KLINIKUM HANAU gGmbH

Clinic for Neurology

Director:

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Dr. med. H. Baas, private university lecturer

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Mr.
Buren Berglund
Nelkenweg 1 b

63456 Hanau

To pass on to primary care physician

Our ref. ???

Contact Dr. ???

Date. 20 April 2007

Patient: Berglund, Buren, born on 18 Nov. 1945, res. Nelkenweg 1 b in 63456 Hanau

Dear Colleague:

I am reporting concerning the above referenced patient who last came to my office as an outpatient on 15 March 2007.

Diagnosis: Morbus Parkinson

The patient's medical history is known; I refer to previous reports.

In the past medical history the patient complained in particular about morning akinesia during the time of 6-10 am as well as stiffness in the evening after 9pm. The current medication as 5 x 125 mg Dopa-Dura, 4 x 0.7 mg Sifrol as well as 5 x 200 mg Comtess.

During the course of the day under this medication, a light end-of-dose akinesia was described with a 3-4 hour effectiveness of individual doses.

During the current examination, the patient was in an on-phase with overall sufficient mobility and only little effects in the walking pattern. In the area of brain nerves clear dysatrophy and clear hypomimia.

Concerning the future treatment, the patient was advised to slightly increase the dosage to a total of 6 x 125 mg Dopa-Dora or 125 mg Madopar LT early in the morning with a simultaneous increase of the Sifrol dosage to 6 x 0.7 mg and increase of the Comtess dosage

With best regards,

Dr. med. H. Baas, private university lecturer
Director
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Mr.
Buren Berglund
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63456 Hanau

To pass on to primary care physician

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Our ref. ??Dr. Rn/AP

Contact Fr.

Date 20 March 2007

Patient: Berglund, Buren, born on 18 Nov. 1945, res. Nelkenweg 16 in 63456 Hanau

Dear Colleague:

I am reporting concerning the above referenced patient who came to my office as an outpatient again on 15 March 2007.

Diagnosis: Morbus Parkinson

The patient's history is known; I refer to previous reports. In the past medical history the patient reported that without changes in the medication, an increase of morning akinesia was experienced during the time of 6-10. No complaints about dyskinesia, for the other times of the day, a slight end-of-dose akinesia was reported with about 3-4 hour effectiveness of a single dose of L-Dopa.

During the examination, the patient was in an On-phase. There was a slight fine-motoric bilateral dysfunction, the walking pattern was hardly affected. In the area of brain nerves moderate dysartrophy as well as hypomimia. Posture slightly bent over and bonded, light to medium-grade bilateral rigor.

Concerning further treatment, a redistribution and slight increase in dosage of the previous medication was recommended in accordance with the table that was given to the patient.

With best regards,

Dr. med. H. Baas, private university lecturer
Director
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KLINIKUM CITY OF HANAU

Clinic for Neurology

Director:

Dr. med. H. Baas, private university lecturer

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Mr.
Buren Berglund
Nelkenweg 16

63456 Hanau

To pass on to primary care physician

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Our ref. ??

Contact Dr. ???

Date ?? ?? ????

Patient: Mr. Buren Berglund, born on 18 Nov. 1945, res. Nelkenweg 16 in 63456 Hanau

Dear Colleague:

I am reporting again concerning the above referenced patient who came to my office as an outpatient again on 23 August 2005.

Diagnosis: Morbus Parkinson

The patient's history is known; I refer to previous reports. In the past medical history the patient reported that the level was satisfactory until about 4-8 weeks ago. Currently, there are complaints about an increase of end-of-dose akinesia as well as night-time akinesia. The current medication is 4 x 125 mg Dopa Dura, 4 x 0.7 mg Sifrol as well as 4 x 100 mg Comtess.

During the current follow-up examination, the psycho-pathological diagnosis was regular. In the area of brain nerves clear hypomimia, in the area of the extremities bilateral Brady kinesis, during examination of walking pattern, a clearly bonded walking pattern. Currently no tremors.

Overall, the symptoms of the patient compared to the previous examination increasingly shows a slight under-dosage and the start of end-of dosage akinesia. A schedule to increase the above medication was therefore given to the patient. The effect remains to be observed, a follow-up appointment was set.

With best regards,

Dr. med. H. Baas, private university lecturer
Director
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Director:

Klinikum Stadt Hanau * P.O. Box 21 64 * 53411 Hanau

Dr. med. H. Baas, private university lecturer

EPI Crisis

Telephone (0 61 81) 2 96-63 10
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Our ref. ??

