2019 January 21st

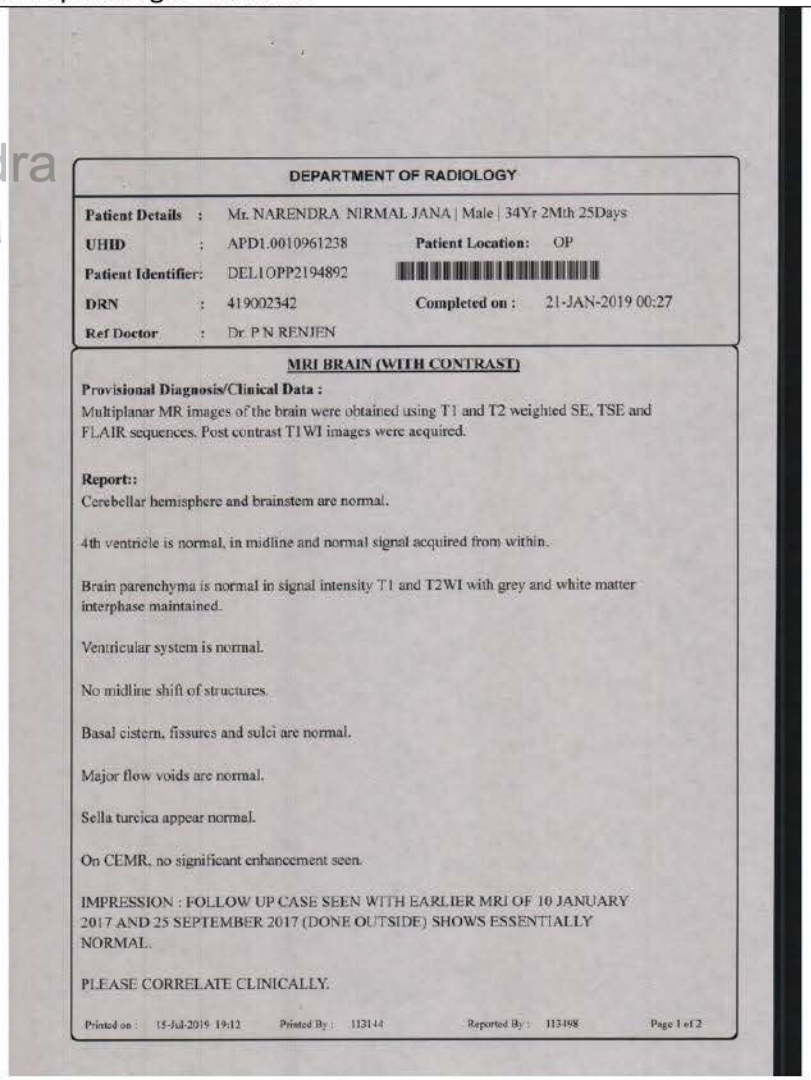
- **Dr. A. S. Arora – Apollo Hospital, New Delhi, India**
  - **Criminal Fraud →**

Radiology – MRI Report by Dr. A.S Arora:

This shows the deluded mentality of fraud in a medical setting, the idea that a entire selection of neurologists in the same hospital fully acknowledge and treat the condition under neurology while the radiologist in the same hospital is instructed to completely ignore any all features of MS in the MRI taken in the hospital. The neurologists explicitly states the nature of the condition and features in the former MRIs indicating MS in the summary of the hospital inpatient. The MRI report is a gross example of fraud (ignoring all features) and easy to demonstrate as fraud more so then any other MRI report before.

So the radiologist works against the neurologist trying to treat the condition in the same hospital.
Apparently the condition doesn't exist if the features of the condition aren't mentioned in the MRI report, which is absurd. Its progressive multiple sclerosis.

The report is given below:



DEPARTMENT OF RADIOLOGY

Patient Details	:	Mr. NARENDRA NIRMAL JANA | Male | 34Yr 2Mth 25Days	
UHID	:	APD1.0010961238	**Patient Location:** OP
Patient Identifier:		DEL1OPP2194892	
DRN	:	419002342	**Completed on :** 21-JAN-2019 00:27
Ref Doctor	:	Dr P N RENJEN	

MRI BRAIN (WITH CONTRAST)

Provisional Diagnosis/Clinical Data :
Multiplanar MR images of the brain were obtained using T1 and T2 weighted SE, TSE and FLAIR sequences. Post contrast T1WI images were acquired.

