2018 July 16th

- **Dr. Jonathan Carter - Mayo Clinic – Phoenix, Arizona**
  - **Criminal Negligence →**

Dr. Jonathan Carter and (Resident) Kate Grimsrud:
With the lack of medical help in San Diego California, I drove to Phoenix Arizona to see a doctor in Mayo Clinic.

The doctor has access to the MRIs that show lesions in the brain, cervical spine, and some historical MRIs. The resident (Dr. Kate Grimsrud) and doctor (Dr. Jonathan Carter) lie about the MRI series and clinical presentation.

The consistent pattering in the US is to deny any acknowledgment that there are any signs of MS even when there is gross evidence of MS. At that point in time there a long history of repeated ER appointments requiring medical treatment and an overabundance of diagnostic tests.

The doctors statements are somewhat artful. The doctor knows that even if a LP (lumbar puncture) was done the results would be falsified like in the past 5 attempts at LP falsifications to try and further the medical condition (the US directs these medical falsifications). If an eye test was done in the US to check for optic neuropathy the results would be falsified, so the only option is a foreign nation.
The consistent pattering in lying about the quality of the MRI images which at that point showed progressive neural atrophy of the cervical spine and lesions in the brain was apparent. Dr. Grimsrud often used the term “give away” to signify pretense when there are (its medical evasiveness) gross lesions along his spinal column and brain.

MAYO CLINIC

Clinical Notes

07/16/2018 – Az/fl Conversion Encounter

Consults

Result Type: Neurology Consult
Result Date: 16 July 2018 00:00 MST
Result Status: Auth (Verified)
Performed By: Grimsrud (Resident MD), Kate Won 17 July 2018 14:22 MST
Verified By: Grimsrud (Resident MD), Kate Won 26 July 2018 11:37 MST

Final

Patient Name: JANA, NARENDRA MR
Medical Record Number: 66190539
DOB: 10/27/1984
Service: Neurology

Service Date: 07/16/2018
Provider Name: Kate W. Grimsrud, M.D.
Account Number: 3817022
Visit Type: Consultation

REFERRAL SOURCE:
Self.

SUPERVISING STAFF:
Dr. Carter.

REASON FOR CONSULTATION:
Multiple sclerosis.

HISTORY OF PRESENT ILLNESS:
Mr. Jana is a 33-year-old gentleman who presents today for further evaluation regarding an outside diagnosis made of multiple sclerosis. Mr. Jana describes that beginning in 2008 he experienced onset of a massive headache that persisted for a period of over 8 years. He actually was evaluated at Mayo Clinic Jacksonville in 2009 with an MRI of the brain noting T1 hyperintensities in the basal ganglia bilaterally of unclear significance. He was seen there in the Neurology Clinic by Dr. Elizabeth Shuster who noted that around High School the patient started to be anorectic, as well as noticing difficulty with memory and concentration. Note states that he had an MRI and saw a neurologist at Beth Israel with no definite diagnosis forthcoming. He started to see a psychiatrist who tried Zyprexa, Risperdal, and Seroquel. In early 2008 he was hospitalized at McLean Psychiatric Center for a week. However, after that time, he continued to deteriorate and he tried to treat himself with different over-the-counter supplements including high doses of manganese, believing that he ingested about 18 g of manganese leading to development of increasing psychosis. At that time his vision had become blurry and he started to notice burning of his hands, feet, and legs, and even the back and sides of his head. He was hospitalized again at which time they put him on perphenazine, sertraline, Neurontin, and metoprolol, and he was able to make some recovery. Dr. Shuster, in 2009, had noted rather subacute change in cognitive status associated with some stomach symptoms. She recommended that the patient have a CSF exam looking for IgG index, oligoclonal bands, as well as amylase and tau protein. He was to undergo a 24-hour urine heavy metal screen due to the concern for manganese poisoning, and there was discussion about checking for metachromatic leukodystrophy with arylsulfatase, and a paroxysmal panel. Ultimately, the patient elected to do the evaluation at home in India and was lost to followup.

