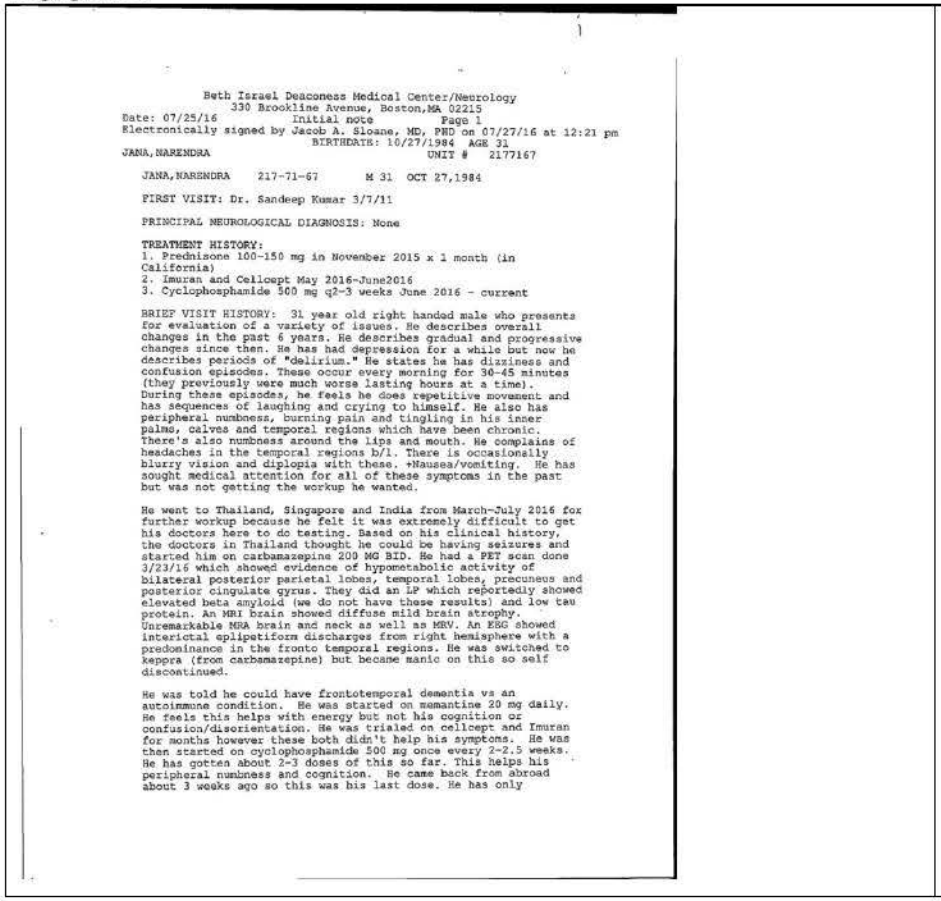
2016 July 25th

- **Dr. Jacob Sloan, Beth Israel Hospital, Boston, Massachusetts**
  - **Negligence →**

Asking for and Being Denied Help in the US Given a Medically Serious Presentation of a Condition inclusive of Seizures, Brain Atrophy, and a Premature Dementia

After I went abroad the first time in 2016 and I came back to the US to ask for help in Beth Israel Boston, Massachusetts. The doctors there deny the autoimmune ethology of the condition and don't recommend the appropriate tests based on the presentation of a premature dementia, seizures, and brain atrophy. The medical findings are serious and not ignorable in medicine, thus fall medical negligence.



Beth Israel Deaconess Medical Center/Neurology
330 Brookline Avenue, Boston,MA 02215
Date: 07/25/16 Initial note Page 1
Electronically signed by Jacob A. Sloane, MD, PHD on 07/27/16 at 12:21 pm
BIRTHDATE: 10/27/1984 AGE 31
JANA,NARENDRA UNIT # 2177167

