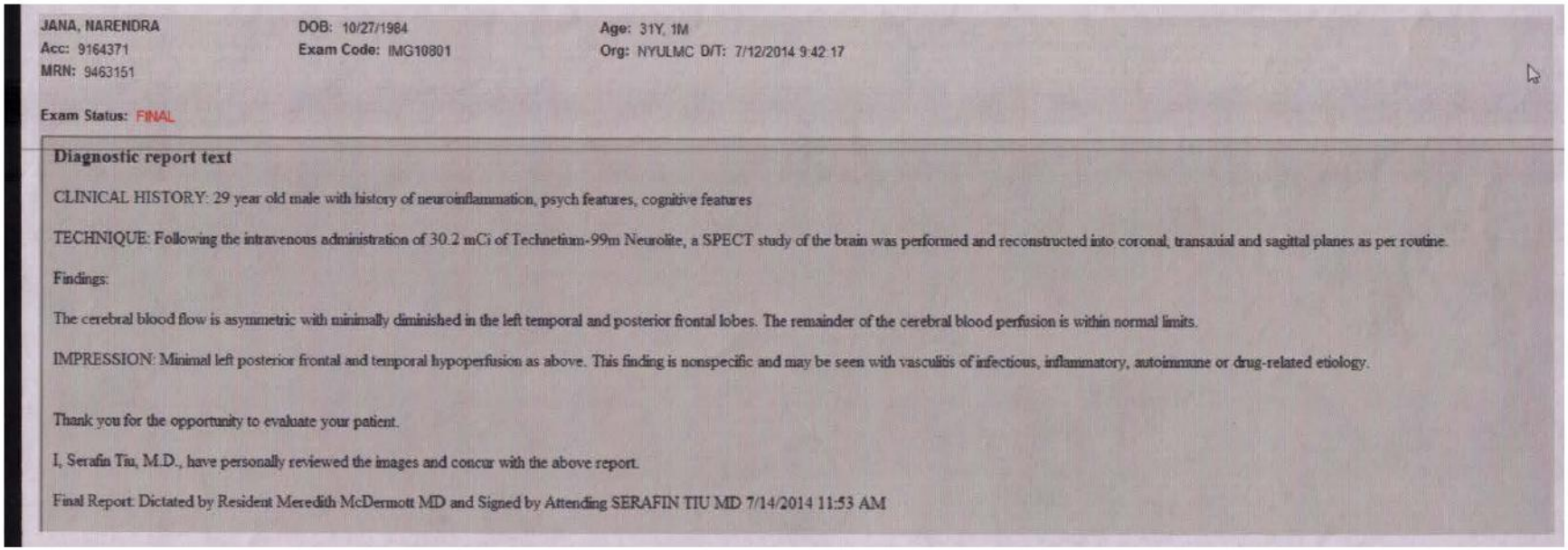
2014 June 17th

- **NYU Neurology - Dr. Soujel Najjar and Kimberly Menzer – NYU Neurology- New York, New York, USA**
  - **Criminal Fraud and Negligence →**

NYU Medical Fraudulated and Falsified Tests (Spectroscopy, EEG, and blood tests) - Dr. Souhel Najjar

In August 2014 an EEG is done in NYU Langone along with a spectroscopy and blood tests for a autoimmune condition.
The EEG report fails to mention some of the features of seizures as a secondary effect of MS.
The blood tests done in July 2014 at NYU may have been falsified or fraudulated by NYU Langone.
A Nuclear Medicine (NM) test called a SPECT is done in July 12th 2014, which shows the effects of a premature dementia as a secondary effect of MS. This is greatly elaborated in another medical setting in the future.
Given simply the SPECT results far more diagnostics of the spinal column and tests for autoimmune condition would be required (medical negligence):



JANA, NARENDRA DOB: 10/27/1984 Age: 31Y, 1M
Acc: 9164371 Exam Code: IMG10801 Org: NYULMC D/T: 7/12/2014 9:42:17
MRN: 9463151

Exam Status: FINAL

Diagnostic report text

CLINICAL HISTORY: 29 year old male with history of neuroinflammation, psych features, cognitive features

TECHNIQUE: Following the intravenous administration of 30.2 mCi of Technetium-99m Neurolite, a SPECT study of the brain was performed and reconstructed into coronal, transaxial and sagittal planes as per routine.

Findings:

The cerebral blood flow is asymmetric with minimally diminished in the left temporal and posterior frontal lobes. The remainder of the cerebral blood perfusion is within normal limits.

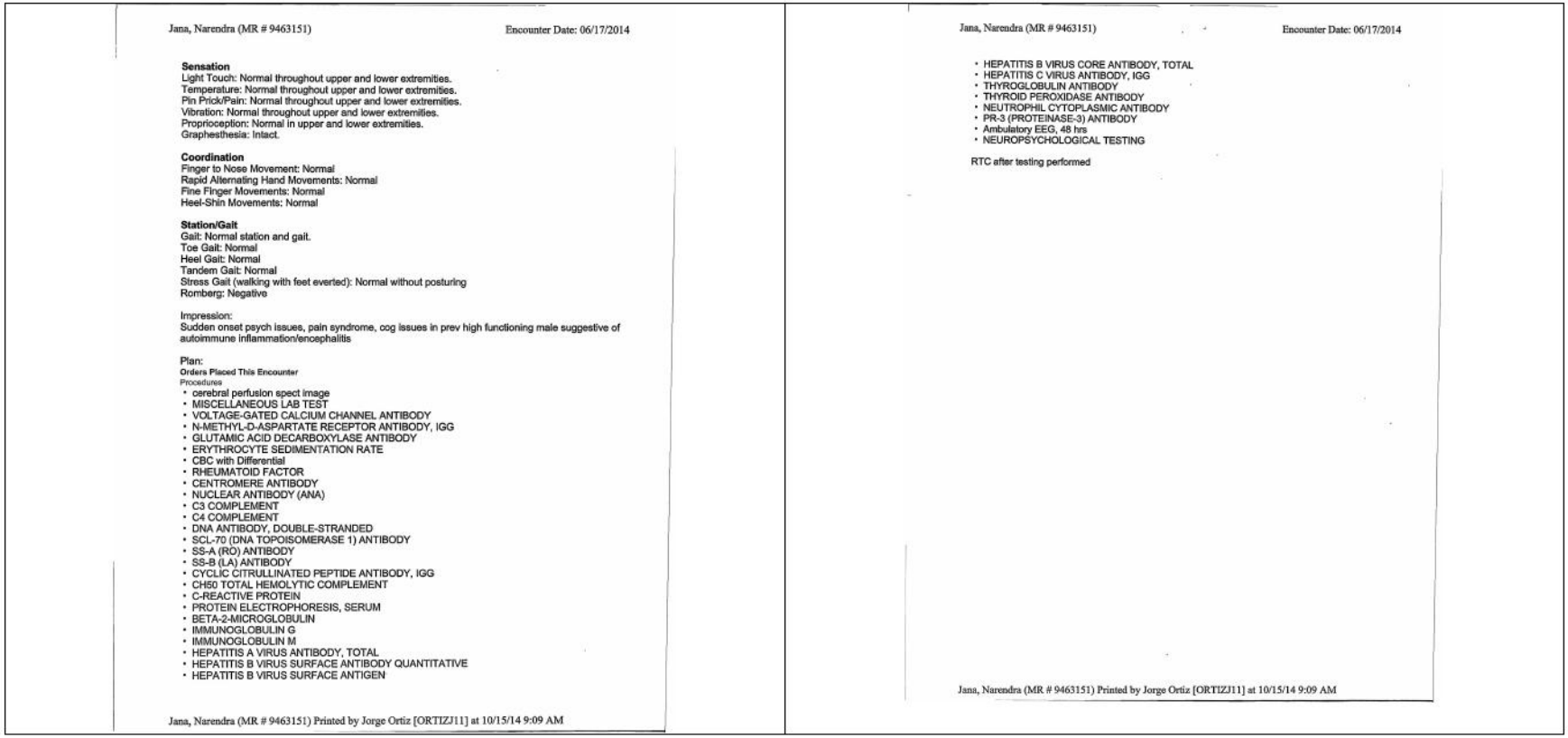
IMPRESSION: Minimal left posterior frontal and temporal hypoperfusion as above. This finding is nonspecific and may be seen with vasculitis of infectious, inflammatory, autoimmune or drug-related etiology.