Report::
Cerebellar hemisphere and brainstem are normal.

4th ventricle is normal, in midline and normal signal acquired from within.

Brain parenchyma is normal in signal intensity T1 and T2WI with grey and white matter interphase maintained.

Ventricular system is normal.

No midline shift of structures.

Basal cistern, fissures and sulci are normal.

Major flow voids are normal.

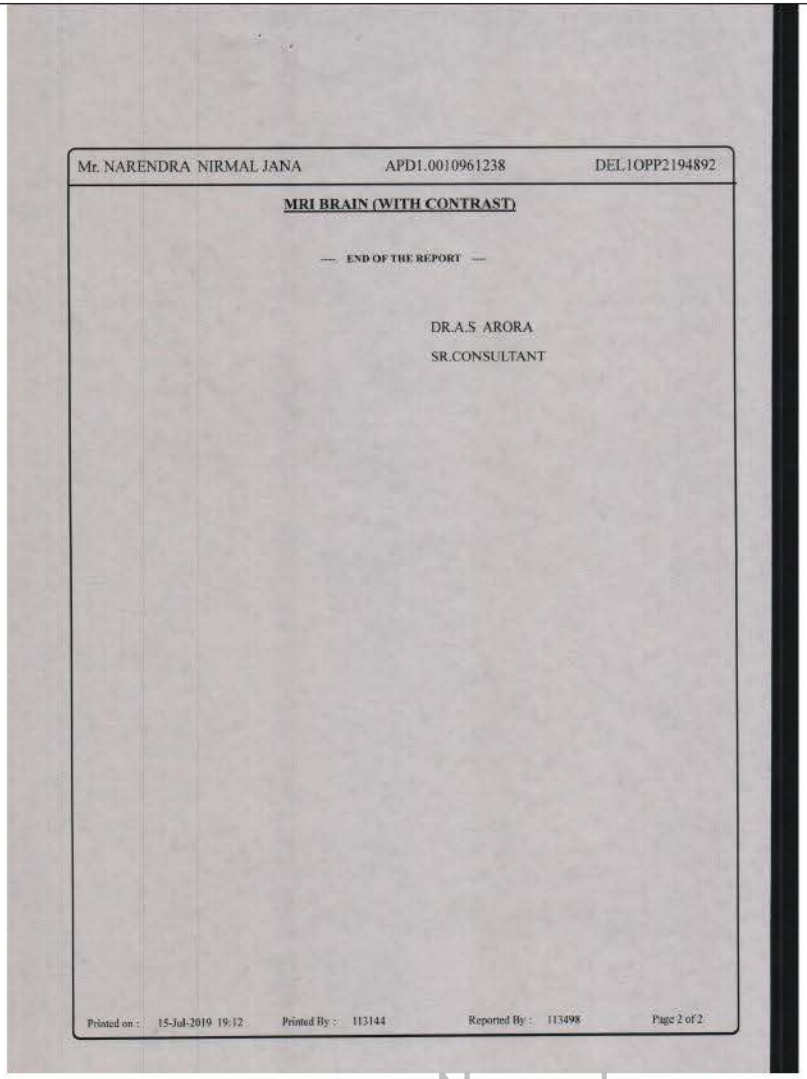
Sella turcica appear normal.

On CEMR, no significant enhancement seen.

IMPRESSION : FOLLOW UP CASE SEEN WITH EARLIER MRI OF 10 JANUARY 2017 AND 25 SEPTEMBER 2017 (DONE OUTSIDE) SHOWS ESSENTIALLY NORMAL.

PLEASE CORRELATE CLINICALLY.

