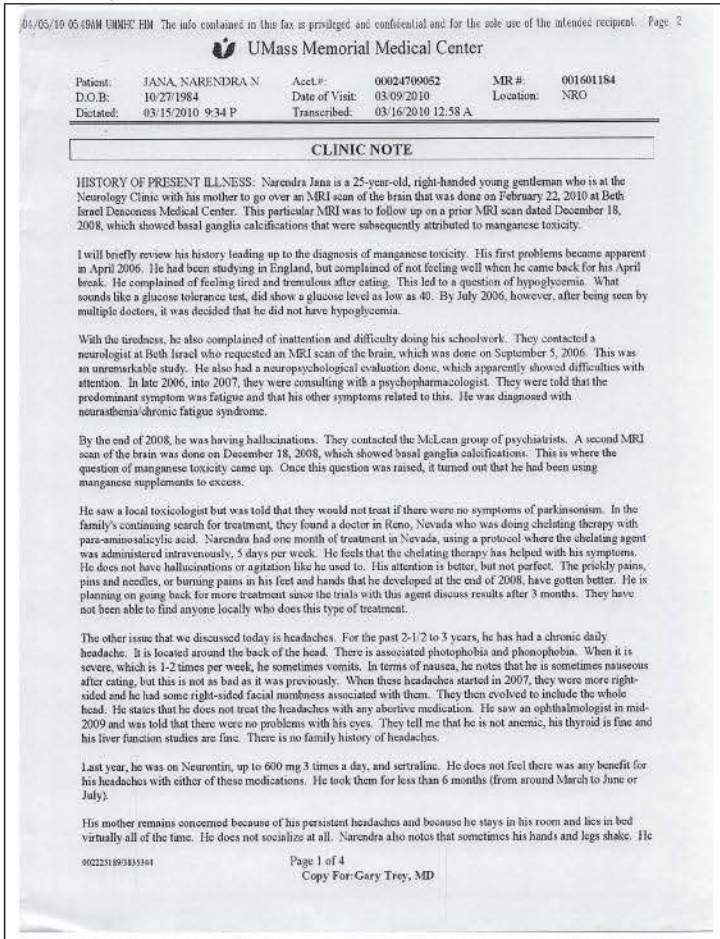
2010 March 15th (appointment on March 9th 2010)

- **Dr. Ellen Salurand – UMass Memorial Hospital – Worcester, MA**
  - **Negligence →**

Dr. Ellen Salurand perpetuates the same type of negligence as the other neurologists but with falsified MRI reports from the February 22nd 2010 MRI.



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UMass Memorial Medical Center

Patient:	JANA, NARENDRA N	Acct.#:	00024709052	MR #:	001601184
D.O.B:	10/27/1984	Date of Visit:	03/09/2010	Location:	NRO
Dictated:	03/15/2010 9:34 P	Transcribed:	03/16/2010 12:58 A		

CLINIC NOTE

HISTORY OF PRESENT ILLNESS: Narendra Jana is a 25-year-old, right-handed young gentleman who is at the Neurology Clinic with his mother to go over an MRI scan of the brain that was done on February 22, 2010 at Beth Israel Deaconess Medical Center. This particular MRI was to follow up on a prior MRI scan dated December 18, 2008, which showed basal ganglia calcifications that were subsequently attributed to manganese toxicity.

I will briefly review his history leading up to the diagnosis of manganese toxicity. His first problems became apparent in April 2006. He had been studying in England, but complained of not feeling well when he came back for his April break. He complained of feeling tired and tremulous after eating. This led to a question of hypoglycemia. What sounds like a glucose tolerance test, did show a glucose level as low as 40. By July 2006, however, after being seen by multiple doctors, it was decided that he did not have hypoglycemia.

With the tiredness, he also complained of inattention and difficulty doing his schoolwork. They contacted a neurologist at Beth Israel who requested an MRI scan of the brain, which was done on September 5, 2006. This was an unremarkable study. He also had a neuropsychological evaluation done, which apparently showed difficulties with attention. In late 2006, into 2007, they were consulting with a psychopharmacologist. They were told that the predominant symptom was fatigue and that his other symptoms related to this. He was diagnosed with neurasthenia/chronic fatigue syndrome.