Thank you for the opportunity to evaluate your patient.

I, Serafin Tiu, M.D., have personally reviewed the images and concur with the above report.

Final Report: Dictated by Resident Meredith McDermott MD and Signed by Attending SERAFIN TIU MD 7/14/2014 11:53 AM

Dr. Soujel Najjar's assistant (Dr. Kimberly Menzer) ordered many of the tests for an auto immune condition in 7/7/2014 but many test result values are falsified or intentionally normalized values in the reports. It was soon thereafter shown to be a progressive form of multiple sclerosis (MS), so a lot of the test results are questionable. Simply given the SPECT test results the tests would be falsified.



Jana, Narendra (MR # 9463151) Encounter Date: 06/17/2014

Sensation
Light Touch: Normal throughout upper and lower extremities.
Temperature: Normal throughout upper and lower extremities.
Pin Prick/Pain: Normal throughout upper and lower extremities.
Vibration: Normal throughout upper and lower extremities.
Proprioception: Normal in upper and lower extremities.
Graphesthesia: Intact.

Coordination
Finger to Nose Movement: Normal
Rapid Alternating Hand Movements: Normal
Fine Finger Movements: Normal
Heel-Shin Movements: Normal

Station/Gait
Gait: Normal station and gait.
Toe Gait: Normal
Heel Gait: Normal
Tandem Gait: Normal
Stress Gait (walking with feet everted): Normal without posturing
Romberg: Negative

Impression:
Sudden onset psych issues, pain syndrome, cog issues in prev high functioning male suggestive of autoimmune inflammation/encephalitis

Plan:
Orders Placed This Encounter
Procedures
- cerebral perfusion spect image
- MISCELLANEOUS LAB TEST
- VOLTAGE-GATED CALCIUM CHANNEL ANTIBODY
- N-METHYL-D-ASPARTATE RECEPTOR ANTIBODY, IGG
- GLUTAMIC ACID DECARBOXYLASE ANTIBODY
- ERYTHROCYTE SEDIMENTATION RATE
- CBC with Differential
- RHEUMATOID FACTOR
- CENTROMERE ANTIBODY
- NUCLEAR ANTIBODY (ANA)
- C3 COMPLEMENT
- C4 COMPLEMENT
- DNA ANTIBODY, DOUBLE-STRANDED
- SCL-70 (DNA TOPOISOMERASE 1) ANTIBODY
- SS-A (RO) ANTIBODY
- SS-B (LA) ANTIBODY
- CYCLIC CITRULLINATED PEPTIDE ANTIBODY, IGG
- CH50 TOTAL HEMOLYTIC COMPLEMENT
- C-REACTIVE PROTEIN
- PROTEIN ELECTROPHORESIS, SERUM
- BETA-2-MICROGLOBULIN
- IMMUNOGLOBULIN G
- IMMUNOGLOBULIN M
- HEPATITIS A VIRUS ANTIBODY, TOTAL
- HEPATITIS B VIRUS SURFACE ANTIBODY QUANTITATIVE
- HEPATITIS B VIRUS SURFACE ANTIGEN

Jana, Narendra (MR # 9463151) Printed by Jorge Ortiz [ORTIZJ11] at 10/15/14 9:09 AM

Jana, Narendra (MR # 9463151) Encounter Date: 06/17/2014

- HEPATITIS B VIRUS CORE ANTIBODY, TOTAL
- HEPATITIS C VIRUS ANTIBODY, IGG
- THYROGLOBULIN ANTIBODY
- THYROID PEROXIDASE ANTIBODY
- NEUTROPHIL CYTOPLASMIC ANTIBODY
- PR-3 (PROTEINASE-3) ANTIBODY
- Ambulatory EEG, 48 hrs
- NEUROPSYCHOLOGICAL TESTING

RTC after testing performed

Jana, Narendra (MR # 9463151) Printed by Jorge Ortiz [ORTIZJ11] at 10/15/14 9:09 AM

The determination that the EEG report downplays the condition and that the blood tests results may be are fraudulated is determined by the future progression of the condition making these tests easy to question.
The neurological evaluation is misstated considering the level of nerve damage to the upper spinal column that had taken place by that point in time.
In the below report I comment on what is likely falsified considering the condition:

NYU Langone MEDICAL CENTER

NYU Langone Radiology
Tisch Hospital
560 1st Avenue, 2nd Floor
New York, NY 10016-6402
212-263-7410

Kimberly Menzer
223 East 34th Street
NEW YORK NY 10016

Patient: Jana, Narendra
DOB: 10/27/1984
MRN: 9463151
ACC: 9164371

NM CEREBRAL PERFUSION WITH SPECT **7/12/14**

Patient: Jana, Narendra
DOB: 10/27/1984
MRN: 9463151
Referring: Kimberly Menzer
CC Recipient(s):
Pt Phone: 781-223-5780

Procedure(s) Date of Service		Acc#
NM CEREBRAL PERFUSION WITH SPECT	9164371	7/12/14

CLINICAL HISTORY: 29 year old male with history of neuroinflammation, psych features, cognitive features

TECHNIQUE: Following the intravenous administration of 30.2 mCi of Technetium-99m Neurolite, a SPECT study of the brain was performed and reconstructed into coronal, transaxial and sagittal planes as per routine.

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IMPRESSION: Minimal left posterior frontal and temporal hypoperfusion as above. This finding is nonspecific and may be seen with vasculitis of infectious, inflammatory, autoimmune or drug-related etiology.

Thank you for the opportunity to evaluate your patient.

I, Serafin Tiu, M.D., have personally reviewed the images and concur with the above report.

Final Report: Dictated by Resident Meredith McDermott MD and Signed by Attending SERAFIN TIU MD 7/14/2014 11:53 AM

The blood tests were done in Quest Diagnostics as stated in the report.

