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Dear Gary Posner:

One of the cases that Sturrock's panel found somewhat impressive--prompting the panel to suggest possible medical research--is the infamous "Cash-Landrum" case. Which prompted me to buy John Schuessler's recent book on the case.

(FYI, enclosed is a photocopy of Sturrock's panel comments on this case.)

Enclosed also are photocopies of portions of the book dealing with the (alleged) medical effects. Betty Cash was the principal "victim," and you'll note that she suffered a prior heart condition and had undergone heart surgery several years prior to the incident. Later, they discovered breast cancer and she underwent a (double, as I recall) masectomy. As of the date that the book went to press in early 1998, I believe that all three principals were still alive--nearly two decades after their exposure to "UFO radiation."

(One of Sturrock's panel of scientists told me that if the story is true, it does not involve ETs or unknown physical phenomena but because of the 20+ helicopters reported in proximity to the "UFO," it involves a secret military test.)

IF you have time to offer comments for possible use in next issue of SUN, say within a couple weeks, would like to have them. This would not preclude you from making a lengthier commentary in next issue of your own Tampa Bay newsletter.

Let's chit-chat after you have a chance to read the enclosures.

Cordially,

"David plays softball and Vickie has grandchildren involved in sports. In the very late evening and night she can attend (games) but if she attempts to go to one during the day, the sun and heat will make her sick sometimes for a week."

STATEMENT BY DAYTON, TEXAS POLICE CHIEF TOMMY WARING:

"I don't know Betty Cash all that good, but I've been knowing the other one (Vickie Landrum) for a number of years and she's never lied to me that I know of and I've had several of her kids in Little League ball teams over the years and as far as I know she's a truthful lady."

When asked if she would make up stories like this, he said: "I don't think so."

STATEMENT BY VICKIE LANDRUM:

"Anyone could have checked to see my and Colby's health was good until December 29, 1980, with a Dr. E.R. Richter - dead now. My and Colby's record has to yet be there. He treated me from 1962 until his death. When I could not get him I used a Reginald Wilson at 258-2624.... They doctored me for colds when I had one. I was operated on in 1960. Dr. Richter did that too. Whenever I need one they was it. Only when I hurt my leg I used a Dr. John T. Pegues, 1409 N. Travis in Liberty. My health was real good. And I got some reading glasses from T.S.O. in Baytown. I'm sure if I need to I could get my records. I'm not trying to hoax anyone. After we was hurt on December 29, 1980, we had nothing but hurt and misery. If the object had not been there I would yet be fine. I sure did not burn myself or my child, hurt our eyes, or pull our hair out!"

Chapter 16
BETTY'S MEDICAL CONDITION IS DEFINED

Betty entered Parkway Hospital in Houston on January 2, 1981, and was discharged on January 19. She re-entered on January 25 and was again discharged on February 9. This began the succession of hospital stays for Betty that have continued to the present.

EXAMINATION BY DR. V.B. SHENOY — Specialty?

Betty appeared to be a burn patient when she was admitted to Parkway Hospital on January 2 by Dr. V.B. Shenoy. Her stated complaint included swelling of the eyes, scalp, and face, along with a terrible headache. These conditions still persisted when she re-entered the hospital on January 25. However, Dr. Shenoy noted she also had a marked alopecia, or hair loss, greater on the right side than on the left. She also had swelling of the eyelids. Dr. Shenoy had specifically noted that Betty had little, if any, hair loss when she entered the hospital the first time. His report includes the following information:

PHYSICAL EXAMINATION: This is a well-built, well-nourished white female in no acute distress.

VITAL SIGNS: Blood pressure 120/80. Respirations 20 per minute. Temperature normal. Heart rate 80 per minute and regular.

HEAD: Normocephalic. The patient has severe swelling of the

scalp associated with crusting and erythema all over the scalp. The patient also has swelling and erythema over the eyelids. There is no evidence of anemia or jaundice. Pupils are normal in size and shape, reacts well to light and accomodation. Oral hygiene is good.
NECK: Supple. No cervical lymphadenopathy. Carotid upstroke is good. No bruit heard over the carotid artery or subclavian artery. Trachea in the midline. Trachea not enlarged. Jugular venous pressure flat at forty-five degrees.
CHEST: Symmetrical on both sides. Moves well with respirations. Vesicular breath sounds heard all over the lung fields. No wheezing, crepitations or pleural friction rub heard.
CARDIOVASCULAR SYSTEM: Point of maximum intensity not felt. First and second heart sounds are normal in character. There is no murmur, gallop, or pericardial friction rub heard.
ABDOMEN: Soft. No hepatosplenomegaly or ascites. No bruit heard over the aortofemoral vessels.
EXTREMITIES: No pedal edema or calf muscle tenderness. Proximal and distal arterial pulsations are well heard.

