2017 August 16th

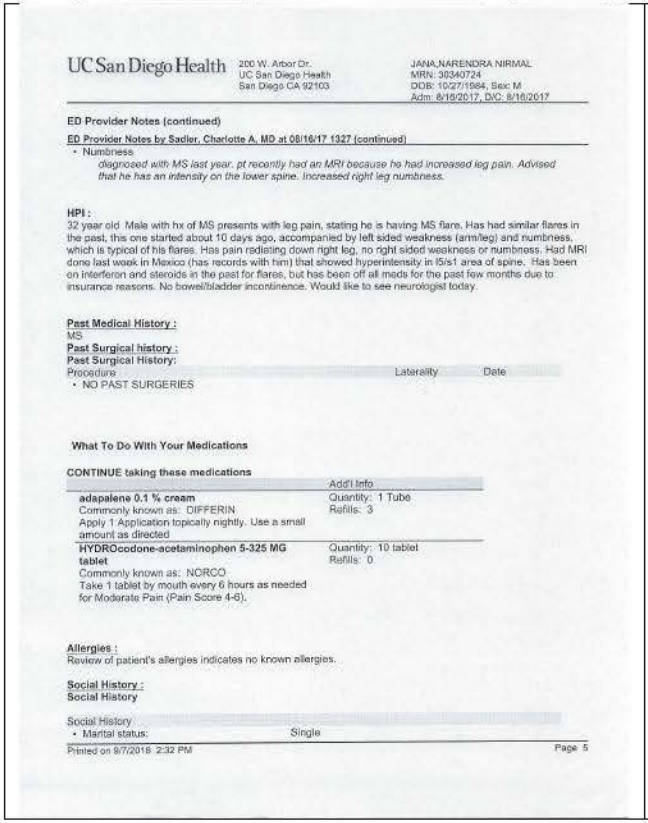
- **Emergency Department - University of California San Diego (UCSD) Hospital – San Diego, California, USA**
  - **Criminal Negligence and Assault in a ER Setting →**

Narendra Jana

UCSD ER Appointment:

With my worsening condition another ER appointment occurs in the US in UCSD San Diego Health.
The condition is severe with some physical immobility from the level of inflammation in the spinal column.

Much of the medical negligence is done in the US with the mindset that I don't understand the nature of the fraudulence that has taken place to further the condition in the past. This simply served as a more clear example of denying medical help in a severe phase of a condition, but this was clearly done with the intent to case harm because much of the report that was written in the ER is incongruent and appears to have an objective purpose.



UC San Diego Health 200 W. Arbor Dr. UC San Diego Health San Diego CA 92103

JANA,NARENDRA NIRMAL
MRN: 30340724
DOB: 10/27/1984, Sex: M
Adm: 8/16/2017, D/C: 8/16/2017

ED Provider Notes (continued)

ED Provider Notes by Sadler, Charlotte A, MD at 08/16/17 1327 (continued)

- Numbness
  diagnosed with MS last year, pt recently had an MRI because he had increased leg pain. Advised that he has an intensity on the lower spine. Increased right leg numbness.

HPI :
32 year old Male with hx of MS presents with leg pain, stating he is having MS flare. Has had similar flares in the past, this one started about 10 days ago, accompanied by left sided weakness (arm/leg) and numbness, which is typical of his flares. Has pain radiating down right leg, no right sided weakness or numbness. Had MRI done last week in Mexico (has records with him) that showed hyperintensity in IS/s1 area of spine. Has been on interferon and steroids in the past for flares, but has been off all meds for the past few months due to insurance reasons. No bowel/bladder incontinence. Would like to see neurologist today.