Results: CBC AND DIFFERENTIAL

Status: Final result
6/18/2014 11:58 PM

Component	Value	Standard Range & Units
WHITE BLOOD CELL COUNT	5.9	3.8 - 10.8 Thous/mcL
RED BLOOD CELL COUNT	4.67	4.20 - 5.80 Mill/mcL
HEMOGLOBIN	13.9	13.2 - 17.1 g/dL
HEMATOCRIT	42.0	38.5 - 50.0 %
MEAN CORPUSCULAR VOLUME	89.9	80.0 - 100.0 fL
MEAN CORPUSCULAR HEMOGLOBIN	29.9	27.0 - 33.0 pg
MEAN CORPUSCULAR HEMOGLOBIN CONC	33.2	32.0 - 36.0 g/dL
RED CELL DISTRIBUTION WIDTH	13.2	11.0 - 15.0 %
PLATELET COUNT	205	140 - 400 Thous/mcL
MEAN PLATELET VOLUME	8.1	7.5 - 11.5 fL
NEUTROPHILS %	47.2	38 - 80 %
LYMPHOCYTES %	42.3	15 - 49 %
MONOCYTES %	8.0	0 - 13 %
EOSINOPHILS %	2.2	0 - 8 %
BASOPHILS %	0.3	0 - 2 %
NEUTROPHILS ABSOLUTE	2785	1500 - 7800 Cells/mcL
LYMPHOCYTES ABSOLUTE	2496	850 - 3900 Cells/mcL
MONOCYTES ABSOLUTE	472	200 - 950 Cells/mcL
EOSINOPHILS, ABSOLUTE	130	15 - 500 Cells/mcL
BASOPHILS ABSOLUTE	18	0 - 200 Cells/mcL
DIFFERENTIAL TYPE	SEE NOTE	

An instrument differential was performed.
Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: SED RATE

Status: Final result
6/19/2014 2:23 AM

Component	Value	Standard Range & Units
ERYTHROCYTE SEDIMENTATION RATE	1	0 - 15 mm/hr

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: BETA-2-MICROGLOBULIN

Status: Final result
6/19/2014 11:03 AM

Component	Value	Standard Range & Units
BETA-2 MICROGLOBULIN	1.54	<or= 2.51 mg/L

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

ESR (a general measure of inflammation) would have to be high considering the inflammatory nature of the condition and the rate of progression of the condition at that point in time.

Results: NUCLEAR ANTIBODY (ANA) IFA — **Status: Final result 6/19/2014 12:09 PM**

Component	Value	Standard Range & Units
ANA SCREEN, IFA	Negative	Negative

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: IMMUNOGLOBULIN G (IGG) — **Status: Final result 6/19/2014 12:26 PM**

Component	Value	Standard Range & Units
IMMUNOGLOBULIN G	978	694 - 1618 mg/dL

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: IMMUNOGLOBULIN M (IGM) — **Status: Final result 6/19/2014 12:26 PM**

Abnormal

Component	Value	Standard Range & Units
IMMUNOGLOBULIN M	**31**	48 - 271 mg/dL

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: C3 COMPLEMENT LEVEL — **Status: Final result 6/19/2014 12:26 PM**

Abnormal

Component	Value	Standard Range & Units
C3 COMPLEMENT LEVEL	**84**	90 - 180 mg/dL

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: C4 COMPLEMENT LEVEL — **Status: Final result 6/19/2014 12:26 PM**

Component	Value	Standard Range & Units
C4 COMPLEMENT LEVEL	21	16 - 47 mg/dL

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: RHEUMATOID FACTOR — **Status: Final result 6/19/2014 12:26 PM**

Some of these IgG markers would not be ideally perfect. IgG markers indicate a immune response. C3 is used to check for certain kidney diseases and Systemic Lupus Erythematosus.

Component	Value	Standard Range & Units
RHEUMATOID FACTOR	5	<14 IU/mL

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: C-REACTIVE PROTEIN (CRP) — **Status: Final result 6/19/2014 12:26 PM**

Component	Value	Standard Range & Units
C-REACTIVE PROTEIN	<0.1	<0.8 mg/dL

Please be advised that patients taking Carboxypenicillins may exhibit falsely decreased C-Reactive Protein levels due to an analytical interference in this assay.

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: CYCLIC CITRULLINATED PEPTIDE ANTIBODY, IGG — **Status: Final result 6/19/2014 2:25 PM**

Component	Value	Standard Range & Units
CCP IGG ANTIBODIES	<16	<20 Units

Negative: Less than 20 Units
Weak Positive: 20 - 39 Units
Moderate Positive: 40 - 59 Units
Strong Positive: 60 or Greater Units

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: DNA ANTIBODY, DOUBLE-STRANDED — **Status: Final result 6/19/2014 3:15 PM**

Component	Value	Standard Range & Units
DSDNA ANTIBODY	<1	< = 4 Negative IU/mL

IU/mL	Interpretation
<=4	Negative
5 - 9	Indeterminate
>=10	Positive

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: SS-A (RO) ANTIBODY — **Status: Final result 6/19/2014 3:15 PM**

Component	Value	Standard Range & Units
SJOGREN'S ANTIBODY ANTI-SS-A	<1.0	<1.0 AI
INTERPRETATION	Negative	Negative

Test Performed at:

C-Reactive protein would have to be high considering the inflammatory nature of the condition. If protein electrophoresis is a low positive it means that C-Protein and ESR would likely have to be high as well.

Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: SS-B (LA) ANTIBODY

Status: Final result
6/19/2014 3:15 PM

Component	Value	Standard Range & Units
SJOGREN'S ANTIBODY ANTI-SS-B	<1.0	<1.0 AI
INTERPRETATION	Negative	Negative

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: SCL-70 (DNA TOPOISOMERASE) ANTIBODY

Status: Final result
6/19/2014 3:15 PM

Component	Value	Standard Range & Units
SCL-70 ANTIBODY	<1.0	<1.0 AI
INTERPRETATION	Negative	Negative

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: CENTROMERE ANTIBODY

Status: Final result
6/19/2014 3:15 PM

Component	Value	Standard Range & Units
CENTROMERE AB SCREEN	<1.0	<1.0 AI
INTERPRETATION	Negative	Negative

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: PROTEIN ELECTROPHORESIS, SERUM

Status: Final result
6/19/2014 3:41 PM

Component	Value	Standard Range & Units
PROTEIN, TOTAL	6.7	6.1 - 8.1 g/dL
PROTEIN ELECTROP. Normal Pattern	SEE NOTE	
ALBUMIN PROTEIN ELECTROPHORESIS	4.01	3.50 - 4.70 g/dL
ALPHA-1-GLOBULIN	0.19	0.10 - 0.30 g/dL
ALPHA-2-GLOBULIN	0.54	0.50 - 1.00 g/dL
BETA GLOBULIN	0.92	0.80 - 1.40 g/dL
GAMMA GLOBULIN	1.04	0.60 - 1.60 g/dL

Test Performed at:
Quest Diagnostics
One Malcolm Avenue

For protein electrophoresis in serum the test results are most likely falsified or misstated, in people with multiple sclerosis and during relapse these markers are generally high.
The note in the report (later in this report) also states that the result is low positive indicating that I am either close to a relapse or in a relapse, indicating the nature of MS. The immediate recommendation given this would be MRIs of brain and spine with cerebrospinal fluid tests. Medical negligence again.

Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: CH50 TOTAL HEMOLYTIC COMPLEMENT

Status: Final result
6/19/2014 5:05 PM

Component	Value	Standard Range & Units
COMPLEMENT TOTAL, CH50	52	31 - 60 U/mL

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: NEUTROPHIL CYTOPLASMIC ANTIBO*

Status: Final result
6/19/2014 6:20 PM

Component	Value	Standard Range & Units
PROTEINASE-3 AB	<1.0	<1.0 AI

Value	Interpretation
<1.0	Antibody Not Detected
> or = 1.0	Antibody Detected

Autoantibodies to proteinase-3 (PR-3) are accepted as characteristic for granulomatosis with polyangiitis (Wegener's), and are detectable in 95% of the the histologically proven cases. The cytoplasmic IFA pattern, (c-ANCA), is based largely on autoantibody to PR-3 which serves as the primary antigen. These autoantibodies are present in active disease state.

