

EXHIBIT A



SHAWN M. COLLINS
EDWARD J. MANZKE
DANIEL C. FABBRI
DAVID J. FISH
MARY P. NEAL
AARON W. RAPIER
SANDRA E. STRASSMAN

February 22, 2005

VIA OVERNIGHT DELIVERY

Met-Coil Systems Corporation TCE PI Trust
Larry Fitzpatrick, Trustee
1009 Lennox Drive
Building 4, Suite 101
Lawrenceville, New Jersey 08648

**Re: Thomas Quandt – 2733 W. 63rd, Downers Grove, IL 60516
Level I Individual Review Claim - Non-Hodgkin's Lymphoma**

Dear Mr. Fitzpatrick:

Enclosed please find a completed individual review form and accompanying materials for the claim of our client, Thomas Quandt, regarding his non-Hodgkin's lymphoma.

As more fully set forth in the enclosed materials, every aspect of Tom's life has been radically affected by his cancer. Less than two years ago, at 59 years of age, Tom was diagnosed with life threatening non-Hodgkin's lymphoma. The effect of the cancer on his body, mind, and indeed entire life, has been devastating. Tom's affidavit sets out the physically taxing course of chemotherapy he underwent over a period of five months, which resulted in immediate nausea and exhaustion, and a continuing loss of energy and stamina. This resulted in Tom giving up many of his favorite activities, including golf and travel.

Tom has lost time out of his life, including time with his family, as a result of his cancer. The constant doctor's visits, as well as the lingering effects of the chemotherapy—which to this day force him to rest in the afternoons as he no longer has the stamina he once had—have had a profound effect on both his personal and family life. He is a changed man as a result of the cancer, and it does not appear that he will ever be able to go back to who he once was. He can no longer fully participate in leisure activities like golf and he can no longer handle the physical stress of a walking tour while on vacation. On top of this, Tom lives everyday knowing that, as his doctors have told him, his cancer can return at any time, without warning. Tom's cancer is currently only in remission, it has not, and cannot, be cured. Every sniffle, muscle pain, or bruise makes him wonder if today is the day; the day the cancer returns.

Larry Fitzpatrick
February 22, 2005
Page 2

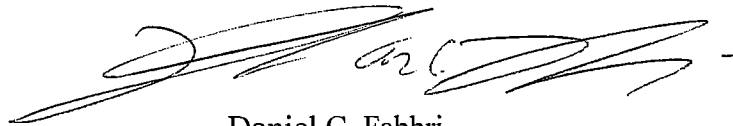
The non-Hodgkin's lymphoma and its resulting treatment has also had an enormous effect on Tom's career as a national sales manager for Olympic Oil, forcing him to forgo both valuable time from work, and his annual bonus, which over his past 21 years with Olympic, has been up to \$15,000.00. On top of this, the out of pocket costs of Tom's ordeal for medical costs he and his family have had to bear, are over \$6,000.00. Tom endured the treatment and its costs, monetary and otherwise, in hopes of ensuring his best chance for survival.

While money can never make his life the same, Tom is entitled to be fully compensated for all his past and future injuries, as well as the fear that his serious disease can return at any given moment. Under the terms of the Trust Distribution Procedures ("TDP"), he is entitled to a payment of \$300,000.00 for his non-Hodgkin's lymphoma

All materials required under the TDP to receive the full \$300,000.00 amount are enclosed for your review. Under the terms of the TDP, residents in Suburban Estates, Area "C", must provide evidence of exposure from 1991 to the exposure termination date, in order to receive the maximum payment. As the enclosed documents show, Tom has lived in his home since 1993, Approx. 85% of the maximum possible time allotted in the TDP. As a resident of Area "C", an exposure level for Tom is assumed. As discussed above, the severity of Tom's illness, coupled with the extensive treatment required to battle it, as well as his resulting damages, should more than make up for the minor shortfall in terms of the maximum exposure period and elevate the amount paid on his claim to the maximum allowed utilizing the "other factors" section of the TDP, §4.3(a)(3)(C).

If you find something is missing, or you require further information/documentation in order to pay this claim, please contact me so that I may provide that to you. Feel free to contact me if you have any questions on this matter, whatsoever.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Fabbri", with a horizontal line extending to the right.

Daniel C. Fabbri

Enclosures

MET-COIL SYSTEMS CORPORATION TCE PI TRUST

INDIVIDUAL REVIEW CLAIM FORM

Submit completed claims to:

Met-Coil Systems Corporation TCE PI Trust
Lawrence Fitzpatrick, Trustee
1009 Lennox Drive
Building 4, Suite 101
Lawrenceville, New Jersey 08648

Instructions for the Claim Form

Complete this claim form as thoroughly and accurately as possible. Please type or print neatly. Should there be insufficient space to list all relevant information, please attach additional sheets. In addition to filing the forms that follow, please ensure the following are enclosed, if applicable:

- Death Certificate (if applicable)
- Certificate of Official Capacity (if personal representative is filing form)
- Medical records as requested in instructions
- Proof of exposure as set out in the instructions
- Copy of cover sheet of complaint (if applicable - see Part 8 below)

Representation

If counsel represents injured party, please print or type the following information:

Attorney Name: Daniel C. Fabbri

Contact Name: Daniel C. Fabbri / Aaron W. Rapier

Name of Law Firm: The Collins Law Firm, P.C.

Firm Address: 1770 N. Park St., Suite 200

Naperville, IL 60563

Attorney Phone: 630/ 527-1595 Fax: 630/ 527-1193

Contact Phone: 630/ 527-1595 Fax: 630/527 - 1193

Attorney's or Law Firm's Tax ID Number: 36 - 4097236

MET-COIL SYSTEMS CORPORATION TCE PI TRUST

INDIVIDUAL REVIEW CLAIM FORM

Part 2: Diagnosed TCE-Related Injuries

Place an X next to the highest level TCE-related Disease Level that has been diagnosed for the injured party and for which medical documentation is attached to this claim form. See instructions for listing of the specific medical criteria and records that must be enclosed for each Disease Level. (Check only the highest applicable Disease Level.)