JANA,NARENDRA 217-71-67 M 31 OCT 27,1984

FIRST VISIT: Dr. Sandeep Kumar 3/7/11

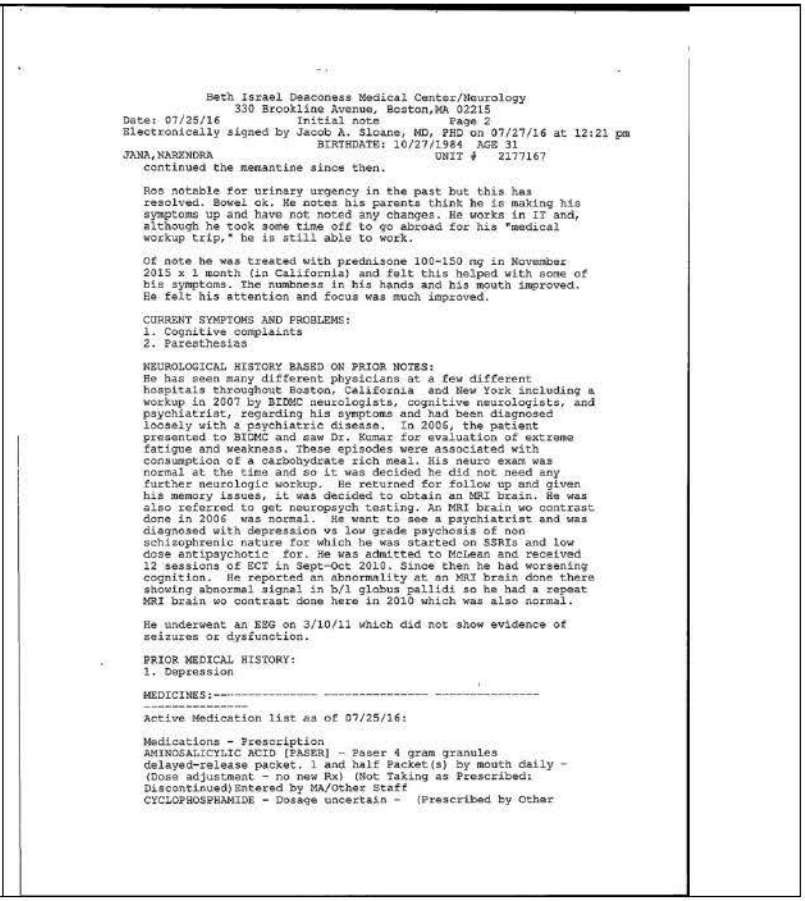
PRINCIPAL NEUROLOGICAL DIAGNOSIS: None

TREATMENT HISTORY:
1. Prednisone 100-150 mg in November 2015 x 1 month (in California)
2. Imuran and Cellcept May 2016-June2016
3. Cyclophosphamide 500 mg q2-3 weeks June 2016 - current

BRIEF VISIT HISTORY: 31 year old right handed male who presents for evaluation of a variety of issues. He describes overall changes in the past 6 years. He describes gradual and progressive changes since then. He has had depression for a while but now he describes periods of "delirium." He states he has dizziness and confusion episodes. These occur every morning for 30-45 minutes (they previously were much worse lasting hours at a time). During these episodes, he feels he does repetitive movement and has sequences of laughing and crying to himself. He also has peripheral numbness, burning pain and tingling in his inner palms, calves and temporal regions which have been chronic. There's also numbness around the lips and mouth. He complains of headaches in the temporal regions b/l. There is occasionally blurry vision and diplopia with these. +Nausea/vomiting. He has sought medical attention for all of these symptoms in the past but was not getting the workup he wanted.

He went to Thailand, Singapore and India from March-July 2016 for further workup because he felt it was extremely difficult to get his doctors here to do testing. Based on his clinical history, the doctors in Thailand thought he could be having seizures and started him on carbamazepine 200 MG BID. He had a PET scan done 3/23/16 which showed evidence of hypometabolic activity of bilateral posterior parietal lobes, temporal lobes, precuneus and posterior cingulate gyrus. They did an LP which reportedly showed elevated beta amyloid (we do not have these results) and low tau protein. An MRI brain showed diffuse mild brain atrophy. Unremarkable MRA brain and neck as well as MRV. An EEG showed interictal epliptiform discharges from right hemisphere with a predominance in the fronto temporal regions. He was switched to keppra (from carbamazepine) but became manic on this so self discontinued.

He was told he could have frontotemporal dementia vs an autoimmune condition. He was started on memantine 20 mg daily. He feels this helps with energy but not his cognition or confusion/disorientation. He was trialed on cellcept and Imuran for months however these both didn't help his symptoms. He was then started on cyclophosphamide 500 mg once every 2-2.5 weeks. He has gotten about 2-3 doses of this so far. This helps his peripheral numbness and cognition. He came back from abroad about 3 weeks ago so this was his last dose. He has only



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continued the memantine since then.

