

Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

12851



7 - PROCEDURES

000001

OPERATION REPORT

Exhibit 3
 KAN-6540
 4-23-98 MAS
 Page 64 of Pages

NAME: [REDACTED]
 ADMISSION DATE: 03/31/98
 DATE OF SURGERY: 04/07/98
 SURGEONS: [REDACTED] MD

PREOPERATIVE DIAGNOSIS:
 Hypoxic encephalopathy, status post a cardiac arrest.

POSTOPERATIVE DIAGNOSIS:
 Hypoxic encephalopathy, status post a cardiac arrest.

OPERATIVE PROCEDURE DONE:
 The placement of a Camino subarachnoid screw, ICP monitor, under local anesthesia.

INDICATIONS FOR THE PROCEDURE:
 The patient is a 22 year-old Caucasian young man who went into cardiac arrest while working out at [REDACTED]. He had CPR and sustained a resultant hypoxic encephalopathy. The patient was admitted to [REDACTED] March 31, 1998, was intubated and correspondingly treated. At the time of the admission, the patient was unresponsive, but was opening his eyes, and would track, but would not do anything to commands and moved all four extremities well with good strength, requiring restraint; although initially he was obtunded, he had come to that point. Now however, seven days after the event, the patient was noted to be less responsive, no longer tracks and was noted to have a decerebrate posturing. Because of this and the question of increased ICP, recommended for an ICP monitor. We have discussed the procedure and risks as well as the options with the patient's parents and family.

PROCEDURE:
 The patient was shaved at the right frontal area and this was prepped and draped in the usual manner. The scalp was infiltrated with 1% Xylocaine and using the Camino cranial access kit, a 1/2cm incision was made over the frontal area about 5-6cm lateral to the midline just anteriorly to the coronal suture. Using the provided twist drill, a twist drill hole was made and the provided subarachnoid screw was carefully placed. The dura was then perforated using the provided 18 gauge needle and the provided blunt probe was used to penetrate the dura. The subarachnoid screw was then placed and the ICP monitor was placed at zero and then carefully placed into the subarachnoid space. The initial reading was 18 and this was then anchored in place. Note that the patient had been receiving

Pt. Name: [REDACTED]
 Adm. Date: 03/31/98
 Billing #: [REDACTED]

BD: [REDACTED]
 Pt. Type: [REDACTED]
 OPERATION REPORT

MR#: [REDACTED]
 RM#: [REDACTED]

CONFIDENTIAL MEDICAL RECORD

000002

OPERATION REPORT

Mannitol 25gm every eight hours. The findings from the procedure done were discussed with the patient's parents. Plan is to use the ICP now and the calculated cerebral perfusion pressure to manage the situation.

[REDACTED] MD

Exhibit 3
KAN-6540
4-23-98 MAS
Page 5 of 5 pages

D: 04/07/98

CC: [REDACTED] MD

000003

Pt. Name: [REDACTED]
Adm. Date: 03/31/98
Billing #: [REDACTED]

BD: [REDACTED]
Pt. Type: [REDACTED]
OPERATION REPORT

MR#: [REDACTED]
RM#: [REDACTED]

CONFIDENTIAL

MEDICAL RECORD

OPERATION REPORT

NAME: [REDACTED]

Exhibit 3
KAN-6540
4-23-98 MAS
Page 6 of 7 pages

ADMISSION DATE: 03/31/98
DATE OF SURGERY:

SURGEONS: [REDACTED] M.D.

PREOPERATIVE DIAGNOSIS:

Dysphagia secondary to sudden death syndrome and cerebral nervous system injury.

POSTOPERATIVE DIAGNOSIS:

Dysphagia secondary to sudden death syndrome and cerebral nervous system injury.

NAME OF OPERATION:

Esophagogastroduodenoscopy and percutaneous endoscopic placement of gastrostomy tube.

DESCRIPTION of PROCEDURE:

Under supplementation of Versed and topical anesthesia, gastroscope was passed through the oropharynx into the esophagus. The esophagus was normal. The squamocolumnar junction was at 40 cm. There was no evidence of reflux esophagitis. The scope was passed into the stomach. The body and antrum of the stomach were normal. The pylorus functioned normally. The duodenal bulb and C loop were normal. The scope was retroflexed in the stomach. The cardia and fundus were normal. The stomach was inflated with air. The lights were dimmed. One could see the air bubble of the stomach on the abdominal skin. In the left upper quadrant of the abdomen a 1 cm area was anesthetized with Xylocaine. A 1 cm incision was made. An 18 gauge needle was inserted through the abdominal wall and into the stomach. A guidewire was threaded through this needle. The guidewire was grasped by a snare, placed down the gastroscope. The gastroscope was then removed, bringing the wire guidewire with it. A graduated 20 French Bard gastrostomy tube was inserted over the guidewire and threaded down the esophagus into the stomach and out the abdominal wall. It was pulled to the 5 cm level. The G tube was quite mobile, could be turned 360 degrees without hindrance. Special appliances were placed on the G tube. Wire was removed. The patient tolerated the procedure well.

[REDACTED] M.D.

D: 04/21/98

CC: [REDACTED]

000004

Pt. Name: [REDACTED]
Adm. Date: 03/31/98
Billing #: [REDACTED]

BD: [REDACTED]
Pt. [REDACTED]
OPERATION REPORT

MR#: [REDACTED]
RM#: [REDACTED]

CONFIDENTIAL MEDICAL RECORD

INPATIENT SUMMARY REPORT

Patient: [REDACTED] ACCT# [REDACTED] UNIT# [REDACTED]

***** HEMATOLOGY *****
 ----- CBC & DIFFERENTIAL -----

Date	04/01/98	03/31/98			Reference	Units
Time	0430	1900				
WBC	PENDING	13.0	H		{5.0-10.0}	k/cumm
RBC	PENDING	5.43			{4.00-6.00}	m/cumm
HGB	PENDING	16.2			{14.0-18.0}	gm/dl
HCT	PENDING	47.3			{41.0-53.0}	%
MCV		87.2			{82.0-100.0}	fl
MCH	PENDING	29.9			{27.0-33.0}	pg
MCHC		34.3			{32.0-36.0}	g/dl
RDW		12.9			{11.0-15.6}	%
PLT	PENDING	332			{150-400}	k/cumm
GRAN %		51			{50-75}	%
LYMPH %		39	H		{20-30}	%
MONO %		8	H		{4-6}	%
EO %		2			{2-4}	%
GRAN #		6.8			{2.0-9.0}	k/cumm
LYMPH #		5.0	H		{1.0-4.0}	k/cumm
MONO #		1.0			{0.1-1.0}	k/cumm
EO #		0.2			{0.1-0.5}	k/cumm

***** BODY FLUID ANALYSIS *****
 ----- MISCELLANEOUS BODY FLUIDS -----

3/31/98 2253 EMESIS BLOOD POSITIVE * {NEGATIVE}

***** CHEMISTRY *****
 ----- ROUTINE CHEMISTRY -----

Date	-----04/01/98-----		03/31/98		Reference	Units		
Time	1515	0447	0430	1900				
NA		137			{135-148}	mmol/L		
K		4.6			{3.5-5.3}	mmol/L		
CL		103			{98-110}	mmol/L		
CO2		20.2	L		{21.0-32.0}	mmol/L		
ANION GAP		14			{5-15}			
GLUCOSE		258	H		{70-109}	mg/dL		
BUN		22	H		{7-20}	mg/dL		
CREATININE		1.8	H		{0.8-1.3}	mg/dL		
CK/CPK	7470	H	5320	H	668	H	{20-232}	U/L
CKMB	57.9	H	58.2	H	11.4	H	{0.0-7.0}	ng/mL
RELATIVE INDEX	0.8		1.1		1.7		{0.0-2.0}	

Exhibit 3
 KAN-6540
 4-23-98 MAS
 Page 9 of 9

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *=ABNORMAL ALPHA D=DELTA

Patient: [REDACTED] 22/M Acct# [REDACTED] Unit# [REDACTED]

INPATIENT SUMMARY REPORT

Patient: [REDACTED] ACCT# [REDACTED] UNIT# [REDACTED]

***** CHEMISTRY ***** (CONTINUED)
 ----- ROUTINE CHEMISTRY ----- (CONTINUED)

Date	Time	Reference	Units
03/31/98	1900		
NA	140	{135-148}	mmol/L
K	3.8	{3.5-5.3}	mmol/L
CL	103	{98-110}	mmol/L
CO2	13.9 L	{21.0-32.0}	mmol/L
ANION GAP	23 H	{5-15}	
GLUCOSE	228 H	{70-109}	mg/dL
BUN	19	{7-20}	mg/dL
CREATININE	1.9 H	{0.8-1.3}	mg/dL

----- MISCELLANEOUS CHEMISTRY -----

DATE/TIME	TEST	RESULT	REF/UNITS
TESTOSTERONE, FREE & TOTAL			
3/31/98 1900	TESTOST FREE	PENDING	{34-194} pg/mL
	TESTOST TOTAL	PENDING	{194-833} ng/dL

----- TOXICOLOGY/THERAPEUTIC DRUG MONITORING -----

Date	Time	Reference	Units
-----04/01/98-----			
0447	0430	03/31/98	1900
LIDOCAINE	1.2	{1.0-6.0}	mcg/mL
THEOPHYLLINE	8.1 L	{10-20}	mcg/mL

----- TOXICOLOGY/THERAPEUTIC DRUG MONITORING -----

DATE/TIME	TEST	RESULT	REF/UNITS
URINE DRUGS OF ABUSE SCREEN			
3/31/98 0100	UR AMPHETAMINES	NEG (<1000 ng/mL)	{NEGATIVE}
	UR BARBITURATES	NEG (< 200 ng/mL)	{NEGATIVE}
	UR PCP	NEG (< 25 ng/mL)	{NEGATIVE}
	UR CANNABINOIDS	NEG (< 50 ng/mL)	{NEGATIVE}
	UR COCAINE	NEG (< 300 ng/mL)	{NEGATIVE}
	UR OPIATES	POS (> 300 ng/mL)	* {NEGATIVE}
	UR BENZODIAZ	NEG (< 200 ng/mL)	{NEGATIVE}
	COMMENT	***** (a)	

NOTES: (a) NO CHAIN-OF-CUSTODY PROTOCOL FOLLOWED. UNABLE TO VERIFY/ DOCUMENT AUTHENTICITY OF SAMPLE.

Exhibit 2
 KAN-6540
 4-23-98 MAS
 Page 98 of Pages

000006 CONFIDENTIAL

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *=ABNORMAL ALPHA D=DELTA

Patient: [REDACTED] 22/M Acct# [REDACTED]

SUMMARY REPORT
PRINTED 04/01/98
TIME 2003

PAGE 4

>>>>> INPATIENT SUMMARY REPORT <<<<<

Patient: [REDACTED]

***** SEROLOGY *****

----- MISCELLANEOUS SEROLOGY -----

DATE/TIME	TEST	RESULT	REF/UNITS
3/31/98 1900	AB HIV 1	PENDING	{NEGATIVE}

Test	Date	Time	Result	Reference	Units
TESTOST FR & WB03	3/31/98	1900	PENDING	{84-402}	ng/dL

Exhibit 3
KAN-6540
4-23-98 MAS
Page 4 of 4

000007 CONFIDENTIAL

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *=ABNORMAL ALPHA D=DELTA

Patient: [REDACTED]

22/M

Acct# [REDACTED]

>>>>> INPATIENT SUMMARY REPORT <<<<<<

Patient: [REDACTED]

***** BLOOD GASES ***** (CONTINUED)

----- ARTERIAL BLOOD GASES ----- (CONTINUED)

Date	Time	CM	ABG PRES	S	ABG SITE
04/06/98	0400	5			
04/05/98	0430	6			
04/04/98	1110	6			
04/04/98	0500	6			
04/02/98	0430	6			(B)

Exhibit 3
 KAN-6540
 4-23-98 MAS
 Page 10 of Pages

(B) RIGHT RADIAL

04/01/98	1200	6			
04/01/98	1010	6			
04/01/98	0440	6			(C)

(C) RIGHT RADIAL

***** HEMATOLOGY *****

----- CBC & DIFFERENTIAL -----

Date	Time	04/07/98 0515	04/04/98 0450	Reference	Units
WBC		9.9	13.3 H	{5.0-10.0}	k/cumm
RBC		4.81	5.00	{4.00-6.00}	m/cumm
HGB		14.1	14.9	{14.0-18.0}	gm/dl
HCT		41.1	43.6	{41.0-53.0}	%
MCV		85.5	87.0	{82.0-100.0}	fl
MCH		29.3	29.7	{27.0-33.0}	pg
MCHC		34.3	34.1	{32.0-36.0}	g/dl
RDW		12.9	13.0	{11.0-15.6}	%
PLT		287	250	{150-400}	k/cumm
DIFFERENTIAL			MANUAL		
BAND %			30 H	{0-10}	%
GRAN %	64			{50-75}	%
SEG %			36 L	{50-70}	%
LYMPH %	15	L	21	{20-30}	%
MONO %	17	H	13 H	{4-6}	%
EO %	3			{2-4}	%
BASO %	1			{0-1}	%
GRAN #	6.3		8.8	{2.0-9.0}	k/cumm
LYMPH #	1.5		2.8	{1.0-4.0}	k/cumm
MONO #	1.7	H	1.7 H	{0.1-1.0}	k/cumm
EO #	0.3			{0.1-0.5}	k/cumm
BASO #	0.1			{0.0-0.2}	k/cumm
POLYCHROM			NOTED		

000008

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *=ABNORMAL ALPHA D=DELTA

>>>>> INPATIENT SUMMARY REPORT <<<<<<

Patient: [REDACTED] ACCT# [REDACTED] UNIT# [REDACTED]

***** BLOOD GASES ***** (CONTINUED)
 ----- ARTERIAL BLOOD GASES ----- (CONTINUED)

ABG PEEP ABG PRES S ABG SITE

Date	Time	CM	CM		
04/14/98	1025			(B)	
(B) RIGHT RADIAL					
04/14/98	0500	3	10		
04/13/98	0500	3	10		
04/12/98	0515	3	10		
04/11/98	0430		10		
04/10/98	1125	3	10		
04/10/98	0430	3	6		
04/09/98	0430	3	6	(C)	

Exhibit 3
 KAN-6540
 4-23-98 MAS
 Page 1 of 7 Pages

(C) RIGHT RADIAL

04/08/98	0430	3			
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***** HEMATOLOGY *****
 ----- CBC & DIFFERENTIAL -----

Date	04/15/98	04/11/98	Reference	Units
Time	0509	0500		
WBC	10.5 H		{5.0-10.0}	k/cumm
RBC	4.99		{4.00-6.00}	m/cumm
HGB	14.5	14.5	{14.0-18.0}	gm/dl
HCT	42.9		{41.0-53.0}	%
MCV	86.0	86.0	{82.0-100.0}	fl
MCH	29.2		{27.0-33.0}	pg
MCHC	33.9	34.5	{32.0-36.0}	g/dl
RDW	11.9		{11.0-15.6}	%
PLT	489 H		{150-400}	k/cumm
GRAN %	74		{50-75}	%
LYMPH %	14 L		{20-30}	%
MONO %	9 H		{4-6}	%
EO %	2		{2-4}	%
BASO %	1		{0-1}	%
GRAN #	7.8		{2.0-9.0}	k/cumm
LYMPH #	1.5		{1.0-4.0}	k/cumm
MONO #	0.9		{0.1-1.0}	k/cumm
EO #	0.2		{0.1-0.5}	k/cumm
BASO #	0.1		{0.0-0.2}	k/cumm

000009

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *=ABNORMAL ALPHA D=DELTA

Patient: [REDACTED] 22/M Acct# [REDACTED]

>>>>> INPATIENT SUMMARY REPORT <<<<<<

Patient: [REDACTED] ACCT# [REDACTED]

***** BODY FLUID ANALYSIS *****

----- MISCELLANEOUS BODY FLUIDS -----

3/31/98 2253 EMESIS BLOOD POSITIVE * {NEGATIVE}

***** CHEMISTRY *****

----- ROUTINE CHEMISTRY -----

Date	04/07/98	-----04/05/98-----	04/04/98	Reference	Units
Time	0515	0435	0435	0450	
NA	133 L		137	133 L	{135-148} mmol/L
K	3.8		3.5	3.8	{3.5-5.3} mmol/L
CL	100		102	100	{98-110} mmol/L
CO2	20.9 L		20.2 L	22.2	{21.0-32.0} mmol/L
ANION GAP	12		15	11	{5-15}
GLUCOSE	112 H		118 H	127 H	{70-109} mg/dL
BUN	20		16	15	{7-20} mg/dL
CREATININE	1.0		1.1	0.9	{0.8-1.3} mg/dL
CALCIUM		9.2			{8.8-10.5} mg/dL
MAGNESIUM		2.1			{1.8-2.4} mg/dL

Date	04/02/98	-----04/01/98-----		Reference	Units
Time	0925	1515	0447	0430	
NA	134 L		137		{135-148} mmol/L
K	3.8		4.6		{3.5-5.3} mmol/L
CL	102		103		{98-110} mmol/L
CO2	21.4		20.2 L		{21.0-32.0} mmol/L
ANION GAP	11		14		{5-15}
GLUCOSE	133 H		258 H		{70-109} mg/dL
BUN	11 D		22 H		{7-20} mg/dL
CREATININE	1.2 D		1.8 H		{0.8-1.3} mg/dL
CK/CPK		7470 H		5320 H	{20-232} U/L
CKMB		57.9 H		58.2 H	{0.0-7.0} ng/mL
RELATIVE INDEX		0.8		1.1	{0.0-2.0}

Exhibit 3
 KAN-6540
 4-23-98 MAS
 Page 02 of Pages

000010

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *-ABNORMAL ALPHA D=DELTA

Patient: [REDACTED] 22/M Acct# [REDACTED]

INPATIENT SUMMARY REPORT

Patient: [REDACTED] ACCT# [REDACTED]

***** CHEMISTRY *****
 ----- ROUTINE CHEMISTRY -----

Date Time	04/15/98 0509	04/11/98 0500	04/10/98 2010	Reference	Units
NA	140	141	139	{135-148}	mmol/L
K	4.7	3.8	4.0	{3.5-5.3}	mmol/L
CL	106	106	100	{98-110}	mmol/L
CO2	27.9	26.3	29.8	{21.0-32.0}	mmol/L
ANION GAP	6	9	9	{5-15}	
GLUCOSE	104	113	132	{70-109}	mg/dL
BUN	17	14	16	{7-20}	mg/dL
CREATININE	0.9	0.8	1.0	{0.8-1.3}	mg/dL
TOTAL PROTEIN	7.3			{6.4-8.2}	gm/dL
ALBUMIN	3.1	L		{3.4-5.0}	gm/dL
CALCIUM	9.7			{8.8-10.5}	mg/dL
BILIRUBIN TOTAL	0.3			{0.0-1.0}	mg/dL
AST/SGOT	62	H		{15-37}	U/L
ALK PHOS	265	H		{50-136}	U/L

----- TOXICOLOGY/THERAPEUTIC DRUG MONITORING -----

Date Time	04/09/98 0430	04/08/98 0450	Reference	Units
PHENYTOIN	< 2.5	L	{10.0-20.0}	mcg/mL
THEOPHYLLINE		3.0	{10-20}	mcg/mL

Exhibit
 KAN-6540
 4-23-98 MAS
 Page 108 of Pages

CONFIDENTIAL
 000011

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *-ABNORMAL ALPHA D=DELTA

Patient: [REDACTED] 22/M Acct# [REDACTED]

>>>>> INPATIENT SUMMARY REPORT <<<<<<

Patient: [REDACTED] ACCT# [REDACTED]

***** HEMATOLOGY ***** (CONTINUED)
 ----- CBC & DIFFERENTIAL ----- (CONTINUED)

Date	04/15/98	Reference	Units
Time	0509		
BASO #	0.1	{ 0.0-0.2 }	k/cumm

***** CHEMISTRY *****
 ----- ROUTINE CHEMISTRY -----

Date	04/18/98	04/15/98	Reference	Units
Time	1100	0509		
NA	143	140	{ 135-148 }	mmol/L
K	4.1	4.7	{ 3.5-5.3 }	mmol/L
CL	106	106	{ 98-110 }	mmol/L
CO2	29.9	27.9	{ 21.0-32.0 }	mmol/L
ANION GAP	7	6	{ 5-15 }	
GLUCOSE	97	104	{ 70-109 }	mg/dL
BUN	15	17	{ 7-20 }	mg/dL
CREATININE	0.9	0.9	{ 0.8-1.3 }	mg/dL
TOTAL PROTEIN		7.3	{ 6.4-8.2 }	gm/dL
ALBUMIN		3.1 L	{ 3.4-5.0 }	gm/dL
CALCIUM		9.7	{ 8.8-10.5 }	mg/dL
BILIRUBIN TOTAL		0.3	{ 0.0-1.0 }	mg/dL
AST/SGOT		62 H	{ 15-37 }	U/L
ALK PHOS		265 H	{ 50-136 }	U/L

----- TOXICOLOGY/THERAPEUTIC DRUG MONITORING -----

Date	04/18/98	Reference	Units
Time	1100		
PHENYTOIN	8.9 L	{ 10.0-20.0 }	mcg/mL

Exhibit 3
 KAN-6540
 4-23-98 MAS
 Page 11 of 2 Pages

CONFIDENTIAL

000012

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *=ABNORMAL ALPHA D=DELTA

Patient: [REDACTED] 22/M Acct# [REDACTED]

INPATIENT SUMMARY REPORT

Patient: [REDACTED] ACCT# [REDACTED]

***** CHEMISTRY ***** (CONTINUED)
 ----- MISCELLANEOUS CHEMISTRY -----

DATE/TIME	TEST	RESULT	REF/UNITS
TESTOSTERONE, FREE & TOTAL			
3/31/98 1900	TESTOST FREE	119	{34-194} pg/mL
	TESTOST TOTAL	419 (d)	{194-833} ng/dL

----- TOXICOLOGY/THERAPEUTIC DRUG MONITORING -----

Date	04/08/98	04/07/98	04/05/98	04/03/98	Reference	Units
Time	0450	0515	0435	0540		
THEOPHYLLINE	{3.0 L}	{3.2 L}	{7.4 L}	{6.6 L}	{10-20}	mcg/mL

Date	04/02/98	-----04/01/98-----	Reference	Units
Time	0925	0447	0430	
LIDOCAINE			{1.0-6.0}	mcg/mL
DIGOXIN	{0.5 L}		{0.8-2.0}	ng/mL
THEOPHYLLINE		{8.1 L}	{10-20}	mcg/mL

----- TOXICOLOGY/THERAPEUTIC DRUG MONITORING -----

DATE/TIME	TEST	RESULT	REF/UNITS
URINE DRUGS OF ABUSE SCREEN			
3/31/98 0100	UR AMPHETAMINES	NEG (<1000 ng/mL)	{NEGATIVE}
	UR BARBITURATES	NEG (< 200 ng/mL)	{NEGATIVE}
	UR PCP	NEG (< 25 ng/mL)	{NEGATIVE}
	UR CANNABINOIDS	NEG (< 50 ng/mL)	{NEGATIVE}
	UR COCAINE	NEG (< 300 ng/mL)	{NEGATIVE}
	UR OPIATES	POS (> 300 ng/mL)	{NEGATIVE} *
	UR BENZODIAZ	NEG (< 200 ng/mL)	{NEGATIVE}
	COMMENT	***** (e)	

NOTES: (d) TEST PERFORMED AT [REDACTED]
 (e) NO CHAIN-OF-CUSTODY PROTOCOL FOLLOWED. UNABLE TO VERIFY/
 DOCUMENT AUTHENTICITY OF SAMPLE.