<input checked="" type="checkbox"/> Level I.	Kidney Cancer Liver Cancer Non-Hodgkin's Lymphoma	Date of Diagnosis <u>02 /28 /03</u>
<input type="checkbox"/> Level II.	Hodgkin's Lymphoma Bladder Cancer Cervical Cancer Esophageal Cancer Leukemia Myeloma Pancreatic Cancer Colon Cancer Squamous Cell Skin Cancer (Mortality) Lung Cancer* Stomach Cancer Ovarian Cancer Prostate Cancer	Date of Diagnosis ____/____/____

* To qualify for a Level II Lung Cancer claim, the injured party must be a non-smoker (or have not smoked for at least 15 years prior to diagnosis) and complete Part 5 of this Claim Form.

The claims must meet the relevant medical criteria and be supported by appropriate medical documentation as delineated in the TCE PI Trust Distribution Procedures (TDP). To support the required Medical/Exposure Criteria appropriate documentation must be included with this Claim Form, including at a minimum, results of medical tests and diagnosis of the treating physician. The medical and exposure criteria for the Disease Levels set forth above are attached as Exhibit A to this Claim Form.

MET-COIL SYSTEMS CORPORATION TCE PI TRUST

INDIVIDUAL REVIEW CLAIM FORM

Part 3: Dependents and Beneficiaries (if injured party is deceased)

List any other persons who may have rights associated with this claim. Be sure to include the injured party's spouse and/or any dependents who derive (or who did derive at the time of the injured person's death) at least one-half of their financial support from the injured party.

Also list beneficiaries who are entitled to pursue an action for wrongful death under applicable state law.

If more than four, please photocopy this page, and insert after current page.

Name: <u>Karen Quandt</u>	Date of Birth: <u>03/28/50</u>
Relationship: <input checked="" type="checkbox"/> Spouse	Financially Dependent? <u>Yes/No</u>
<input type="checkbox"/> Child	(Circle One)
<input type="checkbox"/> Other _____	

Name: _____	Date of Birth: ____/____/____
Relationship: <input type="checkbox"/> Spouse	Financially Dependent? <u>Yes/No</u>
<input type="checkbox"/> Child	(Circle One)
<input type="checkbox"/> Other _____	

Name: _____	Date of Birth: ____/____/____
Relationship: <input type="checkbox"/> Spouse	Financially Dependent? <u>Yes/No</u>
<input type="checkbox"/> Child	(Circle One)
<input type="checkbox"/> Other _____	

Name: _____	Date of Birth: ____/____/____
Relationship: <input type="checkbox"/> Spouse	Financially Dependent? <u>Yes/No</u>
<input type="checkbox"/> Child	(Circle One)
<input type="checkbox"/> Other _____	

MET-COIL SYSTEMS CORPORATION TCE PI TRUST

INDIVIDUAL REVIEW CLAIM FORM

Part 4: Exposure

1. Pathway of Exposure (list address at which exposure occurred or describe alternate exposure route):

2733 W. 63rd Street

Downers Grove, Illinois 60516

(Attach copy of deed, mortgage records, lease, utility bills, school records, tax records, government records, affidavits, or any other credible evidence supporting the answer above.)

2. If location of exposure is private residence, is above site primarily supplied with drinking water from a residential well?

Yes No

(Attach blueprint, site plan, survey, government record, or any other credible evidence supporting the answer above.)

3. List below the period of residence at the above site while primarily supplied with drinking water from a residential well:

Month/Year Exposure Began: 05/93 Month/Year Exposure Ended: 12/04

(Attach credible evidence supporting the answer above. Exposure is deemed under the TDP to end upon the earlier of (i) the date the residence was connected to a municipal water source, (ii) the date a claimant refused such connection, or (iii) the date this claim is filed with the TCE PI Trust.)

4. For most claims, credible evidence of residence within the Designated Area is presumptively valid proof of exposure. To support a claim not based upon residence within the Designated Area, provide testing information below and attach copies of reports from the testing laboratory to this Claim Form.

Sampling Location: _____
Sampler: _____ Sample Date: ____/____/____
Testing Laboratory: _____ Level Detected: _____ ppb
Lab Address: _____ City: _____ State: _____ Zip: _____

MET-COIL SYSTEMS CORPORATION TCE PI TRUST

INDIVIDUAL REVIEW CLAIM FORM

Part 5: Smoking History

NOTE: This information is relevant only to claims involving Disease Level II, Lung Cancer. Thus, this section does not need to be completed if your claim is for other Scheduled Diseases.

For each item, indicate whether injured party has smoked or used the given product. If cigarettes were smoked, indicate the dates they were used, and the amount per day. Indicate fractional packs as appropriate, e.g., three and one-half packs would be entered as 3.5.

Has the injured party ever:		
Smoked Cigarettes?	Yes _____ No _____	
From: ____/____	To: ____/____	Packs per day: ____ - ____
From: ____/____	To: ____/____	Packs per day: ____ - ____
From: ____/____	To: ____/____	Packs per day: ____ - ____
From: ____/____	To: ____/____	Packs per day: ____ - ____

Has the injured party ever:	
Smoked Cigars?	Yes _____ No _____
From: ____/____	To: ____/____
From: ____/____	To: ____/____
From: ____/____	To: ____/____
From: ____/____	To: ____/____

MET-COIL SYSTEMS CORPORATION TCE PI TRUST

INDIVIDUAL REVIEW CLAIM FORM

Part 6: TCE Litigation

Has a lawsuit alleging injury to the injured party for exposure to TCE ever been filed on behalf of the claimant?

Yes _____ No X _____

Two-letter abbreviation of the state in which the suit was originally filed: _____

Name of court in which suit was originally filed: _____

Date on which the suit was originally filed: _____

Has injured party received settlement money from Met-Coil, Formtek, Mestek, or their predecessors, successors and assigns? Yes _____ No _____

What is the current status of this suit? Pending Judgment
 Dismissed Settled

Please attach a photocopy of the endorsed cover sheet of the filed complaint.


MET-COIL SYSTEMS CORPORATION TCE PI TRUST

INDIVIDUAL REVIEW CLAIM FORM

Part 7: Signature Page

All claims must be signed by the injured party, or the person filing on his/her behalf (such as the personal representative or attorney).

I have reviewed the information submitted on this claim form and all documents submitted in support of this claim. To the best of my knowledge under penalty of perjury, the information submitted is accurate and complete.