Component	Value	Standard Range & Units
MYELOPEROXIDASE ANTIBODY	<1.0	<1.0 AI

Value	Interpretation
<1.0	Antibody Not Detected
> or = 1.0	Antibody Detected

Autoantibodies to Myeloperoxidase (MPO) are commonly associated with the following small-vessel vasculitides: microscopic polyangitis, polyarteritisnodosa, Churg-Strauss syndrome, necrotizing and crescentic glomerulonephritis and occassionally Wegener's granulomatosis. The perinuclear IFA pattern, (P-ANCA) is based largely on autoantibody to myeloperoxidase which serves as the primary antigen. These autoantibodies are present in active disease state.

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: THYROID PEROXIDASE (TPO) ANTIBODY

Status: Final result
6/19/2014 7:47 PM

Component	Value	Standard Range & Units
THYROID PEROXIDASE ANTIBODIES	<1	<9 IU/mL

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: THYROGLOBULIN ANTIBODY — **Status: Final result 6/19/2014 7:47 PM**

Component	Value	Standard Range & Units
THYROGLOBULIN AB	<1	< OR = 1 IU/mL

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: HEPATITIS A VIRUS ANTIBODY, TOTAL IGG/IGM — **Status: Final result 6/20/2014 4:58 AM**

Abnormal

Component	Value	Standard Range & Units
HEPATITIS A TOTAL ANTIBODY	**Reactive**	Nonreactive

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: HEPATITIS B VIRUS SURFACE ANTIBODY — **Status: Final result 6/20/2014 4:58 AM**

Component	Value	Standard Range & Units
HEPATITIS B SURFACE ANTIBODY	34	>/=10 mIU/mL

Patient has immunity to hepatitis B virus.
Effective May 27, 2014 this test is being performed using the Ortho Vitros Chemiluminesence method. Quantitative results from this method should not be used interchangeably with other methods.

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: HEPATITIS B VIRUS SURFACE ANTIGEN — **Status: Final result 6/20/2014 4:58 AM**

Component	Value	Standard Range & Units
HEPATITIS B SURFACE ANTIGEN	Non Reactive	Non Reactive

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: HEPATITIS B VIRUS CORE ANTIBODY, TOTAL IGG/IGM — **Status: Final result 6/20/2014 4:58 AM**

Component	Value	Standard Range & Units
HEPATITIS B CORE TOTAL ANTIBODY	Non Reactive	Non Reactive

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: HEPATITIS C VIRUS ANTIBODY, IGG — **Status: Final result 6/20/2014 4:58 AM**

Component	Value	Standard Range & Units
HEPATITIS C VIRUS RATIO	0.04	<1.0 Ratio
HEPATITIS C ANTIBODY	Non Reactive	Non Reactive

Test Performed at:
Quest Diagnostics
One Malcolm Avenue
Teterboro, NJ 07608
Janet Piscitelli, M.D.

Lab Inquiry View Complete Results

Results: GLUTAMIC ACID DECARBOXYLASE ANTIBODY — **Status: Final result 6/21/2014 4:59 PM**

Component	Value	Standard Range & Units
GAD-65 ANTIBODY	<1.0	<=1.0 U/mL

This test was performed at:
Quest Diagnostics Nichols Institute Chantilly
14225 Newbrook Drive
Chantilly, VA 20151

Test Performed at:
Quest Diagnostics Nichols Chantilly
14225 Newbrook Drive
Chantilly, VA 20151
Kenneth Sisco, MD,PhD

Lab Inquiry View Complete Results

Results: VOLTAGE-GATED CALCIUM CHANNEL (VGCC) AB — **Status: Final result 6/25/2014 11:40 PM**

Component	Value	Standard Range & Units
VOLTAGE-GATED CALCIUM CHANNEL AB	<30	<30 pmol/L

Test performed by:
Quest Diagnostics Nichols Institute
33608 Ortega Highway
San Juan Capistrano, California 92690

Test Performed at:
Quest Diagnostics, Nichols Institute
33608 Ortega Highway
San Juan Capistrano, CA 92675
Dr. Jon M. Nakamoto

Lab Inquiry View Complete Results

Results: N-METHYL-D-ASPARTATE RECEPTOR ANTIBODY, IGG — **Status: Final result 6/26/2014 10:09 PM**

Component
INTERPRETATION
SEE NOTE
Comment:
NEGATIVE
This test did not detect abnormal levels of anti-NR1 antibodies.

RESULTS
SEE NOTE
Comment:

Interpretive Result Table

GAD-65 antibodies are present in 10 % of those with multiple sclerosis, it's an antibody against the enzyme that forms neurotransmitter GABA. In epileptics there is GABA dysregulation, the falsified EEG shows epileptic seizures and interictal effects.

The voltage-gate calcium channel test is most likely falsified. In those that have a manganese toxicity in MRI images voltage-gate potassium channel (VGKC) are positive thus this is likely falsified by medical correlation. The medical journal below substantiates it:

PubMed

Format: Abstract

Full text links

FULL TEXT OPEN ACCESS MDPI PMC FREE Full text

Int J Environ Res Public Health. 2018 Apr 18;15(4). pii: E783. doi: 10.3390/ijerph15040783.

Chronic Manganese Toxicity Associated with Voltage-Gated Potassium Channel Complex Antibodies in a Relapsing Neuropsychiatric Disorder.

Ho CSH[1], Ho RCM[2], Quek AML[3,4].

Author information

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2 Department of Psychological Medicine, Yong Loo Lin School of Medicine, National University of Singapore, Singapore 119074, Singapore. pcmrhcm@nus.edu.sg.
3 Division of Neurology, Department of Medicine, Yong Loo Lin School of Medicine, National University of Singapore, Singapore 119228, Singapore. Amy_QUEK@nuhs.edu.sg.
4 Division of Neurology, University Medicine Cluster, National University Hospital, Singapore 119074, Singapore. Amy_QUEK@nuhs.edu.sg.

Abstract

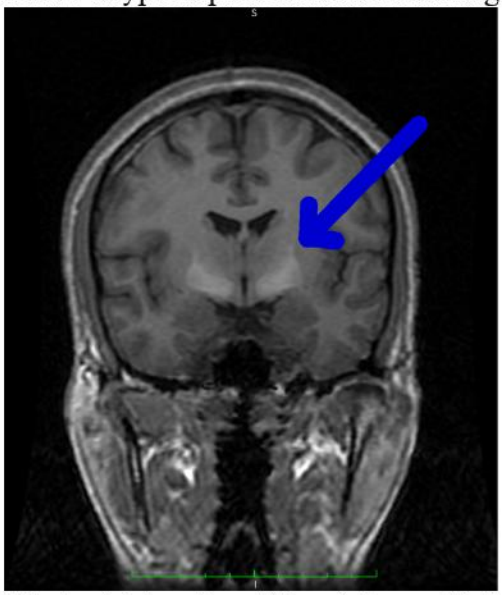
Heavy metal poisoning is a rare but important cause of encephalopathy. **Manganese** (Mn) toxicity is especially rare in the modern world, and clinicians’ lack of recognition of its neuropsychiatric manifestations can lead to misdiagnosis and mismanagement. We describe the case of a man who presented with recurrent episodes of confusion, psychosis, dystonic limb movement and cognitive impairment and was initially diagnosed with anti-voltage-gated potassium channel (VGKC) complex limbic encephalitis in view of previous positive autoantibodies. His failure to respond to immunotherapy prompted testing for heavy metal poisoning, which was positive for Mn. This is the first report to examine an association between Mn and VGKC antibodies and the effects of Mn on functional brain activity using functional near-infrared spectroscopy (fNIRS).

