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Alexander Vuckovic, M.D.

Medical Director

PAVILION DISCHARGE SUMMARY Frank Amodeo

b. 09/01/1960

Admitted to The Pavilion: August 6, 2008
Discharged to Intensive Outpatient
Follow-Up via Dr. Choras and
Ms. O'Rourke: August 21, 2008

History of Present Illness:

This 48 year old married White man was referred to The Pavilion in the context of a likely longstanding Bipolar Mood Disorder as well as a history of legal difficulties stemming from an alleged tax fraud. Mr. Amodeo has been under the care of Dr. Jeffrey Krottenberg in Florida since November of last year, and has been noted to be suffering from a significant elevation of mood, irritability, euphoria, and a likely delusional system, in the context of which he has stated that he wished to become emperor of the world. Complicating the situation has been that Mr. Amodeo has indeed had a great deal of business success, as well as contacts with powerful figures around the nation and the world. Further complicating the matter is that Mr. Amodeo's legal difficulties have led to the likelihood of an imminent indictment on tax fraud charges. The patient has already had a felony conviction, and has been disbarred as an attorney. Mr. Amodeo has recently been on a regime that includes valproic acid and had a brief trial of quetiapine, with unclear impact on his symptom state. He comes here for a thorough evaluation, as well as treatment recommendations.

At the time of Mr. Amodeo's initial assessment his mental status was of a somewhat obese, pleasant gentleman who showed no psychomotor agitation, retardation, tics, tremors, or adventitious movements. He made good eye contact, and was friendly, voluble, with spontaneous speech that was occasionally pressured and tangential, but redirectable. The patient denied any mood disturbance, appeared to be elevated in his mood, and seemed remarkably unconcerned with his serious legal difficulties. He denied obsessions, compulsions, suicidality or homicidality. While he denied delusions, he appeared grandiose, and readily admitted that he believed that he was destined to be emperor of the world, and that his many business activities were geared toward making such an outcome occur. He was grossly cognitively unimpaired. He

appeared to be of above average intelligence. His insight was limited by his delusional symptomatology. His social judgment was grossly appropriate.

Mr. Amodeo was admitted to The Pavilion with a provisional diagnosis on Axis I of Psychosis, NOS, R/O Bipolar Disorder, Manic, with psychotic features, R/O Schizoaffective Disorder, Bipolar Type, and a history of stimulant abuse, specifically pseudoephedrine. On Axis II, we deferred a diagnosis, but had a concern about the likelihood of Narcissistic and Antisocial Personality Disorder. On Axis III, previously diagnosed Obstructive Sleep Apnea was noted, as was previously diagnosed Early Adult Onset Diabetes Mellitus, hypertension, and a history of asthma.

Mr. Amodeo underwent a number of evaluations, consultations, and lab examinations. They included urinalysis, which was benign, urine drug screens which were negative for substances of abuse, a lipid panel, which was notable for cholesterol of 191, triglycerides of 176, HDL of 43, and LDL of 113 mg per deciliter. Serum prolactin was slightly elevated for a male at 19 nanograms per milliliter, with normal of less than 13. Morning cortisol was normal at 15.8 micrograms per deciliter. TSH was normal at 2.42 Miu/ml. B12 was normal at 716 picograms per milliliter, and folic acid was normal at 8.8 nanograms per milliliter. Hemoglobin A1C was elevated at 7.1%. Serum homocysteine was elevated at 10.2 micromoles per liter. Methylmalonic acid was normal at .14 micromoles per liter. A total testosterone was low at 138 nanograms per deciliter. Free testosterone was low at 7.5 nanograms per deciliter. A liver profile was normal, except for a trivially elevated ALT of 45 IU/l, presumably due to valproic acid therapy. A repeat prolactin level remained elevated at 24 nanograms per milliliter. The patient's PSA was normal at 1.3 nanograms per milliliter. Sex hormone binding globulin was low at 6.9 nanomoles per liter. Cardio CRP was elevated at .572 mg per deciliter. The patient's CBC and differential were essentially within normal limits. Valproic acid levels varied, but stayed within the normal range in the 71 to 83 micrograms per milliliter range. The patient's EEG was read as a normal awake, drowsy, and sleep EEG. The patient's overnight sleep study confirmed a likely obstructive sleep apnea syndrome. CPAP was administered and was helpful at 13 centimeters of water pressure. Dr. Evan Murray saw the patient in neurologic consultation and noted non-specific findings, likely related to the effects of his mood disorder, also possible impact of insufficient sleep, and medication side-effects. His clinical history was not very suggestive of a Seizure Disorder or a neuro-degenerative condition, but a very early neurodegenerative condition could not be entirely excluded. His elemental neurologic examination was unremarkable. EKG showed a possible old anterior infarct. Dr. Marian Klepser saw the patient in medical consultation. She noted obesity, hypertension, and metabolic syndrome, and changed his Toprol XL to Labetalol therapy. She recommended follow-up with cardiology. She noted a history of heel pain and leg weakness, and felt that he might have a mild plantar fasciitis. The patient's MRI exam, without contrast, showed no anatomical brain abnormality. At the time of this dictation we are awaiting a repeat MRI with gadolinium, including a pituitary study due to the patient's mild hyperprolactinemia. Cardiologic evaluation by Dr. John Levinson resulted in a recommendation for an echocardiogram, and a nuclear treadmill stress test. These have been done, and we await results. Psychologic and neuropsychologic testing were performed by Dr. Susan Parks, whose results are appended. Dr. Parks felt that the patient showed no significant cognitive deficits, and concurred with the likely clinical diagnosis on Axis

I of a Bipolar Disorder, with psychotic features. On Axis II, Mixed Personality Disorder, with narcissistic and antisocial traits was noted.

Mr. Amodeo's Pavilion course was relatively uneventful. He took part in multiple consultations willingly and saw individual treaters, including Dr. Peter Choras, who was his Pavilion attending psychiatrist, myself on a daily basis, and Ms. Andrea O'Rourke, who acted as a liaison to family, and more particularly his wife. Dr. Jennifer Taylor performed a substance abuse evaluation, and felt that the patient fulfilled criteria for a past psychostimulant dependency. She noted that he still was dependent on caffeinated beverages, in large amounts.

We initiated a trial of antipsychotic medication, first olanzapine, at dosages increasing to 7.5 mg at night. Strikingly, within a week of the administration of olanzapine Mr. Amodeo's previously intractable delusional system appeared to soften considerably, as he acknowledged that he might indeed be suffering from symptoms of Bipolar Illness, and also acknowledged that his hope of becoming emperor of the world was quite unrealistic. He remained seemingly unconcerned about the potential impact of his legal problems, even though during the course of his time here he discovered that he had been indicted on multiple counts of tax fraud, and would be expected to turn himself over to federal authorities upon his return to Florida. During his time here Mr. Amodeo also took part in a forensic consultation by Dr. Katz of Dr. Thomas Gutheil's forensic evaluation group. We are not privy to the results of that consultation. Mr. Amodeo complained of a significant increase in his hunger on olanzapine therapy, and the drug treatment was changed to ziprasidone in the several days prior to his treatment conference. Once again he tolerated this, appeared to lose his severe hunger, and continued to have improvement in his delusional symptoms.

On the 20th of August a treatment conference was held attended by the patient, his Florida forensic psychiatrist, Dr. Danziger, by conference call, and his local treatment team consisting of myself, Dr. Choras, Ms. O'Rourke, Dr. Parks, and Dr. Taylor.

We reviewed the results of Mr. Amodeo's evaluation at The Pavilion and confirmed a likely diagnosis on Axis I of a Bipolar Disorder, Manic, with psychotic features, as well as a history of stimulant dependency, presently in a degree of partial remission. On Axis II, we established that Mr. Amodeo did likely suffer from a Mixed Personality Disorder, with narcissistic and antisocial features. On Axis III, we noted multiple medical problems including metabolic syndrome, prodromal AODM, obstructive sleep apnea syndrome, and a newly discovered hypogonadism. We await the results of the patient's MRI pituitary study.

We strongly recommended continuing local therapy until the patient's Geodon dosage was in a fully therapeutic range, and to that end I increased the patient's dose from 60 to 80 mg on the day of his Pavilion discharge. He was agreeable to staying in the area for the course of the next week, during which time he would be seeing Dr. Choras and Ms. O'Rourke on a regular basis prior to returning to Florida, where he understands he needs to turn himself in to federal authorities.

Mr. Amodeo was discharged outright from The Pavilion on the 20th of August in a moderately improved condition with discharge diagnoses as above.

His medications on discharge included Depakote-ER-3000 mg at bedtime, Fish Oil 3 grams twice daily, Labetalol 300 mg twice daily, enteric coated aspirin 81 mg in the morning, folic acid 1 mg in the morning, Geodon 80 mg at suppertime and Rozerem 8 mg at night. Dr. Danzinger is in the process of obtaining psychiatric aftercare for Mr. Amodeo in Florida for his return, as Dr. Krottenberg will not be able to follow the patient. Mr. Amodeo is aware of this.

At the time of his discharge he was non-suicidal, cooperative with treatment, and willing to follow the treatment team's recommendations.

We are available to Mr. Amodeo and his treaters in any way they deem appropriate in the future.

Alexander Vuckovic, M.D.

McLean Hospital

115 Mill Street, Belmont, Massachusetts 02478-9106 Telephone 617 855-2000, FAX 617 855 3299

August 7, 2008

Dr. Alex Vuckovic Medical Director, The Pavilion McLean Hospital

Re:

Frank Amodeo MR#170910 DOB: 9/1/60

Reason for Referral: Pavilion Evaluation.

Dear Alex:

I had the pleasure of evaluating Mr. Frank Amodeo this afternoon. As you know, he is a 47 year old right-handed Caucasian male who is presently experiencing legal issues stemming from allegations of tax fraud and is presently admitted for clarification of his possible psychiatric diagnoses. Consideration has been given to bipolar disorder, schizoaffective, sociopathy, and/or malingering.