Past Medical History :
MS
Past Surgical history :
Past Surgical History:

Procedure	Laterality	Date
• NO PAST SURGERIES		

What To Do With Your Medications

CONTINUE taking these medications

	Add'l Info
adapalene 0.1 % cream Commonly known as: DIFFERIN Apply 1 Application topically nightly. Use a small amount as directed	Quantity: 1 Tube Refills: 3
HYDROcodone-acetaminophen 5-325 MG tablet Commonly known as: NORCO Take 1 tablet by mouth every 6 hours as needed for Moderate Pain (Pain Score 4-6).	Quantity: 10 tablet Refills: 0

Allergies :
Review of patient's allergies indicates no known allergies.

Social History :
Social History

Social History	
• Marital status:	Single

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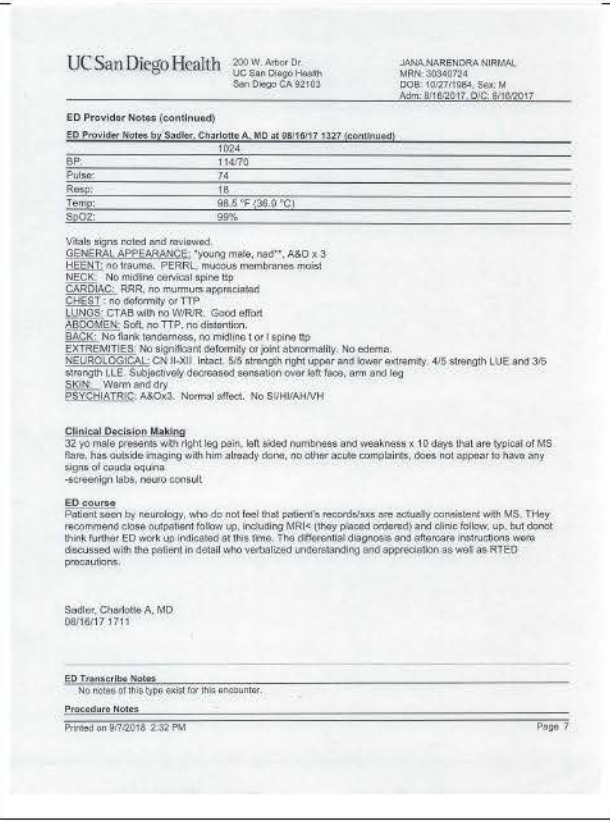

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ED Provider Notes (continued)

ED Provider Notes by Sadler, Charlotte A, MD at 08/16/17 1327 (continued)

	1024
BP:	114/70
Pulse:	74
Resp:	18
Temp:	98.5 °F (36.9 °C)
SpO2:	99%

Vitals signs noted and reviewed.
GENERAL APPEARANCE: *young male, nad**, A&O x 3
HEENT: no trauma. PERRL, mucous membranes moist
NECK: No midline cervical spine ttp
CARDIAC: RRR, no murmurs appreciated
CHEST : no deformity or TTP
LUNGS: CTAB with no W/R/R. Good effort
ABDOMEN: Soft, no TTP, no distention.
BACK: No flank tenderness, no midline t or l spine ttp
EXTREMITIES: No significant deformity or joint abnormality. No edema.
NEUROLOGICAL: CN II-XII intact. 5/5 strength right upper and lower extremity. 4/5 strength LUE and 3/5 strength LLE. Subjectively decreased sensation over left face, arm and leg
SKIN: Warm and dry
PSYCHIATRIC: A&Ox3. Normal affect. No SI/HI/AH/VH

Clinical Decision Making
32 yo male presents with right leg pain, left sided numbness and weakness x 10 days that are typical of MS flare, has outside imaging with him already done, no other acute complaints, does not appear to have any signs of cauda equina
-screenign labs, neuro consult

ED course
Patient seen by neurology, who do not feel that patient's records/sxs are actually consistent with MS. THey recommend close outpatient follow up, including MRI< (they placed ordered) and clinic follow up, but donot think further ED work up indicated at this time. The differential diagnosis and aftercare instructions were discussed with the patient in detail who verbalized understanding and appreciation as well as RTED precautions.