Printed on : 15-Jul-2019 19:12 Printed By : 113144 Reported By : 113498 Page 1 of 2



Mr. NARENDRA NIRMAL JANA APD1.0010961238 DEL1OPP2194892

MRI BRAIN (WITH CONTRAST)

— END OF THE REPORT —

DR.A.S ARORA
SR.CONSULTANT

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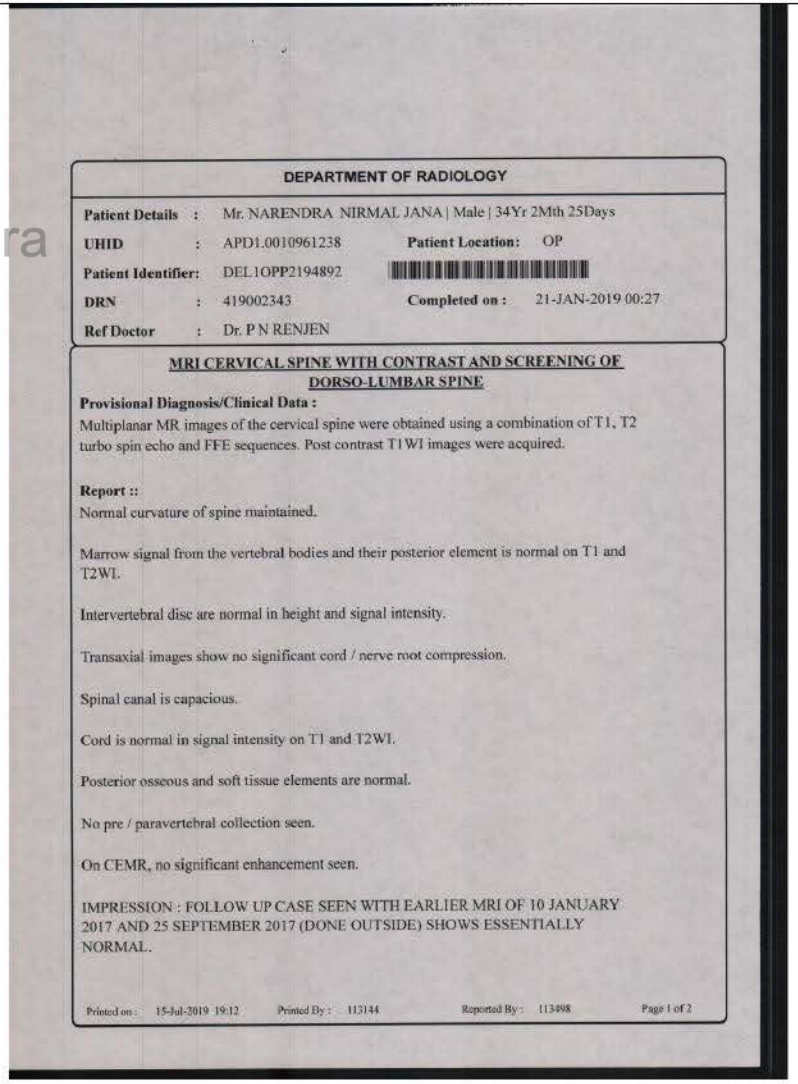
In this MRI report (of brain), the radiologist simply ignores everything, including signs of neurodegeneration, T1, T2 intensities, and the progression of the condition. The radiological report serves as the grossest example of fraud in radiology to date.



DEPARTMENT OF RADIOLOGY

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DRN : 419002343 **Completed on :** 21-JAN-2019 00:27
Ref Doctor : Dr. P N RENJEN

MRI CERVICAL SPINE WITH CONTRAST AND SCREENING OF DORSO-LUMBAR SPINE

Provisional Diagnosis/Clinical Data :
Multiplanar MR images of the cervical spine were obtained using a combination of T1, T2 turbo spin echo and FFE sequences. Post contrast T1WI images were acquired.

Report ::
Normal curvature of spine maintained.

Marrow signal from the vertebral bodies and their posterior element is normal on T1 and T2WI.

Intervertebral disc are normal in height and signal intensity.

Transaxial images show no significant cord / nerve root compression.

Spinal canal is capacious.

Cord is normal in signal intensity on T1 and T2WI.

Posterior osseous and soft tissue elements are normal.

No pre / paravertebral collection seen.

On CEMR, no significant enhancement seen.

IMPRESSION : FOLLOW UP CASE SEEN WITH EARLIER MRI OF 10 JANUARY 2017 AND 25 SEPTEMBER 2017 (DONE OUTSIDE) SHOWS ESSENTIALLY NORMAL.