KEYWORDS: manganese toxicity; neuropsychiatric disorder; voltage-gated potassium channel complex antibodies

PMID: 29669989 PMCID: PMC5923825 DOI: 10.3390/ijerph15040783

[Indexed for MEDLINE] Free PMC Article

I have a typical presentation of a manganese toxicity:



Bilateral intensity of the globus pallidi which eventually causes progressive multiple sclerosis.

INTERPRETIVE RESULT: Negative
TEST: anti-NR1
TECHNICAL RESULT: No abnormal levels of antibodies detected

COMMENT
SEE NOTE
Comment:
Comments: The likelihood that this individual's clinical symptoms are associated with abnormal levels of anti-NR1 antibodies has been reduced. However, this test result does not rule out an autoimmune etiology for the neurological symptoms associated with paraneoplastic disorder.
Recommendations: Health care providers, please contact the Athena Diagnostics Client Services Department at 1-800-394-4493 if you wish to consult with a Laboratory Director regarding this test result.
Other testing available: Athena Diagnostics recommends additional testing, if not already performed. Athena Diagnostics currently offers the following antibody tests: anti-Hu, anti-Yo, anti-Zic4, anti-CV2, anti-Ma1, anti-Ta, anti-Ri, anti-Recoverin, anti-VGCC, anti-VGKC, anti-Amphiphysin, anti-G-AChR, anti-GAD65, anti-LGI1, and anti-CASPR2. Please contact the Athena Diagnostics Client Services Department or visit AthenaDiagnostics.com for information regarding additional testing that may be appropriate based on this individual's clinical presentation.
Background information: Paraneoplastic neurological syndromes or disorders (PNS or PND) are rare immune-mediated disorders resulting from the damage to the nervous system due to remote effects of a tumor (1, 2). PND of the central nervous system may occur in association with either onconeural antibodies directed against intracellular antigens, or antibodies targeted against neuronal surface antigens (1, 3).
Clinical features of PND may include ataxia, limbic or brainstem encephalitis, sensory neuropathy, subacute cerebellar degeneration, dizziness, nystagmus, dysphagia, dysarthria, loss of muscle tone, loss of memory, vision problems, sleep disturbances, dementia, seizures, and/or sensory loss in the limbs (4). In approximately 60% of PND cases, neuropathic symptoms precede a tumor diagnosis (1). Some of the tumors related to PND include small cell lung cancer, ovarian teratoma and carcinoma, thymoma, lymphoma, breast cancer, and/or testicular cancer (2). PND may also include Lambert-Eaton myasthenic syndrome (LEMS), stiff person syndrome, encephalomyelitis, myasthenia gravis, neuromyotonia, and opsoclonus-myoclonus (4). However, these disorders can also occur in individuals without underlying cancer.
N-methyl-D-aspartate receptors (NMDARs) are ionotropic ligand-gated cation channels, which are thought to play a critical role in central nervous system (CNS) synaptic plasticity and signal transmission (5). NMDARs (specifically NR1/NR2 heterodimers) have recently been shown to be a target antigen for antibodies in patients with encephalitis (6, 7). The predominant features of this disorder include acute psychiatric syndromes, seizures, memory deficits, and hypoventilation (8, 9). Majority of patients having encephalitis associated with anti-NMDAR antibodies are young women (6, 7, 10). A few men and children have also been reported (8). Approximately 65% of female encephalitis patients with these antibodies have a detectable tumor, commonly a cystic ovarian teratoma (6). Since neurological symptoms often precede the detection of an occult malignancy, patient monitoring is recommended, and a search for occult cancer should be considered.

METHOD
SEE NOTE
Comment:
Detection of antibodies was performed by indirect immunofluorescence staining on a recombinant cell line expressing the antigen.
Limitations of analysis: Cross-interfering antibodies may be present in samples and appear as borderline or low positive results. Specimen type may affect sensitivity and specificity of this assay. Although rare, false positive or false negative results may occur. All results should be interpreted in the context of clinical findings, relevant history, and other laboratory data.

Reference
SEE NOTE
Comment:
1. Darnell, RB, et al. (2006) Semin Oncol 33: 270-98. (PMID: 16769417)
2. Titulaer, MJ, et al. (2011) Eur J Neurol 18: 19-e3. (PMID: 20880069)
3. Zuliani, L, et al. (2012) J Neurol Neurosurg Psychiatry 83: 638-45. (PMID: 22448032)
4. Rosenfeld, MR, et al. (2010) Oncologist 15: 603-17. (PMID: 20479279)
5. Lau, CG, et al. (2007) Nat Rev Neurosci 8: 413-26. (PMID: 17514195)
6. Dalmau, J, et al. (2008) Lancet Neurol 7: 327-40. (PMID: 18339348)
7. Iizuka, T, et al. (2008) Neurology 70: 504-11. (PMID: 17898324)
8. Florance, NR, et al. (2009) Ann Neurol 66: 11-8. (PMID: 19670433)
9. Dalmau, J, et al. (2008) Lancet Neurol 7: 1091-8. (PMID: 18851928)
10. Niehusmann, P, et al. (2009) Arch Neurol 66: 458-64. (PMID: 19364930)
This test was developed and its performance characteristics have been determined by Athena Diagnostics. Performance characteristics refer to the analytical performance of the test.
Laboratory oversight provided by Joseph J. Higgins, M.D., F.A.A.N., CLIA license holder, Athena Diagnostics (CLIA # 22D0069726)

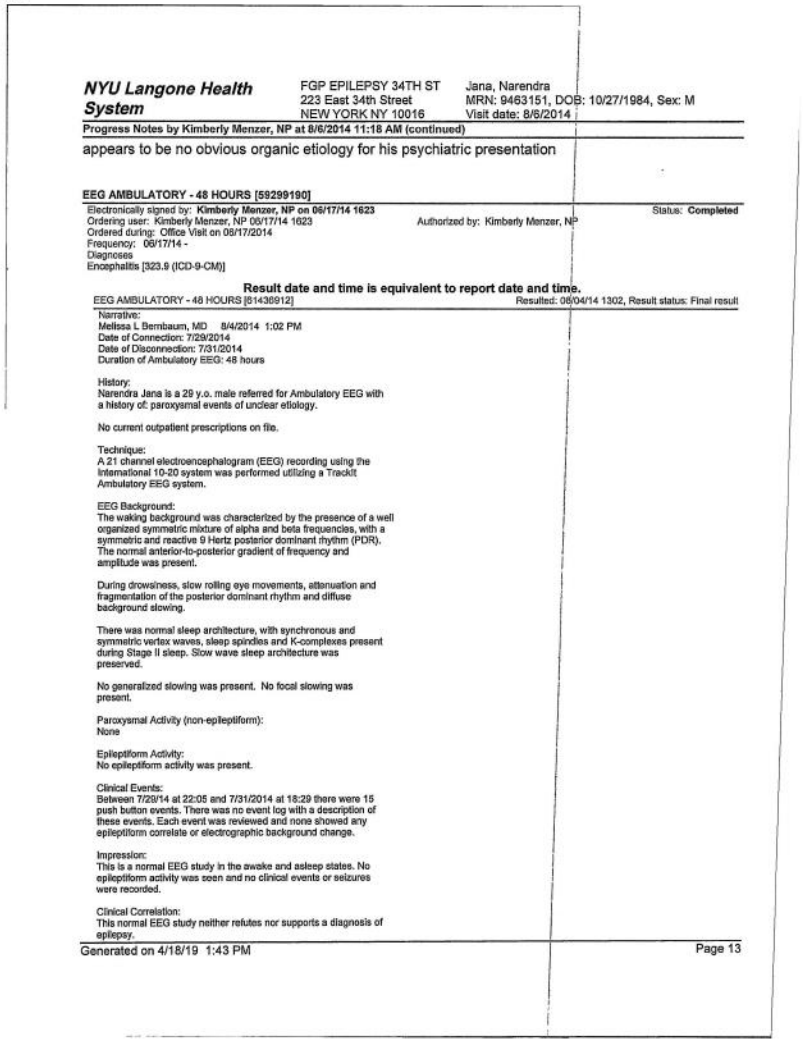
Test Performed by:
Athena Diagnostics, Inc.
Four Biotech Park
377 Plantation Street
Worcester, MA 01605

Test Performed at:
ATHENA DIAGNOSTICS, Inc.
377 Plantation Street Four Biotech Park
Worcester, MA 01605
Joseph J. Higgins, M.D.

