

# CryoTransport Case Report: Patient A-1705

by Jerry B. Lemler, M.D., Alcor Medical Director and CryoTransport Manager  
with Linda Chamberlain, Mathew Sullivan, Hugh Hixon, and Dr. R. Michael Perry



**A-1705 Date of Birth: May 10, 1937**  
**Date of Biostasis: March 22, 2001**

\* \* \* \* \*

## Background History

A-1705 (name withheld, as is our custom) was a sixty-three-year-old retired Ph.D. physicist and a well-known biostasis advocate. He regularly attended and actively participated in numerous life extension-related conferences, both Alcor sponsored and otherwise. On a personal note, my wife (Paula) and I met A-1705 at the Asilomar meeting last June (2000), and we both took quite a liking to this most interesting gentleman.

When I assumed the duties of Medical Director and CryoTransport Manager in early February, I was given a list of significantly ill Alcor members. A-1705 was at the top of this short list, and I contacted him by telephone at his home in the rural Midwest. We had a pleasant enough conversation under the circumstances, predominantly dealing with logistical issues, should an imminent cryosuspension become necessary.

A-1705 was signed up as a whole-body suspension member and for the moment committed himself to remaining so, even after I detailed the virtues of neurovitrification technology and our new Open Option Plan. In his own words, he said he'd process the information I'd given him, and, "take it under advisement."

I was given the name of A-1705's key personnel and with his verbal permission, in turn, contacted his attorney, personal physician, and mortician. Each and every one of these individuals pledged his full support to provide the requisite assistance required to best ensure A-1705's trip to the future. And, in truth, they amply demonstrated their fidelity, in deed as well as word.

In mid-February, A-1705 called to notify me he would be traveling to the Mayo Clinic in Rochester, Minnesota, for a

definitive workup of his advancing metastatic stomach cancer that had initially manifested itself some two years previous. Against my stated recommendation he not drive himself to Minnesota in the middle of the winter (an arduous seven-and-a-half-hour trip), A-1705 nonetheless made the solo sojourn, leaving him in a most exhausted state upon arrival. The exacting Mayo examinations suggested A-1705 return to Rochester in three weeks time for a round of experimental chemotherapy. Our member drove home (barely arriving ahead of a major snow storm), and he and I continued our ongoing telephone dialogue. He was understandably ambivalent about returning to Minnesota, though I encouraged him to proceed with their prescribed protocol.

A-1705 lived alone, with no close family or friends nearby. He never married nor fathered any children. His work and studies, along with the care of his mother, were the essence of his life. When his mother (and closest friend) died a few years back, A-1705 was truly alone. Accordingly, he was unable to secure a ride back to Rochester, and so he personally chauffeured himself again to the North Country. He called upon arrival, from his hospital bed, and said he'd gotten "deathly ill" two times, forcing him to the side of the busy road to gather himself in order to complete the journey.

Further discussions including A-1705's designated mortician, attorney, and personal family physician were conducted by myself (JBL) and were, without question, exceedingly productive. We constructed a plan of action whereby it was decided that if our patient survived his travails in Minnesota, he would be transferred for terminal hospice care in the greater Phoenix area.

I met with and subsequently spoke several times to representatives of a local hospice in the greater Phoenix area. Our thanks go out to Bob Ettinger for his referral of these diligent and compassionate individuals. They proved not only to be compliant with our various needs but ultimately of significant assistance to us in carrying out our mission.

A-1705's second in-patient hospital course in Minnesota was, somewhat predictably, deleterious. He began the experimental chemotherapeutic regimen as scheduled but within a matter of days spiked a fever and developed a dangerously high leukocytosis. A-1705's chief surgeon (who stayed in

regular close contact with me) was of the opinion our member was septic from an intra-abdominal bleed. His recommended course of action was an exploratory laparotomy, which, in fact, occurred on February 24. No active bleeding site was located during the operation, and A-1705 was closed, following ligation of adhesions.