Mr. Amodeo reports feeling that he would be "emperor of the world" since the age of 13 or 15. He states "even in high school when I was President of my class, I would show up for events in a limousine and ensure that the marching band was playing at my arrival". Today he expresses no doubt whatsoever that he will be emperor of the world by the year 2015. He endorses some mild depressive symptoms, but states that this is due to feeling "disconnected from what's out there." Today is the last day of a grand jury evaluation of whether he will be indicted on charges of tax fraud. He states that he was running a company named Mirabilis (Miracle) that included subsidiaries of some 60 other companies. This organization provided staffing for other companies and one of its subsidiaries fell into tax difficulties owing \$180 million dollars to the government. Mr. Amodeo states "I agree with government that these taxes are due", but he states that "I never profited from any of this" and this will be demonstrated in court. He feels that this will "lend credibility" to him allowing him to have the ability to move forward on his plans for implementing a Mirabilis model of employment in all cities in the world, and thereby making governments "irrelevant" and putting him in charge. He feels that this will bring increased peace to the world. He believes that the company Mirabilis is a "test of how I would take over the world" and "it was successful". "It sends a message of power to the world."

He states that he was diagnosed with bipolar in 1995, but may have had mania during law school at the age of 24. At that time, he was engaged in a concurrent Ph.D. program at Georgia State University but did not complete this due to his father developing cancer. He was evaluated in November of 2007 by his psychiatrist, Jeffrey Krotenberg, after Mr. Amodeo had witnessed a video of himself in an apparent manic state giggling and being inappropriate. At that time, he decided to try medications, whereas he had previously been adverse to considering them. At the age of 7, he felt that he had teleported himself and his friends out of the way of a moving train.



He hears a voice in his head which he states, "I'm pretty sure" that it's his own voice telling him what to do. The voice has never instructed him to commit crimes, dangerous acts, or to destroy things. "I've seen people in colors" since the age of 10 or 12. Since February of 2008 at night or in dim light, he has seen people that he knows and is able to dialogue with them. The last time this happened was in early July, 2008.

He denies any history of seizures or head injury. He usually obtains between 7 and 8 hours of sleep each night, but prior to admission for several days he had slept only 7 hours, and then two days prior to admission, had no sleep whatsoever. He has been diagnosed with obstructive sleep apnea in September or October of 2007, but did not use his CPAP machine regularly until July of 2008. He denies any memory or concentrations problems, but feels that he has had difficulty composing his thoughts in writing in "crisp and concise" language. He has had some difficulty with spelling and finding words over the past 3 to 4 months. He also endorses having "wobbly legs" in the morning and experiencing a great deal of ankle and heel pain when standing up in the morning. Several months ago, he had experienced a few falls related to this. After about 45 minutes of walking, the pain improves somewhat, and he is able to walk and climb stairs; however, he feels weak. He also experiences some intermittent numbness in the distal third of both of his legs when he is sitting in a chair for a long time, or sometimes laying in bed. He does not experience this while walking. He denies any lower back pain, radiating symptoms down the legs, incontinence, or problems in his arms. He denies any dysphagia or voice changes. He points out that some friends have noticed a possible mild change in his voice. He denies any droopy eyelids. The patient denies any muscle cramping or myalgias. He endorses some intermittent chronic twitching of the right shoulder that he feels is related to a remote baseball

He has no known drug allergies. His medications include Depakote and Metroprolol.

Past Medical History - Includes hypertension, obstructive sleep apnea, 15 pound weight gain since starting Depakote.

Social History – He earned his J.D. degree at Emory. He denies any history of alcohol, drug, or tobacco use. He has been married to his second wife for 19 years. He has a 22 year old stepson with Down Syndrome, and an 18 year old daughter. See above for additional details.

Family History – His mother had a stroke at age 64. His brother has some type of difficulty that "no one knows the cause of". His brother never left home, never completed high school or college, but has no known mental retardation. There is no family history of Alzheimer's disease, Parkinson's disease, psychosis, or bipolar disorder.

Mental Status Examination – The patient is short, well-dressed, well-groomed, and overweight. He is cooperative, very pleasant, socially engaging and smiles easily. His eye contact is good and his speech is clear with a regular rate, rhythm, and prosody. There are no phonemic or paraphasic errors. He denies hallucinations at this time. His insight is reduced and his judgment is impaired in relation to his delusional thinking. His thought process is linear. He denies suicidal ideation. Tests of orientation, language repetition, naming, reading, writing, spelling, clock drawing, Serial 7's, spelling earth forwards, backwards, and in alphabetical order are intact. Luria hand sequences are learned easily, but sustained with difficulty. Go/No-Go testing reveals mild impulsivity. He registers 4/4 memory items on the first attempt, and after five minutes recalls three spontaneously and one more with cueing. After an additional five minutes, he recalls three spontaneously and one with cueing. Cranial nerves II through XII are intact. Motor strength,

bulk, and tone are normal. There is no pronator drift. He is able to plantarflex his ankle while standing on the same foot time ten times each side. He is able to squat and rise to standing five times consecutively without use of his arms. He is able to run up two flights of stairs and down without difficulty or unsteadiness. Sensory testing reveals normal light touch, sharp, and proprioception. He is Romberg negative. Coordination testing reveals a normal finger-to-nose, rapid alternating movements, fine motor control, and heel to shin examinations. Reflexes are 2+ throughout with both toes downgoing.

Impression — Mr. Frank Amodeo is a 47 year old male admitted for clarification of his psychiatric diagnoses. His cognitive examination revealed grandiosity, delusional thought processes, slight impulsivity, mild attentional difficulties, and mild memory retrieval difficulties. These are non-specific findings, more likely related to the effects of his mood disorder and/or possible psychotic disorder, insufficient sleep, and possible medication side effects. His clinical history is not very suggestive of a seizure disorder or a neurodegenerative condition at this time but a very early neurodegenerative condition cannot be entirely excluded. His elemental neurological examination is unremarkable.

Recommend ongoing management of his psychiatric condition. Brain imaging is reasonable, if he has not been imaged recently or if he is thought to have a change in his behavior compared to baseline, to exclude lesions in limbic regions. Neuropsychological testing would better characterize the mild cognitive difficulties noted on office screening. He should continue using CPAP nightly with a goal of obtaining between 7 and 8 hours of sleep each night. His complaints of "wobbly legs" in the morning seem to be more likely related to pain in the ankles and heels rather than a primary neuromuscular condition. His examination today reveals excellent strength in the lower extremities and no clinical history to clearly point to the presence of a neuromuscular disorder. Recommend evaluation by a podiatrist or rheumatologist for these symptoms in the feet. Weight loss may also be beneficial both for ankle and foot pain and his sleep apnea. Nutritional counseling may be helpful for promoting weight loss.

I would be happy to see Mr. Amodeo in follow-up should any abnormalities be detected during his work-up, or should any neurological issues arise.

Sincerely,

Evan D. Murray, M.D. Behavioral Neurologist

EDM/sc

Myllis

Imaging Center — McLean Hospital — MRI Report

AMODEO, Frank

HALL: Pavilion

MRN: 170910

Referred by Dr. Vuckovic

8/8/08 3:00 pm

MRI EXAMINATION OF THE BRAIN

Clinical History

Bipolar disorder.

Technique

We obtained sagittal T1 weighted images followed by axial proton density, FLAIR, gradient echo, T1, T2 and diffusion weighted images. Coronal FLAIR and SPGR images were obtained.

Findings

No radiographic abnormality is seen.

Ventricular system and subarachnoid spaces are within normal limits. There are no intracranial collections, mass lesions, deformity of ventricular system or shift of midline structures. There are no foci of abnormal signal intensity within the brain parenchyma. No abnormality is seen at craniocervical junction. Midline structures are intact. Vascular flow voids are maintained and paranasal sinuses are essentially clear.

Impression

No anatomical brain abnormality is seen.

AAZ:

8/10/08

emp:

8/10/08

Amie A. Zamani

Amir A. Zamani, M.D. 7:30 am

DATED: 8/23/08

Harvard Medical School

Donald A. Davidoff, Ph.D., ABPDC

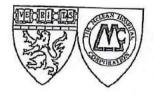
Director

Donald L. Round, Ph.D.

Assistant Director

Susan Parks, Ph.D.

Director of Training



McLean Hospital

An Affiliate of the Massachusetts General Hospital Pariners Healthcare System, Inc.

Department of Neuropsychology

Neuropsychological and Psychodiagnostic Evaluation

Name:

AMODEO, FRANK .

DOB:

9/1/1960

Date of Evaluation:

8/12/2008

Clinician:

Susan Parks, Ph.D.

Unit:

The Pavilion

Referral:

Alex Vuckovic, MD

SOURCES OF INFORMATION: Information contained in this report was derived from direct contact with Mr. Amodeo and McLean Hospital records.

REFERRAL QUESTION: Mr. Amodeo is a 47 year old, right-handed, Caucasian, separated man who was self referred to The Pavilion for a diagnostic evaluation and treatment recommendations.

HISTORY OF PRESENT ILLNESS: Mr. Amodeo came to The Pavilion for a psychiatric evaluation requesting an "objective view" of his manic symptoms. He reported that he was currently under a criminal investigation related to money that is owed to the government following changes in his business. He has reportedly been diagnosed with bipolar disorder and includes grandiose and bizarre thoughts involving beliefs around becoming emperor of the world. He reports being open to psychiatric treatment. Mr. Amodeo has been under the care of Dr. Jeffrey Krotenberg since November 2007.

PAST PSYCHIATRIC HISTORY: Mr. Amodeo reports experiencing symptoms of mania since college and reports suffering from undertreated "mild bipolar disorder" for the past 8 years. He believes his episodes are consistent with a rapid cycling subtype and symptoms have included delusional and grandiose thinking, decreased sleep, racing thoughts, and impulsive spending including impulsively buying a million dollar house and buying a clothing store after walking in it simply to shop. He reports he has been prescribed and taking Depakote since November 2007 with good effects.

PAST MEDICAL HISTORY: Remarkable for high blood pressure, sleep apnea (CPAP for 2 months) diagnosed in September 2007.

SUBSTANCE USE HISTORY: Mr. Amodeo denied any past or current use of illegal drugs or alcohol. He does drink large amounts of caffeinated beverages. Mr. Amodeo is a non-smoker.