Signature of Injured Party or Representative

Daniel C. Fabbri, attorney

Please print the name and relationship to the claimant of the signatory above.

Please review your submission to ensure it is complete.

- Death Certificate (if applicable)
- Certificate of Official Capacity (if personal representative is filing form)
- Medical Records as required by the TDP and as requested in the instructions. (see Exhibit A for Medical/Exposure Criteria)
- Proof of TCE exposure as required in the TDP and requested in Part 4 of the instructions.
- Cover sheet of filed complaint (if Part 6 is applicable).

STATE OF ILLINOIS)
) SS
COUNTY OF DUPAGE)

Affidavit of Thomas Quandt

If called to testify on the matters stated herein, I would testify as follows:


1. My name is Thomas Quandt
2. My date of birth is September 23, 1943.
3. I currently reside at 2733 W. 63rd Street, Downers Grove, IL 60516.
4. I am competent to make the attestations herein based upon my own personal knowledge.
5. From May 10, 1993 until the present day I have resided at 2733 W. 63rd Street, Downers Grove, IL (“the Residence”). A fair and accurate file stamped copy of the Warranty Deed to the Residence is attached as Exhibit A.
6. The Residence is located in what the Met-Coil Systems Corporation TCE PI Trust Distribution Procedures (“TDP”) refers to as the “Mejdrech Class Action Area”, specifically Area “C”.
7. Between May 1993 and December 2004, the primary source of water serving the Residence originated from a private well located on the Residence property. A fair and accurate copy of the original well permit application obtained from the DuPage County Health Department is attached as Exhibit B. As the document indicates, it is for lot 24 in Suburban Estates, the Residence, as stated on the Warranty Deed (Exhibit A).
8. Beyond providing drinking water for me and my wife, Karen, the well also provided the water for our daily cooking, bathing and showering. The well was also the source of water for seasonal gardening and lawn maintenance, which my wife and I routinely did ourselves.
9. Besides my wife Karen, my family also includes my five grown children: Kim, Terry, Kevin, Heidi, and Marianne, ages 30 to 39, as well as three grandchildren: Kira, Emma, and Edie, ages 1 to 14. From time to time my children and grandchildren have visited the residence and been exposed to the contaminated water.
10. My wife Karen is dependent on me for financial support, as I am the primary wage earner for our household. I additionally provide some support for my children and grandchildren, both financial and otherwise.
11. On February 28, 2003, Dr. Claudia Hernandez, M.D. of Loyola Medical Center diagnosed my non-Hodgkin’s lymphoma. A fair and accurate copy of the Surgical

Pathology, including the results of my tissue examination, prepared by Serhan Alkan, M.D., is attached as Exhibit C.

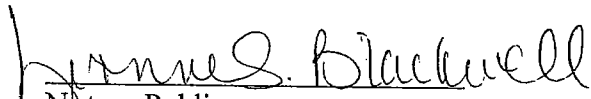
12. Following my diagnosis with non-Hodgkin's lymphoma, I underwent extensive chemotherapy for over a five-month period. I had to endure six chemotherapy doses, which resulted in painful nausea, exhaustion, and during which I was continuously ill and unable to get out of bed. Copies of my chemotherapy orders are attached as Exhibit D. Since completing my chemotherapy, my cancer has been in remission for Approx. the last year.
13. Due to my cancer, I was required to return to Loyola's Cardinal Bernardin Cancer Center regularly for follow-up care, with both Dr. Hernandez and other physicians, such as Dr. Kevin Barton, Asst. Prof. of Medicine Hematology/Oncology. Such follow up visits continue to this day as I go back every six months for tests including blood work, to see if my cancer has returned.
14. I am employed as a national sales manager for Olympic Oil based in Chicago, Illinois, and have worked for this company for 21 years. My annual salary for 2004 was \$95,000.00.
15. After my diagnosis, I repeatedly missed work as a result of doctor's visits, chemotherapy treatments, and follow up care. I lost time from work of Approx. 1 month, which based on my annual salary cost me \$7,917.00 in time lost from work. In addition, I lost Approx. \$7,000.00 more in wages, as I lost my bonus for the year. Previously, my annual bonus ranged from \$5,000.00-\$15,000.00.
16. In addition to the income I lost, I was also forced to expend an estimated \$6,000 in out of pocket medical costs for my treatment.
17. Now, I am concerned whether I will be able to continue in the profession I love and spent so much time learning to master, as my cancer and its related treatment has impeded my ability to fulfill all my professional obligations. Ever since my chemotherapy I must rest in the afternoons as I am physically tired and generally feel drained, often times requiring that I take a nap. I have never been able to regain the stamina I had prior to the development of my cancer.
18. I have lost the opportunity to participate in numerous activities that I love as a result of my cancer. Since I am much more tired today, I can no longer play an 18 hole round of golf, despite having been an avid golfer in the past who enjoyed playing a whole round. I just do not have the energy for it anymore.
19. Prior to my cancer and its treatment I used to travel extensively with my wife Karen. We very much enjoyed taking walking tours while traveling together. Unfortunately, I can no longer do this either, as I do not have the stamina for it.

20. Beyond losing the ability to do the activities I just mentioned, I am concerned that any recurrence of my cancer will cause me to lose more time with my wife, children, and grandchildren. The cancer has already cost me time with them all, due to my treatment, and the resultant loss of energy that I have which continues through today. Even the time that I can now spend with them is different since I cannot do the things I once did with them, as I do not have the strength. Even so much as taking my grandchildren for a walk or playing with them in a park is often too much for me to handle.
21. My long term outlook is uncertain. My non-Hodgkin's lymphoma is currently in remission, but I am told it could recur at any time. I need to go back to Loyola Hospital every six months to check to see if the cancer has returned. In addition, on a regular basis I fear that my cancer may be returning, as a result of what used to be everyday physical issues: a cold, pain in my joints, even a simple bruise. Every one of these gives me pause now, as I fear it is the return of my cancer.
22. It is impossible for me to put a dollar value on my health, as it, and my life with my family, is invaluable to me. Ever since being diagnosed with cancer, my health has deteriorated, as has my spirit, since I live every day knowing that a relapse of my cancer can happen at any time.