Post-operatively, inclusive of assisted breathing in the Surgical ICU, our member continued to regress. Daily conversations with him were no longer possible, even after he was breathing on his own and stepped down to the Intermediate Care Unit. I remained in almost constant contact with A-1705's attending surgeon, hospice intake coordinators, and ActNet members, and our agreed-upon action plan called for the direct transfer of A-1705 from Rochester to a large private hospital in Phoenix, should his condition stabilize sufficiently (not a given by any means) to allow him to make the trip.

Thanks to the expert care of his team of surgeons, after three "touch and go" weeks, A-1705 was discharged from the Mayo facility. On Saturday March 17, he was flown via a med-transport Learjet to Sky Harbor Airport, where he was greeted and taken to the hospital, escorted by Alcor facilities engineer Hugh Hixon (HH) and myself.

### Standby

With the arrival of A-1705 in Phoenix for terminal care, Alcor readied its staff, equipment, and facilities to await pronouncement of our member. Figures 1-3 are illustrative of this highly detailed process. (MLS = Mathew Sullivan.)

A wing of the fourth floor of the Phoenix hospital is set aside for in-patient care of hospice patients, under the supervision of their Medical Director (name withheld, but an excellent practitioner). Hospital personnel directly responsible for A-1705's care were thoroughly vested in his comfort and our procedures.

Figure 1.

| Completed by: | Date:    | INITIAL LOGISTICS  |
|---------------|----------|--|
| LC            | ok       | CryoTransport Team preparations ( <i>CryoTransport Overview Checklist</i> ).   |
| LC            | ok       | Make list of needed consultants (Contact Information).   |
| LC            | ok       | Call consultants (if necessary).   |
| LC            | ok       | Prepare still camera (film in refrigerator and in MARC).   |
| MLS           | N/A      | Order dry ice (900 lbs. WB / 100 lbs. neuro).  |
| MLS           | N/A      | Order first delivery of liquid nitrogen (8 LS160 = WB / 2 LS160 = neuro).  |
| JS            | 19 March | Fuel ambulance #1 (Fuel and use different fuel tank each time).  |
|               |          |  |
| Completed by: | Date:    | INFECTION CONTROL  |
| MLS           | 19 March | Determine patient's infectious disease status (file, physician, CryoTransport Manager).  |
| MLS           | N/A      | Inform surgeon and all staff of any special infectious precautions.  |
| MLS           | 19 March | Post infectious status at OR entrances, at pump, sample station, cooldown bay, and in appropriate offices (if none, post "No Known Infectious Disease"). |
| MLS           | 19 March | Prepare protective wear supply/disposal; red bags at two locations.  |
| MLS           | 20 March | Lock and tape Dr. Lemler's door.   |

### If It's Your Turn

Should you become aware you're suffering from a terminal illness, the time to prepare for an Alcor biostasis procedure is the moment of diagnosis. We don't have to convince you of the desirability of a pronouncement just minutes away from our Scottsdale facility, with your Alcor Standby Team and its life-saving equipment positioned at your bedside.

Teams of Alcor staff and volunteers faithfully stood vigil at A-1705's bedside, beginning Tuesday March 20, when his condition noticeably deteriorated towards an agonal state. Just one day prior to this clinical worsening (March 19), Fred and Linda Chamberlain (LC) secured the necessary paperwork from A-1705 to convert his suspension arrangement from whole-body to Alcor's new Open Option Plan. The Open Option allows Alcor's Medical Director (Jerry B. Lemler, M.D.), and/or senior cryotransport leaders (in his absence), to choose for the suspendee the preferable preservation method at the time of his/her deanimation.