Exhibit 3
 KAN-6540
 4-23-98 MAS
 page 103 of 2 pages

000013

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *=ABNORMAL ALPHA D=DELTA

Patient: [REDACTED] 22/M Acct# [REDACTED]

SUMMARY REPORT
PRINTED 04/08/98
TIME 2003

>>>>> INPATIENT SUMMARY REPORT <<<<<

Patient: [REDACTED] ACCT# [REDACTED]

***** SEROLOGY *****
----- MISCELLANEOUS SEROLOGY -----

DATE/TIME	TEST	RESULT	REF/UNITS
3/31/98 1900	AB HIV 1	NEGATIVE	{NEGATIVE}

Test	Date	Time	Result	Reference	Units
TESTOST FR & WB03	3/31/98	1900	234	{84-402}	ng/dL

Exhibit 3
KAN-6540
4-23-98 MAS
Page 14 of Pages

CONFIDENTIAL

000014

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *=ABNORMAL ALPHA D=DELTA

Patient: [REDACTED] 22/M Acct# [REDACTED]



INPATIENT SUMMARY REPORT



NAME...
 ACCT#...
 UNIT#...
 DOCTOR:

LOCATION:
 AGE/SEX/DOB: 22/M
 STATUS: ADM IN

***** BLOOD GASES *****
 ----- ARTERIAL BLOOD GASES -----

Date	Time	ABG PH {7.35-7.45}	ABG PCO2 {34-45}	ABG PO2 {75-100}	ABG HCO3 {23.0-28.0}	ABG BE {-3.0-3.0}	ABG O2 SAT {93-100}
			mm Hg	mm Hg	meq/L	meq/L	%
04/01/98	1200	7.54 H	24 L	129 H	24.1	-0.6	99
04/01/98	1010	7.53 H	20 L	184 H	21.1 L	-4.2 L	99
04/01/98	0440	7.39	35	210 H	21.4 L	-3.8 L	99
03/31/98	2030	7.36	36	382 H	20.5 L	-5.0 L	100
03/31/98	1900	7.28 L	34	148 H	15.8 L	-9.8 L	99

Date	Time	COLLECTOR	ABG FIO2	ABG VENT R	ABG TIDAL	ABG PEEP	ABG PRES S
			%	CC	CM	CM	
04/01/98	1200		40	18	800	3	6
04/01/98	1010		50	20	800	3	6
04/01/98	0440		60	15	800	3	6
03/31/98	2030		100	15	800	3	6
03/31/98	1900						

ABG SITE

Date	Time	ABG SITE
04/01/98	0440	(A)

(A) RIGHT RADIAL

EX71010
 KAN-6540
 4-23-98 MAS
 Page 96 of Pages

000015

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *=ABNORMAL ALPHA D=DELTA

Patient: [REDACTED] 22/M Acct# [REDACTED]

SUMMARY REPORT
 PRINTED 04/08/98
 TIME 2003

INPATIENT SUMMARY REPORT

NAME... LOCATION:
 ACCT#... AGE/SEX/DOB: 22/M
 UNIT#... STATUS: ADM IN
 DOCTOR:

BLOOD GASES
 ARTERIAL BLOOD GASES

Date	Time	ABG PH {7.35-7.45}	ABG PCO2 {34-45}	ABG PO2 {75-100}	ABG HCO3 {23.0-28.0}	ABG BE {-3.0-3.0}	ABG O2 SAT {93-100}
			mm Hg	mm Hg	meq/L	meq/L	%
04/08/98	0430	7.55 H	27 L	120 H	26.4	2.2	99
04/07/98	0445	7.52 H	30 L	111 H	26.4	2.2	98
04/06/98	1720	7.56 (a)*H	25 L	96	25.6	1.3	98
04/06/98	0400	7.56 (b)*H	27 L	88	26.6	2.4	98
04/05/98	0430	7.52 H	28 L	66 L	24.8	0.4	95
04/04/98	1110	7.50 H	31 L	106 H	25.6	1.2	98
04/04/98	0500	7.45	35	118 H	24.7	0.2	99
04/03/98	0500	7.51 H	28 L	77	24.5	0.1	97
04/02/98	0430	7.55 H	23 L	121 H	24.1	-0.5	99
04/01/98	1200	7.54 H	24 L	129 H	24.1	-0.6	99
04/01/98	1010	7.53 H	20 L	184 H	21.1 L	-4.2 L	99
04/01/98	0440	7.39	35	210 H	21.4 L	-3.8 L	99

Date	Time	ABG TEMP C	COLLECTOR	ABG FIO2 %	ABG VENT R	ABG TIDAL CC	ABG PEEP CM
04/08/98	0430			30	21	800	3
04/07/98	0445	38.1 (c)		30	21	800	3
04/06/98	1720			30	22	800	3
04/06/98	0400			25	22	800	3
(A) FC.RN# 2793							
04/05/98	0430			25	22	800	3
04/04/98	1110			30	20	80	
04/04/98	0500			30	16	800	3
04/03/98	0500			30	16	800	6
04/02/98	0430			35	17	800	3
04/01/98	1200			40	18	800	3
04/01/98	1010			50	20	800	3
04/01/98	0440			60	15	800	3

NOTES: (a) CRITICAL RESULTS CALLED TO [REDACTED] AT 1722. [REDACTED]
 (b) CRITICAL RESULT CALLED TO [REDACTED] AT 0504, 04/06/98 BY [REDACTED]
 (c) TEMP CORRECTED

Exhibit 3
 KAN-6540
 4-23-98 MAS
 Page 100 of

000016

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *=ABNORMAL ALPHA D=DELTA

Patient: [REDACTED] 22/M Acct# [REDACTED]

SUMMARY REPORT
 PRINTED 04/15/98
 TIME 2003

>>>>> INPATIENT SUMMARY REPORT <<<<<<

NAME . . :
 ACCT# . . :
 UNIT# . . :
 DOCTOR :

LOCATION :
 AGE/SEX/DOB : 22/M
 STATUS : ADM IN

Exhibit
 KAN-6540
 4-23-98 MAS
 Page 06 of

***** BLOOD GASES *****
 ----- ARTERIAL BLOOD GASES -----

Date	Time	ABG PH {7.35-7.45}	ABG PCO2 {34-45} mm Hg	ABG PO2 {75-100} mm Hg	ABG HCO3 {23.0-28.0} meq/L	ABG BE {-3.0-3.0} meq/L	ABG O2 SAT {93-100} %
04/15/98	0430	7.41	47 H	79	27.7	3.7 H	96
04/14/98	1415	7.43 (a)	45	104 H	28.0	3.9 H	98
04/14/98	1025	7.42	47 H	99	28.3 H	4.3 H	98
04/14/98	0500	7.45	44	131 H	29.4 H	5.4 H	99
04/13/98	0500	7.40	48 H	106 H	27.6	3.5 H	98
04/12/98	0515	7.43	45	85	27.7	3.7 H	97
04/11/98	0430	7.45	44	86	28.6 H	4.7 H	97
04/10/98	1125	7.42	42	127 H	26.0	1.7	99
04/10/98	0430	7.47 H	35	113 H	25.5	1.1	98
04/09/98	0430	7.49 H	34	95	26.5	2.3	98
04/08/98	0430	7.55 H	27 L	120 H	26.4	2.2	99

COLLECTOR ABG FIO2 ABG DEVICE ABG VENT M ABG VENT R ABG TIDAL

Date	Time	Collector	FIO2 %	Device	VENT M	VENT R	TIDAL CC
04/15/98	0430		25	BLOW-BY			800
04/14/98	1415		25		FLOW-BY		
04/14/98	1025		25				
04/14/98	0500		25		8		800
04/13/98	0500		25		8		800
04/12/98	0515		25		8		800
04/11/98	0430		25		8		800
04/10/98	1125		30		8		800
04/10/98	0430		30		14		800
04/09/98	0430		30		18		800
04/08/98	0430		30		21		800

ABG PEEP ABG PRES S ABG SITE

Date	Time	PEEP CM	PRES S CM	SITE
04/15/98	0430			(A)

(A) RIGHT RADIAL

NOTES: (a)

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *=ABNORMAL ALPHA D=DELTA

Patient: Acct# 22/M Unit#

000017

CONFIDENTIAL

SUMMARY REPORT
 PRINTED 04/16/98
 TIME 2001

INPATIENT SUMMARY REPORT

NAME . . : [REDACTED] LOCATION: [REDACTED]
 ACCT# . . : [REDACTED] AGE/SEX/DOB: 22/M [REDACTED]
 UNIT# . . : [REDACTED] STATUS: ADM IN
 DOCTOR: [REDACTED]

Exhibit 5
 KAN-6540
 4-23-98 MAS
 Page 110 of Pages

***** BLOOD GASES *****
 ----- ARTERIAL BLOOD GASES -----

Date	Time	ABG PH {7.35-7.45}	ABG PCO2 {34-45} mm Hg	ABG PO2 {75-100} mm Hg	ABG HCO3 {23.0-28.0} meq/L	ABG BE {-3.0-3.0} meq/L	ABG O2 SAT {93-100} %
04/16/98	0430	7.42	45	75	27.7	3.7 H	95
04/15/98	0430	7.41	47 H	79	27.7	3.7 H	96

Date	Time	COLLECTOR	ABG FIO2 %	ABG L/M	ABG DEVICE	ABG TIDAL CC	ABG SITE
04/16/98	0430	[REDACTED]		2.0	NC		
04/15/98	0430	[REDACTED]	25		BLOW-BY	800	(A)

(A) RIGHT RADIAL

***** HEMATOLOGY *****
 ----- CBC & DIFFERENTIAL -----

Date	Time	04/15/98	0509	Reference	Units
WBC	10.5	H		{5.0-10.0}	k/cumm
RBC	4.99			{4.00-6.00}	m/cumm
HGB	14.5			{14.0-18.0}	gm/dl
HCT	42.9			{41.0-53.0}	%
MCV	86.0			{82.0-100.0}	fl
MCH	29.2			{27.0-33.0}	pg
MCHC	33.9			{32.0-36.0}	g/dl
RDW	11.9			{11.0-15.6}	%
PLT	489	H		{150-400}	k/cumm
GRAN %	74			{50-75}	%
LYMPH %	14	L		{20-30}	%
MONO %	9	H		{4-6}	%
EO %	2			{2-4}	%
BASO %	1			{0-1}	%
GRAN #	7.8			{2.0-9.0}	k/cumm
LYMPH #	1.5			{1.0-4.0}	k/cumm
MONO #	0.9			{0.1-1.0}	k/cumm
EO #	0.2			{0.1-0.5}	k/cumm
BASO #	0.1			{0.0-0.2}	k/cumm

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *=ABNORMAL ALPHA D=DELTA 000018

Patient: [REDACTED] 22/M Acct# [REDACTED]

SUMMARY REPORT
 PRINTED 04/17/98
 TIME 2017

>>>>> INPATIENT SUMMARY REPORT <<<<<<

NAME...
 ACCT#...
 UNIT#...
 DOCTOR:

LOCATION:
 AGE/SEX/DOB: 22/M
 STATUS: ADM IN

***** BLOOD GASES *****
 ----- ARTERIAL BLOOD GASES -----

Date	Time	ABG PH {7.35-7.45}	ABG PCO2 {34-45} mm Hg	ABG PO2 {75-100} mm Hg	ABG HCO3 {23.0-28.0} meq/L	ABG BE {-3.0-3.0} meq/L	ABG O2 SAT {93-100} %
04/17/98	0430	7.41	47 H	84	27.8	3.7 H	96
04/16/98	0430	7.42	45	75	27.7	3.7 H	95
04/15/98	0430	7.41	47 H	79	27.7	3.7 H	96

Date	Time	COLLECTOR	ABG FIO2 %	ABG L/M	ABG DEVICE	ABG TIDAL CC	ABG SITE
04/17/98	0430			1.0	NC		
04/16/98	0430			2.0	NC		
04/15/98	0430		25		BLOW-BY	800	(A)

(A) RIGHT RADIAL

***** HEMATOLOGY *****
 ----- CBC & DIFFERENTIAL -----

Date	Time	Reference	Units
04/15/98	0509		
WBC	10.5 H	{5.0-10.0}	k/cumm
RBC	4.99	{4.00-6.00}	m/cumm
HGB	14.5	{14.0-18.0}	gm/dl
HCT	42.9	{41.0-53.0}	%
MCV	86.0	{82.0-100.0}	fl
MCH	29.2	{27.0-33.0}	pg
MCHC	33.9	{32.0-36.0}	g/dl
RDW	11.9	{11.0-15.6}	%
PLT	489 H	{150-400}	k/cumm
GRAN %	74	{50-75}	%
LYMPH %	14 L	{20-30}	%
MONO %	9 H	{4-6}	%
EO %	2	{2-4}	%
BASO %	1	{0-1}	%
GRAN #	7.8	{2.0-9.0}	k/cumm
LYMPH #	1.5	{1.0-4.0}	k/cumm
MONO #	0.9	{0.1-1.0}	k/cumm
EO #	0.2	{0.1-0.5}	k/cumm

CONFIDENTIAL

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *=ABNORMAL ALPHA D=DELTA

Patient:

22/M

Acct#

000019

Exhibit 3
 KAN-6540
 4-23-98 MAS
 Page 13 of 2 Pages

>>>>> INPATIENT SUMMARY REPORT <<<<<<

Patient: [REDACTED] ACCT# [REDACTED]

*** MICROBIOLOGY SUMMARY ***

Col	Date	Time	Specimen #	Source	Sp Desc	P/F	Organisms
>	04/02/98	1917	[REDACTED]	SPUTUM	TRAC ASP	F	H INFLUENZ

RESPIRATORY CULTURES AND TESTS

Specimen: [REDACTED] COMP Collected: 04/02/98-1917 Received: 04/02/98-1917
 Source: SPUTUM TRAC ASP
 GRAM STAIN SPUTUM Final 04/02/98

MODERATE NEUTROPHILS
MIXED BACTERIAL FLORA

SPUTUM CULTURE Final 04/04/98

LIGHT GROWTH NORMAL FLORA

Organism 1

HAEMOPHILUS INFLUENZAE
.HEAVY GROWTH
.BETA LACTAMASE PRODUCED ✓

Exhibit 3
KAN-6540
4-23-98 MAS
Page 6 of 7 pages

000020

CONFIDENTIAL

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *-ABNORMAL ALPHA D=DELTA

Patient: [REDACTED] 22/M Acct# [REDACTED] Unit# [REDACTED]

>>>>> INPATIENT SUMMARY REPORT <<<<<<

Patient: [REDACTED] ACCT# [REDACTED] UNIT# [REDACTED]

*** MICROBIOLOGY SUMMARY ***

Col Date	Time	Specimen #	Source	Sp Desc	P/F	Organisms
> 04/13/98	1200	[REDACTED]	SPUTUM	TRAC ASP	F	YST, N CRY

----- RESPIRATORY CULTURES AND TESTS -----

Specimen: [REDACTED] COMP Collected: 04/13/98-1200 Received: 04/13/98-1337

Source: SPUTUM TRAC ASP

GRAM STAIN SPUTUM Final 04/13/98

MANY NEUTROPHILS
MIXED BACTERIAL FLORA

SPUTUM CULTURE Final 04/15/98

Organism 1 YEAST, NOT CRYPTOCOCCUS
.HEAVY GROWTH

Exhibit 3
KAN-6540
4-23-98 MAS
Page 109 of Pages

000021
CONFIDENTIAL

H=HIGH L=LOW *H=CRITICAL HIGH *L=CRITICAL LOW *=ABNORMAL ALPHA D=DELTA

Patient: [REDACTED] 22/M Acct# [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: R/*O BLEED EXAM DATE: 03/31/98
EXAMS: [REDACTED] CT HEAD W/O CONTRAST

(1925 HRS.)

REASON FOR EXAM: Code Red while lifting weights.

CT of the brain without contrast shows some diffuse edema throughout the supratentorial brain. The cisternal spaces appear fairly well maintained. There is decreased density noted in both occipital lobes, the left more so than the right which is consistent with ischemia in these locations. No evidence for hemorrhage, mass, or extra-axial collections is seen. The visualized portions of the paranasal sinuses are clear.

IMPRESSION: 1. There is some diffuse edema throughout the supratentorial brain with the cisternal spaces appearing fairly well maintained. 2. Low density seen in both occipital regions, left greater than the right which is consistent with ischemic events in these locations.

I have personally reviewed these images and approved or corrected the resident physician's interpretation.

** REPORT SIGNATURE ON FILE 04/01/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.
RESIDENT: [REDACTED] M.D.

Exhibit 5
KAN-6540
4-23-98 MAS
Page 122 of Pages

CC: [REDACTED] RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/01/98 (1040)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/01/98 (1128) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: R/O BLEED EXAM DATE: 04/06/98

EXAMS: 000140224 CT HEAD W/O CONTRAST

REASON FOR EXAM: Patient status post cardiac arrest.

Multiple axial CT images were performed without intravenous contrast and compared to previous study of 31 March 1998.

The present study continues to show marked obliteration of the sulci bilaterally consistent for underlying brain edema. There is some low attenuation noted high within the centrum semiovale on the left with near complete obliteration of the normal gray/white differentiation. There is no evidence of hemorrhagic bleed. No mass effect or shift. Due to patient's slight asymmetry in the scanner, posterior fossa is somewhat difficult to interpret. However, no hemorrhagic bleed seen. Previously noted low attenuation within the posterior fossa, i.e. occipital lobe, is still present. The fourth ventricle, third ventricle, and lateral ventricles are well preserved. No obvious evidence of cisternal obliteration.

