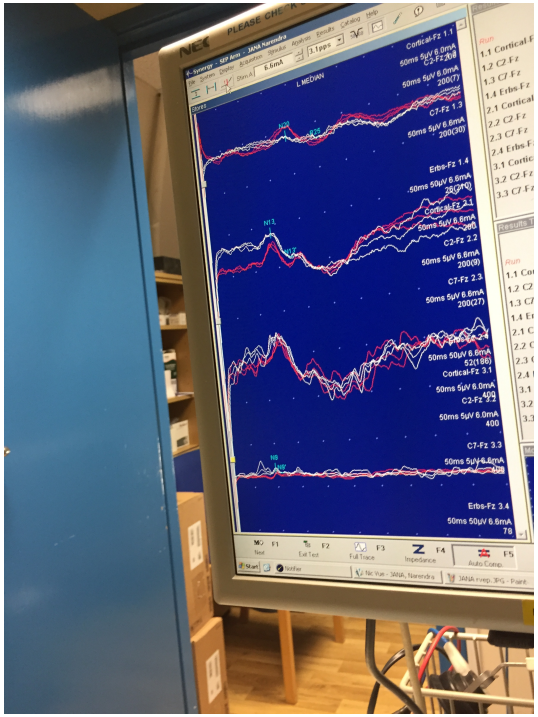
SEP Median	Right (yes)		Left (yes)	
	uV	ms	uV	ms
N20 (scalp)	2.8	19.5	1.1	18.9
N13 (Cv2)	2.8	13.7	3.2	13.9
N11 (Cv7)				
N9 (Erb's point)	3.5	10	5.4	9.8
IPL N9-N13		3.7		4.1
IPL N13-N20		5.8		5
IPL N9-N20		9.5		9.1



Conclusions from the data:

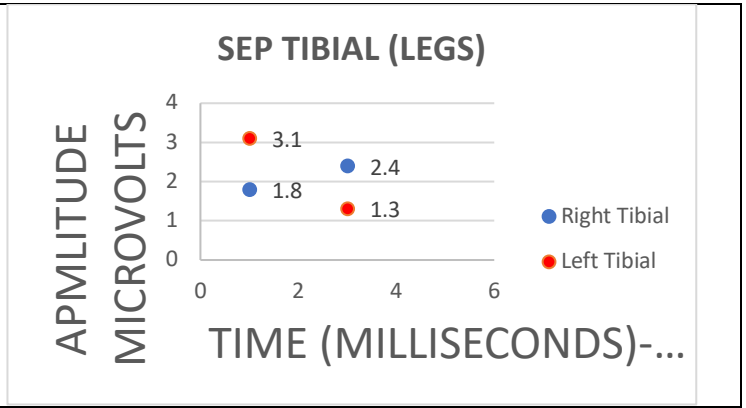
SEP Median
The diminished amplitude of the N20 indicates how a person responds to tactile touch. (less than half of the right hemisphere in the left hemisphere)
That means that there is a lesion in the cortical part of the brain that limits tactile stimulus but only in one hemisphere, the left hemisphere. Thus sensory input is better recognized in one hemisphere than the other, which is the apparent reality as well repeatedly shown in all neurological examinations.

N13 is hard to determine, but it's a abnormal graph in one hemisphere.
N11 isnt measured, but it would determine if there is an effect in the dorsal column nuclei of the spinal cord.
I believe it is measured but its not stated in the data set or the machine wasn't able to measure it because of the abnormal graph (too much noise), the graph was recorded and its shown in the picture to the right (its the third graph):



Legs

SEP Tibial	Right (yes)		Left (yes)	
	uV	ms	uV	ms
P40(scalp)	1.8	34.9	3.1	37.2
N22(T12/L1)		absent		absent
N8 (popliteal fossa)	2.4	7.9	1.3	8
IPL N8-P22				
IPL N22-P40				



Conclusions from the data:

SEP Tibial

The tibial SEP is more clear.

The diminished amplitude in the P40 scalp reading indicates a lesion in the thalamus or thalamocortical radiations, most likely contralaterally, that correlates well with the lesions seen in former MRIs.

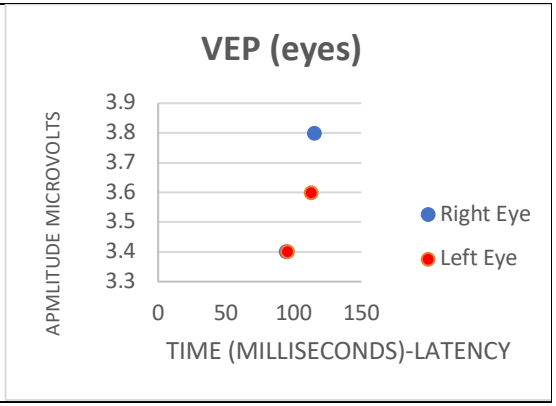
For the N22 reading since the lower limit of normal is 0.3mV, a absent curve for N22 means abnormal (im not older or obese [a little underweight] so it would be an abnormality).

