2016 September 26th

- **Munich, Germany**
  - **Klinikum Der Universitat Munchen – Dr. T. Kumpfer and F. Thaler**
    - **Negligence →**

LMU KLINIKUM DER UNIVERSITÄT MÜNCHEN

INSTITUT FÜR KLINISCHE NEUROIMMUNOLOGIE
Direktoren:
Prof. Dr. med. Reinhard Hohlfeld
Prof. Dr. med. Martin Kerschensteiner

in Assoziation mit der Neurologischen Klinik

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Ihr Zeichen | Unser Zeichen: Dr. Thaler | Munich, 26.09.2016

To whom it may concern

Dear colleagues,

We hereby report considering **Mr Narendra Nirmal JANA, born on 27th of October, 1984,** who was first seen at the 26th September 2016 in our Neuroimmunology Outpatient Department.

Diagnosis: **Brain atrophy with posterior predominance of unknown origin**

Current Treatment: **Interferon beta-1a (Rebif ®) since 4 weeks (4 injections so far)**

Prior treatment: High-dose-Corticosteroids p.o. for 3 weeks in 12/2015
Cyclophosphamide: 800mg p.o. twice per week for 1.5 months
Memantine: 03/2016-05-2016: stopped due to inefficiency

Family history: no autoimmune disorders

Social history: electrical engineer

Epicrisis: In summary, Mr Jana is a 31 year old male patient who first realized hypaesthesia and burning-sensations of hands and feet in 2007. Then, a progressive left-sided hemihypaesthesia developed. Additionally, he noticed a desaturation of colors and problems to estimate the movement of objects in space and an apraxia e.g. when combing his hair. At the end of 2010 he realized personality changes with goofy behavior laughing or crying without any obvious reason. Furthermore, he developed short-term-memory deficits, not remembering where he had put certain objects or driving somewhere and afterwards forgetting how he had come to a certain location. Additionally, he reports episodes during which he was absent. He was seen by several specialists (medical records not available) and at the end of 2015 a therapy with oral corticosteroids for 3 weeks was performed which led to an improvement of symptoms. After consultation in a hospital in Malaysia an oral therapy with cyclophosphamide (400mg twice per week) for 1.5 months was started that also improved his condition. Since we do not have access to any medical documentation and records, it is difficult to reconstruct the rationale for the immunosuppressive therapies. The patient travelled to different countries including India, Thailand and Malaysia to get medical advice and perform diagnostic test. He claims that his condi-

Direktoren: Prof. Dr. Reinhard Hohlfeld, Prof. Dr. Martin Kerschensteiner

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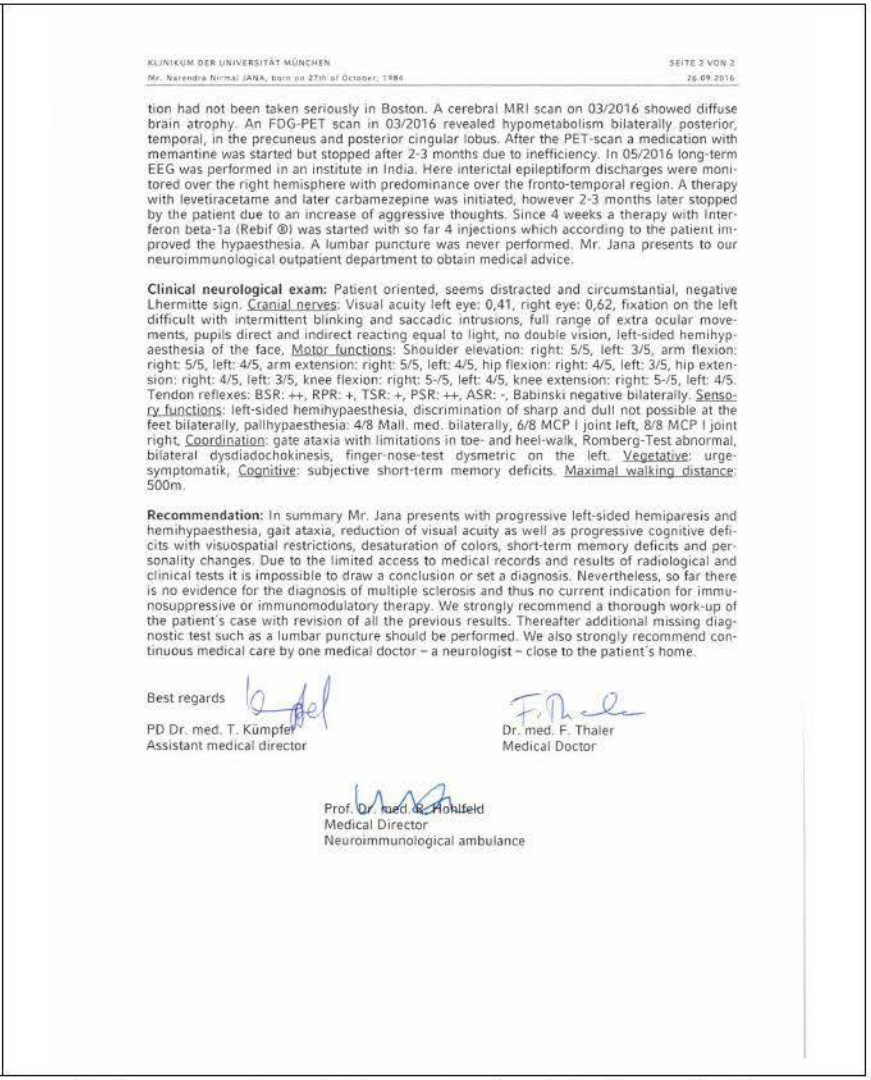
Vorstand: Ärztlicher Direktor: Prof. Dr. Dr. h.c. Karl-Walter Jauch (Vorsitz), Kaufmännischer Direktor: Gerd Koslowski,
Pflegedirektorin: Helle Dokken, Vertreter der Medizinischen Fakultät: Prof. Dr. med. dent. Reinhard Hickel (Dekan)
Institutionskennzeichen: 260 914 050, Umsatzsteuer-Identifikationsnummer gemäß §27a Umsatzsteuergesetz: DE813536017