Presented bone windows reveal diffuse mucosal disease involving the ethmoidal sinuses bilaterally; however, just minimal mucosal disease is seen within the medial aspect of the right maxillary sinus. No evidence of air fluid levels. Incidentally noted is some mild opacification along the midaspect of the left mastoid air cells. Overlying calvarium is intact.

IMPRESSION: 1. Findings most consistent for underlying cerebral swelling with loss of the normal gray/white differentiation with subtle low attenuation, especially high within the centrum semiovale. No evidence of hemorrhagic bleed. These findings are somewhat more conspicuous on today's study. 2. Interval development of ethmoidal sinus disease with some subtle opacification of the left mastoid air cells as noted. Additional follow-up study is recommended with possible MRI to assess gray/white differentiation and underlying edema as warranted.

[REDACTED] MD notified of findings at time of dictation. MRI maybe helpful to

Exhibit 3
KAN-6540
4-23-98 MAS
Page 3 of Pages

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: R/O BLEED EXAM DATE: 04/06/98

EXAMS: [REDACTED] CT HEAD W/O CONTRAST
<Continued>

Exhibit 3
KAN-6540
4-23-98 MAS
Page 34 of Pages

better delineate the edematous changes.

** REPORT SIGNATURE ON FILE 04/08/98 **
REPORTED BY: [REDACTED]
SIGNED BY: [REDACTED]

CC: RADIOLOGY FILE COPY; [REDACTED]
TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/08/98 (1456)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/08/98 (1535) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] M.D. ACCT: [REDACTED]
REASON FOR EXAM: R/O PNEUMONIA EXAM DATE: 03/31/98

EXAMS: [REDACTED] CHEST AP/PA ONLY

(1903 HRS.)

REASON FOR EXAM: Cardiac arrest.

Comparison study is dated 12/18/94. The patient is intubated with the tip of the ET tube 2 cm proximal to the carina. Heart size and pulmonary vascularity are normal. There is some patchy density in the right middle lobe consistent with a small area of atelectasis or infiltrate. The lungs are otherwise clear. There is an electrode pad overlying the right upper lung.

IMPRESSION: 1. ET tube tip as above. 2. There is some density in the right middle lobe consistent with a small area of atelectasis and/or infiltrate.

** REPORT SIGNATURE ON FILE 04/01/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.

Exhibit 3
KAN-6540
4-23-98 MAS
Page 2 of 2 Pages

CC: RADIOLOGY FILE COPY; [REDACTED] M.D.

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/01/98 (0659)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/01/98 (0906) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: PLACEMENT OF PICC LINE EXAM DATE: 03/31/98
EXAMS: [REDACTED] CHEST FOR PICC LINE

(2128 HOURS)

PICC line has been inserted from the left arm and its tip is in the SVC near its junction with the RA.

** REPORT SIGNATURE ON FILE 04/01/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.

CC: RADIOLOGY FILE COPY; [REDACTED]
TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/01/98 (0753)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/01/98 (0935) BATCH NO: [REDACTED]

Exhibit 3
KAN-6540
4-23-98 MAS
Page 24 of Pages

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: CARDIAC ARREST EXAM DATE: 04/01/98
EXAMS: [REDACTED] CHEST AP/PA ONLY

(0242 HOURS)

The ET tube is above the carina by about 3 cm. Lungs are well aerated and clear and are better aerated than on the previous film of March 31, 1998 with improved aeration of the base.

** REPORT SIGNATURE ON FILE 04/01/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.

CC: RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/01/98 (0754)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/01/98 (0935) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: DAILY EXAM DATE: 04/02/98
EXAMS: [REDACTED] CHEST AP/PA ONLY

0238

REASON FOR EXAM: follow up cardiac arrest

A single portable view is obtained and compared to same dated 4-1-98. The heart size, pulmonary vasculature, and mediastinum are within normal limits and unchanged. The nasogastric tube is again seen coiled within the stomach and the endotracheal tube is in satisfactory position above the carina. These are unchanged compared to the previous study. Lungs are clear with no evidence of infiltrate or effusion. Visualized soft tissue and osseous structures demonstrate no acute abnormality.

IMPRESSION: No evidence of acute chest disease. The overall appearance is unchanged compared to the previous study done on 4-1-98.

I have personally reviewed these images and approved or corrected the resident physician's interpretation.

** REPORT SIGNATURE ON FILE 04/03/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.
RESIDENT: [REDACTED]

CC: [REDACTED]; RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/02/98 (1945)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/03/98 (0835) BATCH NO: [REDACTED]

Exhibit 3
KAN-6540
4-23-98 MAS
Page 16 of Pages

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: FOR DOBHOFF PLACEMENT. EXAM DATE: 04/02/98

EXAMS: [REDACTED] CHEST FOR TUBE LOCATION

REASON FOR EXAM: Cardiac arrest.

1046 hours.

A portable view of the chest is compared to prior exam from 4/2/98. The positions of the ET tube, PICC line, and gastric tube are unchanged. There is now a Dobbhoff tube in place which projects below the carina. The heart size and pulmonary vascularity are within normal limits. The left hilum remains somewhat prominent and unchanged. The remainder of the lungs are clear.

IMPRESSION: 1. Interval placement of a Dobbhoff tube, the tip of which projects just below the hilum. Instructions were called to the floor to advance the Dobbhoff tube 20-30 cm. 2. The left hilum remains prominent with no change in the appearance of the chest since the prior exam from same day.

I have personally reviewed these images and approved or corrected the resident physician's interpretation.

** REPORT SIGNATURE ON FILE 04/03/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED]
RESIDENT: [REDACTED] M.D.

CC: [REDACTED] M.D.; RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/03/98 (0806)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/03/98 (0922) BATCH NO: [REDACTED]

Exhibit 3
KAN-6540
4-23-98 MAS
Page 17 of 17 Pages

CONFIDENTIAL

000029

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: FEEDING TUBE PLACEMENT EXAM DATE: 04/02/98

EXAMS: [REDACTED] ABDOMEN FOR TUBE LOC

REASON FOR EXAM: Dobbhoff tube placement.

1147 hours.

A KUB of the abdomen is obtained for Dobbhoff tube placement. The tip of the Dobbhoff tube projects to the distal portion of the second portion of the duodenum. There is also a gastric tube in place, the tip of which projects into the fundus of the stomach.

I have personally reviewed these images and approved or corrected the resident physician's interpretation.

** REPORT SIGNATURE ON FILE 04/03/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED]
RESIDENT: [REDACTED] M.D.

CC: [REDACTED] M.D.; RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/03/98 (0807)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/03/98 (0910) BATCH NO: [REDACTED]

Exhibit 3
KAN-6540
4-23-98 MAS
Page 28 of Pages

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: CARDIAC ARREST. EXAM DATE: 04/03/98

EXAMS: [REDACTED] CHEST AP/PA ONLY

0237 HRS.

REASON FOR EXAM: Cardiac arrest.

Single portable view was obtained and compared to same day of 4-2-98. The heart size and mediastinum are unchanged. There is some prominence of the pulmonary vascularity which may be related to technique. The appearance is not significantly changed compared to the previous study. The lungs are clear with no evidence of infiltrate or effusion. Visualized soft tissue and osseous structures demonstrate no acute abnormality.

PICC line is again seen entering from the left with its tip at the junction of the superior vena cava and right atrium. Feeding tube and nasogastric tube are projected below the gastroesophageal junction. The tips of these catheters are not seen. Endotracheal tube position is unchanged approximately 2 cm above the carina.

IMPRESSION: No evidence of acute chest disease. There is some prominence of pulmonary vasculature which is most likely related to technique.

I have personally reviewed these images and approved or corrected the resident physician's interpretation.

** REPORT SIGNATURE ON FILE 04/04/98 **
REPORTED BY: [REDACTED]
SIGNED BY: [REDACTED]
RESIDENT: [REDACTED]

CC: [REDACTED] RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/04/98 (1548)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/04/98 (1556) BATCH NO: [REDACTED]

Exhibit 3
KAN-6540
4-23-98 MAS
Page 29 of 29 Pages

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: RESP. DIST. EXAM DATE: 04/04/98
EXAMS: [REDACTED] CHEST AP/PA ONLY

Comparison is to the previous days study with ET, NG and Dobbhoff feeding tubes projecting over appropriate structures without apparent change. Central vessels are prominent consistent with some congestion here. No interstitial edema is currently seen. Patient is felt again to be essentially recumbent. This is felt in part responsible for the poor visualization of the left diaphragm but grossly no new infiltrates are seen. Depth of inspiration is not quite as great as on the previous exam.

IMPRESSION: Central vascular congestion with no new areas of infiltrate or atelectasis.

** REPORT SIGNATURE ON FILE 04/06/98 **
REPORTED BY: [REDACTED]
SIGNED BY: [REDACTED]

CC: RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED] Exhibit 3
TRANSCRIBED DATE/TIME: 04/05/98 (1105) KAN-6540
TRANSCRIPTIONIST: [REDACTED] 4-23-98 MAS
PRINTED DATE/TIME: 04/06/98 (1030) BATCH NO: [REDACTED] Page 130 of Pages

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: ON VENT EXAM DATE: 04/05/98

EXAMS: [REDACTED] CHEST AP/PA ONLY

(0214 HOURS)

REASON FOR EXAM: Cardiac arrest.

Since previous exam of one day ago, single AP portable chest shows ET tube tip above the carina unchanged with a PICC line in the SVC. Right lung is clear. Heart size normal with some increasing infiltration in the left lung consistent with pneumonia or aspiration.

IMPRESSION: There is increasing infiltrate of the left lung with good catheter positions.

** REPORT SIGNATURE ON FILE 04/06/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.

CC: RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/06/98 (0826)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/06/98 (0922) BATCH NO: [REDACTED]

PAGE 1

CHART COPY

Exhibit 3
KAN-6540
4-23-98 MAS
Page 3 of 3 Pages

CONFIDENTIAL
000033

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: VENT PT EXAM DATE: 04/06/98

EXAMS: [REDACTED] CHEST AP/PA ONLY

PORTABLE CHEST:
0234 hours.

Exhibit 3
KAN-6540
4-23-98 MAS
Page 32 of Pages

Compared to the previous day's examination, there appears to be some slight improvement in the density of the left hemithorax. This suggests that there may have been some pleural fluid here layering posteriorly as it was a uniform increase in density on the previous study. Currently, the lungs show no confluent infiltrate. There may be some very minimal atelectasis in the right perihilar region with the heart size and mediastinal configuration unchanged. The patient is rotated to the right on this study. The PICC line tip projects over the superior vena cava just above its junction with the right atrium.

IMPRESSION: Interval improvement with there thought to be a decrease in the left effusion. No new areas of consolidation or atelectasis are present, tubes and lines projecting over appropriate structures.

** REPORT SIGNATURE ON FILE 04/08/98 **
REPORTED BY: [REDACTED]
SIGNED BY: [REDACTED]

CC: RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/06/98 (1350)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/08/98 (1057) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: DAILY EXAM DATE: 04/07/98
EXAMS: [REDACTED] CHEST AP/PA ONLY

0226 HRS.

The ET tube, NG tube and feeding tube again evident. There is a soft, rounded opacity over the central right lung measuring about 2.8 cm in craniocaudad dimension. The left lung shows some increased density in the retrocardiac region. Heart size is normal.

IMPRESSION: Soft opacity over central right lung, I believe, is related to something external on the patient as I do see a thin line extending toward the right cardiophrenic sulcus from this region. On the left side there is some density in the left lower lobe which is improved since 4-6-98. This could be resolving pneumonia or resolving atelectasis.

** REPORT SIGNATURE ON FILE 04/08/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.

Exhibit 3
KAN-6540
4-23-98 MAS
Page 15 of 15 Pages

CC: RADIOLOGY FILE COPY; [REDACTED]
TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/08/98 (0812)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/08/98 (1109) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: TUBE PLACEMENT EXAM DATE: 04/07/98
EXAMS: [REDACTED] ABDOMEN FOR TUBE LOC

1613 hours.

The Dobbhoff tube tip is at the junction of the second and third portions of the duodenum.

** REPORT SIGNATURE ON FILE 04/08/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.

Exhibit 3
KAN-6540
4-23-98 MAS
Page 36 of Pages

CC: RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/08/98 (1411)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/09/98 (0754) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: S/P CARDIAC ARREST-VENT DEPENDENT EXAM DATE: 04/08/98
EXAMS: [REDACTED] CHEST AP/PA ONLY

0243 hours.

Tubes and catheters again evident not appreciably changed. The patient is tilted to the right. The heart and lungs are normal. No significant change since 4/7/98. The soft ovoid opacity over the central right lung on the previous film is no longer evident indicating it had been something extraneous.

** REPORT SIGNATURE ON FILE 04/09/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.

Exhibit 3
KAN-6540
4-23-98 MAS
Page 37 of Pages

CC: RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/08/98 (2056)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/09/98 (0915) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: RESP EXAM DATE: 04/09/98
EXAMS: [REDACTED] CHEST AP/PA ONLY

(0238 HOURS)

REASON FOR EXAM: Cardiac arrest.

Single portable view is obtained and compared to previous exam dated 4/8/98. The heart size, pulmonary vasculature, and mediastinum are within normal limits. The lungs are clear with no evidence of infiltrate or consolidation. No pneumothorax or pleural effusion is seen. Nasogastric tube. Dobhoff tube, left sided PICC line, and endotracheal tube are unchanged compared to the previous examination. The visualized soft tissues and osseous structures demonstrate no acute abnormality.

IMPRESSION: No acute chest disease. The overall appearance is unchanged compared to the previous examination dated 4/8/98.

I have personally reviewed these images and approved or corrected the resident physician's interpretation.

** REPORT SIGNATURE ON FILE 04/10/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.
RESIDENT: [REDACTED]

CC: [REDACTED]; RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/09/98 (2041)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/10/98 (0927) BATCH NO: [REDACTED]

EXHIBIT 3
KAN-6540
4-23-98 MAS
Page 38 of Pages

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: CARDIAC ARREST EXAM DATE: 04/10/98
EXAMS: [REDACTED] CHEST AP/PA ONLY

Lungs are well aerated and clear without much change since the film of a day earlier. The tip of the ET tube is above the carina by 4 cm.

** REPORT SIGNATURE ON FILE 04/13/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.

Exhibit 3
KAN-6540
4-23-98 MAS
Page 39 of Pages

CC: RADIOLOGY FILE COPY; [REDACTED]
TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/10/98 (1824)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/13/98 (0845) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: CARDIAC ARREST. EXAM DATE: 04/11/98
EXAMS: [REDACTED] CHEST AP/PA ONLY

0237 hours.

Tubes and catheters are unchanged. There is some increased density in the left infrahilar region. The right lung is clear. Heart size normal. Central vessels are upper normal in size.

IMPRESSION: 1. Question infiltrate versus atelectasis left lower lobe which is a change since previous film. 2. Subjectively, central vessels are smaller than on the previous film.

** REPORT SIGNATURE ON FILE 04/11/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.

Exhibit 3
KAN-6540
4-23-98 MAS
Page 140 of Pages

CC: RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/11/98 (1040)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/11/98 (1701) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: CARDIAC/RESP ARREST EXAM DATE: 04/12/98
EXAMS: [REDACTED] CHEST AP/PA ONLY

0431 hours.

Feeding tube and nasogastric tube again evident. An ET tube is present which is very difficult to evaluate because of film density. This is to the left of the spine with the tip at about T2. On the previous film of 4/11/98, it is noted that the tube was in the same position just to the left of the spine. There is a rectangular region of increased density projected over the medial portion of the heart just to the left of the spine. This appears to be due to an external device of some sort. There is increased density in the right infrahilar region. Heart size normal.

IMPRESSION: There is artifactual increase in density over the heart to the left of the spine caused by an overlying object. This interferes with optimal evaluation of this region. On the right side, changes are suspicious for either atelectasis or early infiltrate in the right infrahilar region.

** REPORT SIGNATURE ON FILE 04/13/98 **
REPORTED BY: [REDACTED]
SIGNED BY: [REDACTED]

Exhibit 3
KAN-6540
4-23-98 MAS
Page 4 of 4 Pages

CC: RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/12/98 (1415)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/13/98 (1030) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: RESPIRATORY DISTRESS EXAM DATE: 04/13/98
EXAMS: [REDACTED] CHEST AP/PA ONLY

0403 HRS.

REASON FOR EXAM: Respiratory distress.

Single portable view was obtained. Comparison to previous study dated 4-12-98. The heart size, pulmonary vascularity and mediastinum are within normal limits. The lungs are clear with no evidence of infiltrate or consolidation. Endotracheal tube and left sided PICC line are again identified. The tip of the PICC line is in the right atrium near its junction with the superior vena cava. Nasogastric tube and Dobhoff tube are again identified extending below the diaphragm. No acute bony or soft tissue abnormalities are identified.

IMPRESSION: The appearance of the chest is within normal limits and unchanged since the previous examination.

I have personally reviewed these images and approved or corrected the resident physician's interpretation.

** REPORT SIGNATURE ON FILE 04/14/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.
RESIDENT: [REDACTED] D.O.

Exhibit
KAN-6540
4-23-98 MAS
Page 142 of Pages

CC: [REDACTED] RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/14/98 (0019)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/14/98 (1024) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: RESPIRATORY DISTRESS EXAM DATE: 04/13/98

EXAMS: [REDACTED] CHEST AP/PA ONLY

0403 HRS.

REASON FOR EXAM: Respiratory distress.

Single portable view was obtained. Comparison to previous study dated 4-12-98. The heart size, pulmonary vascularity and mediastinum are within normal limits. The lungs are clear with no evidence of infiltrate or consolidation. Endotracheal tube and left sided PICC line are again identified. The tip of the PICC line is in the right atrium near its junction with the superior vena cava. Nasogastric tube and Dobhoff tube are again identified extending below the diaphragm. No acute bony or soft tissue abnormalities are identified.

IMPRESSION: The appearance of the chest is within normal limits and unchanged since the previous examination.

I have personally reviewed these images and approved or corrected the resident physician's interpretation.

** REPORT SIGNATURE ON FILE 04/14/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.
RESIDENT: [REDACTED]

Exhibit 3
KAN-6540
4-23-98 MAS
Page 13 of 5 Pages

CC: [REDACTED] RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST [REDACTED]
TRANSCRIBED DATE/TIME: 04/14/98 (0019)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/14/98 (1024) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: RESP EXAM DATE: 04/14/98
EXAMS: [REDACTED] CHEST AP/PA ONLY

(0340 HRS.)

Since the film of a day ago, there have developed a few areas of increased markings in the right lung base, consistent with some mild areas of atelectasis. I don't see any free fluid or underlying cardiac enlargement.

** REPORT SIGNATURE ON FILE 04/15/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.

Exhibit
KAN-6540
4-23-98 MAS
Page 144 of Pages

CC: RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/15/98 (0411)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/15/98 (0852) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: ASTHMA EXAM DATE: 04/15/98

EXAMS: [REDACTED] CHEST AP/PA ONLY

REASON FOR EXAM: Cardiac arrest.

0243 hours.

Since the previous exam of one day ago, a single AP portable chest shows the lungs remain clear. The heart, mediastinum, and bony structures remain normal.

IMPRESSION: Continuing normal chest.

** REPORT SIGNATURE ON FILE 04/17/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.

Exhibit 3
KAN-6540
4-23-98 MAS
Page 145 of 145 Pages

CC: RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/16/98 (1327)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/17/98 (0837) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: RESP EXAM DATE: 04/16/98

EXAMS: [REDACTED] CHEST AP/PA ONLY

REASON FOR EXAM: Cardiac arrest.

0246 hours.

AP portable chest shows the lungs remain clear. The heart, mediastinum, and bony structures remain normal.

IMPRESSION: Continuing negative chest. No active disease.

** REPORT SIGNATURE ON FILE 04/17/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.

Exhibit 2
KAN-6540
4-23-98 MAS
Page 146 of Pages

CC: RADIOLOGY FILE COPY; [REDACTED]

TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/16/98 (1329)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/17/98 (0837) BATCH NO: [REDACTED]

NAME: [REDACTED] LOC: [REDACTED] RADIOLOGY NO: [REDACTED]
DOB: [REDACTED] AGE: 22 SEX: M STATUS: INP UNIT NO: [REDACTED]
ATTENDING PHYS: [REDACTED] ACCT: [REDACTED]
REASON FOR EXAM: RESP FAILURE EXAM DATE: 04/17/98
EXAMS: [REDACTED] CHEST AP/PA ONLY

0239 hours.

The lungs are well aerated and clear. I do not see any active disease, heart failure, or fluid; and the lungs are better aerated now than on the film of a day ago.

