AGENDA

THE MEETING OF THE

DISABILITY PROCEDURES AND SERVICES COMMITTEE
and
BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 NORTH LAKE AVENUE, SUITE 810
PASADENA, CA 91101

9:00 A.M., WEDNESDAY, NOVEMBER 7, 2018 **

The Committee may take action on any item on the agenda,
and agenda items may be taken out of order.

COMMITTEE MEMBERS:

William Pryor, Chair
James P. Harris, Vice Chair
Herman Santos
Gina Zapanta-Murphy
Marvin Adams, Alternate

I. CALL TO ORDER

II. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of September 5, 2018.

III. PUBLIC COMMENT

IV. ACTION ITEMS

A. Recommendation as submitted by Ricki Contreras, Manager, that the Disability Procedures and Services Committee adopt staff's recommendation to submit the Application of Kari Tervo, Ph.D. to the Board of Retirement for final approval to the LACERA Panel of Examining Physicians.

B. Recommendation as submitted by Ricki Contreras, Manager, that the Disability Procedures and Services Committee adopt staff's recommendation to submit the Application of Robert Fisher, M.D. to the Board of Retirement for final approval to the LACERA Panel of Examining Physicians.

C. Recommendation as submitted by Ricki Contreras, Manager, that the Disability Procedures and Services Committee adopt staff's recommendation to submit the Application of Stewart A. Lonky to the Board of Retirement for final approval to the LACERA Panel of Examining Physicians.

D. Recommendation as submitted by Ricki Contreras, Manager, that the Disability Procedures and Services Committee adopt staff's recommendation to submit the Application of Gerald Weingarten, M.D. to the Board of Retirement for final approval to the LACERA Panel of Examining Physicians.

E. Recommendation as submitted by Ricki Contreras, Manager, that the Disability Procedures and Services Committee adopt staff's recommendation to submit the Application of David Paikal, M.D. to the Board of Retirement for final approval to the LACERA Panel of Examining Physicians.

V. ITEMS FOR STAFF REVIEW

VI. GOOD OF THE ORDER

(For information purposes only)

VII. ADJOURNMENT

***The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five (5) or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote, make a motion, or second on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.**

****Although the meeting is scheduled for 9:00 a.m., it can start anytime thereafter, depending on the length of the Board of Retirement meeting. Please be on call.**

Assistive Listening Devices are available upon request. American Sign Language (ASL) Interpreters are available with at least three (3) business days notice before the meeting date.

Any documents subject to public disclosure that relate to an agenda item for an open session of the Committee, that are distributed to members of the Committee less than 72 hours prior to the meeting, will be available for public inspection at the time they are distributed to a majority of the Committee, at LACERA's offices at 300 North Lake Avenue, suite 820, Pasadena, California during normal business hours from 9:00 a.m. to 5:00 p.m. Monday through Friday.

Persons requiring an alternative format of this agenda pursuant to Section 202 of the Americans with Disabilities Act of 1990 may request one by calling the Disability Retirement Services Division at 626-564-2419 from 7:30 a.m. to 5:00 p.m. Monday through Friday, but no later than 48 hours prior to the time the meeting is to commence.

MINUTES OF THE MEETING OF THE

DISABILITY PROCEDURES AND SERVICES COMMITTEE
and
BOARD OF RETIREMENT

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

GATEWAY PLAZA - 300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

WEDNESDAY, SEPTEMBER 5, 2018

COMMITTEE MEMBERS

PRESENT: William Pryor, Chair
James P. Harris, Vice Chair
Herman Santos
Gina Zapanta-Murphy
Marvin Adams, Alternate

ALSO ATTENDING:

BOARD MEMBERS AT LARGE

Vivian H. Gray
Shawn Kehoe

STAFF, ADVISORS, PARTICIPANTS

Ricki Contreras, Disability Retirement Services Division Manager

Tamara Caldwell, Disability Retirement Specialist Supervisor

Francis J. Boyd, Senior Staff Counsel

The Meeting was called to order by Chair Pryor at 10:20 a.m., in the Board Room of Gateway Plaza.

I. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of August 1, 2018.

Mr. Harris made a motion, Mr. Adams seconded, to approve the minutes of the regular meeting of August 1, 2018. The motion passed unanimously.

II. PUBLIC COMMENT

There were no requests from the public to speak.

III. ACTION ITEMS

A. Recommendation as submitted by Francis J. Boyd, Senior Staff Counsel, that the Disability Procedures and Services Committee recommend to the Board of Retirement that it adopt the recommended procedures for members to apply for a correction appeal in regard to their effective date of disability retirement under Government Code section 31541.1.

Mr. Santos made a motion, Mr. Harris seconded, to approve to accept staff's recommendation and submit the recommendation to the Board of Retirement for approval. The motion passed unanimously.

IV. FOR INFORMATION

A. Blood-borne Infectious Disease Presumption – Presentation by Francis J. Boyd, Senior Staff Counsel.

Mr. Boyd and Ms. Contreras were present to answer any questions.

V. GOOD OF THE ORDER

Committee members commended staff on a job well done regarding above action item.

VI. ADJOURNMENT

With no further business to come before the Disability Procedures and Services

Committee, the meeting was adjourned at 10:43 a.m.

October 26, 2018

TO: Disability Procedures & Services Committee
William Pryor, Chair
James P. Harris, Vice Chair
Herman Santos
Gina Zapanta-Murphy
Marvin Adams, Alternate

FROM: Ricki Contreras, Manager
Disability Retirement Services

FOR: November 7, 2018, Disability Procedures and Services Committee Meeting

SUBJECT: **CONSIDER APPLICATION OF KARI TERVO, Ph.D., AS A LACERA PANEL PHYSICIAN**

On August 7, 2018, staff and Legal Counsel interviewed California Medical Evaluators regarding Kari Tervo, Ph.D., a physician seeking appointment to the LACERA Panel of Examining Physicians.

Attached for your review and consideration are:
- Staff's Interview Summary and Recommendation
- Panel Physician Application
- Curriculum Vitae
- Sample Report(s)

IT IS THEREFORE RECOMMENDED THAT THE COMMITTEE accept the staff recommendation to submit the application of Kari Tervo, Ph.D., to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

JJP:RC:mb

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

October 26, 2018

TO: Ricki Contreras, Manager
Disability Retirement Services

FROM: Tamara L. Caldwell, DRS Supervisor
Disability Retirement Services

FOR: November 7, 2018 Disability Procedures & Services Committee

SUBJECT: Recommendation for Neuropsychologist Applying for LACERA's Panel of Examining Physicians

RECOMMENDATION

Based on our efforts to provide a diverse panel of examining physicians in several geographic locations throughout Los Angeles and surrounding counties, staff recommends the Application of Kari Tervo, Ph.D be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

On August 7, 2018, staff and Legal Counsel met with California Medical Evaluators at the LACERA offices to discuss several candidates for the LACERA Panel of Examining Physicians. California Medical Evaluators (CME) is a doctor-owned management and marketing company focused on serving the medical and legal communities. CME provides full-service administration of physician's medical-legal practices. CME was founded by Gregory Marusak, MD and Gabor Vari, MD who cumulatively span over two decades of experience in the medical-legal industry. They are both UCLA residency graduates and remain active on the UCLA faculty. Since its inception, CME has steadily grown, adding physicians, staff and offices to better serve clients and community. CME has highly experienced doctors in all specialties throughout California and pride themselves on providing a comprehensive and tailored experience for both legal and medical professionals.

Kari Tervo, PhD is a clinical psychologist, neuropsychologist, and Qualified Medical Evaluator, licensed in the State of California. She has 10 years of post-degree experience, and has been performing ancillary workers' compensation duties for five years. She has worked in a number of environments, including forensic and hospital settings. Her scope of diagnostic expertise is expansive, and ranges from depression, pain, and adjustment disorders to severe mental illnesses such as schizophrenia. She is particularly skilled in the assessment of substance use disorders. She has expertise in working with numerous demographics (such as different ages, backgrounds, and difficulties).

Along with QME services, Dr. Tervo also provides cognitive-behavioral therapy and neuropsychology evaluations for individuals who require significant care for their medical needs. In her clinical work, she specializes in mood regulation and helping clients adjust to difficult situations. Dr. Tervo earned her PhD in Clinical Psychology from the University of Maryland – College Park, an APA-accredited program. There, she specialized in schizophrenia and neuropsychology. She spent her undergraduate career at the University of Michigan, where she won numerous awards and scholarships. She graduated with High Distinction as a member of Phi Beta Kappa. In her free time, Dr. Tervo likes to write about topics ranging from mental illness stigma reduction to events in pop culture. Moreover, she is a member of Toastmasters, International, where she has won several awards for her prepared and impromptu speeches. Dr. Tervo enjoys providing the skills, analysis, and experience you expect when seeking a Qualified Medical Evaluator.

Staff reviewed the new LACERA Panel Physician Guidelines with the physician's management team, which included a lengthy discussion regarding the Rules in Evaluating Applicants, Disability Retirement Law Standards, and a thorough explanation of what is expected when preparing Panel Physician's written report for the Board of Retirement. Staff also discussed report submission timeframes, fee schedule and billing procedures, additional diagnostic testing request requirements, and advised of the requirement of maintaining a valid medical license, Board Certification, and insurance coverage. Staff also advised that all physicians must immediately report any lapses, suspensions or revocation of medical license, Board Certification, or insurance coverage, or be subject to immediate suspension or termination from LACERA Panel of Examining Physicians.

CME confirmed that they would be responsible in making sure that Dr. Tervo adhered to the rules set forth in the Guidelines and all other requirements as discussed. CME was informed that a Quality Control Questionnaire is sent to each applicant regarding their visit, which affords the applicant an opportunity to provide feedback concerning their experience during the medical appointment.

On September 21, 2018, Board Medical Advisor Vito Campese, M.D., reviewed Dr. Tervo's application and medical credential and indicated he is in agreement with submitting the Application of Kari Tervo, Ph.D to the Disability Procedures and Services Committee for consideration.

IT IS THEREFORE RECOMMENDED THAT YOUR COMMITTEE adopt staff's recommendation to submit the Application of Kari Tervo, Ph.D to the Board of Retirement for final approval to the LACERA Panel of Examining Physicians.

Attachments

RC:tlc:mb

Kari Tervo, Ph.D.
Office Location Details

Location	ADA Parking	ADA Restrooms	Lobby/Waiting Room Seating	Patients Per Day	Average Wait Time	Evaluation Time
2158 E Florence Avenue Walnut Park, CA 90255	Yes	Yes	15	5-10	0 – 5 Minutes	30 Minutes – 3 Hours
13100 Brooks Drive, Suite 107 Baldwin Park, CA 91706	Yes	Yes	7	5-10	0-5 Minutes	30 Minutes – 3 Hours
12966 Euclid Street, Suite 508 Garden Grove, CA 92840	Yes	Yes	10	5-10	0-5 Minutes	30 Minutes - 3 Hours
9161 Sierra Avenue, Suite 207 Fontana, CA 92335	Yes	Yes	6	5-10	0-5 Minutes	30 Minutes – 3 Hours
1918 Business Center Drive, Suite 215 San Bernardino, CA 92408	Yes	Yes	8	5-10	0-5 Minutes	30 Minutes – 3 Hours

1. CME has 47 employees including, but not limited to, medical assistants, provider liaisons, and administrative support.
2. Bianka Kuretil will be LACERA's point of contact for scheduling appointments and addressing issues and complaints. Contact: 310-625-7475 and bkureti@calmedeval.com
3. Physician review patient history prior to examination.
4. Only CME physicians share these offices for evaluations.

LACERA

Los Angeles County Employees Retirement Association

300 N. Lake Ave., Pasadena, CA 91101 ■ Mail to : PO Box 7060, Pasadena, CA 91109-706 626/564-2419 • 800/786-6464

GENERAL INFORMATION		Date 8/14/18
Group Name: CALIFORNIA MEDICAL EVALUATORS	Physician Name: KARI TERVO, PhD	
I. Primary Address: 11620 WILSHIRE BLVD, SUITE 340, LA, CA, 90025		
Contact Person BIANKA KURETI	Title ACCOUNT EXECUTIVE	
Telephone: 888.853.7944	Fax 866.288.9958	
II. Secondary Address 11620 WILSHIRE BLVD, SUITE 340, LA, CA, 90025		
Contact Person DOUGLAS STODDARD	Title VICE PRESIDENT, SALES & MARKETING	
Telephone 323.6453644	Fax 213.377.5152	

PHYSICIAN BACKGROUND		
Field of Specialty CLINICAL PSYCHOLOGY	Subspecialty NEUROPSYCHOLOGY	
Board Certification ☑ Yes ☐ No	License # PSY23273	Expiration Date 8/31/2019

EXPERIENCE
Indicate the number of years experience that you have in each category.

Evaluation Type

I. Workers' Compensation Evaluations
- ☐ Defense How Long? _____
- ☐ Applicant How Long? _____
- ☐ AME How Long? _____
- ☐ IME How Long? _____
- ☑ QME How Long? 4 years

II. ☐ Disability Evaluations How Long? _____

For What Public or Private Organizations?

Currently Treating? ☒ Yes ☐ No

Time Devoted to: Treatment > 30 % Evaluations _____ %

Estimated Time from Appointment to Examination	Able to Submit a Final Report in 30 days?
☑ 2 weeks ☐ 3-4 Weeks ☐ Over a month	☑ Yes ☐ No

LACERA's Fee Schedule	
Examination and Initial Report by Physician	$1,500.00 flat fee
Review of Records by Physician	$350.00/hour
Review of Records by Registered Nurse	$75.00/hour
Supplemental Report	$350.00/hour

-OVER-

Other Fees	
Physician's testimony at Administrative Hearing (includes travel & wait time)	$350.00/hour
Deposition Fee at Physician's office	$350.00/hour
Preparation for Expert Testimony at administrative Hearing	$350.00/hour
Expert Witness Fees in Superior or Appellate Court	$3,500.00 half day $7,000 full day
Physician agrees with LACERA's fee schedule?	No
Comments	

Name of person completing this form:

BIANKA KURETI Title: ACCOUNT EXECUTIVE

(Please Print Name)

Physician Signature: Kari Tervo, Ph.D., QME Date: 08/14/2018

FOR OFFICE USE ONLY Physician Interview and Sight Inspection Schedule	
Interview Date:	Interview Time:
Interviewer:	

California Medical Evaluators
11620 Wilshire Blvd., Suite 340
Los Angeles, CA 90025
Ph: 888-853-7944
Fx: 213-478-0550
info@calmedeval.com

KARI TERVO, PhD, QME
CLINICAL PSYCHOLOGY/NEUROPSYCHOLOGY

EDUCATION

- **Michigan Technological University, Houghton, MI**: Guest student (1996)
- **University of Michigan, Ann Arbor**: B.A. with High Distinction, Psychology (1994 – 1997)
- **Doctoral Program in Clinical Psychology, University of Maryland**—College Park *M.A.*, 2002, *Ph.D.*, (2004)
- **Pre-Doctoral Intern in Clinical Psychology, Washington, D.C.** Veteran's Affairs Medical Center (2003 – 2004)
- Neuropsychology Postdoctoral Fellow, **University of Pennsylvania** (2004 -2005)

FORENSIC EXPERIENCE

- Kari Tervo, Ph.D., Forensic Neuropsychology Consulting. California License: PSY 23273 (2001 – Present)

  Industrial medicine evaluations

  Expert witness services

  Higher-level analyses (e.g., single-case research design, critical thinking)

  Record review with critical analysis

  Deposition preparation

  Work product critique

  Integrative summary exhibits

  Rebuttals to opposing experts

  Timelines

  Graphing of case data

- Forensic Neuropsychology Consultant, Executive Mental Health. Review, evaluate, summarize, and integrate pertinent information for forensic neuropsychology evaluations. Case examples include serial murder, pediatric traumatic brain injury, sexual assault, and medical malpractice. (2006 – 2011)

WORKERS' COMPENSATION EXPERIENCE

- Designated as Qualified Medical Evaluator. (2014)

- Record Reviewer, Arnold Gilberg, M.D. (psychiatry). Review and summarize medical records from a variety of specialties for workers' compensation cases, with a focus on history and factors of apportionment. Occasional supplemental report writing. (2011 – Present)
- Medical Historian for several QME psychiatrists. Obtain history of workers' compensation applicants, including history of injury, medical and psychiatric histories, and history in other domains. Narrative history, test interpretation, and report writing. (2009 – Present)
- Pre-Doctoral Internship in clinical psychology, Washington, D.C. Veteran's Affairs Medical Center. *Treatment:* Individual therapy with individuals with a variety of mental illnesses, including acutely ill psychiatric ward inpatients and individuals with Borderline Personality Disorder. Led daily inpatient and outpatient psychotherapy and psychoeducational groups. *Assessment:* Intake and diagnostic interviews for Psychology Service programs, administration and interpretation of personality tests. *Neurocognitive Assessment:* Administered and interpreted a variety of neurocognitive tests with a variety of patients, including geriatric and traumatic brain injury patients. Wrote reports, debriefed patients. (2003 -2004)

CLINICAL EXPERIENCE

- Licensed Psychologist (PSY 23273). Forensic, neuropsychological, psychoeducational, and clinical evaluations and therapy services. (2011 – Present)
- Licensed Psychologist/Psychological Assistant (license 2010; PSY 23273), Executive Mental Health. Forensic, neuropsychological, psychoeducational, and clinical evaluations and therapy services. (2007 – 2011)
- Psychology Associate, Maria Zimmitti Cohn and Associates. Neuropsychological, psychoeducational, and clinical evaluations and therapy services. (2006 -2007)
- Neuropsychology Postdoctoral Fellow, University of Pennsylvania. Neuropsychological evaluations and determined diagnoses of various dementias, ADHD, learning disabilities, and other disorders. (2004 – 2005)
- Pre-Doctoral Internship in clinical psychology, Washington, D.C. Veteran's Affairs Medical Center. *Treatment:* Individual therapy with individuals with a variety of mental illnesses, including acutely ill psychiatric ward inpatients and individuals with Borderline Personality Disorder. Led daily inpatient and outpatient psychotherapy and psychoeducational groups. *Assessment:* Intake and diagnostic interviews for Psychology Service programs, administration and interpretation of personality tests. *Neurocognitive Assessment:* Administered and interpreted a variety of neurocognitive tests with a variety of patients, including geriatric and traumatic brain injury patients. Wrote reports, debriefed patients. (2003 – 2004)
- Externship in clinical psychology, University of Maryland at Baltimore and Baltimore Veteran's Administration Hospital. *Treatment:* Co-led behavioral treatment group for dually-diagnosed individuals with severe mental illnesses (schizophrenia, bipolar disorder). *Assessment:* Administered battery of psychological measures (e.g., PANSS) to individuals with severe mental illnesses. *Cognitive testing:* Wisconsin Card Sorting Test, Wechsler Memory Scales-III, WAIS-III, RBANS. (2002 -2003)

- Training in cognitive and neuropsychological assessment, University of Maryland, College Park: Doctoral Program in Clinical Psychology, Psychology Clinic. *Cognitive testing:* Administered battery of cognitive and neuropsychological tests (including the WAIS-III, Woodcock Johnson-3, Wisconsin Card Sorting Test, Trails A and B, and others), interpreted results, wrote reports, debriefed clients. *Supervision:* supervised report-writing of students with less experience. (2001)

- Therapist in training, University of Maryland, College Park: Doctoral Program in Clinical Psychology, Psychology Clinic. *Intake:* Administered structured clinical interviews and determined client concerns. *Therapy:* Hourly therapy sessions utilizing empirically supported treatments. *Psychodiagnostic Tests:* Administered tests including the Beck Depression Inventory, Social Phobia and Anxiety Inventory, Minnesota Multiphasic Personality Inventory-2, and others. (2000 – 2003)

- Crisis Line Services/Office Assistant, Dial Help, Inc., Houghton, MI. *Clinical Services:* Completed intensive training to increase empathy and problem-solving skills, and to understand substance abuse, domestic violence, and other problems. Assisted crisis line callers with a range of situations. *Administration:* Improved and expanded organization's resources. Assisted in creating on-line referral system. *Public Relations:* Created informational posters regarding child abuse, elder abuse, and organization programs. Promoted volunteer training by creating a public service announcement and flier. (1997)

RESEARCH EXPERIENCE

- Neuropsychology Postdoctoral Fellow, University of Pennsylvania. Designed protocols and collected data examining aspects of memory in schizophrenia patients and normal controls. Utilized SPSS, Excel, and SAS in data analyses. (2004 – 2005)

- Student Investigator, University of Maryland, College Park: Doctoral Program in Clinical Psychology, Dissertation Research. Collected and analyzed interview and neurocognitive data examining neurocognitive characteristics of putative schizotypes. Ph.D. obtained December, 2004. (2002 – 2004)

- Research Assistant, University of Maryland, College Park: Doctoral Program in Clinical Psychology, Maryland Center for Schizophrenia Research. *Clinical Research Interviewing:* Administered Structured Clinical Interview for DSM-IV, International Personality Disorders Evaluation, Family Interview for Genetic Studies. Debriefed participants. *Neuropsychological Testing:* Administered Degraded Stimulus Continuous Performance Task, WAIS-III, WMS-III. *Coordination:* Mass mailing, database organization. *Data Analysis:* Utilized SPSS and Excel in data analyses. (2002 – 2003)

- Student Investigator, University of Maryland, College Park: Doctoral Program in Clinical Psychology, Master's Thesis Research. Designed and implemented procedures for behavioral observation and interview study of parents and children. Trained raters/assistants. Created database and participant tracking system. Master's degree obtained May, 2002. (2000 – 2002)

- Research Assistant, University of Maryland, College Park: Doctoral Program in Clinical Psychology, Maryland Center for Anxiety Disorders. *Participant Screening:* Obtained informed consent, administered battery of psychological measures, administered intelligence tests, performed structured interviews (e.g., Anxiety Disorders Interview

Schedule). *Coordination:* Obtained space for administration of research battery, scheduled participant appointments. *Therapy:* Group and individual treatment sessions for research protocol, facilitating peer generalization activities. *Data Analysis:* Utilized SPSS and Excel in data analyses, performed data rotations and statistical tests. *Materials Acquisition:* Performed literature searchers and obtained academic articles. (1999 – 2000)

- Study Coordinator, Cocaine Infusion Lab, University of California, Los Angeles.

  Participant Screening: Vitals, 12-lead ECGs, HIV pre-test counseling, lab ordering, extensive social history with emphasis on drug use habits, mental status exams, battery of psychological tests (Structured Clinical Interview for DSM-IV, Addiction Severity Index, Beck Depression Inventory, and others). *Coordination:* Coordinated activities between investigators and research assistants, attending and admitting physicians, nursing staff. *Protocol Administration:* Drafted and submitted informed consent forms, supporting documents, and progress reports to institutional review boards and clinical research center. Communicated with hospital pharmacy regarding randomization, participant and experimenter blinding with regard to drug administration. Maintained progress of several ongoing National Institute on Drug Abuse-funded research protocols. *Data Analysis:* Utilized SPSS and Excel in data analyses and data compilation, performed statistical tests. *Data Management:* Working knowledge of Standard Operating Procedures guidelines, including FDA reporting procedures. (1998 – 1999)

- Research Assistant, University of Michigan, Ann Arbor: Department of Psychology. Coded raw data into Microsoft Office programs. Utilized research skills for library materials acquisition. Prioritized completion of various projects. Used spreadsheets and word processors. Performed various office tasks. (1996 – 1997)

PUBLICATIONS & PRESENTATIONS

- **Tervo, K.** (2007). The neurocognitive consequences of substance use and schizophrenia: Is there an additive effect? Neuropsychology and Substance Use: State of the Art and Future Directions. Ari Kalechstein and Wilfred Van Gorp, Eds. Psychology Press.
- **Tervo, K.** (2006). How Shy is Too Shy? Social Anxiety in Children. Presented for the Maria Zimmitti Cohn and Associates Lecture Series (Washington, D.C.) and for the Mothers of North Arlington Lecture Series (Arlington, VA).
- Newton, T., Kalechstein, A., **Tervo, K.**, and Ling, W. (2003). Irritability following abstinence from cocaine predicts euphoric effects of cocaine administration. Addictive Behaviors, 28(4), 817-822.
- Turner, S., Beidel, D., Roberson-Nay, R., and **Tervo, K.** (2003). Parenting behaviors in parents with anxiety disorders. Behaviour Research & Therapy, 41 (5), 541-544.
- **Tervo, K.**, Leung, W., Adams, K., Collins, L., Aghevli, M., & Blanchard, J. (2003). Neuropsychological characteristics of putative schizotypes: A comparative study. Poster presented at the 18th annual meeting of the Society for Research in Psychopathology, Toronto, Ontario, Canada.
- Leung, W, Aghevli, M., Collins, L.M., Adams, K., **Tervo, K.**, & Blanchard, J. (2003). An examination of the relationship between neuropsychological indices and the temporal stability of social anhedonia in putative schizotypes. Poster presented at the 18th annual

meeting of the Society for Research in Psychopathology, Toronto, Ontario, Canada.

- Aghevli, M., Leung, W., Collins, L., Adams, K., **Tervo, K.**, & Blanchard, J. (2003,). The relationship between minor physical anomalies, social anhedonia and obstetric complications in the prediction of schizophrenia-spectrum pathology. Poster presented at the 18th annual meeting of the Society for Research in Psychopathology, Toronto, Ontario, Canada.

- Collins, L.M., Biondo, K., Aghevli, M., **Tervo, K.**, Leung, W., Adams, K., & Blanchard, J. (2003). Signs vs. symptoms approach to assessing schizotypy: An examination of the incremental validity of a behavioral rating scale. Poster presented at the 18th annual meeting of the Society for Research in Psychopathology, Toronto, Ontario, Canada.

- Blanchard, J., Aghevli, M., **Tervo, K.**, Leung, W., Collins, L., and Adams, K. (2003). Social anhedonia and schizophrenia-proneness: Initial results from the Maryland Longitudinal Study of Schizotypy. Poster session presented at the annual conference of the International Congress on Schizophrenia Research, Colorado Springs, CO.

- Adams, K., Collins, L., Leung, W., **Tervo, K.**, Aghevli, M., and Blanchard, J. (2003). Do family environment and social support predict psychopathology in putative schizotypes? Poster session presented at the annual conference of the International Congress on Schizophrenia Research, Colorado Springs, CO.

- **Tervo, K.**, Collins, L., Leung, W., Adams, K., & Aghevli, M. (2003). Global functioning and clinical characteristics of putative schizotypes in a community sample. Poster presented at the 7th annual Department of Psychology poster session, University of Maryland, College Park, MD.

- Aghevli, M., **Tervo, K.**, Leung, W., Collins, L., Adams, K., & Blanchard, J. (2002). Developmental instability, obstetric complications and psychopathology in a community sample putatively at risk for schizophrenia-spectrum disorders. Poster presented at the 17th annual meeting of the Society for Research in Psychopathology, San Francisco, CA.

- Leung, W.W., Collins, L.M., Adams, K.A., Aghevli, M., **Tervo, K.**, & Blanchard, J. (2002). The identification of schizotypy: Examining the utility of combining neuropsychological and psychometric indicators. Poster presented at the 17th annual meeting of the Society for Research in Psychopathology, San Francisco, CA.

- **Tervo, K.**, Adams, K., Collins, L., Aghevli, M., Leung, W., & Blanchard, J. (2002). Clinical and individual difference characteristics of putative schizotypes: A comparison of community and college samples. Poster presented at the 17th annual meeting of the Society for Research in Psychopathology, San Francisco, CA.

- Collins, L., Adams, K., Buchanan, A., Aghevli, M., Leung, W., **Tervo, K.**, & Blanchard, J. (2002). The psychometric detection of schizophrenia-proneness: Examining the role of sex and ethnicity in a community sample. Poster presented at the 6th annual Department of Psychology poster session, University of Maryland, College Park, MD.

- **Tervo, K.**, Howard, C., Leung, W., Aghevli, M., and Blanchard, J. (2001). What individual difference factors account for the heterogeneity of clinical characteristics in putative schizotypes? Poster session presented at the annual conference of the Society for Research in Psychopathology, Madison, WI.

- Aghevli, M., Blanchard, J., **Tervo, K.**, and Leung, W. (2001). Is there a schizotypy taxon outside the classroom? Examining the latent structure of putative schizotypy questionnaires in a community sample. Poster session presented at the annual conference of the Society for Research in Psychopathology, Madison, WI.
- **Tervo, K.** and Beidel, C. (2001). A behavioral observation study of parental characteristics associated with childhood social phobia. Poster session presented at the annual conference of the Association for the Advancement of Behavior Therapy, Philadelphia, PA.
- Aghevli, M., **Tervo, K.**, Leung, W., Howard, C., and Blanchard, J. (2001). Predictors of clinical psychopathology in a college sample putatively at risk for schizophrenia-spectrum disorders. Poster session presented at the annual conference of the Association for the Advancement of Behavior Therapy, Philadelphia, PA.
- Newton, T., Ling, W., Kalechstein, A., Uslaner, J., and **Tervo, K.** (2001). Risperidone pre-treatment reduces the euphoric effects of experimentally administered cocaine. Psychiatry Research, 102 (3), 227-233.
- **Tervo, K.**, Howard, C., Leung, W., Aghevli, M., Blanchard, J. (2001). Study participation rates and characteristics of individuals at high risk for schizophrenia-spectrum disorders. Poster session presented at the annual Department of Psychology poster session, University of Maryland at College Park.
- Tan, A., Kalechstein, A., Fiala, M., Lindholm, J., Vakulenko, M., **Tervo, K.**, Newton, T. (1998). Cocaine-induced sympathetic activation associated with craving and immune function and subjective response. Poster session presented at the annual School of Medicine Research Presentation Forum, University of California at Los Angeles.

HONORS

- Third Place, Evaluator, International Speech Contest, Toastmasters, International (2014)
- Best Evaluator award, Toastmasters, International (2014)
- Best Speaker award, Toastmasters, International (2014)
- Best Speaker/Best Impromptu Speaker award (four-time winner), Toastmasters, International (2013)
- Grand Prize Winner, American Express Passion Project contest (2013)
- Maryland Senatorial Scholarship (2002)
- Goldhaber Award, University of Maryland (2001)
- Program of the Year, Michigan Leadership Awards. For symposium entitled, "Affirmative Action 101: Understanding the Controversy." As a member of the Michigan Student Assembly Women's Issues Commission, University of Michigan, Ann Arbor (1998)
- Phi Beta Kappa (1998)
- James B. Angell Scholar, University of Michigan, Ann Arbor (1998)
- Class Honors, University of Michigan (1998)
- James B. Angell Scholar, University of Michigan, Ann Arbor (1997)

California Medical Evaluators
P: (888) 853-7944 F: (866) 288-9958
11620 Wilshire Blvd Ste. 340 Los Angeles CA 90025

- B.A. with High Distinction, Psychology. University of Michigan, Ann Arbor. GPA: 3.85 (1997)
- University of Michigan Alumnae Association Scholarship (1997)
- College of Literature, Science and the Arts Scholarship, University of Michigan, Ann Arbor (1997)
- Michigan Competitive Scholarship (1997)
- Class Honors, University of Michigan (1997)
- Psi Chi National Psychology Honor Society (1996)
- Golden Key National Honor Society (1996)
- One of six (of approximately 600) students to achieve a grade of A+ in Statistics 402 (Brenda Gunderson, Ph.D.; University of Michigan—Ann Arbor) (1996)
- University of Michigan Alumni Association Scholarship (1996)
- American Association of University Women Scholarship (1996)
- Class Honors, University of Michigan (1996)
- Michigan Competitive Scholarship (1996)
- Class Honors, University of Michigan (1995)
- Michigan Competitive Scholarship (1995)
- Lishinski Scholarship (1994)
- Michigan Competitive Scholarship (1994)
- Social Studies Department Graduating Senior Award, Houghton High School (1994)
- English Department Graduating Senior Award, Houghton High School (1994)

APPENDIX: FORENSIC WORK PRODUCT EXCERPTS

Rebuttal to Opposing Expert, Sample One: Expert Retained by Defendant

[...]Dr. F 's evaluation is further flawed because he conferred an unrealistically low Global Assessment of Functioning scale score.

Global Assessment of Functioning Score

According to the treatment plan, Dr. F r conferred a Global Assessment of Functioning (GAF) scale score of 38, and stated that this score was given because Ms. was experiencing "severe" symptoms that were causing "major impairment" in her functioning across the domains of "school, work, and interpersonal relationships with family and friends."

The DSM-IV-TR defines a GAF in the range of 31-40 as follows: "Some impairment in reality testing or communication (e.g., speech is sometimes illogical, obscure, or irrelevant) OR major impairment in several areas, including work, school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work. . .)" (American Psychological Association, 2000). GAF scores in this range are typically conferred to patients who are mildly psychotic or are experiencing severe functional limitations, such as not being able to work because of symptom severity.

A review of Ms. global functioning in her interview with this evaluator in 4/11 revealed that she was experiencing good, if not excellent, functioning across multiple domains. Specifically, she was reportedly doing well at a university, which she was attending on a part-time basis while holding a full-time job. She was enjoying her job and performing well. Interpersonally, she and her boyfriend were discussing the possibility of marriage.

Regardless of the severity of GAF rating that Dr. conferred, Ms. eportedly has co-occurring AD/HD, which is itself associated with lower GAF scores (e.g., Biederman, Faraone, Mick, Williamson, Wilens, et al., 1999). Irrespective of this, Ms. clearly was not demonstrating any functional impairments at the time of this evaluator's examination (which included record review and validity measurements), which occurred less than two months after Dr. l s evaluation. It is unlikely, if not impossible, that her functioning improved from a 38-level GAF to an 85-level GAF (the score this evaluator conferred) in a six-week period.

The lack of record review or the gathering of other collateral or objective information, in concert with the inappropriate use of the term "complex" in relation to Ms. PTSD, and the inappropriately low GAF that was conferred, calls into question the credibility of Dr. conclusions. His appropriateness as an expert witness in this case is further weakened by his treatment plan, as detailed below. [...]

Rebuttal to Opposing Expert, Sample Two: Expert Retained by Plaintiff

[...]1. Dr. . claims that Mr. had symptoms of both depression and mania during the "same period of time" (which is not defined). Mr. reported to Dr. I :hat he "frequently experienced" symptoms of depression and mania "at the same time." This is certainly possible, and is the basis for the mixed episode designation. However, it is not possible to have mutually exclusive symptoms simultaneously. Dr. I i claims that Mr. n was simultaneously anhedonic *and* had excessive involvement in pleasurable activities. Given the diagnosis of Bipolar II, which involves a four-day hypomanic episode at minimum rather than a week-long manic episode, it is unlikely that Mr. would experience switching between these two extremes of behavior in such a short period of time. As a matter of fact, if he did, Mr. could not meet criteria for a hypomanic episode.

2. Dr. .:otes that Mr. I reported "planning six days ahead when he is manic." He uses this as an example of excessive goal-directed activity; however, it is actually an example of intact executive functioning even while manic, considered to be a predictor of shorter duration of hospitalization (Levy, et al., 2009).

3. Individuals who attempt suicide and have active manic or psychotic symptoms are routinely admitted to psychiatric wards on 5150 holds, stabilized, and released after three days to outpatient treatment. There is no published or clinical data to support the recommendation for three to four months of hospitalization for passive suicidal ideation. That duration is excessive for the problem, beyond standard treatment even for active suicidality (which has not been demonstrated by Mr. .. and not supported by any data or standards of routine care.[...]

Record Review Format

A. Pre-Incident Medical History

- Mr. had obesity, hypertension, asthma, and joint pain.

B. Post-Incident Medical History

- Diabetic monitoring was performed through the Dept.

C. Pre-Incident Mental Health History

- Mr. had a history of mental illness since age , with several involuntary hospitalizations.

D. Post-Incident Mental Health History

- Mr. tended eight sessions of supportive therapy related to the incident. He reported benefit, including decreased nightmares, improved sleep, and improved social relationships.

E. Substance Use History

- Mr. began using alcohol at age He drank 8-10 beers at a time.
- Mr. eported that he lost jobs due to his substance use. (20; 7)

F. Employment and Education History

- Mr. completed high school. (20;)
- Mr. reported that he has lost jobs due to hallucinations and delusions.

G. Legal History

- Mr. was arrested for DUI in

H. Family and Social History

- Mr. was raised in by his mother and grandmother.
- Mr. reported that he has never been married and has no children on (cite) On the same day, he told another practitioner that he was married at age divorced at , and that he has children. (cite)

Higher-Level Analysis

Background: is prescribed medication, and subsequently develops a gambling problem. Did the medication cause Mr. (gambling problem?

Content: The following table excerpt applies the A-B-A-B single-case design to show that the medication caused problem gambling in ;. The construction of this table utilized data elicited during record review, which was interpreted in the context of relevant literature.

A	March,	Low dose of medication initiated	Urge to gamble not experienced.
B	April July,	Medication had been progressively increased over past several months	Urge to gamble re-emerges.
B	July,	Medication at 36 mg/day	Gambling "out of control" with excessive losses.
A	October,	Medication reduced to 18 mg/day	Urge to gamble less intense, but preoccupation remains.
A	November,	Medication rapidly tapered.	Urge to gamble rapidly dissipates and resolves.

Case Data Graph

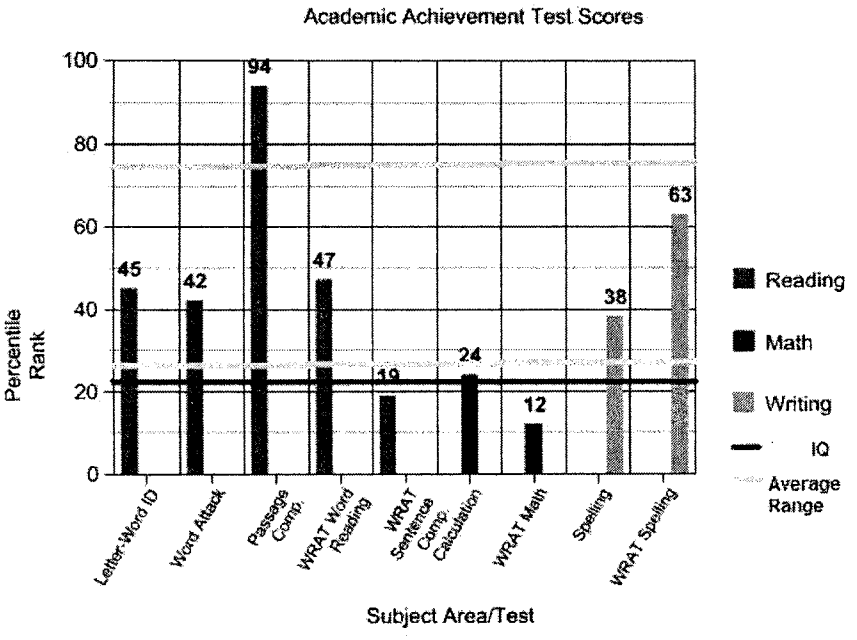


Figure One. ; current academic functioning is within normal limits in relation to his demonstrated WISC-IV Full Scale IQ.

KARI TERVO, PH.D., QME
Licensed Clinical Psychologist
Qualified Medical Evaluator
PO Box 7831
Beverly Hills, CA 90212
(310) 880-7710

NEUROPSYCHOLOGICAL EVALUATION

Patient: [redacted]
Date of Birth: [redacted]
Age: [redacted]
Evaluating Neuropsychologist: Kari Tervo, Ph.D.
Date of Evaluation: June [redacted]

EVALUATION RESULTS: SUMMARY AND OVERVIEW

[redacted] performed variably and/or in the impaired range in the domains of general intellectual functioning, attention/information processing speed, language functioning, verbal learning and memory, executive functioning, and psychological functioning. He has a number of symptoms of depression. His current neuropsychological profile indicates diagnoses of Cognitive Disorder Not Otherwise Specified, AD/HD by history, Mood Disorder Secondary to a General Medical Condition, and Cannabis Dependence.

Recommendations include psychotherapy, psychiatry evaluation and treatment, memory and language strategies, and monitoring/treatment of his AD/HD and Cannabis Dependence. Cognitive rehabilitation is not indicated at this time. Follow-up neuropsychological evaluation in one year is recommended.

Additionally, I would like to review more of [redacted] medical records, including any brain imaging studies subsequent to his head injury.

REFERRAL INFORMATION

Mr. [redacted] is a [redacted]-year-old man. His date of birth is [redacted]. He lives with his wife and his [redacted]-year-old son. He drove himself to the evaluation.

[redacted] was referred by his attorney, [redacted] for neuropsychological evaluation of the potential sequelae of a head injury sustained in a motorcycle accident.

HISTORY OF THE INJURY

I refer the reader to the report of Dr. [redacted] with whom whose office I am associated, for a full accounting of [redacted] injury history. Briefly, he was involved in a motor vehicle accident on that resulted in a head injury involving loss of consciousness for approximately five minutes.

I note that I was not provided with contemporaneous medical records regarding the injury.

REVIEW OF MEDICAL RECORDS

I have reviewed a number of brain imaging studies that were performed after [redacted] head injury, but before his head injury. Though CT indicated abnormalities, EEG was unremarkable. I note that I have not received brain imaging studies that were performed subsequent to [redacted] head injury.

On Dr. [redacted] evaluated [redacted] and diagnosed post-concussive syndrome and mild traumatic brain injury. At that time, [redacted] reported mood and cognitive changes. Dr. [redacted] recommended neuropsychiatric evaluation. He indicated that "the accident" caused [redacted] neurological profile, but did not specify which accident in the context of [redacted] prior head injuries.

I have reviewed Dr. [redacted] psychiatry report of He reported several prior head injuries. He reported marital conflicts. He reported mood and behavioral changes in the context of his head injury. Dr. [redacted] diagnosed [redacted] with Mood Disorder Secondary to a General Medical Condition (head injury), Cannabis Dependence, and Alcohol Dependence in full remission, by history. A GAF of 50 was conferred. Continued psychotropic medication treatment was recommended.

I have reviewed Dr. [redacted] neuropsychology report of . That evaluation was performed subsequent to a concussion with loss of consciousness and axonal shearing. I note that Dr. [redacted] indicated that [redacted] had a dependence on cannabis. Neuropsychological testing results, which are reviewed further in the discussion section of this report, indicated memory and language deficits. Potential symptoms of mania were noted.

CLINICAL INTERVIEW WITH [redacted]

SOCIAL HISTORY

I refer the reader to Dr. [redacted] report for a full accounting of [redacted] social history.

[redacted] has a 12th grade education. He was an "A to C" student.

MENTAL HEALTH HISTORY

[redacted] has not undergone psychiatric hospitalization. He had not taken psychiatric medications prior to the incident.

As a child, he was diagnosed with AD/HD. He was not prescribed a medication. For part of his school day, he attended a smaller class with more assistance, which was helpful for him.

He had treated with a psychologist prior to the injury, but was not in psychotherapy at the time of the injury. As of , he was seeing a psychologist, Dr. [redacted] but he is no longer seeing that professional. Moreover, he is no longer seeing Dr. [redacted] in psychiatry because he is not interested in taking psychotropic medications at this time. If he wished to return to psychotherapy, he would return to Dr. [redacted] but he is not interested in psychotherapy at this time.

SUBSTANCE USE HISTORY

[redacted] does not smoke cigarettes.

He does not drink alcohol. Ten years ago, he drank to excess (a six pack of beer a day) and perceives that he probably had an alcohol problem. His wife was also drinking to excess. His parents were both alcoholics, and they were worried about having a serious problem themselves, so they both quit drinking alcohol.

[redacted] smokes marijuana every day. He feels that marijuana motivates him and helps him focus. He has cut "way back" because he is not as interested in smoking, but he is still smoking 4-5 days per week. He grows his own marijuana, which he has been smoking since he was He sometimes feels he cannot get by without it because his motivation decreases if he does not use it. Marijuana helps him focus and increases his interest in problem-solving. "It keeps me more awake," he stated.

He denied the use of other substances. When he was a teenager, he experimented with

cocaine, but did not use it chronically.

MEDICAL HISTORY

[redacted] is generally healthy. He denied a history of sleep apnea, frequent nighttime urination, hypertension, high cholesterol, cancer, or respiratory problems.

The applicant has a history of head injuries other than that sustained in the . incident. Approximately years ago, he was in a motorcycle accident in which he landed on his head and lost consciousness for five minutes. He went to the hospital, where he was diagnosed with concussion. Approximately years ago, he was riding a motorcycle while wearing a helmet when he hit a tree. He was "semi-knocked out" despite not hitting his head very hard. In , he lost consciousness for five minutes, but cannot recall the circumstances of the incident. He reports two days of anterograde amnesia after that incident. He had a period of seizures after that incident that resolved on its own without medication.

CURRENT MEDICATIONS

[redacted] is not taking any medications.

He is prescribed Lexapro and Trintellix, but he does not take them because he does not perceive any benefit to them.

He is prescribed testosterone, but does not want to take it because "I just don't like medications at all."

ACTIVITIES OF DAILY LIVING

[redacted] gets up at approximately 6 am. He brushes his teeth and bathes. He uses the restroom, and then gets dressed. He has coffee, but he does not typically eat breakfast. He goes to work. He comes home from work at 5:30 pm. He eats dinner (either his wife makes it, or they will eat at a restaurant). After dinner, he watches television (e.g., Westerns). He goes to bed at approximately 9 pm.

With respect to his work activities, [redacted] owns the [redacted] which involves field work and a retail component. He does restoration work and other activities related to glass, including framing and gluing/adhesives. He works 9-10 hours per day, 50 hours per week in the field and retail components combined. He also does bookkeeping at home, for a total of 60 hours per week. Business is going well. He earns approximately [redacted] per year. The company is 85 years old and the company has a good reputation.

However, he would like to retire within the next year, and would be able to retire on a financial basis if he sold his business.

On the weekends, he may do some home repairs or work on motorcycles. He also catches up on work.

He is independent for bathing, grooming, eating, and toileting.

He cooks some, but not much. His wife does the cooking and grocery shopping.

He and his wife both do household chores.

He socializes every weekend with friends. He is able to enjoy himself. He sometimes socializes with family; his wife has family in the area. He sometimes sees his sister in , but not very often.

He does not attend religious services.

He last traveled two months ago when he went to [redacted] which his wife enjoys. He does not have any upcoming travel plans.

CURRENT COMPLAINTS

Physical Complaints

[redacted] feels "okay" physically these days.

He reported mild knee pain on stairclimbing. This began about six months ago. He does not relate it to the injury.

Emotional Complaints

[redacted] mood is "okay" these days. However, he also reported that he has some difficulty feeling strong emotions since the injury.

He reported some anhedonia and loss of motivation. He has lost motivation to ride or work on his motorcycles because he doesn't feel like it. He does go snowboarding, and he is able to get to work on time. He feels motivated to work, and does so successfully.

He reports mild irritability.

He has mixed feelings about engaging in social activities because "people seem to ask a lot of questions," and that interferes with his focus. However, his relationship with his wife of years is "good." Additionally, he still is in touch with his friends from biking.

He reported that his confidence is lower these days, which he relates to the injury and feeling "different" with respect to his cognition. This lack of confidence results in a fear that he will be unable to complete work projects, though he is always able to complete them.

He is sometimes anxious, but he reports that this is a motivator for him to get his work done on time.

His energy level is low.

He has been sleeping more than usual since the accident. He is "tired all the time" since after the incident. He perceives this is related to the low testosterone condition that began after the accident. He usually gets around 8 hours of sleep per night, which he perceives as too much. He sleeps well, however, and likes to get up fairly early because she opens his business at 8 pm. He denies nightmares.

He denied feeling hopeless.

He denied feeling helpless.

He denied suicidal ideation and homicidal ideation.

He denied hallucinations and delusions.

Cognitive Complaints

Cognitive Processing Speed:

Prior to injury: [redacted] did not perceive that he had a difficulty with cognitive processing speed prior to the injury.

After injury: [redacted] feels he has some cognitive slowing. He finds it difficult to finish projects sometimes as a result, which increases his anxiety.

Attention:

Prior to injury: [redacted] reports that he had some difficulties with attention throughout his life related to his childhood diagnosis of AD/HD. He also reported hyper-focus and being preoccupied with a task at hand. However, he denied that he had significant difficulties with attention in his adulthood.

After injury: [redacted] perceives that he has difficulty focusing on the details of what people are saying in conversation. He is able to focus on movies and TV shows, but has difficulty with focusing while reading. Additionally, he is not comfortable with driving since the accident because he finds it difficult to pay attention to details on the road.

Memory:

Prior to injury: [redacted] perceives that his memory was "good."

After injury: Currently, he reports some difficulties with memory. He must write down details he needs to remember. He forgets faces. His memory difficulties sometimes interfere with task completion because he sometimes forgets details.

His memory loss affects his business "a little bit." Sometimes, he forgets to bring materials into the field, but not often. He does not remember details of past projects sometimes. He does feel that his work performance has suffered because of his most recent head injury due to forgetting techniques that that he has known quite some time, but he also says he is changing and improving things and is flexible with his technique.

Visual-Spatial Functioning:

Prior to injury: [redacted] did not have difficulties in this domain.

After injury: [redacted] currently denies difficulties in this domain.

Language:

Prior to injury: [redacted] did not have difficulties in this domain.

After injury: He reports some confrontation naming problems and difficulties with spontaneous word generation (e.g., he could not recall the word "balance" when he was preparing an invoice).

Executive Functioning:

Prior to [redacted] injury: [redacted] had "a little" difficulty with planning and organization when he was very busy, but otherwise denies executive functioning difficulties.

After [redacted] injury: He has some difficulty with sequencing, and sometimes performs the last step first and catches himself. Additionally, he has some difficulty with initiation of projects, though he completes them. He denied difficulties with problem-solving.

BEHAVIORAL OBSERVATIONS

[redacted] is a right-handed [redacted]-year-old [redacted] man. He wore a blue t-shirt and jeans. He had long hair, and was balding somewhat in front. He had a beard. He was well-groomed.

He reported that he slept well the night prior to the evaluation.

His speech was normal with regard to volume, rate, and tone. He did not evidence gross word-finding problems on exam.

[redacted] attention and memory appeared to be adequate for the purposes of engaging in the evaluation and recalling his history, injuries, symptoms, and treatment.

[redacted] affect was mildly restricted throughout the exam. He was not tearful on exam. His stated mood was "okay." He was generally well-related throughout the exam.

He denied suicidal ideation. He was pleasant and cooperative throughout the evaluation. Rapport was good throughout the evaluation. Comprehension appeared generally intact. Thoughts were relevant and goal-directed, and there was no evidence of formal thought disorder.

Psychomotor activity was within normal limits, and there were no signs of severe tremors, abnormal posturing, bizarre gesturing, or other involuntary movements. Both hearing and vision were adequate for the purposes of this evaluation.

The obtained battery is believed to be an accurate reflection of [redacted] current cognitive functioning and sufficient to address the referral questions.

EVALUATION PROTOCOL

b-test
Beck Anxiety Inventory (BAI)
Beck Depression Inventory-II (BDI-II)
Clinical Interview with [redacted]
Controlled Oral Word Association Test (FAS, Animals)
Repeatable Battery for Assessment of Neuropsychological Status, Update (RBANS)
Review of Available Records (sychiatry report; neuropsychology report)
Stroop Test
Symbol Digit Modalities Test (SDMT)
Test of Memory Malingering
Trail Making Test, Parts A & B
Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV)
Wide Range Assessment of Memory and Learning, Second Edition (WRAML-2; selected subtests)
Wisconsin Card Sorting Test (WCST)

NEUROPSYCHOLOGICAL TESTING RESULTS

Pre-Morbid Intellectual Functioning

[redacted] pre-morbid intellectual functioning is estimated to be in the average range. He has 12 years of education. He earned As to Cs in school, where he spent part of his time in a smaller classroom with more support. He works as a glass worker. These characteristics are consistent with pre-morbid intellectual functioning in the average range.

Motivation and Effort

Tests of motivation and effort were not within normal limits. His performance on the b-test (e-score = 44.4; head injury norms; normal effort) and TOMM (Trial 1 = 49; Trial 2 = 50) indicated normal effort.

Note: On the b-test, [redacted] asked to clarify the instructions while he was on the second stimulus. On that stimulus, he circled some non-b stimuli because he misunderstood the directions. On clarification, he stopped circling non-b stimuli. Those errors were not counted as commission errors given that he initially misunderstood the directions.

General Intellectual Functioning

On the WAIS-IV, [redacted] performance was in the average range on an overall index of general intellectual ability (WAIS-IV FSIQ = 102, 55%ile). A composite score of

perceptual reasoning was in the high average range (WAIS-IV PRI = 117, 87%ile). A composite score of verbal comprehension was in the low average range (WAIS-IV VCI = 87, 19%ile). A composite score of processing speed was in the average range (WAIS-IV PSI = 97, 42%ile). A composite score of working memory was in the average range (WAIS-IV WMI = 105, 63%ile).

Note: The VCI and PRI index scores are significantly different.

Attention/Information Processing Speed

Attention and information processing speed were in the impaired to low average ranges. An index score of processing speed was in the average range (WAIS-IV, Processing Speed, 42%ile). He performed in the average range on a timed measure of visual scanning (WAIS-IV Symbol Search, 50%ile). He performed in the average range on parallel timed measures of visual-motor processing (WAIS-IV Coding, 63%ile; SDMT, 45%ile). On a measure of visual scanning and processing speed, he performed in the average range (WAIS-IV Symbol Search; 50%ile). On a timed measure of simple word recognition, he performed in the borderline impaired range (Stroop Test, Word, 8%ile). On a timed measure of visual attention, he performed in the borderline impaired range (Stroop Test, Color, 7%ile).

On a timed numeric-sequencing task, [redacted] performed in the average range (Trails A; 39%ile, 29 seconds, 0 errors). On verbal measures of sequencing, [redacted] performed in the average range (WAIS-IV Digit Span, 37%ile; WRAML-2 Number-Letter, 50%ile). On a visual measure of sequencing, [redacted] performed in the average range (WRAML-2 Finger Windows, 25%ile).

Visual-Spatial Functioning

Visual-perceptual functioning was in the average to superior ranges, and in the high average range overall (WAIS-IV Perceptual Reasoning, 87%ile). On a complex task of visual construction, he performed in the high average range (RBANS Figure Copy, 84%ile). On that measure, his approach was holistic. On a measure of visual-motor construction, [redacted] performed in the superior range (WAIS-IV Block Design, 91%ile). On a measure of visual abstract reasoning, he performed in the average range (WAIS-IV Matrix Reasoning, 63%ile). He performed in the superior range on a visual measure of determining part-whole relationships (WAIS IV Visual Puzzles, 91%ile). On a measure of line orientation, he performed in the average range (RBANS Line Orientation, 26-50%ile).

Language Functioning

Language functioning was in the low average to average ranges. Speech was generally fluent. Receptive language abilities appeared intact. Phonemic verbal fluency fell in the

low average range (COWAT FAS, 19%ile). Semantic verbal fluency performance fell in the low average to average range (RBANS Semantic Fluency, 16%ile; COWAT Animals, 12%ile). On a measure of vocabulary, he performed in the low average range (WAIS-IV Vocabulary, 16%ile). On measure of verbal abstract reasoning, he performed in the average range (WAIS-IV Similarities, 50%ile). On a measure of fund of information, he performed in the low average range (WAIS-IV Information, 9%ile).

Verbal Learning and Memory

Verbal learning and memory were in the impaired to average ranges.

On a story-learning task, he performed in the borderline impaired range on immediate recall (WRAML-2, Story Memory, Immediate, 5%ile). When asked to recall story elements after a delay, he performed in the borderline impaired range (WRAML-2 Story Memory, Delayed Recall, 3%ile). Recognition memory fell in the impaired range (WRAML-2 Story Memory Recognition, 2%ile). On a parallel measure of contextual memory, he performed in the average range with respect to both immediate and delayed recall (RBANS Story Memory, Immediate, 63%ile; Delayed Recall, 50%ile).

On a list-learning task, he performed in the low average range with respect to immediate recall (WRAML-2 List Learning, Immediate, 9%ile) and in the impaired range when asked to recall the list after a delay (WRAML-2 List Learning, Delayed Recall, 2%ile). On a parallel measure of non-contextual memory, he performed in the average range with respect to immediate recall (RBANS List Learning, Immediate, 50%ile), and in the average range with respect to delayed recall (RBANS List Learning, Delayed Recall, 26-50%ile). Recognition memory was within normal limits (RBANS List Learning Recognition, WNL).

Non-Verbal Learning and Memory

Non-verbal learning and memory were in the impaired to high average ranges.

On a measure of non-contextual design memory, [redacted] performed in the high average range (WRAML-2 Design Memory, 75%ile). When asked to recall elements of a previously-seen complex design, he performed in the average range (RBANS Figure Recall, 37%ile). On a measure of memory for contextual visual details, he performed in the impaired range (WRAML-2 Picture Memory, <1%ile).

Executive Functioning

Executive functioning performance was in the borderline impaired to high average ranges. Planning, organization, and conceptualization as assessed by a complex figure task was

within normal limits (RBANS Figure Copy). On a measure of response inhibition, his performance was in the average range (Stroop Test, Color-Word, 42%ile) [redacted] performed in the average range on an alpha-numeric sequencing task, (Trails B, 71 seconds, 0 errors, 70%ile). On a measure of verbal abstraction, he performed in the average range (WAIS-IV Similarities, 50%ile). On a measure of visual abstraction, he performed in the average range (WAIS-IV Matrix Reasoning, 63%ile). On a measure of conceptualization, set-shifting, and cognitive flexibility, his performance was in the borderline impaired to average ranges (WCST; Total Errors, 30%ile; Perseverative Errors, 30%ile; Categories Completed; 6-10%ile; Trials to Complete First Category; WNL). On a measure of sentence repetition, he performed in the low average range (WRAML-2 Sentence Memory, 16%ile).

Psychological Functioning

On a self-report measure of anxiety, [redacted] endorsed a mild level of symptoms of anxiety (Beck Anxiety Inventory, 11, mild). On a self-report measure of depression, he reported a moderate level of symptoms of depression (Beck Depression Inventory-II, 21, moderate).

MULTI-AXIAL DIAGNOSIS

Axis I: Cognitive Disorder, Not Otherwise Specified

Attention-Deficit/Hyperactivity Disorder, by history

Mood Disorder Associated with a General Medical Condition (head injury)

Cannabis Dependence

Axis II: Deferred

Axis III: s/p four traumatic brain injuries (most recent March , by history; low testosterone

Axis IV: Cognitive decline, Partner Illness

Axis V: 57

DISCUSSION

Mr. [redacted] is a year-old [redacted] man. His date of birth is [redacted]. He lives at [redacted]. He lives with his wife and his -year-old son. He drove himself to the evaluation.

[redacted] was referred by his attorney, [redacted] for neuropsychological evaluation of the potential sequelae of a head injury sustained in a motorcycle accident.

Results of the current evaluation demonstrate that [redacted] performed within normal limits in the following domains:

1) Effort
2) Visual-Spatial Functioning

Results of the current evaluation demonstrate that [redacted] performed variably or in the impaired range in the following domains:

1) General Intellectual Abilities
2) Attention and Information Processing Speed
3) Learning and Memory
4) Language Functioning
5) Executive Functioning
6) Psychological Functioning

Discussion of Effort and Credibility:

[redacted] credibility is considered to be moderate to high. Several factors support his credibility: The reported mechanism of injury is consistent with the current testing results. He did not pan-endorse psychological symptoms. His self-report of his cognitive difficulties was consistent with the injury and testing results. His clinical presentation (e.g., restricted affect) is consistent with a traumatic brain injury. He reportedly had an active occupational, social, and recreational life prior to the injury. He continues to report successful behavior in those realms, though somewhat curtailed post-injury. He works full-time and has an adequate income. He performed within normal limits on tests of effort.

However, [redacted] credibility is somewhat reduced by two factors. He reported that he forgets work techniques that he has known for quite some time, which is not consistent with traumatic brain injury. Additionally, his recognition memory for a narrative was worse than his recall memory, which is an atypical result. However, I have considered that the latter may reflect fluctuating attention, rather than feigned impairment.

Given the medical-legal nature of the evaluation and the fact that I was not able to review medical records that might corroborate or disconfirm his report, I have considered that he may have been putting forth inconsistent effort on evaluation measures; however, the majority of his overall presentation and profile suggests credible and consistent effort.

Discussion of Diagnoses:

With regard to diagnoses, I have conferred Axis I diagnoses of Cognitive Disorder, Not Otherwise Specified (NOS); Attention-Deficit/Hyperactivity Disorder (AD/HD), by history; Mood Disorder Associated with a General Medical Condition (head injury), and Cannabis Dependence.

On Axis III, I note medical diagnoses of Traumatic Brain Injuries and low testosterone.

Cognitive Disorder, Not Otherwise Specified

[redacted] reported subjective deficits in processing speed, attention, memory, language, and executive functioning. He indicated that, subjectively, his visual-spatial functioning is intact. Current neuropsychological testing confirms that there is variability in [redacted] attention, memory, language functioning, and executive functioning, in the context of normal effort and several prior head injuries resulting in concussion and loss of consciousness. On testing, he demonstrated mild deficits/variability in language fluency, mild to moderate deficits in immediate verbal recall, a moderate deficit/variability in delayed verbal memory, a severe deficit in contextual visual memory, and a mild deficit in problem-solving. He reports some functional difficulties related to his cognitive decrements, including occupational difficulties and driving difficulties.

Consistent with his occupation of and his perception of intact visual-perceptual skills, his performance on measures of visual-spatial functioning was within normal limits and represented a relative strength.

These deficits and variability are present in the context of prior head injuries, and not in the context of delirium, dementia, or acute intoxication. Therefore, this constellation of cognitive symptoms meets criteria for a diagnosis of Cognitive Disorder, Not Otherwise Specified.

Attention-Deficit/Hyperactivity Disorder, by History

[redacted] reports that he was diagnosed with AD/HD as a child, and that he spent part of his time in school in smaller classes with extra support. He reports current attentional difficulties, particularly while driving. On testing, he had variability in attention and executive functioning, which is common in AD/HD. AD/HD was not specifically assessed

during this exam (e.g., with behavioral and sustained attention measures), but the applicant's report of a prior diagnosis, current reported symptoms, and current cognitive profile, taken together, indicate a diagnosis of AD/HD, by history.

Mood Disorder Due to a General Medical Condition (Head Injury)

I concur with Dr. [redacted] assessment that [redacted] psychological profile meets criteria for a diagnosis of Mood Disorder due to a General Medical Condition (head injury). [redacted] self-reported moderate symptoms of depression. He additionally reports current depressed mood, anhedonia, low motivation, low emotional tone, low confidence, mild social withdrawal, irritability, anxiety, hypersomnia, fatigue, and cognitive decrements. On exam, his affect was restricted. He has a current GAF of 57, indicating moderate symptoms. His symptoms in this regard have emerged in the context of his head injury and related dysfunction. These symptoms are associated with a general medical condition (history of head injuries). Given these factors, the diagnosis of Mood Disorder due to a General Medical Condition is conferred, as opposed to a diagnosis of Major Depressive Disorder.

I note that depression can contribute to cognitive difficulties, including difficulties in processing speed, attention, working memory, and decision-making. His depression is considered to be at least a partial contributor to his current cognitive presentation.

Cannabis Dependence

[redacted] reported that he has been smoking marijuana since he was years old. Since then, he has smoked marijuana on a daily or nearly-daily basis. He reports that he relies on the substance for motivation and focus. Dr. [redacted] has conferred a diagnosis of Cannabis Dependence, and I concur with that impression.

Causation (With Respect to Current Testing Results vs. Testing Results)

With respect to causation of [redacted] deficits and diagnoses, I have compared his performance in Dr. [redacted] evaluation with his performance on the current evaluation.

With respect to causation of [redacted] current cognitive deficits, it is necessary to individually examine each area of deficit (despite the umbrella diagnosis of Cognitive Disorder Not Otherwise Specified) to determine whether the cause of each deficit was [redacted] prior head injuries, the injury, his pre-existing history of AD/HD, and/or his cannabis dependence.

Additionally, he has diagnoses of AD/HD, Cannabis Dependence, and Mood Disorder Secondary to a General Medical Condition, the causation of which will also be discussed in this section.

I note that [redacted] subjective report of his emotional and cognitive status has changed somewhat in comparison to the time of the . . evaluation, but that some symptoms are stable. He continues to report deficits in processing speed, attention, and memory, but at the time of the current evaluation, he no longer reports impatience, psychotic symptoms, impulsive behavior/poor judgment, or concrete thinking. Dr. [redacted] tested him approximately four months post-injury, and those symptoms appear to have resolved. Moreover, though he is still reporting processing speed complaints, his processing speed is currently within normal limits.

Causation of Memory Deficits

I have reviewed the neuropsychological report of Dr. [redacted] That evaluation was conducted approximately months after [redacted] suffered a head injury resulting in loss of consciousness after a motorcycle accident. Dr. [redacted] found that [redacted] had borderline impaired verbal memory recall and mildly reduced verbal fluency. She also found that he had exaggerated emotional valence. Results were within normal limits in other domains.

In comparison, the current results indicate that [redacted] neuropsychological profile has remained relatively stable even in the context of the head injury, with the exception of his memory, which is now significantly variable, and his psychological profile, which indicates moderate depression.

Dr. [redacted] found that [redacted] verbal and visual memory were intact, with the exception of borderline impaired delayed recall for narrative information. On current exam, [redacted] verbal and visual memory were significantly variable, with verbal memory ranging from the impaired to average ranges, and visual memory ranging from the impaired to high average ranges. His deficits in this domain range from mild to severe. This represents a significant interim change in his overall memory profile.

The current neuropsychological profile represents interim aggravation of [redacted] pre-existing verbal and visual memory deficits. Within reasonable medical probability, his verbal and visual memory deficits were permanently aggravated. That aggravation was 100% caused by the head injury.

Causation of Language Deficits

I note that [redacted] performed in the low average range on a measure of phonemic fluency (in the language domain) at the time of the current evaluation and the time of the evaluation. I note that his performance on a measure of semantic fluency was in the average range, whereas his current performance on parallel measures of semantic fluency was in the average and low average ranges. Overall, this represents a mild language deficit.

This deficit is in the context of low average overall verbal comprehension (WAIS-IV VCI, 19%ile), but also represents interim worsening of the language profile. Therefore, it is considered an aggravation of a pre-existing mild deficit.

Within reasonable medical probability, [redacted] mild language functioning deficit represents a permanent aggravation of his pre-existing variability in that domain. That aggravation was 100% caused by the head injury.

Causation of Attention/Executive Functioning Deficits

I note that [redacted] performance on one measure of attention (Trails A) was significantly better at the time of the current evaluation than at the time of the evaluation. That is, he performed in the average range at the time of the current evaluation, and in the impaired range at the time of the evaluation. I also note that he performed within normal limits on measures of simple attention (color and word naming) at the time of the evaluation, but in the borderline impaired range at the time of the current evaluation. The current attention profile, therefore, reflects improved task-related focus, but worse simple attention.

I note that [redacted] demonstrated mild variability in attention and executive functioning in both the current evaluation and the evaluation. [redacted] has a diagnosis of AD/HD, by history. Attention and executive functioning deficits are common in AD/HD.

Within reasonable medical probability, [redacted] variable attention and executive functioning profiles are 100% related to his pre-existing diagnosis of AD/HD. His AD/HD does not appear to have been permanently aggravated by the head injury.

Causation of Mood Disorder Associated with a General Medical Condition

Additionally, whereas Dr. [redacted] found that [redacted] had exaggerated emotional valence and minimal symptoms of depression, the current evaluator observed that he had restricted affect on exam, with self-report of restricted emotional valence and moderate

symptoms of depression. This represents a significant change in his overall psychological profile.

Within reasonable medical probability, [redacted] interim restriction of emotional valence with accompanying moderate symptoms of depression (Mood Disorder Associated with a General Medical Condition) were 100% caused by the head injury.

Causation of Cannabis Dependence

[redacted] has a diagnosis of Cannabis Dependence. I considered that [redacted] regular use of cannabis may have contributed to the changes seen in his neuropsychological profile. However, he was reportedly using a similar amount of cannabis at the time of the neuropsychological evaluation. Given the relative stability of his cannabis use, it is unlikely that such use was a significant contributor to the interim worsening/variability of his neuropsychological profile. I note that his regular use of cannabis may contribute to cognitive decrements relative to people who do not use cannabis, but that his documented interim ipsative impairments/variability are, within reasonable medical probability, more likely related to his head injury.

Within reasonable medical probability, the diagnosis of Cannabis Dependence is 100% pre-existing and does not appear to have been permanently aggravated by the injury.

Prognosis: Cognition

Given that [redacted] head injury occurred in and he is more than one year post-injury at the time of the current evaluation, it is unlikely that his cognitive deficits will substantially improve with the passage of time.

Discussion of MRI Results vis a vis Current Neuropsychological Testing Results

Via an e-mail, [redacted] attorney, [redacted] has asked me to address the reportedly normal brain MRI results in the context of the applicant's report of cognitive symptoms (note: I did not receive results from any imaging that may have occurred after the head injury). Though MRI is a valuable diagnostic tool with respect to neurological diagnosis and potentially to identify the location of a head injury, concussions do not always result in visual lesions/swelling on MRI, particularly if the MRI was performed after a period of recovery from a concussion. It is possible to have a normal MRI, yet have abnormal neuropsychological testing results. Neuropsychological testing can reveal the behavioral (outward) effects of a concussion even when brain MRI is grossly unremarkable.

RECOMMENDATIONS

1) [redacted] has a diagnosis of Cognitive Disorder, Not Otherwise Specified, with deficits or variability in memory and language that cannot be fully accounted for by his pre-existing AD/HD. He reports some functional deficits with respect to these decrements, but indicates that he generally functions well and is able to manage his business and relationships. Therefore, a formal course of cognitive rehabilitation is not indicated at this time.

2) [redacted] would benefit from the use of memory strategies, such as planners and repetition. His contextual verbal memory was better than his non-contextual verbal memory, and it is recommended that he use memory strategies that place information to be remembered in a context (e.g., a story).

3) Given his mild deficit and variability in verbal fluency, it is recommended that [redacted] provide himself and be provided with extra time to formulate his verbal utterances. He may benefit from rehearsing what he wants to say before he says it, either sub-vocally or in writing.

4) [redacted] has a diagnosis of Mood Disorder Due to a General Medical Condition. He reports depressed mood, anhedonia, low motivation, low emotional tone, low confidence, mild social withdrawal, irritability, anxiety, hypersomnia, fatigue, and cognitive decrements. Depression can worsen his cognition, and vice versa. Following Dr. [redacted] it is recommended that he be evaluated by a psychiatrist for appropriate pharmacotherapy. This should be provided on a once-monthly basis for at least six months, with additional sessions at the discretion of his treating psychiatrist. Moreover, it is recommended that he undergo individual weekly psychotherapy with a psychologist (preferably a health psychologist) for at least six months, with additional sessions at the discretion of his treating psychologist. I note that he is not interested in pharmacotherapy or psychotherapy at this time, but recommend that provision for such be made.

5) [redacted] has a pre-existing diagnosis of AD/HD and demonstrated variable attention on current and exams. He may benefit from psychotropic medication treatment for AD/HD.

6) [redacted] has a pre-existing diagnosis of Cannabis Dependence. It is recommended that his mental healthcare providers monitor this diagnosis and provide [redacted] with psychoeducation on the cognitive, behavioral, and emotional effects of cannabis.

7) [redacted] is more than one year post-injury. His cognitive condition is unlikely to improve with the additional passage of time, but it may deteriorate. Follow-up neuropsychological testing is recommended in one year in order to monitor [redacted] cognitive condition and to make recommendations with respect to any further decline.

8) I was provided with limited medical records. Existing records may corroborate or refute his account and provide additional important information. My opinions may be altered or clarified by information contained in those records and allow me to comment more definitively on his credibility. I would like to review those records. Upon receipt, I will generate a supplemental report.

Thank you for this referral, and for the opportunity to evaluate [redacted] for this most interesting case and condition.

Kari Tervo, Ph.D., QME
Licensed Clinical Psychologist
Qualified Medical Evaluator
PSY 23273

Date of Report: July

[redacted]

NEUROPSYCHOLOGICAL EVALUATION

Patient: [redacted]
Date of Birth: [redacted]
Age: [redacted]
Evaluating Neuropsychologist: Kari Tervo, Ph.D.

EVALUATION RESULTS: BRIEF OVERVIEW

Mr. [redacted] performed variably and/or in the impaired range in the domains of general intellectual functioning, attention/information processing speed, language functioning, verbal learning and memory, executive functioning, psychological functioning, and effort. He has a number of symptoms of depression and anxiety. His current neuropsychological profile indicates diagnoses of Post-Traumatic Stress Disorder, Expressive Aphasia, Depressive Disorder, Not Otherwise Specified, and Post-Concussion Syndrome.

Recommendations include cognitive rehabilitation, psychotherapy, psychiatry evaluation and treatment, continued neurological follow-up, and speech-language pathology evaluation. Additionally, I would like to review Mr. [redacted] medical records.

REFERRAL INFORMATION

Mr. [redacted] is a [redacted]-year-old man of [redacted] descent. His date of birth is [redacted] He was referred for neuropsychological evaluation by his attorney, [redacted] subsequent to suffering significant injuries after being hit by a car as a pedestrian on [redacted].

HISTORY OF THE INJURY

On [redacted], the applicant was a pedestrian who was using a crosswalk when he was struck by a vehicle. He lost consciousness. He suffered injuries to his right shoulder, neck, low back, and head.

He reported that his low back was fractured and that he suffered disc displacement in the accident.

The applicant was hospitalized for over a month after the accident. For approximately three weeks, he was in a coma.

For some time after the accident, Mr. [redacted] was unable to walk. He eventually recovered his ability to walk, but he is unable to sustain long periods of walking.

He has subsequently undergone shoulder, neck, and spinal surgeries.

He is currently in treatment with a neurologist, who has prescribed exercises for cognition and unrecalled anti-seizure medications, but he reports that the medications make him fatigued.

Additionally, Mr. [redacted] has been engaging in mental health treatment with a psychologist and psychiatrist subsequent to his injuries.

REVIEW OF MEDICAL RECORDS

With the exception of a psychiatry evaluation report by [redacted] M.D., no medical records were made available to this evaluator for review.

CURRENT MEDICATIONS

Mr. [redacted] is currently taking the following medications:

Soma, dose unrecalled.

Lexapro, 15 mg.

An unrecalled sleep medication.

An unrecalled anti-seizure medication(s).

CLINICAL INTERVIEW WITH MR. [redacted]

Social History:

The plaintiff graduated from high school. He denied a history of special education, tutoring, learning disabilities, or behavioral problems while in elementary or high school.

After high school, he attended three years of college at [redacted] as a psychology major. He earned Bs and Cs. He left school because he was offered a job at a bank.

Just prior to the accident, he was working in marketing for a printing company. He was performing very well, and had been working there for approximately three years. He denied difficulties with task completion, work performance, attention, or organization with respect to his work duties prior to the accident.

Mr. [redacted] is not currently working, and has not since the accident. He is supported

financially by his family and his partner, with whom he lives. He is not currently receiving disability payments.

Current Complaints:

Physical Complaints:

Mr. [redacted] reported significant fatigue. He naps at least twice a day for 15-60 minutes. He stated, "A lot of my sleeping is done during the day." He has some nights during which he sleeps well, but his sleep is frequently interrupted by pain in his shoulder and neck.

He naps at least twice a day for 15-60 minutes, "a lot of my sleeping is done during the day." Has some nights where he sleeps well, and some nights where he is in pain in shoulder and neck"

He remains with pain in his right shoulder, neck, head, and back. He has been instructed not to lift heavy things.

Sometimes, when he is concentrating on a task, he feels light-headed.

Soma has been prescribed for pain, but, even when he takes it before bed, he has a "hangover" effect in the morning. Hence, he tries not to take it every day.

He has also been prescribed Lexapro, 15 mg. However, he denies that the medication has been beneficial thus far.

Emotional Complaints:

According to Dr. [redacted] psychiatric evaluation report (excerpted below), Mr. [redacted] has been experiencing the following psychiatric symptoms:

Mr. [redacted] has been avoiding people. He does not trust people. He keeps to himself.

He has nightmares and flashbacks about the accident.

He is anxious. This affects his sleep.

He feels irritable and angry.

His energy level is quite low.

He reported anhedonia and a loss of interest in his typical hobbies. He no longer feels motivated to go out, work out at the gym, or socialize with friends.

According to the current clinical interview of Mr. [redacted] has been experiencing the following symptoms:

His mood is low. He feels depressed.

He feels hopeless.

He worries his condition may not improve. Moreover, he worries that he cannot contribute to his relationship with his partner due to his injuries.

He feels helpless and unproductive. He stated, "I feel like I'm of no use."

He is very anxious when he is driving. He stated, "I have these fears that I'm going to do it to someone else. I've developed a fear of driving under a bridge because I'm afraid it's going to fall on me." He is also fearful of being rear-ended.

He feels social anxiety due to his cognitive problems. He feels nervous when calling to make a payment or when in the grocery store. He stated, "If strangers speak to me, I feel stupid because I have to take my time to process things or say something."

He denied suicidal ideation. "I survived it," he stated. "I've been to death and back."

Cognitive Complaints:

Mr. [redacted] denied pre-accident cognitive difficulties.

Cognitive Processing Speed: Mr. [redacted] reported significant difficulties with processing speed. "Simple things get me exhausted," he stated. He is reluctant to speak to strangers because of the time it takes him to gather his thoughts.

Attention: Mr. [redacted] stated that the primary reason he is not working is because he has difficulties with attention and focus. He feels significantly fatigued after spending five minutes focusing on reading or any other task.

Memory: Mr. [redacted] reported significant difficulties with memory. Even though he has been to the office in which the current evaluation took place on a number of occasions, he must use his navigation unit each time. He has frequently taken the wrong freeway to go to that office despite repeat visits and familiarity with the surrounding area.

Mr. [redacted] reported that he has difficulty remembering names, and that he has to take notes and put information in his phone. He also indicated that retaining written information is difficult.

Mr. [redacted] reported that his partner has told him on two occasions that he forgot to turn the stove off. Hence, he does not use the stove anymore.

Visual-Spatial Functioning: Mr. [redacted] reported difficulties with visual-spatial functioning. He recently had difficulty connecting a new television set to the cable box, speakers, and internet. Even though he used to perform such activities with ease, he now has to ask for help.

Language: Mr. [redacted] reported word-finding difficulties, both with respect to spontaneous generation and confrontation naming. For instance, this morning, he wanted to ask his partner to make something for breakfast, and he could not think of the word "tater tots."

Executive Functioning:

Working Memory: Mr. [redacted] reported significant difficulty with tracking conversations. He feels his working memory is poor.

Planning: Mr. [redacted] reported that he has significant difficulty planning his day. Planning exhausts him. He resists planning his day because he feels he cannot "keep up" with other people or his own requirements. Moreover, if he plans, he worries about not being able to complete his plan, whether due to cognitive difficulties or fatigue. "There's no point of planning," he stated.

Organization: His organization is "okay." His partner hires a housekeeper on a weekly basis, which provides for ease in home organization.

Initiation/Motivation: Mr. [redacted] has difficulty finishing projects that he has started. Sometimes, he feels overwhelmed by the task and ceases participation. Sometimes, he lacks the motivation to continue.

BEHAVIORAL OBSERVATIONS

Mr. [redacted] is a right-handed [redacted]-year-old man of [redacted] descent. He was casually dressed. He wore a t-shirt and jeans. His hair and beard were only fairly groomed, but his hygiene appeared adequate.

Mr. [redacted] appeared fatigued and anergic. Every 15 minutes or so, he asked to take a short break because he felt overwhelmed and fatigued. These breaks were granted. On some

occasions, he left the room, but on some, he stayed at the evaluation desk until he felt ready to continue.

He reported that he did not sleep well the night prior to the evaluation due to nightmares, which he has had since the accident. He was noted to stammer and show hesitancy when he spoke. He frequently displayed word-finding problems, stating, "What's the word?" He frequently started sentences, and then stopped them. His speech was normal with regard to volume and tone, but his rate of speech was slow.

Mr. [redacted] attention and memory appeared to be adequate for the purposes of engaging in the evaluation and recalling his history, injuries, symptoms, and treatment. However, he appeared to lose track of the pertinent topic at times.

Mr. [redacted] affect was blunted throughout the exam. His affect was typically depressed and anxious. He smiled once or twice, but did not laugh. He was not tearful on exam. His stated mood was "tired."

He denied suicidal ideation. He was pleasant and cooperative throughout the evaluation. Rapport was good throughout the evaluation. Comprehension appeared generally intact. Thoughts were relevant and goal-directed, and there was no evidence of formal thought disorder.

Psychomotor activity was within normal limits, and there were no signs of severe tremors, abnormal posturing, bizarre gesturing, or other involuntary movements. Both hearing and vision were adequate for the purposes of this evaluation.

The evaluation was discontinued prior to the administration of all planned neuropsychological battery tests. After approximately four hours of the evaluation session, and despite a number of short breaks, Mr. [redacted] appeared distressed and stated that he was too fatigued to continue. Hence, the evaluation was discontinued after administration of the majority of most of the planned tests.

The obtained battery is believed to be an accurate reflection of Mr. [redacted] current cognitive functioning and sufficient to address the referral questions.

EVALUATION PROTOCOL

b-test
Clinical Interview with Mr. [redacted]
Controlled Oral Word Association Test (FAS, Animals)
Review of Available Records (psychiatry report)
Rey-Osterreith Complex Figure Task (copy)

Stroop Test
Symbol Digit Modalities Test (SDMT)
Test of Memory Malingering
Trail Making Test, Parts A & B
Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV)
Wechsler Memory Scales, Fourth Edition (WMS-IV; selected subtests)
Wisconsin Card Sorting Test (WCST)

NEUROPSYCHOLOGICAL TESTING RESULTS

Pre-Morbid Intellectual Functioning

Mr. [redacted] pre-morbid intellectual functioning is estimated to be in the average range. He has 15 years of education. He denied learning disabilities. He earned Bs and Cs in college. Prior to his injury, he worked in marketing for a printing company. These characteristics are consistent with pre-morbid intellectual functioning in the average range.

Motivation and Effort

Tests of motivation and effort were not within normal limits. His performance on the b-test (e-score = 807.33; head injury norms; suspect effort) and TOMM (Trial 1 = 35; Trial 2 = 24) indicated suspect effort. NOTE: Please see "Discussion," below, with respect to interpretation of effort testing results.

General Intellectual Functioning

On the WAIS-IV, Mr. [redacted] performance was in the impaired range on an overall index of general intellectual ability (WAIS-IV FSIQ = 70, 2%ile). On an index of general intellectual ability that is less sensitive to the influence of working memory and processing speed, Mr. [redacted] performance was in the borderline impaired range (WAIS-IV GAI = 75, 5%ile). A composite score of perceptual reasoning was in the borderline impaired range (WAIS-IV PRI = 71, 3%ile). A composite score of verbal comprehension was in the low average range (WAIS-IV VCI = 83, 13%ile). A composite score of processing speed was in the impaired range (WAIS-IV PSI = 68, 2%ile). A composite score of working memory was in the borderline impaired range (WAIS-IV WMI = 74, 4%ile).

Attention/Information Processing Speed

Attention and information processing speed were in the impaired to low average ranges. An index score of processing speed was in the impaired range (WAIS-IV, Processing

Speed, 2%ile). He performed in the impaired range on a timed measure of visual scanning (WAIS-IV Symbol Search, 1%ile). He performed in the borderline impaired range on parallel timed measures of visual-motor processing (WAIS-IV Coding, 5%ile; SDMT, <1%ile). On a timed measure of simple word recognition, he performed in the impaired range (Stroop Test, Word, <1%ile). On a timed measure of visual attention, he performed in the impaired range (Stroop Test, Color, <1%ile).

On a timed numeric-sequencing task, Mr. [redacted] performed in the impaired range (Trails A; <1%ile, 47 seconds, 0 errors). On a measure of digit sequencing, Mr. [redacted] performed in the low average range (WAIS-IV Digit Span Forward, 9%ile).

Visual-Spatial Functioning

Visual-perceptual functioning was in the impaired to low average ranges. Visuospatial/Constructional abilities were in the borderline impaired range overall (WAIS-IV Perceptual Reasoning, 3%ile). On a complex task of visual construction, he performed in the impaired range (Rey-Osterreith Complex Figure Task, Copy, <1%ile). On that measure, his approach was piecemeal, and many of the elements of the design were poorly-reproduced. On a measure of visual-motor construction, Mr. [redacted] performed in the impaired range (WAIS-IV Block Design, 2%ile). On a measure of visual abstract reasoning, he performed in the low average range (WAIS-IV Matrix Reasoning, 9%ile). He performed in the borderline impaired range on a visual measure of determining part-whole relationships (WAIS IV Visual Puzzles, 5%ile).

Language Functioning

Language functioning was in the low average to average ranges. Speech was generally fluent, but he exhibited frequent spontaneous word-finding problems and halting speech on exam. Receptive language abilities appeared intact. Phonemic verbal fluency fell in the borderline impaired range (COWAT FAS, 3%ile). Semantic verbal fluency performance fell in the low average range (COWAT Animals, 12%ile). On a measure of vocabulary, he performed in the low average range (WAIS-IV Vocabulary, 16%ile). On measure of verbal abstract reasoning, he performed in the low average range (WAIS-IV Similarities, 16%ile). On a measure of fund of information, he performed in the average range (WAIS-IV Information, 25%ile).

Verbal Learning and Memory

On a story-learning task, he performed in the impaired range (WMS-IV Logical Memory I, <1%ile). When asked to recall story elements after a delay, he performed in the impaired

range (WMS-IV Logical Memory II, <1%ile). Recognition memory fell in the impaired range (WMS-IV Story Memory Recognition, 19/30), though it is noted that he was able to correctly identify or reject most of the stimuli.

Non-Verbal Learning and Memory

A measure of delayed visual memory of a semi-complex geometric figure was not administered because the plaintiff requested to terminate the evaluation due to fatigue.

Executive Functioning

Executive functioning performance was in the impaired to borderline impaired ranges. Planning, organization, and conceptualization as assessed by a complex figure task was impaired. On a measure of response inhibition, his performance was in the impaired range (Stroop Test, Color-Word, 1%ile) Mr. [redacted] performed in the impaired range on an alpha-numeric sequencing task, (Trails B, 2 minutes, 16 seconds, 2 errors, <1%ile). On a measure of verbal abstraction, he performed in the low average range (WAIS-IV Similarities, 9%ile). On a measure of visual abstraction, he performed in the low average range (WAIS-IV Matrix Reasoning, 9%ile). On a measure of conceptualization, set-shifting, and cognitive flexibility, his performance was in the impaired to borderline impaired ranges (WCST; Total Errors, 2%ile; Perseverative Errors, 5%ile; Categories Completed; 2-5%ile; Trials to Complete First Category; 6-10%).

MULTI-AXIAL DIAGNOSIS

Axis I: Post-Concussion Syndrome

Expressive Aphasia

Post-Traumatic Stress Disorder

Depressive Disorder, Not Otherwise Specified

Axis II: Deferred

Axis III: s/p traumatic brain injury (October), aphasia, musculoskeletal pain.

Axis IV: Health concerns, Cognitive decline

Axis V: 52

DISCUSSION

Mr. [redacted] is a [redacted]-year-old man of [redacted] descent. His date of birth is [redacted]. He was referred for neuropsychological evaluation in the context of a head injury suffered in an [redacted] vehicle vs. pedestrian accident in which he was the pedestrian. He was reportedly in a coma for approximately three weeks after the accident.

Results of the current evaluation demonstrate that Mr. [redacted] performed variably or in the impaired range in the following domains:

1) Effort
2) General intellectual abilities
3) Attention and Information Processing Speed
4) Learning and Memory
5) Visual-Spatial Functioning
6) Language Functioning
7) Executive Functioning
8) Psychological Functioning

Discussion of Effort and Credibility:

Mr. [redacted] credibility is considered to be moderate. Several factors support his credibility: The reported mechanism of injury and reported outcome of three-week coma are consistent with the current testing results. He did not pan-endorse psychological symptoms. His self-report of his cognitive difficulties was consistent with the injury and testing results. His clinical presentation (e.g., blunted affect, word-finding difficulties) is consistent with a severe head injury. He reportedly had an active occupational, social, and recreational life prior to the injury.

However, Mr. [redacted] performance on effort tests suggests suspect effort. He made a very large number of commission errors on the b-test (b-test; commission errors = 73). That is, he circled a large number of b-like stimuli. It is noted that he did not make any "d" errors. The reason for this pattern of performance is unclear. However, it is noted that, during the administration of the measure, Mr. [redacted] asked for a reminder of what the stimulus to be circled looked like. Hence, his fluctuating attention and fatigue, as indicated by his self-report, presentation on exam, and on other measures suggests a contribution of fatigue, attention difficulties, and/or working memory difficulties.

On the TOMM, Mr. [redacted] performed worse on the second trial than on the first trial, and performed well below the normal-effort cut-off score for the second trial. The reason for this pattern of performance is unclear. However, it is noted that, during the administration

of the measure, which requires consistent attention throughout the sequential exhibition of 50 stimuli. Mr. [redacted] attention appeared to waver. Hence, his fluctuating attention and fatigue, as indicated by his self-report, presentation on exam, and on other measures suggests a contribution of fatigue and attention difficulties.

Mr. [redacted] injury history (including a severe head injury and reported three-week coma less than one year ago) clinical presentation (e.g., blunted affect, fluctuating attention, fatigue), better recognition memory than spontaneous recall, and best performance in domains that are typically the most preserved after head injury (vocabulary, fund of information) suggests that his head injury was the most likely contributor to his impaired performance on effort measures. That his performance was almost universally impaired within and across domains, rather than exhibiting wide variability within or across domains, further supports this conclusion.

However, given the medical-legal nature of the evaluation and the fact that I was not able to review medical records that might corroborate or disconfirm his report, I have considered that he may have been putting forth inconsistent effort on evaluation measures. Therefore, the current evaluation results were interpreted with caution.

Discussion of Diagnoses:

With regard to diagnoses:

I have conferred Axis I diagnoses of Post-Concussion Syndrome, Expressive Aphasia, Post-Traumatic Stress Disorder, Chronic, and Depressive Disorder, Not Otherwise Specified.

On Axis III, I note a medical diagnosis of Traumatic Brain Injury.

Post-Concussion Syndrome

Mr. [redacted] was in a vehicle vs. pedestrian accident in [redacted] that resulted in concussion and a three-week coma. Medical records regarding his Glasgow Coma Scale score on the scene or his hospital course and neurological follow-up were not available for my review, and I am not able to determine at this time whether Mr. [redacted] suffered a mild, moderate, or severe traumatic brain injury. However, a three-week coma indicates a severe traumatic brain injury.

Since then, he has reported new subjective deficits in numerous cognitive domains, such as attention, memory, and executive functioning. Neuropsychological testing confirms that Mr. [redacted] is currently experiencing cognitive deficits in a number of domains. Moreover, he reported persistent depressed mood, fatigue, and sleep difficulties. His cognitive and

psychological presentations, in this regard, meet criteria for a diagnosis of Post-Concussion Syndrome. Within reasonable medical probability, these deficits and symptoms were predominantly caused by the accident.

I note that I do not have medical records to confirm the location of and other details regarding Mr. [redacted] brain injury. However, he was reportedly in a coma for three weeks, which can be associated with diffuse deficits.

Traumatic brain injuries, regardless of severity, are associated with specific to diffuse cognitive difficulties of varying severity for 9-12 months post-injury. Cognitive deficits remaining after 9-12 months post-injury are unlikely to significantly resolve. At the time of the current evaluation, Mr. [redacted] was approximately eight months post-injury.

Expressive Aphasia

Mr. [redacted] reportedly suffered a severe traumatic brain injury in [redacted] after which he was reportedly in a coma for three weeks. On interview, he noted frequent word-finding difficulties, both with respect to spontaneous word generation and confrontation naming. On interview, he was noted to speak in a slow, halting manner and exhibited word-finding difficulties. On testing, phonemic and semantic fluency were in the borderline impaired to low average ranges, respectively. Taken together, these characteristics are consistent with a diagnosis of Expressive Aphasia. Within reasonable medical probability, the motor vehicle accident of caused Mr. [redacted] Expressive Aphasia.

Post-Traumatic Stress Disorder, Chronic

I have conferred a diagnosis of Post-Traumatic Stress Disorder (PTSD). Mr. [redacted] was in an accident in in which he sustained a head injury and musculoskeletal injuries, and was reportedly in a coma for three weeks. He has undergone several surgeries since then, and has been seen in neurological follow-up, which has included provision for anti-seizure medications (commonly prescribed prophylactically after a severe head injury).

Since then, based on Dr. [redacted] report and the current clinical interview, Mr. [redacted] has been experiencing symptoms of PTSD such as hyper-arousal, intrusive thoughts, flashbacks, psychophysiological symptoms of anxiety, and avoidance. Given that these symptoms arose in response to an identifiable stressor that caused significant injury, his constellation of symptoms in this regard meets criteria for Post-Traumatic Stress Disorder. Within reasonable medical probability, the motor vehicle accident of caused Mr. [redacted] PTSD.

Depressive Disorder, Not Otherwise Specified

Mr. [redacted] reported significant symptoms of depression, including low mood, helplessness, hopelessness, anhedonia, self-reproach, poor motivation, low energy, sleep difficulties, irritability, cognitive problems, and fatigue. On exam, his affect was blunted.

His symptoms in this regard have emerged in the context of his head injury and related dysfunction. These symptoms are associated with a general medical condition (concussion) eight months post-injury. His depressive symptoms may resolve as his cognitive deficits plateau approximately one year post-injury. Given these factors, the diagnosis of Depressive Disorder, Not Otherwise Specified is conferred, as opposed to a diagnosis of Major Depressive Disorder.

Additionally, depression can contribute to cognitive difficulties, including difficulties in processing speed, attention, working memory, and decision-making. His depression is considered to be at least a partial contributor to his current cognitive presentation.

Within reasonable medical probability, the accident of [redacted] caused Mr. [redacted] Depressive Disorder, Not Otherwise Specified.

Within reasonable medical probability, considering Mr. [redacted] estimated average pre-injury education, occupation, and functioning, his current neuropsychological presentation was predominantly caused by the incident of [redacted]. Whether his cognitive deficits will indefinitely remain in their present state is unclear at this time, as he is approximately eight months post-incident.

RECOMMENDATIONS

1) Mr. [redacted] has diagnoses of post-concussive syndrome and aphasia. He exhibited significant impairments across cognitive domains on testing, and he reported that his subjective cognitive difficulties significantly interfere with his day-to-day activities. Given that I did not receive medical records for review of his treatment course, it is not clear whether Mr. [redacted] has engaged in a formal course of cognitive rehabilitation. Nevertheless, given his injury, history, and current evaluation results, I strongly recommend that Mr. [redacted] undergo evaluation for the provision of a formal cognitive rehabilitation program in order to improve his cognition, self-care, administrative activities, household management activities, and occupational capacity.

2) Mr. [redacted] reported significant memory difficulties since his injury, and memory performance was impaired on exam. He uses navigation software even to go to familiar places, and has gotten on the wrong freeway even though he is familiar with the area. His partner has told him that he has left the stove on. Given these

characteristics, I recommend that the practitioner who evaluates him for cognitive rehabilitation consider whether Mr. [redacted] should undergo such a program on at least partially an inpatient basis at a cognitive rehabilitation center.

3) Mr. [redacted] has diagnoses of PTSD and Depressive Disorder NOS. Following Dr. [redacted] report, I recommend that Mr. [redacted] engage in weekly individual psychotherapy with a cognitive-behavioral therapist.

4) Given the diagnoses of PTSD and Depressive Disorder NOS, following Dr. [redacted] report, I recommend that Mr. [redacted] continue in follow-up with his psychiatrist.

5) Mr. [redacted] has a diagnosis of Expressive Aphasia. I recommend that he undergo speech-language pathology evaluation in order to further clarify his speech difficulties and to determine his prognosis and strategies for communication.

6) Mr. [redacted] suffered a severe head injury in with significant cognitive and emotional residuals. I recommend that he continue in follow-up with his neurologist.

7) Mr. [redacted] is eight months post-injury. The effects of his concussion may improve within the next several months, and will most likely plateau by approximately 12 months post-injury. It is recommended that he be seen in neuropsychological re-evaluation approximately 12-15 months post-injury to confirm the extent of his cognitive difficulties and any interval improvement or worsening at that time.

8) I was not provided with Mr. [redacted] medical records. These may corroborate or refute his account and provide additional important information. My opinions may be altered or clarified by information contained in those records and allow me to comment more definitively on his credibility. I would like to review those records. Upon receipt, I will generate a supplemental report.

Thank you for this referral, and for the opportunity to evaluate Mr. [redacted] for this most interesting case and condition.

Kari Tervo, Ph.D., QME
Licensed Clinical Psychologist

Qualified Medical Evaluator
PSY 23273

October 26, 2018

TO: Disability Procedures & Services Committee
William Pryor, Chair
James P. Harris, Vice Chair
Herman Santos
Gina Zapanta-Murphy
Marvin Adams, Alternate

FROM: Ricki Contreras, Manager
Disability Retirement Services

FOR: November 7, 2018, Disability Procedures and Services Committee Meeting

SUBJECT: **CONSIDER APPLICATION OF ROBERT FISHER, M.D., AS A LACERA PANEL PHYSICIAN**

On August 7, 2018, staff and Legal Counsel interviewed California Medical Evaluators regarding Robert Fisher, M.D., a physician seeking appointment to the LACERA Panel of Examining Physicians.

Attached for your review and consideration are:
- Staff's Interview Summary and Recommendation
- Panel Physician Application
- Curriculum Vitae
- Sample Report(s)

IT IS THEREFORE RECOMMENDED THAT THE COMMITTEE accept the staff recommendation to submit the application of Robert Fisher, M.D., to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

JJP:RC:mb

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

October 26, 2018

TO: Ricki Contreras, Manager
Disability Retirement Services

FROM: Tamara L. Caldwell, DR S Supervisor
Disability Retirement Services

FOR: November 7, 2018 Disability Procedures & Services Committee

SUBJECT: Recommendation for Rheumatologist Applying for LACERA's Panel of Examining Physicians

RECOMMENDATION

Based on our efforts to provide a diverse panel of examining physicians in several geographic locations throughout Los Angeles and surrounding counties, staff recommends the Application of Robert Fisher, M.D. be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

On August 7, 2018, staff and Legal Counsel met with California Medical Evaluators at the LACERA offices to discuss several candidates for the LACERA Panel of Examining Physicians. California Medical Evaluators (CME) is a doctor-owned management and marketing company focused on serving the medical and legal communities. CME provides full-service administration of physician's medical-legal practices. CME was founded by Gregory Marusak, MD and Gabor Vari, MD who cumulatively span over two decades of experience in the medical-legal industry. They are both UCLA residency graduates and remain active on the UCLA faculty. Since its inception, CME has steadily grown, adding physicians, staff and offices to better serve clients and community. CME has highly experienced doctors in all specialties throughout California and pride themselves on providing a comprehensive and tailored experience for both legal and medical professionals.

Dr. Fisher received both his Bachelor's degree and his Medical degree from University of Michigan, where he was the Chief Resident in Urology in medical school. He interned at Sinai Hospital in Detroit and then spent three years in the United States Air Force as a general medical officer. His Residency in Internal Medicine and his Fellowship in Rheumatology were both completed at Wadsworth V.A. Hospital. Dr. Fisher has practiced Internal Medicine and Rheumatology out of his office in Santa Monica for over 45 years. He is also on the medical staff at Santa Monica Hospital Medical Center and St. John's Hospital and Health Center. He has been a QME and IME for over 25 years.

Staff reviewed the new LACERA Panel Physician Guidelines with the physician's management team, which included a lengthy discussion regarding the Rules in Evaluating Applicants, Disability Retirement Law Standards, and a thorough explanation of what is expected when preparing Panel Physician's written report for the Board of Retirement. Staff also discussed report submission timeframes, fee schedule and billing procedures, additional diagnostic testing request requirements, and advised of the requirement of maintaining a valid medical license, Board Certification, and insurance coverage. Staff also advised that all physicians must immediately report any lapses, suspensions or revocation of medical license, Board Certification, or insurance coverage, or be subject to immediate suspension or termination from LACERA Panel of Examining Physicians.

CME confirmed that they would be responsible in making sure that Dr. Fisher adhered to the rules set forth in the Guidelines and all other requirements as discussed. CME was informed that a Quality Control Questionnaire is sent to each applicant regarding their visit, which affords the applicant an opportunity to provide feedback concerning their experience during the medical appointment.

On September 21, 2018, Board Medical Advisor Vito Campese, M.D., reviewed Dr. Fisher's application and medical credential and indicated he is in agreement with submitting the Application of Robert Fisher, M.D. to the Disability Procedures and Services Committee for consideration.

IT IS THEREFORE RECOMMENDED THAT YOUR COMMITTEE adopt staff's recommendation to submit the Application of Robert Fisher, M.D. to the Board of Retirement for final approval to the LACERA Panel of Examining Physicians.

Attachments

RC:tlc/mb

Robert Fisher, M.D.
Office Location Details

Location	ADA Parking	ADA Restrooms	Lobby/Waiting Room Seating	Patients Per Day	Average Wait Time	Evaluation Time
6851 Lennox Avenue, Suite 405 Van Nuys, CA 91405	Yes	Yes	5	5-10	0 – 5 Minutes	30 Minutes – 3 Hours
2158 E Florence Avenue Walnut Park, CA 90255	Yes	Yes	15	5-10	0 – 5 Minutes	30 Minutes – 3 Hours

1. CME has 47 employees including, but not limited to, medical assistants, provider liaisons, and administrative support.
2. Bianka Kuretil will be LACERA's point of contact for scheduling appointments and addressing issues and complaints. Contact: 310-625-7475 and bkureti@calmedeval.com
3. Physician review patient history prior to examination.
4. Only CME physicians share these offices for evaluations.

LACERA

Los Angeles County Employees Retirement Association

300 N. Lake Ave., Pasadena, CA 91101 ■ Mail to : PO Box 7060, Pasadena, CA 91109-706 626/564-2419 • 800/786-6464

GENERAL INFORMATION		Date 8/14/18
Group Name: CALIFORNIA MEDICAL EVALUATORS	Physician Name: ROBERT FISHER, MD	
I. Primary Address: 11620 WILSHIRE BLVD, SUITE 340, LA, CA, 90025		
Contact Person BIANKA KURETI	Title ACCOUNT EXECUTIVE	
Telephone: 888.853.7944	Fax 866.288.9958	
II. Secondary Address 11620 WILSHIRE BLVD, SUITE 340, LA, CA, 90025		
Contact Person DOUGLAS STODDARD	Title VICE PRESIDENT, SALES & MARKETING	
Telephone 323.6453644	Fax 213.377.5152	

PHYSICIAN BACKGROUND		
Field of Specialty INTERNAL MEDICINE	Subspecialty RHEUMATOLOGY	
Board Certification ☑ Yes ☐ No	License # C27201	Expiration Date 8/31/2020

EXPERIENCE
Indicate the number of years experience that you have in each category.

Evaluation Type

I. Workers' Compensation Evaluations
- ☐ Defense How Long? _____
- ☐ Applicant How Long? _____
- ☐ AME How Long? _____.
- ☒ IME How Long? 23 years
- ☒ QME How Long? atleast 3 years

II. ☐ Disability Evaluations How Long? _____

For What Public or Private Organizations?

Currently Treating? ☑ Yes ☐ No

Time Devoted to: Treatment 30 % Evaluations %

Estimated Time from Appointment to Examination	Able to Submit a Final Report in 30 days?
☒ 2 weeks ☐ 3-4 Weeks ☐ Over a month	☑ Yes ☐ No

LACERA's Fee Schedule	
Examination and Initial Report by Physician	$1,500.00 flat fee
Review of Records by Physician	$350.00/hour
Review of Records by Registered Nurse	$75.00/hour
Supplemental Report	$350.00/hour

-OVER-

Other Fees	
Physician's testimony at Administrative Hearing (includes travel & wait time)	$350.00/hour
Deposition Fee at Physician's office	$350.00/hour
Preparation for Expert Testimony at administrative Hearing	$350.00/hour
Expert Witness Fees in Superior or Appellate Court	$3,500.00 half day $7,000 full day
Physician agrees with LACERA's fee schedule?	**No**
Comments	

Name of person completing this form:

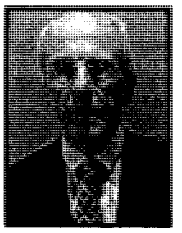
BIANKA KURETI Title: ACCOUNT EXECUTIVE

(Please Print Name)

Physician Signature: Robert Fisher MD Date: 08/14/2018

FOR OFFICE USE ONLY Physician Interview and Sight Inspection Schedule	
Interview Date:	Interview Time:
Interviewer:	

California Medical Evaluators
11620 Wilshire Blvd., Suite 340
Los Angeles, CA 90025
Ph: 888-853-7944
Fx: 213-478-0550
info@calmedeval.com



Robert Fisher, MD, QME

Rheumatology

EDUCATION

- **Wadsworth V.A. Hospital, Los Angeles, CA** (1965 – 1969)
  Internal Medicine, Residency
- **Wadsworth V.A. Hospital, Los Angeles, CA** (1968 – 1969)
  Rheumatology, Fellowship
- **University of Michigan Medical School** (1957 – 2002)
  Chief Resident in Urology
- **University of Michigan** (1954 – 1957)
  Undergraduate education

WORK EXPERIENCE

- **Private Practice, Santa Monica, CA** (1969 – Present)
  Internal Medicine and Rheumatology

BOARD CERTIFICATION

- **American Board of Internal Medicine** (1972)

MEDICAL SOCIETIES

- **Los Angeles Rheumatology Society**

INDEPENDENT MEDICAL EXAMINER

- **State of California, Department of Industrial Relations** (1990 – Present)

QUALIFIED MEDICAL EXAMINER

- **State of California, Department of Industrial Relations** (1991 – Present)

MEDICAL STAFF

- **St. John's Hospital and Health Center, Santa Monica, CA** (1969 – Present)
- **Santa Monica Hospital Medical Center** (1969 – Present)

Robert Fisher, M.D., Q.M.E.

DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE
QUALIFIED MEDICAL EXAMINER

All Correspondence To:
11620 Wilshire Boulevard, Suite 340
Los Angeles, CA 90025
Tel: (888) 853-7944
Fax: (213) 377-5152

PANEL QUALIFIED MEDICAL EVALUATION IN THE SPECIALTY OF RHEUMATOLOGY

April

[redacted]

[redacted]

[redacted]

I

[redacted]

Re:	[redacted]
Applicant's DOB:	
Employer:	
WCAB No.:	
Date of Injury:	
Claim/File No.:	[redacted]
Panel No.:	
Date of Evaluation:	March
Place of Evaluation:	
Interpreter name and #:	[redacted]

Dear Parties:

Pursuant to your authorization, [redacted] underwent a Panel Qualified Medical Evaluation, in the specialty of Internal Medicine, on [redacted], at my Walnut Park, California office. The undersigned acted in the capacity of Panel Qualified Medical Examiner, in the specialty of Internal Medicine.

I, Dr. Fisher, conducted the interview, reviewed all records, performed a physical examination, and formulated the diagnosis, conclusions, and discussion, including the opinion on causation, temporary disability, permanent disability, degree of disability, future care, work restrictions, and apportionment. The report was authored and edited by Dr. Fisher. All opinions expressed herein are solely the opinions of Dr. Fisher.

Prior to the evaluation, the entire medical file made available to the undersigned was fully reviewed. All of the records reviewed were instrumental in this examiner arriving at the opinions as expressed in this report.

Before I began the examination, the applicant was informed that this evaluation was being done exclusively in connection with the Workers' Compensation claim at the request of attorney, attorneys or insurance companies, and that no treatment relationship existed. The applicant was also made aware that any communication between us is not privileged (no doctor-patient confidentiality exists) and that any information provided, as well as the results of any testing and my conclusions regarding the case, would be included in a report that may be read by people involved in the resolution and/or litigation of the claim. The applicant was advised of his or her rights pursuant to QME regulation 40. The applicant stated that the aforementioned was understood, and agreed to proceed with the evaluation. The report belongs to the party or parties requesting the evaluation.

BILLING

This is a complex comprehensive Medical-Legal Evaluation. This report is being billed under **ML 104-95 (3)** based on regulation section 9795 in title 8 CCR.
This report qualifies for **ML 104-95 (3)** as previously agreed per the enclosed signed authorization letter and as there are "extraordinary circumstances" relating to the medical condition for which this applicant was examined. **The pre-authorization letter has been attached as an appendix to this report.**

Per 8 CCR 9795,

ML104	5	*Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances*. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for any of the following:
		(1) An evaluation which requires four or more of the complexity factors listed under ML 103; In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon.
		(2) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician;
		(3) A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances. When billing under this code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.

This code best reflects the time spent and/or the complexity of this evaluation. The best proof in regard to the complexity of this evaluation is the medical/legal report, which reflects the complex issues. The issues of complexity may be reflected by the following: Multiple body parts are examined; present and prior work history; past medical history; family and social history; a complex medical history; a complex history due to the applicant being a difficult historian; there are complex issues of causation or apportionment; adverse parties have obtained their own complex and conflicting evaluation requiring interpretation.

Billed Under **ML 104-95 (3)**, time spent includes:

1. Face-to-face interview with the applicant:	**2.00 hours**
2. Review of medical records:	**10.00 hours**
3. Preparation, dictation and correction of this report:	**5.00 hours**
4. Medical Research:	**2.00 hours**

To Whom It May Concern:

I examined [redacted] a [redacted] on March 26, 2018 in my Walnut Park office. I spent two hours of face-to-face time with this patient obtaining a history and physical examination. Additionally I spent 10 hours of medical record review, 5 hours of preparation, dictation, and correction of this report and 2 hours of medical research. I was assisted in my examination by a professional Spanish language interpreter,

REVIEW OF FILE

NON-MEDICAL RECORDS:

Panel Qualified Medical Examination Letter, signed by [redacted], dated

This examiner agreed to evaluate the applicant in his capacity of a Panel Qualified Medical Examiner in Internal Medicine on March

The examiner was provided with a complete file and the Applications for Adjudications of Claims.

The applicant's injury involving the back, shoulder, and legs had been admitted as to orthopedic claims. Defendant's denied any claims involving psychiatric or rheumatological issues. CT claims had been denied.

Panel QME in Orthopedic Surgery, issued a report, in which he requested an evaluation by PQMEs in Psychiatry and Rheumatology.

Consistent with the workers' compensation regulations, the examiner was requested to use the AMA Guides on whole body impairment to determine the appropriate level that applicant was impaired, and by which injury and part of body.

