EVALUATION BY DR. TAGHI SHAFIE

Dr. Shafie conducted the EEG test on January 29, with the following results:

REPORT: The background activity consists of 9-10 cycles per second symmetrical and synchronous with medium voltage activity appearing on both hemispheres. No focal or generalized abnormality is seen during this recording.

HYPERVENTILATION & PHOTIC STIMULATION: Did not produce any abnormal changes.

CLINICAL INTERPRETATION: A essentially normal EEG.

Chapter 17
BETTY IS HOSPITALIZED REPEATEDLY

Betty's wonderful mother Pauline Collins came to Houston to care for Betty. And as soon as Betty was able to travel, they went back to her mother's home in Birmingham, Alabama. Unfortunately, her medical problems have persisted over the years and she has been hospitalized several dozen times as the result. Her visits to her doctor's office are too numerous to count. It is not necessary to discuss all of those events, but the following summary shows the extent of her medical problems, as documented in hospital records, for the year or so following the UFO encounter. It also clearly shows the progressive effects of the radiation exposure from her close encounter. Records of all of Betty's treatments are on file.

Betty was hospitalized from May 27 through June 1, 1981, at the Lloyd Nolan Hospital and Clinic in Fairfield, Alabama, under the care of Dr. Whittaker. Dr. Whittaker said his examination was basically confined to the skin, with the following results: "The patient has numerous nevi, telangiectasia, seborrheic keratoses, etc. and over areas of her body she has splotchy, erythematous, macular rash which is confined primarily to the lower trunk, extremities and primarily to the high lower extremities including the anterior and

posterior thighs as well as the buttock area. I could see no obvious blister at this time, although the patient pointed out to me a couple of areas where blisters originally occurred and apparently have opened and drained. Although she has some tenderness from the splotchy areas, she does not describe any itching. She has an intense pain when she takes a hot bath and states she has to take cold baths. The patient also states that she has chronic bowel problems ever since the UFO encounter."

"This patient has a ring-like appearance to the areas of erythema, almost like a tinia or ringworm type lesion over the back; however, the lesions over the lower extremities, and particularly over the thighs are more compatible with irregular macular erythematous scaly areas. She also states that before the exposure or encounter (described in her file), that she had a fair amount of hair on her legs. Now her legs are quite hairless. She also has numerous telangiectasia over the exposed portions of her hands, arms and what is interesting is that the area on her fourth finger where her rings were seems to be a protected area. The skin is whiter, she has a few fine hairs. On feeling this patient's regrowth of hair is quite fine and silky, again similar to that seen following growth after loss from radiation."

Although Betty had always been a healthy and vibrant individual, she had little resistance to disease following the UFO encounter. She was again hospitalized at Lloyd Nolan from September 29 through October 4, 1981, because of chest pains. Diagnosis revealed she had bronchitis and she was only released from the hospital because of a death in the family. She was still cancer-free at this time, but other changes in her systems were becoming apparent as noted below.

PHYSICAL EXAMINATION: Temperature 96.4, pulse 56, respirations 24, blood pressure 128/70. Neck was normocephalic without any abrasions. Pupils equal round and reactive to light. Extra occular movements intact. Fundi benign. Throat without

erythema. There were no masses or thyromegaly. Neck was supple. Chest revealed bilateral rales. CV-regular rate and rhythm without murmur. There was no JVD. Peripheral pulses were all good. Abdomen was soft, non-tender. There were no masses. There were normal bowel sounds.

LABORATORY: CBC revealed white count of 5,500 with 60 segs, 39 lymphs, 1 eosin. Hemoglobin 13.1, hematocrit 38.1, blood gases on admission were pH 7.519, PCO2 25.5, PO2 112.5. Routine urinalysis was negative. CPK was 49, SGOT 22. Follow CPK was 24 with CPK MB band O. On admission the SMA/6 revealed a potassium 4.0, sodium 130, CO2 31, Chloride 93, BUN 9, glucose 188. Chest film on admission, with a portable chest film showed no definite pulmonary infiltrate. OCG revealed normal oral cholecystogram. Upper GI series was normal. Follow up chest films revealed the lungs clear except for mild prominence of lung markings in the left retrocardiac area. This did not appear to represent definite infiltrate and is probably not significant. Chest was otherwise unremarkable.

NUCLEAR MEDICINE REPORT: The liver is at the upper limits of normal in size measuring just greater than 25cms at the mid clavicular line. One does note a rather prominent left lobe in the mid epigastrium. There is a fairly uniform distribution of the isotope throughout the organ, and no focal filling defects are identified. The spleen is also at the upper limits of normal in size measuring about 11cms, and again no focal filling defects are seen. There is a normal liver/spleen ratio in the uptake of the isotope.

Betty's condition had not improved since leaving the hospital; therefore, she was forced to return to Lloyd Nolan Hospital for another ten days starting on October 17, 1981. Dr. Whittaker was again her attending physician.

ADMITTING STATEMENT: The patient was a 52 year old white female with recent discharge from hospital for presumed bronchitis.

The patient was discharged at this time but before complete resolution because of illness in the family. The patient now returns without much improvement. The patient has been on antibiotics for two weeks. At this admission the patient states no improvement, with her primary complaints being weakness, decreased appetite, diarrhea, head cold and cough productive of yellowish sputum. She denies any fever, hemoptysis, or vomiting. The patient had coronary artery bypass graft five years ago and has also had exposure to high dose of radiation on December of 1980, with subsequent radiation sickness. Medications given at admission are Lanoxin, Lasix, Persantine, Inderal, Isordil, Nitroglycerin and Premarin.

