2017 September 25th onward till September 17th 2018

- **CI3M Radiology Clinic – Mexico City, Mexico**
  - **Criminal Fraud →**

September 25th, (Brain, Cervical, Thorasic, and Lumbar), **October 18th 2017** (Brain Flair Images)
December 5th 2017 MRI (Brain and Cervical)
May 30th 2018 (Brain and Cervical)
June 11th 2018 (Thorasic and Lumbar)
July 25th 2018 (Brain and Cervical T2 Images Flair)
September 17th 2018 (Brain and Cervical)

MRIs (sequential MRIs done in the same clinic at 3T resolution)
– CI3M (Centro Nacional de Investigación en Imagenología e Instrumentación Médica), Mexico City, Mexico.

A number of MRIs are recorded in CI3M in Mexico City that are useful for determining disease pathology and progression in the setting of Multiple Sclerosis.
Though the radiology reports are falsified (as directed by the United States) the treating neurologists all determined that there was progressive neurological atrophy in the MRIs cumulating to a diagnosis of secondary progressive MS due to a lack of appropriate treatment. (when the appropriate medications aren't given it causes neurological damage from inflammation, thus typifying the effect of negligence as neurological damage):

Since MRIs are additive (that means a feature shown in the first MRI is apparent in all MRIs, excluding T1 images). All the brain MRIs show these features:

Hospital Angeles DEL PEDREGAL

Dr. Luis Enrique Amaya Sánchez
Neurología y Medicina Interna
CED. ESP. NEUROLOGIA 3872864 CED. ESP. MEDICINA INTERNA 3872860 UNAM

Mexico City to April 10, 2019

To Whom It May Concern:

By means of the present report that finds me taking care of the patient Narendra Jana of 34 years of age whom is carrier of demyelinating disease of the type of multiple sclerosis, initially recurrent-remitting variety, but now secondary progressive form.

The patient presented a picture of left optic neuritis, which was initially managed with methylprednisolone 1 gm IV every 24 hours for 3 days, approximately 2 months after which he presented improvement, but later he presented paresthesia and dysesthesia in the left extremities, subsequently presenting with weakness mainly in the hand and later in the left leg.

The first historical ER presentation where appropriate medications are given is in September 19th 2017 in Hospital Angeles, Mexico City preceded by a brain, cervical MRI with contrast on August 25th 2017. The August 25th 2017 MRI shows T1 enhanced lesions in the cervical spine and a T1 intensity in the globus pallidi (basal brain) with T2 intensities in the cervical spine. The patient presenting with "acute pain 9/10, low back. And left thoracic limb, associated to numbness and paraesthesia in the same distribution" and "difficulty for walking and sitting discomfort, with only tolerance of laying position". Methylprednisolone is administered for 5 days to a positive response.

A MRI was done immediately thereafter in September 25th 2017 with contrast that shows a reduction of T1 intensities in cervical column and basal brain; there are T2 intensities in the FLAIR image sequences image along corpus callosum and posterior brain (occipital lobe) in the series with mild features of Dawson fingers.

In the next ER appointments was with similar clinical presentation and his subsequent MRI images showed increase of demyelinating lesion and cervical atrophy

In my initial clinical examination, documented marked decreased mentation papilla pallor in the left eye, and a little bit nystagmus when he looking to the left side, as well as motor and sensory deficits in the left body with an EDSS 4.5 rating, the last resonance performed 2 and a half months ago showed an increase in lesion load and a neuropsychological reports dated August 11th 2018, indicated reduced processing speed with his executive functioning and decision making mostly preserved. Tests for visual attention and task switching is below cut off. Tests with respect to global functioning, memory functioning, attention span, and language are average.

Based on the above, it was decided to start treatment with plasmapheresis for which required Niagara type catheter placement, as well as hospitalization in infusion center to apply 3 plasmapheresis sessions consisting of 2-volume replacement with 5% immunoglobulin 2 bottles per liter without complication, however despite the medications given the positive effects were only transient (lasting only a few months); it was determined why this was the case. In a comparison between the MRIs taken in January 10th 2017, September 25th 2017, May 30th 2018, and August 28th 2018 it was shown that the patient has

Hospital Angeles del Pedregal
Centro de Especialidades Quirúrgicas
Periférico Sur Nº 3787 Cons. 478, 4º Piso
Col. Héroes de Padierna, México D.F. C.P. 10700

D.G.P. 1292116

Tel. Dir 5652 6042 / 5135 3906
Conm 5449 5500 EXT. 4478
Urgencias 5278 4848 Pm 10406945
E-mail: luisamaya@prodigy.net.mx

As doctor Amaya mentions, all MRIs Flair and T2 Images taken of the Brain in this MRI clinic would have "T2 intensities in the FLAIR image sequence [images] along corpus callosum and posterior brain (occipital lobe) in the series with mild features of Dawson fingers." So for example Dr. Jonathan Carter in Mayo Clinic lying about these features in a July 16th 2018 appointment couldn't be defended by Dr. Carter; all MRIs have these features.

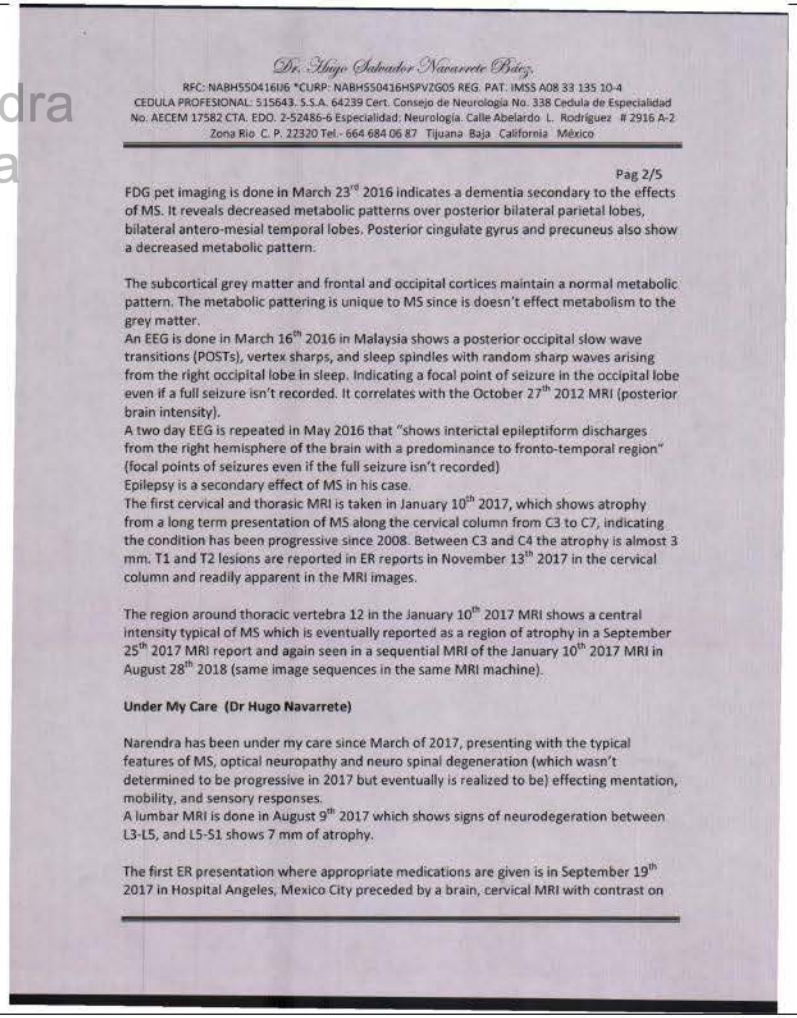
Dawson's fingers are unique to MS (only happens in MS) thought they are mild.