Alcor's twenty-four-hour/day standby vigil-keepers included staff members Linda Chamberlain, Fred Chamberlain, Dr. Jerry B. Lemler, Hugh Hixon, and Jessica Lemler, along with the valuable assistance of Alcor volunteers Jerry Searcy (JS), Bruce Cohen, and P. M. Early Thursday morning, March 22, at 0500 hours, A-1705 developed a Cheyne-Stokes breathing pattern, prompting me to

redraw a second batch of stabilization medications. Fortunately, the hospital staff allowed us not only unlimited pre- and post-morbid access to our patient, but further permitted us to station our MARC (Mobile Advanced Rescue Cart) in A-1705's room, enhancing its availability for immediate use (see Figure 4).

### Cardiopulmonary Arrest and Local Transport

At 0545 hours, March 22, 2001, Member A-1705 deanimated, with pronouncement by designated nursing personnel (upon notification by Alcor standby representatives within minutes of the event) (see Figure 5). Cardiopulmonary stabilization was immediately begun following pronouncement in A-1705's hospital room, along with Alcor Central, with Hugh Hixon behind the Alcor ambulance wheel, as Linda Chamberlain and Dr. Jerry Lemler attended to the MARC and its valuable contents. Due to A-1705's unusual anatomy (he

Figure 2.

| Completed by: | Date:    | Time: | OPERATING ROOM (Initial Preparations)   |
|---------------|----------|-------|---|
| MLS           | 20 March | 17:05 | Set wall clock to correct time.   |
| MLS           | 19 March |       | Remove all excess equipment.  |
| MLS           | 19 March |       | Place table dump buckets (kick pails).  |
| MLS           | 19 March |       | Remove trash.   |
| MLS           | 19 March |       | Prepare remote monitoring system.   |
| MLS           | 20 March | 14:57 | Place new tape in video recorder.   |
| MLS           | 19 March |       | Turn on video recorder.   |
| MLS           | 20 March |       | Place 12 of each data log on (2) clipboards (forms on perfusionist cabinet).    |
| MLS           | 20 March |       | Place Surgeon Checklist, Datasheet, and SOP on clipboard.                       |
| MLS           | 20 March |       | Place Burr Hole Checklist, Datasheet, and SOP on clipboard (as above).          |
| MLS           | 19 March |       | Prepare infection control filter (unlock switches, hook up tubing, test, etc.). |
| MLS           |          |       | Prepare Perfusion Station ( <i>Perfusionist Checklist</i> )                     |
| MLS           | 19 March |       | Locate crackphone microphones (pre-sterilized).                                 |
| MLS           | 19 March |       | Clean all non-metal surfaces (10% bleach).                                      |
| JS            | 19 March |       | Vacuum and mop floor with disinfectant or 10% bleach solution.                  |
| MLS           | 19 March |       | Lay floor mats on each side of operating table.                                 |
| JS            | 19 March |       | Clean and dry operating table (10% bleach).                                     |
| MLS           | 19 March |       | Wipe down equipment (Windex - perfusion machine & other electronics).           |
|               |          |       |   |
| Completed by: | Date:    |       | OR BATHROOM   |
| JS            | 19 March |       | Empty garbage and wash all surfaces and sink (10% bleach).                      |
|               |          |       |   |
| Completed by: | Date:    |       | SCRUB ROOM  |
| MLS           | 20 March | 15:14 | Remove excess equipment.  |
| JS            | 19 March |       | Wash all surfaces and sink with soap and water.                                 |
| JS            | 19 March |       | Wash all surfaces and sink with 10% bleach solution.                            |
| JS            | 19 March |       | Lay out betadine scrub brushes.   |
| JS            | 19 March |       | Lay out surgical gowns.   |
| JS            | 19 March |       | Lay out surgeon's gloves.   |