Lab Inquiry View Complete Results

A lot of these tests are idealistically normal considering the nature of the condition. It should be put in the general pattern of fraudulated medical tests in other medical settings. It's an involved way of medical criminal fraud.

The EEG report does not describe the clinical presentation or EEG data:



Progress Notes by Kimberly Menzer, NP at 8/6/2014 11:18 AM (continued)

appears to be no obvious organic etiology for his psychiatric presentation

EEG AMBULATORY - 48 HOURS [59299190]

Electronically signed by: **Kimberly Menzer, NP on 08/17/14 1623** Status: **Completed**
Ordering user: Kimberly Menzer, NP 08/17/14 1623 Authorized by: Kimberly Menzer, NP
Ordered during: Office Visit on 08/17/2014
Frequency: 08/17/14 -
Diagnoses
Encephalitis [323.9 (ICD-9-CM)]

Result date and time is equivalent to report date and time.

EEG AMBULATORY - 48 HOURS [61439912] Resulted: 08/04/14 1302, Result status: Final result

Narrative:
Melissa L Bernbaum, MD 8/4/2014 1:02 PM
Date of Connection: 7/29/2014
Date of Disconnection: 7/31/2014
Duration of Ambulatory EEG: 48 hours

History:
Narendra Jana is a 29 y.o. male referred for Ambulatory EEG with a history of: paroxysmal events of unclear etiology.

No current outpatient prescriptions on file.

Technique:
A 21 channel electroencephalogram (EEG) recording using the International 10-20 system was performed utilizing a TrackIt Ambulatory EEG system.

EEG Background:
The waking background was characterized by the presence of a well organized symmetric mixture of alpha and beta frequencies, with a symmetric and reactive 9 Hertz posterior dominant rhythm (PDR). The normal anterior-to-posterior gradient of frequency and amplitude was present.

During drowsiness, slow rolling eye movements, attenuation and fragmentation of the posterior dominant rhythm and diffuse background slowing.

There was normal sleep architecture, with synchronous and symmetric vertex waves, sleep spindles and K-complexes present during Stage II sleep. Slow wave sleep architecture was preserved.

No generalized slowing was present. No focal slowing was present.

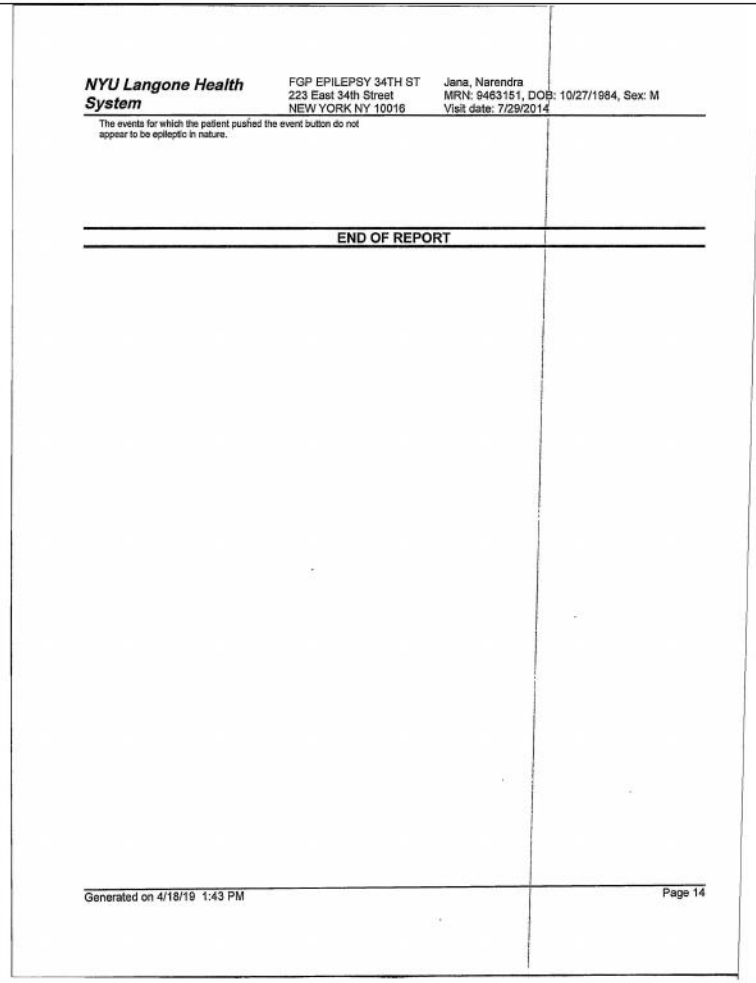
Paroxysmal Activity (non-epileptiform):
None

Epileptiform Activity:
No epileptiform activity was present.

Clinical Events:
Between 7/29/14 at 22:05 and 7/31/2014 at 18:29 there were 15 push button events. There was no event log with a description of these events. Each event was reviewed and none showed any epileptiform correlate or electrographic background change.

Impression:
This is a normal EEG study in the awake and asleep states. No epileptiform activity was seen and no clinical events or seizures were recorded.

Clinical Correlation:
This normal EEG study neither refutes nor supports a diagnosis of epilepsy.



The events for which the patient pushed the event button do not appear to be epileptic in nature.

END OF REPORT

The next document goes into detail about how the EEG report in this setting are falsified. The report ignores features of seizures. The type of seizures I have are predominantly absence seizures.

In the reports written by the doctors assistant, Dr. Kimberly Menzer, there is an attempt to downplay the condition after the blood tests are falsified. Falsifying the neurological presentation and then stating the condition is a “immunodeficiency syndrome” (the opposite of autoimmune condition), a statement that is medically impossible given the progression of the condition.
So a medically impossible statement with many medically impossible blood test results:

Progress Notes **Narendra Jana (MR# 9463151)**

Progress Notes Info

Author	Note Status	Last Update User	Last Update Date/Time
Kimberly Menzer, NP	Signed	Kimberly Menzer, NP	6/18/2014 3:56 PM

Progress Notes

29 y/o M presents for evaluation of constellation of symptoms.
Reports hx of the following:
Onset depression post college, which he could best describe as feeling sad. He is unable to provide much detail but states for 3-4 years he underwent trials of multiple meds including: "stimulants, MAOIs, ssris, snris"--cannot recall names. He during that time began to "self medicate" with supplements including manganese and began to experience "massive nerve pain" at which time he was found to have elevated manganese level and an MRI showed increased signal in b/l global pallidus. Due to lack of improvement he underwent ECT in 2010.