A MRI was done immediately thereafter in September 25th 2017 with contrast that shows a reduction of T1 intensities in cervical column and basal brain; there are T2 intensities in the FLAIR image sequences image along corpus callosum and posterior brain (occipital lobe) in the series with mild features of Dawson fingers.

The T2 intensity mentioned in the cervical spine would appear as either T2 intensities or atrophy in the next MRI series. And would appear in all future MRIs starting from January 10th 2017.

The first historical ER presentation where appropriate medications are given is in September 19th 2017 in Hospital Angeles, Mexico City preceded by a brain, cervical MRI with contrast on August 25th 2017. The August 25th 2017 MRI shows T1 enhanced lesions in the cervical spine and a T1 intensity in the globus pallidi (basal brain) with T2 intensities in the cervical spine. The patient presenting with "acute pain 9/10,

Dr. Hugo Navarrete mentions it in his report:



Dr. Hugo Salvador Navarrete Báez.

RFC: NABH550416IU6 *CURP: NABH550416HSPVZG05 REG. PAT. IMSS A08 33 135 10-4
CEDULA PROFESIONAL: 515643. S.S.A. 64239 Cert. Consejo de Neurologia No. 338 Cedula de Especialidad No. AECEM 17582 CTA. EDO. 2-52486-6 Especialidad: Neurologia. Calle Abelardo L. Rodriguez # 2916 A-2 Zona Rio C. P. 22320 Tel.- 664 684 06 87 Tijuana Baja California México

Pag 2/5

FDG pet imaging is done in March 23rd 2016 indicates a dementia secondary to the effects of MS. It reveals decreased metabolic patterns over posterior bilateral parietal lobes, bilateral antero-mesial temporal lobes. Posterior cingulate gyrus and precuneus also show a decreased metabolic pattern.

The subcortical grey matter and frontal and occipital cortices maintain a normal metabolic pattern. The metabolic pattering is unique to MS since is doesn't effect metabolism to the grey matter.
An EEG is done in March 16th 2016 in Malaysia shows a posterior occipital slow wave transitions (POSTs), vertex sharps, and sleep spindles with random sharp waves arising from the right occipital lobe in sleep. Indicating a focal point of seizure in the occipital lobe even if a full seizure isn't recorded. It correlates with the October 27th 2012 MRI (posterior brain intensity).
A two day EEG is repeated in May 2016 that "shows interictal epileptiform discharges from the right hemisphere of the brain with a predominance to fronto-temporal region" (focal points of seizures even if the full seizure isn't recorded)
Epilepsy is a secondary effect of MS in his case.
The first cervical and thorasic MRI is taken in January 10th 2017, which shows atrophy from a long term presentation of MS along the cervical column from C3 to C7, indicating the condition has been progressive since 2008. Between C3 and C4 the atrophy is almost 3 mm. T1 and T2 lesions are reported in ER reports in November 13th 2017 in the cervical column and readily apparent in the MRI images.

The region around thoracic vertebra 12 in the January 10th 2017 MRI shows a central intensity typical of MS which is eventually reported as a region of atrophy in a September 25th 2017 MRI report and again seen in a sequential MRI of the January 10th 2017 MRI in August 28th 2018 (same image sequences in the same MRI machine).

Under My Care (Dr Hugo Navarrete)

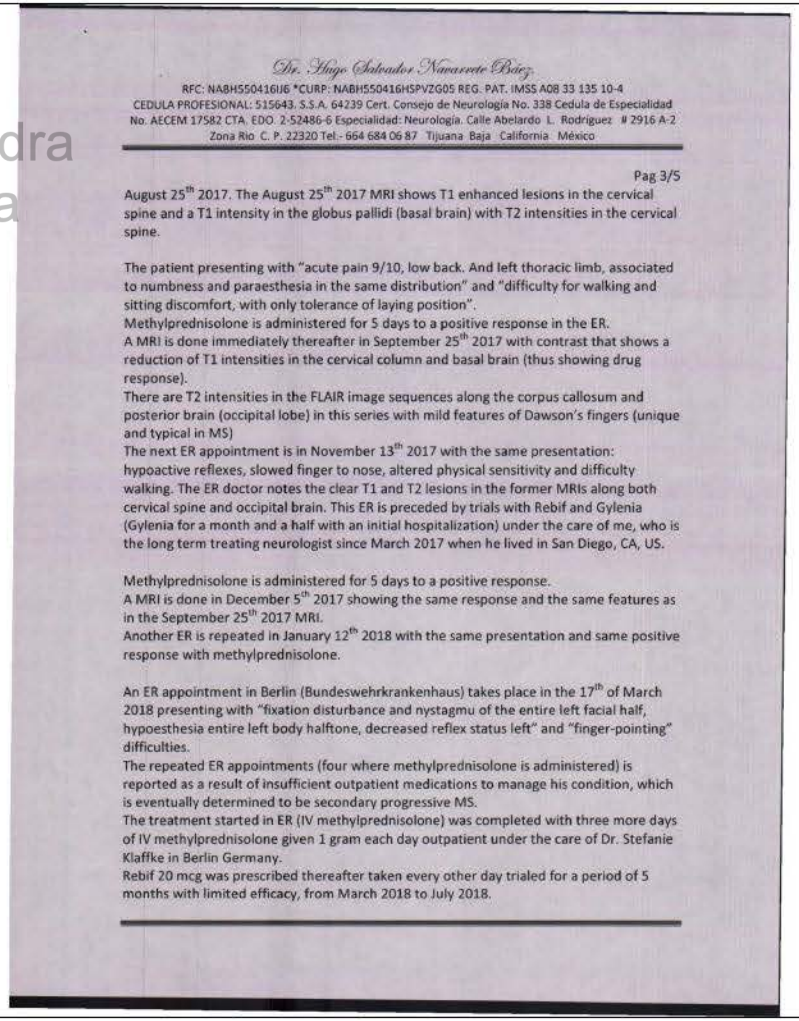
Narendra has been under my care since March of 2017, presenting with the typical features of MS, optical neuropathy and neuro spinal degeneration (which wasn't determined to be progressive in 2017 but eventually is realized to be) effecting mentation, mobility, and sensory responses.
A lumbar MRI is done in August 9th 2017 which shows signs of neurodegeration between L3-L5, and L5-S1 shows 7 mm of atrophy.

The first ER presentation where appropriate medications are given is in September 19th 2017 in Hospital Angeles, Mexico City preceded by a brain, cervical MRI with contrast on

Dr. Hugo typifies it better:

A lumbar MRI is done in August 9th 2017 which shows signs of neurodegeration between L3-L5, and L5-S1 shows 7 mm of atrophy.

The lumbar MRI done in August 9th 2017 shows signs of neurodegeneration between L3-L5, and L5-S1 shows 7mm of atrophy. That means that all future Lumbar MRIs would shows the same features or worse.