Contact Dr. B/uw

Date 21 Sep 2004

Patient: Berglund, Buren, born on 18 Nov. 1945, res. Nelkenweg 16 in 63456 Hanau

The above referenced patient last came to my office as an outpatient on 20 Sep. 2004

Diagnosis: Morbus Parkinson

The patient's medical history is known; I refer to previous reports. . In the past medical history the patient reported increased difficulties walking. The current medication is continued with 4 x 0.7 mg Sifrol as well as 4x 125 mg Dopa Dura. When asked, the patient complained about the onset of en—of-dosage akinesia, no dyskinesia.

During the current follow-up examination, the psycho-pathological diagnosis was regular. Clear hypomimia and low-grade dysarthrophy. Predominantly left sided slight to medium-grade Brady kinesis. Slightly bonded walking pattern, currently no tremors.

Concerning the future treatment I suggested the additional intake of 4 x 100 mg Entacapon to the patient for the beginning fluctuation with end-of-dosage akinesia. The effect remains to be observed, a follow-up appointment was agreed to.

With best regards,

Dr. med. H. Baas, private university lecturer
Director
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Our ref. ??

Contact Dr. B/uw

Date 06 Feb 2004

Patient: Berglund, Buren, born on 18 Nov. 1945, res. Nelkenweg 16 in 63456 Hanau

The above referenced patient last came to my office as an outpatient for a check-up on 28 Jan. 2004.

Diagnosis: Morbus Parkinson at stage 2-3 according to Hoehn & Yahr

The patient's medical history is known; I refer to my previous reports. In the past medical history the patient reported that the previously reported tremor increased slightly, additional there were complaints about a morning akinesia with otherwise sufficient mobility. The preventative medication with 4 x 0.7 mg Sifrol and 4x 125 mg Dopa Dura has been continued without a change, significant side effects have not occurred. The patient is not subjectively hindered in the motor skills involving every day activities.

During the current follow-up examination, a slight to medium-grade characteristic Parkinson syndrome in stage 2-3 in accordance to Hoehn & Yahr was found. A tremor was not evident during the actual examination, the mobility overall was sufficient. Concerning the future treatment I recommended an unchanged continuation of the previous medication. A follow-up appointment was recommended in about 6 months.

With best regards,

Dr. med. H. Baas, private university lecturer
Director
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Our ref. ??

Contact Dr. B/uw

Date 06 Aug 2003

Patient: Berglund, Buren, born on 18 Nov. 1945, res. Nelkenweg 16 in 63456 Hanau

The above referenced patient came to my office for an outpatient check-up on 31 July 2003.

Diagnosis: Morbus Parkinson

The patient's medical history is known; I refer to previous reports.

In the past medical history the patient reported that 2 weeks prior a thromboses in the leg veins occurred with known familiar clotting. The increase of the Sifrol medication to 4 x 0.7 mg Sifrol brought an improvement of the motor skills. No complaints about significant side effects.

During the current follow-up examination the extrapyromidalmotoric dysfunction had improved significantly. The walking pattern was still bonded, there still was clear fine motoric dysfunction of the left hand as well as a slight slowness of the left leg.

Overall, the patient seems to be well adjusted with the current medication. I recommended an unchanged continuation of the previous medication as well as a follow-up appointment in about 6 months.

In regards to the initiated Macumar medication interaction with changes of the TPZ through the accompanying medication with Sifrol can certainly not be ruled out, respectively tight controls of the TFZ and respectively the INR are recommended.

With best regards,

Dr. med. H. Baas, private university lecturer
Director
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EPI CRISIS

Our ref. ??

Contact Dr. B/uw

Date 06 Aug 2003

Patient: Berglund, Buren A., born on 18 Nov. 1945, res. Nelkenweg 16 in 63456 Hanau

I report briefly the results of the additional diagnostic results of the above referenced patient:

EEG Result: Well pronounced Alpha EEG around 10.5 Hz without hard result or seizure specific potential.

AEP Result: ???, regular peaks and IPL.

With best regards

Dr. med. H. Baas, private university lecturer
Director
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Our ref. ??

Contact PO Dr. Baas/v.N.
Date 16 June 2003

Patient: Berglund, Buren A., born on 18 Nov. 1945, res. Nelkenweg 16, 63456 Hanau

Dear Colleague:

I report about the above referenced patient who first came to my office for an outpatient examination on 12 June 2003.

