

A F F I D A V I T

Before me, personally appeared Mr. Menford Bersing and his wife Harriet Bersing, who upon being duly sworn, depose and say as follows:

The drug LEUKERAN was prescribed for Mr. Menford Bersing, by his Physician, and was taken by Mr. Bersing for approximately one year. The attached Xeroxed copies of Mr. Bersing's Pharmaceutical Prescriptions, issued by his Physician, were never filled since his introduction to the ALOE VERA GEL.

The Prescriptions were accepted as a precautionary measure, to have in his possession, to be filled, if the need would have arisen.

The discontinuation of the drug, LEUKERAN, was done on Mr. Menford Bersing's own initiative, without the knowledge or consent of his Physician.

FURTHER AFFIANT SAYETH NAUGHT.

Menford Bersing  
Mr. Menford Bersing  
Harriet Bersing  
Mrs. Harriet Bersing

SWORN TO AND SUBSCRIBED, BEFORE ME, THIS 15<sup>th</sup> DAY OF OCTOBER, 1985.

Edmond B. Hedio  
Notary Public

(SEAL)

My Commission expires:

A F F I D A V I T

Before me, personally appeared Mr. Menford Bersing and his wife Harriet Bersing, who upon being duly sworn, depose and say as follows:

Both of us, Mr. Menford Bersing and my wife Harriet Bersing have carefully gone over the attached Medical History of Mr. Menford Bersings' bout with Cancer and his cure of Cancer with drinking the GENUINE ALOE VERA GEL, and ATTEST that all INFORMATION contained in this report is true and accurate and all personal history is factual.

FURTHER AFFIANTS SAYETH NAUGHT.

Menford Bersing  
Mr. Menford Bersing-Patient

Harriet Bersing  
Mrs. Harriet Bersing-Wife

SWORN TO AND SUBSCRIBED, BEFORE ME, THIS 15<sup>th</sup> DAY OF OCTOBER, 1985.

Edmund C. Stodie  
Notary Public

SEAL

My Commission Expires:

6-8-86

Stamp.

006

LA CROSSE LUTHERAN HOSPITAL  
DISCHARGE SUMMARY

Patient Menford Bersing Clinic No. 31 62 47 Room No. \_\_\_\_\_

DATE OF ADMISSION: October 16, 1975

DATE OF DISCHARGE: October 24, 1975

SUMMARY: This 75-year-old gentleman was admitted for evaluation of continuing weight loss and recurrent episodes of epigastric pain, nausea, and vomiting. His history was consistent with an intermittent intestinal obstruction. He was given a bowel prep and taken to surgery at which time a small bowel lymphoma was found and a segmental resection of the distal ileum was found. Postoperatively he did quite well. He was seen by the hematology service who recommended a Cytosan, Prednisone, Vincristine type of therapy. His final path diagnosis came back malignancy lymphoma, 80% mixed lymphocytic type and 20% histiocytic with mesenteric extension. Margins of resection were free of tumor. He was discharged on October 24, 1975, with the skin sutures removed prior to discharge.

DISCHARGE MEDICATIONS: 1. Darvon compound, 1 q.4hours p.r.n. pain.


He was started on weekly injections of B-12, 100 mg. I.M. for one month and he will return to see Dr. Schaldach and Dr. Keimowitz in one week.

FINAL DIAGNOSES: 1. Malignant lymphoma of small bowel.

COMPLICATIONS: None.

CONSULTATIONS: Dr. Keimowitz.

PROCEDURES: 1. Resection of terminal ileum.

  
Emma K. Ledbetter, MD/Fred A. Schaldach, MD/jmo

DD:12/19/75

DT:12/22/75

LA CROSSE, WISCONSIN 54601

MR. HERFORD BERSING

SS \_\_\_\_\_ DATE Nov 2/77

Leuban 2 yr  
TAB 7 Daily  
# 100

IO. Rue Keimond  
0, 1, 2, 3, 4 or 6 months.