As medical logic states, if there is no measured response in the N22 lumbar measurement there must be an abnormality in the P40 measurement. And that is the case, there is a limited amplitude in the P40. The limited amplitude means nerve damage, even if T1 lesions aren't currently present due to medication response (Rituximab).

The scalp SEP further highlights the abnormality.

VEP

Monocular stimulation (visual acuity)	Right (6/9)		Left (6/9)	
P100	uV	ms	uV	ms
Large (0.8 degrees)	3.8	115.3	3.6	112.8
Stimulus field sice 20 degrees				
Small (0.25 degrees) checks	3.4	94.3	3.4	95.5
Stimulus field size 16 degrees				



Conclusions from the data:

VEP

The VEP is a good (and most direct) indication that the medication for MS (Rituximab) is working, which means that it reduced neuroinflammation around the optic nerve enough so the latencies changed.

With 4 VEPS that showed abnormal latencies and a single VEP that shows latencies that are an improvement (its still about 3.3 milliseconds latency in the right eye from normal values), it means the medications are effective.

Monoclonal antibodies are an effective way of treating MS and this was a progressive form of MS until Rituximab was applied.

The point is that the abnormalities are clear and contrary to the statement in the report, given below:

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.

Which is why I cancelled the MRI and LP for now, I would rather not replicate the situation of negligence as the country I am seeking asylum from when there are clear aberrations between findings and data.

Epilepsy

As for epilepsy, its known that I have seizures. It would be easy to measure the preictal effects of a seizure but its harder to materialize a seizure. You could only determine it by inference or long term ambulatory EEGs. Its also not productive treating it under epilepsy because its neuroinflammatory in nature (clinical syndrome gets far worse on antiepileptic medications).

MRI

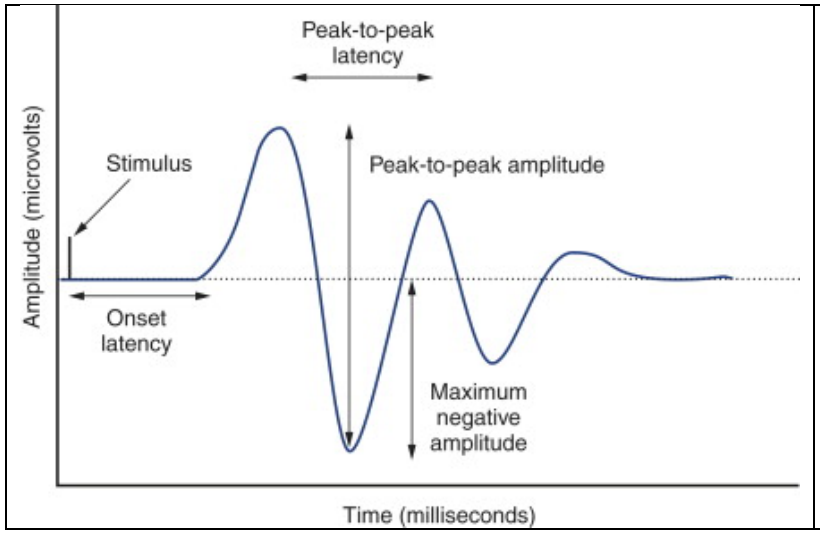
Another MRI isn't needed because the last MRI was in July (less than 3 months) and it showed lesions in the cervical spine and brain.

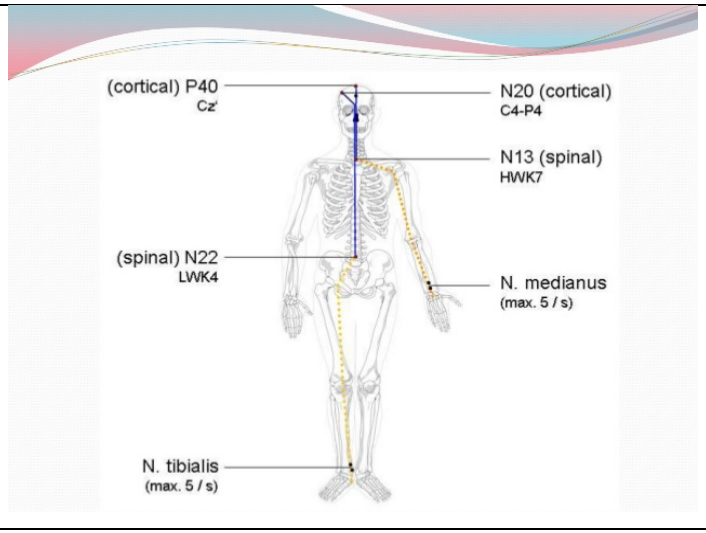
Instructions on how to open that and former MRI series:

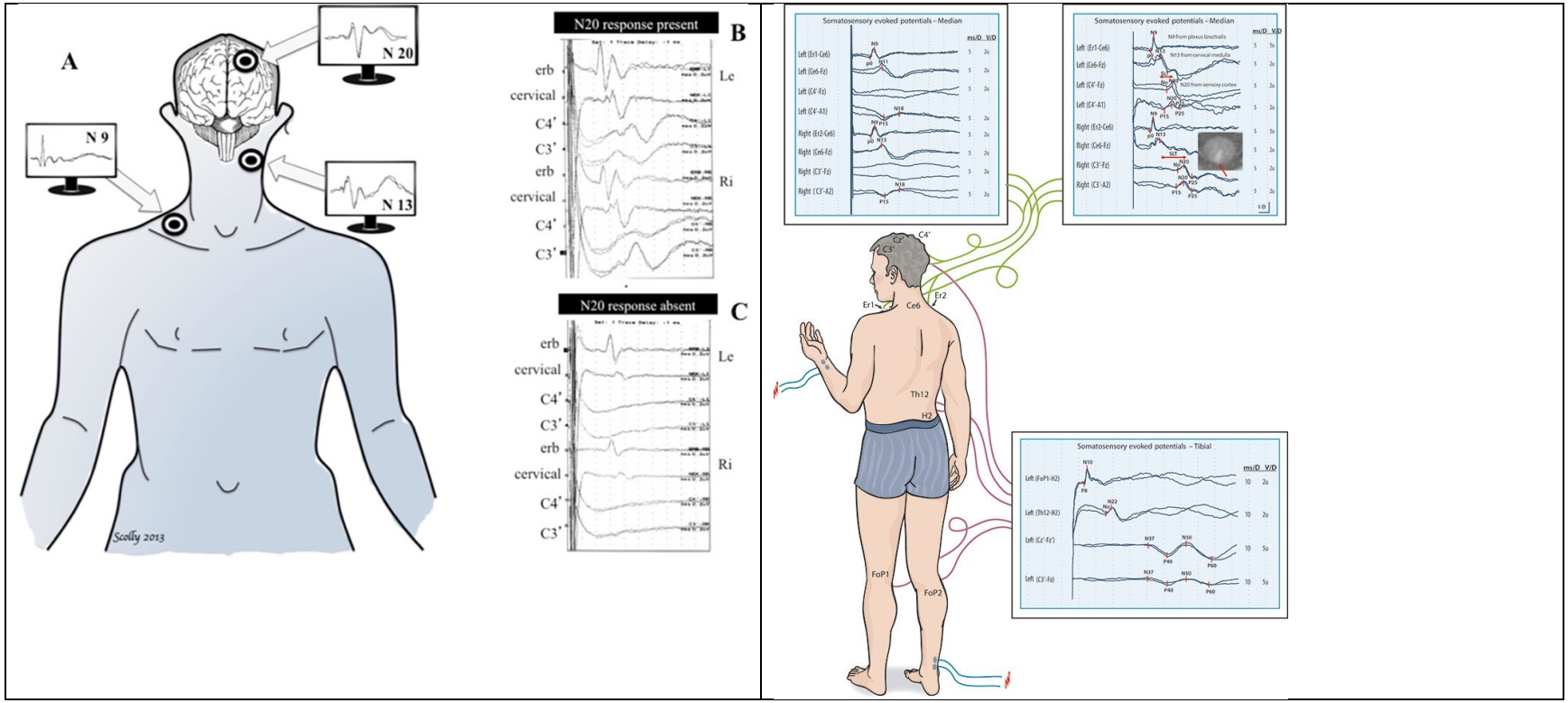
First transfer CD image files to your local desktop computer.
Then double click the file (it should open as a CD in either a Mac or a Windows PC because they are ISO files [disk images])
Then any DICOM viewer would be able to view the files.

If needed I could simply burn CDs with the MRI and hand it to you in person.

Reference:






A
N 20
N 9
N 13
Scolly 2013
N20 response present
B
erb
cervical
C4'
C3'
erb
cervical
C4'
C3'
Le
Ri
N20 response absent
C
erb
cervical
C4'
C3'
erb
cervical
C4'
C3'
Le
Ri
Somatosensory evoked potentials – Median
Somatosensory evoked potentials – Median
Somatosensory evoked potentials – Tibial
C4'
C3'
C2'
Er1
Ce6
Er2
Th12
H2
FoP1
FoP2