Sadler, Charlotte A, MD
08/16/17 1711

ED Transcribe Notes
No notes of this type exist for this encounter.

Procedure Notes

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Some of the outstanding statements made in the report are that his symptoms are "typical of a MS flair" but the doctor simply doesn't feel like that "its consistent with MS." Even in a severely effected state the ER doctor still does not feel that any medical workup is necessary (which is medically inappropriate).

Narendra Jana

Narendra Jana

Procedure Notes (continued)

No notes of this type exist for this encounter.

ED Observation Notes

No notes of this type exist for this encounter.

Consult Notes

Consults by Longardner, Katherine Marie, MD at 08/16/17 1317

Author: Longardner, Katherine Marie, MD | Service: Neurology | Author Type: Resident
Filed: 08/16/17 1845 | Date of Service: 08/16/17 1317 | Status: Attested
Editor: Longardner, Katherine Marie, MD (Resident) | Cosigner: Khoromi, Suzan, MD at 08/17/17 1107

Consult Orders:
1. IP Consult To Neurology [140480242] ordered by Sadler, Charlotte A, MD at 08/16/17 1313

Attestation signed by Khoromi, Suzan, MD at 08/17/17 1107

I agree with the assessment and plan as above.
Suzan Khoromi MD

NEUROLOGY CONSULT

Patient Name: Narendra Nirmal Jana Age: 32 year old Sex: male
MRN: 30340724
Location: 17/17 DOA: 8/16/2017, 0 Hours

Reason for Consult: MS Flare
Requesting Physician: Dr. Sadler (ED)

History of Present Illness: *provided by patient, also he brings (incomplete) outside records from various institutions.*

32 year old RH male with past medical history of reported Multiple Sclerosis, who presents to the ED with complaint of an ongoing MS flare. He currently describes lower back pain with radiation down his right medial thigh, through his calf, and into the great toe, he describes it as burning pain and numbness. He states that he began having these symptoms 2 weeks ago; prior to this he went to see a primary care doctor in Mexico in May 2017 who recommended that the patient receive a lumbar MRI, which was completed one week ago, and patient reports it demonstrated hyperintensity of the L5/S1 area. After this MRI, his MD in Mexico recommended that the patient return to medication treatment, and so the patient is here to establish care following these recommendations, and to manage his symptoms.

Neurologic baseline is mild left-sided weakness of arm and leg with "color loss" of his vision. He has had deficits since 2009.

He has had similar symptoms to his current complaints in the past, and states that his symptoms first began back in 2009, with peripheral "burning" and sensory symptoms. He reports that he has continued to have intermittent worsening of these same sensory symptoms of numbness and alternating with pain in his arms and legs since 2009. He states that he usually has flares that affect his vision, in his left eye, and he often

Consult Notes (continued)

Consults by Longardner, Katherine Marie, MD at 08/16/17 1317 (continued)

experiences "short term memory loss," and cervical neck pain. He reports some urinary urgency with previous flares. He denies ever having an LP.

Reports previous symptoms have responded well to intermittent immunomodulatory treatment as below:
Previous meds for his symptoms include:
-Prednisone - Started December 2015, for 3 weeks, discontinued due to unclear reasons
-Subcutaneous IFN - Started in 2015 for "a few weeks", discontinued due to expense, used intermittently while in India in 2016 and Most recently in April 2017 when he was admitted to Sharp after experiencing vision loss.
-Cyclophosphamide - started Sep 2016 in India, used intermittently until several weeks ago
-Methotrexate - started March 2017, stopped May 2017 due to expense, prescribed by MD in Mexico

Summary of outside records, which he brings today (incomplete):
Records include outside documents from Malaysia, Italy, Mexico

Outside Neuropsych testing from Beth Israel Deaconess Medical Center, 2/21/07
"Weakness in attention and executive functioning, slower processing, problems with working memory, sustained attention, planning, excellent verbal testing... psychologic testing reveals significant problems with quality of thinking and mood." Deemed suspected psychiatric illness, vs neurocognitive disorder, possible prodrome to psychotic disorder, vs psychosomatic. However, features against psychiatric disorder include that he was described as organized, with good self-observation and related quality of interactions

Received ECT in 2010 without improvement.