The examiner was requested to take a detailed medical history from the applicant and reviewed the documents provided at this time. The examiner was authorized

to order any outpatient testing that was reasonably necessary in order to reach an opinion on the issues in this case. After considering all of the material and conducting a thorough examination, the examiner was requested to write a report in which answer each of the following questions. The examiner was requested to provide the basis for his opinion with respect to each of the questions set forth below.

Diagnosis:

A. Does the applicant have any psychiatric condition? If so, please provide a precise diagnosis.

Injury AOE/COE:

A. Has the applicant sustained psychiatric injuries as a result of industrial injury?

Temporary Disability:

A. Has the applicant sustained any periods of temporary disability attributable to the industrial injury? If so, please set forth the period or periods of such temporary disability.

B. If you find the applicant to be temporarily disabled at this time, please state when you anticipate that the applicant will become permanent and stationary.

Permanent Disability:

A. Does the applicant have any permanent disability attributable to industrial injury?
If so, please assess the level of disability using the criteria established by the WCAB and per the AMA Guides to the Evaluation of Permanent Impairment (5th Edition).

Apportionment:

A. Please note medical reporting on the issue of apportionment of permanent disability per Labor Code Sections 4663 and 4664. It is imperative that before completing your report, you address the issue of apportionment of permanent disability based on causation. Please note that it is permissible to apportion to pathology.

Please note the law under Senate Bil1899. Please address the following concerning apportionment of permanent disability.

Apportionment per Labor Code Section 4663(a), (b), and (c):

- Labor Code Section 4663(a): "Apportionment of permanent disability shall be based on causation."

-Labor Code Section 4663(b): "Any physician who prepares a report addressing the issue of permanent disability must now address the issue of causation of the permanent disability."

-Labor Code Section 4663(c): (In part) "The physician shall make an apportionment determination by finding what approximate percentage of permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the current disability was caused by other factors, both before and subsequent to the industrial injury, including prior industrial injuries."

Labor Code §4664(a), (b), (c) (l), and (c)(2) states in pertinent part, as follows:

-Labor Code Section 4664(a): "The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment."

- Labor Code Section 4664(b): "If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof."

- Labor Code Section 4664(c) (1): "Over the lifetime of an employee, he cannot receive more than 100% permanent disability to any one 'region of the body'".

-Labor Code Section 4664(c)(2): "The permanent disability rating for each individual injury sustained by an employee arising from the same accident, when added together, cannot exceed 100%."

Therefore, the examiner was requested to note that when commenting in apportionment section, he had to make sure to follow these new guidelines and had them addressed as it pertains to apportionment of permanent disability based on causation, and make sure that his report addressed the issue of permanent disability by giving approximate percentages of permanent disability caused by the direct result of the injury as opposed to an approximate percentage of permanent disability caused by other factors, including prior and subsequent injuries.

Medical Treatment:

A. Has the applicant self-procured any medical treatment for the condition in issue? If so, please provide your opinion with respect to the reasonableness and necessity of such self-procured treatment to cure or to relieve from the effects of the industrial injury.

B. Will the applicant require treatment in the future to cure or relieve from the effects of the industrial injury? If so, please identify the type of treatment, along with the expected frequency and duration.

Work Limitations:

A. As far as your field of specialty is concerned, is the applicant able to perform the usual and customary job duties of the incident employment? If not, please identify which job duties can no longer be performed.

The examiner was requested to supply the basis of his opinions in answering each of the above questions.

Worker's Compensation Claim Form (DWC-1), dated

The applicant was sustained a specific injury on

The rest of the report is written in Spanish.

Worker's Compensation Claim Form (DWC-1), dated

The applicant, who was employed by [redacted] allegedly suffered from cumulative trauma injury to her legs, neck, bilateral extremities, back, shoulders, hips, knees, elbows, muscular –skeletal system and psyche from

Worker's Compensation Claim Form (DWC-1), dated

The applicant alleged that she suffered a specific injury on
She suffered injuries to her knee, shoulders, arms, back, hands and wrist.

Worker's Compensation Claim Form (DWC-1), dated

The applicant sustained cumulative injuries to hips, eyes, shoulder, neck, musculoskeletal system, as well as developed psych and stress while working at by [redacted] from

Application for Adjudication of Claim, dated

The applicant, while working as labor at [redacted] allegedly sustained cumulative trauma injuries to her head, neck, hips including pelvis, lower extremities, and nervous system due to repetitive work from

Employee's Disability Questionnaire, by the Applicant dated

The applicant was a laundry attendant. Her duties at the time of injury were folding of clothes, assisting customers, cleaning and washing. She suffered injuries to her right shoulder, low back, back, tailbone, bilateral leg, bilateral knee, neck, head, ears and bilateral arm. The pain prevented her from performing her job duties. She denied having a disability as a result of another injury or illness.

MEDICAL RECORDS:

Treatment Soap Note, signed by [redacted], R.P.T., dated

Subjective Complaints: The applicant complained of right shoulder and lumbar spine pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Panel Qualified Medical Evaluation, signed by [redacted], M.D., dated

Chief Complaint: The applicant complained of right shoulder and scapula; low back, mid-back, tail bone, bilateral lower extremity pain to feet (Left worse than right), bilateral knee, head and neck; ears, right upper extremity (elbow wrist hand) pain associated with arm tingling, numbness and tingling in the left upper extremity with mild pain.

Current Symptoms: The right/scapular pain was aggravated by all use of the upper extremities. She awakens at night with numb hands.

The neck and back pain were aggravated by standing and walking. She used a cane in the left hand because she could not grip it with the right hand. She could

walk 1 block slowly. She could descend 2 steps in her home, using a handrail and going 1 step at a time.

She could sit for a few minutes continuously (10-15 minutes) before getting up and moving around. She was very inactive and lies down 3 to 4 times per day for 15 to 30 minutes each time. She did home exercises for her knee (demonstrated what appeared to be quads exercises) and her hand (used a putty ball). The leg pain accompanied her back pain.

She took over-the-counter Tylenol for pain because the pain was unbearable.

She was admitted to USC/LA County for 1 and 1/2 day and transferred to Rancho Los
Amigos (about 3 days). Admission was because of headaches and she was discharged with meds which were consumed. She was assessed at the AltaMed clinic on [redacted] and was prescribed Gabapentin which she still taken. She was given other meds at AltaMed for her head but had run out.

She had difficulty in self-care, handwriting, and sexual function. Her right hand predominantly feeling what she touched. She could not remove the lift from a jar. She had difficulty in opening the doors. She did not drive. She could ride for about 5 to 6 blocks secondary to pain. She woke up 3 to 4 times per night.

Physical Demands of Job: She worked up to 32 hours per week, 4 days per week, but when she was initially employed she worked less time. She was on her feet all the time while working. Her job was to keep the Laundromat clean including the machines, windows, restroom, floors, serve customers, and she also did laundry for 'fluff and fold.'

Her job duties were included occasionally lifted/carried 40 pounds bundles of laundry, which she had to weigh; frequently overhead cleaning on top of washers and driers, and climbed ladder to clean front window on the store.

History of the Injury: [redacted], she fell from a folding table, upon which she was standing while investigating a leaking machine. She was getting off the table from a kneeling position and as she put her left foot on the floor (wet because the machine was leaking) it slipped and she fell, struck her left knee and broke her fall with the outstretched right arm. She was able to get up on her own. She had left lower extremity and right arm pain immediately. She continued to work helping the customers. Her neck and back started to hurt about 2 hours later. She informed the employer of the injury the same day by phone. She was sent home early but not sent to the doctor. She did not return to work the next day (she was having difficulty breathing because of chest pain)

and was sent to an occupational medicine clinic. She was x-rayed, given an injection, medications and work restriction. Initially she was home and then returned to work about a month later with restrictions of no mopping, no heavy lifting, no washing clothes, no overhead reaching. She continued to do her job and the employer wanted her to tasks over and above the restrictions but she did not. She went to physical therapy initially while she was still off work.

She acquired an attorney, who did not help her, in February. She got another attorney in , who sent her to a different doctor (Dr. [redacted]) who took her off work, ordered knee and back braces, a TENS unit, ointments and physical therapy. She had a left knee and shoulder MRI and lumbar spine MRI. Dr. [redacted] performed left knee arthroscopic surgery in , after which she was "very slightly" improved. She had pending shoulder surgery. She had not been had a shoulder injection.

Past/Current Medical History: Hypertension treated at AltaMed clinic for which she was prescribed Hydrochlorothiazide and Lisinopril. She was not diabetic.

She had headaches, nausea, vomiting, depression, and nocturia.

She felt depressed and thought that she needed a psychologist. She cried every day.

She underwent right oophorectomy in Mexico

Social History: She was single with 1 child . She lived with a partner and her niece. Her partner and niece had worked. Her partner supported her. She was born in [redacted] and had lived in the US for 23 years. She denied drinking alcohol beverages and using tobacco.

Work History: She started to work for the employer in and last worked in She went off work with an injury. Previously she did not work for1 year, unemployed. Before that she worked for a dog food company for 3 years. Prior to that, she worked for a company that made Ice Pops, for 5-6 years on a temporary basis. There were no prior workers' compensation claims.

Physical Examination:

Cervical spine range of motion was restricted on flexion at 40 degrees, extension at 30 degrees, right rotation at 30 degrees, left rotation at 30 degrees, bilateral lateral bending at 40 degrees.

Shoulder range of motion was restricted on abduction at 80 in the right and 170 in the left; flexion at 90 degrees in the right and 170 in the left; external rotation at 30 degrees in the right and 80 degrees in the left; internal external rotation at 30 degrees in the right and 80 degrees in the left; extension at 20 degrees in the right and 30 degrees in the left and adduction at 20 degrees in the right and 30 degrees in the left.

Elbow range of motion was restricted on flexion at 90 degrees in the right.

Sensory decreased light touch in the right upper extremity.

The upper right upper extremity strength could not grade because of the poor strength secondary to pain.

Cubital Tunnel test was positive in the left.

She had severe antalgic gait in the left.

Lumbar spine range of motion was restricted on flexion at 30 degrees, extension at 5 degrees and bilateral lateral bending at 5 degrees.

There was tenderness in the bilateral scapular, bilateral pectoral and bilateral greater touch.

There was tenderness in the medial and lateral joint line bilaterally.

Effusion difficulty to judge 2 degrees obesity in the left.

Medical record was reviewed.

Diagnoses: 1) Left knee osteoarthritis and degenerative meniscal tears s/p arthroscopic
Meniscectomy. 2) Probable right knee osteoarthritis. 3) Probable right shoulder sprain- unresolved. 4) Probable right wrist/hand sprain – unresolved. 5) Bilateral wrist tendinitis/De Quervain's tenosynovitis. 6) Chronic widespread pain - possible fibromyalgia syndrome. 7) Probable depression. 8) Obesity (BMI>30).

Discussion: The records provided for Dr. [redacted] for these evaluations were scant, as they were for Dr. [redacted]. What could be said with relative certainty was that she had initial complaints of right shoulder pain, right wrist/hand pain and left knee pain upon presentation to Clinica San Miguel, as evidenced by the radiographs performed on the date of injury. Unfortunately, there was no

Doctor's First Report of Occupational Injury or Illness for that date was provided or even a brief office note. There was no record of any subsequent visit to Clinica San Miguel, other than another radiograph of the right foot having been performed there on . By the time she saw Dr. [redacted] she was complaining of neck and back pain, left foot pain and anxiety/depression in addition to what were her original complaints. She went on to be evaluated and treated by Dr. [redacted] and he apparently performed a left knee arthroscopy on a knee, which according to the MRI report of revealed the findings of osteoarthritis and hi-compartmental degenerative meniscal tears. Not surprisingly this surgery had not resulted in significant improvement. Several well-done studies demonstrated the futility of arthroscopic surgery for this problem, degenerative meniscal tears and osteoarthritis. It was probable that she had osteoarthritis of the left knee as well. The main risk factors that the claimant had for osteoarthritis was obesity and female gender. The reasonable medical probability was that her injury of really represented aggravation of a previously existing condition, i.e, knee osteoarthritis. In terms of occupational causation of knee arthritis via a continuous trauma injury, it is reasonably medically improbable that the physical demands of her job were risk factors over the course of her 3-4 years of employment for a cumulative trauma injury resulting in osteoarthritis. Occupational risk factors for osteoarthritis include continuous repetitive squatting, kneeling, climbing and very heavy physical work. According to the applicant's account of the physical demands of her work her squatting, kneeling, and climbing activity was infrequent. Lifting up to 40 lb. of laundry in the course of her day did not constitute heavy physical demand work. However, her specific injury was consistent with aggravation of knee arthritis. Knee arthritis was frequently asymptomatic for long periods of time before it was diagnosed, although in an individual in the 5th decade of life, it was probable that it would eventually become symptomatic. Therefore there was apportionment of causation to the pre-existing disease (knee arthritis), because it was probable that even without the she would eventually have experienced impairment and disability resulting from left knee osteoarthritis.

She exhibited reduced range of cervical and lumbar spine motion. She had no physical findings of radiculopathy and the MRI scans were inconsistent with radiculopathy. The spinal MRI scans, cervical, thoracic and lumbar reveal changes, which were typical in the adult population by the 5th decade of life. These were age-related degenerative changes. The prevalence of these types of changes had been reported in asymptomatic subjects, and simply were more common the older the study population. Likewise she had reduced range of shoulder motion, but her MRI scan showed no specific finding, which could be construed as representing an injury or being remarkable in the context of an individual in the 5th decade of life. The prevalence of acromioclavicular

osteoarthritis in asymptomatic individuals over 30 years had been reported as greater than 90%. In the applicant's age· range the prevalence of rotator cuff tendinosis had been reported to be 58% including those with partial and full thickness tears. The reasonable medical probability was that she had developed chronic shoulder pain as part of a chronic pain syndrome and treatment directed at the right shoulder had little to offer her.

Regarding her right wrist specific injury, it was probable that she developed chronic pain as part of larger picture. She should be checked electrodiagnostically for carpal tunnel syndrome, for which she was at risk because of her female gender, age and obesity. If she was demonstrated to have CTS on electrodiagnosis there would be occupational causation. Her specific injury could be construed at a level of reasonable medical probability to had 'lit up' previously existing, but occult, CTS. Additionally her occupation involved repetitive moderately forceful gripping and grasping, the primary occupational physical demand which was a risk factor for CTS. If she had CTS, there would certainly be apportionment of causation to obesity, which was a very significant risk factor.

The overwhelmingly important issue in the evaluation of this case was the probability that she had a chronic pain syndrome. It appeared probable that she fulfilled the criteria for chronic widespread pain and possible fibromyalgia, based on the criteria promulgated by the American College of Rheumatology. Chronic pain and rheumatology were not within the scope of Dr. [redacted] expertise. The claimant should be referred for a rheumatologic QME in order to address as specific diagnosis as possible, as well as matters of occupational causation or lack of it. She was depressed and appeared so. Depression often accompanies chronic pain and contributed to it. She should be referred for a psychiatric QME for confirmation of diagnosis and matters of causation etc.

Lastly, a full set of records including those initial records from Clinica San Miguel, and the operative report of Dr. [redacted] should be provided.

Disability Status: She was not reached maximum medical improvement.

Causation: The specific injuries to right shoulder, wrist/hand and left knee, with aggravation of left knee osteoarthritis.

The issue on causation was deferred for chronic pain and psychiatric disorder.

Apportionment: The issue on apportionment was deferred.

Impairment: The issue on impairment was deferred.

Work Restrictions: She was placed on sedentary work without use of the right upper extremity for work above chest level or repetitive gripping and grasping.

Medical Care: Psychiatric and rheumatologic QME [were recommended]. Dr. [redacted] strongly recommend against right shoulder surgery in this clinical setting.

Laboratory Report, by [redacted]., M.D., dated

The specimen was collected on

Comprehensive metabolic panel showed increased AST at 60 and ALT at 59.

CBC test was unremarkable.

Complete urinalysis was unremarkable.

Laboratory Report, Lfps, Inc Laboratory Services, dated

The specimen was collected on

The comprehensive drug panel, barbiturates and THC panel and drug screen test did not detect any drugs.

Operative Report, signed by [redacted], M.D., dated

Preoperative and Postoperative Diagnosis: Right shoulder subacromial impingement, arthrosis, intraarticular synovitis.

Procedure: 1) Right shoulder arthroscopic subacromial decompression and bursectomy. 2) Right shoulder arthroscopic anterior acromioplasty. 3) Right shoulder arthroscopic partial excision distal clavicle. 4) Right shoulder joint arthroscopic synovectomy and debridement.

Request for Authorization, signed by [redacted], M.D., dated

Authorization for follow up visit in 4 to 6 weeks and oral medications included Ibuprofen 800 mg, Prednisone 10 mg, Gabapentin, Zofran 4 mg and Zovirax 800 mg were requested.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated November 10, 2016.

Subjective Complaints: The applicant complained of mid/upper back, right shoulder, right elbow, right wrist pain rated 8/10. She also complained of lower back and bilateral pain rated at 7/10.

Objective Findings: On the thoracic and lumbar spine examination, there was grade 2 tenderness to palpation over the paraspinal muscles, and 2 palpable spasms. There was restricted range of motion of the thoracic and lumbar spine. Straight leg raise test was positive bilaterally.

There was grade 2 tenderness to palpation in the right shoulder. Passive range of motion on abduction was 90 degrees, forward flexion was 90 degrees, internal rotation was 30 degrees and external rotation was 20 degrees.

There was no sign of infection over the applicant's right shoulder surgical wound.

Comments: She would start physical therapy as soon as possible. She was status post subacromial decompression on

Diagnoses: 1) Thoracic spine strain/sprain. 2) Lumbar spine strain/sprain with radiculitis, lumbar spine discogenic disease, per MRI dated 3) Right shoulder strain/sprain, tendinitis, bursitis, impingement, per MRI dated failure of conservative care including injection. 4) Right shoulder subacromial decompression on . 5) Right elbow strain/sprain. 6) Right elbow lateral epicondylitis. 7) Right wrist strain/sprain, right wrist carpal tunnel syndrome, per NCV dated 8) Right knee pain, compensatory. 9) Left knee meniscal tear-completed tear medial and lateral meniscus per MRI dated 10) Status post left knee arthroscopic surgery, dated with residual symptoms. 11) Osteoarthritis of the left knee. 12) Depression due to pain.

Treatment Plan: Authorization for physical therapy was requested.

Work Status: She was to remain TTD until She needed current care.

Return Appointment: She was scheduled for a follow-up examination on

Correspondence, signed by [redacted], M.D., dated

The applicant was seen for a Panel Qualified Medical Evaluation. While Dr. [redacted] was speaking with the applicant and reviewing the medical records, Dr. identified the psychiatry and rheumatology QME that were outside the area of his expertise.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated

Subjective Complaints: The applicant complained of right shoulder pain rated at 4-6/10.

Objective Findings: There was grade 2 tenderness in the right shoulder. Right shoulder range of motion was restricted.

Diagnoses: 1) Thoracic pine strain/sprain. 2) Lumbar spine strain/sprain with radiculitis, lumbar spine discogenic disease, per MRI dated . 3) Right shoulder strain/sprain, tendinitis, bursitis, impingement, per MRI dated , failure of conservative care including injection. 4) Right elbow strain/sprain. 5) Right elbow lateral epicondylitis. 6) Right wrist strain/sprain, right wrist carpal tunnel syndrome, per NCV dated . 7) Right knee pain, compensatory. 8) Left knee meniscal tear-completed tear medial and lateral meniscus per MRI dated 9) Status post left knee arthroscopic surgery, dated with residual symptoms. 10) Osteoarthritis of the left knee. 11) Status post right subacromial decompression arthroscopy

Therapies: She was to continue her conservative therapy. Authorization for physical therapy 3 times a week for 6 weeks and medical transportation was requested.

She was to follow up with her primary treating physician.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated

Subjective Complaints: The applicant complained of pain in the lower back that radiated in the pattern of bilateral L2 and L3 dermatomes, in the mid/upper back, right shoulder, right elbow, and bilateral knee. She also complained of pain and numbness in the right wrist.

The mid/upper back and lower back pain was rated at 8/10. The pain in the right shoulder, right elbow, and right wrist and bilateral knee was rated at 7/10.

Objective Findings: On the thoracic spine and lumbar spine examination, there was grade 2 tenderness to palpation over the paraspinal muscles and 2 palpable spasms. Straight leg raise test was positive bilaterally.

There was grade 2 tenderness to palpation and 2 palpable spasms in the right shoulder, right elbow, right wrist and right knee. Range motion of thoracic, lumbar, right shoulder, right elbow, right wrist and right knee was restricted.

Comments: She complained of increased lumbar spine pain with decreased range of motion. She was pending lumbar epidural steroid injection with Dr. [redacted].

Diagnoses: 1) Thoracic spine strain/sprain. 2) Lumbar spine strain/sprain with radiculitis, lumbar spine discogenic disease, per MRI dated . 3) Right shoulder strain/sprain, tendinitis, bursitis, impingement, per MRI dated , failure of conservative care including injection. 4) Right elbow strain/sprain. 5) Right elbow lateral epicondylitis. 6) Right wrist strain/sprain, right wrist carpal tunnel syndrome, per NCV dated 7) Right knee pain, compensatory. 8) Left knee meniscal tear-completed tear medial and lateral meniscus per MRI dated 9) Status post left knee arthroscopic surgery, dated with residual symptoms. 10) Osteoarthritis of the left knee. 11) Depression due to pain.

Treatment Plan: She was to continue physical therapy of the lumbar spine, left shoulder and left knee, 3 times a week for 4 weeks.

Work Status: She was to remain TDD until

Return Appointment: She was scheduled for a follow-up examination on

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated

Subjective Complaints: The applicant complained of mid/upper back pain rated 8-9/10. She also complained of low back, right shoulder, right elbow, right wrist and bilateral knee pain rated at 8/10.

Objective Findings: There was grade 2 tenderness to palpation in the bilateral knee. The range motion of the mid/upper, low back, right shoulder, right elbow, right wrist and bilateral knee was restricted.

Diagnoses: 1) Thoracic spine strain/sprain. 2) Lumbar spine strain/sprain with radiculitis, lumbar spine discogenic disease, per MRI dated 3) Right shoulder strain/sprain, tendinitis, bursitis, impingement, per MRI dated , failure of conservative care including injection. 4) Right elbow strain/sprain. 5) Right elbow lateral epicondylitis. 6) Right wrist strain/sprain, right wrist carpal tunnel syndrome, per NCV dated 7) Right knee pain, compensatory. 8) Left knee meniscal tear-completed tear medial and lateral meniscus per MRI dated . 9) Status post left knee arthroscopic surgery, dated with residual symptoms. 10) Osteoarthritis of the left knee. 11) Depression due to pain. 12) Status post right subacromial decompression arthroscopy

Treatment Plan: Authorization for physical therapy of the lumbar spine and right shoulder (post-op rehab) 3 times a week for 4 weeks was requested.

Work Status: She was to remain TDD until

Physical Therapy Report, signed by [redacted], dated

The applicant underwent electrical stimulation, TENS, therapeutic exercise and manual therapy.

Treatment Soap Note, signed by [redacted], R.P.T., dated

Subjective Complaints: The applicant complained of right shoulder and lumbar spine pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation manual therapy/myofascial, therapeutic exercises and TENS.

Request for Authorization for Medical Treatment, signed by [redacted], M.D., dated

Authorization for physical therapy of the right shoulder 3 times a week for 6 weeks was requested.

Secondary Treating Physician's Progress Report, signed by [redacted], M.D., dated

Subjective Complaints: The applicant was in severe pain each day but managed to control her pain with over-the-counter medications. She denied side effects with the use of oral and topical medications. The pain was rated at 6/10 without the use of medication. She was unable to get her by mouth medications. Surgery shoulder was on She was to start her physical therapy tomorrow on right shoulder after surgery on .

Objective: She walked with a limp to the right. Her lumbar range of motion decreased 40%. Sensory decreased light touch bilateral L5-S1.

Diagnoses: 1) Lumbar radiculitis bilateral L5-S1. 2) Right shoulder surgery.

Treatment Plan: Authorization for Norco 10/325 mg, Lunesta 1.0 mg, Omeprazole 20 mg, transdermal medication, Gabapentin and Cyclobenzaprine was requested. She was instructed to discontinue all medication prescribed by the primary treating physician including but not limited to ibuprofen 600 mg, Prednisone 10 mg, Gabapentin, Zofran 4 mg and Zovlrax 800 mg. Authorization for lumbar epidural L5-S1 bilateral for lumbar stenosis after failed conservative therapy and follow up visit for 4 weeks was requested.

Work Status: The issue on work status was deferred to the applicant's primary treating physician.

Secondary Treating Physician's Progress Report, signed by R.P.T., dated

Subjective Complaints: The applicant complained of intermittent moderate achy low back pain, numbness and tingling, associated with movement, sitting, standing, walking, bending, twisting and overhead reaching. She also complained of constant severe achy, sharp right shoulder pain, numbness and tingling, aggravated by movement, reaching, grabbing/grasping, gripping, squeezing, pushing and pulling repetitively.

Objective Findings: Lumbar Spine Examination – Her motor strength was graded at 4/5. She had impaired function, mobility, strength, balance, endurance, and gait.

Lumbar range of motion was restricted on flexion at 3 degrees, extension at 5 degrees and bilateral lateral bending at 15 degrees.

There was tenderness to palpation of the bilateral SI joints, lumbar paravertebral muscles and right gluteus. There was muscle spasm of the bilateral gluteus.

Right Shoulder Examination - Her motor strength was graded at 3-/5. There was moderate swelling of right shoulder and forearm. She had impaired function, mobility, strength, balance, and endurance. There was instability with overhead movements.

Right shoulder range of motion was restricted on flexion at 110 degrees, extension at 5 degrees, adduction at 45 degrees, abduction at 120 degrees, internal rotation at 80 and external rotation at 45 degrees.

There was tenderness to palpation of the anterior shoulder, inferior border of the scapula, levator scapulae, medial border of the scapula, subscapularis and trapezius. There was muscle spasm of the anterior shoulder, lateral shoulder, posterior shoulder, supraspinatus and trapezius.

Diagnoses: 1) Lumbosacral sprain/strain. 2) Right shoulder sprain/strain.

Treatment Plan: Treatment interventions consisted of manual therapy/electrical stimulation for the lumbar spine, home exercise program and therapeutic exercises/TENS for the right shoulder.

Work Status: She was to remain off-work unti

Operative Report, signed by [redacted], M.D., dated [redacted]

Preoperative and Postoperative Diagnoses: 1) Lumbosacral radiculopathy. 2) Lumbosacral disc herniation. 3) Lumbosacral spinal stenosis. 4) Lumbosacral spondylosis.

Procedure Performed. 1) Bilateral L5 transformational epidural steroid. 2) Bilateral L5 medical branch epidural steroid. 3) Bilateral transformational epidural steroid. 4) Bilateral S1 doral (sic) branch steroid injection. 5) Fluoroscopic guidance injection.

Medical Report, Beverly Hills Ambulatory Surgery Center, dated [redacted]

Vital Signs: Blood pressure was [157/79] mmHg. Pulse rate was 64 bpm. Respiratory rate was 16 bpm. The applicant weighed

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated [redacted].

Subjective Complaints: The applicant complained of mid/upper back, low back, right shoulder, right elbow, right wrist and left knee pain rated at 7/10. She also complained of right knee pain rated at 6/10.

Objective Findings: There was grade 2 tenderness to palpation in the mid/upper, low back, right shoulder, right elbow, right wrist and bilateral knee. The range of motion of the low back and right shoulder was restricted.

Straight leg raising test was positive bilaterally. Tinel's and Phalen's tests were positive in the right.

Diagnoses: 1) Thoracic spine strain/sprain. 2) Lumbar spine strain/sprain with radiculitis, lumbar spine discogenic disease, per MRI dated June 14, 2014. 3) Right shoulder strain/sprain, tendinitis, bursitis, impingement, per MRI dated June 14, 2014, failure of conservative care including injection. 4) Right elbow strain/sprain. 5) Right elbow lateral epicondylitis. 6) Right wrist strain/sprain, right wrist carpal tunnel syndrome, per NCV dated 7) Right knee pain, compensatory. 8) Left knee meniscal tear-completed tear medial and lateral meniscus per MRI dated 9) Status post left knee arthroscopic surgery, dated , with residual symptoms. 10) Osteoarthritis of the left knee. 11) Depression due to pain. 12) Status post right shoulder [surgery] on

Treatment Plan: Authorization for physical therapy of the lumbar spine, right shoulder (post-op) and left knee 3 times a week for [6 weeks] was requested.

Work Status: She was to remain TDD/off work until

Treatment Soap Note, signed by [redacted], R.P.T., dated [redacted]

Subjective Complaints: The applicant complained of right shoulder and lumbar spine pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Request for Authorization, signed by [redacted], M.D., dated [redacted]

Authorizations for follow up visit in 4 to 6 weeks, oral medications and topical creams; epidural steroid injections and urine drug screen were requested.

Treatment Soap Note, signed by [redacted], R.P.T., dated [redacted]

Subjective Complaints: The applicant complained of right shoulder and lumbar spine pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Secondary Treating Physician's Progress Report, Signed By [redacted], R.P.T., dated [redacted]

Subjective Complaints: The applicant complained of intermittent moderate achy low back pain, numbness and tingling, associated with movement, sitting, standing, walking, bending, twisting and overhead reaching. She also complained of constant severe achy, sharp right shoulder pain, numbness and tingling, aggravated by movement, reaching, grabbing/grasping, gripping, squeezing, pushing and pulling repetitively.

Objective: Lumbar Spine Examination - Her motor strength was graded at 4/5. She had impaired function, mobility, strength, balance, endurance, and gait. She used a cane to walk.

Lumbar range of motion was restricted on flexion at 50 degrees, extension at 15 degrees and bilateral lateral bending at 15 degrees.

There was tenderness to palpation of the bilateral SI joints, lumbar paravertebral muscles and right gluteus. There was muscle spasm of the bilateral gluteus.

Right Shoulder Examination - Her motor strength was graded at 3-/5. There was moderate swelling of right shoulder and forearm. She had impaired function, mobility, strength, balance, and endurance. There was instability with overhead movements. She had improved 25%. She also improved with activity of daily living.

Right shoulder range of motion was restricted on flexion at 150 degrees, extension at 10 degrees, adduction at 45 degrees, abduction at 145 degrees, internal rotation at 75 and external rotation at 75 degrees.

There was tenderness to palpation of the anterior shoulder, inferior border of the scapula, levator scapulae, medial border of the scapula, subscapularis and trapezius. There was muscle spasm of the anterior shoulder, lateral shoulder, posterior shoulder, supraspinatus and trapezius.

Diagnoses: 1) Lumbosacral sprain/strain. 2) Right shoulder sprain/strain.

Treatment Plan: Treatment interventions consisted of manual therapy/electrical stimulation for the lumbar spine, home exercise program and therapeutic exercises/TENS for the right shoulder.

Work Status: She was to remain off-work until

Treatment Soap Note, signed by [redacted] D.C., dated

Subjective Complaints: The applicant complained of right shoulder and left knee pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Secondary Treating Physician's Progress Report, signed by [redacted], M.D., dated

Subjective Complaints: The epidural had no relief. The applicant was in severe pain each day but managed to control her pain with over-the-counter medications. She denied side effects with the use of oral and topical medications. The pain was rated at 6/10 without the use of medication. She was unable to get her by mouth medications. Surgery shoulder was on

She was to start her physical therapy tomorrow on right shoulder after surgery on

Objective: She walked with a limp to the right. Her lumbar range of motion decreased 40%. Sensory decreased light touch bilateral L5-S1.

Diagnoses: 1) Lumbar radiculitis bilateral L5-S1. 2) Right shoulder surgery.

Treatment Plan: Authorization for Norco 10/325 mg, transdermal medication, Gabapentin and Cyclobenzaprine was requested. She was instructed to discontinue all medication prescribed by the primary treating physician including but not limited to ibuprofen 600 mg, Prednisone 10 mg, Gabapentin, Zofran 4 mg and Zovlrax 800 mg. Authorization for urine toxicology screen was requested. She was to follow up in 4 weeks.

Work Status: The issue on work status was deferred to the applicant's primary treating physician.

Treatment Soap Note, signed by [redacted] D.C., dated _____

Subjective Complaints: The applicant complained of right shoulder and left knee pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Treatment Soap Note, signed by [redacted], R.P.T., dated _____

Subjective Complaints: The applicant complained of right shoulder and left knee pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Treatment Soap Note, signed by [redacted] D.C., dated _____

Subjective Complaints: The applicant complained of right shoulder and left knee pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Treatment Soap Note, signed by [redacted], R.P.T., dated _____

Subjective Complaints: The applicant complained of right shoulder and left knee pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Treatment Soap Note, signed by [redacted] D.C., dated

Subjective Complaints: The applicant complained of right shoulder and left knee pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated

Subjective Complaints: The applicant complained of mid/upper back, lower back, right shoulder and right knee pain rated at 7/10 and right elbow, right wrist and left knee pain rated at 6/10. She also complained of pain in the lower back with radiation to the bilateral L5 and S1 dermatomes. She also complained of pain and numbness in the right wrist.

Objective Findings: On the thoracic spine and lumbar spine examination, there was grade 2 tenderness to palpation over the paraspinal muscles and 2 palpable spasms.

There was grade 2 tenderness to palpation and 2 palpable spasms in the right shoulder, right elbow, right wrist and bilateral knee. The range motion of thoracic, lumbar and right shoulder was restricted. Supraspinatus tests were positive on the right shoulder.

Comments: She was seen in the Emergency Room on 2 occasions due to facial numbness and drooping. She was diagnosed with Bell's Palsy. She was seen by the QME, the report was pending.

Diagnoses: 1) Thoracic spine strain/sprain. 2) Lumbar spine strain/sprain with radiculitis, lumbar spine discogenic disease, per MRI dated 3) Right shoulder strain/sprain, tendinitis, bursitis, impingement, per MRI dated , failure of conservative care including injection. 4) Status post right shoulder surgery on 5) Right elbow strain/sprain. 6) Right elbow lateral epicondylitis. 7) Right wrist strain/sprain, right wrist carpal tunnel syndrome, per NCV dated 8) Right knee pain, compensatory. 9) Left knee meniscal tear-completed tear medial and lateral

meniscus per MRI dated 10) Status post left knee arthroscopic surgery, dated with residual symptoms. 11) Osteoarthritis of the left knee. 12) Depression due to pain.

Treatment Plan: She was to continue physical therapy of her lumbar spine, right shoulder (post-op) and left knee, 3 times a week for 4 weeks.

Work Status: She was to remain TTD until . She needed current medical care.

Return Appointment: She was scheduled for a follow up examination on

Treatment Soap Note, signed by [redacted] D.C., dated

Subjective Complaints: The applicant complained of right shoulder and left knee pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Request for Authorization, signed by [redacted], M.D., dated

Authorization for Norco 10/325 mg, Transdermal Gabapentin 10% cream and urine drug screen was requested.

Treatment Soap Note, signed by [redacted] D.C., dated

Subjective Complaints: The applicant complained of right shoulder and left knee pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Physical Therapy Note, signed by [redacted] D.C., dated

Subjective Complaints: The applicant complained of right shoulder and left knee pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Physical Therapy Note, signed by [redacted] D.C., dated [redacted]

Subjective Complaints: The applicant complained of right shoulder and left knee pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Secondary Treating Physician's Progress Report, signed by [redacted], R.P.T., dated [redacted]

Subjective Complaints: The applicant complained of intermittent moderate achy low back pain, numbness and tingling, associated with movement sitting, standing, walking, bending, twisting and overhead reaching. She also complained of constant severe achy, sharp right shoulder pain, numbness and tingling, aggravated by movement, reaching, grabbing/grasping, gripping, squeezing, pushing and pulling repetitively.

Objective: Lumbar Spine Examination - Her motor strength was graded at 4/5. She had impaired function, mobility, strength, balance, endurance, and gait. She used a cane to walk. She had improved 15%.

Lumbar range of motion was restricted on flexion at 50 degrees, extension at 15 degrees and bilateral lateral bending at 20 degrees.

There was tenderness to palpation of the bilateral SI joints, lumbar paravertebral muscles and right gluteus. There was muscle spasm of the bilateral gluteus.

Right Shoulder Examination - Her motor strength was graded at 3-/5. There was moderate swelling of right shoulder and forearm. She had impaired function, mobility, strength, balance, and endurance. There was instability with overhead movements. She had improved 25%. She also improved with activity of daily living.

Right shoulder range of motion was restricted on flexion at 160 degrees and extension at 10 degrees.

There was tenderness to palpation of the anterior shoulder, inferior border of the scapula, levator scapulae, medial border of the scapula, subscapularis and trapezius. There was muscle spasm of the anterior shoulder, lateral shoulder, posterior shoulder, supraspinatus and trapezius.

Diagnoses: 1) Lumbosacral sprain/strain. 2) Right shoulder strain/sprain.

Treatment Plan: Treatment interventions consisted of manual therapy/electrical stimulation for the lumbar spine, home exercise program and therapeutic exercises/TENS for the right shoulder.

Work Status: She was to remain off-work until

Physical Therapy Note, signed by [redacted] D.C., dated

Subjective Complaints: The applicant complained of right shoulder and lumbar spine pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Physical Therapy Note, signed by [redacted] D.C., dated

Subjective Complaints: The applicant complained of right shoulder and lumbar spine pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Physical Therapy Note, signed by [redacted] D.C., dated

Subjective Complaints: The applicant complained of right shoulder and lumbar spine pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Physical Therapy Note, signed by [redacted]., dated [redacted]

Subjective Complaints: The applicant complained of right shoulder and lumbar spine pain.

Physical Therapy Treatment Plan: Treatment interventions consisted of electro stimulation, manual therapy/myofascial, therapeutic exercises and TENS/apply neurostimulator.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated [redacted]

Subjective Complaints: The applicant complained of activity-dependent moderate in the upper/mid-back pain, low back, right shoulder, right elbow and right wrist pain. She also complained of constant moderate bilateral knee pain.

Objective Findings: There was tenderness to palpation of the thoracic paravertebral muscles, lumbar paravertebral muscles, anterior right shoulder and anterior left knee.

Diagnoses: 1) Sprain of ligaments of thoracic spine, subsequent encounter. 2) Strain of muscle, fascia and tendon of lower back, subsequent encounter. 3) Sprain of ligaments of lumbar spine, subsequent encounter. 4) Radiculopathy, lumbar region. 5) Other intervertebral disc degeneration, lumbar region. 6) Strain of unspecified muscle, fascial and tendon at shoulder and upper arm level, right arm, subsequent encounter. 7) Unspecified sprain of right shoulder joint, subsequent encounter. 8) Other shoulder lesion, right shoulder. 9) Bursitis of right shoulder. 10) Impingement syndrome of right shoulder. 11) Strain of unspecified muscles, fascia and tendons at forearm level, right arm, subsequent encounter. 12) Unspecified sprain of right elbow, subsequent encounter. 13) Lateral epicondylitis, right elbow. 14) Strain of unspecified muscle, fascia and tendon at right wrist and hand level, subsequent encounter. 15) Unspecified sprain of right wrist, subsequent encounter. 16) Carpal tunnel syndrome, right upper limb. 17) Pain in right knee. 18) Other tear of medial meniscus, current injury, left knee, subsequent encounter. 19) Other tear of lateral meniscus, current injury, left knee, subsequent encounter. 20) Encounter for other specified surgical aftercare. 21) Unilateral primary osteoarthritis, left knee. 22) Other depressive episodes.

Treatment Plan: The PQME/AME report was pending. Therapy was on hold.

Work Status: She was to remain off-work until

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated

Subjective Complaints: The applicant complained of constant upper/mid-back pain, low back, right shoulder, right elbow and right wrist pain rated at 7/10. She also complained of activity-dependent right knee pain rated at 6/10. She also complained of constant left knee pain rated at 6/10.

There was tenderness to palpation of the thoracic paravertebral muscles, lumbar paravertebral muscles, anterior right shoulder and anterior left knee.

Diagnoses: 1) Sprain of ligaments of thoracic spine, subsequent encounter. 2) Strain of muscle, fascia and tendon of lower back, subsequent encounter. 3) Sprain of ligaments of lumbar spine, subsequent encounter. 4) Radiculopathy, lumbar region. 5) Other intervertebral disc degeneration, lumbar region. 6) Strain of unspecified muscle, fascial and tendon at shoulder and upper arm level, right arm, subsequent encounter. 7) Unspecified sprain of right shoulder joint, subsequent encounter. 8) Other shoulder lesion, right shoulder. 9) Bursitis of right shoulder. 10) Impingement syndrome of right shoulder. 11) Strain of unspecified muscles, fascia and tendons at forearm level, right arm, subsequent encounter. 12) Unspecified sprain of right elbow, subsequent encounter. 13) Lateral epicondylitis, right elbow. 14) Strain of unspecified muscle, fascia and tendon at right wrist and hand level, subsequent encounter. 15) Unspecified sprain of right wrist, subsequent encounter. 16) Carpal tunnel syndrome, right upper limb. 17) Pain in right knee. 18) Other tear of medial meniscus, current injury, left knee, subsequent encounter. 19) Other tear of lateral meniscus, current injury, left knee, subsequent encounter. 20) Encounter for other specified surgical aftercare. 21) Unilateral primary osteoarthritis, left knee. 22) Other depressive episodes.

Treatment Plan: She presented for a follow-up evaluation. It had been brought to Dr. [redacted] attention that they were not part of the medical provider network. She was released as last seen and advised to follow up with a physician within the MPN.

Secondary Treating Physician's Progress Report, signed by [redacted], M.D., dated

Subjective Complaints: The Medication Norco was not authorized and not filled. The epidural had no relief. The applicant was in severe pain each day but managed to control her pain with over-the-counter medications. She denied side effects with the use of oral and topical medications. The pain was rated at 6/10 without the use of medication. She was unable to get her by mouth medications.

Surgery shoulder was on She was to start her physical therapy tomorrow on right shoulder after surgery on

Objective: She walked with a limp to the right. Her lumbar range of motion decreased 40%. Sensory decreased light touch bilateral L5-S1.

Diagnoses: 1) Lumbar radiculitis bilateral L5-S1. 2) Right shoulder surgery.

Treatment Plan: One month of transcutaneous electrical nerve stimulation of targeted peripheral nerves to reduce the applicant's pain level and decreased medication consumption, reduce overall inflammation and improved functional levels was recommended. Authorization for Norco 10/325 mg, Diclofenac 2.5%, transdermal medication, Gabapentin 10% and Cyclobenzaprine 4% was requested. She was instructed to discontinue all medication prescribed by the primary treating physician including but not limited to ibuprofen 600 mg, Prednisone 10 mg, Gabapentin, Zofran 4 mg and Zovlrax 800 mg. Authorization for urine toxicology screen was requested. She was to follow up in 4 weeks.

Work Status: The issue on work status was deferred to the applicant's primary treating physician.

Laboratory Report, Premier Medical Laboratory Services, by [redacted], M.D., dated

The specimen was collected on

The drug urine test was inconsistent with Hydrocodone and Hydromorphone.

The drug urine test did not detect prescribed medications for the applicant.

Supplemental Report, signed by [redacted], M.D., dated

Discussion: Dr. [redacted] had tested the applicant for medications currently in her system to monitor in compliance with the pharmacological regime and identify any possible drug interactions related to multiple prescribing physicians.

The results for the tests tested on are as follows:

The applicant's test was inconsistent with her prescribed drug treatment plan.

The results for the tests tested on are as follows:

The applicant's results were consistent with tile prescribed medications.

The medications listed for the applicant would not be detected in this drug test panel.

Integrity test results for Creatinine were abnormal and PH was normal for the report dated

Integrity test results for Creatinine and PH was normal for the report dated

That completes the review of records.

Table A - Itemization of reports with blood pressure and weight:

Date of Encounter	Provider	Applicant's Blood Pressure	Applicant's Heart Rate	Hypertensive / DM Medications	Weight
,	[redacted] M.D.				
,	[redacted] Ambulatory Surgery Center	**[157/79 mmHg]**	**64 bpm**		

WORK HISTORY [redacted]

The patient states that she commenced working some time in and last worked on . She did not undergo a preemployment physical and did not have any work restrictions imposed upon her at the beginning of her employment. During the course of her employment, however, she was on restricted duty; she states from The restrictions included no bending, cleaning or kneeling. She apparently was also on temporary total disability for a short period of time from the date of her work-related injury of

The patient states that she was a and her duties included maintaining the store, which included cleaning the machines, mopping the floors,

emptying the trash, inventory, and she also did fluff and fold two or three times a day. She obtained this job by requesting it and notes that she initially worked three days a week approximately six hours a day for one year and then another year later she worked about four days a week for seven hours a day and states that she rarely worked five days a week eight hours a day. She did not have any overtime. The patient states that she is not working for this employer at the present time but she would return to her work if she were able because she did like it. She stopped working because of medical reasons with pain in her right upper extremity, left lower extremity, and back.

She notes that she did receive Workers' Compensation benefits for two years and State Disability for one year. She has not received any Social Security or unemployment benefits.

She is presently not seeking work and states "I can't push or lift with my right arm" and also "my left leg from my foot to my hip hurts and also my whole back hurts".

The patient denies loss of time from work due to perceived stress. She did not file a grievance or seek a job transfer due to stress. She has not sought psychiatric or medical help due to perceived stress and was never placed on restrictions due to perceived stress. She notes she got along well with her fellow employees and supervisor and was never disciplined. She never threatened to quit her job because of the stress nor has she filed a Workers' Compensation claim regarding stress. She states that she was able to accomplish her job satisfactorily and meet all deadlines but feels that she was harassed after her work-related injury because the employer wanted her to do her full duties in spite of her restrictions. The patient states that she did not seek a job change or make a grievance because "I needed to work." She notes the job was physically demanding because occasionally she would have to lift up to 70 pounds and she states that she did her fluff and fold work two or three times a day. She felt she was able to meet her quotas and deadlines and felt qualified for the job. She stated there were no family problems, which would affect her work, but did state that her family life used to be good and it was not so good now although she did not elaborate.

The patient feels that her work prompted and aggravated her medical condition because she slipped on some water that was on the floor. She had been checking a washimg machine that was leaking and when she stepped down from an elevated area on to the floor, she slipped, falling, and injuring her right upper extremity including the arm, shoulder and her left knee, leg, and back. She states that then having to work subsequently doing her regular job in spite of the work

restrictions which were imposed, this caused her to have increasing pain and difficulty.

The patient is represented by an attorney who was referred by a lady. The attorney is

WORK HISTORY SUBSEQUENT TO EMPLOYMENT WITH [redacted]

She has not worked since stopping this job.

WORK HISTORY PRIOR TO EMPLOYMENT WITH [redacted]

She states she worked at a packaging company for two or three years and prior to that she worked for a company that made . She states this was a seasonal job where she would work three or four months a year for three or four years. Prior to that, she worked at a company trimming clothing for three years and before that she worked in a different , company trimming clothing for one-half year. She notes that at none of these previous employments did she suffer any work-related injury or illness.

HISTORY OF PRESENT ILLNESS

On , the patient states that she had a slip and fall injury when she was getting off of a table and stepped onto the floor which was covered with water. She had been checking one of the washing machines that had been leaking. When she stepped down, her foot slipped and she fell onto her outstretched right arm and left lower extremity. She reported this injury to "the person in-charge" who then reported it to her supervisor. She notes that there was a delay in getting a hold of the supervisor and the patient did manage to finish her shift and left the laundromat around 8 o'clock at night. Apparently the following day, she was having a lot of pain and she called in to work and told them she could not come and she was referred to the where she underwent examination, x-rays, and then was prescribed physical therapy. In the clinic, the patient was also placed at that time on temporary total disability until when she returned to work with restrictions.

She states that in spite of her restrictions, her employer wanted her to do full duty as before and as a result after three or four months, she was having increasing pain and was unable to continue her work.

PRESENT COMPLAINTS

The patient states that she is now having pain in her entire back, her right arm, shoulder, left leg, knee, and lower back. She also notes that she has headaches that come with increased back pain. She also has had headaches which she was hospitalized for at the Hospital and subsequently at the Rancho Los Amigos Hospital. This episode, however, according to the medical records was actually an episode of Bell's palsy and really unrelated to her work.

The patient is complaining also of anxiety and depression and states that she was hospitalized for that recently in at the Hospital. She also notes that she has been treated for her headaches and anxiety and depression at the Clinic. She complains of numbness in her left thumb, hand, and foot, which was off and on and she has problems sleeping on her left side because of the pain in her left leg and problems sleeping on the right side because of pain in her right arm. She notes that she is going to a clinic called Exodus for her anxiety. The patient was diagnosed with a torn meniscus in the left knee and did undergo surgery on She was also diagnosed with an internal derangement of the right shoulder for which she underwent surgery on . The patient notes that these two surgeries did not improve her condition and she states that they actually made things worse.

She does complain of pain in her chest which she states comes from increased pain in her right shoulder with radiation toward the anterior chest area. She notes that she is getting pain on the left side of her chest now secondary to her acupuncture treatments. She also states that her acupuncture treatments have increased the pain in her knees. She notes that she gets short of breath when her pain in the back increases and then she has to stand and take deep breaths. She is only able to walk a half block using a cane because of pain in her leg and also pain in her left foot. She states that she has difficulty going up the two steps to her house. She notes shortness of breath when she has increased pain when lying in bed and she has to shift her position. She notes occasional shortness of breath when she awakens from her sleep secondary to pain but she also admits to having a history of snoring but states that she has not been observed having episodes of stopping breathing. She does have nocturia two to three times per night. She notes swelling of her feet when she is walking. She also notes that she gets "palpitations" when she has increasing pain or while walking. She denies any history of syncope and states that she has not been told of any heart problems and did undergo preoperative evaluations for both her knee surgery and shoulder surgery and there was no mention of any internal medicine problems. She has had numbness and tingling in her left hand and states that there has been no history of peripheral vascular disease. She does, however, have a history of

hypertension, which apparently was found after her date of injury in
and she also has been told that she is a "prediabetic."

PAST MEDICAL HISTORY

She denies any childhood illnesses or injuries.

As an adult, she did have a right oophorectomy in

ALLERGIES

She is allergic to morphine.

MEDICATIONS

The patient is presently taking hydrochlorothiazide 25 mg and lisinopril 20 mg daily. She has also been prescribed tizanidine 2 mg twice a day, lansoprazole 15 mg twice a day, Naprosyn 500 mg twice a day, lorazepam 0.5 mg p.r.n., and citalopram 10 mg daily. When the patient was asked whether or not she had been taking her medicines, she initially told me that she had not been taking her medicines for two weeks because she had an upper respiratory infection and was taking antibiotics. Later she changed her story and told me that she had continued taking her blood pressure medicines.

PREVIOUS SURGERIES

She has had surgery on her right shoulder, left knee, and her oophorectomy.

She has been hospitalized only for her episode of Bell's palsy.

FAMILY HISTORY

Her father is about age , suffering from hypertension. Her mother died at age , the cause of which she does not know. She has four sisters living and well and she had three brothers, one of whom passed away, the cause of which she does not know. The others are living and well. She has one child who is living and well.

PERSONAL AND SOCIAL HISTORY

The patient was born in [redacted] and presently resides in [redacted]. She attained a sixth grade education. She is not married but cohabiting with a partner for the last eight years. She denies the use of alcohol, tobacco, and illicit drugs.

REVIEW OF SYSTEMS

HEENT: She states that she gets headaches occasionally. She notes that she has trouble with her vision by which she means that she gets diplopia at rare times. She states she has trouble with her hearing secondary to infections and recent trouble with her throat secondary to a recent infection.

Respiratory: She notes shortness of breath with increase in her pains in the back. She also notes no problem really with coughing, fevers, or chills. She does get episodes of sweating with anxiety.

Cardiovascular: She does note chest discomfort, which seems to radiate really from her right shoulder.

Gastrointestinal: She notes occasional nausea, which may be related to medication she had been taking (Norco and Vicodin). She states that she would get that occasionally, may be twice a week. She has not had any vomiting, diarrhea, or change in her bowel habits. She has had pain in her "liver area" but states that she had an ultrasound two or three months ago, which was perfectly normal. She does not complain of any other stomach problems.

Genitourinary: She notes a feeling of incomplete voiding and nocturia but no urgency, frequency, dysuria, polyuria or hematuria.

Endocrinologic: She has normal menses.

Musculoskeletal: As in the present illness and present complaints.

Neurologic: She has numbness and tingling as noted on the left hand.

EFFECTS UPON ACTIVITIES OF DAILY LIVING

When questioned, the patient notes that she does her chores at home slowly but is able to cook and prepare her meals. She is able to do all self-care but again "slowly". She notes it is hard, however, to get off the toilet. She states that she has some trouble writing because of the numbness in her hand and she notes problems with speaking, hearing and seeing, which are really unrelated to her work. Her physical activities are limited stating that she could only stand for 20 minutes and sit for only 15-30 minutes. It was noted that while taking her history, she did have to get up after approximately a half hour and did frequently want to shift her positions. She was noted to be walking with a limp favoring her left knee and she did use a cane in her right hand when walking. She stated that it was hard to get going after sitting for half an hour. Climbing stairs was limited

to two steps. Her sensory functions were actually normal but she noted that there was decreased feeling in the hands because of the numbness. She also stated that recently her taste was not normal. Her non-specialized hand functions were decreased because of problems with the right hand being weak and painful. She states that she would use her left hand and arm to support her right upper extremity when doing things. She had difficulty opening bottles and small jars. She never drove a car and states that she can only ride for 20 or 30 minutes. Her sexual function is decreased because of her pain. Her sleep is disturbed and not restful. She will go to sleep around 9:00 p.m. and frequently wake up two to three hours later. Then she will go back to bed and wake up at 7:00 a.m. She states that the back pain, left leg pain, right arm pain and numbness in the left hand are reasons that her sleep is disturbed.

PHYSICAL EXAMINATION

General: The patient is an obese female, in no acute distress, but walking with a cane and favoring her left leg with a limp and antalgic gait. She stands inches high and weighs Her blood pressure on two occasions measured 131/91 with a pulse of 83.

HEENT: There were no abnormalities noted in the eyes, ears, nose or throat. There was no unusual lymphadenopathy, thyromegaly, or carotid bruits.

Chest: Normal exam but there was tenderness to palpation anteriorly over the sternum.

Lungs: Clear to examination with no wheezes, rales or rhonchi noted.

Heart: There was no evidence of cardiomegaly, murmurs, or extra sounds.

Abdomen: There was no enlargement of liver, kidneys or spleen. The patient was tender to palpation in all quadrants but with no rebound, guarding or rigidity. Bowel sounds were normal. There were no bruits.

Cervical spine: There was a full range of motion although the patient on extremes of motion did grimace.

Lumbar Spine: There was marked decreased range of motion in the lumbar spine with pain along the paravertebral muscles. She noted that pain was greater on the left than on the right. She was unable to flex forward more than five degrees and was not able to laterally flex more than five degrees to the right or left.

Neuromuscular: The deep tendon reflexes were 2+ and equal and symmetrical. There were no Babinski's. The vibratory sense was normal.

Skin: Normal exam.

Lymphatics: There was no unusual lymphadenopathy.

Upper Extremities: There was no evidence of clubbing, cyanosis or edema. Peripheral pulses were intact. There was no evidence of any acute or chronic synovitis in the joints of the fingers, hands, wrists, elbows or shoulders. There was normal range of motion in the joints of the left upper extremity and in the joints of the right upper extremity, although the patient complained of pain when the joints were moved. It was noted that the patient complained of pain when the right shoulder was raised to 80 degrees abduction and with any moderate internal or external rotation.

Lower Extremities: There was no clubbing, cyanosis or edema. The peripheral pulse in the right leg was 2+ and in the left leg was only trace. The left foot was noted to be colder than the right foot. Also the right knee was noted to be warmer than the left knee. There was, however, no evidence of acute or chronic synovial thickening and no evidence of joint effusions in the feet, ankles, or knees. There was marked decreased range of motion in the knees and hips secondary to pain.

IMPRESSION

1. History of work-related slip and fall injury dated
2. History of continuing trauma to
3. Myofascial pain syndrome, rule out fibromyalgia.
4. History of hypertension.
5. History of pre-diabetes.

DISCUSSION

This female worked for [redacted] as a She sustained a specific injury on when she tried to repair a leaking washer. She noted that she had to climb upon a table to check on the washing machine and when she was descending from the table, her foot would not touch the floor, and when it did she slipped because the floor was wet secondary to the leaking laundry machine. As a result, she slipped and fell and injured her right shoulder, her left knee, and her outstretched right arm. Medical records the following day from the and

Urgent Care Clinic revealed that those were her complaints. She noted pain in the right shoulder, left knee, and the right hand. These areas were x-rayed and there were no abnormalities noted. The patient was placed off work for approximately one month and underwent physical therapy and then returned to work with restrictions of no heavy lifting, stooping, bending or working above shoulder level. She continued working until approximately [redacted] when she claimed to have increasing pain and difficulty and also noted that her employer wanted her to do full duty in spite of her restrictions that were given by the treating clinic. As a result, the patient sought the services of an attorney and was sent to Dr. [redacted], who placed her on temporary total disability, and began conservative therapy for her symptomatology. Apparently, the patient had obtained the services of an attorney one month earlier but decided to change attorneys later.

The patient also has a continuing trauma claim regarding multiple body parts including the ear, arm, lower extremities, nervous system, and psychiatric. This would be a cumulative trauma claim from [redacted]. There was also another cumulative trauma claim from [redacted] involving the ear, mouth, nose, head, neck, arm, wrist, hands, fingers, trunk, back, chest, hips, legs, knee, and nervous system - psychiatric. Medical records received and reviewed do not substantiate the patient being treated for the majority of these alleged cumulative trauma injuries other than treatment for the specific injury to the right shoulder, right hand, and left knee that she sustained on [redacted] It appears that the majority of all of these other complaints developed subsequent to her ceasing work.

The patient was continued on conservative therapy for a number of months by Dr. [redacted]. She did not improve despite treatment with acupuncture, shockwave therapy, physical therapy, etc. MRIs taken of the left knee revealed evidence of some torn menisci as well as osteoarthritis in the knee. Because of the meniscal problem, the patient ultimately had surgery on [redacted]. Subsequent to the surgery, her symptoms continued and in fact her symptoms worsened with increased difficulty walking such that when I examined the patient, she was limping with her left leg and using a cane in order to assist her walking. The cane was also necessary for her to maintain proper balance when walking.

The patient continued to complain of pain in the shoulder, knee, and hand, and began complaining also of pain in her mid and upper back. In spite of conservative therapy and treatment by pain management physicians, her symptoms continued unabated and actually according to her, worsening. An MRI of her right shoulder revealed some impingement syndrome and tendinosis and acromioclavicular osteoarthritis and because of these symptoms and signs,

the patient underwent a right shoulder arthroplasty on [redacted] which again unfortunately did not resolve her symptoms and only made things worse.

On [redacted], the patient was seen by a PQME in Orthopedics, Dr. [redacted] who felt that the majority of her complaints did not correlate with the objective findings on his examination and he felt that because of the patient's chronic pain and complaints of pain all over that there was a possibility that she was suffering from a rheumatologic condition, fibromyalgia, and he requested that she be seen by a PQME in Rheumatology to assess the situation.

When I examined the patient, I noted that she was limping on her left leg, walking slowly, exhibiting some difficulty with balance, and having difficulty getting on and off the examining table, sitting up from a lying position and getting out of a chair with difficulty. In addition, she complained of pain in her entire back, the right arm and shoulder, her left leg and knee, as well as problems with headaches, which seemed to get worse with her back pain. She also complained of anxiety and apparently being hospitalized once for that as well as depression. She stated that she was being treated by her private physician at the [redacted] facility for her headaches as well as for depression and anxiety. She noted numbness in her left thumb, hand, and foot, which seemed to come off and on and complained of problems sleeping because of the pain in her left knee, which made it difficult to sleep on her left side and pain in the right side secondary to the pain in her right shoulder and arm, which made it difficult for her to sleep on her right side. The patient also noted to me that surgery for her knee and shoulder did not help and made her symptoms worse and also acupuncture that she had received in the past had made her symptoms worse.

On physical examination at the time that I saw her, her blood pressure was 131/91 and she stated that she had taken her blood pressure medicines; however, she had also stated previously that she had stopped medications for two weeks prior to seeing me, so it was unclear whether or not she had taken medication. Medical records revealed that when she had urine toxicology test that there was no evidence that she had taken any of her pain medications. The physical examination was rather unremarkable except for tenderness to palpation over her chest and abdomen without any observable objective abnormalities. Also, examination of her extremities was rather unremarkable other than her left foot appeared to be colder than the right with somewhat decreased pulsation in the dorsalis pedis and posterior tibial pulses on the left. Her right knee was noted to be slightly warm compared to the left knee. All the rest of her joint examinations were quite unremarkable other than with decreased range of motion of the shoulders secondary to subjective pain. Range of motion of her cervical spine was noted to be full; however, range of motion of the lumbar spine was markedly decreased secondary to subjective pain. She complained of pain in the

paravertebral muscles to palpation with symptoms being worse on the left compared to the right and she had marked decrease in forward and lateral flexions. She also complained of pain with minimal motion of the hips and knees.

It is evident that the patient complains of pain all over, which would make one certainly think of a fibromyalgia type syndrome. The patient was given a number of questionnaires to fill out and these included the Piper Fatigue Scale, which revealed that she had an average score of 9.6, which put her in the markedly severe fatigue category. In spite of her difficulties that she described with sleeping, her Epworth Sleepiness Score totaled only 5/24, which was within the range of normal. Her questionnaire concerning her activities of daily living revealed moderate-to-marked difficulty in multiple areas including difficulty with sexual functioning. When asked to circle the areas of her body that hurt, she noted the right and left sides of her head, her chest, her right shoulder, her right elbow, her right wrist, her right hand and fingers, the right middle back, the right lower back, and her abdomen. She also noted the left middle back, left lower back, the left thigh, knee, calf, ankle, and both right and left foot. Her answers on the patient self-report questionnaire for the diagnosis of fibromyalgia noted pain in the right jaw, shoulder, upper arm, lower arm, the upper back, chest, abdomen, and lower back as well as the left lower leg, upper leg, hip, and buttock. This gave her a total score for widespread pain index of 11 out of a possible 19. On her Symptom Severity Score, she noted severe fatigue, severe waking up tired and severe trouble thinking and remembering. She also complained of pain and cramps in the lower abdomen, headache, and depression. This gave her a total of 12 out of a possible 12 for a total of 23 out of 31, which was quite positive for the presumptive diagnosis of fibromyalgia. There was one ringer and this, however, that the patient did not actually describe four quadrant pain, which according to the 2016 revision of the ARA criteria for the diagnosis of fibromyalgia as noted in the article by F. Wolfe, M.D., entitled "2016 Revisions to the 2010/2011 Fibromyalgia Diagnostic Criteria."

The patient does, however, satisfy the majority of criteria for the diagnosis and in an article by D. Goldenberg, M.D. entitled "Clinical Manifestations and Diagnosis of Fibromyalgia in Adults." He notes that fibromyalgia is a common cause of chronic pain and the most common cause of generalized musculoskeletal pain in women between the ages of 20 and 55 years. He further notes that fibromyalgia is characterized by widespread musculoskeletal pain and fatigue, often accompanied by cognitive and psychiatric disturbances and the physical examination reveals tenderness in multiple soft tissue anatomic locations and that laboratory testing is normal in the absence of other illnesses. This patient certainly fits into that classification and category. In another article by Dr. [redacted] entitled "Pathogenesis of Fibromyalgia," he notes that this

illness was thought to be a disorder of pain regulation classified under the term of central sensitization. It is my opinion that the patient has developed this fibromyalgia central sensitization subsequent to the specific injury that she suffered on [redacted] and also subsequent to the failed surgery on her knee and on her shoulder, which she alleges has only caused worsening of her symptoms. Unfortunately, it is impossible to know exactly how this central sensitization occurred, but it is postulated that various hormonal and even possibly immunologic factors play a role in allowing the central nervous system to experience pain that would normally not be symptomatic in otherwise healthy people. It is noted further that alterations in pain and sensory processing of the central nervous system are present in the fibromyalgia patients and they perceive noxious stimuli such as heat, electrical current, or pressure as being painful at lower levels of physical stimulation than do healthy controls.

Since the patient does have probable fibromyalgia as a cause of her generalized pains, I used Table 18-4 on page 576 of the AMA Guides to rate her pain syndrome. This table is entitled Ratings Determining Impairment Associated with Pain. On section 1 of Table 18-4, the patient had a total of 18.5. On section 2, she had a total of 9.6. On section 3, she had a total of 10. Then, using Table 18-5, the assessment of pain behavior, she certainly had a number of pain behaviors including facial grimacing, limping, frequent shifting of postures, slow movement, and moving with a guarded protective functioning as well as moaning and using a cane. This would affect her ratings on Table 18-6. On Table 18-5, I would give her a +4 rating for her "pain behavior." Then applying Table 18-6 from page 584 of the AMA Guides, a worksheet for calculating total pain-related impairment score, on line 1, she had a total of 18.5. On line 2, she had a total of 28.8. On line 3, she had a total of 10. On line 4, her global pain behavior rating, I gave her a 4. On line 5, my physician's assessment of credibility, I had to give her a 0 because I could not say that she was more or less credible. As a result, this totaled 61.3 on line 6. Transferring this information to Table 18-7, determining impairment class on the basis of total pain-related impairment score, the patient was at the lowest level of severe impairment with the score being between 61 and 80.

Since fibromyalgia is a pain syndrome, that cannot be rated using Chapter 18. I then had to apply the Almaraz-Guzman decision and I used Table 13-4, criteria for rating impairment due to sleep and arousal disorders. Although the patient did not have a significant arousal problem, she did complain of difficulty sleeping and certainly had marked fatigue. Additionally, when evaluating her pain, I invoked Table 18-3, impairment classification due to pain disorders. The patient using this table fell into class II to III, moderate to moderately severe impairment. Thus, transferring this information to Table 13-4, I felt the patient

fell between class II and III. She had reduced daytime alertness and her ability to perform activities of daily living were significantly limited.

It has now been almost five years since the patient was initially injured and her symptoms have remained unchanged, if not, generally worse. Therefore, I feel that she has reached maximum medical improvement and is permanent and stationary for rating purposes. Objective factors of disability include the x-ray changes and MRI changes noted in her knees, right shoulder, and lumbar spine. In addition, there is some physical evidence of a slight decrease in the temperature of the left foot and inceased temperature in the right knee. Subjective factors of disability include all of her areas of pain and limitation of motion secondary to her perceived pain. Using Table 13-4, I feel that the patient has a 30% whole-person impairment, which is the lower level of class III and I feel that her fibromyalgia is a consequential result of her work-related injury and subsequent failed surgeries on the left knee and right shoulder. I do not find evidence of continuing trauma as a source and cause of her fibromyalgia syndrome. I feel that the fibromyalgia syndrome is 100% related to the specific work-related injury and subsequent attempts at treatment of these injuries. Therefore, I feel that this is 100% industrial in causation and find no cause for apportionment to non-industrial factors.

Thus, the patient I feel is a qualified injured worker entitled to vocational rehabilitation and retraining benefits. Additionally, I feel the patient is entitled to future medical care in the form of doctor visits every two to three months as well as necessary medications and treatment in a cognitive behavioral therapy to try and alleviate her symptomatology. In an article by Dr. Goldenberg entitled "Initial Treatment of Fibromyalgia in Adults," the patient would benefit from patient education regarding the disease as well as treatment approaches including good sleep hygiene, cognitive behavioral therapy, various medications including central pain relievers such as Lyrica and Cymbalta as well as antidepressant medications. Additionally, courses of supervised physical therapy and referral for psychological evaluations would be of possible benefit.

Thank you for the opportunity of seeing this patient in rheumatologic evaluation.

Medical Research:

1. Goldenberg, D., M.D. - "Initial Treatment of Fibromyalgia in Adults." UpToDate. January 8, 2017. Pages 1 through 22.
2. Goldenberg, D., M.D. - "Pathogenesis of Fibromyalgia." UpToDate. January 25, 2016. Pages 1 through 9.
3. Goldenberg, D., M.D. - "Clinical Manifestations and Diagnosis of Fibromyalgia in Adults." UpToDate. April 12, 2016. Pages 1 through 19.

4. Wolfe, F., M.D., et al. - "2016 Revisions to the 2010/2011 Fibromyalgia Diagnostic Criteria." Seminars in arthritis and rheumatism. 2016 DEC; 46(3): 319-329.

SPECIAL COMMENTARY

The above responses and opinions are based on reasonable medical probabilities, as viewed from the perspective of available documentation and information submitted to this examiner, including the applicant's direct anamnesis.

I, Robert Fisher, M.D., Q.M.E., formulated all conclusions and opinions.

Thank you for the opportunity of serving as Qualified Medical Examiner, in the specialty of Internal Medicine, for this most interesting case and condition.

Sincerely,

Robert Fisher, M.D., Q.M.E.
Diplomate, American Board of Internal Medicine

Attachments:
1. Appendix A: Declaration
2. Appendix B: Pre-Authorization Letter
3. Appendix C: Medical Research

APPENDIX A - DECLARATION

Pursuant to AB 1300, LC Sec. 5703, I have not violated Labor Code section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

DATE OF REPORT: April

Dated this y of April at

Robert Fisher, M.D., Q.M.E.
Diplomate, American Board of Internal Medicine

Format: Abstract

Semin Arthritis Rheum. 2016 Dec;46(3):319-329. doi: 10.1016/j.semarthrit.2016.08.012. Epub 2016 Aug 30.

2016 Revisions to the 2010/2011 fibromyalgia diagnostic criteria.

Wolfe F[1], Clauw DJ[2], Fitzcharles MA[3], Goldenberg DL[4], Häuser W[5], Katz RL[6], Mease PJ[7], Russell AS[8], Russell IJ[9], Walitt B[10].

Author information

Abstract

OBJECTIVES: The provisional criteria of the American College of Rheumatology (ACR) 2010 and the 2011 self-report modification for survey and clinical research are widely used for fibromyalgia diagnosis. To determine the validity, usefulness, potential problems, and modifications required for the criteria, we assessed multiple research reports published in 2010-2016 in order to provide a 2016 update to the criteria.

METHODS: We reviewed 14 validation studies that compared 2010/2011 criteria with ACR 1990 classification and clinical criteria, as well as epidemiology, clinical, and databank studies that addressed important criteria-level variables. Based on definitional differences between 1990 and 2010/2011 criteria, we interpreted 85% sensitivity and 90% specificity as excellent agreement.

RESULTS: Against 1990 and clinical criteria, the median sensitivity and specificity of the 2010/2011 criteria were 86% and 90%, respectively. The 2010/2011 criteria led to misclassification when applied to regional pain syndromes, but when a modified widespread pain criterion (the "generalized pain criterion") was added misclassification was eliminated. Based on the above data and clinic usage data, we developed a (2016) revision to the 2010/2011 fibromyalgia criteria. Fibromyalgia may now be diagnosed in adults when all of the following criteria are met: CONCLUSIONS: The fibromyalgia criteria have good sensitivity and specificity. This revision combines physician and questionnaire criteria, minimizes misclassification of regional pain disorders, and eliminates the previously confusing recommendation regarding diagnostic exclusions. The physician-based criteria are valid for individual patient diagnosis. The self-report version of the criteria is not valid for clinical diagnosis in individual patients but is valid for research studies. These changes allow the criteria to function as diagnostic criteria, while still being useful for classification.

KEYWORDS: Classification; Criteria; Diagnosis; Fibromyalgia

PMID: 27916278 DOI: 10.1016/j.semarthrit.2016.08.012

[Indexed for MEDLINE]

MeSH terms

LinkOut - more resources

Author: Don L Goldenberg, MD
Section Editor: Peter H Schur, MD
Deputy Editor: Paul L Romain, MD

INTRODUCTION

Fibromyalgia (FM) is a common cause of chronic widespread musculoskeletal pain, often accompanied by fatigue, cognitive disturbance, psychiatric symptoms, and multiple somatic symptoms. The etiology of the syndrome is unknown, and the pathophysiology is uncertain [1,2]. Despite symptoms of soft tissue pain affecting the muscles, ligaments, and tendons there is no evidence of tissue inflammation.

FM, like other functional somatic syndromes, has been a controversial condition [1,2]. Patients look well, there are no obvious abnormalities on physical examination other than tenderness, and laboratory and radiologic studies are normal. Thus, the role of organic illness had been questioned, and FM was often been considered to be psychogenic or psychosomatic. However, ongoing research suggests that FM is a disorder of pain regulation, often classified as a form of central sensitization [3]. (See "Pathogenesis of fibromyalgia".)

FM is often associated with other conditions that may cause musculoskeletal pain, disruption of sleep, or psychiatric symptoms; features of these conditions may also mimic FM, and the presence of such disorders should be considered in the diagnostic evaluation. (See "Differential diagnosis of fibromyalgia".)

The clinical manifestations and diagnosis of FM will be reviewed here. The differential diagnosis of FM is discussed in detail separately, as are the possible pathogenic mechanisms and treatment of FM in adults, and the clinical manifestations, diagnosis, and treatment of FM in children and adolescents. (See "Differential diagnosis of fibromyalgia" and "Pathogenesis of fibromyalgia" and "Initial treatment of fibromyalgia in adults" and "Treatment of fibromyalgia in adults not responsive to initial therapies" and "Fibromyalgia in children and adolescents: Clinical manifestations and diagnosis" and "Fibromyalgia in children and adolescents: Treatment and prognosis overview".)

EPIDEMIOLOGY

Fibromyalgia (FM) is a common cause of chronic pain and the most common cause of generalized, musculoskeletal pain in women between ages of 20 and 55 years; in the United States and in other countries, the prevalence is approximately 2 to 3 percent and increases with age [4-7]. FM is more common in women than men and occurs in both children and adults [4-8]. It is six times more common in women in reports from specialty clinics, although the female predominance is not as striking in the community and when using survey criteria that do not require a tender point examination [6].

Literature review current through: Mar 2018. | **This topic last updated:** Nov 22, 2017.

REFERENCES

1. Goldenberg DL. Fibromyalgia syndrome. An emerging but controversial condition. JAMA 1987; 257:2782.
2. Clauw DJ. Fibromyalgia: a clinical review. JAMA 2014; 311:1547.
3. Pomares FB, Funck T, Feier NA, et al. Histological Underpinnings of Grey Matter Changes in Fibromyalgia Investigated Using Multimodal Brain Imaging. J Neurosci 2017; 37:1090.
4. Vincent A, Lahr BD, Wolfe F, et al. Prevalence of fibromyalgia: a population-based study in Olmsted County, Minnesota, utilizing the Rochester Epidemiology Project. Arthritis Care Res (Hoboken) 2013; 65:786.
5. Wolfe F, Ross K, Anderson J, et al. The prevalence and characteristics of fibromyalgia in the general population. Arthritis Rheum 1995; 38:19.
6. Jones GT, Atzeni F, Beasley M, et al. The prevalence of fibromyalgia in the general population: a comparison of the American College of Rheumatology 1990, 2010, and modified 2010 classification criteria. Arthritis Rheumatol 2015; 67:568.
7. Walitt B, Nahin RL, Katz RS, et al. The Prevalence and Characteristics of Fibromyalgia in the 2012 National Health Interview Survey. PLoS One 2015; 10:e0138024.
8. Ting TV, Barnett K, Lynch-Jordan A, et al. 2010 American College of Rheumatology Adult Fibromyalgia Criteria for Use in an Adolescent Female Population with Juvenile Fibromyalgia. J Pediatr 2016; 169:181.
9. Fayaz A, Croft P, Langford RM, et al. Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies. BMJ Open 2016; 6:e010364.
10. Collin SM, Bakken IJ, Nazareth I, et al. Trends in the incidence of chronic fatigue syndrome and fibromyalgia in the UK, 2001-2013: a Clinical Practice Research Datalink study. J R Soc Med 2017; 110:231.
11. Perrot S, Vicaut E, Servant D, Ravaud P. Prevalence of fibromyalgia in France: a multi-step study research combining national screening and clinical confirmation: The DEFI study (Determination of Epidemiology of FIbromyalgia). BMC Musculoskelet Disord 2011; 12:224.
12. Senna ER, De Barros AL, Silva EO, et al. Prevalence of rheumatic diseases in Brazil: a study using the COPCORD approach. J Rheumatol 2004; 31:594.
13. Haq SA, Darmawan J, Islam MN, et al. Prevalence of rheumatic diseases and associated outcomes in rural and urban communities in Bangladesh: a COPCORD study. J Rheumatol 2005; 32:348.
14. Brill S, Ablin JN, Goor-Aryeh I, et al. Prevalence of fibromyalgia syndrome in patients referred to a tertiary pain clinic. J Investig Med 2012; 60:685.
15. Bennett RM. Clinical manifestations and diagnosis of fibromyalgia. Rheum Dis Clin North Am 2009; 35:215.
16. Björkegren K, Wallander MA, Johansson S, Svärdsudd K. General symptom reporting in female fibromyalgia patients and referents: a population-based case-referent study. BMC Public Health 2009; 9:402.
17. Aggarwal VR, McBeth J, Zakrzewska JM, et al. The epidemiology of chronic syndromes that are frequently unexplained: do they have common associated factors? Int J Epidemiol 2006; 35:468.

18. Walitt B, Čeko M, Khatiwada M, et al. Characterizing "fibrofog": Subjective appraisal, objective performance, and task-related brain activity during a working memory task. Neuroimage Clin 2016; 11:173.
19. Fuller-Thomson E, Nimigon-Young J, Brennenstuhl S. Individuals with fibromyalgia and depression: findings from a nationally representative Canadian survey. Rheumatol Int 2012; 32:853.
20. Arnold LM, Hudson JI, Keck PE, et al. Comorbidity of fibromyalgia and psychiatric disorders. J Clin Psychiatry 2006; 67:1219.
21. Aguglia A, Salvi V, Maina G, et al. Fibromyalgia syndrome and depressive symptoms: comorbidity and clinical correlates. J Affect Disord 2011; 128:262.
22. Toussaint LL, Vincent A, McAllister SJ, et al. A Comparison of Fibromyalgia Symptoms in Patients with Healthy versus Depressive, Low and Reactive Affect Balance Styles. Scand J Pain 2014; 5:161.
23. Chang MH, Hsu JW, Huang KL, et al. Bidirectional Association Between Depression and Fibromyalgia Syndrome: A Nationwide Longitudinal Study. J Pain 2015; 16:895.
24. Soriano-Maldonado A, Amris K, Ortega FB, et al. Association of different levels of depressive symptoms with symptomatology, overall disease severity, and quality of life in women with fibromyalgia. Qual Life Res 2015; 24:2951.
25. de Tommaso M, Federici A, Serpino C, et al. Clinical features of headache patients with fibromyalgia comorbidity. J Headache Pain 2011; 12:629.
26. Küçükşen S, Genç E, Yılmaz H, et al. The prevalence of fibromyalgia and its relation with headache characteristics in episodic migraine. Clin Rheumatol 2013; 32:983.
27. Wang JC, Sung FC, Men M, et al. Bidirectional association between fibromyalgia and gastroesophageal reflux disease: two population-based retrospective cohort analysis. Pain 2017; 158:1971.
28. Vehof J, Sillevis Smitt-Kamminga N, Kozareva D, et al. Clinical Characteristics of Dry Eye Patients With Chronic Pain Syndromes. Am J Ophthalmol 2016; 162:59.
29. Sawada F, Nomura Y, Goto F, et al. Relationship of physical distress to dizziness in patients with fibromyalgia. Acta Otolaryngol 2016; 136:56.
30. Chen CH, Yang TY, Lin CL, et al. Dry Eye Syndrome Risks in Patients With Fibromyalgia: A National Retrospective Cohort Study. Medicine (Baltimore) 2016; 95:e2607.
31. Scolnik M, Vasta B, Hart DJ, et al. Symptoms of Raynaud's phenomenon (RP) in fibromyalgia syndrome are similar to those reported in primary RP despite differences in objective assessment of digital microvascular function and morphology. Rheumatol Int 2016; 36:1371.
32. Stranden M, Solvin H, Fors EA, et al. Are persons with fibromyalgia or other musculoskeletal pain more likely to report hearing loss? A HUNT study. BMC Musculoskelet Disord 2016; 17:477.
33. Bossema ER, van Middendorp H, Jacobs JW, et al. Influence of weather on daily symptoms of pain and fatigue in female patients with fibromyalgia: a multilevel regression analysis. Arthritis Care Res (Hoboken) 2013; 65:1019.
34. Watson NF, Buchwald D, Goldberg J, et al. Neurologic signs and symptoms in fibromyalgia. Arthritis Rheum 2009; 60:2839.
35. Hughes G, Martinez C, Myon E, et al. The impact of a diagnosis of fibromyalgia on health care resource use by primary care patients in the UK: an observational study based on clinical practice. Arthritis Rheum 2006; 54:177.
36. Arora N, Gupta A, Reddy SB. Antinuclear Antibody and Subserology Testing in the Evaluation of Fibromyalgia: A Teachable Moment. JAMA Intern Med 2017; 177:1369.

37. Lesuis N, van Vliet J, Boers N, et al. The value of routine creatine kinase and thyroid stimulating hormone testing in patients with suspected fibromyalgia: a cross-sectional study. Rheumatology (Oxford) 2016; 55:1273.

38. Maafi AA, Ghavidel-Parsa B, Haghdoost A, et al. Serum Vitamin D Status in Iranian Fibromyalgia Patients: according to the Symptom Severity and Illness Invalidation. Korean J Pain 2016; 29:172.

39. Viola-Saltzman M, Watson NF, Bogart A, et al. High prevalence of restless legs syndrome among patients with fibromyalgia: a controlled cross-sectional study. J Clin Sleep Med 2010; 6:423.

40. Prados G, Miró E, Martínez MP, et al. Fibromyalgia: gender differences and sleep-disordered breathing. Clin Exp Rheumatol 2013; 31:S102.

41. Staud R. Autonomic dysfunction in fibromyalgia syndrome: postural orthostatic tachycardia. Curr Rheumatol Rep 2008; 10:463.

42. Wolfe F, Smythe HA, Yunus MB, et al. The American College of Rheumatology 1990 Criteria for the Classification of Fibromyalgia. Report of the Multicenter Criteria Committee. Arthritis Rheum 1990; 33:160.

43. Wolfe F, Clauw DJ, Fitzcharles MA, et al. The American College of Rheumatology preliminary diagnostic criteria for fibromyalgia and measurement of symptom severity. Arthritis Care Res (Hoboken) 2010; 62:600.

44. Arnold LM, Stanford SB, Welge JA, Crofford LJ. Development and testing of the fibromyalgia diagnostic screen for primary care. J Womens Health (Larchmt) 2012; 21:231.

45. Wolfe F, Clauw DJ, Fitzcharles MA, et al. Fibromyalgia criteria and severity scales for clinical and epidemiological studies: a modification of the ACR Preliminary Diagnostic Criteria for Fibromyalgia. J Rheumatol 2011; 38:1113.

46. Ferrari R, Russell AS. A questionnaire using the modified 2010 American College of Rheumatology criteria for fibromyalgia: specificity and sensitivity in clinical practice. J Rheumatol 2013; 40:1590.

47. Wolfe F, Clauw DJ, Fitzcharles MA, et al. 2016 Revisions to the 2010/2011 fibromyalgia diagnostic criteria. Semin Arthritis Rheum 2016; 46:319.

48. Wolfe F, Fitzcharles MA, Goldenberg DL, et al. Comparison of Physician-Based and Patient-Based Criteria for the Diagnosis of Fibromyalgia. Arthritis Care Res (Hoboken) 2016; 68:652.

49. Yang TY, Chen CS, Lin CL, et al. Risk for Irritable Bowel Syndrome in Fibromyalgia Patients: A National Database Study. Medicine (Baltimore) 2017; 96:e6657.

50. Almansa C, Rey E, Sánchez RG, et al. Prevalence of functional gastrointestinal disorders in patients with fibromyalgia and the role of psychologic distress. Clin Gastroenterol Hepatol 2009; 7:438.

51. Fraga BP, Santos EB, Farias Neto JP, et al. Signs and symptoms of temporomandibular dysfunction in fibromyalgic patients. J Craniofac Surg 2012; 23:615.

52. Kato K, Sullivan PF, Evengård B, Pedersen NL. Chronic widespread pain and its comorbidities: a population-based study. Arch Intern Med 2006; 166:1649.

53. Lai HH, Gardner V, Ness TJ, Gereau RW 4th. Segmental hyperalgesia to mechanical stimulus in interstitial cystitis/bladder pain syndrome: evidence of central sensitization. J Urol 2014; 191:1294.

54. Buchwald D, Goldenberg DL, Sullivan JL, Komaroff AL. The "chronic, active Epstein-Barr virus infection" syndrome and primary fibromyalgia. Arthritis Rheum 1987; 30:1132.

55. McBeth J, Tomenson B, Chew-Graham CA, et al. Common and unique associated factors for medically unexplained chronic widespread pain and chronic fatigue. J Psychosom Res 2015; 79:484.

56. Aaron LA, Buchwald D. A review of the evidence for overlap among unexplained clinical conditions. Ann Intern Med 2001; 134:868.
57. Aaron LA, Bradley LA, Alarcón GS, et al. Psychiatric diagnoses in patients with fibromyalgia are related to health care-seeking behavior rather than to illness. Arthritis Rheum 1996; 39:436.
58. Kayhan F, Küçük A, Satan Y, et al. Sexual dysfunction, mood, anxiety, and personality disorders in female patients with fibromyalgia. Neuropsychiatr Dis Treat 2016; 12:349.
59. Stubbs B. A random effects meta-analysis investigating the prevalence of bipolar disorder in people with fibromyalgia: An updated analysis. J Affect Disord 2016; 191:308.
60. Diaz-Piedra C, Catena A, Sánchez AI, et al. Sleep disturbances in fibromyalgia syndrome: the role of clinical and polysomnographic variables explaining poor sleep quality in patients. Sleep Med 2015; 16:917.
61. Liedberg GM, Björk M, Börsbo B. Self-reported nonrestorative sleep in fibromyalgia - relationship to impairments of body functions, personal function factors, and quality of life. J Pain Res 2015; 8:499.
62. Wu YL, Chang LY, Lee HC, et al. Sleep disturbances in fibromyalgia: A meta-analysis of case-control studies. J Psychosom Res 2017; 96:89.
63. Wolfe F, Häuser W, Hassett AL, et al. The development of fibromyalgia--I: examination of rates and predictors in patients with rheumatoid arthritis (RA). Pain 2011; 152:291.
64. Andersson ML, Svensson B, Bergman S. Chronic widespread pain in patients with rheumatoid arthritis and the relation between pain and disease activity measures over the first 5 years. J Rheumatol 2013; 40:1977.
65. Lee YC, Lu B, Boire G, et al. Incidence and predictors of secondary fibromyalgia in an early arthritis cohort. Ann Rheum Dis 2013; 72:949.
66. Coury F, Rossat A, Tebib A, et al. Rheumatoid arthritis and fibromyalgia: a frequent unrelated association complicating disease management. J Rheumatol 2009; 36:58.
67. Magrey MN, Antonelli M, James N, Khan MA. High frequency of fibromyalgia in patients with psoriatic arthritis: a pilot study. Arthritis 2013; 2013:762921.
68. Bello N, Etcheto A, Béal C, et al. Evaluation of the impact of fibromyalgia in disease activity and treatment effect in spondyloarthritis. Arthritis Res Ther 2016; 18:42.
69. Wolfe F, Petri M, Alarcón GS, et al. Fibromyalgia, systemic lupus erythematosus (SLE), and evaluation of SLE activity. J Rheumatol 2009; 36:82.
70. Torrente-Segarra V, Salman-Monte TC, Rúa-Figueroa Í, et al. Fibromyalgia prevalence and related factors in a large registry of patients with systemic lupus erythematosus. Clin Exp Rheumatol 2016; 34:S40.
71. Segal BM, Pogatchnik B, Henn L, et al. Pain severity and neuropathic pain symptoms in primary Sjögren's syndrome: a comparison study of seropositive and seronegative Sjögren's syndrome patients. Arthritis Care Res (Hoboken) 2013; 65:1291.
72. Lee YC, Lu B, Bathon JM, et al. Pain sensitivity and pain reactivity in osteoarthritis. Arthritis Care Res (Hoboken) 2011; 63:320.
73. Haliloglu S, Carlioglu A, Akdeniz D, et al. Fibromyalgia in patients with other rheumatic diseases: prevalence and relationship with disease activity. Rheumatol Int 2014; 34:1275.
74. Nordeman L, Gunnarsson R, Mannerkorpi K. Prevalence and characteristics of widespread pain in female primary health care patients with chronic low back pain. Clin J Pain 2012; 28:65.
75. Genc H, Nacir B, Duyur Cakit B, et al. The effects of coexisting fibromyalgia syndrome on pain intensity, disability, and treatment outcome in patients with chronic lateral epicondylitis. Pain Med 2012; 13:270.

76. Choy E, Perrot S, Leon T, et al. A patient survey of the impact of fibromyalgia and the journey to diagnosis. BMC Health Serv Res 2010; 10:102.

77. Gittins R, Howard M, Ghodke A, et al. The Accuracy of a Fibromyalgia Diagnosis in General Practice. Pain Med 2018; 19:491.

78. Walitt B, Katz RS, Bergman MJ, Wolfe F. Three-Quarters of Persons in the US Population Reporting a Clinical Diagnosis of Fibromyalgia Do Not Satisfy Fibromyalgia Criteria: The 2012 National Health Interview Survey. PLoS One 2016; 11:e0157235.

79. Annemans L, Wessely S, Spaepen E, et al. Health economic consequences related to the diagnosis of fibromyalgia syndrome. Arthritis Rheum 2008; 58:895.

80. Kim SK, Kim SH, Lee CK, et al. Effect of fibromyalgia syndrome on the health-related quality of life and economic burden in Korea. Rheumatology (Oxford) 2013; 52:311.

81. Baron R, Perrot S, Guillemin I, et al. Improving the primary care physicians' decision making for fibromyalgia in clinical practice: development and validation of the Fibromyalgia Detection (FibroDetect®) screening tool. Health Qual Life Outcomes 2014; 12:128.

82. Masters ET, Mardekian J, Emir B, et al. Electronic medical record data to identify variables associated with a fibromyalgia diagnosis: importance of health care resource utilization. J Pain Res 2015; 8:131.

Author: Don L Goldenberg, MD
Section Editor: Peter H Schur, MD
Deputy Editor: Paul L Romain, MD

INTRODUCTION

Fibromyalgia is a chronic pain disorder that is challenging to treat. Effective interventions include a number of nonpharmacologic and pharmacologic therapies that are often provided in combination. Patients with fibromyalgia generally respond best to a multidisciplinary, individualized treatment program that incorporates both clinician and non-clinician providers, including physical medicine, rehabilitation, and mental health specialists [1].

The initial steps in the treatment of fibromyalgia in adults will be reviewed here. The treatment of fibromyalgia in adults who do not respond to initial therapies; the pathogenesis, clinical manifestations, diagnosis, and differential diagnosis of fibromyalgia; and fibromyalgia in children and adolescents are discussed separately. (See "Treatment of fibromyalgia in adults not responsive to initial therapies" and "Pathogenesis of fibromyalgia" and "Clinical manifestations and diagnosis of fibromyalgia in adults" and "Differential diagnosis of fibromyalgia" and "Fibromyalgia in children and adolescents: Clinical manifestations and diagnosis".)

OVERVIEW OF TREATMENT

Treatment of fibromyalgia is directed at reducing the major symptoms of this disorder, including chronic widespread pain, fatigue, insomnia, and cognitive dysfunction [1,2]. A variety of modalities are employed, using a stepwise approach (table 1). (See "Clinical manifestations and diagnosis of fibromyalgia in adults".)

The issue of who should assume primary responsibility for the treatment of patients with fibromyalgia has been controversial. Most specialty groups recommend that the initial management of patients with fibromyalgia can and should be carried out in the primary care setting [1-3]. Ideally, treatment should include an integrated, multidisciplinary nonpharmacologic and pharmacologic approach, but there have been relatively few trials that have formally evaluated such a combined approach to therapy. (See "Treatment of fibromyalgia in adults not responsive to initial therapies", section on 'Multidisciplinary treatment programs'.)

The initial approach to all patients with fibromyalgia should include:

Literature review current through: Mar 2018. | **This topic last updated:** Jun 08, 2017.

REFERENCES

1. Clauw DJ. Fibromyalgia: a clinical review. JAMA 2014; 311:1547.
2. Goldenberg DL, Burckhardt C, Crofford L. Management of fibromyalgia syndrome. JAMA 2004; 292:2388.
3. Fitzcharles MA, Ste-Marie PA, Goldenberg DL, et al. Canadian Pain Society and Canadian Rheumatology Association recommendations for rational care of persons with fibromyalgia: a summary report. J Rheumatol 2013; 40:1388.
4. Busch AJ, Webber SC, Richards RS, et al. Resistance exercise training for fibromyalgia. Cochrane Database Syst Rev 2013; :CD010884.
5. Bidonde J, Busch AJ, Webber SC, et al. Aquatic exercise training for fibromyalgia. Cochrane Database Syst Rev 2014; :CD011336.
6. Häuser W, Klose P, Langhorst J, et al. Efficacy of different types of aerobic exercise in fibromyalgia syndrome: a systematic review and meta-analysis of randomised controlled trials. Arthritis Res Ther 2010; 12:R79.
7. Perrot S, Russell IJ. More ubiquitous effects from non-pharmacologic than from pharmacologic treatments for fibromyalgia syndrome: a meta-analysis examining six core symptoms. Eur J Pain 2014; 18:1067.
8. Goldenberg DL, Simms RW, Geiger A, Komaroff AL. High frequency of fibromyalgia in patients with chronic fatigue seen in a primary care practice. Arthritis Rheum 1990; 33:381.
9. Aaron LA, Burke MM, Buchwald D. Overlapping conditions among patients with chronic fatigue syndrome, fibromyalgia, and temporomandibular disorder. Arch Intern Med 2000; 160:221.
10. Hughes G, Martinez C, Myon E, et al. The impact of a diagnosis of fibromyalgia on health care resource use by primary care patients in the UK: an observational study based on clinical practice. Arthritis Rheum 2006; 54:177.
11. Annemans L, Wessely S, Spaepen E, et al. Health economic consequences related to the diagnosis of fibromyalgia syndrome. Arthritis Rheum 2008; 58:895.
12. Pfeiffer A, Thompson JM, Nelson A, et al. Effects of a 1.5-day multidisciplinary outpatient treatment program for fibromyalgia: a pilot study. Am J Phys Med Rehabil 2003; 82:186.
13. Luciano JV, Martínez N, Peñarrubia-María MT, et al. Effectiveness of a psychoeducational treatment program implemented in general practice for fibromyalgia patients: a randomized controlled trial. Clin J Pain 2011; 27:383.
14. Lera S, Gelman SM, López MJ, et al. Multidisciplinary treatment of fibromyalgia: does cognitive behavior therapy increase the response to treatment? J Psychosom Res 2009; 67:433.
15. Rooks DS, Gautam S, Romeling M, et al. Group exercise, education, and combination self-management in women with fibromyalgia: a randomized trial. Arch Intern Med 2007; 167:2192.
16. Kaleth AS, Slaven JE, Ang DC. Does increasing steps per day predict improvement in physical function and pain interference in adults with fibromyalgia? Arthritis Care Res (Hoboken) 2014; 66:1887.
17. Busch AJ, Schachter CL, Overend TJ, et al. Exercise for fibromyalgia: a systematic review. J Rheumatol 2008; 35:1130.
18. Bircan C, Karasel SA, Akgün B, et al. Effects of muscle strengthening versus aerobic exercise program in fibromyalgia. Rheumatol Int 2008; 28:527.
19. Hooten WM, Qu W, Townsend CO, Judd JW. Effects of strength vs aerobic exercise on pain severity in adults with fibromyalgia: a randomized equivalence trial. Pain 2012; 153:915.

20. Brosseau L, Wells GA, Tugwell P, et al. Ottawa Panel evidence-based clinical practice guidelines for strengthening exercises in the management of fibromyalgia: part 2. Phys Ther 2008; 88:873.
21. Sañudo B, Galiano D, Carrasco L, et al. Effects of a prolonged exercise program on key health outcomes in women with fibromyalgia: a randomized controlled trial. J Rehabil Med 2011; 43:521.
22. Sañudo B, Galiano D, Carrasco L, et al. Aerobic exercise versus combined exercise therapy in women with fibromyalgia syndrome: a randomized controlled trial. Arch Phys Med Rehabil 2010; 91:1838.
23. Sañudo B, Carrasco L, de Hoyo M, McVeigh JG. Effects of exercise training and detraining in patients with fibromyalgia syndrome: a 3-yr longitudinal study. Am J Phys Med Rehabil 2012; 91:561.
24. Puiu T, Kairys AE, Pauer L, et al. Association of Alterations in Gray Matter Volume With Reduced Evoked-Pain Connectivity Following Short-Term Administration of Pregabalin in Patients With Fibromyalgia. Arthritis Rheumatol 2016; 68:1511.
25. Häuser W, Petzke F, Sommer C. Comparative efficacy and harms of duloxetine, milnacipran, and pregabalin in fibromyalgia syndrome. J Pain 2010; 11:505.
26. Häuser W, Petzke F, Üçeyler N, Sommer C. Comparative efficacy and acceptability of amitriptyline, duloxetine and milnacipran in fibromyalgia syndrome: a systematic review with meta-analysis. Rheumatology (Oxford) 2011; 50:532.
27. Häuser W, Bernardy K, Uçeyler N, Sommer C. Treatment of fibromyalgia syndrome with antidepressants: a meta-analysis. JAMA 2009; 301:198.
28. Häuser W, Wolfe F, Tölle T, et al. The role of antidepressants in the management of fibromyalgia syndrome: a systematic review and meta-analysis. CNS Drugs 2012; 26:297.
29. Kim SC, Landon JE, Solomon DH. Clinical characteristics and medication uses among fibromyalgia patients newly prescribed amitriptyline, duloxetine, gabapentin, or pregabalin. Arthritis Care Res (Hoboken) 2013; 65:1813.
30. Goldenberg DL, Felson DT, Dinerman H. A randomized, controlled trial of amitriptyline and naproxen in the treatment of patients with fibromyalgia. Arthritis Rheum 1986; 29:1371.
31. Carette S, McCain GA, Bell DA, Fam AG. Evaluation of amitriptyline in primary fibrositis. A double-blind, placebo-controlled study. Arthritis Rheum 1986; 29:655.
32. Bennett RM, Gatter RA, Campbell SM, et al. A comparison of cyclobenzaprine and placebo in the management of fibrositis. A double-blind controlled study. Arthritis Rheum 1988; 31:1535.
33. Carette S, Bell MJ, Reynolds WJ, et al. Comparison of amitriptyline, cyclobenzaprine, and placebo in the treatment of fibromyalgia. A randomized, double-blind clinical trial. Arthritis Rheum 1994; 37:32.
34. Tofferi JK, Jackson JL, O'Malley PG. Treatment of fibromyalgia with cyclobenzaprine: A meta-analysis. Arthritis Rheum 2004; 51:9.
35. Arnold LM, Keck PE Jr, Welge JA. Antidepressant treatment of fibromyalgia. A meta-analysis and review. Psychosomatics 2000; 41:104.
36. O'Malley PG, Balden E, Tomkins G, et al. Treatment of fibromyalgia with antidepressants: a meta-analysis. J Gen Intern Med 2000; 15:659.
37. Carette S, Oakson G, Guimont C, Steriade M. Sleep electroencephalography and the clinical response to amitriptyline in patients with fibromyalgia. Arthritis Rheum 1995; 38:1211.
38. Uçeyler N, Häuser W, Sommer C. A systematic review on the effectiveness of treatment with antidepressants in fibromyalgia syndrome. Arthritis Rheum 2008; 59:1279.
39. Clauw DJ, Mease P, Palmer RH, et al. Milnacipran for the treatment of fibromyalgia in adults: a 15-week, multicenter, randomized, double-blind, placebo-controlled, multiple-dose clinical trial. Clin Ther 2008;

30:1988.

40. Mease PJ, Clauw DJ, Gendreau RM, et al. The efficacy and safety of milnacipran for treatment of fibromyalgia. a randomized, double-blind, placebo-controlled trial. J Rheumatol 2009; 36:398.
41. Rico-Villademoros F, Slim M, Calandre EP. Amitriptyline for the treatment of fibromyalgia: a comprehensive review. Expert Rev Neurother 2015; 15:1123.
42. Schmidt-Wilcke T, Clauw DJ. Fibromyalgia: from pathophysiology to therapy. Nat Rev Rheumatol 2011; 7:518.
43. Reynolds WJ, Moldofsky H, Saskin P, Lue FA. The effects of cyclobenzaprine on sleep physiology and symptoms in patients with fibromyalgia. J Rheumatol 1991; 18:452.
44. Quimby LG, Gratwick GM, Whitney CD, Block SR. A randomized trial of cyclobenzaprine for the treatment of fibromyalgia. J Rheumatol Suppl 1989; 19:140.
45. Moldofsky H, Harris HW, Archambault WT, et al. Effects of bedtime very low dose cyclobenzaprine on symptoms and sleep physiology in patients with fibromyalgia syndrome: a double-blind randomized placebo-controlled study. J Rheumatol 2011; 38:2653.
46. Arnold LM, Lu Y, Crofford LJ, et al. A double-blind, multicenter trial comparing duloxetine with placebo in the treatment of fibromyalgia patients with or without major depressive disorder. Arthritis Rheum 2004; 50:2974.
47. Arnold LM, Rosen A, Pritchett YL, et al. A randomized, double-blind, placebo-controlled trial of duloxetine in the treatment of women with fibromyalgia with or without major depressive disorder. Pain 2005; 119:5.
48. Russell IJ, Mease PJ, Smith TR, et al. Efficacy and safety of duloxetine for treatment of fibromyalgia in patients with or without major depressive disorder: Results from a 6-month, randomized, double-blind, placebo-controlled, fixed-dose trial. Pain 2008; 136:432.
49. Vitton O, Gendreau M, Gendreau J, et al. A double-blind placebo-controlled trial of milnacipran in the treatment of fibromyalgia. Hum Psychopharmacol 2004; 19 Suppl 1:S27.
50. Gendreau RM, Thorn MD, Gendreau JF, et al. Efficacy of milnacipran in patients with fibromyalgia. J Rheumatol 2005; 32:1975.
51. Branco JC, Zachrisson O, Perrot S, et al. A European multicenter randomized double-blind placebo-controlled monotherapy clinical trial of milnacipran in treatment of fibromyalgia. J Rheumatol 2010; 37:851.
52. Arnold LM, Gendreau RM, Palmer RH, et al. Efficacy and safety of milnacipran 100 mg/day in patients with fibromyalgia: results of a randomized, double-blind, placebo-controlled trial. Arthritis Rheum 2010; 62:2745.
53. Arnold LM, Zhang S, Pangallo BA. Efficacy and safety of duloxetine 30 mg/d in patients with fibromyalgia: a randomized, double-blind, placebo-controlled study. Clin J Pain 2012; 28:775.
54. Lunn MP, Hughes RA, Wiffen PJ. Duloxetine for treating painful neuropathy, chronic pain or fibromyalgia. Cochrane Database Syst Rev 2014; :CD007115.
55. Branco JC, Cherin P, Montagne A, et al. Longterm therapeutic response to milnacipran treatment for fibromyalgia. A European 1-year extension study following a 3-month study. J Rheumatol 2011; 38:1403.
56. Goldenberg DL, Clauw DJ, Palmer RH, et al. Durability of therapeutic response to milnacipran treatment for fibromyalgia. Results of a randomized, double-blind, monotherapy 6-month extension study. Pain Med 2010; 11:180.
57. Häuser W, Urrútia G, Tort S, et al. Serotonin and noradrenaline reuptake inhibitors (SNRIs) for fibromyalgia syndrome. Cochrane Database Syst Rev 2013; :CD010292.

58. Arnold LM, Palmer RH, Ma Y. A 3-year, open-label, flexible-dosing study of milnacipran for the treatment of fibromyalgia. Clin J Pain 2013; 29:1021.

59. Sayar K, Aksu G, Ak I, Tosun M. Venlafaxine treatment of fibromyalgia. Ann Pharmacother 2003; 37:1561.

60. Wiffen PJ, Derry S, Moore RA, et al. Antiepileptic drugs for neuropathic pain and fibromyalgia - an overview of Cochrane reviews. Cochrane Database Syst Rev 2013; :CD010567.

61. Moore A, Wiffen P, Kalso E. Antiepileptic drugs for neuropathic pain and fibromyalgia. JAMA 2014; 312:182.

62. Häuser W, Bernardy K, Uçeyler N, Sommer C. Treatment of fibromyalgia syndrome with gabapentin and pregabalin--a meta-analysis of randomized controlled trials. Pain 2009; 145:69.

63. Crofford LJ, Rowbotham MC, Mease PJ, et al. Pregabalin for the treatment of fibromyalgia syndrome: results of a randomized, double-blind, placebo-controlled trial. Arthritis Rheum 2005; 52:1264.

64. Mease PJ, Russell IJ, Arnold LM, et al. A randomized, double-blind, placebo-controlled, phase III trial of pregabalin in the treatment of patients with fibromyalgia. J Rheumatol 2008; 35:502.

65. Crofford LJ, Mease PJ, Simpson SL, et al. Fibromyalgia relapse evaluation and efficacy for durability of meaningful relief (FREEDOM): a 6-month, double-blind, placebo-controlled trial with pregabalin. Pain 2008; 136:419.

66. Tzellos TG, Toulis KA, Goulis DG, et al. Gabapentin and pregabalin in the treatment of fibromyalgia: a systematic review and a meta-analysis. J Clin Pharm Ther 2010; 35:639.

67. Arnold LM, Russell IJ, Diri EW, et al. A 14-week, randomized, double-blinded, placebo-controlled monotherapy trial of pregabalin in patients with fibromyalgia. J Pain 2008; 9:792.

68. Üçeyler N, Sommer C, Walitt B, Häuser W. Anticonvulsants for fibromyalgia. Cochrane Database Syst Rev 2013; :CD010782.

69. Arnold LM, Emir B, Murphy TK, et al. Safety profile and tolerability of up to 1 year of pregabalin treatment in 3 open-label extension studies in patients with fibromyalgia. Clin Ther 2012; 34:1092.

70. Arnold LM, Goldenberg DL, Stanford SB, et al. Gabapentin in the treatment of fibromyalgia: a randomized, double-blind, placebo-controlled, multicenter trial. Arthritis Rheum 2007; 56:1336.

71. Wolfe F, Anderson J, Harkness D, et al. Health status and disease severity in fibromyalgia: results of a six-center longitudinal study. Arthritis Rheum 1997; 40:1571.

72. Walitt B, Fitzcharles MA, Hassett AL, et al. The longitudinal outcome of fibromyalgia: a study of 1555 patients. J Rheumatol 2011; 38:2238.

73. Fitzcharles MA, Da Costa D, Pöyhiä R. A study of standard care in fibromyalgia syndrome: a favorable outcome. J Rheumatol 2003; 30:154.

74. White KP, Speechley M, Harth M, Ostbye T. Comparing self-reported function and work disability in 100 community cases of fibromyalgia syndrome versus controls in London, Ontario: the London Fibromyalgia Epidemiology Study. Arthritis Rheum 1999; 42:76.

75. Walitt B, Nahin RL, Katz RS, et al. The Prevalence and Characteristics of Fibromyalgia in the 2012 National Health Interview Survey. PLoS One 2015; 10:e0138024.

76. Castro-Sánchez AM, Matarán-Peñarrocha GA, López-Rodríguez MM, et al. Gender differences in pain severity, disability, depression, and widespread pressure pain sensitivity in patients with fibromyalgia syndrome without comorbid conditions. Pain Med 2012; 13:1639.

77. Reisine S, Fifield J, Walsh S, Forrest DD. Employment and health status changes among women with fibromyalgia: a five-year study. Arthritis Rheum 2008; 59:1735.

78. Kim CH, Luedtke CA, Vincent A, et al. Association of body mass index with symptom severity and quality of life in patients with fibromyalgia. Arthritis Care Res (Hoboken) 2012; 64:222.

79. Mundal I, Gråwe RW, Bjørngaard JH, et al. Psychosocial factors and risk of chronic widespread pain: an 11-year follow-up study--the HUNT study. Pain 2014; 155:1555.

80. Toussaint LL, Vincent A, McAllister SJ, et al. A Comparison of Fibromyalgia Symptoms in Patients with Healthy versus Depressive, Low and Reactive Affect Balance Styles. Scand J Pain 2014; 5:161.

81. Edwards RR, Bingham CO 3rd, Bathon J, Haythornthwaite JA. Catastrophizing and pain in arthritis, fibromyalgia, and other rheumatic diseases. Arthritis Rheum 2006; 55:325.

82. Dreyer L, Kendall S, Danneskiold-Samsøe B, et al. Mortality in a cohort of Danish patients with fibromyalgia: increased frequency of suicide. Arthritis Rheum 2010; 62:3101.

83. Ratcliffe GE, Enns MW, Belik SL, Sareen J. Chronic pain conditions and suicidal ideation and suicide attempts: an epidemiologic perspective. Clin J Pain 2008; 24:204.

84. Gilbert JW, Wheeler GR, Storey BB, et al. Suicidality in chronic noncancer pain patients. Int J Neurosci 2009; 119:1968.

85. Carville SF, Arendt-Nielsen L, Bliddal H, et al. EULAR evidence-based recommendations for the management of fibromyalgia syndrome. Ann Rheum Dis 2008; 67:536.

86. Häuser W, Thieme K, Turk DC. Guidelines on the management of fibromyalgia syndrome - a systematic review. Eur J Pain 2010; 14:5.

Author: Don L Goldenberg, MD
Section Editor: Peter H Schur, MD
Deputy Editor: Paul L Romain, MD

INTRODUCTION

Fibromyalgia (FM) is a chronic pain disorder with unknown etiology and unclear pathophysiology [1,2].

There is no evidence that a single event "causes" FM. Rather, many physical and/or emotional stressors may trigger or aggravate symptoms. These have included certain infections, such as a viral illness or Lyme disease, as well as emotional or physical trauma [1-3].

A detailed description of the clinical manifestations of FM and an approach to the diagnosis of FM in adults and children are presented separately. (See "Clinical manifestations and diagnosis of fibromyalgia in adults" and "Fibromyalgia in children and adolescents: Clinical manifestations and diagnosis".)