FAMILY HISTORY: Mr. Amodeo's father is reportedly a gambler and was diagnosed with liver cancer in 1987. His brother is reportedly "isolative" with possible psychiatric problems. His mother suffered a CVA a year ago.

SOCIAL, DEVELOPMENTAL AND ACADEMIC HISTORY: Mr. Amodeo was a product of a vaginal birth with the only complication including his mother smoking during his pregnancy. He was born in Detroit and was raised in Orlando. He met all developmental milestones appropriately although he did report having a surgery to correct a stomach blockage in his first year of life. Mr. Amodeo reports himself as a good student and never experienced any academic difficulties earning mostly As. When asked to describe himself as a child, he reported that he was "smart,charismatic,I got along with others." He played football and baseball. He attended the University of Central Florida and graduated in 1983 with a degree in Political Science. He attended Emory Law School from 1984-87 while he was attending Georgia State where he was reportedly enrolled in a Doctoral Program. He started his own business while he was in school. He reportedly worked for a law firm from 1988-1990 and has been self employed since 1990.

When asked about abuse, Mr. Amodeo reported two events including having a babysitter who was abusive to his brother (age 5) and his aunt being murdered after she left from babysitting Mr. Amodeo. He stated, "I was probably the last person in our family to see her alive."

Mr. Amodeo's father, Frank is 67 and his mother, Margaret is 65. She has been recovering from a CVA suffered in April 2007. Mr. Amodeo was married previously for 3 years and he had no children from that marriage. Mr. Amodeo has been remarried to Claire for 19 years, but the couple is currently going through a difficult time. They have one daughter, Mia, who will be 18 in a month, is a senior in high school and will be going to college next year. Claire has a son, Gentry, to a previous marriage. He is 22 years old and reportedly has Down's syndrome. Mr. Amodeo is the eldest of three.

BEHAVIORAL OBSERVATIONS: Mr. Amodeo is a well appearing male who appears his stated age. He was comfortably dressed in casual clothes and his grooming was neat. He sat in an upright position and made good eye contact. He was attentive to the examiner which remained consistent throughout the evaluation. Speech was fluent with normal rate, tone, rhythm and volume and reflected an average lexicon. His affect was stable. He put forth good effort on all neuropsychological and psychological tests. He denied suicidal and homicidal ideation. His associations were generally logical and coherent with a goal directed stream of thoughts; however, he did endorse thoughts of being the world leader and that he refers to the "committee on his hands." He talked about how it is difficult for him to know what is reality and what is delusional given his high powered career, achievements and connections. He did not appear to attend to internal stimuli during the testing session. He demonstrated some, but limited insight into his psychiatric symptoms. Due to Mr. Amodeo's good effort and attention, this evaluation is regarded as an adequate representation of his current level cognitive functioning and psychological functioning.

SYNTHESIS OF TEST FINDINGS AND RECOMMENDATIONS: Mr. Amodeo is a 47 year old, right-handed, Caucasian, separated man who was self referred to The Pavilion for a diagnostic evaluation and treatment recommendations. He was diagnosed with Bipolar Disorder and has been taking Depakote as prescribed since November 2007.

Mr. Amodeo's clinical presentation is quite complex and suggests the presence of a mood disorder with psychotic features and unique personality characteristics that highly influence his behaviors. His mood disorder is consistent with a Bipolar I Disorder with rapid cycling. Although testing strongly and clearly supports the presence of longstanding depressive issues, it is very likely that Mr. Amodeo utilized his manic symptoms as a way to avoid his depression. Additionally, his cognitive features associated with his manic presentation (i.e., over-incorporation, grandiosity) may have been a strength in achieving the impressive progress that he has historically demonstrated. This appears to have begun many years ago when he was concurrently completing two graduate programs and continued throughout his lifetime, being involved in multiple high level corporate situations simultaneously. However, when Mr. Amodeo's symptoms of his bipolar disorder are not adequately managed, he demonstrates delusional symptoms including grandiosity and poor reality testing. Thus, he runs a fine line between using the energizing aspects of his mood disorder and tilting into a state of severe symptoms that are destabilizing. Clinical history juxtaposed against his test findings suggest the latter has more recently occurred and his recent state of distress has made it more difficult for him to function. Caution should be made that as his manic symptoms are better managed, his depression and issues accompanying his depression (i.e., poor self image, issues about his impending future) may become overwhelming to him and his suicide risk factors may become more of a pressing issue. Thus, careful monitoring of depressive and manic symptoms is highly suggested and careful discussion around suicidal ideation is highly recommended.

Mr. Amodeo's clinical presentation is underscored by the presence of narcissistic and antisocial features. In the context of mania, these symptoms may have become amplified, making it difficult to discern what behaviors resulted from the mood disorder, as well as what behaviors were being driven by his personality features as there is some overlap (i.e., grandiosity, impulsivity). Mr. Amodeo does not reach the full diagnostic criteria for neither Narcissistic nor Antisocial personality disorders exclusively. However, he does present with features of both of these disorders that negatively impact his functioning and relationships with others; thus, his presentation is most consistent with a Personality Disorder Not Otherwise Specified with Narcissistic and Antisocial features.

A multimodal treatment approach is recommended. Careful psychopharmacology will be required because of his extreme medication sensitivity. With regard to psychotherapy, Cognitive Behavioral Therapy is suggested because of his cognitive style where he is over-incorporative and at times loses touch with reality. Thus, straight-forward and structured, skill-focused work that CBT encourages appears to be the best fit for Mr. Amodeo. Dialectical Behavioral Skills could also be woven into his psychotherapy. Specific techniques that are suggested include self assessment (i.e., gaining self awareness of the earlier warning signs of emotions), detection of early, moderate, and significant warning signs of his illness (both mania and depression), mood monitoring with focus on reframing distorted thinking, reality testing, distress tolerance skills and practicing mindfulness. At times, Mr. Amodeo's emotions may feel so overwhelming that he may periodically be at risk to act impulsively. Therefore, impulse control skills should also be reviewed, even if not the primary focus of therapy. In addition to management of his Bipolar illness, Mr. Amodeo demonstrates character traits consistent with a Personality with Narcissistic and Antisocial traits. These symptoms may become more amplified during periods of mood instability and this should be addressed in psychotherapy.

Mr. Amodeo's performance on the neuropsychological evaluation revealed strong cognitive abilities. Testing suggests adequate abilities in simple attention, concentration, executive controls, language abilities, visuospatial functioning and memory. Mr. Amodeo is a bright individual (FSIQ-109,

VIQ=109, PIQ=107) with many cognitive strengths. His pattern of IQ test scores suggests the presence of well developed cognitive abilities with no indication of learning difficulties.

DIAGNOSTIC IMPRESSIONS:

Axis I

296.64 Bipolar I Disorder, Most Recent Episode Mixed, Severe with psychotic

Axis II

301.9 Personality Disorder Not Otherwise Specified (Narcissistic and Antisocial

Traits)

Axis III

High Blood Pressure, Sleep Apnea

Axis IV

Life Stressors

Axis V

GAF=50-55/100

EVALUATION PROCEDURES:

Wechsler Abbreviated Scale of Intelligence (WASI)

Digit Span

Trail Making A and B

Controlled Oral Word Association Test and Semantic Fluency

Stroop Color Word Test

Boston Cancellation Test

Boston Naming Test 15 card screen of the Boston Diagnostic Aphasia Examination

Rey-Osterreith Complex Figure

Logical Memory I and II -Stories A and B of the Wechsler Memory Scale-Revised

California Verbal Learning Test II Short Form (CVLT-II-SF)

Wisconsin Card Sorting Test (64 card version)

Clock Drawing Test

Rorschach Inkblot Test (Exner Scoring System)

Millon Clinical Multiaxial Inventory –III

Beck Hopelessness Scale

Beck Depression Inventory-II

Beck Suicide Scale

Sentence Completion

Clinical Interview

Record Review

COGNITIVE TEST RESULTS (please refer to attached score page for scores and ranges): Orientation, Intellectual and Motor Skills: Mr. Amodeo was oriented to self, date, place and circumstances around his evaluation and hospitalization. He showed no difficulty with left-right orientation. His performance on the WASI revealed a FSIQ estimate of 109 which falls within the Average range with commensurate verbal (VIQ estimate=109, average) and performance (PIQ estimate=107, average) based skills.

Language Functions: Mr. Amodeo's confrontation abilities fell within normal limits (13/15 BNT). He missed the two most difficult items, initially calling a yoke a "bridle." He benefited from phonemic cues for both missed items. His performance on the Vocabulary subtest of the WASI indicated above average abilities in expressive vocabulary, verbal knowledge and fund of information. His average performance on the Similarities WASI subtest indicates adequate verbal abstraction and reasoning abilities.

Visuospatial Functions: Mr. Amodeo's performance on the WASI matrix reasoning subtest indicated average abilities in nonverbal fluid reasoning. Of note, there was notable intratest scatter within this subtest. His performance on the Block Design test also fell within the average range indicating adequate abilities in visual construction. He was able to complete all of the 2x2 designs and earned maximum speed points for all of these designs. He was able to quickly see the gestalt and utilized a block by block approach to solve each item. He was only able to complete one of the four 3x3 designs. The design completed was done quickly and utilizing his good approach strategies and earned speed points. However, he began to struggle with the next designs, breaking configuration once. When asked to copy the Rey Complex figure, his final score fell within normal limits despite utilizing a part oriented and fragmented approach. His final product resembled the exemplar with mild inaccuracies.

Learning and Memory: Mr. Amodeo's performance on verbal memory tests was largely within normal limits. His performance on a 9 word list learning task (CVLT-II-SF) indicated mildly impaired abilities on the first of the 4 learning trials, a measure of concentration and working memory (Standard Score -1.5, mildly impaired). However, he demonstrated an adequate learning curve over the complete learning trial portion of this test (4, 8, 8 and 7/9 words, T=50). He was able to recall 8/9 words at the short delayed free recall trial (average, Standard Score 0.5). After a longer delay, he was able to recall 8/9 words without cuing (above average, Standard Score 1) and 8/9 with cueing (above average, Standard Score 1). Discriminability was solid and he was able to identify 9/9 words on a recognition trial (Standard Score 0.5) with no false positives (Standard Score 1, above average). He tended to utilize a serial clustering strategy to learn the words, meaning that he tended to learn and recall them in the order than they were presented, rather than using a semantic clustering strategy which involves clustering the information into meaningful categories to make learning more efficient. On a second verbal learning test (WMS-R Logical Memory, contextual learning), he was able to take in 31/50 details across 2 stories (average) and after a delay was able to recall 33/50 details (above average). On a recognition format trial, he was able to correctly answer 18/21 questions, consistent with his acquisition trial.