Dr. Shenoy's report on January 25 provided the following laboratory results: Laboratory data revealed SMA-12 showing mild elevation of alkaline phosphatase, LDH, and serum triglycerides. ANA was negative. Vitamin B-12 serum level was normal. Quantitative analysis of heavy metals from the hair was insufficient. CBC revealed mild normocytic, normochromic anemia. Urinalysis was normal. RPR was nonreactive. Latex RA test and ANA were negative. Fasting two hour postprandial blood sugar was normal. Glycohemoglobin, however, was mildly elevated. T-3, T-4, and T-7 index was normal. Chest x-ray revealed minimal atelectasis in the lingular segment of the upper lobe of the left lung. Xeromammogram was negative. Electroencephalogram was essentially normal. Skull biopsy was consistent with alopecia areata.
TEST: LEAD, ARSENIC, AND MERCURY (HAIR): Quantity not

sufficient to process in test conducted on February 9.
VITAMIN B-12: 1036H (reference values: 200-900)
HEMOLYSIS (January 26): Albumin: 3.4 g/dl. Alk. Phosphatase: 120 U/L. BUN: 9 mg/dl. Calcium: 9.0 mg/dl. Cholesterol: 257 mg/dl. Glucose: 187 mg/dl. LDH: 309 U/L. SGOT: 17 U/L. Phosohorus: 3.2 mg/dl. Total Protein: 7.1 g/dl. A/G: 0.9. Globulin: 3.7. Total Bilirubin: 0.3 mg/dl. Uric acid: 5.7 mg/dl. Sodium: 135 mEq/L. Potassium: 4.9 mEq/L. Chloride: 97 mEq/L. CO2: 25mEq/L. Iron: 57 mg/dl. CPK: 10 U/L. Creatinine: 0.8 mg/dl. Triglyceride: 256 mg/dl. BUN/Creatinine: 11.3. Balance: 17.9.
URINALYSIS (voided on January 4): Specific Gravity: 1.008. Blood: 2+. pH: 6.0. RBC: 4-8/HPF. WBC: 3-5/HPF. Bacteria: few.
BLOOD TEST (taken on January 2): WBC: 8.1. RBC: 3.1. HGB gr: 12.9. HCT gm: 27. MCV: 91. MCH: 31.8. MCHC %: 35.1. DIFFERENTIAL: Poly: 81, Stab: 8, Lymph: 9, and Mono: 2. PLATELET: Appear normal.

Drugs administered for the purpose of treating her injuries and relieving her pain included the following: Keflin, IV DSW 50ML, Lanoxin tab, Persantine, Inderal, Dalmane, Tylenol, Benadryl, Solu-medrol, Prostaphlin, Ampicillin, IV N.S. 0.9%, Talwin, Betadine solution, Domeboro eff. tab, Fedsol SP, Premarin, Sinequan, Motrin, Amoxicillin, Zomax, and Dalmane.

EVALUATION BY DR. K. KUMAR

Dr. K. Kumar saw Betty for an evaluation of the headache. She said Betty was admitted "with cellulitis of the face, especially around the eyes and had a severe headache." Neither the EEG nor the CAT scan revealed any abnormalities.

On January 29, Dr. Kumar said: "The patient had been doing fairly well until the sudden onset of the cellulitis. No definite etiology of the cellulitis was established during the last admission;

but she was treated with antibiotics and steroids and did very well. The patient was discharged, recovered well from the cellulitis and with the headache much better, and says that as soon as she went home she started having diarrhea and soon after that her headaches started getting much worse and after some time her hair started falling off. At this time, the patient is admitted for evaluation of alopecia, diarrhea and headaches. At the time of being seen, the diarrhea has more or less been controlled. The headaches have gotten increasingly more severe and the patient had two injections last night."

Dr. Kumar's report goes on to say: "On examination, a 51 year old white female looks much younger than stated age. On general examination, alopecia of the scalp is present with two large areas of complete hair loss on either side of the head in the parietotemporal region. The cellulitis of the face has markedly improved at this time. Lymphadenopathy is present in the retroauricular and posterior cervical lymph nodes. Vital signs are stable."

A summary of Dr. Kumar's medical examination is as follows:
CARDIOVASCULAR: A scar is seen in the midline in the chest. Otherwise, heart sounds are well heard and no adventitious sounds are heard. No murmurs are present, no bruits heard over the carotids.
CENTRAL NERVOUS SYSTEM: Cranial nerves - patient is alert and oriented. Seems to be very rational and neither very anxious or depressed. Cranial nerves - pupils are equally reactive to light. Eye movements are full with no nystagmus being noted. Visual fields are full in all four quadrants. Funduscopic examination shows sharp disc margins and normal vasculature. The face is symmetrical, tongue is in the midline, pallate moves up equally well on both sides, no dysphagia is present.
NECK: Supple at this time.
MOTOR SYSTEM: Power is 5/5 in all four limbs. Reflexes are bilaterally symetrical. Plantars are downgoing.