FM is only one of many causes of widespread pain. A discussion of the differential diagnosis of FM and the broad differential diagnosis is presented separately. (See "Differential diagnosis of fibromyalgia".)

PATHOGENESIS

Fibromyalgia (FM) is considered to be a disorder of pain regulation, classified often under the term central sensitization [1,2,4] (see 'Altered pain processing' below). FM shares several features with other common pain disorders that are considered to be more central rather than peripheral pain conditions, such as migraine, tension headaches, temporomandibular joint disorder, and irritable bowel syndrome; these features include common genetic and central nervous system pain processing characteristics. More limited studies have suggested there might also be a role for peripheral neuropathic mechanisms or focal tissue changes in some patients. (See 'Peripheral pain mechanisms' below.)

Literature review current through: Mar 2018. | **This topic last updated:** Sep 06, 2017.

REFERENCES

1. Sarzi-Puttini P, Atzeni F, Mease PJ. Chronic widespread pain: from peripheral to central evolution. Best Pract Res Clin Rheumatol 2011; 25:133.

2. Schmidt-Wilcke T, Clauw DJ. Fibromyalgia: from pathophysiology to therapy. Nat Rev Rheumatol 2011; 7:518.
3. Goldenberg DL. Do infections trigger fibromyalgia? Arthritis Rheum 1993; 36:1489.
4. Staud R. Abnormal pain modulation in patients with spatially distributed chronic pain: fibromyalgia. Rheum Dis Clin North Am 2009; 35:263.
5. Meeus M, Nijs J. Central sensitization: a biopsychosocial explanation for chronic widespread pain in patients with fibromyalgia and chronic fatigue syndrome. Clin Rheumatol 2007; 26:465.
6. Simms RW, Roy SH, Hrovat M, et al. Lack of association between fibromyalgia syndrome and abnormalities in muscle energy metabolism. Arthritis Rheum 1994; 37:794.
7. Häkkinen A, Häkkinen K, Hannonen P, Alen M. Force production capacity and acute neuromuscular responses to fatiguing loading in women with fibromyalgia are not different from those of healthy women. J Rheumatol 2000; 27:1277.
8. Lund E, Kendall SA, Janerot-Sjøberg B, Bengtsson A. Muscle metabolism in fibromyalgia studied by P-31 magnetic resonance spectroscopy during aerobic and anaerobic exercise. Scand J Rheumatol 2003; 32:138.
9. Cordero MD, de Miguel M, Carmona-López I, et al. Oxidative stress and mitochondrial dysfunction in fibromyalgia. Neuro Endocrinol Lett 2010; 31:169.
10. Buskila D, Sarzi-Puttini P. Biology and therapy of fibromyalgia. Genetic aspects of fibromyalgia syndrome. Arthritis Res Ther 2006; 8:218.
11. Arnold LM, Hudson JI, Hess EV, et al. Family study of fibromyalgia. Arthritis Rheum 2004; 50:944.
12. Limer KL, Nicholl BI, Thomson W, McBeth J. Exploring the genetic susceptibility of chronic widespread pain: the tender points in genetic association studies. Rheumatology (Oxford) 2008; 47:572.
13. Smith SB, Maixner DW, Fillingim RB, et al. Large candidate gene association study reveals genetic risk factors and therapeutic targets for fibromyalgia. Arthritis Rheum 2012; 64:584.
14. Arnold LM, Fan J, Russell IJ, et al. The fibromyalgia family study: a genome-wide linkage scan study. Arthritis Rheum 2013; 65:1122.
15. Martínez-Jauand M, Sitges C, Rodríguez V, et al. Pain sensitivity in fibromyalgia is associated with catechol-O-methyltransferase (COMT) gene. Eur J Pain 2013; 17:16.
16. Inanir A, Karakus N, Ates O, et al. Clinical symptoms in fibromyalgia are associated to catechol-O-methyltransferase (COMT) gene Val158Met polymorphism. Xenobiotica 2014; 44:952.
17. Zhang L, Zhu J, Chen Y, Zhao J. Meta-analysis reveals a lack of association between a common catechol-O-methyltransferase (COMT) polymorphism val^{158}met and fibromyalgia. Int J Clin Exp Pathol 2014; 7:8489.
18. Park DJ, Kim SH, Nah SS, et al. Association between catechol-O-methyl transferase gene polymorphisms and fibromyalgia in a Korean population: A case-control study. Eur J Pain 2016; 20:1131.
19. Jones KD, Gelbart T, Whisenant TC, et al. Genome-wide expression profiling in the peripheral blood of patients with fibromyalgia. Clin Exp Rheumatol 2016; 34:S89.
20. Solak Ö, Erdoğan MÖ, Yıldız H, et al. Assessment of opioid receptor μ1 gene A118G polymorphism and its association with pain intensity in patients with fibromyalgia. Rheumatol Int 2014; 34:1257.
21. Kosek E, Martinsen S, Gerdle B, et al. The translocator protein gene is associated with symptom severity and cerebral pain processing in fibromyalgia. Brain Behav Immun 2016; 58:218.

22. Tour J, Löfgren M, Mannerkorpi K, et al. Gene-to-gene interactions regulate endogenous pain modulation in fibromyalgia patients and healthy controls-antagonistic effects between opioid and serotonin-related genes. Pain 2017; 158:1194.

23. Feng J, Zhang Z, Wu X, et al. Discovery of potential new gene variants and inflammatory cytokine associations with fibromyalgia syndrome by whole exome sequencing. PLoS One 2013; 8:e65033.

24. Dadabhoy D, Crofford LJ, Spaeth M, et al. Biology and therapy of fibromyalgia. Evidence-based biomarkers for fibromyalgia syndrome. Arthritis Res Ther 2008; 10:211.

25. Desmeules JA, Cedraschi C, Rapiti E, et al. Neurophysiologic evidence for a central sensitization in patients with fibromyalgia. Arthritis Rheum 2003; 48:1420.

26. Staud R, Weyl EE, Riley JL 3rd, Fillingim RB. Slow temporal summation of pain for assessment of central pain sensitivity and clinical pain of fibromyalgia patients. PLoS One 2014; 9:e89086.

27. Jensen KB, Kosek E, Petzke F, et al. Evidence of dysfunctional pain inhibition in Fibromyalgia reflected in rACC during provoked pain. Pain 2009; 144:95.

28. Julien N, Goffaux P, Arsenault P, Marchand S. Widespread pain in fibromyalgia is related to a deficit of endogenous pain inhibition. Pain 2005; 114:295.

29. Montoya P, Sitges C, García-Herrera M, et al. Reduced brain habituation to somatosensory stimulation in patients with fibromyalgia. Arthritis Rheum 2006; 54:1995.

30. Salemi S, Aeschlimann A, Wollina U, et al. Up-regulation of delta-opioid receptors and kappa-opioid receptors in the skin of fibromyalgia patients. Arthritis Rheum 2007; 56:2464.

31. Harris RE, Clauw DJ, Scott DJ, et al. Decreased central mu-opioid receptor availability in fibromyalgia. J Neurosci 2007; 27:10000.

32. Russell IJ, Orr MD, Littman B, et al. Elevated cerebrospinal fluid levels of substance P in patients with the fibromyalgia syndrome. Arthritis Rheum 1994; 37:1593.

33. Haas L, Portela LV, Böhmer AE, et al. Increased plasma levels of brain derived neurotrophic factor (BDNF) in patients with fibromyalgia. Neurochem Res 2010; 35:830.

34. Kwiatek R, Barnden L, Tedman R, et al. Regional cerebral blood flow in fibromyalgia: single-photon-emission computed tomography evidence of reduction in the pontine tegmentum and thalami. Arthritis Rheum 2000; 43:2823.

35. Giesecke T, Gracely RH, Williams DA, et al. The relationship between depression, clinical pain, and experimental pain in a chronic pain cohort. Arthritis Rheum 2005; 52:1577.

36. Emad Y, Ragab Y, Zeinhom F, et al. Hippocampus dysfunction may explain symptoms of fibromyalgia syndrome. A study with single-voxel magnetic resonance spectroscopy. J Rheumatol 2008; 35:1371.

37. Lutz J, Jäger L, de Quervain D, et al. White and gray matter abnormalities in the brain of patients with fibromyalgia: a diffusion-tensor and volumetric imaging study. Arthritis Rheum 2008; 58:3960.

38. Wood PB, Patterson JC 2nd, Sunderland JJ, et al. Reduced presynaptic dopamine activity in fibromyalgia syndrome demonstrated with positron emission tomography: a pilot study. J Pain 2007; 8:51.

39. Wood PB, Schweinhardt P, Jaeger E, et al. Fibromyalgia patients show an abnormal dopamine response to pain. Eur J Neurosci 2007; 25:3576.

40. Burgmer M, Pogatzki-Zahn E, Gaubitz M, et al. Fibromyalgia unique temporal brain activation during experimental pain: a controlled fMRI Study. J Neural Transm (Vienna) 2010; 117:123.

41. Kuchinad A, Schweinhardt P, Seminowicz DA, et al. Accelerated brain gray matter loss in fibromyalgia patients: premature aging of the brain? J Neurosci 2007; 27:4004.

42. Burgmer M, Gaubitz M, Konrad C, et al. Decreased gray matter volumes in the cingulo-frontal cortex and the amygdala in patients with fibromyalgia. Psychosom Med 2009; 71:566.

43. Hsu MC, Harris RE, Sundgren PC, et al. No consistent difference in gray matter volume between individuals with fibromyalgia and age-matched healthy subjects when controlling for affective disorder. Pain 2009; 143:262.

44. Pomares FB, Funck T, Feier NA, et al. Histological Underpinnings of Grey Matter Changes in Fibromyalgia Investigated Using Multimodal Brain Imaging. J Neurosci 2017; 37:1090.

45. Harris RE, Sundgren PC, Craig AD, et al. Elevated insular glutamate in fibromyalgia is associated with experimental pain. Arthritis Rheum 2009; 60:3146.

46. Mhalla A, de Andrade DC, Baudic S, et al. Alteration of cortical excitability in patients with fibromyalgia. Pain 2010; 149:495.

47. Valdés M, Collado A, Bargalló N, et al. Increased glutamate/glutamine compounds in the brains of patients with fibromyalgia: a magnetic resonance spectroscopy study. Arthritis Rheum 2010; 62:1829.

48. Foerster BR, Petrou M, Edden RA, et al. Reduced insular γ-aminobutyric acid in fibromyalgia. Arthritis Rheum 2012; 64:579.

49. Loggia ML, Berna C, Kim J, et al. Disrupted brain circuitry for pain-related reward/punishment in fibromyalgia. Arthritis Rheumatol 2014; 66:203.

50. Kamping S, Bomba IC, Kanske P, et al. Deficient modulation of pain by a positive emotional context in fibromyalgia patients. Pain 2013; 154:1846.

51. Jensen KB, Srinivasan P, Spaeth R, et al. Overlapping structural and functional brain changes in patients with long-term exposure to fibromyalgia pain. Arthritis Rheum 2013; 65:3293.

52. Kim DJ, Lim M, Kim JS, et al. Altered white matter integrity in the corpus callosum in fibromyalgia patients identified by tract-based spatial statistical analysis. Arthritis Rheumatol 2014; 66:3190.

53. Cagnie B, Coppieters I, Denecker S, et al. Central sensitization in fibromyalgia? A systematic review on structural and functional brain MRI. Semin Arthritis Rheum 2014; 44:68.

54. Truini A, Tinelli E, Gerardi MC, et al. Abnormal resting state functional connectivity of the periaqueductal grey in patients with fibromyalgia. Clin Exp Rheumatol 2016; 34:S129.

55. Fallon N, Chiu Y, Nurmikko T, Stancak A. Functional Connectivity with the Default Mode Network Is Altered in Fibromyalgia Patients. PLoS One 2016; 11:e0159198.

56. López-Solà M, Woo CW, Pujol J, et al. Towards a neurophysiological signature for fibromyalgia. Pain 2017; 158:34.

57. Moldofsky H. The significance of dysfunctions of the sleeping/waking brain to the pathogenesis and treatment of fibromyalgia syndrome. Rheum Dis Clin North Am 2009; 35:275.

58. Roizenblatt S, Neto NS, Tufik S. Sleep disorders and fibromyalgia. Curr Pain Headache Rep 2011; 15:347.

59. Rizzi M, Sarzi-Puttini P, Atzeni F, et al. Cyclic alternating pattern: a new marker of sleep alteration in patients with fibromyalgia? J Rheumatol 2004; 31:1193.

60. Roehrs T, Diederichs C, Gillis M, et al. Nocturnal sleep, daytime sleepiness and fatigue in fibromyalgia patients compared to rheumatoid arthritis patients and healthy controls: a preliminary study. Sleep Med 2013; 14:109.

61. Mork PJ, Nilsen TI. Sleep problems and risk of fibromyalgia: longitudinal data on an adult female population in Norway. Arthritis Rheum 2012; 64:281.

62. McBeth J, Lacey RJ, Wilkie R. Predictors of new-onset widespread pain in older adults: results from a population-based prospective cohort study in the UK. Arthritis Rheumatol 2014; 66:757.
63. Yeung WK, Morgan K, Mckenna F. Comparison of sleep structure and psychometric profiles in patients with fibromyalgia, osteoarthritis and healthy controls. J Sleep Res 2018; 27:290.
64. Adler GK, Kinsley BT, Hurwitz S, et al. Reduced hypothalamic-pituitary and sympathoadrenal responses to hypoglycemia in women with fibromyalgia syndrome. Am J Med 1999; 106:534.
65. Torpy DJ, Papanicolaou DA, Lotsikas AJ, et al. Responses of the sympathetic nervous system and the hypothalamic-pituitary-adrenal axis to interleukin-6: a pilot study in fibromyalgia. Arthritis Rheum 2000; 43:872.
66. McLean SA, Williams DA, Stein PK, et al. Cerebrospinal fluid corticotropin-releasing factor concentration is associated with pain but not fatigue symptoms in patients with fibromyalgia. Neuropsychopharmacology 2006; 31:2776.
67. Weissbecker I, Floyd A, Dedert E, et al. Childhood trauma and diurnal cortisol disruption in fibromyalgia syndrome. Psychoneuroendocrinology 2006; 31:312.
68. McLean SA, Williams DA, Harris RE, et al. Momentary relationship between cortisol secretion and symptoms in patients with fibromyalgia. Arthritis Rheum 2005; 52:3660.
69. Geenen R, Bijlsma JW. Deviations in the endocrine system and brain of patients with fibromyalgia: cause or consequence of pain and associated features? Ann N Y Acad Sci 2010; 1193:98.
70. Wingenfeld K, Heim C, Schmidt I, et al. HPA axis reactivity and lymphocyte glucocorticoid sensitivity in fibromyalgia syndrome and chronic pelvic pain. Psychosom Med 2008; 70:65.
71. Jones KD, Deodhar P, Lorentzen A, et al. Growth hormone perturbations in fibromyalgia: a review. Semin Arthritis Rheum 2007; 36:357.
72. El Maghraoui A, Tellal S, Achemlal L, et al. Bone turnover and hormonal perturbations in patients with fibromyalgia. Clin Exp Rheumatol 2006; 24:428.
73. Solano C, Martinez A, Becerril L, et al. Autonomic dysfunction in fibromyalgia assessed by the Composite Autonomic Symptoms Scale (COMPASS). J Clin Rheumatol 2009; 15:172.
74. Maekawa K, Twe C, Lotaif A, et al. Function of beta-adrenergic receptors on mononuclear cells in female patients with fibromyalgia. J Rheumatol 2003; 30:364.
75. Kadetoff D, Kosek E. The effects of static muscular contraction on blood pressure, heart rate, pain ratings and pressure pain thresholds in healthy individuals and patients with fibromyalgia. Eur J Pain 2007; 11:39.
76. Riva R, Mork PJ, Westgaard RH, et al. Catecholamines and heart rate in female fibromyalgia patients. J Psychosom Res 2012; 72:51.
77. Kadetoff D, Kosek E. Evidence of reduced sympatho-adrenal and hypothalamic-pituitary activity during static muscular work in patients with fibromyalgia. J Rehabil Med 2010; 42:765.
78. Lerma C, Martinez A, Ruiz N, et al. Nocturnal heart rate variability parameters as potential fibromyalgia biomarker: correlation with symptoms severity. Arthritis Res Ther 2011; 13:R185.
79. Maia MM, Gualano B, Sá-Pinto AL, et al. Juvenile fibromyalgia syndrome: Blunted heart rate response and cardiac autonomic dysfunction at diagnosis. Semin Arthritis Rheum 2016; 46:338.
80. Nishikai M, Tomomatsu S, Hankins RW, et al. Autoantibodies to a 68/48 kDa protein in chronic fatigue syndrome and primary fibromyalgia: a possible marker for hypersomnia and cognitive disorders. Rheumatology (Oxford) 2001; 40:806.
81. Bazzichi L, Rossi A, Massimetti G, et al. Cytokine patterns in fibromyalgia and their correlation with clinical manifestations. Clin Exp Rheumatol 2007; 25:225.

82. Uçeyler N, Häuser W, Sommer C. Systematic review with meta-analysis: cytokines in fibromyalgia syndrome. BMC Musculoskelet Disord 2011; 12:245.

83. Sturgill J, McGee E, Menzies V. Unique cytokine signature in the plasma of patients with fibromyalgia. J Immunol Res 2014; 2014:938576.

84. Staud R. Peripheral pain mechanisms in chronic widespread pain. Best Pract Res Clin Rheumatol 2011; 25:155.

85. Üçeyler N, Zeller D, Kahn AK, et al. Small fibre pathology in patients with fibromyalgia syndrome. Brain 2013; 136:1857.

86. Oaklander AL, Herzog ZD, Downs HM, Klein MM. Objective evidence that small-fiber polyneuropathy underlies some illnesses currently labeled as fibromyalgia. Pain 2013; 154:2310.

87. Giannoccaro MP, Donadio V, Incensi A, et al. Small nerve fiber involvement in patients referred for fibromyalgia. Muscle Nerve 2014; 49:757.

88. Caro XJ, Winter EF. Evidence of abnormal epidermal nerve fiber density in fibromyalgia: clinical and immunologic implications. Arthritis Rheumatol 2014; 66:1945.

89. Ge HY, Nie H, Graven-Nielsen T, et al. Descending pain modulation and its interaction with peripheral sensitization following sustained isometric muscle contraction in fibromyalgia. Eur J Pain 2012; 16:196.

90. Gerdle B, Forsgren MF, Bengtsson A, et al. Decreased muscle concentrations of ATP and PCR in the quadriceps muscle of fibromyalgia patients--a 31P-MRS study. Eur J Pain 2013; 17:1205.

91. Srikuea R, Symons TB, Long DE, et al. Association of fibromyalgia with altered skeletal muscle characteristics which may contribute to postexertional fatigue in postmenopausal women. Arthritis Rheum 2013; 65:519.

Robert Fisher, M.D., Q.M.E.

DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE
QUALIFIED MEDICAL EXAMINER

All Correspondence To:
11620 Wilshire Boulevard, Suite 340
Los Angeles, CA 90025
Tel: (888) 853-7944
Fax: (213) 377-5152

PANEL QUALIFIED MEDICAL EVALUATION
IN THE SPECIALTY OF INTERNAL MEDICINE

January

[redacted]

[redacted]

[redacted]

[redacted]

Re: [redacted]
Applicant's DOB: [redacted]
Employer: [redacted]
WCAB No.: [redacted]
Date of Injury:
Claim/File No.: [redacted]
Panel No.: [redacted]
Date of Evaluation:
Place of Evaluation:

Interpreter name and #: [redacted]

Dear Parties:

Pursuant to your authorization, [redacted] underwent a Panel Qualified Medical Evaluation, in the specialty of Internal Medicine, on , at my [illegible] office. The undersigned acted in the capacity of Panel Qualified Medical Examiner, in the specialty of Internal Medicine.

I, Dr. Fisher, conducted the interview, reviewed all records, performed a physical examination, and formulated the diagnosis, conclusions, and discussion, including the opinion on causation, temporary disability, permanent disability, degree of disability, future care, work restrictions, and apportionment. The report was authored and edited by Dr. Fisher. All opinions expressed herein are solely the opinions of Dr. Fisher.

Prior to the evaluation, the entire medical file made available to the undersigned was fully reviewed. All of the records reviewed were instrumental in this examiner arriving at the opinions as expressed in this report.

Before I began the examination, the applicant was informed that this evaluation was being done exclusively in connection with the Workers' Compensation claim at the request of attorney, attorneys or insurance companies, and that no treatment relationship existed. The applicant was also made aware that any communication between us is not privileged (no doctor-patient confidentiality exists) and that any information provided, as well as the results of any testing and my conclusions regarding the case, would be included in a report that may be read by people involved in the resolution and/or litigation of the claim. The applicant was advised of his or her rights pursuant to QME regulation 40. The applicant stated that the aforementioned was understood, and agreed to proceed with the evaluation. The report belongs to the party or parties requesting the evaluation.

BILLING

The report qualifies for Procedure Code **ML-104** as there are "extraordinary circumstances" relating to the medical condition for which this applicant was examined. This code best reflects the time spent and/or the complexity of this evaluation. The best proof in regard to the complexity of this evaluation is the medical/legal report which reflects the complex issues. The issues of complexity are reflected by the following: Multiple body parts are examined; present and prior work history; past medical history; family and social history; a complex psychiatric history; a complex history due to the applicant being a difficult historian; there are complex issues of causation or apportionment; adverse parties

have obtained their own complex and conflicting evaluation requiring interpretation.

This is a Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances (**ML-104**). The following complexity factors apply:

COMPLEXITY FACTORS

☐ (1) Two or more hours of face-to-face time by the physician

☒ (2) Two or more hours of record review by the physician

☒ (3) Two or more hours of medical research by the physician

☐ (4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor;

☒ (5) Six or more hours spent on any combination of three complexity factors (1)-(3), **which shall count as three complexity factors**

☒ (6) Addressing the issue of medical causation

☐ (7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), or two or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.

☐ (8) A psychiatric or psychological evaluation, which is the primary focus of the medical-legal evaluation

☐ (9) Where the evaluation is performed for injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before June 30 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.

Billed under **ML-104**, time spent includes:

1. Face-to-face interview with the applicant:	**1.75 hours**
2. Review of medical records:	**9.00 hours**
3. Preparation, dictation, and correction of this report:	**4.00 hours**
4. Medical research:	**2.00 hours**

To Whom it May Concern:

I examined [redacted] a 54-year-old male on 01/08/2018, in my Walnut Park office. I was assisted by a professional Spanish language interpreter, , certificate number

This examination was authorized because the patient had amended his initial claim to include internal, weight gain, pain, and psych complaints.

WORK HISTORY WITH [redacted]

The patient states he began working for this organization in , and last worked on He did undergo a pre-employment physical, at which time no restrictions were placed upon him. During the course of his work, he did not have any work restrictions and also during the course of his work, he was never on temporary total disability. He was, however, placed on temporary total disability subsequent to his work-related injury on

The patient states that he was an order selector, working in a warehouse for . The patient states that he would collect items and place them on a pallet. These items would weigh up to 70 pounds and he apparently had to lift approximately 1200 items in a day. He states that of these 1200 items, perhaps 500 of them weighed up to 700 pounds. He also would move these items on the pallet and also with a forklift.

He obtained this job by being recommended by a friend. He worked six days a week, 10 to 12 hours per day, and was paid for his overtime. He is presently not working for the employer but states that he did like his job and if he were able he would return. He had left work because of medical reasons secondary to the accident that he suffered on

He did receive Workers' Compensation benefits for two years and he states that he also received some state disability benefits but "very little." He has not received any unemployment benefits or any other monetary benefits.

He is presently not seeking employment and states that "I am not feeling right yet. I feel less than 50%."

The patient states that he did not lose any time from work or suffer any illness related to stress. He did not file a grievance or seek a job transfer nor did he seek medical or psychiatric treatment due to perceived stress. He was never placed on restrictions due to stress and states that he got along well with fellow employees and supervisors and never was disciplined. He never threatened to quit his job nor has he filed a Workers' Compensation claim regarding stress. The patient feels that he was able to accomplish his job satisfactorily and meet all deadlines. As noted, he feels the job was physically demanding but he felt qualified for the job and states that his family life was good and there was nothing in his family life that would interfere or affect his work.

The patient is presently represented by attorney . He was referred to this attorney by a friend.

WORK HISTORY SUBSEQUENT TO EMPLOYMENT WITH [redacted]

He has not worked since his date of injury.

REVIEW OF FILE

NON-MEDICAL RECORDS:

Cover Letter, signed by Michael Tom, Esq., dated

The examiner was asked to evaluate the applicant in his capacity as the Panel Qualified Medical Examiner in the field of Internal Medicine on
He was provided copies of all workers' compensation claim forms, applications, medical reports and other relevant documents for his review.

He was authorized to either order or perform any reasonable and necessary diagnostic testing that would assist him in his evaluation and was asked to provide the parties with a medical report that was based on reasonable medical probability and that was reliable and substantial medical evidence.

The applicant, was employed as a warehouse worker (on the date of injury), who alleged a specific injury on to the left foot/ankle, low back, right knee. He later amended the application for adjudication of claim to include internal, weight gain, pain and psyche.

The insurance carrier accepted injury AOE/COE for the left foot only.

The parties proceeded to a Panel QME in orthopedic named Dr. ....., who found industrial causation for the left foot diagnosing a left foot fracture with hardware removal and osteopenia of the left ankle.

The applicant received some medical treatment from . Hospital, . He was asked to review medical reports from the doctors and any other physicians whose reports he had received and indicate in his report whether he agree or disagree with the findings of his treating doctor and indicate under reasonable medical probability, whether he was finding internal conditions caused by his employment.

This examiner was asked to evaluate the applicant and issue a medical report based on substantial medical evidence indicating whether he find, from an internal medicine expert, whether the applicant sustained an injury AOE/COE as a warehouse worker at [redacted] This examiner was asked to only discuss those body parts/conditions relevant to his area of expertise and defer all other parts/conditions outside of his expertise to the appropriate specialist.

The parties subpoenaed records and were forwarded to this examiner for his review.

Following this examiner's evaluation of the applicant and review of all pertinent materials, he was asked to issue a narrative report containing his findings on all issues he felt to be appropriate, including the following:

1) A detailed history.

2) Whether your findings upon examination are consistent with the injuries and symptoms being alleged by the applicant.

3) Whether the applicant suffered work related injury as alleged, and if so, to what body parts did you find to have been injured. Defendant respectfully request that your findings are based upon physical examination, face-to-face evaluation and the evidence presented. Letters and correspondence from legal counsel, defense or applicant, and pleadings, are not evidence and should not have any weight.

4) Whether as a result of work related injury, there have been any periods of total temporary disability or partial temporary disability. If temporary disability is

found, what are the relevant periods, and the evidence, which you are relaying upon to make this determination.

5) Whether any of the diagnostic studies and treatment already received by the applicant has been reasonable and necessary to cure and relieve a found industrial injury; whether any of the diagnostic studies and treatment already received by the applicant has not been reasonable and necessary to cure and relieve a found industrial injury.

6) Whether the applicant's condition has reached maximal medical improvement, and if so on what date the applicant's condition reached that point.

7) If the applicant's condition has reached maximal medical improvement, an analysis of the applicant's impairment and disability at the time of the evaluation is hereby requested. Please note that in this case, permanent disability must be defined in accordance with the 5th edition of the AMA guides.

(a) In providing analysis under the AMA Guides 5th edition, the parties wish for you to address both impairment and disability.

i. Impairment per AMA is defined as, alteration of one's health status, a deviation in a body part or organ system and it's functioning.

ii. Disability per AMA is defined as, alteration of an individuals' capacity to meet personal, social, or statutory demands, or statutory regulatory requirements, because of an impairment.

(b) Parties also wish for you to provide a strict interpretation of the AMA Guides 5th edition as well as an alternative analysis, if you feel such analysis is warranted. Both Labor Code and case law, allows you to provide alternative impairment within the AMA Guides.

8) However, if you believe that the applicant's condition has not yet reached the maximal improvement stage, the parties still wish for you to provide a current whole person impairment determination, as they may wish to resolve the issue, notwithstanding.

9) The parties wish for you to report on the applicant's condition as found at the time of your physical evaluation and face to face meeting, as well as the evidence presented to you, by the parties. Parties do not wish for you to discuss parts of body that are not part of the evidentiary record, if required, the parties would develop the record, accordingly.

10) With regard to the issue of apportionment: what approximate percentage of any permanent disability you may find was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage, if any, of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including but not limited to prior industrial injuries, prior accidents or events and the synergistic affect of daily living activities as it relates to any evidence of degenerative deterioration.

In addition, the case of City of Jackson v. WCAB, the 3rd District Court of California (April 26, 2017) makes no distinction "between allowing apportionment based on a preexisting congenital or pathological condition and allowing apportionment based on a preexisting degenerative condition caused by heredity or genetics."

Please note, regarding any apportionment or other conclusions, including causation, it is imperative that your findings and conclusions are based on medical history, physical examination, diagnostic studies, and medical studies, combined to meet the standard of substantial medical evidence. City of Jackson v. WCAB, 3rd District Court of California (April 26, 2017)

11) Whether the applicant requires further or future medical treatment, and if so the nature and extent of the reasonable and necessary treatment. Your opinions regarding future medical are well appreciated and will be utilized in conjunction with other medical evidence in any determination per Labor Code Section 4610.

12) Whether the applicant is able to perform the applicant's usual and customary job duties, or whether modified job duties, or supplemental job displacement benefits are required. If you find that the disability from all conditions for which compensation is claimed has reached maximum medical improvement and if you find that the injury has caused permanent partial disability, please fill out the attached Physician's Return-to-Work & Voucher Report (for injures occurring on or after January 1, 2013). The purpose of the form is to fully inform the employer of the work capacities and activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work. The information contained on the form is for voucher purposes and is not considered in any permanent impairment rating or any permanent disability indemnity.

Cover Letter, signed by Roxana Soltani, dated _____

The examiner was provided with a medical index and medical records of the applicant. He was informed that the defendant under a separate cover would send additional records. He was asked to ensure that all medical records were

provided. He was advised that if he was missing anything, he was to contact the parties immediately.

Application for Adjudication of Claim, dated

It was claimed that the applicant sustained specific injuries on while employed as a at [redacted] to his left foot and ankle due to being crushed between a pallet jack and a wall. The claim included injuries to his right leg due to repetitive syndrome.

Amended Application for Adjudication of Claim, dated

It was claimed that the applicant sustained specific injuries on while employed as a at [redacted] to his left foot and ankle due to being crushed between a pallet jack and a wall. The claim included injuries to his right leg due to repetitive syndrome. The claim was amended to include weight gain and injuries to his internal [system] and psyche.

Deposition of M.D., dated

Dr. Paveloff had the chance to review his report. He had one date that he had wrong, when he put instead of on something, location of the incorrect year was unrecalled.

He had a typographical error on Page 13, end of the paragraph, last sentence where he had put "" instead of ""

[Off Note: It was requested that a copy of the doctor's report where in " " was changed into " " be provided.]

He denied being provided records from the end of to the first few days of December. He testified that it did not cause him to have any problem analyzing the case.

[Off Note: It was requested that medical records of the applicant from and medical records from L.A. County hospital be provided.]

The doctor testified that the applicant had been honest to him regarding the applicant's shoulders early on when the applicant was using his crutches.

The doctor opined that it may or may not be possible that the applicant's shoulder might pop up as an issue again; if the applicant had another surgery and

was using crutches again, the same thing with the applicant's hands as it was from the crutches.

He testified that it was possible for the applicant to have problems with his right knee, if his walking became antalgic again as it was bothering him before when he was limping more.

The doctor did not provide the applicant any disability for the low back. He testified that the applicant had temporary problems with his low back that had resolved at the time of the doctor's evaluation. Which was not any different from anybody that the doctor had treated who had an injury. The doctor testified that some patient had a problem and then it would go away. The doctor did not rate the disability in anticipation in the future that it might had pain again.

The doctor testified that the applicant at the time of evaluation adamantly denied having any residual pain or limitation with any of the body parts. The doctor testified that he did not doubt the applicant's credibility.

The doctor testified that there was no way of telling whether the findings of the CT of the pelvis of 3-mm generalized bulging disk at L5-S1 was caused by the traumatic injury at Cingular unless the applicant had an MRI or CT prior to the injury for comparison. The doctor also pointed out that as people age, the spines degenerate and cause disk bulges and disk protrusions. The doctor also pointed out that disk bulges and MRI findings did not necessarily correlate with pain.

The doctor testified that exacerbation of back pain was possible, if the applicant had an increased antalgic gait for a prolonged period.

The doctor denied knowing whether if the applicant ever had returned to any restricted duty or if the employer did not provide any light-duty work.

The doctor had recommended that a "pain psychologist" see the applicant. He testified that the applicant had a traumatic injury.

The doctor testified that he could not comment on whether the applicant might had a post-traumatic stress disorder. The doctor denied being told by the applicant about the medical and hospital bill paid and the inattention to his claim by the employer or the claims administrator. The doctor denied asking specifically if the applicant had sleep disorder or sexual issues. The doctor denied giving the applicant the Epworth test.

The doctor noted that the applicant was taking Omeprazole. The doctor testified that the applicant would need to see an internist but denied knowing what the ratable conditions were.

The doctor testified that in his permanent-disability opinion, he opined utilizing the combined values chart or adding the impairment ratings provide the same total whole person impairment of 16%. The doctor was unsure if it was just an error in the transcription. He testified using the combined values chart to come up with the whole person impairment. He testified knowing that he could opine that the disabilities could be added.

The doctor would not oppose if there were a possibility for the disabilities to be added for the weakness that would give a higher impairment.

The doctor denied recalling seeing the applicant on and providing a medical-legal evaluation report but he testified recognizing his signature on the report. The doctor denied being provided with his report dated by the time he was provided with the applicant' medical records.

The doctor testified that he was not able to review his report in September and was not able to recall what was in it. However, he testified that reviewing the medical records, it was medically probable that give the severity of the applicant's injury and the antalgic gait, the prolonged use of crutches, that at least temporarily he could had flared up or he could had injured the other body parts that were being treated. The low back, the right knee and the shoulders. The applicant had some hand pain. Moreover, that the applicant progressed through his treatment, from what the doctor could read and that the applicant's gait had improved. The applicant was able to get rid of the crutches. The applicant had some therapy. The other body parts at least at the time that the doctor had saw the applicant at the time of discharge were no longer symptomatic.

The doctor testified that all the low back examination and neurologic examination except for the weakness of the left foot and ankle, which was documented, were completely normal.

The doctor testified that the applicant's weakness was the method used in giving the applicant with the greatest level of permanent disability versus simply gait derangement. The doctor testified taking the one with the greatest level of impairment and that the applicant's impairment was accurately reflected in the applicant's weakness.

The doctor noted that the applicant underwent 2 left ankle surgeries. The applicant underwent removal of hardware that helped alleviated the pain but not eliminate the pain.

The doctor opined that the applicant was able to return to modified work with permanent restrictions. The applicant was precluded from repetitive squatting or kneeling, prolonged standing or walking greater than 15 minutes at a time and lifting or carrying greater than 30 pounds. The doctor placed the applicant on vocational rehabilitation or supplemental job-displacement benefits. The doctor testified that the applicant was not able to return to his prior job as a warehouseman.

The doctor recommended that an orthopedic specialist for future medical care see the applicant. Dr. . also saw the applicant on Dr. opined that Dr. . recommendation of Lidocaine injection and consideration of a fusion, if the applicant's pain was significantly relieved by the injection, was medically reasonable.

The doctor was not able to recall whether being provided documents with specific dates of hire on his initial report dated

The doctor was provided the time to review his report dated
He denied changing his opinion upon review of the medical record.

MEDICAL RECORDS:

Doctor's First Report of Occupational Injury or Illness, signed by

The applicant sustained injuries on while employed as a to his left foot/ankle when it was caught on a forklift while moving.

Subjective Complaints: He complained of left foot/ankle pain.

Diagnosis: Left distal tibia/fibula fracture.

Treatment: He was provided pain medications and splint. He was referred to orthopedics for possible surgical treatment.

Work Status: He was instructed remain off work and return to work on .

Emergency Medical Service Report, [redacted], dated [redacted]

The applicant complained of fracture to the left ankle with deformity. His foot was caught in a forklift.

Vital Signs: At 1044 H, his blood pressure was 158/75 mmHg and pulse rate was 78 bpm.

At 1102 H, his blood pressure was 138/86 mmHg and pulse rate was 71 bpm.

At 1110 H, his blood pressure was 128/82 mmHg and pulse rate was 76 bpm.

At 1115 H, upon transfer to emergency department, his blood pressure was 128/79 mmHg and pulse rate was 76 bpm.

Triage Note, [redacted] Hospital of [redacted], dated [redacted]

Vital Signs: The applicant weighed [redacted] and his blood pressure was 128/79 mmHg. Pulse rate was 76 bpm.

Emergency Department Triage Report, signed by [redacted], dated [redacted]

Narrative: The applicant was brought in by ambulance from work with complaints of left foot/ankle pain. He was working and his foot accidentally was caught on a forklift. He had angular deformity on the left ankle. He was administered with Morphine 6 mg and Zofran 4 mg on the field for pain management. His pain had improved from 10/10 to 8/10.

Vital Signs: The applicant weighed [redacted] and his blood pressure was 128/79 mmHg. Pulse rate was 76 bpm.

Vital Signs Report, [redacted] Hospital of [redacted] dated [redacted]

At 2319 H, his blood pressure was 128/79 mmHg and pulse rate was 76 bpm. He weighed

X-rays of the Left Ankle signed by . dated .

Impression: Acute comminuted fractures of the right distal tibia and fibula, with displacement of the distal fibula.

Doctor's First Report of Occupational Injury or Illness, signed by

The applicant sustained specific injuries on while employed at [redacted] to his left foot. His left foot slipped as he was driving the pallet jack. He hit his left foot between the cargo and the wall. His foot bent completely.

Subjective Complaints: He complained of frequent throbbing left ankle pain with mild swelling rated 5/10.

Current Medication: He was on Vicodin.

Diagnoses: 1) Left fracture, comminuted tibia distal. 2) Left fracture, left fibula, closed distal.

Treatment Rendered: He was provided with a CAM Walker. He was prescribed Norco 10 mg 1 every 6 hours. He was dispensed with a small cold/hot pack.

Treatment Plan: He was instructed to continue with crutches. He was precluded from weight bearing. He was instructed to elevate his extremity. Orthopedic surgery consultation was requested.

Work Status: He was placed on temporary disability. He was instructed to remain off work for 2 days.

Progress Report, by

The applicant was discharged home with prescription for Vicodin, when necessary for pain. He was instructed to follow-up with orthopedic surgeon/workers' compensation.

Prescription, signed by M.D., dated

The applicant was prescribed Vicodin every 4 to 6 hours when necessary #20.

Medication Administration Record, [redacted] Hospital of [redacted], dated [redacted]

The applicant was administered Hydromorphone 10 mg/ml intravenously, Ketorolac 30 mg/ml intravenously and Lorazepam 2 mg/ml.

Vital Signs Report, [redacted] Hospital of [redacted] dated [redacted]

At 0055 H, the applicant had a blood pressure of 136/72 mmHg and heart rate was 88 bpm.

At 0132 H, his blood pressure was 132/72 mmHg and heart rate was 81 bpm.

At 0242 H, his blood pressure was 128/90 mmHg and heart rate was 79 bpm.

At 0333 H, his blood pressure was 126/72 mmHg and heart rate was 76 bpm.

At 0409 H, his blood pressure was 124/76 mmHg and heart rate was 72 bpm.

Laboratory Report, signed by [redacted]., dated [redacted]

The rapid drug screening showed negative results for 10-panel screening.

Orthopaedic Surgery Consultation, signed by [redacted], dated [redacted]

Occupational Title and Description: The applicant was employed at [redacted] in the capacity of [redacted] for the past 6 months.

The physical demands of his usual and customary work included prolonged standing and walking, along with frequent pushing, pulling, heavy lifting and loading, along with repetitive bending, stooping, squatting, kneeling and climbing activities.

History of occupational Injury: While at work on [redacted], he was driving a pallet jack when his left leg inadvertently slipped off, causing his left ankle to forcefully strike an adjacent a wall. His left ankle became pinned between the wall and the pallet jack, resulting in the onset of immediate sharp pain and intense swelling. He was unable to bear weight on the extremity.

He was unable to continue and the injury was immediately reported to the employer, who was summoned an ambulance.

Medical Course: He had been evaluated by paramedics at the scene of the accident. He was examined and received an injection of morphine and a splint was applied to the left ankle. Once stabilized, he was transported to Huntington Park Memorial Hospital, where he received an intramuscular pain injection. He was subsequently discharged home.

Upon referral made by his employer, he was evaluated at Medical Center on , at which time he was examined and repeat left ankle x-rays were obtained, medications were prescribed, and he was placed in a CAM walker. He was then placed on temporary total disability. STAT orthopaedic surgery consultation was recommended.

He was seen with his employer, [redacted]

Work Status: He had not returned to work in any capacity since .

Present Complaints: His left ankle symptoms had slightly improved since the date of injury.

He currently complained of constant moderate left ankle pain that radiated to the left knee area, and was accompanied by swelling. He states that he was unable to bear weight on the left lower extremity.

Standing, walking and weightbearing activities aggravated his left leg symptoms. He indicated that pain medications and avoiding the above activities were both temporarily beneficial in reducing his left ankle symptoms.

Present Medication: He was on Norco.

Physical Examination: He weighed .

Diagnostic Impression: 1) Left ankle/distal, plafond fracture, intra-articular, severely comminuted and displaced. 2) Left ankle, lateral malleolus fracture. 3) Left ankle and tibia crush injury.

Discussion: There were no medical records provided from the hospital for review.

Medical Causation: Based upon all the information provided and assuming the accuracy of history elicited by the applicant absent any information suggesting otherwise. It was opined that the specific industrial injury of [redacted] represented the sole and proximate cause of his current impairment and need for treatment and was consistent with the diagnoses.

Orthopaedic Treatment: In view of the positive clinical and left ankle/tibia radiographic findings, prompt surgery was recommended consisting of open reduction internal fixation with bone graft, to be performed on an expedited basis.

Authorization for surgery was requested. He would receive intravenous antibiotic during the surgery as well as oral antibiotic post-surgery. He required extensive post-surgery rehabilitation in order to regain mobility and strength.

Work Status: He was considered temporarily totally disabled. He was instructed to remain off work.

He was instructed to return for follow-up on [redacted].

Operative Report, signed by [redacted] M.D., dated [redacted]

Preoperative and Postoperative Diagnoses: 1) Left ankle distal tibial-plafond fracture comminuted displaced intraarticular. 2) Left ankle lateral malleolus fracture displaced.

Procedure: 1) Open reduction internal fixation of the left distal tibial plafond fracture with 2.7 ankle trauma assistant-Syhthes plate with total of 12 screws. 2) Open reduction internal fixation of left ankle lateral malleolus with 2.7 mm lateral Synthes plate with total of seven screws. 3) Local bone graft.

Letter of Authorization, signed by [redacted] dated [redacted]

Authorization for open reduction internal fixation of the left ankle and for follow-up visits had been approved.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated [redacted]

Subjective Complaints: The applicant complained of left ankle pain. He was on temporary total disability. He was on Amoxicillin and Norco.

Diagnosis: 1) Status post open reduction internal fixation left ankle, distal tibia – plafond fracture – lateral malleolus fracture – local bone graft –

Treatment Plan: He was provided refill prescriptions for Norco by mouth every night when necessary. He was prescribed Naprosyn 500 mg by mouth 2 times per day with food. He was instructed to ice and elevate his extremity. He was instructed to wear his splint. He was instructed to return for follow-up on

Work Status: He was placed on temporary total disability until

The rest of the report is illegible.

Primary Treating Physician's Progress Report, signed by _____, dated _____

Subjective Complaints: The applicant complained of left ankle pain. He was on crutches. He was on temporary total disability. He was on Norco.

Diagnosis: 1) Status post open reduction internal fixation left ankle, distal tibia – plafond fracture – lateral malleolus fracture – local bone graft –

Treatment Plan: He was provided refill prescriptions for Norco by mouth every 6 hours for pain when necessary and Naprosyn 500 mg by mouth 2 times per day with food. He was instructed to return for follow-up on

Work Status: He was placed on temporary total disability until

Prescription, [by _____,] dated _____

The applicant was prescribed Amoxicillin 500/125 mg.

Primary Treating Physician's Progress Report, signed by _____ M.D., dated _____

Subjective Complaints: The applicant was on 2 crutches. He had decreased pain. He complained of burning left toes pain with numbness.

Medications: He was on Norco and Naprosyn.

Diagnosis: 1) Status post open reduction internal fixation left ankle, distal tibia – plafond fracture – lateral malleolus fracture – local bone graft –

Treatment Plan: X-rays of the left ankle was requested. He was placed on CAM Walker. He was prescribed Naprosyn 500 mg by mouth 2 times per day and Prilosec 20 mg 1 by mouth 2 times per day. Post-operative physical therapy was requested. He was instructed to return for follow-up on

Work Status: He was placed on temporary total disability until

The rest of the report is illegible.

Request for Authorization for Medical Treatment, signed by ., dated

Authorization for physical therapy 3 times per week for 4 weeks was requested.

Letter of Authorization, by ssa Arauz, dated

The requested physical therapy 2 times per week for 4 weeks had been authorized.

Primary Treating Physician's Progress Report, signed by M.D., dated

Subjective Complaints: The applicant was on 2 crutches. He continued to wear the CAM Walker. He had decreased pain in the left ankle.

Medications: He was on Prilosec and Naprosyn.

Diagnosis: 1) Status post open reduction internal fixation left ankle, distal tibia – plafond fracture – lateral malleolus fracture – local bone graft –

Treatment Plan: X-rays of the left ankle was requested. He was provided refill prescriptions for Naprosyn and Prilosec. He was instructed to continue to use his CAM Walker. He was instructed to return for follow-up on

Work Status: He was placed on temporary total disability until

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated [redacted]

Subjective Complaints: The applicant continued to use his CAM Walker and crutches. He had finished 7 physical therapies. He had decreased pain. He complained of persisting pain. He had limited ankle motion.

Medications: He was on Prilosec and Naprosyn.

Diagnosis: 1) Status post open reduction internal fixation left ankle, distal tibia – plafond fracture – lateral malleolus fracture – local bone graft –

Treatment Plan: X-rays of the left ankle was requested. He was provided refill prescriptions for Naprosyn and Prilosec. He was instructed to continue to use his CAM Walker. Additional physical therapy 3 times per week for 4 weeks was requested. He was instructed to return for follow-up on

Work Status: He was placed on temporary total disability until

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated [redacted]

Subjective Complaints: The applicant had completed 12 postoperative physical therapy. He had decreased ankle pain that was exacerbated by motion. He had stopped to use the cane but continued to use the CAM Walker.

Medications: He was on Naprosyn.

Diagnosis: 1) Status post open reduction internal fixation left ankle, distal tibia – plafond fracture – lateral malleolus fracture – local bone graft –

Treatment Plan: X-rays of the left ankle was requested. He was provided refill prescription for Naprosyn. Additional physical therapy 3 times per week for 4 weeks was requested. He was instructed to return for follow-up on

Work Status: He was placed on temporary total disability until

SOAP Note, Coast Medical Center, dated [redacted]

Chief Complaint: The applicant complained of rash in his back since Sunday. He complained of very painful back chest pain and severe burning rash in the area. He also complained of rib cage pain.

Subjective: He had painful rash on the upper back that had burning feeling that turned to the chest for 3 days. It was getting worse.

Vital Signs: He weighed [redacted] and his blood pressure was 125/84 mmHg. Pulse rate was 56 bpm.

Assessment: Shingles, right side of the back.

Plan: He was prescribed Acyclovir 800 mg 1 by mouth 2 times per day for 10 days, Prednisone 20 mg, Vicodin 5/500 mg 1 by mouth every 6 hours and Toradol 60 mg IM.

The rest of the report is illegible.

Initial Comprehensive Primary Treating Physician's Report, signed by [redacted] M.D., dated [redacted]

History of Injury: On [redacted], the applicant was using a pallet jack when his left foot slipped and was twisted by the jack 180 degrees. His left ankle was pinned against the wall by the jack. Somehow, he moved steered away the jack as he yelled for help. An ambulance transported him to a hospital.

History of Treatment: He had been given 3 doses of Morphine by the paramedic due to the intensity of the pain. He was briefly examined at the hospital and released home the following day. He was contacted later by the company and referred to [redacted] who scheduled him for left ankle surgery. He underwent surgery on [redacted]. Medication for pain relief and a boot were dispensed. He was started on a course of 12 postoperative therapy sessions in [redacted]. He remained under the care of [redacted] through [redacted].

His pain persisted and he had asked for further medication, which his physician did not provide.

Subsequent x-rays had showed loose hardware. He was advised that if he was able to bear the pain nothing should be done, however if the pain increased he would undergo hardware removal. He was not using a boot and was told to start

bearing weight. Nevertheless, he was unable to tolerate the pain and returned to using the walking boot.

His left foot continued to be very swollen. He was unable to walk over 100 feet. Therefore, he developed lower back pain and had been forcing his right leg and arm to get up from a seated position as well as walking. He noted a significant weight gain.

Furthermore, he developed shingles and had sharp pain in his body. It occurred on . He presented to the hospital on and was treated. He inquired as to why he experienced onset, the physician indicated it was due to stress. Since that episode, his shingles dissipated. He had cramping in the inguinal right side and he underwent previous herniorrhaphy on that side.

To date, he was elevating his left leg and he was performing home exercise regimen as best as possible.

Job Description: He began employment with [redacted] on as a

He worked 8 hours per day, 5 days per week plus over time. His duties at the time of injury entailed pulling orders for world food. He prepared orders and placed on pallets, pulling pallets with a pallet jack that was loaded onto a trailer.

His job activities required frequent standing, walking, walking on uneven surfaces, lifting up to 50 pounds, carrying up to 50 pounds, squatting, pivoting, sitting, balancing, climbing stairs, finger manipulation, pushing/ pulling up to 60 pounds, twisting/torqueing, simple gripping, power gripping, reaching above shoulder level, reaching below shoulder level, looking down, looking-up, looking over the shoulder, working overhead, bending, stooping, twisting, driving forklift equipment; working around equipment; operation of foot controls or repetitive hand and foot movement.

Current Work Status: He was currently not working. He last worked on and was currently not receiving disability benefits.

Employment History: Prior to working for he worked for as an for approximately 9 months. He worked 6 years for as a

Present Complaints: He complained of intermittent pain in his right arm and was felt 65% of the time. His pain radiated to the shoulder and down to the hand and fingers. He had episodes of numbness and tingling in his right hand. His pain

increased with reaching, gripping and grasping. His pain level became worse in the evening depending on activities. He also had difficulty sleeping and awakens with pain and discomfort.

He complained of intermittent pain in the lower back and was felt 75% of the time. He attributed the pain to his left ankle injury and use of crutches and walker to ambulate. He also had difficulty sleeping and awakens with pain and discomfort.

He complained of continuous left foot and ankle pain, which was felt 95% of the time. His pain increased whether in movement or at rest. He experienced ongoing swelling, cramping, numbness and tingling in his left foot and toes. His left ankle/ foot had given out, causing him to lose his balance. He had difficulty standing and walking for any period of time and was using the walking boot again. His pain worsened when he flexed/extended or rotated his foot/ankle. He walked with an uneven gait. His pain level became worse in the evening depending on activities. He also had difficulty sleeping and awakened with pain and discomfort. Pain medication provided him pain improvement temporarily.

He complained of having difficulty sleeping. He was unable to find a comfortable position secondary to his pain. He felt fatigued throughout the day and found himself lacking concentration and memory at times.

He complained of bouts of depression, stress and anxiety. He experienced feelings of sadness, frustration, desperation, anguished, anger and useless. He was upset because he had difficulty doing his activities of daily living. He lacked motivation to do any activities. He was also worried over his medical condition, financial situation and the future.

Surgical History: He had undergone surgery to his left ankle, tibia and fibula. In), he underwent inguinal herniorrhaphy on the right.

Activities of Daily Living: Since the date of work-related injury there were episodes of increased pain to his lower back, left ankle, causing difficulty taking a shower, getting dressed, driving for prolonged periods of times, doing house chores and grocery shopping, standing, walking, reaching and lifting. He avoided lifting. Furthermore, he was aware of proper body mechanics.

Impression: Closed ankle fracture not otherwise specified.

Treatment Plan: Review of medical records was requested. EMG/NCS of the bilateral lower extremity was requested. CT of the left ankle was requested. He was prescribed Norco -apap 10-325 1 by mouth 2 times per day #60, Naproxen

sodium 550 mg 1 tablet daily #30 and Omeprazole Dr 20 mg 1 tablet daily #30. He was instructed to return for follow-up in 4 weeks.

Work Status: He was placed on temporary total disability for 6 weeks.

Primary Treating Physician's Progress Report, signed by _____, dated _____

Interim History: The applicant was seen for follow-up evaluation. There had been no significant improvement since the last examination. EMG/NCS showed left peroneal traumatic neuropathy; CT of the left ankle had not been done yet. He continued to have difficulty walking.

Impression: 1) Closed ankle fracture not otherwise specified. 2) Lumbar sprain/strain.

Treatment Plan: CT of the left ankle would be review. He was instructed to continue with his medications. Chiropractic care 3 times per week for 4 weeks for the left ankle was requested. He was prescribed Norco -apap 10-325 1 by mouth 2 times per day #60, Naproxen sodium 550 mg 1 tablet daily #30 and Omeprazole Dr 20 mg 1 tablet daily #30. He was instructed to return for follow-up in 4 weeks.

Work Status: He was placed on temporary total disability for 6 weeks.

Physical Medicine Qualified Medical Evaluation, signed by _____, dated _____

The applicant was examined on .

Current Complaints: The applicant complained of left foot and ankle pain, lower back pain, right knee pain secondary to altered gait and change in biomechanics relative to the left lower extremity, left foot and ankle, right shoulder and right-hand pain secondary to crutch use with regard to change in gait of the left lower extremity, left foot and ankle.

History of Injury: He was employed as a warehouse man beginning on (with [redacted] through [redacted] His last day of work was on

His job duties as a warehouse man required preparing of orders, shipments, sorting of products and wrapping products, preparing shipments and ordering for loading while using an electric pallet jack. He worked 8 hours plus overtime

hours, 6 days per week, requiring 80% of the time standing and 20% of the time walking. There was frequent requirement of bending of the back and neck, twisting of the back and neck and pushing/pulling. There was a frequent requirement of simple gripping/grasping, strong grasping, overhead reaching and repetitive motions of elbows and wrists. There was an intermittent requirement of squatting and stooping, as well as typing/finger dexterity. He had a lifting requirement of 50 pounds or more to include products of fruit and produce on a continuous basis.

On , he was working at his usual and customary duties as a warehouse man. He was operating an electric pallet jack while standing and was making a right turn into another aisle. While turning the pallet jack, he suddenly felt excruciating and sudden pain in his left foot and ankle. He looked down and saw that his left and ankle was being "crushed" by the electric pallet jack against the wall. He was unable to recall the specific details, but he did recall that someone managed to release his foot. He denied any direct knowledge of witnesses. However, someone helped him back on his feet and that the injury might had been captured by the surveillance camera.

Following the incident, he screamed due to substantial pain. He was approached by additional coworkers. He was assisted back to his feet by coworkers and his supervisor, , obtained the report.

A short time later, paramedics arrived at the scene. He was transported to Los Angeles County Hospital where he was seen by the attending physician. However, he did not recall any diagnostic studies, but recalled being administered Morphine injection by paramedics. Nothing further was done. His foot was placed in a cast/splint. The next morning, he was contacted by the agency, [redacted] and he was advised that he would be having an evaluation with the company physician.

He was then examined by orthopedic surgeon. X-rays of his left foot and ankle were obtained revealing fracture. Consequently, he was immediately scheduled for left foot and ankle surgery on to include multiple plates and screws. He was placed off work, temporarily totally disabled per .

Post-operatively, he underwent 24 sessions of physical therapy, noting some benefit

Secondary to altered gait and change in biomechanics and use of mobilizing crutches, he developed lower back pain and right knee pain.

He continued to be under the care of on a monthly basis to include conservative care until when he was released off from. care due to issues of the workers' compensation company not authorizing and not paying for treatment.

Dr. recommended a second procedure to include removal of retained hardware, which was recommended to be undertaken in However, the second surgery was not performed, as no authorization could be provided.

He continued to ambulate with the use of crutch on his right side for which he developed symptoms involving his right shoulder, right wrist, and hand.

Medical History: In he was diagnosed with shingles.

Surgical History: In , he underwent right inguinal hernia repair, non-industrial.

On , he underwent left foot and ankle surgery by relative to the work-related specific injury that occurred on .

Current Medications: He was currently on Naproxen and Omeprazole/Prilosec.

Review of Systems: He had general weight gain. He has a history of constipation secondary to chronic medication use, resolved. He had anxiety, depression and difficulty sleeping. He was clenching his jaw. He had additional musculoskeletal complaints of cramps.

Activities of Daily Living: He was able to perform activities such as lifting, carrying, driving a car, standing, sitting, reclining, walking, climbing of stairs, bending, stooping, carrying groceries and garbage, pushing a vacuum cleaner, making his bed, doing dishes and doing laundry, but with modification or assistance.

Physical Examination: He weighed . His blood pressure was 128/83 mmHg and pulse rate was 63 bpm.

Diagnoses: 1) Status post open reduction/internal fixation, performed on , relative to distal tibiofibular fracture. 2) Radiographic examination of the left foot/ankle dated revealed distal tibiofibular fracture with non-union and evidence of broken hardware to included plates and screws on the medial aspect with subsequent findings of anterior angulation of the distal tibia, not well healed. 3) Lumbar

spine musculoligamentous sprain/strain with right sacroiliac joint sprain secondary to overcompensation and change in biomechanics and altered gait of the left foot/ankle. 4) Right knee sprain with resultant patellofemoral arthralgia secondary to change of altered gait and change in biomechanics relative to the left foot and ankle. 5) Right shoulder strain secondary to crutch use relative to change in biomechanics and altered gait of the left lower extremity. 6) Right wrist strain secondary to crutch use with regard to change in biomechanics and altered gait of the left lower extremity.

Discussion: His symptoms were caused as a result of the specific work-related injury that occurred on , during his employment as a man at [redacted]

Based on the provided history, findings on physical examination and review of available diagnostic studies, it appeared that he indeed sustained a specific work-related injury that occurred on while employed as a warehouse man at [redacted]

Furthermore, based on the provided history and findings on physical examination, it would also appear that he sustained injuries to his lumbar spine and right knee secondary to altered gait and change in biomechanics relative to the left foot and ankle, which was felt to be caused as a compensable consequence of the specific work-related injury that occurred on

Medical records were requested for review.

CT of the left ankle and foot was requested. Authorization for a STAT referral to an orthopedic trauma specialist was requested.

Disability Status: He was not maximum medical improvement pending additional diagnostic studies and consultation with an orthopedic trauma specialist. He was placed on temporary total disability pending further evaluation by CT and the orthopedic trauma specialist.

Impairment Rating: Impairment rating and disability was deferred.

Primary Treating Physician's Progress Report, signed by

Interim History: The applicant was seen for follow-up evaluation. There had been no significant improvement since the last examination. He continued to

have significant left ankle pain and swelling. He was waiting for him to undergo a CT of the left ankle. He was awaiting an appointment with the chiropractor.

Impression: 1) Closed ankle fracture not otherwise specified. 2) Lumbar sprain/strain.

Treatment Plan: He was instructed to continue with his current medications. He was instructed to continue with his current chiropractic care. He was prescribed Norco -apap 10-325 1 by mouth 2 times per day #60, Naproxen sodium 550 mg 1 tablet daily #30 and Omeprazole Dr 20 mg 1 tablet daily #30. He was instructed to return for follow-up in 4 weeks.

Work Status: He was placed on temporary total disability for 6 weeks.

Initial Evaluation Treatment Report of the Primary Treating Physician, signed by , M.D., dated

Chief Complaint: The applicant complained of low back pain, left ankle/foot pain, right foot pain, right knee pain, depression/anxiety and right groin pain. The left ankle was the only accepted body part.

Job Description: He began employment with [redacted] as an in . He worked 8 to 4 hours a day, 6 days a week. His job duties at the time of the injury included operating a pallet jack, working in warehouse, picking and pulling orders, lifting heavy boxes, stacking box onto pallets, loading and unloading trucks, and counting orders and taking inventory.

He described the activities required included prolonged standing, walking, as well as repetitive bending, stooping, squatting, repetitive pushing and pulling, and lift to 100 pounds, repetitive gripping, grasping, twisting, turning, and lifting to 50 pounds.

Current Work Status: He was currently off work on disability. He last work on . He was receiving benefits from the insurance carrier.

History of Injury: On , while performing his usual and customary job duties he was operating a pallet jack at which time his left foot slipped off the jack and the pallet jack ran over his left foot. He had immediate extreme pain and swelling in his left foot and ankle. Paramedics were summoned to the scene. Morphine was administered. He was transferred via ambulance to a hospital. He recalled screaming in the emergency room with pain. Several hours later he was discharged home with medications, crutches and he was placed off work on disability.

The following day he was referred to a clinic. He underwent a physical examination; x-ray studies were completed and he was told that he fractured 3 bones in his ankle. His foot and ankle was placed in an immobilizer and medications were prescribed.

Two days later, he was referred to an orthopedic surgeon, That day immediate surgery was completed. He was diagnosed with a left ankle/distal tibial plafond fracture, which extended into the intraarticular space and was severely comminuted and displaced.

He underwent open reduction and internal fixation of left distal tibial plafond fracture as well as an open reduction and internal fixation of the left ankle lateral malleolus fracture. Multiple screws and bone graft were placed.

He was kept off work on disability.

Two months later the cast was removed and he was placed in an orthopedic boot. He was started on a course of physical therapy. He remained symptomatic with left ankle pain and swelling.

By , he noted the onset of pain in his low back as well as his right knee and foot, which he attributed to compensating for the injured left ankle.

He was discharged by orthopedic surgeon, in .

He was then referred to physical medicine specialist,
pain medications were provided.

Present Pain Complaints: He complained of continuous 8/10 pain in the left ankle and foot. There was constant swelling, numbness, and tingling. There was decreased range of motion of the ankle and he had difficulty with weightbearing. He complained of right foot pain. He had tenderness over the sole of the right foot aggravated by weightbearing. He complained of right knee pain. He had sharp and intermittent pain in the right knee with catching and crepitus. He complained of low back pain. He had intermittent pain in his low back with pain radiating to the right leg. He complained of right armpit pain. He had armpit pain from the continuous use of a crutch under his right arm. He had psyche complaints. He had depression, anxiety and insomnia. He complained of right groin pain. He had tenderness and discomfort in the right groin.

Activities of Daily Living: He had difficulty completing all normal activities of daily living such as walking, standing, bathing, dressing, cleaning his house, grocery shopping, and driving. He was using a crutch to ambulate. He was

unable to lift heavy weights. As a result of the pain and function limitation, he had developed problems with depression, anxiety and insomnia.

Social History: He was in the Airforce in [redacted] for many years.

Medical History: He had undergone hernia repair in and open reduction internal fixation for the left ankle fracture in

Current Medications: He was on naproxen and Omeprazole.

Physical Examination: He weighed

Diagnostic Impression: 1) Status post left distal tibial plafond fracture severely comminuted with intra-articular extension. (a) Status post open reduction and internal fixation of distal tibial plafond fracture on , with persistent residuals. 2) Status post left ankle lateral malleolus open reduction and internal fixation on . 3) Right knee pain. 4) Right foot metatarsalgia. 5) Adjustment disorder with depressed mood and anxiety.

Plan: Postoperative CT of the left ankle was requested. Ankle/foot specialty surgical consultation was requested. Orthotics for the right foot and Canadian crutch were recommended. CT of the pelvis was requested. Psychosocial evaluation was requested. Qualitative urine drug testing was requested.

Disability Status: He was instructed to remain on temporary total disability.

Primary Treating Physician's Progress Report, signed by dated

Interim History: The applicant was seen for follow-up evaluation. There had been no significant improvement since the last examination. CT of the ankle was reviewed. The fracture had not healed yet. He was seen by QME who recommended follow up with an orthopedic surgeon relative to the left ankle fracture.

Impression: 1) Closed ankle fracture not otherwise specified. 2) Lumbar sprain/strain.

Treatment Plan: STAT orthopedic surgeon consultation was requested. He was prescribed Norco -apap 10-325 1 by mouth 2 times per day #60, Naproxen sodium 550 mg 1 tablet daily #30 and Omeprazole Dr 20 mg 1 tablet daily #30. He was instructed to return for follow-up in 4 weeks.

Work Status: He was placed on temporary total disability for 6 weeks.

Supplemental Report, signed by [redacted], dated [redacted]

The applicant was seen for follow-up evaluation. He had no significant change in his condition. He complained of continued severe left ankle pain and swelling. CT of the left ankle was provided for review.

Diagnostic Impression: 1) Status post left distal tibial plafond fracture severely comminuted with intra-articular extension. (a) Status post open reduction and internal fixation of distal tibial plafond fracture on [redacted] with persistent residuals. 2) Status post left ankle lateral malleolus open reduction and internal fixation on [redacted] 3) Right knee pain. 4) Right foot metatarsalgia. 5) Adjustment disorder with depressed mood and anxiety.

Plan: Ankle/foot specialty surgical consultation was requested. Orthotics for the right foot and Canadian crutch were recommended. CT of the pelvis was requested. Psychosocial evaluation was requested.

Disability Status: He was instructed to remain on temporary total disability.

Request for Authorization for Medical Treatment, signed by [redacted], dated [redacted]

Authorization for Canadian crutch, CT of the right pelvis and ankle/foot orthopedic consultation was requested.

Request for Authorization for Medical Treatment, signed by [redacted], dated [redacted]

Authorization for ankle/foot orthopedic consultation was requested.

CT of the Pelvis, signed by [redacted], dated [redacted].

Impression: 1) The osseous structures of the pelvis and hips were intact. 2) The sacroiliac joints and hip joints are normally visualized. 3) Degenerative changes at the symphysis pubis were present with bony spurring primarily involving the left side of the pubic bone more than right with mild subchondral sclerosis and cystic changes also present. 4) At L4-L5, broad-based central bi-paracentral 4-mm disc protrusion right greater than left indents the thecal sac and impinges upon both traversing L5 nerve roots. No significant central spinal stenosis was seen. 5) At L5-S1, moderate disc degenerative narrowing was present with 3-

mm generalized bulging disc annulus abutting but not displacing the traversing S1 nerve roots. No bony stenosis was seen. 6) Postsurgical changes in the right inguinal region related to prior hernia surgery was seen. No definite recurrent hernia was identified. Clinical correlation was advised however.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated [redacted].

Subjective Complaints: The applicant was pending authorization for ankle/foot orthopedic specialty consultation following tibia plafond fracture with persistent residuals and evidence of nonunion by CT.

Diagnostic Impression: 1) Status post left distal tibial plafond fracture severely comminuted with intra-articular extension. (a) Status post open reduction and internal fixation of distal tibial plafond fracture on [redacted], with persistent residuals. 2) Status post left ankle lateral malleolus open reduction and internal fixation on [redacted]. 3) Right knee pain. 4) Right foot metatarsalgia. 5) Adjustment disorder with depressed mood and anxiety.

Plan: Ankle/foot specialty surgical consultation was requested. Orthotics for the right foot was recommended.

Disability Status: He was instructed to remain on temporary total disability.

Request for Authorization for Medical Treatment, signed by [redacted] M.D., dated [redacted]

Authorization for ankle/foot specialty surgical consultation and orthotics for the right foot was requested.

Primary Treating Physician's Progress Report, signed by [redacted] M.D. and [redacted], M.D., dated [redacted]

Subjective Complaints: The applicant was seen for follow-up evaluation. He continued to complain of left ankle and foot pain. The pain was constant. He was authorized to see orthopedic foot doctor and the appointment needed to be scheduled.

Diagnostic Impression: 1) Status post left distal tibial plafond fracture severely comminuted with intra-articular extension. (a) Status post open reduction and internal fixation of distal tibial plafond fracture on [redacted] with persistent residuals. 2) Status post left ankle lateral malleolus open reduction and

internal fixation on 3) Right knee pain. 4) Right foot metatarsalgia. 5) Adjustment disorder with depressed mood and anxiety.

Plan: He was instructed to continue Omeprazole. He was pending ankle foot orthopedic consultation for nonunion tibial fracture. He continued to require orthotics for the right foot metatarsalgia.

Disability Status: He was instructed to remain on temporary total disability.

Insurance Workers' Compensation Follow-up Visit, signed by , M.D., dated

The applicant had a closed injury during his work at Cingular Corporation. He had an open reduction and internal fixation of a distal tibia-fibula fracture. He went on to uneventfully heal but has been unable to work because of continued pain in his right distal tibia and a probable nonunion of the fracture.

He worked for Cingular corporation as an order selector.

He was walking with a crutch.

He was asked to obtain his current CAT scan disc and his original fracture film. He had also asked him to get CBC, sedimentation rate and a C-reactive protein as screenings for infection.

It was requested that the applicant follow-up with for surgery.

X-rays of the Left Ankle, Weight bearing, signed by ., dated

Findings: Metallic places and screws were seen transfixing fractures of the distal tibia and fibula. There was some degree of callus formation with some deformity to the distal tibia. The ankle mortise appeared to be intact.

Impression: Status post open reduction internal fixation of fractured discal tibia and fibula.

Progress Note, signed by dated

The applicant was using a single arm cane to not put as much pressure on the left lower extremity. He did not feel unstable due to the left lower extremity only pain and swelling.

Some documentation was provided. A radiology report for a CT done on [redacted] Discs or films images were not provided.

Request for Authorization, signed by [redacted], dated [redacted]

Authorization for orthopedic specialist surgery consultation, CBC with differential ESR and C-reactive protein was requested.

Prescription, signed by [redacted], dated [redacted]

The applicant was prescribed CBC with differential ESR and C-reactive protein.

Primary Treating Physician's Progress Report, signed by [redacted], M.D. and [redacted] M.D., dated [redacted]

Subjective Complaints: The applicant was seen for follow-up evaluation. He continued to complain of left ankle and foot pain. The pain was constant. He saw [redacted] on [redacted] and obtained MR1 of the left ankle and [redacted] ordered CBC, sed rate, and C-reactive protein for assessment prior to surgery, which was still pending.

Diagnostic Impression: 1) Status post left distal tibial plafond fracture severely comminuted with intra-articular extension. (a) Status post open reduction and internal fixation of distal tibial plafond fracture on [redacted], with persistent residuals. 2) Status post left ankle lateral malleolus open reduction and internal fixation on [redacted] 3) Right knee pain. 4) Right foot metatarsalgia. 5) Adjustment disorder with depressed mood and anxiety.

Plan: He was instructed to continue with Omeprazole and Naprosyn. CBC, sedimentation rate and C-reactive protein was requested. He continued to require orthotics for the right foot metatarsalgia.

Disability Status: He was instructed to remain on temporary total disability.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated [redacted].

Subjective Complaints: The applicant's treatment remained in limbo. He had been unable to complete a follow up consultation with ankle/foot orthopedic specialist [redacted] wanted to review all prior imaging studies, which had been recovered, and also wanted to see him only after completion of the CBC, sedimentation rate and C-reactive protein. They were unable to receive

authorization for the laboratory studies and was therefore, unfortunately hiss future treatment recommendations including need for possible arthrodesis were delayed.

Diagnostic Impression: 1) Status post left distal tibial plafond fracture severely comminuted with intra-articular extension. (a) Status post open reduction and internal fixation of distal tibial plafond fracture on , with persistent residuals. 2) Status post left ankle lateral malleolus open reduction and internal fixation on 3) Right knee pain. 4) Right foot metatarsalgia. 5) Adjustment disorder with depressed mood and anxiety.

Plan: He was instructed to continue with Omeprazole and Naprosyn. CBC, sedimentation rate and C-reactive protein was requested. He continued to require orthotics for the right foot metatarsalgia.

Disability Status: He was instructed to remain on temporary total disability.

Request for Authorization for Medical Treatment, signed by , dated

Authorization for CBC with differential ESR and C-reactive protein was requested.

Primary Treating Physician's Progress Report, signed by M.D., dated

Subjective Complaints: The applicant's treatment remained in limbo. He had been unable to complete work up with ankle/foot orthopedic specialist who was requesting CBC, sedimentation rate and C-reactive protein. He was to follow up with and at Cedars Ankle and Foot Surgical Department on completion of laboratory studies. He was to be reevaluated with the laboratory studies and with the CT scan disc. At that time point, he would likely require surgery with findings of nonunion left distal tibial plafond fracture. He continued to have severe medial ankle joint pain.

Diagnostic Impression: 1) Status post left distal tibial plafond fracture severely comminuted with intra-articular extension. (a) Status post open reduction and internal fixation of distal tibial plafond fracture on , with persistent residuals. 2) Status post left ankle lateral malleolus open reduction and internal fixation on . 3) Right knee pain. 4) Right foot metatarsalgia. 5) Adjustment disorder with depressed mood and anxiety.

Plan: He was instructed to continue with Omeprazole and Naprosyn. CBC, sedimentation rate and C-reactive protein was requested. He continued to require orthotics for the right foot metatarsalgia.

Disability Status: He was instructed to remain on temporary total disability.

Laboratory Report, [redacted] Hospital, dated [redacted]

The hematology panel showed increased levels of eosinophils at 3.3.

The rest of the report is illegible.

Laboratory Report, [redacted] dated [redacted]

The samples were collected on [redacted].

The CRP results were pending.

Laboratory Report, LabCorp, dated [redacted]

The samples were collected on [redacted]

The CRP was within normal limits.

Correspondence, by [redacted], dated [redacted].

It was requested that the authorization request for orthopedic consultation with Dr. [redacted] be reviewed.

Letter of Authorization, [redacted], dated [redacted]

The requested treatment for orthopedic consultation with [redacted] had been authorized.

Progress Note, signed by [redacted], dated [redacted]

The applicant complained of constant sharp pain rated 6/10 with swelling at the end of the day.

X-rays of the Left Ankle, signed by

Impression: 1) Progressive healing of distal tibial fracture. 2) Multiple fractured tibial screws and some long tibial screws as before. 3) Incongruity at the tibial plafond as before. 4) Mild secondary osteoarthritis of tibiotalar joint with medial talar dome subchondral cyst, as before. 5) Healed distal fibular fracture with stable hardware.

Insurance Workers' Compensation Evaluation, signed by , M.D., dated

Chief Complaint: The applicant complained of left leg pain.

History of Present Illness: He sustained a work-related injury to his left lower extremity in He was operating a forklift when his foot got caught in some type of mechanism and he sustained a hyper plantar flexion rotational injury. He was diagnosed with a left tibial pilon intra-articular distal tibia and fibula fracture. He was referred by the worker's compensation carrier to , who performed an open reduction and internal fixation of the left tibia and fibula. He was followed for a period time by He was then discharged from his care.

He was seen at the in . He was diagnosed with a delayed nonunion; however, no specific treatment was rendered at that time. He was being evaluated for persistent pain in his left lower leg. He frequently used a single crutch or a cane. He could walk short distances without external supports. He was only taking Naprosyn for control of symptoms.

Medical History: He has a history GERD and shingles.

Surgical History: He had undergone remote hernia repair.

Current Medications: He was on Naprosyn and Prilosec.

Diagnostic Impression: 1) Closed comminuted intra-articular fracture left distal tibia, status post open reduction, internal fixation. 2) Healed fracture with retained prominent broken painful hardware. 3) Posttraumatic osteoarthrosis left tibiotalar joint.

Plan: Authorization for removal of the broken hardware in the tibia and fibula was strongly requested.

X-rays of the Left Ankle, signed by [redacted], dated [redacted]

Impression: 1) Progressive healing of distal tibial fracture. 2) Multiple fractured tibial screws and some long tibial screws as before. 3) Incongruity at the tibial plafond as before. 4) Mild secondary osteoarthritis of tibiotalar joint with medial talar dome subchondral cyst, as before. 5) Healed distal fibular fracture with stable hardware.

Status Report, signed by [redacted], dated [redacted]

Work Status: The applicant was instructed to remain off work.

Disability Status: He was placed on temporary total disability.

Progress Note, signed by [redacted], dated [redacted]

The applicant was weightbearing using a cane. He was seen for pre-operative procedures. He was scheduled to have hardware removal in the left tibia by [redacted] on [redacted].

Preoperative History and Physical Examination, signed by [redacted] M.D., dated [redacted]

Chief Complaint: The applicant complained of left leg pain.

History of Present Illness: He sustained a work-related injury to his left tibia and fibula in an industrial accident in [redacted]. He was operating a forklift when his foot got caught in the forklift and he sustained a complex hyper plantar flexion rotational injury. He was diagnosed with a left tibial pilon intra-articular distal tibia and fibula fracture. He was treated by open reduction and internal fixation after the injury. Eventually, he was diagnosed with persistent pain and delayed nonunion. He could walk very short distances without external supports. He was on Naprosyn for pain relief. He had been unable to return to work.

Current Medications: He was on Naprosyn and Prilosec.

Final Diagnosis: 1) Closed comminuted intra-articular fracture left distal tibia, status post open reduction, internal fixation. 2) Healed fracture with retained prominent broken painful hardware. 3) Posttraumatic osteoarthrosis left tibiotalar joint.

Plan: He was scheduled for removal of the broken hardware in the tibia and fibula.

Electrocardiogram, signed by ., dated .

Ventricular rate 59 bpm. PR – 170. QRS – 90. QT – 416. QTc – 411.

Interpretation: 1) Sinus brachycardia. 2) Otherwise normal EKG.

Laboratory Report, Medical Center, dated .

The CBC showed increased levels of absolute monocytes and decreased levels of MPV.

The metabolic panel showed increased values of glucose at 136.

The PTT, C-reactive protein and sedimentation rate were otherwise within normal limits.

Pre-anesthesia Assessment Note, signed by dated .

Proposed procedure: Tibial hardware removal.

Pre-Operative Diagnosis: Fracture of lower end of tibia, left.

Medical History: The applicant has a history of shingles.

Surgical History: He has history of hernia repair in and open reduction internal fixation of the left distal tibia on

Current Medications: He was on Naprosyn 500 mg 1 tablet by mouth 2 times per day daily with food and Prilosec 20 mg DR.

Vital Signs: He weighed s. His blood pressure was 136/83 mmHg and pulse rate was 65 bpm.

Operative Report, signed by M.D., dated .

Preoperative and Postoperative Diagnosis: Complex intraarticular fracture, left distal tibia and fibula, status post open reduction, internal fixation.

Operative Procedure: Complex removal of hardware, left distal tibia and fibula.

Post-Anesthesia Assessment Note, signed by [redacted], dated [redacted]

Vital Signs: The applicant had a blood pressure of 130/79 mmHg and heart rate was 70 bpm.

Surgical Pathology Report, signed by [redacted], dated [redacted]

Specimen: Orthopedic hardware.

Prescription, signed by [redacted], M.D., dated [redacted]

The applicant was prescribed Norco 10/325 mg.

The rest of the report is illegible.

X-rays Surgery Fluoroscopy of the Left Ankle, signed by [redacted], M.D., dated [redacted]

Impression: 1) Status post distal tibia and fibula hardware removal, with 2 screw remnants remaining in the distal tibia. 2) Chronic, healed distal tibia and fibula retrocurvatum fracture deformities. 3) Mild posttraumatic osteoarthritis of the medial superior tibiotalar joint.

Flowsheet, [redacted] Medical Center, dated [redacted]

At 0625 H, the applicant weighed [redacted]. His blood pressure was 136/83 mmHg and pulse rate was 65 bpm.

At 1110 H, his blood pressure was 130/79 mmHg and pulse rate was 77 bpm.

At 1115 H, his blood pressure was 131/72 mmHg and pulse rate was 64 bpm.

At 1130 H, his blood pressure was 117/76 mmHg and pulse rate was 63 bpm.

At 1145 H, his blood pressure was 126/70 mmHg and pulse rate was 77 bpm.

At 1200 H, his blood pressure was 125/68 mmHg and pulse rate was 66 bpm.

At 1215 H, his blood pressure was 121/81 mmHg and pulse rate was 63 bpm.

At 1230 H, his blood pressure was 121/77 mmHg and pulse rate was 68 bpm.

At 1245 H, his blood pressure was 124/83 mmHg and pulse rate was 62 bpm.

At 1300 H, his blood pressure was 125/90 mmHg and pulse rate was 65 bpm.

At 1315 H, his blood pressure was 126/89 mmHg and pulse rate was 66 bpm.

At 1330 H, his blood pressure was 121/72 mmHg and pulse rate was 64 bpm.

At 1345 H, his blood pressure was 119/86 mmHg and pulse rate was 60 bpm.

At 1400 H, his blood pressure was 118/76 mmHg and pulse rate was 62 bpm.

At 1415 H, his blood pressure was 116/82 mmHg and pulse rate was 60 bpm.

At 1430 H, his blood pressure was 131/89 mmHg and pulse rate was 70 bpm.

At 1445 H, his blood pressure was 128/84 mmHg and pulse rate was 60 bpm.

Progress Note, signed by _____, dated _____.

The applicant was not weight bearing in left short leg splint and crutches. He was doing well. He complained of minimal discomfort.

Insurance Workers' Compensation Post-Operative Visit, signed by _____ M.D., dated [illegible]

The applicant was seen for his first postoperative visit.

Interim History: He was 1 week following the complex removal of hardware from the left distal tibia and fibula. He was doing well. He was still taking some pain medication.

Diagnostic Impression: Fracture, left distal tibia and fibula status post hardware removal.

Plan: He was placed into a short-leg CAM Walker. He was instructed to partial protective weightbearing with crutches. He was prescribed outpatient physical therapy. He was instructed to follow-up in 6 weeks.

Progress Note, signed by [illegible] dated [illegible].

The applicant was weight bearing without aid. He complained of ankle swelling.

X-rays of the Left Ankle, signed by [redacted], dated [redacted]

Impression: 1) Mild to moderate retrocurvatum of fractures of distal tibia and fibula status post hardware removal. 2) Mild posttraumatic osteochondral defect of medial axilla of tibial plafond.

Orthopedic Physical Therapy Evaluation, signed by [redacted], dated [redacted]

Primary Diagnosis: Left ankle pain.

Allergies: The applicant is allergic to Betadine.

Medical History: He was status post left hardware removal from the left distal tibia and fibula. He had seen the doctor on [redacted], with cast removal. He had weaned self off off CAM boot. He mentioned that the hardware was damaged with pain and there was a delay in the second surgery due to insurance issues. Initial accident was at work, equipment grabbed his left foot and twisted on [redacted]. He had initial surgery to repair fractures on [redacted].

Medical History: He has a history of shingles.

Pain Assessment: He complained of throbbing left ankle pain rated 5/10 at rest and 8/10 with activity. Naprosyn in the morning/evening alleviated the pain. Walking, sitting and standing exacerbated the pain. The pain was worse in the evening.

Current Lelve of Function: He was currently placed on temporary total disability.

Clinical Assessment: Skilled physical therapy intervention was required to address impairments for decreased pain with activities of daily livings.

Physical Therapy Daily Note, signed by [redacted] dated [redacted]

The applicant underwent physical therapy.

Orthopedic Initial Evaluation of the Primary Treating Physician, signed by M.D., dated .

Employment History: He was employed from to at [redacted] as an order selector.

Current Work Status: He was currently not working.

Occupational History: He started working for [redacted] Inc. and was assigned to [redacted] as an order selector In . He was a full-time employee at the time of the injury. His work entailed picking orders in the warehouse, operating a stand-up forklift and pallet jacks, building and breaking down pallets and loading and unloading merchandise.

Physically, he was required to stand, walk, bend his neck and back, lift, carry, squat, climb, twist his neck and back, repetitively use his hands, do simple grasping, do strong' gripping, reach forward/above/below, push, and pull.

History of Injury: On during the course of employment, he injured his left ankle. He was operating a stand-up forklift when his left foot slipped off the forklift and into a wall, trapping his foot in between the wall and the edge of the forklift. He felt immediate left ankle and foot pain and his coworkers came to his assistance. His supervisor was informed of the accident, the paramedics were called and he was transported to a local hospital by ambulance.

He was examined by the emergency room physician on call. X-rays were obtained, which revealed a fractured left ankle. He was given Morphine injections and the ankle and foot were immobilized in a temporary cast. He was sent home.

On , he was examined by advised the applicant that he needed emergency surgery. The surgery was performed by on . Hardware was inserted.

He continued treating with post surgery and received physical therapy.

He started a course of treatment with a doctor, name unrecalled. He received pain medication and therapy but treated with him for only a short while due to not being satisfied with his progress.

He then started treating with Dr. He was prescribed pain control medication but he did not receive any further treatment.

He subsequently started a course of treatment with examined him and referred him for another MRI of the left ankle. He was advised that he needed another left ankle surgery to remove hardware. On , he underwent left ankle surgery performed by , but not all of the hardware could be removed.

He continued treating with until . He attended 3/12 authorized sessions of physical therapy.

Current Complaints: He complained of intermittent mild right knee pain, with popping. He complained of intermittent moderate left ankle and foot pain, which was aggravated by all weight-bearing activities. He had swelling. The pain was rated 4/10 to 6/10. Before the accident he ran 10 miles a day, biked for an hour a day, and swam 3,000 meters per day.

Current Medications: He was on oral medications, name of medications unrecalled.

Surgical History: He had undergone inguinal hernia repair in

Physical Examination: He weighed

Current Diagnosis: Work-related left distal tibia plafond and distal fibula fracture status post on with delayed union and malangulation of the tibia; status post hardware removal

Authorization for medication and physical therapy program was requested.

Discussion: It was reasonable that he sustained an industrial injury.

He was advised to perform home therapeutic exercises. He was advised to continue with his authorized physical therapy.

Disability Status: He was placed on modified duty. He was precluded from sitting over 30 minutes per hour.

He was instructed to return for re-evaluation on

Physical Therapy Daily Note, signed by [redacted] dated [redacted].

The applicant underwent physical therapy.

Physical Therapy Daily Note, signed by [redacted] dated [redacted]

The applicant underwent physical therapy.

Progress Note, signed by [redacted], dated [redacted]

The applicant was status post complex removal of hardware, left distal tibia and fibula on [redacted] He was weightbearing without aid. He was doing well and improving but did complain of left ankle stiffness and pain. He was active in physical therapy 2 times per week.

Physical Therapy Daily Note, signed by [redacted], dated [redacted]

The applicant underwent physical therapy.

Insurance Workers' Compensation Follow-up Visit, signed by [redacted] M.D., dated [redacted]

The applicant was seen for periodic visit.

Interim History: He was 3-1/2 months following removal of hardware from his left distal tibia and fibula. He was currently attending outpatient physical therapy, was only taking occasional nonsteroidal anti-inflammatories. He had less pain, greater ability to get around. He was no longer using external supports and had not yet returned to work.

Diagnostic Impression: 1) Intra-articular fracture left distal tibia, status post internal fixation. 2) Recent hardware removal. 3) Residual malalignment and mild degenerative osteoarthritis of the left ankle.

Recommendations and Plan: A short-leg Jobst stocking or Sigvaris stocking was requested. CT of the left distal tibia and ankle with 3D reconstructions was requested. He was instructed to remain on temporary total disability.

Physical Therapy Daily Note, signed by , dated

The applicant underwent physical therapy.

Physical Therapy Daily Note, signed by

The applicant underwent physical therapy.

Physical Therapy Daily Note, signed by dated

The applicant underwent physical therapy.

Primary Treating Physician's Orthopedic Re-evaluation, signed by , M.D., dated

The applicant was seen for re-evaluation.

Subjective Complaints: He complained of continued intermittent mild right knee pain. He had intermittent mild left ankle and foot pain, which he rated as 3/10 while at rest. He had been going to physical therapy, which had improved his range of motion and had 3 sessions left. He had been swimming and could not walk up to one mile.

Current Diagnosis: Work-related left distal tibia plafond and distal fibula fracture status post on with delayed union and malangulation of the tibia; status post hardware removal

Treatment Plan: Authorization for additional physical therapy 2 times per week for 4 weeks was requested.

Disability Status: He was placed on modified duty. He was precluded from sitting over 30 minutes per hour.

He was instructed to return for re-evaluation on

Physical Therapy Daily Note, signed by ., dated

The applicant underwent physical therapy.

Physical Therapy Daily Note, signed by dated

The applicant underwent physical therapy.

Physical Therapy Daily Note, signed by , P.T., dated .

The applicant underwent physical therapy.

CT of the Left Ankle, signed by ., dated

Impression: Malunion distal tibial fracture with secondary osteoarthritic change of the tibiotalar joint.

Primary Treating Physician's Orthopedic Re-evaluation, signed by , M.D., dated

The applicant was seen for re-evaluation.

Subjective Complaints: He complained of swelling in the left ankle today due to walking yesterday. He complained of intermittent moderate bilateral ankle pain. He talked to the ankle surgeon about his swelling who ordered a CT for evaluation.

Current Diagnosis: Work-related left distal tibia plafond and distal fibula fracture status post on with delayed union and malangulation of the tibia; status post hardware removal

Treatment Plan: Authorization for additional physical therapy 2 times per week for 4 weeks was requested. He was advised to perform home therapeutic exercises for range of motion and strengthening purposes.

Disability Status: He was placed on modified duty. He was precluded from sitting over 30 minutes per hour.

He was instructed to return for re-evaluation on

Status Report, signed by M.D., dated

Work Status: The applicant was instructed to remain off work.

Disability Status: He was placed on temporary total disability.

Worker's Compensation Follow-up Report, signed by [redacted] M.D., dated [redacted]

The applicant was seen for periodic visit.

Interim History: He was 6-1/2 months following removal of hardware from his left tibia and fibula for a previous intra-articular tibial pilon fracture that occurred in [redacted]. He had a postoperative course of therapy, which had now been completed. He was up ambulatory. He was no longer using external support. He was off pain medicine. He continued to complain of some ankle pain, persistent ankle swelling and some pain in the forefoot. He recently had an outpatient CT scan to further delineate the persistent complaints.

Final Diagnoses: 1) Complex intra-articular fracture left distal tibia status post open reduction and internal fixation. 2) Hardware removal, left tibia and fibula. 3) Malunion left distal tibia with residual articular impaction and articular incongruity.

Recommendations and Plan: Consultation with [redacted] was recommended. He might require an osteotomy or ankle arthroplasty.

Progress Note, signed by [redacted], M.D., dated [redacted]

History of Present Illness: The applicant was seen for evaluation on [redacted] at the foot and ankle Center of Cedars-Sinai Medical Center in Los Angeles for left-sided ankle pain.

Vital Signs: His blood pressure was 142/89 mmHg and heart rate was 63 bpm.

Assessment: 1) Left ankle arthritis. 2) Achilles' tendinopathy.

Treatment Plan: Orthotic and shoe modification was recommended. Anti-inflammatory medications were recommended. Surgery was recommended only after failure of all conservative management.

Orthopedic Consultation, signed by [redacted] M.D., dated [redacted]

History of Present Illness: The applicant sustained an injury in [redacted]. He had open reduction, internal fixation. He had anterior ankle pain from a pilon fracture. The also had posterior Achilles tendon pain. He was using boots.

Assessment: Ankle arthritis.

Plan: Authorization for physical therapy, anti-inflammatory medications and ankle fusion was requested.

Physical Therapy Discharge Summary, signed by _____ ., dated _____

Subjective Assessment: The applicant complained of off/on pain with slight improvements.

Plan: He had slight gains. He stopped physical therapy and wanted to follow-up with his doctor. He had not called back to re-scheduled.

Re-evaluation Report, signed by _____ ., dated _____

The applicant was seen for re-evaluation.

Interim History: He was employed by Singular as a forklift driver.

During the course of his employment on 3, while performing his usual and customary duties at work a fork lift rolled over his left ankle. He developed immediate pain thereafter. He reported the injury to his employer that day. He was examined the following day. Radiographs were obtained revealing 3 fractures of the ankle. A short-leg splint was applied.

He was referred to orthopedic surgeon He subsequently underwent open reduction internal fixation of the left ankle by He underwent 24 sessions of postoperative physical therapy.

On he underwent surgery by for hardware removal, 2 plates and 14 pins. He still had 5 pins.

He was currently not working. He was doing nothing during the day. He could only walk one mile. He had pain over the medial distal leg.

Present Complaints: He complained of minimal pain rated 2/10. He was ambulating with crutches and was wearing a walking boot.

He weighed

Work History: He worked for his employer for 1 year. His physical requirements included standing, driving a fork lift, walking, bending, kneeling, squatting,

sitting, lifting, carrying, pushing and pulling. He last worked for the employer the date of injury.

Surgical History: he had undergone 2 surgeries for his left ankle.

Medications: He was on Hydrocodone and Omeprazole.

Impressions: Status post-industrial injury on , distal tibia and fibula fracture, status post open reduction internal fixation and subsequent hardware removal on (2 weeks ago)

Plan: An additional surgery was requested to correct deformity.

Work Status: He was on temporary total disability.

He was instructed to return for follow-up when necessary.

Medical Report, signed by , M.D., dated

Medical records were provided for review.

Dr. proposed a surgery to correct the deformity remaining after the injury. Dr. considered ankle arthrodesis.

Supplemental Report, signed by M.D., dated

Injection of Lidocaine into the applicant's ankle joint was recommended. If his pain was significantly relieved with the injection, he should be offered an ankle arthrodesis (fusion).

Request for Authorization, signed by M.D., dated

Authorization for surgery was requested.

The report was poorly reproduced.

Panel Qualified Medical Evaluation in Physical Medicine and Rehabilitation, signed by , dated

History of Injury: The applicant was employed with [redacted] and was assigned to work at [redacted] as an r starting back in

As part of the usual and customary duties, he was required to pick orders in the warehouse, operate a standup forklift and pallet jacks, build and breakdown pallets, and load and unload merchandise. On , he was operating a standup forklift when his left foot slipped off the forklift and was trapped between a pallet jack and the wall. He reported immediate left foot and ankle pain and was taken to the local emergency room with paramedics. He was diagnosed with multiple fractures in the distal tibia and fibula as well as a tibial plafond fracture. He was seen by and underwent open reduction and internal fixation of the left ankle distal tibial plafond fracture and distal malleolar fracture with local bone grafting on . He continued to follow up with postoperatively and was provided with pain medications and continued a temporary disability status. He was subsequently referred for physical therapy at the end of . He progressed through physical therapy up through March 2014 and remained temporarily totally disabled.

Around , his care was transferred to . During this time, he was continued with further therapy including chiropractic treatments and medications for pain, which included Norco, Naproxen, and Omeprazole. He remained temporarily totally disabled.

He was subsequently transferred for care tc , a pain management specialist. He was treating with from approximately up until While treating with , he received further physical therapy as well as requested a referral for orthopedic consultation with at i Medical Center. While treating with from to what appeared to be he remained temporarily totally disabled. He was subsequently evaluated by s at Orthopedic Department. ; subsequently, performed hardware removal on the left ankle on .

His care was subsequently transferred tc on advised him to continue with physical therapy and placed him on modified duty status with restrictions of 30 minutes of sitting per hour. He continued to treat with from approximately up to At which time, he was continued on physical therapy, provided medications and placed on modified duty.

He was subsequently seen by at i Medical Center for orthopedic consultation regarding possible further surgery. A CT demonstrated a cyst in the talus and tibia medially. He had retained hardware. There was slight flexion of the articular fracture. His assessment was ankle arthritis and he requested anti-inflammatory medication in the form of Celebrex

and further physical therapy to treat predominantly the soft tissue complaints of the left Achilles. He might require further surgery in the form of ankle fusion.

He was subsequently seen by [redacted] at the [redacted] Orthopedic Institute for what appeared to be a third opinion regarding possible surgery. His report that [redacted] was recommending additional surgery to correct the deformity and that [redacted] was requesting arthrodesis. It was recommended that he should have a Lidocaine injection to the ankle joint and if the pain was significantly relieved with the injection then he should proceed with ankle arthrodesis.

He did initially have some shoulder pain when he was using his crutches. After discontinuing use of the crutches, the shoulder pain subsequently resolved. He has a history of pain in both hands, again predominantly with crutch use from gripping the crutches but since discontinuing the crutches, the hand pain had resolved. He had occasional popping in the finger joints, but no limitation in activity or use of the hands. There was mention of complaints of right knee pain, which again had improved and resolved since improvement of his gait mechanics. Lastly, there was mention intermittent low back pain in the past when his gait was more antalgic but this had also improved and resolved.

Overall, his symptoms had improved since the date of the injury and had about 60% improvement in his left ankle pain after the second surgery for hardware removal, but he continued with residual symptoms involving the left foot and ankle.

He had been unable to return back to his usual and customary duties as a warehouseman and that no modified duty has been made available to him and as such, he had remained on a temporary total disability status since the date of injury to the current date.

Current Complaints: He complained of constant sharp stabbing pain measuring 4/10 in intensity in the distal posterior left leg and ankle. The pain would increase to a level of 6/10 to 7/10 with walking greater than 1 mile and/or standing for greater than 15 minutes. Along with the elevation of pain, increased swelling around the left ankle with walking greater than 1 mile and standing greater than 15 minutes. He was unable to run or jump as he was previously. He had some weakness of the left lower extremity versus the right with prolonged standing and walking. The weakness and swelling limits his ability to walk greater than miles stand for longer than 15 minutes at a time.

Since his date of injury, he gained approximately 50 pounds due to decreased activity level.

He complained of increased sense of frustration and hopelessness as a result of the loss of his ability to return back to recreational activities such as swimming, jogging and parachuting as well as his ability to return to his employment.

Current Medications: He was on Naproxen 2 times per day and Omeprazole 1 by mouth daily.

Diagnoses: 1) Status post left distal tibia, fibula, and tibial plafond' fracture with open reduction and internal fixation on followed by hardware removal on with residual pain, weakness and gait abnormality. 2) Symptoms of depression secondary to loss of function in the left lower extremity and persistent pain.

Causation: It was opined that based on history obtained as well as of medical records, the applicant sustained a specific injury as a result of the trauma sustained on to the distal left leg and ankle.

Disability Status: He was considered temporarily totally disabled from the date of injury, up until when he was returned to modified duty. From through he was considered temporarily partially disabled; however, as no modified duty was provided to him, he was considered administratively temporarily totally disabled during that period of time. If no further surgical intervention was to be performed at this time, he would be considered permanent and stationary and to had reached maximum medical improvement. He was considered permanent and stationary as of

AMA Impairment Rating: Utilizing table 17-8 on page 532, he was given a 7% whole person impairment for plantar flexor weakness, 5% whole person impairment for dorsiflexor/extensor weakness, 2% whole person impairment for invertor weakness and 2% whole person impairment for evertor weakness as he measured grade 4/5 with all the muscle movements. Utilizing the combined values chart or adding impairment ratings provided the same total whole person impairment of 16%. In addition, his pain did increase the burden of his condition slightly and as such, a 3% whole person impairment was added for his pain condition. This equated to a 19% whole person impairment for his clinical condition

Apportionment: Apportionment had been determined taking into consideration Labor Code 4663 and 4664 and the Escobedo and Almaraz-Guzman and Guzman III decisions.

He had no pre-existing pathology with regard to the left distal leg and ankle and no prior impairment as well as no subsequent injuries this area and as such, there was no apportionment indicated in this case. One hundred percent (100%) of his left leg/ankle impairment was due to the specific injury of

Restrictions: He was able to return to modified work at this time and required permanent work restrictions to include no repetitive squatting, or kneeling, no prolonged standing or walking of greater than 15 minutes at a time, no lifting 'and/or carrying greater than 30 pounds, and he should be allowed to alternate sitting and standing as needed for pain and/or swelling of the left ankle.

Vocational Rehabilitation: He would not be able to return back to his usual and customary duties as a warehouseman and, as such was, considered a qualified injured worker and was entitled to vocational rehabilitation and/or supplementary job displacement benefits.

Future Medical Care: Ongoing orthopedic care with a certified foot and ankle specialist was recommended to include provision of medication such as nonsteroidal antiinflammatory medications and either proton pump inhibitors such as Omeprazole or H2 blocker such as Zantac to reduce the risk for possible gastrointestinal complications. Medications such as TCA's i.e. Nortriptyline and/or Cymbalta might be recommended for management of his chronic pain and sensitivity. A trial of use of a Lidocaine patch 5% 1 daily on the ankle to desensitize the incisional scars and increase function was recommended. Laboratory studies on a yearly basis to include a CBC and comprehensive metabolic panel to evaluate for development of any anemia or kidney/liver abnormalities was recommended.

Approximately 16 physical therapy sessions per year to include land-based and/or pool-based physical therapy for treatment of any flareup or aggravation of his current condition was recommended. Therapy might include electrical stimulation for pain management/edema control, soft tissue mobilization, range of motion and therapeutic exercises.

Further surgery was recommended by the foot and ankle orthopedic specialist, then this should be provided to him with appropriate post-operative therapy.

Referral to a pain psychologist for evaluation of his psychological condition with regards to his frustration and symptoms of depression secondary to his chronic pain was recommended.

A provision of 3 to 4 visits with a dietician to review a diet plan and meal plan was recommended.

Evaluation for the use of custom-made orthotics for his feet/ankles given pronation noted was recommended.

That completes the review of records.

Table A - Itemization of reports with blood pressure and weight:

Date of Encounter	Provider	Applicant's Blood Pressure	Applicant's Heart Rate	Hypertensive / DM Medications	HgA1c Value	Weight
	Hospital of	158/75 mmHg (Comment: At 1044 H) 138/86 mmHg (Comment: At 1102 H) 128/82 mmHg (Comment: At 1110 H) 128/79 mmHg (Comment: At 1115 H, upon transfer to ED)	78 bpm (Comment: At 1044 H) 71 bpm (Comment: At 1102 H) 76 bpm (Comment: At 1110 H) 76 (Comment: At 1115 H, upon transfer to ED)			
	y Hospital of	128/79 mmHg	76 bpm			pounds
		128/79 mmHg	76 bpm			pounds
	Hospital of	128/79 mmHg (Comment:	76 bpm			pounds

	Park	At 2319 H)				
	Hospital of n	136/72 mmHg (Comment: At 0055 H) 132/72 mmHg (Comment: At 0132 H) 128/90 mmHg (Comment: At 0242 H) 126/72 mmHg (Comment: At 0333 H) 124/76 mmHg (Comment: At 0409 H)	88 bpm (Comment: At 0055 H) 81 bpm (Comment: At 0132 H) 79 bpm (Comment: At 0242 H) 76 bpm (Comment: At 0333 H) 72 bpm (Comment: At 0409 H)			
	M.D.					pounds
	Center	125/84 mmHg	56 bpm			pounds
	M.D.	128/83 mmHg	63 bpm			pounds
	M.D.					pounds
	M.D.		59 bpm			
		136/83 mmHg	65 bpm			pounds

	D.O.					
	[redacted], D.O.	130/79 mmHg	70 bpm			
[redacted]	[redacted] Medical Center	136/83 mmHg (Comment: At 0625 H) 130/79 mmHg (Comment: At 1110 H) 131/72 mmHg (Comment: At 1115 H) 117/76 mmHg (Comment: At 1130 H) 126/70 mmHg (Comment: At 1145 H) 125/68 mmHg (Comment: At 1200 H) 121/81 mmHg (Comment: At 1215 H) 124/77 mmHg (Comment:	65 bpm (Comment: At 0625 H) 77 bpm (Comment: At 1110 H) 64 bpm (Comment: At 1115 H) 63 bpm (Comment: At 1130 H) 77 bpm (Comment: At 1145 H) 66 bpm (Comment: At 1200 H) 63 bpm (Comment: At 1215 H) 68 bpm (Comment: At 1230 H) 62 bpm (Comment: At 1245 H) 65 bpm (Comment:			pounds

		At 1230 H) 124/83 mmHg (Comment: At 1245 H) 125/90 mmHg (Comment: At 1300 H) 126/89 mmHg (Comment: At 1315 H) 121/72 mmHg (Comment: At 1330 H) 119/86 mmHg (Comment: At 1345 H) 118/76 mmHg (Comment: At 1400 H) 116/82 mmHg (Comment: At 1415 H) 131/89 mmHg (Comment: At 1430 H) 128/84	At 1300 H) 66 bpm (Comment: At 1315 H) 64 bpm (Comment: At 1330 H) 60 bpm (Comment: At 1345 H) 62 bpm (Comment: At 1400 H) 60 bpm (Comment: At 1415 H) 70 bpm (Comment: At 1430 H) 60 bpm (Comment: At 1445 H)			

		mmHg (Comment: At 1445 H)				
	M.D.					pounds
	M.D.	142/89 mmHg	63 bpm			
	M.D.					pounds

WORK HISTORY PRIOR TO EMPLOYMENT WITH [redacted]

He worked at a company called [redacted] for one year, doing similar warehouse type work and prior to that he worked in a warehouse for [redacted] where he did inventory and distribution. He worked there for six years. At neither of these two previous employments, did he suffer any work-related injury or illness.

HISTORY OF PRESENT ILLNESS

On , the patient states he was driving a forklift when his left foot slipped off the vehicle and became trapped between it and the wall. He suffered immediate pain in the left lower leg and ankle area. He was helped by fellow employees and the paramedics were called. He was subsequently taken to a hospital where he was found to have a fracture of the distal left tibia and fibula. He was placed in a brace and sent home. The following day, he was advised to see who evaluated him with x-rays and examination. Two days later, he was apparently operated upon by at which time he had an open reduction and internal fixation of the fracture. He states that following the surgery he had three months of physical therapy. However, he continued to have pain and states that the pain actually increased after the surgery. He subsequently was seen by a number of different doctors, including In spite of referrals to these doctors, his pain continued. He states that in he went down into and saw a private doctor there who told him that there was a problem with the internal fixation screws and plates and that he needed further surgery. He subsequently saw a concurred that there was a need for removal of the broken hardware and this was accomplished; however, the pain has continued in the left lower leg and ankle area.

During the course of his convalescence from the original surgery and the second surgery, the patient had to use crutches since he was initially non-weightbearing. He states that as a result of the crutch use, he developed pain in his shoulders and hands. The patient states that although he did develop these symptoms, that there apparently was "no attention paid to his other aches and pains in the shoulders, hands, and the right foot secondary to the need to place more weight on the right foot."

More recently, the patient was seen again in [redacted] and he was told that he needed further surgery. He states that he has seen [redacted] and two other doctors and apparently it has been agreed that he does need a third surgery. This apparently was decided approximately one year ago.

PRESENT COMPLAINTS

Presently, the patient is complaining of pain in the left leg, in the foot and ankle. He is also complaining of pain in the right foot because of the need to put more weight on it. He notes cracking sensations in his hands and his shoulders and is now complaining of pain in his back. He also notes that he has "lost" 20 pounds (although he initially gained 20 pounds after his injury).. He denies any problems with chest pains or shortness of breath and states that he is now able to walk on level ground up to one mile, but with pain. He notes he is also able to go up 30 or 40 steps, also with pain. He states that once or twice a week, he will note some shortness of breath when lying in bed. Also, once or twice a week, he will awaken from his sleep, short of breath. He states he does snore and his wife has stated that he has episodes of stopping breathing and she has had to shake him. He is unclear and unsure as to how long he has actually been having those symptoms. He notes nocturia of one or two times per night. He has swelling in the left foot. He has not noticed any palpitations but thinks he may have had some after his surgery. He has not fainted and has no history of heart disease. He denies any numbness or tingling but later stated to me that he had some numbness in the area of his left lower leg surgery. He denies any problems with circulation. He does not have a history of high blood pressure or diabetes.

PAST MEDICAL HISTORY

He denies any childhood illnesses or injuries.

He did have a right inguinal hernia repair in

He denies any history of allergy to medication.

He presently takes Naprosyn and methadone.

The patient has only had three surgeries, one for his hernia and the two on his left ankle and lower leg.

He has been hospitalized only for his two lower leg surgeries.

FAMILY HISTORY

His father is age and his mother is age They are both living and well and in good health with no history of diabetes, high blood pressure or other medical problems. He has one brother, three sisters, and two children, all of whom are living and well.

SOCIAL AND PERSONAL HISTORY

The patient was born in [redacted] and presently resides at [redacted]. He obtained a Bachelor's degree in He is married and denies the use of tobacco, alcohol, and illicit drugs.

REVIEW OF SYSTEMS

HEENT: The patient denies any symptoms.

Respiratory: He denies any cough, fever, chills, or sweats, but he does note some shortness of breath when he walks a mile.

Cardiovascular: He does not have any chest pain.

Gastrointestinal: He denies any nausea, vomiting, diarrhea, changes in bowel habits, indigestion or blood in the stool.

Genitourinary: He denies any urgency, frequency, dysuria, pyuria, or hematuria.

Musculoskeletal: He notes pain in his shoulders, back, and hands and notes cracking sensation in his hands and shoulders and of course he has the pain on the left lower leg and on the right foot.

Neurologic: He does complain of numbness and tingling in the area of his left lower leg surgery.

EFFECTS UPON ACTIVITIES OF DAILY LIVING

When asked directly if he had any problem with self-care and personal hygiene, the patient stated that he did not. When asked directly if he had any problems with communication, he stated to me he did not. When asked regarding his physical activity, he noted that he was able to stand but less than two hours, between one or two hours only. He did not have any particular problem sitting or reclining. When asked whether he had any problem with hearing, seeing, tasting, smelling, or tactile feeling, he stated he did not. When questioned regarding nonspecialized hand functions, he stated that he felt clumsy but did not have any specific difficulty other than the cracking sensations he would note in his hands and fingers. He was able to drive a car and ride in a car without any significant problem and he stated that his sexual function was normal. He did note that his sleep was irregular and that he awakens three to four times per night. He is unsure whether he awoke because of his "situation" or because of pain or because of both. He notes that his sleep was not restful. It should be noted that he does have a history of snoring and stopping breathing at night. His Epworth Sleepiness Scale is normal with a score of 7/24 and his Piper Fatigue Scale averages 5 (mild fatigue).

PHYSICAL EXAMINATION

The patient is a well-developed, well-nourished male in no acute distress. He is able to walk but favors his left leg with a slight limp. His blood pressure is 136/82, the pulse is 61. He is feet inches tall and weighs pounds. At the time of his injury, it is noted in the medical records that his weight was pounds. He does appear his stated age but he appears that he was somewhat angry about his condition and the course of his treatmen and the suppsed lack follow through on his continued pain.

HEENT: This was a normal examination with no abnormality noted in the ears, the pharynx, and the neck. There was no thyromegaly, lymphadenopathy, nor carotid bruits. He had a full range of motion of the neck.

Chest: Normal exam.