** REPORT SIGNATURE ON FILE 04/17/98 **
REPORTED BY: [REDACTED] M.D.
SIGNED BY: [REDACTED] M.D.

Exhibit 3
KAN-6540
4-23-98 MAS
Page 17 of 17 Pages

CC: RADIOLOGY FILE COPY; [REDACTED]
TECHNOLOGIST: [REDACTED]
TRANSCRIBED DATE/TIME: 04/17/98 (1125)
TRANSCRIPTIONIST: [REDACTED]
PRINTED DATE/TIME: 04/17/98 (1146) BATCH NO: [REDACTED]

ECHOCARDIOGRAM REPORT

EXN101C3
KAN-6540
4-23-98 MAS
Page 2 of Pages

PT. NAME: [REDACTED]

ADMISSION DATE: 03/31/98

DOP: 03/31/98

INDICATIONS:
Tachycardia; hypertension; status post sudden death.

PROCEDURE: Echocardiogram

M-Mode, 2-D, and Doppler echocardiography with color flow studies.

1. This is a good quality study.
2. The left atrial dimensions within normal limits with left atrial diameter measured at 2.85 cm.
3. Normal morphology of the mitral valve leaflets with no trace mitral insufficiency and no evidence for stenosis.
4. Mild left ventricular dilatation with left ventricular end diastolic diameter measured at 5.81 cm. The upper limits of normal being 5.6 cm. Moderate global hypokinesis is present with ejection fractions calculated from 43% to 47% and estimated ejection fraction closer to 35%-40%. No evidence for delayed diastolic relaxation is present.
5. Dense aortic root with normal morphology and function of the aortic valve leaflets.
6. Normal right-sided chambers and valves with no evidence for pulmonary hypertension.
7. No evidence for intracardiac mass or thrombi.
8. No evidence for pericardial effusion.

[REDACTED] M.D.

[REDACTED] 04/03/98

Pt. Name: [REDACTED]
Adm. Date: 03/31/98
Bill #: [REDACTED]

BD: [REDACTED]
Pt. Type: ADM

MR#: [REDACTED]
RM#: [REDACTED]

ECHOCARDIOGRAM REPORT

000048

[REDACTED]
[REDACTED]

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Page 1 of 1

ECHOCARDIOGRAM REPORT

PT. NAME: [REDACTED]
ADMISSION DATE: 03/31/98
DOP: 03/31/98

Exhibit 3
KAN-6540
4-23-98 MAS
Page 6 of Pages

INDICATIONS:
Tachycardia; hypertension; status post sudden death.

PROCEDURE: Echocardiogram

M-Mode, 2-D, and Doppler echocardiography with color flow studies.

1. This is a good quality study.
2. The left atrial dimensions within normal limits with left atrial diameter measured at 2.85 cm.
3. Normal morphology of the mitral valve leaflets with no trace mitral insufficiency and no evidence for stenosis.
4. Mild left ventricular dilatation with left ventricular end diastolic diameter measured at 5.81 cm. The upper limits of normal being 5.6 cm. Moderate global hypokinesis is present with ejection fractions calculated from 43% to 47% and estimated ejection fraction closer to 35%-40%. No evidence for delayed diastolic relaxation is present.
5. Dense aortic root with normal morphology and function of the aortic valve leaflets.
6. Normal right-sided chambers and valves with no evidence for pulmonary hypertension.
7. No evidence for intracardiac mass or thrombi.
8. No evidence for pericardial effusion.

[REDACTED] M.D.

[REDACTED]: 04/03/98

000049

CONFIDENTIAL

Pt. Name: [REDACTED]
Adm. Date: 03/31/98
Billing #: [REDACTED]

BD: [REDACTED]
Pt. [REDACTED]

MR#: [REDACTED]
RM#: [REDACTED]

ECHOCARDIOGRAM REPORT

ADULT CARDIOVASCULAR ECHOCARDIOGRAPHY LAB

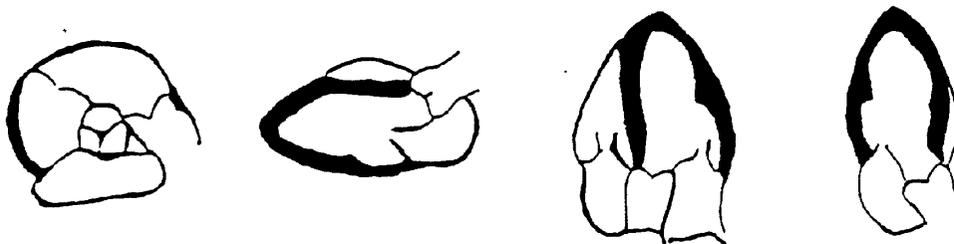
ADDRESSOGRAPH

PATIENT NAME: [REDACTED]
 MEDICAL RECORD NUMBER: [REDACTED]
 ACCOUNT NUMBER: [REDACTED]
 DOB: [REDACTED] AGE: 22
 REFERRING PHYSICIAN: [REDACTED]
 READING CARDIOLOGIST: [REDACTED]
 TECHNICIAN: [REDACTED] DATE: 3/31/98 TIME 1110
 TAPE NUMBER: [REDACTED] HEIGHT: [REDACTED] WEIGHT: [REDACTED]
 ROOM NUMBER: [REDACTED] BODY SURFACE AREA: [REDACTED]
 PATIENT HISTORY: [REDACTED]
 REASON FOR STUDY: Code Blue

PROCEDURE	
<input checked="" type="checkbox"/>	COMPLETE
<input type="checkbox"/>	LIMITED
<input type="checkbox"/>	CHD

ECHOCARDIOGRAPHIC MEASUREMENTS			NORMAL LIMITS
Aorta Diastole	<u>4.09</u> cm	cm/m ²	3.7 cm or 2.2 cm/m ²
LA Dimension	<u>2.85</u> cm	cm/m ²	4.0 cm or 2.1 cm/m ²
RA Dimension	/ cm	cm/m ²	
RV Diastole	/ cm	cm/m ²	4.4 cm or 2.8 cm/m ²
LV Diastole	<u>5.81</u> cm	cm/m ²	5.6 cm or 3.2 cm/m ²
Systole	<u>4.57</u> cm	Variable	
IVS Diastole	<u>.65</u> cm		1.2 cm
LVPW Diastole	<u>.77</u> cm		1.2 cm
Mitral E/A Ratio	<u>1.87</u>	MV Decel Time <u>90</u>	
Isovolumic Relaxation Time		millisecond (85 millisecond 15)	
Ejection Fraction	(Teich) <u>43</u> (Simp) <u>47</u> %	Method of Discs	
Left Ventricle Mass Index	grams/m ²		men 125 grams/m ² women 110 grams/m ²

2-DIMENSIONAL AND COLOR FLOW REPORT



DOPPLER ANALYSIS					
	Peak V m/sec	ΔP mm/Hg Peak/mean	Valve Area cm ²	Regurg. Severity	Jet Velocity m/s
MITRAL				<u>trace</u>	
LVOT					
AORTA Valve Ascending Descending	<u>nl</u>			/	
Tricuspid				/	
Pulmonic					

Pericardial Effusion:	<u>Ø</u>
Shunt:	<u>Ø</u> QP/QS:
IVC response:	<u>nl</u> RV Syst pressure:
AT	MPAP
ET	

000050

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LVOT=left ventricular outflow tract, cm=centimeter, m=meter, v=velocity, s=second, mm=millimeter, p=pressure, Hg=mercury, Regurg=regurgitation, Q=flow, P=pulmonary, S=Symptomatic, AO=aorta, IVC=Inferior vena cava, RV Syst=Right ventricular systolic, AT=acceleration time, ET=ejection time, MPAP=mean pulmonary artery pressure, l=left, A=atrium, r=right, V=ventricle, I=interventricular, S=Septum, P=posterior, W=wall. WHITE/MEDICAL RECORDS, YELLOW/PHYSICIAN, PINK/REFERRING PHYSICIAN, GOLDENROD/DEPARTMENT, GREEN/CHARGES.

04/01/1998 02:30:23 AM
22 years Male

Dept: [redacted]
Room: [redacted]
Oper: [redacted]

Rate 114
PR 147
QRSD 79
QT 276
QTc 380
--AXIS--
P 53
QRS 61
T 52

Sinus tachycardia, rate 114. Normal P axis, rate >= 100

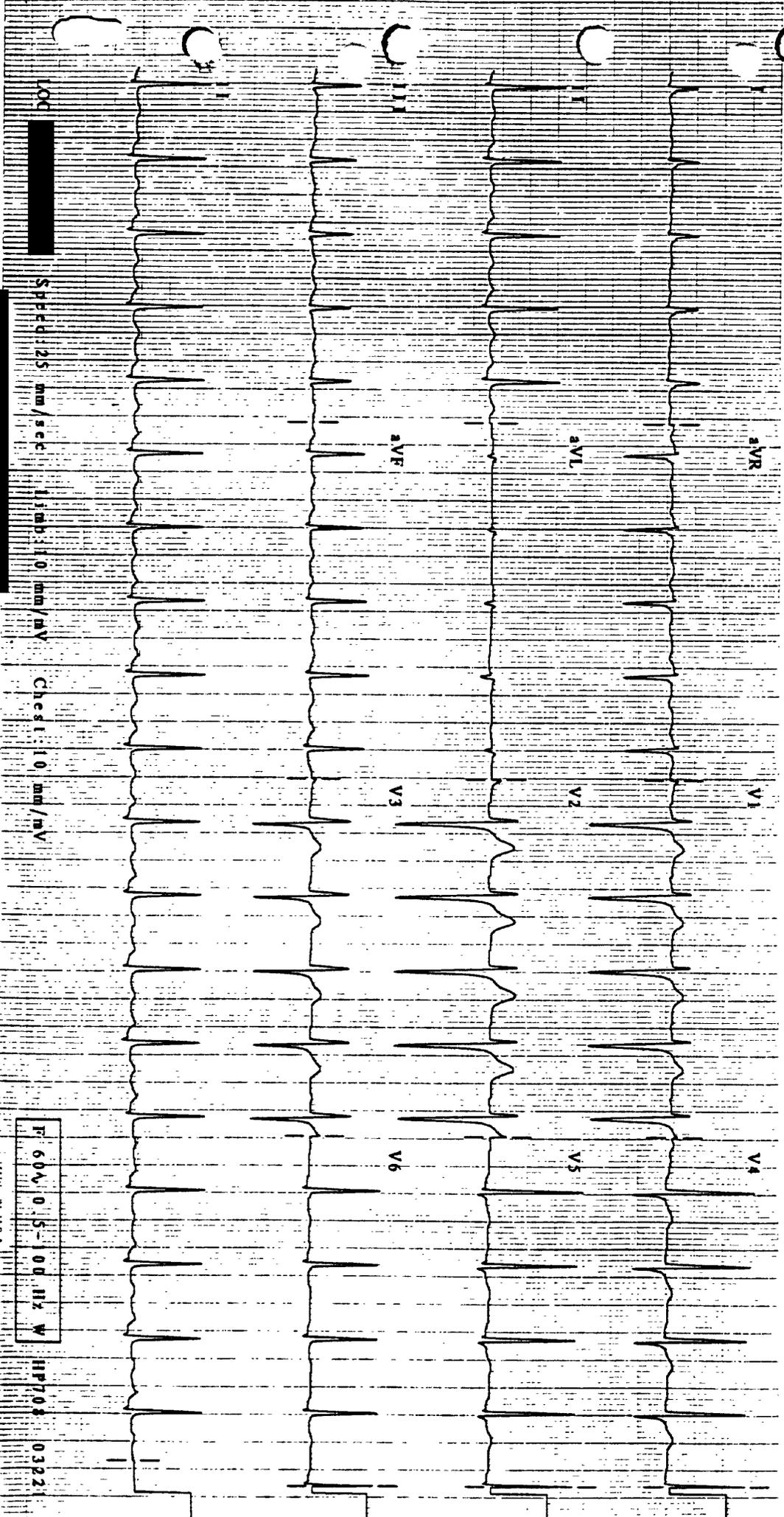
Page 3 of 4
SWS 86-32-4
0459-NKX
Etiology

Requested by: [redacted]

OTHERWISE NORMAL ECG

PRELIMINARY-UNCONFIRMED

CONFIDENTIAL
000051



LOC

Speed: 25 mm/sec

Limb: 1.0 mm/mV

Chest: 1.0 mm/mV

F: 60 Hz, 0.5-0.05 Hz W

HP703 03221

U.S.A.

EKG Strip Mounting Report

DATE _____ TIME _____ PP _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

01 APR 98 13 10 HR 112 RESP 14 SpO2 98 NBP 116/63(83) 25 mm/sec

II

V

DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

01 APR 98 14 45 HR 109 RESP 14 SpO2 98 NBP 118/67(84) 25 mm/sec

II

V

DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

01 APR 98 14 59 HR 109 RESP 12 SpO2 98 NBP 119/63(81) 25 mm/sec

II

V

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ARRHYTHMIA FLOW SHEET

Exhibit 3
KAN-6540
4-23-98 MAS
Page 29 of Pages
000052

ARRHYTHMIA FLOW SHEET

DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____
INTERPRETATION _____

01 APR 98 23:40 HR 107 RESP 17 SpO2 98 NBP 128/77(94) 25 mm/sec

II

V

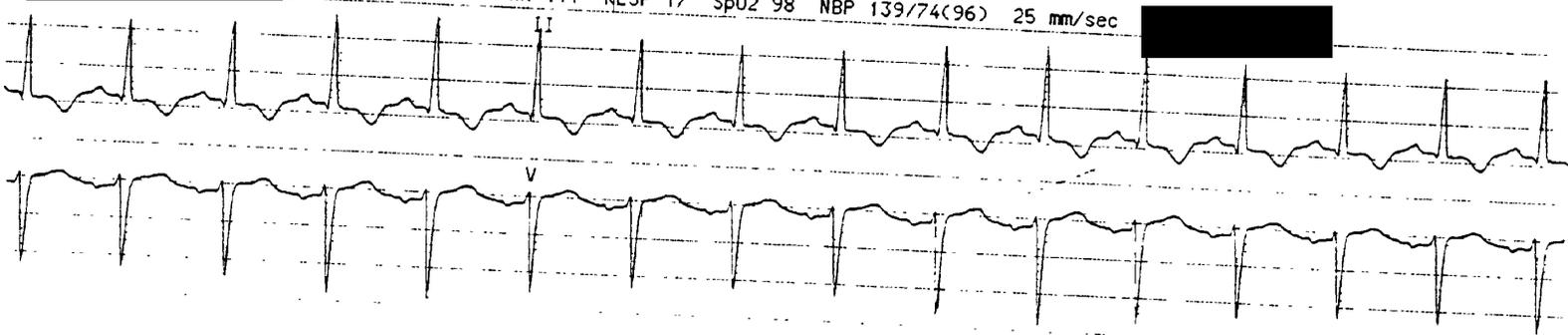


DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

02 APR 98 7:41 HR 111 RESP 17 SpO2 98 NBP 139/74(96) 25 mm/sec

II

V

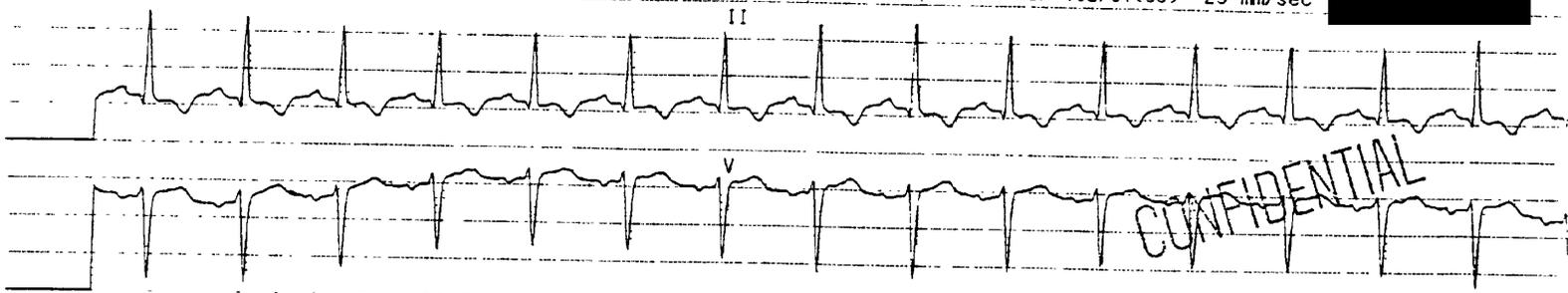


DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

02 APR 98 18:16 HR 119 RESP 16 SpO2 96 NBP 132/61(85) 25 mm/sec

II

V

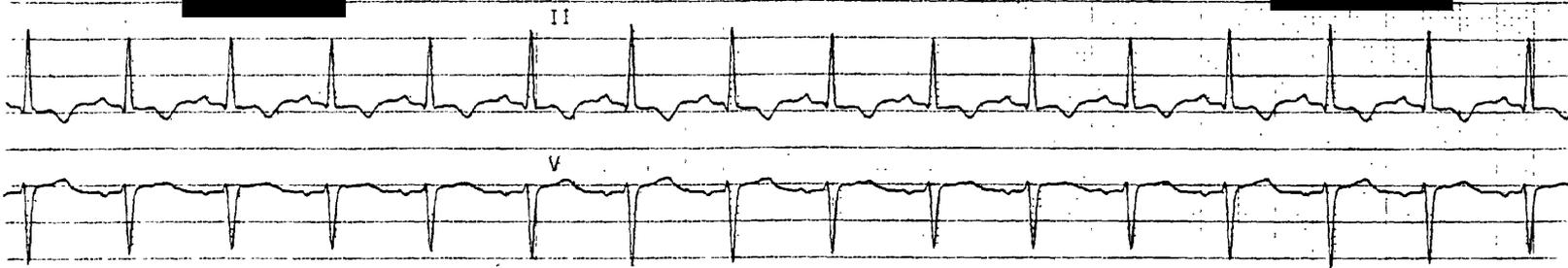


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Exhibit 3
KAN-6540 000053
4-23-98 MAS
Page 2 of 2

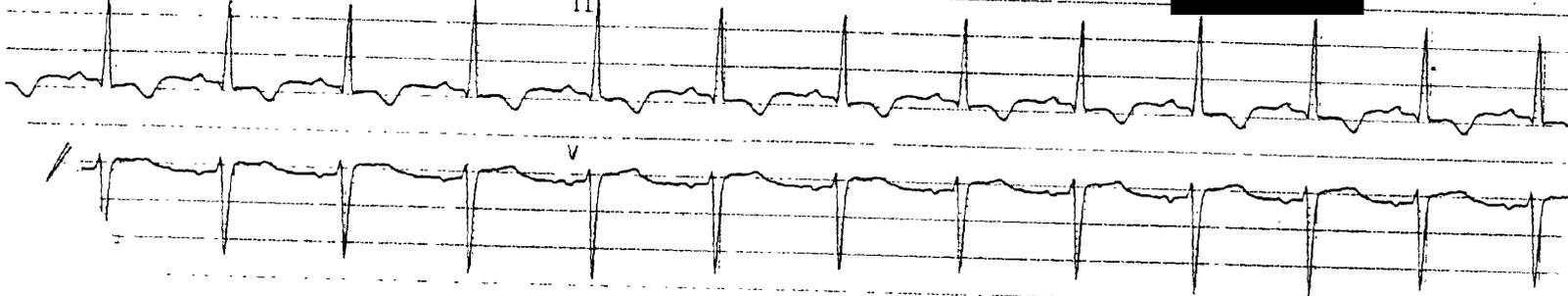
DATE 4/2/98 TIME 2031 PRI 116 QRS .08 RATE 111 MT _____ RN _____
INTERPRETATION _____

02 APR 98 20:31 HR 111 RESP 16 SpO2 97 NBP 127/68(90) 25 mm/sec



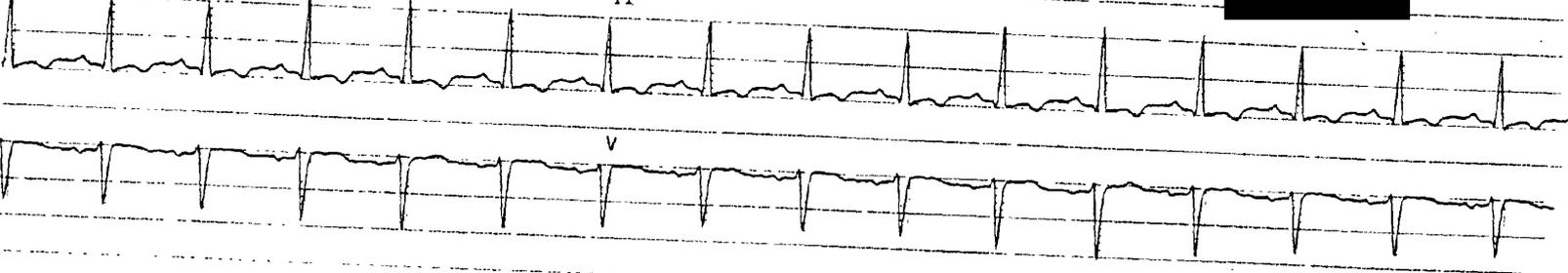
DATE 4/2/98 TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____
INTERPRETATION CMR