Mr. Amodeo's performance on the Rey Visual Memory recall trials indicated adequate storage and recall of complex visual information after short and long delay conditions with no loss of information, despite mild difficulties on the copy trial. His approach was more organized and careful. He first addressed the gestalt, followed by the details. His final result was accurate with mild omission and misplacement of details.

Executive Functions: Mr. Amodeo's maximum forward digit span on a test of simple auditory attention fell within the average range for his age (DF=7, consistent). His responses were quick and accurate. His maximum backward digit span also fell within the average range suggesting adequate abilities in concentration and working memory (DB=5, consistent). His performance on a test of visual scanning was quick and accurate (Trails A, 0 errors, 16 seconds) and fell within the above average range. On Trails B, a more difficult test of divided attention and set shifting, he had no difficulty and completed the trial with good speed, accuracy and self-monitoring (33", 0 errors, above average). A second test evaluating visual scanning and the ability to focus on target stimuli while ignoring irrelevant stimuli (Boston Cancellation Test) fell solidly within the average range on structured and unstructured subtests with novel and over-learned stimuli (Unstructured Symbol: 73", 0 omissions; Unstructured Letter: 63", 1 right and 1 left omission; Structured Symbol: 66", 0 omissions; Structured Letter: 78", 1 right omission). He was able to draw a clock to command and set the time to "10 after 11" without difficulty. On the Stroop Color test, a test of his ability to

focus on target stimuli while disregarding irrelevant stimuli, his performance fell within the average to the above average range. Phonemic fluency fell within the above average range (F=20, A=16, S=20). Semantic fluency fell within the average range (21 animals). On the Wisconsin Card Sorting test, Mr. Amodeo's performance was solid as he was able to complete four categories in 64 trials. He was able to complete the first category within 11 trials.

PSYCHOLOGICAL TEST RESULTS:

Response Style: Mr. Amodeo's responses on his MCMI-II, as well as other psychological tests, suggest no odd test taking behavior and he approached tests in an open and flexible manner.

Psychological Resources/Cognitive Organization: Mr. Amodeo's test results suggest he is in a state of mild, but chronic stimulus overload, making it difficult to access adequate psychological coping resources. This appears to be related to internal and external events that he is currently experiencing and may be related to psychological pain resulting in some object loss. This finding is somewhat unexpected, given evidence on testing that suggests the presence of above average adaptive capacities when compared to others. This leaves him at risk for recurrent episodes of anxiety, tension, nervousness and irritability. During times when he experiences limited frustration tolerance, he may be at risk for acting impulsively or demonstrating emotional outbursts. Currently, he appears to be experiencing substantial levels of intrusive ideation which he has little control over and may involve concern about his future and the lack of needs being met. Interestingly, Mr. Amodeo tends to take in more information than he can organize efficiently and he tends to examine situations to a point beyond necessity. However, when success hinges on his performance, he tends to harness this quality in a positive manner, utilizing it in an efficient manner. Conversely, in time demanding or more stressful situations, his over-incorporative style tends to interfere with effective decision making processes.

Reality Testing: Mr. Amodeo's test results suggest that when he is calm he has an increased chance of engaging in adequate reality testing. However, when he experiences shifts in his mood, resulting in experiencing more intense emotions, his reality testing becomes impaired. He gives evidence of experiencing a diminished ability to think logically and coherently and cannot keep a connected flow of ideas. As a result, he may demonstrate instances when he utilizes arbitrary and circumstantial reasoning and display moments where his thought processes are loose, scattered and confusing to himself and others. He may demonstrate ruminative and circumstantial thinking, ideas of reference and disorganized speech. During these times it may appear that he is out of touch with others and is unable to order his thoughts in a manner where he can adequately communicate with others. Testing suggests the presence of ideas of reference, feelings of grandiosity and irrational jealousy that reaches delusional (paranoid) levels. Cognitive mediation abilities are impaired in that he demonstrates mild to moderate impairment in his ability to form accurate impressions of himself and others. He is vulnerable to misinterpretation of the actions or intensions of others and may have difficulty anticipating the consequences of his own actions or recognizing the boundaries of appropriate behavior.

Although he does not appear to suffer from a pervasive psychotic disorder, Mr. Amodeo's test results suggest that he may suffer from "mini episodes" marked by disorganization, paranoia/suspiciousness, or delusions. This appears to be primarily related to his mood disorder in that his psychosis appears to fluctuate with the changes in the intensity of his mood state. He seems to work quite hard to manage his disorganized and sometimes odd thoughts and when his mood

symptoms are better managed, theses features are often within his awareness. When he is not suffering from rapidly shifting moods, he is typically able to utilize adequate reality testing abilities.

Affect/Impulse Control: Mr. Amodeo's results suggest he is susceptible to episodes of affective disturbance with marked features of depression and mania. While he may frequently be depressed and morose, at other times he may be erratically moody, complaining with underlying feelings of intense anger and discontent that may be directed in a passive aggressive or direct manner. Although he may not openly report feelings of depression, he gives evidence of being predisposed to affective malaise that interferes with his being able to function optimally. Mr. Amodeo shows a maladaptive way of processing affect in which he exerts little control over his emotions which does not suggest that he is incapable of self control, but rather, he chooses not to do so. His Depression Index via the Rorschach Exner Scoring system reached significant levels (5/5). His BDI-II score of 16 is elevated. Endorsed depressive features include feeling sad, discouraged about the future, decreased enjoyment, guilt, expectation to be punished, disappointment in self, self-critical thoughts, irritability, difficulty making decisions, difficulty with initiation, fatigue, decreased appetite with some weight loss and decreased interest in sex. His score of 1/20 on the BHS does not signify concerning levels of hopelessness.

Mr. Amodeo's manic episodes appear to involve a display of expansive and hostile character features, rather than euphoria. During these times he gives evidence of being talkative, restless, hostile, distractible, subject to tantrums and interpersonally disruptive. Evidence of emotional dyscontrol include feeling erratic, quick changing moods and feeling like things are out of control when things do not go as planned.

Mr. Amodeo denies suicidal ideation and his Beck Suicide Scale of 0 suggests no overt suicidality. Of note, his Rorschach Suicide Constellation Scale was clinically significant (8/8) suggesting some suicide potential. Risk factors include feeling emotions quickly and intensely, grandiosity, periods of decreased reality testing, impulsivity, anger and oppositional traits, and a sense of being disconnected from others. He endorsed one item on the Self-Destructive Potential MCMI-III scale including "I feel deeply depressed for no reason I can figure out." It is important to note that the discrepancy between his report of suicidal ideation and the strong indicators of suicide potential elucidated by this evaluation demonstrate diminished awareness which may have implications in treatment regarding his recognition of possible indicators of suicidality.

Self/Interpersonal: Mr. Amodeo's test results suggest he is not paying sufficient attention to himself and may purposefully self avoid; however, despite narcissistic and grandiose features, this tendency towards avoidance may be in effort to avoid engaging in negative self examination. When he does pay attention to himself, he may compare himself unfavorably to others or he may be sensitive to how his actions may affect others. He may attempt to deal with uncertainty about his image of himself or concerns about his self-value in an overly intellectualized manner and he may distort or overlook realistic considerations. Thus, his avoidance has a protective motivation. He appears to have a limited capacity to identify comfortably with others, despite a desire to be close to others. He appears to expect that interactions with others will be characterized by a larger measure of competition, rather than collaboration. Thus, he is at risk of approaching interpersonal relationships too assertively and aggressively. He tends to be a socially withdrawn person and be isolated. Although he may have many people in his life who are important to him, it may not be easy for him to establish and sustain meaningful interpersonal relationships.

Mr. Amodeo appears to experience limited and diminished self-esteem. He tends to have persistent self-deprecation and a tendency to undermine his constructive opportunities. His poor self image of feeling worthless and ineffectual may make ordinary stresses and responsibilities seem excessively demanding. He may have limited capacity to comfortably identify with individuals in his life may feel apprehension or mistrust towards others. His heightened anxiety may become associated with social avoidance. Additionally, his anxiety may cause him to appear edgy, restless and indecisive, which only further exacerbates interpersonal difficulties. He may have a history of feeling disappointed in others and may struggle with trusting and opening up to others because of a fear they will also disappoint him. Because he is not always able to trust others, it may lead to overt destruction, self-defeating behaviors, or expressions of anger. Because he may worry about the consequences of his overtly expressed anger, he may express resentment in a passive aggressive manner or withdrawal from others.

<u>Personality:</u> Mr. Amodeo's MCMI-III resulted in elevated scores on the narcissistic and antisocial personality traits.

Thank you for this referral. It was a pleasure working with Mr. Amodeo.

Susan Parks, Ph.D.