Lungs: Clear to exam with no wheezes, rales, or rhonchi noted.

Heart: Normal exam with no evidence of cardiomegaly, murmurs, or extra sounds. The heart tones were normal.

Abdomen: Normal exam with no enlargement of the liver, kidneys, or spleen. There were no masses, tenderness, or bruits noted.

Back: The patient claimed to have some pain in the lower back but he was able to flex forward with his fingertips missing the floor by approximately six inches.

Extremities: The upper extremities reveal no evidence of clubbing, cyanosis, or edema. There was no evidence of any acute or chronic synovitis in any of the joints on the fingers, wrists, elbows, or shoulders. There were some crepitus sensations noted with range of motion of the shoulders but range of motion of the shoulders, elbows, hands, wrists, fingers was all normal. In the lower extremities, there was no clubbing, cyanosis, or edema. The peripheral pulses were intact. There were swelling and deformity noted of the left lower leg just above the ankle with some lateral deviation of the ankle and foot area. There was also a 6-inch scar noted. There was tenderness to the area of the deformity. The range of motion in the left ankle was decreased as compared to the right. However, the range of motion of the hips and knees was normal.

Neurologic: There was decreased sensation and tingling in the left foot. However, the reflexes were 2+ bilaterally in both upper and lower extremities and there were no Babinski's present.

Skin: Clear to exam.

Lymphatics: There was no unusual lymphadenopathy.

LABORATORY RESULTS

Stool examination was positive for antigen indicating active infestation.

IMPRESSION

1. History of work-related injury,
2. Possible sleep apnea syndrome.
3. History of alleged internal, psych, pain, and weight gain problems.

DISCUSSION

This year-old male worked as a selector for [redacted] He suffered a work-related injury on , when while driving a forklift truck, his left lower leg was caught between the forklift and a wall and his lower leg was crushed and he sustained a fracture of his distal tibia and fibula. He was seen by the Paramedics and subsequently taken to a local hospital where he was given a splint. He was then referred to an orthopedic surgeon, who performed an open reduction and internal fixation of his left ankle fracture on Subsequently, the patient received physical

therapy treatments. However, he continued to have rather significant pain in the left lower leg. It was required that he do nonweightbearing for a number of months and as a result he had to use crutches in order to ambulate. As a result of the crutch use, he developed pain in his arm pits and shoulder area as well as in his wrists. Medical records, however, reveal that his pain in the shoulders and arm pits actually resolved. The patient also secondarily sustained a second operation because of continued pain and he was seen by a number of other orthopedic doctors who noted that the hardware in the leg was broken and needed to be removed. Finally he saw a who performed surgery on to remove the hardware in his left lower leg since it was felt to be causing continued pain. Subsequently, the patient has continued to have pain in the left lower leg but has slowly recuperated and is now able to walk one mile without the use of a cane or crutch. Medical records reveal that the patient did tell his orthopedic doctors that his shoulder and wrist pains had resolved, but at the time that I saw the patient, he was again complaining of pain in those areas and described it as a cracking sensation in the hands, wrists, and shoulders. In addition, he continued to complain of pain in the left lower leg and he also stated there was pain in his right leg because of having to put more stress on it. He also claimed to have pain in his back as a result of his slightly abnormal gait favoring his left leg.

The patient's work-related injury was accepted. However, he has amended his claim to include internal, psyche, weight gain, and pain.

With regard to the patient's complaint of weight gain, it is noted in the medical records at the time of his injury, he weighed pounds and presently he weighs pounds. This is actually less than a 5% weight increase. During the four years that he was disabled, the patient's weight actually went up to pounds but there was no evidence that he had a 50-pound weight increase as noted by in his report on It is probable that the patient did have a weight increase secondary to his decreased activity but this seems to have resolved almost completely and I do not believe that there was any significant weight increase causing any disability.

With regard to the patient's complaint of pain, he certainly has continued pain in his left lower extremity and he complains of the other pains in the right lower extremity, the shoulders, the wrists, and these pains did exist during and after the use of his crutches. He did, however, according to the medical records tell some of his doctors that his pains had resolved. Since these pains seemed to have continued, I feel that they should be evaluated by the orthopedic specialist since I find no evidence of any significant orthopedic abnormality other than the residual abnormality and angulation of the distal left lower leg with it's subsequent swelling. These pains of which the patient complained secondary to

the use of his crutches were previously diagnosed as sprains and strains of the shoulders and wrists and I feel therefore orthopedic evaluation is in order.

With regard to the patient's complaints of internal problems, during my examination and taking of the history and physical examination, he did not complain of any internal problems. The medical records reveal one mention of gastroesophageal reflux disease as noted in the history and physical by on When asked specifically by me whether he had any gastrointestinal complaints, the patient stated "no". Additionally, he is not taking any medications at the present time for gastrointestinal complaints. It is certainly possible that the patient has had episodes of gastroesophageal reflux disease since as noted in an article entitiled "GERD" by the Mayo clinic staff that "both acid reflux and heartburn" are common digestive conditions that many people experience from time to time. When these signs and symptoms occur at least twice each week or interfere with your daily life or when your doctor can see damage on your esophagus, you may be diagnosed with GERD. This possible complication is noted to be a side effect of a medication that the patient has taken and is still taking and that is namely Naprosyn, a nonsteroidal anti-inflammatory drug. In an article by entitled "Nonselective NSAIDs: Overview of Adverse Effects" he notes that gastrointestinal effects of nonsteroidal anti-inflammatory drugs are potentially dyspepsia, peptic ulcer disease, and bleeding. Then another article by Mark Feldman entitled "NSAIDs (including aspirin) Pathogenesis of gastrointestinal toxicity" he notes that topical epithelial injury by many NSAIDs does not appear to be of prime importance of the pathogenesis or clinically important end points (symptomatic ulcers). The pathogenesis of symptomatic peptic ulcer disease caused by repeated exposure to NSAIDs is mainly a consequence of systemic inhibition of gastrointestinal mucosal cyclo-oxygenase (COX) activity. It is medically probable that the patient could have gastrointestinal side effects from his nonsteroidal anti-inflammatory drugs and there is mention in the medical records of a history of gastroesophageal reflux disease. However, at the time of my examination, the patient had no complaints of gastrointestinal symptoms. His gastrointestinal complaints would certainly qualify as a impairment. The patient does have evidence of H. Pylori in his intestinal tract and it apparently has not been treated and would be a non-industrial factor in possible GERD. However, using Table 6-3 on page 121 of the AMA Guides, he would fall into class I with a 0-9% impairment of the whole person. This would include symptoms or signs of upper digestive tract disease and continuous treatment not required and maintenance of weight at a desirable level. At the present time, I feel the patient has reached maximum medical improvement with his gastroesophageal reflux disease and I feel that he reached that certainly at the time of my evaluation. Objective factors of disability are none and at present the subjective factors of disability are none. Thus using Table 6-3, he would have a 0% impairment at the present time.

With regard to the psychiatric complaints, I will leave that to the psychiatric specialist for evaluation and adjudication.

At the present time, because of his musculoskeletal complaints, I feel that orthopedic reevaluation should be considered. However, because of these complaints, using Chapter 18 regarding determination of pain, impairment, I feel that he is entitled to a 3% impairment add on because of his continuing complaints in the shoulders and wrists without any objective findings.

Thank you for the opportunity of evaluating this patient.

MEDICAL RESEARCH

Solomon, D. MD, MPH. "Nonselective NSAIDs: Overview of advese effects". Up To Date. Dec. 15. 2015. Pp 1-21

Mayo Clinic Staff. "GERD" www.mayoclinic.org/diseases. March 25, 2015. Pp 1-9

Feldman, M. MD, MACP, AGAF, FACG. "NSAIDs (including aspirin): Paathogenesis of gastroduodenal toxicity" pp 1-14

SPECIAL COMMENTARY

The above responses and opinions are based on reasonable medical probabilities, as viewed from the perspective of available documentation and information submitted to this examiner, including the applicant's direct anamnesis.

I, Robert Fisher, M.D., Q.M.E., formulated all conclusions and opinions.

Thank you for the opportunity of serving as Qualified Medical Examiner, in the specialty of Internal Medicine, for this most interesting case and condition.

Sincerely,

Robert Fisher, M.D., Q.M.E.
Diplomate, American Board of Internal Medicine

Attachments:

1. Appendix A: Declaration
2. Appendix B: Medical Research

APPENDIX A – DECLARATION

Pursuant to AB 1300, LC Sec. 5703, I have not violated Labor Code section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

DATE OF REPORT: January

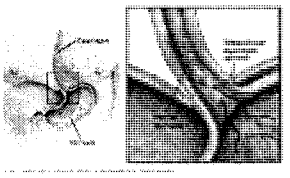
Dated this day of January , at

Robert Fisher, M.D., Q.M.E.
Diplomate, American Board of Internal Medicine

Gastroesophageal reflux disease (GERD)

Overview

Gastroesophageal reflux disease (GERD) when stomach acid frequently flows back into the tube connecting your mouth and stomach (esophagus). This backwash (acid reflux) can irritate the lining of your esophagus.



How heartburn and GERD occur

Many people experience acid reflux from time to time. GERD is mild acid reflux that occurs at least twice a week, or moderate to severe acid reflux that occurs at least once a week.

Most people can manage the discomfort of GERD with lifestyle changes and over-the-counter medications. But some people with GERD may need stronger medications or surgery to ease symptoms.

Symptoms

Common signs and symptoms of GERD include:

- A burning sensation in your chest (heartburn), usually after eating, which might be worse at night

- Chest pain
- Difficulty swallowing
- Regurgitation of food or sour liquid
- Sensation of a lump in your throat

If you have nighttime acid reflux, you might also experience:

- Chronic cough
- Laryngitis
- New or worsening asthma
- Disrupted sleep

When to see a doctor

Seek immediate medical care if you have chest pain, especially if you also have shortness of breath, or jaw or arm pain. These may be signs and symptoms of a heart attack.

Make an appointment with your doctor if you:

- Experience severe or frequent GERD symptoms
- Take over-the-counter medications for heartburn more than twice a week

Request an Appointment at Mayo Clinic

Causes

GERD is caused by frequent acid reflux.

When you swallow, a circular band of muscle around the bottom of your esophagus (lower esophageal sphincter) relaxes to allow food and liquid to flow into your stomach. Then the sphincter closes again.

If the sphincter relaxes abnormally or weakens, stomach acid can flow back up into your esophagus. This constant backwash of acid irritates the lining of your esophagus, often causing it to become inflamed.

Risk factors

Conditions that can increase your risk of GERD include:

- Obesity
- Bulging of the top of the stomach up into the diaphragm (hiatal hernia)
- Pregnancy
- Connective tissue disorders, such as scleroderma
- Delayed stomach emptying

Factors that can aggravate acid reflux include:

- Smoking
- Eating large meals or eating late at night
- Eating certain foods (triggers) such as fatty or fried foods
- Drinking certain beverages, such as alcohol or coffee
- Taking certain medications, such as aspirin

Complications

Over time, chronic inflammation in your esophagus can cause:

- **Narrowing of the esophagus (esophageal stricture).** Damage to the lower esophagus from stomach acid causes scar tissue to form. The scar tissue narrows the food pathway, leading to problems with swallowing.
- **An open sore in the esophagus (esophageal ulcer).** Stomach acid can wear away tissue in the esophagus, causing an open sore to form. An esophageal ulcer can bleed, cause pain and make swallowing difficult.
- **Precancerous changes to the esophagus (Barrett's esophagus).** Damage from acid can cause changes in

the tissue lining the lower esophagus. These changes are associated with an increased risk of esophageal cancer.

By Mayo Clinic Staff

Gastroesophageal reflux disease (GERD) care at Mayo Clinic

Request an Appointment at Mayo Clinic

Diagnosis
treatment

Share on: Facebook Twitter Print Nov. 01, 2017

References

Related

GERD: Can certain medications increase severity?

What causes laryngospasm?

Opera Star's Surgery

Heartburn medicines and B-12 deficiency

Quit-smoking strategies

Weight-loss strategies

Counting calories

Fundoplication

Asthma and acid reflux

Relaxation techniques

Breast-feeding and medications

Upper endoscopy

Needle biopsy

X-ray

Cough

Gastroesophageal reflux disease (GERD)

Topic Outline

NSAIDs (including aspirin): Pathogenesis of gastroduodenal toxicity

Author	Section Editor	Deputy Editor
Mark Feldman, MD, MACP, AGAF, FACG	J Thomas Lamont, MD	Shilpa Grover, MD, MPH, AGAF

INTRODUCTION

Nonsteroidal anti-inflammatory drugs (NSAIDs) are in use throughout the world (table 1). NSAIDs are popular because of their versatile effectiveness as analgesics, antipyretics, and anti-inflammatory agents. Aspirin is also used in low doses as an anti-platelet agent. Unfortunately, aspirin (even in very low doses) and other NSAIDs can injure the gastric and duodenal mucosa, with considerable morbidity and mortality.

The pathogenesis and some clinical aspects of gastroduodenal toxicity attributed to the use of NSAIDs and aspirin will be reviewed here. Other topics, such as other side effects, including injury to the small and large intestine, recommendations for the prevention and treatment of NSAID-induced gastroduodenal injury, and an overview of selective COX-2 inhibitors are discussed elsewhere. (See "NSAIDs: Adverse effects on the distal small bowel and colon" and "Nonselective NSAIDs: Overview of adverse effects" and "NSAIDs (including aspirin): Primary prevention of gastroduodenal toxicity" and "Overview of selective COX-2 inhibitors".)

SYSTEMIC VERSUS TOPICAL EFFECTS

Aspirin and many other nonsteroidal anti-inflammatory drugs (NSAIDs), (eg, ibuprofen, naproxen, indomethacin, and ketorolac) are carboxylic acids [1]. Their pKa values range from 3.50 (aspirin) to 4.85 (ibuprofen). As such, they are not ionized at the acidic pH found in the gastric lumen and thus can be absorbed across the gastric mucosa. Once these drugs move from the acidic environment of the gastric lumen into the pH–neutral mucosa, the drugs ionize and are trapped temporarily in epithelial cells where it may damage these cells.

However, this "topical" epithelial injury by many NSAIDs does not appear to be of prime importance in the pathogenesis of clinically important endpoints (symptomatic

Related articles

- Patient education: Nonsteroidal antiinflammatory drugs (NSAIDs) (Beyond the Basics)
- Aspirin in the primary prevention of cardiovascular disease and cancer
- NSAIDs (including aspirin): Primary prevention of gastroduodenal toxicity
- NSAIDs: Adverse effects on the distal small bowel and colon
- Nonselective NSAIDs: Overview of adverse effects
- Overview of hemostasis
- Overview of selective COX-2 inhibitors

ulcers). The pathogenesis of symptomatic peptic ulcer disease caused by repeated exposure to NSAIDs is mainly a consequence of systemic (post-absorptive) inhibition of gastrointestinal mucosal cyclo-oxygenase (COX) activity. Even intravenous or intramuscular administration of aspirin or NSAIDs can cause gastric or duodenal ulcers in animals and humans [2-5].

THE CENTRAL PROTECTIVE ROLE OF CYCLO-OXYGENASE PRODUCTS (PROSTAGLANDINS)

Cyclo-oxygenase (COX), the rate-limiting enzyme in prostaglandin (PG) synthesis, converts the unsaturated fatty acid arachidonic acid (C20:4) (derived from phospholipids in cell membranes) into PGG2 and then to PGH2 (figure 1). The gastric and duodenal mucosa proceed to convert PGH2 to various prostanoids (prostaglandins and thromboxane A2). PGs such as PGE2 protect the mucosal lining from injury by luminal acid-pepsin.

Literature review current through: Dec 2017. | **This topic last updated:** Nov 28, 2017.

References

▲ Top

1. Flower RJ. The development of COX2 inhibitors. Nat Rev Drug Discov 2003; 2:179.

Related Searches

- Celecoxib
- Cyclooxygenase 2
- Cyclooxygenase 2 inhibitors
- Nonsteroidal antiinflammatory drugs
- Valdecoxib
- Analgesics
- Aspirin
- Nonsteroidal antiinflammatory drug induced bleeding

2. van Oijen MG, Dieleman JP, Laheij RJ, et al. Peptic ulcerations are related to systemic rather than local effects of low-dose aspirin. Clin Gastroenterol Hepatol 2008; 6:309.
3. Hansen DG, Aures D, Grossman MI. Histamine augments gastric ulceration produced by intravenous aspirin in cats. Gastroenterology 1978; 74:540.
4. Estes LL, Fuhs DW, Heaton AH, Butwinick CS. Gastric ulcer perforation associated with the use of injectable ketorolac. Ann Pharmacother 1993; 27:42.
5. Wolfe PA, Polhamus CD, Kubik C, et al. Giant duodenal ulcers associated with the postoperative use of ketorolac: report of three cases. Am J Gastroenterol 1994; 89:1110.
6. Cryer B, Feldman M. Cyclooxygenase-1 and cyclooxygenase-2 selectivity of widely used nonsteroidal anti-inflammatory drugs. Am J Med 1998; 104:413.
7. Jick H. Effects of aspirin and acetaminophen in gastrointestinal hemorrhage. Results from the Boston Collaborative Drug Surveillance Program. Arch Intern Med 1981; 141:316.
8. Blot WJ, McLaughlin JK. Over the counter non-steroidal anti-inflammatory drugs and risk of gastrointestinal bleeding. J Epidemiol Biostat 2000; 5:137.
9. Lanza FL, Codispoti JR, Nelson EB. An endoscopic comparison of gastroduodenal injury with over-the-counter doses of ketoprofen and acetaminophen. Am J Gastroenterol 1998; 93:1051.
10. Yang M, Wang HT, Zhao M, et al. Network Meta-Analysis Comparing Relatively Selective COX-2 Inhibitors Versus Coxibs for the Prevention of NSAID-Induced Gastrointestinal Injury. Medicine (Baltimore) 2015; 94:e1592.
11. Robert A, Nezamis JE, Lancaster C, Hanchar AJ. Cytoprotection by prostaglandins in rats. Prevention of gastric necrosis produced by alcohol, HCl, NaOH, hypertonic NaCl, and thermal injury. Gastroenterology 1979; 77:433.
12. Redfern S, Lee E, Feldman M. Effect of immunization with prostaglandin metabolites on gastroduodenal ulceration. Am J Physiol Gastrointest Liver Physiol 1988; 255:G723.
13. Wallace JL, Miller MJ. Nitric oxide in mucosal defense: a little goes a long way. Gastroenterology 2000; 119:512.
14. Whittle BJ, Lopez-Belmonte J, Moncada S. Regulation of gastric mucosal integrity by endogenous nitric oxide: interactions with prostanoids and sensory neuropeptides in the rat. Br J Pharmacol 1990; 99:607.
15. Whittle BJ, Lopez-Belmonte J. Actions and interactions of endothelins, prostacyclin and nitric oxide in the gastric mucosa. J Physiol Pharmacol 1993; 44:91.
16. Takeuchi K, Yasuhiro T, Asada Y, Sugawa Y. Role of nitric oxide in pathogenesis of aspirin-induced gastric mucosal damage in rats. Digestion 1998; 59:298.
17. Jiménez D, Martin MJ, Pozo D, et al. Mechanisms involved in protection afforded by L-arginine in ibuprofen-induced gastric damage: role of nitric oxide and prostaglandins. Dig Dis Sci 2002; 47:44.

18. Wallace JL, Reuter B, Cicala C, et al. Novel nonsteroidal anti-inflammatory drug derivatives with markedly reduced ulcerogenic properties in the rat. Gastroenterology 1994; 107:173.

19. Kodela R, Chattopadhyay M, Velázquez-Martínez CA, Kashfi K. NOSH-aspirin (NBS-1120), a novel nitric oxide- and hydrogen sulfide-releasing hybrid has enhanced chemo-preventive properties compared to aspirin, is gastrointestinal safe with all the classic therapeutic indications. Biochem Pharmacol 2015; 98:564.

20. Horie-Sakata K, Shimada T, Hiraishi H, Terano A. Role of cyclooxygenase 2 in hepatocyte growth factor-mediated gastric epithelial restitution. J Clin Gastroenterol 1998; 27 Suppl 1:S40.

21. Cheng Y, Lin J, Liu J, et al. Decreased vascular endothelial growth factor expression is associated with cell apoptosis in low-dose aspirin-induced gastric mucosal injury. Am J Med Sci 2015; 349:110.

22. [redacted] C, Barrachina MD, Vallecillo-[redacted] J, et al. Aspirin-induced gastrointestinal damage is associated with an inhibition of epithelial cell autophagy. J Gastroenterol 2016; 51:691.

23. Cryer B, Feldman M. Effects of very low dose daily, long-term aspirin therapy on gastric, duodenal, and rectal prostaglandin levels and on mucosal injury in healthy humans. Gastroenterology 1999; 117:17.

24. Farrell B, Godwin J, Richards S, Warlow C. The United Kingdom transient ischaemic attack (UK-TIA) aspirin trial: final results. J Neurol Neurosurg Psychiatry 1991; 54:1044.

25. Weil J, Colin-Jones D, Langman M, et al. Prophylactic aspirin and risk of peptic ulcer bleeding. BMJ 1995; 310:827.

26. Feldman M, Shewmake K, Cryer B. Time course inhibition of gastric and platelet COX activity by acetylsalicylic acid in humans. Am J Physiol Gastrointest Liver Physiol 2000; 279:G1113.

27. Fiorucci S, de Lima OM Jr, Mencarelli A, et al. Cyclooxygenase-2-derived lipoxin A4 increases gastric resistance to aspirin-induced damage. Gastroenterology 2002; 123:1598.

28. Silverstein FE, Faich G, Goldstein JL, et al. Gastrointestinal toxicity with celecoxib vs nonsteroidal anti-inflammatory drugs for osteoarthritis and rheumatoid arthritis: the CLASS study: A randomized controlled trial. Celecoxib Long-term Arthritis Safety Study. JAMA 2000; 284:1247.

29. Steering Committee of the Physicians' Health Study Research Group. Final report on the aspirin component of the ongoing Physicians' Health Study. N Engl J Med 1989; 321:129.

30. Kato K, Chen MC, Nguyen M, et al. Effects of growth factors and trefoil peptides on migration and replication in primary oxyntic cultures. Am J Physiol 1999; 276:G1105.

31. Babyatsky MW, deBeaumont M, Thim L, Podolsky DK. Oral trefoil peptides protect against ethanol- and indomethacin-induced gastric injury in rats. Gastroenterology 1996; 110:489.

32. Kim JG, Graham DY. Helicobacter pylori infection and development of gastric or duodenal ulcer in arthritic patients receiving chronic NSAID therapy. The

Misoprostol Study Group. Am J Gastroenterol 1994; 89:203.

33. Thillainayagam AV, Tabaqchali S, Warrington SJ, Farthing MJ. Interrelationships between Helicobacter pylori infection, nonsteroidal antiinflammatory drugs and gastroduodenal disease. A prospective study in healthy volunteers. Dig Dis Sci 1994; 39:1085.
34. Loeb DS, Talley NJ, Ahlquist DA, et al. Long-term nonsteroidal anti-inflammatory drug use and gastroduodenal injury: the role of Helicobacter pylori. Gastroenterology 1992; 102:1899.
35. Gubbins GP, Schubert TT, Attanasio F, et al. Helicobacter pylori seroprevalence in patients with rheumatoid arthritis: effect of nonsteroidal anti-inflammatory drugs and gold compounds. Am J Med 1992; 93:412.
36. Chan FK, Sung JJ, Chung SC, et al. Randomised trial of eradication of Helicobacter pylori before non-steroidal anti-inflammatory drug therapy to prevent peptic ulcers. Lancet 1997; 350:975.
37. Chan FK, To KF, Wu JC, et al. Eradication of Helicobacter pylori and risk of peptic ulcers in patients starting long-term treatment with non-steroidal anti-inflammatory drugs: a randomised trial. Lancet 2002; 359:9.
38. Hawkey CJ, Tulassay Z, Szczepanski L, et al. Randomised controlled trial of Helicobacter pylori eradication in patients on non-steroidal anti-inflammatory drugs: HELP NSAIDs study. Helicobacter Eradication for Lesion Prevention. Lancet 1998; 352:1016.
39. Hawkey CJ. Risk of ulcer bleeding in patients infected with Helicobacter pylori taking non-steroidal anti-inflammatory drugs. Gut 2000; 46:310.
40. Papatheodoridis GV, Papadelli D, Cholongitas E, et al. Effect of helicobacter pylori infection on the risk of upper gastrointestinal bleeding in users of nonsteroidal anti-inflammatory drugs. Am J Med 2004; 116:601.
41. Huang JQ, Sridhar S, Hunt RH. Role of Helicobacter pylori infection and non-steroidal anti-inflammatory drugs in peptic-ulcer disease: a meta-analysis. Lancet 2002; 359:14.
42. Papatheodoridis GV, Sougioultzis S, Archimandritis AJ. Effects of Helicobacter pylori and nonsteroidal anti-inflammatory drugs on peptic ulcer disease: a systematic review. Clin Gastroenterol Hepatol 2006; 4:130.
43. Labenz J, Blum AL, Bolten WW, et al. Primary prevention of diclofenac associated ulcers and dyspepsia by omeprazole or triple therapy in Helicobacter pylori positive patients: a randomised, double blind, placebo controlled, clinical trial. Gut 2002; 51:329.
44. Savage RL, Moller PW, Ballantyne CL, Wells JE. Variation in the risk of peptic ulcer complications with nonsteroidal antiinflammatory drug therapy. Arthritis Rheum 1993; 36:84.
45. Langman MJ, Weil J, Wainwright P, et al. Risks of bleeding peptic ulcer associated with individual non-steroidal anti-inflammatory drugs. Lancet 1994; 343:1075.
46. Griffin MR, Piper JM, Daugherty JR, et al.

Nonsteroidal anti-inflammatory drug use and increased risk for peptic ulcer disease in elderly persons. Ann Intern Med 1991; 114:257.

47. Gabriel SE, Jaakkimainen L, Bombardier C. Risk for serious gastrointestinal complications related to use of nonsteroidal anti-inflammatory drugs. A meta-analysis. Ann Intern Med 1991; 115:787.
48. García Rodríguez LA, Jick H. Risk of upper gastrointestinal bleeding and perforation associated with individual non-steroidal anti-inflammatory drugs. Lancet 1994; 343:769.
49. Shorr RI, Ray WA, Daugherty JR, Griffin MR. Concurrent use of nonsteroidal anti-inflammatory drugs and oral anticoagulants places elderly persons at high risk for hemorrhagic peptic ulcer disease. Arch Intern Med 1993; 153:1665.
50. Slattery J, Warlow CP, Shorrock CJ, Langman MJ. Risks of gastrointestinal bleeding during secondary prevention of vascular events with aspirin--analysis of gastrointestinal bleeding during the UK-TIA trial. Gut 1995; 37:509.
51. Allison MC, Howatson AG, Torrance CJ, et al. Gastrointestinal damage associated with the use of nonsteroidal antiinflammatory drugs. N Engl J Med 1992; 327:749.
52. Naschitz JE, Yeshurun D, Odeh M, et al. Overt gastrointestinal bleeding in the course of chronic low-dose aspirin administration for secondary prevention of arterial occlusive disease. Am J Gastroenterol 1990; 85:408.
53. Carson JL, Strom BL, Morse ML, et al. The relative gastrointestinal toxicity of the nonsteroidal anti-inflammatory drugs. Arch Intern Med 1987; 147:1054.
54. Fries JF, Williams CA, Bloch DA, Michel BA. Nonsteroidal anti-inflammatory drug-associated gastropathy: incidence and risk factor models. Am J Med 1991; 91:213.
55. Griffin MR, Ray WA, Schaffner W. Nonsteroidal anti-inflammatory drug use and death from peptic ulcer in elderly persons. Ann Intern Med 1988; 109:359.
56. Piper JM, Ray WA, Daugherty JR, Griffin MR. Corticosteroid use and peptic ulcer disease: role of nonsteroidal anti-inflammatory drugs. Ann Intern Med 1991; 114:735.
57. [redacted] Díaz S, Rodríguez LA. Association between nonsteroidal anti-inflammatory drugs and upper gastrointestinal tract bleeding/perforation: an overview of epidemiologic studies published in the 1990s. Arch Intern Med 2000; 160:2093.
58. Laine L, Curtis SP, Cryer B, et al. Risk factors for NSAID-associated upper GI clinical events in a long-term prospective study of 34 701 arthritis patients. Aliment Pharmacol Ther 2010; 32:1240.
59. García Rodríguez LA, Lin KJ, [redacted] Díaz S, Johansson S. Risk of upper gastrointestinal bleeding with low-dose acetylsalicylic acid alone and in combination with clopidogrel and other medications. Circulation 2011; 123:1108.
60. Dall M, Schaffalitzky de Muckadell OB, Lassen AT, et al. An association between selective serotonin reuptake inhibitor use and serious upper gastrointestinal bleeding. Clin Gastroenterol Hepatol 2009; 7:1314.

61. Meijer WE, Heerdink ER, Nolen WA, et al. Association of risk of abnormal bleeding with degree of serotonin reuptake inhibition by antidepressants. Arch Intern Med 2004; 164:2367.
62. Tata LJ, Fortun PJ, Hubbard RB, et al. Does concurrent prescription of selective serotonin reuptake inhibitors and non-steroidal anti-inflammatory drugs substantially increase the risk of upper gastrointestinal bleeding? Aliment Pharmacol Ther 2005; 22:175.
63. Yuan Y, Tsoi K, Hunt RH. Selective serotonin reuptake inhibitors and risk of upper GI bleeding: confusion or confounding? Am J Med 2006; 119:719.
64. Anglin R, Yuan Y, Moayyedi P, et al. Risk of upper gastrointestinal bleeding with selective serotonin reuptake inhibitors with or without concurrent nonsteroidal anti-inflammatory use: a systernatic review and meta-analysis. Am J Gastroenterol 2014; 109:811.
65. de Abajo FJ, Rodríguez LA, Montero D. Association between selective serotonin reuptake inhibitors and upper gastrointestinal bleeding: population based case-control study. BMJ 1999; 319:1106.
66. Targownik LE, Bolton JM, Metge CJ, et al. Selective serotonin reuptake inhibitors are associated with a modest increase in the risk of upper gastrointestinal bleeding. Am J Gastroenterol 2009; 104:1475.
67. de Abajo FJ, García-Rodríguez LA. Risk of upper gastrointestinal tract bleeding associated with selective serotonin reuptake inhibitors and venlafaxine therapy: interaction with nonsteroidal anti-inflammatory drugs and effect of acid-suppressing agents. Arch Gen Psychiatry 2008; 65:795.
68. Opatrny L, Delaney JA, Suissa S. Gastro-intestinal haemorrhage risks of selective serotonin receptor antagonist therapy: a new look. Br J Clin Pharmacol 2008; 66:76.
69. Pilotto A, Seripa D, Franceschi M, et al. Genetic susceptibility to nonsteroidal anti-inflammatory drug-related gastroduodenal bleeding: role of cytochrome P450 2C9 polymorphisms. Gastroenterology 2007; 133:465.
70. Cryer B, Goldschmiedt M, Redfern JS, Feldman M. Comparison of salsalate and aspirin on mucosal injury and gastroduodenal mucosal prostaglandins. Gastroenterology 1990; 99:1616.

October 26, 2018

TO: Disability Procedures & Services Committee
William Pryor, Chair
James P. Harris, Vice Chair
Herman Santos
Gina Zapanta-Murphy
Marvin Adams, Alternate

FROM: Ricki Contreras, Manager RC
Disability Retirement Services

FOR: November 7, 2018, Disability Procedures and Services Committee Meeting

SUBJECT: **CONSIDER APPLICATION OF STEWART A. LONKY, M.D., AS A LACERA PANEL PHYSICIAN**

On August 7, 2018, staff and Legal Counsel interviewed California Medical Evaluators regarding Stewart A. Lonky, M.D., a physician seeking appointment to the LACERA Panel of Examining Physicians.

Attached for your review and consideration are:
- Staff's Interview Summary and Recommendation
- Panel Physician Application
- Curriculum Vitae
- Sample Report(s)

IT IS THEREFORE RECOMMENDED THAT THE COMMITTEE accept the staff recommendation to submit the application of Stewart A. Lonky, M.D., to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

JJP:RC:mb

NOTED AND REVIEWED:

JJ Popowich

JJ Popowich, Assistant Executive Officer

October 26, 2018

TO: Ricki Contreras, Manager
Disability Retirement Services

FROM: Tamara L. Caldwell, DRS Supervisor
Disability Retirement Services

FOR: November 7, 2018 Disability Procedures & Services Committee

SUBJECT: Recommendation for Internist Applying for LACERA's Panel of Examining Physicians

RECOMMENDATION

Based on our efforts to provide a diverse panel of examining physicians in several geographic locations throughout Los Angeles and surrounding counties, staff recommends the Application of Stewart A. Lonky, M.D. be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

On August 7, 2018, staff and Legal Counsel met with California Medical Evaluators at the LACERA offices to discuss several candidates for the LACERA Panel of Examining Physicians. California Medical Evaluators (CME) is a doctor-owned management and marketing company focused on serving the medical and legal communities. CME provides full-service administration of physician's medical-legal practices. CME was founded by Gregory Marusak, MD and Gabor Vari, MD who cumulatively span over two decades of experience in the medical-legal industry. They are both UCLA residency graduates and remain active on the UCLA faculty. Since its inception, CME has steadily grown, adding physicians, staff and offices to better serve clients and community. CME has highly experienced doctors in all specialties throughout California and pride themselves on providing a comprehensive and tailored experience for both legal and medical professionals.

Dr. Stewart Lonky is one of the leading Internal Medicine/Pulmonary Medicine specialists performing QME and AME evaluations in Los Angeles. He has been in practice doing Medical Legal work since 1984, both evaluating and treating injured workers, and has also served as an expert IME in many cases concerning pulmonary disease and toxic exposures. He is co-author of the book, Invisible Killers; The Truth About Environmental Genocide, published in 2007. He has appeared on numerous radio and television news shows to discuss the topic of every day toxic exposures and how they can affect human health. In addition, he has a busy pulmonary medicine practice in Westchester, near Los Angeles

International Airport, treating patients with various lung diseases and conditions. He completed his pulmonary training at UC San Diego, where he then served for 6 years as a member of the full time teaching and research faculty before entering private practice in Los Angeles in 1982. Dr. Lonky serves on the Board of directors of Nutrapharma Corporation (Coral Springs, FL) and Histologies Corporation (Anaheim, CA). He previously served as Chief Medical Officer of Trylon Corporation (Torrance, CA), responsible for all research and regulatory work for that medical device company. He currently resides in Playa Vista and Santa Barbara.

Staff reviewed the new LACERA Panel Physician Guidelines with the physician's management team, which included a lengthy discussion regarding the Rules in Evaluating Applicants, Disability Retirement Law Standards, and a thorough explanation of what is expected when preparing Panel Physician's written report for the Board of Retirement. Staff also discussed report submission timeframes, fee schedule and billing procedures, additional diagnostic testing request requirements, and advised of the requirement of maintaining a valid medical license, Board Certification, and insurance coverage. Staff also advised that all physicians must immediately report any lapses, suspensions or revocation of medical license, Board Certification, or insurance coverage, or be subject to immediate suspension or termination from LACERA Panel of Examining Physicians.

CME confirmed that they would be responsible in making sure that Dr. Lonky adhered to the rules set forth in the Guidelines and all other requirements as discussed. CME was informed that a Quality Control Questionnaire is sent to each applicant regarding their visit, which affords the applicant an opportunity to provide feedback concerning their experience during the medical appointment.

On September 21, 2018, Board Medical Advisor Vito Campese, M.D., reviewed Dr. Lonky's application and medical credential and indicated he is in agreement with submitting the Application of Stewart A. Lonky to the Disability Procedures and Services Committee for consideration.

IT IS THEREFORE RECOMMENDED THAT YOUR COMMITTEE adopt staff's recommendation to submit the Application of Stewart A. Lonky, M.D. to the Board of Retirement for final approval to the LACERA Panel of Examining Physicians.

Attachments

RC:tlc:mc

Stewart A. Lonky, M.D.
Office Location Details

Location	ADA Parking	ADA Restrooms	Lobby/Waiting Room Seating	Patients Per Day	Average Wait Time	Evaluation Time
13100 Brooks Drive, Suite 107 Baldwin Park, CA 91706	Yes	Yes	7	5-10	0-5 Minutes	30 Minutes – 3 Hours
12966 Euclid Street, Suite 508 Garden Grove, CA 92840	Yes	Yes	10	5-10	0-5 Minutes	30 Minutes - 3 Hours
13800 Heacock Street, Suite C236 Moreno Valley, CA 92553	Yes	Yes	7	5-10	0-5 Minutes	30 Minutes – 3 Hours
1701 Pacific Avenue, Suite 110 Oxnard, CA 93033	Yes	Yes	6	5-10	0-5 Minutes	30 Minutes – 3 Hours

1. CME has 47 employees including, but not limited to, medical assistants, provider liaisons, and administrative support.
2. Bianka Kuretil will be LACERA's point of contact for scheduling appointments and addressing issues and complaints. Contact: 310-625-7475 and bkureti@calmedeval.com
3. Physician review patient history prior to examination.
4. Only CME physicians share these offices for evaluations.

LACERA

Los Angeles County Employees Retirement Association

300 N. Lake Ave., Pasadena, CA 91101 ■ Mail to : PO Box 7060, Pasadena, CA 91109-706 626/564-2419 • 800/786-6464

GENERAL INFORMATION		Date 8/14/18
Group Name: CALIFORNIA MEDICAL EVALUATORS	Physician Name: STEWART ALAN LONKY, MD	
I. Primary Address: 11620 WILSHIRE BLVD, SUITE 340, LA, CA, 90025		
Contact Person BIANKA KURETI	Title ACCOUNT EXECUTIVE	
Telephone: 888.853.7944	Fax 866.288.9958	
II. Secondary Address 11620 WILSHIRE BLVD, SUITE 340, LA, CA, 90025		
Contact Person DOUGLAS STODDARD	Title VICE PRESIDENT, SALES & MARKETING	
Telephone 323.6453644	Fax 213.377.5152	

PHYSICIAN BACKGROUND		
Field of Specialty INTERNAL MEDICINE	Subspecialty PULMONARY MEDICINE	
Board Certification ☑ Yes ☐ No	License # G25948	Expiration Date 01/31/2019

EXPERIENCE
Indicate the number of years experience that you have in each category.

Evaluation Type

I. Workers' Compensation Evaluations

- ☐ Defense How Long? ———
- ☐ Applicant How Long? ———
- ☑ AME How Long? 34 years
- ☐ IME How Long? ———
- ☑ QME How Long? 34 years

II. ☐ Disability Evaluations How Long? ———

For What Public or Private Organizations?

Currently Treating? ☑ Yes ☐ No

Time Devoted to: Treatment > 30 % Evaluations %

Estimated Time from Appointment to Examination

- ☒ 2 weeks
- ☐ 3-4 Weeks
- ☐ Over a month

Able to Submit a Final Report in 30 days?

☑ Yes ☐ No

LACERA's Fee Schedule

Examination and Initial Report by Physician	$1,500.00 flat fee
Review of Records by Physician	$350.00/hour
Review of Records by Registered Nurse	$75.00/hour
Supplemental Report	$350.00/hour

-OVER-

Other Fees	
Physician's testimony at Administrative Hearing (includes travel & wait time)	$350.00/hour
Deposition Fee at Physician's office	$350.00/hour
Preparation for Expert Testimony at administrative Hearing	$350.00/hour
Expert Witness Fees in Superior or Appellate Court	$3,500.00 half day $7,000 full day
Physician agrees with LACERA's fee schedule?	No
Comments	

Name of person completing this form:

BIANKA KURETI Title: ACCOUNT EXECUTIVE

(Please Print Name)

Physician Signature: Howard A. Lenkey MD Date: 08/14/2018

FOR OFFICE USE ONLY Physician Interview and Sight Inspection Schedule	
Interview Date:	Interview Time:
Interviewer:	

California Medical Evaluators
11620 Wilshire Blvd., Suite 340
Los Angeles, CA 90025
Ph: 888-853-7944
Fx: 213-478-0550
info@calmedeval.com

Stewart Lonky, MD, QME
Internal Medicine & Pulmonary

EDUCATION

- **Pepperdine University, Malibu, California** (1993)
  Master's Degree in Business Administration
- **State University of New York, Downstate Medical Center, NY** (1971)
  Doctor of Medicine
- **St. Lawrence University, Canton, New York** (1967)
  Bachelor of Arts

INTERNSHIP & RESIDENCY TRAINING

- **National Institutes of Health, University of California, San Diego, CA** (1974 – 1977)
  Fellow in Pulmonary Disease and Biochemistry
- **University of California, San Diego, CA** (1973 – 1974)
  Senior Resident / Medicine
- **Barnes Hospital, St. Louis, MO** (1972 – 1973)
  Junior Assistant Resident / Medicine
- **State University Kings County Hospital, Brooklyn, NY** (1971 – 1972)
  Intern in Medicine

PROFESSIONAL EXPERIENCE

- **Histologies Corp.** (2009 – Present)
  Member of Board of Directors
- **Nutrapharma Corp.** (2005 – Present)
  Member of Board of Directors
- **The Trylon Corporation, Torrance, CA** (1985 – 2005)
  Vice President and Director, Medical Research and Product Development
- **Daniel Freeman Hospitals, Inglewood and Marina Del Rey** (1984 – 1990)
  Director, Pulmonary Rehabilitation
- **Private Practice, West Los Angeles** (1982 – Present)
  Internal Medicine, Pulmonary Medicine, Critical Care Medicine
- **University of California, San Diego School of Medicine** (1977 – 1982)
  Assistant Professor of Medicine
- **San Diego County Public Health Department** (1975 – 1977)
  Consultant in Pulmonary Disease

PROFESSIONAL APPOINTMENTS

- WCAB Committee to Restructure Pulmonary Disability Rating (1977 – 1992)
- Member of National Institutes of Health Advisory Committee on Alpha-1-Antitrypsin Replacement Therapy. (1980 – 1982)
- Member of Medical Executive Committee, Centinela Hospital, Inglewood, CA (2012 – 2014)
- Chairman, Bioethics Committee, Centinela Hospital, Inglewood, CA (2014 – 2016)

PROFESSIONAL MED-LEGAL EXPERIENCE

- **Treating physician for patients with internal medicine industrial injuries.** (1990 – Present)
- **Served as "expert" witness in Pulmonary medicine cases and toxic Exposure cases in California** (1992 – Present)
- **Qualified Medical Examiner in California for Workers Compensation Cases** (1994 – Present)

PROFESSIONAL SOCIETIES

- American College of Chest Physicians
- California Lung Association
- New York Academy of Science
- Diplomate American Board of Internal Medicine
- Fellowship of American College of Physicians
- American Thoracic Society
- American Federation for Clinical Research

HONORS

- Alpha Omega Alpha, State University of New York Downstate (1970)
- President's Scholarship, St. Lawrence University (1966)
- New York State Regents Scholarship (1964 – 1969)
- Chemist, St. Lawrence University (Chemistry Honorary)
- Beta Beta Beta, St. Lawrence University (Biology Honorary)

BOOKS

- Deitsch, RJ and Lonky, SA (Authors, Eds), 2007. *Invisible Killers; The Truth About Environmental Genocide*. Salt Lake City: Sound Concepts Publishing.

PUBLICATIONS

- Jones, J., and Lonky, S.A.: The use of an injectable contraceptive in the immediate post-partum. NY State Med J 71:22279, 1971.
- Johnson, A.O., Lonky, S.A., And Carleton, R.A.: Combined hypertrophic subaortic stenosis and calcific aortic valvular stenosis. Am J Cardiol 35:706, 1975
- Lonky, S.A., Cantazaro, A., Moser, K.M. and Einstein, H.: Acute coccidioidal pleural effusion. Am Rev Resp Dis 114:681, 1976
- Lonky, S.A., Marsh, J., Steele, R., Jacobs, K., Konopka, R., And Moser, K.M.: Protease and antiprotease responses in lung and pneumonia. Am Rev Respir Dis 121 :685, 1980.
- Lonky, S.A., and Tisi, G.M.: Airway Reactivity in asthma: The use of submaximal flow rates. Chest 77:7 41, 1980.

- Lonky, S.A., and Gochman, N., Smith. S.L., Bergeron-Lynn, G., and Jacobs, K.: Amino Acid analysis of elastin hydrolysates using a lithium citrate gradient: Quantification of elastin from whole lung. Clin Chem Acta 110:227, 19981.
- Lonky, S.A., and Wohl, H.: Stimulation of human Leukocyte elastase by platelet factor 4: Physiologic Morphologic, and biochemical effects on hamster lungs. J Clin Invest 67:817, 1981.
- Lonky, S.A., and Mccarren, J.: Neutrophil enzymes in the lung: Regulation of neutrophil elastase. Am Rev Respir Dis 127:59, 1983.
- Lonky, S.A., and Wohl, H.: Regulation of elastolysis of insoluble elastin by human leukocyte elastase: Stimulation by lysine rich legands, anionic detergents and ionic strength. Biochemistry 22:3714, 1983.
- Wohl, H., Wallach, S., Lonky, S, Hinkley, J. and Mabilia, M.: Structure function relationship in platelet factor 4 and other heparin neutralizing compounds. J Biol Chem.
- Lonky, S.A., and Tisi, G.M.: Evaluation of bronchial reactivity in asthma: A new method. Clin Res 24:123A, 1976
- Minh, V.D., Lonky, S.A., Konopka, R. Moser, K.M.: Effect of chest wall on flow-volume curve. Am Rev Resp Dis 113:255, 1976.
- Lonky, S.A., and Minh, V.D.: Maintenance of constant vital capacity with graded expiratory flow in the dog. Am Rev Resp Dis 117:36422, 1978.
- Minh, V.D., Lonky, S.A., Dolan, G.F. and Konopka, R: expiratory flow in dogs before and after chest wall removal. Fed Proc 37:367, 1978.
- Landers, C.F., Marsh, J., Lonky, S.A., and Moser, K.M.: Human leukocyte elastase: Characterization of a normal Population. Am Rev Resp Dis 117:360, 1978.
- Lonky, S.A., Marsh, Konopka, R., Steele, R. and Moser, K.M.: Protease-antiprotease relationships in experimental canine pneumococcapl pneumonia. m Rev Resp Dis 119:228,1 979.
- Lonky, S.A., Marsh, J., and Wohl, H.: Stimulation of human granulocyte elastase by platelet factor 4 and heparin. Clin Res 24:38A, 1979.
- Lonky, S.A., Jacobs, K. Bergeron-Lynn, G., and Tisi, G.M.: Stimulation of human granulocyte elastase by platelet factor 4: Effect on lung elastic proteins. Clin Res 28:25A, 1980.
- Lonky, S.A., Wohl, H. Jacobs, K. and Bergeron-Lynn, G., and Tisi, G.M.: Stimulation of human granulocyte elastase by platelet factor 4: Physiologic and morphologic changes in hamster lung. Am Rev Respir Dis 121:247, 1980.
- Lonky, S.A., Spragg, R., and Abraham, J: Lung platelet sequestration following the intratracheal instillation of human leukocyte elastase. Clin Res 26,69A, 1981.
- Spragg, R.G., Lonky, S.A., Loomis, W.H., Marsh, J., and Abraham, J.L.: Human neutrophil elastase causes acute high permeability edema in the isolated perfused rabbit lung. Clin Res 30:75A, 1989.
- Lonky, S.A., Spragg, R., Abraham, J.L., and Ginsberg, M.: Intratracheal inoculation of leukocyte elastase is accompanied by pulmonary sequestration of platelets and release of platelet factor 4. Am Rev Resp Dis 125, 276, 1982.
- Hughson, W.G., and Lonky, S.A.: The effect of ozone on the protease-antiprotease system of the dog. Am Rev Respir Dis 124:148, 1982.
- Hughson, W.G., and Lonky, S.A.: The effect of ozone on the protease-antiprotease system of the dog. Am Rev Respir Dis 124:148, 1982.

California Medical Evaluators

P: (888) 853-7944 F: (866) 288-9958

11620 Wilshire Blvd Ste. 340 Los Angeles CA 90025

- Lonky, S.A.: Anaerobi,c lung infection. In Clinical Problems in Pulmonary Medicine. Little, Brown and Co., Boston, Mass. 1980,p.115.
- Felix, J.C., Lonky, N.M., Tamura, K, Yu, K-J, Naidu, Y., Lai, C-R, and Lonky, S.A: Aberrant expression of E-Cadherin in cervical intraepithelial neoplasia correlates with a false-negative Papanicolaou smear. Am J Obstet and Gynecol 2002; 186:1308-14
- Monk, B., Cogan, M., Felix, J., Lonky, N., Bentz, J., Marshall, J., Cestero, R., Rowe, L., and Lonky, S.A. A stiff bristled spiral shaped ectocervical brush: A device for transepithelial tissue biopsy Obstet Gynecol 2002; 100:1276-84
- Lonky, N.M., Felix, J.C., Tsadik, G.W., and Lonky, S.A. False negative hybrid capture II results related to altered adhesion molecule distribution in women with atypical squamous cells Pap smear results and tissue-based human papillomavirus-positive high-gradecervical intraepithelial neoplasia J Lower Gen Tract Dis 2004;8:285-291.
- Tewari, D., Lonky, N., Wilczynski, S., Rowley, M.N., Lonky, S.A, and Johnson, P. Transepithelial sampling of the uterine ectocervix with a stiff-bristled, spiralshaped brush. J Lower Gen Tract Dis 2004; 8:276-279
- Epstein JB, Gorsky M, Lonky S, Silverman S Jr, Epstein JD, and Bride M. The efficacy of oral luminoscopy (Vizilite) in visualising oral mucosal lesions. Spec Care Dentist 2006 Jul-Aug; 26(4): 171-4.
- Epstein JB, Silverman S Jr, Epstein JD, Lonky SA, and Bride MA. Analysis of oral lesion biopsies identified and evaluated by visual examination, chemiluminescence, and toluidine blue. Oral Oncol. 2008 Jun; 44(6): 538-44.
- Flowers J, Lonky SA, and Deitsch EJ. Clinical evidence supporting the use of an activated clinoptilolite suspension as an agent to increase urinary excretion of toxic heavy metals. Nut Diet Suppl 2009; 1: 11-18.

California Medical Evaluators
P: (888) 853-7944 F: (866) 288-9958
11620 Wilshire Blvd Ste. 340 Los Angeles CA 90025

Stewart Lonky, M.D., Q.M.E.

DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE AND PULMONARY MEDICINE
QUALIFIED MEDICAL EXAMINER

All Correspondence To:
11620 Wilshire Boulevard, Suite 340
Los Angeles, CA 90025
Tel: (888) 853-7944
Fax: (213) 377-5152

PANEL QUALIFIED MEDICAL EVALUATION
IN THE SPECIALTY OF INTERNAL MEDICINE

July

[redacted]

[redacted]

[redacted]

[redacted]

Re: [redacted]
Applicant's DOB:
Employer:
WCAB No.:
Date of Injury: CT:
Claim/File No.:
Panel No.:
Date of Evaluation:
Place of Evaluation:

Interpreter name and #:

Dear Parties:

Pursuant to your authorization, [redacted] underwent a Panel Qualified Medical Evaluation, in the specialty of Internal Medicine, on at my Garden Grove, California office. The undersigned acted in the capacity of Panel Qualified Medical Examiner, in the specialty of Internal Medicine.

I, Dr. Lonky, conducted the interview, reviewed all records, performed a physical examination, and formulated the diagnosis, conclusions, and discussion, including the opinion on causation, temporary disability, permanent disability, degree of disability, future care, work restrictions, and apportionment. The report was authored and edited by me, Dr. Lonky. All opinions expressed herein are solely the opinions of Dr. Lonky.

Prior to the evaluation, the entire medical file made available to the undersigned was fully reviewed. All of the records reviewed were instrumental in this examiner arriving at the opinions as expressed in this report.

Before I began the examination, the applicant was informed that this evaluation was being done exclusively in connection with the Workers' Compensation claim at the request of attorney, attorneys or insurance companies, and that no treatment relationship existed. The applicant was also made aware that any communication between us is not privileged (no doctor-patient confidentiality exists) and that any information provided, as well as the results of any testing and my conclusions regarding the case, would be included in a report that may be read by people involved in the resolution and/or litigation of the claim. The applicant was advised of his or her rights pursuant to QME regulation 40. The applicant stated that the aforementioned was understood, and agreed to proceed with the evaluation. The report belongs to the party or parties requesting the evaluation.

BILLING

The report qualifies for Procedure Code **ML-104** as there are "extraordinary circumstances" relating to the medical condition for which this applicant was examined. This code best reflects the time spent and/or the complexity of this evaluation. The best proof in regard to the complexity of this evaluation is the medical/legal report which reflects the complex issues. The issues of complexity are reflected by the following: Multiple body parts are examined; present and prior work history; past medical history; family and social history; a complex history due to the applicant being a difficult historian; there are complex issues of causation or apportionment; adverse parties have obtained their own complex

and conflicting evaluation requiring interpretation.

This is a Comprehensive Medical-Legal Evaluation Involving **Extraordinary Circumstances (ML-104)**. The following complexity factors apply:

COMPLEXITY FACTORS

☒ (1) Two or more hours of face-to-face time by the physician

Circumstances which make this complexity factor applicable to this evaluation: Two or more hours of face-to-face time were required because one or more of the following apply: the subject medical condition was complex, the applicant was a difficult historian, and/or an interpreter was required which prolonged the face-to-face component of this evaluation.

☒ (2) Two or more hours of record review by the physician

Circumstances which make this complexity factor applicable to this evaluation: Two or more hours of record review time were required because one or more of the following apply: A significant volume of medical records were reviewed requiring two or more hours of my record review time, and/or the medical records were complex in nature.

☒ (3) Two or more hours of medical research by the physician

Circumstances which make this complexity factor applicable to this evaluation: Two or more hours of medical research were required because one or more of the following apply: medical research was required in order to investigate current developments regarding the etiology, pathogenesis, pathophysiology, causation, factors relating to the appropriate treatment, and/or disease course of the subject medical condition.

☐ (4) Four or more hours spent on any combination of two of the complexity factors (1) - (3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor.

☒ (5) Six or more hours spent on any combination of three complexity factors (1) - (3), which shall count as three complexity factors

Circumstances which make this complexity factor applicable to this evaluation: Six or more hours were spent on any combination of three complexity factors (1)-(3). See explanations for (1), (2) and (3) above, incorporated herein.

☒ (6) Addressing the issue of medical causation

Circumstances which make this complexity factor applicable to this evaluation: I have addressed the issue of medical causation upon a written request of one or more parties.

☐ (7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate:

☐ the claimant's employment by three or more employers, OR

☐ three or more injuries to the same body system or body region as delineated in the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), OR

☐ two or more or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference

☐ (8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.

☐ (9) Where the evaluation is performed for injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before June 30 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.

Billed under **ML-104**, time spent includes:

1. Face-to-face interview with the applicant:	**2.25**	**hours**
2. Review of medical records:	**34.50**	**hours**
3. Preparation, writing and editing of this report:	**2.50**	**hours**
4. Medical research:	**2.00**	**hours**

Additional time was spent in administering EKG (93000), diagnostic testing which will be billed separately under the current OMFS fee schedule.

HISTORY OF PRESENT ILLNESS

Ms. [redacted] is a -year-old female who commenced employment with [redacted] as a approximately .

She cleaned the operating rooms, mopping floors with unspecified disinfectants (Sani Master), chlorine bleach wipes and sometimes and other chemicals. She would disinfect the sinks and operating tables.

Each time that she cleaned, she used surgical masks and gloves.

With cleaning, she would have burning in her eyes, with her eyes being red eyes all the time. She would experience burning in her nose, and sometimes, burning in her throat. She would cough. At times, her chest would be tight.

The burning in her eyes and the cough began about one year afer she began working. With the change of seasons, she would get bronchitis.

Prior to working at ., she worked at [redacted] Warehouse. She would have a throat infection for which she was treated with "light" medication and she would heal quickly. She did not have a lot of coughing.

She never required a hospitalization, but would consult her primary care physician who would give her a Medrol dose pack, nasal spray and cough syrup with codeine for the cough.

She relates that she never informed her family physician of her symptoms possibly being due to work. She would be seen by either [redacted] her primary care physician, or in his absence, Dr. [redacted]. She would mention to her supervisor her symptoms of coughing and developing bronchitis. She requested a transfer to another department. Her supervisor advised her to

seek medical treatment through her private insurance because it was her problem. Later, she was given an inhaler. She recalls having a type of breathing test.

She does not have less problems at night. She is able to sleep. She does snore, a lot. She does awaken gasping for breath, although not very often. She does not have frequent bloody noses.

About nine years ago, she had an episode of having a bloody nose, possibly she was working at [redacted]

Now, she coughs up clear phlegm.

She is not able to walk up a flight of stairs or walk a city block without becoming short of breath.

She rides a stationary bike for her knee, 10 minutes and then she stops. She rides it slowly. Then she resumes for another 10 minutes. She does this exercise every three days.

Additionally, she experienced the onset of shoulder, elbow, wrist, hands/fingers, and knees due to repetitive cleaning and mopping, carrying heavy trash bags, bags of wet linen; lifting and carrying the linen affected her shoulders. She is not certain of the pounds.

Throughout the seven years she worked there, she would consult her private physician about every two months for either the respiratory or musculoskeletal conditions.

The patient worked until approximately when she was placed off work on disability by her private physician.

PRESENT COMPLAINTS

[redacted] last worked at [redacted] in approximately

Her primary care physician had attempted to give her restrictions of either working in another department or fewer hours, none of which could be accommodated.

For her left knee, she underwent a partial knee replacement in approximately

For her respiratory symptoms, she was referred to a pulmonologist who obtained a CT scan of her lungs in Summer and in early . The first scan showed that she has two spots on the left lung, both of the same size. After the last test, on , , ----, she was re-evaluated by Dr. [redacted] and was informed that neither were cancerous. A chronic cough and asthma were diagnosed. Symbicort was prescribed as she could not afford Breo; however, the Symbicort made her dizzy.

For recurrent upper respiratory symptoms, on , ----, she consulted Dr. [redacted], a physician in her medical group who diagnosed sinusitis, asthma and a sore throat. Amoxicillin Potassium Clavulanate 875-125 mg and Benzonatate 200 mg were prescribed.

Daily, for the last one and one-half years, she has used Breo and it has helped a lot. With the use of Breo, she uses Proair less. In a week, she will use ProAir two-to-three times per week.

She has difficulty cleaning her house due to becoming tired and weak. She has difficulty mopping because she coughs and becomes dizzy. She uses organic chemicals to clean her home and lemon to clean her dishes, otherwise chemicals cause symptoms similar to that of a cold. She does not use bleach.

She applied for Social Security Disability and is receiving it for asthma, osteoarthritis of the knees and the left knee, post knee replacement.

The patient has used her own private insurance for care of her musculoskeletal or respiratory symptoms.

She has not been evaluated by a neutral physician for her musculoskeletal symptoms.

Regarding her activities of daily living, due to her orthopedic symptoms, at times, she is not able to comb her hair. She has difficulty performing her household chores.

OCCUPATIONAL HISTORY

[redacted] commenced employment with [redacted] as a approximately .

Previously, she worked for at [redacted] in pre-shipping. She would put extra buttons and belts into small bags and labelling.

PAST MEDICAL HISTORY

She has hypertension, diabetes mellitus Type II, elevated cholesterol, and thyroid conditions.

HOSPITALIZATIONS/SURGERIES: Appendectomy; More than 20 years ago, she had two thyroid surgeries, one to remove a tumor and one month, later, removal of her thyroid; , and Cesarean-sections; two left bunionectomies; one right bunionectomy; bilateral umbilical herniorrhapies, right first; bilateral carpal tunnel releases in a staged manner, right first; approximately , left partial knee replacement.

On , she is to undergo left inguinal herniorrhaphy.

ALLERGIES: The patient has no known allergies.

MEDICATIONS: Breo 100-25 mcg, 1 puff qd; ProAir 90 mcg, prn; levothyroxine sodium 88 mcg, 1 tab qd; losartan potassium 25 mg, 1 tab qd; glucosamine 500 mg; tramadol 50 mg, 1 tab q.i.d, prn; atorvastatin calcium 20 mg, 1 tab qd; metformin HCI 500 mg, 1 tab b.i.d.

FAMILY HISTORY

The patient's father died at age of kidney disease; the patient's mother died at age of complications of diabetes and hypertension. She has sisters; she has brothers. A sister died of breast cancer.

There is a family history of hypertension through her mother, siblings and her maternal grandmother;
stroke through her mother; diabetes through her maternal grandmother, mother, one brother and four sisters; and cancer through her oldest sister (breast).

SOCIAL HISTORY

The patient is arried with daughters, age ; sons, ages and . She lives with her husband and sons.

HABITS: TOBACCO: She is a non-smoker.

ALCOHOL: About twice year, she drinks wine or liquor.

She grew up in [redacted], she did very little sneezing.

Now she has 3 dogs, and no cats.

REVIEW OF SYSTEMS

The review of systems is remarkable as indicated in the History of Present Illness and Past Medical History.

HEAD: Denied frequent headaches dizziness, syncope and seizure.

EYES: Per the History of Present Illness.

EARS: Denied otalgia, tinnitus and hearing loss.

NOSE: Per the History of Present Illness.

MOUTH/THROAT: Denied frequent sore throat and hoarseness.

RESPIRATORY: Per the History of Present Illness.

CARDIOVASCULAR: Per the Past Medical History.

GASTROINTESTINAL: Denied abdominal pain, dyspepsia, regurgitation, emesis, diarrhea, constipation, melena, and hematochezia.

URINARY: Denied dysuria, frequency, nocturia, urgency, hesitancy, hematuria, and incontinence.

MUSCULOSKELETAL & EXTREMITIES: Per the History of Present Illness.

REVIEW OF FILE

Approximately 2873 pages of records have been received and reviewed by the undersigned. Documents within the records that are not considered of medical importance to this practitioner may not be included in the summary though they have been reviewed in their entirety.

NON-MEDICAL RECORDS:

Joint Panel Qualified Medical Examination, signed by [redacted], Esq., and [redacted], Esq., Undated.

The examiner agreed to examine the applicant in the capacity of a Panel Qualified Medical Examiner.

The applicant was a [redacted] for [redacted] has filed a cumulative trauma Claim from [redacted] involving her arms, shoulders, elbows, hands, fingers, legs, knees, and lungs. Defendant had timely denied the injury claim AOE/COE and the examiner was only being asked to address the alleged injury to her lungs.

Following the examination of the applicant and review of the enclosed medical reports and records, it would be appreciated if the examiner commented on the following issues:

1) Based on your examination of the patient and review of information, do you believe the applicant has sustained an industrial injury within your field or expertise? Are the medical findings consistent with the injury claimed by the applicant?

2) If a disability existed as the result of an industrial injury, is it permanent and stationary, Maximally Medically Improved (MMI) ready for rating? When, in your estimation, did the condition become permanent and stationary/MMI? If the condition is permanent and stationary/MMI, please describe:
a. Permanent disability factors resulting from the injury, including factors, subjective and objective, to which the injury was an aggravating or contributing cause.

b. Please outline your opinion as to any residual subjective complaints. Are the subjective complaints consistent with the medical findings and clinical examination?

c. Does a disability exist such as to incapacitate or restrict the applicant from certain work activities.

3. Pursuant to Labor Code section 4660, it is respectful requested you incorporate the description and measurements of physical impairments and the corresponding

percentages of whole person impairment published in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition).
4. Please describe any and all factors of apportionment. In so doing, it is respectfully requested you comply with the recommended Labor Code section 4663.

Please note that in order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of a permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury including prior industrial injuries

Based upon this law, please provide your determinations on the following issues:
(a) If the applicant does have residual permanent disability, what approximate percentage of permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment?

(b) Please also provide your determination as to what approximate percentage of the permanent disability was caused by other factor both before and subsequent to the industrial injury, including prior industrial injuries.

(c) If you are unable to make an apportionment determination in your report, you must state the specific reason as to why you could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. We can then determine if a consult with other physicians or referral of the applicant to another physician will be necessary to make the final apportionment determination.

(d) Please also request the applicant to disclose any and all previous permanent disabilities or physical impairments. Pursuant to Labor Code Section 4664(b), if the applicant has received a prior Award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of

any subsequent industrial injury. Please incorporate this conclusive presumption within your apportionment determination.

5. Was there any period for which the applicant, due to the industrial injury, was temporarily disabled from work. If so, for what period of time would you estimate the applicant to have been temporarily disabled?

6. In connection with the medical treatment provided to the applicant to date, has it been reasonable medical treatment in light of the incident or injury claimed by the applicant? lf so, please state your assessment of the reasonableness and necessity of such treatment pursuant to M.T.U.S. Guidelines. In your opinion, do you believe there have been any excesses in either treatment or testing?

7. Is further medical treatment reasonably necessary to cure and/or relieve the applicant from the effects of the industrial injury? If so, would you please outline the type of future medical treatment you feel is appropriate. Please identify the modalities of treatment along with their frequency and duration in accordance with the M.T.U.S. Guidelines.

8. Is the applicant capable of returning to her usual and customary occupation as it was at the time of the claimed injury? If a Job Analysis is not presently available, please give us your opinion taking into account the applicant's description of her job duties.

Workers' Compensation Claim Form (DWC 1), dated _____.

The applicant sustained cumulative injury from _____ to _____.
She sustained injury to the right hand, right arm, neck and upper back while doing repetitive gripping and heavy pushing and pulling.

Application for Adjudication of Claim, dated _____

It was claimed that the applicant sustained an injury on cumulative injury form _____ while employed in pre-shipping at [redacted] She sustained injury to the right hand, right arm, neck and upper back due to repetitive gripping and heavy pushing and pulling.

Description of Employee's Job Duties, dated _____

The applicant separated and sorted out the button needed for the different styles that came in. She received the clothes and counted them. She determined the buttons needed and bundles them or attached a belt. She put the belt in a bag. She put the button in a bag and then organized the clothes in different carts for another person. She pushed and pulled carts with clothes to her work area and to her co-workers for completion.

Her job entails occasional walk, fine manipulation (bilateral hand) and reaching above shoulder level. There is frequent bending at the neck and waist, twisting at the neck and waist, and reaching and pulling (bilateral hand). There is constant standing, repetitive use of the hands, simple grasping (bilateral hand), and reaching above shoulder level. Her job requires occasional lifting and carrying up to 25 pounds. There is frequent lifting and carrying up to 10 pounds. The heaviest item she had carried were four or more boxes filled with button and belts weighing approximately 4 to 5 pounds from the stockroom to her work area. She was exposed to dust.

Compromise and Release, dated ____

The parties having filed a Compromise and Release herein settling the case for $, in addition to all sums which might had been paid previously, less credit for permanent disability advances. Award was made in favor of the applicant against [redacted]

She was a and sustained cumulative trauma from , . She sustained injuries to the right hand, right arm, neck, and upper back. The partied agreed to settle any and all claims on account of the said injury by the payment of the sum of $.

Notice of Termination of Vocational Rehabilitation Services, dated

The applicant completed the vocational rehabilitation plan.

Job Function Test, dated ____.

Comment: The applicant was not to change curtained in rooms without assistance. She was not to trash waste handling position. She was not to carry linen bags.

Job Function Test, dated

Comment: The applicant was not to carry linen bag. She should be on minimal overhead work of the right upper extremity. She needed assistance to change curtains.

Job Function Test, dated

Comment: The applicant was able to perform all EVS functions. She was unable to perform outdoor trash/waste handling function.

Leave of Absence, Request Form, [redacted] dated

The applicant requested medical leave from

Job Function Match, by [redacted] M.P.T., dated

The applicant could not be accommodated at this time since she could not perform the essential demands of the job.

Employee Work Status/Accommodation Form, [redacted] dated

The applicant was temporarily disabled from . She would able to work on without restrictions.

Employer's Report of Occupational Injury, by [redacted], dated

The applicant sustained an injury on while employed at [redacted] She worked as She was seen in the emergency room following chemical splash to the left eye.

Leave of Absence, Request Form, dated

The applicant requested medical leave from . She was expected to return in

Employer's Report of Occupational Injury, by [redacted], dated

The applicant sustained an injury on while employed as at [redacted]. She was looking up while cleaning walls and chemicals were dripping and splashing. The chemical got into her left eye.

Employee Health Services Release Form Leave of Absence, dated

The applicant was on medical leave. She was cleared to return to work on Respiratory fit testing was done.

Employer's Report of Occupational Injury, by [redacted], dated

The applicant sustained an injury on while employed as at [redacted] She was cleaning when she sustained minute 3 mm shallow cut on her left 4th finger. She already had her TDAP. She declined treatment. Spot bandages were given to cover the area.

Employer's Report of Occupational Injury, by [redacted], dated

The applicant sustained an injury on while employed as at [redacted] The door closed on her right forearm and small amount of swelling noted. She declined treatment at this time.

Employer's Report of Occupational Injury, by [redacted], dated

The applicant sustained an injury on while employed as [redacted] Her arm got scratched her on anesthesia cart. She declined treatment.

Employer's Report of Occupational Injury, by [redacted], dated

The applicant sustained an injury on while employed as at [redacted] She reported her condition on She had rash/itching since . She was seen at Edinger clinic. It was determined to be non-industrial.

Employee Health Services Release Form Leave of Absence, dated

The applicant was cleared to return to work on full duty on

Employee Health Services Release Form Leave of Absence, dated

The applicant was cleared to return to work to full duty on

Employer's Report of Occupational Injury, by [redacted], dated

The applicant sustained an injury on while employed at at [redacted] She was cleaning the room when she developed rash on the right arm after using cleaning products.

Employee Health Services Release Form Leave of Absence, dated

The applicant had been on leave of absence beginning . She was cleared to return to full duty on .

Employee Health Services Release Form Leave of Absence, dated

The applicant had been on leave of absence beginning . She was cleared to return to work on

Workers' Compensation Claim Form (DWC 1), dated

The applicant sustained cumulative trauma from to . Due to repetitive and cumulative trauma of job duties as exposure to cleaning solvents in housekeeping on a daily basis, she sustained injury to the bilateral shoulders, elbows, hands/fingers, bilateral knees and lungs.

Application for Adjudication of Claim, dated .

It was claimed that the applicant sustained cumulative injury from while employed t surgery at [redacted] Due to repetitive and cumulative trauma of job duties and exposure to cleaning solvents used in housekeeping on a daily basis, she sustained injury to the upper extremity, lower extremity and respiratory systems.

Deposition of [redacted] Volume I, dated .

The applicant was currently taking Tramadol for pain in her knees, hands, elbows and shoulders, as prescribed by [redacted] She had been going to Medical Group for years. She had been taking medication for her thyroid for 20 years, as prescribed by [redacted] She was also taking medication for high blood pressure for 7 months, which was also prescribed by [redacted] She had been taking her blood pressure medicine once a day.

She last worked on . at [redacted] Since leaving the hospital, she had received three months disability. Her disability was certified by [redacted] She stopped receiving disability because her doctor went on vacation and the paperwork was not filled out. She stopped working because her knees, elbows, shoulders, and hands were hurting. She also had asthma. She stopped working as she was put off from work by [redacted] and Dr. [redacted]. She sent the paperwork to the hospital, which was given by her doctor. In , she informed that she was not coming back anymore.

She filed a workers' compensation claim when she realized about her knee. She started to get sicker in May. After a year of not working, she filed a workers' compensation claim because she did not think her body parts were damaged. [redacted] told to her that the left knee was damaged because of the type of work she had.

[redacted] told to her that her work accelerated her problem. She was advised to talk to her supervisor. The applicant spoke with her manager and asked if she could be transferred to another floor and not in the surgery. She told her manager that she was having problem with her knees, hands, elbows and shoulders. On , her last day of work, she went on medical leave. She did not tell to anyone that she was leaving because of her medical benefits. She filed a claim because she was not going back to work.

She started working at [redacted] in . She was diagnosed of asthma 3 years ago by [redacted] She would see [redacted] every two months. She was not able to breath and her oxygen level was very low. She had a spirometry test three years ago. She was given inhaler which she last used last year. She was using her inhaler in the morning and evening. Prior to working at the hospital, she worked at for nine months. After working at , she worked at . Her job entailed packing and unpacking boxes with clothing. She left because it was far from her home. At , she was doing housekeeping at the surgery rooms.

She left because she had hernia surgery at the right belly button. Her surgery was not work-related. Before going to [redacted], she was off work for about two to three months. Before working at [redacted], she was babysitting a boy for one year. Before babysitting, she worked at [redacted] for 17 years. She was employed at [redacted] from through . She was assigned in the shipping department. She left the company because injured her both hands. She then filed a workers' compensation claim. She injured her both hands, neck and upper back as she was carrying heavy things, putting buttons and using machines. She filed cumulative trauma injury. Her case was settled in for about $ She underwent vocational rehabilitation after her settlement. She planned to be a medical assistant. She did not go back to [redacted] because of her neck and back problem. She also underwent carpal tunnel surgery on both hands after she left her job.

She had been involved in motor vehicle accident approximately years ago. She moved forward and injured her back. She was seen by a doctor, physical therapist and chiropractor. She received $

Deposition of [redacted] Volume II, dated .

The applicant was not working. [redacted] placed her on disability for life. She was waiting for the appointment from the judge to see if she could be declared disabled or not. Her primary care physician is [redacted] Since , she was seen by [redacted] and Dr. [redacted]. She was seeing [redacted] for treatment of her right pinky finger which she broke last year. Her right pinky finger had not healed and was told it would remain crooked. She also saw [redacted] who performed her left knee surgery.

Since her last deposition, she was given medication for asthma. She received an inhaler, which she used it in the morning, noon, and night. She had been using it for approximately two months. Dr. [redacted] told to her that she had fibromyalgia.

She filed a claim dated claiming injury to her bilateral shoulders, elbows, hands, fingers, bilateral knees, and lungs as a result of repetitive and cumulative job as exposure to cleaning solvents used in housekeeping on a daily basis from through Her first day of employment was in . She worked at for a while. She worked at before working at 's. While employed at , she was assigned in a hospital doing housekeeping. She was employed at for less than a year.

While working at [redacted], she was always part of the surgery housekeeping from until her last day of work. was her supervisor and was their manager. She was assigned to clean 15 surgery rooms. She worked 5 days a week. She would clean the surgery room when a patient leaves. She would remove the linen and the red trash that was contaminated. She would put them in a cart with wheels. She would clean everything with towels. She would move the bed, lamps or lights, and table. She would also mop and make the bed again. She would throw out the trash and wait as the room was constantly used. She could be cleaning the room alone or with someone else. Aside from the

operating room, they also received calls from the recovery room and preop. They would have to walk a distance from another operating room that was in another location, but at the same hospital.

She attributed her injuries to her repetitive work. Sometimes she did not even have enough time to take her break. She was claiming injury to her bilateral shoulder. The right shoulder hurt the most. She started to have pain in the right shoulder about years ago. She started having pain in the shoulder approximately six to seven months toward the end of . She mentioned having shoulder pain to [redacted]. She had an injection to the shoulder while she working at [redacted]. She denied having shoulder pain prior to . She also had complaints in both elbows. She started having elbow pain around . She denied having elbow pain prior to . She started receiving treatment for the elbow in . Her hand and finger complaints started in . Afterwards, she underwent surgery and it no longer hurt. [redacted] only performed the left hand surgery.

She stopped working at [redacted] because of her injury. After she left [redacted], the pain stopped because she underwent carpal tunnel surgery. She underwent right hand surgery in Santa Ana. She did not have any complaints in her right hand afterwards until she started working for [redacted]. Her left hand symptoms started while working at [redacted]. The pain went away after she underwent surgery.

She started having pain in both knees in approximately . Her bilateral knee started to hurt at the end of The knee questionnaire from Dr. [redacted] record was discussed. She admitted that she fell at home in , but denied sustaining any injury. Her knee would pop and it would hurt a lot due to repetitive bending. She denied having swelling of the knee after the fall. However, it was indicated in Dr. [redacted] questionnaire that she had mild swelling of the knee.

Deposition of ; Volume III, dated .

The applicant was not working due to illness. She last worked at in . Dr. [redacted] placed her off work due to her illness. Since her last day of work, she was given PTO. She also applied Social Security disability

claim in which she went to a court at the beginning of . The court responded and she was put on disability for life. The court relied on [redacted] and Dr. [redacted] opinions. She had not received any benefits until her case resolved. [redacted] was her family doctor for years. Other than [redacted] she was also seeing [redacted] was also her family doctor for about years. She last saw [redacted] about months ago because her knee was hurting and she had asthma. She was sent for physical therapy that helped her knee condition. For her asthma, she was prescribed inhaler. She used the inhaler three times a day. She would also use the inhaler depending how much she needed it. She had been using the inhaler three times a day for approximately years. She was first diagnosed of asthma approximately years ago by [redacted] Prior to , she had suffered a lot of throat infections and a lot of coughing. The first time she went to a doctor for her throat infection was when she had a surgery for a tumor in the throat approximately years ago. She stayed in the hospital for her throat surgery. She was coughing a lot before it was found out her throat tumor. After the surgery, she would have throat infection about once a year. Before her surgery, she would have throat infection approximately every month.

She also underwent partial left knee replacement in . She underwent left hand carpal tunnel surgery in approximately . Prior to her hand surgery, she underwent surgery to her feet bunion in . Due to her surgery, she missed time work for approximately four months. During those four months, she was receiving State Disability. She was off work for months after the surgery and received State Disability as well. Prior to her bunion surgery, she also underwent hernia surgery in . She was off work for months. She also received State Disability. She also underwent surgery to her appendix. Prior to working at , she underwent right carpal tunnel release.

Approximately in , she broke her right hand. At that time, she already stopped working at . She broke her right pinky finger while at home. She was going to bath when she slipped and grabbed really hard. She fell on her left knee.

She was diagnosed of rheumatoid arthritis in approximately [redacted] first told her that she had rheumatoid arthritis. She was started on medication and was sent for therapy. She was told that she had arthritis in both hands. She

also had rheumatoid arthritis to both shoulders. Due to her rheumatoid arthritis, her joints in the hands and shoulders hurt a lot.

She also sustained an injury while working at when some liquid fell into her eyes. She was then working approximately . She also sustained injury to her knees. She sustained injury to her right shoulder in when the door suddenly closed and hit her shoulder. She was sent to a doctor once. She was given medication and did not miss any time from work. She then returned to her regular and usual customary job.

Notice of Termination of Vocational Rehabilitation Services, Undated.

The applicant completed vocational rehabilitation plan.

Amended Compromise and Release, Undated.

The partied having filed a Compromise and Release, settling the case for $ in addition to all sums which might had been paid previously less credit for Permanent Disability advances. Award was made in favor of the applicant against .

Employee/Supervisor Work-Related Injury/Incident, Undated.

The applicant sustained an injury on . She went to the cleaning room when she sustained burn injury to the arm. She was restricted to keep chemicals away from the body parts.

Employee/Supervisor Work-Related Injury/Incident, Undated.

The applicant sustained an injury on . She was cleaning patient's room when a chemical splashed on the left eye.

Employee/Supervisor Work-Related Injury/Incident, Undated.

The applicant sustained an injury on when a sani cloth splashed on her left eye. She was looking up when chemicals were dripping and splashing while cleaning the walls.

Employee/Supervisor Work-Related Injury/Incident, Undated.

The applicant sustained an injury on when a door closed injuring her right arm.

Employee/Supervisor Work-Related Injury/Incident, Undated.

The applicant sustained an injury on . She sustained injury to the right side of the face and bridge of the right socket of the eye with a pole of a mop. She sustained contusion and eye injury.

Employee/Supervisor Work-Related Injury/Incident, Undated.

The applicant sustained an injury on when her arm was scratch on anesthesia cart.

Employee/Supervisor Work-Related Injury/Incident, Undated.

The applicant developed a rash.

Employee/Supervisor Work-Related Injury/Incident, Undated.

The applicant sustained an injury on

Leave of Absence, Undated.

The applicant was on medical leave on . She returned to work on

Leave of Absence, Undated.

The applicant was on medical leave on She returned to work on

Leave of Absence, Undated.

The applicant was on medical leave on). She was expected to return to work after weeks.

Employee Health Services Release From Leave of Absence, Undated.

The applicant was cleared to return to work on

Job Description, Undated.

The applicant worked as environmental services aide. Her job summary included cleaning and servicing building areas according to established schedules, policies and procedures. She performed variety of environmental services duties to maintain the hospital in a sanitary, orderly and attractive condition.

Leave of Absence, Undated.

The applicant was on medical leave on

Leave of Absence, Undated.

The applicant was on leave on). She was expected to return to work on).

Job Function Test, Undated.

The applicant had no work restrictions. She was allowed to wear splint at work.

Job Function Test, Undated.

The applicant passed 5 out of 5 job functions.

MEDICAL RECORDS:

Physician's Note, by , dated

Her blood pressure was 110/70 mmHg and pulse rate was 82 beats per minute. She weighed pounds.

Plan: She was to undergo laboratory tests.

The rest of the note is illegible.

Laboratory Report, [redacted] dated

On lipid panel, there was high cholesterol at 379, triglycerides at 236, HDL cholesterol at 92 and LDL cholesterol at 240. There was low thyroxine at 0.8 and T7 calculation at 0.2; there was high TSH serum at 129.6. On CBC, there was high RBC at 5.45; there was low MCV at 79 and MCH at 25.9.

Radiation Therapy Consultation, signed by [redacted] M.D., [redacted] dated

The applicant came for postoperative thyroid carcinoma consultation.

History of Present Illness: She was seen at the request of [redacted] for consideration of thyroid ablation because of her recently excised thyroid carcinoma. Her history dated back to when she saw her physician because of difficulty swallowing. An ultrasound was done which revealed a mass of 1.5 cm in greatest dimensions near the right isthmus. On an FNA revealed poorly differentiated follicular carcinoma. A chest radiograph was negative. On she underwent a right thyroid and isthmus removal which revealed a well-differentiated papillary carcinoma, multi-focal and measuring 0.9 cm in greatest dimensions. Two lymph nodes contained metastatic disease. She then transferred her care to UCI where she had a complete thyroidectomy on . They placed her on Cytomel and recommended post-operative radioactive thyroid ablation. She came for that purpose.

Medical History: She had been a healthy woman with no medical conditions.

Current Medication: She was on Cytomel.

Weight: She weighed pounds compared to pounds one year earlier.

Surgeries: She underwent thyroidectomy on .

Social History: She worked in a shipping department.

Physical Examination: Her face was quite edematous. Her neck wound was well healed.

Impression: Stage T2N1M0 well-differentiated papillary carcinoma multifocal of the thyroid.

Discussion: She was scheduled for 120 mCi of I-131 at Chapman Medical Center as an outpatient on She was advised to refrain from becoming pregnant for 6 months after ablation.

Physician's Note, by , M.D., dated .

The applicant came for review of her thyroid.

Her blood pressure was 130/80 mmHg and weighed pounds.

She was on Darvocet.

The rest of the note is illegible.

X-rays of the Chest, signed by [redacted]., M.D., dated

Impression: Normal chest.

Laboratory Report, [redacted] dated

There was high mumps AB Igg at 3.75.

Physician's Note, by , M.D., dated .

History of Present Illness: The applicant came for review of her thyroid surgery. She lost a little weight. She complained of occipital headache for 7 days.

Her blood pressure was 130/80 mmHg and weighed pounds.

She was on Darvocet.

Plan: She was to proceed for thyroid scan and laboratory tests. She was off work until .

The rest of the note is illegible.

Laboratory Report, [redacted] dated

The results were unremarkable.

Physician's Note, by [redacted], M.D., dated

History of Present Illness: The applicant came for review of her thyroid. She gained 6 pounds.

Her blood pressure was 110/70 mmHg and weighed pounds.

Plan: She was to undergo laboratory tests.

The rest of the note is illegible.

Laboratory Report, [redacted] dated

There was low TSH serum at 0.1.

Thyroid Sonogram, signed by [redacted], D.O., dated

Impression: Thyroid not seen secondary to surgery and hormonal supplement. No abnormality was noted.

Medical Report, signed by [redacted], M.D., dated

The applicant returned today for recheck on her thyroid disease. She was scheduled for a complete body scan in the morning. She was complaining of fatigue. She had not been taken her thyroid replacement medicine secondary to her schedule exam. Her ultrasound of her thyroid was normal.

Physical Examination: Her blood pressure was 110/70 mmHg and pulse rate was 80 beats per minute. She weighed pounds.

Impression: Thyroid carcinoma, status post thyroidectomy.

She was to resume thyroid replacement medicine in the morning. Her thyroid stimulating hormone was to be rechecked in six weeks.

Thyroid Body Scan, signed by [redacted], M.D., [redacted] dated

Impression: Physiologic secretion of the radiopharmaceutical by gut and urinary tract. No evidence of functioning metastases was seen.

Chart Note, dated

History of Present Illness: The applicant underwent thyroid and bone scan at [redacted] Radiology yesterday with oral I-131. She developed a tingling sensation throughout her body with a slight rash and numbness and some tightness in her chest.

Examination: Her blood pressure was 114/80 mmHg.

Impression: She has allergic reaction to I-1131.

Plan: She was given 2 cc of Celestone intramuscularly and was told to present herself to [redacted] Emergency Room should symptoms increased or are not improved for further treatment.

Physician's Note, by , M.D., dated

History of Present Illness: The applicant came for review of her thyroid. She complained of fatigue.

Her blood pressure was 110/70 mmHg and pulse rate was 82 beats per minute. She weighed pounds.

Plan: She was to undergo laboratory tests.

The rest of the note is illegible.

Physician's Note, by [redacted] M.D., dated [redacted]

History of Present Illness: The applicant came for review of her thyroid condition.

Her blood pressure was 110/70 mmHg and pulse rate was 82 beats per minute. She weighed [redacted] pounds. There was erythema noted on the oral cavity.

Impression: Upper respiratory tract infection.

Plan: She was to undergo laboratory tests.

The rest of the note is illegible.

Laboratory Report, [redacted] dated [redacted]

There was low TST serum at 0.1.

Physician's Note, by [redacted], M.D., dated [redacted]

History of Present Illness: The applicant complained of cough and sputum that was yellow and brown. She also complained of headache.

Her blood pressure was 124/80 mmHg and weighed [redacted] pounds.

Impression: Upper respiratory infection.

Plan: She was prescribed Ciprofloxacin 500 mg.

Laboratory Report, [redacted] dated [redacted]

There was high cholesterol at 229 and LDL cholesterol at 145.

Physician's Note, by l, M.D., dated

History of Present Illness: The applicant complained of cough and headache.

Her blood pressure was 120/80 mmHg and weighed pounds.

She was placed off-work until . She was to undergo laboratory tests.

Laboratory Report, [redacted] dated

There was low TSH serum at 0.05.

Physician's Note, by M.D., dated .

The applicant's blood pressure was 106/74 mmHg and weighed pounds.

Medication: she was on Synthroid.

Plan: She was to undergo laboratory tests.

The rest of the note is illegible.

Laboratory Report, [redacted] dated .

There was low TSH serum at 0.05.

Health Questionnaire, [redacted] dated

The applicant has history of chest pain, thyroid disease, depression, weight gain, high cholesterol and chicken pox.

Family History: Her mother had high blood pressure and diabetes. She sister had diabetes.

Medical History: She underwent 3 C-sections and 2 thyroid cancer.

Her blood pressure was 102/68 mmHg and pulse rate was 68 beats per minute. She weighed pounds.

Medication: She was on Synthroid.

Assessment: Hypothyroidism.

Plan: She was to undergo EKG, Pap smear and laboratory tests. She was to continue Synthroid.

Laboratory Report, [redacted] dated .

There was high cholesterol at 247, triglycerides at 204 and LDL cholesterol at 134. There was low TSH serum at 0.05. On CBC with differential, there was low MCV at 80 and MCH at 26.2. On urinalysis, there were few bacteria noted.

History and Physical Report, by [redacted] M.D., dated .

History of Present Illness: The applicant came for follow-up. She has a history of thyroid carcinoma diagnosed ago status post total thyroidectomy followed by radiation therapy. She was currently in a clinical remission. She was taking thyroid replacement at this time, Synthroid, 0.1 mg. Her last TSH was done on , and TSH at that time was less than 0.05. She had occasional palpitations when she was taking her medications, as well as some mild insomnia. Her weight had been stable.

She was also complaining of some right hand pain. She suffered an accident while at work when she was lifting an object. Since that time, she had been experiencing pain in the second digit at the metacarpophalangeal joint. She noticed some mild erythema and edema. It was present primarily with movement. She had taken some over-the-counter Aleve with mild relief of her symptoms.

She was also complaining of some right knee pain with ambulation.

Medical History: Significant of thyroid cancer status post total thyroidectomy and radiation therapy in .

Medications: She was on Synthroid 0.1 mg.

Family History: Her father died from kidney disease at the age of .

Physical Examination: Her blood pressure was 120/80 mmHg and pulse rate was 70 beats per minute.

Assessment: 1) Thyroid cancer, clinically in remission. 2) Right hand pain, most likely related to musculoskeletal strain. 3) Hypercholesterolemia. 4) Health care maintenance.

Plan: Her TSH was to be checked. She was to continue Synthroid 0.1 mg. She was to undergo x-ray. She was prescribed Naprosyn 375 mg. He lipid panel was to be repeated.

X-rays of the Right Hand, signed by [redacted] M.D., [redacted] dated .

Impression: No evidence of fracture, dislocation or inflammatory arthritic process.

X-rays of the Right Knee, signed by [redacted] M.D., [redacted] dated .

Impression: Degenerative joint disease.

Laboratory Report, [redacted] dated .

There was high LDL cholesterol at 184 and cholesterol/HDL at 4.7.

Laboratory Report, [redacted] dated .

There was high MCH at 26.9.

Laboratory Report, [redacted] dated [redacted].

There was low TSH serum at 0.10 and high CPK at 172.

Progress Note, by [redacted] M.D., dated [redacted].

History of Present Illness: The applicant complained of upper respiratory infection-type symptoms. She had some sore throat as well as fevers and chills and chest congestion. She had yellowish phlegm. There were no sick contacts at home.

She was also complaining of right knee and right heel pain. She underwent x-rays at her last office visit, which demonstrated degenerative joint disease at the right knee. She had been complaining of pain in the right heel consistent with plantar fasciitis. She had not been using any medications over-the-counter or otherwise for the right knee or right heel pain.

She would like to check-up on labs that she had done last Saturday regarding her thyroid and cholesterol levels. She was started on Lipitor, 20 mg approximately six weeks ago, and was decreased on her dose of Synthroid to 0.088 mg. Clinically, she was euthyroid.

She felt quite well today.

Physical Examination: Her blood pressure was 108/80 mmHg and pulse rate was 80 beats per minute. She weighed [redacted] pounds.

Assessment: 1) Hypothyroidism. 2) Hypercholesterolemia. 3) Plantar fasciitis. 4) Upper respiratory infection. 5) Right knee degenerative joint disease. 6) Health care maintenance.

Plan: She was to decrease Synthroid to 0.075 mg. Her TSH and lipid panel was to be checked. She was to continue Lipitor 20 mg. She was advised to use over-the-counter non-steroidal anti-inflammatory medication as needed. She was given samples of Augmentin 875 mg. She was advised of supportive care measures, rest, hydration and Tylenol. She was on Neoprene and knee sleeve.

Progress Note, by [redacted] M.D., dated [redacted].

History of Present Illness: The applicant came for follow-up.

She was complaining of some very mild dysphagia for the last three days. Her dysphagia was present only when she was swallowing saliva and not present with liquids or with solid foods. She denied any sore throat and also denied any cough. She had no fever or chills. She had no other symptoms consistent with upper respiratory infection. She had noticed some very mild swelling in her neck over the last three days, as well. Clinically, she was euthyroid. She did recover well from her upper respiratory infection that she had at the last office visit. The right plantar fasciitis and right knee pain that she was having at the last office visit were also resolved. Overall, she was feeling quite well today.

Physical Examination: Her blood pressure was 120/80 mmHg and pulse rate was 76 beats per minute. She weighed pounds. She had some mild cervical lymphadenopathy.

Assessment: 1) Hypothyroidism. 2) Dysphagia. 3) Hypercholesterolemia. 4) Health care maintenance.

Plan: She was advised of supportive care, Tylenol, fluids and rest. She was to monitor worsening dysphagia or swelling in her neck. Her lipid was to be check.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted]

The applicant had been complaining of cough for four days. Her chest hurts when she coughs. She had body aches. She had a little bit of diarrhea.

History of Present Illness: She had cough, congestion and sore throat for 4 days. She failed over the counter medication. She had increasing cough and fatigue that hurts when she breathe.

Vital Signs: Her blood pressure was 124/80 mmHg and pulse rate was 64 beats per minute. She weighed pounds.

Medical History: She has history of anemia, hyperlipidemia, hypothyroidism, osteoarthritis, premenstrual disorder, and tingling. She also has history of thyroid procedure years ago twice, appendectomy years ago, umbilical hernia repair years ago twice, bunion correction with metatarsal osteotomy by Green-Waterman procedure on the left foot on and bilateral bunionectomy year.

Medications: She was on Metrogel 1%, Levothyroxine sodium 88 mcg, Simvastatin 20 mg, and Allopurinol 300 mg.

Family History: She has family history of coronary artery disease, diabetes mellitus, hypertension, hyperlipidemia, and malignant carcinoma of the breast. Her father died at the age of due to renal failure and gout. Her mother died at the age of due to diabetes and hypertension.

Personal History: She worked as per in operating rooms. She had one sister who died of breast cancer. of the sibling had diabetes mellitus.

Assessment: Possible pneumonia.

Plan: She was to increase fluid intake. She was advised to take time off. She was to undergo chest x-rays. She was prescribed Z-pak and Promethazine VC with codeine.

Progress Note, by [redacted] M.D., dated [redacted].

History of Present Illness: The applicant came for follow-up.

She was complaining of a cough that was productive of clear phlegm. She had this for several days now. She had been using over-the-counter cough syrup with no relief of her symptoms. She also complained of a very mild sore throat.

She had been complaining of occasional palpitations and feeling of very thirsty all the time with frequent urination.

She was also complaining of abdominal bloating and a six-pound weight gain since the last office visit despite eating only very small portions and drinking a lot of fluids.

She was concerned about her thyroid given her history of thyroid cancer. She had been taking Zocor for her hypercholesterolemia and would like to have her cholesterol levels checked.

Physical Examination: Her blood pressure was 128/74 mmHg and pulse rate was 80 beats per minute. She weighed pounds.

Assessment: 1) Cough. 2) Hypercholesterolemia. 3) Thyroid cancer. 4) Abdominal pain. 5) Palpitations. 6) Health care maintenance.

Plan: She was to continue with supportive care, rest and increased oral hydration. She was given a prescription for Phenergan with codeine. She was to continue Zocor 40 mg and Synthroid. Her lipid, LFT, TSH, amylase, H. pylori, were to be checked. Treadmill stress test would be considered.

Laboratory Report, [redacted] dated .

There was high TSH serum at 10.21. There was high H. pylori antibody Igg at 1.55 and H. pylori antibody IgA at 2.42. On urinalysis, there was few bacteria noted.

Progress Note, by [redacted] M.D., dated .

History: The applicant came for follow-up. She was complaining of pain in her right hand in the interosseous muscle between the first and second digits. The pain extended up into her arm and into her shoulder. She is right-handed and was doing repetitive type motions at work using a type of gun that she used to attach labels to clothing and garments. She had noted the pain approximately two hours after she returned home from work on a daily basis. She had not used any over-the-counter medications. There was some swelling of the area involved in the hand. She had reported her aches and pains to her boss but they have told her that she required a note from her medical doctor stating that these aches and pains were related to repetitive motion that she did at her job and not related to

her thyroid condition. She otherwise was doing well. She has not had any recurrent episodes of palpitations that she was reporting at her last office visit. Her abdominal pain was slightly better after she was treated with Helicobacter pylori with a Prev-pak. Clinically she was euthyroid. She was increasing her dose of Synthroid about six weeks ago to 0.088 mg. Her TSH was to be checked in another week. She continued to take Zocor 40 mg.

Physical Examination: Her blood pressure was 120/80 mmHg and pulse rate was 88 beats per minute. She weighed pounds.

Assessment: 1) Right hand pain secondary to musculoskeletal strain related to her repetitive motions at work. 2) Hypercholesterolemia. 3) Hypothyroidism. 4) Healthcare maintenance.

Plan: She was given a note stating that her injury was related to her job. She was also given a prescription for Lodine 200 mg as needed for her pain. She was recommended to decrease this repetitive-type motion at work if possible. She was on Zocor 40 mg and Synthroid 0.088 mg. Her lipid panel, liver function tests, and TSH would be checked.

Laboratory Report, [redacted] dated [redacted].

TSH serum was at normal range.

Progress Note, by [redacted] M.D., dated [redacted].

History: The applicant presented for follow-up. She continued to have problems with her right upper extremity with paresthesia in the hand and in the forearm and extending into the shoulder. She was now complaining of pain in the right neck and the right shoulder-blade area. Her symptoms were persistent. It was much worse after she returned home from work at the end of the day. She did report again doing repetitive motions at work using a trigger type of a gun for clothing labeling. She was seen two weeks ago for the same type of problem and was prescribed non-steroidal anti-inflammatory medications and advised to seek a Workman's Compensation evaluation with her company physician; however, she informed her company of her symptoms and they were reluctant to provide her with a Workman's Compensation evaluation. Her symptoms were slightly

worse today. Clinically she was euthyroid and was on Synthroid 0.075 mg. She was tolerating her Zocor 40 mg without difficulty.

Physical Examination: Her blood pressure was 118/70 mmHg and pulse rate was 80 beats per minute. She weighed pounds.

Assessment: 1) Right upper extremity and right neck pain, most likely this was related to repetitive motion at work, possible carpal tunnel syndrome. 2) Hypercholesterolemia. 3) Hypothyroidism. 4) Healthcare maintenance.

Plan: She would benefit from ergonomic changes at work and also would benefit from Workman's Compensation evaluation through her work. She was to continue Zocor 40 mg and Synthroid 0.075 mg. Her lipid panel and TSH were to be checked on her next visit.

Progress Note, by [redacted] M.D., dated _____

History of Illness: The applicant came for follow-up. She continued to have pain in her neck, mid- and upper back, and in her right upper extremity. Her symptoms had progressively gotten worse since the last time she came. She had failed Lodine and Naprosyn. She has not yet had a Workers' Compensation evaluation through her work and has not had any type of ergonomic changes despite a medical note stating that her symptoms were most likely related to repetitive activities at work. She has retained a lawyer for this problem and they would be proceeding with an inquiry in the near future.

She was having difficulty sleeping at nighttime because of the chronic neck, upper extremity and back pain.

Clinically she was euthyroid with normal energy levels, normal bowel patterns and normal eating habits. Her weight had been stable. She had lost two to three pounds since her last office visit.

She continued to take Zocor for her hypercholesterolemia with no myalgia and no abdominal pain.

Physical Examination: Her blood pressure was 134/80 mmHg and pulse rate was 70 beats per minute. She weighed [redacted] pounds.

Assessment: 1) Right upper extremity, right neck and right back pain secondary to work related activities. 2) Hypercholesterolemia. 3) Hypothyroidism. 4) Health care maintenance.

Plan: She was given a work excuse for two weeks. She was on Tylenol with codeine as she has failed non-steroidal, anti-inflammatory medications. She was recommended ergonomic changes at work with also a Workers' Compensation evaluation. She was on Zocor 40 mg. She was to continue Synthroid 0.075 mg. Her lipid and LFT were to be checked on her next visit.

Medical Report (Incomplete), signed by [redacted] M.D., Orthopedic Surgeon dated [redacted]

The applicant continued working her regular duties, and developed a lump between the right thumb and index finger. Again, she reported this to her employer but she was not sent for medical attention.

She then saw her own primary care doctor for her complaints of pain, swelling and numbness in the right wrist, hand and fingers, as well as the lump between the thumb and index finger. X-rays were taken which were negative for fracture. Pain medication was prescribed.

She continued working her regular duties, which aggravated her right wrist, hand and fingers.

In [redacted], the system was changed and she was taken off her regular job duties of placing the buttons on the clothes. She was to count the pieces, such as buttons and belts, and prepare them for placement by other people; however, she continued using the gun to place the tags on the clothes. This aggravated her right wrist, hand and fingers. The work load was increased and it became difficult for her, but she continued to work. During this time, the pain began to travel up the right arm, right shoulder, neck and middle back. She asked to be given a different job to perform.

She then saw her own physician for her complaints, and medication was prescribed. She was placed on restrictions, but these were not honored by her employer. She was given a letter from her physician stating that she needed to be changed from her current position, but again this was not honored.

She continued working her regular duties, which also involved bringing carts full of clothes to her work station, and then pushing it down the line when the cart was done. Approximately days ago, she began to experience pain in the left shoulder, left hand and left wrist.

She had not received any other medical treatment for her complaints.

Present Status: She complained of pain in the neck, which comes and goes; burning pain in the mid back which was present all the time; pain in the right shoulder, which was present all the time, and travelled down the right arm; pain in the right wrist, hand and fingers, which comes and goes, varying in intensity; numbness in the right hand and fingers during the night; lump between the right thumb and index finger; swelling in the right wrist area and in the hand; weakness in the right hand, which had caused her to drop things; pain in the left shoulder, which comes and goes; and pain in the left wrist and hand, which comes and goes; numbness also in the wrist, hand and fingers.

Work Status: She had been employed at the time of the incident as a person by [redacted] since . . . She was still working for this employer as a person, performing her regular duties. She had missed two weeks from work due to the injuries, and she had left early due to the pain in her hands and arms. She was not currently receiving benefits from any source.

Job Description: At the time of the injury, her job duties included placing the tags, buttons and belt hoops on the clothes and pulling the carts forward once they were full of clothes. This required standing, walking, pulling, pushing, carrying and lifting up to 25 pounds, repetitive use of her hands, cutting with scissors, packaging the buttons and then closing the zip lock bags, packaging belts in plastic bags, stooping, leaning, reaching, and using a small gun to put the tickets on the clothes.

Prior Employment History: She did not have a previous employer.

Medical History: She had thyroid problem. She had a tumor removed from her neck area twice four years ago. She had Cesarean sections in , -- -- and .

Medications: She was on Synthroid and Hydrocodone.

Physical Examination: She weighed pounds.

Diagnoses: 1) Cervical and upper thoracic spine sprain/strain. 2) Rule out right upper extremity radiculopathy; rule out right carpal tunnel syndrome. 3) Left upper extremity pain due to overcompensation for neck and right upper extremity pain and weakness.

Disability Status: She was temporarily totally disabled through, at least, .

Treatment Recommendations: She was examined in the capacity of a primary treating physician relative to her cervical spine, thoracic spine, right shoulder and upper extremity and left shoulder/hand/wrist symptoms, which had been attributed to an industrial injury that she sustained on a continuous trauma basis from while employed by [redacted] as a ; person. She had been found to remain symptomatic at this time and in need of further evaluation and treatment.

Of note was missing page 1.

Progress Note, by [redacted] M.D., dated .

History of Illness: The applicant came for follow up with no acute complaints. She did see the Workman's Compensation doctor through her place of employment for right upper extremity paresthesia for pain and neck pain. Work up was in progress at this time. She had been to physical therapy and had been taking anti-inflammatory medication and Vicodin as needed and muscle relaxants. She was scheduled for an MRI of her cervical spine this week. She had been off work since last Monday and her symptoms had improved slightly

since being seen by her Workman's Compensation physician, otherwise without acute complaints. She continued to take Synthroid 0.88 mg and clinically was euthyroid. She self-discontinued Zocor one month ago because she ran out of this medication. Her last lab check was TSH at that time was 3.0. Last cholesterol check was and cholesterol within normal limits at that point while she was on medication. She was due for CPE but had not yet made an appointment for her annual well woman exam.

Physical Examination: Her blood pressure was 140/80 mmHg and pulse rate was 72 beats per minute. She weighed pounds.

Impressions: 1) Hypothyroidism. 2) Hypercholesterolemia. 3) Right upper extremity, pain and paresthesia secondary to work related work injury. 4) Health care maintenance.

Plan: She was to continue Synthroid .088 mg and Zocor 40 mg. Her TSH, lipid panel and liver panel were to be checked. She needed CPE.

Laboratory Report, [redacted] dated

There was high cholesterol at 240, triglycerides at 152 and LDL cholesterol at 147.

MRI of the Cervical Spine, signed by [redacted] M.D., [redacted] dated .

Conclusions: 1) C3-C4 intervertebral disc space with l to 2 mm broad-based disc bulge with minimal central canal stenosis and no neuroforaminal stenosis. 2) C3-C4 intervertebral disc space with 1 to 2 mm broad-based disc bulge with resultant minimal central canal stenosis and no significant neuroforaminal stenosis. 3) No evidence of Chiari-I malformation, demyelinating disease or syrinx.

AOE/COE Orthopedic Evaluation, signed by [redacted], M.D., Orthopedic Surgeon dated .

Chief Complaints: The applicant complained of pain and numbness in the upper extremity. She complained of pain in the cervical spine.

History of Present Illness: She developed pain and numbness in her right upper extremity and neck secondary to the repetitive demands of her work activities at [redacted] She worked in the shipping department and the job requires that she apply buttons and tags to clothing. She also had to pack boxes. It was described that her work as being very repetitive and needed to use a gun to apply the tags and buttons. She began to note problems in and she reported this to her supervisor. She sought treatment initially through Medical Group which was a private insurance. X-rays were obtained and was provided with medications and she was told this was a work injury. She received no treatment after she reported this to her supervisor. She continued to work with pain and claimed that since she was not provided with medical care, she obtained an attorney. She had been referred to see a doctor who has ordered some tests, provided her with medications, and had taken her off work. She had persistent complaints of neck and right arm pain associated with numbness. She came for an orthopedic AOE/COE evaluation with regard to her injury.

Job Title/Work History: She was employed in the shipping department of [redacted] working 9 hours a day, 5 days a week. Her job required her to unload stock, apply button, belts, and tags to clothing. This involved using a tagging-gun. She had to grip continually throughout the day with frequent lifting. She had performed this type of work for years and had been with her employer for about years. She had been off work from to present time. She missed two weeks of work in

Present Complaints: She complained of neck pain extending into the upper back and right hand. The pain was worse when she was working. The pain was stabbing and burning. She noted spasm in the right upper extremity. She noted intermittent numbness in her hand. Activities such as lifting intensified the pain. Rest diminished the pain.

Medications: She was on thyroid medication, Darvocet, Soma and Zantac.

Physical Examination: She weighed pounds.

Impressions: l) Questionable right carpal tunnel syndrome. 2) Cervical musculoligamentous strain with possible right-sided radiculopathy.

Discussion: She was recommended to undergo an EMG/nerve conduction velocity study. A supplemental report would be issued outlining Dr. [redacted] opinion regarding the applicant. It was Dr. [redacted] understanding that applicant's work activities were certainly possible that her symptoms were related to her work on the basis of cumulative trauma. However, before a decision was to be made, a review of the EMG/NCV study would be appropriate to make sure that was no any other specific underlying pathology that might be causing her symptoms.

Permanent and Stationary Status: She was not permanent and stationary and required orthopedic care.

Disability Status: She might return to work with the restriction of light use of the right upper extremity, no repetitive grip, push and pull activities, no heavy lifting.

Recommended Treatment: She was recommended to undergo EMG/NCV study.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., Orthopedic Surgeon dated .

The applicant's MRI revealed 1 to 2 mm disc bulge at the cervical spine and was doing better.

Treatment Plan: She was to continue physical therapy.

Work Status: She was off work for weeks.

Certificate of Disability, by [redacted] M.D., dated

The applicant was off work through

Nerve Conduction Report, by [redacted], M.D., dated

This EMG/NCV of both upper limbs were abnormal and consistent with bilateral, moderate carpal tunnel syndrome, right worse than left.

Primary Treating Physician's Supplemental Orthopedic Evaluation, signed by [redacted] M.D., Orthopedic Surgeon dated

Current Work Status: The applicant was not working. She was receiving disability benefits from the workers' compensation carrier.

Present Complaints: She complained of burning, aching, spasms and stiffness in her neck and mid back. She had difficulty turning her head. There was pain and swelling in the right hand, with difficulty making a fist. There was pain in the left wrist and weakness in both hands.

Diagnoses: 1) Cervical and upper thoracic spine sprain/strain, with disc bulge at C3-C4, per MRI. 2) Bilateral carpal tunnel syndrome, right worse than left. 3) Left upper extremity pain due to overcompensation for neck and right upper extremity pain and weakness.

Disability Status: She was temporarily totally disabled through, at least,

Treatment Recommendations: She was recommended bilateral carpal tunnel release. She was to continue physical therapy and symptomatic medication.

Progress Note, by [redacted] M.D., dated

History of Illness: The applicant came for follow-up. She was still seeing [redacted] of orthopedic surgery. She had a Workers' Compensation case for her chronic neck pain and bilateral carpal tunnel syndrome. She had been taking Flexeril, Ibuprofen and Darvocet on an as needed basis for her on going symptoms. She also had participated in physical therapy with minimal relief of her symptoms. She had not discussed epidural injections into the neck with [redacted] but she would do so at her next office appointment.

She had been complaining of some fatigue recently. She had not had her TSH done since . She was off her cholesterol medications because she ran out of it.

Her stomach had been giving her more trouble. She was taking Ranitidine twice a day for gastritis, but was not working very well for her.

Her sister, who was year-old, was recently diagnosed with breast cancer, and she was very concerned about having breast cancer herself. She would like to have a mammogram.

Physical Examination: Her blood pressure was 124/80 mmHg and pulse rate was 88 beats per minute. She weighed pounds.

Assessment: 1) Hypercholesterolemia. 2) Hypothyroidism. 3) Neck pain secondary to degenerative disc disease.

Plan: Her lipid panel and TSH would be checked. She was to continue Synthroid 0.75 mg. She was to continue current medication. She was to consider epidural injection to the neck.

Laboratory Report, [redacted] dated

There was high cholesterol at 257, triglycerides at 168, and LDL cholesterol at 162. On CBC, there was low hemoglobin at 9.2, hematocrit at 29.5, MCV at 64, MCHC at 19.8; there was high RDW at 16.3 and platelet count at 484.

Primary Treating Physician's Supplemental Orthopedic Evaluation, by [redacted] M.D., dated

Interim History: The applicant was last examined on . Since that time, she has continued to receive physical therapy. She denied sustaining any new or further injury.

Current Work Status: She was not working. She was receiving disability benefits from the workers' compensation carrier.

Present Complaints: She complained of inflammation of the right hand in the afternoon. There was numbness in the right hand and burning pain that went from the right side of the neck to the mid back and down through the right arm.