By the end of 2008, he was having hallucinations. They contacted the McLean group of psychiatrists. A second MRI scan of the brain was done on December 18, 2008, which showed basal ganglia calcifications. This is where the question of manganese toxicity came up. Once this question was raised, it turned out that he had been using manganese supplements to excess.

He saw a local toxicologist but was told that they would not treat if there were no symptoms of parkinsonism. In the family's continuing search for treatment, they found a doctor in Reno, Nevada who was doing chelating therapy with para-aminosalicylic acid. Narendra had one month of treatment in Nevada, using a protocol where the chelating agent was administered intravenously, 5 days per week. He feels that the chelating therapy has helped with his symptoms. He does not have hallucinations or agitation like he used to. His attention is better, but not perfect. The prickly pains, pins and needles, or burning pains in his feet and hands that he developed at the end of 2008, have gotten better. He is planning on going back for more treatment since the trials with this agent discuss results after 3 months. They have not been able to find anyone locally who does this type of treatment.

The other issue that we discussed today is headaches. For the past 2-1/2 to 3 years, he has had a chronic daily headache. It is located around the back of the head. There is associated photophobia and phonophobia. When it is severe, which is 1-2 times per week, he sometimes vomits. In terms of nausea, he notes that he is sometimes nauseous after eating, but this is not as bad as it was previously. When these headaches started in 2007, they were more right-sided and he had some right-sided facial numbness associated with them. They then evolved to include the whole head. He states that he does not treat the headaches with any abortive medication. He saw an ophthalmologist in mid-2009 and was told that there were no problems with his eyes. They tell me that he is not anemic, his thyroid is fine and his liver function studies are fine. There is no family history of headaches.

Last year, he was on Neurontin, up to 600 mg 3 times a day, and sertraline. He does not feel there was any benefit for his headaches with either of these medications. He took them for less than 6 months (from around March to June or July).

His mother remains concerned because of his persistent headaches and because he stays in his room and lies in bed virtually all of the time. He does not socialize at all. Narendra also notes that sometimes his hands and legs shake. He

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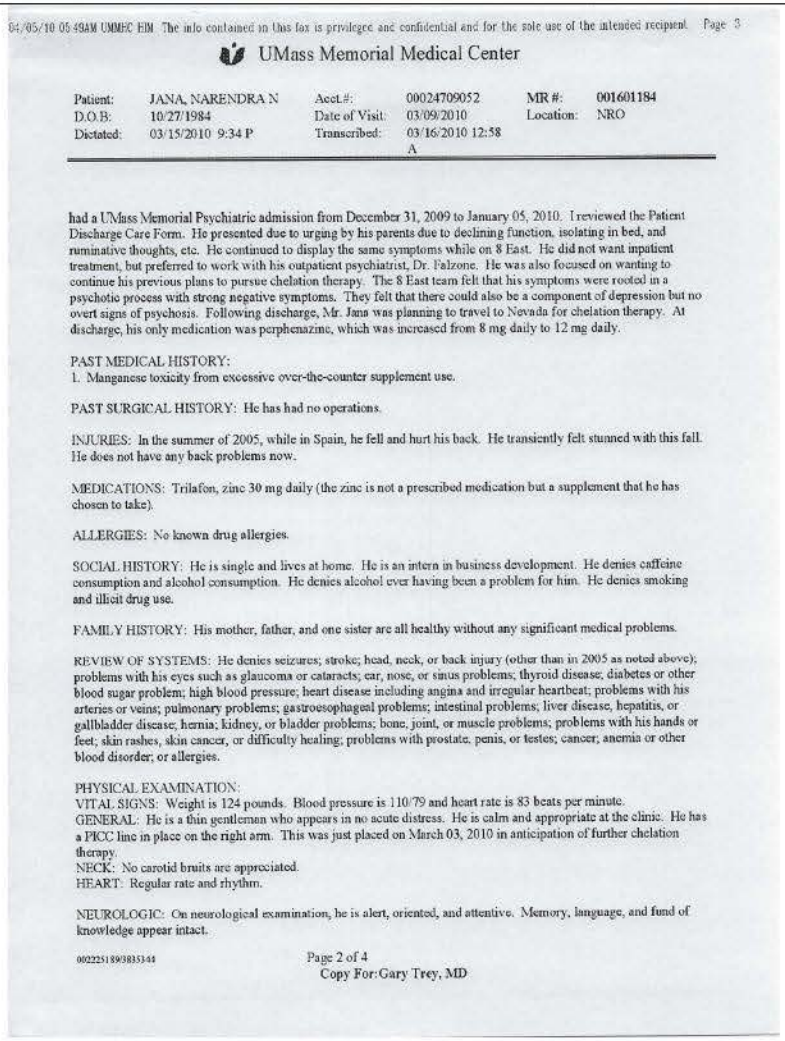
Copy For:Gary Trey, MD