FURTHER AFFIANT SAYETH NAUGHT.


Thomas Quandt

Subscribed and sworn to before
me on this 22nd day of February, 2005.


Notary Public



WARRANTY DEED
Joint Tenancy
Statutory (ILLINOIS)
(Individual to Individual)

CAUTION: Consult a lawyer before using or acting under this form. Neither the publisher nor the seller of this form makes any warranty with respect thereto, including any warranty of merchantability or fitness for a particular purpose.

THE GRANTORS

Michael J. Hosek and Valerie E. Hosek, his wife,

of the Village of Downers Grove County of DuPage
State of Illinois for and in consideration of
Ten dollars (10.00) DOLLARS,
and other good and valuable consideration hand paid,
CONVEY and WARRANT to

Thomas A. Quandt

(The Above Space For Recorder's Use Only)

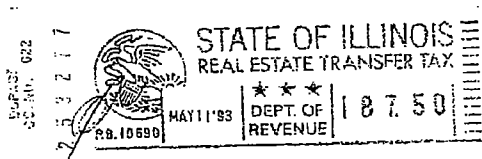
(NAMES AND ADDRESS OF GRANTEE(S))

not in Tenancy in Common, but in JOINT TENANCY, the following described Real Estate situated in the County of DuPage in the State of Illinois, to wit:

Lot 24 in Suburban Estates, being a Subdivision of the Northeast 1/4 of the Northeast 1/4 of Section 23 and the Northwest 1/4 of the Northwest 1/4 of Section 24, Township 38 North, Range 10, East of the Third Principal Meridian. According to the Plat thereof recorded May 24, 1955 as Document 758224, in DuPage County, Illinois.

93-03-833 B A U M

93016824



RECORDED
DU PAGE COUNTY

R 93-093762

93 MAY 11 PM 2:45

AFFIX "RIDERS" OR REVENUE STAMPS HERE

hereby releasing and waiving all rights under and by virtue of the Homestead Exemption Laws of the State of Illinois. TO HAVE AND TO HOLD said premises not in tenancy in common, but in joint tenancy forever.

Permanent Real Estate Index Number(s): 08-23-205-005

Address(es) of Real Estate: 2733 W. 63rd Street, Downers Grove, IL 60516

DATED this 10th day of May 19 93

PLEASE PRINT OR TYPE NAME(S) BELOW SIGNATURE(S)

Michael J. Hosek (SEAL) Valerie E. Hosek (SEAL)
Michael J. Hosek Valerie E. Hosek

State of Illinois, County of DuPage ss. I, the undersigned, a Notary Public in and for said County, in the State aforesaid, DO HEREBY CERTIFY that

15 Michael J. ~~Hosek~~ and Valerie E. Hosek

personally known to me to be the same person s whose name s subscribed to the foregoing instrument, appeared before me this day in person, and acknowledged that he signed, sealed and delivered the said instrument as their voluntary act, for the uses and purposes therein set forth, including the release and waiver of the right of homestead.



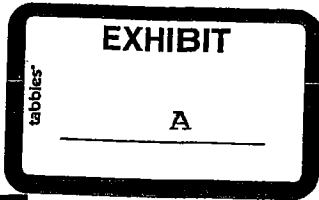
Given under my hand and official seal, this 10th day of May 19 93

Commission expires 2/22 19 97
Kevin M. Kelly
NOTARY PUBLIC

This instrument was prepared by Kevin M. Kelly, Attorney at Law, 2211 York Road, Suite 315 Oak Brook, IL 60521 (NAME AND ADDRESS)

MAIL TO: Allen Gabe (Name)
135 S. LaSalle (Address)
Chicago IL 60603 (City, State and Zip)

SEND SUBSEQUENT TAX BILLS TO:
Thomas A. Quandt (Name)
2733 W. 63rd St. (Address)
Downers Grove, IL 60516 (City, State and Zip)
grantees address



SUBMIT IN DUPLICATE

DU PAGE COUNTY HEALTH DEPARTMENT
209 East Liberty Drive
Wheaton, Illinois
Wheaton 8-6565

Date.....

Name..... Tel. No. *5-4880*

Mailing address. *2136-17th Ave, Broadview*
Request a permit for - Septic System. *X* Well. *X* Septic Repair. *X* Well Repair. *X*

on the property described as: Lot. *24* Block..... Township. *Lisle*

Subdivision. *Suburban Estates*

Property fronts on..... *67th St.* & is..... (~~East~~) (West) of *Walnut* St
and..... (North) (South) of..... Street.

TYPE OF BUILDING: Residence. *X* No. Bedrooms. *3* No. Baths. *1 1/2* No. persons served. *5*
Restaurant... Seating Capacity..... Lst. No. meals per day.....
Other (specify).....
No. toilets. *2* Urinals..... Lavatories. *2* Sinks. *1* Showers. *1*
Other fixtures (specify)..... *4*

WELL: Drilled. *X* Driven... Dug... Estimated depth. *15* ft. Diameter *4 1/2* inches
Well ~~is~~... is not... to be in a pit. Pit drains to sump..... surface.....
Casing to extend... in. above pit floor (or ground), ends... in. below ground.
Type of pump. *1/2 HP* *1/2* Type of well seal... *Sanitary Well Seal*
Pressure storage..... *4* gallons.

SEPTIC TANK: Capacity. *750* gals. No. compartments. *1* Cap. inlet compartment.....
Pre-cast conc. *X* Poured in place... Coated metal... Metal... Masonry.....

SEEPAGE FIELD: Total length trenches. *200* ft. Width of trenches. *24-42* inch

TEST RESULTS: Depth of test hole. *29* in. Test hole. *12* in. sq. or in dia.
Total time for 5" seepage..... *75* min. Depth of ground water. *19* ft.

I hereby certify that the tests reported above were made by me on
(date)..... *August 1, 1955*, on the property described in
this application, and that said tests were made in accordance with
the requirements of the Du Page County Health Department.

Ernest A. Knapman
Signature

..... Check here if FHA or VA financing is anticipated.