Dr. Hugo Salvador Navarrete Báez.

RFC: NABH550416IJ6 *CURP: NABH550416HSPVZG05 REG. PAT. IMSS A08 33 135 10-4
CEDULA PROFESIONAL: 515643. S.S.A. 64239 Cert. Consejo de Neurología No. 338 Cedula de Especialidad
No. AECEM 17582 CTA. EDO. 2-52486-6 Especialidad: Neurología. Calle Abelardo L. Rodriguez # 2916 A-2
Zona Rio C. P. 22320 Tel.- 664 684 06 87 Tijuana Baja California México

Pag 3/5

August 25th 2017. The August 25th 2017 MRI shows T1 enhanced lesions in the cervical spine and a T1 intensity in the globus pallidi (basal brain) with T2 intensities in the cervical spine.

The patient presenting with "acute pain 9/10, low back. And left thoracic limb, associated to numbness and paraesthesia in the same distribution" and "difficulty for walking and sitting discomfort, with only tolerance of laying position".
Methylprednisolone is administered for 5 days to a positive response in the ER.
A MRI is done immediately thereafter in September 25th 2017 with contrast that shows a reduction of T1 intensities in the cervical column and basal brain (thus showing drug response).
There are T2 intensities in the FLAIR image sequences along the corpus callosum and posterior brain (occipital lobe) in this series with mild features of Dawson's fingers (unique and typical in MS)
The next ER appointment is in November 13th 2017 with the same presentation: hypoactive reflexes, slowed finger to nose, altered physical sensitivity and difficulty walking. The ER doctor notes the clear T1 and T2 lesions in the former MRIs along both cervical spine and occipital brain. This ER is preceded by trials with Rebif and Gylenia (Gylenia for a month and a half with an initial hospitalization) under the care of me, who is the long term treating neurologist since March 2017 when he lived in San Diego, CA, US.

Methylprednisolone is administered for 5 days to a positive response.
A MRI is done in December 5th 2017 showing the same response and the same features as in the September 25th 2017 MRI.
Another ER is repeated in January 12th 2018 with the same presentation and same positive response with methylprednisolone.

An ER appointment in Berlin (Bundeswehrkrankenhaus) takes place in the 17th of March 2018 presenting with "fixation disturbance and nystagmu of the entire left facial half, hypoesthesia entire left body halftone, decreased reflex status left" and "finger-pointing" difficulties.
The repeated ER appointments (four where methylprednisolone is administered) is reported as a result of insufficient outpatient medications to manage his condition, which is eventually determined to be secondary progressive MS.
The treatment started in ER (IV methylprednisolone) was completed with three more days of IV methylprednisolone given 1 gram each day outpatient under the care of Dr. Stefanie Klaffke in Berlin Germany.
Rebif 20 mcg was prescribed thereafter taken every other day trialed for a period of 5 months with limited efficacy, from March 2018 to July 2018.

There are T2 intensities in the FLAIR image sequences along the corpus callosum and posterior brain (occipital lobe) in this series with mild features of Dawson's fingers (unique and typical in MS)
The next ER appointment is in November 13th 2017 with the same presentation: hypoactive reflexes, slowed finger to nose, altered physical sensitivity and difficulty walking. The ER doctor notes the clear T1 and T2 lesions in the former MRIs along both cervical spine and occipital brain. This ER is preceded by trials with Rebif and Gylenia (Gylenia for a month and a half with an initial hospitalization) under the care of me, who is the long term treating neurologist since March 2017 when he lived in San Diego, CA, US.

All MRIs would have to have T2 intensities in the FLAIR image sequences along the corpus callosum and posterior brain (occipital lobe) since 2012 as Dr. Hugo and the ER doctor in late 2017 in Brazil (Dr. Ana Andorinho) mentions.

The ER doctor in Brazil also mentions that T2 intensities in the thoracic with may show up as a T2 intensity or signs of neurodegeneration and atrophy in future MRI series.

Narendra
Jana

Hospital Angeles
TIJUANA

Dr. Francisco A. Gutiérrez Manjarrez
Medicina Interna • Neurología • Neurofisiología
Universidad Nacional Autónoma de México
Ced. Prof. Neurología: 6926514

He also has FDG PET in March, 2016 that show evidence of hypometabolic activity of bilateral posterior parietal lobes, temporal lobes, precuneus and posterior cingulate gyrus suggesting neurodegenerative of these regions with secondary effect of Multiple Sclerosis.
A neuropsychological report dated August 11- 2018 indicates reduced processing speed with his executive functioning and decision making mostly preserved. Tests for visual attention and task switching is below cut off. Tests with respect to global functioning, memory functioning, attention span, and language are average.

His condition worsened by December of 2018 and it was determined by a comparison of several MRI images from August 2017 to December of 2018 (brain and cervical spine) that that he suffers from secondary progressive MS.
Another VEP done in January shows bilateral optic neuritis, correlating well with his presentation of secondary progressive MS.

With the progression of his condition he consulted with several hospitals in Europe and finally presented his case to a neurologist in New Delhi, India; Dr. Pushpendra Renjen, whose neurology team determined that he does indeed have secondary progressive MS. The doctor repeated the VEP test and showed that his optic neuropathy is also progressing, bilateral with significant delays in both eyes. He was administered Rituximab at a dose of 1 gram separated by 2 weeks (January 15- and 29- of 2019) and has been progressively recovering since January of 2019 with his condition stabilizing with the more clinically effective medications (monoclonal antibodies).
His next IV of rituximab is scheduled on July or August of 2019.

Actually, Jana is currently stable due to Rituximab, with an EDSS 1.5 scale, under medical treatment and surveillance.

Considering the progressive nature of his MS I consider it important to continue with follow-up studies such as MRI of the brain, cervical spine and thorax with gadolinium every 3 to 6 months, general laboratories every 2 months to evaluate liver, kidney and blood function and not to suspend its established treatment.

Dr. Francisco Alejandro Gutierrez Manjarrez

Av. Paseo de los Héroes #10999, Consultorio 703 y 705, Zona Rio • Tijuana, B. C. • C.P. 22010
Tel. (664) 635-18-38 y 39 • drgutmanjarrez@gmail.com

