

EXHIBIT

INHHHH

E.J. NOBLE HOSPITAL
77 W. Barney Street
Gouverneur, NY 13642

RADIOLOGY DEPARTMENT

HANCE, LINTON ROOM NO: OPD X-RAY NO: 26696

REFERRING PHYSICIAN: DR. REYES EXAM DATE: 4/2/96

BONE SCAN:

The study was performed using Technetium 99-m HGP. Whole body imaging was performed. This is compared with plain radiographs of the patient's ribs done April 2, 1996.

Areas of increased activity are seen involving the posterior left 8th and 9th ribs. This appears to be at the level of a pleural based mass which is seen in the patient's left lower lobe posteriorly. A recent CT scan of the chest was also performed demonstrating this pleural based mass with suggestion of erosion into the chest wall and possibly some adjacent rib involvement. The patient's chest CT also demonstrates chronic interstitial lung disease and pleural based calcifications.

The remaining osseous skeleton demonstrates normal distribution of the radiopharmaceutical. No abnormal areas of increased or decreased activity are appreciated in the region of the thoracic or lumbar spines. The pelvis is within normal limits. Some juxtaarticular activity about the knees is noticed consistent with degenerative type arthritis.

INTERPRETATION:

There is increased activity involving posterior left ribs at around the 8th and 9th level. This is at the level of a pleural based mass which may be causing increased rib activity due to rib erosion. Given the chest CT findings this is likely either a mesothelioma or a lung carcinoma. This would be very amendable to CT guided lung biopsy.

CRB/mb
DOB: 7/31/20
D:4/4/96
T:4/4/96

Dr. Rowe-Butter

E.J. NOBLE HOSPITAL
77 W. Barney Street
Gouverneur, NY 13642

RADIOLOGY DEPARTMENT

HANCE, LINTON

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CT OF THE CHEST:

Scanning was performed at the level of the sternoclavicular joints and proceeding caudally using 10 mm. thick slices to the level of the adrenal glands. Additional scanning using 5 mm. thick slices was performed for evaluation of the left lower lobe, posteriorly.

Filming was performed using lung and mediastinal windows.

FINDINGS:

Advanced emphysematous lung disease is noticed with evidence of emphysematous bullae in the right lower lobe. Thickened interstitial markings are also noticed bilaterally.

The presence of a large pleurally based lesion is noticed involving the left lower lobe, posteriorly, measuring approximately 5.9 x 5.4 cm. Several images reveal also extension of this lesion, posteriorly into the chest wall.

No clear evidence of metastatic lung lesions. No mediastinal lymphadenopathy is identified.

FINAL IMPRESSION:

Advanced emphysematous lung disease with the presence of emphysematous bullae in the right lower lobe. The presence of a large soft tissue mass is noticed in the left lower lobe, posteriorly, which is pleurally based and measures approximately 5.9 x 5.4 cm. Extension posteriorly into the chest wall is identified.

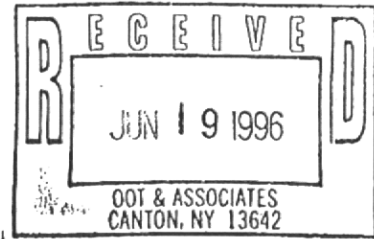
Malignant lesion such as mesothelioma is high on the differential list. Fine needle biopsy for a final diagnosis is suggested.

DOB: 7/31/20
D:4/2/96
T:4/2/96 mb

R.A. Prijic M.D.

Handwritten signatures:
Prijic
Reyes

COPY



E. J. NOBLE HOSPITAL
77 W. BARNEY STREET
GOUVERNEUR, NY 13642

TRANSFER SUMMARY

HANCE, Linton

Dr. Reyes

Hosp.# 00-19-88

DATE OF ADMISSION: 04/05/96
DATE OF TRANSFER: 04/09/96

Mr. Hance is transferred to A. Barton Hepburn Hospital under Dr. Palao's service since 04/09/96.