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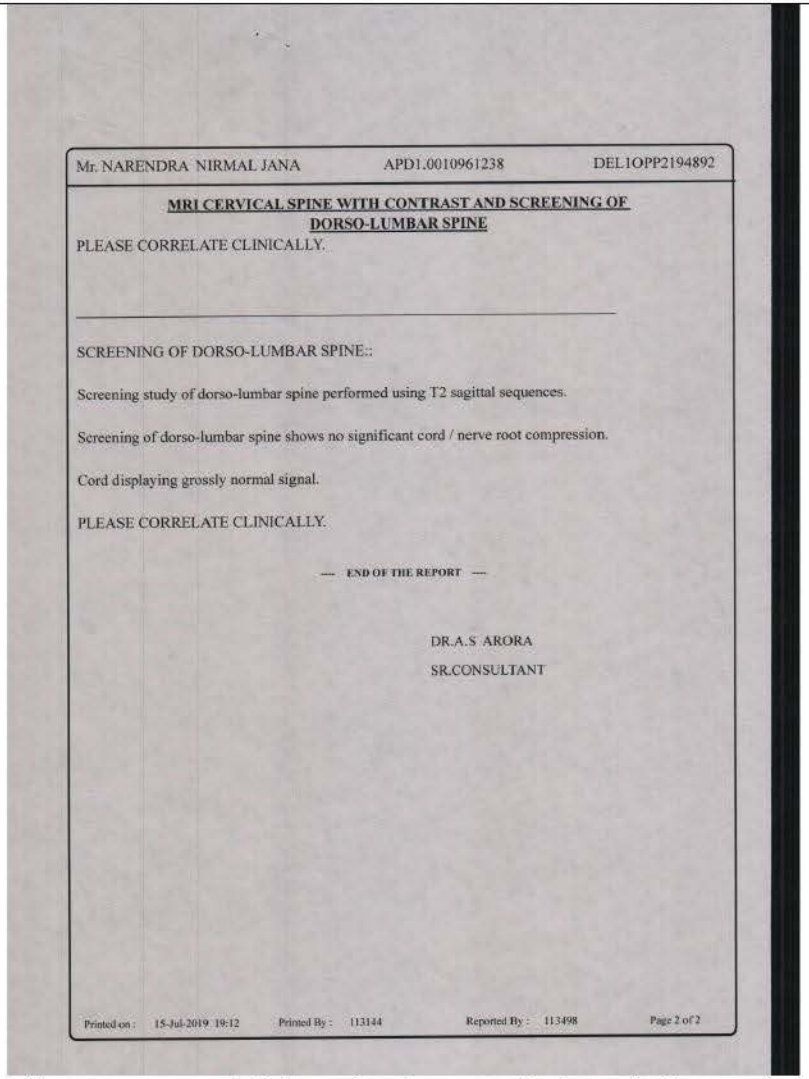

Mr. NARENDRA NIRMAL JANA APD1.0010961238 DEL1OPP2194892

MRI CERVICAL SPINE WITH CONTRAST AND SCREENING OF DORSO-LUMBAR SPINE

PLEASE CORRELATE CLINICALLY.

SCREENING OF DORSO-LUMBAR SPINE::

Screening study of dorso-lumbar spine performed using T2 sagittal sequences.

Screening of dorso-lumbar spine shows no significant cord / nerve root compression.

Cord displaying grossly normal signal.

PLEASE CORRELATE CLINICALLY.

— END OF THE REPORT —

DR.A.S ARORA
SR.CONSULTANT

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In this MRI report (of dorso-lumbar spine), the radiologist simply ignores everything, including signs of neurodegeneration, T1, T2 intensities, and the progression of the condition. The radiological report serves as the grossest example of fraud in radiology to date.

The contrast report is another MRI done in New Delhi but in a different clinic (the MRI is done on July 21st 2019):

H·O·D HOUSE of DIAGNOSTICS

Report

NABH Accredited Medical Imaging Services MIS-2016-0027

Lab Serial No.	: 011907004632	Category	: GENERAL
Patient Name	: Mr. NARENDRA JANA	Reg. Date	21-Jul-19 08:57 PM
Age/Sex	: 34 YRS / M	Sample.coll.Date	:
Referred By	: Dr. PUSHPENDRA NATH RENJEN	Report Date	: 22-Jul-2019 06:59PM
TestName	: 3T MRI CERVICAL SPINE		
Center	: 15 Hargovind Enclave, Delhi - 110092		