SEPTIC SYSTEM CONTRACTOR. *BOKAY BROS. EXCAVATING, SEPTIC, INC.*

WELL DRILLER. *A-1. WELL. CO. CHICAGO*

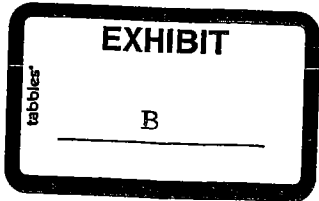
I hereby agree to fulfill all requirements of the Du Page County Health Department
in installing the system covered by this permit.

BOKAY BUILDERS, INC.
Ernest A. Knapman
Signature

AUG 2 1955

Permit expires..... NO. *102902*

MAKE SKETCH OF SEVERAL..... MAY 2 1955

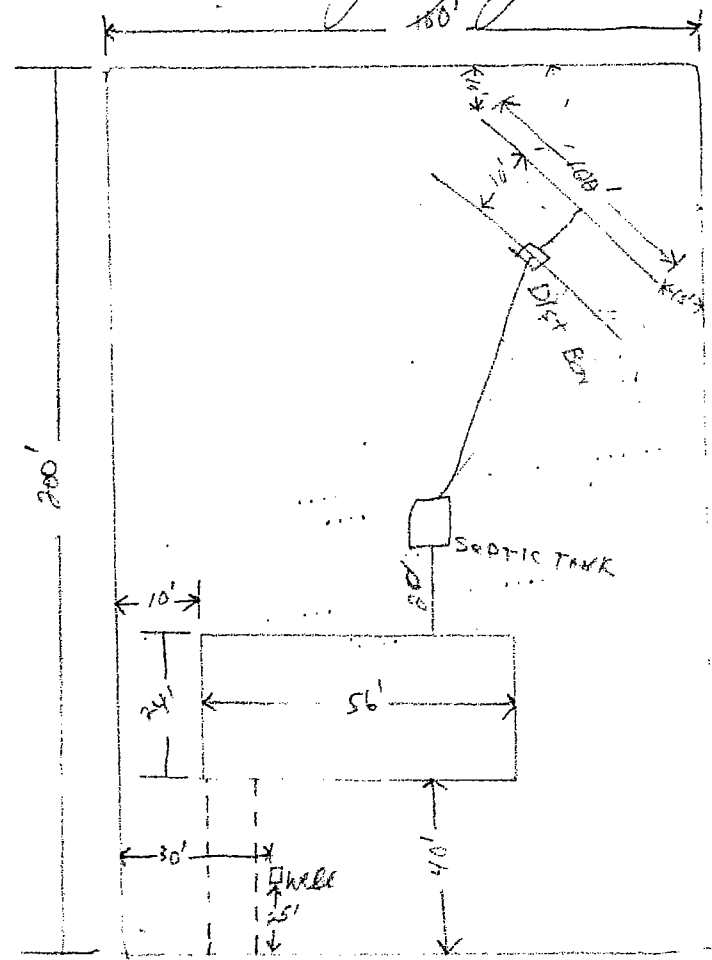


~~APPROVED~~ ✓ ~~DISAPPROVED~~ INSPECTOR *H. A. Hart* DATE *5-17-56*

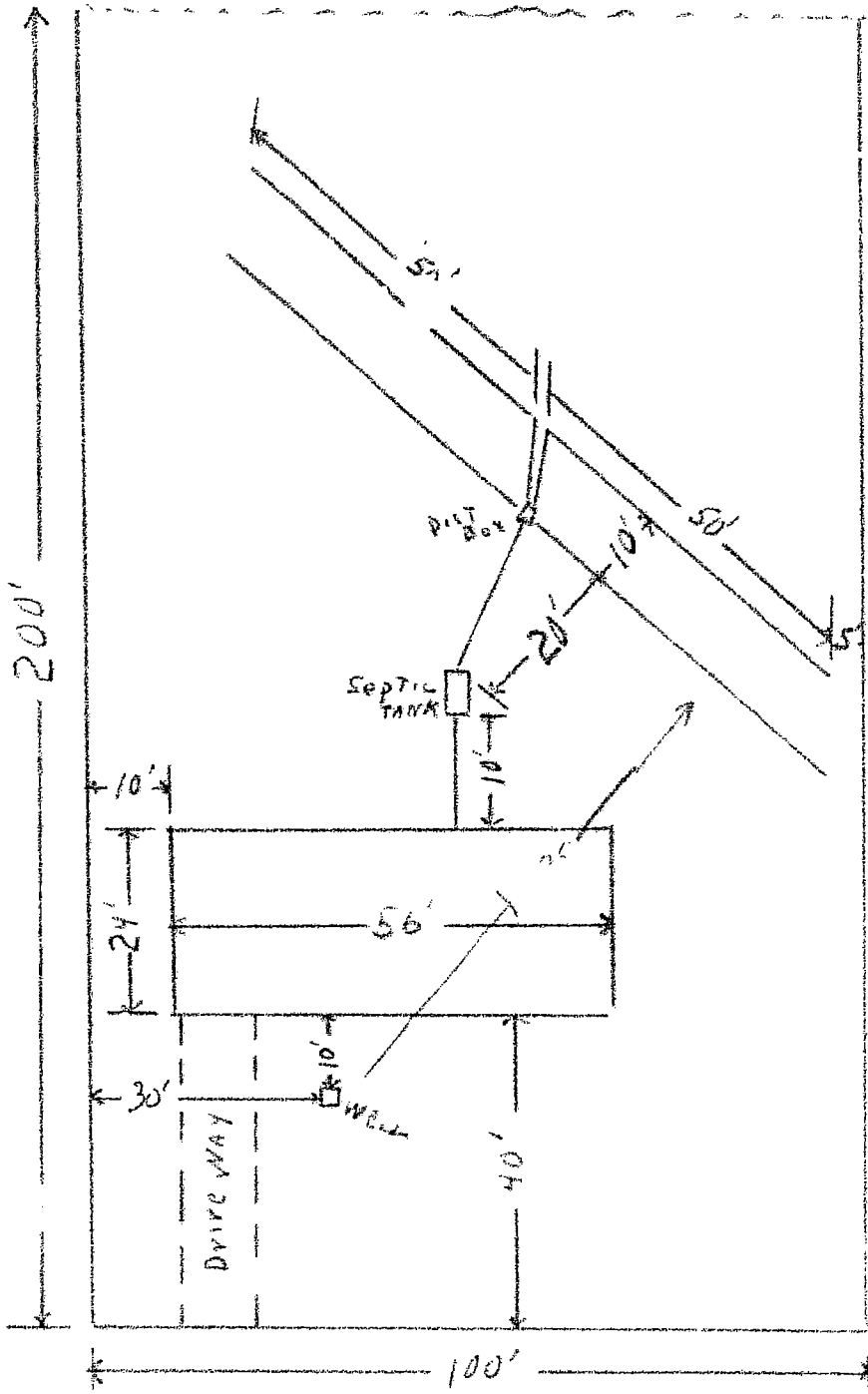
FINAL INSPECTION - INSPECTOR..... DATE.....