- PROVISIONAL DIAGNOSIS:
1. Bilateral pneumonia.
 2. Hemoptysis probably, secondary to CA of the lung.
 3. Rule out presence of mesothelioma.
 4. Chronic interstitial lung disease with emphysema to bullae right lower lobe.
 5. Chronic obstructive pulmonary disease.
 6. Benign prostatic enlargement.

- TRANSFER DIAGNOSIS:
1. Bilateral lower lobe pneumonia.
 2. Possible CA of the lung.
 3. Rule out mesothelioma.
 4. History of coronary artery disease with status post CHF.
 5. History of chronic obstructive pulmonary disease with chronic interstitial lung disease, secondary to talcosis.
 6. Benign prostatic enlargement.

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS: Please see history and physical form. *meds I have*

DISCHARGE SUMMARY: This is the case of a 75-year-old white male who is a known case of coronary artery disease, CHF, COPD with chronic interstitial lung disease, secondary to talcosis with enlarged prostate hematuria, with normal PSA who was admitted on 04/05/96 for left sided chest pain and hemoptysis. The patient is a non-compliant patient who refused to be followed up regularly, had just been found to have a possible left lower lobe mass, questionable mesothelioma, verified by CT scan done on April 2, 1996 with bone scan showing increased activity in the posterior left ribs at 8th and 9th level, question of possible metastatic focus found of lung cancer. He was started on Naprosyn on Tuesday of this week when he finally decided to have a CAT scan and a bone scan done, but apparently came back on

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TRANSFER SUMMARY
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HANCE, Linton

Dr. Reyes

Hosp.# 00-19-88

04/05/96 because the pain got worse and intolerable, not relieved by Naprosyn.

This time the patient was also complaining of increasing shortness of breath with hemoptysis. There was no fever or chills. His appetite has been fair and there is no other site of pain. The patient has not shown any weight loss since the last visit to my office 3 months ago. The patient was initially seen in the Emergency Room and found to have crackles bibasal lung field with bilateral infiltrate on the chest x-ray with a white count of 21,400 with segs of 80 and lymphs of 19, hemoglobin 14.8, hematocrit of 42. His blood gas showed a P02 of 50, pH 7.43, PC02 36.2. ADDENDUM: The patient's sputum culture showed positive Serratia Marcescens, which is sensitive to everything including Septra, only resistant to Cefazolin.

HOSPITAL COURSE: He was admitted to the hospital with diagnosis of bilateral pneumonia and started on IV Rocephin 1 gram q24 hourly, after obtaining sputum cytology, gram stain, and blood cultures. He was kept comfortable with Morphine IV at 1 mg per hour, titrated up to 3 mg per hour to keep chest pain free. He was continued on Albuterol and Atrovent aerosol therapy q.i.d. alternately and 2 liters of oxygen via nasal cannula. ABG and pulse oximetry was followed up in the hospital and oxygen was titrated accordingly based on the blood gases obtained. The patient was started on MS Contin 30 mg b.i.d on 04/06/96 and MSO 4 mg qd hourly p.r.n. for pain. His O2 was increased to 4 liters per minute by nasal cannula for persistent hypoxemia despite O2 therapy at 2 liters per minute. Incidentally the patient was found to have a slight abnormality in PT PTT for which he was started on Vitamin K sub q. The patient showed clinical improvement while in the hospital. On my arrival on 04/09/96 I spoke to the patient and told him since he has persistent hemoptysis and because of the mass in his lung he needs further evaluation, such as bronchoscopy, possible thoracoscopy. He was referred to Dr. Palq who accepted the patient for transfer and immediate further diagnostic workup at A. Barton Hepburn Hospital. The patient was subsequently transferred in stable condition after he agreed to the further workup. Appropriate papers were filled out and the patient was transferred with stable vital signs not in respiratory distress, comfortable with O2 inhalation at 4 liters per minute. No neck vein engorgement with bilateral crackles. Heart has been regular and abdomen is soft and non-tender and no peripherals or central cyanosis.

FTR/dh

D: 04/09/96 (1743 hours)

T: 04/09/96

Fe. T. Reyes, M.D.