The patient states that since his visit to Mayo Clinic Jacksonville with Dr. Shuster, over the next several years he developed a complete lack of sensation in his palms and toes. He describes that he was bed ridden for 2 years stating that intermittently he was unable to feel both of his arms, legs, and face. He states that he was traveling the world for his work in IT, in 2016, when he was evaluated in Bangkok with workup including an FDG-PET that reported hypometabolism in the bilateral parietal lobes, and bilateral anterior mesial temporal lobes. He also, at that time, had an EEG that showed some possible epileptiform discharges in the right frontotemporal regions. He denies any clinical seizure activity, and is unable to definitively tell me whether he was placed on antiepileptics for this specifically. He states that antiepileptics have not helped his condition as a whole, and that he has tried multiple, though the the only one that he is able to recall at this time is Keppra.

In January 2017, he presented to an outside facility emergency department where he was provided with high-dose IV methylprednisolone. He noted that his headache diminished for the first time in 8 years. In March and April of 2017, he noted intermittent decrease in visual acuity, visual loss in the left visual field, and left hemisensory loss. He describes multiple visits about every 7-9 weeks to various emergency departments where he would receive IV methylprednisolone.

At one point he was seen by a neurologist in Germany who felt his symptoms were consistent with multiple sclerosis, and provided him a prescription for Gilenya. He took this for 1-1/2 months, but ultimately it was unaffordable. From March 2018 to present he has been on Rebif 22 mcg subcutaneously 3 times per week,

My statement by statement response:

The recommendations stated by Dr. Grimsrud as by Dr. Schuster were never done in 2009. I wouldn't have hesitated. The other oddity is that she states "the patient elected to do the evaluation at home in India and was lost to follow-up". That statement is never made in the report by Dr. Schuster and isn't reflective of Dr. Schuster. It may be reflective of the sentiment that since I look Indian so home must be in India and thus I should do medical tests in India; its nonsensical. India was never mentioned in 2009. Of course in a 10 year span between Mayo Clinic in Florida and then Arizona, home is still Massachusetts, United States.
Its an oddity that a clinician would think I was from India when its clear that I grew up in Massachusetts in 2009 as well; it may indicate the psychology of the medical professions in this setting.
If these tests were recommended I would have definitely done them in 2009 but the recommendation appears to be ignored by the diagnosticians.

Only methylprednisolone or plasmapheresis in a emergency would produce a response to MS in the last statement.

Dr. Kate Grimsrud lies about the MRI images of Brain and Cervical and thoracic spine. Cervical and thoracic spine have central lesions and brain MRIs have mid brain lesions (corpus callosum).

These lesions were discussed with treating physicians abroad and clearly visible in the MRIs. There is a delusional mentality among clinicians in the US that simply making statements in a medical report when there is clear evidence of repeated fraud in former tests that it would somehow validate the fraudulated statements.

Because there are lesions in the cervical and thoracic spine and in future MRIs showing progressive neurodegeneration in the Cervical Spine there is no way it could be “give-away”, there is no way to have quick reactions responses or normal reflexes given these findings.

again provided through a physician in Germany. He feels that on this medication he has noted decrease in headache, and improvement in his mobility and walking.

The patient has never throughout this time undergone lumbar puncture for CSF studies. When I initially asked him why he stated that the MRI findings should be sufficient to make the diagnosis and it was not necessary. When the patient was later asked, again, why he did not undergo a lumbar puncture throughout this entire time, he stated that he had been begging his various providers for a lumbar puncture but they were unwilling to do this.

The patient continues to describe loss in the left visual field, along with decreased visual acuity. He describes that he does not have pain associated with ocular movements, but he does have more difficulty moving his eyes to leftward gaze. He has not seen a neuroophthalmologist with regards to this. He has not had any further testing in terms of visual evoked potentials or OCTs.