MRI BRAIN

STUDY PROTOCOLS:

FLAIR T1W AND FAST SPIN ECHO T2W HIGH RESOLUTION AXIAL IMAGES OF BRAIN WERE OBTAINED ON A HIGH RESOLUTION DEDICATED PHASED ARRAY SURFACE COIL USING TWIN GRADIENT 16 CHANNEL HIGH DENSITY 3.0 TESLA SYSTEM WITH ZOOM GRADIENT COIL AND CORRELATED WITH T2W SAGITTAL, CORONAL, FLAIR AND DIFFUSION AXIAL IMAGES. NON CONTRAST STUDY WAS DONE. TOTAL NUMBER OF FILMS - 4.

Clinical History: Headache, follow up case of multiple sclerosis.

Findings:

Subtle T2/FLAIR hyperintense foci are seen in the medial aspect of the bilateral thalami and tail of the hippocampi.

Rest of cerebral parenchyma is normal in signal intensity with maintained grey and white matter differentiation.

No evidence of restricted diffusion or blooming seen.

Prominence of the cortical sulci in the bilateral parietal parasagittal location is seen.

Corpus callosum appears normal.

Rest of bilateral basal ganglia and thalami are normal in volume and signal intensity.

Ventricles are normal in shape, size outline and volume. Septum is in midline.

Basal cisterns and sylvian fissures are normal.

Sella and parasellar region are normal.

Brainstem is central and normal in signal intensity.

Fourth ventricle is central and normal.

Cerebellum is normal in signal intensity.

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Fellow in Body Imaging and Int. (USA)
DMC Reg. No. 34971

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Major intracranial flow voids preserved.

Mild thinning of the retrobulbar segment of the left optic nerve is seen.

Rest of orbits are normal.

Mild rightwards DNS seen.

IMPRESSION: MR IMAGING OF BRAIN REVEALS:

Subtle T2/FLAIR hyperintense foci in the medial aspect of the bilateral thalami and tail of the hippocampi - Resolving plaques of known MS

Prominence of the cortical sulci in the bilateral parietal parasagittal location

Mild thinning of the retrobulbar segment of the left optic nerve

ADVISED: CLINICAL CORRELATION.

MRI CERVICAL SPINE

STUDY PROTOCOLS:

SPIN ECHO T1 AND FAST SPIN ECHO T2W HIGH RESOLUTION SAGGITAL IMAGES OF CERVICAL SPINE WERE OBTAINED ON A DEDICATED SURFACE COIL USING 3.0 TESLA HIGH GRADIENT SYSTEMS AND CORRELATED WITH T1W AND T2 W AXIAL IMAGES. NON CONTRAST STUDY WAS DONE. TOTAL NUMBER OF FILMS - 3.

Clinical History: Vertigo, neck pain.

Findings:

Minimal linear T2 hyperintense signal is seen in the anterior aspect of the cervical cord at C5 and C6 vertebral level. No apparent bulk loss of the cervical cord noted at present.

Straightening of cervical spine seen.

Cervical vertebrae show mild marginal spur formation. The vertebrae are normal in alignment and marrow signal.