Licensed Psychologist

Neuropsychologist

Training Director, Neuropsychology Post Doctoral Training Program

Instructor in Psychology, Department of Psychiatry, Harvard Medical School

Mall

McLean Hospital Harvard Medical School		Amodeo, Frank 09/01/60		MRN: 170910	
115 Mill Street		08/12/08		Hall: Wyman Referral: Vuckovic	
Belmont, MA 02478	Age:			ucation: 19	
	Gender:	1			ál g
			T-Score 0-39	Level of Functioning	
ł.			40-59	Above average Average	
			60-64	Borderline	
1	Adult Neuropsychological To	est Battery	65-69	Mildly impaired	
8	Summary of Scores		70-79	Moderately impaired	
1	© 2001 Miles Tarter, Ps	y.D.	80-89 90+	Severely impaired	
Table of Contents	Raw	T-Score	26Ha	Profoundly impaired Level of Functioning	
Intelligence					
Vocabulary (WASI)	63	37	0004		
Similarities (WASI)	50	50	90% 50%	above average	
Block Design (WASI)	57	43	75%	average	
Matrix Reasoning (WASI)	53	47	61%	average	
Verbal IQ	109	44	73%	average	
Performance IQ	107	45	68%	average	
Full 4 IQ	109	44	73%	average	
Attention/Concentration					
Digits Forward (WMS-R) points	10	43	79%	average	
Digits Backward (WMS-R) points	8	44	73%	nverage	
Executive Controls					
Trails A	16	34	95%	above average	
Fmils B	33	29	98%	above average	
Cancellation Letters	NEWS TO A SHIP	46	68%	average	
Cancellation Symbols		49	58%	average	
Cancellation Structured	4	50	53%	average	
Cancellation Unstructured		45	73%	average	
OWAT emantic Fluency: Animals	56	30	98%	above average	
troop Word	21	55	34%	average	
troop Color	79	38 47	88%	above average	
troop Color/Word	43	47	61% 61%	average	. 1
nterference	-	55	30%	average	
isconsin Card Sorting Test	Errors=10	48	30%	average	
Perseverations	5	56		average	
Learing to Learn	0			within expeted range	- 1
anguage	121 - 212				
oston Naming Test (BDAE)	13 out of 15	Mean = 12.9	_ SD = 1.9	average	- 1
ocabulary (WASI) milarities (WASI)	63	37 50	90% 50%	above average	
			3070	average	
suospatial y-O Copy	31		2-5%	mildly impaired	
ock Design (WASI)	57	43	75%	average	
atrix Reasoning (WASI)	53	47	61%	average	
emory					
gical Memory I (WMS-R)	31	44	75%	average	
gical Memory II (WMS-R)	33	38	90%	above average	
gical Memory Recognition	18	86%		SAFRIOTE-	
gical Memory Retention	Nounce	106%			
LT-II SF; List A Trial I	4	SS -1.5		mildly impaired	
LT-II List A Trial 1-4	27	50	50%	average	1
LT-II Short Free	8	SS 0.5		average	
LT-II Long Free LT-II Long Cued	8 	SS I		above average	
LT-II Long Cued LT-II Recognition Hits	9 out of9	SS 1 SS 0.5		above average	
criminability	y out 619	SS 0.5		average	
nantic Clustering	Name of the last o	SS -0.5		above average	
ial Clustering	-	SS -0.5 SS 2.5		average above average	
Immediate Recall	18.5	54	34%	uverage	
Delayed Recall	71	49	53%	uverage	
Retention					

Imaging Center — McLean Hospital — MRI Report

AMODEO, Frank

HALL: Pavilion

MRN: 170910

Referred by Dr. Vuckovic

8/18/08 11:00 am

MRI OF PITUITARY WITH AND

WITHOUT CONTRAST

Clinical History

Hyperprolactinemia.

Technique

Sagittal T1 and coronal T1 weighted images were obtained before and after injection of contrast. Movement artifacts are present on many of these images.

Findings

Sella turcica is not expanded. The dorsum sella is asymmetric being larger on the right side and more hyperintense. This is likely insignificant. The pituitary itself is rather small. It has a concave superior margin. It is best seen on coronal T1 weighted noncontrast images no. 10 and 11. With injection of contrast, the enhancement is more or less homogeneous as seen on image no. 11. Infundibulum of pituitary is minimally shifted to the left side but no cause for this infundibula shift is evident on this examination. Suprasellar cistem is clear. Optic chiasm is unremarkable. No parasellar abnormality is seen.

Impression

I doubt there is any pituitary abnormality. Minimal deviation of infundibulum from right to left is likely insignificant. No pituitary or suprasellar mass is detected.

AAZ:

8/23/08

emp:

8/24/08

Amu A. 2 amam

Amir A. Zamani, M.D. 7:30 am

DATED: 8/28/08

Masor

Amodeo, Frank 170910 WYM

Recording Date:8/13/2008

Report Date: 8/13/2008

Background Activity:

This is a digitally acquired electroencephalogram. Both referential and differential montages are examined. Electrodes are placed in accordance with the international 10-20 system.

Alpha:

Frequency: 9-10 Hz

Amplitude: 40-70 uV

Location: Occipital

Alpha activity was symmetric and reactive to eye opening.

Beta:

Frequency: 15-28 Hz

Amplitude: 5-10 uV

Location: Anterior

Other Activity:

No focal slowing or epileptiform activity is noted. EKG reveals a sinus rhythm.

Hyperventilation:

Normal response.

Sleep:

Normal drowsiness and sleep. Stage I and II present. Loud snoring with snoring associated arousals occurred.

Photic Stimulation:

Normal photic response. A small amount of photic driving occurred between 15-20Hz.

Interpretation:

Normal awake, drowsy and sleep EEG. Loud snoring with snoring associated arousals suggest obstructive sleep disordered breathing. Clinical correlation and follow up of this finding is recommended.

Evan D. Murray, MD Department of Neurology McLean Hospital

42100

un Keyreer un r/s/08 Left exist deviation Inferior inferct, age undetermined the acula chauses Interpretation: *** Age and gender specific ECG analysis *** Left axis deviation GEMS ET MAC1200 FRANK AMODEO 000170910, MOBILEXUSA Male, 47 Years (09/01/1960) UNIT: PAU 404 ms 168 ms 108 ms 920 ms 916 / 14/ -33/ Measurement Results: 392 / FACILITY: MCLEAN P. RR/PP. P/QRS/T

McLean Hospital

115 Mill Street, Belmont, Massachusetts 02478-9106 Telephone 617 855-2000, FAX 617 855-3299

SUBSTANCE ABUSE CONSULTATION NOTE



Patient Name:

Frank Amodeo

Medical Record #:

170910

Date of Birth:

09/01/60

Date of Evaluation:

08/09/08

I was asked to see Mr. Amodeo for the purpose of a substance use consultation. The details of his psychiatric history are documented elsewhere in the chart.

Mr. Amodeo is a 47-year-old married white man who lives in Orlando, Florida with his wife. He stated that, with the exception of a sip of champagne at his own wedding, he has never consumed alcohol. He also denies any illicit substance use or abuse of prescription medications.

Mr. Amodeo did report a significant history of drinking stimulant beverages throughout most of his life. He said that he drank at least 1.5 gallons of caffeinated soda starting at age 9 or 10 when he was in Little League and that this pattern continued through age 16. Mr. Amodeo said that between ages 16 and 29 his consumption of caffeinated beverages increased to approximately 3 gallons per day. He noted that he typically would consume a pitcher of iced tea per sitting. Mr. Amodeo said that between ages 29 and 40, he was prescribed Isoclure for asthma. He said that when this medication was no longer available, he substituted 16 Sudafed tablets daily in addition to his 3-gallon per day consumption of caffeinated beverages. Mr. Amodeo said that he was "almost continuously manic" during this approximately 11-year period with the exception of a 6-month hiatus in 1999, during which he did not take any Sudafed and his consumption of stimulant beverages was reduced to approximately 1 gallon per day.

Mr. Amodeo said that at age 40 he began running in order to lose weight and improve his overall health. He noted that he no longer required Sudafed and found that whenever he had a cold or flu and took cold medication with a stimulant, he felt "buzzed" and the people around him noticed a significant elevation in his mood. He said that during this period, a psychologist named Dr. Lewis raised the suspicion of a possible bipolar disorder

Mr. Amodeo said that his physican recommended that Mr. Amodeo decrease his consumption of stimulant beverages and, prior to entering the McLean Hospital Pavilion, Mr. Amodeo was able to reduce his consumption from 3 gallons per day to 2 gallons per day and is working to further reduce his stimulant beverage consumption.

<u>Assessment</u>: In my opinion, Mr. Amodeo meets criteria for Stimulant Dependence in addition to his other psychiatric symptoms. The co-occurrence of chemical dependency and psychiatric illness suggests that a comprehensive treatment program must address both disorders simultaneously.

Mr. Amodeo acknowledged the ways in which stimulant beverage use has helped him to maintain a high level of energy throughout high school, where he earned a 3.9 GPA from Oakridge High School in Orlando, "mostly straight A's" from the University of Central Florida, and enabled him to attend Emory Law School during the day while pursuing a graduate degree in economics at night. Mr. Amodeo also acknowledged the ways in which stimulant beverage use has helped him to bolster his self-confidence and ability to manage multiple tasks simultaneously.

Mr. Amodeo acknowledged the extent of his stimulant beverage use during the past approximately four decades and the magnitude of the lifestyle changes that will be required to discontinue his dependency and cope with functioning at a less rapid pace. I believe that Mr. Amodeo would benefit from psychoeducation regarding the relationship between stimulant beverage use and his psychiatric instability, and urge Mr. Amodeo to continue individual psychotherapy in addition to psychopharmacological management to help maintain stability.

Recommendations

- Continue psychopharmacological and psychotherapeutic strategies to maintain stability.
- Continue to reduce stimulant beverage use under the supervision of a physician.

Jennifer Taylor, Ph.D.

Dyzlov

Subj:

RE: Frank A

Date:

8/14/2008 2:58:36 P.M. Eastern Daylight Time

From: 10:

JLcvinson@Levinsonharris.com Alpsy@aol.com

et, voila!

Frank Amodeo

John Levinson, MD, PhD Levinson Harris Medical Group 535 Boylston Street 7th Floor Boston MA 02114 Phone 617-247-3444 Fax 617-247-9444

Clinical summary for Frank Amodeo

Report: 08/14/2008

Unit No: 463-97-03

Age: 47

Birthdate: 09/01/1960

Address: 2875 S.orange Ave Ste500 1810

Orlando, fl 32806 home #: 407-855-0055 work #: 407-373-4351 Genl MD: T. Higgins Ref MD: Alex Vuckovic Last office visit: 08/14/2008

Next office visit: / / (approximate)

ECG: 08/14/2008: SR 77/-40 - LADEV, POSSIBLE OIMI, NSSTTWAS Main Dx: ABNL ECG, HTN

*** Family & Social Hx ***

Fhx: Stroke, Hypertension, Diabetes, Cancer

Spouse: Claire Holland

Occupation: President AGMI Strategy Co

SHx: Lives with spouse in Orlando. Trained in law/econ

Alcohol: Social alcohol Substance: No substance abuse

Caffeine: 3 or more/day

Diet: Ad lib

Exercise: Active with regular walking exercise

Tobacco: Never

*** Current Medications ***

Metoprolol

100 mg - 1 QD

Depakote

500 mg - 6 QD

Cpap

Threader A 11 AAAA .