Neuropsychiatric testing from Boston University Neurology
"No difficulty with memory, but difficulty learning and encoding, severe mood problems though to be affecting memory."

SPECT brain 7/12/14: minimal left posterior front and temporal hypoperfusion, nonspecific

Bumurund International MRI brain, MRA of brain and neck, MRV brain 3/12/16
IMPRESSION: Mild diffuse brain atrophy which is slightly too advanced for age; MRA of brain and neck and MRV brain are unremarkable.

Long term video EEG 5/5/16 (uncertain facility): interictal epileptiform discharges from R hemisphere with predominance in the fronto-temporal regions, ictal semiology considered non-epileptic events with no ictal EEG changes.

Sharp Rees Steely 5/5/17 Serum labs

HA1c 5.4%, liver panel abd CMP anl,TSH 1.57, lipid panel wnl, Utox negative

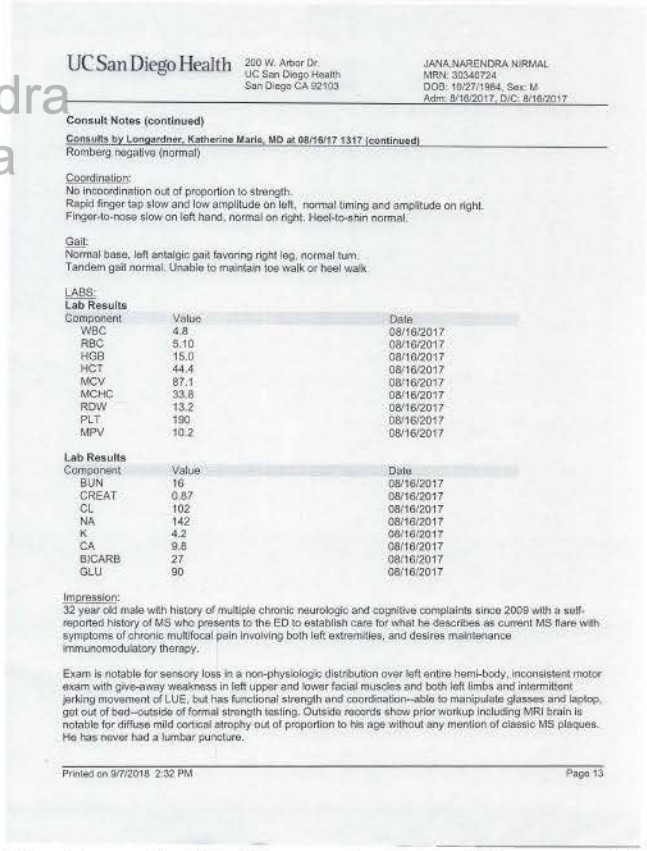
MRI lumbar spine w/wo 8/9/17 in Mexico: Herniated disc at L5-S1 on left side

He shows me his outside imaging on his personal laptop including coronal brain MRI which shows some possible mild diffuse cortical atrophy and questionable bilateral symmetric inferior posterior FLAIR hyperintensities in occipital lobes, also sagittal MRI thoracic spine which show questionable FLAIR hyperintensity in mid-thoracic cord

Narendra Jana

Every single diagnostic that the doctor mentions in the report indicates a sever neurological ethology of the condition but she still refuses medical treatment in a sever state.

Narendra Jana



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Consult Notes (continued)

Consults by Longardner, Katherine Marie, MD at 08/16/17 1317 (continued)

Romberg negative (normal)

Coordination:
No incoordination out of proportion to strength.
Rapid finger tap slow and low amplitude on left, normal timing and amplitude on right.
Finger-to-nose slow on left hand, normal on right. Heel-to-shin normal.