MAY BE FILLED AT PHARMACY OF YOUR CHOICE.  
02874

LA CROSSE, WISCONSIN 54601

R. FOR MERRICK BERSING

ADDRESS \_\_\_\_\_ DATE SEP 29/77

Leuban 2 yr  
TAB 7 MON → FRI  
# 100

LABIL  
RIG. NO. Rue Keimond  
REFILL 0, 1, 2, 3, 4 or 12 months.

MAY BE FILLED AT PHARMACY OF YOUR CHOICE.  
Form 1302874

**GUNDERSEN CLINIC, LTD.**

LA CROSSE, WISCONSIN 54601

R. BERSING HERFORD

SS \_\_\_\_\_ DATE Dec 1/78

Leuban 2 yr  
TAB 7: Mon, Wed, Fri  
# 100

O. Rue Keimond  
0, 1, 2, 3, 4 or 12 months.

MAY BE FILLED AT PHARMACY OF YOUR CHOICE.  
32874

## GUNDERSEN CLINI LTD.

HISTORY NO. 31 62 47 NAME BERSING, Menford Route 1 Taylor, WI 54659

## INTERNAL MEDICINE

November 20, 1975. He returns today for his second course of CVP. He required hospitalization on the 11u of November with fever and leukopenia which was presumably drug-induced. His hemoglobin now is 10.6, hematocrit 31.8. White count was returned to 3500 with 51 polys and 20 bands. Platelets appeared low normal.

His other symptoms of treatment included some alopecia, change in his voice and constipation.

His exam is unremarkable today other than his frailty. No evidence of wound infection.

We discussed the options, that is, either no more therapy, the same therapy, reduced dosage of the same therapy, or an alternate CVP program. With their approval I have decided to continue with the same protocol but to reduce doses in the following manner: Prednisone to be reduced to 120 mg. daily times 5; Cytoxan to be reduced to 400 mg. daily times 5, Vincristine reduced to 1 mg. intravenously today. These were administered and he is to return in 3 weeks time. RMKelmowitz/slh

## INTERNAL MEDICINE

December 12, 1975. Patient did not keep today's appointment. RMKelmowitz/slh

## INTERNAL MEDICINE

December 31, 1975. He returns weighing 102 lb. He was hospitalized in Black River Falls following his second treatment course, with high fevers but no cause for site of infection other than urinary tract. The latter was assumed to be the origin because of symptoms of dysuria.

Since having spontaneously recovered, he has gradually felt stronger. On examination today he appears pale, emaciated, and rather weak. He has, however, no evidence of adenopathy or hepatosplenomegaly and no evidence of any abdominal masses.

His hemoglobin is 10, hematocrit 31.6, white count 6100 with a normal differential.

In this elderly man with presumed widespread mixed, nonHodgkin's lymphoma, he seems to have, recently, at least, been suffering more from our therapy than from the disease itself. Accordingly, I have decided to treat him more conservatively with Leukeran, 2 mg. daily and to follow him. Should his disease become more active, I will become more aggressive in therapy. His family understands this. He will return to see me in two weeks time. RMKelmowitz/slh

NOV. 22, 1975, MR. BERSING STARTED TAKING THE GENUINE ALOE VERA GEL. HE DRANK 1 TO 2 PINTS PER DAY.

#### INTERNAL MEDICINE

October 31, 1975. He comes in weighing 102 lb. He's been well since discharge from the hospital. At that time he had a resection of a non-Hodgkin's lymphoma, mixed lymphocytic, histiocytic, diffuse type, involving the terminal ileum and extending into the mesentery. Spleen was not thought to be enlarged. Liver was not grossly involved although biopsies were not taken. One mesenteric lymph node showed reactive hyperplasia. Bone marrow aspiration and biopsy showed significant lymphoid infiltration, compatible with lymphomatous involvement of the bone marrow.