| Completed by: | Date:    | Time: | OPERATING ROOM (Final Preparations)                             |
|---------------|----------|-------|---|
|               |          |       | Prepare back table for surgery. Lay out:                        |
| MLS           | 19 March |       | Sternal saw tray  |
| MLS           | 19 March |       | Burr hole tray  |
| MLS           | 19 March |       | Main tray   |
| MLS           | 19 March |       | Supplemental surgical tray                                      |
|               |          |       | Place electrocautery supplies on back table:                    |
| MLS           | 19 March |       | 4 each sterile gauze package                                    |
| MLS           | 19 March |       | Betadine scrub bottle   |
| MLS           | 19 March |       | Betadine solution bottle  |
| MLS           | 19 March |       | 40 alcohol swabs  |
| MLS           | 19 March |       | Electrocautery plate  |
| MLS           |          |       | Electrocautery gel  |
| MLS           | 19 March |       | Extra surgeon's gloves  |
| MLS           | 19 March |       | Drape back table.   |
|               |          |       | Prepare burr hole surgical area:                                |
| MLS           | 20 March | 15:14 | Place (2) I.V. poles at head of OR table (for burr hole drape). |
|               |          |       |   |
| Completed by: | Date:    |       | LABORATORY  |
| HH            | pre-made |       | Mix perfusate (100L = WB / 50 L = neuro).                       |
| HH            | pre-made |       | Dilute and filter perfusate.                                    |

Figure 3.

Figure 4.