Aspirin 81 mg - 1 QD

*** Allergy List ***

There are no allergies in the database for this patient

*** Problem List ***

- 1. ABNL ECG W ?IMI INA
- 2. HYPERTENSION
- 3. OBESITY
- 4. GLUCOSE INTOLERANCE
- 5. BIPOLAR DISORDER
- 6. SLEEP APNEA OBSTRUCTIVE

*** Procedure List ***

1. 08/13/2008 hs crp=0.572 (hi risk) tsh 2.42

*** Fluoroscopy List ***

There are no fluoroscopies in the database for this patient

*** Weights & Lipids ***

Date Wt Chol LDL HDL TG Ratio Medications

05/29/2008 F 0 248 167 49 162 5.0 08/14/2008 F 233 191 113 43 176 4.4

*** Visit Report ***

Visit Date: 08/14/2008 @ OFC

Weight: 233 pounds, with BMI of 37.6

Vitals: 125/80 @ 76 reg L=R

General: Healthy appearing centrally obese man HEENT: EOMI PERRL no arcus Dentition OK Skin: Without stigmata of cardiac disease

JVP: 5cm

Carotids: Normal in upstroke & without bruits

Thyroid: Normal, nonnodular
Chest: No dullness, clear to P&A
Cor: ?PMI, RRR w soft S4

Abdomen: NBS, Nontender, w/o masses, bruits, hsm Ext: No c/c/e, no stasis changes or ulcers, nl gait

Pulses: Full & symmetric UE's & LE's Neuro: Ox3, CN intact, general motor OK

Narrative:

Outpatient Cardiovascular Consultation

>> Chief Complaint.

Abnormal EKG, possible metabolic syndrome

>>Present Illness.

This is the first office visit for this 47 year-old man referred by Dr. Vukovich for the problems above among others. The patient is now at the Pavilion in order to have a thorough reassessment of his psychiatric status. He tells me that he has bipolar disorder with a significant manic component but that there is question as to how much of the illness and especially the mania are related to his work.

The coronary risk factors include hypertension which he says was only diagnosed perhaps three months ago, obesity, and gender. He is felt to have perhaps pre-diabetes as well but no one has diagnosed frank diabetes. He has never abused tobacco. There is no family history of atherosclerotic disease. With regard to known coronary cardiac risk factors, he has never used Redux for Phen-Fen, never had rheumatic fever.

His weight has been going up steadily. Three months ago, in response to LDL of 167 he tells me that his internist told him in no uncertain terms that he either needed to tighten up on the diet and lose weight or get medications by the fall. The patient has cut portions, almost completely discontinued snacks, and says he has lost 5 pounds. Follow-up labs which I have shown under today's date are significantly improved from the ones three months ago.

He says that he has progressive exertional dyspnea and he describes mild huffing and puffing which he believes is related to allergy and asthma as well as perhaps overweight. He does not have tightness or pain.

He has not had palpitations, syncope, presyncope, and so forth — but he does tell me that his heart rate has been noted to be fast and that has been attributed to the fact that he has about 25 cups each day of caffeinated tea.

He was diagnosed as having sleep apnea and started using CPAP just last month. He says he is compliant on a regular basis.

He says that he has not had cardiovascular noninvasive testing as we talked about echocardiography and stress testing given his abnormal EKG.

>>Allergies, Medications, Past Medical and Surgical History, Family Medical History.

See lists above. He is married but separated. He trained in the law and in economics and is now president of AQMI Strategy Corp. which purchases and turns around businesses then either liquidating or selling them. He says mostly they liquidate. His life is enormously stressful. He is now in a position where he is thinking very seriously about changing what he does do something much more relaxing.

>>Review of Systems.

Positives: Beyond the above he only notes the psychiatric and asthma-related issues. He has also recently had some trouble with his left foot as he has been exercising more at the urging of his physician in Florida.

Otherwise negative -- details to be found in the paper record

>>Physical Examination. Above

>>Laboratory.

Lipids from recently are shown above and are much better than studies from three months ago.

CRP is on the high risk side. TSH is normal.

Fasting sugar from back in May was 131 in Florida. Sugar more recently at 99 is top normal.

Renal function is normal.

Glycohemoglobin at 7.1 is elevated.

>>Assessment & Recommendations.

In summary, this is a 47-year-old man with issues as noted below. NOTE that he is unsure of his medications and believes that the metoprolol has been changed to some other similar medication. I believe he is on long-acting metoprolol.

ABNL ECG -

His EKG does indeed look like old inferior infarction. However, many people with this EKG will turn out never to have had infarction — it can be a false positive. With his various risk factors it is certainly worth knowing unequivocally. I believe that his huffing and puffing dyspnea is on the basis of deconditioning and overweight with perhaps an element of asthma — but this dyspnea is obviously another reason to proceed toward noninvasive testing.

>> nuclear treadmill stress test off metoprolol the day of the study
>> we will get these next week and he and I will confer by telephone with the
results.

OSA -

Sleep apnea diagnosed in being treated with CPAP.

HTN -Controlled nicely

LIPIDS -

His current lipids are fine for primary prevention unless he does indeed have diabetes. With his glycohemoglobin being 7.1 it may well be that we are moving in that direction. However, he has been losing weight and his lipids are clearly already better so I do not think it would be essential at this point to treat. If his stress test comes back positive for coronary disease we would be stuck treating him to the secondary prevention guideline. Same is true if his tendency toward diabetes does not resolve. Finally, he has an elevated CRP which would be another concern in this regard.

>> would recommend rechecking CRP with lipids in three months

PREVENTION -

Weight loss is going to be his major target. His blood pressure, sleep apnea, lipids, and glucose intolerance are all related to obesity. His dyspnea is probably also related to obesity. He is working hard and succeeding so for now I think there is nothing to do but continue. Of course we also spoke about his truly heroic caffeine consumption.

Thank you very much, Alex, for asking me to participate in this patient's care. Please let me know if I have missed anything important or if my speech recognition system has encrypted portlons of this letter to you.

Sincerely,

John R. Levinson, M.D. Ph.D.

Prepared by computer speech recognition - please excuse transcription errors

I am using the free version of SPAMfighter for private users. It has removed 2 spam emails to date. Paying users do not have this message in their emails. Try SPAMfighter for free now!



Affiliations: MA - Brigham and Women's Hospital * Beth Israel Deaconess Medical Center * Faulkner Hospital * Hallmark Health * Marlborough Hospital Massachusetts Eye and Ear Infirmary * McLean Hospital * New England Sinai Hospital * Southcoast Hospitals Group * NY - Beth Israel Medical Center

Date: 08/18/08

Re: Frank Amodeo DOB: 09/01/60

Dr. Alexander Vuckovic.

Dear Dr. Vuckovic:

Thank you for referring Frank Amodeo. He is a patient with obstructive sleep apnea. He is a 47-year-old man who has been in the pavilion undergoing a complete evaluation for possible bipolar disease. He has been on Depakote at 3000 mg and still states that he maintains a low level. He has gained weight with the Depakote, and that may be contributing in part to his sleep apnea.

The patient has had obstructive sleep apnea diagnosed previously in Florida, and he states that he was diagnosed a year ago, September 2007 in Orlando, and he has just started using CPAP July 2008. His symptoms are excessive daytime sleepiness and loud snoring. He has no longer been able to sleep with his significant other, and that has prompted him to start using his CPAP.

Sleep History: The patient goes to bed at approximately 11 to 11:30 p.m., wakes at 6:30 to 7:30 a.m. He thinks that he sleeps 6-7 hours in bed. Before Depakote he was taking a nap for an hour on Saturday and Sunday, and since he has been using Depakote he has been napping daily.

He has a nasal pillow for his CPAP and he does sleep on his side, so a mask change to a different type of nasal pillow may be warranted. Unfortunately he did not bring any of his equipment with him.

The patient considers himself retired.

He does not have symptoms of restless legs. He will wake up in the morning feeling his legs and feet somewhat weak and painful. He also notices that when he sits for a long period of time and then it goes away with movement.

The patient rarely has a feeling of being suffocated at night. He always snores and frequently wakes up gasping for air. He will wake once a night with the need to go to the bathroom.

Re: Frank Amodeo DOB: 09/01/60 Page 2

Epworth Sleepiness score is 13/24, and in the last 6-7 months he has had an unpleasant dry mouth in the morning.

Family History: Notes he has 2 children and 3 siblings. Mother is 64 and has had a stroke. Father is 67 and has had cancer. His children are age 22 and 18, and there is no known sleep apnea in the family.

Social History: The patient is married, has had a complicated business social situation. He does not consume ethanol or tobacco but does have 2-1/2 galloons of iced tea a day with sweetener. from a restaurant.

On exam Frank is 5 feet 6 inches tall, weighs 230 pounds. Neck is 47 cm. Blood pressure is 122/81, pulse is 71, and pulse oximetry 97% saturation. Mallampati score is III/IV. His uvula tends to sit on the back of his tongue. It folds. It is long and thick. I do not see significant tonsillar tissue, but there are prominent posterior tonsillar folds. His nose is blocked. He has used Nasonex in the past.

Medications: The patient has recently started Geodon and a different blood pressure medicine. He does not remember what, but he had been on Depakote at high dose of 3000 mg a day. He did feel that it helped, but it does not sound like he has ever been on Lamictal.

This patient has known sleep apnea. He had a polysomnogram on August 8, 2008 and it was done as a titration study as ordered, but he had some events at the lower pressures, 5 and 6 cm. At 5 cm of pressure his respiratory disturbance index was significantly elevated. It was considered 120, but that was only because it was a very short time until he went up to 6 cm. At 6 cm his respiratory disturbance index was 11.3, and he did very well at 10 cm with an index of 4.35. Snoring stopped at 10 cm, and he thinks that is what he set it at home.