He now returns for his first course of chemotherapy. His examination is unremarkable except for marble-sized node high in the left axilla. His weight was 43 kilos with a height of 168 cm. which figured out to a body area of 1.45 sq. meters. CVP was calculated in the following way: Cytosan 400 mg. per meter sq. times 5. days, 580 mg. per day but with 50 mg. tablets he will receive 550 mg. a day; Prednisone, 100 mg. per sq. meter times 5 days which calculates out to 145 mg. but because of the 20 mg. tablet size, he will take but 140 mg. a day for 5 days; Vincristine, 1.4 mg. per meter sq. calculated to 2.0 mg. per IV, however, because of his age I gave him only 1.5 mg. IV and subsequently will give him but 1 mg. IV.

Because the terminal ileum was resected, I recommended Vitamin B-12, 100 micrograms empirically each month. He will return to see me in three weeks time. RMKeimowitz/slh

#### SURGERY

October 31, 1975. Excellent postoperative course to date. Wound is healing uneventfully. He will continue care with Dr. Keimowitz and I will see him on a p.r.n. basis. FASchaldach/lbe

November 11, 1975. <sup>75</sup> PATIENT ADMITTED TO THE HOSPITAL. (LJLogan) Discharged 11-14-<sup>75</sup>

INTERNAL MEDICINE  
January 16, 1976. He comes in weighing 105 lb. and feeling well. He is well tolerating the Leukeran and examination today demonstrates no hepatosplenomegaly or lymphadenopathy. Hemoglobin is elevated to 11.1, hematocrit 34.2, white count 4800 with a normal diff.

I've asked that he continue the Leukeran 2 mg. a day, have Dr. Aprahamian check him in one month and see me in two months. RMKeimowitz/slh

INTERNAL MEDICINE  
March 12, 1976. Patient cancelled today's appointment. RMKeimowitz/slh

INTERNAL MEDICINE  
March 19, 1976. Comes in weighing 110. Since his visit to Dr. Aprahamian on the 18th of February developed pleuritic chest pain which he was hospitalized for and told was fluid on his lung. No treatment was given and he was then discharged with apparent improvement.

On exam today, he does appear better. Weight is 110. Hemaglobin is 11, hematocrit 33.8, white count 4,200 with fairly normal differential. Physical exam is unremarkable. Repeat chest x-ray showed blunting in both angles, unchanged from those films taken in November.

I recommended that he continue the Leukeran 1 tablet daily. He will return in two months' time. I don't understand the pleuritic chest pain particularly in light of the persistent costophrenic angle blunting. RMKeimowitz/lmp

INTERNAL MEDICINE  
May 20, 1976. He comes in today weighing 111 lb. He has continued to feel better, with a better appetite, greater strength. His hemoglobin is up to 11.7, hematocrit 34.5, white count 4800 with a normal differential and adequate numbers of platelets on smear. Hemoglobin is 12.5, hematocrit 35 at Dr. Aprahamian's office last month. White count at that time was 5800. No differential was recorded.

On examination today I am unable to palpate any nodes. No organomegaly noted. In general he does look well. I have asked that he continue with the Leukeran, 2 mg. daily and return in approximately 6 weeks for repeat evaluation. In the meantime he will have a CBC done by Dr. Aprahamian. I explained to his wife that in the event of recurrent disease, more aggressive chemotherapy may again be necessary. RMKeimowitz/slh

May 26, 1976 Chart reviewed by Tumor Board Committee.

OVER

CONSULTATION REQUEST

Clinic Number 31 62 47 Date 10/17/75  
Name BERSING, Menford Room No. 416-1  
Referred to: Special Hematology Dept. \_\_\_\_\_  
Referred by: Dr. Schaldach  
Services performed BONE MARROW ASP. & BIOPSY  
Examining Physician Dr. Keimowitz

SECRETARIES' AND WARD CLERK'S STUB

Examine Patient with Special Reference To:

BM75-340

PLEASE SEE PATIENT AND

Advise only.....

Advise and treat.....

Accept in transfer.....