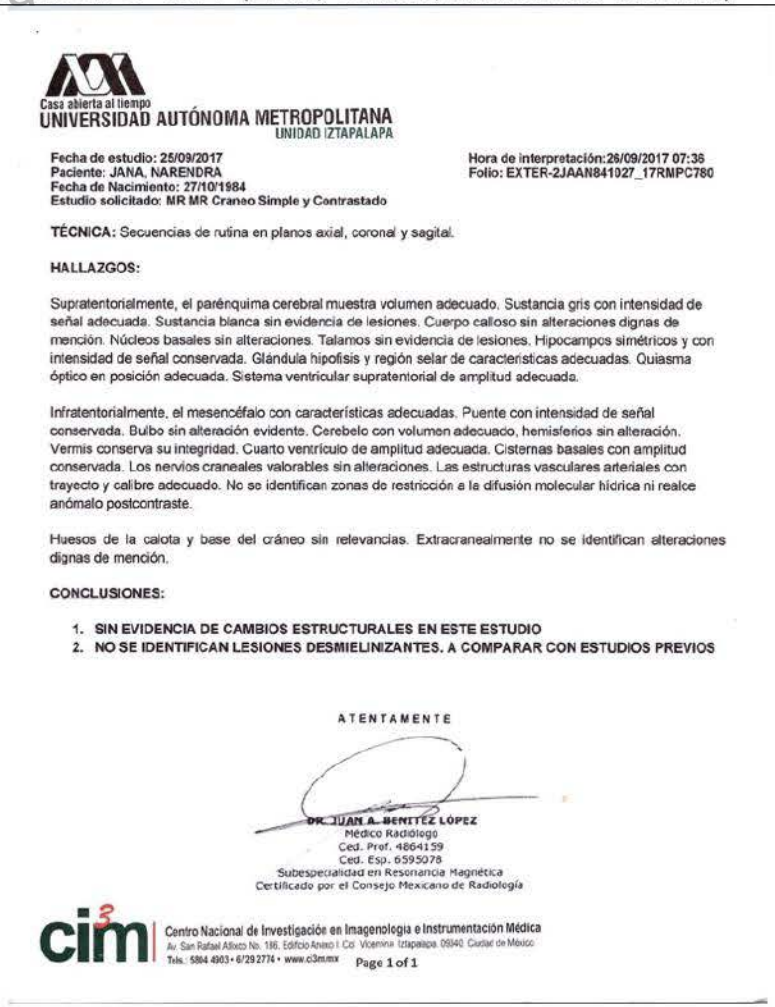
As mentioned by Dr. Franciso Manjarrez the T2 intensities along the cervical column eventually appear as atrophy which typifies the condition as secondary progressive MS.

His condition worsened by December of 2018 and it was determined by a comparison of several MRI images from August 2017 to December of 2018 (brain and cervical spine) that that he suffers from secondary progressive MS.
Another VEP done in January shows bilateral optic neuritis, correlating well with his presentation of secondary progressive MS.

Narendra Jana

The actual MRI reports for these MRIs are aggressive attempts at trying to hide the nature of multiple sclerosis and the progression of the condition. All these reports fail to mention the prevalence of brain and spine inflammatory lesions that eventually cause progressive neurodegeneration.

September 25th 2017 (Brain, Cervical, Lumbar and Thoracic)



Casa abierta al tiempo
UNIVERSIDAD AUTÓNOMA METROPOLITANA
UNIDAD IZTAPALAPA

Fecha de estudio: 25/09/2017
Paciente: JANA, NARENDRA
Fecha de Nacimiento: 27/10/1984
Estudio solicitado: MR MR Craneo Simple y Contrastado

Hora de interpretación:26/09/2017 07:36
Folio: EXTER-2JAAN841027_17RMPC780

TÉCNICA: Secuencias de rutina en planos axial, coronal y sagital.

HALLAZGOS:

Supratentorialmente, el parénquima cerebral muestra volumen adecuado. Sustancia gris con intensidad de señal adecuada. Sustancia blanca sin evidencia de lesiones. Cuerpo calloso sin alteraciones dignas de mención. Núcleos basales sin alteraciones. Talamos sin evidencia de lesiones. Hipocampos simétricos y con intensidad de señal conservada. Glándula hipofisis y región selar de caracteristicas adecuadas. Quiasma óptico en posición adecuada. Sistema ventricular supratentorial de amplitud adecuada.

Infratentorialmente, el mesencéfalo con características adecuadas. Puente con intensidad de señal conservada. Bulbo sin alteración evidente. Cerebelo con volumen adecuado, hemisferios sin alteración. Vermis conserva su integridad. Cuarto ventrículo de amplitud adecuada. Cisternas basales con amplitud conservada. Los nervios craneales valorables sin alteraciones. Las estructuras vasculares arteriales con trayecto y calibre adecuado. No se identifican zonas de restricción a la difusión molecular hídrica ni realce anómalo postcontraste.

Huesos de la calota y base del cráneo sin relevancias. Extracranealmente no se identifican alteraciones dignas de mención.

CONCLUSIONES:

1. **SIN EVIDENCIA DE CAMBIOS ESTRUCTURALES EN ESTE ESTUDIO**
2. **NO SE IDENTIFICAN LESIONES DESMIELINIZANTES. A COMPARAR CON ESTUDIOS PREVIOS**

ATENTAMENTE

DR. JUAN A. BENITEZ LÓPEZ
Médico Radiólogo
Ced. Prof. 4864159
Ced. Esp. 6595078
Subespecialidad en Resonancia Magnética
Certificado por el Consejo Mexicano de Radiología

cim | Centro Nacional de Investigación en Imagenología e Instrumentación Médica
Av. San Rafael Atlixco No. 186, Edificio Anexo I, Col. Vicentina, Iztapalapa, 09340, Ciudad de México
Tels.: 5804 4903 • 6729 2774 • www.ci3m.mx

Page 1 of 1

The brain radiological report is a gross lie. There are clear T2 intensities in the midbrain.

Casa abierta al tiempo
UNIVERSIDAD AUTÓNOMA METROPOLITANA
UNIDAD IZTAPALAPA

Fecha de estudio: 25/09/2017
Paciente: JANA, NARENDRA
Fecha de Nacimiento: 27/10/1984
Estudio solicitado: MR 4260-20016 COLUMNA CERVICAL

Hora de interpretación:26/09/2017 08:55
Folio: EXTER-2JAAN841027_17RMPC780

TÉCNICA: Cortes axiales y sagitales en secuencias de rutina

HALLAZGOS:

Adecuada alineación de la columna cervical. Unión craneovertebral sin alteraciones aparentes. Cuerpos vertebrales integros, con intensidad de señal adecuada. Apófisis odontoides de C2 integra. Apófisis articulares y articulaciones facetarias de características normales. Resto de los elementos posteriores sin alteración.

Discos intervertebrales con disminución de altura e intensidad de señal, principalmente en C3-4 con protrusiones discales en múltiples niveles que comprimen al saco dural.

C3-4 con protrusión posterocentral.

C4-5 con ensanchamiento discal.

C5-6 con protrusión posterocentral.

C6-7 con protrusión posterocentral, estenosis neuroforaminal y contacto radicular derecho.

C7-D1

Conducto raquídeo de amplitud normal. Ligamentos amarillos de grosor adecuado. Ligamentos longitudinales e interespinosos sin alteración. La medula con intensidad de señal y morfología normal, sin evidencia de masas o lesiones. Estructuras adyacentes, tejidos pre y paravertebrales sin alteraciones. Porciones valorables del encéfalo sin relevancias que comentar. No hay evidencia de lesiones captantes con el medio de contaste.

CONCLUSIONES:

1. **DISCOPATIA DEGENERATIVA CON PROTRUSIONES DISCALES EN LOS NIVELES SEÑALADOS**
2. **ESTENOSIS NEUROFORAMINAL Y CONTACTO RADICULAR COMO SE HA DESCRITO**
3. **SIN EVIDENCIA DE LESIONES MEDULARES EN ESTE ESTUDIO**

ATENTAMENTE

DR. JUAN A. BENITEZ LÓPEZ
Médico Radiólogo
Ced. Prof. 4864159
Ced. Esp. 6595078
Subespecialidad en Resonancia Magnética
Certificado por el Consejo Mexicano de Radiología

cim | Centro Nacional de Investigación en Imagenología e Instrumentación Médica
Av. San Rafael Atlixco No. 186, Edificio Anexo I, Col. Vicentina, Iztapalapa, 09340, Ciudad de México
Tels.: 5804 4903 • 6729 2774 • www.ci3m.mx

Page 1 of 1

The cervical spine report is a gross lie. Prominent inflammation and lesions in the cervical spine.