| Date:    | Time: | Time status: | NOTES  |
|----------|-------|--------------|--|
| 20 March | 14:30 |              | Patient at Phoenix Hospital. Weight 60 kg; I.V.s in readiness  |
| 20 March | 14:30 |              | 500 cc of 20 g/100 cc mannitol, 500 cc of 10 g/100 cc dextran 40 (rheomacrodex)  |
| 20 March | 14:30 |              | Drew up 120 mg diprivan (propofol, 12 cc soln.)  |
| 20 March | 14:35 |              | Drew up 60 mEq potassium chloride (30 cc soln.)  |
| 20 March | 14:43 |              | Drew up 25,000 units sodium heparine (2.5 cc soln.)  |
| 20 March | 14:48 |              | Drew up 10 mg vecuronium (norcuron, 10 cc soln.)   |
| 20 March | 17:39 |              | Drew up 2 g deferoxamine (desferal, 8 cc soln.)  |
| 20 March | 17:47 |              | Drew up 0.6 mg nimodipine (0.6 cc soln.)   |
| 20 March | 18:16 |              | Drew up 20 g vasopressin (20 cc soln.)   |
| 20 March | 18:19 |              | Drew up 180 mg chlorpromazine (thorazine, 7.2 cc soln.)  |
| 20 March | 18:24 |              | Drew up 1 g methylprednisolone (solumedrol, 8 cc soln.)  |
| 20 March | 18:27 |              | Drew up 10 mg bactrim (10 cc soln.)  |
| 20 March | 18:29 |              | Drew up 60 mg gentamicin sulfate (1.5 cc soln.)  |
| 20 March | 21:00 | Est          | Patient asleep with some flashes of alertness. Morphine earlier today reduced heart rate   |
|          |       |              | Approximately 40 lbs ice in break room. MARC (Mobile Advanced Rescue Cart) placed in 4th floor hallway, and nurses given tour. They were quite interested in our equipment and procedures.   |
| 20 March | 22:25 | Est          | Bagged ice--10 bags, using scoop cup from nurses.  |
|          |       |              | Red-painted electrical outlets in rooms are hospital's generator-backed essential bus. NGC O2 fittings in rooms release by pushing in on fitting while pulling down on button above fitting.   |
| 20 March | 22:39 |              | Patient breathing getting shallow, even somewhat labored   |
| 20 March | 22:47 |              | Noted: nurses have heparin, THAM, streptokinase, other items including I.V. line   |
| 20 March | 22:52 |              | Nurse check of patient. Breathing shallower.   |
| 20 March | 22:57 |              | Forehead scrunched up, indicating possible pain. Gave sublingual morphine.   |
| 20 March | 22:57 |              | Respirations 24/min. O2 saturation 96%   |
| 20 March | 23:31 |              | Hung THAM and Dextran-40   |
| 20 March | 23:40 |              | Rolled patient--no bowel movement  |
| 21 March | 00:10 |              | Patient breathing regularly  |
| 21 March | 00:37 |              | Patient no change  |
| 21 March | 01:00 |              | Patient about the same   |
| 21 March | 01:14 |              | Patient respirations 24/min.   |
| 21 March | 01:40 |              | Vitals: blood pressure 120/90; 91% O2 saturation; 28 resp/min.; breathing deeper, color better, circles under eyes, kidneys working  |
| 21 March | 02:06 |              | Occasional cessation of breathing and other signs noted--wringing of shoulders, expression indicating problems   |
| 21 March | 02:12 |              | Breathing somewhat erratic   |
| 21 March | 02:14 |              | Breathing better. Morphine administered  |
| 21 March | 02:35 |              | Raccoon eyes, noted--a sign of "blood pooling"   |
| 21 March | 05:14 |              | Pulse rate 140-160/min.; capillary refill time 1 sec (hands), 4 sec (feet); resp 28/min.; O2 saturation 94-96%; marked edema of extremities  |
| 21 March | 07:40 |              | Pulse rate 120-140/min.; capillary refill time 1 sec (hands), 2 sec (feet); resp 22/min.   |
| 21 March | 08:55 |              | Pulse rate 120/min.; capillary refill time 1 sec (hands), 2 sec (feet); resp 20/min.; increasing edema   |
| 21 March | 09:45 |              | Pulse rate 116/min.; capillary refill time 1 sec (hands), 2 sec (feet); resp 28/min.; just given morphine (note:all morphine is given as morphine sulfate)   |
| 21 March | 10:49 |              | Pulse rate 120/min.; capillary refill time 1 sec (hands), 1 sec (feet); resp 32/min.; increasing edema right hand, increasing lung congestion  |
| 21 March | 11:55 |              | Pulse rate 120/min.; capillary refill time 1 sec (hands), 2 sec (feet); resp 30/min.   |
| 21 March | 14:28 |              | Pulse rate 120/min.; capillary refill time 1 sec (hands), 1 sec (feet); resp 26/min.   |
| 21 March | 15:04 |              | Pulse rate 125/min.; capillary refill time 1 sec (hands), 2 sec (feet); resp 28/min.; breathing seems sharp and rapid, but rate is not that different  |
| 21 March | 17:26 |              | Pulse rate 120/min.; capillary refill time 1 sec (hands), 1 sec (feet); resp 22/min.   |
| 21 March | 18:27 |              | Pulse rate 120/min.; capillary refill time 1 sec (hands), 1 sec (feet); resp 24/min.; blood pressure 122/62. No change in condition.   |
| 21 March | 19:40 |              | Pulse rate 120/min.; capillary refill time 1 sec (hands), 1 sec (feet); resp 28/min.; O2 saturation 92%. No change in condition.   |
| 21 March | 20:40 |              | Pulse rate 122/min.; capillary refill time 1 sec (hands), 1 sec (feet); resp 28/min.; 1 mg ativan given to control twitch. Non-responsive when asked if in pain. 10 mg morphine sulfate being given at 6 hr. intervals, and PRN based on nsg assessment of pain. Will increase dose to 15 mg depending on estimated pain levels. |
| 21 March | 21:40 |              | Pulse rate 120/min.; capillary refill time 1 sec (hands), 1 sec (feet); resp 20/min.; 20 mg morphine sulfate given.  |
| 21 March | 23:07 |              | Nurse checked; gave morphine; breathing very gurgly.   |
| 22 March | 02:20 |              | Pulse rate 138/min.; capillary refill time 1 sec (hands), 2 sec (feet); resp 22/min.; blood pressure 100/60  |
| 22 March | 04:00 |              | Pulse rate 136/min.; capillary refill time 1 sec (hands), 2 sec (feet); resp 24/min.   |
| 22 March | 05:10 | Est          | Made decision to redraw meds based on patient's altered breathing pattern.   |
| 22 March | 05:18 |              | Drew up 120 mg diprivan (propofol, 12 cc coln, replacing previous sample).   |
| 22 March | 05:24 |              | Drew up 10 mg vecuronium (norcuron, 10 cc soln, replacing previous sample).  |
| 22 March | 05:28 |              | Drew up 60 mEq potassium chloride (30 cc soln, replacing previous sample).   |
| 22 March | 05:39 |              | Drew up 250,000 units streptokinase (streptase, 5 cc soln).  |
| 22 March | 05:44 |              | Drew up 250,000 units sodium heparin (2.5 cc soln, replacing previous sample).   |