02 APR 98 23:58 HR 96 RESP 16 SpO2 98 NBP 135/71(93) 25 mm/sec



DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____
INTERPRETATION _____

03 APR 98 15:13 HR 112 RESP 12 SpO2 96 NBP 133/65(84) 25 mm/sec



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ARRHYTHMIA FLOW SHEET

Exhibit 3
KAN-6540
4-23-98 MAS
Page 27 of 27 Pages

000054

ARRHYTHMIA FLOW SHEET

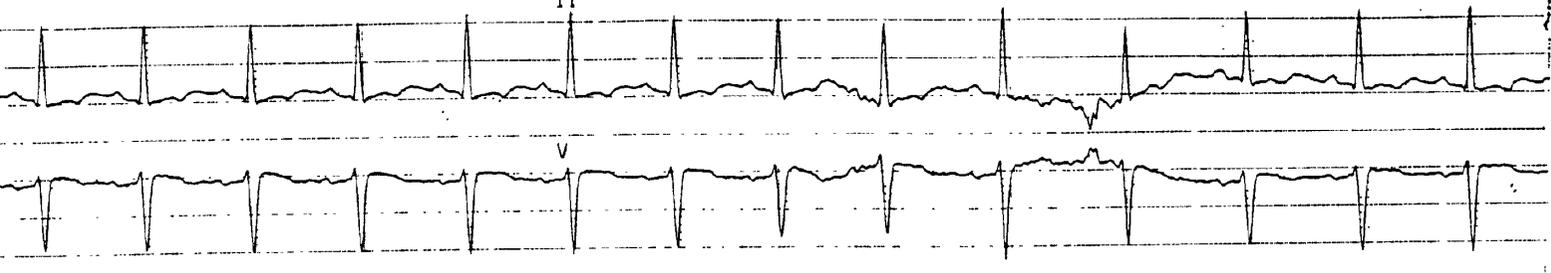
DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

04 APR 98 1:40 HR 97 RESP 23 SpO2 96 NBP 144/74(98) 25 mm/sec

II

V



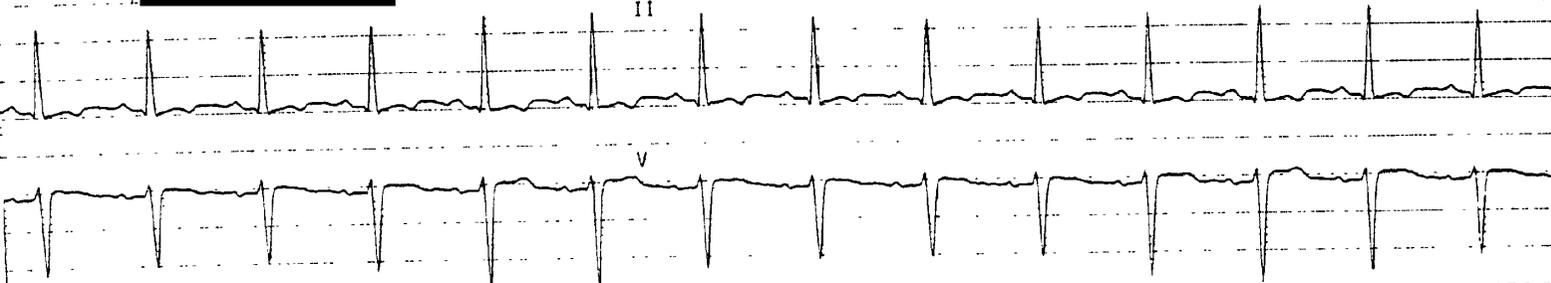
DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

04 APR 98 8:59 HR 104 RESP 20 SpO2 96 NBP 127/60(83) 25 mm/sec

II

V



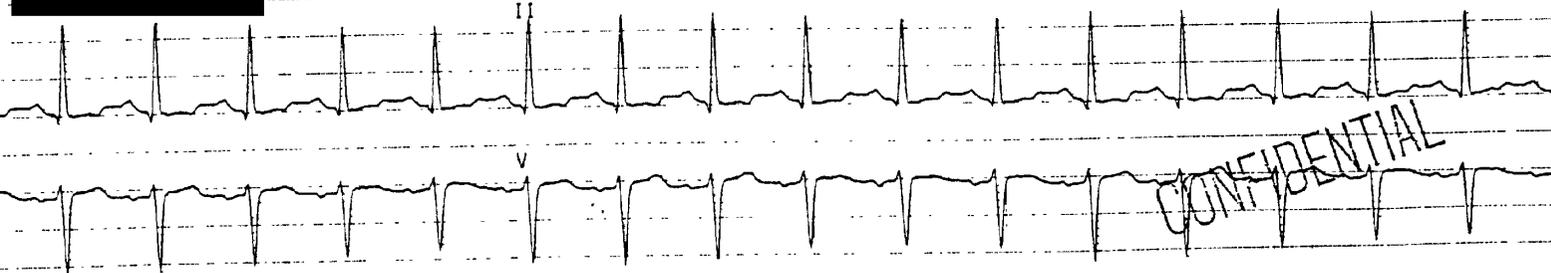
DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

04 APR 98 13:21 HR 122 RESP 22 SpO2 95 NBP 119/46(71) 25 mm/sec

II

V



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EXHIBIT 3
KAN-6540
4-23-98 MAS
Page 300 of Pages

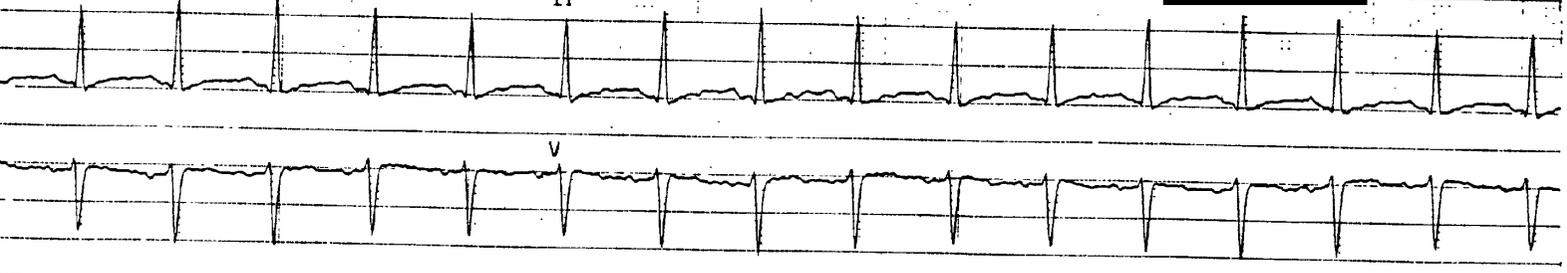
DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

04 APR 98 20:11 HR 117 RESP 18 SpO2 96 NBP 104/68(82) 25 mm/sec

II

V



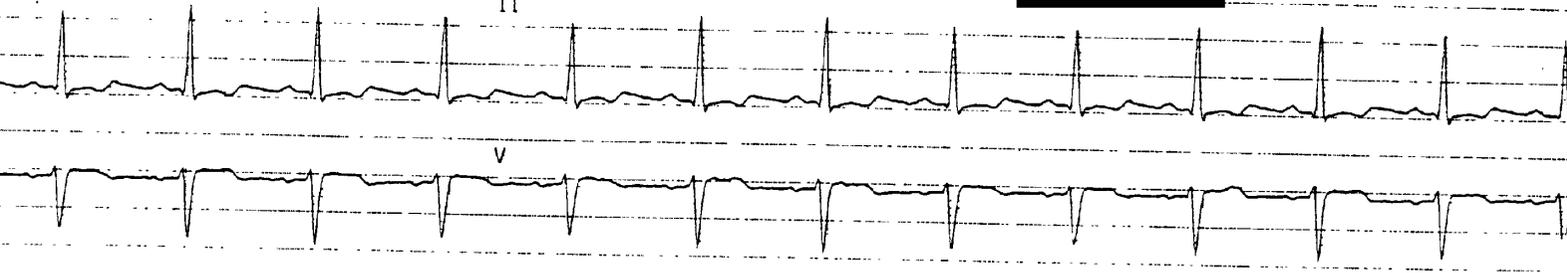
DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

05 APR 98 5:49 HR 90 RESP 29 SpO2 99 NBP -?- 25 mm/sec

II

V



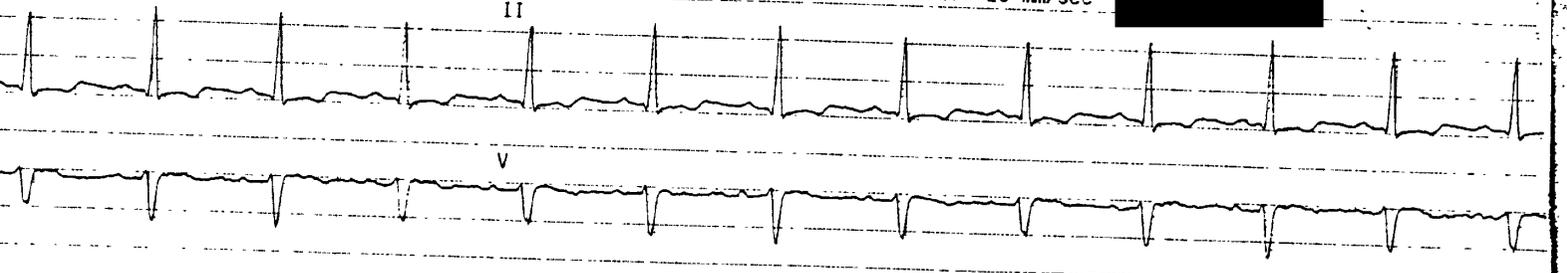
DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

05 APR 98 7:58 HR 92 RESP 22 SpO2 100 NBP 111/61(78) 25 mm/sec

II

V



[Redacted]

ARRHYTHMIA FLOW SHEET

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Exhibit 3
KAN-6540
4-23-98 MAS
Page 30 of Pages

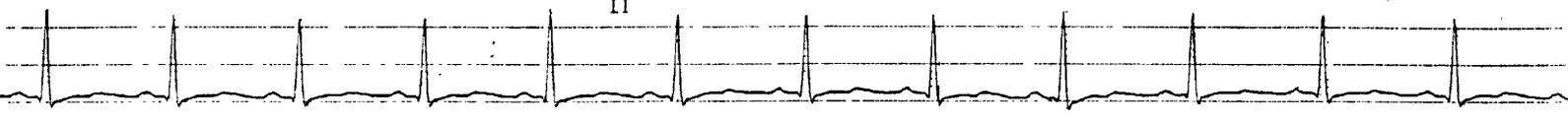
000056

ARRHYTHMIA FLOW SHEET

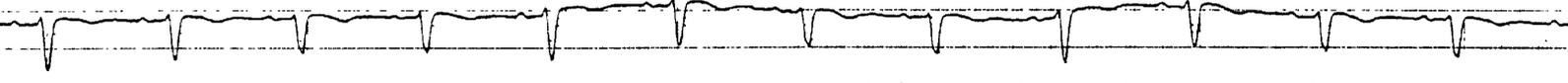
DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____
INTERPRETATION _____

05 APR 98 12:09 HR 87 RESP 22 SpO2 100 NBP 118/52(72) 25 mm/sec

II



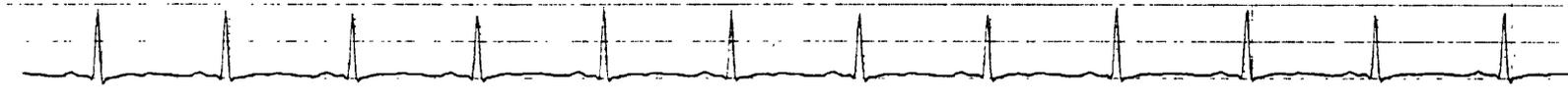
V



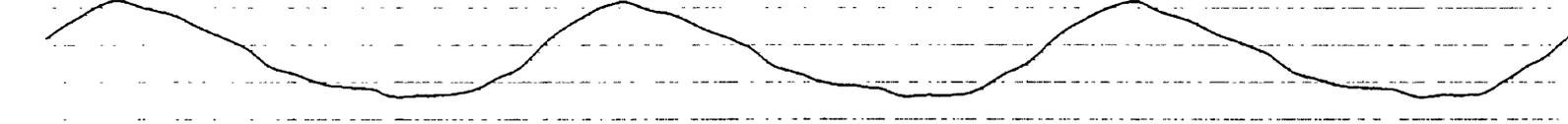
DATE 4/5/98 TIME _____ PRI .16 QRS .06 RATE _____ MT _____ RN _____
INTERPRETATION SK - 5 ectopics

05 APR 98 16:05 HR 87 RESP 22 PULSE -?- SpO2 99 NBP 112/53(73) 25 mm/sec

II



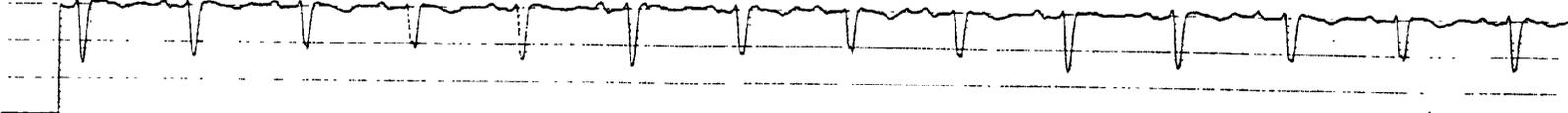
RESP



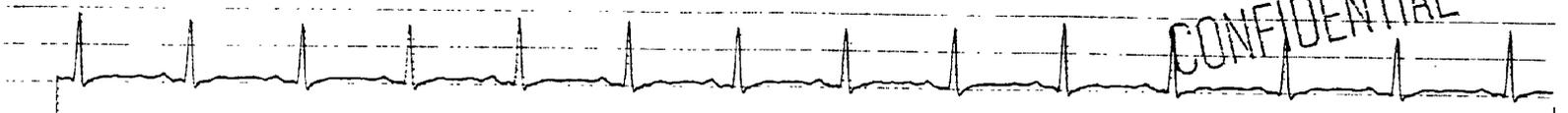
DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____
INTERPRETATION _____

06 APR 98 0:54 HR 101 RESP 22 PULSE -?- SpO2 97 NBP 124/56(79) 25 mm/sec

V



II



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Exhibit 3
KAN-6540
4-23-98 MAS
Page 302 of Pages
000057

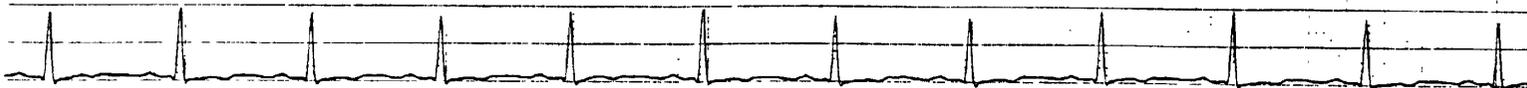
EKG Strip Mounting Report

DATE 4/6/98 TIME 0731 PRI - QRS - RATE 85 MT - RN [REDACTED]

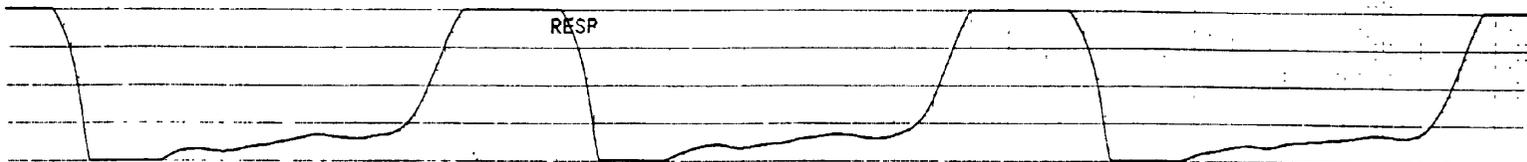
INTERPRETATION SR

[REDACTED] 06 APR 98 7.31 HR 85 | RESP 22 PULSE -?- SpO2 99 NBP 114/69(84) 25 mm/sec [REDACTED]

II



RESP

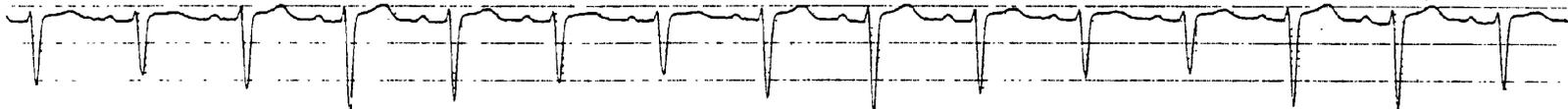


DATE 4/6/98 TIME 1553 PRI 118 QRS .10 RATE 111 MT - RN [REDACTED]

INTERPRETATION LT

[REDACTED] 06 APR 98 15.53 HR 111 | RESP 22 PULSE -?- SpO2 100 NBP 123/51(72) 25 mm/sec [REDACTED]

V



II

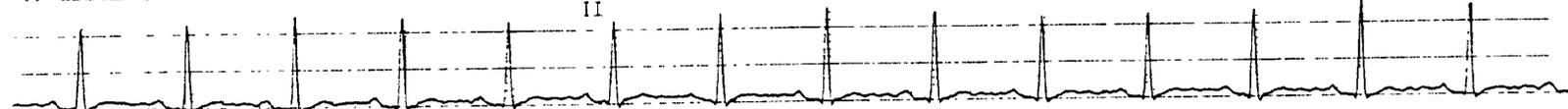


DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

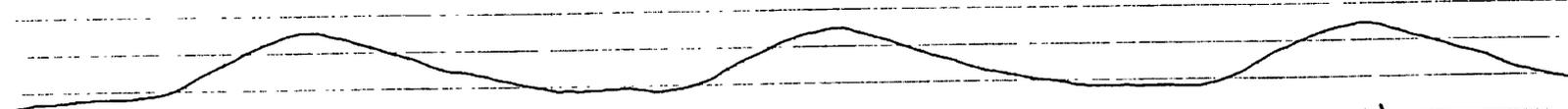
INTERPRETATION _____

[REDACTED] 07 APR 98 3:11 HR 103 | RESP 21 PULSE -?- SpO2 96 NBP 147/73(97) 25 mm/sec [REDACTED]

II



RESP



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[REDACTED]
ARRHYTHMIA FLOW SHEET

Exhibit 3
KAN-6540
4-23-98 MAS
Page 3 of 3 Pages

000058

ARRHYTHMIA FLOW SHEET

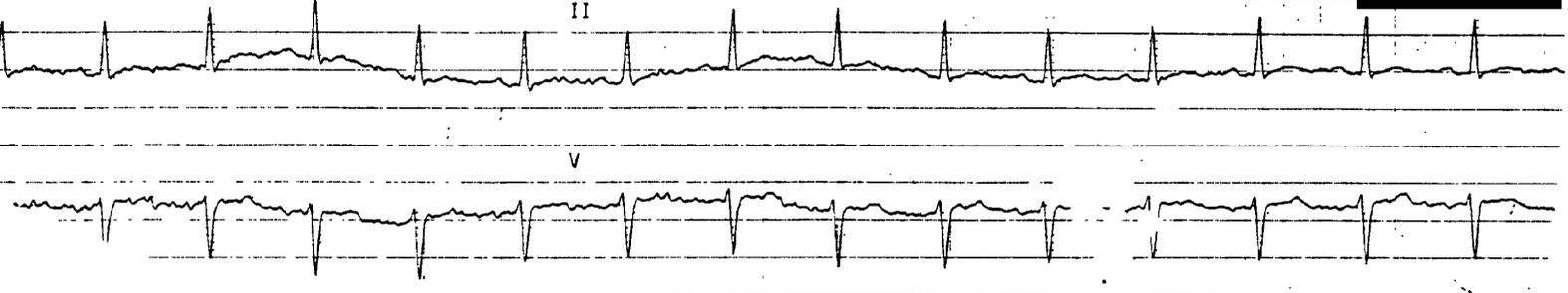
DATE 4/7/98 TIME 0755 PRI _____ QRS _____ RATE 105 MT _____ RN _____

