

### Case Summary

A 76 years old male, Prahladbhai Jani (Chunriwala Mataji), gives a detailed description about his life. He left home at the age of 7 years and wandered in the jungles of Mt. Abu, Girnar, Narmada, etc. At the age of 11 years he had some supernatural experience and this changed his life. According to him he has no desire to eat, drink liquids or pass urine or stool since then. He had been physically fit. Almost daily he goes in a state of extreme bliss (Samadhi) where he experiences enormous light and strength. He attributes his strength to an elixir coming out through his palate.

He has studied up to 3 standards & knows to read and write with limited abilities.

According to him he did not speak for about 45 years (Maunbrat). In 1942 he was taken at J.J. Hospital and was under care of doctors & police for 45 days. One and half years back he was investigated by Dr. Sudhir V. Shah for initial analysis of his state of health.

He has no past history of any major illnesses, hospitalization [save 1942 for observations], major or minor surgeries or drug intake.

Mr. Jani accepted to undergo all non invasive procedures and blood investigations but refused for any invasive procedure from the beginning. He never wanted anything to be introduced through anyway to his body.

It was decided to study him by a panel of doctors, which included

Dr. Sudhir V. Shah (Consultant Neurophysician, Sterling Hospital/Associate Professor of Neurology at K. M. School of PGMR, Ahmedabad)

Dr. Urman Dhruv (Physician & Secretary of Association of Physicians of Ahmedabad (APA))

Dr. V. N. Shah (Diabetologist, Director-Sterling Hospital)

Dr. Bharat Gadhavi (General Surgeon/Medical Superintendent-Sterling Hospital)

Dr. Kandarp Parikh (Urologist)

Dr. Dinesh Patel/Dr. Hemant Patel (Radiologists)

Dr. Sanjay Mehta (Neuro Radiologist & Sonologist)

Dr. Gargey Sutaria (Radiologist)

Dr. Sanjiv Haribhakti (G. I. Surgeon)

Dr. Navneet Shah (Physician, Endocrinologist)

Dr. Prakash Darji/Dr. Sonal Dalal/ Dr. Pankaj Shah (Nephrologists)

Dr. Bansi Saboo (General Physician)

Dr. Shrenik Shah (Cardiologist)

Dr. Dhanesh Patel (General Surgeon)

Dr. O. M. Modi (Senior Physician)

Dr. Hemang Desai (Psychiatrist)

Dr. Jayesh Sheth (Genetician & Endocrinologist)

Dr. Dhaval Modi (Ophthalmologist)

Dr. Jayeeta Chaudhary (Dietician)

Dr. Mukesh Patel (Pulmonologist)

Dr. Ruchir Shah (ENT Surgeon)

Dr. Sanjiv Shah (M.D. Pathologist)

Dr. Sandip Shah (M.D. Pathologist)

Several other doctors also examined him from time to time.

He was kept in Sterling Hospital (Gurukul Road, Ahmedabad) from 13/11/03 (10:00 AM) to 22/11/03 (10:00 AM) for observation. Directors of Sterling Hospital specially Dr. V. N. Shah and the management committee of Sterling Hospital kindly consented to look after the ethical aspects and the funds for the project including various tests.

The strict monitoring to ascertain the genuinity of his claim (Not eating anything, not drinking anything, not passing urine and not passing stool) was done by the unbiased august body i.e. Association of Physicians of Ahmedabad, under precise protocol set by the Secretary of the Association, Dr. Urman Dhruv, along with executive committee of the association.

The research panel of doctors was headed by Dr. Sudhir V. Shah (Consultant Neurophysician, Sterling Hospital/Associate professor of neurology at K. M. School of PGMR, Ahmedabad).

During the project, Dr. Sudhir Shah was in touch with Professor Dr. Selvamurthy frequently who is the over all controller of Defence laboratories including DIPAS (Defence Institute of Physiology and Allied Sciences), New Delhi. He was kind enough to guide the protocol of monitoring as well as further tests for the project.

During the study period Mr. Jani was completely monitored by doctors, staff members and security people all throughout the day.

He was asked to make an affidavit to undergo the study with clear understanding that if his health or medical parameters deteriorate then panel of doctors will withdraw from the study. He was kept in ICU for 24 hours i.e. 13/11/03 (10:00 AM to 14/11/03 (10:00 AM) and then was kept in a room with glass door. The toilet door was sealed. CCTV camera was set in the room for the rest of the period of study i.e. from 14/11/03 to 22/11/03 (10:00 AM). Medical officers on duty were assigned the job to monitor him. Staff persons were deputed on round the clock duty for 9 days and nights continuously to stay with Mr. Jani in the same room to closely watch him and make sure that he does not eat, drink, pass urine or stool. The video tapes were reviewed for all 24 hours of all these days by committee. Mr. Jani was not allowed to go out of the room except for sonography of bladder and MRI testings, but even during that period, he was all the way accompanied by doctors. He agreed not to take bath or have body sponging for first seven days as decided by the panel.