Diagnoses: 1) Cervical and upper thoracic spine sprain/strain, with disc bulge at C3-C4, per MRI. 2) Bilateral carpal tunnel syndrome, right worse than left. 3) Left upper extremity pain due to overcompensation for neck and right upper extremity pain and weakness.

Disability Status: She was temporarily totally disabled through, at least,

Treatment Recommendations: An authorization for a bilateral carpal tunnel release was to be obtained. She was to continue with symptomatic medication and physical therapy for both hands three times a week for four to six weeks.

Treating Physician's Report of Disability, dated .

The treating physician was unable to give opinion concerning applicant's ability to return to the pre-injury occupation.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., Orthopedic Surgeon dated .

Work Status: The applicant remained off work for weeks.

The rest of the note is illegible.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated

Work Status: The applicant remained off work for weeks.

The rest of the note is illegible.

Operative Report, by [redacted] M.D., Orthopedic Surgeon dated _____

Preoperative and Postoperative Diagnosis: Carpal tunnel syndrome on the right.

Operation Performed: Carpal tunnel release.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated _____.

Work Status: The applicant remained off work for weeks.

The rest of the note is illegible.

Treating Physician's Report of Disability, signed by [redacted], M.D., dated _____

[redacted] was unable to give an opinion concerning applicant's ability to return to the pre-injury occupation. It was expected that Dr. [redacted] would be able to provide an opinion on or about 12 months. Applicant was recovering from her symptoms. She had pending symptoms on the left carpal tunnel release.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., Orthopedic Surgeon dated _____.

Work Status: The applicant remained off work for weeks.

The rest of the note is illegible.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., Orthopedic Surgeon dated _____.

Work Status: The applicant remained off work for weeks.

The rest of the note is illegible.

Primary Treating Physician's Permanent and Stationary Report (Incomplete), signed by [redacted] M.D., dated

History: The applicant had been seen for an injury to her cervical and thoracic spine, bilateral shoulders and upper extremities, which had been attributed to her usual work with [redacted] She had worked for that employer from to mid- , as a press shipping person. That work had required frequent repetitive use of the bilateral upper extremities. A hand gun was used with both hands to place tags and extra buttons on the clothing.

Over time, she began experiencing pain and numbness to the right wrist and hand, which would increase when squeezing the gun. She reported the symptoms to her employer, but she was not referred for medical attention at that time, and continued with her regular work.

She eventually saw her primary care doctor, who prescribed medication. However, she found her work to continue to aggravate her symptoms. In her work was changed, so she did not put buttons on the clothes, but still had to use the gun for tags, which aggravated the right wrist. During that time, her work load was increased. Her pain began to travel up the arm.

She was seen by a physician who placed her on restrictions, which were not accepted by her employer. As she continued with her work, she found her pain to extend to the left shoulder and arm, due to overuse while attempting to guard the right upper extremity. She then came for further evaluation.

She was seen initially on , presenting with complaints to her neck and upper back, bilateral shoulders, wrists and hands. She was found to be in need of treatment at that time, which was to include medication and physical therapy. EMG/nerve conduction studies of the upper extremities and an MRI of the cervical spine were ordered. She was temporarily totally disabled at that time.

She was seen next on The MRI study had been done which revealed 1 to 2 mm disc bulges at C3-C4 and C4-C5. The electrodiagnostic study was pending. She had been referred to [redacted] by the insurance

company, who had ordered an EMG. Her treatment was continued at that time, and she remained temporarily totally disabled.

She had completed her electrical evaluation on which was discussed with her during her return visit on The study had revealed evidence of moderate bilateral carpal tunnel syndrome, worse on the right. Surgery for the bilateral wrists was recommended. In the meantime, she was to continue with her conservative treatment, and remained temporarily totally disabled. That status continued when seen on Subsequently, surgery was approved.

She underwent right carpal tunnel release on . She was seen for a wound check on , and the sutures were removed on A course of physical therapy was prescribed and she remained temporarily totally disabled.

Some improvement in her pain was reported when seen on Her other symptoms were noted to continue. Her therapy was continued at that time, as well as her disability status. Her therapy was found to be helping with her function when seen on , so her treatment was continued for another six weeks.

She had been seen today for re-evaluation. She had been continuing with her therapy and taking her medication. Her symptoms to the left hand continued at this time, as well as to the neck and upper back. She was not ready for surgery to the left wrist. She had no new symptoms at this time.

Job Description: Her job duties with [redacted] Inc. included placing the tags, buttons and belt hoops on the clothes and pulling the carts forward once they were full of clothes. This required standing, walking, pulling, pushing, carrying and lifting up to 25 pounds, repetitive use of her hands, cutting with scissors, packaging the buttons and then closing the zip lock bags, packaging belts in plastic bags, stooping, leaning, reaching, and using a small gun to put the tickets on the clothes.

Current Work Status: She was not working. She was receiving disability benefits from the workers' compensation carrier.

Present Complaints: She complained of intermittent pain in the back of his neck which travelled to the upper back. The right hand had pain and became swollen on occasion and there was numbness on the left hand.

Of note were missing pages 6, 7, and 8.

Orthopedic Qualified Medical Evaluation, signed by [redacted] M.D., Orthopedic Surgery dated

History of Injury: The applicant began working for [redacted] as an inspector in . In approximately , she became a pre-shipping sorter. She began to note pain in her right wrist/hand in approximately , which she felt was secondary to the repetitive use of her right hand. Around the same time, she also noted pain in her left wrist and hand, which she felt was secondary to favoring her right wrist/hand. She reported the pain to her supervisor, but a report was not made and she not sent for her treatment. In early , she saw her primary care physician, [redacted] and medication was prescribed. She was given work modifications. She gave the work modifications to her employer but it was not accepted. She continued to perform her regular job duties, during which time her bilateral wrist/hand pain gradually increased. In , she noted the gradual onset of pain in her neck that radiated across the top of both shoulders and the top of both shoulder blades, which she felt was secondary to the constant pushing and pulling of carts loaded with clothes. She reported the injury to her employer, but a report was not made. She continued to perform her regular job duties until . The pain in her neck, across the top of her shoulders, upper back, and bilateral wrists/hands gradually increased as she continued performing her regular duties. She had difficulty sleeping. Also, prolonged sitting would trigger her symptoms.

She retained the services of an attorney because her employer would not send her for treatment.

In , she was referred by her attorney to Dr. [redacted]. X-rays were obtained. She received physical therapy until , which provided temporary relief. Medication was provided. On , she underwent an MRI scan of her cervical spine. On , she

underwent electrical studies of the bilateral upper extremities. On , she underwent right carpal tunnel release. The surgery helped a little bit. She received physical therapy postoperatively for approximately three months, which provided temporary relief. On , she was deemed Permanent and Stationary by [redacted].

She had not worked since . She was receiving workers' compensation benefits. She would be finishing vocational rehabilitation as a medical assistant in four weeks.

Present Complaints: She complained of constant neck pain rated at 3/10. Carrying or lifting anything heavier than 10 pounds, sweeping, scrubbing, or mopping caused increase neck pain. Reaching overhead caused a little bit of increased neck pain. She noted decreased motion of her neck. She noted radiation of pain across the top of her right shoulder to her right upper arm. Less often, she noted radiation of pain across the top of her left shoulder.

She complained of aching intermittent daily right wrist/hand pain. Writing caused pain in her right wrist/hand. She sometimes had pain in her right wrist/hand when she was not doing anything. Lifting, grasping or repetitive activities caused pain in her right wrist/hand. She had decreased strength of her right hand.

She had numbness of her left wrist/hand at night and early morning, but not during the day.

She had pain between the shoulder blades at least three times a week rated up to 8/10. Anything, even sitting down and doing nothing, caused pain between the shoulder blades. Lifting, bending, standing, sitting and walking caused pain between the shoulder blades.

Prior to her injury, she could lift 35 to 40 pounds. Currently, she could lift up to 10 pounds.

Employment Status: She had not worked since . She was receiving workers' compensation benefits. She would be finishing vocational rehabilitation as a medical assistant in four weeks.

Job Description: A Description of Employee's Job Duties form was signed by [redacted] dated . Applicant worked at [redacted] as pre-shipping. She worked 8 hours per day, 40 hours per week. She separates and sorts out the button needed for the different styles that came in. She received the clothes and counted them. She determined the buttons needed and bundles them number or a belt. She puts the belt in a bag. She puts the button in a bag then organized the buttons in the different carts for another person. She occasionally required walking, bending and twisting at the waist and neck, reaching above shoulder level and carrying up to 10 pounds. ·She was frequently required to push and pull with both hands and lift up to 10 pounds. ·She was constantly required to stand, use her hands repetitively, perform simple grasping with both hands and reach below shoulder level.

A Description of Employee's Job Duties form was signed by [redacted] dated . Applicant worked at [redacted]. She worked 8 hours per day, 40 hour per week plus 8 hours overtime per week. She separates and sorts out the button needed for different styles that came in. She received the clothes and counts them. She determined the buttons needed and bundles them or attaches a belt. She puts the belt in a bag. She puts the button in a bag and then organized the clothes in different carts for another person. She pushes and pulls carts with clothed into her work area and to her co-workers for completion. She was occasionally required to walk, perform fine manipulation with both hands, reach above shoulder level, lift 11 to 50 pounds and carry up to 25 pounds. She was frequently required to bend and twist at the neck and waist, push and pull with both hands and lift up to 10 pounds. She was constantly required to stand, use her hands repetitively, perform simple grasping with both hands and reach below shoulder level. The heaviest item required to carry was four or more boxes filled with buttons and belts approximately 4 to 5 pounds. She carried the boxes from stock room to her work area. She was exposed to dust.

With regard to the one signed on , she related that walking was performed frequently 3 to 6 hours. She constantly performed reaching above shoulder level. With regard to the one signed dated , she related she was never given light work.

She felt she was not capable of performing her usual and customary job duties. She would not be able to lift, carry, push, pull or perform fine manipulation.

Prior Periods of Employment: She had been employed by from to . She was not currently employed.

Medical History: She underwent C-section in and She underwent umbilical hernia repair in . She had tumor surgery of the neck twice, and thyroid. She underwent right carpal tunnel release on She underwent appendectomy in . She was hospitalized for all the noted surgeries except the umbilical hernia repair and right carpal tunnel release. In she had fracture at the toe of her left foot when she bumped her foot against a wall.

Allergies: She is allergic to Tylenol.

Medications: She was on Synthroid.

Physical Examination: She weighed pounds.

Diagnoses: 1) Slight degenerative change of the cervicothoracic spine. 2) Cervicothoracic strain. 3) Bilateral carpal tunnel syndrome. 4) Status post right carpal tunnel release.

Disability Status: She could be considered Permanent and Stationary.

Causation: It was medically reasonable that she could sustain injury to her bilateral wrists from her job duties on a continuous trauma basis. According to her statements as well as the job descriptions provided in the medical records, she was required to constantly perform simple grasping with her bilateral hands.

Causation for the cervicothoracic spine was less clear as she stated that the etiology of her complaints was from constantly pushing and pulling carts loaded with clothes. This in and of itself was not necessarily sufficient to cause a cervicothoracic sprain. It was noted, however, that the job description dated revealed that in addition to frequently pushing and pulling, she was also frequently required to bend at the neck. This frequent activity

might be sufficient to aggravate the early degenerative change of the cervical spine and render it symptomatic. If, however, it was determined that she was not frequently required to bend at the neck, then the industrial causation for her cervicothoracic spine would become questionable.

Work Restrictions/Work Capacity: For the cervicothoracic spine, she was precluded from repetitive overhead work. For the right wrist, she was precluded from repetitive forceful grasping and repetitive fine manipulation. For the left wrist, she had a prophylactic preclusion from repetitive very fine manipulation and repetitive very forceful grasping.

Future Medical Care: She already had a sufficient physical therapy for her cervicothoracic spine and should be well verse in cervicothoracic exercises and precautions. She should perform those exercises at home and might take over the counter medications as needed.

Although periodic prescription medications might be indicated, she was certainly not a candidate for surgery or benefit from epidural injections.

For the left wrist, she should have a provision for carpal tunnel release should that became more symptomatic.

For the right wrist, she did not require repeat surgical intervention, however, she should be allowed to access to her treating physician for period of exacerbation.

Vocational Rehabilitation: She was already undergoing vocational rehabilitation.

Apportionment: She had some early degenerative changes about the cervicothoracic spine. However, as she denied prior injuries, symptomatology, treatment or disability to her cervicothoracic spine, [redacted] would not be able to apportion to this pre-existing change. If it was determined that her work activities caused injury, then 100% of her residual disability would be secondary to her employment with [redacted]

As far as the bilateral wrists were concerned, she denied prior injuries, symptomatology or treatment pertaining to the bilateral wrists. Apportionment would not be warranted

Primary Treating Physician's Supplemental Orthopedic Evaluation, signed by [redacted] M.D., Orthopedic Surgeon dated

Interim History: The applicant was last seen on She denied any new or further injury.

Current Work Status: She was not working this time. She was receiving benefits from the Workers' Compensation carrier.

Present Complaints: She complained of increased pain in her neck, upper and mid back, both shoulders, and both wrists.

Diagnoses: 1) Cervical and upper thoracic spine sprain/strain. 2) Carpal tunnel syndrome, left wrist. 3) Status post carpal tunnel release, right wrist.

Disability Status: She remained permanent and stationary.

Medical Note, [redacted] dated

The applicant complained of lump in the neck that measure 6 cm. It was increasing in size. She had occasional sharp pain.

Her blood pressure was 128/88 mmHg and pulse rate was 72 beats per minute. She weighed pounds.

Impression: Anemia.

The rest of the note is illegible,

Nuclear Medicine Iodine-131 Whole Body Scan, signed by [redacted], M.D., [redacted] dated

Impression: No Scintigraphic evidence of recurrent or residual disease.

Medical Note, [redacted] dated

The applicant complained of intermittent pain. She wanted repeat Pap. She complained of fatigue that was chronic and constant.

Her blood pressure was 124/72 mmHg and weighed . pounds.

Impression: Fatigue.

Plan: She was scheduled for Pap next month.

The rest of the note is illegible.

Laboratory Report, [redacted] dated _____

There was high cholesterol at 278, triglycerides at 165, LDL cholesterol at 186 and cholesterol/HDL ratio at 4.7. On CBC, there was low MCV at 81 and high RDW at 16.8.

Medical Note, [redacted] dated _____

The applicant wanted repeat Pap.

Her weight was ! pounds.

Impression: Fatigue.

The rest of the note is illegible.

Laboratory Report, [redacted] dated

The results were unremarkable.

Radiograph Study of the Chest, [redacted] dated

Impression: Normal PA chest.

Work Status, signed by [redacted], M.D., Internal Medicine dated

The applicant was to take off work from to She was to return to work without restrictions on

Medical Note, [redacted] dated

The applicant did not complain of fatigue or myalgia.

Her blood pressure was 122/80 mmHg and pulse rate was 68 beats per minute. She weighed pounds.

Impressions: 1) Positive PPD test. 2) Anemia. 3) Increase lipid.

Plan: She was prescribed Lovastatin 40 mg. She was to undergo laboratory tests.

The rest of the note is illegible.

Medical Note, [redacted] dated

The applicant complained of sore throat and fatigue. She was taking Dimetapp.

Her blood pressure was 120/84 mmHg and pulse rate was 76 beats per minute. She weighed pounds.

Impressions: 1) Upper respiratory infection. 2) Positive PPD. 3) Increase lipid.

Plan: She was prescribed INH 300 and Lovastatin 40 mg.

Laboratory Report, [redacted] dated

There was high cholesterol at 150 and TSH serum at 0.29.

Medical Note, [redacted] dated

The applicant complained of left arm pain. Her pain was increased with use.

Her blood pressure was 100/78 mmHg and pulse rate was 60 beats per minute. She weighed [redacted] pounds.

Impressions: 1) Positive PPD. 2) Increased cholesterol.

Plan: She was prescribed INH and Lovastatin 40 mg.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted].

The applicant came for thyroid check.

History of Present Illness: She had plastic surgery and was happy with the results. She had new job at [redacted] as [redacted] She complained post-menopausal symptoms. After having menses, she had vaginal itch that started 3 months ago. Her sister had PMP at [redacted] She had finished her TB medication on [redacted]. She needed follow-up of Pap.

Medications: She was on Levothyroxine Sodium 88 mcg, Naproxen 500 mg, Lovastatin 40 mg, Hydrocodone-Acetaminophen 5-500 mg, and Diclofenac sodium CR 100 mg.

Vital Signs: Her blood pressure was 120/85 mmHg and pulse rate was 72 beats per minute. She weighed [redacted] pounds.

Assessment: 1) Hyperlipidemia. 1) Hypothyroidism. 3) Premenstrual disorder. 4) Anemia.

Plan: She was to continue Lovastatin 40 mg and Levothyroxine. She was referred to gynecologist. Her CBC was to be checked.

Laboratory Report, [redacted] dated [redacted].

There was low TSH serum at 0.14. On lipid panel, there was high cholesterol at 269, triglycerides at 177 and LDL cholesterol at 1476.

Medical Note, signed by [redacted], M.D., [redacted] dated [redacted]

Medications: The applicant was on Losartan and Levothyroxine.

Her blood pressure was 159/88 mmHg and weighed pounds.

The rest of the note is illegible.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted]

The applicant came with lift arm pain and numbness.

History of Present Illness: She complained of left hand paresthesia for one month. It was intermittent and worse with reset (sic). She had difficulty to sleep due to paresthesia. Use used over the counter medication with no relief. She was doing well with thyroid prescription. She had good energy level. She was exercising to lose weight.

Medications: She was on Levothyroxine sodium 88 mcg, Naproxen 500 mg, Lovastatin 40 mg, Hydrocodone-acetaminophen 5-500 mg, Diclofenac sodium CR 100 mg and Fluconazole 200 mg.

Vital Signs: Her blood pressure was 122/82 mmHg and pulse rate was 78 beats per minute. She weighed pounds.

Assessment: 1) Tingling. 2) Hyperlipidemia. 3) Hypothyroidism. 4) Papillary adenocarcinoma of the thyroid gland.

Plan: She was prescribed Medrol dose pack, and Ibuprofen 600. She was to undergo laboratory tests.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted].

The applicant felt better from her last visit due to taking medication.

History of Present Illness: Her left arm was better after Medrol and NSAID. She had upper respiratory infection and was not better after antibiotic. She had been working at [redacted] as [redacted] for [redacted] months. She had good energy level on current thyroid prescription. She needed COE. She requested I-131.

Medications: She was on Levothyroxine Sodium 88 mcg, Naproxen 500 mg, Lovastatin 40 mg, Hydrocodone-Acetaminophen 5-500 mg, Diclofenac Sodium CR 100 mg, Fluconazole 200 mg, Methylprednisolone (Pak) 4 mg, Ibuprofen 600 mg and Zithromax 250 mg.

Vital Signs: Her blood pressure was 110/82 mmHg and pulse rate was 76 beats per minute. She weighed [redacted] pounds.

Assessment: 1) Hyperlipidemia. 2) Hypothyroidism. 3) Papillary adenocarcinoma of the thyroid gland, stable, status post thyroidectomy. 4) Anemia.

Plan: She was to continue diet and exercise. Her lipid, CBC and TSH were to be checked. She was referred for nuclear medicine study.

Bilateral Mammography, signed by [redacted], M.D., [redacted] dated [redacted].

Impression: Assessment Category: 1-negative.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted]

The applicant came with small bump on her legs for six months. It was not better with Hydrocortisone.

Medications: Levothyroxine Sodium 88 mcg, Lovastatin 40 mg, Hydrocodone-Acetaminophen 5-500 mg, Fluconazole 200 mg, Ibuprofen 600 mg and Naproxen 500 mg.

Vital Signs: Her blood pressure was 108/80 mmHg and pulse rate was 56 beats per minute. She weighed pounds.

Assessment: 1) Hyperlipidemia. 2) Gram-negative folliculitis.

Plan: She was to discontinue Fluconazole 200 mg and Ibuprofen 600 mg. Her Lovastatin 40 mg was renewed. She was prescribed clindamycin HCL 150 mg.

Progress Note, signed by [redacted] M.D., [redacted]
dated _____

The applicant came with right great toe blister and thyroid check.

History of Present Illness: she complained of bilateral knee/arm pain. She had x-ray done and wanted to review. She complained of skin rash. She failed on Clindamycin and wanted different medication. She was having problem scheduling thyroid scan. She had blister on the right big toe. She needed thyroid level check.

Medications: She was on Levothyroxine sodium 88 mcg, Lovastatin 40 mg, Hydrocodone-Acetaminophen 5-500 mg, Naproxen 500 mg, and Clindamycin HCl 150 mg.

Vital Signs: Her blood pressure was 105/80 mmHg and pulse rate was 80 beats per minute. She weighed pounds.

Assessment: 1) Hyperlipidemia. 2) Hypothyroidism. 3) Papillary adenocarcinoma of the thyroid gland, stable, status post thyroidectomy. 4) Gram-negative folliculitis. 5) Osteoarthritis.

Plan: She was to continue diet and exercise. She was to continue Levothyroxine 88 mcg. She was referred for nuclear medicine study. She was on trial of Keflex and Diclofenac 75 mg.

Laboratory Report, [redacted] dated .

The results were unremarkable.

Progress Note, signed by [redacted] M.D., [redacted] dated

The applicant came for follow-up of rash and bilateral hand pain.

History of Present Illness: Her rash was slightly better. She complained of bilateral hand pain, some swollen joints that were constant and worse with use. She had occasional paresthesia at digits 3, 4, and 5, left greater than the right. She also complained of bilateral knee pain. Her toe blister was better.

Medications: She was on Levothyroxine sodium 88 mcg, Lovastatin 40 mg, Hydrocodone-Acetaminophen 5-500 mg, Naproxen 500 mg, and Diclofenac sodium 75 mg.

Vital Signs: Her blood pressure was 110/80 mmHg and pulse rate was 76 beats per minute. She weighed . pounds.

Assessment: 1) Hyperlipidemia. 2) Hypothyroidism. 3) Papillary adenocarcinoma of the thyroid gland, stable, status post thyroidectomy. 4) Gram-negative folliculitis. 5) Osteoarthritis.

Plan: She was prescribed Lovastatin 40 mg. She was to continue Levothyroxine 88 mg. She was referred for nuclear medicine study. Her arthritis panel was to be checked.

Laboratory Report, [redacted] dated

On lipid panel, there was high cholesterol at 245 and LDL cholesterol at 145.

Radiograph Study of the Bilateral Hands, signed by [redacted] M.D., [redacted] dated

Impressions: 1) Narrowing of the radiocarpal joint, consistent with degenerative changes. 2) Rare erosions of the interphalangeal joints, raising the issue of inflammatory arthritis.

Laboratory Report, [redacted] dated [redacted].

There was low thyroglobulin at less than 0.5. On absolute counts (CBC), there were low absolute neutrophils at 14392. On CBC with differential, there was high WBC at 16.6, RBC at 5.26, and platelet count at 401; there was low MCH at 82. On CMP, there was low glucose at 104.

Medical Correspondence, signed by [redacted], M.D., dated [redacted].

This was addressed to [redacted]

The applicant presented with symptoms of pain in both hands, especially the PIP joints and DIP joints and occasionally the MCP joints. She also had pain in the neck, shoulders, upper and lower back. She had some degree of stiffness and fatigue. She denied any history of photosensitivity, Raynaud's phenomena, alopecia, mucosal ulcers, weight loss, seizure disorder etc. There was no history of urethritis or conjunctivitis. There was no history of psoriasis, podagra or kidney stones.

She had been on Levothyroxine for hypothyroidism. Her work required cleaning, mopping and heavy lifting. She also had difficulty performing activities like squatting and kneeling. In addition, she had pain in the shoulders with some difficulty reaching back.

Discussion: She was to start Flexeril 5 mg and Voltaren 50 mg.

Final Diagnostic Impressions: 1) Osteoarthritis of the hands. 2. Rule out rheumatoid arthritis. 3) Myofascial pain syndrome.

Laboratory Report, [redacted] dated [redacted].

The results were unremarkable.

Progress Note, signed by [redacted] M.D., [redacted] dated J

History of Present Illness: The applicant came with irregular menses. She was seeing [redacted] for her thyroid. She was seeing [redacted] for her arthritis which was under control. She was still on Prednisone and Methotrexate. She wanted to off on Prednisone due to weight gain. She never went to gyne last year for irregular menses. She had minimal cramps/pain.

Medications: She was on Flexeril 5 mg, Levothyroxine sodium 100 mcg, Folic acid 1 mg, Prednisone 20 mg, Methotrexate 2.5 mg, and Hydroxyzine pamoate.

Vital Signs: Her blood pressure was 108/70 mmHg and pulse rate was 64 beats per minute. She weighed pounds.

Assessment: 1) Hypothyroidism. 2) Rheumatoid arthritis.

Plan: She was to continue Levothyroxine 88 mcg. She was to continue Methotrexate. Her Prednisone was to be decreased. She was referred to gynecologist.

Laboratory Report, dated

The results were unremarkable.

Laboratory Report, [illegible], dated

There was low TSH serum at 0.11. On CBC, there was low MCHC at 25.8.

Progress Note, signed by [redacted] M.D., [redacted] dated

The applicant came for thyroid check. She presented with productive cough with clear mucous.

History of Present Illness: She complained of gaining weight. She had poor appetite and had minimal exercise. She complained of upper respiratory

infection for one month. She had cough and occasional yellow phlegm. She was not seeing Dr. [redacted] due to insurance. Her rheumatoid arthritis was stable. She felt good since she was not working. She self-discontinued Losartan. She was seeing gynecologist. She had abnormal Pap.

Medication: She was on Levothyroxine sodium 100 mcg.

Vital Signs: Her blood pressure was 105/70 mmHg and pulse rate was 68 beats per minute. She weighed pounds.

Assessment: 1) Cervical Pap smear was abnormal. 2) Hyperlipidemia. 3) Hypothyroidism. 4) Papillary adenocarcinoma of the thyroid gland, stable, status post thyroidectomy. 5) Rheumatoid arthritis. 6) Upper respiratory infection. 7) Anemia.

Plan: She was to undergo repeat laboratory test. She was to continue Levothyroxine 88 mcg.

Bilateral Mammography, signed by [redacted] M.D., [redacted] dated .

Impression: Assessment Category: 2-Benign findings.

Radiograph Study of the Left Shoulder, by [redacted] M.D., [redacted] dated .

Impression: Normal shoulder.

Radiograph Study of the Left Elbow, by [redacted] M.D., [redacted] dated .

Impression: Normal left shoulder.

Radiograph Study of the Left Hand (Incomplete), by [redacted] M.D., [redacted] dated

Of note was missing page 2.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted].

The applicant came for her thyroid and arthritis.

History of Present Illness: She was worried about weight gain. She was eating healthy. She was trying to exercise twice a week. She was back on Methotrexate. Her blood pressure was good.

Medications: She was on Methotrexate 2.5 mg, Folic acid 1 mg, Levothyroxine sodium 100 mg, and Azithromycin 250 mg.

Vital Signs: Her blood pressure was 124/86 mmHg and pulse rate was 64 beats per minute. She weighed pounds.

Assessment: 1) Recent weight gain. 2) Hyperlipidemia. 3) Hypothyroidism. 4) Papillary adenocarcinoma of the thyroid gland, stable, status post thyroidectomy. 5) Rheumatoid arthritis.

Plan: She needed to increase her exercise to 5 times a week. She was to undergo repeat laboratory tests. She was to continue Levothyroxine 88 mcg. Shew was to resume Methotrexate 12.5 mg weekly and folate.

Laboratory Report, [redacted] dated [redacted].

On CMP, there was low carbon dioxide at 20. On CBC, there was low MCH at 26.7 and high RDW at 16.3. On lipid panel, there was high cholesterol total at 286, triglycerides at 191 and LDL-cholesterol at 180. There was low TST at 0.11.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted]

The applicant came for left ring and middle finger numbness.

History of Present Illness: She complained of left hand/finger pain and paresthesia for 2 weeks. She went to the emergency room for her symptoms.

She was diagnosed of carpal tunnel syndrome. She was given Vicodin that caused nausea. She was also given wrist brace. Her symptoms were now worse and was radiating to her shoulder. She used her hand a lot at work. She is left handed. She wanted a flu shot. She started on cholesterol medication and needed laboratory test. She was still on thyroid medications and was tolerating well.

Medications: She was on Folic acid 1 mg, Levothyroxine Sodium 100 mcg, Methotrexate 2.5 mg, Hydrocortisone 2.5% cream, and Lovastatin 40 mg.

Vital Signs: Her blood pressure was 120/70 mmHg and pulse rate was 80 beats per minute. She weighed [redacted] pounds.

Assessment: 1) Tingling. 2) Hyperlipidemia. 3) Hypothyroidism. 4) Rheumatoid arthritis. 5) Need for prophylactic vaccination against influenza.

Plan: She was on trial of Medrol dose pack. Her Diclofenac was refilled. She was referred to neurologist. She was to continue Levothyroxine 88 mcg. She was to continue Methotrexate 12.5 weekly and folate.

Laboratory Report, [redacted] dated [redacted]

There was high TSH at 0.19. On lipid panel, there was high cholesterol total at 228.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted]

The applicant came with a growth on her left arm. She needed referral to a neurologist.

History of Present Illness: She complained of left biceps mass. She needed new referral to oncologist.

Medications: She was on Folic Acid 1 mg, Levothyroxine sodium 100 mcg, Methotrexate 2.5 mg, Hydrocortisone 2.5% cream, Lovastatin 40 mg, Methylprednisolone (Pak) 4 mg, and Diclofenac sodium CR 100 mg.

Vital Signs: Her blood pressure was 120/70 mmHg and pulse rate was 80 beats per minute. She weighed [redacted] pounds.

Assessment: 1) Tingling. 2) Spasm of the biceps muscle. 3) Hyperlipidemia. 4) Hypothyroidism. 5) Papillary adenocarcinoma of the thyroid gland, stable status post thyroidectomy. 5) Rheumatoid arthritis.

Plan: Her Diclofenac was refilled. She was referred to neurologist. She was on trial of Quinine. She was to continue Lovastatin 40 mg and Levothyroxine 88 mcg. She was to continue Methotrexate 12.5 mg and folate. She was referred to oncologist.

Laboratory Report, [redacted], dated [redacted].

On CBC, there was low hemoglobin at 11.4, MCV at 73.6, MCH at 23.9; there was high RDW at 17.8. On lipid panel, there was high cholesterol total at 237 and LDL-cholesterol at 147. There was low TSH at 0.04.

Neurologic Consultation, signed by [redacted], M.D., Neurologist dated [redacted]

This was addressed to [redacted]

The applicant was being evaluated for a four-month history with gradual onset numbness and tingling and pain of the left upper extremity.

She had a severe pain, and numbness and tingling sensation starting in the left hand ring and middle finger that radiated up 10 the lateral aspect of the forearm and arm, going up to the shoulder and reaching up to the left side of the neck. She was diagnosed with arthritis, probably rheumatoid arthritis, one to two years ago.

She also complained of persistent pain starting at the neck, base of the skull, shooting to the back of the head and going to the front/forehead region.

Medications: She was on Levothyroxine, Simvastatin, Diclofenac 100 mg, Methotrexate 205 mg, and folic acid.

Medical History: She has history of arthritis (probably rheumatoid arthritis), thyroid cancer status post-surgery about five years ago and now hypothyroid, and hyperlipidemia.

Impression: Her symptoms were highly consistent with left C7 radiculopathy. She had an underlying history of thyroid cancer as well as rheumatoid arthritis since she was on Methotrexate. Unfortunately, there were no medical records available during this visit.

Recommendations: She needed MRI of the cervical spine, EMG/NCV of bilateral upper extremities and re-evaluation in about four weeks.

Progress Note, signed by [redacted] M.D., [redacted]
dated [redacted].

The applicant came with painful lump on the left breast, headache for 3 days and nausea.

History of Present Illness: She complained of left breast mass which she noted over the weekend. She complained of occasional radiation of the left arm. Her sister had breast cancer. She was taking Excedrin recently with some relief. She also had fatigue. She had neurologist consultation and possibly a pinched nerve caused paresthesia.

Medications: She was on Folic Acid 1 mg, Levothyroxine sodium 100 mcg, Hydrocortisone 2.5 % cream, Methylprednisolone (Pak) 4 mg, Diclofenac sodium CR 100 mg, Quinine sulfate 325 mg, Methotrexate 2.5 mg, and Simvastatin 40 mg.

Vital Signs: Her blood pressure was 110/70 mmHg and pulse rate was 80 beats per minute. She weighed pounds.

Assessment: 1) Tingling. 2) Mastodynia. 3) Rheumatoid arthritis. 4) Anemia.

Plan: She was to continue NSAID. She was to undergo breast dz (sic). She was to continue Methotrexate 12.5 weekly and folate. She was to repeat CBC test.

Laboratory Report, [redacted], dated [redacted]

On CBC, there was low hemoglobin at 10.8, hematocrit at 33.4, MCV at 72.9, and MCH at 32.3; there was high RDW at 18.1 and platelet count at 409.

MRI of the Cervical Spine without Contrast, signed by [redacted] M.D., [redacted] dated [redacted]

Impression: No disc protrusion or stenosis was identified.

NCV/EMG Examination, signed by [redacted], M.D., [redacted] dated [redacted]

Impression: Bilateral upper extremity nerve conduction velocity study as well as EMG examination was performed. These studies showed prolonged distal motor latency and slowing of sensory conduction velocity across the wrist for left median nerve consistent with left-sided carpal tunnel syndrome.

Bilateral Mammography, signed by [redacted], M.D., [redacted] dated [redacted]

Impression: Negative (assessment category 1).

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted]

The applicant came with rash on the face.

History of Present Illness: She complained of mild depression. Her mother was sick. She was on Prozac in the past which she took for 2 years and quit about 6 years ago. She was also on Paxil in the past. She complained of occasional tearing, sadness, and anhedonia. She had pimples on the face. She completed neurological test on the left hand and hand severe neuropathy. She was using wrist brace. She was still on thyroid medication. She needed laboratory check on cholesterol.

Medications: She was on Folic Acid 1 mg, Levothyroxine sodium 100 mcg, Hydrocortisone 2.5% cream, Methylprednisolone (Pak) 4 mg, Diclofenac sodium CR 100 mg, Quinine sulfate 325 mg, Methotrexate 2.5 mg, and Simvastatin 40 mg.

Vital Signs: Her blood pressure was 100/64 mmHg and pulse rate was 80 beats per minute. She weighed pounds.

Assessment: 1) Tingling. 2) Hyperlipidemia. 3) Hypothyroidism, stable. 4) Papillary adenocarcinoma of the thyroid gland, stable, status post thyroidectomy. 5) Acne. 6) Rheumatoid arthritis. 7) Depression. 8) Anemia.

Plan: She was to continue NSAID, wrist brace, Lovastatin 40 mg, Levothyroxine 88 mcg, Methotrexate 12.5 weekly, and folate. Her TSH was to be checked and was to repeat CBC. She was to resume Fluox and was to consider counseling.

Laboratory Report, , dated .

On lipid panel, there was high cholesterol total at 211.

Medical Report, signed by [redacted], M.D., dated

The applicant worked as clothing packer who previously underwent right carpal tunnel release with good results in approximately . She now developed similar symptoms in the left hand and wrist, although she had a greater component of pain. These symptoms began approximately one year ago. She had numbness and tingling that was worse in the left middle and ring fingers, with pain in the same digits. She denied triggering of those digits. Her symptoms were worse at night, and often awaken her from sleep at night. When the symptoms became especially severe, she presented to the emergency room, where she was given a compression glove. She was later seen by her primary care physician, [redacted] who referred her for nerve conduction studies, which were performed by [redacted] approximately one month. [redacted] requested these results. She showed significant left carpal tunnel syndrome. She had used a wrist brace at night with some benefit, and had not received therapy

or injections. Her symptoms were alleviated mainly with use of the glove, the wrist brace at night, and some medications.

Diagnosis: Probable left carpal tunnel syndrome.

Plan: She would like to proceed with left carpal tunnel release. [redacted] would like to see the electrodiagnostic study report prior to scheduling the surgery.

Medical Note, [redacted] dated .

The applicant complained of cramping.

Her blood pressure was 126/84 mmHg and pulse rate was 95 beats per minute. She weighed pounds.

Medication: She was on Thyroxine.

Plan: She was to undergo ultrasound and laboratory tests on CBC.

The rest of the note is illegible.

Medical Report, signed by [redacted], M.D., [redacted] dated .

The applicant was having a surgery on .

History of Present Illness: She worked as clothing packer who previously underwent right carpal tunnel release with good results in approximately She had now developed similar symptoms in the left hand and wrist. Her left hand symptoms began approximately year ago. She had numbness and tingling that are worse in the left middle and right fingers, with pain in the same digits. Her symptoms were worse at night and often awaken her from sleep. She was given compression gauze in the emergency room. She underwent nerve conduction studies in approximately evealing left carpal tunnel syndrome. She used a night wrist brace with some benefit. She now elected to proceed with left carpal tunnel release.

Medications: She was on Levothyroxine and Lovastatin.

Family History: Significant for hypertension, diabetes, and cancer.

Diagnosis: Left carpal tunnel syndrome.

Plan: She was to undergo left carpal tunnel release.

Pelvic Sonogram, signed by [redacted], M.D., [redacted] dated _____

Impressions: 1) Right ovarian dominant follicle or follicular cyst. 2) No other abnormalities were noted.

Progress Note, signed by [redacted] M.D., [redacted] dated _____.

The applicant came with spasm of the right side of the abdomen and for discussion of her ultrasound. She needed blood work.

History of Present Illness: She underwent carpal tunnel surgery on . Her symptoms were better. She was still weak with no paresthesia. Her left should pain had resolved. She complained of occasional edema in the legs. It was worse at the end of the day and was better in the morning. She complained of intermittent abdominal pain at the right upper quadrant. She had crampy abdominal pain that lasted minutes to hours. It was resolved spontaneously. She had vaginal bleeding and went to UCC. She underwent laboratory tests and ultrasound of the pelvis. Her vaginal bleeding had resolved. She was getting a new job. She had positive PPD and needed chest x-rays.

Medications: She was on Levothyroxine sodium 100 mcg, Lovastatin 40 mg, Fluconazole 150 mg, and Medroxyprogesterone acetate 10 mg.

Vital Signs: Her blood pressure was 120/80 mmHg and pulse rate was 80 beats per minute. She weighed __ pounds.

Assessment: 1) Abdominal pain. 2) PPD showed induration and was interpreted as positive. 3) Hyperlipidemia. 4) Carpal tunnel syndrome, status post left wrist surgery.

Plan: She was to undergo ultrasound of the right upper quadrant. She was to undergo chest x-rays. She was to continue Lovastatin 40 mg. She was to continue physical therapy.

X-rays of the Chest, signed by [redacted], M.D., [redacted] dated

Impression: Normal chest.

Laboratory Report, dated

The results were unremarkable.

Progress Note, signed by [redacted], M.D., [redacted] dated

The applicant came for follow-up of her thyroid.

History of Present Illness: She complained of joint pain that was severe recently. She had not been on rheumatoid arthritis medications. She was taking Methotrexate/folate previously. She was on Aleve with minimal relief. She had not seen rheumatologist since She had been taking thyroid medication. She felt fatigue and was not sleeping well. She had not had seen endocrinologist for her thyroid cancer. Her last appointment was years ago. She was not taking cholesterol medications and needed laboratory test. She got a flu shot at work.

Medications: She was on Levothyroxine sodium 100 mcg, Lovastatin 40 mg, and Furosemide 20 mg.

Vital Signs: Her blood pressure was 102/60 mmHg and pulse rate was 88 beats per minute. She weighed pounds.

Assessment: 1) Hyperlipidemia. 2) Hypothyroidism. 3) Papillary adenocarcinoma of the thyroid gland, status post thyroidectomy. 4) Rheumatoid arthritis. 5) Anemia.

Plan: She was to undergo repeat laboratory tests. Her Levothyroxine was refilled. She was to continue NSAID. She was prescribed Vicodin. She was referred to rheumatologist.

Laboratory Report, Quest Diagnostics, dated

There was low TSH at 0.03. On lipid panel, there was high cholesterol total at 279, triglycerides at 297 and LDL-cholesterol at 157. On CBC differential, there was high RBC at 5.14 and RDW at 18; there was low MCV at 75.4 and MCH at 75.4.

Progress Note, signed by [redacted], M.D., [redacted] dated

The applicant came for laboratory work discussion.

History of Present Illness: She has allergy symptoms. She was taking Benadryl in the morning that caused her a lot of fatigue. She complained of rhinorrhea and itchy eyes. She needed referral to [redacted] She was still on Levothyroxine.

Medications: She was on Lovastatin 40 mg, Furosemide 20 mg, Hydrocodone-acetaminophen 5-500 mg, and Levothyroxine sodium 100 mcg.

Vital Signs: Her blood pressure was 120/80 mmHg and pulse rate was 88 beats per minute. She weighed pounds.

Assessment: 1) Hyperlipidemia. 2) Hypothyroidism. 3) Papillary adenocarcinoma of the thyroid gland, status post thyroidectomy. 4) Rheumatoid arthritis. 5) Anemia.

Plan: She was to start Simvastatin. She was to continue Levothyroxine 100 mcg and Vicodin. She was to undergo repeat laboratory test.

Medical Note, [redacted] dated

The applicant complained of sore throat, slight cough, chest pain, vaginal itch and discharge.

Her blood pressure was 122/86 mmHg and pulse rate was 80 beats per minute. She weighed pounds.

Assessment: Upper respiratory infection.

Plan: She was prescribed Robitussin.

Medical Note, Endocrinology Medical Group, dated

The applicant has history of thyroid cancer. She was occasionally nervous. She had trouble sleeping.

Medications: She was on Levothyroxine 100 mg and Simvastatin 401 mg.

Her blood pressure was 100/70 mmHg and weighed pounds.

Plan: She was to obtained old records for pathology report. She was to undergo laboratory tests on T4, TSH, Igg antibodies.

Progress Note, signed by [redacted], M.D., [redacted] dated

The applicant came with dry cough and joint pain.

History of Present Illness: She still complained of upper respiratory infection. She went to UCC on . She was diagnosed of viral upper respiratory infection. She was still having cough. She continued to have arthralgia. She was unable to make appointment to rheumatologist. She started Simvastatin and tolerated well. Her laboratory test would be check soon.

Medications: She was on Furosemide 20 mg, Hydrocodone-acetaminophen 5-500 mg, Levothyroxine sodium 100 mcg, Simvastatin 40 mg, and Fluconazole 150 mg.

Assessment: 1) Hyperlipidemia. 2) Rheumatoid arthritis. 3) Upper respiratory infection.

Plan: She was to undergo repeat laboratory tests. She was to continue NSAID and Vicodin. Her Diclofenac was refilled. She was prescribed Z-pack.

Laboratory Report, Quest Diagnostics, dated

On CMP, there was low carbon dioxide at 18. On lipid panel, there was high cholesterol total at 213. There was low TSH at 0.04.

Rheumatology Consultation, signed by [redacted] M.D., dated

The applicant was seen for initial evaluation of chronic rheumatoid arthritis. Her symptoms started about three years ago with pain involving her hands, elbows, and cervical spine. She described a significant amount of pain with limitation in range of movements. She was seen by [redacted] a rheumatologist and was diagnosed with rheumatoid arthritis. She was started on Methotrexate, which did not seem to improve any of her symptoms. It appeared that she might have been taking Enbrel injections, which did seem to significantly alleviate her symptoms. She lost her insurance, and the symptoms involving her hands, elbows, and shoulders had slowly returned. She had pain involving her hands and swelling involving her elbows and decreasing range of movement in both shoulders. She rated her pain at 5/10.

Medications: She was on Thyroxine, calcium and Ibuprofen.

Physical Exam: Her blood pressure was 120/80 mmHg and pulse rate was 78 beats per minute. She weighed pounds.

Impression: History of chronic rheumatoid arthritis.

Recommendations: She was to obtain medical records from her previous rheumatologist. She was to undergo laboratory tests on rheumatoid factor, CRP, CCP, and sedimentation rate. She was to undergo x-rays of the bilateral hand and foot. She was on trial of Medrol Dosepak.

X-rays of the Bilateral Shoulder, signed by [redacted], D.O., [redacted] dated [redacted]

Impression: Right-sided calcific tendinitis. Otherwise, generally normal study with no change in the left side over three years.

X-rays of the Bilateral Elbow, signed by [redacted], D.O., [redacted] dated [redacted]

Impression: Normal study.

X-rays of the Bilateral Hand, signed by [redacted], D.O., [redacted] dated [redacted]

Impression: Normal.

Laboratory Report, Quest Diagnostics, dated [redacted]

On CMP, there was high BUN/creatinine ratio at 25. On CBC with differential, there was high WBC at 14.3, absolute neutrophils at 8566 and absolute monocytes at 1802; there was low MCV at 78.8.

Progress Note, signed by [redacted], M.D., [redacted] dated [redacted]

The applicant complained of itching and redness of the cheeks for 8 days.

History of Present Illness: She complained of facial rash that started several days ago. Chemical exposure at work was not known. She touched her face after using a chemical cleaning agent. She had some erythema, pustule formation in the left cheek and right chin region. She was better now and still had mild irritation. She needed refill on thyroid medication. She was still on statin. She

had workman's' compensation injury to the right arm and wrist with pain. She had some improvement. She still required to do the same job duties at work.

Medications: She was on Furosemide 20 mg, Hydrocodone-acetaminophen 5-500 mg, Levothyroxine sodium 100 mcg, Simvastatin 40 mg, Azithromycin 250 mg, Promethazine-codeine 6.25-10 mg/5 ml syrup, and Diclofenac sodium CR 100 mg.

Vital Signs: Her blood pressure was 112/78 mmHg and pulse rate was 64 beats per minute. She weighed pounds.

Assessment: 1) Hyperlipidemia. 2) Hypothyroidism. 3) Papillary adenocarcinoma of the thyroid gland, status post thyroidectomy. 4) Rosacea. 5) Rheumatoid arthritis.

Plan: She was to continue Simvastatin 40 mg and Levothyroxine 100 mg. She was on trial of Metrogel.

Comprehensive Workers' Compensation Consultation, signed by [redacted], M.D., dated

History of Present Illness: The applicant was EVS employee (housekeeping) at [redacted] She injured her right major upper extremity while at work on The injury occurred while pushing and pulling a heavy linen cart. She also repeatedly lifted heavy bags of linen on that date. She initially felt a "hot" sensation in the right wrist and forearm.

She awakened from sleep on the morning of , with swelling in the right hand and wrist accompanied by pain. She also experienced pain in the right thumb.

She was evaluated by [redacted] at [redacted] Occupational Medicine Department on approximately [redacted] diagnosed her with tendinitis. A wrist brace was provided, which she used for two weeks. Ibuprofen was also prescribed. Her pain decreased slightly with these measures.

She attended approximately 12 sessions of supervised therapy, with improvement. She was also evaluated by her primary care physician, who administered some form of injection into the deltoid region of the right shoulder. Her symptoms decreased significantly after that injection. The pain became much less frequent, and also much less severe.

Current Complaints: She complained of occasional pain in the right major wrist, and in the right lateral elbow. The pain might occur even at rest, and generally increased when lifting heavy objects. She denied any numbness in the digits of her right hand, but experienced rare and mild tingling at the tips of the right middle and ring fingers. Her symptoms were alleviated with use of a wrist brace, and previously by supervised therapy and a shoulder injection. Her symptoms had no longer awakened her from sleep at night.

Occupational History: She had been employed as an EVS worker (housekeeper) at [redacted] in Orange since . In addition to cleaning activities, she sometimes pushed or pulled a heavy linen cart and loads bags of linen into the cart.

Previously, she was employed as a warehouse worker at a [redacted] store warehouse in Lake Forest, California, for year. She did not experience any significant upper extremity complaints related to that employment.

Medical Illnesses: She had thyroid cancer.

Previous Surgeries: She underwent three cesarean sections, hernia repair, two thyroid surgeries, and right and left carpal tunnel release with full relief of symptoms.

Medications: She was on Sulindac as needed, thyroid replacement and Simvastatin.

Family History: Significant for diabetes and kidney problems.

Diagnoses: 1) Mild right lateral epicondylitis. 2) Right wrist pain, improving. 3) Possible right volar wrist ganglion. 4) Possible right distal flexor carpi radialis

tendinitis. 5) History of right and left carpal tunnel releases with full resolution of symptoms.

Comments and Treatment Recommendations: She might require additional evaluation such as MRI. If she did have evidence of a ganglion cyst at the volar radial wrist, then surgical excision would be indicated. Corticosteroid injection to areas of localized tenderness such as the distal flexor carpi radialis sheath could be indicated.

Work Restrictions: She might continue to perform her usual and customary job duties without restrictions.

Progress Note, signed by [redacted], M.D., [redacted] dated .

The applicant came for follow-up. She needed mammogram, laboratory work up, and referral to see [redacted] She had thick big toe nail that was very itchy.

History of Present Illness: She still complained of fatigue. She was still on thyroid medication and was tolerating well. She also needed referral to see rheumatologist. The prescription from [redacted] helped a lot. She had changes at the toenail which was thick and had ridges. She had a lot of skin tag at the neck. She was still on statin and needed laboratory test.

Medications: She was on Furosemide 20 mg, Sulindac 150 mg, Hydrocodone-acetaminophen 5-500 mg, Levothyroxine sodium 100 mcg, and Metrogel l % gel.

Vital Signs: Her blood pressure was 110/78 mmHg and pulse rate was 80 beats per minute. She weighed pounds.

Assessment: 1) Hyperlipidemia. 2) Hypothyroidism. 3) Papillary adenocarcinoma of the thyroid gland, status post thyroidectomy. 4) Onychomycosis. 5) Rheumatoid arthritis.

Plan: She was to continue Simvastatin and Levothyroxine 100 mcg. She was to undergo laboratory tests. She was to resume Vicodin. She was referred to rheumatologist.

Laboratory Report, Quest Diagnostics, dated _____

On CBC with differential, there was low hematocrit at 34.8 and MCV at 34.8; there was high RDW at 19.3. On CMP, there was high glucose at 104 and low carbon dioxide at 20. There was low TSH at 0.02.

Progress Note, signed by [redacted], M.D., [redacted] dated _____.

The applicant had heavy menses for weeks.

History of Present Illness: She complained of heavy menses for weeks. She had a lot of cramps and blood clots. She had similar episode months ago. She complained of fatigue and pain in the legs. She had normal menstrual period, 3 days heavy and 4 days light.

Medications: She was on Furosemide 20 mg, Sulindac 150 mg, Hydrocodone-acetaminophen 5-500 mg, Levothyroxine sodium 100 mcg, Metrogel 1 % gel, Simvastatin 40 mg, and Clotrimazole-betamethasone 1-0.05 % cream.

Vital Signs: Her blood pressure was 120/70 mmHg and pulse rate was 80 beats per minute. She weighed pounds.

Assessment: Menometrorrhagia.

Plan: She was to undergo laboratory test and ultrasound.

MRI of the Right Hand with and without Contrast, by [redacted], M.D., dated _____.

Conclusions: 1) Mild osteoarthritis, first carpometacarpal joint. 2) No evidence for infectious/inflammatory arthritis. 3. Ganglion cyst vs. eccentric collection of

joint fluid, radial aspect of the wrist. MRI wrist could be done for further evaluation, if clinically indicated.

Laboratory Report, Quest Diagnostics, dated [redacted]

There was low TSH at 0.02. ON CBC with differential, there was high RDW at 15.6.

Pelvic Ultrasound, signed by [redacted], [redacted] dated [redacted]

Impression: No abnormality identified.

Medical Note, Endocrinology Medical Group, dated [redacted]

History of Present Illness: The applicant old records were received.

Medication: She was on Levothyroxine 100 mcg.

Her blood pressure was 118/78 mmHg and pulse rate was 87 beats per minute. She weighed [redacted] pounds.

Plan: She was to undergo laboratory tests. She was scheduled for thyroid scan.

The rest of the note is illegible.

Progress Note, signed by [redacted], [redacted] dated [redacted]

The applicant came with diarrhea and dizziness for 3 days.

History of Present Illness: She complained of headache, diarrhea, and dizziness for 3 days. She also had dry cough. She had headache at the frontal that was pressure like. She had diarrhea for 3 to 5 days. Her stool was brown and loose. She had endocrinologist follow-up last year. She recently had thyroid scan.

Medications: She was on Furosemide 20 mg, Sulindac 150 mg, Hydrocodone-acetaminophen 5-500 mg, Metrogel 1% gel, Simvastatin 40 mg, Clotrimazole-betamethasone 1-0.05 % cream, and Levothyroxine sodium 100 mcg.

Vital Signs: Her blood pressure was 128/70 mmHg and pulse rate was 76 beats per minute. She weighed . pounds.

Assessment: 1) Influenza. 2) Papillary adenocarcinoma of the thyroid gland, status post thyroidectomy.

Plan: She was prescribed Compazine. She needed repeat thyroid scan.

Medical Note, Urgent Care dated

The applicant complained of body ache, sore throat, cough and runny nose.

Her blood pressure was 124/82 mmHg and pulse rate was 80 beats per minute. She weighed . pounds.

She had chest pain with cough. She complained body aches for 2 days. She had phlegm that was colored green.

Assessment: Upper respiratory infection.

Work Status, signed by [redacted]., Internal Medicine dated

The applicant could not lift more than 10 pounds and could not vacuum.

Work Status, signed by [redacted]., Internal Medicine dated

The applicant stayed off work until . She could return to work on .

Doctor's First Report of Occupational Injury or Illness, signed by [redacted], M.D., dated ,

The applicant sustained an injury on) while employed as at [redacted] She was using cleaning solution when it splashed on her eyes.

Subjective Complaints: She complained of eye chemical splash.

Diagnoses: 1) Foreign body, external eye, unspecified. 2) Foreign body entering the eye. 3) Acute chemical conjunctivitis. 4) Accident on industrial premises.

Treatment Rendered: She underwent visual acuity test, exam with slit, and exam with fluorescein. She was prescribed Tetracaine drops. The left eye was to be irrigated with water for 20 minutes. Poison control was contacted. She was to discontinue on chemical exposure. She was prescribed Erythromycin ophthalmic ointment.

Work Status: She was to return on her regular work.

Medical Note, signed by [redacted], D.P.M., dated

The applicant was to have bilateral bunion surgery. She would need approximately 3 weeks out of work. She could be on non-weight bearing and was to keep her feet elevated to reduce edema and pain.

Medical Note, signed by [redacted], D.P.M., dated

The applicant was scheduled for bilateral bunion surgery on

Work Status, signed by [redacted], D.P.M., dated

The applicant was to return to work on with no restrictions.

Work Status, signed by [redacted], D.P.M., dated

The applicant was still having pain and swelling on both feet. She would return to work on).

Work Status, signed by [redacted], M.D., dated

The applicant was off-work from to . She might return to work on .

Work Status Form, signed by [redacted], M.D., [redacted] dated [redacted].

The applicant was TTD until .

Employee Work Status/Accommodation Form, signed by [redacted], M.D., dated [redacted]

The applicant would be able to return to work on with no restrictions.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted].

The applicant came for thyroid check.

History of Present Illness: She had changed doctor. Her mother died from diabetes mellitus. She had thyroid disease. She had pain at the bunion and bunionette surgery did not help with the pain.

Vital Sign: Her blood pressure was 110/66 mmHg and pulse rate was 80 beats per minute. She weighed pounds.

Medications: She was on Clotrimazole-betamethasone 1-0.05% external cream, Simvastatin 40 mg, Prochlorperazine maleate 10 mg, Metrogel 1% external gel, Promethazine VC/Codeine 6.25-5-10 mg/5ml, Mucinex D 120-1200 mg, and Levothyroxine sodium 100 mcg.

Family History: Significant for family history of coronary artery disease, diabetes mellitus, essential hypertension, hyperlipidemia, malignant carcinoma of the breast, malignant neoplasm of the large intestine, and thyroid disorder.

Review of Systems: She felt lack of energy.

Assessment: 1) Hypothyroidism. 2) Keloid scar. 3) Complications of medical care. 4) Need for pneumococcal vaccination. 5) Need for prophylactic vaccination against diphtheria-tetanus-pertussis.

Plan: She was to discontinue Clotrimazole-betamethasone 1-0.05% external cream, Promethazine VC/codeine 6.25-5-10 mg/5ml oral syrup, Simvastatin 40 mg, Prochlorperazine maleate 10 mg, and Levothyroxine Sodium 100 mcg. She was prescribed Levothyroxine Sodium 88 mcg. Requested were Pneumovax and Boostrix. Depression treatment was considered.

Laboratory Report, Quest Diagnostics, dated _____

There was high HgbA1c at 5.7. On lipid panel, there was high cholesterol total at 305 and LDL-cholesterol at 195. On urinalysis, there were few bacteria noted. There was high vitamin B12 at >2000. There was low vitamin D at 20.

Progress Note, signed by [redacted] M.D., [redacted] dated _____

The applicant came for follow-up for her keloid on her feet.

History of Present Illness: She had a Kenalog shot in her foot keloids. This caused tremendous reaction that was common with Triamcinolone which stopped in eight days. The bunion scars were softer but some adhesions were still noted at some points, it was worse on the left fifth digit.

Vital Signs: Her blood pressure was 104/80 mmHg and pulse rate was 64 beats per minute. She weighed . pounds.

Medications: She was on Metrogel 1 %external gel, Mucinex D 120-1200 mg, Levothyroxine sodium 88 mcg, Meloxicam 15 mg, ProAir HFA 108 (90 Base) mcg/actuation, Promethazine-DM 6.25-15 MG/5 ml, Tramadol HCL 50 mg, Simvastatin 20 mg, and Vitamin D (Ergocalciferol) 50000 unit.

Assessment: Gout.

Plan: She was prescribed Allopurinol 300 mg. She was administered Celestone Soluspan 1 cc of Xylocaine 1% plain in to the right medial and lateral and left lateral foot scars.

X-rays of the Left Hand, signed by [redacted], M.D., [redacted] dated

Impressions: 1) Mild changes of osteoarthritis in the second third and fifth distal interphalangeal joints. 2) Small bone cyst in the third metacarpal head and capitate. 3) No joint erosions identified.

X-rays of the Right Hand, signed by [redacted], M.D., [redacted] dated

Impressions: 1. Minimal osteoarthritic change at the fifth distal interphalangeal joint. 2) No joint erosions identified.

X-rays of the Left Foot, signed by [redacted], M.D., [redacted] dated

Impressions: 1) Postoperative changes in the first metatarsal head and neck. 2) Possible superimposed gouty erosion and soft tissue tophus adjacent to the first metatarsal head. 3) Possible soft tissue gouty tophus adjacent to the fifth metatarsal head with questionable small erosion.

X-rays of the Right Foot, signed by [redacted], M.D., [redacted] dated

Impression: Gouty tophi and erosions at the first and fifth metatarsal heads.

Laboratory Report, Quest Diagnostics, dated

The results were unremarkable.

Work Status, [redacted] dated

The applicant was off-work from to

Podiatric Consultation, signed by [redacted] D.P.M., [redacted] dated _____

The applicant had a bunion surgery about _ · ago. She had pain at the surgical site. She had what looked like a Taylor bunionectomy as well. The 5th toe of the left foot was now displaced and laid on top of the 4th toe. She saw [redacted] for the pan and she was given HC injections on all 4 surgical sites but did not help.

Medications: She was on Metrogel 1 %external gel, Mucinex D 120-1200 mg, Levothyroxine sodium 88 mcg, Meloxicam 15 mg, ProAir HFA 108 (90 Base) mcg/actuation, Promethazine-DM 6.25-15 MG/5 ml, Tramadol HCL 50 mg, Simvastatin 20 mg, Allopurinol 300 mg, and Vitamin D (Ergocalciferol) 50000 unit.

Summary: The deformities present would require further surgery with an osteotomy of the first and fifth metatarsals. She was given foam padding to pad and protect the areas. She was encouraged to wear shoes with wide toe box. She was to be re-evaluated in two weeks.

Progress Note, signed by [redacted] D.P.M., [redacted] dated _____.

The applicant came for follow-up for her bilateral foot. The left foot 4th and 5th toe were displaced causing pain for a year and had pain at the incision area were another provided did a bunionectomy. The right foot had pain at the incision area.

Medications: She was on Metrogel 1% external gel, Mucinex D 120-1200 mg, Levothyroxine sodium 88 mcg, Meloxicam 15 mg, ProAir HFA 108 (90 Base) mcg/actuation, Promethazine-DM 6.25-15 MG/5 ml, Tramadol HCL 50 mg, Simvastatin 20 mg, Allopurinol 300 mg, and Vitamin D (Ergocalciferol) 50000 unit.

Summary: The surgical procedure was explained. She would call at such time that she wished to proceed. She initially decided to have the left foot first.

Doctor's First Report of Occupational Injury or Illness, signed by [redacted] M.D., dated

The applicant sustained an injury on while employed as at [redacted] She was at the operating room and there was no specific causation but she developed skin rash.

Subjective Complaints: She complained of bilateral legs/arms irritation.

Diagnosis: Dermatitis, non-specific.

Treatment Rendered: Dispensed were Benadryl 25 mg and Hydrocortisone 1%. She was to return to work per job function test.

Medical Note, by [redacted] dated

Beginning on Tuesday, applicant and co-worker named [redacted] began developing rash like lesion on the legs and arms with itching. Applicant had also itchiness at the chin area. [redacted] stated that there were no cleaning products and no new scrub uniform. Both women were assigned to the operating room.

A 3rd employee named [redacted] supposedly had some rash but was not working today. The operating room supervisor had not heard any operating room staff complaints of any lesions.

Primary Treating Physician's Permanent and Stationary Report, signed by [redacted] M.D., dated

Description of Injury: The applicant developed a rash and pruritus on She came to [redacted] office on and gave no specific incident. She worked in the emergency (sic) room.

Present Complaints: She complained of rash on the left and arms.

Diagnosis: Dermatitis, non-specific.

Future Medical Treatment Comments: She was capable of performing her usual and customary duties without restrictions.

Impaired Activities: She was to work on full duty on . She was discharged from care.

Progress Note, signed by [redacted] M.D., [redacted] dated

The applicant complained of tiredness, dizziness and sleepy all the time. She also came for follow-up of swelling on both feet.

History of Present Illness: She was exhausted and felt like she could sleep longer. She had right back pain for the last week or so.

Vital Signs: Her blood pressure was 108/90 mmHg and pulse rate was 60 beats per minute. She weighed pounds.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, Meloxicam 15 mg, ProAir HFA 108 (90 Base) mcg/actuation, Promethazine-DM 6.25-15 MG/5 ml, Tramadol HCL 50 mg, Simvastatin 20 mg, Allopurinol 300 mg, and Allopurinol 300 mg.

Assessment: 1) Avitaminosis D. 2) Hypothyroidism. 3) Gout. 4) Hallux valgus. 5) Anemia.

Plan: Ordered were laboratory tests on uric acid, vitamin D and urine analysis. She was to continue Levothyroxine 100 mcg. She was to follow-up [redacted] to arrange her surgery in December.

Laboratory Report, , dated

On urinalysis, there were few bacteria noted. There was low TSH at 0.13.

Progress Note, signed by [redacted] D.P.M., [redacted] dated

The applicant right foot still had pain at the incision area. The left foot had pain on the ball of the foot between the 2nd and 3rd toe.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, Meloxicam 15 mg, ProAir HFA 108 (90 Base) mcg/actuation, Promethazine-DM 6.25-15 MG/5 ml, Tramadol HCL 50 mg, Simvastatin 20 mg, Allopurinol 300 mg, and Allopurinol 300 mg.

Summary: She was scheduled for surgery for bunionectomy with osteotomy of the 5th metatarsal of her left foot. She was having almost constant pain and had difficulty with enclosed shoes.

Progress Note, signed by [redacted] D.P.M., [redacted] dated [redacted]

The applicant came for preoperative visit. She was to have surgery on [redacted]. She was having left foot bunionectomy with osteotomy and 5th toe metatarsal osteotomy.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, Meloxicam 15 mg, ProAir HFA 108 (90 Base) mcg/actuation, Promethazine-DM 6.25-15 MG/5 ml, Tramadol HCL 50 mg, Simvastatin 20 mg, and Allopurinol 300 mg.

Assessment: 1) Hallux valgus. 2) Bunion.

Plan: She was given walking boot. She was prescribed Hydrocodone-acetaminophen 5-500 mg.

Medical Report, signed by [redacted] M.D., [redacted] dated [redacted]

The applicant came for preoperative visit.

History of Present Illness: she would have a left bunion and bunionette correction and fix of the lifted toe with [redacted]

Vital Signs: Her blood pressure was 108/72 mmHg and pulse rate was 64 beats per minute. She weighed [illegible] pounds.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, Meloxicam 15 mg, ProAir HFA 108 (90 Base) mcg/actuation, Promethazine-DM 6.25-15 MG/5 ml, Tramadol HCL 50 mg, Simvastatin 20 mg, Allopurinol 300 mg, and Hydrocodone-acetaminophen 5-500 mg.

Assessment: 1) Visit for pre-admission testing. 2) Bunion.

Plan: She was to undergo x-rays of the chest and laboratory tests.

X-rays of the Chest, signed by [redacted] M.D., [redacted] dated [illegible]

Impression: No acute process.

ECG Report, dated [illegible]

Interpretation: Sinus rhythm. Normal ECG.

Laboratory Report, [illegible], dated [illegible]

The results were unremarkable.

Medical Report, signed by [redacted] D.P.M., [redacted] dated [illegible]

Chief Complaints: The applicant complained of left foot pain.

History of Present Illness: She underwent a bunionectomy and fifth metatarsal surgery on her left foot several years ago. Initially, she did quite well; however, subsequently she continued to have pain. She related her discomfort when she wore any enclosed shoes. Any extended periods of standing and walking or activity were painful. Her employment required almost constant standing and walking, and this also increased her symptoms. Considering the ongoing pain, as

well as the deformities that were present, it had been mutually decided to proceed with further surgery in an attempt to give her definitive relief of her symptoms.

Medical history: She has history of thyroid cancer. She had elevated cholesterol.

Surgical History: She underwent C-sections [illegible], carpal tunnel surgery, thyroid cancer surgery, appendectomy, hernia repair, and bunion surgery.

Medications: She was on Simvastatin, Allopurinol and Levothyroxine.

Social History: She worked at [redacted] as maintenance. She worked often 12 hours shift which exacerbated her foot pain.

Impression: She had been admitted for elective surgery to remove the internal fixation screw from the first metatarsal, bunionectomy with osteotomy, as well as fifth metatarsal osteotomy.

Plan: She was now to proceed with the scheduled surgery.

Operative Report, signed by Chester [redacted] D.P.M., [redacted] dated [illegible]

Preoperative and Postoperative Diagnosis: Hallux abducto valgus with associated bunion deformity of the left foot and Tailor's bunion deformity of the left foot.

Name of Operation: 1) Bunionectomy with first metatarsal osteotomy and screw fixation of the right foot. 2) Fifth metatarsal osteotomy with screw fixation of the left foot.

Progress Note, signed by [redacted] D.P.M., [redacted] dated [illegible]

The applicant came for postoperative check. She had a lot of pain and the medications were not helping very much. She wanted stronger pain medication.

History of Present Illness: She was one week status postoperative. She was having less discomfort about the surgical site. She complained of pain particularly on the side and would like stronger pain medication. Her activities were restricted as directed. The dressings were intact and removed.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, Meloxicam 15 mg, ProAir HFA 108 (90 Base) mcg/actuation, Promethazine-DM 6.25-15 MG/5 ml, Tramadol HCL 50 mg, Simvastatin 20 mg, Allopurinol 300 mg, and Hydrocodone-acetaminophen 5-500 mg.

Assessment: 1) Hallux valgus. 2) Tailor's bunion on the left foot.

Plan: The area was cleansed and sterile dressings were applied. She was advised to continue restricting activities and was to keep the foot and leg elevated. She was to use ice as needed. She was to continue with the surgical shoe. She was on weight bearing to tolerance. She was to be re-valuated in one week with x-rays.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted]

For two days, the applicant had a growth on the left side of the neck that was itchy, tender, red, getting larger, getting more bumps, and pain that shoots up to her head. She had pinprick sensation on the left hand and had also red spots.

History of Present Illness: She had two days history of left sided neck lesions, left neck pain and facial pain, and minimal headache.

Vital Signs: Her blood pressure was 110/70 mmHg and pulse rate was 64 beats per minute. She weighed , pounds.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, Meloxicam 15 mg, ProAir HFA 108 (90 Base) mcg/actuation, Promethazine-DM 6.25-15 MG/5 ml, Tramadol HCL 50 mg, Simvastatin 20 mg, Allopurinol 300 mg, and Hydrocodone-acetaminophen 5-500 mg.

Assessment: Possible herpes zoster (shingles).

Plan: She was prescribed Valtrex 1 gram, Atarax 25, and zoster titters.

Progress Note, signed by [redacted] D.P.M., [redacted] dated [redacted]

The applicant came for follow-up of the left foot. She was 2 weeks status postoperative. She came for suture removal. Her medication was giving her nausea.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, Meloxicam 15 mg, ProAir HFA 108 (90 Base) mcg/actuation, Simvastatin 20 mg, Allopurinol 300 mg, and Hydrocodone-acetaminophen 5-500 mg.

Summary: She as now able to bear full weight on the foot. She was restricting activities as directed. Dressings were intact, and removed. The incision site looked good, sutures were removed. Postoperative x-rays showed good alignment of the osteotomy and first metatarsal phalangeal joint. She was advised to begin normal bathing and massage the scar. She was to begin active and passive range of motion of the first metatarsal phalangeal joint. She would use Caban for support and compression. She was advised to remain in the surgical shoe for one week and then attempt enclosure to tolerance. She was to be re-evaluated in 2 weeks.

X-rays of the Left Foot, signed by [redacted] M.D., [redacted] dated [redacted]

Impression: Soft tissue swelling and gauze present from recent surgery. Osteotomies at the first and fifth metatarsal heads with slight apex medial and lateral angulation respectively. Screws traverse the osteotomy sites. Unremarkable remaining digits.

Progress Note, signed by [redacted] D.P.M., [redacted] dated [redacted]

The applicant came for follow-up. She was still wearing cam boot and she felt much better. She was unable to wear a regular tennis shoe.

History of Present Illness: She came for postoperative evaluation. She was wearing cam walker boot. She had tried to wear tennis shoes but was unable to fit into them. She had some mild pain along the great toe.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, Meloxicam 15 mg, ProAir HFA 108 (90 Base) mcg/actuation, Simvastatin 20 mg, Allopurinol 300 mg, and Hydrocodone-acetaminophen 5-500 mg.

Assessment: 1) Hallux varus. 2) Tailor's bunion on the left foot. 3) After care following surgery of the musculoskeletal system.

Plan: She was recommended to massage and apply lotion to the incision site. She was to gradually increase physical activity/range of motion and decreased cam walker boot use. She was to follow-up in 3 weeks.

Progress Note, signed by [redacted] D.P.M., [redacted] dated :

The applicant came for postoperative check on the left foot. She was still having swelling but no pain.

History of Present Illness: She was 6 weeks status postoperative. She had been increasing her range of motion and activity of the left foot. She had no complaints of pain but noted some tightness around the incision site. She was able to wear supportive shoes without pain. She did not feel comfortable returning to work at the present time. There was swelling in her left foot, most notable at night.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, Meloxicam 15 mg, ProAir HFA 108 (90 Base) mcg/actuation, Simvastatin 20 mg, Allopurinol 300 mg, and Hydrocodone-acetaminophen 5-500 mg.

Assessment: 1) Hallux valgus of the left foot. 2) Tailor's bunion on the left foot.

Plan: She was encouraged to increase her range of motion and physical activity. She was recommended daily walks. She was to use Coban for compression. She

was to follow-up in 3 weeks. She would be allowed to return to work as soon as she could wear enclosure comfortably.

Progress Note, signed by [redacted] M.D., [redacted] dated

The applicant came with four days of cough. Her chest hurt when she coughed. She had body aches and little bit of diarrhea.

History of Present Illness: She had cough, congestion, and sore throat for 4 days. She failed over the counter medication. She had increasing cough and fatigue.

Vital Signs: Her blood pressure was 124/80 mmHg and pulse rate was 64 beats per minute. She weighed pounds.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, Meloxicam 15 mg, ProAir HFA 108 (90 Base) mcg/actuation, Simvastatin 20 mg, and Allopurinol 300 mg.

Assessment: Possible pneumonia.

Plan: She was to undergo chest x-ray. She was prescribed Z-pak and Prometh VC with codeine.

X-rays of the Chest, signed by [redacted] M.D., [redacted]

Impression: No acute cardiopulmonary disease.

Work Status, signed by [redacted] D.P.M., dated

The applicant was off work from She might return to work on with no restrictions.

Progress Note, signed by [redacted] M.D., [redacted] dated

The applicant presented with cough and chest congestion.

History of Present Illness: She was seen by another doctor and got Z-pak but was not better after one month of illness. She still had foul discharge that was dark yellow then later in the day it might be light.

Vital Signs: Her blood pressure was 120/80 mmHg and pulse rate was 72 beats per minute. She weighed . pounds.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, Meloxicam 15 mg, ProAir HFA 108 (90 Base) mcg/actuation, Simvastatin 20 mg, and Allopurinol 300 mg.

Assessment: Possible pneumonia.

Plan: She was prescribed Levofloxacin 500 mg and vitamin D (Ergocalciferol) 50000 units.

Progress Note, signed by [redacted] D.P.M., [redacted] dated .

The applicant came for follow-up for her left foot. She was still having pain at the incision area. She was still unable to wear normal shoes comfortably.

History of Present Illness: She presented for postoperative follow-up. She was 8 weeks postoperative and had gradually increased her physical activity. She was wearing enclosed shoes. She observed edema to her left foot after 4 to 6 hours of standing or walking. She had been elevating her left foot and was icing it.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, ProAir HFA 108 (90 Base) mcg/actuation, Simvastatin 20 mg, Allopurinol 300 mg, Levofloxacin 500 mg and vitamin D 50000 units.

Assessment: 1) Hallux valgus of the left foot. 2) Tailor's bunion on the left foot.

Plan: She was to wear Tubigrip. She was to continue to massage the scar and continue bending the toe. She was given a note to go back to work on next Monday.

Progress Note, signed by [redacted] D.P.M., [redacted] dated .

The applicant came for recheck of the left foot. She was having a lot of pain and swelling.

History of Present Illness: Her pain occurred acutely 2 days ago. This occurred while she was at work. Her job required constant standing and walking as well as going up and down stairs. She had a lot of pain and swelling. She was to be referred for an x-ray.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, ProAir HFA 108 (90 Base) mcg/actuation, Simvastatin 20 mg, Allopurinol 300 mg, Levofloxacin 500 mg and vitamin D 50000 units.

Plan: Her symptoms were consistent with stress fracture. Applied was low dye strapping and flexible cast. She was encouraged to try and wear a supportive shoe. She was to discuss with her employer the possibility of limiting her work activities. Perhaps working on shorter shifts or limits her standing and walking activity.

X-rays of the Left Foot, signed by [redacted], M.D., [redacted] dated .

Impressions: 1) No acute fracture or dislocation. 2) Postsurgical appearance of first and fifth metatarsal bunionectomy and healed osteotomies. 3) Spurring at the insertion of the Achilles tendon.

Progress Note, signed by [redacted] D.P.M., [redacted] dated .

The applicant came for recheck of her pain and swelling in the left foot. A soft cast was placed during her previous visit and it helped. She complained of pain in the 5th toe of the left foot.

History of Present Illness: She had been keeping her feet elevated and restricting her activity. She complained of pain in the 5th toe of the left foot due to the wrap.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, ProAir HFA 108 (90 Base) mcg/actuation, Simvastatin 20 mg, Allopurinol 300 mg, Levofloxacin 500 mg and vitamin D 50000 units.

Assessment: 1) Fracture of the metatarsal bone. 2) Hallux valgus. 3) Tailor's bunion on the left foot.

Plan: She would gradually start to increase activity to tolerance. An arch support and strap was applied. She was to return to work in 2 weeks. She was to follow-up in one week.

Progress Note, signed by [redacted] D.P.M., [redacted] dated [redacted]

The applicant came for postoperative check on the left foot. She was doing well and was not having much pain or swelling.

History of Present Illness: She was having much less discomfort on the left foot. Padding was applied on her last visit and it helped. She was to be casted by orthotics.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, ProAir HFA 108 (90 Base) mcg/actuation, Simvastatin 20 mg, Allopurinol 300 mg, Levofloxacin 500 mg and vitamin D 50000 units.

Assessment: 1) Fracture of the metatarsal bone. 2) Hallux valgus. 3) Tailor's bunion on the left foot.

Plan: Applied was low-dye strapping on the left foot. She was given a note to return to work on Monday. She was to follow-up next week for orthotics. She was casted for orthotics.

Work Status, signed by [redacted] D.P.M., [redacted] dated [redacted]

The applicant was off-work from [redacted] to [redacted].

Progress Note, signed by [redacted] D.P.M., [redacted] dated [redacted]

The applicant came for recheck of the left foot. She was doing better. She came to pick up her orthotics.

History of Present Illness: She was seen for dispensing of orthotics. The orthotics appeared well. She was back at work and with her normal activities was having less discomfort to her left foot.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, ProAir HFA 108 (90 Base) mcg/actuation, Simvastatin 20 mg, Allopurinol 300 mg, Levofloxacin 500 mg and vitamin D 50000 units.

Assessment: 1) Fracture of the metatarsal bone. 2) Hallux valgus.

Plan: She was advised to break them in over the next week, increasing the time she worn until she was comfortable. She was to be re-evaluated in two weeks.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted]

Chief Complaints: The applicant complained of cough with runny nose and sinus pressure for 2 months.

History of Present Illness: She was sick for about 2 months. She had sore throat, cough, runny nose, sinus and chest congestion, and ear pain. She was given Zpack and then Levaquin by [redacted] in January.

Vital Signs: Her blood pressure was 120/80 mmHg and pulse rate was 70 beats per minute. She weighed pounds.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, ProAir HFA 108 (90 Base) mcg/actuation, Simvastatin 20 mg, Allopurinol 300 mg, and vitamin D 50000 units.

Assessment: Bronchitis.

Plan: She was on trial of steroids.

Progress Note, signed by [redacted] M.D., [redacted] dated

The applicant came with knee and hand pain and headache.

History of Present Illness: She had hand deformity and tightness. She had pain at the shoulder, elbows and knees.

Vital Signs: Her blood pressure was 112/82 mmHg and pulse rate was 68 beats per minute. She weighed pounds.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, ProAir HFA 108 (90 Base) mcg/actuation, Simvastatin 20 mg, Allopurinol 300 mg, Methylprednisolone 4 mg, and vitamin D 50000 units.

Assessment: 1) Avitaminosis D. 2) Hypothyroidism. 3) Gout.

Plan: She was to discontinue Simvastatin. She was to undergo laboratory test and x-rays of the hand. She was to follow-up [redacted]

X-rays of the Bilateral Hand, signed by [redacted] dated

Impression: Mild osteoarthrosis.

Laboratory Report, [redacted], dated

There was high TSH at 22.98.

Rheumatology Consultation, signed by [redacted], M.D., [redacted] dated

The applicant complained of pain at the finger and hand, swelling, stiffness, crackling, redness in hands, lower back pain, elbow pain, and shoulder pain. She had been taking Motrin 400 mg daily.

History of Present Illness: She was referred for rheumatoid arthritis. She was diagnosed with rheumatoid arthritis more than years ago and was under the care of [redacted] She had been on Methotrexate and Enbrel in the past. However due to her insurance changed, she was on the medications only for a short time. She was on Methotrexate pills and had little relief of her symptoms. She had better relief with the Enbrel. She has a history of positive PPD secondary to a history of BCG vaccination. She was treated for the positive PPD. Her chest x-ray was negative.

Over the last year she had worsening symptoms, complaining of polyarthralgias and fatigued. She had noticed swelling and pain, with redness and warmth in her fingers, wrists and feet. Morning stiffness lasted more than an hour. She had generalized myalgia.

Her rheumatoid factor and anti-CCP anti-bodies had been consistently negative. Her most recent hand x-rays showed mild osteoarthritis, but no erosions or other destructive processes.

She had a strong family history of rheumatoid arthritis in her father and siblings. Her father also had gout.

Vital Signs: Her blood pressure was 130/90 mmHg and pulse rate was 72 beats per minute. She weighed pounds.

Review of Systems: Significant for dry mouth, oral ulcers, dry eyes, eye redness, shortness of breath, photosensitivity, malar rash, and paresthesia.

Assessment: 1) Osteoarthritis. 2) Rheumatoid arthritis. 3) Arthralgia in multiple sites. 4) Myofascial pain syndrome.

Plan: She was to undergo laboratory tests and MRI of the hands. She was to start Piroxicam 20 mg. She was recommended sleep study.

Laboratory Report, Quest Diagnostics, dated

There was reactive hepatitis B surface antibody. On CMP, there was low carbon dioxide at 20 and high calcium at 10.4.

Progress Note, signed by [redacted] D.P.M., [redacted] dated .

The applicant had pain and swelling in the left forefoot. She wore the orthotics but the left one was painful.

History of Present Illness: She had acute onset of pain involving her left foot that started yesterday. It was so tender that she was unable to finish her work.

Medications: She was on Metrogel 1% external gel, Allopurinol 300 mg, Vitamin D (Ergocalciferol) 50000 unit, Levothyroxine sodium 88 mcg, Motrin IB 200 mg, and Piroxicam 20 mg.

Assessment: 1) Fracture of the metatarsal bone. 2) Hallux valgus. 3) Bunion.

Plan: Ordered was x-rays of the left foot. She was prescribed Ibuprofen 600 mg. She was given a note to not to work tomorrow. She would return to work on Saturday as she felt comfortable.

MRI of the Left Wrist without Contrast, signed by [redacted] M.D., [redacted] dated .

Impression: Scattered carpal erosions are present. Distal second and third metatarsal head erosions were present which did not involve articular surfaces. There was no significant synovitis.

MRI of the Right Wrist without Contrast, signed by [redacted], M.D., [redacted] dated [redacted]

Impression: Mild synovitis surrounding distal pole of the scaphoid with associated small erosion. Additional small radial erosion involving fourth metacarpal head with associated mild MCP synovitis present.

X-rays of the Left Foot, signed by [redacted], M.D., [redacted] dated [redacted]

Impressions: 1) Postsurgical changes of the first and fifth toes with satisfactory alignment and no evidence of hardware complications. 2) No evidence of acute osseous abnormalities. 3) Mild dorsal calcaneal enthesopathy.

Progress Note, signed by [redacted] D.P.M., [redacted] dated [redacted]

The applicant came for recheck of the left foot. She was doing better and was having less pain. She was wearing the compression stocking. The orthotics still hurt.

History of Present Illness: She was having less discomfort on her left foot. She had taken the wrap off.

Medications: She was on Metrogel 1% external gel, Allopurinol 300 mg, Vitamin D (Ergocalciferol) 50000 unit, Levothyroxine sodium 88 mcg, Motrin IB 200 mg, and Piroxicam 20 mg.

Assessment: 1) Fracture of the metatarsal bone. 2) Hallux valgus. 3) Bunion.

Plan: She was recommended to wear the enclosed shoe for the next 4 to 5 weeks. She was put lotion on her foot. Her orthotics was adjusted. She was to use tubigrip. She was to return on her daily routine.

Progress Note, signed by [redacted], M.D., [redacted] dated [redacted]

The applicant came for follow-up of her rheumatoid arthritis.

History of Present Illness: In the interim, there were no significant changes. The Piroxicam provided little help. She continued to have foot pain especially in the left fifth toe and right mid foot. Laboratory test was negative her rheumatoid factor and anti-CCP antibodies as well as ANA. However, her MRI of the hands and wrists showed erosions and synovitis.

Vital Signs: Her blood pressure was 128/80 mmHg and pulse rate was 80 beats per minute. She weighed pounds.

Medications: She was on Metrogel 1% external gel, Allopurinol 300 mg, Vitamin D (Ergocalciferol) 50000 unit, Levothyroxine sodium 88 mcg, Motrin IB 200 mg, and Piroxicam 20 mg.

Assessment: 1) Foot pain. 2) Taking high risk medication. 3) Rheumatoid arthritis. 4) Gouty arthropathy. 5) Arthralgia in multiple sites.

Plan: She was to undergo laboratory tests. She was to start Methotrexate 10 mg and folic acid. She was to take Piroxicam as needed. She was to undergo MRI of the feet; x-rays of the sacroiliac joint and hip.

X-rays of the Chest, signed by [redacted], M.D., [redacted] dated .

Impression: Normal examination.

X-rays of the Sacroiliac Joints, signed by [redacted], M.D., [redacted] dated .

Impression: No significant abnormality observed.

X-rays of the Bilateral Hip including Pelvis, signed by [redacted] M.D., [redacted] dated .

Impression: No significant abnormality observed.

Laboratory Report, Quest Diagnostics, dated [redacted]

There was positive quantiferon (R) TB gold. On CBC with differential, there was high hematocrit at 45.3. On CMP, there was high glucose at 105 and calcium at 10.3.

Progress Note, signed by [redacted], M.D., [redacted] dated [redacted]

The applicant came for follow-up of her rheumatoid arthritis and foot pain. She felt her medication was not helping. She had pain with walking. She had morning stiffness that lasted 1 to 2 hours.

History of Present Illness: She continued to have pain in most of her joints including her shoulders and hands. She was taking Methotrexate 4 tablets once a week with increasing fatigue and hair thinning. She was taking folic acid 1 mg daily. She has noticed swelling, and pain and warmth in the metacarpophalangeal joint and proximal interphalangeal joint of her hands.

Laboratory test on her last visit was remarkable for positive Quantiferon. She has a history of positive BCG vaccination and positive PPD. She was treated with various medications, the names of which she did not recall, for approximately 9 months. She worked in the health field and had received chest x-rays to monitor.

Vital Signs: Her blood pressure was 130/82 mmHg and pulse rate was 80 beats per minute. She weighed pounds.

Medications: She was on Metrogel 1% external gel, Allopurinol 300 mg, Levothyroxine sodium 88 mcg, Motrin IB 200 mg, Piroxicam 20 mg, vitamin D (Ergocalciferol) 50000 unit, Methotrexate 2.5 mg, and folic acid 1 mg.

Assessment: 1) Taking high-risk medication. 2) Rheumatoid arthritis RF negative.

Plan: She was to undergo laboratory tests. She was to increase Methotrexate to 5 tablets once a week. She was to increase folic acid 1 mg twice a day. She was

to take 1500 mg of calcium and 1000 IU of vitamin D. She was to continue Piroxicam daily over the next 2 to 3 weeks. She was to start Prednisone 10 mg. She was referred to infectious disease.

Laboratory Report, , dated

On CMP, there was high glucose at 115.

Progress Note, signed by [redacted] M.D., [redacted] dated

The applicant felt pain at the eye socket. The rheumatologist was considering the use of Humira but needed to check out a positive Quantiferon TB.

Vital Signs: Her blood pressure was 118/84 mmHg and pulse rate was 68 beats per minute. She weighed pounds.

Medication: She was on Amoxicillin-potassium clavulanate 875-125 mg.

Assessment: Orbital cellulitis of the left eye.

Ordered: She was to discontinue Piroxicam 20 mg. She was to undergo x-rays of the sinus series. She was prescribed Augmentin 875 mg.

X-rays of the Sinus, signed by [redacted], M.D., [redacted] dated

Impression: Normal waters view of the paranasal sinuses.

Progress Note, signed by [redacted], M.D., [redacted] dated

The applicant came for follow-up of her rheumatoid arthritis.

History of Present Illness: She continued to have pain in the small joints of her hands and feet. She also complained of pain all over. She had seen [redacted] infectious disease for evaluation of her positive Quantiferon in anticipation of

possibly starting her on a biologic. She saw him last week. She was going to obtain records from [redacted] regarding what treatment she had received in the past. She has a history of positive PPD and BCG vaccination. She had negative chest x-rays.

She noticed swelling, redness, and warmth in her hands. She also complained of mid and lower back pain paraspinal. The pain was there all day. She worked cleaning up the surgical suite.

Vital Signs: Her blood pressure was 120/70 mmHg and pulse rate was 64 beats per minute. She weighed pounds.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, Motrin IB 200 mg, vitamin D (Ergocalciferol) 50000 unit, Folic acid 1 mg, Methotrexate 2.5 mg, Prednisone 10 mg, and Amoxicillin-Pot clavulanate 875-125 mg.

Assessment: 1) Taking steroids. 2) Taking high risk medication. 3) Rheumatoid arthritis.

Plan: She was to increase Methotrexate to 6 tables once a week. She was to continue folic acid and Prednisone 10 mg. She was to take 1500 mg of calcium and 800 to 1000 IU of vitamin D. She was to perform weight bearing exercises. She was referred to physical therapy and was to follow-up infectious disease.

Laboratory Report, , dated

On CMP, there was high glucose at 109 and ALT at 42.

Progress Note, signed by [redacted], M.D., [redacted] dated

The applicant came for follow-up of her rheumatoid arthritis. She had mid upper back and lower back pain for one month. It hurts when she move, sit, stand, and after 15 minutes of walking the pain went away. She had more pain from sitting up. Her medications were to be renewed. She had seen in infectious disease.

History of Present Illness: She had been doing well since her last visit. She felt much better since she increased her Methotrexate dose to 6 tablets once a week. She had no side effects from the medication. She was currently taking folic acid 2 mg daily. She had not seen in the infectious disease specialist for follow-up. There were no recommendations regarding treatment versus no treatment in light of her positive Quantiferon tests.

She had minimal joint pain and warmth. Today she complained mostly of low back pain, localizing to the sacral and lumbar spine.

Vital Signs: Her blood pressure was 118/80 mmHg and pulse rate was 82 beats per minute. She weighed . . pounds.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, Motrin IB 200 mg, Vitamin D (Ergocalciferol) 50000 unit, folic acid 1 mg, Amoxicillin-Pot clavulanate 875-125 mg, Methotrexate 2.5 mg, and Prednisone 10 mg.

Assessment: 1) Lower back pain. 2) Taking steroid. 3) Taking high risk medication. 4) Rheumatoid arthritis.

Plan: She was to undergo laboratory tests and x-rays of the lumbar spine. She was to decrease Prednisone to 5 mg daily for one month then 5 mg every other day for one month. She was to take 1500 mg of calcium and 800 to 1000 IU of vitamin D daily. She was to continue Methotrexate and folic acid 2 mg. She was to perform low back exercises.

Laboratory Report, _____ dated _____

On CMP, there was high glucose at 128 and ALT at 42.

Progress Note, signed by [redacted], M.D., [redacted] dated _____

The applicant presented for evaluation of her rheumatoid arthritis. She was having more pain on her hands. She would like new infectious disease doctor.

History of Present Illness: In the interim, she had no significant flare-ups. However, she was complaining of a two-week history of worsening pain in the right hand more than left. The pain was worse at the distal interphalangeal joint and proximal interphalangeal joint. She pointed to the nodules on these joints. They were swollen and red. She also complained of low back pain, exacerbated with walking. It was also worse when she gets up from sitting position. She was currently on Methotrexate 6 tablets once a week and folic acid 2 mg daily. The last 2 weeks, she had been tapering the Prednisone 5 mg every other day as directed. She has tried to contact the infectious disease Dr. [redacted] office in regards to a follow-up. However, she had been frustrated at not receiving her response. She only saw him once to evaluate the positive Quantiferon-Gold test results.

Vital Signs: Her blood pressure was 96/70 mmHg and pulse rate was 76 beats per minute. She weighed __ pounds.

Assessment: 1) Rheumatoid arthritis. 2) Osteoarthritis. 3) Low back pain. 4) Dry mouth.

Plan: She was to increase Methotrexate to 7 tables once a week. She was to stop Prednisone. She was to undergo laboratory tests. She was to continue folic acid 2 mg daily. She was referred to infectious disease. She was to take NSAID's or Tylenol as needed. Adding Hydroxychloroquine would be considered. She was to undergo x-rays of the lumbar spine. She was to start Evoxac.

X-rays of the Lumbar Spine, signed by [redacted], M.D., [redacted] dated _____

Impression: Minimal multilevel degenerative spondylosis.

Laboratory Report, , dated _____

The results were unremarkable.

Medical Note, by [redacted], M.D., dated _____.

The applicant presented for consultation. She was treated at the Orange County for pulmonary TB in 1993. Her PPD had been positive since 1993. She reacted on 8 months of INH. Recently, she had been on Methotrexate and Prednisone 3 months ago. Currently, she complained of polyarthralgia and low back pain.

Vital Signs: Her blood pressure was 112/80 mmHg and pulse rate was 70 beats per minute. She weighed pounds.

Medications: She was on Levothyroxine 88 mcg, Simvastatin, Prednisone, and Methotrexate.

Assessment: 1) Positive PPD since 1993. 2) Rheumatoid arthritis (seronegative). 3) Osteoarthritis. 4) Gout. 5) AR/RA. 6) Hypothyroidism. 7) History of thyroid papillary cancer, status post thyroidectomy. 8) Dyslipidemia. 9) Chronic low back pain syndrome. 10) History of depression. 11) History of anemia. 12) Left carpal tunnel syndrome.

Plan: There was no need for additional latent TB therapy since she was on immunosuppression in

The rest of the note is illegible.

Progress Note, signed by [redacted] M.D., [redacted] dated

The applicant had rheumatoid negative RF and was on Methotrexate 6 per week. She did not have appointment with rheumatologist until next month.

Vital Signs: Her blood pressure was 120/90 mmHg and pulse rate was 68 beats per minute. She weighed pounds.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, Vitamin D (Ergocalciferol) 50000 unit, folic acid 1 mg, Methotrexate 2.5 mg, Prednisone 10 mg, and Cevimeline HCL 30 mg.

Assessment: 1) Lower back pain. 2) Rheumatoid arthritis RF negative.

Plan: She was to discontinue Prednisone 10 mg. She was to increase Methotrexate to 8 per week. She was prescribed Methylprednisolone 10 mg.

Progress Note, signed by [redacted], M.D., [redacted] dated]

The applicant came for follow-up of her rheumatoid arthritis and osteoarthritis. She had low back pain and wrist pain. [redacted] gave medication for her back pain but it was not related to rheumatoid arthritis. She had increased her Methotrexate to 7 tablets. She was seen by infectious disease doctor.

History of Present Illness: She complained of back pain and pelvic/hip pain. She also had increasing pain in her hands. She was having difficulty holding objects. Last week she dropped a box and bruised her left knee. Morning stiffness lasted more than one hour. She continued to have swelling and warmth in her hands.

She was tolerating Evoxac, Methotrexate 7 tablets once a week, and folic acid 2 mg daily. She had not been on Prednisone since her last visit.

Vital Signs: Her blood pressure was 110/72 mmHg and pulse rate was 82 beats per minute. She weighed ' pounds.

Medications: She was on Metrogel 1% external gel, Levothyroxine sodium 88 mcg, Vitamin D (Ergocalciferol) 50000 unit, folic acid 1 mg, Methotrexate 2.5 mg, Cevimeline HCL 30 mg and Methylprednisolone 4 mg.

Assessment: 1) Rheumatoid arthritis. 2) Fibromyalgia. 3) Osteoarthritis.

Plan: She was to increase Methotrexate to 8 tablets once a week. She was to continue folic acid. She was to undergo laboratory tests. She was referred to physical therapy. She was prescribed Celebrex.

Laboratory Report, dated]

On CMP, there was high glucose at 173, calcium at 10.5, and albumin at 5.2; there was low chloride at 97. On CBC with differential, there was high WBC at

12.4, hemoglobin at 15.7, hematocrit at 45.7, absolute neutrophils at 6027; there were low absolute eosinophils at 12.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted]

The applicant presented with joint pain and sore throat.

History of Present Illness: She was cleared by infectious disease for getting shots. She went to the infectious disease to be evaluated about positive Quantiferon test. She had completed INH in 2004 to 3005 with [redacted] Celebrex did not help.

Vital Signs: Her blood pressure was 120/90 mmHg and pulse rate was 64 beats per minute. She weighed pounds.

Medications: She was on Metrogel 1% external gel, Cevimeline HCl 30 mg, Methotrexate 2.5 mg, folic acid 1 mg, vitamin D (Ergocalciferol) 50000 unit, Levothyroxine sodium 88 mcg, and Celebrex 200 mg.

Assessment: 1) Anxiety. 2) Streptococcal sore throat. 3) Rheumatoid arthritis. 4) Arthralgia in multiple sites.

Plan: She was prescribed Hydroxychloroquine sulfate 200 mg, Celebrex 400 mg and Amoxicillin-Pot clavulanate 875-125 mg.

Laboratory Report, [redacted] dated [redacted]

There was positive rapid strep.

Progress Note, signed by [redacted], M.D., [redacted] dated [redacted]

The applicant came with sore throat and pain in the chest when coughing. She had fever that started this morning.

History of Present Illness: She had cough and fever for 3 days. She took medication for [sore] throat in the past.

Vital Signs: Her blood pressure was 129/78 mmHg and pulse rate was 82 beats per minute. She weighed [illegible] pounds.

Medications: She was on Metrogel 1% external gel, Cevimeline HCL 30 mg, Methotrexate 2.5 mg, folic acid 1 mg, vitamin D (Ergocalciferol) 50000 unit, Levothyroxine sodium 88 mcg, Celebrex 200 mg, Celebrex 400 mg, Hydroxychloroquine sulfate 200 mg, and Amoxicillin-Pot clavulanate 875-125 mg.

Assessment: Sore throat.

Plan: She was to try Zithromax 250 mg. She was off work today and tomorrow. She was prescribed Promethazine-Codeine 6.25-10 mg/5ml oral syrup.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted]

The applicant came for follow-up of her sore throat and cough. Her symptom had worsened. She had now shortness of breath and coughing up thick green mucus.

Vital Signs: Her blood pressure was 118/80 mmHg and pulse rate was 110 beats per minute. She weighed [illegible] pounds.

Medications: She was on Metrogel 1% external gel, Cevimeline HCL 30 mg, Methotrexate 2.5 mg, folic acid 1 mg, vitamin D (Ergocalciferol) 50000 unit, Levothyroxine sodium 88 mcg, Celebrex 200 mg, Hydroxychloroquine sulfate 200 mg, and Promethazine-codeine 6.25-10 mg/5ml.

Assessment: 1) Cough. 2) Bronchitis.

Plan: She was administered Xopenex 1.25 mg/3 ml inhalation nebulization solution.

Progress Note, signed by [redacted] M.D., [redacted] dated .

The applicant came with joint pain.

History of Present Illness: She had pain at the hands, distal fingers, feet, knees and elbows.

Vital Signs: Her blood pressure was 130/92 mmHg and pulse rate was 68 beats per minute. She weighed pounds.

Medications: She was on Cevimeline HCL 30 mg, folic acid 1 mg, vitamin D (Ergocalciferol) 50000 unit, Levothyroxine sodium 88 mcg, Celebrex 200 mg, Hydroxychloroquine sulfate 200 mg, Promethazine-codeine 6.25-10 mg/5ml, Azithromycin 250 mg, Metrogel l% external gel, and Methotrexate 2.5 mg.

Assessment: 1) Papillary adenocarcinoma of the thyroid gland, status post thyroidectomy. 2) Gout.

Plan: She was to discontinue Azithromycin 250 mg and vitamin D (Ergocalciferol) 50000 units. She was to undergo laboratory tests. Requested was Ketorolac tromethamine 60 mg/2 ml. She was prescribed Colorys 0.6 mg.

Laboratory Report, [illegible] dated .

There was low thyroglobulin at less than 0.2.

Rheumatology Progress Note, signed by [redacted] M.D., dated

Chief Complaints: The applicant was seen today for a secondary opinion of chronic rheumatoid arthritis. She was last seen in , but an MRI of her hand at that point did not reveal any active disease and she was also asymptomatic. About a year ago, she had started to experience diffuse joint pains in her bilateral hands, knees, and feet. She underwent bilateral foot bunionectomy surgery, however with no relief of her symptoms. In June of , an MRI of her right wrist was obtained which revealed some possible mild reactive rheumatoid

arthritis with slight erosive disease and she was started on Methotrexate. Since then, the dose had been increased to 20 mg weekly and Hydroxychloroquine was added with no relief of her symptoms. She was also started on Allopurinol and Colorys for supposed gout in her distal fingers with no relief. She also complained of diffuse shoulder, neck, and lower back pain for the last one year. She had been taking Celebrex and Ibuprofen with no relief of her symptoms. Currently, her pain level was at 7/10.

Physical Exam: Her blood pressure was 141/93 mmHg and pulse rate was 94 beats per minute. She weighed pounds.

Medications: She was on folic acid 1 mg, Hydroxychloroquine 200 mg, Colcrys 0.6 mg, Levothyroxine 88 mcg, and Methotrexate sodium 2.5 mg.

Impression/Diagnoses: 1) Rheumatoid arthritis. 2) Osteoarthritis. 3) Fibromyalgia.

Plan: She was to discontinue Allopurinol, Colcyrs, and Hydroxychloroquine. She was to decrease Methotrexate 15 mg weekly. She was to start Cymbalta 30 mg daily. She was to undergo injection at the right third distal interphalangeal joint.

Progress Note, signed by [redacted] M.D., [redacted] dated .

Chief Complaints: The applicant complained of high blood pressure, tiredness and pain at the right thumb and ring finger.

History of Present Illness: She felt tired and sleepy. She was back on 8 Methotrexate per week.

Vital Signs: Her blood pressure was 128/90 mmHg and pulse rate was 74 beats per minute. She weighed pounds.

Medications: She was on Levothyroxine Sodium 88 mcg, Metrogel 1% external gel, Methotrexate 2.5 mg, and Cymbalta 60 mg.

Assessment: 1) Hypothyroidism. 2) Anemia.

Plan: She was to undergo laboratory test.

Laboratory Report, s, dated

On CMP, there was high glucose at 123, AST at 36 and ALT at 76. On CBC with differential, there was high hematocrit at 45.3, absolute neutrophil at 7832; there was low absolute eosinophil at 11. There was low TSH at 0.14.

Progress Note, signed by [redacted] M.D., [redacted] dated

The applicant came for her bilateral foot and new issue. She had pain and redness at the right and was very sensitive on the bunion area. She had left foot pain and redness on the 5th toe and pain on the ball of the foot. She underwent surgery of the left foot in . She wore orthotics and had not had any recent x-rays.

History of Present Illness: She had bilateral foot pain. She complained of discomfort and swelling on the lateral 5th metatarsal on both feet. It was worse on the right than the left. Her symptoms occurred daily. She wore orthotics regularly but did not bring them today.

Medications: She was on Metrogel 1% external gel, Methotrexate 2.5 mg, Cymbalta 60 mg, and Levothyroxine sodium 75 mcg.

Assessment: 1) Bone spur. 2) Tailor's bunion on the left foot.

Plan: Applied were several layers of Webril attached to Coban to cushion the lateral aspect of the 5th metatarsal. She should bring her orthotic on her next visit.

Progress Note, signed by [redacted] M.D., [redacted] dated

The applicant came for persistent knee pain.

Vital Signs: Her blood pressure was 122/98 mmHg and pulse rate was 60 beats per minute. She weighed [redacted] pounds.

Medications: She was on Metrogel 1% external gel, Methotrexate 2.5 mg, Cymbalta 60 mg, and Levothyroxine sodium 75 mcg.

Assessment: 1) Osteoarthritis. 2) Tendonitis.

Plan: Requested was x-rays of the right hand. A thumb spica splint was ordered.

X-rays of the Right Hand, signed by [redacted] M.D., [redacted] dated [redacted]

Impressions: 1) 3 views of the right hand show no acute fractures or dislocations. No abnormal erosion of the bones to suggest an inflammatory arthritis. 2) There was mild osteoarthrosis involving multiple interphalangeal joints and the metacarpophalangeal joint of the thumb with joint space narrowing and early spurring. This has progressed since the prior study in [redacted]. 3) Soft tissue structures show no abnormalities.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted]

The applicant came for bilateral foot swelling.

History of Present Illness: She complained of pain involving the lesser heads of both feet especially after wearing her work shoes for 8 hours. She had been wearing her orthotics as directed.

Medications: She was on Metrogel 1% external gel, Methotrexate 2.5 mg, Cymbalta 60 mg, and Levothyroxine sodium 75 mcg.

Assessment: 1) Hallux valgus. 2) Tailor's bunion. 3) Capsulitis.

Plan: Her work shoes lining were replaced with 0.5-inch plastazote inserts.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted]

The applicant came with joint pain.

Vital Signs: Her blood pressure was 129/90 mmHg and pulse rate was 64 beats per minute. She weighed [redacted] pounds.

Medications: She was on Metrogel 1% external gel, Methotrexate 2.5 mg, Cymbalta 60 mg, and Levothyroxine sodium 75 mcg.

Assessment: Rheumatoid arthritis without rheumatoid factor.

Plan: She was to undergo laboratory test. Extensive FMLA form were filled out.

Laboratory Report, [redacted] dated [redacted]

There was high ALT at 39.

Progress Note, signed by [redacted] PA-C., [redacted] dated [redacted]

The applicant complained of headache, body aches and dizziness that started yesterday. Her blood pressure was elevated. She was also complaining of right ear pain.

History of Present Illness: She had two days history of otalgia, rhinitis, and headache.

Vital Signs: Her blood pressure was 134/89 mmHg and pulse rate was 73 beats per minute. She weighed [redacted] pounds.

Medications: She was on Metrogel 1% external gel, Methotrexate 2.5 mg, Cymbalta 60 mg, and Levothyroxine sodium 75 mcg.

Assessment: 1) Acute otitis media. 2) Headache. 3) Vertigo.

Plan: She was prescribed Amoxicillin 500 mg. She was to increase water intake and decreased caffeine.

Progress Note, signed by [redacted] M.D., [redacted] dated

The applicant came with joint pain.

History of Present Illness: She started Embrel for her arthritis. She did not go to work.

Vital Signs: Her blood pressure was 122/80 mmHg and pulse rate was 64 beats per minute. She weighed pounds.

Medications: She was on Metrogel 1% external gel and Levothyroxine sodium 75 mcg.

Assessment: 1) Gout arthropathy. 2) Osteoarthritis. 3) Rheumatoid arthritis.

Plan: She was to return on as needed basis.

Progress Note, [redacted] dated

The applicant came for FMLA form.

Vital Signs: Her blood pressure was 106/80 mmHg and pulse rate was 72 beats per minute. She weighed pounds.

Medications: She was on Metrogel 1% external gel and Levothyroxine sodium 75 mcg.

Assessment: 1) Fibromyalgia. 2) Hallux valgus. 3) Osteoarthritis. 4) Rheumatoid arthritis without rheumatoid factor.

Plan: FMLA was completed.

Laboratory Report, [redacted] dated [redacted]

On CMP, there was high AST at 36 and ALT at 64.

Work Status, signed by [redacted] M.D., [redacted] dated [redacted]

The applicant was off work from August [redacted] to September [redacted] She might return to work on September [redacted] with no restrictions.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted]

The applicant had cough for 10 days, sore throat and fatigue.

History of Present Illness: She became ill on September [redacted]. She had sinus congestion, sore throat, productive cough, and fatigue. She took a little Promethazine cough syrup.

Vital Signs: Her blood pressure was 134/82 mmHg and pulse rate was 77 beats per minute. She weighed [redacted] pounds.

Medications: She was on Metrogel 1% external gel and Levothyroxine sodium 75 mcg.

Assessment: 1) Sore throat. 2) Acute sinusitis. 3) Acute bronchitis.

Plan: She was prescribed Azithromycin 250 mg and Promethazine 6.25-15 mg/5 mg. She was to increase fluid intake.

Laboratory Report, [redacted] dated [redacted]

On CMP, there was high glucose at 136 and ALT at 46.

Progress Note, signed by [redacted] M.D., [redacted] dated [redacted]

The applicant complained of cough and cold.

History of Present Illness: She had cough with a lot of phlegm for 10 days. She had pain at the back and chest with cough. She had runny nose. She had left ear pain. She had been taking Tylenol and Mucinex with minimal relief.

Vital Signs: Her blood pressure was 140/80 mmHg and pulse rate was 74 beats per minute. She weighed pounds.

X-rays of the Chest, signed by [redacted] M.D., [redacted] dated

Impression: No acute cardiopulmonary disease.

Progress Note, signed by [redacted] M.D., [redacted] dated

The applicant still had cough and congestion in the morning and afternoon.

History of Present Illness: She got her medications form another doctor. She had antibiotics and some capsules. She had ear infection. She had phlegm and cough. She wanted to use codeine syrup and another antibiotic.

Vital Signs: Her blood pressure was 110/72 mmHg and pulse rate was 66 beats per minute. She weighed pounds.

Medications: She was on Metrogel 1% external gel, Cymbalta CPEP, Levothyroxine sodium 88 mcg, Methotrexate, Amoxicillin-Pot Clavulanate 875-125 mg, Benzonatate 200 mg, Meloxicam 15 mg, and Tramadol HCL 50 mg.

Assessment: 1) Hyperactivity of the bladder. 2) Bronchitis.

Plan: She was prescribed Azithromycin 250 mg and Promethazine-codeine 6.25-10 mg/5 ml.

Progress Note, signed by [redacted] M.D., [redacted] dated

The applicant had two weeks congestion and problem with breathing. She had cough with green phlegm.

History of Present Illness: She had cough, congestion, and sore throat for 5 days. She failed over the counter medications.

Vital Signs: Her blood pressure was 114/80 mmHg and pulse rate was 64 beats per minute. She weighed pounds.

Medications: She was on Cymbalta CPEP, Levothyroxine sodium 88 mcg, Enbrel SureClick solution, Meloxicam 15 mg, Tramadol HCL 50 mg, and Omeprazole 20 mg.

Assessment: Acute bronchitis.

Plan: She was prescribed Azithromycin 250 mg, promethazine VC/codeine 6.25-5-10 mg/5 ml, ProAir HFA 108 (90 base) mcg/actuation, and Mucinex 30-600 mg. She was to increase fluid intake. She was advised to take time off.

Progress Note, signed by [redacted] M.D., [redacted] dated

The applicant had chest tightness. She had cough with phlegm. She also had headache.

History of Present Illness: She got her Azithromycin from [redacted] She was using her inhaler twice a day. She needed to increase to four times a day.

Vital Signs: Her blood pressure was 124/100 mmHg and pulse rate was 60 beats per minute. She weighed pounds.