After ECT, onset of the following symptoms:
-Immediately following ECT, was completely incoherent and was without recall of these days.
-Nerve pain continued and continues to this day: r elbow, r flank, R>L calf, L lateral hand, R parietal, temporal and occipital, and L parietal occipital--burning, stabbing, consistent but waxes and wanes. Reports nerve pain exacerbated by eating
-He would get in his car, drive aimlessly x 30-45 min unknowingly, come to, have to put GPS to go home. He received a speeding ticket, and states he almost lost his license but can't recall why.
-Spending: made purchases he was unaware of, ipod, expensive meals without awareness, or picking up the check at dinner with friends
Sought neuro evals and relates he was thought to have ECT delirium
-Mood and temperament change, occurs in combination with nerve pain, irritable. If he is not moody he gets goofy, also can occur on daily basis, laughs to self, feels senseless, than cries--emotionally labile and uncontrollable. Mood changes also exacerbated also by eating and physical activity. He may also feel less aware, less able to remain focused on task. He begins to "stupidly laugh" ~ 1hour until better
-"psychobabble states"-repeats fragments of words or non words in his head, he is aware of it but can't stop it. X 15 min. also occurs after eating or activity
-OCD: has repetivie internal thought processes, often negative comments someone has said.
-Color distortion: things look white washed
-Difficulty in perception in physical motion: halo or trail of the movement
-Decreased executive function. Planning. Understanding concepts

DATA:
REEGs slowing per his report
MRI 2008 as above, states had another last year
neuropsych eval 2011
Has not brought reports for review

Sees psychiatrist-- Valentine Riteri MD

Moved to nyc 2.5 months ago. Works in IT. No issues socializing.

ECT is an inappropriate recommendation for those with brain lesions (increased signal intensity). It causes neurological damage.

Nerve pain is described accurately from spinal cord lesions.

These events ("get in his car, drive aimlessly") are called automatic behaviours in neurology that occur in those with epilepsy, since the brain changes due to seizures. (getting around and driving aimlessly). These are all effects of epilepsy.
Seizures cause short term memory loss but nothing I purchased was out of the ordinary (nothing beyond my monetary means).

Didn't have ECT delirium, I was having repeated seizures. It perpetuated for years after ECT.

Effects in mood are due to midbrain lesions. The statement "laughs to self, feels senseless, then cries--emotionally labile" is called pseudobulbar effect that

Jana, Narendra (MR # 9463151) Encounter Date: 06/17/2014

General Examination:

General Appearance: No acute distress.
Vitals: BP 113/64 | Pulse 69 | Ht 1.689 m (5' 6.5") | Wt 51.211 kg (112 lb 14.4 oz) | BMI 17.95 kg/m2
HEENT: Normocephalic, atraumatic, conjunctivae pink, sclerae clear, tongue and mucous membranes moist. No dysmorphic features are present.
Neck: Supple with normal range of movement and no meningismus.
Cardiovascular: Regular rate and rhythm with normal S1 and S2. No S3, S4 or murmur. Normal carotid pulsations with no bruits. Normal, palpable peripheral pulses bilaterally.
Pulmonary: Lungs clear to auscultation bilaterally without wheezes, rales or rhonchi.
Skin: No rashes or abnormal pigmentation. No neurocutaneous lesions present.
Musculoskeletal: Normal muscle bulk.

Neurological Examination:

Mental Status
State: Patient is awake and alert. Patient answers questions and follows commands appropriately.
Spontaneity of speech and motor behavior are normal.
Orientation: Oriented to person, place and time.
Language: Speech is fluent with normal prosody. There is no dysarthria. Naming, repetition and comprehension are intact.
Mood and Affect: flat and a bit odd
Eye contact is normal.
Memory: Recent and remote memory are normal. Registers 3/3 objects. Recalls 3/3 objects.
Attention/Concentration: Normal. Able to spell WORLD backwards.
Judgment/Fund of Knowledge: Normal

Cranial Nerves
CN II: Visual fields intact to confrontation. Fundoscopic examination is normal with no evidence of disc edema or pallor. Pupils are equal, round and reactive to light and accommodation.
CN III, IV, VI: Normal. Extraocular muscles are intact without nystagmus or diplopia.
CN V: Normal. Facial sensation is symmetric. Muscles of mastication normal and symmetric.
CN VII: Normal. Facial musculature is symmetric.
CN VIII: Normal. Hearing is intact bilaterally.
CN IX, X: Normal. The palate rises symmetrically and the uvula is midline.
CN XI: Normal. Sternocleidomastoid 5/5 and trapezius 5/5 bilaterally.
CN XII: Normal. The tongue is midline with no evidence of atrophy.

Motor
Bulk and tone are normal throughout. There are no abnormal movements.
Upper extremity strength is full (5/5) bilaterally.
Lower extremity strength is full (5/5) bilaterally.
There is no pronator drift.
No tremor or adventitious movements are seen.

Reflexes
Biceps: Right 2+/4 and Left 2+/4
Triceps: Right 2+/4 and Left 2+/4
Brachioradialis: Right 2+/4 and Left 2+/4
Patellar: Right 2+/4 and Left 2+/4
Achilles: Right 2+/4 and Left 2+/4
Plantar Response:Normal. Bilateral toes are downgoing (Babinski sign absent).
Hoffman's: Absent

Jana, Narendra (MR # 9463151) Printed by Jorge Ortiz [ORTIZJ11] at 10/15/14 9:09 AM

happens in neurodegenerative conditions like multiple sclerosis.

These are all the effects of seizures and neuroinflammation from multiple sclerosis.
Colour distortion is due to optic neuropathy.
The decreased executive planning is due to intermittent seizures and rapidly vacillates within hours.

Fundoscopic examination is misstated, has pale optic disks which were apparent in high resolution images from tests.
Has gross optic neuropathy.
Does have nystagmus due to inflammation of optic nerves.

The motor nerve tests are probably falsely stated, has spine lesions.

The reflex tests are misstated, has spinal cord lesions.

Sensation
Light Touch: Normal throughout upper and lower extremities.
Temperature: Normal throughout upper and lower extremities.
Pin Prick/Pain: Normal throughout upper and lower extremities.
Vibration: Normal throughout upper and lower extremities.
Proprioception: Normal in upper and lower extremities.
Graphesthesia: Intact.

Coordination
Finger to Nose Movement: Normal
Rapid Alternating Hand Movements: Normal
Fine Finger Movements: Normal
Heel-Shin Movements: Normal

Station/Gait
Gait: Normal station and gait.
Toe Gait: Normal
Heel Gait: Normal
Tandem Gait: Normal
Stress Gait (walking with feet everted): Normal without posturing
Romberg: Negative

Impression:
Sudden onset psych issues, pain syndrome, cog issues in prev high functioning male suggestive of autoimmune inflammation/encephalitis

Plan:
Orders Placed This Encounter
Procedures
- cerebral perfusion spect image
- MISCELLANEOUS LAB TEST
- VOLTAGE-GATED CALCIUM CHANNEL ANTIBODY
- N-METHYL-D-ASPARTATE RECEPTOR ANTIBODY, IGG
- GLUTAMIC ACID DECARBOXYLASE ANTIBODY
- ERYTHROCYTE SEDIMENTATION RATE
- CBC with Differential
- RHEUMATOID FACTOR
- CENTROMERE ANTIBODY
- NUCLEAR ANTIBODY (ANA)
- C3 COMPLEMENT
- C4 COMPLEMENT
- DNA ANTIBODY, DOUBLE-STRANDED
- SCL-70 (DNA TOPOISOMERASE 1) ANTIBODY
- SS-A (RO) ANTIBODY
- SS-B (LA) ANTIBODY
- CYCLIC CITRULLINATED PEPTIDE ANTIBODY, IGG
- CH50 TOTAL HEMOLYTIC COMPLEMENT
- C-REACTIVE PROTEIN
- PROTEIN ELECTROPHORESIS, SERUM
- BETA-2-MICROGLOBULIN
- IMMUNOGLOBULIN G
- IMMUNOGLOBULIN M
- HEPATITIS A VIRUS ANTIBODY, TOTAL
- HEPATITIS B VIRUS SURFACE ANTIBODY QUANTITATIVE
- HEPATITIS B VIRUS SURFACE ANTIGEN

Sensation tests are misstated. Has limited sensation of my left hemisphere due to spinal cord lesions.