Casa abierta al tiempo
UNIVERSIDAD AUTÓNOMA METROPOLITANA
UNIDAD IZTAPALAPA

Fecha y Hora de Estudio: 26/09/2017 11:56
Paciente: JANA, NARENDRA
Fecha de Nacimiento: 27/10/1984
Médico que refiere: AQC
Estudio solicitado: MR 4260-20017 COLUMNA TORACICA
Datos Clínicos: FALTA DE HABILIDADES MOTORAS FINAS Y CONVULSIONES PREVIOS A TERAPIA CON METHYPREDNISONE IV. REMISIÓN DE ESCLEROSIS MÚLTIPLE DESPÚES DE 5 IV METHYPREDNISONE.

Hora de interpretación:26/09/2017 09:06
Folio: EXTER-2JAAN841027_17RMPC780

TÉCNICA: Se realizaron secuencias de rutina en planos sagital, coronal y axial.

HALLAZGOS:

Adecuada alineación de la columna dorsal. Los cuerpos vertebrales se encuentran íntegros, de altura adecuada con intensidad de señal normal.

Articulaciones facetarias de características normales. Articulaciones costovertebrales sin alteraciones. El resto de los elementos del arco posterior sin alteraciones.

Discos intervertebrales de altura e intensidad de señal normal. Neuroforamenes con amplitud normal. Conducto raquídeo de amplitud adecuada. Ligamentos amarillos de grosor adecuado. Ligamentos longitudinales e interespinosos sin alteraciones.

La medula visible, cono medular y raíces de la cauda equina de aspecto adecuado. Cono a nivel de D12. Tejidos paravertebrales dentro de parámetros normales. Estructuras adyacentes sin relevancias

CONCLUSIONES:

1. SIN EVIDENCIA DE LESINOES DESMIELINIZANTES EN ESTE ESTUDIO.

ATENTAMENTE

DR. JUAN A. BENITEZ LÓPEZ
Médico Radiólogo
Ced. Prof. 4864159
Ced. Esp. 6595078
Subespecialidad en Resonancia Magnética
Certificado por el Consejo Mexicano de Radiología

cim
Centro Nacional de Investigación en Imagenología e Instrumentación Médica
Av. San Rafael Atlixco No. 186, Edificio Anexo I, Col. Vicentina, Iztapalapa, 09340, Ciudad de México
Tels.: 5804 4903 • 6729 2774 • www.ci3m.mx

Page 1 of 1

Casa abierta al tiempo
UNIVERSIDAD AUTÓNOMA METROPOLITANA
UNIDAD IZTAPALAPA

Fecha de estudio: 25/09/2017
Paciente: JANA, NARENDRA
Fecha de Nacimiento: 27/10/1984
Estudio solicitado: MR 4260-20018 COLUMNA LUMBAR O LUMBOSACRA

Hora de interpretación:26/09/2017 09:10
Folio: EXTER-2JAAN841027_17RMPC780

TÉCNICA: Se realizaron secuencias de rutina en planos sagital, coronal y axial.

HALLAZGOS:

Rectificación de la columna lumbosacra.

Cuerpos vertebrales íntegros, de altura adecuada con intensidad de señal normal.

Articulaciones facetarias de características normales. El resto de los elementos del arco posterior sin alteraciones.

Discos intervertebrales con disminución de la altura e intensidad de señal en L5-S1, con protrusiones discales que comprimen al saco dural y ensanchamientos discales que ocasionan moldeamiento.

L5-S1 con protrusión discal posterocentral, compresión al saco dural así como posible contacto a la raíz izquierda de S1

Conducto raquídeo de amplitud adecuada. Ligamentos amarillos de grosor adecuado. Ligamentos longitudinales e interespinosos sin alteraciones.

La medula visible, cono medular y raíces de la cauda equina de aspecto adecuado. Cono a nivel de D12. No se identfiican lesione smesdulares ni zonas de realce anómalo postgadolinio.

Tejidos paravertebrales dentro de parámetros normales. Estructuras adyacentes sin relevancias.

CONCLUSIONES:

1. **RECTIFICACIÓN LUMBOSACRA**
2. **DISCOPATIA DEGENERATIVA GRADO II DE PFIRMANN CON PROTRUSIÓN DISCAL Y CONTACTO RADICULAR COMO SE HA SEÑALADO**
3. **SIN EVIDENCIA DE LESIONES DESMIELINIZANTES EN ESTE ESTUDIO.**

ATENTAMENTE

DR. JUAN A. BENITEZ LÓPEZ
Médico Radiólogo
Ced. Prof. 4864159
Ced. Esp. 6595078
Subespecialidad en Resonancia Magnética
Certificado por el Consejo Mexicano de Radiología

cim
Centro Nacional de Investigación en Imagenología e Instrumentación Médica
Av. San Rafael Atlixco No. 186, Edificio Anexo I, Col. Vicentina, Iztapalapa, 09340, Ciudad de México
Tels.: 5804 4903 • 6729 2774 • www.ci3m.mx

Page 1 of 1

The radiologist tries to mis typify the cervical spine neurodegeneration as “disk degeneration” in a young patient with no osteopathic complaints (medical impossibility).

Casa abierta al tiempo
UNIVERSIDAD AUTÓNOMA METROPOLITANA
UNIDAD IZTAPALAPA

Fecha y Hora de Estudio: 26/09/2017 11:55
Paciente: JANA, NARENDRA
Fecha de Nacimiento: 27/10/1984
Médico que refiere: AQC
Hora de interpretación:26/09/2017 09:10
Folio: EXTER-2JAAN841027_17RMPC780
Estudio solicitado: MR 4260-20018 COLUMNA LUMBAR O LUMBOSACRA
Datos Clínicos: FALTA DE HABILIDADES MOTORAS FINAS Y CONVULSIONES PREVIOS A TERAPIA CON METHYPREDNISONE IV. REMISIÓN DE ESCLEROSIS MÚLTIPLE DESPÚES DE 5 IV METHYPREDNISONE.

TÉCNICA: Se realizaron secuencias de rutina en planos sagital, coronal y axial.

HALLAZGOS:

Rectificacion de la columna lumbosacra. Cuerpos vertebrales íntegros, de altura adecuada con intensidad de señal normal. Articulaciones facetarias de características normales. El resto de los elementos del arco posterior sin alteraciones.

Discos intervertebrales con disiminucion de la altura e intensidad de señal en L5-S1, con protrusiones discales que comprimen al saco dural y ensanchamientos discales que ocasionan moldeamiento. L5-S1 con protrusion discal posterocentral, compresion al saco dural así como posible contacto a la raiz izquierda de S1.

Conducto raquídeo de amplitud adecuada. Ligamentos amarillos de grosor adecuado.Ligamentos longitudinales e interespinosos sin alteraciones. La medula visible, cono medular y raíces de la cauda equina de aspecto adecuado. Cono a nivel de D12. No se identfiican lesiones medulares ni zonas de realce anomalo postgadolinio

Tejidos paravertebrales dentro de parámetros normales. Estructuras adyacentes sin relevancias.