Medications: She was on Cymbalta CPEP, Levothyroxine sodium 88 mcg, Enbrel SureClick solution, Meloxicam 15 mg, Tramadol HCL 50 mg, Omeprazole 20 mg, Promethazine VC/Codeine 6.25-5-10 mg/5ml oral syrup, Mucinex DM 30-100 mg, ProAir HFA 108 (90 base) mcg/actuation, and Azithromycin 2.50 mg.

Assessment: Cough.

Plan: She was prescribed Amoxicillin-Pot clavulanate 875-125 mg and Benzonatate 200 mg. She was to return to work on .

Progress Note, signed by [redacted] M.D., [redacted] dated .

The applicant came to do paperwork for disability and work disability. She stopped work on and started disability on to She was returning on

Vital Signs: Her blood pressure was 112/90 mmHg and pulse rate was 68 beats per minute. She weighed pounds.

Medications: She was on Cymbalta CPEP, Levothyroxine sodium 88 mcg, Enbrel SureClick solution, Meloxicam 15 mg, Tramadol HCL·50 mg, Omeprazole 20 mg, Promethazine VC/Codeine 6.25-5-10 mg/5ml oral syrup, Mucinex DM 30-100 mg, ProAir HFA 108 (90 base) mcg/actuation, Amoxicillin-Pot clavulanate 875-125 mg, and Benzonatate 200 mg.

Assessment: Bronchitis.

Plan: Form was completed. She had three disability sets including online.

Progress Note, signed by [redacted] M.D., [redacted] dated .

The applicant upper body hurts. She stopped Enbrel at her last visit due to her cold and cough. She was asked not to take her injection by [redacted] She was requesting change of rheumatology doctor.

History of Present Illness: She was seen by rheumatology on monthly basis. There were no records from over last 12 months available. She had been told not rheumatoid arthritis and all medications were stopped. She continued with diffuse pains and aches. She had been followed by [redacted] the past year, and

was recently given disability. She returned to work but now with joint pains and aches.

Vital Signs: Her blood pressure was 124/80 mmHg and pulse rate was 72 beats per minute. She weighed [illegible] pounds.

Assessment: Myofascial pain syndrome with possible sleep disturbances.

Plan: She was to undergo breast digital mammogram screening. She wanted to change to another rheumatologist. Work note was given. She was to continue all medications. She was to consult internal medicine.

Mammography Screening, signed by [redacted], M.D., [redacted] dated [redacted]

Conclusion and Recommendations: Left breast medial retroareolar asymmetries. Recommend additional mammographic views and/or targeted ultrasound evaluation of the left breast.

Progress Note, signed by [redacted], M.D., [redacted] dated [redacted]

The applicant came with joint pain for 3 weeks.

History of Present Illness: Her hips, shoulders, elbows, wrist, and hand joints hurt. Her joint pain was chronic but more severe for 3 weeks. She worked as [illegible] in an operating room for 7 years. Her hands turn red and the finger joints swell in the evening. She was on Methotrexate and Enbrel that did not help. She worked every other weekend. Her current work did not allow her to reduce work hours.

Vital Signs: Her blood pressure was 126/88 mmHg and pulse rate was 62 beats per minute. She weighed [illegible] pounds.

Medications: She was on Levothyroxine sodium 88 mcg and Omeprazole 20 mg.

Assessment: Rheumatoid arthritis.

Plan: She was referred to [redacted] She was advised to discuss with primary care physician for possible disability.

Progress Note, [redacted] dated / _____.

The applicant needed FMLA forms to be done.

Vital Signs: Her blood pressure was 140/88 mmHg and pulse rate was 64 beats per minute. She weighed pounds.

Medications: She was on Levothyroxine sodium 88 mcg and Omeprazole 20 mg.

Assessment: 1) History of bronchitis. 2) Arthralgia of multiple sites. 3) Lower back pain. 4) Capsulitis.

Plan: Disability and family medical leave form for completion.

Digital Mammogram Unilateral, signed by [redacted], M.D., [redacted] dated _____

Conclusion and Recommendations: There was an 8 mm cyst at the 11:00 retroareolar left breast. Recommend her to return to yearly screening.

X-rays of the Right Shoulder, signed by [redacted], M.D., [redacted] dated _____

Impression: 3 views of the right shoulder demonstrated a 2 mm calcification at the level of the supraspinatus tendon attachment to the greater tuberosity. Remaining bones were normal.

X-rays of the Left Shoulder, signed by [redacted], M.D., [redacted] dated _____

Impression: There was periosteal reaction best seen on the lateral view of the inferior glenoid. No obvious fracture was seen. MRI could be helpful for further evaluations.

X-rays of the Left Elbow, signed by [redacted], [redacted] dated

Impression: 3 views of the left elbow demonstrated normal joint space with no erosive changes or joint effusion. Normal bony mineralization was seen.

X-rays of the Right Elbow, signed by [redacted], [redacted] dated

Impression: 3 views of the right elbow demonstrated normal joint space with no erosive changes or joint effusion. Normal bony mineralization was seen.

X-rays of the Bilateral Hand, signed by [redacted] dated

Impression: 1) Mild osteoarthritis of the radiocarpal joints bilaterally. 2) Subtle erosive changes of the distal interphalangeal joints of the left second and bilateral third digits. These have worsened since prior study. 3) Mild arthritis of the distal interphalangeal joints of the fifth digits bilaterally.

Laboratory Report, , dated

On CMP, there was high glucose at 234, AST at 38 and ALT at 63. There was high rheumatoid factor at 14.

Progress Note, signed by [redacted] dated

The applicant felt better being out of work. She did not get any disability money yet.

Vital Signs: Her blood pressure was 122/96 mmHg and pulse rate was 72 beats per minute. She weighed pounds.

Medications: She was on Levothyroxine sodium 88 mcg and Omeprazole 20 mg.

Assessment: Rheumatoid arthritis.

Plan: She was prescribed Humira pen 40 mg/0.8 ml subcutaneous kit.

Progress Note, signed by [redacted], [redacted] dated [redacted]

The applicant's disability was not accepted in written form and this needed to be done online. It was noted that this process was completed online with success.

Medical Report, by [redacted], Pacific Rheumatology Medical Center dated [redacted]

History of Present Illness: The applicant had been referred with history of rheumatoid. She was diagnosed about 2 years ago with rheumatoid arthritis by [redacted] She was treated with Methotrexate, Plaquenil and Enbrel without any result and she started on Humira 40 mg which she received one dose so far without improvement. Celebrex helped more than any other pain medications that she tried. The pain was essentially mechanical with worsening physical activity (she was [redacted] and worked in operating room) and improving with rest. The pain was 70/100. She had negative rheumatoid serologies as well. Today she was complaining of pain in the fingers and the hips associated with 20 minutes of morning stiffness. She had x-rays of the hands that showed possible erosive changes in the distal interphalangeal joint plus osteoarthritis changes. The HAQ score was 2.5.

Assessment: 1) Degenerative joint disease of hand. 2) Long term drug therapy. 3) Lateral epicondylitis.

Plan: She was referred to physical therapy. She was prescribed Azulfidine 500 mg. She was to undergo laboratory tests.

Progress Note, signed by [redacted], [redacted] dated [redacted]

History of Present Illness: The applicant had itching of the face for two weeks. She had some spot with liquid. She used Naproxen on it and it calmed down.

Vital Signs: Her blood pressure was 114/84 mmHg and pulse rate was 72 beats per minute. She weighed . pounds.

Medications: She was on Omeprazole 20 mg, Levothyroxine sodium 88 mcg, and Humira pen 49 mc/0.8 ml.

Assessment: 1) Localized primary osteoarthritis of the carpometacarpal joint. 2) Osteoarthritis. 3) Seborrheic dermatitis of the scalp.

Plan: She was prescribed ketoconazole 2% external cream.

Medical Report (Incomplete), Rheumatology Medical Center dated .

History of Present Illness: The applicant came to check and fill out her disability forms. She was taking Humira 40 mg every other week and Azulfidine 1000 mg.

Medical Report, by [redacted]., Rheumatology Medical Center dated .

History of Present Illness: The applicant was having forms for disability. She was taking Azulfidine 1000 mg and Humira 40 mg every other week. She had not notice any change with Humira so far but claimed that the Azulfidine was helping well. She was going to have the laboratory test next week. She was complaining of pain in the right middle finger and right thumb.

Assessment: 1) Lateral epicondylitis. 2) Long term drug therapy. 3) Degenerative joint disease of hand. 4) Acquired trigger finger.

Plan: She was to continue Azulfidine and stop Humira after her last injection next week. She agreed to the steroid injection to the right 3rd and 5th trigger fingers. She completed the disability form for employer.

Laboratory Report, , dated .

On CMP, there was high glucose at 100, AST at 49, and ALT at 56. On CBC, there was high RBC at 5.15 and hematocrit at 46.5.

Medical Report, by [redacted] Rheumatology Medical Center dated

History of Present Illness: The applicant came for injection of the right 3rd and 5th finger.

Assessment: Acquired trigger finger.

Procedure: She was administered 40 mg of Depomedrol mixed with 0.5 cc of Lidocaine 25 gauge needle into the 3rd flexor tendon of the right hand and 5th digit of the right hand.

Medical Report, signed by [redacted] dated

The applicant needed bone density and colonoscopy. She was fasting. She needed note for work. She would need permanent disability.

History of Present Illness: She came for routine physical check-up. She complained of myalgia. She was seeing rheumatologist.

Vital Signs: Her blood pressure was 142/92 mmHg and pulse rate was 72 beats per minute. She weighed [redacted] pounds.

Medications: She was on Sulfasalazine 500 mg and Ketoconazole 2% external cream.

Assessment: 1) Encounter for preventive health examination. 2) Hyperlipidemia. 3) Hypothyroidism. 4) Myofascial pain syndrome; with possible sleep disturbance. 5) Screening for malignant neoplasm of cervix.

Plan: She was to undergo colonoscopy. She was to continue rheumatologist visit.

Medical Report, by [redacted] Rheumatology Medical Center dated

History of Present Illness: The applicant came for status check and to complete her disability forms. She was satisfied with the trigger finger injections. She had pain in her fingers occasionally and Azulfidine was not helping much.

Assessment: 1) Acquired trigger finger. 2) Degenerative joint disease of hand. 3) Lateral epicondylitis. 4) Long term drug therapy.

Plan: She was to continue Azulfidine 200 mg and start Tylenol #3 as needed. She had completed the disability form and was to follow-up in few weeks.

X-ray Dexa Bone Density Axial, by [redacted], Radiology dated

Interpretation: Based on the WHO classification, the bone mineral density was normal.

Medical Report, by [redacted], Pacific Rheumatology Medical Center dated

History of Present Illness: The applicant was following up since the pain in the fingers was not improving. She took Tylenol #3 which gave her constipation. She was back on Tramadol. She did not think that Azulfidine was helping.

Assessment: 1) Lateral epicondylitis. 2) Acquired trigger finger. 3) Degenerative joint disease of hand. 4) Long term drug therapy.

Plan: She was to stop Azulfidine and try Plaquenil 200 mg. She was to continue Tramadol.

Progress Note, signed by [redacted] dated

The applicant came for follow-up of hypertension. She had pain all over the body.

History of Present Illness: She painful hands and hips. She did not want to do anything. She sat around and did not even walk.

Vital Signs: Her blood pressure was 150/100 mmHg and pulse rate was 72 beats per minute. She weighed pounds.

Medications: She was on Levothyroxine sodium 88 mcg, Sulfasalazine 500 mg, and Ketoconazole 2% external cream.

Assessment: 1) Rosacea. 2) Papillary adenocarcinoma of thyroid, status post thyroidectomy.

Plan: She was prescribed Tramadol HCL 50 mg, Hydroxychloroquine sulfate 200 mg, Prednisone 5 mg, Losartan potassium 50 mg, Metronidazole 1% cream, and Escitalopram oxalate 10 mg. She was to undergo laboratory tests.

Laboratory Report, , dated

There was low thyroglobulin at less than 0.1.

Medical Report, by [redacted]., Rheumatology Medical Center dated

History of Present Illness: The applicant came for status check. She started Plaquenil 3 weeks ago and was also taking Prednisone which was prescribed by her primary care physician as tapering dose. She felt better probably since she started the Prednisone. She was also applying for disability.

Assessment: 1) Degenerative joint disease of hand. 2) Acquired trigger finger. 3) Lateral epicondylitis. 4) Long term drug therapy.

Plan: She was to continue Prednisone and Plaquenil. Her fingers were permanently deformed and she would need permanent disability due to her medical condition. She completed the forms for her functional status. She was to follow-up in six weeks. She was referred to ophthalmologist.

Progress Note, signed by [redacted] dated [redacted]

The applicant's Levothyroxine sodium 88 mcg was renewed.

Medical Report, by [redacted] dated [redacted]

History of Present Illness: The applicant fell at home and injured her right fifth finger. The left knee was also injured and now had fluid.

Vital Signs: Her blood pressure was 130/100 mmHg and pulse rate was 82 beats per minute. She weighed [redacted] pounds.

Medications: She was on Ketoconazole 2% external cream, Hydroxychloroquine sulfate 200 mg, Tramadol HCL- 50 mg, Prednisone 5 mg, Losartan potassium 50 mg, Metronidazole 1% external gel, Escitalopram Oxalate 10 mg, and Levothyroxine sodium 88 mcg.

Assessment: Mallet deformity of the third finger of the right hand.

Plan: She was to undergo x-rays of the right fifth finger and left knee. She was referred to [redacted]

X-ray of the Right Fifth Finger, by [redacted] Radiology dated [redacted]

Impression: Fractures of the base of the fifth distal phalanx were associated with severe arthritic change and flexion deformity.

X-rays of the Left Knee, by [redacted], dated [redacted]

Impressions: 1) Knee joint effusion. 2) Suspect synovial osteochondroma posteriorly.

Medical Report, signed by [redacted] Surgeon, [redacted] dated [redacted].

The applicant complained of pain at the right little finger.

Diagnosis: Traumatic arthritis of the right little finger distal joint.

Treatment: She was a candidate for surgery to fuse the distal joint of her right little finger. She declined surgery. She was treated with splint of the right little finger. She was to return sooner if she changed her mind regarding surgery.

Medical Report, signed by [redacted]., dated

History of Present Illness: The applicant came for follow-up. She had no insurance for few months. She had stopped Plaquenil and Prednisone. She was complaining of pain at the elbow and left knee. She had x-rays of the left knee which was told to have bone to bone changes. She was also complaining of pain on both shoulders. She fractured her right small finger recently.

Vital Signs: Her blood pressure was 131/101 mmHg and pulse rate was 106 beats per minute. She weighed pounds.

Medications: She was on Losartan 25 mg.

Assessment: 1) Lateral epicondylitis. 2) Degenerative joint disease of the hand. 3) Acquired trigger finger.

Plan: She agreed to try steroid injection for the elbows and knees once authorization was approved. She was to continue Plaquenil.

Progress Note, by [redacted] dated

The applicant had pain on the left knee. She was to follow-up her arthritis condition and hypertension.

Vital Signs: Her blood pressure was 130/100 mmHg and pulse rate was 83 beats per minute. She weighed pounds.

Medication: She was on Levothyroxine sodium 88 mcg.

Assessment: 1) Chondromalacia of the left patella. 2) Osteoarthrosis.

Plan: She was referred to orthopedic surgery. She was prescribed Losartan potassium 25 mg and Diclofenac sodium 50 mg. Her Levothyroxine sodium 50 mg was renewed. She was to make decision about fusing the fractured pinky.

Progress Note, by [redacted]., Rheumatology Medical Center dated

The applicant came for left knee steroid injection.

Medications: Losartan 50 mg.

Vital Signs: Her blood pressure was 139/89 mmHg and pulse rate was 74 beats per minute. She weighed pounds.

Assessment: Knee joint effusion.

Plan: She was to undergo laboratory tests.

Laboratory Report, , dated

There was high monocyte/macrophage on the left knee.

Medical Report, signed by [redacted]., dated

The applicant came for steroid injection to the left tennis elbow. Laboratory showed normal synovial fluid. She was going to see orthopedist next week.

Vital Signs: Her blood pressure was 121/81 mmHg and pulse rate was 76 beats per minute. She weighed pounds.

Medications: She was on Losartan 25 mg.

Assessment: 1) Lateral epicondylitis. 2) Knee joint effusion.

Plan: She was administered 40 mg Depomedrol mixed with 1 cc Lidocaine at the left lateral epicondyle.

Medical Report, signed by [redacted]., dated

History of Present Illness: The applicant came for right elbow lateral epicondyle steroid injection. The synovial fluid was negative for gout, infection or inflammation. She continued to have knee pain and it buckles.

Medications: She was on Losartan 25 mg.

Vital Signs: Her blood pressure was 118/78 mmHg and pulse rate was 60 beats per minute. She weighed pounds.

Assessment: 1) Lateral epicondylitis. 2) Derangement of the knee.

Plan: She was administered 40 mg Depomedrol mixed with 1 cc of Lidocaine at the right lateral epicondyle. She was to undergo MRI of the left knee.

MRI of the Left Knee without IV Contrast, signed by [redacted] dated

Impressions: 1) Discoid meniscus involving the medial meniscus. There was a complex tear noted of the posterior horn of the medical meniscus. There was a questionable flip fragment seen posteriorly. A loose body could give a similar appearance. 2) Osteoarthritis with marginal spur formation. 3) Moderate amount of joint effusion.

Medical Report, by [redacted] Orthopedic Surgeon dated

History: The applicant left knee pain started over a year ago. She did not recall any specific injury. She had seen Dr. [redacted] from rheumatology for general joint pain. She did have a left knee intra-articular cortisone injection with aspiration performed 2 weeks ago with minimal improvement. She had pain along the medial aspect of her knee. She had pain with weight bearing activities.

She rates her pain level as medium in severity. She occasionally felt a popping sensation in any. She ambulated without assistive devices.

Physical Examination: She weighed pounds.

Plan: She was recommended with left medial robotic-assisted partial knee replacement (MAKOplasty). She would like to schedule for left medial partial knee replacement surgery.

CT of the Left Knee without IV Contrast, signed by [redacted], Outpatient Pavillon dated

Impression: No fractures or dislocations of the left hip, knee or ankle.

Progress Note, signed by [redacted] dated

The applicant came for preoperative left knee replacement.

History of Present Illness: She was going to have a left Makopasty medial replacement on

Vital Signs: Her blood pressure was 128/92 mmHg and pulse rate was 74 beats per minute. She weighed pounds.

Medications: She was on Losartan potassium 25 mg, Diclofenac sodium 50 mg, and Levothyroxine sodium 88 mcg.

Assessment: 1) Osteoarthrosis. 2) Preoperative examination.

Plan: She was to undergo laboratory tests. She was medically cleared for surgery.

X-rays of the Chest, [redacted] dated ,

Impression: Normal chest radiograph.

Laboratory Report, dated

There was high glucose at 109.

ECG Report dated

Interpretation: Normal sinus rhythm. Normal ECG.

Medical Report, signed by [redacted] dated

The applicant came for preoperative left knee replacement.

History of Present Illness: She was going to have a left Makopasty medial replacement on

Vital Signs: Her blood pressure was 128/92 mmHg and pulse rate was 74 beats per minute. She weighed pounds.

Medications: She was on Losartan potassium 25 mg, Diclofenac sodium 50 mg, and Levothyroxine sodium 88 mcg.

Assessment: 1) Osteoarthrosis. 2) Preoperative examination.

Plan: She was to undergo laboratory tests. She was medically cleared for surgery.

Progress Note, signed by [redacted], Orthopedic Surgeon, [redacted] dated

The applicant came for preoperative examination of the left knee.

Vital Signs: Her blood pressure was 159/88 mmHg and pulse rate was 77 beats per minute. She weighed pounds.

Assessment: 1) Primary localized osteoarthrosis of the lower leg. 2) Joint pain.

Treatment: She was to undergo x-rays of the left knee.

History and Physical Report, signed by [redacted]., Orthopedic Surgeon, [redacted] dated

Planned Procedure: Left knee medial partial knee replacement.

Diagnosis: Left knee severe medial compartment osteoarthritis.

History: The applicant had left knee pain that started over a year ago. On previous evaluation, she was noted to have evidence of severe medial compartment osteoarthritis with associated medial meniscus tear. She failed previous conservative treatment, and was felt to be an appropriate candidate for medial partial knee replacement surgery. She had a previous cortisone injection, been followed by a rheumatologist as well. She had been seen by her primary care doctor and cleared for surgery. It was noted that she had some allergies in the past to costume jewelry.

Current Medications: She was on Diclofenac and glucosamine. She stopped Losartan and Levothyroxine.

Physical Examination: Her blood pressure was 159/88 mmHg and weighed pounds.

Plan: She wished to proceed with the planned surgery. She planned to use Eliquis for DVT prophylaxis after surgery.

Operative Report, by [redacted]., dated

Preoperative and Postoperative Diagnosis: Left knee advanced medial compartment osteoarthritis.

Name of Operation: Left medial unicompartmental knee replacement (Makoplasty).

History and Physical Report, signed by [redacted], [redacted] dated _____

Planned Procedure: Left knee medial partial knee replacement.

Diagnosis: Left knee severe medial compartment osteoarthritis.

History: The applicant had left knee pain that started over a year ago. On previous evaluation, she was noted to have evidence of severe medial compartment osteoarthritis with associated medial meniscus tear. She failed previous conservative treatment, and was felt to be an appropriate candidate for medial partial knee replacement surgery. She had a previous cortisone injection, been followed by a rheumatologist as well. She had been seen by her primary care doctor and cleared for surgery. It was noted that she had some allergies in the past to costume jewelry.

Current Medications: She was on Diclofenac and glucosamine. She stopped Losartan and Levothyroxine.

Physical Examination: Her blood pressure was 159/88 mmHg and weighed pounds.

Plan: She wished to proceed with the planned surgery. She planned to use Eliquis for DVT prophylaxis after surgery.

Discharge Summary, signed by [redacted], dated _____

Admission Diagnoses: 1) Left knee advanced medial compartmental osteoarthritis. 2) No significant medical history.

Discharge Diagnoses: 1) Left knee advanced medial compartmental osteoarthritis. 2) No significant medical history.

Discharge Disposition: She planned to go home following discharge from the hospital.

Medical Report, signed by [redacted], [redacted] Medical Center dated [redacted].

History of Present Illness: The applicant came for status check. She was taking Tramadol, Azulfidine and Norco. She had a partial left knee replacement 3 weeks ago and was recovering slowly. She was having pain at night. She was going to physical therapy to improve her range of motion.

Assessment: 1) Derangement of the knee. 2) Lateral epicondylitis. 3) Long term drug therapy. 4) Degenerative joint disease of the hand.

Plan: She was to continue current management and was to follow-up in 2 months.

Initial Evaluation, signed by [redacted], [redacted] Therapy dated [redacted].

The applicant was seen for physical therapy evaluation and treatment.

Medical Note, signed by [redacted], Orthopedic Surgeon, [redacted] dated [redacted]

The applicant underwent left knee unicompartmental replacement. She had pain at night and swollen. She already started physical therapy. Pain medications did not help. Incisions were healing well. She walked with a walker.

Plan: She was to continue physical therapy.

X-rays of the Left Knee, by [redacted], [redacted] Radiology dated [redacted].

Technique: Three views of the left knee demonstrated interval partial, medial compartment knee prosthesis. The alignment was anatomic. There was no fracture. There was moderate size joint effusion.

Medical Note, signed by [redacted], Orthopedic Surgeon, [redacted] dated [redacted]

The applicant was doing well with range of motion. She still had moderate to severe pain. She was taking pain medication and had therapy. She ambulated with cane. She took Norco at night. She felt she was progressing slowly.

Assessment: Status post left medial unicompartmental replacement.

Plan: She was to continue physical therapy and home exercise program.

Progress Evaluation, signed by [redacted] dated [redacted].

The applicant was seen for physical therapy treatment.

Medical Report, signed by [redacted]., dated [redacted]

History of Present Illness: The applicant came for status check. She underwent a left knee partial replacement by [redacted] She was having pain in her left knee and was told it was part of the arthritis and no further management was done. She was also having trouble sleeping due to knee pain. Currently she was having more widespread body pain in the last couple of months.

Vital Signs: Her blood pressure was 97/62 mmHg and pulse rate was 86 beats per minute. She weighed pounds.

Assessment: 1) Derangement of the knee. 2) Knee joint effusion. 3) Degenerative joint disease of the hand. 4) Generalized aches and pains.

Plan: She was to start Gabapentin 100 mg and was to follow-up [redacted] She was deferred to orthopedist. She was to follow-up in 3 months.

Laboratory Report, [redacted] dated [redacted]

On BMP, there was high glucose at 109. On CBC with differential, there was high RBC at 5.14 and hematocrit at 45.4.

History and Physical Report, signed by [redacted], [redacted] dated [redacted]

Planned Procedure: Left knee manipulation under anesthesia.

Diagnosis: Left knee stiffness status post medial partial knee replacement.

History: The applicant underwent left medial unicompartmental knee replacement on [redacted] without complication. Her postoperative course had been notable for ongoing stiffness with limitations in her knee flexion. She had range of motion 0-130 degrees preoperatively. Her flexion had plateaued at 90 degrees postoperatively. She had been doing physical therapy on a regular basis; however, did stop doing her home exercises.

Plan: She was scheduled for left knee manipulation under anesthesia and would like to proceed. She would resume physical therapy.

Operative Report, signed by [redacted], Orthopedic Surgeon, [redacted] dated [redacted]

Preoperative and Postoperative Diagnosis: Left knee stiffness, status post medial partial knee replacement.

Name of Operation: Left knee manipulation under anesthesia.

Medical Report, by [redacted], [redacted] dated [redacted]

The applicant had headache and throbbing pain. She had tiredness also.

History of Present Illness: She continued with left partial knee replacement pain.

Vital Signs: Her blood pressure was 124/92 mmHg and pulse rate was 73 beats per minute. She weighed [redacted] pounds.

Medications: She was on Losartan potassium 25 mg, Diclofenac sodium 50 mg, and Levothyroxine sodium 88 mg.

Assessment: Headache.

Medical Note, signed by [redacted], [redacted] dated [redacted]

The applicant felt she had increase range of motion since her surgery. She was going to physical therapy next week. She felt her knee was very swollen.

Assessment: 1) Status post left medial unicompartmental replacement. 2) Status post left knee MUA.

Plan: She was to continue physical therapy and home exercise program.

Medical Report, signed by [redacted], M.D., dated [redacted]

History of Present Illness: The applicant came for status post check. She had stopped taking Gabapentin since the knee was hurting less. She had a manipulation of the left knee under anesthesia which helped. She was having some pain in the right elbow in the past couple of weeks.

Vital Signs: Her blood pressure was 114/74 mmHg and pulse rate was 64 beats per minute. She weighed pounds.

Assessment: 1) Lateral epicondylitis. 2) Derangement of knee. 3) Degenerative joint disease of hand.

Plan: She was to continue steroid injection to the right elbow lateral epicondyle.

Progress Note, signed by [redacted], dated [redacted]

The applicant had left knee pain and numbness of the tip of the fingers.

History of Present Illness: She has left knee replacement in and was better with swelling.

Vital Signs: Her blood pressure was 140/102 mmHg and pulse rate was 80 beats per minute. She weighed pounds.

Medications: She was on Losartan Potassium 25 mg, Diclofenac sodium 50 mg, and Levothyroxine sodium 88 mcg.

Assessment: 1) Fibromyalgia. 2) Arthralgia of multiple sites. 3) Carpal tunnel syndrome. 4) Status post total left knee replacement.

Plan: Her Diclofenac sodium 50 mg, Losartan potassium 25 mg and Levothyroxine sodium 88 mcg were renewed. She was prescribed Tramadol HCL 50 mg.

Medical Report, signed by [redacted]., dated

History of Present Illness: The applicant came for status check. Since she stopped Gabapentin, she had more whole body pain as well as back pain. Gabapentin caused some skin and eye dryness. She did not receive steroid injection to the right elbow because of insurance change. The left knee pain had improved after the surgery.

Vital Signs: Her blood pressure was 120/84 mmHg and pulse rate was 74 beats per minute. She weighed pounds.

Medication: She was on Losartan 25 mg.

Assessment: 1) Lateral epicondylitis. 2) Generalized aches and pains. 3) Derangement of the knee. 4) Acquired trigger finger.

Plan: She was to start Cymbalta 30 mg. She agreed to try steroid injection to the right elbow lateral epicondyle.

Medical Report, signed by [redacted]., dated

History of Present Illness: The applicant was taking Cymbalta but complained of drowsiness. She was also taking Tramadol that helped sometimes.

Vital Signs: Her blood pressure was 128/87 mmHg and pulse rate was 94 beats per minute. She weighed pounds.

Medication: She was on Losartan 25 mg.

Assessment: 1) Generalized body aches and pains. 2) Degenerative joint disease of hand. 3) Acquired trigger finger.

Plan: She was instructed to stop Cymbalta and agreed to start Lyrica 50 mg.

Medical Report, signed by [redacted]., dated

History of Present Illness: The applicant was feeling well with Lyrica 50 mg.

Vital Signs: Her blood pressure was 130/93 mmHg and pulse rate was 80 beats per minute. She weighed pounds.

Medications: She was on Losartan 25 mg.

Assessment: 1) Generalized aches and pains. 2) Degenerative joint disease of hand. 3) Acquired trigger finger. 4) Impingement syndrome of the shoulder region.

Plan: She was to decrease Lyrica from 50 mg to 25 mg daily. She should consider steroid injection for the right shoulder if pain continued. She was referred to physical therapy.

Medical Report, signed by [redacted]., dated

History of Present Illness: The applicant came for steroid injection to the right shoulder.

Vital Signs: Her blood pressure was 145/82 mmHg and pulse rate was 85 beats per minute. She weighed pounds.

Medications: She was on Losartan 25 mg.

Assessment: Impingement syndrome of the shoulder region.

Plan: She agreed to receive steroid injection to the right shoulder.

X-rays of the Right Shoulder, signed by [redacted] dated [redacted].

Impression: Mild glenohumeral and acromioclavicular osteoarthrosis. No fracture identified. Alignment was unremarkable.

Medical Report, by [redacted] Orthopedic Surgeon dated

Chief Complaints: The applicant complained of right shoulder pain.

History: She was a housewife with chronic right shoulder pain that started 3 years ago. She did not recall any specific injury. She had pain with elevation of her arm and reaching back. She had multiple cortisone injections in her right shoulder without improvement. The last injection was in December and was performed by her rheumatologist. She rates her pain level as medium in severity. She took Tylenol for pain.

Physical Examination: She weighed pounds.

Plan: She was recommended MRI of the right shoulder.

Doctor's First Report of Occupational Injury or Illness, signed by [redacted], Orthopedic Surgeon Undated.

The applicant sustained an injury while working in pre-shipping at [redacted] After years of doing work, she started having pain, swelling and numbness on her right hand.

Diagnoses: 1) Cervical and upper thoracic sprain/strain. 2) Rule out upper extremity radiculopathy. 3) Rule out carpal tunnel syndrome. 4) Left upper extremity pain.

Treatment Rendered: She was to undergo physical therapy, MRI of the cervical spine, and EMG/NCV of upper extremities.

Work Status: She was placed TTD on [redacted].

Progress Note, [redacted], Undated.

Chief Complaints: The applicant complained of shortness of breath and facial swelling.

Vital Signs: Her blood pressure was 118/68 mmHg and pulse rate was 90 beats per minute. She weighed [redacted] pounds.

Plan: Medrol Dosepak was ordered.

The rest of the note is illegible.

Medical Report, by [redacted]., Undated.

Chief Complaints: The applicant complained of thyroid cancer.

History of Present Illness: She was diagnosed with thyroid cancer after a biopsy done in [redacted] and was reported to be cancer of the thyroid. The nature of which was unknown. Dr. [redacted] did not believe it was papillary carcinoma. She subsequently presented and wished to have radiation treatment. She was seen in consultation by Dr. [redacted] and subsequently was scheduled for radiation ablative therapy. She underwent thyroid function tests which revealed that she was severely hypothyroid with a TSH of 129.6 and she was suffering from symptoms including fatigue and weight gain. She had no fever, no chills, no cough, no production of sputum, no chest pain, no nausea, no vomiting, no diarrhea, no constipation, and she had no palpitations. She had been in her usual state of health otherwise.

Medical History: She has history of thyroid cancer.

Surgical History: She had thyroid biopsy done with a surgical scar in the neck.

Medications: She was on Darvocet-N 100.

Physical Examination: Her blood pressure was 130/80 mmHg and weighed pounds.

Diagnoses: 1) Thyroid carcinoma, status post biopsy, papillary carcinoma. 2) Hypothyroidism secondary to thyroid carcinoma. 3) Arthralgia secondary to hypothyroidism.

Plan: She was cleared to undergo surgical procedure as specified by Dr. [redacted]. She was to start Synthroid 0.125 mg.

That completes the review of records.

Table A - Itemization of reports with blood pressure and weight:

Date of Encounter	Provider	Applicant's Blood Pressure	Applicant's Heart Rate	Hypertensive / DM Medications	HgA1c Value	Weight
December	[redacted]	110/70 mmHg	82 bpm			pounds
December	[redacted]					pounds
December	[redacted]	130/80 mmHg				pounds
February	[redacted]	130/80 mmHg				pounds
May	[redacted]	110/70 mmHg				pounds
July	[redacted]	110/70 mmHg	82 bpm			pounds
August		114/80 mmHg				
August	[redacted]	110/70 mmHg	82 bpm			pounds
September	[redacted]	110/70 mmHg	82 bpm			pounds

November	[redacted]	124/80 mmHg				pounds
November	[redacted]	120/80 mmHg				pounds
May	[redacted]	106/74 mmHg				pounds
July		102/68 mmHg	68 bpm			pounds
August	[redacted]	120/80 mmHg	70 bpm			
October	[redacted]	108/80 mmHg	80 bpm			pounds
November	[redacted]	120/80 mmHg	76 bpm			pounds
December	[redacted]	124/80 mmHg	64 bpm			pounds
January	[redacted]	128/74 mmHg	80 bpm			pounds
March	[redacted]	120/80 mmHg	8 bpm			pounds
April	[redacted]	118/70 mmHg	80 bpm			pounds
June	[redacted]	134/80 mmHg	70 bpm			pounds
August	[redacted]					pounds
August	[redacted]	140/80 mmHg	72 bpm			pounds
September	[redacted]					pounds
October	[redacted]	124/80 mmHg	88 bpm			pounds
March	[redacted]					pounds
June		128/88 mmHg	72 bpm			pounds

[redacted]
July

July		124/72				pounds
July ,						pounds
August		122/80 mmHg	68 bpm			pounds
November		120/84 mmHg	76 bpm			pounds
January		100/78 mmHg	60 bpm			pounds
April	[redacted]	120/85 mmHg	72 bpm			pounds
May	Dr. [redacted]	159/88 mmHg				pounds
June	[redacted]	122/82 mmHg	78 bpm			pounds
June	[redacted]	110/82 mmHg	76 bpm			pounds
July	[redacted]	108/80 mmHg	56 bpm			pounds
August	[redacted]	105/80 mmHg	80 bpm			pounds
August ,	[redacted]	110/80 mmHg	76 bpm			pounds
January	[redacted]	108/70 mmHg	64 bpm			pounds
April	[redacted]	105/70 mmHg	68 bpm			pounds
August	[redacted]	124/86 mmHg	64 bpm			pounds
October	[redacted]	120/70 mmHg	80 bpm			pounds
December	[redacted]	120/70 mmHg	80 bpm			pounds
February	[redacted]	110/70 mmHg	80 bpm			pounds

April	[redacted]	110/64 mmHg	80 bpm			pounds
May		126/84 mmHg	95 bpm			pounds
August	[redacted]	120/80 mmHg	80 bpm			pounds
November	[redacted]	102/60 mmHg	88 bpm			pounds
December	[redacted]	120/80 mmHg	88 bpm			pounds
January		122/86 mmHg	80 bpm			pounds
January		100/70 mmHg				pounds
April	[redacted]	120/80 mmHg	78 bpm			pounds
April	[redacted]	112/78 mmHg	64 bpm			pounds
August	[redacted]	110/78 mmHg	80 bpm			pounds
October	[redacted]	120/70 mmHg	80 bpm			pounds
November		118/78 mmHg	87 bpm			pounds
February	[redacted]	128/70 mmHg	76 bpm			pounds
May		124/82 mmHg	80 bpm			pounds

April		110/66 mmHg	80 bpm			pounds
May					5.7	
June		104/80 mmHg	64 bpm			pounds
September		108/90 mmHg	60 bpm			pounds
October		108/72 mmHg	64 bpm			pounds
November		110/70 mmHg	64 bpm			pounds
December		124/80 mmHg	64 bpm			pounds
January		120/80 mmHg	72 bpm			pounds
February		120/80 mmHg	70 bpm			pounds
April		112/82 mmHg	68 bpm			pounds
May		130/90 mmHg	72 bpm			pounds
June		128/80 mmHg	80 bpm			pounds
July		130/82 mmHg	80 bpm			pounds
August		118/84 mmHg	68 bpm			pounds
August		120/70 mmHg	64 bpm			pounds
September		118/80 mmHg	82 bpm			pounds

October	Dr. [redacted]	96/70 mmHg	76 bpm			pounds
November	Dr. [redacted]	112/80 mmHg	70 bpm			pounds
November	[redacted]	120/90 mmHg	68 bpm			pounds
November	Dr. [redacted]	110/72 mmHg	82 bpm			pounds
December	[redacted]	120/90 mmHg	64 bpm			pounds
December	Dr. [redacted]	129/78 mmHg	82 bpm			pounds
January	[redacted]	118/80 mmHg	110 bpm			pounds
January	[redacted]	130/92 mmHg	68 bpm			pounds
February	Dr. [redacted]	141/93 mmHg	94 bpm			pounds
April	[redacted]	128/90 mmHg	74 bpm			pounds
May	[redacted]	122/98 mmHg	60 bpm			pounds
July	[redacted]	129/90 mmHg	64 bpm			pounds
July		134/89 mmHg	73 bpm			pounds
August	[redacted]	122/80 mmHg	64 bpm			pounds
September		106/80 mmHg	72 bpm			pounds
September	Dr. [redacted]	134/82 mmHg	77 bpm			pounds
December	Dr. [redacted]	140/80 mmHg	74 bpm			pounds

January	[redacted]	110/72 mmHg	66 bpm			pounds
March	Dr. [redacted]	114/80 mmHg	64 bpm			pounds
March	Dr. [redacted]	124/100 mmHg	60 bpm			pounds
April	[redacted]	112/90 mmHg	68 bpm			pounds
April	Dr. [redacted]	124/80 mmHg	72 bpm			pounds

April	Dr. [redacted]	126/88 mmHg	62 bpm			pounds
April		140/88 mmHg	64 bpm			pounds
May	[redacted]	122/96 mmHg	72 bpm			pounds
June	[redacted]	114/84 mmHg	72 bpm			pounds
July	Dr. [redacted]	142/92 mmHg	72 bpm			pounds
August	[redacted]	150/100 mmHg	72 bpm	Losartan potassium 50 mg		pounds
February	Dr. [redacted]	130/100 mmHg	82 bpm	Losartan potassium 50 mg		pounds
March	Dr. [redacted]	131/101 mmHg	106 bpm			pounds
March	Dr. [redacted]	130/100 mmHg	83 bpm	Losartan potassium 25 mg		pounds
March	Dr. [redacted]	139/89 mmHg	74 bpm	Losartan 50 mg		pounds
March	Dr. [redacted]	121/81 mmHg	76 bpm	Losartan 25 mg		pounds

April	Dr. [redacted]	118/78 mmHg	60 bpm	Losartan 25 mg		pounds
April	Dr. [redacted]					pounds
May	[redacted]	128/92 mmHg	74 bpm	Losartan potassium 25 mg		pounds
May	[redacted]	128/92 mmHg	74 bpm	Losartan potassium 25 mg		pounds
May	Dr. [redacted]	159/88 mmHg	77 bpm			pounds
May	Dr. [redacted]	159/88 mmHg				pounds
August	Dr. [redacted]	97/62 mmHg	86 bpm			pounds
September	Dr. [redacted]	124/92 mmHg	73 bpm			pounds
October	Dr. [redacted]	114/74 mmHg	64 bpm			pounds
December	[redacted]	140/102 mmHg	80 bpm	Losartan potassium 25 mg		pounds
January	Dr. [redacted]	120/84 mmHg	74 bpm	Losartan 25 mg		pounds
June	Dr. [redacted]	128/87 mmHg	94 bpm	Losartan 25 mg		pounds
August	Dr. [redacted]	130/93 mmHg	80 bpm	Losartan 25 mg		pounds
December	Dr. [redacted]	145/82 mmHg	85 bpm	Losartan 25 mg		pounds
January	Dr. [redacted]					pounds
Undated		118/68 mmHg	90 bpm			pounds
Undated	Dr. [redacted]	130/80				pounds

	Shahbazian	mmHg				

PHYSICAL EXAMINATION

BLOOD PRESSURE: 145/78

PULSE: 86

RESPIRATIONS: 14

WEIGHT: 3 lbs.

HEIGHT: in.

BMI: 26

HEENT: Normocephalic, atraumatic. The fundi are benign, without hemorrhages or exudates. The pharynx is clear, and tympanic membranes are normal. 2+ -3+ erythema and edema with some thinning and erosion of the mucosa noted.

NECK: Supple and without jugulo-venous distension. The carotids are 2+ bilaterally. There are no masses. There is no thyromegaly.

NODES: There is no lymphadenopathy noted.

CHEST: Percussion note is normal, with normal diaphragmatic motion. There are normal breath sounds with no rales, no ronchi and no wheezing.

HEART: The PMI is at the 5th left intercostal space, at the mid-clavicular line. There are no heaves or thrusts. The S1 and S2 are normal. No murmurs or rubs are heard.

ABDOMEN: The abdomen is soft, non-tender, and non-distended. There is no organomegaly. There are no masses. The bowel sounds are normal. There is no pelvic area tenderness.

EXTREMITIES: There is no cyanosis, no clubbing, or edema.

NEUROLOGIC: There are no focal neurologic findings.

LABORATORY DATA

A complete blood count was obtained. The hemoglobin and hematocrit were normal. The white blood cell count was mildly elevated to 13,400. The platelet count was within normal limits.

A chemistry-7 panel was obtained. Serum electrolytes, BUN, and creatinine were normal. The glucose was mildly elevated to 116.

A complete chemistry profile was obtained. The cholesterol was 216. The triglycerides were 314. The remainder of the chemistry profile was normal.

An H. pylori antibody titer was normal.

A hemoglobin A1c was elevated mildly to 6.0, which is consistent with a prediabetic state.

A resting pulmonary function study was obtained on this patient. The lung volumes were within normal limits. The expiratory flow rates in both large and small airways were normal. There was no evidence of any obstructive defect. The flow-volume curves were normal. There was no improvement in flow rates after bronchodilators. These are normal resting pulmonary function studies.

A methacholine challenge test was obtained on this patient. Increasing doses of methacholine were administered starting at 0.025 mg/mL and increasing to 25 mg/mL. At no time did the patient experience a decrease in expiratory flow rates in either large or small airways as measured by FEV1 or FEF25-75%. This is interpreted as a negative methacholine challenge test with no evidence of reactive airways disease.

EKG is normal.

DIAGNOSES

1. History of exposure to multiple chemical fumes from cleaning including what the patient believes are bleach, ammonia, and other chemicals as yet unidentified

2. Chronic rhinitis with no apparent evidence of clinical sinusitis at this time, but need CT of sinuses to rule this out
3. History of dyspnea and cough, probably related to postnasal drip and possible irritation of tracheobronchial tree
4. No evidence of asthma or small airways disease
5. History of multiple musculoskeletal and orthopedic injuries, deferred to the specialist in orthopedic surgery
6. History of past eye injury from splash of chemicals, currently resolved
7. History of hypercholesterolemia, on statin drugs
8. History of diabetes mellitus type 2
9. History of hypertension, currently on medications
10. History of thyroid disease, status post removal of tumor from thyroid, on replacement therapy.

IMPRESSION AND DISCUSSION

I have had the opportunity to evaluate [redacted] in my role as a Panel Qualified Medical Evaluator in Internal Medicine and Pulmonary Disease. I have been asked to address the issue of respiratory or pulmonary injuries in this patient. As part of her claim, there is an injury to her "lungs," and [redacted] did work as a , starting in .

As I reviewed her medical records, however, I know the number of orthopedic injuries and only an occasional mention of respiratory problems, although in her history, she complained of significant respiratory issues as a result of her exposure to as yet unnamed and unidentified cleaning agents. Currently, she remains on a Breo inhaler, which includes both a long-acting beta agent and an inhaled corticosteroid and uses a ProAir inhaler, which may well have influenced her results in her pulmonary function studies. I have performed a full pulmonary function study on this patient and note that the flow rates in both large and small airways are normal and note also that a methacholine challenge did not disclose any drop in either large or small airways flow rates. The error rate of such a test is not zero, but it is remarkably low, and at this juncture, she is either on adequate therapy for her asthmatic condition or she does not have active asthma.

I have not been provided with material safety data sheets or list of the ingredients of chemicals that she was exposed to. However, she states that she was exposed to various cleaning agents, including those that were fairly pungent, and she believes contained chlorine bleach and perhaps disinfectants with ammonia. It would be very helpful for me to have a full list of the chemical agents to which she was exposed during the course of her employment at [redacted].

It has long been known that exposure to various cleaning agents can cause significant upper and lower respiratory tract irritation, and in some cases, sensitization. In an article published in 2014 in the Journal of Asthma, an article entitled "Asthma and Rhinitis in Cleaning Workers: A Systematic Review of Epidemiologic Studies," it was shown that in those individuals working in the cleaning industry, with the large number of the products on the market, as much as just under 80% of patients in the industry either have asthma or rhinitis as a complication. In this article, bronchial hyperreactivity or airflow obstruction was only one of the many complications, and nasal edema, erythema, and increased discharge were also indicated as complications.

The use of ammonia in cleaning agents has been long recognized, and in the Annals of Otology, Rhinology, and Laryngology published in 1979, it was shown that nasal airway resistance was significantly increased at levels of 100 parts per million of ammonia in human volunteers. There was a progressive increase in resistance as the ammonia exposures increased in either concentration or in time and what was most important in this study is that both allergic and non-allergic individuals reacted similarly. We know that there is no significant history of allergy in [redacted] and no prior history of any asthma. That is according to her history, and the medical records that I have certainly did not demonstrate any evidence of respiratory illnesses dating back to the late 1990s.

This non-allergic feature has been described in literature as being a feature that leads to what is referred to as "irritant" mediated upper respiratory problems. In an article in the Journal Current Opinion in Allergy and Clinical Immunology in April 2013 entitled "Non-IgE-mediated and Irritant-Induced Work-Related Rhinitis," it was shown that workers that were exposed to various chemicals, biocides, wood dust, and even metal filings had a non-IgE-mediated irritant-induced occupational rhinitis. These types of inflammatory changes in the nasal mucosa can even lead to a loss of sense of smell, the growth of nasal polyps, and infection of the sinuses secondary to tissue swelling. The relationship of this non-IgE-mediated nasal edema and erythema to the eventual development of cough and asthma was only touched upon in this article, but it is my opinion that with reasonable medical probability, the stimulus for her cough, bronchospasm, and the diagnosis of asthma and treatment with bronchodilators may well have been secondary to an irritant effect rather than an allergic effect.

In an article published in the Immunology and Allergy Clinics of North America in 2016 entitled "Non-Allergic Rhinitis Environmental Determinants," it was shown that the term "vasomotor rhinitis or idiopathic non-allergic rhinitis" seems to be fitting in these individuals. It was remarked and shown in this paper from various studies that this kind of nasal irritation even occurs in non-allergic and

allergic patients. The kinds of environmental triggers do include cold air, second hand tobacco smoke, wood smoke, fragrances, cleaning products, and industrial chemicals.

The fact that the treating physician has treated [redacted] with an albuterol inhaler and now with a Breo inhaler became apparent after . I do not have any of the medical records from the physician who actively started her on bronchodilators, and cannot comment as to whether or not clinical wheezing was noted on her examination. I have found no evidence of any spirometries that were done previously, but it is very possible that with treatment with inhaled beta-2 agents and with inhaled corticosteroids, there has been a "remission" in this patient who is no longer being exposed.

The fact that hospital workers and hospital cleaners are exposed to a significant subset of potentially toxic agents was pointed out in article published in 2009 in the Journal Environmental Health. This article entitled "Characterization of Occupational Exposures to Cleaning Products Used for Common Cleaning Tasks - A Pilot Study of Hospital Cleaners," it was shown that at least in Massachusetts, routine cleaning in the hospital setting unfortunately uses a combination of many different disinfectants and bactericidal chemicals. Some of these include quaternary ammonium compounds, 2-butoxyethanol, and even ethanolamines. These are particularly irritating to the respiratory mucosa, and it was shown that hospital workers working with these products are at risk of acute and chronic inhalation exposures to many of these volatile organic compounds. Since many are used in spray form, as [redacted] commented on, it is reasonably medically probable that her exposures were fairly constant during the time that she was working on the cleaning group. An article entitled "Exposures to Volatile Organic Compounds among Healthcare Workers: Modeling the Effects of Cleaning Tasks and Product Use" was recently published in the Annals of Work Exposures and Health in June 2018. The area air measurements from 100 hospital workers at four different hospitals showed that ethanol, acetone, 2-propanol, and chloroform were all potential exposures. These volatile organic compounds, once again, are not only irritants but can be absorbed into the bloodstream and have systemic effects as well.

It is my opinion that the rhinitis that has developed in [redacted] is, with reasonable medical probability, a product of her exposures in the workplace. At this time, there is no active asthma and no abnormalities seen that would indicate asthma, yet, the fact that she is on inhaled bronchodilators and inhaled corticosteroids makes the assignment of an impairment somewhat tricky. Because the AMA Guides make an allowance for awarding "points" in Tables 5-9 and 5-10 for individuals on various medications, it must be stated that a

pulmonary impairment is present.

DISABILITY

From an upper respiratory perspective, there is chronic rhinitis with possible sinusitis, awaiting further studies with a CT scan of the sinuses. Given the amount of inflammation and airflow obstruction in the upper airway, using Table 11-6 in the AMA Guides, it is my opinion that a Class II impairment is present with a 5% whole-person impairment rating being appropriate.

From a pulmonary perspective, one must only look at Table 5-9 to recognize that on the medications she is taking, I am compelled to award at least one point if not two points to [redacted] which using Table 5-10 in the Guides would give her a minimum of a 10% whole-person impairment from a pulmonary perspective. Although there is no evidence of active asthma in this patient, the argument could be made that she is in remission because of these medications.

CAUSATION

There is little doubt in my mind that her rhinitis is a result of her exposures to the volatile organic chemicals and various cleaning agents that she was exposed to. With regard to her lower respiratory tract impairment, I feel the same, with regard to causation, with no prior history of allergies or the need for bronchodilator medication, her current impairment is secondary to these workplace exposures.

APPORTIONMENT

With regard to apportionment, it is my opinion that 100% of the upper and lower respiratory tract disabilities associated with the impairments listed are secondary to her workplace exposures.

WORK RESTRICTIONS

Given the exposures and her response, she is clearly precluded from being exposed to any environment to which chemical fumes or volatile organic chemicals are being utilized.

RECOMMENDATIONS

I look forward to the receipt of a CT scan of the sinuses. I am also looking forward to the receipt of any additional medical records which may exist in

which pulmonary function studies or an explanation as to why she was started on bronchodilators is given. It is my opinion that she requires ongoing treatment with nasal inhalers and corticosteroids, and will certainly let it to remain to the treatment physicians to determine how long she will be on inhaled bronchodilators. These should be provided for on an industrial basis, as well as followup by a specialist in internal medicine or pulmonary disease at least twice a year and performing a pulmonary function study at least once a year. I would leave it to the treating physicians to decide whether to continue the inhaled bronchodilators.

I appreciate the opportunity of evaluating [redacted] and trust that this report will be helpful in the management of her case. If I can provide anything further, please feel free to contact me.

SPECIAL COMMENTARY

The above responses and opinions are based on reasonable medical probabilities, as viewed from the perspective of available documentation and information submitted to this examiner, including the applicant's direct anamnesis.

I, Stewart Lonky, M.D., Q.M.E., formulated all conclusions and opinions.

Thank you for the opportunity of serving as Qualified Medical Examiner, in the specialty of Internal Medicine, for this most interesting case and condition.

Sincerely,

Stewart Lonky, M.D., Q.M.E.
Diplomate, American Boards of Internal Medicine & Pulmonary Medicine

Attachments:
1. Appendix A: Declaration
2. Appendix B: EKG Test Results
3. Appendix D: Medical Research

APPENDIX A - DECLARATION

Pursuant to AB 1300, LC Sec. 5703, I have not violated Labor Code section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

DATE OF REPORT: July

Dated this day of July

Stewart Lonky, M.D., Q.M.E.
Diplomate, American Boards of Internal Medicine & Pulmonary Medicine

Journal

Journal of Asthma

Volume 51, 2014 - Issue 1

44926 Views 10 CrossRef citations Altmetric

Review Article

Asthma and rhinitis in cleaning workers: a systematic review of epidemiological studies

Ilenia Folletti, MD, Jan-Paul Zock, PhD, MD, Gianna Moscato, MD & Andrea Siracusa, MD

Pages 18-28 | Received 18 Apr 2013, Accepted 05 Aug 2013, Accepted author version posted online: 09 Aug 2013, Published online: 18 Sep 2013

Download citation https://doi.org/10.3109/02770903.2013.833217

Abstract

Objective: This article presents a systematic review of epidemiological studies linking cleaning work and risk of asthma and rhinitis. *Methods*: Published

quality of studies was evaluated using the Strengthening of the Reporting of Observational Studies in Epidemiology (STROBE) statement checklist of 22 items for cross-sectional, cohort and case–control studies. *Results*: Increased risk of asthma or rhinitis has been shown in 79% of included epidemiological studies. In four studies the increased risk of asthma in cleaning workers was confirmed by objective tests, such as bronchial hyper-reactivity or airflow obstruction. Level of exposure to cleaning products, cleaning sprays, bleach, ammonia, mixing products and specific job tasks has been identified as specific causes of asthma and rhinitis. *Conclusions*: Possible preventive measures encompass the substitution of cleaning sprays, bleach and ammonia, avoidance of mixing products, the use of respiratory protective devices, worker education and medical surveillance.

Keywords: Asthma, epidemiology, occupation, respiratory diseases, risk factors, work-related

SAGE journals

Annals of Otology, Rhinology & Laryngology

Effect of Ammonia on Nasal Resistance in Atopic and Nonatopic Subjects

J. A. McLean, MD, K. P. Mathews, MD, W. R. Solomon, MD, P. R. Brayton, MS, N. K. Bayne, MS

First Published March 1, 1979

Abstract

Nasal airway resistance (NAR) was assessed from the slope of pressure-flow curves obtained during normal nasal breathing. Volunteers were classified as atopic or nonatopic according to strict criteria. 100 ppm NH_3 was introduced into each nostril for periods ranging from 5 to 30 seconds with frequent NAR monitoring. A progressive increase in NAR responses was obtained with incremental NH_3 exposures, but no significant difference was noted between the mean response of atopic and nonatopic subjects. Control exposures to compressed air under the same pressure generally produced only a small change in NAR, while aerosolized buffered saline increased NAR more than compressed air. The nasal response to NH_3 was effectively inhibited by intranasal atropine administration but not by chlorpheniramine. The described procedure provides a safe and simple method for studying semiquantitatively the short-term effects of inhaled irritants on the nose.

References

1. McLean JA, Mathews KP, Clarkowski AA, : The effects of topical saline and isoproterenol on nasal airway resistance. J Allergy Clin Immunol 58: 563–574, 1976. Google Scholar Medline

2. McLean JA, Mathews KP, Solomon WR, . The effect of histamine and methacholine on nasal airway resistance in atopic and nonatopic subjects; comparison with bronchial challenge and skin test responses. J Allergy Clin Immunol 59: 165–170, 1977. Google Scholar Medline

Non-IgE-mediated and irritant-induced work-related rhinitis

Siracusa, Andrea; Folletti, Ilenia; Moscato, Gianna

Current Opinion in Allergy & Clinical Immunology: April 2013 - Volume 13 - Issue 2 - p 159–166
doi: 10.1097/ACI.0b013e32835e12e7
OCCUPATIONAL DISEASE: Edited by Susan M. Tarlo and Piero Maestrelli

Abstract **Author Information**

Purpose of review: Recently there has been growing interest in non-IgE-mediated and irritant-induced occupational rhinitis due to old and new low-molecular-weight and irritant agents. The purpose of this review is to summarize the scientific evidence on agents and work activities responsible for non-IgE-mediated and irritant-induced occupational rhinitis and work-exacerbated rhinitis published in 2011 and 2012.

Recent findings: Several epidemiological, surveillance and experimental studies, case reports and reviews showed that workers exposed to drugs, wood dust, chemicals, metals and biocides are at high risk of non-IgE-mediated and irritant-induced occupational rhinitis; among activities at risk are healthcare, antibiotic manufacturing and cleaning workers. Work-exacerbated rhinitis has not been specifically studied, but it is reasonable to expect that it is frequently associated with work-exacerbated asthma. Recently, work-related anosmia/microsmia, nasal polyps and sinusitis have also been described. Reducing or eliminating workplace exposure to the specific agent has been confirmed to be effective in preventing symptoms of nonallergic occupational rhinitis.

Summary: In consideration of the relevance of non-IgE-mediated and irritant-induced work-related rhinitis, physicians should recognize work-related rhinitis symptoms due to old and new low-molecular-weight and irritant agents. The mechanisms of non-IgE-mediated and irritant-induced occupational rhinitis remain largely unclear and need to be studied further. Substitution of responsible agents, reduction or elimination of exposure at the workplace should be enforced as effective measures.

[a]Occupational Allergology Unit, Department of Clinical and Experimental Medicine, University of Perugia, Perugia

[b]Allergy and Immunology Unit, Fondazione Salvatore Maugeri, Institute of Care and Research, Scientific Institute of Pavia, Pavia, Italy

Correspondence to Andrea Siracusa, MD, Borgo 20 giugno 87, 06121 Perugia, Italy. Tel: +39 075 32781, 39 0339 725 4969; fax: +39 0744 205 762; e-mail: asiracusa70@gmail.com

Nonallergic Rhinitis
Environmental Determinants

Dennis Shusterman, MD, MPH

KEYWORDS

• Nonallergic rhinitis • Environment • Air pollution • Chemical irritants
• Ambient temperature • Ambient humidity

KEY POINTS

- Nonallergic rhinitis (NAR) is a broad term, including conditions of known etiology, as well as a residual group whose main phenotypic characteristic is nonspecific nasal hyperreactivity.
- This hyperreactive subgroup has been variously labeled as having vasomotor rhinitis, idiopathic NAR, noninfectious NAR, and nonallergic, noninfectious, perennial rhinitis; nonallergic rhinopathy has also been proposed.
- Nonspecific nasal hyperreactivity is found, not only in idiopathic NAR, but also in a subset of allergic rhinitis patients.
- Common nonallergic environmental triggers include cold and dry air, second-hand tobacco smoke, wood smoke, fragrances and cleaning products, and industrial chemicals.
- A subset of individuals with apparent NAR may instead have local allergic rhinitis, characterized by mucosal-only production of relevant antigen-specific IgE. Nasal antigen challenge is necessary to identify this subset of patients.

Allergic Rhinitis
Dunlap, Jones et al

Novel, Alternative, and Controversial Therapies of Rhinitis
Sunda, Pandi et al

INTRODUCTION

From the perspective of the environment, the nose serves as the portal of entry to the respiratory tract, filtering and conditioning inspired air, as well as signaling the quality of the surrounding atmosphere.[1] In this exposed position, the nose is vulnerable to the effects of physical or chemical agents, and may manifest acute, subacute, or chronic pathophysiologic changes.

Individuals who experience acute and reversible nasal symptoms (obstruction and/or hypersecretion) triggered by ambient physical or chemical exposures, and who do so without evidence of a typical allergic (immunoglobulin [Ig]E-mediated) mechanism, can be considered to have "environmental nonallergic rhinitis" ("environmental NAR").

Author Disclosure: No support was received for the writing of this article. The author has no commercial conflicts regarding the subject matter of this article.
Division of Occupational & Environmental Medicine, University of California, San Francisco, Campus Box 0843, San Francisco, CA 94143, USA
E-mail address: Dennis.Shusterman@ucsf.edu

Immunol Allergy Clin N Am 36 (2016) 379–399
http://dx.doi.org/10.1016/j.iac.2015.12.013 immunology.theclinics.com
0889-8561/16/$ – see front matter

"Nonallergic rhinitis" (NAR) is defined by intermittent or persistent nasal symptoms without evidence of immunoglobulin E–mediated sensitization to relevant aeroallergens. The largest subgroup is idiopathic, and is characterized by nasal hyperreactivity to nonspecific environmental triggers, including temperature, humidity, and chemical exposures. As nonspecific nasal hyperreactivity is often found in the absence of mucosal inflammation, some clinicians refer to this condition as "nonallergic rhinopathy." Irritant rhinitis can arise de novo after high level and/or prolonged exposure to airborne irritant chemicals. We review the range of environmentally induced nonallergic nasal symptoms and signs, and explore issues of pathophysiology unique to environmental chemical exposures.

Research Open Access Open Peer Review

Characterization of occupational exposures to cleaning products used for common cleaning tasks-a pilot study of hospital cleaners

Adela Bello, Margaret M Quinn, Melissa J Perry and Donald K Milton

Environmental Health 2009 **8**:11

https://doi.org/10.1186/1476-069X-8-11

Received: 12 May 2008 | Accepted: 27 March 2009 | Published: 27 March 2009

Open Peer Review reports

Abstract

Background

In recent years, cleaning has been identified as an occupational risk because of an increased incidence of reported respiratory effects, such as asthma and asthma-like symptoms among cleaning workers. Due to the lack of systematic occupational hygiene analyses and workplace exposure data, it is not clear which cleaning related exposures induce or aggravate asthma and other respiratory effects. Currently, there is a need for systematic evaluation of cleaning products ingredients and their exposures in the workplace. The objectives of this work were to: a) identify cleaning products' ingredients of concern with respect to respiratory and skin irritation and sensitization; and b) assess the potential for inhalation and dermal exposures to these ingredients during common cleaning tasks.

Methods

We prioritized ingredients of concern in cleaning products commonly used in several hospitals in Massachusetts. Methods included workplace interviews, reviews of product Materials Safety Data Sheets and the scientific literature on adverse health effects to humans, reviews of physico-chemical properties of cleaning ingredients, and occupational hygiene observational analyses. Furthermore, the potential for exposure

in the workplace was assessed by conducting qualitative assessment of airborne exposures and semi-quantitative assessment of dermal exposures.

Results

Cleaning products used for common cleaning tasks were mixtures of many chemicals, including respiratory and dermal irritants and sensitizers. Examples of ingredients of concern include quaternary ammonium compounds, 2-butoxyethanol, and ethanolamines. Cleaning workers are at risk of acute and chronic inhalation exposures to volatile organic compounds (VOC) vapors and aerosols generated from product spraying, and dermal exposures mostly through hands.

Conclusion

Cleaning products are mixtures of many chemical ingredients that may impact workers' health through air and dermal exposures. Because cleaning exposures are a function of product formulations and product application procedures, a combination of product evaluation with workplace exposure assessment is critical in developing strategies for protecting workers from cleaning hazards. Our task based assessment methods allowed classification of tasks in different exposure categories, a strategy that can be employed by epidemiological investigations related to cleaning. The methods presented here can be used by occupational and environmental health practitioners to identify intervention strategies.

Keywords

Inhalation Exposure | Exposure Category | Chemical Ingredient | Dermal Exposure | Cleaning Product

Background

Cleaning products have become an indispensable part of our modern lives. They are used on a daily basis in nearly all workplaces and homes. In recent years, cleaning has been identified as an occupational risk, because of an increased incidence of asthma and asthma-like symptoms among cleaning workers [1, 2, 3, 4, 5, 6, 7]. Adverse effects on skin, such as occupational hand dermatitis, have also been reported by few studies of hospital cleaning workers [8, 9]. Results from epidemiological investigations support the hypothesis that exposure to cleaning products is related to the development and/or exacerbation of respiratory symptoms, including asthma [10, 11, 12, 13, 14, 15, 16, 17]. The design of existing epidemiologic studies on cleaning has not allowed identification of agents responsible for asthma and other reported respiratory symptoms. This is related directly to the incomplete exposure assessment strategies carried out in these studies. Due to the lack of systematic occupational hygiene analyses and workplace exposure data, there is a need for systematic evaluation of cleaning products ingredients and their exposures in the workplace.

Exposures to Volatile Organic Compounds among Healthcare Workers: Modeling the Effects of Cleaning Tasks and Product Use

Feng-Chiao Su, Melissa C Friesen, Aleksandr B Stefaniak, Paul K Henneberger, Ryan F LeBouf, Marcia L Stanton, Xiaoming Liang, Michael Humann, M Abbas Virji ✉

Annals of Work Exposures and Health, wxy055, https://doi.org/10.1093/annweh/wxy055
Published: 21 June 2018 **Article history** ▾

Abstract

Objectives

Use of cleaning and disinfecting products is associated with work-related asthma among healthcare workers, but the specific levels and factors that affect exposures remain unclear. The objective of this study was to evaluate the determinants of selected volatile organic compound (VOC) exposures in healthcare settings.

Methods

Personal and mobile-area air measurements ($n = 143$) from 100 healthcare workers at four hospitals were used to model the determinants of ethanol, acetone, 2-propanol, *d*-limonene, α-pinene, and chloroform exposures. Hierarchical cluster analysis was conducted to partition workers into groups with similar cleaning task/product-use profiles. Linear mixed-effect regression models using log-transformed VOC measurements were applied to evaluate the association of individual VOCs with clusters of task/product use, industrial hygienists' grouping (IH) of tasks, grouping of product application, chemical ingredients of the cleaning products used, amount of product use, and ventilation.

Results

Cluster analysis identified eight task/product-use clusters that were distributed across multiple occupations and hospital units, with the exception of clusters consisting of housekeepers and floor strippers/waxers. Results of the mixed-effect models showed significant associations between selected VOC exposures and several clusters, combinations of IH- generated task groups and chemical ingredients, and product application groups. The patient/personal cleaning task using products containing chlorine was associated with elevated levels of personal chloroform and α-pinene exposures. Tasks associated with instrument sterilizing and disinfecting were significantly associated with personal *d*-limonene and 2-propanol exposures. Surface and floor cleaning and stripping tasks were predominated by housekeepers and floor strippers/waxers, and use of chlorine-, alcohol-, ethanolamine-, and quaternary ammonium compounds-based products was associated with exposures to chloroform, α-pinene, acetone, 2-propanol, or *d*-limonene.

Conclusions

Healthcare workers are exposed to a variety of chemicals that vary with tasks and ingredients of products used during cleaning and disinfecting. The combination of product ingredients with cleaning and disinfecting tasks were associated with specific VOCs. Exposure modules for questionnaires used in epidemiologic studies might benefit from seeking information on products used within a task context.

Keywords: cleaning and disinfecting, healthcare, hierarchical clustering, modeling; volatile organic compounds

Issue Section: Original Articles

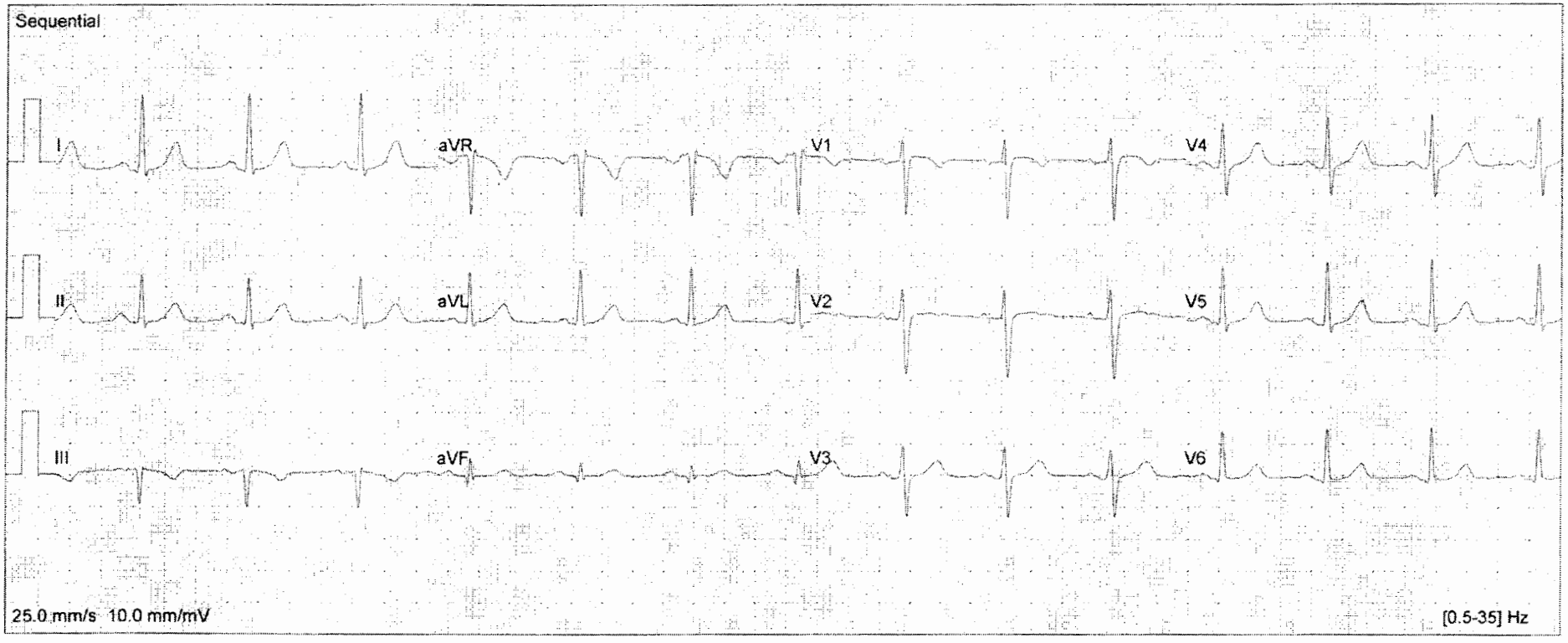
Welch Allyn CardioPerfect Workstation

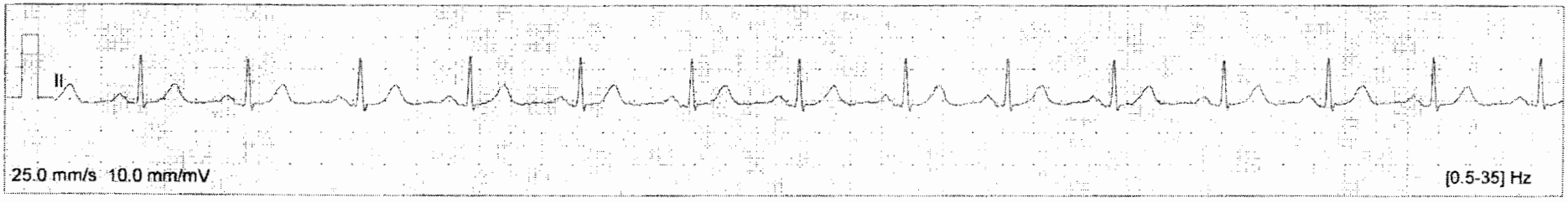
Name:
Number:
Gender:
Birthdate: years

P / PR: 118 ms / 145 ms
QRS: 85 ms
QT / QTc / QTd: 345 ms / 394 ms / -
P/QRS/T axis: 37° / 5° / 13°
Heartrate: 88 bpm

Recorded:
Recorded by:
Referring physician:
Ordering physician:
Attending physician:
Location:
Comment:

UNCONFIRMED INTERPRETATION





Stewart Lonky, M.D., Q.M.E.

DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE AND PULMONARY MEDICINE
QUALIFIED MEDICAL EXAMINER

All Correspondence To:
11620 Wilshire Boulevard, Suite 340
Los Angeles, CA 90025
Tel: (888) 853-7944
Fax: (213) 377-5152

PANEL QUALIFIED MEDICAL EVALUATION IN THE SPECIALTY OF INTERNAL MEDICINE/PULMONARY MEDICINE

July

[redacted]

[redacted]

[redacted]

[redacted]

Re: [redacted]
Applicant's DOB:
Employer:
WCAB No.:
Date of Injury:
Claim/File No.: [redacted]
Panel No.:
Date of Evaluation:
Place of Evaluation:

Dear Parties:

Pursuant to your authorization, [redacted] underwent a Panel Qualified Medical Evaluation, in the specialty of Internal Medicine/Pulmonary Medicine, on C ____, at my Garden Grove office. The undersigned acted in the capacity of Panel Qualified Medical Examiner, in the specialty of Internal Medicine/Pulmonary Medicine.

I, Dr. Lonky, conducted the interview, reviewed all records, performed a physical examination, and formulated the diagnosis, conclusions, and discussion, including the opinion on causation, temporary disability, permanent disability, degree of disability, future care, work restrictions, and apportionment. The report was authored and edited by me, Dr. Lonky. All opinions expressed herein are solely the opinions of Dr. Lonky.

Prior to the evaluation, the entire medical file made available to the undersigned was fully reviewed. All of the records reviewed were instrumental in this examiner arriving at the opinions as expressed in this report.

Before I began the examination, the applicant was informed that this evaluation was being done exclusively in connection with the Workers' Compensation claim at the request of attorney, attorneys or insurance companies, and that no treatment relationship existed. The applicant was also made aware that any communication between us is not privileged (no doctor-patient confidentiality exists) and that any information provided, as well as the results of any testing and my conclusions regarding the case, would be included in a report that may be read by people involved in the resolution and/or litigation of the claim. The applicant was advised of his or her rights pursuant to QME regulation 40. The applicant stated that the aforementioned was understood, and agreed to proceed with the evaluation. The report belongs to the party or parties requesting the evaluation.

BILLING

The report qualifies for Procedure Code **ML-104** as there are "extraordinary circumstances" relating to the medical condition for which this applicant was examined. This code best reflects the time spent and/or the complexity of this evaluation. The best proof in regard to the complexity of this evaluation is the medical/legal report which reflects the complex issues. The issues of complexity are reflected by the following: Multiple body parts are examined; present and prior work history; past medical history; family and social history; a complex history due to the applicant being a difficult historian; there are complex issues

of causation or apportionment; adverse parties have obtained their own complex and conflicting evaluation requiring interpretation.

This is a Comprehensive Medical-Legal Evaluation Involving **Extraordinary Circumstances (ML104)**. The following complexity factors apply:

COMPLEXITY FACTORS

☒ (1) Two or more hours of face-to-face time by the physician

Circumstances which make this complexity factor applicable to this evaluation: Two or more hours of face-to-face time were required because one or more of the following apply: the subject medical condition was complex, the applicant was a difficult historian, and/or an interpreter was required which prolonged the face-to-face component of this evaluation.

☒ (2) Two or more hours of record review by the physician

Circumstances which make this complexity factor applicable to this evaluation: Two or more hours of record review time were required because one or more of the following apply: A significant volume of medical records were reviewed requiring two or more hours of my record review time, and/or the medical records were complex in nature.

☒ (3) Two or more hours of medical research by the physician

Circumstances which make this complexity factor applicable to this evaluation: Two or more hours of medical research were required because one or more of the following apply: medical research was required in order to investigate current developments regarding the etiology, pathogenesis, pathophysiology, causation, factors relating to the appropriate treatment, and/or disease course of the subject medical condition.

☐ (4) Four or more hours spent on any combination of two of the complexity factors (1) - (3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor.

Six or more hours spent on any combination of three complexity

factors (1) - (3), which shall count as three complexity factors

☒ (5) **Circumstances which make this complexity factor applicable to this evaluation: Six or more hours were spent on any combination of three complexity factors (1)-(3). See explanations for (1), (2) and (3) above, incorporated herein.**

Addressing the issue of medical causation

☒ (6) **Circumstances which make this complexity factor applicable to this evaluation: I have addressed the issue of medical causation upon a written request of one or more parties.**

Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate:

☐ (7) the claimant's employment by three or more employers, OR

☐ three or more injuries to the same body system or body region as delineated in the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), OR

☐ three or more injuries to the same body system or body region as delineated in the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), OR

☐ two or more or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference

☐ (8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.

Billed under **ML-104**, time spent includes:

1. Face-to-face interview with the applicant: **2.00 hours**
2. Review of medical records: **4.25 hours**
3. Preparation, writing and editing of this report: **1.50 hours**
4. Medical research: **2.00 hours**

Additional time was spent in administering EKG (93000) diagnostic testing, which will be billed separately under the current OMFS.

HISTORY OF PRESENT ILLNESS

[redacted] is a [illegible] year-old [illegible] who commenced employment with the [redacted] since [illegible]. Initially, he worked as a [illegible], followed by a [illegible] until he was promoted to a [illegible].

In [illegible], [redacted] was assigned to th[illegible] t station. Then, he was called to active military duty and returned to the station in August [illegible]. He did notice some symptoms when working the day shift, but when he began working the night shift, he just began to feel sick. He worked night shift for about 10 months.

While at the [illegible] station at [redacted], he was a [illegible], working nights. During that time he would became sick with symptoms of difficulty breathing, nasal congestion and sinuses. He would take off time. He worked about 10 months, 6 p.m. to 6 a.m. It took about four months before he began to feel intense symptoms such that he would have to go outside to breathe. Others at station were getting sick, as well. He would have problems breathing through his nose, for which he would buy Afrin to help clear his nasal passages. He continued to experience symptoms of Sneezing, runny nose, and nasal congestion. He did not have a cough.

He never contracted pneumonia.

He relates that there had been cuts in cleaning of station the station which had been built in the 1970s. It was "constantly dirty, with filth everywhere." Mice and rats come into the station.

He had been assigned to the station for [illegible] n and [illegible] f years previously, but he worked more so outside. He did have nasal problems, nasal congestion; he had substantial difficulty breathing through his nose. He snored a lot. He consulted a physician who indicated that there was blockage in his nose and his nasal membranes were edematous. He underwent surgery to cut back the cartilage, and he was able to breathe again. He left the station again.

After he began to work there in [illegible], an analysis of the station was paid for and mold was found. On the roof, the rats and bats and birds were dropping feces on vents. The city cleaned it while everyone was working; "It was like a bomb going off." During this time, his symptoms did not worsen, yet they did not

improve, either. He bought his own hand sanitizer to clean everything.

He did not feel that after the supposide cleaning that anything was any better. Pigeons were still on the roof, and rats and mice were still at the station.

[redacted] worked until he injured his back while working; he was rearened by another police vehicle. At the end of he was placed on temporary total disability. Recently, he received a lumbar epidural steroid injection with 40% relief of his pain.

PRESENT COMPLAINTS

[redacted] has been off work since when he was placed on temporary total disability for another injury.

He relates that since he has been off for months, he feels much better with regard to his upper respiratory symptoms.

In early , he was referred Dr. [redacted]. He evaluated him and told him to continue using over-the-counter Afrin.

OCCUPATIONAL HISTORY

Mr. [redacted] commenced employment with the [redacted] since . Initially, he worked as a followed by a r until he was promoted to a

He worked for 4 months, it was so bad that he could not work in the environment-a lot of transients. The odors were tremendous. He did not feel well and would come to work sick. He would have skin rashes.

Twice during his career, he was stationed to the Division.

PAST MEDICAL HISTORY

He has a history of an elevated cholesterol.

He has an unspecified prostate condition

He has had bronchitis about twice in last 10 years.

PAST INJURIES: Multiple.

HOSPITALIZATIONS/SURGERIES: Left & right inguinal hernia; , surgery to repair deviated septum.

ALLERGIES: The patient has no known allergies.

MEDICATIONS: Generic for Lipitor

FAMILY HISTORY

The patient's father died at age of prostate cancer; the patient's mother died at age) from unknown causes. He has brothers.

There is a family history of hypertension through brother and cancer through his father (prostate).

SOCIAL HISTORY

The patient is married with daughters and 1 son. He lives with his wife.

HABITS: TOBACCO: He is a non-smoker. He stopped smoking 30 years, having smoked less than three years ago.

ALCOHOL: He drinks beer, wine and liquor.

REVIEW OF SYSTEMS

The review of systems is remarkable as indicated in the History of Present Illness and Past Medical History.

HEAD: Denied frequent headaches dizziness, syncope and seizure.

EYES: Denied glaucoma, cataracts, blurred and double vision, and seeing spots and halos.

EARS: Denied otalgia, tinnitus and hearing loss.

NOSE: Per the History of Present Illness.

MOUTH/THROAT: Denied frequent sore throat and hoarseness.

RESPIRATORY: Denied cough, exertional dyspnea, acute dyspnea, chest tightness, and wheezing.

CARDIOVASCULAR: Denied hypertension, angina-like pain, palpitations, orthopnea, paroxysmal nocturnal dyspnea, and ankle swelling.

GASTROINTESTINAL: Denied abdominal pain, dyspepsia, regurgitation, emesis, diarrhea, constipation, melena, and hematochezia.

URINARY: Denied dysuria, frequency, nocturia, urgency, hesitancy, hematuria, and incontinence.

MUSCULOSKELETAL & EXTREMITIES: Per the History of Present Illness and Past Medical History.

REVIEW OF FILE

Approximately 111 pages of records have been received and reviewed by the undersigned. Documents within the records that are not considered of medical importance to this practitioner may not be included in the summary though they have been reviewed in their entirety.

NON-MEDICAL RECORDS:

Applicant Attorney's Advocacy Letter, signed by [redacted], dated

The examiner agreed to evaluate the applicant in the capacity of a Qualified Medical Examiner in the field of internal medicine on June 25, 2018. Consistent with the Application/Notice of Claim provided, the examiner was to evaluate the applicant's lungs.

To assist the examiner in preparing for the examination, the parties had forwarded the entire medical file, any subpoenaed medical records, the Application for Adjudication of Claim, the Answer of defendant, (s ;, and a copy of the applicant's deposition transcript, if one was taken, under separate cover.

It was requested that the report address the following:

1) A detailed medical history;

2) Your diagnosis;

3) Your determination as to whether the medical findings are consistent with the work injury alleged by applicant;

4) Whether any further treatment is reasonably necessary to cure or relieve from the effects of the alleged injury. If treatment is necessary, please describe the scope and expected duration of such treatment;

5) If applicant is presently temporarily disabled as a result of an industrially caused or aggravated injury, please indicate whether such disability is total temporary disability or partial temporary disability;

6) If the applicant is now permanent and stationary and meets the criteria for permanent disability rating, please give the date the applicant reached the permanent and stationary plateau and describe with specificity the factors of permanent disability (both objective and subjective) which resulted from the industrially caused or aggravated injury. If you believe that the applicant can return to regular job duties, please specifically so state, giving the reasons for your conclusions;

7) Please address the issue of apportionment in detail as to the following:

a) Had there been any pre-existing disability that you were able to deduce at the time of your examination that would interfere or actually did interfere with the type of work activities performed by the applicant?

b) Did the applicant have a pre-existing condition which was unrelated to and not aggravated by industrial exposure which would have reasonably progressed in such a way as to have caused disability at the time of your examination, absent the industrial injury?

c) Have there been any subsequent factors that may have caused further disability to the applicant?

d) Pursuant to Senate Bill 899, please indicate what percentage of the applicant's disability is directly attributable to the industrial injury herein.

e) Please address permanent disability per the AMA guidelines.

8) Please address the issue of vocational rehabilitation in detail as to whether or not the applicant is able to return to his regular job duties as described to you by the applicant at the time of the examination. If the applicant cannot return to the described job, please indicate whether the applicant would be able to return to

work if the current job duties were modified. Please indicate what work restrictions would be applicable to this applicant. Enclosed please find the Physician's Return-to-Work and Voucher Report. The parties ask that you please fill out and return along with your report.

If you find the applicant capable of usual and customary occupation, please indicate on what date the applicant could reasonably have been, or should be, expected to return to such employment. If you find the applicant to be a Qualified Injured Worker for purposes of vocational rehabilitation, please state the medical causes for such findings.

This letter constituted the examiner's authority to perform all tests which were necessary to the completion of comprehensive report. However, if hospitalization was required, the parties requested that the examiner obtain their consent before proceeding.

Advocacy Letter, signed by [redacted], dated _____

The applicant was scheduled for a Panel Qualified Medical Examination on , in the examiner's Garden Grove office.

A list of all records, both medical and non-medical, which were pertinent to the examiner's evaluation of the applicant was included with this letter. Review all medical and non-medical records provided and examine the applicant with respect to all parts of the body or medical conditions listed on the enclosed claim form(s) and/or application for adjudication of claims(s) that were within the examiner's area of medical expertise.

Address each injury claimed and indicate the examiner's findings and opinions relative thereto. The examiner was authorized to administer all x-rays and tests required for diagnostic purposes to assist him in completing his comprehensive medical-legal examination, but obtain prior authorization if he believed hospitalized testing, or other treatment, was necessary.

This claim involved a [redacted]-year-old [redacted] who had been with the [redacted] since [redacted]. The examiner was requested to address compensability, extend of TTD and/or PD.

He was requested to conduct a comprehensive examination and furnish the parties with a narrative medical-legal report setting forth his findings. His report should address the following:

1) A detailed medical history.

2) The current diagnoses.

3) Are the medical findings consistent with the injury claimed by the applicant? In other words, if there us disability, was such disability precipitated or aggravated by industrial causes described by the applicant.
a) If you determine the applicant sustained a psyche injury, please provide industrial causation findings in accordance with Labor Code §§ 139.2U) (4), 3208.3.

4) If industrially-caused or aggravated disability exists, is it the result of a specific incident, or is it the result of one or more periods of cumulative trauma, or a combination? If disability is a result, either in whole or in part, of one or more period(s) of cumulative trauma, state your opinion as to when each commenced and ended.

5) If the applicant is presently temporarily disabled as a result of industrially-caused or aggravated injury (ies), is it:

a) Temporary total?

b) Temporary partial? If so, state the extent of ability to work (i.e., work restrictions), including the applicant's ability to perform alternative or modified duties.

c) Please indicate the period(s) of temporary total and/or partial disability.

6) If you find that the applicant was temporarily totally disabled during any period of time after the date of injury or illness as a result thereof (besides that addressed in item #5 above), please indicate the start and ending dates of such periods of disability.

7) If you find that the applicant's industrial injury or illness is not yet Permanent and Stationary (has not reached Maximal Medical Improvement) and is in need of further medical treatment at this time, please indicate the extent and scope of medical treatment you believe to be necessary for the injuries or conditions identified as industrially-caused. Please issue your opinion as to the scope of further medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his/her industrial injury in accordance with Labor Code § 4604.5 (ACOEM Occupational Medicine Practice Guidelines), § 5307.27 (Medical Treatment Utilization Schedule), and/or Cal. Code of Regs. § 9792.25

(other scientifically and evidence -based medical treatment guidelines that are nationally recognized by the medical community).

8) If you find that the applicant's industrial injury or illness is Permanent and Stationary (has reached Maximal Medical Improvement), please describe:

a) Permanent disability factors (whether objective, subjective, or both) resulting from the industrial causation or aggravation. If you do believe that the applicant should be restricted in his job duties as a result of his/her industrial injury, please set forth these permanent work restrictions with as much specificity as possible.

b) Pursuant to Labor Code § 4660(a), (b) (1), (d), please determine the applicants' whole person impairment (WPI) using the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition). Provide a WPI rating only for those injuries or conditions that are industrially-caused.

i) Pursuant to Almaraz/Guzman II, please provide: (1) a WPI rating that is within the "four corners of the AMA Guides"; (2) a WPI rating using a traditional application of the AMA Guides to determine a scheduled permanent disability; (3) if applicable, describe and explain the reason for any modification of a traditional AMA Guides rating; and (4) describe and detail the reasons for the modified application of the AMA Guides that most accurately reflects the applicants' impairment.

ii) Please attach the results of your measurements/testing to support the substantiality of your findings, including specific figures, tables, and page numbers in the AMA Guides.

c. Pursuant to Labor Code § 4663, apportionment of permanent disability shall be based on causation. Any physician preparing reports on the issue of permanent disability must address the issue of causation. The physician must make an apportionment determination by findings what approximate percentage of the permanent disability was caused by the direct result of the industrial injury, and what approximate percentage of the permanent disability was caused by other factors, such as non-industrial factors, both before and subsequent to the industrial injury in question, including prior industrial injuries.

d) The extent and scope of future medical care, if any, that is reasonably required to cure or relieve the injured worker from the effects of his/her industrial injury in accordance with Labor Code § 4604.5 (ACOEM Occupational Medicine Practice Guidelines), § 5307.27 (Medical Treatment Utilization Schedule),

and/or Cal. Code of Regs. § 9792.25 (other scientifically and evidence based medical treatment guidelines that are nationally recognized by the medical community).

In preparing the examiner's report, it was required that he identify all information received from the parties, reviewed in preparation of the report, and relied upon in the formulation of his opinion.

Personal Record, signed by [redacted], CIEC, CAC, DPH, [redacted], dated [redacted].

This was a report entitled "Limited Mold Inspection" which was authorized by and performed at the request of Mr. [redacted] with City of [redacted] Department of General Services, Division.

This Limited Mold Inspection included a visual inspection and assessment of the suspect area and the collection of a mold air sample, a mold surface sample, moisture readings and digital photographs.

If the subject property was built before 1990 asbestos might be present in the building materials. Asbestos testing of all building materials that might be disturbed during renovation or remediation should occur. However, if the site is located in the SCAQMD area and exceeds 100 SF, no date applies. All buildings must be surveyed prior to renovation or demolition.

If the subject property was built prior to 1979 lead might be present in the building materials. Lead testing of all painted or glazed surfaces that might be disturbed during renovation or remediation should occur.

Historical Data: Per Mr. [redacted] of the City of [redacted] Department of General Services, Division visible suspect fungal growth occurred at the HVAC Registers in the Detective Area. Evidence of suspect visible fungal growth at the registers in the Detective Area was present with unknown source or origin date. No repairs had been made at the time of the inspection.

Visual Inspection and Sampling Methodology: The inspection was limited to the area where moisture and/or fungal activity was suspected to be present.

Site and Subject Are Description: The building composition includes a brick exterior and composite drywall interior on a concrete slab foundation. The area inspected was limited to the Detective Area.

Housekeeping: Visual inspection of the area indicated that there was good housekeeping. The affected building material was noted to be in good condition. There was visible suspect fungal growth on the affected material. No visibly decaying plant life or consumables were noted in the area inspected.

Moisture Assessment and Visual Observations: On the day of the investigation, the area included in the scope of service were inspected visually for mold content and probed for moisture content utilizing a GE ProtimeterTM moisture probe. Moisture was considered elevated at a level above 18 percent (relative to wood substrate). For ease of interpretation moisture was reported in None Detected, Low, Moderate, or High. The area visually inspected was the Detective Area. All materials were dry at the time of the inspection. However, visible suspect fungal growth was present in the detective area, registers. Visible suspect fungal growth was present on the registers.

Non-viable Mold Air Sampling: Non-Viable air sampling was collected to characterize airborne mold content, if any. Air sampling was conducted utilizing a bio-air pump calibrated at 15 liters per minute. A mold air cassette was attached to the pump and air was filtered through the cassette where an adhesive filter collects organic and nonorganic particulates. The openings of the cassette were then sealed and transported to the laboratory for analysis. Control air sample(s) is/are obtained for a benchmark comparison to the inspected/tested area(s).

Non-viable mold surface sampling (tape swab): Swab samples were collected by removing cap from sterile container, inserting swab so it contacts moist sponge and by swiping a cotton swab over the subject area surface and sealed in a sterile tube.

Analytical Results for Non-Viable Mold Air Sampling: Two mold air samples were obtained during this inspection. It was determined that 1 sample contained low spore content and was below the control (exterior) comparison sample. These results indicated that a microbial hazard did not exist in the area inspected/tested. The sample from the detective area showed a spore count of 340 spores. Out of the 340, 100 were Aspergillus/Penicillium, 40 Basidiospores, and 200 Cladosporium. The exterior sample showed 8,297 spores. Of the 8,297, 570were Aspergillus/Penicillium, 530 Basidiospores, and 6,860 Cladosporium.

Non-Viable Mold Surface Sampling: One mold surface sample via swab collection was obtained during this inspection. Out of sample various mold genres were present in the one sample. The one sample had multiple genres present at rare to high levels. These results indicate that a microbial hazard

might exist in the area tested that contain elevated fungal counts. Samples from the metal register in the detective area showed rare amount of Alternaria, bipolaris, curvularia, myxcomycetes, ulocladium, and unidentified spores. Low amount of Aspergillus/penicillium and high amount of clasdosporium were present in the area. Molds were present and elevated in the detective area.

Discussion: There are no regulations or guidelines that quantify acceptable or unacceptable levels of mold spore content in the air for either total mold spore count or mold spore count for individual genre. The current general industry standard of mold content in air samples states that "typically mold levels should be lower indoors than outdoors and similar in diversity of genera". In cases where the exterior samples were abnormally low or high for mold content (typical instances include where a day could be windy, raining or there was snow cover), the Certified Indoor Environmental Consultant (CIEC) reviews each sample analysis by genre and overall mold content. Final determination of potential mold exposure and activity and remedial recommendations provided were based on a combined analysis of data including but not limited to, a review of the air and surface analytical results (as applicable), review of on-site conditions including building use, building history, moisture/water intrusion activity, visible water damage and/or mold conditions, length of water exposure, occupant health related symptoms (as applicable), and any other information obtained during the assessment combined with historical professional experience with similar projects. Fungal spores were present in almost all environments and do not proliferate indoors unless environmental requirements exist. Fungi activity varies by genre with differing needs for light, dampness, consumables (building materials, food), and temperature. In general fungi requires air, moisture content above 15%, and cellulose-based materials such as wood, glue, paper products (drywall backing) carpet, clothing, etc. Based on the investigation, fungal proliferation was evident in the area inspected.

Conclusions: A microbial health hazard did not exist in the area assessed at this subject site. Airborne levels of mold spores were not elevated in the area inspected/tested. There was a possibility of increased fungal activity and acute exposure to the ambient air if the affected building materials suffered direct impact, were not properly dried and treated, were impacted by air movement, and/or were impacted by further moisture intrusion. Surface levels of mold spores were present and elevated at the HVAC Registers in the Detective Area location tested during this inspection. There was a possibility of increased fungal activity and acute exposure to the ambient air if the affected building materials suffered direct impact, were not properly dried and treated, were impacted by air movement, and/or impacted by further moisture intrusion.

Per CAL-OSHA/DPH, all molds under proper conditions and concentrations are capable of adversely affecting human health. Therefore, it was clear that reductions and prevention of mold exposure was needed to decrease the risk to human health.

Recommendations: Mold decontamination should be conducted utilizing state-of-the-art protocol and control methods. This removal should occur at the visibly water damaged/mold impacted materials. For the HVAC registers and duct work, all registers and duct work should be decontaminated with a proprietary biocide such as IAQ 2000 or with a 10% bleach and water solution. This janitorial surface cleaning could be conducted by a either a trained and competent in-house staff member or a remediation contractor.

Mold might exist beyond the areas identified. If mold exists beyond above scope of remediation, stop and contact the owner for approval for additional work to be conducted. A wipe down of all affected/exposed surfaces that were not remediated such as the wood studs, plywood all surfaces near affected areas, should be cleaned with a 10 to 1 bleach and water solution or an EPA approved proprietary biocide with a contact time of 15 minutes.

Subsequent to all remediation activities, an inspection should be conducted to ensure all visible fungal growth was absent and all materials were dry. All common areas that were not included in the scope of services should have critical barriers installed. Air scrubbing should continue for 2 to 24 hours subsequent to completion of all mold decontamination activities. The primary air filter should be replaced regularly during work activities and again when all remedial work had been completed and post decontamination air scrubbing was initiated.

Porous surfaces (upholstery. carpet, clothing etc.) might not properly decontaminate and might need to be disposed of. The water intrusion sources should be located and remedied to prevent further damage and future fungal activity.

This work should be conducted under the direction of an environmental hygienist and a post mold remediation verification assessment should be conducted to verify completeness of remediation. A-Tech Consulting's post remediation verification was based on the following criteria: Moisture level readings of inspected materials below 18 percent (relative to wood substrate), the absence of visible mold growth or outer visible debris, as well as air and/or surface sample analytical results indicating absence of amplified quantities of mold in the containment that were at a minimum, in balance with the control sample(s).

Microscopic Examination of Fungal Spores, Fungal Structures, Hyphae, and Other Particulates from Swab Samples (EMSL Method: M041), signed by [redacted] dated

Non-viable air spore trap was conducted in and a non-viable tape lift-swab-bulk were done for 5 days.

Non-Viable air sampling were collected from the detective area and exterior samples. Non-viable tape lift-swab-bulk samples were collected from the detective area register.

Workers' Compensation Claim (DWC 1), dated

The applicant was claiming respiratory injury as a result of exposure to mold spores on

Workers' Compensation Claim (DWC 1), dated

The applicant allegedly sustained a specific injury on to his lungs due to repeated exposure to airborne irritants while working his usual and customary job duties as a police at

Application for Adjudication of Claim, dated

It was claimed that the applicant sustained a specific injury on
to his respiratory system due to repeated exposure to airborne irritants while working his usual and customary job duties as a police with City of [redacted].

Personal Record, signed by [redacted], [redacted]. Testing, dated

The swab samples from the detective area register revealed high amount of cladosporium, low Aspergillus/penicillium, and rare amount of Alternaria, bipolaris, curvularia, myxcomycetes, ulocladium, and unidentified spores. Molds were present and elevated in the detective area.

Workers' Compensation Claim (DWC 1), dated

The applicant allegedly sustained a specific injury on o his back while working his usual and customary job duties as a police with [redacted]

Application for Adjudication of Claim, dated [redacted].

It was claimed that the applicant sustained a specific injury on to his back while working his usual and customary job duties as a police with [redacted].

MEDICAL RECORDS:

Doctor's First Report of Occupational Illness or Injury, signed by [redacted], M.D., occupational medicine, dated [redacted]

History of the Accident or Exposure Happened: A mold was discovered in Station ventilation. He began having respiratory problems.

History of Present illness: The applicant, a [redacted] male. worked as a police with the [redacted] Division. Mold were discovered in Station ventilation and began having respiratory problems." Dr. [redacted] reviewed his complete health history and the review of systems obtained on [redacted] included in the medical record. No chemical or toxic exposure was reported. There were no known pre-existing conditions that might interfere with the treatment or delay/impede the recovery process. There was a specific event of an injury or illness. Mold discovered in Station ventilation, began having respiratory problems last 3.5 months. There were no known prior acute trauma or cumulative trauma to the affected body part. There had been no ongoing treatment for the prior trauma or exposure. There were no known hobbies/sports complications. He complained of sinuses stuffed up while at work.

He is a right-hand dominant.

Respiratory Complaints: He complained at this time was stuffiness while working. He described the quality as dull. It was mild. He had symptoms for 3.5 months. The frequency was intermittent. The symptoms were exacerbated by being at work. The symptoms were lessened by home.

Objective Findings: He weighed pounds. His pulse rate was 47 bpm and his blood pressure were 111/71 mmHg.

Diagnosis: Mold exposure.

Treatment Rendered: He underwent pulmonary functional test.

Treatment Plan: He was expected to have MMI on . Narcotics were not prescribed. He was a old male [redacted] officer complained of mold discovered in station ventilation. He began having respiratory problems last 3.5 months. He suffered from stuffy nose at night while at work. He denied coughing or wheezing. He was prescribed Flonase nasal spray 2 puffs twice a day as needed and pulmonary functional test normal during night. He had follow up in 1 day.

Medical Report, signed by [redacted], M.D., occupational medicine, [redacted], dated .

Respiratory Complaints: The applicant was employed as a
Molds were discovered in the Station ventilation and he began having respiratory problems. There were no known prior acute trauma or cumulative trauma to the affected body parts. There had been no ongoing treatment for the prior trauma or exposure. He complained of stuffiness while working. He described the quality as dull. It was mild. He had symptoms for 3.5 months. The frequency was intermittent. The symptoms were exacerbated by being at work and were lessened at home.

Relevant History: He is a right-hand dominant. He had tetanus in

Occupational History: He was employed for or more. He worked for 40 hours per week. Main job characteristics included prolonged standing or walking. He denied any lost work-time as a result of this injury. He confirmed other source of employment. Other sources of employment included army reserve.

Surgical History: He underwent left hernia surgery in and right hernia surgery in . He underwent surgery for deviated septum.

Medical History: He worked in a hazardous environment in the Southeast station. He had work-related injuries/illnesses in multiple/feet, back, neck, legs, and whole body. He has an existing permanent disability of feet, back, neck, legs with whole body impairment of 17%.

Social History: He did not use tobacco. He drank alcohol/alcoholic beverages-social per week.

Review of Systems: There was a sinus but not under treatment. There was also a coughing, which was under treatment.

Injury Details: His injury or condition was caused at work, dated

Physical Examination: He weighed pounds. His pulse rate was 47 bpm and his blood pressure was 111/71 mmHg.

Diagnosis: Mild exposure.

Causation: The findings on exam and diagnosis were consistent with the injury reported by the applicant. Prior factors such as injuries/medical conditions/diseases/prior activities or exposures were not contributing to the findings. The findings could not be possibly produced by natural progression of pre-existing conditions or aging. The reported injury/exposure was not causing an aggravation to the above pre-existing condition. In conclusion, the reported injury, more likely than not, was causing the current symptoms and findings.

Procedures: Pulmonary functional test was obtained.

Treatment Plan: He was expected to reach MMI on Narcotics were not prescribed. He was a [redacted] officer complaining of mold discovered in station ventilation. He began having respiratory problems in the last 3.5 months. He suffered stuffy nose at night while at work. He denied coughing or wheezing. He was prescribed Flonase nasal spray 2 puffs twice a day as needed and pulmonary functional test normal during night. He was to follow up in 1 day.

Work Status: He was advised to continue to work without restrictions.

Doctor's First Report of Occupational Illness or Injury, signed by [redacted], M.D., [redacted] dated

Subjective: The applicant was employed as police at [redacted]. On he was working when he developed low back pain after bending over to pick up some bags. The pain was described as dull, moderately severe and intermittent. He had these symptoms for 1 day. The symptoms were exacerbated by bending and lifting. The symptoms were alleviated by rest.

Vital Signs: Blood pressure was 156/98 mmHg. Pulse rate was 88 bpm. He weighed pounds.

Diagnosis: Lumbosacral strain, initial encounter.

Treatment: Authorization for chiropractic therapy was requested. Back support, back heat therapy pad and dual corpak hot cold packs were dispensed. Orphenadrine Citrate ER 100 mg and Etodolac ER 600 mg were also dispensed.

Work Status: He was to return to his work on [redacted].

Primary Treating Physician's Progress Report, signed by [redacted], M.D., [redacted] dated [redacted]

Subjective Complaints: The applicant complained of low back pain that was rated at 6/10 for 7 days. The pain was described as sharp, moderately severe and constant. The symptoms were exacerbated by bending and lessened by rest.

Vital Signs: Blood pressure was 118/76 mmHg. Pulse rate 50 bpm.

Diagnosis: Lumbosacral strain, initial encounter.

Treatment Plan: Authorization for chiropractic therapy 3 times a week for 2 weeks was pending. He was to continue current meds and DME. Authorization for MRI of the lumbar spine was requested. He was to follow up in 1 week.

Work Status: He was placed off work until [redacted].

Primary Treating Physician's Progress Report, signed by [redacted], M.D., [redacted] dated [redacted]

History of Illness: The applicant was here for a follow-up visit for his injury sustained on [redacted]. The treatment was tolerated. He was currently off work. He was tolerating his current medication. There was no new symptom.

Present Complaints: He complained of low back pain rated at 3-8/10 for 14 days. The pain was dull, moderately severe and extremely severe and intermittent. The symptoms were exacerbated by walking and sitting on soft support.

Vital Signs: Blood pressure was 116/77 mmHg. Pulse rate was 54 bpm.

Diagnosis: Lumbosacral strain, initial encounter.

Treatment Plan: Authorization for chiropractic therapy 3 times a week for 2 weeks was still pending. Ibuprofen 800 mg was prescribed. He would continue his muscle relaxant. He was to follow up in 1 month.

Work Status: He was to remain off work until

Primary Treating Physician's Progress Report, signed by [redacted], M.D., [redacted] dated

History of Present Illness: The applicant presented for a follow-up visit. His low back pain was not improved. The treatment was followed and tolerated. He was currently off work. The DME were helping with the symptoms. Light duty was being accommodated.

Present Complaints: He complained of low back pain that was rated at 8/10 for 21 days. The pain was described as sharp, moderately severe and intermittent. The symptoms were exacerbated by bending and lessened by rest.

Vital Signs: Blood pressure was 122/77 mmHg. Pulse rate was 49 bpm.

Diagnosis: Lumbosacral strain, initial encounter.

Treatment Plan: Ibuprofen 800 mg and Orphenadrine Citrate ER 100 mg were prescribed. He was to continue current meds and DME. Chiropractic therapy was scheduled to start today. MRI of the lumbar spine was scheduled on December . He was to follow up in 1 month.

Work Status: He was to remain off work until

MRI of the Lumbar Spine without Contrast, signed by [redacted], M.D., Stand-up MRI of [redacted] dated

Impression: 1) Mild levoscoliosis with the apex at L4. 2) Multilevel degenerative changes of the lumbar intervertebral discs and facets including a broad-based 3 mm left posterior lateral protrusion and annular fissure at L1-L2, a broad-based 4 mm posterior central extrusion at L3-L4 extending 3 mm superiorly from the intervertebral disc level and posterior central annular fissure, a 6 mm posterior central extrusion at L4-L5 extending 5 mm inferiorly from intervertebral disc level and a 5 mm annular disc bulge at L5-S1 with bilateral pars defects causing grade 2 degenerative anterolisthesis of L5 on S1. 3) Moderate left L1-L2, moderate right L4-L5 and bilateral neural foraminal narrowing. 4) Mild L1-L2, L2-L3, moderate L3-L4 central canal stenosis.

Injury Status Report, signed by [redacted], M.D., dated [redacted].

The applicant was placed on TTD until [redacted].

Primary Treating Physician's Progress Report, signed by [redacted], M.D., [redacted] dated [redacted]

Subjective Complaints: The applicant complained of low back pain that was rated at 9/10 for 29 days. The pain was described as dull, extremely severe and constant. The symptoms were exacerbated by bending and lessened by rest.

Vital Signs: Blood pressure was 126/83 mmHg. Pulse rate was 57 bpm.

Diagnosis: Lumbosacral disc herniation.

Treatment Plan: He was to continue current medications and DME. Authorization for referral for spine surgery evaluation was requested. He was to follow up in 1 week. Orphenadrine Citrate ER 100 mg was prescribed.

Work Status: He was to remain off work until [redacted].

Initial Orthopedic Evaluation, signed by [redacted], M.D., orthopedics, [redacted] dated [redacted]

Chief Complaint: The applicant complained of low back pain with buttock radiation bilaterally.

History of Present Injury: He worked for [redacted] Division. He was involved in a motor vehicle accident roughly 3 days ago and in [redacted], he lifted heavy weight resulting in mid and lower back pain. The pain level was rated at 7/10. The pain was dull and sharp discomfort with no prior history of symptoms and no traveling of pain. He denied any overt pins-and-needles, numbness and tingling. He had constant pain with bending and stooping. Lying down seemed to help. He complained of stiffness in the lower back, but no weakness, swelling, grinding, locking or giving way. No bowel or bladder dysfunction. There was no deformity or scar.

Medical Treatment to Date: He had chiropractic treatment. No physical therapy or acupuncture. He had not had recent epidural injections, but he had successful injections years ago.

Medical History: He denied having a history of high blood pressure, diabetes or cardiac, pulmonary, renal or gastrointestinal disorders.

Hospitalizations: He denied any hospitalizations.

Surgical History: He had no previous history of surgical procedures.

Allergies: He had no known allergies to medications.

Social History: He denied alcoholic beverages consumption and smoking tobacco.

Vital Signs: Blood pressure was 131/87 mmHg. Pulse rate was 58 bpm.

Diagnosis: Lumbar strain, underlying spondylosis.

Recommendations: TTD would be extended for the next 4 weeks. He was encouraged for home exercises, core strengthening, weight reduction, stretching, walking, swimming, stationary bike and elliptical machine. He was a candidate for acupuncture 2 times a week for 4 weeks for the next 4 weeks in addition to pain management consultation prior to reassessment. He should likely subside in terms of pain levels over the next 6 weeks and conservative care was mainstay in his case.

Causation: It appeared that he sustained an injury to the lumbar spine arising out of and caused by the industrial exposure on [redacted].

MRI of the Cervical Spine without Contrast, signed by [redacted], M.D., Stand-up MRI of [redacted] dated [redacted]

Impression: 1) Lordotic reversal was mild at C5-C6; disc degeneration was moderate at C5-C6 as well as mild at C3-C4 and C6-C7. 2) C3-C4 mild spinal cord flattening centrally with stenosis and mild bilateral foraminal stenosis. 3) C5-C6 mild to moderate spinal cord flattening to the left with stenosis as well as moderate left and mild to moderate right foraminal stenosis. 4) C6-C7 mild to moderate spinal cord flattening centrally with stenosis as well as moderate left and mild to moderate right foraminal stenosis. 5) No frank disc extrusion or intrinsic spinal cord pathology throughout the study. 6) Relationship of findings to the applicant's injury was indeterminate.

MRI of the Thoracic Spine without Contrast, signed by [redacted], M.D., Stand-up MRI of [redacted] dated [redacted]

Impression: 1) Kyphotic exaggeration was moderate from T1 through T10; chronic anterior wedging was 10% at T7, T9, and T10; disc degeneration was mild to moderate from T6-T7 through T11-T12. 2) T2-T3 mild spinal cord flattening centrally without stenosis. 3) T5-T6 mild spinal cord flattening centrally without stenosis. 4) T7-T8 mild spinal cord flattening to the right without stenosis. 5) T8-T9 mild spinal cord flattening to the left without stenosis. 6) T9-T10 small central disc extrusion; mild spinal cord flattening centrally without stenosis. 7) T10-T11 mild to moderate spinal cord flattening to the left without stenosis. 8) No central canal stenosis, foraminal stenosis, or intrinsic spinal cord pathology throughout the study. 9) Relationship of findings to the applicant's injury was indeterminate.

Progress Note, signed by [redacted], M.D., dated

Reason for Appointment: The applicant complained of neck and mid-back pain.

History of Present Illness: He sustained a specific injury to his lumbar spine on , while working as a er with [redacted] Department.