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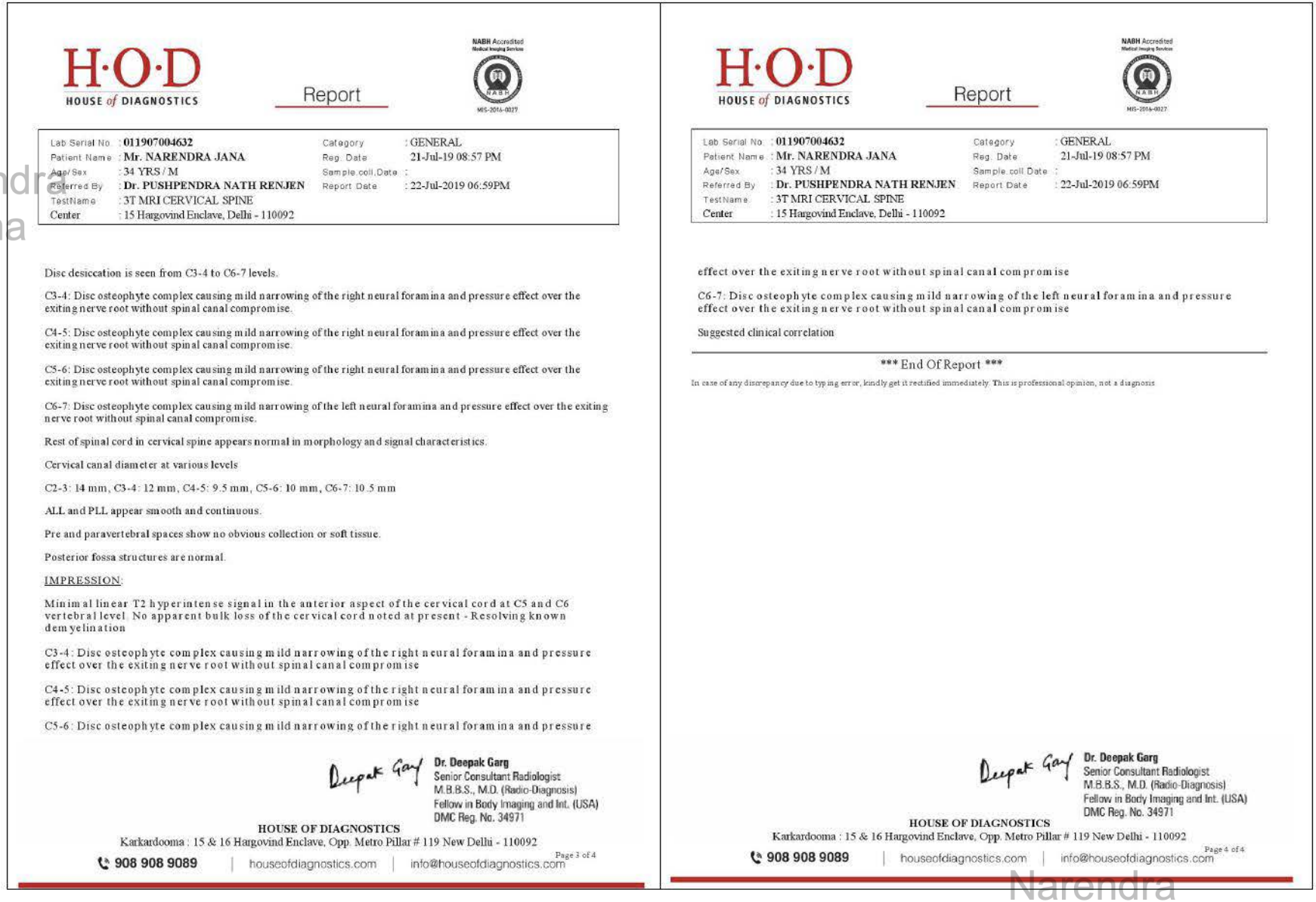

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Disc desiccation is seen from C3-4 to C6-7 levels.

C3-4: Disc osteophyte complex causing mild narrowing of the right neural foramina and pressure effect over the exiting nerve root without spinal canal compromise.

C4-5: Disc osteophyte complex causing mild narrowing of the right neural foramina and pressure effect over the exiting nerve root without spinal canal compromise.

C5-6: Disc osteophyte complex causing mild narrowing of the right neural foramina and pressure effect over the exiting nerve root without spinal canal compromise.

C6-7: Disc osteophyte complex causing mild narrowing of the left neural foramina and pressure effect over the exiting nerve root without spinal canal compromise.

Rest of spinal cord in cervical spine appears normal in morphology and signal characteristics.

Cervical canal diameter at various levels

C2-3: 14 mm, C3-4: 12 mm, C4-5: 9.5 mm, C5-6: 10 mm, C6-7: 10.5 mm

ALL and PLL appear smooth and continuous.

Pre and paravertebral spaces show no obvious collection or soft tissue.

Posterior fossa structures are normal.