SENSORY: Patient says that pinprick and vibration are mildly diminished in the left foot but this seems to be equivocal. In the upper extremities pin and vibration are symmetrical.
CEREBELLAR: Patient has no ataxia, can do a good tandem walk, is able to stand on either lower extremity. No nystagmus is seen. Finger to nose test is normal.

EXAMINATION BY DR. JOSEPH DARSEY

Dr. Darsey conducted an eye examination on January 26, with the following results:
VISUAL ACUITY EXAMINATION: In the distance, each eye is 20/30 plus. Left eye is 20/30 plus. The skin of the lids shows a flat erythematous area under the right brow. There is a dry scaly eruption on the forehead and lid skin. Extraocular motility is full. The conjunctiva is normal bilaterally. The corneas are clear bilaterally. Anterior chambers are deep and clear bilaterally. Ocular tension is 10 mm right eye, 11 mm left eye. The pupils are 4 mm and react 2+ out of 4 with direct response and the consensual and accomodative reflexes are intact. There is no Marcus Gunn pupillary phenomenon. There is an iris atrophy. The pupils were dilated with Mydriacyl and Neosynephrine for intraocular exam. There is a minus a quarter circle, myoptic refractive error in each eye, but the visual acuity in the distance remains 20/30. The lenses are clear bilaterally, except for an occasional punctate white opacity in each lens. The inferior zonular attachments are symmetrically visible OU. There is no posterior subcapsular cataract or equatorial lens opacity. The disc, macula and vessels appear normal in each eye, with zanthochromic macula with light reflex.

EVALUATION BY DR. SOLOMON BRICKMAN

Dr. Brickman made the following observations on January 5: The examination revealed crusted areas of her scalp and marked swelling of her forehead and edema and crusting of her right eyelid,

and edema of both eyelids, and cheeks. There was pain palpated in her scalp. The submandibular area was puffy and tender to touch as was the neck area. No weakness of hand grip, or her push was noted. There was no pain on straightening her legs from a flexed position. A clinical diagnosis cellulitis with secondary edema of the scalp and face is made.

Later, on January 28, Dr. Brickman provided the following evaluation of the alopecia: There is no family history of alopecia, vitiligo, or thyroid problems. The examination revealed round spots of alopecia on the scalp. Within those areas there were areas of black hair regrowth. Mild depression of some areas of the scalp were noted and occasionally scaly areas which would probably correspond to the areas of dermatitis several weeks ago. Occasional hairs in the scalp are noted which are wide distally and markedly narrowed as they approach the scalp. Tender lymph node on the left side is noted. No major scalp pain is present. Touching the scalp did not elicit the tenderness that she experiences in her head, nor her headaches. Clinical diagnosis is alopecia areata.

EVALUATION BY DR. K. B. FUNG — Radiol?

The results of Dr. Fung's evaluation are as follows:

CT SCAN OF THE HEAD: Films were taken with and without infusion of contrast medium. The visualized ventricles are unremarkable. The pineal body and the choroid plexus are visualized with calcification. There is no definite evidence of localized increased or decreased density seen in the brain. The vein of Galen is visualized on the post-contrast film is unremarkable. The middle cerebral arteries are fairly well visualized and are unremarkable. Opinion: there is no remarkable change seen on CT scan of the head.

CERVICAL SPINE: The visualized bony structures are unremarkable. There is no fracture or dislocation seen in the cervical spine. Some prominence of the left transverse process of

C7 is identified.

CHEST FILM, PA AND LATERAL VIEWS: There is minimal radio-opacity seen in the left Lung Field and it is not certain if this is indicating some minimal inflamatory changes. Otherwise, the size of the cardiac silhouette is borderline.

PARANASAL SINUSES: The paranasal sinuses are well developed and aerated. Otherwise, there is no remarkable change seen in the paranasal sinuses.

XEROMAMMOGRAPHY BILATERALLY: The left breast is slightly larger than the right side. Otherwise, there is no definite evidence of occupying mass or abnormal calcification seen in both breasts. Opinion: There is no remarkable change seen in the xeromammography examination bilaterally.

EVALUATION BY DR. JOE HADEN

Dr. Haden provided the following information of the January 29 skin sample laboratory analysis:

GROSS: The specimen, unlabeled, designated skin biopsy consists of a core of tan skin 0.4 cm. in diameter and 0.7 cm. in depth. Bisected and submitted entirely.

MICROSCOPIC: Slides have sections through the bisected halves of the above segments demonstrating two segments of skin. The epidermis is well differentiated stratified squamous epithelium. In one focus adjacent to a hair follicle opening the dermis shows dissolution of intercellular bridges. One mature hair follicle with relatively unremarkable contained hair shaft is present but there are fairly numerous superficially placed immature hair follicle structures some of which are surrounded by loosely arranged lymphocytic infiltrate. No evidence of malignant neoplasia.

PATHOLOGIC DIAGNOSIS: Skin biopsy, histologic features consistent with alopecia areata.