Clinical opinions of system examination of all experts were obtained including cardiac, renal, neurological, urological, gastrointestinal, general medical, pulmonological, ophthalmic, ENT, psychiatry and others. A series of investigations were done as per protocol defined earlier as well as additional tests were carried out as per suggestions of the team.

Clinically all his systems were generally normal. All his special senses were also ok except moderate hearing loss. However, his pulse remained at 42-46/min, BP about 114/80 mmHg and respiration around 12-14/min. His cognition and behavior was all right.

His weight was taken daily. His clinical examination including vital data and general examination and systemic examination was done daily. Urinary volume in the bladder was checked by ultrasound twice daily at 10:00 AM & 6:00PM. This showed that there was urine accumulation, which ultimately decreased on its own without passing.

Blood samples were checked regularly with frequent monitoring of CBC, RFT, electrolytes, sugar and acetone. There was mild alteration in renal parameters and there was slight fall in weight, which subsequently stabilized. Otherwise all reports were in normal range. Genetic study report is awaited. The above study was done for the period of 10 days.

## Pertinent Clinical Investigations

### Hematology

Blood Group: "A" +ve

Date:	12/11/03	14/11/03	16/11/03	18/11/03
Hb:	10.8 G%	11.3 G%	11.5 G%	12.3 G%
T.RBC:	4.17	4.37	4.49	4.87
TC:	4880 /c.mm.	5780 /c.mm.	5640 /c.mm.	8180 /c.mm.
DC:	40/47/10/03/00	47/41/09/03/00	52/36/09/03/00	66/27/04/03/00
PC:	3,52,000 /c.mm.	4,25,000 /c.mm.	4,53,000 /c.mm.	5,03,000 /c.mm.
ESR:	After 1 hr: 10 mm			
Blood Indices:				
HCT:	35.8	37.9	38.5	42.0
MCV:	85.9	86.7	85.7	86.2
MCH:	25.9	25.9	25.6	25.3
MCHC:	30.2	29.8	29.9	29.3

Date: 20/11/03  
Hb: 12.9 G%  
T.RBC: 5.17 m/c.mm.  
TC: 7690 /c.mm.  
DC: 62/25/04/05/01  
PC: 4,86,000 /c.mm.  
MPV: 9.0 fl  
ESR: After 1 hr: 25 mm  
After 2 hr: 52 mm

Blood Indices:

HCT: 42.2  
MCV: 81.6  
MCH: 25.0  
MCHC: 30.6

### Biochemistry

Date: 12/11/03  
Prolactin: 3.80  
S. Cortisol: 12.2 microgm/dL  
S. Total Proteins:  
Total Proteins: 7.27  
Albumin: 4.05  
Globulin: 3.22  
A/G Ratio: 1.26

Gamma GT: 31.0 U/L

Thyroid Function Test:

T-3: 0.86 ng/ml  
T-4: 5.90  
TSH: 3.15 microIU/ml  
Lipid Profile:  
S. Cholesterol: 216.0 mg/dl  
S. Triglycerides: 127.6 mg/dl  
HDL: 57.2 mg/dl  
Direct LDL: 118.9 mg/dl  
Cal. LDL: 133.28 mg/dl  
Very low density lipoprotein: 26 mg/dl  
LDL/HDL: 2.079  
Cholesterol/HDL: 3.776

S. Electrolytes:  
S. Na+: 139.8 mmol/L  
S. K+: 4.61 mmol/L  
S. Cl-: 103.2 mmol/L  
S. Acid Phosphatase:  
Total Acid Phosphatase: 4.58 IU/L  
Non Prostatic ACP: 2.58 IU/L  
Prostatic Phosphatase: 135.19 IU/L

S. Bilirubin:  
Total Bilirubin: 0.48 mg/dl  
Conj: 0.10 mg/dl  
Unconj: 0.38 mg/dl  
Delta: 0 mg/dl  
SGPT: 21.0 U/L  
SGOT: 22.0 U/L  
S. Alk. Phosphatase: 95.0 U/L

FBS: 85.7 mg/dl  
Blood Urea: 33.0 mg/dl  
S. Creatinine: 1.36 mg/dl  
S. Uric acid: 5.26 mg/dl  
S. Acetone : 10 mg/dl  
Human Growth Hormone: 0.14 ng/ml

Date: 14/11/03  
Blood Urea: 46.9 mg/dl  
S. Creatinine: 1.53 mg/dl  
S. Na+: 145.1 mmol/L  
S. K+: 4.60 mmol/L  
S. Cl-: 107.0 mmol/L  
S. Acetone : 10 mg/dl