Ros notable for urinary urgency in the past but this has resolved. Bowel ok. He notes his parents think he is making his symptoms up and have not noted any changes. He works in IT and, although he took some time off to go abroad for his "medical workup trip," he is still able to work.

Of note he was treated with prednisone 100-150 mg in November 2015 x 1 month (in California) and felt this helped with some of his symptoms. The numbness in his hands and his mouth improved. He felt his attention and focus was much improved.

CURRENT SYMPTOMS AND PROBLEMS:
1. Cognitive complaints
2. Paresthesias

NEUROLOGICAL HISTORY BASED ON PRIOR NOTES:
He has seen many different physicians at a few different hospitals throughout Boston, California and New York including a workup in 2007 by BIDMC neurologists, cognitive neurologists, and psychiatrist, regarding his symptoms and had been diagnosed loosely with a psychiatric disease. In 2006, the patient presented to BIDMC and saw Dr. Kumar for evaluation of extreme fatigue and weakness. These episodes were associated with consumption of a carbohydrate rich meal. His neuro exam was normal at the time and so it was decided he did not need any further neurologic workup. He returned for follow up and given his memory issues, it was decided to obtain an MRI brain. He was also referred to get neuropsych testing. An MRI brain wo contrast done in 2006 was normal. He want to see a psychiatrist and was diagnosed with depression vs low grade psychosis of non schizophrenic nature for which he was started on SSRIs and low dose antipsychotic for. He was admitted to McLean and received 12 sessions of ECT in Sept-Oct 2010. Since then he had worsening cognition. He reported an abnormality at an MRI brain done there showing abnormal signal in b/l globus pallidi so he had a repeat MRI brain wo contrast done here in 2010 which was also normal.

He underwent an EEG on 3/10/11 which did not show evidence of seizures or dysfunction.

PRIOR MEDICAL HISTORY:
1. Depression

MEDICINES:
Active Medication list as of 07/25/16:

Medications - Prescription
AMINOSALICYLIC ACID [PASER] - Paser 4 gram granules delayed-release packet, 1 and half Packet(s) by mouth daily - (Dose adjustment - no new Rx) (Not Taking as Prescribed: Discontinued)Entered by MA/Other Staff
CYCLOPHOSPHAMIDE - Dosage uncertain - (Prescribed by Other

Provider: 500 mg 1 cap every two weeks)Entered by MA/Other Staff
LEVETIRACETAM [KEPPRA] - Dosage uncertain - (Prescribed by Other Provider: 1000 mg 2x daily)Entered by MA/Other Staff
MEMANTINE - Dosage uncertain - (Prescribed by Other Provider: 20 mg 2x daily)Entered by MA/Other Staff
PREDNISONE - Dosage uncertain - (Prescribed by Other Provider: 10-100 mg 1 tab every few weeks)Entered by MA/Other Staff
SERTRALINE [ZOLOFT] - Dosage uncertain - (Prescribed by Other Provider; Dose adjustment - no new Rx) (Not Taking as Prescribed: Discontinued)Entered by MA/Other Staff
TRILAFON - Dosage uncertain - (Prescribed by Other Provider) (Not Taking as Prescribed: Discontinued)Entered by MA/Other Staff

ALLERGIES: NKDA

SOCIAL HISTORY:
Lives: lives in Bolton with family
Marital status: single
Children: none
Employment: works in IT
Insurance concerns: None
History of Smoking: None
History of Drug/Alcohol Abuse: None

FAMILY MEDICAL HISTORY: No MS in family.
None known

PHYSICAL EXAMINATION:
VITALS: BP: 130/80 . Heart Rate: 75 Weight. 110 Ht 5'6"

GENERAL: No acute distress. Poor eye contact.

NECK: Carotids are without bruit. Neck movements are full range, non-tender.

CARDIOVASCULAR: Regular rate and rhythm without murmur. Peripheral pulses are present and there is no edema.

LUNGS: Clear to auscultation.

MENTAL STATUS: Patient is alert and oriented to time, place and person. Able to follow multi step commands. The patient has good attention and concentration. Registration is 5/5 and recall is 5/5 objects after 5 minutes. Speech and language: No aphasia, no dysarthria.