Diagnosis: Parkinson Syndrome

In the past medical history the patient reported that a tremor of his left arm first occurred in 1998. In further course it then came to a fine-motoric dysfunction on the left, later also on the right, overall pregredient symptomatic. An initially performed cCT and EEG remained without pathological results. Under initial therapy with an L-Dopa medication, a stable improvement of the motoric took place over the course of several years. Currently the patient complains now abut an increased end-of-dosage akinesia. The current medication was 3 x 0.7 mg Sifrol, 4 x 125 mg Dopadura as well as the intake of various anti-hypertension meds. When asked, psychosis or dyskinesia was not confirmed.
The family medical history shows a noteworthy familiar indisposition with illness of numerous male family members.

During the current examination the pathological result was regular. In the area of brain nerves clear hypomimia as well as slight dysarthrophy. In the area of the extremity motoric left-sided Brady kinesis. Muscle tone in the sense of a rigora bilateralis slightly elevated, slight resting tremor of the right arm. Walking pattern overall bonded with left-sided lowered pendulum movements, standing tests unsecure also under increased difficult condition. Reflex behavior regular..

In summary, this is a case of Parkinson Syndrome, currently in stage 3 - according to Hoehn & Yahr. Overall, the patient seems under-medicated, I have therefore recommended an increase of the Sifrol dosage to 4 x 0.7 mg. Finally, I request ***Wv.***. A transfer of externally performed diagnostic measures for the family members has also been requested.

With best regards,
Dr. med. H. Baas, private university lecturer
Director
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DR. MED. GERD GALLE
Neurologist and Psychiatrist
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Dr. med. Gerd Galle * Stadtmühlweg 4 * 92637 Weiden / OPP

Friday, 21 Aug. 1998
Dr. Ga / Sl

Joint practice
Dr. med. Horst Hanak
Dr. med. Josef Aloia Lechner
General Practitioners
Neue Amberger Str. 6

92655 Grafenwöhr

Fax (09641) 91804

Mr. Berlund Buren A. born 18 Nov. 1945
Res. 91261 Kirchenthumbach, Heidestr. 2

Diagnosis Morbus Parkinson

Dear Colleagues:

I examined the above patient on 20 August 1998.
The family is said to have a very significant imposition for Morbus Parkinson. He has problems with the left arm for a while, it trembled.

EXAMINATION RESULTS
NEUROLOGICAL
A hypomimia can be found in the brain nerve area.
Modest rigor on the left arm, modest akinesia on the left arm. Modest idle tremble. No pareses. Normal reflex behavior. No pyramidal tract signs. No sensibility dysfunctions.

EEG
Lower tension EEG, high level of underlying radioactivity. No found source. No potential for spasms.

UDS
Supraorbital on both sides orthogradal flow. With compression of extern??? No change in flow. In the fork area on both sides of externa and interna it can be well differentiated, with normal perfusion noise.

CRANIUM CT
Medium, normal width of ventricle system. No pathological density changes in brain parenchum. Infected hardening of left maxillary sinus. Orbital sinus with normal content.

This is a clinical Parkinson Syndrome with al three cardinal symptoms. A cerebral process could be ruled out by computer topography. I have started a medical treatment with 3 x 1 Madopat 125.

With best regards,

(Dr. med. G. Galle)

DR. MED. GERD GALLE
Neurologist and Psychiatrist
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Friday, 21 Aug. 1998
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Joint practice
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Dr. med. Josef Aloia Lechner
General Practitioners
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92655 Grafenwöhr

Fax (09641) 91804

Mr. Buren A. BERGLUND, born 18 Nov. 1945
Res. Kufmainer Strasse 40, 95506 Immxxxxxx

Diagnosis Unknown ??? Parkinson

Dear Colleagues:

I examined the above patient on 09 June 2000.
The medical history is well known. The patient has taken 3 x 125 mg Madopar, also did physical therapy. Nevertheless, left side deteriorated.

EXAMINATION RESULTS
NEUROLOGICAL
Hypomimia and hypertosis of neck muscle tissue and rigor of left sided extremities. No tooth rotting phenomenon. Distinct Parkinson tremor, in???. In resting position. Walk was bonded on left side.

I have given the patient prescription in addition to Madopar in form of Dopergin 0.3 mg, 20 tablets. Of these, he should daily take respectively 1/? tablet in the first and second week, starting in the third week one tablet. If side effects occur he should contact me. He may not stop taking the medication on his own account. Before he finishes the medication he should come back for a follow-up examination.

With best regards,

On behalf of Dr. Med. R ????
Dr. Med. G. Galle

PS: The wife brought an article that the company Upjohn has brought a new antagonist to market. She should find out the name of the medication, so that we can discuss it the next time.