PHYSICAL EXAMINATION: On admission revealed a 52 year old white female, that was uncomfortable with a non-productive cough and obvious respiratory congestion. The patient looked dry at this time. Vital signs: BP 120/68, pulse 64, respirations 20, temperature 97, HEENT exam - pupils equal, round and reactive to light and accomodation. EOMs intact. There were no masses, or adenopathy. The patient did have rhinitis and sinus congestion. There were no JVD noted. Chest exam revealed coarse breath sounds. There was no wheezing or rales present. CV - normal sinus rhythm with an S4 at the apex. There was a well healed midsternal scar. There were no murmurs, rubs, or clicks. Abdomen was soft, non-tender with normal bowel sounds. No masses. Extremities - no edema, clubbing or cyanosis. Skin and mucous membranes were dry.

LABORATORY DATA: Laboratory data during the stay was essentially unremarkable. SMA 18 revealed a Trig. of 258, with the remainder within normal limits. The CBC revealed a white count of 8,800 with 66% Segs., 26% Lymph, 5% Monos and EOS 2%, 1% BASO with HGB of 12.2 and HCT of 35.3. Routine urinalysis was negative. RPR was negative. AFB of sputum was negative. She was discharged as having chronic bronchitis and chronic

obstructive pulmonary disease.

The effects of the radiation exposure were becoming more pronounced as she was admitted to Lloyd Nolan Hospital again on November 26, 1981. This time she stayed until December 7.

ADMITTING CONDITIONS: Atypical chest pain. This patient is a 52 year old white female who had onset of a left arm and chest pain on the day of admission, lasting two hours with accompanying diaphoresis. No relief from Nitroglycerine. The patient recently has been feeling fine, no cough, no sputum production, SOB or congestive symptoms. The patient also had palpations and soreness of the left costal area.

PHYSICAL EXAMINATION: The exam showed an alert, cooperative white female with BP 120/70, pulse 60, respirations 16, afebrile. Chest - few rales on both sides. CV - no gallops or rubs. Grade 2 systolic murmur, in the left lower sternal border, radiating to the apex. Aortic and pulmonic area - no JVD at 30 degrees. Extremities - no edema. EKG shows sinus rhythm, old anteroseptal MI. Chest X-ray normal.

LABORATORY ANALYSIS: Cardiac enzymes negative. The patient was admitted to CCU and treated with MI protocol. EKG showed no change from previous one, but showed an old anteroseptal MI. After 2-3 days in CCU she had a negative EKG. She had a workup for GI disease. OCG, upper GI were negative. Cervical spine films normal. CBC was remarkable for HGB of 11.1. SMA 6/12 essentially unremarkable. Also had a CV Doppler carotid artery study that was unremarkable. Derm. consult - patient had radiation exposure as well as actenic exposure. Impression was radiation dermatitis. She had biopsy of skin and report was pending at time of discharge. The patient did well, but did have some intermittent chest pain, non-cardiac in origin. She had some numbness in the left arm. She developed a small pedal edema.

Dr. Robert Dudley, a pathologist, provided the following biopsy

report: Specimen No. 1: 0.7 x 0.5 cms. diagnosed as seborrheic keratosis. Specimen No. 2: 1.5 x 1 cm. diagnosed as seborrheic keratosis. Specimen No. 3: 0.3 cm dia., diagnosed as hyperkeratotic epithelial hyperplasis. rhd. The samples were taken from the left dorsum hand, left mid-back, and right palm respectively.

Not radiation

Although she is not sure why it happened, Betty experienced the first of several falls. The first incident was on February 13, 1982, when she fell in the bathtub. She was taken to Lloyd Nolan Hospital where it was determined that her elbow was injured and was placed in a splint.

On March 30, 1982, Betty returned to Lloyd Nolan Hospital for clinical services related to her skin condition. The dermatology consult had the same results as before. => Still no radiation injuries

Throughout the month of March, Betty had arm and chest pains that would last from minutes to a half hour or longer. Therefore, on April 2, 1982, she went to Lloyd Nolan Hospital for a stress test. She felt tired and weak after the pain subsided. The stress test was terminated after 12 minutes and 30 seconds because of fatigue. She achieved a heart rate of 134/minute and had chest pain at 7 minutes into the test. Interpretation of the test results: 1) Positive submax stress test, and 2) Poor exercise tolerance. => So? Sedentary? Smoker?

Because her problems were continuing to mount, Dr. Luis Pineda conducted a bone marrow test on Betty on July 14, 1982, with the following results:

PERIPHERAL BLOOD: Erythrocytes show mild degree of anisocytosis. There is a tendency toward microcytosis. Few target cells are seen. Leukocytes and platelets are normal in number and morphology. Approximately 10% of the neutrophils are polysegmented showing more than 4 lobules.

BONE MARROW ASPIRATION: Marrow particles are present.

Megakaryocytes are present in normal numbers. Myeloid to erythroid ration is 3:1. Both myeloid and erythroid series shows normal process of maturation. I do not see any infiltration by abnormal cells.

BONE MARROW IRON STAINING: There is marked decrease of stainable iron in the bone marrow.

BONE MARROW BIOPSY: Cellularity is variable arranging form areas of few to 60%. Areas of bone marrow necrosis are identified. Megakaryocytes are seen in normal number. Bone marrow architecture is preserved. I do not see any evidence of fibrosis, granuloma formation or malignant infiltration.

FINAL DIAGNOSIS: Abnormal non-diagnostic bone marrow - a) Bone marrow necrosis. b) Decreased iron storage. => Nothing about radiation

In the months and years that followed, Betty continued to be hospitalized several times each year due to a continuation of the aforementioned problems.

From chronic smoking? age? diabetes?