The patient denies any symptoms of facial weakness, but he does have significant numbness in the left side of his face, and notes that at times his entire face will become numb. He additionally reports some intermittent dysarthria, as well as occasional word-finding difficulties. He reports profound weakness in the entire left side, along with diminished sensation, particularly in the palms. He does not describe any bowel or bladder dysfunction. He has had persistent fatigue and some mild decrease in cognition, though comments that he is still significantly more intelligent than most other people that he meets.

He describes positive Lhermitte's sign and Uhthoff sign by name.

Throughout the evaluation, the patient continually refers to his laptop on which he has put together multiple presentation slides to present his data. The patient has also undergone his own trial testing with medication, in that he has had a number of MRIs and FDG-PETs done both before, during, and after trials of medication including IV methylprednisolone and Rebif. He believes that there are clear findings on these imaging studies that argue for treatment response, and therefore, prove to him the diagnosis of his condition and the treatment he believes is necessary.

CURRENT MEDICATIONS:
Rebif 22 mcg subcutaneous 3 times per week.
B-Complex.

ALLERGIES:
He describes intolerance to Keppra in that it caused psychiatric disturbance.

PAST MEDICAL/SURGICAL HISTORY:
Question of multiple sclerosis made by an outside neurologist in Germany.
History of possible schizophreniform disorder or some form of psychosis.
History of question of manganese toxicity.

SOCIAL HISTORY:
The patient works in IT and travels the world for his job. He denies any alcohol, tobacco, or illicit drug use.

FAMILY HISTORY:
No known family history of MS or other autoimmune disease.

REVIEW OF SYSTEMS:
A 10-point review of systems was performed, was as stated in the HPI, otherwise negative.

PHYSICAL EXAM:
Vital Signs: Temperature 36.6, pulse 86, blood pressure 132/79, height 170 cm, weight weight 93.0 kg.
General: The patient appears in no apparent distress.
HEENT: Head is normocephalic, atraumatic.
Neck: Supple with no Lhermitte's sign.
Neuro:
Mental Status: The patient is alert and oriented to person, place, date, and situation. He is able to provide full details of his past medical history. He becomes argumentative when we entertain the idea that the patient may not have a diagnosis of multiple sclerosis.
Cranial Nerves: Pupils are equal, round, and reactive to light. On visual field testing, he has a left homonymous hemianopsia for the periphery of the left visual field. Extraocular movements are intact, though he has a preference to not maintain a leftward gaze with his eyes moving all the way to the left and then quickly snapping back to center gaze. Facial sensation is diminished to light touch and pinprick in V1, V2, and V3 on the left compared to the right. Facial motor strength is symmetric. Palate elevates normally. Tongue protrudes midline. Sternocleidomastoid strength is normal bilaterally. Trapezius strength is normal on the right. He has give-way phenomenon on the left.
Motor: Testing of his motor strength reveals give-way phenomenon in all muscles tested on the left in a somewhat fluctuating pattern. He has full strength in the right upper and lower extremities. No abnormal movements or tremor are noted. Unable to adequately assess tone as the patient has difficulty relaxing.
Coordination: There is no ataxia with finger-to-nose or heel-to-shin bilaterally, though the patient does perform these movements on the left quite slowly. He has good accuracy. Similarly, rapid alternating movements on the left are accurate, but very slowed.
Reflexes: Intact, normal, and symmetric in the bilateral biceps, triceps, brachioradialis, patellar, and Achilles. Plantar response is flexor bilaterally. No clonus.
Sensation: Decreased to light touch, vibration, and pinprick throughout the left upper and lower extremities without crossing the midline.
Gait: He has a somewhat antalgic appearing gait with the left leg swinging much slower than the right. He is able to walk on his heels and his toes. He also can tandem walk, though does it quite slowly.