IMPRESSION:

Minimal linear T2 hyperintense signal in the anterior aspect of the cervical cord at C5 and C6 vertebral level. No apparent bulk loss of the cervical cord noted at present - Resolving known demyelination

C3-4: Disc osteophyte complex causing mild narrowing of the right neural foramina and pressure effect over the exiting nerve root without spinal canal compromise

C4-5: Disc osteophyte complex causing mild narrowing of the right neural foramina and pressure effect over the exiting nerve root without spinal canal compromise

C5-6: Disc osteophyte complex causing mild narrowing of the right neural foramina and pressure

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effect over the exiting nerve root without spinal canal compromise

C6-7: Disc osteophyte complex causing mild narrowing of the left neural foramina and pressure effect over the exiting nerve root without spinal canal compromise

Suggested clinical correlation

*** End Of Report ***

In case of any discrepancy due to typing error, kindly get it rectified immediately. This is professional opinion, not a diagnosis

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The contrast report is more honest, and does mention that the T2 intensities and lesions in the brain and cervical spine typical of MS. But there is some deluded reasoning in this report as well, features of neurodegeneration are typified as “disk osteophyte complex” (this falsification is US directed). It was already demonstrated in the MRI from Latvia over two MRIs how neurodegeneration presents in the spinal column, which the US instructed the radiologist to typify as “disk osteophyte complex”. That’s a gross mis-typification and serves as an example of trying to avoid the long term effects of neurodegeneration due to what

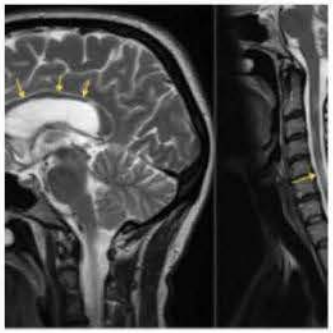
was in the past clear medical negligence now causing neurological injury. The US didn't want to acknowledge the neurological injury so they falsified radiology reports to an impossible extent.

The neurodegeneration is typical of MS and exemplified in this medical journal, what is stated as "disk osteophyte complex" is the progressive effects of neurodegeneration from long term MS. Only MS that has existed for more than 10 years would have these features.

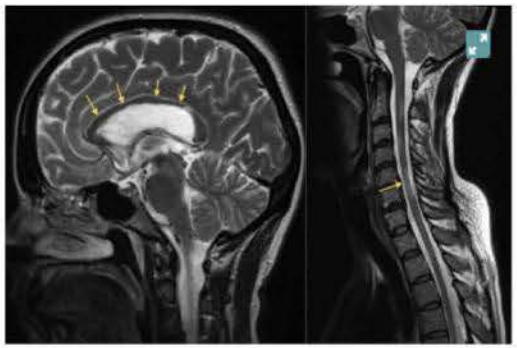
This spinal cord atophy is present is the cervical spine (much like brain atrophy) and is due to the long term effects of MS.

This is described in medical journals as a common long term effect of MS:

MULTIPLE SCLEROSIS – SPINAL CORD ATROPHY

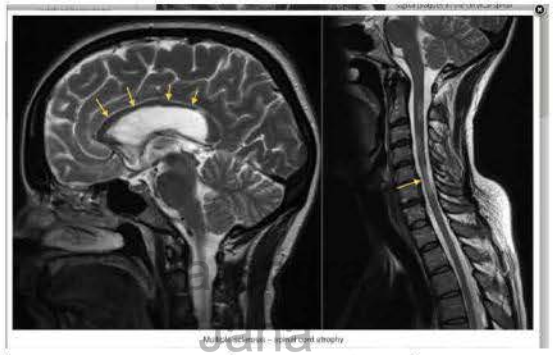


Multiple sclerosis – spinal cord atrophy



Multiple sclerosis – spinal cord atrophy. One of the imaging features of advanced multiple sclerosis is atrophy of the corpus callosum, illustrated in the sagittal T2-weighted image on the left here (arrows). Note the bright CSF. The patient also had multiple high-signal plaques in the cervical spinal cord, seen on the sagittal T2-weighted cervical spine image on the right. Note the focal area of thinning of the spinal cord (arrow), due to atrophy.

Multiple Sclerosis Spinal Cord Atrophy, http://www.svuhradiology.ie/case-study/multiple-sclerosis-spinal-cord-atrophy/, Saint Vincents Radiology.



Spinal cord atrophy is present in the cervical spine (much like brain atrophy) and is due to long term neurodegeneration due to MS and isn't a "disk osteophyte complex". The above is a medical journal that describes the pathology; typicality in medicine.