Your permit for the installation or installations described on reverse side is hereby granted. ANY DEVIATION FROM THE APPROVED PLANS SHALL AUTOMATICALLY VOID THIS PERMIT.

DATE *5/22/56* BY *J. Kelly*



63rd St.



LEADS
 SCALE: 5' = 1/4"

LOT # 24 - 0310-17



LOYOLA
UNIVERSITY
HEALTH SYSTEM

Loyola University Chicago

Loyola Medical Laboratories
Department of Pathology

SURGICAL PATHOLOGY REPORT

Patient Name: **QUANDT, THOMAS**

Med. Rec. #: **378155**

DOB: **9/23/1943 (Age: 59)**

Gender: **M**

Soc. Sec. #: **358-34-7318**

Physician(s): **Claudia Hernandez, MD**

Location: **OAKB**

Service:

Billing #: **037815510104**

Client: **LOYOLA**

Accession #: **S03-3546**

Obtained: **2/25/03**

Received: **2/26/03**

Reported: **2/28/03**

Specimen(s) Received

Right upper back

FINAL DIAGNOSIS

SKIN, RIGHT UPPER BACK; BIOPSY:

-SUPERFICIAL AND DEEP ATYPICAL DERMAL LYMPHOID INFILTRATE CONSISTENT WITH INVOLVEMENT BY NON-HODGKIN LYMPHOMA, B-CELL TYPE (SEE COMMENT)

Comment

The biopsy of skin shows superficial and deep lymphocytic infiltrate composed of mixture of small and large lymphoid cells. The periadnexal infiltrate shows cluster of large cells. There immunohistochemical stains for CD3, CD20, CD30 and bcl-2 were performed. This analysis shows that large cells are positive for CD20 and background T-cells stains with CD3. Bcl-2 staining is negative. These features are consistent with involvement by cutaneous large B-cell lymphoma.

Electronically Signed Out
Serhan Alkan, MD

Clinical Information and History

Pt with atypical lymphoid infiltrate; solitary plaque on back approximate 20 cm x 17 cm

Gross Description

The specimen, received in formalin labeled "right upper back", consists of a punch biopsy of skin measuring 0.35 x 0.2 x 0.5 cm. The specimen is entirely submitted in a single purple cassette. Three additional punch biopsies were submitted separately for flow cytometric analysis (two biopsies) and molecular pathology (1 biopsy).

Anna E. Sienko, MD
Izak B. Dimenstein

Microscopic Description

The attending pathologist whose signature appears on this report has reviewed the diagnostic slides and has edited the gross and/or microscopic portion of the report in rendering the final microscopic diagnosis.

SNOMED Code(s):

1: M40000 M69700 P1140 T02451 T09020

EXHIBIT

tabbles*

C

QUANDT, THOMAS

378155

Loyola University Medical Center 2160 S. First Ave Maywood, IL 60153

Pathology: (708) 327-2572 FAX: (708) 327-2620

John M. Lee, M.D., Ph.D., Chairman

S03-3546

Page 1 of 2

Billing Fee Code(s): 1: L4, IMPERX, IMPERX, IMPERX, IMPERX



LOYOLA UNIVERSITY HEALTH SYSTEM

Loyola University Chicago

CHEMOTHERAPY ORDERS

QUANDT, THOMAS

037 8155

Date: <u>6/20/03</u>		START ON: <u>6/20/03</u>	
Ht: <u>69.7</u> (cm / inches)	Wt: <u>214</u> (kg / lbs)	BSA: <u>2.14</u> m ²	
Cycle # <u>1</u>	Day(s) <u>1-5</u>	Regimen or Study Protocol	CHOP
Dose adjustments: Give: _____ % of _____		[drug(s)]	
Reason: <u>6/16/03 30mg</u>			
Wait for lab results	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parameters	MUGA= <u>6/16/03</u> BILI= <u>1.5</u> <u>5/22/03</u>
<ol style="list-style-type: none"> PROCHLORPERAZINE (COMPazine) SR 15MG PO BID X 2 DAYS. ONDANSETRON (ZOFran) <u>24mg</u> PO PRE-CHEMO, 4HRS & 8HRS POST-CHEMO (X1 DAY). LORAZEPAM (Ativan) 1MG <u>PO</u> IV Q6HRS PRN <u>N/V</u> X3 DAYS. <u>X1</u> <u>at/barton</u> DIPHENHYDRAMINE (BENADRYL) 25MG PO/IV Q6HRS PRN N/V X3 DAYS. [INDICATION=ANTIEMETIC]. CYCLOPHOSPHAMIDE (CYTOXAN) (750MG/M²) = <u>1600</u> MG IVP X1 DOSE. DOXORUBICIN (50MG/M²) = <u>107</u> MG IVP X1 DOSE. VINCRIStINE (1.4MG/M²; <u>2</u>MG CAP) = <u>2</u> MG IVP X1 DOSE. PREDNISONE 100MG PO DAILY X5 DAYS. 			
<p>IF EXTRAVASATION OF DOXORUBICIN OCCURS , INITIATE COLD PACK AND CONTACT PHYSICIAN. IF EXTRAVASATION OF VINCRIStINE OCCURS, INITIATE WARM PACK AND CONTACT PHYSICIAN FOR WYDASE ORDER.</p>			
<p>**CUMULATIVE DOSE (INCLUDING CURRENT ORDER) OF DOXORUBICIN= <u>50</u> MG/M²</p> <p><u>weekly CBC/ID</u> <u>RTC 7/10 2 CBC/ID, CMP/LSH</u> <u>CHOP - 7/10 change to 7/15</u> <u>2 visit</u></p>			
Physician signature: <u>[Signature]</u>		M.D. <u>Dr. Barton</u> <u>in neuroonc.</u>	
Verification Process:	Order/Treatment	Administration	Patient Identification
Date: <u>6/20</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Day _____ of _____	Rph <u>[Signature]</u>	RN/RPh <u>[Signature]</u>	RN <u>[Signature]</u>
			2nd <u>[Signature]</u>

NOTE: Physician's signature must accompany each entry, including standing orders; date instituting and discontinuing the order must be recorded. Nurse must sign each procedure as instituted or discontinued.