IMPRESSION/REPORT/PLAN:
We reviewed the imaging studies as uploaded into QREADS including MR imaging of the brain, cervical and thoracic spine from January 2017, and brain from September 2017. There are no lesions of any questionable significance, including no lesions that are suspicious for demyelinating disease. The patient remarks that he does have a number of other MRIs, including his last MRI which was performed in June 2018, however, he elected knowingly not to provide these films as he feels that what he has provided should be sufficient for us, and if we decide to become his prescribing provider, only then will he make the decision to provide

us with the remainder of his medical records.

Assessment and Plan:
#1 This is a 33-year-old right-handed gentleman presenting for further evaluation, with a prior outside diagnosis of multiple sclerosis, currently on Rebif, without clinical examination or radiologic features to support that diagnosis
We discussed with the patient in detail that there are no findings that would suggest an underlying diagnosis of multiple sclerosis at this time. We reviewed the imaging studies in detail with the patient, including the areas that had previously been in question, and provided education that these areas are not concerning for demyelinating disease, and in fact can be seen commonly in normal individuals. We offered the patient further testing for evaluation regarding his ongoing symptoms. This would include lumbar puncture with opening pressure, as well as CSF studies including oligoclonal bands and IgG index. Also, we recommended the patient be seen by Neuroophthalmology, and offered to help coordinate that evaluation here. The patient himself has elected to do these studies outside of Mayo Clinic. We urged him that it would be much preferred to do them here to ensure that they be done in a proper manner, however, he declined.

At this time, given that we do not feel the patient has a diagnosis of MS, we have told him we would not prescribe any disease-modifying therapy. The patient stated that he will plan to continue to receive his disease-modifying therapy through a physician that he has found in Germany. We attempted to provide education regarding the diagnostic criteria of multiple sclerosis, however, the patient was not inclined to have further discussion as such.

I will not plan on seeing the patient back in my clinic, though I would be happy to see him on an as-needed basis should he wish to follow our recommendations in the future. This patient was seen and evaluated with Dr. Carter, please refer to the supervisory note.

KWG:dpz
D: 07/17/2018 14:22
T: 07/18/2018 09:50
REVISED DATE: 07/18/2018 TRANS: pab

Reference: MCAF-6184458768

Progress Notes

Result Type: Neurology Supervisory Note
Result Date: 16 July 2018 00:00 MST
Result Status: Auth (Verified)
Performed By: Carter MD, Jonathan on 19 July 2018 10:24 MST
Verified By: Carter MD, Jonathan on 20 July 2018 10:03 MST

"Final"

Patient Name: JANA, NARENDRA MR
Medical Record Number: 66190539
DOB: 10/27/1984
Service: Neurology

Service Date: 07/16/2018
Provider Name: Jonathan L. Carter, M.D.
Account Number: 3817022
Visit Type: Supervisory Note

CHIEF COMPLAINT/REASON FOR VISIT:
Narendra Jana is a 33-year-old male who is self-referred for evaluation of a reported outside diagnosis of MS.

HISTORY OF PRESENT ILLNESS:
The patient's history is outlined in Dr. Grimsrud's neurology resident consultation note of 7/16/2018. I reviewed the history and examination findings with Dr. Grimsrud, performed key portions of the history and examination myself, and was there throughout the counseling session. As noted, the patient had a previous neurologic evaluation at Mayo Clinic Jacksonville in 2009 when he presented with a number of symptoms, including severe headache, anorexia, and cognitive symptoms. He also had a significant psychiatric history at that point with some psychotic symptoms. He had an extensive workup by Dr. Shuster without a definite diagnosis, and the patient ultimately did not return for follow-up. Since that time, he has continued to have a number of neurologic symptoms that are summarized in Dr. Grimsrud's note. This has led him to seek medical opinions around the world, including evaluations in Bangkok, Thailand, where he had 3 FDG PET scans that were reported to show some hypometabolism in the bilateral parietal lobes and the anterior mesiotemporal lobes. He had an EEG that was reported as showing some possible epileptiform discharges in the right frontotemporal region. Eventually, he presented to an outside emergency department, and he was treated empirically with high-dose IV methylprednisolone and states that he had significant reduction in his headache for the first time in 8 years. However, he then began to have visual symptoms, including episodes where he would go nearly blind in both eyes, and he returned to the emergency department multiple times for courses of IV methylprednisolone. He apparently saw a neurologist in Germany, and he does have records from that neurologist, but they are in German, and he did not share the records with us. He states that the neurologist diagnosed him with MS. He was initially tried on Gilenya, but the patient was