CRANIAL NERVES: Pupils are 3 mm, equal and reactive. Optic discs: normal margins, no edema. Patient with difficulty reading snellen chart even with his glasses although he is able to read all of his paperwork and prior workup with his glasses on without difficulty. Visual fields are full to confrontation. No nystagmus, no INO. Facial sensation decreased on V1-V3 on left to light touch and pinprick. No facial palsy, hearing is intact. Soft palate elevates symmetrically. Sternocleidomastoids function

The optic disk were far from normal margins, the visual fields are severly contrained and worsening. I am going blind at that time.
In May 29th of 2017 I go to the ER due to this instance of neglegence and for going blind due to optic neuropathy. Its reported that I am going deaf in a previous appointment in the US. I do (did) have nystagmus.

is normal. Tongue

protrudes in the midline.

MOTOR: No drift. Right hemibody full strength. Left hemibody with give way weakness. +Hoover testing. There is no atrophy, fasciculation. Normal tone.

COORDINATION: No dysmetria or dysdiadachokinesia

SENSORY: Decreased to ALL modalities on left hemibody.

GAIT: Normal base, normal arm swing, tandem normal. Romberg is negative.

DTRs: 2+ throughout. Plantar responses are flexor.

TESTING:
25FTW: 7.36/7.25 (7/25/16)

REVIEW OF MRI SCANS:
BIDMC:
1. MRI brain wo contrast 2006: normal
2. MRI brain wo contrast 2010: normal

WORKUP FROM ABROAD:
PET scan 3/23/16 : evidence of hypometabolic activity of bilateral posterior parietal lobes, temporal lobes, precuneus and posterior cingulate gyrus.

MRI brain: diffuse mild brain atrophy.

Unremarkable MRA brain and neck as well as MRV.

REVIEW OF ANCILLARY TESTING:
2009:
Vitamin B12: 1709
AST/ALT: 61/86, Alk phos: 126
TSH, cortisol, testosterone normal
LDL 98

EEG on 3/10/11 which did not show evidence of seizures or dysfunction

EEG repeated in India with interictal epileptiform discharges from right hemisphere with a predominance in the fronto temporal regions.

ASSESSMENT: 31 year old right handed male who presents for evaluation of a variety of issues. The patient complains of paresthesias in all extremities and his mouth as well as episodic cognitive issues which are mainly in the morning but can persist throughout the day. He is still able to work and denies other members of the family noticing any changes. Prior workup has included at least 4 MRI's, 2 of which were normal (done at BIDMC

in 2006 and 2010) and one done in Thailand which showed mild atrophy. He also had a PET scan of the brain (also done abroad) which showed hypometabolic activity of bilateral posterior parietal lobes, temporal lobes, precuneus and posterior cingulate gyrus. An EEG done abroad showed interictal eplipetiform discharges. Although the patient was initially on antiepipleptic treatment, he self discontinued them due to side effects. He currently remains on memantine daily and cyclophoshamide q2-3 weeks. After reviewing the workup he presents with, we do not feel he has multiple sclerosis. The benefits of cyclophosphamide in his condition do not outweigh the risks so we do not recommend continuing it. There is a possibility the epileptiform discharges seen on EEG are clinically significant given his episodic confusion so it may be worthwhile to further pursue this. He may also benefit from seeing a cognitive neurologist.

1. At this time do not feel he needs any further workup from an MS perspective or further treatment with an immune agent such as cyclophosphamide.
2. Recommend seeing a cognitive neurologist and epileptologist
3. Do not feel memantine is indicated in this patient however he feels it helps with his energy
4. Follow up if needed

Amount of Time spent with patient: 60 minutes
Amount of Time spent counseling patient: 30 minutes

Please let me know if I can be of further assistance.

Sincerely,

Ursela Siddiqui MD
Neuro-Immunology Fellow

Patient seen, examined and discussed with Dr. Siddigui. I personally confirmed or edited all elements of this note during our combined evaluation and take full responsibility for the contents of this note.

Sincerely,

Jacob Sloane, MD

The doctors statement is inappropariate, the appropriate diagnostics at this point would be a full brain, cervical, and thorasic spine MRI along with nerve conduction tests. The consequence was repeated ER appointments abroad due to negelegence in the US.

By this point its apparent that the problem isn't only that the doctors in the US are limiting the diagnostics and medical help for MS in the US, its that as presented in the next instance of medical fraudulence they are also directing medical fraud in foreign nations to support the medically unsubstantiated statements made in the United States. So their fraudulence and negligence as a nation remains unchecked and rampant. There is no legal barrier to stop perpetuated fraud and negligence.
They don't appear to understand that fraud is illegal everywhere and that perpetuating it in foreign nations doesn't make the fraud taking place in the US (with the intent to cause harm) any less illegal.