*Note to figures 4 and 5:*

A-1705 Standby and Suspension Records: Some times are approximate, indicated by “Est” in the Time Status column, which is otherwise blank. Unspecified times can be considered to fall between enclosing, specified times in same locale or theater, again with allowance for inexactness. Units of measurement: unless otherwise noted, temperatures are in degrees Celsius (°C), pressures are in millimeters of mercury (mm Hg), flow rates are in milliliters per minute (ml/min), and times are in 24 hr. mountain standard time (MST: Arizona and Alcor Central time).

**Figure 5.**

| Date:    | Time: | Time status: | NOTES  |
|----------|-------|--------------|--|
| 22 March | 05:45 | Est          | Cardiopulmonary arrest. Patient is pronounced.   |
| 22 March | 05:47 | Est          | No airway placed; anatomy bad. I.V. started (THAM, Mannitol, Dextran 40). Used Ambu Cardiopump for meds circulation.   |
| 22 March | 05:48 |              | Administered sodium heparin (25,000 units, 2.5 cc).  |
| 22 March | 05:51 |              | Administered diprivan (120 mg, 12 cc).   |
| 22 March | 05:52 |              | Administered streptokinase (250,000 units, 5 cc). Administered vecuronium (10 mg, 10 cc).  |
| 22 March | 05:53 |              | Administered potassium chloride (60 mEq, 30 cc). Administered vasopressin (20 mg, 20 cc).  |
| 22 March | 05:56 |              | Administered nimodipine (0.6 mg, 0.6 cc).  |
| 22 March | 05:57 |              | Placed patient into ice bath; put ice bags around head.  |
| 22 March | 05:58 |              | Administered deferoxamine (2 g, 8 cc).   |
| 22 March | 05:59 |              | Positioned thumper and oxygen.   |
| 22 March | 06:00 |              | Started thumper and oxygen.  |
| 22 March | 06:10 | Est          | Spray cooling device useless due to patient's anatomy. Rerouted tubing to have diffuser cool head.   |
| 22 March | 06:14 |              | Administered bactrim (10 mg, 10 cc). Administered gentamicin sulfate (60 mg, 1.5 cc).  |
| 22 March | 06:15 |              | Administered chlorpromazine (180 mg, 7.2 cc). Administered methylprednisolone (1 g, 8 cc). Meds terminated.  |
| 22 March | 06:20 | Est          | Disconnect MARC from wall power and O2, and moved out. Thumper temporarily shut off while going through lobby.   |
| 22 March | 06:31 |              | Ambulance with patient left hospital for Alcor Central.  |
| 22 March | 06:45 | Est          | In ambulance: tympanic temperature probes placed. No airway placed, precluded by unusual anatomy, secondary to long-standing ankylosing spondylitis and consequent torticollis. Icewater diffuser held in place by hand. |
| 22 March | 07:01 |              | Patient arrived at Alcor.  |

suffered from a chronic ankylosing spondylitis and severe cervical torticollis, leaving him with a severe twisting neck deformity), the spray cooling device was reconfigured, using the diffuser to manually cool the patient's head during transit.