INTERPRETATION SR

07 APR 98 7 55 HR 105 RESP 12 PULSE -?- SpO2 98 NBP 147/89(107) | 25 mm/sec

II

V



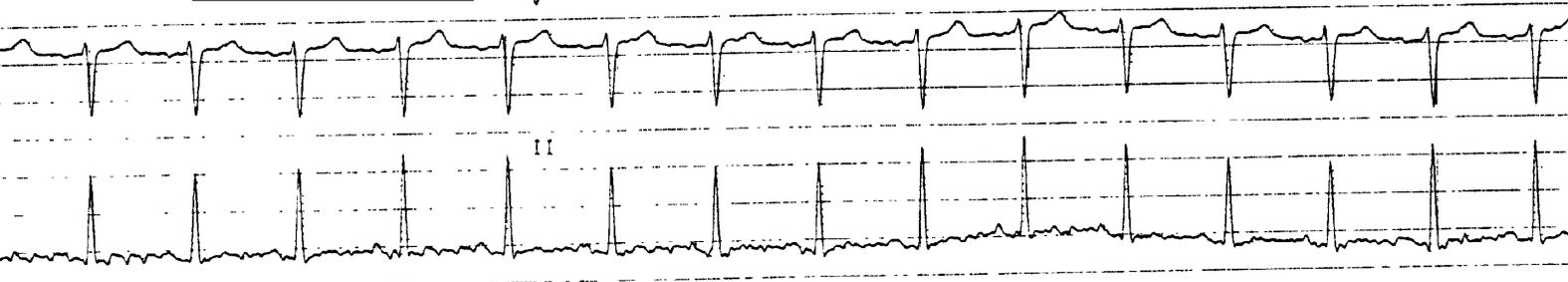
DATE 4/7/98 TIME 1939 PRI .16 QRS .12 RATE 108 MT _____ RN _____

INTERPRETATION ST

07 APR 98 19:39 HR 108 RESP 21 PULSE -?- SpO2 97 NBP 128/63(84) | 25 mm/sec

V

II



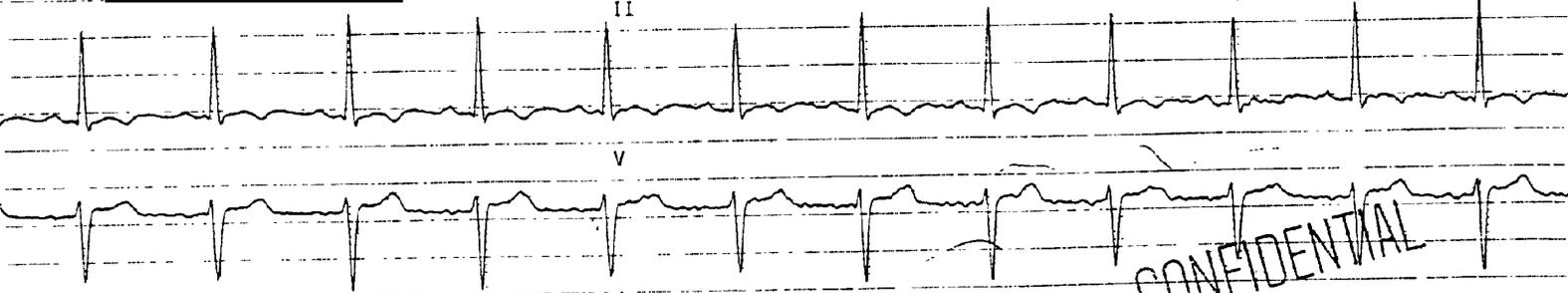
DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

08 APR 98 8 08 HR 91 RESP 23 PULSE -?- SpO2 99 NBP 126/66(87) | 25 mm/sec

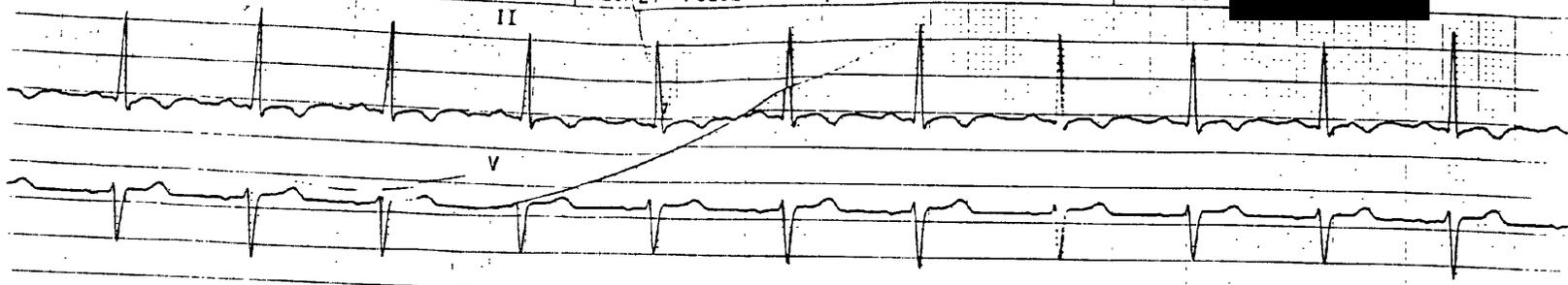
II

V



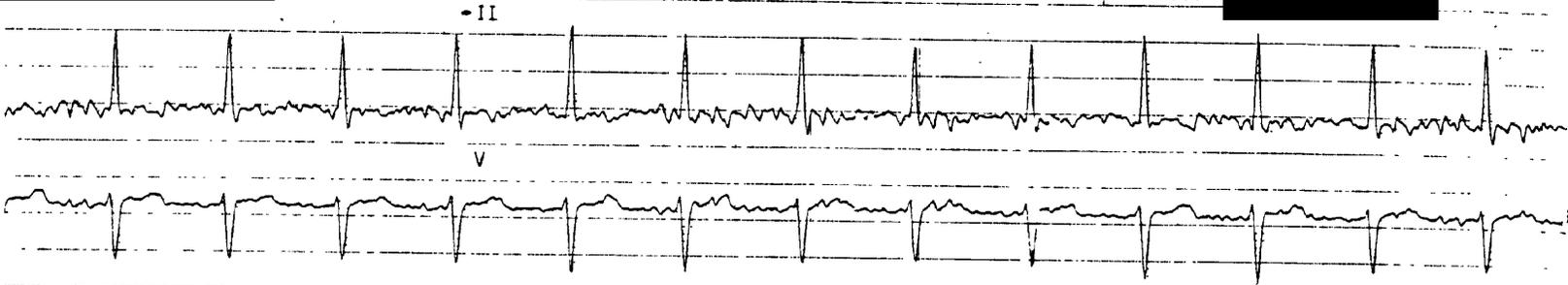
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08 APR 98 19:56 HR 82 | RESA 21 PULSE -?- SpO2 96 NBP 118/62(81) 25 mm/sec



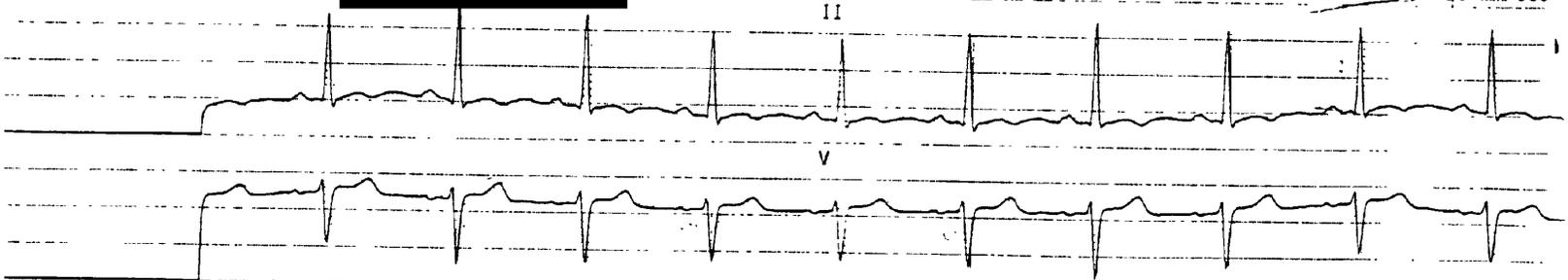
INTERPRETATION _____

09 APR 98 0 15 HR 96 | RESP 29 PULSE -?- SpO2 98 NBP 115/60(79) 25 mm/sec



INTERPRETATION _____

09 APR 98 7 07 HR 34 | RESP 35 PULSE -?- SpO2 98 NBP 127/68(90) 25 mm/sec



[Redacted]

ARRHYTHMIA FLOW SHEET

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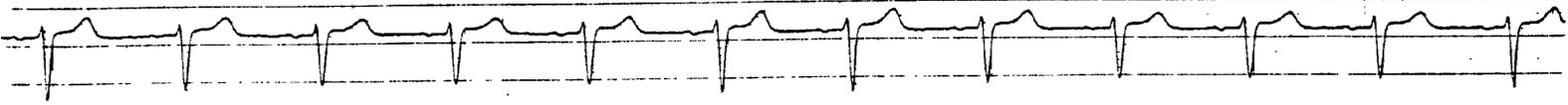
ARRHYTHMIA FLOW SHEET

DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

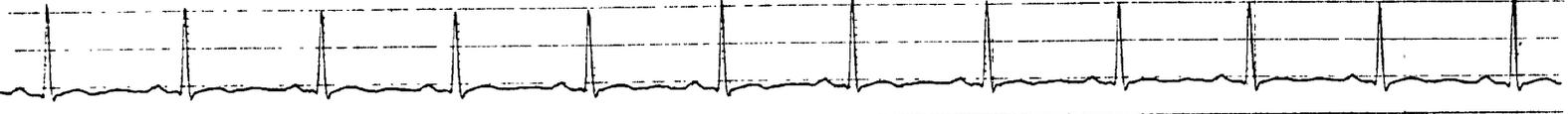
INTERPRETATION _____

09 APR 98 19:30 HR 83 | RESP 8 PULSE -?- SpO2 94 NBP 104/51(70) 25 mm/sec

VI



II

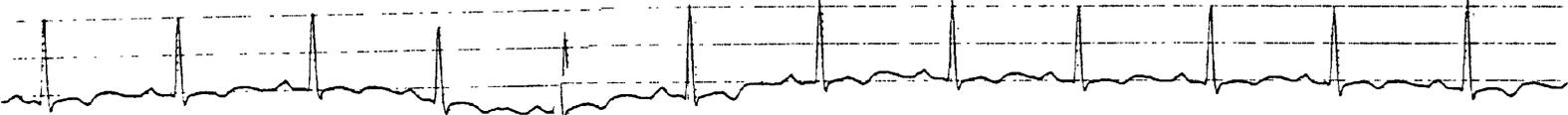


DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

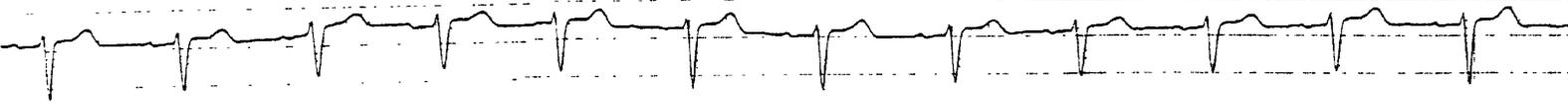
INTERPRETATION _____

10 APR 98 4 05 HR 87 | RESP 47 PULSE -?- SpO2 97 NBP 128/68(86) 25 mm/sec

II



V

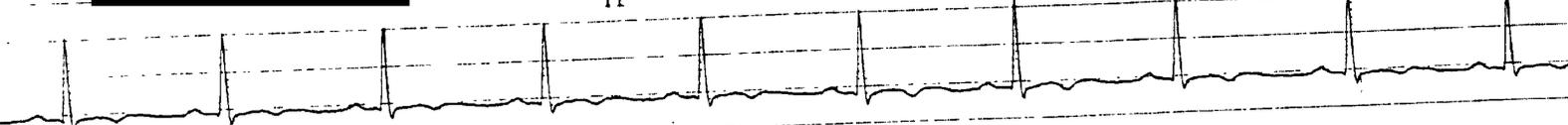


DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

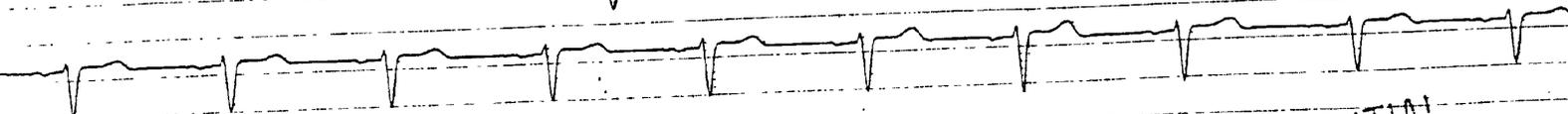
INTERPRETATION _____

10 APR 98 10 41 HR 69 | RESP 0 PULSE -?- SpO2 100 NBP 131/55(80) 25 mm/sec

II



V



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EKG Strip Mounting Report

Exhibit 3
KAN-6540
4-23-98 MAS
Page 306 of Pages

000061

ARRHYTHMIA FLOW SHEET

DATE _____ TIME _____ PRI _____ QRS _____

INTERPRETATION _____

10 APR 98 19:51 HR 93 | RESP 12 PULSE -?- SpO2 96 NBP 108/67(83) 25 mm/sec

II

V

DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

11 APR 98 5:33 ** HR 46 < 50 HR 46 RESP 0 PULSE -?- SpO2 99 NBP 115/49(72) 25 mm/sec

II

V

*pt - coughing - Bradycardia
? valve*

DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

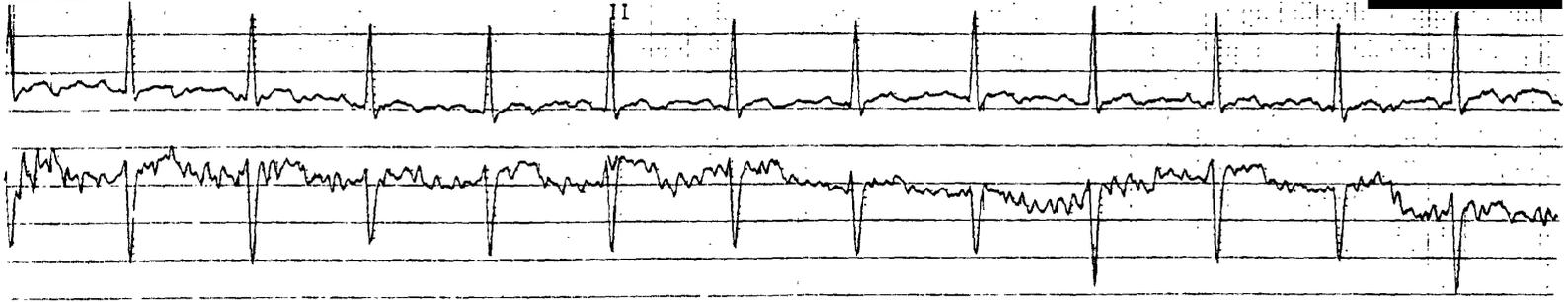
11 APR 98 8:26 HR 92 | RESP 12 PULSE -?- SpO2 97 NBP 113/58(78) 25 mm/sec

II

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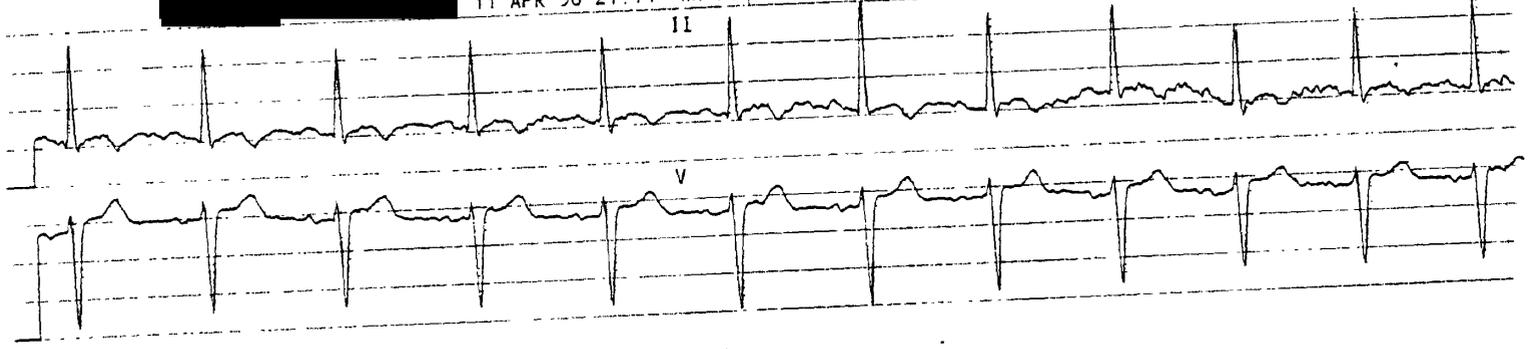
DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____
INTERPRETATION _____

11 APR 98 14:48 HR 93 | RESP 14 PULSE -?- SpO2 97 NBP 125/61(83) 25 mm/sec



DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____
INTERPRETATION _____

11 APR 98 21:14 HR 92 | RESP 18 PULSE -?- SpO2 98 NBP 119/72(87) 25 mm/sec



DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____
INTERPRETATION _____

11 APR 98 23:51 RESP ERRATIC HR 105 RESP 20 PULSE -?- SpO2 91 NBP 135/66(88) 25 mm/sec



ARRHYTHMIA FLOW SHEET

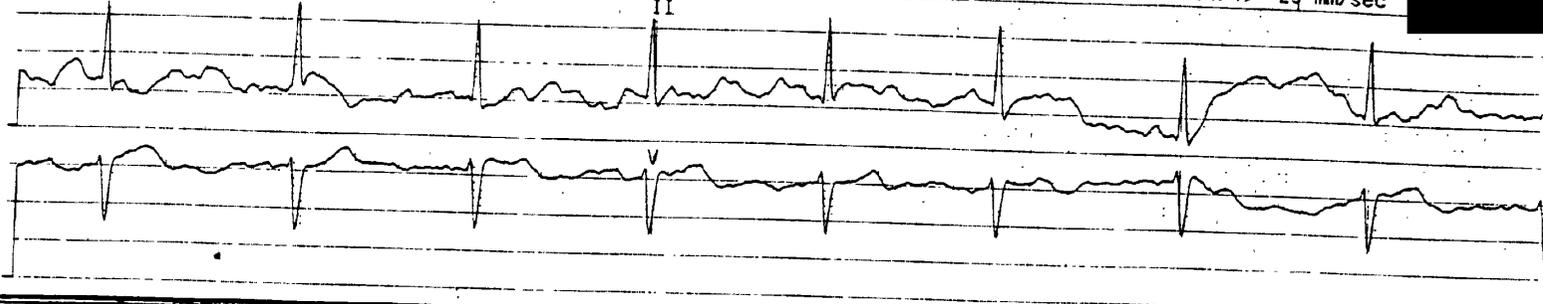
Exhibit 3
KAN-6540
4-23-98 MAS
Page 308 of Pages

CONFIDENTIAL

000063

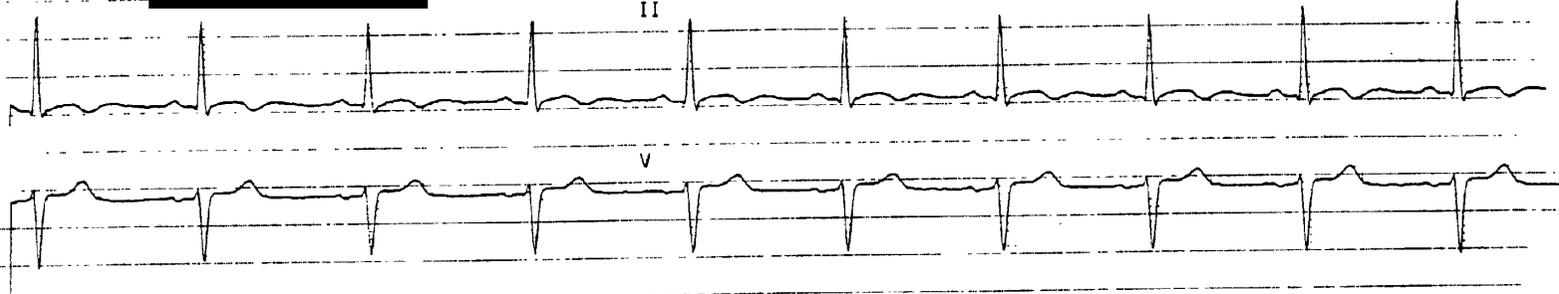
DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____
INTERPRETATION _____