Gait:
Normal base, left antalgic gait favoring right leg, normal turn.
Tandem gait normal. Unable to maintain toe walk or heel walk

LABS:

Lab Results

Component	Value	Date
WBC	4.8	08/16/2017
RBC	5.10	08/16/2017
HGB	15.0	08/16/2017
HCT	44.4	08/16/2017
MCV	87.1	08/16/2017
MCHC	33.8	08/16/2017
RDW	13.2	08/16/2017
PLT	190	08/16/2017
MPV	10.2	08/16/2017

Lab Results

Component	Value	Date
BUN	16	08/16/2017
CREAT	0.87	08/16/2017
CL	102	08/16/2017
NA	142	08/16/2017
K	4.2	08/16/2017
CA	9.8	08/16/2017
BICARB	27	08/16/2017
GLU	90	08/16/2017

Impression:
32 year old male with history of multiple chronic neurologic and cognitive complaints since 2009 with a self-reported history of MS who presents to the ED to establish care for what he describes as current MS flare with symptoms of chronic multifocal pain involving both left extremities, and desires maintenance immunomodulatory therapy.

Exam is notable for sensory loss in a non-physiologic distribution over left entire hemi-body, inconsistent motor exam with give-away weakness in left upper and lower facial muscles and both left limbs and intermittent jerking movement of LUE, but has functional strength and coordination--able to manipulate glasses and laptop, get out of bed--outside of formal strength testing. Outside records show prior workup including MRI brain is notable for diffuse mild cortical atrophy out of proportion to his age without any mention of classic MS plaques. He has never had a lumbar puncture.

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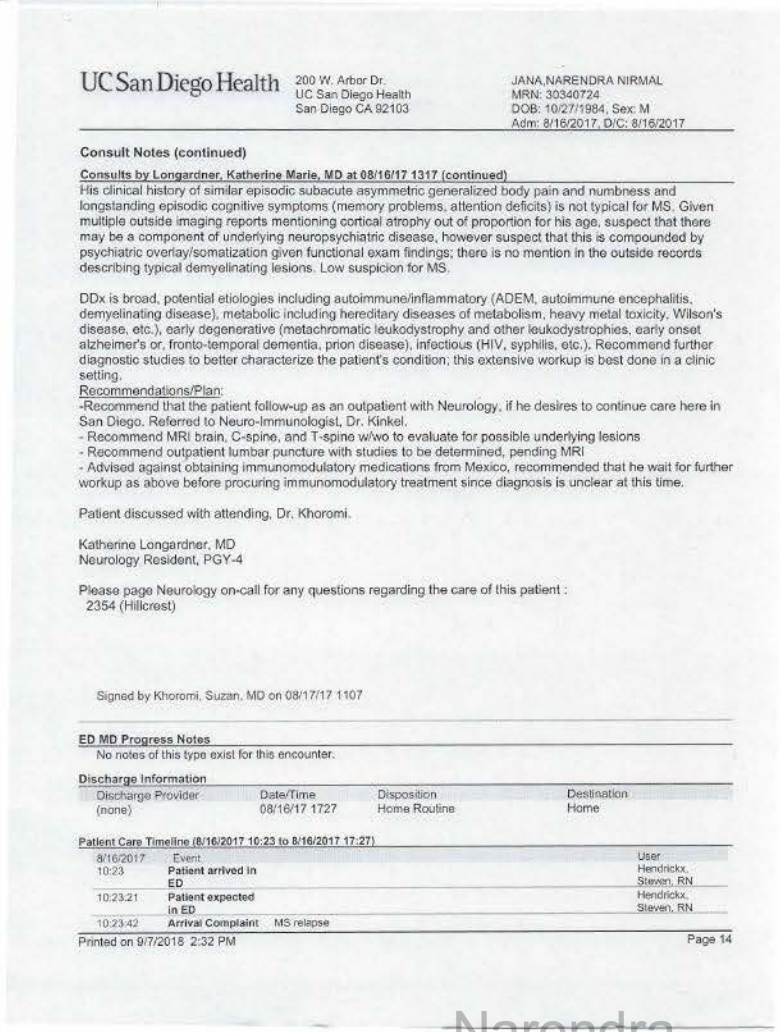
The doctor in the ER uses the term “give away” (meaning pretense) but the next MRI done in Tijuana Mexico shows gross lesions both T1 and T2 in the cervical spine that would make it easy to show that its not “give away”. Since the MRI in January 2017 was recorded to be fraudulated the doctor also has no defense in fraud. Repeated instances of illegality followed by other instances of illegality (illegality to support illegality).