LOYOLA
UNIVERSITY
HEALTH SYSTEM

Loyola University Chicago

CHEMOTHERAPY ORDERS

105-00

PATIENT NAME:

QUANDT, THOMAS

M.R. NUMBER:

037 8155

D.O.B.:

Date: 7/7/03 START ON: 7/15/03

Ht: 70 (cm/inches) Wt: 219 (kg/lbs) BSA: 2.14 m²

Cycle: 2 Day(s): 1-5 Regimen or Study Protocol: CHOP for Non-Hodgkin's Lymphoma

Dose adjustments: Give: _____ % of _____ [drug(s)]
Reason:

Wait for lab results: Yes No Parameters: ANC > 1500 plt > 150

Premedication:

Give on Day 1

- Ondansetron 24mg PO/ODT (if unable to take oral give Ondansetron 16mg IVPB)
- Lorazepam 1mg PO/IV PRN
- Prochlorperazine 10mg PO/IV PRN

Chemotherapy:

Give on Day 1

- Cyclophosphamide 750 mg/m² = 1600 mg IV push *
* Doses > 1100 mg are given IVPB in 150 ml NS over 30-60 minutes.
- Doxorubicin ** 50 mg/m² = 107 mg IV push.
- Vincristine 1.4 mg/m² = 2 mg IV push.
 Max. dose = 2 mg
- Prednisone 100 mg PO QD, Days 1 - 5, (prescription given).

7/9/03
3.9) 16.3 (217)
ANC = 2300
OK to use
per Dr. Barton

Hematopoietic support:

Filgrastim (G-CSF) _____ mcg SC QD for _____ doses, start on: _____

Lab orders: CRP = diff 9 wks CMP in 3 wks REV.2/02

Next Tx: 3 wks Next MD Visit: 3 wks Next RN visit: _____

**Cumulative Doxorubicin Dose (including current order) = 100 mg/m²

Physician signature: [Signature] M.D.

Verification Process:
Date: 7-15-03
Order/Treatment: [Signature] Rph
Administration: [Signature] RN/MD
Patient Identification: [Signature] RN
Day _____ of _____ [Signature] RN/RPh/MD

NOTE: Physician's signature must accompany each entry, including standing orders; date instituting and discontinuing the order must be recorded. Nurse must sign each procedure as instituted or discontinued.



LOYOLA UNIVERSITY HEALTH SYSTEM
Loyola University Chicago

#10500
WBC 5.6
Hgb 15.0

PATIENT NAME: QUANDT, THOMAS
M.R. NUMBER:
D.O.B.: 037 8155

CHEMOTHERAPY ORDERS

P of 206

Date: 8/5/03 Gran 66 ANC 3700 START ON: 8/5/03
 Ht: 69.7 (cm inches) Wt: 214 (kg lbs) BSA: 2.14 m²
 Cycle # 3 Day(s) 1-5 Regimen or Study Protocol CHOP for Non-Hodgkin's Lymphoma
 Dose adjustments: Give: _____ % of _____ [drug(s)]
 Reason:
 Wait for lab results Yes No Parameters

Premedication: Give on Day 1

- Ondansetron 24mg PO/ODT (if unable to take oral give Ondansetron 16mg IVPB)
- Lorazepam 1mg PO/IV PRN
- Prochlorperazine 10mg PO/IV PRN

Chemotherapy: Give on Day 1

Cyclophosphamide 750 mg/m² = 1600 mg IV push *
 * Doses > 800 mg are given IVPB in 150 ml NS over 30-60 minutes.
 Doxorubicin ** 50 mg/m² = 107 mg IV push.
 Vincristine 1.4 mg/m² = 2 mg IV push.
 Max. dose = 2 mg
 Prednisone 100 mg PO QD, Days 1 - 5, (prescription given).

Hematopoietic support:

Filgrastim (G-CSF) _____ mcg SC QD for _____ doses, start on: _____

Lab orders: CMP
CRP = diff q wk REV.2/02

Next Tx: _____ Next MD Visit: 9/9/03 Next RN visit: _____

See Green Order Sheet
 **Cumulative Doxorubicin Dose (including current order) = 150 mg/m²

Physician signature: [Signature] M.D.
 Verification Process:
 Date: 8-5-03
 Day _____ of _____
 Order/Treatment: [Signature] Rph
 Administration: [Signature] RN/MD
 Patient Identification: [Signature] RN

NOTE: Physician's signature must accompany each entry, including standing orders; date instituting and discontinuing the order must be recorded. Nurse must sign each procedure as instituted or discontinued.



LOYOLA UNIVERSITY HEALTH SYSTEM
Loyola University Chicago

10500
9-23-03
WBC 5.5 ANC 3900
Hgb 14.6 Grom 70
p-21/166

PATIENT NAME: QUANDT, THOMAS
M.F. NUMBER: 0378155
D.O.B.:

CHEMOTHERAPY ORDERS

Date: 9-23-03 START ON: 9-23-03

Ht: 191.7 (cm/inches) Wt: 218 (kg/lbs) BSA: 2.14 m²

Cycle # 4 Day(s) Regimen or Study Protocol **CHOP for Non-Hodgkin's Lymphoma**

Dose adjustments: Give: _____ % of _____ [drug(s)]
Reason:

Wait for lab results Yes No Parameters

Premedication: Give on Day 1

- Ondansetron 24mg PO/ODT (if unable to take oral give Ondansetron 16mg IVPB)
- Lorazepam 1mg PO/IV PRN
- Prochlorperazine 10mg PO/IV PRN

Chemotherapy: Give on Day 1

Cyclophosphamide 750 mg/m² = 1600 mg IV push *
* Doses > 800 mg are given IVPB in 150 ml NS over 30-60 minutes.