The ambulance arrived at Alcor Central at precisely 0701 hours, and A-1705 was transferred to the operating table without incident. Tympanic probe readings at 0719 hours were: left: 20.7°C, right: 19.9°C. This means the patient's temperature had been reduced by approximately 17°C, in only 94 minutes!

**Cephalic Isolation**

Surgery was performed by Alcor surgeons Dr. José Kanshepolsky and Dr. Nancy McEachern, assisted by myself. A-1705's head was shaved and prepped for burr hole placement by Dr. Kanshepolsky at 0729 hours.

**Burr Hole (Before Perfusion)**

7:29 Shave/prep patient's head

**Left burr hole:**

- 7:34 Retraction completed
- 7:35 Pilot dimple completed
- 7:47 Main hole completed
- 7:48 Skull/dura separation completed
- 7:48 Brain exposure completed

**Right burr hole:**

- 7:30 Retraction completed
- 7:34 Pilot dimple completed
- 7:41 Main hole completed
- 7:42 Skull/dura separation completed
- 7:42 Brain exposure completed

Cephalic isolation was accomplished without incident at 0909 hours, after both carotid arteries had been clamped. The left vertebral artery was cannulated at 0912 hours (est.), with the right following immediately after at 0922 hours (est.). Right carotid artery cannulization was confirmed at 0937 hours, while the left was secured at 0941 hours. The surgeons acknowledged having some difficulty with the carotid cannulizations, attributable in their opinion to A-1705's previously documented aberrant anatomy.

**Neuro Washout**

At 0945 hours (est.) the circuit was configured for washout with B1 compound. Five minutes later, at 0950 hours, the perfusion pressure was increased to 60-80 mm Hg, and the circuit was opened. A-1705's washout commenced at 0954 hours and was successfully terminated at 1006 hours. At this juncture of the proceedings, neurosurgeon Dr. José Kanshepolsky noted "The brain looks good!"

*(continued on page 57)*

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*(continued from page 11)*

We, at Alcor, wish to thank everyone who participated in this most successful cryotransport, as well as all our volunteers who offered us their time and expertise, who weren't called in. The case of A-1705 illustrates the value of terminal hospice care in a skilled and empathetic environment close to Alcor Central. Additionally, the low temperatures recorded so soon following pronouncement attest to the intrinsic viability of Alcor's cryotransport protocols. Details of the cryoprotective phase of A-1705 will be placed on our web site, ([www.alcor.org](http://www.alcor.org)), with hard copy to be published at a later date.

### **Tooting Our Own Horn**

We didn't say it first, but we don't deny it either. Alcor patient A-1705, in our estimation, received the highest quality suspension performed anywhere, anytime, by anyone! His chances of reaching the distant future are better than any person who has ever lived. Many factors support this proclamation, not the least of which was the instant availability and especially high quality of local terminal hospice care.

Alcor has initiated (and plans to maintain), a superb working relationship with a large, well-established, Phoenix-based hospice organization. The groundwork for this coopera-

tive venture was swiftly and painstakingly laid by Alcor Medical Director Dr. Jerry Lemler via personal visits to the hospice administrative offices and numerous telephone conversations with their Medical Director and intake coordinators.

As mentioned in the accompanying A-1705 Suspension Report, hospice personnel (prior to, during, and following our five-day presence), were appropriately inquisitive and solicitous in assisting our staff in optimally carrying out our (and A-1705's) desires. In fact, they demonstrated a level of enthusiasm rarely seen these days amongst health care workers.

Even if you're not in the final definitive stage (and especially if you're not) of a terminal illness, our new hospice alignment may offer you a prime opportunity for a first-class ticket to the future. Living arrangements under our local hospice auspices are quite varied and include options for each level of care required. At one end of the spectrum, for the most independent patients, are designated apartment complexes. As a patient is likely to progressively need more intensive interaction, assisted living venues, nursing home facilities, and finally, in-patient care arrangements are offered.

If you desire more detailed information about Phoenix-area hospice services, give Alcor a call! Ask for Dr. Lemler at extension 102.