Some of the coordination tests are wrongly stated along with gait tests.

Impression statements shows intent in subsequent fraud through the same clinical setting.

- HEPATITIS B VIRUS CORE ANTIBODY, TOTAL
- HEPATITIS C VIRUS ANTIBODY, IGG
- THYROGLOBULIN ANTIBODY
- THYROID PEROXIDASE ANTIBODY
- NEUTROPHIL CYTOPLASMIC ANTIBODY
- PR-3 (PROTEINASE-3) ANTIBODY
- Ambulatory EEG, 48 hrs
- NEUROPSYCHOLOGICAL TESTING

RTC after testing performed

Progress Notes **Narendra Jana (MR# 9463151)**

Progress Notes Info

Author	Note Status	Last Update User	Last Update Date/Time
Kimberly Menzer, NP	Signed	Kimberly Menzer, NP	8/6/2014 4:40 PM

Progress Notes

29 y/o M who returns in follow up.
SYmptoms unchanged since initial visit. Predominant problems are:
Mood: temperament, changing mood, impulsivity and lack of inhibition
Nerve pain and hand tremors
DATA:
AEEG normal with symptoms

SPECT: mildly hypoperfusion of posterior L frontal and TL--Minimal left posterior frontal and temporal hypoperfusion as above. This finding is nonspecific and may be seen with vasculitis of infectious, inflammatory, autoimmune or drug-related etiology.

Labs: IgM low at 31, C3 84 low
Neuropsych: please review file, presentation most c/w conversion d/o

In addition to our tests, he saw endo and work up normal he recalls. FBS normal, glucose tolerance test not ordered by endo.
Review of Systems - Negative except cognitive issues, mood issues, nerve pain

General Examination:

General Appearance: No acute distress.

BP 124/77 | Pulse 68 | Ht 1.676 m (5' 6") | Wt 50.803 kg (112 lb) | BMI 18.09 kg/m2

Neurological Examination:

Mental Status

State: Patient is awake and alert. Patient answers questions and follows commands appropriately. Spontaneity of speech and motor behavior are normal.

Orientation: Oriented to person, place and time.

Language: Speech is fluent with normal prosody. Tangential, paraphasic errors.

Mood and Affect: flat and a bit odd

Eye contact is reduced

Memory: Recent and remote memory are normal. Registers 3/3 objects. Recalls 3/3 objects.

Attention/Concentration: Normal. Able to spell WORLD backwards.

Judgment/Fund of Knowledge: Normal

Cranial Nerves

CN II: Visual fields intact to confrontation. Fundoscopic examination is normal with no evidence of disc edema or pallor. Pupils are equal, round and reactive to light and accommodation.

CN III, IV, VI: Normal. Extraocular muscles are intact without nystagmus or diplopia.

CN V: Normal. Facial sensation is symmetric. Muscles of mastication normal and

Has brain lesions and the typical effects of MS. Nerve pain and hand tremors. The other effects are due to brain inflammation due to MS and seizures.
AEEG test is misstated and falsified in this clinical setting.

Reiterated SPECT report.

There were no mood issues, the more prevalent problem was physical pain from spinal cord lesions, the effects of persistent seizures (frequent and uncontrolled), and occasional immobility from spinal cord lesions.

I believe she simply copied the falsely stated cranial nerve, motor, reflex, sensation, and station/gait statements from 6/17/2014 which were falsely stated.

symmetric.
CN VII: Normal. Facial musculature is symmetric.
CN VIII: Normal. Hearing is intact bilaterally.
CN IX, X: Normal. The palate rises symmetrically and the uvula is midline.
CN XI: Normal. Sternocleidomastoid 5/5 and trapezius 5/5 bilaterally.
CN XII: Normal. The tongue is midline with no evidence of atrophy.

Motor

Bulk and tone are normal throughout. There are no abnormal movements.
Upper extremity strength is full (5/5) bilaterally.
Lower extremity strength is full (5/5) bilaterally.
There is no pronator drift.
No tremor or adventitious movements are seen.

Reflexes

Biceps: Right 2+/4 and Left 2+/4
Triceps: Right 2+/4 and Left 2+/4
Brachioradialis: Right 2+/4 and Left 2+/4
Patellar: Right 2+/4 and Left 2+/4
Achilles: Right 2+/4 and Left 2+/4
Plantar Response:Normal. Bilateral toes are downgoing (Babinski sign absent).
Hoffman's: Absent

Sensation

Light Touch: Normal throughout upper and lower extremities.

Coordination

Finger to Nose Movement: Normal
Rapid Alternating Hand Movements: Normal
Fine Finger Movements: Normal
Heel-Shin Movements: Normal

Station/Gait

Gait: Normal station and gait.
Toe Gait: Normal
Heel Gait: Normal
Tandem Gait: Normal
Stress Gait (walking with feet everted): Normal without posturing
Romberg: Negative

Impression:
The primary encounter diagnosis was Immunodeficiency. A diagnosis of Depression was also pertinent to this visit.
Borderline low C3 and IgM and abn SPECT scan indicates certain level of

Does has optic neuropathy with repeated tests.

Reflexes, sensation, coordination, and gait are falsely stated.

C3 is used to check for certain kidney diseases and Systemic Lupus Erythematosus. SPECT shows the typical effects of neurological injury from either neurological insult, the reduced metabolic patterns

Jana, Narendra (MR # 9463151) Encounter Date: 08/06/2014

immunodeficiency which is more prevalent in individuals with depression than healthy and not necessarily pathogenic but rather an association
Plan:
Orders Placed This Encounter
Procedures
- Ambulatory referral to Rheumatology

Would recommend trial minocycline to reduce potential inflammation which is not part of an autoimmune process but has been documented in other cases of MDD intractable to meds. Minocycline's pharmacologic activity is mediated through anti microglial activity and reduces proinflammatory cytokines
Due to low C3 and IgM refer to rheumatology Dr Bruce Solitar.
Requested he continue close work with a psychiatrist.
Patient was not very receptive to continuing psychiatric care and resists explanation that there appears to be no obvious organic etiology for his psychiatric presentation

Jana, Narendra (MR # 9463151) Printed by Jorge Ortiz [ORTIZJ11] at 10/15/14 9:10 AM

typical in frontotemporal lobe dementias, dementias secondary to MS (which was later shown clearly in studies done abroad), or temporal lobe lesions typical of MS. NM SPECT shows all three.
The protein electrophoresis in serum the test result is misstated, in people with multiple sclerosis and during relapse these markers are generally high. This test showing a low positive as stated in the note which means there is an autoimmune process taking place.
The last statement by Dr. Menzer "encounter diagnosis of *immunodeficiency*" is an illogical statement in medicine. With protein electrophoresis in a low positive its clearly an autoimmune condition.

Its clear and easy to demonstrate fraud in this test.