CONCLUSIONES:

1. RECTIFICACION LUMBOSACRA.
2. DISCOPATIA DEGENERATIVA GRADO II DE PFIRMANN CON PROTRUSION DISCAL Y CONTACTO RADICULAR COMO SE HA SEÑALADO.
3. SIN EVIDENCIA DE LESIONES DESMIELINIZANTES EN ESTE ESTUDIO.

ATENTAMENTE

DR. JUAN A. BENITEZ LÓPEZ
Médico Radiólogo
Ced. Prof. 4864159
Ced. Esp. 6595078
Subespecialidad en Resonancia Magnética
Certificado por el Consejo Mexicano de Radiología

cim3 Centro Nacional de Investigación en Imagenología e Instrumentación Médica
Av. San Rafael Atlixco No. 186, Edificio Anexo I, Col. Vicentina, Iztapalapa, 09340, Ciudad de México
Tels.: 5804 4903 • 6729 2774 • www.cl3m.mx

Narendra
Jana

No MRI report was written for the **December 5th 2017 MRI** of the Brain and Cervical

May 30th 2018, (Brain, Cervical)

Casa abierta al tiempo
UNIVERSIDAD AUTÓNOMA METROPOLITANA
UNIDAD IZTAPALAPA

Fecha de estudio: 30/05/2018 **Hora de interpretación:30/05/2018 06:06**
Paciente: JANA, NARENDRA NIRMAL **Folio: EXTER-2JAAN841027_18RMPC404**
Fecha de Nacimiento: 27/10/1984
Médico que refiere: DR HUGO NAVARRETE BAEZ
Estudio solicitado: MR 4260-20118 NEUROEJE (2 REGIONES)
Datos Clínicos: MULTIPLE ESCLEROSIS. RM DE RUTINA.

TÉCNICA: Secuencias de rutina en planos axial, coronal y sagital.

HALLAZGOS:

CRANEO

Supratentorialmente, el parénquima cerebral muestra volumen adecuado. Sustancia gris con intensidad de señal adecuada.

Sustancia blanca con intensidad de señal adecuada. Cuerpo calloso sin alteraciones dignas de mención. Núcleos basales sin alteraciones. Talamos sin evidencia de lesiones. Hipocampos simétricos y con intensidad de señal conservada. Glándula hipófisis y región selar de características adecuadas. Quiasma óptico en posición adecuada. Sistema ventricular supratentorial de amplitud adecuada. Infratentorialmente, el mesencéfalo con características adecuadas. Puente con intensidad de señal conservada. Bulbo sin alteración evidente. Cerebelo con volumen adecuado, hemisferios sin alteración. Vermis conserva su integridad. Cuarto ventrículo de amplitud adecuada.

Cisternas basales con amplitud conservada. Los nervios craneales valorables sin alteraciones. Las estructuras vasculares arteriales con asimetria por menor calibre de la vertebral derecha. No se identifican zonas de restricción a la difusión molecular hídrica. Tampoco se identifican zonas de realce anómalo postgadolinio. Huesos de la calota y base del cráneo sin relevancias. Extracranealmente no se identifican alteraciones dignas de mención. No se identifican lesiones que sugieran actividad desmielinizante

COLUMNA CERVICAL

Rectificacion de la columna cervical. Cuerpos vertebrales integros, con intensidad de señal adecuada. Apófisis odontoides de C2 integra. Unión craneovertebral sin alteraciones aparentes. Articulaciones facetarias de características adecuadas. Resto de los elementos posteriores sin alteración.

Discos intervertebrales con disminución de su altura e intensidad de señal. C3-4 a C5-6 con abultamientos discales que moldean al saco dural. C6-7 con protrusion discal posterocentral que comprime al saco dural. Se asocia estenosis neuroforaminal bilateral con posible contacto radicular izquierdo. Ligamentos amarillos de grosor adecuado.

cim
Centro Nacional de Investigación en Imagenología e Instrumentación Médica
División Ciencias Básicas e Ingeniería
Av. San Rafael Atlixco No. 186, Edificio Anexo 1, Col. Vicentina Iztapalapa, 09340, Ciudad de México
Tels. 5729 5724 • 5804 4600 • www.cim.mx

Fecha de estudio: 30/05/2018 **Hora de interpretación:30/05/2018 06:06**
Paciente: JANA, NARENDRA NIRMAL **Folio: EXTER-2JAAN841027_18RMPC404**
Fecha de Nacimiento: 27/10/1984
Médico que refiere: DR HUGO NAVARRETE BAEZ
Estudio solicitado: MR 4260-20118 NEUROEJE (2 REGIONES)
Datos Clínicos: MULTIPLE ESCLEROSIS. RM DE RUTINA.

Conducto raquídeo de amplitud reducida en c6-7. La medula con intensidad de señal y morfología normal, sin evidencia de masas o lesiones que sugieran actividad desmielinizante.
Ligamentos longitudinales e interespinosos sin alteración. Estructuras adyacentes sin alteraciones. No se identifican zonas de captación anormal de medio de contraste. Las estructuras vasculares corroboran dominancia de la vertebral izquierda.

CONCLUSIONES:

1. **Dominancia de la arteria vertebral izquierda, a considerar posible insuficiencia vertebro-basilar**
2. **Sin evidencia de anomalías estructurales encefálicas demostrables en este estudio.**
3. **Protrusiones y abultamientos discales en los niveles descritos asociadas posible contacto radicular como se ha descrito**
4. **Raquiestenosis cervical relativa**
5. **Sin evidencia de lesiones que sugieran actividad desmielinizante. A criterio del medico tratante se sugiere complementar con secuencias FLAIR milimetricas**

ATENTAMENTE

DR. JUAN A. BENITEZ LÓPEZ
Médico Radiólogo
Ced. Prof. 4864159
Ced. Esp. 6595078
Subespecialidad en Resonancia Magnética
Certificado por el Consejo Mexicano de Radiología

The radiologist restated a mis-typification of the cervical spine neurodegeneration as “disk degeneration”. Clear criminal medical fraud.

The remaining spinal column (thoracic and lumbar) MRI was done on the **11th of June**:

Casa abierta al tiempo
UNIVERSIDAD AUTÓNOMA METROPOLITANA
UNIDAD IZTAPALAPA

Fecha y Hora de Estudio: 11/06/2018 02:24 — **Hora de interpretación:11/06/2018 06:35**
Paciente: NIRMAL JANA, NARENDRA — **Folio: EXTER-2JAAN841027_18RMPC435**
Fecha de Nacimiento: 27/10/1984
Médico que refiere: DR. HUGO BAEZ
Estudio solicitado: MR 4260-20118 NEUROEJE (2 REGIONES)
Datos Clínicos: ESCLEROSIS MULTIPLE

TÉCNICA: Cortes axiales y sagitales en secuencias de rutina

HALLAZGOS:

DORSAL

Rectificación de la xifosis dorsal. Los cuerpos vertebrales se encuentran íntegros, de altura adecuada con intensidad de señal normal.

Articulaciones facetarias de características normales. Articulaciones costovertebrales sin alteraciones. El resto de los elementos del arco posterior sin alteraciones. Discos intervertebrales con altura e intensidad de señal normal.