Report of Consultation and Recommendations:

PERIPHERAL BLOOD SMEAR: Peripheral blood smear revealed mild to moderate aniso and poikilocytosis. Although the cells were predominantly normochromic and normocytic, a fair number of round macrocytes and a smaller number of microspherocytes. Platelets were present and adequate. White cell series was normal in appearance and differential although there was a slight increase in five-lobed polys.

BONE MARROW: The aspirate consisted of primarily fibrin clumps with significantly reduced cellularity. In those few areas in which marrow elements could be seen, there seemed to be a mild increase in erythroid activity with questionable megaloblastic maturation. Granulocyte series appeared normal and there was no evidence of lymphoid infiltration. Megakaryocytes were present. Bone marrow iron stores were mildly reduced.

Bone Marrow Biopsy and Clot Section revealed areas of lymphoid infiltration. The lymphocyte were predominantly small and well differentiated, noncleaved. There were larger forms present however, no obvious Reed-Sternberg cells were seen.

IMPRESSION: Lymphoproliferative disorder, malignant.

Signed   
R. M. Keimowitz, /jag

INTERNAL MEDICINE

January 12, 1977. He comes in weighing 124 lb. All of his GI symptoms have improved spontaneously. He is on Leukeran 2 mg. a day. Upper GI and small bowel series was performed today and appeared normal to my interpretation. I will write to him in the event that they are not normal; otherwise he need not return to see me for another two months. RKWeimowitz/slh

INTERNAL MEDICINE

March 21, 1977. He comes in weighing 125 lb. He has felt wonderfully. His examination fails to show any lymphadenopathy or hepatosplenomegaly. Hemoglobin now is up to 13.2, hematocrit 44.3, white count 5100 with a normal diff.

As noted above, his repeat bone marrow in August did not show lymphomatous involvement and his most recent barium swallow and small bowel follow through was also normal.

He is to continue with the Leukeran 2 mg. daily and return in 3 months. RKWeimowitz/slh

INTERNAL MEDICINE

June 24, 1977. He comes in weighing 123 1/2 lb. He has been quite well since his last visit, other than enucleation of his right eye as a result of a combination of factors, from both glaucoma and cataracts. He has had no night sweats or fevers. Appetite is good and he remains physically active.

On examination he appears very well. Weight is 123 1/2 lb. No evidence of hepatosplenomegaly or lymphadenopathy. No abdominal masses noted. His hemoglobin is down a bit to 12.5, hematocrit 37.2, white count 6200 with a normal diff. Platelets appeared adequate.

I have reduced his Leukeran to 1 tablet (2 mg.) to be taken Monday through Friday, skip week-ends. I will see him in 3 months and again in 6 months, at which time repeat bone marrow and small bowel series will be obtained. RKWeimowitz/slh

INTERNAL MEDICINE

September 23, 1977. Weight is 123 1/2 lb. He has been feeling wonderfully. He ran out of Leukeran 4 weeks ago but did not call me for a refill. On exam he looks well with no evidence of lymphadenopathy or hepatosplenomegaly. Hemoglobin today is 13, hematocrit 33, white count 6100 with a normal differential.

This is most unusual to have a patient with histiocytic lymphoma, diffuse, stage IV be doing so well after such little therapy. I have asked that the Leukeran be continued, 2 mg. Monday through Friday. He will return in 3 months for another bone marrow and chest x-ray. RKWeimowitz/slh

INTERNAL MEDICINE

December 16, 1977. Comes in at 123. He has been very well since his last visit with no complaints. His physical examination today reveals a well nourished elderly man with no hepatosplenomegaly or lymphadenopathy. CBC was normal. The hemoglobin was 13.6. Hematocrit 41. White count 6,100 with a normal differential and adequate platelets. Chest x-ray looked unchanged to me. Repeat bone marrow exam was performed. The aspirate as well as the biopsy demonstrated a marked increase in fatty material. Good bone plus was not obtained on two tries. He is to continue with the Leukeran 2 mg. Monday thru Friday and return to see me in three months time. He will be taking a trip down south during the winter and will be followed by Dr. Bonham. I'll write to him about the bone marrow

GUNDERSEN CLIN. C, LTD.