I describe an effect called pseudobulbar effect in the medical report prominent in those who have MS, “laughing or crying without any obvious reason”. Its due to mid brain lesions.

There are two opposite statements in “Recommendation”, “progressive left-sided hemiparesis and hemihypaesthesia, gait ataxia, reduction of visual acuity as well as progressive cognitive deficits with visuospatial restrictions, desaturation of colors, short-term memory deficits and personality changes” indicates optic neuropathy and lesions in the spinal cord.
This is in contrast with the next statement: “Nevertheless, so far there is no evidence for the diagnosis of multiple sclerosis and thus no current indication for immunosuppressive or immunomodulatory therapy.”

The first statement is a direct indication of the condition multiple sclerosis.



tion had not been taken seriously in Boston. A cerebral MRI scan on 03/2016 showed diffuse brain atrophy. An FDG-PET scan in 03/2016 revealed hypometabolism bilaterally posterior, temporal, in the precuneus and posterior cingular lobus. After the PET-scan a medication with memantine was started but stopped after 2-3 months due to inefficiency. In 05/2016 long-term EEG was performed in an institute in India. Here interictal epileptiform discharges were monitored over the right hemisphere with predominance over the fronto-temporal region. A therapy with levetiracetame and later carbamezepine was initiated, however 2-3 months later stopped by the patient due to an increase of aggressive thoughts. Since 4 weeks a therapy with Interferon beta-1a (Rebif ®) was started with so far 4 injections which according to the patient improved the hypaesthesia. A lumbar puncture was never performed. Mr. Jana presents to our neuroimmunological outpatient department to obtain medical advice.

Clinical neurological exam: Patient oriented, seems distracted and circumstantial, negative Lhermitte sign. Cranial nerves: Visual acuity left eye: 0,41, right eye: 0,62, fixation on the left difficult with intermittent blinking and saccadic intrusions, full range of extra ocular movements, pupils direct and indirect reacting equal to light, no double vision, left-sided hemihypaesthesia of the face, Motor functions: Shoulder elevation: right: 5/5, left: 3/5, arm flexion: right: 5/5, left: 4/5, arm extension: right: 5/5, left: 4/5, hip flexion: right: 4/5, left: 3/5, hip extension: right: 4/5, left: 3/5, knee flexion: right: 5-/5, left: 4/5, knee extension: right: 5-/5, left: 4/5. Tendon reflexes: BSR: ++, RPR: +, TSR: +, PSR: ++, ASR: -, Babinski negative bilaterally. Sensory functions: left-sided hemihypaesthesia, discrimination of sharp and dull not possible at the feet bilaterally, pallhypaesthesia: 4/8 Mall. med. bilaterally, 6/8 MCP I joint left, 8/8 MCP I joint right, Coordination: gate ataxia with limitations in toe- and heel-walk, Romberg-Test abnormal, bilateral dysdiadochokinesis, finger-nose-test dysmetric on the left. Vegetative: urge-symptomatik, Cognitive: subjective short-term memory deficits. Maximal walking distance: 500m.

Recommendation: In summary Mr. Jana presents with progressive left-sided hemiparesis and hemihypaesthesia, gait ataxia, reduction of visual acuity as well as progressive cognitive deficits with visuospatial restrictions, desaturation of colors, short-term memory deficits and personality changes. Due to the limited access to medical records and results of radiological and clinical tests it is impossible to draw a conclusion or set a diagnosis. Nevertheless, so far there is no evidence for the diagnosis of multiple sclerosis and thus no current indication for immunosuppressive or immunomodulatory therapy. We strongly recommend a thorough work-up of the patient´s case with revision of all the previous results. Thereafter additional missing diagnostic test such as a lumbar puncture should be performed. We also strongly recommend continuous medical care by one medical doctor – a neurologist – close to the patient´s home.

Best regards

PD Dr. med. T. Kümpfel
Assistant medical director

Dr. med. F. Thaler
Medical Doctor

Prof. Dr. med. B. Hemmer
Medical Director
Neuroimmunological ambulance

Dr. Thaler in the appointment was in direct opposition to her supervisor in the appointment (she understood that I needed the medications) but she was clearly limited in her ability to diagnose the condition due to the situation around my case.

Doctors often don’t like mis typifying my condition but they are forced to.
In future appointments in the hospital there is a refusal to give an appointment at all or attempts at circumvention of it in avoidance of acknowledgement or treatment of multiple sclerosis.