Unfortunately the patient received his CPAP from Walgreens Home Care, and he has had no followup.

I suggested that the patient continue to use his CPAP at 10 cm. If he wanted to bring his machine in to check it, we would be happy to do that. He should be seen by a home care respiratory therapist when he gets back to Florida, which is his choice, and if he loses 20 or 30 pounds he might become a very good candidate for surgery. I would like to see him back any time the patient feels that it is necessary, but I understand he will be leaving in a few days.

Re: Frank Amodeo DOB: 09/01/60

Page 3

He clearly does have sleep apnea, does benefit from CPAP and I think now is more motivated to use it regularly. He understands more about maintenance and the importance of persistence.

Thank you very much for referring this patient.

Yours sincerely.

Sandra Horowitz, M.D.

South Hornity

Tel: 617-783-1441 Fax: 617-783-1458 Sleep HealthCenters

SH/712134/2264

CC:

Oriver 1



CPAP Polysomnography Report

Patient Name: Amodeo, Frank Patient D.O.B.: 9/1/1960

Patient Age: 47

Patient Gender: Male

Height: 65.0 In

Weight: 224.0 Lb

Test Date: 8/8/2008

Test Location: Framingham

Referring MD: Alexander Yuckovic, MD

<u>History:</u> The patient was diagnosed with sleep apnea by prior polysomnography. This study is performed to determine the appropriate CPAP pressure. He has been on CPAP for 6 weeks, but previous studies are not available.

<u>Technical Summary:</u> Attended in-laboratory recording montage included: EEG, EOG, EMG, EKG, nasal thermistor flow, nasal pressure, pharyngeal snoring, respiratory effort (2 channels), anterior tibialis EMG, SaO2 and body position. Continuous Positive Airway Pressure (CPAP) was initiated at the beginning of the study. This study was performed in accordance with the AASM scoring manual.

		Stage R Latency	64 min		1	PLM arousal index	0.0
		Stage R	33.6%			PLM Index	0.0
Sleep Latency	47 min	Stage N3	4.2%		1		+
Sleep Efficiency	85.8%	Stage N2	56.9%			1	
Total Sleep Time	360 min	Stage N1.	5.3%	Baseline SaO2	95.0%	1	+
Total Recording Time	419 min	WASO	12 min	Min SaO2	92.0%		-1
ALL NIGHT DATA			1.	<u> </u>	7	1]

CPAP was titrated from 5 to 13 cm of water pressure. A pressure of 11-13 cm of water was most effective and was observed during supine-REM sleep. in this study he had 41 apneas and hypopneas. At 5 cm h20 pressure he had frequent events that improved by 11 cm H20 pressure.

EKG Findings: Single-lead demonstrated no clinically significant abnormalities.

EEG Findings: Three channel EEG demonstrated no seizure activity.

Further Interpretive Notes: The patient reported that sleep was worse than usual, awoke feeling awake but not alert and would be willing to wear CPAP at home. He complained of many dreams during the night and light sleep.

Diagnosis:

Obstructive Sleep Apnea 327.23

Discussion:

- Treatment for moderate obstructive sleep apnea is often warranted even in the absence of clinical symptoms. Recommended options include positive airway pressure, custom-made oral appliances, or upper airway surgery. Regardless of treatment approach for the obstructive sleep apnea, maximization of nasal airway patency, weight loss if appropriate, and avoidance of sedatives and alcohol in proximity to bedtime are strongly encouraged.
- This study shows the effectiveness of CPAP in treating sleep-disordered breathing. Consider a trial of CPAP at 13 cm of water pressure during sleep with clinical follow-up to assess treatment response. It would be useful to have his pre CPAP data and to check his own CPAP for current pressure. History suggests he has a CPAP unit but has gained weight and may need an increased pressure.

Note was made of vivid dreams during the test and REM was early at 64 minutes. The may be a sign of sleep deprivation but is also noted with mood disorder and narcolepsy.



Clinical correlation is recommended for all patients undergoing polysomnography. Caution is recommended with driving or during other activities requiring alertness for safety.

Thank you for referring this patient for a sleep study and interpretation. If you have any questions or comments, please feel free to give us a call.

Sandra Horowitz, M.D., FRCP(C)

Board Certified in Sleep Medicine Medical Director, Sleep Health Centers at Framingham

Mivi

Nutrition Consult/ McLean Pavilion Program

Name: Frank Amodeo
Date of Consult: 8/12/08

<u>Referral Purpose</u>: To assess current nutrition status and eating behaviors and to make recommendations to help promote healthy weight management, optimal health and normalized eating.

Summary of Consult

Frank is a 47-year old man who comes to the Pavilion for treatment and evaluation of symptoms related to Bipolar Disorder. He notes an 18lb weight gain since November due to Depakote. This was on top of the 30lbs he had gained in the 8 years prior. He attributes weight gain to sedentary lifestyle and increased focus on work accompanied by a lot of stress. However, he has been controlling portions over the past 5-6 weeks after showing signs of insulin resistance. Frank has also started walking 4 miles most days at the beginning of July and is gradually rebuilding some muscular stamina.

Frank's weight is 222lbs, 156% of ideal weight for height of 5'6". His BMI is 36 placing him in the obese category and at risk for health complications. Labs on 8/07/08 indicate Hemoglobin A1c is elevated at 7.1, but glucose was normal at 99. Lipids were not available at time of consult. Moderate weight loss of 10-15% would significantly improve blood sugar regulation and help prevent high cholesterol/ heart disease in the future. This would be a weight goal of 190-200lbs. Recommend working toward this over the course of the year and reevaluating at that point.

Frank reports that his diet until recently consisted mainly of calorie dense fast food. His eating per recent diet recall has improved some now that he is being mindful about choices. A typical day includes two eggs with cheese or an omelet, bacon and wheat toast (at a diner), a roast beef or turkey sandwich for lunch and a filet mignon, baked potato with butter and vegetables for dinner. Although this is an improvement, Frank would benefit from decreasing saturated fat and increasing intake of fruits and vegetables. It may be helpful for him to work with a dietitian who can help him strategize around making gradual dietary changes.

Frank notes a tendency to turn to high carbohydrate foods to elevate his mood. Caffeine serves this purpose as well; "it counteracts the depression". Food also offers distraction and pleasure. Frank goes on to say that he tends to snack more when anxious. He would benefit from developing some alternative coping skills and increasing awareness of physical hunger cues.

Although Frank drinks a lot of caffeinated beverages, he takes in very little other fluid, including water. He drinks 3 gallons of iced tea a day which is a decrease from the 5-6 gallons he was drinking a couple months ago. Caffeine could be contributing significantly to anxiety and it would be beneficial for him to gradually cut back and add in more water. Frank has started taking fish oil pills (6g/day). Also recommend a multivitamin and B-complex due to high level of stress.

Recommendations

- Gradual weight loss of 10-15% (190-2001bs)
- · Decrease saturated fat in diet (i.e. cheese, red meat, butter)
- Increase fruit and vegetable intake

- Increase intake of lean proteins (fish, chicken, beans, tofu)
- Regular exercise 45-60 minutes a day optimally for weight loss, starting at low intensity and gradually progressing
- Continue fish oil supplement
- Add multivitamin and B-complex
- Gradually cut down on iced tea to ≤ 40oz a day and increase water/other fluids
- Work with a dietitian around weight loss
- Avoid concentrated sweets (juice, sugar, sweets)
- Good regulation of blood sugar

Amy Gleason Gardner, MS RD Nutrition Therapist Pavilion Program, McLean Hospital 617-855-2268

1550 rev 08/02

McLean Hospital Progress notes

Page /

	No. Name Transle Asom do -
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8/11/08	
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McLEAN HOSPITAL
PROGRESS NOTES

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NORTH SHORE MEDICAL CENTER LABORATORIES

Page 1

Salem Hospital Laboratory 81 Highland Ave Salem, MA 01970 (978)741-1215 Ext. 4134

NITRITE UA

Union Hospital Laboratory 500 Lynnfield St Lynn, MA 01904 (781)581-9200 Ext 3456

***** LABORATORY REPORT *****

	AAAAA LABORATORY	REPORT *****	
Patient: AMODEO, FRANK Unit # : 10226283 Acct # : 001046797880 DOB : 09/01/1960 Phone #: 617-855-2000	Loc: MCLNPAV Sex: M Age: 47Y	Copy To Phys: VUCKOVIC, ALEXA	
1110110 #. 617-855-2000	U.	Printed: 08/07/2008 at 06:31	
TEST	ABN RESULT	NORMALS UNITS	
			========
08/06/2008 at 12:30	Or	dering Physician: VUCKOVIC,	
URINE DRUG SCREEN AMPHETAMINES (U) BARBITURATE (U) BENZODIAZEPINES (U) CANNABINOIDS (U) COCAINE METAB (U) OPIATES (U) DAU COMMENT		[NEG] [NEG] [NEG] [NEG] [NEG] [NEG] [NEG] positive screening results sl	
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{NS} = Processed and/or performed at NSMC, 81 Highland Ave/ Salem, MA

NEG

[NEG]

NS

NS

Page 1

NORTH SHORE MEDICAL CENTER LABORATORIES

Salem Hospital Laboratory 81 Highland Ave Salem, MA 01970 (978)741-1215 Ext 4134

Union Hospital Laboratory 500 Lynnfield St Lynn, MA 01904 (781)581-9200 Ext 3456

**** LABORATORY REPORT ****

Patient: A	MODEO, FRANK
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Unit # : 10226283