Neuroforámenes con amplitud normal. Conducto raquídeo de amplitud adecuada. Ligamentos amarillos de grosor adecuado. Ligamentos longitudinales e interespinosos sin alteraciones.

La medula visible, cono medular y raíces de la cauda equina de aspecto adecuado. Cono a nivel de L1. No hay realces anómalos postgadolinio.

Tejidos paravertebrales dentro de parámetros normales. Estructuras adyacentes sin relevancias.

LUMBAR

Adecuada alineación de la columna lumbosacra. Cuerpos vertebrales íntegros, de altura adecuada con intensidad de señal normal. Articulaciones facetarias de características normales . El resto de los elementos del arco posterior sin alteraciones.

Discos intervertebrales con disminución de altura e intensidad de señal. L2-3 a L4-5 con abultamientos que moldean al saco dural. L5-S1 con protrusión discal posterocentral y contacto a la raíz izquierda de S1.Conducto raquídeo de amplitud adecuada. Ligamentos amarillos de grosor adecuado. Ligamentos longitudinales sin relevancias. Interespinosos con hiperseñal difusa y realce postgadolinio en L4-5.

La medula visible, cono medular y raíces de la cauda equina de aspecto adecuado. Cono a nivel de L1. Tejidos paravertebrales dentro de parámetros normales. Estructuras adyacentes sin relevancias.

cim3 Centro Nacional de Investigación en Imagenología e Instrumentación Médica
Av. San Rafael Atlixco No. 186, Edificio Anexo I, Col. Vicentina, Iztapalapa, 09340, Ciudad de México
Tels.: 5804 4903 • 6729 2774 • www.ci3m.mx

Fecha y Hora de Estudio: 11/06/2018 02:24 — **Hora de interpretación:11/06/2018 06:35**
Paciente: NIRMAL JANA, NARENDRA — **Folio: EXTER-2JAAN841027_18RMPC435**
Fecha de Nacimiento: 27/10/1984
Médico que refiere: DR. HUGO BAEZ
Estudio solicitado: MR 4260-20118 NEUROEJE (2 REGIONES)
Datos Clínicos: ESCLEROSIS MULTIPLE

Se compara con estudios previos de septiembre del 2017 en la cual no se identificaba la hiperseñal y realce de los ligamentos interespinosos.

CONCLUSIONES:

1. **DISCOPATIA DEGENERATIVA GRADO III DE PFIRRMANN CON ABULTAMIENTOS Y PROTRUSIONES DISCALES QUE CONDICIONA CONTACTO RADICULAR COMO SE HA DESCRITO.**
2. **DATOS QUE SUGIEREN SÍNDROME DE BAASTRUP.**
3. **RECTIFICACION DE LA COLUMNA DORSAL.**

ATENTAMENTE

DR. JUAN A. BENITEZ LÓPEZ
Médico Radiólogo
Ced. Prof. 4864159
Ced. Esp. 6595078
Subespecialidad en Resonancia Magnética
Certificado por el Consejo Mexicano de Radiología

The MRI report for the **July 24th 2018** brain and cervical MRI was consistent with clinical fraud that took place in previous instances.

Casa abierta al tiempo
UNIVERSIDAD AUTÓNOMA METROPOLITANA
UNIDAD IZTAPALAPA

Fecha y Hora de Estudio: 24/07/2018 04:21
Paciente: NIRMAL JANA, NARENDRA
Fecha de Nacimiento: 27/10/1984
Médico que refiere: DR. HUGO BAEZ
Estudio solicitado: MR 4260-20118 NEUROEJE (2 REGIONES)
Datos Clínicos: ESCLEROSIS MULTIPLE

Hora de interpretación:24/07/2018 06:52
Folio: EXTER-2JAAN841027_18RMPC404

TÉCNICA: Secuencias de rutina en planos axial, coronal y sagital.

HALLAZGOS:

CRANEO

Supratentorialmente, el parénquima cerebral muestra volumen adecuado. Sustancia gris con intensidad de señal adecuada. Sustancia blanca con intensidad de señal adecuada. Cuerpo calloso sin alteraciones dignas de mención. Núcleos basales sin alteraciones. Talamos sin evidencia de lesiones. Hipocampos simétricos y con intensidad de señal conservada. Glándula hipófisis y región selar de características adecuadas. Quiasma óptico en posición adecuada. Sistema ventricular supratentorial de amplitud adecuada.

Infratentorialmente, el mesencéfalo con características adecuadas. Puente con intensidad de señal conservada. Bulbo sin alteración evidente. Cerebelo con volumen adecuado, hemisferios sin alteración. Vermis conserva su integridad. Cuarto ventrículo de amplitud adecuada.

Cisternas basales con amplitud conservada. Los nervios craneales valorables sin alteraciones. Huesos de la calota y base del cráneo sin relevancias. Extracranealmente no se identifican alteraciones dignas de mención. No se identifican lesiones que sugieran actividad desmielinizante.

COLUMNA CERVICAL

Rectificacion de la columna cervical. Cuerpos vertebrales íntegros, con intensidad de señal adecuada. Apófisis odontoides de C2 integra. Unión craneovertebral sin alteraciones aparentes

Articulaciones facetarias de características adecuadas. Resto de los elementos posteriores sin alteración. Discos intervertebrales con disminución de su altura e intensidad de señal.

No es posible valorar protrusiones o abultamientos discales en este estudio así como los ligamentos amarillos ni el conducto raqudeo. La medula con intensidad de señal y morfología normal, sin evidencia de masas o lesiones que sugieran actividad desmielinizante.

cim3 Centro Nacional de Investigación en Imagenología e Instrumentación Médica
Av. San Rafael Atlixco No. 186, Edificio Anexo I, Col. Vicentina, Iztapalapa, 09340, Ciudad de México
Tels.: 5804 4903 • 6729 2774 • www.ci3m.mx

Fecha y Hora de Estudio: 24/07/2018 04:21
Paciente: NIRMAL JANA, NARENDRA
Fecha de Nacimiento: 27/10/1984
Médico que refiere: DR. HUGO BAEZ
Estudio solicitado: MR 4260-20118 NEUROEJE (2 REGIONES)
Datos Clínicos: ESCLEROSIS MULTIPLE

Hora de interpretación:24/07/2018 06:52
Folio: EXTER-2JAAN841027_18RMPC404

Ligamentos longitudinales e interespinosos sin alteración. Estructuras adyacentes sin alteraciones.

Se compara con el estudio previo de mayo del presente sin encontrar NINGUNA lesion que sugiera proceso desmielinizante a nivel encefalico ni medular cervical.