He was feeling worse. The pain was rated at 7/10.

Current Medications: He was taking Ibuprofen.

Allergies: He had no known drug allergies.

Vital Signs: He weighed pounds.

Assessments: 1) Low back pain, unspecified back pain laterality, unspecified chronicity, with sciatica presence unspecified. 2) Lumbar stenosis with neurologic claudication. 3) Acquired spondylolisthesis. 4) Cervical radiculopathy. 5) Neck pain. 6) Mid back pain. 7) Cervical spinal stenosis.

Treatment: He was referred to Dr. [redacted] for pain management. The applicant would see Dr. [redacted] after the injections were completed. He was to monitor his weight.

That completes the review of records.

Table A - Itemization of reports with blood pressure and weight:

Date of Encounter	Provider	Applicant's Blood Pressure	Applicant's Heart Rate	Hypertensive / DM Medications	HgA1c Value	Weight
March	[redacted], M.D.	111/71 mmHg	47 bpm			pounds
November	[redacted], M.D.,	156/98 mmHg	88 bpm			pounds
December	[redacted] M.D.,	118/76 mmHg	50 bpm			
December	[redacted], M.D.	116/77 mmHg	54 bpm			
December	[redacted], M.D.	122/77 mmHg	49 bpm			
December	[redacted], M.D.	126/83 mmHg	57 bpm			
January	[redacted], M.D.	131/87 mmHg	58 bpm			
February	[redacted] M.D					pounds

PHYSICAL EXAMINATION

BLOOD PRESSURE: 134/85

PULSE: 52

RESPIRATIONS: 12

WEIGHT: lbs.

HEIGHT: in.

BMI: 36

HEENT: Normocephalic, atraumatic. The fundi are benign, without hemorrhages or exudates. The pharynx is clear, and tympanic membranes are

normal. Nasal membranes show 3+ edema and 3+ erythema
NECK: Supple and without jugulo-venous distension. The carotids are 2+ bilaterally. There are no masses. There is no thyromegaly.

NODES: There is no lymphadenopathy noted.

CHEST: Percussion note is normal, with normal diaphragmatic motion. There are coarse breath sounds with no rales, no ronchi and no wheezing.

HEART: The PMI is at the 5th left intercostal space, at the mid-clavicular line. There are no heaves or thrusts. The S1 and S2 are normal. No murmurs or rubs are heard.

ABDOMEN: The abdomen is soft, non-tender, and non-distended. There is no organomegaly. There are no masses. The bowel sounds are normal. There is no pelvic area tenderness.

EXTREMITIES: There is no cyanosis, no clubbing, or edema.

NEUROLOGIC: There are no focal neurologic findings.

LABORATORY DATA

A complete blood count was obtained. The hemoglobin and hematocrit are normal. The white blood cell is within normal limits. The platelet count is normal.

A chemistry-7 panel was obtained. Serum electrolytes, BUN, creatinine, and glucose were all within normal limits.

A complete chemistry profile was obtained. The cholesterol was 231 and triglycerides were elevated at 195. The remainder of the chemistry panel shows all levels essentially within normal limits.

A total IgE level was 69, which is normal.

IgE level against common household allergens was run. Against D. pteronyssinus, IgE was elevated to 1.89. The IgE to D. farinae was also elevated to 1.97. Antibodies to cockroach antigen were also mildly elevated to 0.22. Other antibodies to dog dander, cat dander, various grasses and trees were all negative.

An IgE panel against common molds was also run. Aspergillus, Candida, Mucor, Fusarium, Phoma, Epicoccum, Stemphylium, Cladosporium, Alternaria, or Penicillium: All of these IgE levels were negative or non-detected.

An H. pylori titer was negative.

Hemoglobin A1c level was 5.6.

A complete pulmonary function study was obtained. The lung volumes are entirely normal. The expiratory flow rates in large and small airways were normal with no significant improvement after bronchodilators. The FEV1/FVC ratio was normal. The distribution of ventilation by nitrogen washout was normal. The diffusion capacity was normal. These are essentially normal pulmonary function studies with no evidence of obstructive or restrictive disease.

Because of this gentleman's complaints, a methacholine challenge test was obtained. Increasing doses of methacholine beginning at 0.025 mg/ml up to 25 mg/ml were inhaled by the patient and flow volume loops were obtained. At the highest level of methacholine at 25 mg/ml, there was a 21% drop in the FEF25-75%. Otherwise, there was no evidence of any bronchoconstriction. The FEV1 was normal within the normal testing range. This is a negative methacholine challenge test for the presence of the asthma or reactive airways disease.

A sinus CT scan was ordered on this patient.

EKG was normal.

DIAGNOSES

1. History of exposure to indoor air environment with probable contamination with multiple dusts
2. Exposure to indoor environment with exposure to various molds
3. Development of moderate-to-severe chronic rhinitis
4. Rule out any evidence of concomitant bronchospasm or asthma
5. Possible chronic sinusitis, awaiting further definition by CT scan of the sinuses
6. Postnasal drip with occasional cough
7. History of hypercholesterolemia persisting
8. History of multiple orthopedic injuries and musculoskeletal injuries, referred to appropriate specialist in orthopedics

IMPRESSION AND DISCUSSION

I have had the opportunity to evaluate Mr. [redacted] in my role as a Panel Qualified Medical Evaluator in Internal Medicine and Pulmonary Disease. [redacted] has worked with [redacted]) since and according to his history, he spent much of his time in the Station at The roles that he played in that facility have been outlined in the history above, and during the course of his employment, he began developing nasal symptoms of nasal congestion, sinus pain, and postnasal drip. He actually did not complain of actual wheezing or asthma but had almost uncontrollable episodes of sneezing, runny nose, and nasal congestion such that he had difficulty breathing and then sleeping at night.

I have had the opportunity to review the environmental study that was conducted, and find that some of the information on that study is somewhat confusing, but we will try to simplify this information. This was a report entitled "Limited Mold Inspection," which was obviously authorized and performed at the request of Mr. [redacted] with the City of [redacted] , and this limited mold inspection included a visual and air sampling as well as some surface sampling.

While it is clear that at the time of the sampling, the number of mold spores that were in the air at the station was less than those found outside, which is usually a sign that there is no significant infestation or contamination. It was pointed out that the sampling, on the "register" in the detective area, showed rare amounts of Alternaria, but moderate-to-high amounts of Cladosporium and intermediate levels of Aspergillus and Penicillium molds. It was pointed out by the author of this that "air movement" could disturb these molds, causing them to become airborne and therefore contaminate the air.

Quite obviously, the above information makes it fairly obvious that at times when either air conditioning or heating was taking place, these mold species that were present on the "registers" through which this forced air would be sent, would be disturbed and become airborne. Therefore, one must take with a grain of salt, the information of air sampling in the detective area when the air conditioning and ventilation systems are turned off. The report itself makes it quite clear that when the ventilation system is on, these spores would be disturbed and become airborne.

It is my opinion that it is reasonably medically probable that during the course of the employment at [redacted] that [redacted] was exposed not only to the spores of various molds but also to various dusts and animal droppings as

he described.

It should be stated at this juncture that this gentleman has a normal pulmonary function study and a normal methacholine challenge. Therefore, it is my opinion that it is reasonably medically probable that there is no asthma present in this gentleman.

[redacted] has developed what appears to be chronic rhinitis. I have also asked that a Sinus CT scan be obtained. From his history, it does appear that [redacted] did have a significant amount of headache, sinusitis-type symptoms, along with what appears to have been very severe nasal congestion.

I have diagnosed this gentleman with rhinitis, and the question at this point is why if this is secondary to antigens that he is exposed to in the workplace would he not have an elevated IgE level to various molds? This is a fairly good question, and caused me to do a fair amount of research regarding the possibility that we are dealing with the IgE negative form of rhinitis.

In an article published in the Journal of Environmental Health Perspectives in 2011 entitled "Respiratory and Allergic Health Effects of Dampness, Mold, and Dampness-Related Agents: A Review of Epidemiologic Evidence," a review of the literature was performed with a review of many studies up to and including 2009. There was no question that epidemiologic studies and med analysis showed that indoor dampness and mold were associated consistently with not only asthma, but rhinitis as well. This was also associated with skin changes such as eczema. As one reads through this article, it becomes apparent that when IgE levels against particular antigens were measured, there was an inconsistency with the presence of specific IgE antibodies, and even total IgE levels and the presence of disease.

In the Journal of Allergy and Clinical Immunology in 2013, an article entitled, "The Association of Indoor Dampness and Molds with Rhinitis Risk: A Systematic Review and Med Analysis" was published and showed that the risk of rhinitis to viable mold was consistently increased in all the studies looked at with a risk ratio of 1.82, and the association of rhinoconjunctivitis was also elevated. The associations were extraordinarily strong when one looked at the "mold odor," suggesting the importance of microbial causal agents. Once again, indoor dampness and mold problems are well known to be associated with the development of rhinitis.

If we are not dealing with IgE-mediated issues, then what are we dealing with? In the Journal of Allergy and Clinical Immunology in February 2006 in an article

entitled, "Medical Effects of Mold Exposure," it is known that exposure to molds can cause human disease through well-defined mechanisms. In this lengthy paper which was considered to be a "state of the art" review, allergic rhinitis, allergic bronchopulmonary aspergillosis, sinusitis, and hypersensitivity pneumonia were all looked at. What was determined by reviewing that article is that the association between IgE antibodies and even IgG antibodies and exposure to mold is far from a certainty. There are a number of patients who develop reactions to molds that are not mediated through the IgE mechanism. This was described actually in more detail earlier in an article entitled, "Allergy and Toxic Mold Syndrome" published in the annals of allergy, asthma, and immunology. This was referred as a "controversial diagnosis" which has become less controversial in the 13 years since the publication of this article. It is pointed out in this article that molds can induce asthma and allergic rhinitis through IgE-mediated mechanisms, but it is also pointed out that these mold metabolites and not intact mold antigen can be involved in a syndrome known as "sick building syndrome." What was interesting was that only half of the patients who had symptoms upon exposure to environment known to be contaminated with mold had skin test reactions or IgE antibodies associated with the mold. Symptoms that are attributed to the toxic affects of molds and not attributable to the IgE or other immune mechanisms were considered to be curious, and in need of further evaluation as to the pathogenesis.

Subsequently since that paper was published and many other articles have supported the fact that in known moldy environments, there is evidence of clinical illness without antibody titers or skin test reactivity, eosinophils have been implicated, the use of nasal smears for eosinophils has gained popularity, and other non-immunologic mechanisms have been implicated. This mechanism of illness was discussed in 2010 in an article published in the Proceedings of the American Thoracic Society entitled, "Allergic Fungal Rhinitis and Rhinosinusitis" describing the fact that many cases that are attributed to routine allergy are really not secondary to allergic reaction with IgE antibodies but rather an allergic response against the fungi with an eosinophilic response, and would increase mucin, mucostasis, and even sinus opacification. It has been seen in studies that a vast majority of cases of chronic rhinosinusitis demonstrated that certain fungi, particularly Alternaria, are capable of eliciting a "modified" allergic response that is completely independent of IgE.

Given the scientific data above, it is certainly not out of the question that [redacted] developed a reaction to the moisture ridden mold containing workspace at the [redacted] where he was working as a [redacted] Clearly, his history of getting worse symptoms in the building that dissipated when he left goes along with this picture.

His physical examination shows moderate-to-severe rhinitis, and the question about sinusitis is still left unanswered. The fact that he is able to generate an IgE response to house dust mite and to cockroach antigen shows that he is not "anergic," but he is capable of having a allergic response to certain antigens. However, with his normal total IgE level and the severity of his rhinitis, I have come to the conclusion that with reasonable medical probability he is not what we would consider to be an "allergic individual."

Rather, it is apparent from the history and the physical findings that a significant portion of his chronic rhinitis derives from a non-IgE-mediated allergic-type response in his nasal cavity.

DISABILITY

It is my opinion that there is no respiratory disability from a pulmonary perspective.

With regard to his upper respiratory impairment, I have utilized Table 11-6 in the AMA Guides. It is my opinion that [redacted] has an impairment that is consistent with a Class I impairment with a 7% whole-person impairment. It is my opinion that this impairment is at maximal medical improvement at this time for rating purposes.

CAUSATION AND APPORTIONMENT

With regard to causation, it is my opinion that, as described above, that among the causes of this gentleman's chronic rhinitis and disability secondary to this is the exposures that he experienced during the course of his employment at [redacted]. At this juncture, it is impossible for me to ignore the allergy to common house dust, and to cockroach antigen, which could be encountered in any situation, including home and other venues. However, until I have had the opportunity to review additional information regarding his sinuses and come to a final conclusion regarding impairment, I will defer any decision regarding apportionment of disability related to his upper respiratory tract abnormalities.

WORK RESTRICTIONS

At this juncture, this gentleman would be restricted from any exposure to a heavily moist environment or an environment in which there is a high likelihood of mold spores being present. It is my opinion that other than this, there are no work restrictions that would be placed on this gentleman at this time.

RECOMMENDATIONS

I look forward to the receipt of Dr. [redacted] report and the CT scan of the sinuses. I also look forward to receiving further information regarding his prior medical records and any evidence that there was a history of allergies, rhinitis, sinusitis, or even conjunctivitis or eczema when he was younger. If those medical records do exist, I would appreciate the opportunity of reviewing them.

Once I have the other medical records mentioned above as well as the CT scan of his sinuses, final conclusion regarding impairment and disability as well as apportionment can be made.

I appreciate the opportunity of evaluating this gentleman and trust that this report will be helpful in the management of his case. If I can provide any further information, please feel free to contact me.

SPECIAL COMMENTARY

The above responses and opinions are based on reasonable medical probabilities, as viewed from the perspective of available documentation and information submitted to this examiner, including the applicant's direct anamnesis.

I, Stewart Lonky, M.D., Q.M.E., formulated all conclusions and opinions.

Thank you for the opportunity of serving as Qualified Medical Examiner, in the specialty of Internal Medicine, for this most interesting case and condition.

Sincerely,

_____
Stewart Lonky, M.D., Q.M.E.
Diplomate, American Boards of Internal Medicine & Pulmonary Medicine

Attachments:

1. Appendix A: Declaration
2. Appendix B: EKG Test Results
3. Appendix C: Medical Research

APPENDIX A - DECLARATION

Pursuant to AB 1300, LC Sec. 5703, I have not violated Labor Code section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

DATE OF REPORT: July

Dated this day of July , at

Stewart Lonky, M.D., Q.M.E.
Diplomate, American Boards of Internal Medicine & Pulmonary Medicine

Welch Allyn CardioPerfect Workstation

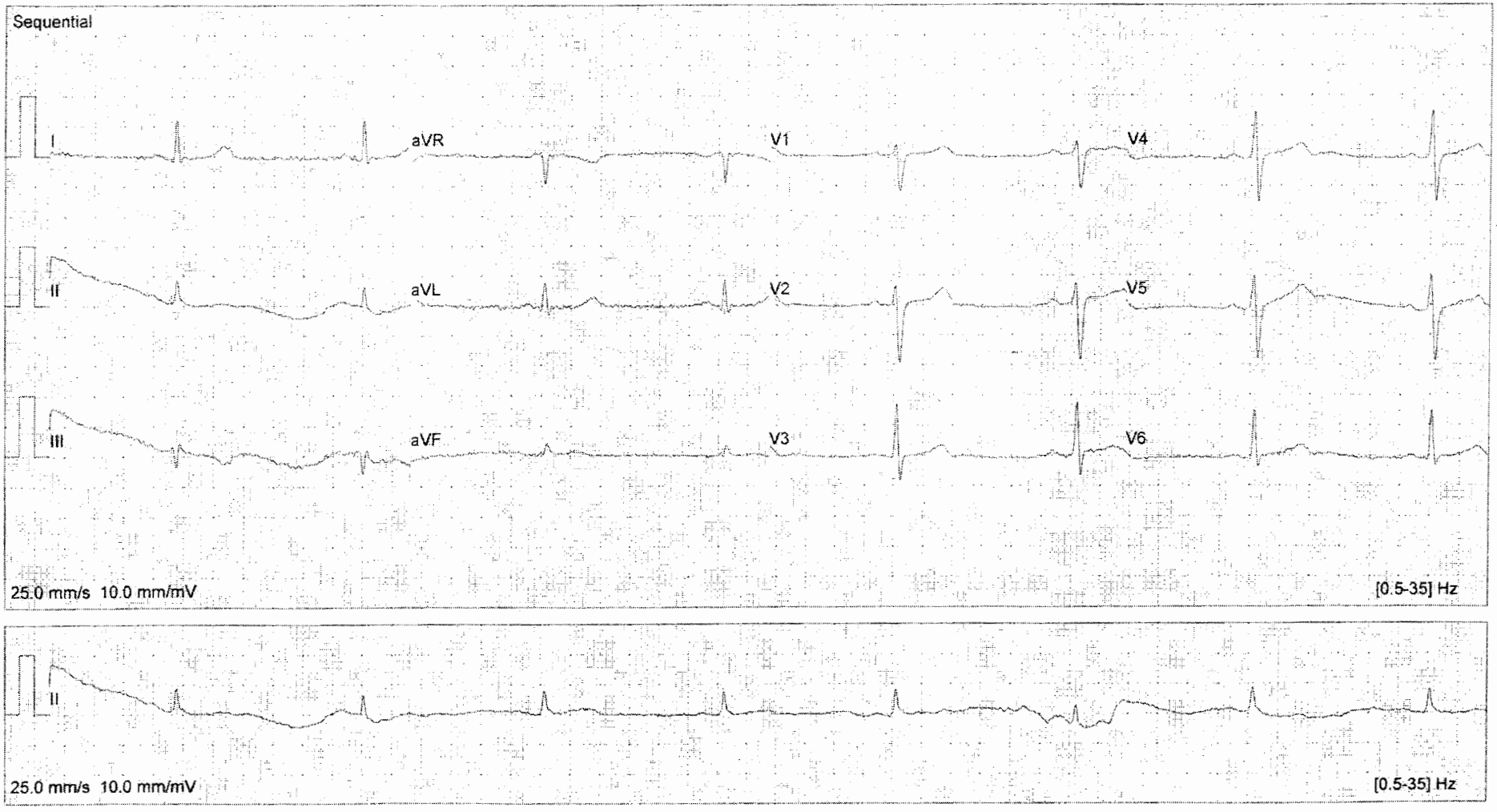
Name:	
Number:	
Gender:	Unknown
Birthdate:	years
P / PR:	132 ms / 162 ms
QRS:	110 ms
QT / QTc / QTd:	453 ms / 436 ms / -
P/QRS/T axis:	4° / 15° / -16°
Heartrate:	50 bpm

Recorded:	
Recorded by:	
Referring physician:	
Ordering physician:	
Attending physician:	
Location:	
Comment:	

UNCONFIRMED INTERPRETATION

warning: sex not available, assumed
sinus bradycardia
minor inferior repolarization disturbance, consider ischemia,
LV overload or aspecific change
flat or low negative T in aVF
with negative T in III

ECG without significant abnormalities



ehp ENVIRONMENTAL HEALTH PERSPECTIVES

Environ Health Perspect. 2011 Jun; 119(6): 748–756
Published online 2011 Jan 28. doi: 10.1289/ehp.1002410
Review

PMCID: PMC3114807
PMID: 21268828

Respiratory and Allergic Health Effects of Dampness, Mold, and Dampness-Related Agents: A Review of the Epidemiologic Evidence

Mark J. Mendell,[1,2] Anna G. Mirer,[3] Kerry Cheung,[4] My Tong,[1] and Jeroen Douwes[4]

[1] Indoor Air Quality Section, Environmental Health Laboratory Branch, California Department of Public Health, Richmond, California, USA
[2] Indoor Environment Department, Environmental Energy Technologies Division, Lawrence Berkeley National Laboratory, Berkeley, California, USA
[3] Department of Population Health Sciences, University of Wisconsin School of Medicine and Public Health, Madison, Wisconsin, USA
[4] Centre for Public Health Research, Massey University, Wellington, New Zealand
Address correspondence to M.J. Mendell, California Department of Public Health, 850 Marina Bay Parkway, G365, Richmond, CA 94804 USA. Telephone: (510) 620-2862. Fax: (510) 620-2625. E-mail: mark.mendell@cdph.ca.gov
The authors declare they have no actual or potential competing financial interests.

Received 2010 May 7; Accepted 2011 Jan 26.

Abstract

Go to:

Objectives

Go to:

Many studies have shown consistent associations between evident indoor dampness or mold and respiratory or allergic health effects, but causal links remain unclear. Findings on measured microbiologic factors have received little review. We conducted an updated, comprehensive review on these topics.

Data sources

Go to:

We reviewed eligible peer-reviewed epidemiologic studies or quantitative meta-analyses, up to late 2009, on dampness, mold, or other microbiologic agents and respiratory or allergic effects.

Data extraction

Go to:

We evaluated evidence for causation or association between qualitative/subjective assessments of dampness or mold (considered together) and specific health outcomes. We separately considered evidence for associations between specific quantitative measurements of microbiologic factors and each health outcome.

Data synthesis

Go to

Evidence from epidemiologic studies and meta-analyses showed indoor dampness or mold to be associated consistently with increased asthma development and exacerbation, current and ever

diagnosis of asthma, dyspnea, wheeze, cough, respiratory infections, bronchitis, allergic rhinitis, eczema, and upper respiratory tract symptoms. Associations were found in allergic and nonallergic individuals. Evidence strongly suggested causation of asthma exacerbation in children. Suggestive evidence was available for only a few specific measured microbiologic factors and was in part equivocal, suggesting both adverse and protective associations with health.

Conclusions

Go to

Evident dampness or mold had consistent positive associations with multiple allergic and respiratory effects. Measured microbiologic agents in dust had limited suggestive associations, including both positive and negative associations for some agents. Thus, prevention and remediation of indoor dampness and mold are likely to reduce health risks, but current evidence does not support measuring specific indoor microbiologic factors to guide health-protective actions.

Keywords: allergy, asthma, dampness, fungi, indoor air, moisture, mold

Dampness and mold exposures in buildings are common, with estimates ranging from 18% to 50% of buildings (Gunnbjornsdottir et al. 2006; Mudarri and Fisk 2007). A large number of studies in many geographical regions have found consistent associations between evident indoor dampness or mold and respiratory or allergic health effects in infants, children, and adults [Institute of Medicine (IOM) 2004; World Health Organization (WHO) Europe 2009]. A review by the IOM (2004) reported documented associations, but not documented causal relationships, between indoor dampness and upper respiratory tract symptoms, cough, wheeze, and asthma symptoms in sensitized persons, but not for asthma development. A more recent review by WHO up to 2007 expanded the observed associations to include asthma development, current asthma, dyspnea, and respiratory infections (WHO Europe 2009). Associations were found in both atopic and nonatopic individuals. Other published reviews or opinion pieces on this topic are available (e.g., Bornehag et al. 2004; Douwes 2005; Mudarri and Fisk 2007).

The consistent associations between evident dampness or mold and health may represent underlying causal relationships between fungal exposures and health. However, conventional quantitative measurements of fungi or other microbiologic exposures, such as counts of culturable airborne fungi, have shown less consistent associations with health effects than have qualitative assessments of visible dampness or water damage, visible mold, or mold odor. Thus, although a causal role for microbiologic exposures is plausible and likely, the evidence for this is still weak (Douwes and Pearce 2003). This is likely attributable in part to the lack of valid exposure assessment methods for the still unknown causal agents, microbial and possibly nonmicrobial, that increase with dampness and directly cause adverse respiratory and allergic effects.

Much additional epidemiologic research on qualitative and quantitative assessments of dampness and dampness-related agents has become available in the last few years. The present review combines findings of the IOM review of findings up to 2003 (IOM 2004) and a new assessment of later published studies. In this review we provide *a*) an updated, comprehensive review of available epidemiologic evidence on qualitative assessments of dampness or mold factors, and *b*) a new synthesis of evidence on quantitative measurements of microbiologic factors. Earlier work on this review (summarizing literature through 2007) was originally done to support the WHO Guidelines for Indoor Air Quality related to dampness and mold (2009).

Methods

Go to

The online database PubMed (National Library of Medicine 2010) was searched using three groups of keywords such as dampness, damp, "water damage," moisture, humidity, fungi, fungus, mold, mould, bacteria, or microorganisms, crossed with health, asthma, allergy, eczema, wheeze, cough, respiratory,

Journal of Allergy and Clinical Immunology
Volume 132, Issue 5, November 2013, Pages 1099-1110.e18

Rhinitis, sinusitis, and upper airway disease

Association of indoor dampness and molds with rhinitis risk: A systematic review and meta-analysis

Maritta S. Jaakkola MD, PhD [a, b, c] ✉, Reginald Quansah PhD [a], Timo T. Hugg PhD [a, d], Sirpa A.M. Heikkinen BSc [a, b, c], Jouni J.K. Jaakkola MD, PhD [a, c, d]

https://doi.org/10.1016/j.jaci.2013.07.028

Background

A substantial proportion of the world's population is exposed to indoor dampness-related exposures. Since the 1990s, studies have assessed the relation between indoor dampness and mold and rhinitis, but the evidence has been inconclusive. No previous meta-analysis has been reported on this topic.

Objective

We conducted a systematic review and meta-analysis of studies on the relations between indoor dampness and mold and the risk of different types of rhinitis and investigated whether these relations differ according to the type of exposure.

Methods

A systematic search of the Ovid MEDLINE and EMBASE databases was conducted (1950 through August 2012), and reference lists of relevant articles were reviewed. Cross-sectional, case-control, and cohort studies in children or adults were selected according to *a priori* criteria and evaluated by 3 authors independently.

Results

Thirty-one studies on rhinitis, allergic rhinitis (AR), or rhinoconjunctivitis were included. In meta-analyses the largest risk was observed in relation to mold odor (rhinitis: 2.18 [95% CI, 1.76-2.71]; AR: 1.87 [95% CI, 0.95-3.68]). The risk related to visible mold was also consistently increased (rhinitis: 1.82 [95% CI, 1.56-2.12]; AR: 1.51 [95% CI, 1.39-1.64]; rhinoconjunctivitis: 1.66 [95% CI, 1.27-2.18]). In addition, exposure to dampness was related to increased risk of all types of rhinitis.

Conclusion

This meta-analysis provides new evidence that dampness and molds at home are determinants of rhinitis and its subcategories. The associations were strongest with mold odor, suggesting the importance of microbial causal agents. Our results provide evidence that justifies prevention and remediation of indoor dampness and mold problems, and such actions are likely to reduce rhinitis.

Outline Purchase Export

< **Previous** article

Next article >

Key words

Rhinitis; mold; dampness; case-control; longitudinal; cross-sectional; meta-analysis

Abbreviations used

AR, Allergic rhinitis; EE, Effect estimate

Clinical & Experimental Allergy / Volume 8, Issue 2

Influence of ageing on IgE-mediated reactions in allergic patients

Y. HANNEUSE, G. DELESPESSE, D. HUDSON, F. DE HALLEUX, J. M. JACQUES

First published: March 1978
https://doi.org/10.1111/j.1365-2222.1978.tb00461.x
Cited by: 36

Summary

The influence of age and sex has been evaluated in 326 allergic patients on the following parameters: total serum IgE concentration, serum concentration of specific IgE antibodies against seventeen common allergens, mean number of positive allergens, absolute numbers of circulating eosinophils, corticosteroid dependence and response to sodium cromoglycate (DSCG). The results indicate that age and sex significantly influence the IgE antibody production in these patients. The data strongly suggests the appearance during ageing of a progressive natural desensitization. This contrasts with the increased frequency of corticosteroid-dependent cases during ageing. There is an inverse relation between age and response to DSCG therapy.

Journal of Allergy and Clinical Immunology
Volume 117, Issue 2, February 2006, Pages 326-333

Environmental and occupational respiratory disorders

The medical effects of mold exposure

Robert K. Bush MD, FAAAAI [a], Jay M. Portnoy MD, FAAAAI [b], Andrew Saxon MD, FAAAAI [c], Abba I. Terr MD, FAAAAI [d], Robert A. Wood MD [e] [*] [✉]

Show more

https://doi.org/10.1016/j.jaci.2005.12.001

Referred to by Correction

Journal of Allergy and Clinical Immunology, Volume 134, Issue 5, November 2014, Pages 1217

Download PDF

Correction

Journal of Allergy and Clinical Immunology, Volume 117, Issue 6, June 2006, Pages 1373

Download PDF

Exposure to molds can cause human disease through several well-defined mechanisms. In addition, many new mold-related illnesses have been hypothesized in recent years that remain largely or completely unproved. Concerns about mold exposure and its effects are so common that all health care providers, particularly allergists and immunologists, are frequently faced with issues regarding these real and asserted mold-related illnesses. The purpose of this position paper is to provide a state-of-the-art review of the role that molds are known to play in human disease, including asthma, allergic rhinitis, allergic bronchopulmonary aspergillosis, sinusitis, and hypersensitivity pneumonitis. In addition, other purported mold-related illnesses

and the data that currently exist to support them are carefully reviewed, as are the currently available approaches for the evaluation of both patients and the environment.

Previous article Next article

Key words

Mold; fungi; hypersensitivity; allergy; asthma

Abbreviations used

ABPA, Allergic bronchopulmonary aspergillosis; CRS, Chronic rhinosinusitis; HP, Hypersensitivity pneumonitis; MVOC, Volatile organic compound made by mold; VOC, Volatile organic compound

Annals of Allergy, Asthma & Immunology

Volume 94, Issue 2, February 2005, Pages 234-239

ORIGINAL ARTICLES

Allergy and "toxic mold syndrome"

David A. Edmondson DO *, Mark E. Nordness MD *, Michael C. Zacharisen MD *, Viswanath P. Kurup PhD *, †, Jordan N. Fink MD *

Show more

https://doi.org/10.1016/S1081-1206(10)61301-4

Background

"Toxic mold syndrome" is a controversial diagnosis associated with exposure to mold-contaminated environments. Molds are known to induce asthma and allergic rhinitis through IgE-mediated mechanisms, to cause hypersensitivity pneumonitis through other immune mechanisms, and to cause life-threatening primary and secondary infections in immunocompromised patients. Mold metabolites may be irritants and may be involved in "sick building syndrome." Patients with environmental mold exposure have presented with atypical constitutional and systemic symptoms, associating those symptoms with the contaminated environment.

Objective

To characterize the clinical features and possible etiology of symptoms in patients with chief complaints related to mold exposure.

Methods

Review of patients presenting to an allergy and asthma center with the chief complaint of toxic mold exposure. Symptoms were recorded, and physical examinations, skin prick/puncture tests, and intracutaneous tests were performed.

Results

A total of 65 individuals aged 1½ to 52 years were studied. Symptoms included rhinitis (62%), cough (52%), headache (34%), respiratory symptoms (34%), central nervous system symptoms (25%), and fatigue (23%). Physical examination revealed pale nasal mucosa, pharyngeal "cobblestoning," and rhinorrhea. Fifty-three percent (33/62) of the patients had skin reactions to molds.

Conclusions

Mold-exposed patients can present with a variety of IgE- and non-IgE-mediated symptoms. Mycotoxins, irritation by spores, or metabolites may be culprits in non-IgE presentations; environmental assays have not been perfected. Symptoms attributable to the toxic effects of molds and not attributable to IgE or other immune mechanisms need further evaluation as to pathogenesis. Allergic, rather than toxic, responses seemed to be the major cause of symptoms in the studied group.

< **Previous** article **Next** article >

Proceedings of the American Thoracic Society

Home > All AnnalsATS Issues > Vol. 7, No. 3 | May 15, 2010

Allergic Fungal Rhinitis and Rhinosinusitis

Daniel L. Hamilos [1]

+ Author Affiliations

Received: September 08, 2009 Accepted: November 13, 2009

Abstract

The intent of this article is to review the published literature addressing the role of fungi as causative agents in allergic rhinitis and rhinosinusitis. Ambient mold spores are widely distributed in nature, and an estimated 3 to 10% of the world's population is allergic to molds. There are compelling epidemiologic links between mold (fungal) allergy and illnesses such as asthma and "asthma with allergic rhinitis." Fungal allergy is more prevalent in areas of high ambient mold spore concentrations. However, epidemiologic studies have failed to demonstrate a direct relationship between fungal allergy and allergic rhinitis either via outdoor or indoor exposure. Fungal allergy is clearly linked to a subset of chronic rhinosinusitis (CRS) known as allergic fungal rhinosinusitis (AFRS). This condition represents an intense allergic response against colonizing fungi giving rise to formation of allergic (eosinophilic) mucin, mucostasis, and sinus opacification. A broader role for colonizing fungi has been postulated in CRS owing to the demonstration of fungi in mucus in the vast majority of cases of CRS, and *in vitro* studies demonstrating that certain fungi, particularly *Alternaria*, elicit a "modified" allergic response in patients with CRS that is independent of IgE.

Keywords: allergic rhinitisrhinosinusitisfungalallergymold

October 26, 2018

TO: Disability Procedures & Services Committee
William Pryor, Chair
James P. Harris, Vice Chair
Herman Santos
Gina Zapanta-Murphy
Marvin Adams, Alternate

FROM: Ricki Contreras, Manager RC
Disability Retirement Services

FOR: November 7, 2018, Disability Procedures and Services Committee Meeting

SUBJECT: **CONSIDER APPLICATION OF GERALD WEINGARTEN, M.D., AS A LACERA PANEL PHYSICIAN**

On August 7, 2018, staff and Legal Counsel interviewed California Medical Evaluators regarding Gerald Weingarten, M.D., a physician seeking appointment to the LACERA Panel of Examining Physicians.

Attached for your review and consideration are:
- Staff's Interview Summary and Recommendation
- Panel Physician Application
- Curriculum Vitae
- Sample Report(s)

IT IS THEREFORE RECOMMENDED THAT THE COMMITTEE accept the staff recommendation to submit the application of Gerald Weingarten, M.D., to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

JJP:RC:mb

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

October 26, 2018

TO: Ricki Contreras, Manager
Disability Retirement Services

FROM: Tamara L. Caldwell, DRS Supervisor
Disability Retirement Services

FOR: November 7, 2018 Disability Procedures & Services Committee

SUBJECT: Recommendation for Cardiologist Applying for LACERA's Panel of Examining Physicians

RECOMMENDATION

Based on our efforts to provide a diverse panel of examining physicians in several geographic locations throughout Los Angeles and surrounding counties, staff recommends the Application of Gerald Weingarten M.D. be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

On August 7, 2018, staff and Legal Counsel met with California Medical Evaluators at the LACERA offices to discuss several candidates for the LACERA Panel of Examining Physicians. California Medical Evaluators (CME) is a doctor-owned management and marketing company focused on serving the medical and legal communities. CME provides full-service administration of physician's medical-legal practices. CME was founded by Gregory Marusak, MD and Gabor Vari, MD who cumulatively span over two decades of experience in the medical-legal industry. They are both UCLA residency graduates and remain active on the UCLA faculty. Since its inception, CME has steadily grown, adding physicians, staff and offices to better serve clients and community. CME has highly experienced doctors in all specialties throughout California and pride themselves on providing a comprehensive and tailored experience for both legal and medical professionals.

Dr. Gerald Weingarten has been practicing internal medicine and cardiology for forty-one years. He is Board Certified in Internal Medicine since 1972. A native of Detroit, Michigan, he did his pre-medical studies at the University of Michigan and received his medical degree from Wayne State University School of Medicine. He then migrated to California to complete his residency in Internal Medicine and Cardiology at Cedars-Sinai Medical Center and Wadsworth VA/UCLA Hospital. He next served two years as an Internist and Chief of Medicine at Mount Home AFB, Idaho. He returned to the San Fernando Valley to establish his private practice of Internal Medicine in 1974. He is currently on the staff of Providence Tarzana

Medical Center and the Jewish Home for the Aging. He has been past Chief of Medicine at Sherman Oaks Hospital, Jewish Home for the Aging and past President of Phi Delta Epsilon Medical Fraternity, San Fernando Valley Graduate Club. He has practiced as an AME, QME and IME for thirty years. He is a Medical Expert for the Social Security Administration Disability Adjudication and Review Office.

Staff reviewed the new LACERA Panel Physician Guidelines with the physician's management team, which included a lengthy discussion regarding the Rules in Evaluating Applicants, Disability Retirement Law Standards, and a thorough explanation of what is expected when preparing Panel Physician's written report for the Board of Retirement. Staff also discussed report submission timeframes, fee schedule and billing procedures, additional diagnostic testing request requirements, and advised of the requirement of maintaining a valid medical license, Board Certification, and insurance coverage. Staff also advised that all physicians must immediately report any lapses, suspensions or revocation of medical license, Board Certification, or insurance coverage, or be subject to immediate suspension or termination from LACERA Panel of Examining Physicians.

CME confirmed that they would be responsible in making sure that Dr. Weingarten adhered to the rules set forth in the Guidelines and all other requirements as discussed. CME was informed that a Quality Control Questionnaire is sent to each applicant regarding their visit, which affords the applicant an opportunity to provide feedback concerning their experience during the medical appointment.

On September 21, 2018, Board Medical Advisor Vito Campese, M.D., reviewed Dr. Weingarten's application and medical credential and indicated he is in agreement with submitting the Application of Gerald Weingarten, M.D. to the Disability Procedures and Services Committee for consideration.

IT IS THEREFORE RECOMMENDED THAT YOUR COMMITTEE adopt staff's recommendation to submit the Application of Gerald Weingarten, M.D. to the Board of Retirement for final approval to the LACERA Panel of Examining Physicians.

Attachments

RC:tlc/mb

Gerald Weingarten, M.D.
Office Location Details

Location	ADA Parking	ADA Restrooms	Lobby/Waiting Room Seating	Patients Per Day	Average Wait Time	Evaluation Time
6851 Lennox Avenue, Suite 405 Van Nuys, CA 91405	Yes	Yes	5	5-10	0 – 5 Minutes	30 Minutes – 3 Hours
2158 E Florence Avenue Walnut Park, CA 90255	Yes	Yes	15	5-10	0 – 5 Minutes	30 Minutes – 3 Hours
1701 Pacific Avenue, Suite 110 Oxnard, CA 93033	Yes	Yes	6	5-10	0-5 Minutes	30 Minutes – 3 Hours

1. CME has 47 employees including, but not limited to, medical assistants, provider liaisons, and administrative support.
2. Bianka Kuretil will be LACERA's point of contact for scheduling appointments and addressing issues and complaints. Contact: 310-625-7475 and bkureti@calmedeval.com
3. Physician review patient history prior to examination.
4. Only CME physicians share these offices for evaluations.

LACERA

Los Angeles County Employees Retirement Association

300 N. Lake Ave., Pasadena, CA 91101 ■ Mail to : PO Box 7060, Pasadena, CA 91109-706 626/564-2419 • 800/786-6464

GENERAL INFORMATION		Date 8/14/18
Group Name: CALIFORNIA MEDICAL EVALUATORS	Physician Name: GERALD WEINGARTEN, MD	
I. Primary Address: 11620 WILSHIRE BLVD, SUITE 340, LA, CA, 90025		
Contact Person BIANKA KURETI	Title ACCOUNT EXECUTIVE	
Telephone: 888.853.7944	Fax 866.288.9958	
II. Secondary Address 11620 WILSHIRE BLVD, SUITE 340, LA, CA, 90025		
Contact Person DOUGLAS STODDARD	Title VICE PRESIDENT, SALES & MARKETING	
Telephone 323.645.3644	Fax 213.377.5152	

PHYSICIAN BACKGROUND		
Field of Specialty INTERNAL MEDICINE	Subspecialty CARDIOLOGY	
Board Certification ☐ Yes ☐ No	License # C 31540	Expiration Date 4/30/2019

EXPERIENCE
Indicate the number of years experience that you have in each category.

Evaluation Type

I. Workers' Compensation Evaluations

- ☐ Defense How Long? _____
- ☐ Applicant How Long? _____
- ☑ AME How Long? 33 years
- ☑ IME How Long? 33 years
- ☑ QME How Long? 33 years

II. ☐ Disability Evaluations How Long? _____

For What Public or Private Organizations?

Currently Treating? ☑ Yes ☐ No

Time Devoted to: Treatment > 30 % Evaluations %

Estimated Time from Appointment to Examination	Able to Submit a Final Report in 30 days?
☒ 2 weeks ☐ 3-4 Weeks ☐ Over a month	☑ Yes ☐ No

LACERA's Fee Schedule

Examination and Initial Report by Physician	$1,500.00 flat fee
Review of Records by Physician	$350.00/hour
Review of Records by Registered Nurse	$75.00/hour
Supplemental Report	$350.00/hour

-OVER-

Other Fees	
Physician's testimony at Administrative Hearing (includes travel & wait time)	$350.00/hour
Deposition Fee at Physician's office	$350.00/hour
Preparation for Expert Testimony at administrative Hearing	$350.00/hour
Expert Witness Fees in Superior or Appellate Court	$3,500.00 half day $7,000 full day
Physician agrees with LACERA's fee schedule?	No
Comments	

Name of person completing this form:

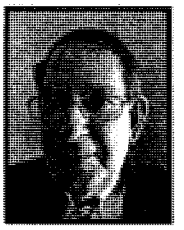
BIANKA KURETI Title: ACCOUNT EXECUTIVE

(Please Print Name)

Physician Signature: Carl M. Weyman MD Date: 08/14/2018

FOR OFFICE USE ONLY Physician Interview and Sight Inspection Schedule	
Interview Date:	Interview Time:
Interviewer:	

California Medical Evaluators
11620 Wilshire Blvd., Suite 340
Los Angeles, CA 90025
Ph: 888-853-7944
Fx: 213-478-0550
info@calmedeval.com



Gerald Weingarten, MD, QME

Internal Medicine, Cardiologist

EDUCATION

- **Wayne State University School of Medicine, Detroit, MI** (1964 – 1968)
  Doctor of Medicine
- **Wayne State University School of Medicine, Detroit, MI** (1962 – 1964)
  Bachelor of Science in Psychology
- **University of Michigan, Ann Arbor, MI** (1960 – 1962)
  Undergraduate Education

INTERNSHIP AND RESIDENCY

- **Cedars Sinai Medical Center, Los Angeles, CA** (1971 – 1972)
  Residency Internal Medicine
- **Wadsworth VA - UCLA, Los Angeles, CA** (1970 – 1971)
  Residency Internal Medicine
- **Cedars Sinai Medical Center, Los Angeles, CA** (1969 – 1970)
  Residency Internal Medicine
- **Cedars Sinai Medical Center, Los Angeles, CA** (1968 – 1969)
  Internship Mixed Medicine

WORK EXPERIENCE

- **Medical Group of Encino, CA** (2016 – Present)
  Private Practice
- **California Medical Evaluators, Los Angeles, CA** (2015 – Present)
  QME Practice
- **Gerald M. Weingarten M.D., Sherman Oaks, CA** (1977 – 2016)
  Solo Practice
- **Gerald M. Weingarten M.D., Encino, CA** (1977 – 2016)
  Solo Practice
- **Greenberger and Natelson M.D.** (1975 – 1977)
- **Donald Luber M.D.** (1974)

APPOINTMENTS

- Chief of Staff, Jewish Home for the Aging (1983 – 1984)
- Medical Staff, Jewish Home for the Aging (1974 – 2016)
- Phi Delta Epsilon Medical Fraternity, San Fernando Graduate Club, President (1985 – 1986)
- Chief of Medicine, Sherman Oaks Community Hospital (1992 – 1994)

- Medical Director, Pinnacle Home Health (1995 – 1999)
- Credentials Committee Tarzana Regional Medical Center (2002 – 2013)
- Active Staff, Tarzana Regional Medical Center (1974 – Present)
- Q.M.E., A.M.E. STATE OF California
- Disability Evaluator, Medical Expert, Social Security Administration, Federal Contractor (1994 – Present)

BOARD CERTIFICATION

- American Board of Internal Medicine (1972)

MEMBERSHIPS

- Los Angeles County Medical Association 1974-2003
- California Medical Association 1974-2003
- American Society of Internal Medicine
- California Society of Industrial Medicine and Surgery founding member till 2005
- Los Angeles Society of Internal Medicine 1980-1990
- Diplomate American Board of Internal Medicine 1972 – Present
- American College of Physicians

PRESENT HOSPITAL AFFILIATIONS

- Tarzana Regional Medical Center, Tarzana, CA
- Jewish Home for the Aging, Los Angeles, CA

LICENSES

- Board of Medical Examiners, State of California
- Q.M.E. License, State of California
- Narcotics License D.E.A.

Gerald Weingarten, M.D., Q.M.E.

DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE
QUALIFIED MEDICAL EXAMINER

All Correspondence To:
11620 Wilshire Boulevard, Suite 340
Los Angeles, CA 90025
Tel: (888) 853-7944
Fax: (213) 377-5152

PANEL QUALIFIED MEDICAL EVALUATION
IN THE SPECIALTY OF INTERNAL MEDICINE/CARDIOLOGY

[redacted]

Re: [redacted]
Applicant's DOB:
Employer:
Date of Injury:
Claim/File No.: [redacted]
Panel No.:
Date of Evaluation:
Place of Evaluation:

Dear Parties:

Pursuant to your authorization, [redacted] underwent a Panel Qualified Medical Evaluation, in the specialty of Internal Medicine, on [redacted], at my Oxnard, California office. The undersigned acted in the capacity of Panel Qualified Medical Examiner, in the specialty of Internal Medicine.

I, Dr. Weingarten, conducted the interview, reviewed all records, performed a physical examination, and formulated the diagnosis, conclusions, and discussion, including the opinion on causation, temporary disability, permanent disability, degree of disability, future care, work restrictions, and apportionment. The report was authored and edited by Dr. Weingarten. All opinions expressed herein are solely the opinions of Dr. Weingarten.

Prior to the evaluation, the entire medical file made available to the undersigned was fully reviewed. All of the records reviewed were instrumental in this examiner arriving at the opinions as expressed in this report.

Before I began the examination, the applicant was informed that this evaluation was being done exclusively in connection with the Workers' Compensation claim at the request of attorney, attorneys or insurance companies, and that no treatment relationship existed. The applicant was also made aware that any communication between us is not privileged (no doctor-patient confidentiality exists) and that any information provided, as well as the results of any testing and my conclusions regarding the case, would be included in a report that may be read by people involved in the resolution and/or litigation of the claim. The applicant was advised of his or her rights pursuant to QME regulation 40. The applicant stated that the aforementioned was understood, and agreed to proceed with the evaluation. The report belongs to the party or parties requesting the evaluation.

BILLING

The report qualifies for Procedure Code **ML-104** as there are "extraordinary circumstances" relating to the medical condition for which this applicant was examined. This code best reflects the time spent and/or the complexity of this evaluation. The best proof in regard to the complexity of this evaluation is the medical/legal report which reflects the complex issues. The issues of complexity are reflected by the following: Multiple body parts are examined; present and prior work history; past medical history; family and social history; a complex psychiatric history; a complex history due to the applicant being a difficult historian; there are complex issues of causation or apportionment; adverse parties

have obtained their own complex and conflicting evaluation requiring interpretation.

This is a Comprehensive Medical-Legal Evaluation Involving **Extraordinary Circumstances (ML-104)**. The following complexity factors apply:

COMPLEXITY FACTORS

☐ (1) Two or more hours of face-to-face time by the physician

Circumstances which make this complexity factor applicable to this evaluation: Two or more hours of face-to-face time were required because one or more of the following apply: the subject medical condition was complex, the applicant was a difficult historian, and/or an interpreter was required which prolonged the face-to-face component of this evaluation.

☒ (2) Two or more hours of record review by the physician

Circumstances which make this complexity factor applicable to this evaluation: Two or more hours of record review time were required because one or more of the following apply: A significant volume of medical records were reviewed requiring two or more hours of my record review time, and/or the medical records were complex in nature.

☐ (3) Two or more hours of medical research by the physician

Circumstances which make this complexity factor applicable to this evaluation: Two or more hours of medical research were required because one or more of the following apply: medical research was required in order to investigate current developments regarding the etiology, pathogenesis, pathophysiology, causation, factors relating to the appropriate treatment, and/or disease course of the subject medical condition.

☐ (4) Four or more hours spent on any combination of two of the complexity factors (1) - (3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor.

☒ (5) Six or more hours spent on any combination of three complexity factors (1) - (3), which shall count as three complexity factors

Circumstances which make this complexity factor applicable to this evaluation: Six or more hours were spent on any combination of three complexity factors (1)-(3). See explanations for (1), (2) and (3) above, incorporated herein.

☒ (6) Addressing the issue of medical causation

Circumstances which make this complexity factor applicable to this evaluation: I have addressed the issue of medical causation upon a written request of one or more parties.

☐ (7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate:

☐ the claimant's employment by three or more employers, OR

☐ three or more injuries to the same body system or body region as delineated in the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), OR

☐ two or more or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference

☐ (8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.

Billed under **ML-104**, time spent includes:

1. Face-to-face interview with the applicant: **1.00 hour**
2. Review of medical records: **5.00 hours**
3. Preparation, writing and editing of this report: **2.00 hours**
4. Medical research: **1.00 hours**

Up to Date , Epidemology of coronary heart disease, Authors Peter Wf. Wilson M.D., Pamela s. Douglas M.D.

Additional time was spent in administering EKG (93000) diagnostic testing, which will be billed separately under the current OMFS.

According to the cover letter from State Compensation Insurance Fund, there is a dispute over compensability of reported injury for heart. Date of heart injury was

[redacted]

HISTORY OF PRESENT ILLNESS AND WORK HISTORY

[redacted] is a -year-old male. He retired from [redacted] as a on Again, he worked as a for the [redacted] for years. He was assigned to [redacted] for years. His last years, he was employed as an . He was in charge of the shooting range. He was in charge ordering and storing the range equipment for the prison. His last three years, he did a lot of overtime and worked in other areas. He would have to supervise the inmates. He was in a number of high stress situations through the years because of riots, etc. He states he took a voluntary retirement. He had no concurrent jobs while he was working at the prison. He has not worked since retirement. Since retirement, he has moved from [redacted]. During his tenure with the prison, he was not treated for any internal medical conditions. He now lives in [redacted] with his wife. He states he lived in [redacted] until .

On , he states he had a heart attack. According to what he tells me in the medical records, he was having episodes of chest pain lasting up to 10 minutes in the 24-hour period prior to his heart attack. Two to three weeks prior to the heart attack, he was having shortness of breath climbing up flight of stairs. He also had more fatigue four to five weeks prior to the heart attack. Prior to his heart attack, he exercised on a treadmill and played golf. He was able to run two miles without any difficulty but prior to the heart attack, he noticed he had more shortness of breath in the second mile.

The rescue squad took him to . On the day of his heart attack, he was having extreme pain in his chest radiating to his back that lasted 10 to 15 minutes. He also had jaw pain.

They performed an angiogram at and he had a 99% blockage in his mid LAD, the left anterior descending coronary artery. This was stented. Since that time, he has been seeing his cardiologist and sees a primary care doctor. He has not had any cardiac stress test since his myocardial infarction and is able to do all activities. His present medications include atorvastatin 20 mg daily, baby aspirin daily, and Plavix 75 mg daily. He has a prescription for nitroglycerin but does not need to use it.

In regards to present physical activities, he has no restrictions. He no longer runs on the treadmill but walks on the treadmill. He does not have any limitation on any other activities. His hobbies are playing golf. He does not know his present

cholesterol level. In regards to cardiac risk factors, he did smoke for six years prior to his myocardial infarction but only smoked one pack per week.

PAST MEDICAL HISTORY

He was born in .

CHILDHOOD ILLNESSES

None serious.

EDUCATION

Twelfth grade.

MILITARY SERVICE

None.

ADULT ILLNESSES

None additional.

OPERATIONS

He had replacement of his ACL in his right knee. This was an industrial injury. He had shoulder surgery on the right for torn labrum.

PRIOR EMPLOYMENT

He worked for [redacted] in a truck trailer. He had no industrial injuries working for them.

ADDITIONAL ACCIDENTS AND INJURIES

None.

PERSONAL HABITS

Tobacco: He started smoking at age He quit after his myocardial infarction. He averaged one pack per week.

Alcohol: He drinks vodka averaging two glasses per day. He has done this for five years.

Coffee and Caffeine: Two cups per day.

FAMILY HISTORY

He has been married for ' years to his second wife. He was married _ years to his first wife. He has one child age

His father is , living and healthy. He does not know his mother's history. He has no siblings.

LIVING ARRANGEMENTS

He lives in [redacted] in a two-storey house. It has a swimming pool. He swims in the pool. He does not do any outside household chores as he has a pool man and has no glass.

REVIEW OF SYSTEMS

Head: No headaches, dizziness or syncope.

Eyes: Wears reading glasses.

Ears: Has hearing loss. States this is due to exposure to noise on the range. He has 45% hearing loss on the right ear and 35% on the left.

Nose, Mouth, and Throat: Unremarkable.

Cardiopulmonary: He states two months ago he had an episode of chest pain and tightness of his chest but it went away. He has had nothing since.

Gastrointestinal: Occasional heartburn. He has not had a colonoscopy. No diarrhea or constipation.

GU: Unremarkable.

Musculoskeletal: Unremarkable.

Vascular: Unremarkable.

Endocrine: He states sometimes his blood pressure is high, but is usually normal, but he has some increased fatigue since his heart attack.

PHYSICAL EXAMINATION

Vital Signs: Height weight pounds, blood pressure 149/99, pulse 78, temperature 97.2, O2 saturation 97%. Repeat blood pressure 125/91.

General: Tanned, physically fit male, in no acute distress.

Head: Normocephalic.

Eyes: Pupils are equal and reactive to light and accommodation. Sclerae white. Conjunctivae pink.

Ears: Canals clear. Drums normal. Gross hearing to tuning fork is intact bilaterally.

Nose, Mouth and Throat: No abnormalities.

Neck: No neck vein distention. No adenopathy. No thyromegaly. Trachea midline. Carotid pulses equal bilaterally without bruit.

Chest: Normal contours.

Lungs: Clear to auscultation and percussion.

Heart: Regular rhythm. No murmurs, rubs, heaves, or gallops.

Abdomen: No hepatosplenomegaly or masses. Bowel sounds are normoactive. No tenderness.

Extremities: No calf tenderness or edema.

Neurologic: Cranial nerves, sensory-motor coordination intact. Reflexes equal bilaterally. Gait normal.

Skin: Tanned.

DIAGNOSTIC STUDIES

A 12-lead electrocardiogram was obtained and was within normal limits.

[redacted]

QUESTIONNAIRES

An activities of daily living questionnaire indicates some difficulty climbing a flight of 10 stairs, working outdoors, some difficulty sleeping through the night, having a restful sleep, and feels refreshed after sleep.

An Epworth Sleepiness Scale questionnaire reveals a score of 8.

REVIEW OF MEDICAL RECORDS

REVIEW OF FILE

NON-MEDICAL RECORDS:

Cover Letter, signed by , Esq., dated .

Dr. Weingarten had agreed to see the applicant as a Qualified Medical Examiner on Monday, at 2:00 p.m. in the Oxnard office. In addition to the included medical records, the adjuster will be forwarding any medical records in his possession along with his cover letter.

Please take a careful history from the applicant and review the documents being submitted to you at this time. You are authorized to order any outpatient testing which you feel is reasonably necessary in order for you to reach an opinion on the issues in this case. After considering all of the materials sent to you, and conducting a thorough examination, please write a report in which you answer each of the following questions. Be sure to provide the basis for your opinion with the respect to each of the questions set forth below.

If you are unable to address all facets of the injury please refer the client out for the necessary consult or advise the parties of the need for an additional QME evaluation.

BACKGROUND

The Applicant, born on , while employed during the period of to with Defendant, [redacted] as a , sustained injury arising out of and in the course of employment in the form of a heart attack.

[redacted]

DIAGNOSIS

(A) Does the applicant have any condition referable to your field of specialty? If so, please provide a precise diagnosis.

INJURY- AOE/COE

(A) Has the applicant sustained injury to the parts of the body in issue as a result of industrial injury?

TEMPORARY DISABILITY:

(A) Has the applicant sustained any period of or periods of temporarily disability attributed to the industrial injury? If so, please set forth the period or periods of such temporarily disability.

(B) If you find the applicant to be temporary disabled at this time, please state when you anticipate that applicant will become permanent and stationary.

PERMANENT DISABILITY:

(A) Does the applicant have any impairment attributed to industrial injury? If so, please utilize the Fifth Edition of the AMA Guides to determine the extent of impairment.

(B) If you feel the strict application of the AMA Guides is inaccurate as it relates to the Applicant's impairment, please explain why. Then, please provide the chapter, table or method that you feel most accurately reflects the applicant's impairment. Please be sure to substantiate your opinions.

APPORTIONMENT:

(A) Consistent with L.C. §§ 4663 and 4664, please provide apportionment based on causation to industrial and non-industrial factors.

(B) Has the applicant sustained any subsequent injury? If so, please set forth the level of disability which the applicant would have at this present time solely as the result of such subsequent injury absent the occurrence of the alleged industrial injury or injuries.

MEDICAL TREATMENT:

(A) Has the applicant self-procured any medical treatment for the condition in issues? If so, please provide your opinion with respect to the reasonableness and necessity of such self-procured treatment to cure or to relieve from the effects of industrial injury.

(B) Will the applicant require treatment in the future to cure or relieve from the effects of the industrial injury? If so, please identify the type of treatment, along with the expected frequency or duration.

QUALIFIED INJURED WORKER:

(A) As far as you field of specialty is concerned, is the applicant able to perform the usual and customary job duties of the incident employment? If not, please identify which job duties can no longer be performed.

([redacted] - Cl from AA-7-9-19-Weingarten-4.pdf_Pages 1-3)

MEDICAL RECORDS:

History and Physical Examination, signed by [redacted], M.D., Orthopedic Surgeon, [redacted], dated [redacted].

Chief Complaint: The applicant presented with right knee instability.

History of Present Illness: The applicant had been working as a [redacted] at [redacted] He tripped over a fence and landed on his knee while running through an obstacle course. He heard a pop and his knee gave way and was unable to continue the course. He had a fall and injured his knee ligament, a year before at work, and had never returned to normal since then. He was functional until the injury. Since then, he was able to return to work, but had apprehension over giving way with running and jumping. He was noted to have anterior instability and he was now admitted for an anterior cruciate reconstruction and other necessary repairs.

Physical Exam: Musculoskeletal: Right lower extremity: The applicant had apprehension on hopping and squatting. There was 1/4 mid-third medial joint line tenderness. Previously, there was 2/4 femoral medial collateral ligament tenderness. There was 2/4 posterior third medial tenderness. Ligament exam demonstrated a 2+ anterior Lachman and drawer increased over 0 on the opposite side. There was 1/4 medial and no instability. Pivot shift had apprehension.

Diagnostic Studies: X-rays of the AP and lateral views of the right knee showed right knee anterior cruciate deficiency with healing grade 1-2 medial collateral ligament tear and possible medial meniscal tear.

Impression: Right knee anterior cruciate deficiency with healing grade 1-2 medical collateral ligament tear and possible medial meniscal tear.

Plan: The applicant wished to proceed with arthroscopy, anterior cruciate ligament reconstruction, possible meniscectomy, and other necessary repairs.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 84-86)

Operative Report, signed by [redacted], M.D., Orthopedic Surgeon/[redacted], P.A.-C., [redacted], dated [redacted]

Preoperative Diagnosis: Right knee anterior cruciate deficiency.

Operations Performed: 1) Diagnostic arthroscopy, right knee, with arthroscopically assisted anterior cruciate ligament reconstruction with autogenous patellar tendon graft. 2) Partial Medial and Lateral Meniscectomy.

Postoperative Diagnoses: Right Knee Anterior Cruciate Deficiency and Medial and Lateral Meniscal Tears.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 87-89, 99)

Laboratory Report, dated

Labs revealed low Hemoglobin and Hematocrit.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Page 100)

Progress Notes, from [redacted], dated

The applicant was discharged home per MD orders.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Page 130)

History and Physical Examination, signed by [redacted], M.D., Otolaryngologist, [redacted]

Chief Complaint: The applicant presented with complaint of snoring.

History of Present Illness: The applicant had problem with longstanding snoring and occasionally, when he was on his back, he would stop breathing. He was admitted for first stage laser-assisted uvulopalatoplasty.

Review of Systems: He had difficulty breathing through the nose and snored a lot.

Impression: Snoring.

Plan: First stage laser-assisted uvulopalatoplasty was recommended and the applicant wished to proceed with the surgery.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 57-59)

Operative Report, signed by [redacted], M.D., Otolaryngologist, , dated

Pre/Postoperative Diagnosis: Snoring.

Operations Performed: First stage laser-assisted uvulopalatoplasty.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Page 60)

MR Arthrography of the Right Shoulder, signed by [redacted], M.D., Diagnostic Radiologist, [redacted], dated

Impression: 1) Intact right rotator cuff tendon, without evidence of partial or full thickness tears. 2) Increased right acromiohumeral distance consistent with ligamentous laxity or joint effusion.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 52-53)

MRI of the Right Shoulder with Arthrographic Contrast, signed by [redacted], M.D., Diagnostic Radiologist, [redacted], dated

Comparison: Right shoulder arthrography on

Impression: 1) Acute moderate osteoarthritis of the right acromioclavicular joint space, with distal acromial inferior osteophyte impinging on the right rotator cuff

[redacted]

tendon. 2) Markedly attenuated right rotator cuff tendon, with full thickness tear in the supraspinatus component and high-grade tears in the subscapularis and infraspinatus components. 3) Subtle fraying of the superior glenoid labrum. Partial tear of the inferior glenoid labrum, with degenerative appearance of the anterior and posterior glenoid labrum. 4) Disrupted posterior band of the inferior glenohumeral ligament, with high-grade tear or disruption of the anterior band; laxity of the middle glenohumeral ligament; with partial tear or strain of the superior glenohumeral ligament.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 43-44)

Office Visit, signed by [redacted], M.D., Orthopedic Surgeon, [redacted], dated [redacted]

Date of Injury: [redacted]

Subjective: The applicant presented with complaints of recurrent dislocation of his right shoulder. His first right shoulder dislocation occurred when he was exercising, about 10 years ago. He believed that he had had 25 dislocations since then. The last one occurred before six months, when he was changing a shirt. He thought that his first dislocation was posterior, but described that the recurrent dislocations were with abduction and external rotation of his right arm, making them seemed more likely to be anterior dislocations.

Physical Exam: Greater tuberosity was tender to deep palpation bilaterally. Range of motion: Abduction was 180 degrees, internal rotation right hand to the lower lumbar spine and external rotation was 45 degrees. Attempts, at anterior, inferior and posterior subluxation of either shoulder, were made with marked guarding and were impossible to carry out.

Diagnostic Studies: X-rays, dated [redacted], of the right shoulder AP downshift, scapular oblique and axillary views did not demonstrate a Hill-Sachs lesion and was normal.

Impression: Right shoulder rotator cuff tear. Right shoulder recurrent anterior dislocation.

Recommendations: Recommended exam under anesthesia, arthroscopy, Bankart repair and rotator cuff repair. Confirmatory second opinion was requested with Dr. [redacted] He was advised to follow up after consult.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 45, 48-49)

Utilization Review, dated [redacted]

Requested authorization for consult with [redacted] M.D., was approved.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Page 14)

Office Visit, signed by [redacted] M.D., Orthopedic Surgeon, [redacted], dated [redacted]

Date of Injury: [redacted]

Chief Complaint: The applicant presented with recurrent dislocation and instability of the right shoulder.

History of Present Illness: The applicant had been working as a [redacted] at [redacted]. He stated that while performing baton-striking drills, he was striking an opponent and sustained a posterior dislocation of his right shoulder about 10 years ago. He was unable to reduce this and was brought to the local emergency room and this was reduced under an IV sedation. He had some physical therapy and later returned to full duty. He stated that despite self-reliant measures included a home exercise program and weightlifting; he had had 25 to 30 dislocation episodes. He had always been able to self-reduce these, but they have become more painful. He had occasional pain with overhead activities and was awakened when he rolled on his right shoulder at night.

Physical Exam: Extremities: He demonstrated 90% active range of motion. Rotator cuff testing was 4+/5 in supraspinatus. There was mild impingement and mild painful arc. He had positive apprehension. Positive Jobe's relocation was noted in the lateral decubitus position. Anterior and posterior instability in the lateral decubitus position could not be assessed due to muscle guarding.

Diagnostic Studies: Fluoroscan x-rays, 4 views of bilateral shoulders, revealed right shoulder mild degenerative changes of the AC joint, type 1-2 acromial configuration, normal acromiohumeral interval, and small Hill-Sachs lesion on axillary lateral or external rotation view. Left shoulder demonstrated mild-to-moderate degenerative changes of the AC joint, type 1-2 acromial configuration, normal acromiohumeral interval, and normal glenohumeral joint.

Impression: Right shoulder recurrent instability with possible anterior and posterior components with impingement symptomatology with an overlap syndrome picture.

Plan: Recommended examination under anesthesia, diagnostic arthroscopy and bursoscopy and correction as indicated, which most likely included stabilization, possible anterior and combined posterior labral repairs, possible rotator cuff repair, possible subacromial decompression, and other corrections as indicated at the time of diagnostic arthroscopy and bursoscopy. He was advised to return to Dr. [redacted] and to follow up as needed.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 33-35)

Preoperative History and Physical, signed by [redacted] M.D., Orthopedic Surgeon, and [redacted] P.A.-C., [redacted], dated [redacted]:

Reason for Admission: The applicant was admitted for right shoulder arthroscopy and correction. He presented with right shoulder pain and instability.

Impression: Remained unchanged.

Plan: The applicant wished to proceed with right shoulder examination under anesthesia, diagnostic arthroscopy and bursoscopy, arthroscopic stabilization, possible anterior and combined posterior labral repairs, possible rotator cuff repair, possible subacromial decompression, and other corrections as indicated at the time of diagnostic arthroscopy and bursoscopy.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 27-29, 30-32)

Operative Report, signed by [redacted] M.D., Orthopedic Surgeon, [redacted], dated [redacted]

Preoperative Diagnoses: Right shoulder, recurrent anterior instability with glenohumeral joint degenerative joint disease.

Procedures Performed: 1) Examination under anesthesia of both shoulders. The left shoulder demonstrated grade 2 anterior physiologic laxity. No inferior or posterior instability. The right shoulder demonstrated grade 3 anterior instability. No inferior or posterior instability. 2) Diagnostic arthroscopy and bursoscopy demonstrated advanced osteoarthritis changes of the glenohumeral joint with an engaging Hill-Sachs defect, 50% contact grade 4 concentric wear of the humeral head, and a 3 x 3 cm anterior glenoid, grade 4 defect with an ALPSA (Anterior

Labroligamentous Periosteal Sleeve Avulsion) lesion anteriorly. Subacromial bursoscopy demonstrated no significant impingement. Intra-articular view of subscapularis, supraspinatus and infraspinatus tendons were within normal limits. Longhead of the biceps tendon and its anchor were within normal limits. 3) Arthroscopic extensive debridement, partial synovectomy, and labral debridement. 4) Chondroplasty of the humeral head and glenoid with microfracture of the 3 x 3 cm, grade 4 anterior glenoid lesion. 5) Arthroscopic anterior Bankart ligament and labral reconstruction with 2 Smith and Nephew BIORAPTOR anchors and #1 PDS suture. 6) Arthroscopic remplissage procedure with 2 Smith and Nephew BIORAPTOR anchors double-aimed with 2 #2 Ultrabraid sutures. 7) Injection of right glenohumeral joint with 15 cc of sterile venous blood obtained from the patient via the anesthesiologist and injected into the right glenohumeral joint to promote healing at the end of the procedure.

Note: Intra-operatively, there was a small articular surface tear of the supraspinatus tendon, which was debrided to stable tissue.

Postoperative Diagnoses: Right shoulder, recurrent anterior instability with glenohumeral joint Degenerative Joint Disease, with engaging Hill-Sachs defect.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 24-26)

Office Visit, signed by [redacted] M.D., Orthopedic Surgeon, and [redacted] P.A.-C., dated [redacted]

History of Present Illness: The applicant was status post right shoulder arthroscopic remplissage with 2 BIORAPTOR anchors, Bankart repair with 2 BIORAPTOR anchors, microfracture of the anterior glenoid 2.5 x 3 cm lesion, chondroplasty of the humeral head and glenoid. He had been compliant with his Gunslinger sling and was performing home exercises.

Physical Exam: Wounds were healing well. Sutures were removed and Steri-Strips were applied. The right shoulder demonstrated passive forward flexion to 140 degrees in the supine position.

Impression: Status post right shoulder arthroscopy and correction.

Plan: He was advised to continue home exercises and begin physical therapy in one week. He was advised to follow up after 2 weeks.

Work Status: He was recommended to remain off work in the interim.

[redacted]

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Page 23)

Physical Therapy Notes, signed by [redacted], P.T., Physical Therapy, dated

The applicant received six treatments from to status post surgery. Therapy consisted of active, passive, stretching, upper body, scapular strengthening, lifeline and rotator cuff strengthening exercises. He was pleased with the steady progress and stated his pain level was 1/10.

Objective: Passive range of motion of right shoulder had improved.

Assessment: His right shoulder range of motion was progressing and he was instructed home exercise program.

Plan: He had 12 visits remaining, and goals were set for future visits. He was advised a follow up with his physician.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Page 41)

Office Visit, signed by [redacted] M.D., Orthopedic Surgeon, dated

History of Present Illness: The applicant continued to perform home exercises and tolerated well. He stated that he moved his shoulder wrong in a shower approximately 3 weeks ago, and had increased pain since then.

Diagnostic Data: FluoroScan x-rays of the right shoulder demonstrated moderate degenerative changes of the acromioclavicular joint, normal acromiohumeral interval, normal-appearing glenohumeral joint with mild glenohumeral joint osteoarthritic changes, and concentric reduction seen in axillary lateral with Hill-Sachs lesion.

Impression: Remained unchanged.

Plan: Norco 10/325 mg was prescribed. He was advised to continue home exercises, preceded by heat and followed by ice, and continue with physical therapy. He was advised to discontinue his Donjoy UltraSling after 2 weeks and return to clinic in 6 weeks.

Work Status: He was recommended to remain off work in the interim.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 21-22)

Physical Therapy Notes, signed by [redacted] P.T., Physical Therapy, dated

The applicant received 18 treatments from to Therapy consisted of active, passive, stretching, upper body, scapular strengthening, lifeline and rotator cuff strengthening exercises. He was pleased with the steady progress and stated his pain level was 1/10.

Assessment: His right shoulder range of motion had increased and his strength was improving gradually. He was instructed home exercise program.

Plan: He was advised to follow up with his physician.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Page 40)

Office Visit, signed by [redacted] M.D., Orthopedic Surgeon, and P.A.-C., dated

History of Present Illness: The applicant presented status post surgery. He continued to perform his home exercise and was attending formal physical therapy.

Impression: Remained unchanged.

Plan: He was advised to continue home exercises, preceded by heat and followed by ice and continue with physical therapy. He was advised to return to clinic in 6 weeks.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 13, 20)

Utilization Review, dated

Requested authorization for physical therapy 2 times a week for 6 weeks was approved.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 37-38)

Physical Therapy Notes, signed by [redacted], P.T., Physical Therapy, dated

[redacted]

The applicant received 18 treatments from to . Therapy consisted of active, passive, stretching, upper body, scapular strengthening, lifeline and rotator cuff strengthening exercises. He stated that he experienced a slight intermittent right shoulder discomfort.

Assessment: His right shoulder range of motion had increased, and his strength was improving gradually. He was instructed on home exercise program.

Plan: He was advised to follow up with his physician.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Page 39)

Office Visit, signed by [redacted] M.D., Orthopedic Surgeon/ [redacted], P.A.-C., dated

History of Present Illness: The applicant presented status post surgery. He continued to perform his home exercise and was attending formal physical therapy and working on strength training.

Impression: Remained unchanged.

Plan: He was advised to continue home exercises, physical therapy and strength training. He was advised to return to clinic in 6 weeks.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 12, 19)

Physical Therapy Notes, signed by P.T., Physical Therapy, dated

The applicant was received treatment from to Therapy consisted of active, passive, stretching, upper body, scapular strengthening, lifeline and rotator cuff strengthening exercises. He had reported that his right shoulder felt stronger and more stable.

Assessment: His right shoulder range of motion had increased, and his strength was progressing well. He was instructed on home exercise program.

Plan: He was advised to follow up with his physician.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Page 36)

[redacted]

Office Visit, signed by [redacted] M.D., Orthopedic Surgeon/ [redacted] P.A.-C., dated

History of Present Illness: The applicant presented status post surgery and he no longer used ice, heat or anti-inflammatories.

Impression: Remained unchanged.

Diagnosis: Other affections of shoulder region, not elsewhere classified. Osteoarthritis.

Plan: He was advised to continue home exercise program. He mentioned QME evaluation report, was requested for review. He was advised to return to clinic in 6 weeks.

Work Status: He was recommended on work full duty.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 9-10)

Addendum, signed by [redacted] M.D., Orthopedic Surgeon, dated

The report stated that the applicant was permanent and stationary, which was believed to be somewhat premature by Dr. [redacted] Dr. [redacted] awarded 1% person impairment and included future medical care, which was not specific. The applicant was advised to return to clinic in 6 weeks.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Page 8)

Office Visit, signed by [redacted] M.D., Orthopedic Surgeon, and [redacted] P.A.-C., dated

History of Present Illness: The applicant was doing quite well until when he had 2 consecutive days of very heavy work involving the right upper extremity. He stated that when he reached for and lifted a leaf blower with his right arm, he felt immediate sharp shooting pain. Since that time, his shoulder was mildly painful. He was applying ice, but had not taken any medications for the exacerbation. He continued his home exercises and worked on full duty.

Impression: Doing well, status post right arthroscopic correction. Recent exacerbation of pain due to lifting injury. No instability.

Diagnosis: Other affections of shoulder region, not elsewhere classified.

Plan: He was encouraged to continue his home exercises and take over-the-counter Ibuprofen. He was advised to apply ice, if his pain worsened. Dr. [redacted] opined that patients, who were having extensive repairs including remplissage, not considered a permanent and stationary until one year postoperatively. Therefore, the applicant was asked to follow up after 6 weeks for reassessment and sooner, if there were any changes or problems. If he continued to have symptoms, he would require imaging including possible MRI gadolinium arthrogram and arthroscopic surgery.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 6-7)

Office Visit, signed by [redacted] M.D., Orthopedic Surgeon, and [redacted] P.A.-C., dated [redacted]

History of Present Illness: The applicant presented status post surgery. He did not take any medications and applied ice as needed. He continued to work in full duty.

Impression: Doing well, status post right shoulder arthroscopic correction.

Diagnosis: Remained unchanged.

Plan: He continued to progress and had good range of motion. He felt that he was gaining strength. He continued his self-rehabilitation at home and in the gym. With the type of surgery he had, a permanent and stationary status expected one year postoperatively. He was advised to follow up after 6 weeks.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 4-5)

Office Visit, signed by [redacted] M.D., Orthopedic Surgeon, and [redacted] P.A.-C., dated [redacted]

History of Present Illness: The applicant presented status post surgery. He stated that he was doing extremely well with no complaints. Strength was back 100% and was on full duty. He continued ice occasionally, was doing light home exercises and went to gym couple of times a week.

Impression: Doing extremely well, status post right shoulder arthroscopic correction.

Diagnosis: Remained unchanged.

Plan: He was referred to Dr. [redacted] for permanent and stationary evaluation and authorization was requested for the same. He was advised to follow up as needed.

([redacted] initial eval meds-7-9-18-Weingarten-134.pdf_Pages 2-3)

That Completes the Review of Records.

Table A - Itemization of reports with blood pressure and weight:

Date of Encounter	Provider	Applicant's Blood Pressure	Applicant's Heart Rate	Hypertensive / DM Medications	HgA1c Value	Weight
	, M.D.	110/80	72			lbs
	[redacted] M.D.					lbs

RC: DMP
2018-0612001

There is a rescue squad report from City of . He was given nitroglycerin en route. The report is dated . There was a discharge summary dated It states -year-old male patient with no significant past medical history, who presented to ER with complaints of chest pain. The pain started a day ago. It was substernal. It resolved completely followed by multiple episodes. Tonight, he had three episodes within a half an hour and decided to come in. He underwent a cardiac catheterization which showed 99% subtotal occlusion of the LAD. He had a stent placed in the proximal LAD. He was discharged on dual platelet therapy and Lipitor. There is emergency room report dated . The same history was provided. There are no other risk factors. It states troponin is slightly elevated. There is a cardiac catheterization report. Left anterior descending has a proximal 99% subtotal occlusion. Chest x-ray, no acute disease.

We reviewed our additional orthopedic records in regards to his right shoulder with right rotator cuff tear full-thickness and his surgery on the right shoulder. There are also records from in regards to snoring and surgery for uvulopalatoplasty.

DIAGNOSTIC IMPRESSIONS

1. Acute coronary syndrome, with 99% LAD lesion status post stenting.
2. Dyslipidemia.
3. History of tobacco smoking.
4. Status post right shoulder surgery for torn rotator cuff.
5. Status post right knee surgery for repair of anterior cruciate ligament.

DISCUSSION

[redacted] is a -year-old male. He was employed as a for years with the State of . He spent years at [redacted] His last assignment was that of . He was responsible for storing weapons and the shooting range. He also worked overtime, doing other duties this past three years. He states that he retired on This was a voluntary retirement. He had no concurrent employment. He has not worked since his retirement. He moved to [redacted] in He lives with his wife. He was active physically during his employment playing golf, lifting weights, and walking on a treadmill. He did have an injury to his right shoulder with a torn rotator cuff which he states was industrially related and an injury to his right knee with a torn anterior cruciate ligament, which also was industrially related. He was unaware of any risk factors for heart disease. He was never told he had an elevated cholesterol. He did smoke for six years prior to his myocardial infarction but only averaged a pack of cigarettes per week. He did drink alcoholic beverages, averaged two vodkas per night. He had no other medical problems. Once in a while his blood pressure was elevated but it was generally normal. On he started having substernal chest pain radiating to his jaw. His wife called the rescue squad and he was taken to [redacted] where his troponin was borderline elevated and he underwent a cardiac catheterization which showed a 99% obstruction in his left anterior descending coronary artery. He was diagnosed with one-vessel coronary artery disease and had a stent placed. Since that time, he has not had any specific cardiac testing. He has not had a treadmill exercise test. He is doing all activities with no restriction. He claims he might have some shortness of breath but this is nonspecific. He was taking Plavix, aspirin, and low-dose atorvastatin. I do not know what his cholesterol levels are. Again, there are no restrictions on his activities. On physical examination, there were no specific findings. His first blood pressure was elevated but his second blood pressure was 125/91. His electrocardiogram was completely normal.

Causation:

Arteriosclerotic heart disease with acute coronary syndrome with one-vessel coronary artery disease status post stenting 99% lesion left anterior descending coronary artery is industrially related.

Reason for Opinion:

[redacted] worked as a 'h the State of for . years and ' years total. He was exposed to the usual undue stressors of his employment and a presumption applies in this case. He had a very few risk factors. There is no family history of heart disease. I do not know what his cholesterol level is but he has never told he had hypercholesterolemia. He does not have hypertension or diabetes. He did smoke cigarettes but only for a short period of time averaging a pack per week. Again, he has minimal risk factors for the development of coronary artery disease. There is no information to rebut the presumption. He was at home doing sedentary activities at the time of his myocardial infarction. His onset of coronary artery disease occurred within the five-year retirement period. Therefore, his heart disease would be considered industrially related.

Apportionment:

Apportionment would not apply in this case because of the presumption.

Medical Treatment:

All medical treatment for his coronary artery disease would be provided for on an industrial basis including his hospitalization at [redacted] and subsequent cardiology visits. He would need life time medical care to see his cardiologist and have routine cardiac testing including stress echocardiograms and EKGs for followup. His medication including his lipid medication should be provided for on an industrial basis.

Work Restrictions:

This would not apply in this case because he is retired.

Permanent and Stationary Status:

This would not apply in this case but he was permanent and stationary as of six weeks post stenting.

Restrictions on Physical Activities:

None would be anticipated.

Permanent Impairment:

He would be rated under Table 3-6A Criteria for Rating Permanent Impairment due to coronary heart disease. He would have a class II impairment. He has acute coronary syndrome and has recovered from angioplasty and stenting. He should be able to walk on a treadmill to level established to cause energy expenditure of at least 7 METS. He has no restriction of ADLs. He would have a 10% impairment of the whole person. He had borderline troponins. He has a normal EKG and had minimal cardiac damage.

If any further information or explanations are needed, please feel free to contact me.

[redacted]

SPECIAL COMMENTARY

The above responses and opinions are based on reasonable medical probabilities, as viewed from the perspective of available documentation and information submitted to this examiner, including the applicant's direct anamnesis.

I, Gerald Weingarten, M.D., Q.M.E., formulated all conclusions and opinions.

Thank you for the opportunity of serving as Qualified Medical Examiner, in the specialty of Internal Medicine, for this most interesting case and condition.

Sincerely,

Gerald Weingarten, M.D., Q.M.E.
Diplomate, American Board of Internal Medicine

Attachments:
1. Appendix A: Declaration
2. Appendix B: EKG Test Results
3. Appendix C: Medical Research

[redacted]

APPENDIX A - DECLARATION

Pursuant to AB 1300, LC Sec. 5703, I have not violated Labor Code section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

DATE OF REPORT:

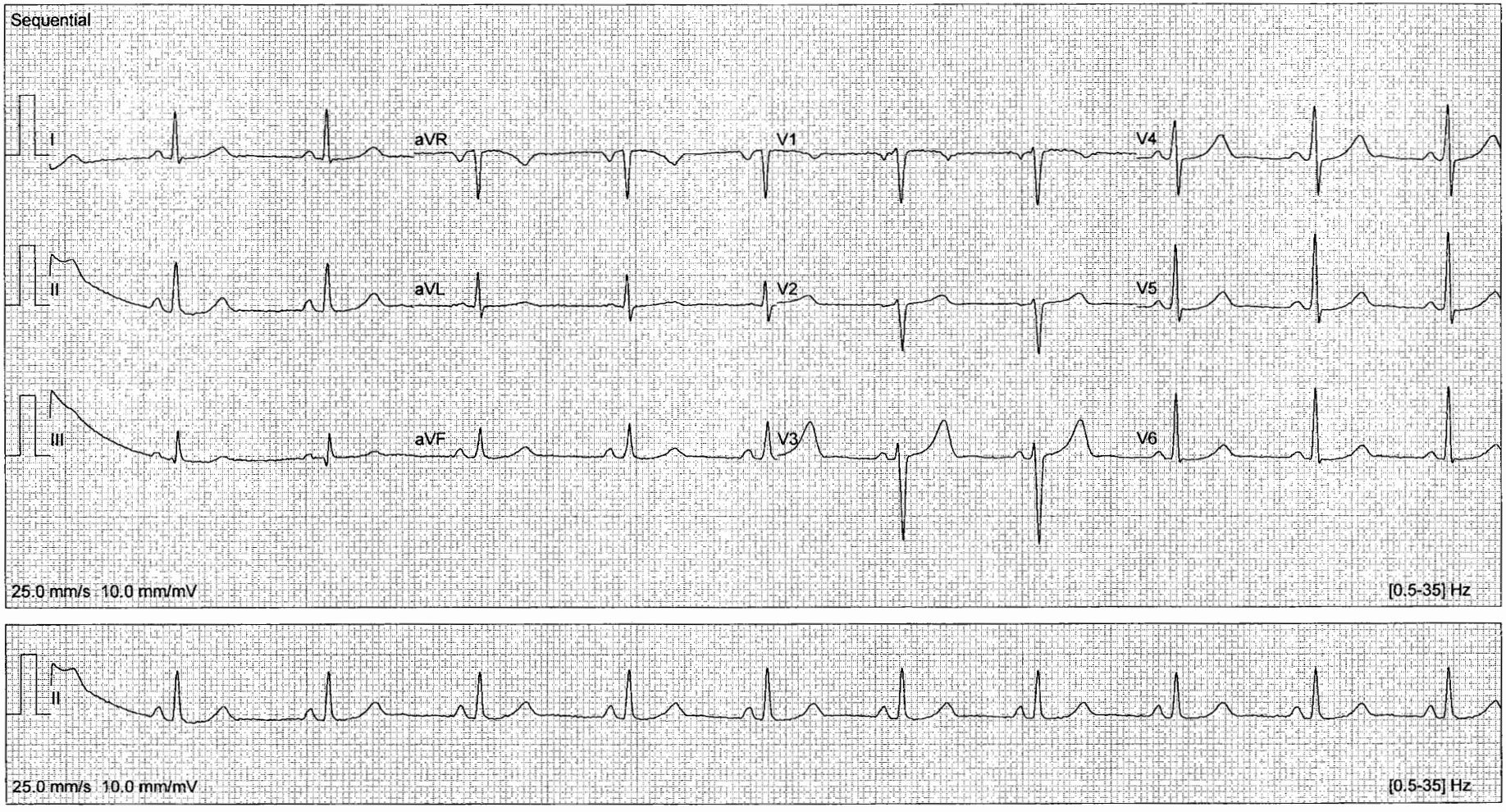
Dated this th day of , at I

Gerald Weingarten, M.D., Q.M.E.
Diplomate, American Board of Internal Medicine

Welch Allyn CardioPerfect Workstation

Name:	[redacted]	Recorded:	UNCONFIRMED INTERPRETATION
Number:		Recorded by:	
Gender:		Referring physician:	sinus rhythm
Birthdate:		Ordering physician:	
		Attending physician:	Normal ECG
		Location:	
		Comment:	

P / PR:	97 ms / 127 ms
QRS:	91 ms
QT / QTc / QTd:	435 ms / 444 ms / -
P/QRS/T axis:	49° / 47° / 38°
Heartrate:	65 bpm



Authors: Peter WF Wilson, MD, Pamela S Douglas, MD

Section Editors: Bernard J Gersh, MB, ChB, DPhil, FRCP, MACC, Patricia A Pellikka, MD, FACC, FAHA, FASE, Juan Carlos Kaski, DSc, MD, DM (Hons), FRCP, FESC, FACC, FAHA

Deputy Editor: Brian C Downey, MD, FACC

INTRODUCTION

Coronary heart disease (CHD) is a major cause of death and disability in developed countries. Although CHD mortality rates worldwide have declined over the past four decades, CHD remains responsible for about one-third or more of all deaths in individuals over age 35 [1-3]. It has been estimated that nearly one-half of all middle-aged men and one-third of middle-aged women in the United States will develop some manifestation of CHD [4].

Population-based epidemiologic data, such as that from the Framingham Heart Study, provide the best assessment of the risk factors that contribute to the development of coronary heart disease (CHD) and to the way it evolves, progresses, and terminates because these data are less encumbered by the unavoidable selection bias of clinical trials data. In addition, epidemiologic data provide critical information regarding targets for the primary and secondary prevention of CHD.

This topic will discuss the incidence, prevalence, trend in mortality, and general prognosis of CHD. The discussion of outcomes after myocardial infarction is found elsewhere. (See "Prognosis after myocardial infarction".)

The incidence, prevalence, and prognosis of non-coronary cardiovascular disease (CVD) such as cerebrovascular or peripheral artery disease are discussed elsewhere. (See "Clinical features and diagnosis of lower extremity peripheral artery disease", section on 'Epidemiology and risk factors' and "Etiology, classification, and epidemiology of stroke", section on 'Epidemiology'.)

DEFINITIONS

The terms incidence, prevalence, coronary heart disease, coronary artery disease, and cardiovascular disease, as used in this topic, are defined as follows:

Literature review current through: Jul 2018. | **This topic last updated:** Apr 06, 2017.

1. Rosamond W, Flegal K, Furie K, et al. Heart disease and stroke statistics--2008 update: a report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. Circulation 2008; 117:e25.
2. Nichols M, Townsend N, Scarborough P, Rayner M. Cardiovascular disease in Europe 2014: epidemiological update. Eur Heart J 2014; 35:2950.
3. Benjamin EJ, Blaha MJ, Chiuve SE, et al. Heart Disease and Stroke Statistics-2017 Update: A Report From the American Heart Association. Circulation 2017; 135:e146.
4. Lloyd-Jones DM, Larson MG, Beiser A, Levy D. Lifetime risk of developing coronary heart disease. Lancet 1999; 353:89.
5. GBD 2013 Mortality and Causes of Death Collaborators. Global, regional, and national age-sex specific all-cause and cause-specific mortality for 240 causes of death, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. Lancet 2015; 385:117.
6. Towfighi A, Zheng L, Ovbiagele B. Sex-specific trends in midlife coronary heart disease risk and prevalence. Arch Intern Med 2009; 169:1762.
7. Deedwania PC, Carbajal EV. Silent myocardial ischemia. A clinical perspective. Arch Intern Med 1991; 151:2373.
8. Roger VL, Weston SA, Killian JM, et al. Time trends in the prevalence of atherosclerosis: a population-based autopsy study. Am J Med 2001; 110:267.
9. Webber BJ, Seguin PG, Burnett DG, et al. Prevalence of and risk factors for autopsy-determined atherosclerosis among US service members, 2001-2011. JAMA 2012; 308:2577.
10. Gordon T, Kannel WB, Hjortland MC, McNamara PM. Menopause and coronary heart disease. The Framingham Study. Ann Intern Med 1978; 89:157.
11. Lerner DJ, Kannel WB. Patterns of coronary heart disease morbidity and mortality in the sexes: a 26-year follow-up of the Framingham population. Am Heart J 1986; 111:383.
12. Kannel WB. Prevalence and clinical aspects of unrecognized myocardial infarction and sudden unexpected death. Circulation 1987; 75:II4.
13. Go AS, Iribarren C, Chandra M, et al. Statin and beta-blocker therapy and the initial presentation of coronary heart disease. Ann Intern Med 2006; 144:229.
14. Ergin A, Muntner P, Sherwin R, He J. Secular trends in cardiovascular disease mortality, incidence, and case fatality rates in adults in the United States. Am J Med 2004; 117:219.
15. Arciero TJ, Jacobsen SJ, Reeder GS, et al. Temporal trends in the incidence of coronary disease. Am J Med 2004; 117:228.
16. Yusuf S, Reddy S, Ounpuu S, Anand S. Global burden of cardiovascular diseases: Part II: variations in cardiovascular disease by specific ethnic groups and geographic regions and prevention strategies. Circulation 2001; 104:2855.
17. Lopez AD, Mathers CD, Ezzati M, et al. Global and regional burden of disease and risk factors, 2001: systematic analysis of population health data. Lancet 2006; 367:1747.
18. Yusuf S, Reddy S, Ounpuu S, Anand S. Global burden of cardiovascular diseases: part I: general considerations, the epidemiologic transition, risk factors, and impact of urbanization. Circulation 2001;

20. Critchley J, Liu J, Zhao D, et al. Explaining the increase in coronary heart disease mortality in Beijing between 1984 and 1999. Circulation 2004; 110:1236.
21. Rodríguez T, Malvezzi M, Chatenoud L, et al. Trends in mortality from coronary heart and cerebrovascular diseases in the Americas: 1970-2000. Heart 2006; 92:453.
22. Beaglehole R, Reddy S, Leeder SR. Poverty and human development: the global implications of cardiovascular disease. Circulation 2007; 116:1871.
23. Furman MI, Dauerman HL, Goldberg RJ, et al. Twenty-two year (1975 to 1997) trends in the incidence, in-hospital and long-term case fatality rates from initial Q-wave and non-Q-wave myocardial infarction: a multi-hospital, community-wide perspective. J Am Coll Cardiol 2001; 37:1571.
24. Rogers WJ, Frederick PD, Stoehr E, et al. Trends in presenting characteristics and hospital mortality among patients with ST elevation and non-ST elevation myocardial infarction in the National Registry of Myocardial Infarction from 1990 to 2006. Am Heart J 2008; 156:1026.
25. Chen J, Normand SL, Wang Y, et al. Recent declines in hospitalizations for acute myocardial infarction for Medicare fee-for-service beneficiaries: progress and continuing challenges. Circulation 2010; 121:1322.
26. Hardoon SL, Whincup PH, Lennon LT, et al. How much of the recent decline in the incidence of myocardial infarction in British men can be explained by changes in cardiovascular risk factors? Evidence from a prospective population-based study. Circulation 2008; 117:598.
27. Roger VL, Weston SA, Gerber Y, et al. Trends in incidence, severity, and outcome of hospitalized myocardial infarction. Circulation 2010; 121:863.
28. Parikh NI, Gona P, Larson MG, et al. Long-term trends in myocardial infarction incidence and case fatality in the National Heart, Lung, and Blood Institute's Framingham Heart study. Circulation 2009; 119:1203.
29. Kuulasmaa K, Tunstall-Pedoe H, Dobson A, et al. Estimation of contribution of changes in classic risk factors to trends in coronary-event rates across the WHO MONICA Project populations. Lancet 2000; 355:675.
30. McGovern PG, Pankow JS, Shahar E, et al. Recent trends in acute coronary heart disease--mortality, morbidity, medical care, and risk factors. The Minnesota Heart Survey Investigators. N Engl J Med 1996; 334:884.
31. Capewell S, Morrison CE, McMurray JJ. Contribution of modern cardiovascular treatment and risk factor changes to the decline in coronary heart disease mortality in Scotland between 1975 and 1994. Heart 1999; 81:380.
32. Capewell S, Beaglehole R, Seddon M, McMurray J. Explanation for the decline in coronary heart disease mortality rates in Auckland, New Zealand, between 1982 and 1993. Circulation 2000; 102:1511.
33. Cooper R, Cutler J, Desvigne-Nickens P, et al. Trends and disparities in coronary heart disease, stroke, and other cardiovascular diseases in the United States: findings of the national conference on cardiovascular disease prevention. Circulation 2000; 102:3137.
34. McGovern PG, Jacobs DR Jr, Shahar E, et al. Trends in acute coronary heart disease mortality, morbidity, and medical care from 1985 through 1997: the Minnesota heart survey. Circulation 2001; 104:19.
35. Rosamond WD, Chambless LE, Folsom AR, et al. Trends in the incidence of myocardial infarction and in mortality due to coronary heart disease, 1987 to 1994. N Engl J Med 1998; 339:861.

infarction, heart failure and stroke, 1994-2004. CMAJ 2009; 180:1304.

38. Preis SR, Hwang SJ, Coady S, et al. Trends in all-cause and cardiovascular disease mortality among women and men with and without diabetes mellitus in the Framingham Heart Study, 1950 to 2005. Circulation 2009; 119:1728.
39. Fox CS, Evans JC, Larson MG, et al. Temporal trends in coronary heart disease mortality and sudden cardiac death from 1950 to 1999: the Framingham Heart Study. Circulation 2004; 110:522.
40. Fox CS, Coady S, Sorlie PD, et al. Increasing cardiovascular disease burden due to diabetes mellitus: the Framingham Heart Study. Circulation 2007; 115:1544.
41. Levi F, Lucchini F, Negri E, La Vecchia C. Trends in mortality from cardiovascular and cerebrovascular diseases in Europe and other areas of the world. Heart 2002; 88:119.
42. Reddy KS. Cardiovascular disease in non-Western countries. N Engl J Med 2004; 350:2438.
43. Okrainec K, Banerjee DK, Eisenberg MJ. Coronary artery disease in the developing world. Am Heart J 2004; 148:7.
44. Sheifer SE, Manolio TA, Gersh BJ. Unrecognized myocardial infarction. Ann Intern Med 2001; 135:801.
45. Kannel WB, Cupples LA, Gagnon DR. Incidence, precursors and prognosis of unrecognized myocardial infarction. Adv Cardiol 1990; 37:202.
46. Kannel WB. Lipids, diabetes, and coronary heart disease: insights from the Framingham Study. Am Heart J 1985; 110:1100.
47. Sigurdsson E, Thorgeirsson G, Sigvaldason H, Sigfusson N. Unrecognized myocardial infarction: epidemiology, clinical characteristics, and the prognostic role of angina pectoris. The Reykjavik Study. Ann Intern Med 1995; 122:96.
48. Jónsdóttir LS, Sigfusson N, Sigvaldason H, Thorgeirsson G. Incidence and prevalence of recognised and unrecognised myocardial infarction in women. The Reykjavik Study. Eur Heart J 1998; 19:1011.
49. de Torbal A, Boersma E, Kors JA, et al. Incidence of recognized and unrecognized myocardial infarction in men and women aged 55 and older: the Rotterdam Study. Eur Heart J 2006; 27:729.
50. Davidoff R, Goldman AP, Diamond TH, et al. The natural history of the Q wave in inferoposterior myocardial infarction. S Afr Med J 1982; 61:611.
51. Richter A, Herlitz J, Hjalmarson A. QRS complex recovery during one year after acute myocardial infarction. Clin Cardiol 1987; 10:16.
52. Kannel WB, Abbott RD. A prognostic comparison of asymptomatic left ventricular hypertrophy and unrecognized myocardial infarction: the Framingham Study. Am Heart J 1986; 111:391.
53. Levy D, Salomon M, D'Agostino RB, et al. Prognostic implications of baseline electrocardiographic features and their serial changes in subjects with left ventricular hypertrophy. Circulation 1994; 90:1786.
54. Levy D, Garrison RJ, Savage DD, et al. Prognostic implications of echocardiographically determined left ventricular mass in the Framingham Heart Study. N Engl J Med 1990; 322:1561.
55. Verdecchia P, Carini G, Circo A, et al. Left ventricular mass and cardiovascular morbidity in essential hypertension: the MAVI study. J Am Coll Cardiol 2001; 38:1829.
56. Kors JA, de Bruyne MC, Hoes AW, et al. T axis as an indicator of risk of cardiac events in elderly people. Lancet 1998; 352:601.

58. Kannel WB, Dannenberg AL, Abbott RD. Unrecognized myocardial infarction and hypertension: the Framingham Study. Am Heart J 1985; 109:581.

59. Shlipak MG, Elmouchi DA, Herrington DM, et al. The incidence of unrecognized myocardial infarction in women with coronary heart disease. Ann Intern Med 2001; 134:1043.

60. Orencia A, Bailey K, Yawn BP, Kottke TE. Effect of gender on long-term outcome of angina pectoris and myocardial infarction/sudden unexpected death. JAMA 1993; 269:2392.

61. Hemingway H, McCallum A, Shipley M, et al. Incidence and prognostic implications of stable angina pectoris among women and men. JAMA 2006; 295:1404.

62. LaCroix AZ, Guralnik JM, Curb JD, et al. Chest pain and coronary heart disease mortality among older men and women in three communities. Circulation 1990; 81:437.

63. Maddox TM, Stanislawski MA, Grunwald GK, et al. Nonobstructive coronary artery disease and risk of myocardial infarction. JAMA 2014; 312:1754.

64. Chow BJ, Small G, Yam Y, et al. Incremental prognostic value of cardiac computed tomography in coronary artery disease using CONFIRM: COroNary computed tomography angiography evaluation for clinical outcomes: an InteRnational Multicenter registry. Circ Cardiovasc Imaging 2011; 4:463.

65. Maddox TM, Reid KJ, Spertus JA, et al. Angina at 1 year after myocardial infarction: prevalence and associated findings. Arch Intern Med 2008; 168:1310.

66. White HD, Barbash GI, Modan M, et al. After correcting for worse baseline characteristics, women treated with thrombolytic therapy for acute myocardial infarction have the same mortality and morbidity as men except for a higher incidence of hemorrhagic stroke. The Investigators of the International Tissue Plasminogen Activator/Streptokinase Mortality Study. Circulation 1993; 88:2097.

67. Maynard C, Litwin PE, Martin JS, Weaver WD. Gender differences in the treatment and outcome of acute myocardial infarction. Results from the Myocardial Infarction Triage and Intervention Registry. Arch Intern Med 1992; 152:972.

68. Hochman JS, McCabe CH, Stone PH, et al. Outcome and profile of women and men presenting with acute coronary syndromes: a report from TIMI IIIB. TIMI Investigators. Thrombolysis in Myocardial Infarction. J Am Coll Cardiol 1997; 30:141.

69. Chang WC, Kaul P, Westerhout CM, et al. Impact of sex on long-term mortality from acute myocardial infarction vs unstable angina. Arch Intern Med 2003; 163:2476.

70. Hochman JS, Tamis JE, Thompson TD, et al. Sex, clinical presentation, and outcome in patients with acute coronary syndromes. Global Use of Strategies to Open Occluded Coronary Arteries in Acute Coronary Syndromes IIb Investigators. N Engl J Med 1999; 341:226.

71. Roger VL, Farkouh ME, Weston SA, et al. Sex differences in evaluation and outcome of unstable angina. JAMA 2000; 283:646.

72. Kannel WB, Thomas HE Jr. Sudden coronary death: the Framingham Study. Ann N Y Acad Sci 1982; 382:3.

73. Zheng ZJ, Croft JB, Giles WH, Mensah GA. Sudden cardiac death in the United States, 1989 to 1998. Circulation 2001; 104:2158.

74. Byrne R, Constant O, Smyth Y, et al. Multiple source surveillance incidence and aetiology of out-of-hospital sudden cardiac death in a rural population in the West of Ireland. Eur Heart J 2008; 29:1418.

76. Kannel WB, Doyle JT, McNamara PM, et al. Precursors of sudden coronary death. Factors related to the incidence of sudden death. Circulation 1975; 51:606.

77. Gillum RF. Sudden coronary death in the United States: 1980-1985. Circulation 1989; 79:756.

78. Kannel WB, Wilson PW, D'Agostino RB, Cobb J. Sudden coronary death in women. Am Heart J 1998; 136:205.

79. Berger CJ, Murabito JM, Evans JC, et al. Prognosis after first myocardial infarction. Comparison of Q-wave and non-Q-wave myocardial infarction in the Framingham Heart Study. JAMA 1992; 268:1545.

80. Kannel WB, Cupples LA, D'Agostino RB. Sudden death risk in overt coronary heart disease: the Framingham Study. Am Heart J 1987; 113:799.

81. Marchioli R, Barzi F, Bomba E, et al. Early protection against sudden death by n-3 polyunsaturated fatty acids after myocardial infarction: time-course analysis of the results of the Gruppo Italiano per lo Studio della Sopravvivenza nell'Infarto Miocardico (GISSI)-Prevenzione. Circulation 2002; 105:1897.

82. Torp-Pedersen C, Køber L. Effect of ACE inhibitor trandolapril on life expectancy of patients with reduced left-ventricular function after acute myocardial infarction. TRACE Study Group. Trandolapril Cardiac Evaluation. Lancet 1999; 354:9.

83. Myerburg RJ, Kessler KM, Castellanos A. Sudden cardiac death. Structure, function, and time-dependence of risk. Circulation 1992; 85:I2.

84. Chugh SS, Uy-Evanado A, Teodorescu C, et al. Women have a lower prevalence of structural heart disease as a precursor to sudden cardiac arrest: The Ore-SUDS (Oregon Sudden Unexpected Death Study). J Am Coll Cardiol 2009; 54:2006.

85. Kim C, Fahrenbruch CE, Cobb LA, Eisenberg MS. Out-of-hospital cardiac arrest in men and women. Circulation 2001; 104:2699.

86. Cupples LA, Gagnon DR, Wong ND, et al. Preexisting cardiovascular conditions and long-term prognosis after initial myocardial infarction: the Framingham Study. Am Heart J 1993; 125:863.

87. Choudhri AH, Cleland JG, Rowlands PC, et al. Unsuspected renal artery stenosis in peripheral vascular disease. BMJ 1990; 301:1197.

88. Bucher HC, Griffith LE, Guyatt GH. Effect of HMGcoA reductase inhibitors on stroke. A meta-analysis of randomized, controlled trials. Ann Intern Med 1998; 128:89.

89. Crouse JR 3rd, Byington RP, Hoen HM, Furberg CD. Reductase inhibitor monotherapy and stroke prevention. Arch Intern Med 1997; 157:1305.

Gerald Weingarten, M.D., Q.M.E.

DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE
QUALIFIED MEDICAL EXAMINER

All Correspondence To:
11620 Wilshire Boulevard, Suite 340
Los Angeles, CA 90025
Tel: (888) 853-7944
Fax: (213) 377-5152

PANEL QUALIFIED MEDICAL EVALUATION
IN THE SPECIALTY OF INTERNAL MEDICINE

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Re: [redacted]
Applicant's DOB: [redacted]
Employer: [redacted]
WCAB No.: [redacted]
Date of Injury: [redacted]
Claim/File No.: [redacted]
Panel Number: [redacted]
Date of Evaluation: [redacted]
Place of Evaluation: [redacted]

Interpreter name and #: [redacted]

Dear Parties:

Pursuant to your authorization, [redacted] underwent a Panel Qualified Medical Evaluation, in the specialty of Internal Medicine, on , at my Los Angeles office. The undersigned acted in the capacity of Panel Qualified Medical Examiner, in the specialty of Internal Medicine.

I, Dr. Weingarten, conducted the interview, reviewed all records, performed a physical examination, and formulated the diagnosis, conclusions, and discussion, including the opinion on causation, temporary disability, permanent disability, degree of disability, future care, work restrictions, and apportionment. The report was authored and edited by Dr. Weingarten. All opinions expressed herein are solely the opinions of Dr. Weingarten.

Prior to the evaluation, the entire medical file made available to the undersigned was fully reviewed. All of the records reviewed were instrumental in this examiner arriving at the opinions as expressed in this report.

Before I began the examination, the applicant was informed that this evaluation was being done exclusively in connection with the Workers' Compensation claim at the request of attorney, attorneys or insurance companies, and that no treatment relationship existed. The applicant was also made aware that any communication between us is not privileged (no doctor-patient confidentiality exists) and that any information provided, as well as the results of any testing and my conclusions regarding the case, would be included in a report that may be read by people involved in the resolution and/or litigation of the claim. The applicant was advised of his or her rights pursuant to QME regulation 40. The applicant stated that the aforementioned was understood and agreed to proceed with the evaluation. The report belongs to the party or parties requesting the evaluation.

BILLING

The report qualifies for Procedure Code **ML-104** as there are "extraordinary circumstances" relating to the medical condition for which this applicant was examined. This code best reflects the time spent and/or the complexity of this evaluation. The best proof in regard to the complexity of this evaluation is the medical/legal report which reflects the complex issues. The issues of complexity are reflected by the following: Multiple body parts are examined; present and prior work history; past medical history; family and social history; a complex psychiatric history; a complex history due to the applicant being a difficult historian; there are complex issues of causation or apportionment; adverse parties

have obtained their own complex and conflicting evaluation requiring interpretation.

This is a Comprehensive Medical-Legal Evaluation Involving **Extraordinary Circumstances (ML-104)**. The following complexity factors apply:

COMPLEXITY FACTORS

☐ (1) Two or more hours of face-to-face time by the physician

Circumstances which make this complexity factor applicable to this evaluation: Two or more hours of face-to-face time were required because one or more of the following apply: the subject medical condition was complex, the applicant was a difficult historian, and/or an interpreter was required which prolonged the face-to-face component of this evaluation.

☒ (2) Two or more hours of record review by the physician

Circumstances which make this complexity factor applicable to this evaluation: Two or more hours of record review time were required because one or more of the following apply: A significant volume of medical records were reviewed requiring two or more hours of my record review time, and/or the medical records were complex in nature.

☐ (3) Two or more hours of medical research by the physician

Circumstances which make this complexity factor applicable to this evaluation: Two or more hours of medical research were required because one or more of the following apply: medical research was required in order to investigate current developments regarding the etiology, pathogenesis, pathophysiology, causation, factors relating to the appropriate treatment, and/or disease course of the subject medical condition.

☐ (4) Four or more hours spent on any combination of two of the complexity factors (1) - (3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor.

☒ (5) Six or more hours spent on any combination of three complexity

factors (1) - (3), which shall count as three complexity factors

Circumstances which make this complexity factor applicable to this evaluation: Six or more hours were spent on any combination of three complexity factors (1)-(3). See explanations for (1), (2) and (3) above, incorporated herein.

☒ (6) Addressing the issue of medical causation

Circumstances which make this complexity factor applicable to this evaluation: I have addressed the issue of medical causation upon a written request of one or more parties.

☐ (7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate:

☐ the claimant's employment by three or more employers, OR

☐ three or more injuries to the same body system or body region as delineated in the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), OR

☐ two or more or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference

☐ (8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.

Billed under **ML-104**, time spent includes:

1. Face-to-face interview with the applicant: **1.00 hour**
2. Review of medical records: **8.00 hours**
3. Preparation, writing and editing of this report: **3.00 hours**
4. Medical research: **1.00 hour**

Medical research - NSAIDs, pathogenesis of gastroduodenal toxicity, authored Mark Feldman, MD, MACP. The healthy gastric and duodenal mucosa constitutively use COX-1 to produce its mucosal-protective prostaglandins.

Many NSAIDs block COX-1 and COX-2 more or less equally and thus may impair gastric PG production at low concentrations.

Additional time was spent in administering EKG (93000) diagnostic testing, which will be billed separately under the current OMFS.

According to the defense cover letter, I am asked if there is any objective evidence of injury in my field of specialty.

From the deposition, I assume that there is a claim for hypertension and GERD, which has been denied.

History is obtained with the aid of a Spanish-American interpreter.

HISTORY OF PRESENT ILLNESS AND WORK HISTORY

Mr. is a -year-old who is employed by [redacted] for years. He states he last worked on When asked if he is on disability, he states he is not receiving any Disability benefits, does not know if his job has been terminated. He states that he works in sanitation and maintenance. He cleaned all apartments. He worked from 4 p.m. to 10 p.m.

While working at [redacted] he had a concurrent job at a store working from 6 a.m. to 2:30 p.m. He worked at the store for years. He stopped working at the store on the same date. When asked why he stopped working at the store, he states he was receiving benefits from [redacted]

PRIOR EMPLOYMENT

He worked for company in shipping and receiving. He also worked on a clothing store. When asked what type of injuries he had at [redacted] he states that he had an injury to his right shoulder and arm. He claims that this was a continuous trauma type injury but then states that he had a specific injury on . He claims he was moving big barrels of meat that were full. He had to drag them 35 feet. He injured his right shoulder and neck. As a result of that injury, he received medication. He does not remember the names of the medication. He also received physical therapy and acupuncture. He has had two surgeries on his right shoulder, the last one was in He has chronic pain in his right shoulder and right neck.

PRESENT MEDICATIONS

Naproxen 500 mg once a day. He states he was only prescribed this a week ago. Lisinopril 10 mg a daily for hypertension, pantoprazole 40 mg daily for heartburn, and atorvastatin 20 mg daily for elevated cholesterol.

ALLERGIES TO MEDICATIONS

None.

MEDICAL CONDITIONS

Hypertension. He states he was diagnosed with hypertension in . He has been on medication since that time. When asked how it is related to his job, he could not provide me any answer.

