


2013 November 8th

- Dr. Stefanos Kales - Cambridge Health Alliance – Cambridge, Massachusetts
 - Criminal Negligence →

Cambridge Health Alliance - Dr. Stefanos Kales

Dr. Stefanos Kales replicates the same medical negligence as Dr. Ellen Salurand in March 15th 2010, denying treatment for a condition under toxicology. The treatment under toxicology and neurology is similar.

<p> Cambridge Health Alliance Division of Occupational and Environmental Medicine</p> <p>Stefanos N. Kales MD, MPH, FACP, FACOEM Division Chief, Occupational & Environmental Medicine Medical Director, Employee & Industrial Medicine (617) 665-1580 Fax (617) 665-1672</p> <p>November 8, 2013</p> <p>Charles Rosenbaum, MD 65 Fremont Street Marlborough, MA 01752</p> <p>RE: Narendra Jana – DOB 10/27/1984 CHA U#1217141</p> <p>Dear Dr. Rosenbaum:</p> <p>I had the pleasure of seeing Mr. Narendra Jana for consultation on November 13, 2013, with Dr. Laurent Benedetti, a resident in the Harvard Occupational and Environmental Medicine. The purpose of today's consultation was to address his questions regarding ingested Manganese exposure.</p> <p>History:</p> <p>Mr. Jana provided a detailed account of his symptoms and exposure history. Briefly, he explained that over a three month period at the end of 2008 he reports taking 50 mg. of manganese pill supplements, and is concerned there was excessive exposure. Since then he explains he has been experiencing distressing neurologic and cognitive symptoms.</p> <p>He is presently a masters student in electrical engineering at Boston University. He does participate in IT engineering work study. He denies any other known occupational or environmental exposure to manganese. His hobbies include biking. There is no report of other non-work environmental exposures or hobbies that put him at risk of manganese exposure.</p> <p>Past Medical History:</p> <p>His past medical history is significant for depression and he has been under psychiatric care in the past. He reports he continues to receive counseling. He reports remote head injury in college, with no loss of consciousness.</p> <p>Family History:</p> <p>Mr. Jana denies any known family history of mental illness or seizures.</p> <p>Cambridge Hospital • Department of Medicine • Suite 427 1493 Cambridge Street • Cambridge, MA 02138</p>	<p>Jana, Narendra November 8, 2013 Page 2</p> <p>Habits:</p> <p>Mr. Jana denies any cigarette, alcohol or other recreational drug use.</p> <p>Allergies:</p> <p>Mr. Jana states he has had adverse reactions to Risperdal.</p> <p>Medications:</p> <p>Omega 3, Zinc, Niacin</p> <p>Herbal or complimentary remedies: Mr. Jana states he has received chelating treatment with para amino salicylic acid for manganese toxicity with limited benefit. However, his symptoms persist.</p> <p>Review of Systems:</p> <p>In addition to the symptoms described in Mr. Jana's history, he denies fevers, chills, nausea, vomiting, diarrhea, chest pain, cough, difficulty breathing or skin rash.</p> <p>Physical Examination:</p> <p>Vitals: BP 112/70 HR: 68 Wt: 122 lb Ht: 66" BMI: 19.7 Well-groomed, thin, well-developed 29 year old right handed male. On exam, skin appeared normal. No cervical or supraclavicular lymphadenopathy. Face symmetric, tongue midline, pupils equal reactive to light and accommodation. Cranial nerves II-X grossly intact. Ears without evidence of inflammation or drainage. Tympanic membrane normal. Lungs clear to auscultation bilaterally. Heart regular in rate and rhythm without murmurs, rubs or gallops. Abdomen soft, nontender, nondistended. Muscle tone normal. 5/5 strength in upper and lower extremities, equal and symmetric. No fasciculations observed. No evidence of upper or lower extremity dysmetria. No evidence of dysidiadochokinesia. Slight, fine resting tremor observed in both hands not associated with intention. Romberg negative and gait normal. Deep tendon reflexes in upper and lower extremities within normal limits throughout. Judgment and orientation to place, person and time normal. Mood and affect appropriate. Full range of motion in upper and lower extremities with full range of motion at the hip.</p> <p>Labs:</p> <p>Manganese blood : None detected Manganese urine corrected for creatinine : 2.3 (<3 ug/g Cr)</p> <p>MRI Brain Review:</p> <p style="text-align: right;">Narendra Jana</p>
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The blood test by Dr. Kales is most likely falsified since future MRIs show prominent MRI features of manganese toxicity in the brain.

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Jana

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Two brain MRIs were reviewed by the Cambridge Health Alliance Department from 12/18/2008 and 10/27/2102. Findings revealed a high signal in the globus pallidus bilaterally on the 12/18/2008 study, but this was not apparent on the later study. The final impression was no significant intracranial abnormality.

Impressions:

Mr. Jana is a pleasant, 29 year old male who seeks consultation today for possible manganese exposure. Based on current labs, there is no evidence to support manganese toxicity at present. Blood tests for manganese and manganese urine corrected for creatinine levels do not show evidence of toxicity. The later brain MRI study did not show evidence of persistent pathology compared to the initial MRI read. Based on our exam and test results, we cannot explain Mr. Jana's current symptomatology as being related to manganese and would not recommend any clinical treatment directed at manganese toxicity at this time. Further follow up with Neurology and/or Psychiatry is advised.

Thank you for the opportunity to participate in Mr. Jana's care.

Sincerely,



Stefanos N. Kales, MD, MPH, FACP, FACOEM

cc: Mr. Narendra Jana

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Dr. Kales references a MRI with a falsified report in his report, the 2012 December 27th MRI.

Both blood and urine tests are most likely falsified considering the presentation of toxicity in all future MRIs including the most recent MRIs in 2019. The toxin is hard to remove without treatment in hospital settings.

Most toxicologists know this: Manganese (because it builds up in our skeletal system and muscles) wouldn't show up in an MRI after chelation but will become visible within a month after chelation due to the nature of the toxicity (the toxicity is persistent).

All future MRIs show a T1 intensity in the basal ganglia of my brain that goes down to the cervical spinal column. The toxicity causes neuroinflammation and effects the CNS resulting in multiple sclerosis. The toxin also effects specifically iron and copper metabolism (clinical research articles available) along with mitochondrial functioning.

Most MRIs have fraudulent reports to try and hide the clear presence of a toxin in the central nervous system but any lay person could see the toxicological feature in the MRI without a radiology report.

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