12 APR 98 19:55 HR 63 | RESP 9 PULSE -?- SpO2 93 NBP 109/55(74) 25 mm/sec



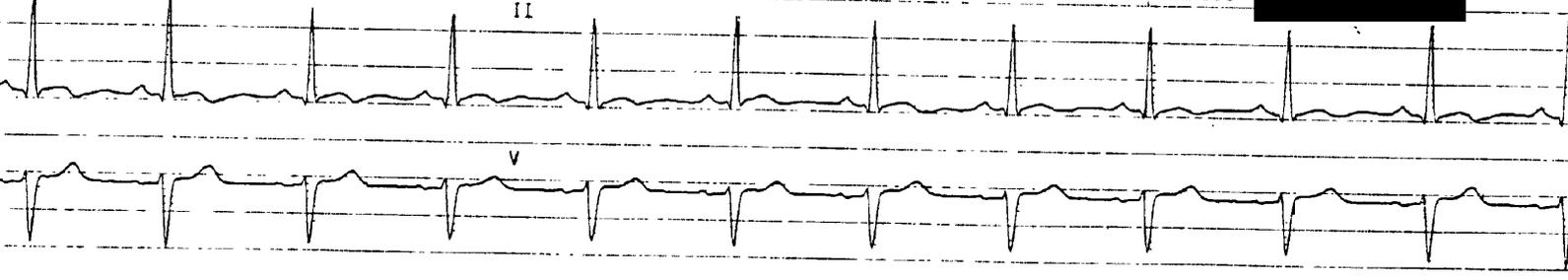
DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____
INTERPRETATION _____

12 APR 98 22 08 HR 74 | RESP 7 PULSE -?- SpO2 96 NBP 108/54(73) 25 mm/sec



DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____
INTERPRETATION _____

13 APR 98 2:43 HR 81 | RESP 6 PULSE -?- SpO2 96 NBP 115/48(68) 25 mm/sec



[Redacted patient information]

ARRHYTHMIA FLOW SHEET

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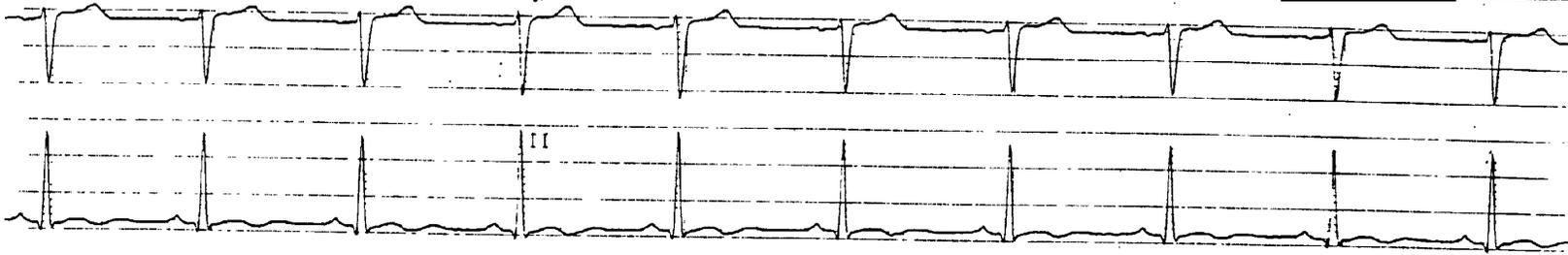
Exhibit 3
KAN-6540
4-23-98 MAS
Page 39 of Pages

000064

ARRHYTHMIA FLOW SHEET

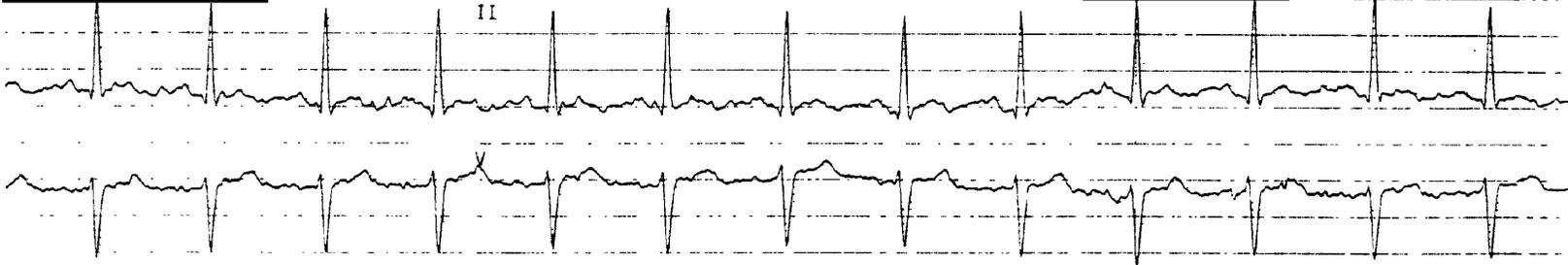
DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____
INTERPRETATION _____

13 APR 98 19:56 HR 74 | RESP 5 SpO2 96 NBP 100/45(63) 25 mm/sec



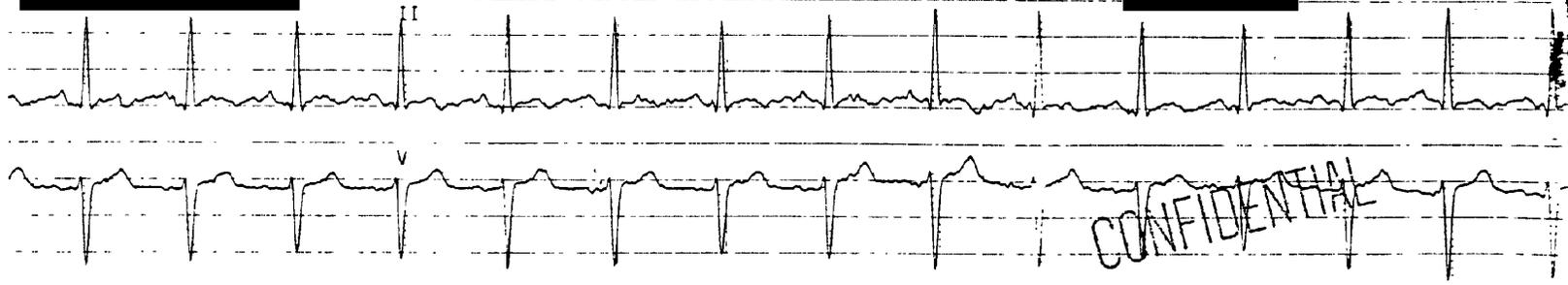
DATE 4/14/98 TIME 08:57 PRI _____ QRS _____ RATE 94 MT _____ RN _____
INTERPRETATION NSR

14 APR 98 8 57 HR 94 | RESP 14 SpO2 94 NBP 105/56(73) 25 mm/sec



DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____
INTERPRETATION _____

14 APR 98 23 49 HR 108 | RESP 16 SpO2 97 NBP 110/52(72) 25 mm/sec



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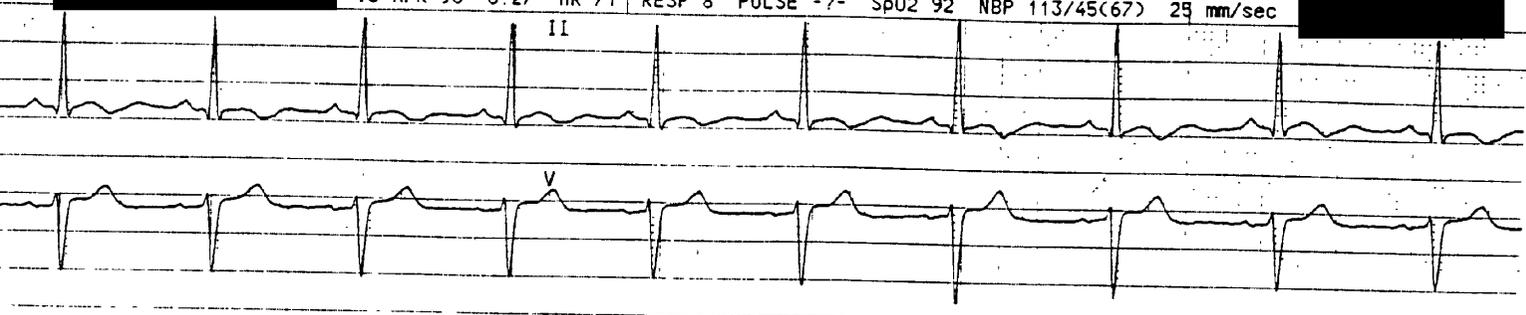
Exhibit 3
KAN-6540
4-23-98 MAS
Page 3/0 of Pages 000065

EKG Strip Mounting Report

DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

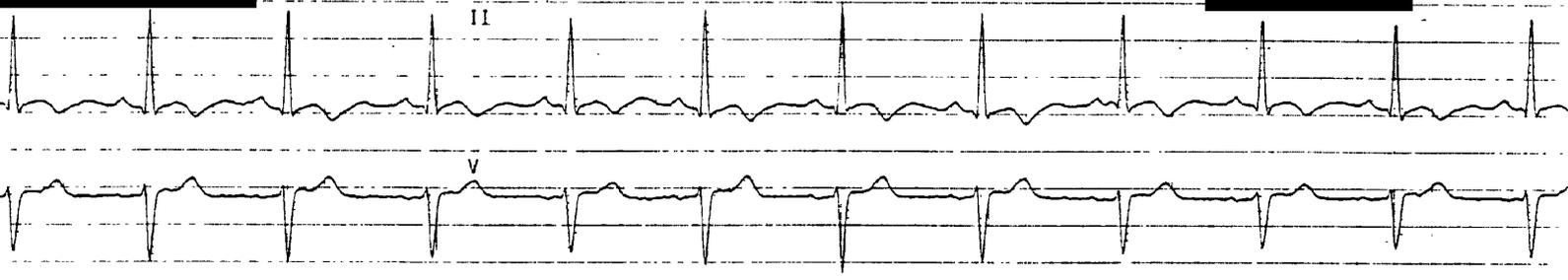
13 APR 98 6:27 HR 71 | RESP 8 PULSE -?- SpO2 92 NBP 113/45(67) 25 mm/sec



DATE 4/17/98 TIME 07:27 PRI _____ QRS _____ RATE 80 MT _____ RN _____

INTERPRETATION NSR

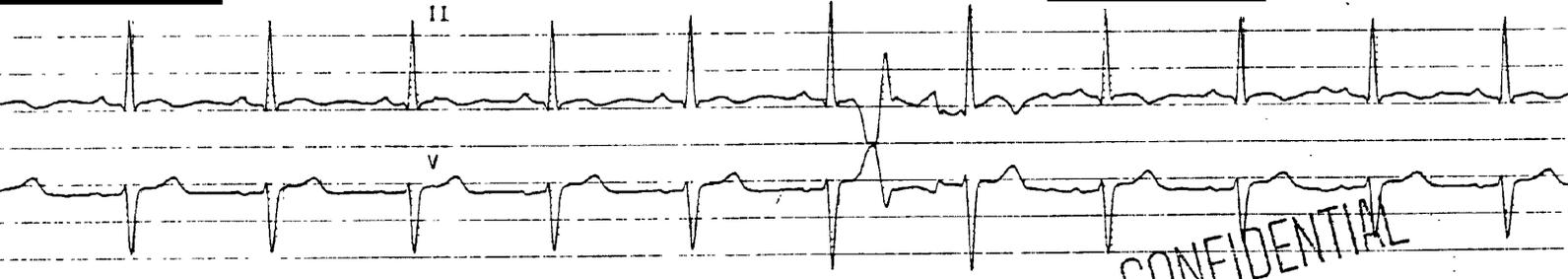
13 APR 98 7:27 HR 80 | RESP 7 PULSE -?- SpO2 94 NBP 137/55(80) 25 mm/sec



DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

13 APR 98 8:37 HR 108 RESP 8 SpO2 93 NBP 107/42(65) 25 mm/sec



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[Redacted]

ARRHYTHMIA FLOW SHEET

[Redacted]

000066

Exhibit 3
KAN-6540
4-23-98 MAS
Page 31 of Pages

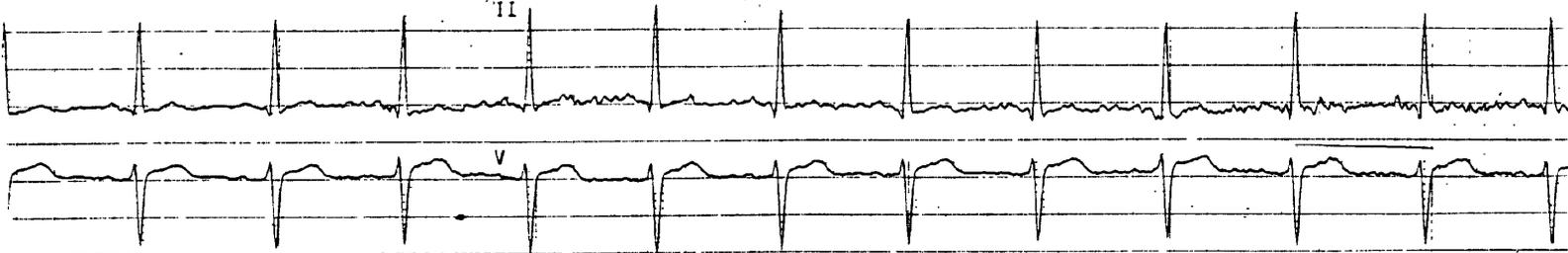
[Redacted]

ARRHYTHMIA FLOW SHEET

DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

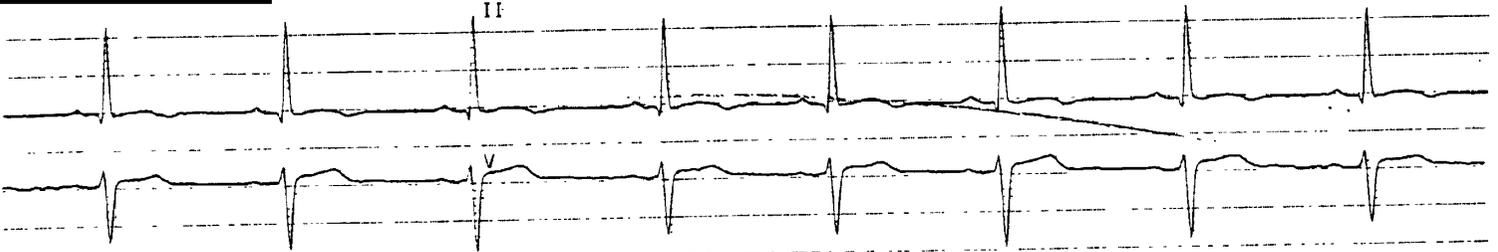
17 APR 98 1:53 HR 87 RESP 23 SpO2 96 NBP 118/46(71) 25 mm/sec



DATE 4/17/98 TIME 7:14 PRI 18 QRS 102 RATE 65 MT _____ RN _____

INTERPRETATION SR

17 APR 98 7:18 HR 65 RESP 23 SpO2 96 NBP 96/42(59) 25 mm/sec



DATE _____ TIME _____ PRI _____ QRS _____ RATE _____ MT _____ RN _____

INTERPRETATION _____

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Exhibit 3
KAN-6540
4-23-98 MAS
Page 3 of 2 Pages 000067

**NEURODIAGNOSTICS
REPORT OF ELECTROENCEPHALOGRAM (EEG) STUDY**

EEG NO: [REDACTED]

DATE: 04/01/98

NAME: [REDACTED]

DATE OF BIRTH: [REDACTED]

MEDICAL RECORD NO: [REDACTED]

ACCT #: [REDACTED]

REFERRING DR: [REDACTED]

LOCATION: [REDACTED]

22-year-old patient who collapsed in the gym and was in v-fib, now unresponsive and on the ventilator.

This EEG is recorded on a 21-channel machine using the standard 10-20 system of electrode placement. Background activity is very poorly developed. It's of extremely low amplitude. At time very low amplitude background waves are 8 hz. On increasing the gains, these are better visualized and they are about 8 to 9 hz. Intermixed is some frontal slowing of 2 to 3 hz and bi-laterally symmetrical.

Activating methods of hyperventilation could not be performed; patient is on a ventilator. Photic stimulation produced no definite driving pattern. No seizure discharges were seen throughout this recording.

EKG monitor showed sinus tachycardia.

IMPRESSION: Abnormal EEG showing significant amount of background suppression. Constant with post arrest encephalopathy. There is no evidence of seizures.

Exhibit 3
KAN-6540
4-23-98 MAS
Page 10 of Pages

ELECTROENCEPHALOGRAPHER: [REDACTED] MD

000068

CONFIDENTIAL

NEURODIAGNOSTICS
REPORT OF ELECTROENCEPHALOGRAPH (EEG) STUDY

EEG NO: [REDACTED]

DATE: 04/01/98

NAME: [REDACTED]

DATE OF BIRTH: [REDACTED]

MEDICAL RECORD NO: [REDACTED]

ACCT #: [REDACTED]

REFERRING DR: [REDACTED]

LOCATION: [REDACTED]

22-year-old patient who collapsed in the gym and was in v-fib, now unresponsive and on the ventilator.

This EEG is recorded on a 21-channel machine using the standard 10-20 system of electrode placement. Background activity is very poorly developed. It's of extremely low amplitude. At time very low amplitude background waves are 8 hz. On increasing the gains, these are better visualized and they are about 8 to 9 hz. Intermixed is some frontal slowing of 2 to 3 hz and bi-laterally symmetrical.

Activating methods of hyperventilation could not be performed; patient is on a ventilator. Photic stimulation produced no definite driving pattern. No seizure discharges were seen throughout this recording.

EKG monitor showed sinus tachycardia.

IMPRESSION: Abnormal EEG showing significant amount of background suppression. Constant with post arrest encephalopathy. There is no evidence of seizures.

Exhibit 3
KAN-6540
4-23-98 MAS
Page 15 of 1 Pages

PRELIMINARY REPORT
When signed report received.

