Oct 5, 2012

922 E. FRANKLIN ST

DUQUOIN, ILL

62832

The Honorable Shelley C. Chapman

One Bowling Green

Courtroom 621

New York, New York 10004-1408

I am writing this letter asking you to stand with the many coal miners whose the benifits we so desperably need.

There are many of us whos health is very seroudy effected if the Judge who will file the Bankruptcy takes away the care so many of us depend upon.

As you can read the enclosed letter it will explain in detail my present health.

Sadly to say my health continues to worsen. My hopes, along with many others that we are needing to prevail against the Peabody, arch & Patriot for life saving health.

Most Sincerely,

Dalton R Tandie

J.G. HILTON, M.D.
H.B.S.C., Ph.D., C.M., F.R.C.P. (C)
Associate Professor, Physiology & Medicine
Southern Illinois University

SOUTHERN DEPENDA-CARE

COPY

HEMATOLOGY & ONCOLOGY
1275A Cedar Court
Carbondale, Illinois 62901
(618) 457-4492

Patient: Dalton Landis

Visit: 5/22/95

Copy: Dr. Scott

Thank you for allowing me to see Dalton Landis who I have been following since 4/26/95. The patient has a very common presentation in oncology which is disease which involves the bone in a diffuse manner, however, is difficult to diagnose in regards to the underlying disease process. The patient presented with a history of bony pain and a bone scan done on 3/13/95 revealed areas of increased radioactivity in areas involving the right anterior second rib, left anterior third rib, right posterior tenth rib, and left side of L3 vertebra, all of these showing a pattern which was consistent with metastatic disease. The patient was appropriately worked up because of his prior history of bladder CA with a CT of the abdomen and pelvis on 3/21/95. These studies revealed a left sided pleural effusion and what appeared to be pulmonary and hepatic granulomata disease. There were small hepatic masses, one of which was believed to be a cyst, but others which were more difficult to diagnose. There were lymph nodes that were somewhat more prominent than average and these appeared to be on the left side although these were not pathognomonic for lymphadenopathy. There was a slight inhomogeneous thickening of the wall of the urinary bladder, again, nothing definitive. There was also inhomogeneity in regards to the distention of portions of the colon and small bowel, however, these were difficult to assess. The patient was seen by me with this history and the laboratory findings and we, therefore, embarked on trying to find the origin of his almost assured metastatic disease. A chest x-ray was done during the original work-up on 3/21/95 and this showed no lesions of the chest and no pleural effusions. I sent off a myriad of antigens looking for a clue as to where the origin might be with a CEA, alpha-fetoprotein, prostatic specific antigen, thyroglobulins, CA 19-9, Chem 18, and CBC, all revealing no abnormalities. The rib which had been biopsied by Dr. McCain one week prior to this had shown no evidence of metastatic disease. The patient has lost approximately 7-8 pounds and continues to have pain in the bony regions. The patient was then instructed by myself that the next area that should be sought after would be that of the liver masses, however, he declined to have this done given the past experience of one of his friends. Clearly, Dr. Scott, we are dealing with almost certainly an adeno CA primary unknown with mets to bone, however, no visceral involvement at present. The

patient is losing weight consistent with this, however, it is difficult at this point to make any diagnostic decisions without tissue. I have relayed to the patient that if he does not want to have the liver biopsy done, then what we should do is wait a period of 1-2 months and take a look and see where the progression of the disease exhibits itself in regards to skeletal mets or, hopefully, visceral mets that we can accurately diagnose. The patient prefers this method and, therefore, we have asked him to come back in a period of one month at which time we will redo the tests and if the disease activity has increased in an area that would be easily biopsied, we would get tissue at that time. I know that it is hard to watch a patient progress under your eyes, however, I have dealt with this disease many times and this is almost certainly what has to be done in certain situations. I will sit with you in regards to waiting for the diagnosis to present itself and at that time, we will make recommendations as to how to treat his disease.

J. G. Hilton, M.D.

JGH/sm

Dictated but not read.

Family History: Is positive for his father having died of cancer, etiology unknown, mother is living at age 81. He has 2 brothers and 2 sisters, one of the sisters has breast CA, both brother and sister have heart problems.

Social History: Patient is a smoker of one package of cigarettes per day.

Functional Inquiry: Positive for headaches, dizzy spells, sinus problems, abdominal pain, coronary artery-like symptoms, joint pains, ankle swelling, and muscle cramps.

Physical Examination: The patient appears cachectic, his vitals are 130/76, pulse 78, respiratory 18.
Heent: Pupils are normal and reactive, thyroid normal, mucosal membranes were moist and free of any infiltrates.
Chest: Air entry good bilaterally, chest clear to auscultation. Trachea was midline.
Cardiovascular Examination: JVP was at the sternal angle, heart sounds were normal, no murmurs heard.
Abdominal: Soft-nondistended abdomen with no organomegaly noted.
Neurological: Within normal limits.

Assessment and Plan: The patient, I think, has a high probability of having metastatic disease. Whether this is from bladder or not remains to be seen, however, I think our best source of investigation would be to go back and do plain views of the ribs, as well as CT of the ribs, and if there are erosions present, we can accept that there is a CA. If these prove to be negative as the bone biopsy was, then I would go ahead and biopsy the liver where the small masses are suggestive of metastatic disease. I will get back to you in regards to his further investigations.

J. G. Hilton, M.D.
JGH/sm

Dictated but not read.