I confused the effects of seizures with psych effects, they are seizures. I was uninformed of how it presents.
Optic neuropathy isn't prevalent in 2008 but still exists, lying in bed is due to what is seen later as lesions and neurodegeneration of the cervical spine. There is an inability to communicate due to disease process (dementia) and the "hands and legs shake" are due to daily recurrent seizures (thousands of seizures over years). Seizures don't have movement (seismology) since they are absence seizures but recorded.



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had a UMass Memorial Psychiatric admission from December 31, 2009 to January 05, 2010. I reviewed the Patient Discharge Care Form. He presented due to urging by his parents due to declining function, isolating in bed, and ruminative thoughts, etc. He continued to display the same symptoms while on 8 East. He did not want inpatient treatment, but preferred to work with his outpatient psychiatrist, Dr. Falzone. He was also focused on wanting to continue his previous plans to pursue chelation therapy. The 8 East team felt that his symptoms were rooted in a psychotic process with strong negative symptoms. They felt that there could also be a component of depression but no overt signs of psychosis. Following discharge, Mr. Jana was planning to travel to Nevada for chelation therapy. At discharge, his only medication was perphenazine, which was increased from 8 mg daily to 12 mg daily.

PAST MEDICAL HISTORY:
1. Manganese toxicity from excessive over-the-counter supplement use.

PAST SURGICAL HISTORY: He has had no operations.

INJURIES: In the summer of 2005, while in Spain, he fell and hurt his back. He transiently felt stunned with this fall. He does not have any back problems now.

MEDICATIONS: Trilafon, zinc 30 mg daily (the zinc is not a prescribed medication but a supplement that he has chosen to take).

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: He is single and lives at home. He is an intern in business development. He denies caffeine consumption and alcohol consumption. He denies alcohol ever having been a problem for him. He denies smoking and illicit drug use.

FAMILY HISTORY: His mother, father, and one sister are all healthy without any significant medical problems.

REVIEW OF SYSTEMS: He denies seizures; stroke; head, neck, or back injury (other than in 2005 as noted above); problems with his eyes such as glaucoma or cataracts; ear, nose, or sinus problems; thyroid disease; diabetes or other blood sugar problem; high blood pressure; heart disease including angina and irregular heartbeat; problems with his arteries or veins; pulmonary problems; gastroesophageal problems; intestinal problems; liver disease, hepatitis, or gallbladder disease; hernia; kidney, or bladder problems; bone, joint, or muscle problems; problems with his hands or feet; skin rashes, skin cancer, or difficulty healing; problems with prostate, penis, or testes; cancer; anemia or other blood disorder; or allergies.

PHYSICAL EXAMINATION:
VITAL SIGNS: Weight is 124 pounds. Blood pressure is 110/79 and heart rate is 83 beats per minute.
GENERAL: He is a thin gentleman who appears in no acute distress. He is calm and appropriate at the clinic. He has a PICC line in place on the right arm. This was just placed on March 03, 2010 in anticipation of further chelation therapy.
NECK: No carotid bruits are appreciated.
HEART: Regular rate and rhythm.

NEUROLOGIC: On neurological examination, he is alert, oriented, and attentive. Memory, language, and fund of knowledge appear intact.

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Psychiatry is a non objective profession, these effects are due to a toxicological effect. Dr. Salurand's negligence causes gross neurodegeneration by 2012 additive to negligence under toxicology, specifically posterior brain atrophy and what is later imaged as cervical spine atrophy down to lumbar spine atrophy.