Date: 15/11/03  
S. Na+: 143.7 mmol/L  
S. Acetone: 30.0 mg/dl (Present)

Date: 16/11/03  
Blood Urea: 59.6 mg/dl  
S. Creatinine: 1.52 mg/dl  
S. Na+: 148.3 mmol/L  
S. K+: 4.97 mmol/L  
S. Cl-: 106.8 mmol/L  
RBS: 84.9 mg/dl  
S. Acetone: 30.0 mg/dl (Present)

Date: 18/11/03  
S. Uric acid: 11.44 mg/dl  
SGPT: 10.0 U/L  
S. Acetone: 30.0 mg/dl (Present)  
Blood Urea: 63.7 mg/dl  
S. Creatinine: 1.75 mg/dl  
S. Na+: 154.3 mmol/L  
S. K+: 4.37 mmol/L  
S. Cl-: 107.5 mmol/L

ABG: (Venous Blood)  
PH: 7.31  
PCO2: 48  
PO2: 23  
TCO2: 25  
HCO3: 23  
BE: -3.0  
O2 sat: 35%  
Venous RBS: 162.0 mg/dl

Date: 20/11/03  
T-3: 0.97 ng/ml  
T-4: 9.0 ug/dl  
TSH: 2.1 ulu/dl  
Plasma Cortisol:  
AM: 11.0 ug/dl  
FBS: 76 mg%  
Blood Urea: 77 mg%  
S. Creatinine: 1.7 mg%  
S. Na+: 155.9 M.Eq/L  
S. K+: 4.67 M.Eq/L  
S. Cl-: 115.9 M.Eq/L  
SGPT: 24 Units/ml  
S.Acetone : 30 mg\dl

Date: 21/11/03  
Blood Urea: 87.5 mg/dl  
S. Creatinine: 1.46 mg/dl  
S. Na+: 143.5 mmol/L  
S. K+: 4.16 mmol/L  
S. Cl-: 101.5 mmol/L  
S. Acetone: 30.0 mg/dl (Present)

Date: 25/11/03  
S. K+: 3.40 mmol/L  
SGPT: 23.0  
S. Creatinine: 1.40 mg/dl  
S. Na+: 137.5 mmol/L  
Blood Urea: 48.2 mg/dl  
RBS: 99.8 mg/dl

**Audiological Evaluation:** (17/11/03)

Bilateral severe to profound degree of sensori-neural hearing loss.

**ECG and cardiac evaluation were normal.**

**Radiological Investigations**

X-Ray Chest PA (12/11/03):  
No significant abnormality detected.

USG Abdomen (12/11/03):  
No significant abnormality detected.

Doppler examination of carotid, vertebral, abdominal aorta and peripheral arterial system of lower limbs were quite normal.

MR Angiography of Brain, Neck & abdomen was unremarkable.

MR Oesophagus: Normal study

MR cholanigopancreatography: Normal study

MR Abdomen – pelvis: Presence of bowel gas and solid faecal material.  
Gall bladder collapsed.

Urinary bladder partially filled with urine around 70ml

MR Myelography: Normal study

**Cartography (26/11/03):**

Normal study.

After day 10, the committee is satisfied with following matter:

1. The protocol was strictly adhered to.
2. Mr. Jani has not passed or dribbled urine during these 10 days.
3. He has not taken anything by mouth or by any other routes not even water for 10 days.
4. All his parameters remained within the range determined by the committee.
5. He has shown evidence of formation of urine, which seems to be reabsorbed from his bladder wall. However at present the committee does not have any scientific explanation for the same but the help of senior scientists and medical personnel of the country is being taken for the same.

We are surprised as to how he has survived despite above particularly without passing urine for 10 days and remaining generally physically fit.

However it should be made very clear that we have confirmed the claim over 10 days only and we as scientists and responsible doctors cannot say anything regarding validity of the claim of his sustaining without food, drinks, urination and excretion of stools over several years.

Our attempt is to understand this wonderful phenomenon having confirmed from our side over these 10 days and we are not sure whether this is reproducible in other human beings by the way of YOGA as he practices or by other methods like Genetic Engineering. If so, also we are not sure whether and how it can contribute to human welfare. At the moment, we are trying to analyse the results and trying to learn for the betterment of science. Probably, some invasive investigations may help understand this process but from the beginning Mr. Jani has refused any invasive procedure or any sort of injections be it a dye only.

Dr. Urman Dhruv  
(Physician & Secretary  
of APA)

Dr. S. V. Shah  
(Consultant Neurology &  
Head of Research Committee)

Dr. V. N. Shah  
(Diabetologist  
Director-Sterling Hospital)