Acct # : 001046816771

DOB : 09/01/1960 Phone #: 617-855-3574

Loc: MCLNPAV Sex: M

Copy To Phys: VUCKOVIC, ALEXANDER

Age: 47Y

Printed: 08/08/2008 at 06:30

ABN RESULT NORMALS

08/07/2008 at 08:00 Ordering Physician: VUCKOVIC, ALEXANDER

COMPLETE BLOOD COUNT						
WBC		10.20				
RBC		4.66	,	[4.0-11.0]	K/uL	NS
HGB				[4.60-6.20]	M/uL	NS
HCT		14.1		[14.0-18.0]	G/DL	NS
MCV		40.8		[40.0-54.0]	8	NS
MCH		87.5		[81.0-99.0]	FL	NS NS
MCHC		30.3		[27.0-31.0]	PG	
PLATELET		34.7		[32.0-36.0]	G/DL	NS
		204		[150-450]		NS
RDW-CV		14.2		[11.0-16.0]	K/uL	NS
DIFFERENTIAL				[22.0-10.0]	6	NS
NEUTROPHIL	L	47.6		[54.0-62.0]		
LYMPHOCYTE	H	41.3		[25.0-33.0]	용	NS
MONOCYTE	H	8.5			%	NS
EOSINOPHIL		2.0		[3.0-7.0]	%	NS
BASOPHIL		0.6	1	[0.0-3.0]	용	NS
ABS NEUT COUNT		4.80	1	[0.0-1.0]	용	NS
COMP METAB PANEL		2.00	//	[1.8-7.0]	K/UL	NS
SODIUM		141	11	₽ 1772 € 1765		3000000
POTASSIUM		4.3	11/1 - 1	[135-146]	MEQ/L	NS
CHLORIDE		100	11/ 2	[3.6-5.0]	MEQ/L	NS
CARBON DIOXIDE			100	[100-110]	MEQ/L	NS
ANION GAP		28	6,0	[20-29]	MEQ/L	ns
GLUCOSE		13	V	[8-16]	meg/L	
BUN		99	0	[65-99]	MG/DL	NS
CREATININE		18		[5-21]	MG/DL	NS
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CALCIUM		9.0		[3.3-4.8]	G/DL	NS
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ALK PHOS		68		[0.4-1.2]	MG/DL	NS
ALT	H	41		[0-100]	U/L	NS
AST	11			[0-35]	IU/L	NS
JIPID PANEL		25		[0-46]	U/L	NS
CHOLESTEROL					Series of Control	TAID
CITOTED LEVOR		191		[0-200]	MG/DL	NS
					/	745

NORTH SHORE MEDICAL CENTER LABORATORIES

Page 2

Salem Hospital Laboratory 81 Highland Ave Salem, MA 01970 (978)741-1215 Ext 4134

Union Hospital Laboratory 500 Lynnfield St Lynn, MA 01904 (781)581-9200 Ext 3456

**** LABORATORY REPORT ****

Patient: AMODEO, FRI	Patie	at:	AMODEO	. FRANK
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Unit # : 10226283

Acct # : 001046816771

: 09/01/1960

Phone #: 617-855-3574

Loc: MCLNPAV

Copy To Phys: VUCKOVIC, ALEXANDER

Sex: M

Age: 47Y

Printed: 08/12/2008 at 06:30

TEST

======================================	ABN RESUI	T ======		NORMALS	UNITS	
08/07/2008 at 08:00		0		Physician:	VUCKOVIC, AL	
LIPID PANEL TRIGLYCERIDE HDL CHOL/HDL LDL NON HDL CHOL DEPAKENE CORTISOL AM	(CON 176 43 4.4 113 148.6 87	TINUED)		[0-250] [>39] [<5] [40-130]	MG/DL MG/DL MG/DL MG/DL UG/ML	ns ns ns ns
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08/12/08 06:41 North Shore Salem Medical Center (978)741-1215

Page 5

NORTH SHORE MEDICAL CENTER LABORATORIES

Page 3

Salem Hospital Laboratory 81 Highland Ave Salem, MA 01970 (978)741-1215 Ext 4134

Union Hospital Laboratory 500 Lynnfield St Lynn, MA 01904 (781)581-9200 Ext 3456

***** LABORATORY REPORT ****

Patient: AMODEO, FRANK

Unit # : 10226283 Acct # : 001046816771

DOB : 09/01/1960

Phone #: 617-855-3574

Loc: MCLNPAV

Copy To Phys: VUCKOVIC, ALEXANDER

Sex: M Age: 47Y

Printed: 08/12/2008 at 06:30

TEST

ABN RESULT

H

NORMALS

08/07/2008 at 08:00

Ordering Physician: VUCKOVIC, ALEXANDER

CARDIO CRP

CARDIO CRP

(CONTINUED)

[0.00-0.30]

MG/DL

0.572 Relative Risk (Cardiac)

Low: <0.10 mg/dl

Average: 0.10- 0.30 mg/dl

High: >0.30 mg/dl

PERFORMED AT:

NORTH SHORE MEDICAL CENTER

500 LYNNFIELD STREET

LYNN, MA 01904

{MC} = Processed and/or performed at Mayo Clinic, Rochester, MN.

(NS) = Processed and/or performed at NSMC, 81 Highland Ave, Salem, MA

(UH) = Processed and/or performed at Union Hosp., 500 Lynnfield St, Lynn, MA

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Page 1

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Union Hospital Laboratory 500 Lynnfield St Lynn, MA 01904 (781)581-9200 Ext 3456

***** LABORATORY REPORT ****

TOTTO . MINODEO . FRANK	Patient:	AMODEO.	FRANK
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Unit # : 10226283 Loc: MCLNPAV Copy To Phys: MCLEAN, NON-STAFF

ABN RESULT

Acct # : 001046899736 : 09/01/1960

Sex: M Age: 47Y

Phone #: 617-855-3574 Printed: 08/13/2008 at 14:05

TEST

NORMALS UNITS

08/12/2008 at 08:00		Ordering Physician:	MCLEAN, NON-S	TAFF
LIVER PANEL TOTAL PROTEIN ALBUMIN BILIRUBIN, TOTAL DIRECT BILI ALK PHOS ALT AST DEPAKENE FREE T4 FT4	6.8 3.6 0.4 0.0 53 H 45 25	[6.1-8.3] [3.3-4.8] [0.4-1.2] [0.0-0.2] [0-100] [0-35] [0-46] [50-100]	G/DL G/DL MG/DL MG/DL U/L IU/L U/L U/L UG/ML	NS NS NS NS NS
PROLACTIN	0.6 24	[0.6-1.6] REFERENCE RANGE: (I MALE: FEMALE:	NG/DL NG/ML NG/ML) 3-13	
PSA TOTAL T3 ANTI-HAV ANTI HBC HBSAB HBSAG IEP C ANTIBODY JEX HORM. BIND. GLOB	1.3 108 NEG NEG NEG NEG	PRE-MENOPAUSAL: POST-MENOPAUSAL: [0.0-4.0] [87-178] [NEG] [NEG] [NEG] [NEG] [NEG]	3-27 3-20 NG/ML NG/DL	
SHBG	6.9 Reference	range: 10 to 60	nmol/L	

{NE} = Test performed by Mayo Medical Laboratories New England, Wilmington, MA [NS] = Processed and/or performed at NSMC, 81 Highland Ave, Salem, MA

Vrinor

U8/15/U8 16:08 North Shore Salem Medical Center (978)741-1215

NORTH SHORE MEDICAL CENTER LABORATORIES

Page 1

Salem Hospital Laboratory 81 Highland Ave Salem, MA 01970 (978)741-1215 Ext 4134

Union Hospital Laboratory 500 Lynnfield St Lynn, MA 01904 (781) 581-9200 Ext 3456

***** LABORATORY REPORT *****

Patient: AMODEO, FRANK

Unit # : 10226283 Loc: MCLNPAV Copy To Phys: MCLEAN, NON-STAFF Acct # : 001046975031

Sex: M

DOB : 09/01/1960 Age: 47Y

Phone #: 617-855-3574 Printed: 08/15/2008 at 16:00

ABN RESULT NORMALS

08/15/2008 at 08:00

Ordering Physician: MCLEAN, NON-STAFF

DEPAKENE

83

[50-100]

UG/ML

[NS] = Processed and/or performed at NSMC, 81 Highland Ave, Salem, MA

NORTH SHORE MEDICAL CENTER LABORATORIES

Page 1

Salem Hospital Laboratory 81 Highland Ave Salem, MA 01970 (978)741-1215 Ext 4134

Union Hospital Laboratory 500 Lynnfield St Lynn, MA 01904 (781)581-9200 Ext 3456

***** LABORATORY REPORT ****

Patient: AMODEO, FRANK

Jnit # : 10226283

Acct # : 001047008592

DOB : 09/01/1960

Phone #: 617-855-3574

Loc: MCLNPAV

Copy To Phys: MCLEAN, NON-STAFF

Sex: M Age: 47Y

Printed: 08/19/2008 at 06:30

PEST

ABN RESULT

NORMALS

UNITS

08/17/2008 at 21:30

==========

Ordering Physician: MCLEAN, NON-STAFF

JRINE DRUG SCREEN AMPHETAMINES (U) BARBITURATE (U) BENZODIAZEPINES (U) CANNABINOIDS (U) COCAINE METAB (U) OPIATES (U) DAU COMMENT

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[NEG] [NEG] [NEG] [NEG] [NEG] [NEG] Please Note:

NS NS NS NS NS NS NS

Unconfirmed positive screening results should not be used for non-medical purposes.

Confirmation may be performed at physician's

request.

ETHANOL (U)

NEG

[NEG]

[NS] = Processed and/or performed at NSMC, 81 Highland Ave, Salem, MA

08/19/08 16:11 North Shore Salem Medical Center (978)741-1215

Page 1

NORTH SHORE MEDICAL CENTER LABORATORIES

Page 1

Salem Hospital Laboratory 81 Highland Ave Salem, MA 01970 (978) 741-1215 Ext 4134

Union Hospital Laboratory 500 Lynnfield St Lynn, MA 01904 (781)581-9200 Ext 3456

***** LABORATORY REPORT ****

Patient: AMODEO, FRANK

Unit # : 10226283

Acct # : 001047032857

Loc: MCLNPAV

Copy To Phys: VUCKOVIC, ALEXANDER

Sex: M DOB : 09/01/1960 Age: 47Y

Printed: 08/19/2008 at 16:00

Phone #: 617-855-3574

ABN RESULT

NORMALS

08/19/2008 at 08:00

Ordering Physician: VUCKOVIC, ALEXANDER

DEPAKENE

TEST

73

[50-100]

UG/ML

{NS} = Processed and/or performed at NSMC, 81 Highland Ave, Salem, MA

l qvav