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Consult Notes (continued)

Consults by Longardner, Katherine Marie, MD at 08/16/17 1317 (continued)

His clinical history of similar episodic subacute asymmetric generalized body pain and numbness and longstanding episodic cognitive symptoms (memory problems, attention deficits) is not typical for MS. Given multiple outside imaging reports mentioning cortical atrophy out of proportion for his age, suspect that there may be a component of underlying neuropsychiatric disease, however suspect that this is compounded by psychiatric overlay/somatization given functional exam findings; there is no mention in the outside records describing typical demyelinating lesions. Low suspicion for MS.

DDx is broad, potential etiologies including autoimmune/inflammatory (ADEM, autoimmune encephalitis, demyelinating disease), metabolic including hereditary diseases of metabolism, heavy metal toxicity, Wilson's disease, etc.), early degenerative (metachromatic leukodystrophy and other leukodystrophies, early onset alzheimer's or, fronto-temporal dementia, prion disease), infectious (HIV, syphilis, etc.). Recommend further diagnostic studies to better characterize the patient's condition; this extensive workup is best done in a clinic setting.

Recommendations/Plan:
-Recommend that the patient follow-up as an outpatient with Neurology, if he desires to continue care here in San Diego. Referred to Neuro-Immunologist, Dr. Kinkel.
- Recommend MRI brain, C-spine, and T-spine w/wo to evaluate for possible underlying lesions
- Recommend outpatient lumbar puncture with studies to be determined, pending MRI
- Advised against obtaining immunomodulatory medications from Mexico, recommended that he wait for further workup as above before procuring immunomodulatory treatment since diagnosis is unclear at this time.

Patient discussed with attending, Dr. Khoromi.

Katherine Longardner, MD
Neurology Resident, PGY-4

Please page Neurology on-call for any questions regarding the care of this patient :
2354 (Hillcrest)

Signed by Khoromi, Suzan, MD on 08/17/17 1107

ED MD Progress Notes

No notes of this type exist for the encounter.

Discharge Information

Discharge Provider	Date/Time	Disposition	Destination
(none)	08/16/17 1727	Home Routine	Home

Patient Care Timeline (8/16/2017 10:23 to 8/16/2017 17:27)

	Event		User
8/16/2017 10:23	**Patient arrived in ED**		Hendrickx, Steven, RN
10:23:21	**Patient expected in ED**		Hendrickx, Steven, RN
10:23:42	**Arrival Complaint**	MS relapse	

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Narendra Jana

There is inconsistency and a lack of correlation in her ER report; making statements that don’t substantiate the medical evidence.

The doctor in the ER practices negligence and assault (by withholding medications in a sever medical state) and then downplays effects leading to a much more sever consequence in an ER appointment immediately to follow in a foreign nation; Mexico City, Mexico. In the ER appointment in Mexico City the medications are given to a positive effect and with no consequence and no negative effect.

The audio recordings of the ER appointment show the full situation and are explicit to show the severity of the situation. The collective data over two hospitals describes the nature of the assault taken place.

Narendra Jana

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