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Cranial nerves II-XII are intact. Fundi reveal sharp disks with venous pulsations. Visual fields are full to confrontation. Pupils are equal, round and reactive to light. Extraocular movements are full, without nystagmus. Facial sensation is normal. There is no facial asymmetry. Hearing is intact to finger rub bilaterally. Palate elevates in the midline. Shoulder shrug is strong and equal. Tongue is midline.

On motor examination, there is no pronator drift. Power is 5/5 in both upper extremities and lower extremities. Tone and bulk are normal. There are no abnormal movements.

Sensory examination is notable for a slight decrease in vibratory sense at the great toe bilaterally. Position sense of the great toe, pinprick, temperature and graphesthesia are intact.

Deep tendon reflexes are 2- and symmetric at the biceps, brachioradialis, triceps, knees, and ankles. Toes are downgoing bilaterally.

Coordination testing is intact to finger-to-nose and rapid repetitive finger movements.

Gait is normal. He is able to toe walk, heel walk, and tandem walk. Romberg is negative.

PRIOR TESTING:
1. MRI scan of the brain at McLean Hospital, December 18, 2008. "On T1 weighted images, increase signal intensity is noted within the globus pallidi bilaterally. This may represent a pattern of mineralization. Other entities which could cause this include hyperalimentation, iron metabolism abnormalities to include a few. It is probably insignificant in this particular patient." The MRI is otherwise unremarkable.
2. MRI scan of the brain done at Beth Israel Deaconess Medical Center, February 22, 2010. This is a normal study without signal abnormality involving the deep nuclei. It is compared to a study from September 05, 2006. There is no change noted compared to that study. I reviewed the images of the February 22, 2010 study and agree with the interpretation.

IMPRESSION: Narendra Jana is a 25-year-old gentleman with a history of inattention and difficulty doing schoolwork beginning in 2006, progressing to agitation and hallucinations by the end of 2008. It seems that he carries a tentative diagnosis of schizophrenia, but he has also been diagnosed with manganese toxicity, from overuse of supplements. He is now status post 1 month of chelation therapy and reports improvement in agitation, hallucinations, and attention, although his attention is still not perfect. He continues to isolate himself in his room and spends most of the day lying down or sleeping, although his parents continue to encourage him to get up and be more active. He is planning to return to Nevada for further chelation therapy, which sounds reasonable by their report of the improvement that he has already received. The calcifications in the basal ganglia have resolved. I do not have anything further to add in this regard as I am not familiar with the pros and cons of this therapy. By their report, he saw a toxicologist here who did not recommend treatment unless symptoms of parkinsonism were evident.

In terms of the chronic daily headaches, with exacerbations 1 to 2 times per week, I suggested a trial of gabapentin beginning with 300 mg once a day and increasing in 300 mg increments, as needed and tolerated, up to 600 mg 3 times a day. He is given a prescription for 180 capsules with no refills.

The February 22nd MRI has erased MRI planes and images (fraud in medicine). There is no interpretation that could be derived from this MRI and the written MRI report is fraud.

As a neurologist Dr. Salurand would have known that the toxicity is unresolvable due to how it distributes in our physiology. The treatment should be dialysis with concomitant chelation to reduce the toxicity and limit neurological damage. EDTA (given in IV then) only has a temporary effect followed with anti inflammatory (Para Aminosalicylic Acid) medication that has a limited effect. This is why all future MRIs (that don't have erased series images and which aren't fraudulent) show the same toxicity.

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I am also concerned about his continued use of supplements. He indicates that he is only taking a zinc supplement currently. Both his mother and I encouraged him simply to eat a balanced diet and not to take any mineral supplements.

RECOMMENDATIONS:
1. Begin a trial of gabapentin 300 mg once a day, increasing in 300 mg increments, as needed and tolerated, up to 600 mg 3 times a day. He is given a prescription for 180 capsules with no refills.
2. He is encouraged to discontinue taking any mineral supplements.
3. Followup at the Neurology Clinic in 2 months.

E-Signed By
Ellen Salurand, MD 04/04/2010 18:28

Ellen Salurand, MD

Patient evaluated by and note dictated by: Ellen Salurand, MD

FJ
002225189/3835344

cc: Gary Trey, MD

Zinc improves plasticity (neurological functioning) in neurodegeneration, its used frequently in neurology for other clinical syndromes like Wilson's disease.