It would be unwise to repeat a lumbar puncture in the US because the US directed the falsification of a lumbar test abroad in Berlin, Germany under Dr. Daniela Bermpohl in March 2018. There is more evidence to show the disease progression in this appointment then most patients with MS, indeed it's the clearest presentation of MS a patient could have.

Dr. Carters statement that there are no areas of signal intensity in the cervical and thoracic is a gross lie, the MRIs have clear intensities and the typical features of MS. The “give-away” statement is medical evasiveness. Current and future MRIs show a grosser pathology.

The condition becomes progressive (showing progressive neurological damage to brain and spine). It’s a clear effect of negligence perpetuated by Dr. Jonathan Carter and his resident Kate Grimsrud.

unable to afford that medication. He was then started on Rebif 22 mcg subcu 3 times weekly in March 2016. He has subsequently had multiple MRI scans done both before and after courses of methylprednisolone and while on Rebif, and he showed us multiple images on his laptop, although provided us only with a limited series of images that were loaded into QREADS. The MRI of the brain shows some faint linear increased signal at the occipital horn of the lateral ventricles bilaterally, which is a normal finding in many individuals. We reviewed his brain MRI from 9/25/2017 in QREADS which shows these findings. Specifically, there were no areas of signal hyperintensity in the periventicular white matter suggestive of "Dawson's fingers," although the patient felt that these were present based on his understanding of outside radiology reports. We also reviewed MRI imaging of the cervical and thoracic spine and MRI of the brain from 1/10/2017, and there were no other abnormal findings. Specifically, there were no areas of signal hyperintensity in the spinal cord, although the patient states that there are signal abnormalities there. The patient showed us a number of MRI images showing that the small T2 hyperintensities in the occipital poles had changed on the FLAIR images in response to steroids, which he interprets as a therapeutic response to the steroids and Rebif.

The remainder of the patient's past medical history, review of systems, family history, and social history is summarized in Dr. Grimsrud's note as is his current neurologic examination. His examination shows multiple nonorganic features, including prominent blepharospasm on extraocular muscle testing and inability to maintain leftward gaze. He had give-way weakness on the left side and a nonorganic-appearing gait disorder amongst other findings.

IMPRESSION/REPORT/PLAN:

#1 History of multiple neurologic symptoms with reported outside diagnosis of multiple sclerosis, and possible functional neurologic disorder.
The patient presents for evaluation of what he feels is multiple sclerosis, and to obtain a prescription for his Rebif so that it will be covered by his insurance. In reviewing all of the clinical features as well as his imaging findings, we find no evidence to support a diagnosis of relapsing remitting MS. He does not meet any of the current clinical criteria or radiographic criteria for a diagnosis of MS. He has not had longitudinal evaluation from a MS neurologist and seems to have directed most of his care through emergency department visits. We had a long discussion with the patient regarding the fact that we could not confirm a diagnosis of MS and would need to do additional testing before we would be comfortable prescribing any MS medication. Given his reported prominent headache, a spinal tap would certainly be reasonable. The patient was very adamant that he has a diagnosis of MS and presented a great deal of data that he feels supports this diagnosis. At the end of the interview, we agreed that we had reached an impasse, and the patient will follow up with the neurologist that he has seen once in Germany. If he changes his mind and would like to return for further evaluation, we would be happy to set that up.

JLC:clt
D: 07/19/2018 10:24
T: 07/19/2018 15:24

Reference: MCAF-6187397396