CONCLUSIONES:

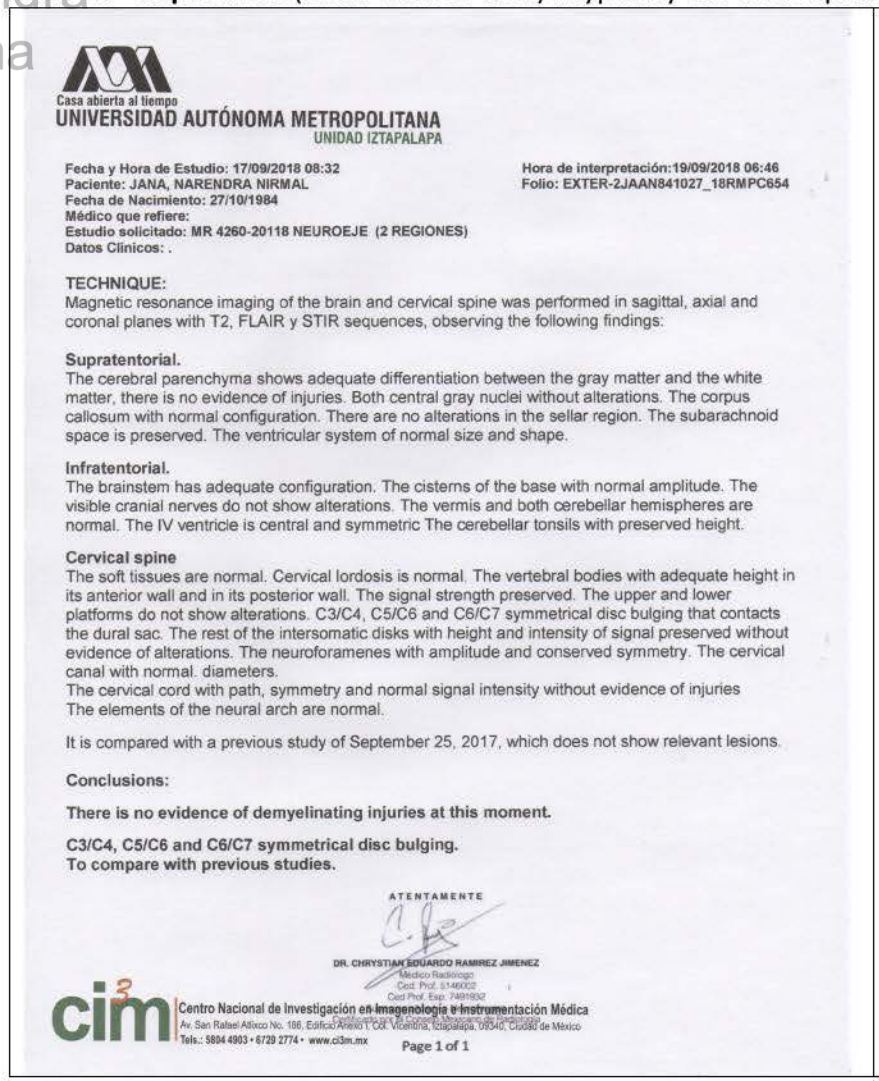
1. **Sin evidencia de lesiones que sugieran actividad desmielinizante ni cambios relevantes en relacion al estudio previo.**

ATENTAMENTE

DR. JUAN A. BENITEZ LÓPEZ
Médico Radiólogo
Ced. Prof. 4864159
Ced. Esp. 6595078
Subespecialidad en Resonancia Magnética
Certificado por el Consejo Mexicano de Radiología

Narendra Jana

2018 17th September (Brain and Cervical) Atypically the MRI report appears to have been written in English in a Mexican clinic.



Casa abierta al tiempo
UNIVERSIDAD AUTÓNOMA METROPOLITANA
UNIDAD IZTAPALAPA

Fecha y Hora de Estudio: 17/09/2018 08:32
Paciente: JANA, NARENDRA NIRMAL
Fecha de Nacimiento: 27/10/1984
Médico que refiere:
Estudio solicitado: MR 4260-20118 NEUROEJE (2 REGIONES)
Datos Clinicos: .

Hora de interpretación:19/09/2018 06:46
Folio: EXTER-2JAAN841027_18RMPC654

TECHNIQUE:
Magnetic resonance imaging of the brain and cervical spine was performed in sagittal, axial and coronal planes with T2, FLAIR y STIR sequences, observing the following findings:

Supratentorial.
The cerebral parenchyma shows adequate differentiation between the gray matter and the white matter, there is no evidence of injuries. Both central gray nuclei without alterations. The corpus callosum with normal configuration. There are no alterations in the sellar region. The subarachnoid space is preserved. The ventricular system of normal size and shape.

Infratentorial.
The brainstem has adequate configuration. The cisterns of the base with normal amplitude. The visible cranial nerves do not show alterations. The vermis and both cerebellar hemispheres are normal. The IV ventricle is central and symmetric The cerebellar tonsils with preserved height.

Cervical spine
The soft tissues are normal. Cervical lordosis is normal. The vertebral bodies with adequate height in its anterior wall and in its posterior wall. The signal strength preserved. The upper and lower platforms do not show alterations. C3/C4, C5/C6 and C6/C7 symmetrical disc bulging that contacts the dural sac. The rest of the intersomatic disks with height and intensity of signal preserved without evidence of alterations. The neuroforamenes with amplitude and conserved symmetry. The cervical canal with normal. diameters.
The cervical cord with path, symmetry and normal signal intensity without evidence of injuries
The elements of the neural arch are normal.

It is compared with a previous study of September 25, 2017, which does not show relevant lesions.

Conclusions:

There is no evidence of demyelinating injuries at this moment.

C3/C4, C5/C6 and C6/C7 symmetrical disc bulging.
To compare with previous studies.

ATENTAMENTE

DR. CHRYSTIAN EDUARDO RAMIREZ JIMENEZ
Médico Radiólogo
Ced. Prof. 5146002
Ced Prof. Esp. 7491932

cim Centro Nacional de Investigación en Imagenología e Instrumentación Médica
Av. San Rafael Atlixco No. 186, Edificio Anexo 1, Col. Vicentina, Iztapalapa, 09340, Ciudad de México
Tels.: 5804 4903 • 6729 2774 • www.ci3m.mx

Page 1 of 1

This entire English written report is criminal medical fraud characteristic of all radiology reports written in this clinic.

There is gross evidence of injury and brain atrophy. The corpus callosum has features of Dawson's fingers typical of MS.

The C3/C4, C5/C6, and C6/C7 are regions of progressive neurological atrophy from medical negligence.
The cervical spine canal shows progressive neurological atrophy (stenosis) that is typical of secondary progressive multiple sclerosis.

There is a reduction in T1 lesions but there is prevalence of T2 lesions, which typically shows as atrophy in the spinal column after the T2 inflammation presents for a period of time.

Conclusions:
The spinal column shows gross neurological injury from C3 to C7.
These reports were written to further the criminal medical negligence that had taken place in the United States. An attempt at hiding physical harm after criminal negligence.

Though its determined that I have secondary progressive MS by several neurologists with gross presentation from the last MRI images to the first MRI series image in this MRI clinic with clear difference between former images (atrophy and neurodegeneration), the statements are falsified in the MRI report from the MRI clinic.

By oddity and atypicality the last report tries to highlight a negation of specifically neurodegeneration thus indicating that the radiologist understood what was happening (that the condition was progressing with radiological evidence) and attempted to support the US through falsifying the MRI report. The word choice and the quality of the statements is the last report are specifically odd and atypical of MRI reports; its ties to make a intelligent statement but ends up showing fraud in a clearer way.

The condition progresses from this point forward as well (causing more medical appointments and emergency room visits), highlighting the unrealistic nature of trying to falsify MRI reports. The reports in this clinical are gross clinical fraud.