ELECTROENCEPHALOGRAPHER: [REDACTED] MD

000069

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Patient File :
 Name :
 Id :

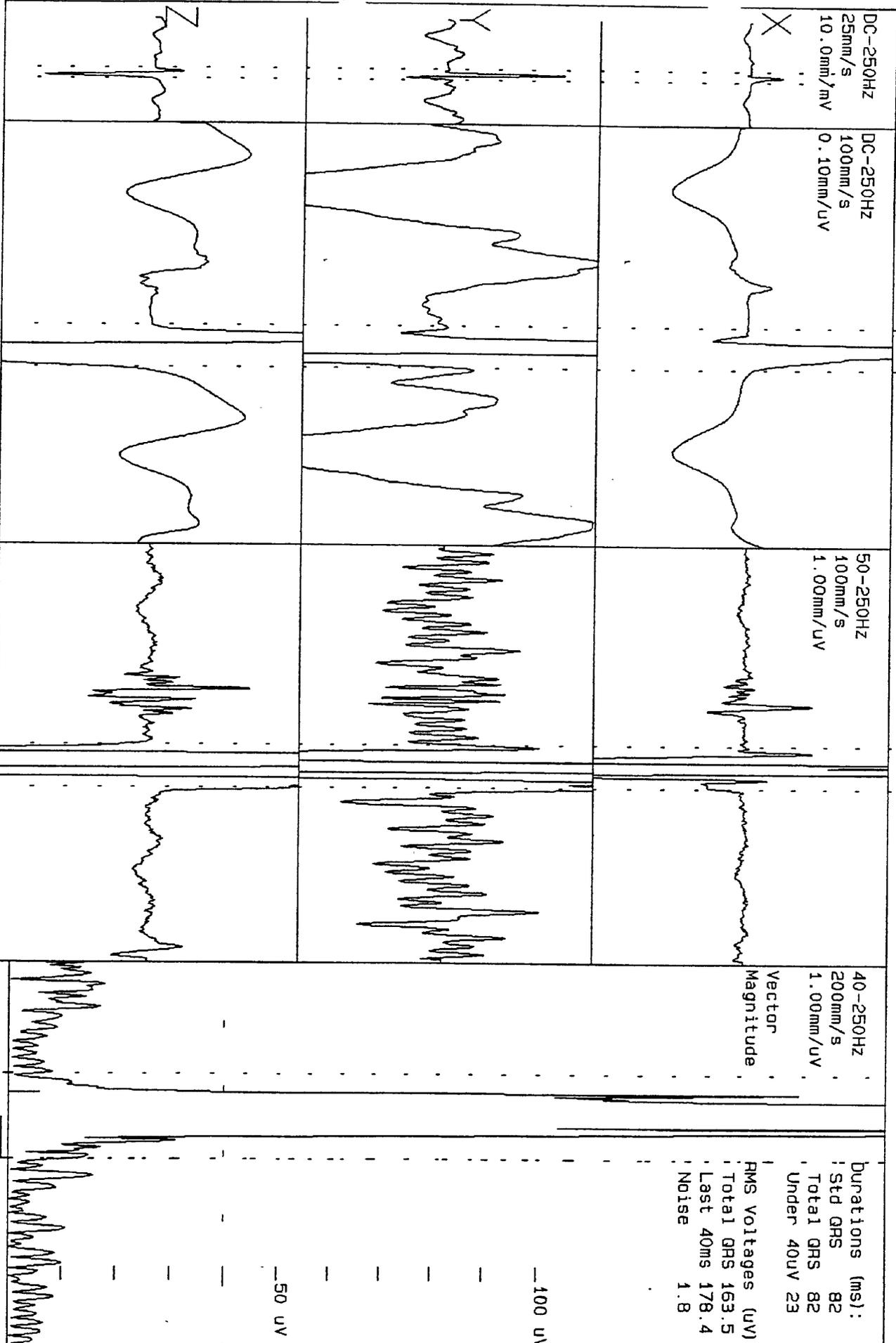
Date : 04/02/98
 Time : 11:36
 Age : 22
 Gender : Male
 Height :
 Weight :
 Race : Caucasian

Medication 1 :
 Medication 2 :
 Systolic BP : 134
 Diastolic BP : 80
 Option :

Plot Time : 12:15:57
 Plot Date : 04-02-1998

Exhibit 3
 KAN-6580 MAS
 Page 15 of 5 Pages

000070



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Patient File :
Name :
Id :

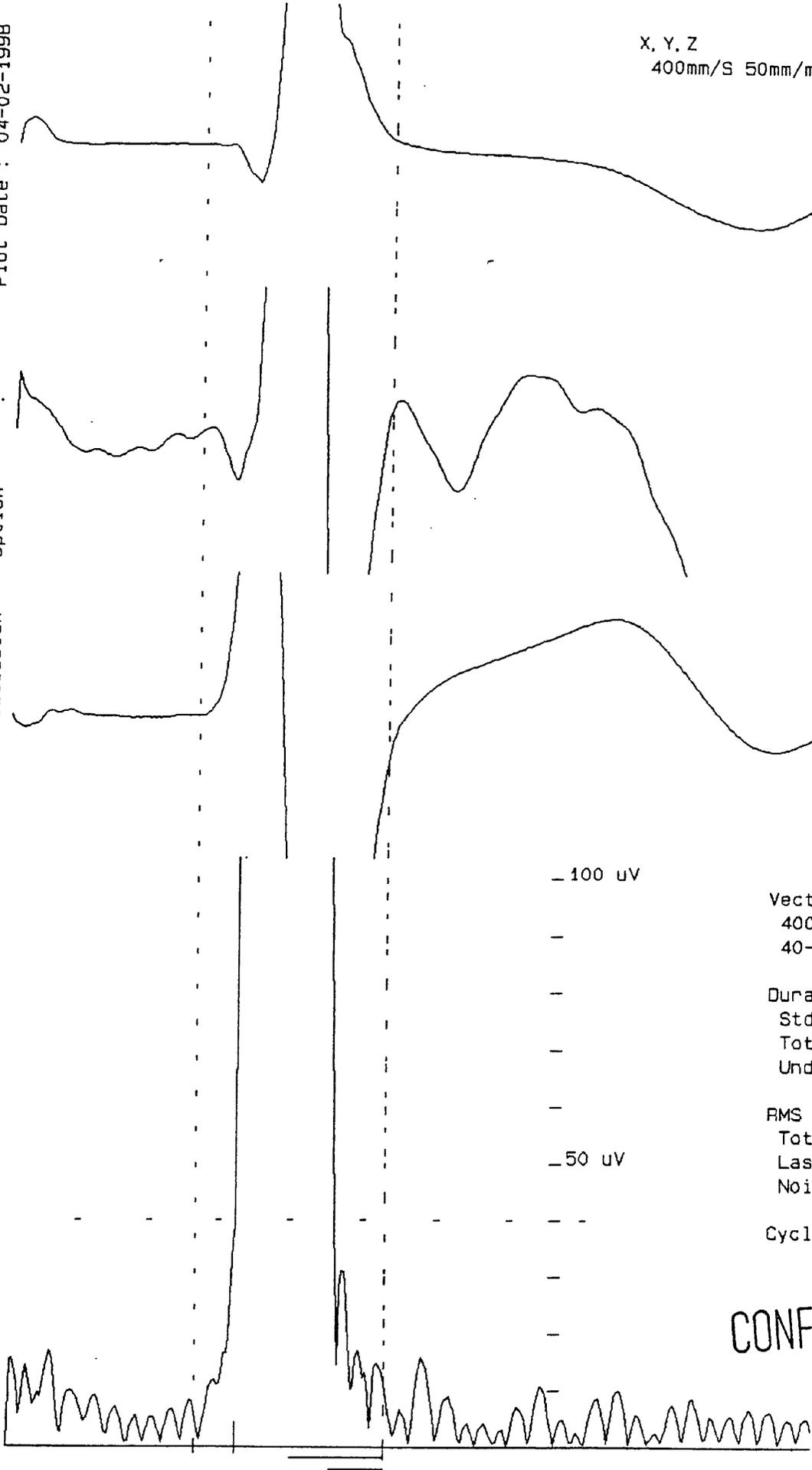
Date : 04/02/98
Time : 11:36

Age : 22
Gender : Male
Height :
Weight :
Race : Caucasian

Medication 1 :
Medication 2 :
Systolic BP : 134
Diastolic BP : 80
Option :

Plot Time : 12:16:25
Plot Date : 04-02-1998

Signal Averaged 205 Cycles High Resolution



X, Y, Z
400mm/S 50mm/mV DC-250Hz

Exhibit 5
KAN-6540
4-23-98 MAS
Page 156 of Pages

Vector Magnitude
400mm/S 1.00mm/uV
40-250Hz

Durations (ms):
Std QRS 82
Total QRS 82
Under 40uV 23

RMS Voltages (uV):
Total QRS 163.5
Last 40ms 178.4
Noise 1.8

Cycles 205.0

CONFIDENTIAL

000071

Patient File : [REDACTED]
 Name : [REDACTED]
 Id. : [REDACTED]

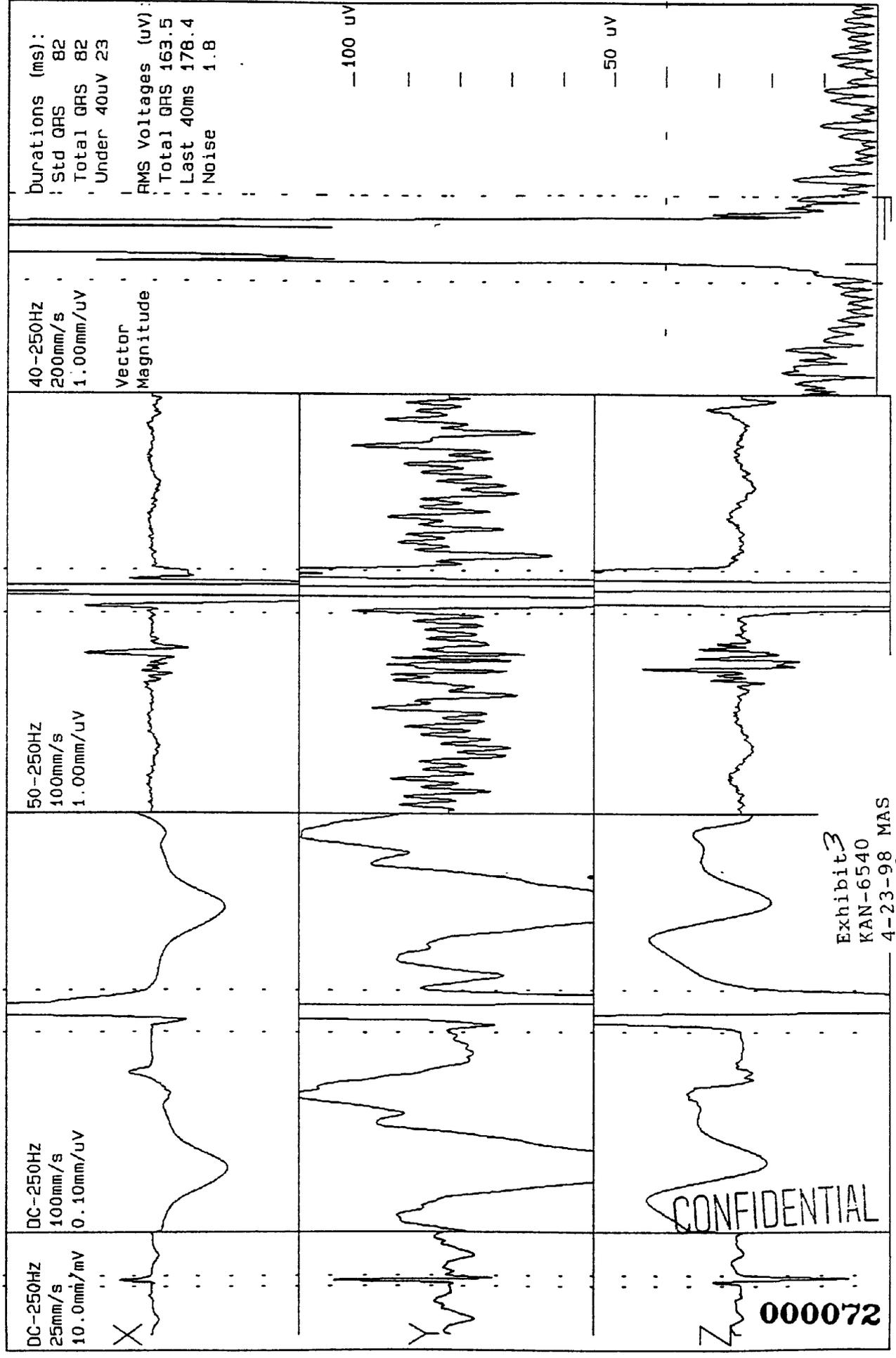
Medication 1 :
 Medication 2 :
 Systolic BP : 134
 Diastolic BP : 80
 Option :

Age : 22
 Gender : Male
 Height :
 Weight :
 Race : Caucasian

Date : 04/02/98
 Time : 11:36

Plot Time : 12:15:57
 Plot Date : 04-02-1998

Signal Averaged 205 Cycles X, Y, Z & VECTOR



CONFIDENTIAL

000072

Patient File :
Name :
Id :

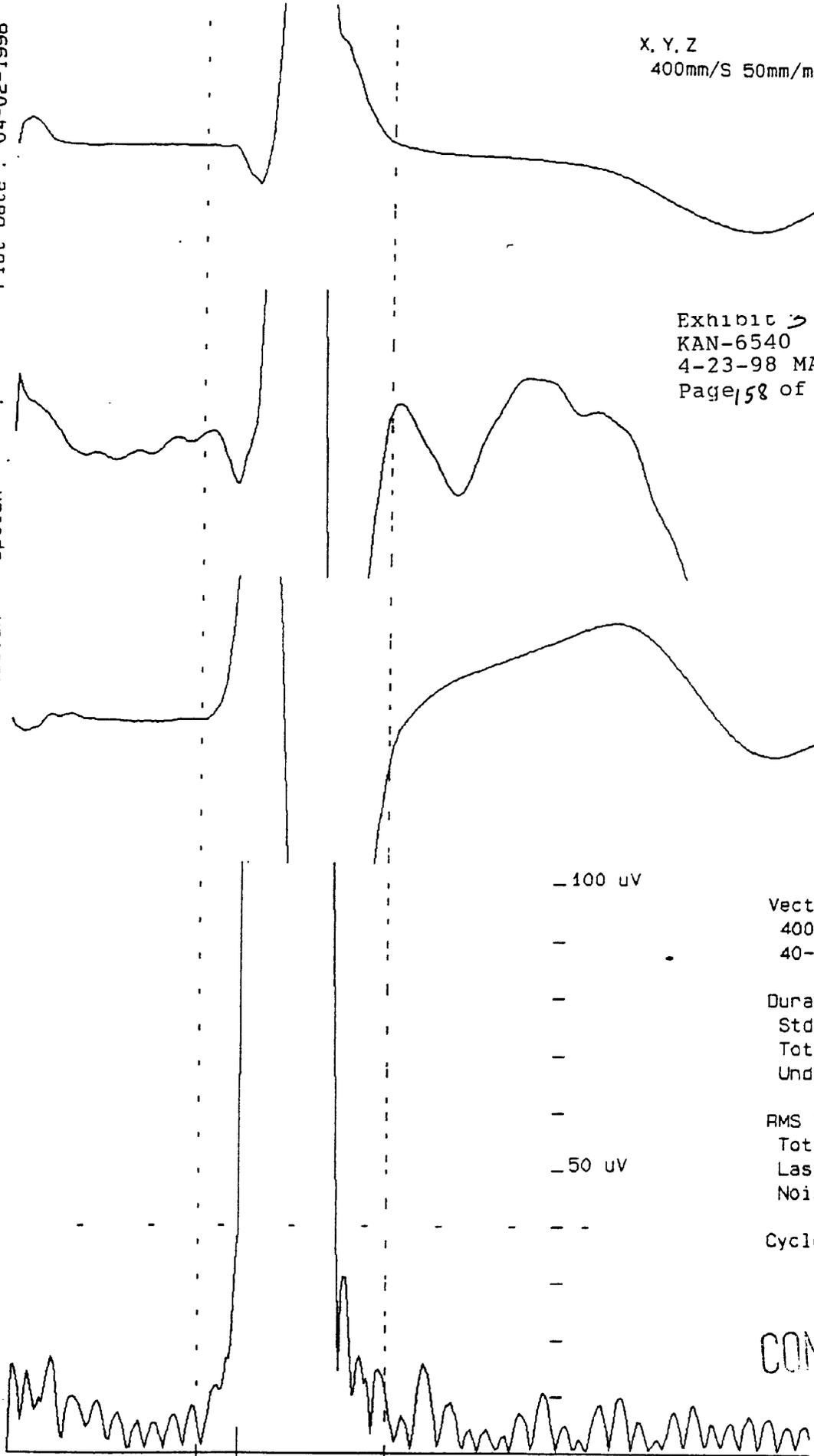
Date : 04/02/98
Time : 11:36

Age : 22
Gender : Male
Height :
Weight :
Race : Caucasian

Medication 1 :
Medication 2 :
Systolic BP : 134
Diastolic BP : 80
Option :

Plot Time : 12:16:25
Plot Date : 04-02-1998

Signal Averaged 205 Cycles High Resolution



X, Y, Z
400mm/S 50mm/mV DC-250Hz

Exhibit 5
KAN-6540
4-23-98 MAS
Page 58 of Pages

100 uV

Vector Magnitude
400mm/S 1.00mm/uV
40-250Hz

Durations (ms):
Std QRS 82
Total QRS 82
Under 40uV 23

50 uV

RMS Voltages (uV):
Total QRS 163.5
Last 40ms 178.4
Noise 1.8

Cycles 205.0

CONFIDENTIAL

000073

NEURODIAGNOSTICS
REPORT OF ELECTROENCEPHALOGRAM (EEG) STUDY

EEG NO: [REDACTED]

DATE: 04/06/98

NAME: [REDACTED]

DATE OF BIRTH: [REDACTED]

MEDICAL RECORD NO: [REDACTED]

ACCT #: [REDACTED]

REFERRING DR: [REDACTED]

LOCATION: [REDACTED]

22-year-old patient who was found unresponsive in the gym and was in v-fib and was shocked by EMS. Down time was about 5 minutes or more. Patient has been unresponsive on a ventilator in ICU.

This EEG is recorded on a 21-channel machine using the standard 10-20 system of electrode placement. Background activity is poorly developed, fairly depressed and is probably about 4 to 5 hz. At times, low amplitude beta waves are present. There was some eye movement and myogenic artifact.

No seizure discharges were seen throughout this recording. Most of the time, it was a very low amplitude record.

Activating methods of hyperventilation could not be performed. Photic stimulation was not done.

IMPRESSION: Abnormal EEG showing diffuse background suppression and slowing, consistent with post anoxic encephalopathy. Compared to previous EEG of 4/1/98, there is no significant change. There is no evidence of seizures.

Exhibit 3
KAN-6540
4-23-98 MAS
Page 153 of 153 Pages

[REDACTED]
ELECTROENCEPHALOGRAPHER: _____

[REDACTED] MD

CONFIDENTIAL 000074

ADMISSION DATA

DATE: 4-26-98 TIME: 1245-71300

ADMITTED: Cart
Wheelchair
Ambulatory
Bedside
VITAL SIGNS: P 70 B/P 110/65
R SMO2 98%
I
No N/A

MEDICAL HISTORY:

Lungs
Heart
Hypertension
Renal
Diabetic
Pregnant

SURGICAL HISTORY:

PRECAUTIONS: Hepatitis AIDS Seizure
Diabetic TB

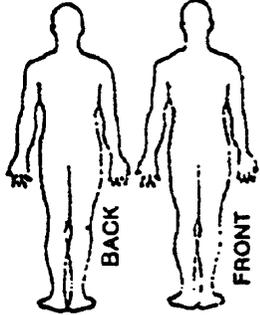
REPORT OF PROCEDURE

Procedure Name: EGD/PEG Doctor:

N/A
Xylocaine % gargle cc
Dyclone % gargle cc
Xylocaine % Spray oral-pharynx cc
Xylocaine 2% jelly lubricate scope
Xylocaine 4% 25cc with NS 25cc s/or 2% Xylocaine injected through scope endobronchially cc
Xylocaine % cc injected through scope endobronchially
 cc NS with cc Adrenalin 1:1000 injected through scope endobronchially cc
Xylocaine 1% with Epi 100,000 cc injected through scope endobronchially

Burricome
Master Probe: Yes No Jaws: Cantery: Yes No Coag Cut
O₂ per & liters Endostat: Yes No Watts
Cardiac Monitor: Yes No Blend Cut Coag
Patient Return to Room 4-215 per Cart with escort
Side Rails Up: Yes No

MEDICATION AND ROUTE	DOSE	TIME	ADMINISTERED BY
<u>Vermed IV</u>	<u>3.5mg</u>	<u>1245</u>	<u>Dr [redacted]</u>



000075

Exhibit 3
KAN-6540
4-23-98 MAS
Page 67 of 70 pages

DATE: 4-20-98

TIME: 1245 → 1300

INDICATIONS:

ESOPHAGUS:

STOMACH:

DUODENUM:

IMPRESSION:

RECOMMENDATIONS:

MEDICATION ORDER:

<u>Hylicam</u>	Topical Anesthesia
Valium	<u>0</u> mg IV
Atropine	<u>0</u> mg IV
Versed	<u>3.5</u> mg IV
Phenergan	<u>0</u> mg IV
Glucagon	<u>0</u> mg IV
Reglan	<u>0</u> mg IV
Other	<u>0</u>

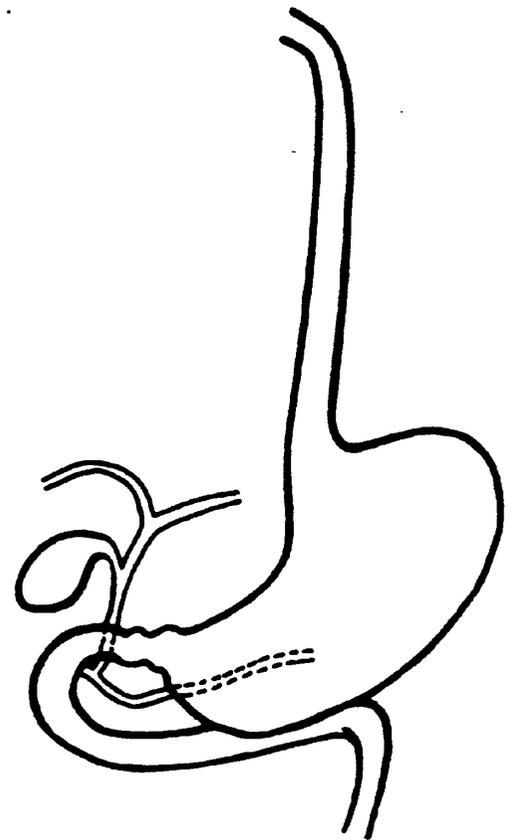


Exhibit 3
 KAN-6540
 4-23-98 MAS
 Page 1 of 1 Pages

Biopsy 0 Cytology 0 Other 0
 Endoscopy Serial # [REDACTED]

000076, M.D.

Physician Signature

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