Doxorubicin ** 50 mg/m² = 107 mg IV push.

Vincristine 1.4 mg/m² = 2 mg IV push.
 Max. dose = 2 mg

Prednisone 100 mg PO QD, Days 1 - 5, (prescription given).

*9/23/03
5.5) 14.6/166
ANC=3900*

Hematopoietic support:

Filgrastim (G-CSF) _____ mcg SC QD for _____ doses, start on: _____

Lab orders: CRP = diff, c-1 P 9 weeks REV.2/02

Next Tx: (3) 10-16-03 Next MD Visit: (3) 10-16-03 Next RN visit: _____
IPMART KB

**Cummulative Doxorubicin Dose (including current order)= _____ mg/m²

Physician signature: [Signature] M.D.

Verification Process:

Date:	Order/Treatment	Administration	Patient Identification
<u>9-23-03</u>	<u>[Signature]</u> Rph	<u>[Signature]</u> RN/MD	<u>[Signature]</u> RN
Day _____ of _____	<u>[Signature]</u> RN/RPh	<u>[Signature]</u> RN/RPh/MD	<u>[Signature]</u> RN

NOTE: Physician's signature must accompany each entry, including standing orders; date instituting and discontinuing the order must be recorded. Nurse must sign each procedure as instituted or discontinued.



LOYOLA
UNIVERSITY
HEALTH SYSTEM

Loyola University Chicago

CHEMOTHERAPY ORDERS

10609

PATIENT NAME:

QUANDT, THOMAS

M.R. NUMBER:

0378155

D.O.B.:

Date: 10/16/03		START ON: 10/16/03	
Ht: 70 (cm / inches)	Wt: 219 (kg / lbs)	BSA: 2.14 m ²	
Cycle # 5	Day(s) 1-5	Regimen or Study Protocol	CHOP for Non-Hodgkin's Lymphoma
Dose adjustments: Give: _____ % of _____ [drug(s)]			
Reason:			
Wait for lab results <input type="checkbox"/> Yes <input type="checkbox"/> No Parameters			
Premedication:		Give on Day 1	
<input checked="" type="checkbox"/> Ondansetron 24mg PO/ODT (if unable to take oral give Ondansetron 16mg IVPB) <input checked="" type="checkbox"/> Lorazepam 1mg PO/IV PRN <input checked="" type="checkbox"/> Prochlorperazine 10mg PO/IV PRN			
Chemotherapy:		Give on Day 1	
Cyclophosphamide 750 mg/m ² = 1600 mg IV push * * Doses > 800 mg are given IVPB in 150 ml NS over 30-60 minutes.			
Doxorubicin ** 50 mg/m ² = 107 mg IV push.			
Vincristine 1.4 mg/m ² = 2 mg IV push. <input checked="" type="checkbox"/> Max. dose = 2 mg			
Prednisone 100 mg PO QD, Days 1 - 5, (prescription given).			
Hematopoietic support:			
<input type="checkbox"/> Filgrastim (G-CSF) _____ mcg SC QD for _____ doses, start on: <u>later</u>			
Lab orders: CBC = diff 9 weeks CMP 3 weeks		4.0) 14.4 (161) ANC 2700 REV. 2/02 CR	
Next Tx: 3 weeks		Next MD Visit: 3 weeks	
		Next RN visit: 0.9	
**Cumulative Doxorubicin Dose (including current order) = 250 mg/m ²			
Physician signature: <u>[Signature]</u>		M.D.	
Verification Process: <u>[Signature]</u> Order/Treatment Administration Patient Identification			
Date: 10-16-03	Rph	RN/MD	RN
Day _____ of _____	RN/RPh	RN/RPh/MD	2nd

NOTE: Physician's signature must accompany each entry, including standing orders; date instituting and discontinuing the order must be recorded. Nurse must sign each procedure as instituted or discontinued.



LOYOLA UNIVERSITY HEALTH SYSTEM

Loyola University Chicago

CHEMOTHERAPY ORDERS

#10609
11-25-03
WBC 4.5
Hgb 14.8
Plt 150
AWE 2800

PATIENT NAME:

QUANDT, THOMAS

M.R. NUMBER:

DOB: 0378155

Date: 11/25/03

START ON: 11/25/03

Ht: 70 (cm/inches)

Wt: 219 (kg/lbs)

BSA: 2.19 m²

Cycle: 6 Days: 1-5

Recommendation: Standard Protocol

CHOP for Non-Hodgkin's Lymphoma

Dose adjustments: Give: _____ % of _____ [drug(s)]

Reason:

Wait for lab results: Yes No Parameters

Premedication:

Give on Day 1

- Ondansetron 24mg PO/ODT (if unable to take oral give Ondansetron 16mg IVPB)
- Lorazepam 1mg PO/IV PRN
- Prochlorperazine 10mg PO/IV PRN

Chemotherapy:

Give on Day 1

Cyclophosphamide 750 mg/m² = 1600 mg IV push *

* Doses > 1100 mg are given IVPB in 150 ml NS over 30-60 minutes.

Doxorubicin ** 50 mg/m² = 107 mg IV push.

Vincristine 1.4 mg/m² = 2 mg IV push.

Max. dose = 2 mg

Prednisone 100 mg PO QD, Days 1 - 5, (prescription given).

Hematopoietic support:

Filgrastim (G-CSF) _____ mcg SC QD for _____ doses, start on: _____

CMP 3 weeks

Lab orders: CBC diff 7 weeks x 4

REV 2/02

Next Tx: _____ Next MD Visit: _____ Next RN visit: _____

**Cumulative Doxorubicin Dose (including current order) = 300 mg/m²

Physician signature: _____ M.D.

Verification Process:

Order/Treatment

Administration

Entry/Identification

Date: 11-25-03

Signature

Rph

Signature

RN/MD

Signature

RN

Day _____ of _____

Signature

RN/RPh

Signature

RN/RPh/MD

Signature

2nd

NOTE: Physician's signature must accompany each entry, including standing orders; date instituting and discontinuing the order must be recorded. Nurse must sign each procedure as instituted or discontinued.