Form 1315 57.

Menford Bersing

Route 1

Taylor, Wisconsin

HISTORY NO.

31 62 47

INTERNAL MEDICINE

August 31, 1976. Returns today weighing 113½. He has been fine. Approximately 3-4 weeks ago he discontinued the Leukeran on his own because it made him somewhat nauseated. His hematocrit today is 37. He has a normal white count and normal differential.

On physical examination there is no evidence of hepatosplenomegaly or lymphadenopathy.

I have asked that he go back on the Leukeran 2 mg. daily until I notify him to the contrary or unless he develops significant side effects. A bone marrow is obtained and I will write to him about the results. I find it hard to believe that such little chemotherapy has irradiated his disease. Leukeran may be effective in keeping his disease under control although we are not dealing with a favorable histology. RMKeimowitz/bjj

INTERNAL MEDICINE

December 2, 1976. He weighs 119 today and looks very well. He now has a full head of hair as well. His physical exam was unremarkable with no evidence of hepatosplenomegaly or lymphadenopathy. CBC is normal.

At this time with a normal bone marrow, he has to be considered in complete remission. As he is tolerating Leukeran 2 mg. daily this will be continued. I will see him again in 3 months. RMKeimowitz/bjj

INTERNAL MEDICINE

January 5, 1977. He returns today weighing 120 lb. He is seen as an extra because of nonproductive cough and nausea, unassociated with fever, vomiting or abdominal pain. All of these symptoms seem to have improved some except for the nausea. In spite of this symptom, however, he has maintained if not gained weight.

On examination today he appears fine. He has no lymphadenopathy or hepatosplenomegaly. Chest x-ray is unchanged although he does have evidence of blunting in both angles. CBC is normal. Rectal is normal. Stool guaiac is negative.

The only abnormality that I might be concerned about is some nonspecific fullness in the right side of his abdomen. Therefore, with this questionable finding and his symptoms of nausea, repeat upper GI and small bowel will be ordered. He has been obtaining some relief with antacids so these are to be continued. RMKeimowitz/slh

## GUNDERSEN CLINIC, LTD.

HISTORY NO.

31 62 47

NAME

Lenford versing Route 1 Taylor, WI

## INTERNAL MEDICINE

May 15, 1979. Patient cancelled appointment. RMKeimowitz/lbc

## INTERNAL MEDICINE

May 30, 1978. He comes in today weighing 128 3/4 lb. He has been well except for recent respiratory illness for which he is being treated by his local physician and is responding. He has had no recurrent fever, night-sweats, anorexia, or change in his bowel habits.

On exam he looks well. There is no lymphadenopathy or hepatosplenomegaly. Breath sounds are decreased. Coarse rhonchi heard. Heart is not enlarged. Normal sinus rhythm. No murmurs heard. Rectal is normal. Prostate not enlarged. Stool guaiac negative.

CBC revealed hemoglobin is up to 14.7, hematocrit 44.3.

He has no evidence of disease. I suggested that he continue with the Leukeran 2 mg. Monday through Friday. He will return in six months' time and will continue with his monthly B-12 shots. RMKeimowitz/slh

## INTERNAL MEDICINE

December 1, 1978. He comes in weighing 134 lb. (60.6 kg.) He has been well, so well that he discontinued his Leukeran. He has continued the Vitamin B-12, however.

On exam today he appears very well. BP is 130/90. No adenopathy or hepatosplenomegaly. Stool guaiac is negative. Prostate not enlarged.

He did have what I thought to be a stage IV diffuse histiocytic lymphocytic lymphoma, treated initially with surgical resection and then followed by CVP and more recently single agent chemotherapy. His most recent bone marrow showed no evidence of disease, whereas it was involved initially. He seems to be in complete remission. I encouraged him to continue with the Leukeran 2 mg. Monday, Wednesday, and Friday and the B-12.

Because of dyspnea, probably related to his previous emphysema, chest x-ray will be ordered today and will write him about the results. RMKeimowitz/slh