Heartburn and GERD symptoms. He states he has had these symptoms for 5 to 6 years. He states he used to take bicarbonate of soda 3 years ago. He was given pantoprazole. This helps prevent the heartburn. When he takes it, it works good.

In regards to his hypertension, he is unaware of any complications.

Present symptomatology

He states besides his right shoulder and neck pain, he has pain in his legs and low back. The pain comes and goes. He has pains in his hands and fingers.

PAST MEDICAL HISTORY

He was born in [redacted], came to the United States at age . In [redacted], he did construction type work.

EDUCATION

Second grade education.

CHILDHOOD ILLNESSES

He states he has had a problem with his tonsils.

MILITARY SERVICE

None.

ADULT ILLNESSES

See hypercholesterolemia, hypertension, and GERD symptoms.

OPERATIONS

He has had two surgeries on his right shoulder.

ACCIDENTS AND INJURIES

20 years ago, he was in an automobile accident. He also was in another automobile accident three years ago, but states he has had no residuals.

PERSONAL HABITS

Tobacco - he has smoked for 30 years. He averages two to three cigarettes per day. In the past, he smoked up to eight cigarettes per day. Alcohol, he states he has not had any alcoholic beverages for the past 30 years. Coffee and caffeine, one to two cups per day.

FAMILY HISTORY

His father died at age . He had asthma and lung problems from smoking.

His mother died when he was years of age. He does not know the reason.

He has one sibling with diabetes. She is deceased with complications. He has two children, living and healthy.

LIVING ARRANGEMENTS

He lives in an apartment with 16 steps. He lives with his daughter. His daughter is . He states he was able to do cooking, cleaning, and washing in the apartment. He does not drive at the present time as he has no car.

REVIEW OF SYSTEMS

Head: He has headaches and dizziness and nausea 3 to 4 times per week. He takes Aleve for headaches. I told him this is the same as Naprosyn.

Eyes: He wears glasses for reading.

Ears: No loss of hearing or tinnitus.

Nose, Mouth, and Throat: No difficulty swallowing or hoarseness.

Cardiopulmonary: He states he gets chest pains and has had numerous electrocardiograms. He also recently had a Holter monitor with palpitations. He has no shortness of breath. He states he has no heart problems.

Gastrointestinal: See present illness. No constipation or diarrhea.

GU: He states he has no symptoms and no nocturia.

Endocrine: He denies diabetes.

Vascular: He states he has some swelling in his legs.

PHYSICAL EXAMINATION

Vital Signs: Blood pressure 154/99, respirations 12, pulse 54, temperature 97.6, height , and weight pounds.

Head: Normocephalic.

Eyes: Pupils are equal, reactive to light, and accommodation. Sclerae white. Conjunctivae pink.

Ears: Canals are clear. Drums are normal. There is wax in both canals. Gross hearing intact bilaterally.

Nose, Mouth, and Throat: No abnormalities.

Neck: No neck vein distention. No adenopathy. No thyromegaly. Trachea is midline.

Chest: Normal contours.

Lungs: Clear to auscultation and percussion.

Heart: Regular rhythm. No murmurs, rubs, heaves, or gallops.

Abdomen: No hepatosplenomegaly or masses. Bowel sounds are normoactive. No tenderness.

Extremities: There is no edema present.

Vascular: Peripheral pulses are intact.

Musculoskeletal: Reveals decreased range of motion of the right shoulder especially on internal rotation.

DIAGNOSTIC STUDIES

A 12-lead electrocardiogram is within normal limits.

QUESTIONNAIRES

An Epworth sleepiness scale questionnaire reveals a score of 16.

Activities of daily living questionnaire states he has much difficulty taking shower, some difficulty washing his body, much difficulty turning on and off the faucets, getting on and off the toilet, dressing himself, and opening a carton of milk. He states he was unable to lift 20 pounds. He has much difficulty getting out of bed, climbing a flight of 10 stairs and working outdoors, doing light house work or shopping.

REVIEW OF MEDICAL RECORDS

REVIEW OF FILE

Approximately 745 pages of records have been received and reviewed by the undersigned. Documents within the records that are not considered of medical importance to this practitioner may not be included in the summary though they have been reviewed in their entirety.

[redacted]

NON-MEDICAL RECORDS:

Defendant's Advocacy Letter, signed by [redacted], dated

The examiner was set to evaluate the applicant in the capacity as the Panel Qualified Medical Evaluator on

The parties requested that the examiner address the following issues in the report:

1) Your diagnosis and prognosis.

2) Your objective findings.

3) The applicant's subjective complaints and whether the subjective complaints are supported by the objective evidence of injury.

4) Please indicate whether this individual's condition is temporary or permanent and stationary for rating purposes. Please also state the date(s) said condition(s) became permanent and stationary.

5) If there was any industrially caused temporary disability, please indicate the period(s) of such temporary disability, and whether the temporary disability was total (could do no work) or partial (could do some type of work functions).

6) Please indicate what, if any, disability this individual has. Please describe any disability with language in accordance with the Workers' Compensation Guidelines. When assessing permanent disability please assess disability pursuant to the Ratings Schedule in effect until December 31, 2004 and likewise, please assess disability pursuant to the AMA Guides for assessing disability after January 1, 2005.

7) If there is disability as a consequence of this individual's employment, please comment on whether there is apportionment to pre-existing industrial or non-industrial causes, or both. Please state the basis upon which you find apportionment is or is not applicable.

8) If there is apportionment based on a progressive disease process theory, please indicate the level of disability solely attributed to that disease process absent the claimed industrial injury.

9) If there is disability, please state the extent and/or what relationship, if any, said disability has to this individual's continued employment at the job held on the date of injury.

10) Please indicate what, if any, prophylactic work restrictions, or other specific work restrictions, you would place on this individual with respect to the applicant's occupation and ability to compete in the open labor market because of the claimed industrially caused disability.

11) Please indicate what, if any medical care mayor will be required in the future to cure or relive this individual of the effects of the injuries. Please include your recommendations regarding medication, frequency and duration of medical care, etc.

You are authorized to conduct such diagnostic tests as you deem necessary and appropriate to effectuate your determination of this individual's condition as it relates to the claimed industrial disability.

Please comment on all aspects of this individuals' current condition, within your specialty, with particular emphasis on causation, apportionment, the date applicant became permanent and stationary and whether the treatment received was necessary and if not, why not.

Employee's Disability Questionnaire, dated .

The applicant was injured on while employed at [redacted] He was arranging butcher's display, stacking meat packages, cleaning display, labelling, and wrapping meats when he injured his right shoulder. Due to his injury, he could not lift more than 10 pounds and had difficulty pushing and pulling with the right arm.

Deposition of , M.D.,

A discussion was held off the record. [redacted] would issue permanent and stationary report because the prior report was before the total shoulder replacement surgery. [redacted] would issue a new one and include the rating. Mr. gave authorization to [redacted] for the functional capacity. [redacted] was going to determine the appropriate analysis to rate the applicant whether it be arthroplasty or loss of strength. [redacted] was going to evaluate all the body parts and was to give discussion whether it was industrial or non-industrial. [redacted] prescribed Omeprazole to the applicant and it would be appropriate that an internist would evaluate it on

industrial basis. [redacted] would ask the applicant if he had symptoms that were gastrointestinal and if he had, this would be deferred to a specialist; the same issue with regard to hypertension and psychiatric issues.

Physician's Return to Work and Voucher Report, dated _____.

The applicant could reach above shoulder, crawl and push/pull up to 4 hours. He was not able to lift, push or pull more than 15 pounds.

Employee's Disability Questionnaire, dated _____

The applicant was filling cases, cleaning tables at butcher, mopping the floor and pulling a large box weighing 300 pounds at the time of his injury. He sustained injury to the right shoulder, right arm, right hand, knees and legs.

Due to his injury, he was not able to lift heavy, push and pull, sit, stand, and walk.

Description of Employee's Job Duties, dated _____

The applicant was a [redacted] at [redacted] He worked 6 hours per day, 30 hours a week. His job responsibilities included lifting, pulling, pushing, cleaning floors and tables at butchers department.

He would occasionally climb, kneel, and power grasp with the left hand. He would frequently bend (neck and waist), squat, twist (neck and waist), simple grasp (right and left hand), and power grasp (right hand). He would constantly walk, stand, use the right hand, and repetitively use the hand.

He occasionally lifted and carried up to 75 pounds. He frequently lifted and carried up to 50 pounds. He lifted and carried for a distance of up to 5 feet.

He worked on beef mixer, grinder, and cutter. He worked in the fridge. He used bleach. He operated mixer. He used gloves and goggles.

MEDICAL RECORDS:

Work Slip, by [redacted] M.D., [redacted], dated _____.

The applicant was off work until [redacted] He could not constantly lift heavy objects over 20 pounds until [redacted]

Doctor's First Report of Occupational Injury (Incomplete), signed by [redacted], D.O., dated

The applicant sustained an injury on [redacted] while working as a [redacted] at [redacted] He was pulling a container full of meat trimmings when he felt a pop in his right upper arm.

Diagnosis: Biceps tendon rupture.

Work Status: He was placed on modified work on [redacted] He was precluded from lifting, pushing or pulling over 25 pounds. He was not to lift above the shoulder on the right side.

Of note was missing attachment.

Primary Treating Physician's Progress Report, signed by [redacted] D.O., dated

Subjective Complaints: The applicant came for follow-up on balling of his right biceps muscles. He had no pain. He continued to perform his regular duty. He had MRI of his right biceps tendon proximal attachment on [redacted] The preliminary verbal report indicated a biceps tendon tear but Dr. [redacted] was recommending MRI of the left shoulder to focus on the insertion point of the biceps tendon. He stated that the technician should have focused more on the shoulder. Because of this, he would like the applicant to return for a more focused MRI at no additional charge.

Objective Findings: His blood pressure was 100/76 mmHg and pulse rate was 60 beats per minute.

Diagnosis: Biceps tendon rupture.

Treatment Plan: He was to return for MRI of the right shoulder on the insertion of the biceps tendon.

Work Status: He remained on modified work. He was precluded from lifting, pushing or pulling over 25 pounds. He was not to lift above the shoulder on the right side.

MRI of the Right Shoulder, by [redacted], M.D., Radiology, [redacted], dated

Impressions: 1) There are full-thickness and complete tear of the supraspinatus and infraspinatus tendons, with retraction to the level of the glenohumeral joint. 2) Severe acromioclavicular joint degenerative changes have increased the risk for impingement. 3) There was secondary superior translation of the humeral head to the complete rotator cuff tear as it touches to the inferior aspect of the acromion. 4) There was a full-thickness and complete tear of the biceps tendon at its site of attachment to the supraglenoid tubercle, with 5 cm of retraction. 5) Full-thickness and incomplete tear of the subscapularis tendon was seen. 6) Glenohumeral joint osteoarthritic changes were seen with joint effusion.

Primary Treating Physician's Progress Report, signed by [redacted] D.O., dated

Subjective Complaints: The applicant came for follow-up on balling of his right biceps muscles. He had no pain. He continued to perform his regular duty. He had MRI of his right biceps tendon proximal attachment on The preliminary verbal report indicated a biceps tendon tear but Dr. [redacted] was recommending MRI of the left shoulder to focus on the insertion point of the biceps tendon. He stated that the technician should have focused more on the shoulder. Because of this, he would like the applicant to return for a more focused MRI at no additional charge.

Objective Findings: His blood pressure was 120/78 mmHg and pulse rate was 64 beats per minute. He weighed pounds.

Diagnoses: 1) Biceps tendon rupture, right. 2) Rotator cuff tear, right.

Treatment Plan: Requested was orthopedic consultation. He was prescribed Nabumetone 500 mg.

Work Status: He remained on modified work. He was precluded from lifting, pushing or pulling over 25 pounds. He was not to lift above the shoulder on the right side.

Comprehensive Orthopedic Consultation Report, signed by [redacted], M.D., [redacted], dated

The applicant suffered an injury of the right biceps during the performance of his work duties as a with [redacted] on

History of Injury: On while pulling a container of meat weighing approximately 200 pounds at waist level towards him, he felt some

pain and a pop of his right biceps. He continued working and finished his shift. He went home and when he removed his shirt he noticed a lump on his right biceps.

The following day, he reported the injury to his manager but was not sent for treatment. He continued working until when he reported injury to another manager who checked his biceps and referred him to his private physician. He was told that his employer should send him for treatment as this was work related.

He was referred to Medical Group. Medication was prescribed and he was placed on modified duty. An MRI scan of the right shoulder was done. He presented today for orthopedic consultation.

Present Complaints: He complained of pain that started at the right temple area down to the right side of neck down to the right shoulder, followed by headaches. He had difficulty reaching upwards. There was weakness in the right arm. There was numbness and swelling of the right hand.

Medical History: He suffered from high blood pressure. He smoked one to two cigarettes per day.

Employment History: He was employed by [redacted] as a since

Diagnoses: 1) Rupture of the long head of biceps, right shoulder. 2) Chronic rotator cuff arthropathy.

Discussion: He was not recommended surgical intervention. His pain had much improved. He could try to return to regular work. He was referred back to Dr. [redacted].

Primary Treating Physician's Progress Report, signed by [redacted] D.O., [redacted], dated

Subjective Complaints: The applicant still had pain in the biceps when lifting. He had pain in the back to the right shoulder when using the right upper extremity with force. He had been working on modified duty.

Objective Findings: His blood pressure was 120/70 mmHg and pulse rate was 72 beats per minute. He weighed pounds.

Diagnoses: 1) Biceps tendon rupture, right. 2) Rotator cuff tear, right.

Treatment Plan: Requested was physical therapy of 3 times a week for 2 weeks. He was prescribed Nabumetone 500 mg.

Work Status: He remained on modified work. He was precluded from lifting, pushing or pulling over 25 pounds. He was not to lift above the shoulder on the right side.

Primary Treating Physician's Progress Report, signed by [redacted], P.A., dated

Subjective Complaints: The applicant's symptoms had no improvement. It was temporarily relieved by therapy and use of medications. It was aggravated by abduction and he was unable to sleep well. He rated his right shoulder pain at 8/10, right elbow at 7/10 and wrist/hand at 6/10.

Objective Findings: His blood pressure was 135/92 mmHg and pulse rate was 46 beats per minute.

Diagnoses: 1) Right shoulder strain/sprain rule out internal derangement/tear/impingement. 2) Right elbow strain/sprain rule out internal derangement versus carpal tunnel syndrome. 3) Right wrist strain/sprain rule out internal derangement versus carpal tunnel syndrome. 4) Right hand strain/sprain.

Treatment Plan: MRI report was to be obtained. He was referred to pain management. EMG/NCV of the bilateral upper extremities and physical therapy of two times a week for 4 weeks were requested. He was given pain cream. Requested also was extracorporeal shockwave therapy.

Work Status: He remained on modified work. He was limited to use the right/left hand. He was precluded from overhead work and sports. He must wear braces. He was not to lift over 15 pounds.

Primary Treating Physician's Progress Report, by M.D., dated

Subjective Complaints: The applicant's right shoulder pain was constant and rated at 8/10. His right elbow pain was rated at 8/10. The right wrist/hand pain was rated at 9/10 and pain was elicited with repetitive use. He was waiting MRI result from the previous clinic.

Objective Findings: His blood pressure was 143/92 mmHg and pulse rate was 57 beats per minute.

[redacted]

Diagnoses: 1) Right shoulder strain/sprain rule out internal derangement/tear/impingement. 2) Right elbow strain/sprain rule out internal derangement versus carpal tunnel syndrome. 3) Right wrist strain/sprain rule out internal derangement versus carpal tunnel syndrome. 4) Right hand strain/sprain.

Treatment Plan: MRI result was to be obtained. He was referred for pain management, EMG/NCV of the bilateral upper extremities, and physical therapy of 2 times a week for 4 weeks. He was also referred to orthopedist, extracorporeal shockwave therapy, NIOS testing, and FCE.

Work Status: He remained on modified work. He was limited to use the right/left hand. He was precluded from overhead work and sports. He must wear braces. He was not to lift over 15 pounds.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., orthopedic surgery, dated

Subjective Complaints: The applicant continued to have pain in his neck, right shoulder, and lower back.

Diagnoses: 1) Right shoulder biceps tendon rupture, MRI confirmed. 2) Right shoulder rotator cuff tear, full thickness, MRI confirmed. 3) Right shoulder AC joint arthrosis. 4) Right shoulder Impingement syndrome. 5) Cervical strain. 6) Lumbar strain.

Treatment Plan: He was awaiting authorization for right shoulder surgery. He was prescribed Anaprox 550 mg, Omeprazole 20 mg, and Ondansetron 4 mg.

Work Status: He was precluded from lifting with the right upper extremity, prolonged weight bearing, lifting greater than ten pounds, prolonged bending, stooping, squatting or kneeling.

Utilization Review, signed by [redacted], M.D., [redacted] dated

The requested right shoulder arthroscopy, subacromial decompression, AC joint resection, rotator cuff repair, and possible biceps tendon reconstruction were certified.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., orthopedic surgery, dated

Subjective Complaints: The applicant had no improvement and continued with significant pain. He received authorization for his shoulder surgery.

Diagnoses: 1) Right shoulder biceps tendon rupture, MRI confirmed. 2) Right shoulder rotator cuff tear, full thickness, MRI confirmed. 3) Right shoulder AC joint arthrosis. 4) Right shoulder Impingement syndrome. 5) Cervical strain. 6) Lumbar strain.

Treatment Plan: He was scheduled for right shoulder surgery. He was prescribed Anaprox 550 mg.

Work Status: He was precluded from lifting with the right upper extremity, prolonged weight bearing, lifting greater than ten pounds, prolonged bending, stooping, squatting or kneeling.

Laboratory Report, [redacted] s, dated [redacted]

On CBC, there was high MCV at 98.5.

Preoperative History and Physical, by [redacted] M.D., pain management, dated [redacted]

The applicant was scheduled for repair of right shoulder rotator cuff injury.

History of Injury: He sustained an industrial injury to his right shoulder while pulling a heavy barrel with meat or.

Present Complaints: He complained of intermittent right shoulder pain with popping, clicking and grinding sensation. The pain radiated to his arm and hand. The pain was increased with overhead reaching.

Medical History: He has a history of hypertension. He had a prior motor vehicle accident years ago with low back injury.

Medications: He was on Naprosyn and Accupril.

Physical Examination: His blood pressure was 140/75 mmHg and pulse rate was 44 beats per minute. He weighed pounds.

Diagnostic Impression: 1) Right shoulder rotator cuff tear. 2) Marked sinus bradycardia.

Discussion: He was medically clear to proceed with surgical intervention.

Operative Report, by [redacted] M.D., [redacted], dated [redacted]

Preoperative Diagnoses: 1) Right shoulder rotator cuff tear. 2) Impingement syndrome right shoulder. 3) Acromioclavicular joint arthrosis. 4) Biceps tendon rupture.

Postoperative Diagnoses: 1) Acromioclavicular joint arthrosis. 2) Chronic rotator cuff tear. 3) Calcific tendinitis rotator cuff. 4) Labral tear. 5) Biceps tendon rupture.

Procedure: 1) Right shoulder arthroscopy. 2) Subacromial decompression. 3) Acromioclavicular joint resection. 4) Attempted open rotator cuff repair. 5) Debridement calcific tendinitis. 6) Debridement rotator cuff. 7) Debridement labral tear. 8) Sling application.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated [redacted]

Subjective Complaints: The applicant was status post right shoulder arthroscopy, subacromial decompression, acromioclavicular joint resection and attempted rotator cuff repair. He was doing well. The pain that he had before the surgery was gone, but he did have operative type pain and limited motion of the shoulder.

Diagnoses: 1) Right shoulder status post arthroscopy, subacromial decompression, acromioclavicular joint resection and failed rotator cuff repair. 2) Biceps tendon rupture, right. 3) Cervical strain. 4) Lumbar strain.

Treatment Plan: He was to start physical therapy of 3 times a week for 6 weeks. He was prescribed Anaprox 550 mg.

Work Status: He was placed on TTD.

Physical Therapy Evaluation, signed by [redacted], R.P.T., [redacted], dated [redacted]

The applicant was seen for physical therapy evaluation and treatment.

Physical Therapy Note, [redacted], dated [redacted]

The applicant was seen for physical therapy treatment.

Utilization Review, signed by [redacted], M.D., dated

The requested 18 postoperative physical therapy was modified to 12 sessions while Ondansetron was non-certified.

Physical Therapy Note, [redacted], dated

The applicant was seen for physical therapy treatment.

Physical Therapy Note, dated

The applicant was seen for physical therapy treatment.

Physical Therapy Note, [redacted], dated

The applicant was seen for physical therapy treatment.

Physical Therapy Note, [redacted], dated

The applicant was seen for physical therapy treatment.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated

Subjective Complaints: The applicant was status post right shoulder arthroscopy and failed rotator cuff repair. He was feeling a lot better in terms of his pain. He felt approximately 30% improvement with regard to his pain.

Diagnoses: 1) Chronic rotator cuff tear right shoulder. 2) Right shoulder status post arthroscopy, subacromial decompression, acromioclavicular joint resection and failed rotator cuff repair. 3) Biceps tendon rupture, right. 4) Cervical strain. 5) Lumbar strain.

Treatment Plan: He was to continue current therapy of 3 times a week for the next 6 weeks. If he developed arthritis, he would need a total shoulder replacement. He would follow up in one month for re-evaluation. He was prescribed Anaprox 550 mg. Functional capacity assessment was indicated.

Work Status: He remained TTD.

Physical Therapy Note, , dated

The applicant was seen for physical therapy treatment.

Physical Therapy Note, lated

The applicant was seen for physical therapy treatment.

Physical Therapy Note, , dated

The applicant was seen for physical therapy treatment.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated

Subjective Complaints: The applicant's pain was substantially improved status post right shoulder arthroscopy with a failed rotator cuff repair; however he still had limitation of motion and strength in the right upper extremity.

Diagnoses: 1) Chronic rotator cuff tear right shoulder. 2) Frozen right shoulder. 3) Right shoulder status post arthroscopy, subacromial decompression, acromioclavicular joint resection and failed rotator cuff repair. 4) Biceps tendon rupture, right. 5) Cervical strain. 6) Lumbar strain.

Treatment Plan: He was to continue physical therapy of 3 times a week for 6 weeks. He might be a candidate for a reverse total shoulder replacement in the future. He was to follow up in one month. He was prescribed Anaprox 550 mg.

Work Status: He remained TTD.

Medical-Legal Functional Capacity Evaluation, , dated

Summary of Work Capacity: The applicant could reach, grasp, and push/pull intermittently up to 4 hours. He could frequently crawl up to 6 hours. He could constantly stand, walk, sit, bend, squat, twist, reach (leg) and grasp up to 6 hours.

AMA Impairment Rating: With regard to the right shoulder, he had 10% WPI. He had 2% WPI for pain. The total WPI was 12%.

Vital Signs: His blood pressure was 138/50 mmHg and pulse rate was 50 beats per minute. He weighed pounds.

Request for Authorization, signed by [redacted] M.D., orthopedic surgery, dated

Authorization was requested for functional capacity evaluation.

Utilization Review, [redacted] dated

The requested additional postoperative physical therapy of 3 times a week for 6 weeks was modified to 12 visits.

Physical Therapy Note, , dated .

The applicant was seen for physical therapy treatment.

Physical Therapy Note, , dated .

The applicant was seen for physical therapy treatment.

Physical Therapy Note, , dated

The applicant was seen for physical therapy treatment.

Physical Therapy Note, , dated

The applicant was seen for physical therapy treatment.

Physical Therapy Note, , dated

The applicant was seen for physical therapy treatment.

Physical Therapy Note, dated

The applicant was seen for physical therapy treatment.

Physical Therapy Note, , dated

The applicant was seen for physical therapy treatment.

Physical Therapy Note, , dated

The applicant was seen for physical therapy treatment.

Physical Therapy Note, , dated .

The applicant was seen for physical therapy treatment.

Physical Therapy Note, , dated .

The applicant was seen for physical therapy treatment.

Physical Therapy Note, , dated .

The applicant was seen for physical therapy treatment.

Physical Therapy Note, , dated

The applicant was seen for physical therapy treatment.

Physical Therapy Note, , dated

The applicant was seen for physical therapy treatment.

Permanent and Stationary Evaluation, signed by [redacted] M.D., orthopedic surgery, dated

Chief Complaints: The applicant complained of pain in the neck, right shoulder, and back.

Occupation: He worked for [redacted] for the last years.

History of Injury: He was status post work related injury that occurred on . He injured his neck, back and right upper extremity at work. He reported his injury and was referred for treatment. He was treated conservatively with continued pain in his neck, back, and right upper extremity. On , he underwent a right shoulder arthroplasty, subacromial decompression, acromioclavicular resection with attempted repair of a massive rotator cuff tear, however, the rotator cuff and labrum were unable to be repaired and were debrided. He continue to have weakness in the right shoulder with loss of motion.

Medical History: He has a history of hypertension.

Diagnoses: 1) Chronic rotator cuff tear of the right shoulder. 2) Frozen right shoulder. 3) Right shoulder status post arthroplasty, subacromial decompression,

acromioclavicular resection and failed rotator cuff repair. 3) Biceps tendon rupture, right. 4) Cervical strain. 5) Lumbar strain.

Disability Status: He was permanent and stationary.

Vocational Rehabilitation: He could be considered a qualified injured worker if his work restrictions were not able to be accommodated by his employer.

Work Restrictions: He was precluded from using the right upper extremity above the waist level. He was not to lift greater than 10 pounds with the right upper extremity.

Impairment Rating: He was referred to Safety Works for Residual Functional Capacity Assessment.

Dr. adopted and incorporated the Functional Capacity Evaluation with the impairment ratings as his own. Applicant had a 32% whole person impairment rating.

Future Medical Care: Provision should be made to have future orthopedic visits, physical therapy, anti-inflammatory medications, pain medications, as well as shoulder biceps repair, reverse total shoulder replacement surgery if he developed arthrosis, possible revision rotator cuff repair, and pain management therapeutic injections for the cervical and lumbar spine.

He was prescribed Diclofenac XR, Omeprazole 20 mg, and Tramadol ER 150 mg.

Apportionment: There was no basis for apportionment.

Causation: His symptoms were related to the industrial injury.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., orthopedic surgery, dated

Subjective Complaints: The applicant continued to complain of pain in his right shoulder, neck and back with no improvement.

Diagnoses: 1) Chronic rotator cuff tear of the right shoulder. 2) Frozen right shoulder. 3) Right shoulder status post arthroplasty, subacromial decompression, acromioclavicular resection and failed rotator cuff repair. 3) Biceps tendon rupture, right. 4) Cervical strain. 5) Cervical strain. 6) Lumbar strain.

Treatment Plan: He would like to return to work. He was limited from lifting above the shoulder level with right upper extremity. He was prescribed Diclofenac XR, Omeprazole 20 mg, and Tramadol ER 150 mg.

Work Status: He was permanent and stationary.

Request for Authorization, signed by [redacted] M.D., orthopedic surgery, dated

Authorization was requested for MRI of the bilateral shoulder.

Request for Authorization, signed by [redacted] M.D., orthopedic surgery, dated .

Authorization was requested for Diclofenac XR 100 mg, Omeprazole 20 mg, and Tramadol ER 150 mg.

Operative Report, signed by [redacted] M.D., orthopedic surgery, dated .

Preoperative and Postoperative Diagnosis: Right shoulder degenerative joint disease and rotator cuff tear.

Operation Performed: 1) Right reverse shoulder arthroplasty. 2) Tension band fixation, proximal humerus.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., orthopedic surgery, dated .

Subjective Complaints: The applicant's pain in his right shoulder was worsening with moderate to severe pain and inability to lift his shoulder overhead or more than 20 to 30 degrees of abduction. He had significant loss of strength. He had no relief since his surgery due to his chronic rotator cuff tear. His back and neck pain were also moderate to severe. He was also getting numbness and tingling to his right upper extremity. His pain was rated 10/10 at its worst and it was constant. Hs pain was worst with use of the right upper extremity and also with bending, stooping, and lifting with his back.

Diagnoses: 1) Chronic rotator cuff tear of the right shoulder. 2) Frozen right shoulder. 3) Right shoulder status post arthroplasty, subacromial decompression, acromioclavicular resection and failed rotator cuff repair. 3) Biceps tendon

rupture, right. 4) Cervical strain. 5) Radiculitis of the right upper extremity. 6) Lumbar strain.

Treatment Plan: It was indicated that he was to undergo electrodiagnostic testing of the upper extremities. Requested were either reverse total shoulder or total shoulder replacement surgery. He was prescribed Diclofenac XR 100 mg, Omeprazole 20 mg, and Tramadol ER 150 mg. He was referred for functional restoration programs.

Work Status: He was permanent and stationary as of

Primary Treating Physician's Progress Report, signed by [redacted] M.D., orthopedic surgery, dated

Subjective Complaints: The applicant continued to improve with his right shoulder status post reverse total shoulder surgery. He was now able to lift his arm up to the side and to the front which he was unable to do prior to his surgery. He still had some pain and felt the he had atrophy over the right shoulder musculature.

X-rays revealed excellent position of the reverse total shoulder and circulage (sic) wire.

Diagnoses: 1) Right shoulder status post reverse total shoulder replacement. 2) Frozen right shoulder, improving. 3) Right shoulder status post arthroscopy, subacromial decompression, acromioclavicular joint resection and failed rotator cuff repair. 4) Biceps tendon rupture, right. 5) Cervical strain. 6) Radiculitis right upper extremity. 7) Lumbar strain.

Treatment Plan: Additional postoperative physical therapy of three times a week for six weeks was indicated. He was prescribed Percocet 5/325 mg. He was to follow up in one month.

Work Status: He was placed on TTD post-surgery/permanent and stationary.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., orthopedic surgery, dated

Subjective Complaints: The applicant continued to have constant sharp pain over the anterior aspect of the right shoulder which he rated at 2/10. His function had improved substantially. He got some improvement with medications.

Diagnoses: 1) Right shoulder status post reverse total shoulder replacement. 2) Frozen right shoulder. 3) Tendinitis of the right shoulder. 4) Right shoulder status post arthroscopy, subacromial decompression, acromioclavicular joint resection and failed rotator cuff repair. 5) Cervical strain. 6) Radiculitis right upper extremity. 7) Lumbar strain.

Treatment Plan: He was referred for chronic pain management with Dr. [redacted] He was prescribed Diclofenac XR 100 mg and Omeprazole 20 mg. He was to follow up as needed.

Work Status: He was permanent and stationary.

Initial Orthopedic Panel Qualified Medical Evaluation, signed by [redacted] M.D., orthopedic surgery, dated .

Job Description: The applicant began working for his employer on , as a . He described his work as labeling and filling meat cases, cleaning tables, machines and preparing the work area for the next day. His jobs required and activities included lifting/carrying trash bags weighing up to 20 to 60 pounds, frequent walking, squatting, bending, pulling/pushing, reaching overhead and gripping/grasping. He would frequently lift objects up to 85 pounds and carried these objects about 50 feet at most. He always stood or walked while at work and performing his usual and customary duties. He worked 6 hours per day, 5 days per week. He had a concurrent job as at . His work as included cleaning, sweeping and mopping.

Current Work Status: He was currently on leave with his employer and he last work on .

History of Injury: He worked for the subject employer as a . His date of hire was . He worked part-time (30 hours a week) and that his annual salary at the time of injury was $.

At the time of the claimed specific injury, his supervisor's name was . He did not know last name. Prior to the date of claimed specific industrial injury (SI:), he did not experience any difficulties performing his usual and customary duties at the worksite. He returned to work roughly one month after his claimed specific industrial injury (SI:).

On the day of his injury, he was in his usual and customary duties. While he was attempting to pull a 250 t 230-pound barrel of meat, he felt strong pulling

sensation and then a popped in his right arm (pointing to his right biceps muscle bell). His initial right arm symptoms at the time of injury was a sharp quality pain localizing to a bulge in his right arm. This pain was intermittent rated the initial right arm pain at 10/10. He tried nothing to alleviate the right arm pain initially. He completed his work shift on the date of his injury (SI:). Performing his usual duties at that time would exacerbate his right arm symptoms. He also noted a bulge of his right biceps muscle immediately after his injury. The appearance of the permanent muscle bulge did not bothered him.

He had onset of constant burning pain localizing to his right shoulder area rated at 10/10. His pain was alleviated by nothing and exacerbated by pushing activities.

He informed his employer of his condition on or around to the supervisor's assistant, . He was offered no help initially. The supervisor's assistant told him to use your own health coverage and visit his own doctor. He continued working his usual and customary duties and went to see his own private physician, who told to him that "this was not his business" and that "he should go see a worker's compensation doctor." He reported his injury again 6 days after he sustained it. His supervisor sent him to the occupational physician where he was only examined. He told that he was not initially provided any treatment. The occupational physician eventually ordered physical therapy treatments but that it did not help to alleviate his right arm symptoms.

Post-injury Details: Since the industrial events occurred, he had been treated with pain medications, multiple right shoulder surgeries, physical therapy, group therapy, magnetic resonance imaging studies and acupuncture. He was only offered physical therapy under the treatment of his occupational physician but later added that a new physician chosen by his attorney also ordered physical therapy for his right upper extremity. His initial physical therapy consisted of massaging; yellow, green, red and brown Theraband exercises; hot/cold modalities and a TENS unit.

After hiring his lawyer, he switched his care to a treating physician that his attorney had recommended. Under the care of the second treating physician he was offered additional physical therapy, acupuncture, pain medications and psychiatric treatment. He completed a right shoulder magnetic resonance imaging test in early He was not informed of the results of this diagnostic test.

In [redacted] his second treating orthopedic surgeon, began discussing option for surgical treatment. He completed his first right surgery

shoulder surgery (delayed open right rotator cuff debridement and repair; right acromioclavicular joint resection; right labral tear debridement; and right subacromial decompression) in . After the surgery, his symptoms did not improve. He complained of sharp quality pain localizing to his right shoulder (pointing to his rotator cuff) that was intermittent and rated at 6/10. His symptoms were alleviated by pain medications and exacerbated with use of his right arm. He continued physical therapy and pain medications, which did not help either.

He completed his second right shoulder surgery (right reverse total shoulder arthroplasty) on The second surgery did not help reduce his complaints much either. The second surgery just reduced the level of his pain localizing to his right shoulder to 5/10 in severity from a 6/10. He continued therapy for 18 sessions, which did not help reduce his symptoms further. He continued to see a doctor once a month for medication refills but no other physical treatments were planned.

The intermittent symptoms localizing to his right biceps changed to a pulling sensation.

He was under the care of [redacted] for medications.

Non-industrial Factors: He was a party to a lawsuit over years ago from a rear end motor vehicle accident which he did not sustain any injuries as a result of. The case had been settled. He could provide no further details about this lawsuit. He had no other accidents, no sporting injuries and says he had not served in the military.

Job History: He had worked as a for [redacted] from and was currently on leave.

He worked as for from . He stopped working when he injured while working at the subject employer. The defense attorney letter indicated that this concurrent job was with .

He worked in shipping and receiving for some clothing warehouse from and stopped working because the business closed.

He worked as a for some company in 1997 and stopped working because he moved.

Social History: He smoked 2 to 4 cigarettes daily. He used to drink alcoholic beverages in the past and stopped completely [illegible] years ago.

Medical and Surgical History: He had been previously diagnosed with hypertension, right long head of the right biceps tendon rupture, right shoulder subacromial impingement, right acromioclavicular degenerative joint disease, chronic right rotator cuff tear and right rotator cuff arthropathy. He underwent two right shoulder surgeries in relation to this claim.

Current Medications: He was on Tizanidine HCL 2 mg, Nortriptyline 25 mg, Lisinopril 10 mg, and Pantoprazole SOD 40 mg.

Physical Examination: He weighed [illegible] pounds.

Musculoskeletal Diagnoses: 1) Right long head of the biceps tendon rupture. 2) Right chronic rotator cuff tear; status post delayed open rotator cuff repair. 3) Right rotator cuff arthropathy; status post reverse total shoulder arthroplasty. 4) Right acromioclavicular degenerative joint disease; status post acromioclavicular joint resection.

Causation: He sustained a specific trauma orthopedic industrial injury (SI: [illegible] to his right shoulder and arm with regard to his right long head of the biceps tendon rupture in that at least 1% of his injury was due to work related activities.

The injury occurred primarily as a result of the pre-existing pathology of the shoulder. Use of the right arm in leisure and on the job in combination with the chronic right shoulder pathology interacted to lead to the rupture of the right long head of the biceps tendon.

It was concluded that he did not sustain a specific trauma orthopedic industrial injury (SI: [illegible] to his right shoulder and arm with regard to his pre-existing right chronic rotator cuff tear, right rotator cuff arthropathy and right acromioclavicular degenerative joint disease. The pathology and chronic shoulder injury pre-existed the specific industrial injury (SI: [illegible]) and was not caused by it in any way. Rather, the pre-existing right shoulder pathology and chronic injury in part caused the specific injury.

Dates of Temporary Partial Disability and Temporary Total Disability:

He appropriately became temporarily partially disabled on a specific industrial basis starting on [illegible] when Dr. [illegible] ordered it for the first time

due to his accepted specific industrial right biceps tendon rupture (SI:). He continued to be temporarily partially disabled on a specific industrial basis (SI:) with temporary work restrictions and temporary work modifications as written by Dr. from until , when Dr. returned him to regular duty because he reported much improvement in his right shoulder and arm pain and wanted to get back to regular duty.

He was appropriately placed on temporarily partially disability status on by Dr. when he experienced recurrent pain localizing to his biceps when lifting and right shoulder symptoms with regular work activities. This indicated that the long head of the biceps rupture was still healing and that further work exacerbated his symptoms. However, the shoulder symptoms were due to his pre-existing right chronic rotator cuff tear, right rotator cuff arthropathy and right acromioclavicular degenerative joint disease and not the specific trauma injury (right long head of the biceps tendon rupture SI:). Therefore, the temporary partial disability starting on was on a specific industrial basis (as symptoms were reported in the area of the balled up rupture long head of the biceps muscle in the right arm.

He continued to be temporarily partially disabled regarding his specific trauma injury (right long head of the biceps tendon rupture SI: while attending physical therapy until he became maximally medically improved and permanent and stationary on

Further periods of temporary partial disability after were unrelated to the specific trauma injury claim (SI:) for the acute right long head of the biceps tendon rupture. They apply only to the pre-existing shoulder pathology (right chronic rotator cuff tear, right rotator cuff arthropathy and right acromioclavicular degenerative joint disease).

Maximum Medical Improvement and Permanent and Stationary Status: He reached maximal medical improvement and permanent and stationary status with regard to his right upper extremity specific trauma injury (SI:) on

Permanent disability, Subjective/Objective Disability Factors and Impairment Rating: There was no ratable permanent disability related to his specific trauma right long head of the biceps tendon rupture (SI:). The appearance of the Popeye muscle bulge did not bother him so consideration of any perceived disability for deformity or disfigurement did not apply.

Permanent disability related to his right upper extremity and surgical treatments of the right upper extremity, if any, would be secondary to his preexisting right chronic rotator cuff tear, right rotator cuff arthropathy and right acromioclavicular degenerative joint disease. Dr. [redacted] would not have recommended right shoulder surgery on a specific industrial basis (SI:) but was evaluating this case retrospectively. Dr. [redacted] concluded that it would only have been appropriate to consider the surgical treatments performed on the right shoulder as part of either a nonindustrial claim or as part of a continuous industrial claim, if such a claim could be substantiated based on reasonable medical evidence. Dr. [redacted] had been asked to consider the specific industrial claim (SI:) and would limit his evaluation to this.

Opinion Regarding Prior Treatment: he received appropriate conservative treatment of his accepted specific industrial right long head of the biceps tendon rupture (SI: 2). Surgical intervention for the specific industrial injury (SI: was not indicated and was appropriately avoided by his initial treating orthopedic surgeon Dr.

Future Medical Treatment: His right longhead of the biceps tendon rupture has healed with no ratable disability and would require no future specific treatment on a specific industrial basis (SI:).

Work Modification and Work Restrictions: Dr. [redacted] deferred to the treating physician.

Need for Additional Agreed Medical or Qualified Evaluations in another Specialty: Dr. [redacted] suggested a need for any other agreed or qualified medical evaluation in another specialty.

Apportionment: Since there was no ratable industrially based disability due to the right longhead of the biceps tendon rupture, a discussion of apportionment was moot.

Since there was no ratable industrially based disability, apportionment did not apply to the specific industrial injury (SI:).

Workers' Compensation Pain Management Follow-up Evaluation, by [redacted] M.D., anesthesiology and pain medicine, dated

Interval History: The applicant was seen for right shoulder pain as well as compensatory cervical strain and shoulder pain rated at 6/10. It was sharp intermittent pain that was worse with looking down and up. He had pain since

. He had improvement with Nortriptyline in the past as well as Tizanidine. However, he wanted to discontinue oral medicines at our last visit, however, at this visit he would like to try something new as his pain was continuing and the topical Voltaren gel was not approved.

Medical History: He has a history of GERD, insomnia, depression, anxiety and high blood pressure.

Impression: He was seen with right shoulder pain and compensatory right cervical strain.

Plan: He was offered C7-T1 interlamilar epidural steroid injection. He should be assessed by a psychologist. He was prescribed Voltaren gel 1% and Gabapentin 300 mg. He was to follow up in one month.

Workers' Compensation Pain Management Follow-up Evaluation, by [redacted] M.D., anesthesiology and pain medicine, dated [redacted]

Interval History: The applicant had right shoulder pain that was chronic as well as compensatory right cervical strain. Currently, he had neck pain rated at 6/10 and it was constant, dull, achy, intermittent, sharp and stabbing. His pain radiated to the right arm. It was improved by Tizanidine as well as Nortriptyline in the past. However, he did not want to use pharmacotherapy. Discussed was Voltaren. He was concerned after discussion with his pharmacy about the side effect of increasing blood pressure.

Impression: He had right shoulder pain and compensatory cervical strain.

Plan: He was referred for cognitive behavioral therapy of 2 to 3 times a week for 6 weeks and acupuncture of 2 to 3 times a week for 6 weeks.

Workers' Compensation Initial Pain Management Consultation, by [redacted] M.D., anesthesiology and pain medicine, dated [redacted]

Interval History: The applicant came to discuss with his chronic right shoulder pain, neuropathic in nature and rated at 7/10. It was dull, constant, achy, with intermittent sharp pain that was worse with abduction. He had some numbness. He had improvement in the past with Tizanidine, however, he did not want any oral medicines or any injections at this time.

Impression: He had right shoulder pain and compensatory cervical strain.

Plan: Requested were acupuncture and massage therapy of 2 to 3 times a week for 6 weeks and psychotherapy or 2 to 3 times a week for 6 weeks.

Workers' Compensation Pain Management Follow-up Evaluation, by [redacted] M.D., anesthesiology and pain medicine, dated

Interval History: The applicant came to discuss his right shoulder pain as well as his compensatory cervical strain. He currently had neck pain as well as right shoulder pain rated at 8/10. It was achy, dull, and constant with intermittent sharp pain. It was worse with abduction of the right shoulder and looking down. It was improved with Diclofenac. He also had intermittent numbness.

Medical History: He has a history of depression, GERD, high blood pressure and anxiety.

Impression: He had compensatory cervical strain and right shoulder pain.

Plan: Dr. [redacted] was again asking acupuncture, manual therapy and massage therapy of 2 to 3 times a week for 6 weeks. He was referred for psychotherapy. He was prescribed Diclofenac 100 mg. He was to follow up in one month.

Workmans' Compensation Pain Management Follow-up Office Visit, by [redacted] M.D., anesthesiology and pain medicine, dated ,

Interval History: The applicant had right shoulder pain as well as chronic neck pain. His right shoulder pain was the worst pain rated at 7/10. It was constant, dull, with aching, stabbing, and intermittent pain. It was worse with abduction of the right shoulder as well as internal rotation, looking down and looking over his right shoulder. It was improved with physical therapy with the use of band as well as manual and massage therapy. He was still waiting approval for acupuncture.

Medical History: He has a history of depression, high blood pressure, anxiety and GERD.

Review of Systems: Significant for anxiety, depression, high blood pressure and GERD.

Impression: He had shoulder pain and compensatory cervical radicular pain.

Plan: Requested were manual therapy, acupuncture therapy, massage therapy and physical therapy of two to three times a week for six weeks.

Request for Authorization, signed by [redacted] M.D., anesthesiology and pain medicine, dated [redacted]

Authorization was requested for manual therapy, massage therapy, and physical therapy of 3 times a week for 6 weeks.

Workmans' Compensation Pain Management Follow-up Office Visit, signed by [redacted] M.D., anesthesiology and pain medicine, dated [redacted].

Interval History: The applicant was seen with chronic right shoulder pain and wanted to use minimal medications and treatment. His pain was rated at 7/10. It was constant, achy, and dull, with intermittent pain. It was worse with abduction and internal rotation. He had improvement with manual massage therapy in the past and was waiting for acupuncture. He had prescription of Lidocaine patch, however he had been hesitant to take all the medications including topical medications. He had been hesitant to try.

Medical History: He has a history of high blood pressure, anxiety, depression and GERD.

Review of Systems: Significant for high blood pressure, anxiety, depression and heartburn.

Impression: He had chronic right shoulder pain with compensatory cervical radiculopathy.

Plan: He was prescribed Lidoderm patch 5%. He was referred for physical therapy of 2 times a week for 5 weeks. He was to follow up in one month.

Request for Authorization, signed by [redacted] M.D., anesthesiology and pain medicine, dated [redacted].

Authorization was requested for Lidoderm patch; and physical therapy, acupuncture, manual therapy and massage therapy of 3 times a week for 6 weeks.

[redacted]

Functional Capacity Assessment, signed by [redacted], D.C., dated

Job Demands: The applicant could frequently walk, bend (neck and waist), simple grasp (right and left hand), and fine manipulation (right and left hand). He could occasionally sit, stand, squat, kneel, crawl, twist (neck and back), power grasp (right and left hand), push/push (right and left hand) and reach above and below shoulder. He could rarely climb.

He could occasionally lift or carry up to 50 pounds with a distance of 50 feet. He could occasionally push/pull up to 75 pounds with a distance of 50 feet.

Workmans' Compensation Pain Management Follow-up Office Visit, by [redacted] M.D., anesthesiology and pain medicine, dated

Interval History: The applicant came to discuss about his chronic right shoulder pain as well as his neck pain. He rated his pain at 7/10. It was constant achy pain with intermittent stabbing in his neck that would shoot into his right upper extremity. It was worse with looking down as well as abduction of his arm. It was improved with massage therapy in the past. He still had not had his acupuncture.

Medical History: He has a history of GERD, anxiety, depression, and high blood pressure.

Review of Systems: Significant for high blood pressure, anxiety, depression, and heartburn.

Impression: He had right shoulder pain with compensatory cervical radicular pain.

Plan: His Lidoderm patch was refilled. Requested were physical therapy, acupuncture sessions, manual therapy, and massage therapy of 2 to 3 times a week for 6 weeks. He was to try heating pad. He was to follow up in one month.

Workers' Compensation Pain Management Follow-up Office Visit, by [redacted] M.D., pain medicine, dated

Interval History: The applicant had neck pain rated at 6/10. His pain was constant achy with shooting of pain in the right upper extremity. It was worse with flexion and improved with Gabapentin 100 mg and Lidoderm patch.

Medical History: He has a history of GERD (gastroesophageal reflux disease), high blood pressure, anxiety and depression. He has a history of right shoulder surgery.

Medications: He was on Gabapentin 100 mg and Lidoderm patch 5%.

Impression: He had chronic right shoulder pain and compensatory cervical radicular pain related to his initial injury.

Plan: He was prescribed Gabapentin 100 mg and Lidoderm patch 5%. He was to undergo physical therapy, acupuncture therapy of three times as week for six weeks. He was referred for psychotherapy. He was to follow up in one month.

Complex Orthopedic Panel Qualified Medical-Legal Examination, signed by [redacted], M.D., dated [redacted].

Job Description: The applicant began employment with [redacted] as a [redacted] in approximately [redacted]. His usual and customary job activities included taking meat from the butchers and stocking it in cold cases, sweeping, throwing away trash and cleaning the meat department. He worked 6 hours a day, 5 days per week.

Work Status since Industrial Trauma: He had concurrent employment with [redacted] as a [redacted] at the time of injury.

Following the date of injury, [redacted] he continued working regular duties for both employers until approximately [redacted] when he was placed on restricted duties.

His pre-injury job as a [redacted] with [redacted] was not a heavy job but he mentioned the injury anyway to the employer. His duties remained unchanged after the injury.

He continued working with restrictions at [redacted] until [redacted] when he was placed on TTD. He also stopped working for [redacted] at the same time and had not returned to work for any employer since [redacted].

He believed he received workers' compensation benefits until approximately 2015. He received a check from EDD in the amount of $ [redacted] He had been drawing from those funds in his bank to date and denied receiving any other benefits. He denied having closed or settled his claim.

[redacted]

Concurrent Employment: He started working for [redacted] as a janitor on approximately The work duties included sweeping, mopping and picking up small upholstery trash. He worked 8 hours a day, 5 days per week.

He denied any increase of neck or right shoulder pain from this job between and when he stopped working.

History of Injury: He presented with a history of an injury which occurred on While working for [redacted] as a he pulled forcefully on a large barrel full of meat debris and trash. He estimated the barrel weighed 300 to 350 pounds. He tried to drag the barrel across the floor but experienced a sudden strain with pain in the neck and right shoulder. He denied any injury to the left shoulder.

He was able to continue working and completed the work shift. He reported the injury to the employer the next day, . Within 1-2 weeks, he also noted pain in the right biceps region.

On approximately the employer referred him to an industrial clinic near Van Nuys. X-rays were taken of the neck and right shoulder. He was prescribed medications. He received approximately 16 sessions of physical therapy to the neck and right shoulder but noted only temporary benefit.

In approximately , MRIs were performed of the neck and right shoulder. He did not know the results but stated that damage was noted in both areas.

In approximately , he retained an attorney and was referred to Dr. [redacted]. X-rays were taken of the neck and right shoulder. He was prescribed medications.

In approximately early [redacted] performed a right shoulder open surgery.

Following the surgery, he received approximately 12 sessions of physical therapy to the right shoulder. There was no improvement noted with the surgery.

In approximately mid- , [redacted] referred him to Dr. [redacted] a pain management doctor. He was prescribed medications.

On , [redacted] performed a 2nd right shoulder open surgery.

Following the surgery, he received approximately 12 sessions of physical therapy to the right shoulder. There was improvement noted with the surgery.

He believed he saw [redacted] intermittently for a few visits each year until February of 2017. He continued seeing Dr. [redacted] for medications one time per month.

He remained under the care of Dr. [redacted] and was last examined on [redacted].

He had not received further medical care or treatment to the best of his recollection.

In approximately [redacted], he noted the onset of groin pain and sexual dysfunction. He did not know what caused the onset of symptoms. He denied having seen a doctor for these problems.

He denied any other injured areas as a result of his injury.

At the time just prior to this injury, he denied having difficulty with the neck, right shoulder and right biceps region.

Prior Employment: Prior to working for [redacted] he was employed by [redacted] as a shipping/receiving worker for approximately 20 years.

Current Complaints: He complained of mild pain in the trapezius muscles on the right side. The pain radiated into the shoulder.

He had static sensation at the anterior right shoulder that radiated into the biceps muscle down toward the elbow. He had deformity of the biceps muscle.

Medical History: He has a history of hypertension.

Medications: He was on Gabapentin, Omeprazole, and Lisinopril.

Orthopedic Surgeries: He underwent right open shoulder surgeries in approximately early [redacted] and [redacted].

Tobacco: He currently smoked 4 to 6 cigarettes per week and had done so for approximately 5 years. Prior to this, he smoked approximately 7 cigarettes per day for 20 years.

Physical Examination: He weighed pounds.

Diagnoses: 1) Status post right shoulder rotator cuff tear/biceps tendon rupture, 2) MRI study of the right shoulder dated revealed: 1) There were full thickness and complete tears of the supraspinatus and infraspinatus tendons, with retraction to the level of the glenohumeral joint. 2) Severe acromioclavicular joint degenerative changes have increased the risk of impingement. 3) There was secondary superior translation of the humeral head to the complete rotator cuff tears as it touches to the inferior aspect of the acromion. 4) There was a full-thickness and complete tear of the biceps tendon as its site of attachment to the supraglenoid tubercle, with 5 cm of retraction. 5) Full thickness and incomplete tear of the subscapularis tendon was seen. 6) Glenohumeral joint osteoarthritic changes were seen with joint effusion. 3) Operative report dated . Pre-operative diagnoses: 1) Right shoulder rotator cuff tear. 2) Impingement syndrome right shoulder. 3) Acromioclavicular joint arthrosis. 4) Biceps tendon rupture. Postoperative Diagnoses: 1) Acromioclavicular joint arthrosis. 2) Chronic rotator cuff tear. 3) Labral tear. 4) Biceps tendon rupture procedure: 1) Right shoulder arthroscopy. 2) Subacromial decompression. 3) Acromioclavicular joint resection. 4) Attempted open rotator cuff repair. 5) Debridement calcific tendinitis. 6) Debridement rotator cuff. 7) Debridement labral tear. 8) Sling application. 4) Operative report dated Post/pre-operative diagnoses: Right shoulder degenerative joint disease and rotator cuff tear. Procedure: 1) Right reverse shoulder arthroplasty. 2) Tension band Fixation, proximal humerus. 5) Essentially normal clinical findings, cervical spine, with no objective or reproducible evidence of permanent impairment.

Causation: Dr. [redacted] was fairly and reasonably convinced that the right shoulder/biceps injury on was industrial in nature.

Treatment: Recommended treatment included physical therapy of 20 visits, acromioplasty, rotator cuff repair, postoperative physical therapy, and reverse shoulder arthroplasty.

Temporary Disability Periods: Temporarily and totally disabled inclusive dates were to ; and . Temporarily and partially disabled inclusive date was to .

Permanent Partial Disability Period: Permanent and partially disabled inclusive dates were to .

[redacted]

Maximum medical improvement dates were [redacted] following his first surgery on [redacted]; and [redacted] following his second surgery on [redacted].

Whole Person Impairment: With regard to the right shoulder, based on Section 16.4 of the AMA Guides, 5th Edition, the shoulder impairment could be rated using the range of motion method. He had flexion of 150 degrees or 2% UEI; extension of 40 degrees or 1% UEI; abduction of 120 degrees or 3% UEI; external rotation of 50 degrees or 1% UEI; and internal rotation of 50 degrees or 2% UEI with a total of 5% UEI. Utilizing table 16-3, page 439, the 9% upper extremity impairment converted to 5% whole person impairment.

Based on Section 16.7b of the AMA Guides, 5th Edition, the shoulder impairment could be rated based on the level of arthroplasty. He underwent right reverse shoulder arthroplasty on [redacted]. Utilizing Table 16-27, that would have an equivalent of 30% upper extremity impairment. Utilizing table 16-3, page 439, the 30% upper extremity impairment converted to 18% whole person impairment.

Pain Assessment: It would appear that the pain-related impairment had increased the burden of his condition slightly, in terms of self-care and physical activities, thereby increasing the overall computed right shoulder percentage by 3%.

Work Capacity: He was precluded from lifting, pushing or pulling over 15 pounds and repetitive above shoulder activities.

Ability to Return to Work: With no reasonable accommodation by his employer, he would be considered medically eligible for vocational rehabilitation services and an appropriate candidate for the Voucher Program.

Apportionment: Apportionment of the permanent residual right shoulder impairment based on causation was 100% industrially related to the injury sustained on [redacted] and 0% of the impairment was caused by other factors both prior to and/or subsequent to the industrial injury.

Future Medical Care: He was advised to use moist heat application and over-the-counter anti-inflammatory medication and analgesic medication for pain relief. There should also be a continuance of a home exercise program.

The recommendations from the accepted medical guidelines of 10 maximum physical therapy sessions, 4 initial acupuncture visits, or 9 maximum chiropractic visits should apply. There would be no extension of treatment beyond the

recommended maximum or initial trial unless objective evidence of functional improvement could be demonstrated.

Provision should also be made for revision arthroplasty in the future.

Initial Comprehensive Pain Management Report, signed by [redacted], P.A.C., dated .

Chief Complaints: The applicant complained of neck pain since . It occurred constant, chronic and rated at 8/10. It was sharp, stabbing and radiated to the right upper extremity. It was aggravated by movement. His neck pain was due to work injury.

He complained of right shoulder pain since . It was constant, chronic and rated at 8/10. It was aching and aggravated by movement. He was moving heavy object at work when he heard a loud pop in his shoulder. It was found that he had torn biceps and in need of surgery.

Physical Examination: His blood pressure was 154/88 mmHg and pulse rate was 53 beats per minute. He weighed pounds.

Diagnoses: 1) Cervical radiculopathy/herniated disc. 2) Right shoulder pain. 3) Biceps tear status post-surgical repair.

Plan: He was scheduled for translaminar epidural at C6-C7 on the right. An opioid agreement for treatment was discussed. He was referred for physical therapy.

Request for Authorization, signed by [redacted], M.D., Pain Management dated .

Authorization was requested for consultation and follow-up, urine toxicology test, translaminar epidural injection at C6-C7, and physical therapy.

Physical Therapy Note, [redacted], Undated.

The applicant was seen for physical therapy treatment.

Physical Therapy Initial Evaluation, Undated.

The applicant was seen for physical therapy treatment.

Medical Report, by [redacted] M.D., Undated.

The applicant complained of pain in the right shoulder, right arm, right hand, and back.

Occupation: He worked for [redacted] for the past years.

History of Injury: He was status post work related injury that occurred on He injured his neck, back, and right upper extremity at work. He reported the injury and was referred for treatment. He had MRI on that showed complete full thickness tear of the supraspinatus and infraspinatus tendons with retraction to the level of glenohumeral joint, severe osteoarthritis of the acromioclavicular joint and a complete tear of the biceps tendon at the super glenoid tubercle with 5 cm of retraction. There was full thickness incomplete tear of the subscapularis tendon as well and an osteoarthritic glenohumeral joint. He had not had surgery performed. He continued to have pain and weakness of the right upper extremity. He had continued pain in his neck and back.

Medical History: He has a history of hypertension.

Assessment: 1) Right shoulder biceps tendon rupture, MRI confirmed. 2) Right shoulder rotator cuff tear, full thickness, MRI confirmed. 3) Right shoulder acromioclavicular joint arthrosis. 4) Right shoulder impingement syndrome. 5) Cervical strain. 6) Lumbar strain.

Plan: He was indicated for a right shoulder arthroscopy, subacromial decompression, acromioclavicular joint resection and rotator cuff repair and possible biceps tendon reconstruction. Requested were postoperative therapy and ice therapy unit. He was prescribed Anaprox 550 mg, Prilosec 20 mg, and Ondansetron 4 mg. He was to start physical therapy of 3 times a week for 6 weeks.

Work Status: He was precluded from lifting with the right upper extremity, prolonged weight bearing, lifting greater than ten pounds, prolonged bending, stooping, squatting or kneeling.

Causation: His symptoms were causally related to the industrial injury.

That completes the review of records.

Table A - Itemization of reports with blood pressure and weight:

Date of Encounter	Provider	Applicant's Blood Pressure	Applicant's Heart Rate	Hypertensive / DM Medications	HgA1c Value	Weight
	Dr. [redacted]	100/76 mmHg	60 bpm			
	Dr. [redacted]	120/78 mmHg	64 bpm			pounds
	Dr. [redacted]	120/70 mmHg	72 bpm			pounds
		135/92 mmHg	46 bpm			
	Dr. [redacted]	143/92 mmHg	57 bpm			
	Dr. [redacted]	140/75 mmHg	44 bpm			pounds
		138/50 mmHg	50 bpm			pounds
	Dr. [redacted]				Lisinopril	pounds
	Dr. [redacted]				Lisinopril	pounds
		154/88 mmHg	53 bpm			pound

GW: cnv/mfp
2018-0714003

REVIEW OF PERTINENT MEDICAL RECORDS

Reviewed approximately 745 pages of records. According to the employee's disability questionnaire, the applicant was injured on [redacted] He was arranging butchers equipment, including displays labels and wrapping meats when he injured his right shoulder. There is another description in employee's job duties indicating he was a meat wrapper who worked 30 hours per week. He also would clean floors, tables and butcher department. He occasionally lifted and carried up to 75 pounds. There is another Doctor's Report of Work Injury indicating that he was pulling container of meat trimmings when he felt a pop in

his right upper arm. Diagnosis was biceps tendon rupture and primary treating reported his blood pressure was 100/76. An MRI of the shoulder in there was full thickness and complete tear of the supraspinatus and infraspinatus tendons. There is another blood pressure dated , normal at 120/78. A comprehensive orthopedic consultation in tates he has high blood pressure. In , blood pressure was 135/92. In blood pressure was 143/92 and a preoperative history and physical from dated states he was on Naprosyn and Accupril, blood pressure 140/75. On blood pressure was 138/50, weight was pounds. A report from Dr. [redacted] dated he was declared permanent and stationary. He was on diclofenac XR, omeprazole, and tramadol. In he was on diclofenac XR 100 mg, omeprazole 20 mg. In , he weighed pounds. He was on tizanidine 2 mg, nortriptyline, lisinopril 10 mg and pantoprazole. He had follow-up evaluation by Dr. [redacted] pain management dated . He states he has a diagnosis of depression, GERD, high blood pressure, and anxiety. He was prescribed diclofenac 100 mg. In he was on gabapentin and a Lidoderm patch. On , blood pressure was 154/88, weight pounds, is schedule for epidural C6-C7 on the right. There is another note where it states he was prescribed naproxen, Prilosec, and ondansetron 4 mg. He has had physical therapy 3 times a week for 6 weeks.

DIAGNOSTIC IMPRESSIONS

1. Industrial injury dated with torn right biceps tendon and rotator cuff tear complete right shoulder status post two shoulder surgeries.
2. Hypertension.
3. Gastroesophageal reflux disease.

DISCUSSION

Mr. [redacted] is a year-old [redacted] male who is employed by [redacted] for years. He is presently on disability but receiving no benefits. He last worked on He states that he had a specific injury on He was pushing a barrel containing meat and dragging it 35 feet and according to the medical records he felt a pop in his right arm and shoulder. He was diagnosed with a torn biceps tendon and complete rotator cuff tear. He has had two shoulder surgeries but still has chronic pain in his right shoulder. According to the medical records, he was treated with anti-inflammatories, physical therapy, and acupuncture. He is presently on prescription Naprosyn one per day, which was only started a week ago. He also claims of chronic pain in his back and leg. He walks with a cane in his right hand. He has history of

hypertension, which he states started in before his injury. He has been on lisinopril 10 mg daily. He states he has had heartburn for the past five to six years, three years ago he was started on pantoprazole. Before that, he took bicarbonate of soda. From the medical records, it indicates that he was started on proton-pump inhibitors when his doctors prescribed anti-inflammatories. He states his blood pressure has always been under control. He states his GERD symptoms are under control when he takes the pantoprazole. Since he has been off work for his injury, there has been no significant weight gain. He does not drink alcoholic beverages. He does smoke cigarettes as mentioned in the body of my report. He has headaches, dizziness, and sometimes nausea and takes Aleve. He does not realize this is the same medication as Naprosyn. He has noncardiac chest pains. Recently, he had a Holter monitor placement. He states he does not have any heart problems. On physical examination, he weighed pounds. His blood pressure was 154/99. Review of multiple blood pressure readings indicates his blood pressure essentially has been under control over the last eight years. He has decreased range of motion of his right shoulder.

Causation:

1. Hypertension is not industrially related.
2. GERD has been aggravated and accelerated by his use of antiinflammatory drugs to treat his right shoulder injury at work.

Reason for Opinion:

In regards to his hypertension condition, it developed independent of his use of antiinflammatory drugs. In reviewing the medical records, there was no connection with the use of antiinflammatory drugs to the development of his hypertension condition. His blood pressure has remained normal on medication even though he used antiinflammatory drugs as prescribed by his treating physicians for his shoulder condition on an intermittent basis. His age, sex, and ethnicity are all risk factors for his development of hypertension.

In regards to his GERD symptoms, he never sought any medical treatment for this condition according to the medical records. He was placed on proton pump inhibitors as prophylactic treatment when he was placed on antiinflammatory drugs. It was only mentioned in notes from that he had a diagnosis of GERD. Medical records document the use of antiinflammatory drugs and these are aggravating factors in GERD symptoms. There has been an aggravation of his non-industrial GERD symptoms as he now requires prescription medication to prevent his symptoms and only required non-prescription medications such as bicarbonate of soda in the past.

Permanent Impairment:

1. Hypertension. His hypertension would be rated under Table 4-2, Criteria for Rating Permanent Impairment due to hypertensive cardiovascular disease. He has a class I impairment with normal blood pressure and antihypertensive medication. There is no evidence of end-organ damage. He would have a 5% impairment of the whole person.
2. In regards to his GERD symptoms, he would be rated under Table 6-3 Criteria for Rating Permanent Impairment due to upper digestive tract disease. He has a class II impairment with 10% impairment of the whole person. He has symptoms and signs of upper digestive tract disease and requires appropriate dietary restrictions and drugs for control of symptoms. There is no significant weight loss or effect on the ADLs.

Apportionment:

1. In regards to hypertension, I would apportion 100% to non-industrial causation. His age, sex, and his ethnicity are all risk factors for the development of hypertension. I would apportion 0% to industrial causation. Even though he took nonsteroidal antiinflammatory drugs which can aggravate hypertension, there is no evidence of this in the medical records. His blood pressure levels were all normal even during the periods he took anti inflammatory drugs.
2. I would apportion 75% to nonindustrial causation. He developed GERD symptoms a number of years ago and was taking over-the-counter bicarbonate of soda on a p.r.n. basis. After he was placed on nonsteroidal antiinflammatory drugs to treat his right upper extremity injury, he required daily pantoprazole prescription medication to prevent and treat his GERD symptoms. I would apportion 25% to industrial causation as a secondary consequence type injury with aggravation and acceleration of preexisting symptoms.

Medical Treatment:

All medical treatment for his GERD symptoms should be provided for on an industrial basis. This would basically be the use of antacid medications such as pantoprazole or other proton pump inhibitors, some of which are now the over the counter.

In regards to his hypertension condition, this should be treated with antihypertensive drugs on a nonindustrial basis.

Work Restrictions:

There are no work restrictions in regards to his internal medical conditions.

Permanent and Stationary Status:

He is permanent and stationary for rating purposes in regards to his hypertension and GERD symptoms. As of the date of my report, there is no temporary disability for these conditions.

[redacted]

SPECIAL COMMENTARY

The above responses and opinions are based on reasonable medical probabilities, as viewed from the perspective of available documentation and information submitted to this examiner, including the applicant's direct anamnesis.

I, Gerald Weingarten, M.D., Q.M.E., formulated all conclusions and opinions.

Thank you for the opportunity of serving as Qualified Medical Examiner, in the specialty of Internal Medicine, for this most interesting case and condition.

Sincerely,

Gerald Weingarten, M.D., Q.M.E.
Diplomate, American Board of Internal Medicine

Attachments:

1. Appendix A: Declaration
2. Appendix B: EKG Test Results
3. Appendix C: Medical Research

[redacted]

APPENDIX A - DECLARATION

Pursuant to AB 1300, LC Sec. 5703, I have not violated Labor Code section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

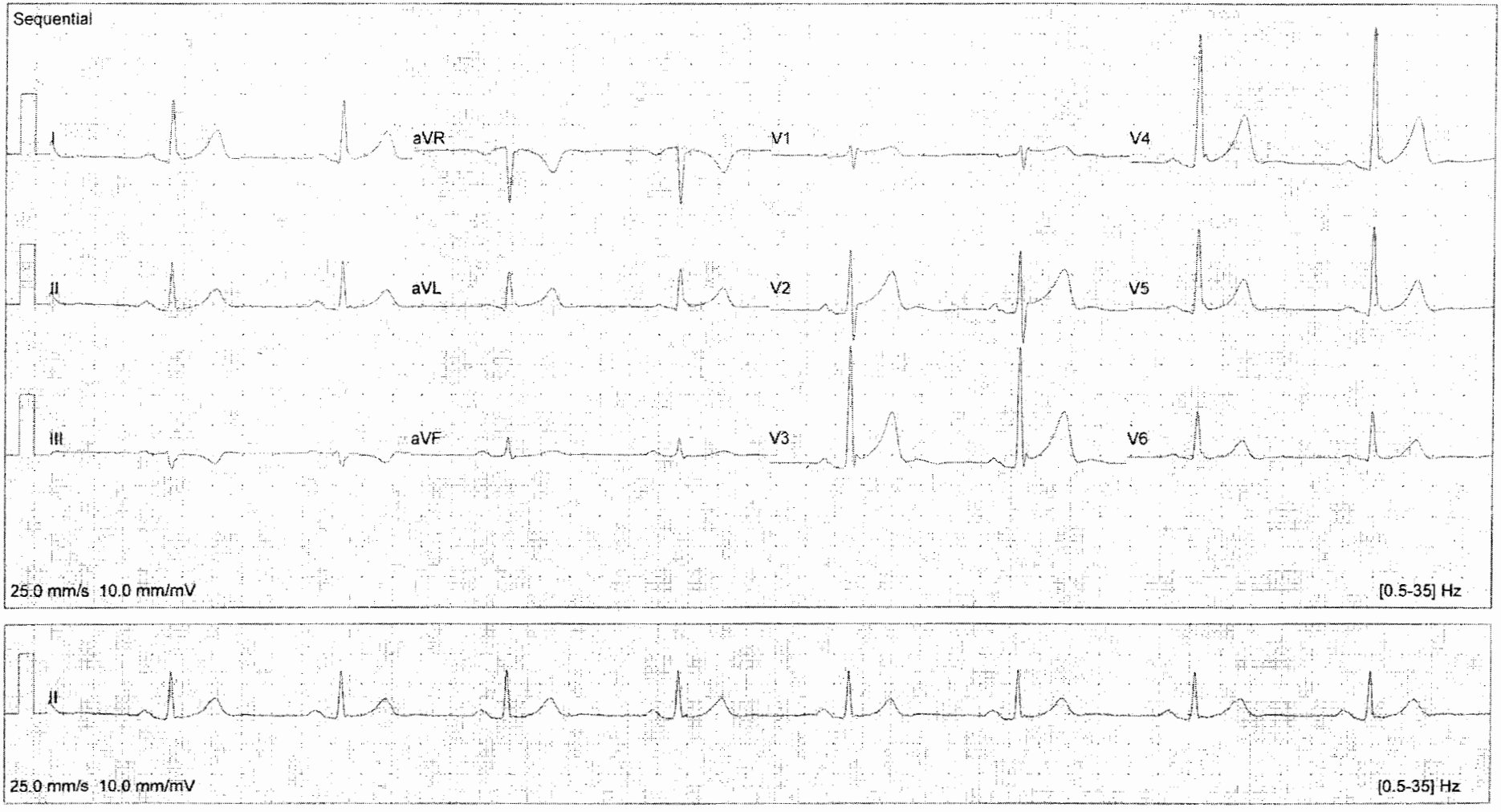
DATE OF REPORT:

Dated this st day o at l

Gerald Weingarten, M.D., Q.M.E.
Diplomate, American Board of Internal Medicine

Welch Allyn CardioPerfect Workstation

Name:		Recorded:	[illegible] PM	UNCONFIRMED INTERPRETATION	
Number:		Recorded by:			
Gender:		Referring physician:		warning: sex not available, assumed	
Birthdate:		Ordering physician:		sinus rhythm (slow)	
		Attending physician:		RSR' in V1	
P / PR:	125 ms / 182 ms	Location:			
QRS:	95 ms	Comment:		Normal variant of ECG	
QT / QTc / QTd:	435 ms / 421 ms / -				
P/QRS/T axis:	50° / 13° / 14°				
Heartrate:	52 bpm				



TOPIC OUTLINE

GRAPHICS View All

RELATED TOPICS

Author
Mark Feldman, MD, MACP, AGAF, FACG
Section Editor
J Thomas LaMont, MD
Deputy Editor
Shilpa Grover, MD, MPH
Disclosures

All topics are updated as new evidence becomes available and our peer review process is complete.
Literature review current through: Oct 2013. | This topic last updated: Jan 2, 2013.

INTRODUCTION — Nonsteroidal antiinflammatory drugs (NSAIDs) are in use throughout the world (table 1). NSAIDs are popular because of their versatile effectiveness as analgesics, antipyretics, and as antiinflammatory agents. Aspirin is also used as an anti-thrombotic agent. Unfortunately, aspirin and most other NSAIDs can injure the gastric and duodenal mucosa, with considerable morbidity and mortality.

The pathogenesis and clinical manifestations of gastroduodenal toxicity attributed to the use of NSAIDs and aspirin will be reviewed here. Other topics, such as other side effects, including injury to the small and large intestine, recommendations for the prevention and treatment of NSAID-induced gastroduodenal injury, and an overview of selective COX-2 inhibitors are discussed elsewhere. (See "NSAIDs: Adverse effects on the distal small bowel and colon" and "Nonselective NSAIDs: Overview of adverse effects" and "NSAIDs (including aspirin): Primary prevention of gastroduodenal toxicity" and "Overview of selective COX-2 inhibitors" .)

SYSTEMIC VERSUS TOPICAL EFFECTS — Aspirin and many other NSAIDs are carboxylic acid derivatives [1]. As a result, they are not ionized at the acidic pH found in the gastric lumen and thus can be absorbed across the gastric mucosa. Once the drug moves from the acidic environment of the gastric lumen into the pH–neutral mucosa, the drug ionizes and is trapped temporarily in epithelial cells where it may damage these cells.

However, this "topical" epithelial injury by many NSAIDs does not appear to be of prime importance in the pathogenesis of clinically important endpoints (symptomatic ulcers) [2]. The pathogenesis of symptomatic peptic ulcer disease caused by exposure to NSAIDs is mainly a consequence of systemic (post-absorptive) inhibition of GI mucosal cyclooxygenase (COX) activity. Even intravenous or intramuscular administration of aspirin or NSAIDs can cause gastric or duodenal ulcers in animals and humans [3-5].

THE CENTRAL ROLE OF CYCLOOXYGENASE PRODUCTS (PROSTAGLANDINS) — COX, the rate-limiting enzyme in prostaglandin (PG) synthesis, converts the unsaturated fatty acid arachidonic acid (C20:4) (derived from phospholipids in cell membranes) into PGG2 and then to PGH2 (figure 1). The gastric and duodenal mucosa proceed to convert PGH2 to various prostanoids (prostaglandins and thromboxane A2) PGs such as PGE2 protect the mucosal lining from injury by luminal acid-pepsin.

There are at least two forms of COX in the body, COX-1 and COX-2 [1]. These two proteins are 50 to 60 percent homologous and are coded on different chromosomes. COX-1 is a constitutive enzyme with a fairly steady rate of expression in most cells of the body. In contrast, COX-2 is expressed in many cells only when bacterial polysaccharides, pro-inflammatory cytokines such as TNFa or IL-1b, or growth factors (mitogens) induce its expression. The brain, heart, and aorta also express a variant form of COX-1, dubbed COX-3, with levels in brain tissue around 5 percent of those of COX-1 [1]. COX-3 in the brain may be one target of acetaminophen (paracetamol) [6].

The healthy gastric and duodenal mucosa constitutively use COX-1 to produce its mucosal-protective PGs [7]. Many NSAIDs block COX-1 and COX-2 more or less equally (ie, are non-selective) and thus may impair gastric PG production at low (<1 μM) concentrations (table 1). Examples include ibuprofen , indomethacin , and naproxen . Drugs that more selectively inhibit COX-2 than COX-1 have less suppressive effects on gastric PG synthesis (table 1). Examples include celecoxib and etodolac . As a result, selective inhibitors of COX-2, and also COX–3 inhibitors such as acetaminophen , preserve PG-mediated GI mucosal protection [8-10]. However, COX-2 selective inhibitors may still block COX-1 at clinically recommended doses and thus have the potential

to also block COX-1 in the stomach and duodenum and cause damage. (See "Overview of selective COX-2 inhibitors".)

MECHANISMS OF GASTRODUODENAL PROTECTION BY ENDOGENOUS PGS — Many mucosal functions are altered by endogenous PGs and by exogenously administered PGs; these changes may contribute to the mucosal protective effects of PGs. While it is true that certain PGs such as PGE2 reduce gastric acid secretion, hypochlorhydria does not entirely explain the mucosal protection observed with PGE2. In animals, for example, doses of PGE2 far too low to inhibit gastric acid secretion profoundly protect against gastric injury induced by aspirin, alcohol, and other gastric irritants [11]. This non-antisecretory effect of PGs has been referred to as "cytoprotection". Some of the cytoprotective mechanisms of PGs include:

- Stimulation of glycoprotein (mucin) secretion by epithelial cells
- Stimulation of bicarbonate secretion by epithelial cells
- Stimulation of phospholipid secretion by epithelial cells
- Enhancement of mucosal blood flow and oxygen delivery to epithelial cells via local vasodilation
- Increased epithelial cell migration towards the luminal surface (restitution)
- Enhanced epithelial cell proliferation

The first two mechanisms, stimulation of epithelial mucin and bicarbonate secretion, combine to form an alkaline, unstirred water layer on the surface of the gastric mucosa, which retards diffusion of acid-pepsin from the lumen into the mucosa. Gastric and duodenal injury by acid and pepsin occurs when the protective functions are compromised as a consequence of PG deficiency induced by a COX-1 inhibiting NSAID or, experimentally, by antibodies to PGs. This damage may eventually lead to gastric and/or duodenal ulcer formation, with or without serious ulcer complications (bleeding, perforation, and obstruction).

ROLE OF NITRIC OXIDE — Generation of nitric oxide (NO) may be a key intermediate in cytoprotection. Similar to the role of COX-1, constitutive NO synthase (NOS) is important in the maintenance of an intact mucosal lining. Two enzymes contribute to the basal, constitutive NOS activity: neuronal NOS (nNOS, type I) and endothelial NOS (eNOS, type III). The cytoprotective mechanisms of NO parallel PG effects and include:

- Mediation of the release of gastric mucin
- Stimulation of alkaline fluid secretion
- Maintenance of epithelial barrier function
- Enhancement of mucosal blood flow

In some but not all models, inducible NO synthase (iNOS, type II) produces high levels of NO leading to physiological responses that are often quite different than seen in the basal state. Inducible NOS is generally associated with inflammatory states, similar to COX-2 [12]. However, the relationship between the various NOS and COX enzymes has not been fully elucidated. Most studies implicate both enzymes in the maintenance of gastric mucosal integrity as well as in epithelial restitution [13,14]. Manipulation of NO levels in models of NSAID-induced mucosal damage suggest a protective role for both NO and PGs [15,16].

Because of the importance of NO in mucosal defense, NSAIDs coupled to NO itself or to NO donors have been developed [17]. These novel compounds are undergoing evaluation in clinical trials [18].

SPECTRUM OF GASTRODUODENAL MUCOSAL INJURY — Injury to the stomach or duodenum by NSAIDs can range from subtle alterations in gastric mucosal barrier function through microscopic damage to surface cells to gross injury visible through an endoscope or at the time of surgery for an ulcer complication.

The most subtle change is disruption of mucosal barrier function, manifest as increased mucosal permeability to hydrogen ions (which then diffuse more rapidly from the lumen into the mucosa) and to sodium ions (which then diffuse more rapidly from the mucosa into the lumen). Disruption of the gastric mucosal barrier and the resultant damage to surface cells by gastric acid may result in macroscopic injury over time if repair mechanisms are ineffective.

Repair mechanisms include rapid migration of deeper epithelial cells lining gastric pits to cover the damaged surface (restitution) and less rapid regeneration of new epithelial cells from progenitor cells (proliferation). Epithelial restitution and proliferation both require adequate amounts of well-oxygenated blood at a pH close to 7.4. PGs and NO have important roles in these repair mechanisms, while COX inhibitors can disrupt these PG-dependent reparative processes. Gastric restitution has been associated with induction of COX-2 [19]. The importance of the inhibition of COX-2 on gastric restitution in NSAID-induced injury is not yet known.

Macroscopic injury by NSAIDs ranges from edema, erythema, subepithelial hemorrhage, erosions (mucosal breaks, without visible depth to the lesion), and ulcers (mucosal breaks, with visible depth to the lesion). Only erosive/ulcerative lesions are considered clinically important, although lesser lesions may be precursors of erosive lesions if reparative mechanisms fail. Development of the full spectrum of lesions in the PG-depleted stomach or duodenum requires acid and pepsin; potent acid inhibition (eg, with PPIs) markedly protects against their development. (See "NSAIDs (including aspirin): Primary prevention of gastroduodenal toxicity".)

Gastric damage — The GI mucosa uses COX-1 to generate mucosal-protective PGs. Aspirin doses as low as 10 mg/day inhibit gastric PG generation considerably and can damage the stomach [20]. Epidemiologic and placebo-controlled studies indicate that the risk of serious, clinically-relevant GI damage increases as the aspirin dose is raised [8,21,22].

After low-dose aspirin therapy is stopped, the human stomach requires five to eight days to recover its COX-1 activity and its ability to synthesize protective PGs, suggesting a very slow turnover of gastric COX-1 [23]. Thus, gastric mucosa somewhat resembles the platelet, which requires 10 to 14 days to recover from aspirin.

Although aspirin inhibits COX-1 and also COX-2, certain COX-2-mediated reactions can still occur after aspirin has been given, such as the conversion of arachidonic acid to the fatty acid 15-hydroxyeicosatetraenoic acid (15-HETE); 15-HETE is then converted to 15-epi lipoxin A4 by another enzyme, 5-lipoxygenase (5-LOX). Studies in animals have demonstrated enhanced production of 15-epi lipoxin A4 following aspirin exposure [24]. Furthermore, this lipoxin minimizes gastric damage by aspirin (ie, it is cytoprotective). This protective effect of 15-epi lipoxin A4 can be abolished — with more gastric damage resulting — by administering a selective COX-2 inhibitor [24]. Therefore, the combination of low-dose aspirin and a COX-2 selective inhibitor may lead to more GI damage than low-dose aspirin alone.

In contrast to aspirin , which acetylates COX irreversibly, most NSAIDs inhibit COX-1 and COX–2 reversibly [1]. Nevertheless, even transient COX-1 inhibition in the gastric mucosa by an NSAID is sufficient to predispose the stomach to injury. That this injury is due to loss of PG-mediated cytoprotection is supported by the observation that NSAID-related gastric damage is prevented by PGE analogs such as misoprostol [25].

Misoprostol does not primarily protect the stomach by inhibiting its ability to produce hydrochloric acid because drugs that inhibit gastric acid secretion to the same or slightly greater extent as misoprostol, such as histamine-2 receptor antagonists (H2RAs), have little or no protective effect against NSAID-induced gastric damage. On the other hand, the relative failure of H2RAs to protect the stomach from damage by NSAIDs can be overcome by using higher H2RA doses or by using more potent acid-inhibitory compounds such as the proton pump inhibitors. (See "NSAIDs (including aspirin): Primary prevention of gastroduodenal toxicity".)

Duodenal damage — Aspirin doses as low as 325 mg every other day increase the risk of duodenal ulcers [26]. In contrast to the stomach, damage to the duodenal mucosa by aspirin and NSAIDs seems to depend highly upon gastric acid. Thus, not only misoprostol but also by histamine-2 blockers with their modest acid inhibition can largely prevent endoscopic evidence of duodenal injury by NSAIDs. PPIs are also highly effective. These observations related to the pathogenesis of gastric and duodenal injury lay the groundwork for using either a PPI or misoprostol in the prevention of NSAID-induced gastroduodenal ulcers. (See "NSAIDs (including aspirin): Primary prevention of gastroduodenal toxicity".)

NSAID-INDUCED GASTRIC TOXICITY NOT MEDIATED THROUGH COX-1 INHIBITION — While inhibition of COX-1 is the major mechanism by which NSAIDs produce gastric injury, mediators besides PGs

(and NO) may also be involved. As an example, interference with factors that mediate restitution or adaptive protection may contribute to mucosal injury.

Adaptive protection refers to the observation that mild gastric irritants induce enhanced cytoprotection. COX-1, COX-2, and NO as well as various growth factors, such as transforming growth factor (TGF)-beta and TGF-alpha, appear to participate in these adaptive processes [27]. Endogenous trefoil factor proteins are also associated with mucosal protection in indomethacin -induced injury [28]. NSAIDs probably interfere with growth factors and other mediators responsible for restitution and adaptive protection, further contributing to their toxicity.

ROLE OF HELICOBACTER PYLORI INFECTION — The role of Helicobacter pylori (H. pylori) infection in NSAID-induced gastritis or ulcer formation is complex [29-37].

Multiple studies of varying design have evaluated the relationship between NSAIDs and H. pylori in the development of peptic ulcer disease [29,30,32,36,37]. At least two meta-analyses concluded that NSAID use and H. pylori infection represent independent and synergistic risk factors for uncomplicated and bleeding peptic ulcer disease [38,39]. In the more recent meta-analyses (with a total of 21 studies) [39]:

- The risk of uncomplicated peptic ulcer disease was significantly higher among H. pylori positive compared with H. pylori negative NSAID users (OR 1.81).
- Ulcers were common in H. pylori positive compared with H. pylori negative patients irrespective of NSAID use (OR 4.03) and in NSAID users compared with nonusers irrespective of H. pylori status (OR 3.10).

A related question is whether eradication of H. pylori prior to NSAID treatment can reduce the risk of PUD. At least four controlled trials have addressed this issue, but results have differed [33-35,40].

- In one study, 92 patients with musculoskeletal pain, who were also infected with H. pylori, were randomized to naproxen alone (750 mg/day) for eight weeks or to a one-week course of triple therapy for H. pylori followed by the same dose of naproxen [33]. After eight weeks, H. pylori was still present in all 47 patients in the naproxen-only group compared to only 5 of 45 patients (11 percent) in the triple-therapy group. Development of a peptic ulcer (defined as a mucosal break of 5 mm or more in diameter with a well-defined ulcer crater by endoscopy) was more common in the patients treated only with naproxen (26 versus 7 percent with anti-H. pylori therapy); two of the three patients in the latter group had failure of H. pylori eradication.
- A second trial (performed by the same authors) involved 102 patients with arthritis who were randomly assigned to eradication therapy or placebo eradication therapy followed by a six-month course of diclofenac slow release (100 mg daily) [34]. Inclusion criteria required that patients had not previously been treated with a NSAID, had a positive urea breath test indicating H. pylori infection, had dyspepsia or an ulcer history, and required long-term NSAID treatment. During follow-up, the probability of endoscopically-detected ulcers was significantly higher in the placebo-treated group (34 versus 12 percent). The probability of complicated ulcers (defined as "symptomatic or bleeding") was also higher in the placebo group (27 versus 4 percent).
- A third trial randomly assigned 660 H. pylori-positive patients who were having musculoskeletal complaints that would require a NSAID for at least five weeks to receive diclofenac for five weeks, diclofenac plus omeprazole for five weeks, diclofenac for five weeks and triple therapy for the first week, or diclofenac for five weeks with triple therapy for the first week followed by omeprazole for the next four weeks [40]. All therapeutic strategies (H. pylori eradication, proton pump inhibitor therapy, or their combination) were equally effective in preventing endoscopically-detected NSAID ulcers and in reducing NSAID-related dyspeptic symptoms.
- Another trial included 285 patients already requiring therapy with NSAIDs, who were infected with H. pylori and had current or previous PUD, dyspepsia, or both [35]. Patients were continued on their NSAID and randomized to omeprazole plus antibiotics for one week or omeprazole plus placebo for one week. Patients in both groups were equally likely to remain ulcer free at six months (56 versus 53 percent). Furthermore, fewer baseline gastric ulcers (but not duodenal ulcers) healed among patients who

underwent H. pylori eradication. The failure of H. pylori eradication to enhance ulcer healing at six months was unexpected and unexplained.

Recommendations regarding H. pylori testing in patients taking requiring NSAIDs are presented separately. (See "NSAIDs (including aspirin): Primary prevention of gastroduodenal toxicity".)

RISK OF GASTROINTESTINAL COMPLICATIONS — The risk for the development of significant NSAID-induced gastrointestinal bleeding or perforation due to a peptic ulcer has been evaluated in multiple studies [26,41-56]. An important determinant is the duration of therapy. The administration of NSAIDs for a short period of time (less than one week) in healthy people is unlikely to result in any significant gastroduodenal toxicity. Longer duration of therapy is associated with an increased risk of developing complications. On the other hand, gastroduodenal complications are most common within the first three months after the initiation of therapy. Gastroduodenal toxicity may develop even in patients taking low doses of aspirin (such as for cardiovascular prophylaxis) [56], which, despite the low dose, can be associated with a significant decrease in gastric mucosal prostaglandin concentrations [20]. (See "Benefits and risks of aspirin in secondary and primary prevention of cardiovascular disease", section on 'Bleeding risk'.)

Besides duration of exposure, a number of other factors are associated with an increased risk of gastroduodenal toxicity and complications from NSAIDs. These include increasing age, higher NSAID dose(s), a past history of gastroduodenal toxicity from NSAIDs, a past history of peptic ulcer disease and concurrent use of glucocorticoids, anticoagulants, and clopidogrel (and probably of, bisphosphonates and selective serotonin reuptake inhibitors [SSRIs]) [26,41,53,55-60].

Studies have suggested that SSRIs are associated with an increased risk of UGI bleeding, particularly in patients taking NSAIDs [57-59,61-64]. A possible mechanism is platelet serotonin depletion, which may adversely influence the hemostatic response to vascular injury [53]. (See "Overview of hemostasis".) A systematic review found that the magnitude of the attributable risk was unclear and based upon weak evidence [65]. However, the available data suggested that the risk was highest with concurrent use of SSRIs and NSAIDs or aspirin (a 12- to 15-fold increase in risk of GI bleeding compared with a 2.8- to 1.7-fold increase with SSRIs alone). The authors suggested that the risk was of sufficient magnitude to warrant preventive measures (such as a PPI) in patients with other risk factors (advanced age or history of an upper gastrointestinal bleed) who are simultaneously prescribed an SSRI with a nonselective NSAID or aspirin.

With respect to dose, the risk of toxicity with "over-the-counter" NSAIDs taken at recommended doses appears to be lower than with prescription NSAIDs (or over-the-counter NSAIDs used at doses comparable to a prescription dose) [66].

The risk of toxicity may not be uniform among the NSAIDs. Many studies of varying design have described gastrointestinal toxicity of different NSAIDs. (See "NSAIDs (including aspirin): Primary prevention of gastroduodenal toxicity", section on 'Nonselective NSAIDs'.)

Genetic predisposition due to polymorphism of cytochrome P450 2C9 may delay the metabolism of several NSAIDs, with a prolonged duration of drug enhancing the ulcerogenic effect [60]. Whether these variations can be used to modify care in individual patients has not yet been determined.

American College of Gastroenterology recommendations — The American College of Gastroenterology had issued guidelines for risk stratifying patients with regard to NSAID-related GI toxicity (table 2). These guidelines are discussed elsewhere. (See "NSAIDs (including aspirin): Primary prevention of gastroduodenal toxicity", section on 'Risk factors'.)

RELATIONSHIP BETWEEN DYSPEPTIC SYMPTOMS AND GASTRODUODENAL MUCOSAL INJURY — The majority of the biochemical, microscopic and macroscopic gastric lesions caused by NSAIDs produce very little in the way of symptoms. On the other hand, aspirin and many NSAIDs, and even acetaminophen [10], may produce dyspeptic symptoms (epigastric discomfort, upper abdominal pain, nausea, epigastric fullness or bloating), especially as the dose of the drug is increased.

There is little correlation between the dyspeptic symptoms sometimes seen with these drugs and the presence or absence of erosive/ulcerative lesions in the stomach and duodenum. Two examples illustrate this point. First, patients may present with severe ulcer complications from an NSAID with no preceding dyspeptic "warning" symptoms. Second, acetaminophen and salicylsalicylic acid (salsalate) commonly produce dyspepsia, especially when used in higher doses, but neither blocks gastric COX activity over a wide range of doses or causes damage to the gastric mucosa (table 1) [7,10,67].

These observations emphasize that studies evaluating gastric and duodenal toxicity of NSAIDs should not include dyspepsia as a part of a combined GI endpoint. In most instances the mechanism for the drug-related dyspepsia has not been determined. Dyspepsia and ulcer formation should be viewed as separate issues when using analgesic drugs.

INFORMATION FOR PATIENTS — UpToDate offers two types of patient education materials, "The Basics" and "Beyond the Basics." The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading level, and they answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or e-mail these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on "patient info" and the keyword(s) of interest.)

- Beyond the Basics topics (see "Patient information: Nonsteroidal antiinflammatory drugs (NSAIDs) (Beyond the Basics)")

SUMMARY AND RECOMMENDATIONS

- Mucosal damage by aspirin and NSAIDs is primarily a consequence of inhibition of COX-1 in the upper GI tract. COX-1 inhibition reduces mucosal generation of protective prostaglandins such as PGE2. (See 'The central role of cyclooxygenase products (prostaglandins)' above and 'Mechanisms of gastroduodenal protection by endogenous PGs' above.)
- The duration and dose of NSAIDs, increasing age, a past history of gastroduodenal toxicity from NSAIDs, peptic ulcer disease, and concurrent use of glucocorticoids, anticoagulants, clopidogrel and, possibly, bisphosphonates and selective serotonin reuptake inhibitors are associated with an increased risk of gastroduodenal toxicity and complications from NSAIDs. (See 'Risk of gastrointestinal complications' above.)
- Strategies to avoid mucosal damage include using antiinflammatory or analgesic drugs that have minimal effects on COX-1 at usual doses, such as acetaminophen , or non-acetylated salicylates, or a selective COX-2 inhibitor, and prescribing either a potent inhibitor of gastric acid production such as a proton pump inhibitor or a prostaglandin E analog such as misoprostol together with the NSAID. (See 'Risk of gastrointestinal complications' above.)

  These strategies, though effective, are expensive and may not be cost-effective and in the case of selective COX-2 inhibitors may impart an increased risk of cardiovascular disease. (See "NSAIDs (including aspirin): Primary prevention of gastroduodenal toxicity" .)

REFERENCES

1. Flower RJ. The development of COX2 inhibitors. Nat Rev Drug Discov 2003; 2:179.

2. van Oijen MG, Dieleman JP, Laheij RJ, et al. Peptic ulcerations are related to systemic rather than local effects of low-dose aspirin. Clin Gastroenterol Hepatol 2008; 6:309.
3. Hansen DG, Aures D, Grossman MI. Histamine augments gastric ulceration produced by intravenous aspirin in cats. Gastroenterology 1978; 74:540.
4. Estes LL, Fuhs DW, Heaton AH, Butwinick CS. Gastric ulcer perforation associated with the use of injectable ketorolac. Ann Pharmacother 1993; 27:42.
5. Wolfe PA, Polhamus CD, Kubik C, et al. Giant duodenal ulcers associated with the postoperative use of ketorolac: report of three cases. Am J Gastroenterol 1994; 89:1110.
6. Botting RM. Mechanism of action of acetaminophen: is there a cyclooxygenase 3? Clin Infect Dis 2000; 31 Suppl 5:S202.
7. Cryer B, Feldman M. Cyclooxygenase-1 and cyclooxygenase-2 selectivity of widely used nonsteroidal anti-inflammatory drugs. Am J Med 1998; 104:413.
8. Jick H. Effects of aspirin and acetaminophen in gastrointestinal hemorrhage. Results from the Boston Collaborative Drug Surveillance Program. Arch Intern Med 1981; 141:316.
9. Blot WJ, McLaughlin JK. Over the counter non-steroidal anti-inflammatory drugs and risk of gastrointestinal bleeding. J Epidemiol Biostat 2000; 5:137.
10. Lanza FL, Codispoti JR, Nelson EB. An endoscopic comparison of gastroduodenal injury with over-the-counter doses of ketoprofen and acetaminophen. Am J Gastroenterol 1998; 93:1051.
11. Robert A, Nezamis JE, Lancaster C, Hanchar AJ. Cytoprotection by prostaglandins in rats. Prevention of gastric necrosis produced by alcohol, HCl, NaOH, hypertonic NaCl, and thermal injury. Gastroenterology 1979; 77:433.
12. Wallace JL, Miller MJ. Nitric oxide in mucosal defense: a little goes a long way. Gastroenterology 2000; 119:512.
13. Whittle BJ, Lopez-Belmonte J, Moncada S. Regulation of gastric mucosal integrity by endogenous nitric oxide: interactions with prostanoids and sensory neuropeptides in the rat. Br J Pharmacol 1990; 99:607.
14. Whittle BJ, Lopez-Belmonte J. Actions and interactions of endothelins, prostacyclin and nitric oxide in the gastric mucosa. J Physiol Pharmacol 1993; 44:91.
15. Takeuchi K, Yasuhiro T, Asada Y, Sugawa Y. Role of nitric oxide in pathogenesis of aspirin-induced gastric mucosal damage in rats. Digestion 1998; 59:298.
16. Jiménez D, Martin MJ, Pozo D, et al. Mechanisms involved in protection afforded by L-arginine in ibuprofen-induced gastric damage: role of nitric oxide and prostaglandins. Dig Dis Sci 2002; 47:44.
17. Wallace JL, Reuter B, Cicala C, et al. Novel nonsteroidal anti-inflammatory drug derivatives with markedly reduced ulcerogenic properties in the rat. Gastroenterology 1994; 107:173.
18. Fiorucci S, Santucci L, Gresele P, et al. Gastrointestinal safety of NO-aspirin (NCX-4016) in healthy human volunteers: a proof of concept endoscopic study. Gastroenterology 2003; 124:600.
19. Horie-Sakata K, Shimada T, Hiraishi H, Terano A. Role of cyclooxygenase 2 in hepatocyte growth factor-mediated gastric epithelial restitution. J Clin Gastroenterol 1998; 27 Suppl 1:S40.
20. Cryer B, Feldman M. Effects of very low dose daily, long-term aspirin therapy on gastric, duodenal, and rectal prostaglandin levels and on mucosal injury in healthy humans. Gastroenterology 1999; 117:17.
21. Farrell B, Godwin J, Richards S, Warlow C. The United Kingdom transient ischaemic attack (UK-TIA) aspirin trial: final results. J Neurol Neurosurg Psychiatry 1991; 54:1044.
22. Weil J, Colin-Jones D, Langman M, et al. Prophylactic aspirin and risk of peptic ulcer bleeding. BMJ 1995; 310:827.
23. Feldman M, Shewmake K, Cryer B. Time course inhibition of gastric and platelet COX activity by acetylsalicylic acid in humans. Am J Physiol Gastrointest Liver Physiol 2000; 279:G1113.
24. Fiorucci S, de Lima OM Jr, Mencarelli A, et al. Cyclooxygenase-2-derived lipoxin A4 increases gastric resistance to aspirin-induced damage. Gastroenterology 2002; 123:1598.
25. Silverstein FE, Faich G, Goldstein JL, et al. Gastrointestinal toxicity with celecoxib vs nonsteroidal anti-inflammatory drugs for osteoarthritis and rheumatoid arthritis: the CLASS study: A randomized controlled trial. Celecoxib Long-term Arthritis Safety Study. JAMA 2000; 284:1247.
26. Final report on the aspirin component of the ongoing Physicians' Health Study. Steering Committee of the Physicians' Health Study Research Group. N Engl J Med 1989; 321:129.
27. Kato K, Chen MC, Nguyen M, et al. Effects of growth factors and trefoil peptides on migration and replication in primary oxyntic cultures. Am J Physiol 1999; 276:G1105.

28. Babyatsky MW, deBeaumont M, Thim L, Podolsky DK. Oral trefoil peptides protect against ethanol- and indomethacin-induced gastric injury in rats. Gastroenterology 1996; 110:489.
29. Kim JG, Graham DY. Helicobacter pylori infection and development of gastric or duodenal ulcer in arthritic patients receiving chronic NSAID therapy. The Misoprostol Study Group. Am J Gastroenterol 1994; 89:203.
30. Thillainayagam AV, Tabaqchali S, Warrington SJ, Farthing MJ. Interrelationships between Helicobacter pylori infection, nonsteroidal antiinflammatory drugs and gastroduodenal disease. A prospective study in healthy volunteers. Dig Dis Sci 1994; 39:1085.
31. Loeb DS, Talley NJ, Ahlquist DA, et al. Long-term nonsteroidal anti-inflammatory drug use and gastroduodenal injury: the role of Helicobacter pylori. Gastroenterology 1992; 102:1899.
32. Gubbins GP, Schubert TT, Attanasio F, et al. Helicobacter pylori seroprevalence in patients with rheumatoid arthritis: effect of nonsteroidal anti-inflammatory drugs and gold compounds. Am J Med 1992; 93:412.
33. Chan FK, Sung JJ, Chung SC, et al. Randomised trial of eradication of Helicobacter pylori before non-steroidal anti-inflammatory drug therapy to prevent peptic ulcers. Lancet 1997; 350:975.
34. Chan FK, To KF, Wu JC, et al. Eradication of Helicobacter pylori and risk of peptic ulcers in patients starting long-term treatment with non-steroidal anti-inflammatory drugs: a randomised trial. Lancet 2002; 359:9.
35. Hawkey CJ, Tulassay Z, Szczepanski L, et al. Randomised controlled trial of Helicobacter pylori eradication in patients on non-steroidal anti-inflammatory drugs: HELP NSAIDs study. Helicobacter Eradication for Lesion Prevention. Lancet 1998; 352:1016.
36. Hawkey CJ. Risk of ulcer bleeding in patients infected with Helicobacter pylori taking non-steroidal anti-inflammatory drugs. Gut 2000; 46:310.
37. Papatheodoridis GV, Papadelli D, Cholongitas E, et al. Effect of helicobacter pylori infection on the risk of upper gastrointestinal bleeding in users of nonsteroidal anti-inflammatory drugs. Am J Med 2004; 116:601.
38. Huang JQ, Sridhar S, Hunt RH. Role of Helicobacter pylori infection and non-steroidal anti-inflammatory drugs in peptic-ulcer disease: a meta-analysis. Lancet 2002; 359:14.
39. Papatheodoridis GV, Sougioultzis S, Archimandritis AJ. Effects of Helicobacter pylori and nonsteroidal anti-inflammatory drugs on peptic ulcer disease: a systematic review. Clin Gastroenterol Hepatol 2006; 4:130.
40. Labenz J, Blum AL, Bolten WW, et al. Primary prevention of diclofenac associated ulcers and dyspepsia by omeprazole or triple therapy in Helicobacter pylori positive patients: a randomised, double blind, placebo controlled, clinical trial. Gut 2002; 51:329.
41. Savage RL, Moller PW, Ballantyne CL, Wells JE. Variation in the risk of peptic ulcer complications with nonsteroidal antiinflammatory drug therapy. Arthritis Rheum 1993; 36:84.
42. Langman MJ, Weil J, Wainwright P, et al. Risks of bleeding peptic ulcer associated with individual non-steroidal anti-inflammatory drugs. Lancet 1994; 343:1075.
43. Griffin MR, Piper JM, Daugherty JR, et al. Nonsteroidal anti-inflammatory drug use and increased risk for peptic ulcer disease in elderly persons. Ann Intern Med 1991; 114:257.
44. Gabriel SE, Jaakkimainen L, Bombardier C. Risk for serious gastrointestinal complications related to use of nonsteroidal anti-inflammatory drugs. A meta-analysis. Ann Intern Med 1991; 115:787.
45. García Rodríguez LA, Jick H. Risk of upper gastrointestinal bleeding and perforation associated with individual non-steroidal anti-inflammatory drugs. Lancet 1994; 343:769.
46. Shorr RI, Ray WA, Daugherty JR, Griffin MR. Concurrent use of nonsteroidal anti-inflammatory drugs and oral anticoagulants places elderly persons at high risk for hemorrhagic peptic ulcer disease. Arch Intern Med 1993; 153:1665.
47. Slattery J, Warlow CP, Shorrock CJ, Langman MJ. Risks of gastrointestinal bleeding during secondary prevention of vascular events with aspirin--analysis of gastrointestinal bleeding during the UK-TIA trial. Gut 1995; 37:509.
48. Allison MC, Howatson AG, Torrance CJ, et al. Gastrointestinal damage associated with the use of nonsteroidal antiinflammatory drugs. N Engl J Med 1992; 327:749.
49. Naschitz JE, Yeshurun D, Odeh M, et al. Overt gastrointestinal bleeding in the course of chronic low-dose aspirin administration for secondary prevention of arterial occlusive disease. Am J Gastroenterol 1990;

85:408.
50. Carson JL, Strom BL, Morse ML, et al. The relative gastrointestinal toxicity of the nonsteroidal anti-inflammatory drugs. Arch Intern Med 1987; 147:1054.
51. Fries JF, Williams CA, Bloch DA, Michel BA. Nonsteroidal anti-inflammatory drug-associated gastropathy: incidence and risk factor models. Am J Med 1991; 91:213.
52. Griffin MR, Ray WA, Schaffner W. Nonsteroidal anti-inflammatory drug use and death from peptic ulcer in elderly persons. Ann Intern Med 1988; 109:359.
53. Piper JM, Ray WA, Daugherty JR, Griffin MR. Corticosteroid use and peptic ulcer disease: role of nonsteroidal anti-inflammatory drugs. Ann Intern Med 1991; 114:735.
54. Hernández-Díaz S, Rodríguez LA. Association between nonsteroidal anti-inflammatory drugs and upper gastrointestinal tract bleeding/perforation: an overview of epidemiologic studies published in the 1990s. Arch Intern Med 2000; 160:2093.
55. Laine L, Curtis SP, Cryer B, et al. Risk factors for NSAID-associated upper GI clinical events in a long-term prospective study of 34 701 arthritis patients. Aliment Pharmacol Ther 2010; 32:1240.
56. García Rodríguez LA, Lin KJ, Hernández-Díaz S, Johansson S. Risk of upper gastrointestinal bleeding with low-dose acetylsalicylic acid alone and in combination with clopidogrel and other medications. Circulation 2011; 123:1108.
57. Dall M, Schaffalitzky de Muckadell OB, Lassen AT, et al. An association between selective serotonin reuptake inhibitor use and serious upper gastrointestinal bleeding. Clin Gastroenterol Hepatol 2009; 7:1314.
58. Meijer WE, Heerdink ER, Nolen WA, et al. Association of risk of abnormal bleeding with degree of serotonin reuptake inhibition by antidepressants. Arch Intern Med 2004; 164:2367.
59. Tata LJ, Fortun PJ, Hubbard RB, et al. Does concurrent prescription of selective serotonin reuptake inhibitors and non-steroidal anti-inflammatory drugs substantially increase the risk of upper gastrointestinal bleeding? Aliment Pharmacol Ther 2005; 22:175.
60. Yuan Y, Tsoi K, Hunt RH. Selective serotonin reuptake inhibitors and risk of upper GI bleeding: confusion or confounding? Am J Med 2006; 119:719.
61. de Abajo FJ, Rodríguez LA, Montero D. Association between selective serotonin reuptake inhibitors and upper gastrointestinal bleeding: population based case-control study. BMJ 1999; 319:1106.
62. Targownik LE, Bolton JM, Metge CJ, et al. Selective serotonin reuptake inhibitors are associated with a modest increase in the risk of upper gastrointestinal bleeding. Am J Gastroenterol 2009; 104:1475.
63. de Abajo FJ, García-Rodríguez LA. Risk of upper gastrointestinal tract bleeding associated with selective serotonin reuptake inhibitors and venlafaxine therapy: interaction with nonsteroidal anti-inflammatory drugs and effect of acid-suppressing agents. Arch Gen Psychiatry 2008; 65:795.
64. Opatrny L, Delaney JA, Suissa S. Gastro-intestinal haemorrhage risks of selective serotonin receptor antagonist therapy: a new look. Br J Clin Pharmacol 2008; 66:76.
65. Fries JF, Williams CA, Ramey DR, Bloch DA. The relative toxicity of alternative therapies for rheumatoid arthritis: implications for the therapeutic progression. Semin Arthritis Rheum 1993; 23:68.
66. Pilotto A, Seripa D, Franceschi M, et al. Genetic susceptibility to nonsteroidal anti-inflammatory drug-related gastroduodenal bleeding: role of cytochrome P450 2C9 polymorphisms. Gastroenterology 2007; 133:465.
67. Cryer B, Goldschmiedt M, Redfern JS, Feldman M. Comparison of salsalate and aspirin on mucosal injury and gastroduodenal mucosal prostaglandins. Gastroenterology 1990; 99:1616.

Topic 8 Version 7.0

Stomach

Cyclooxygenase (COX) 1 and 2 in normal, inflamed, and ulcerated human gastric mucosa FREE

PDF

L M Jackson[a], K C Wu†, [a], Y R Mahida[a], D Jenkins[b], C J Hawkey[a]

Author affiliations +

Abstract

BACKGROUND AND AIMS Constitutive cyclooxygenase (COX) 1 is believed to mediate prostaglandin dependent gastric protection. However, gastric mucosa contains cells capable of expressing inducible COX-2. We therefore investigated COX-1 and COX-2 expression, localisation, and activity in normal and abnormal human gastric mucosa.

METHODS COX-1 and COX-2 distribution was investigated by light and electron microscopic immunohistochemistry and by western blot analysis, and their contribution to prostaglandin (PG)E_2 synthesis using selective enzyme inhibitors.

RESULTS There was strong parietal cell COX-1 and COX-2 immunoreactivity in all sections and isolated cells, with macrophage and myofibroblast reactivity in some sections. Immunostaining was specifically abolished by antigen absorption. Western blot analysis confirmed COX-1 and 2 expression. COX-1 and COX-2 immunostaining was increased in *Helicobacter pylori* gastritis, particularly the mid glandular zone and lamina propria inflammatory cells. This was associated with increased ex vivo PGE_2 synthesis (62.4 (13.5) pg/mg *v* 36.3 (15.5) pg/mg in uninflamed mucosa; p<0.007) which was significantly inhibited by COX-1 but not COX-2 inhibition. Increased COX-2 immunostaining in macrophages, endothelial cells, and myofibroblasts (with reduced epithelial expression) was seen at the rim of ulcers.

CONCLUSION COX-2, as well as COX-1, is expressed by normal human gastric mucosa and is increased at the rim of ulcers. Although both are increased with *H pylori*, COX-1 contributes more than COX-2 to gastric PGE_2 production.

http://dx.doi.org/10.1136/gut.47.6.762

Endogenous prostaglandins are important for protection of the gastric mucosa against a wide variety of insults.[1 2] Non-steroidal anti-inflammatory drugs (NSAIDs) cause gastric injury by inhibiting synthesis of prostaglandins (PGs) via cyclooxygenase (COX) enzymes.[3 4] Two isoforms of cyclooxygenase have been recognised. COX-1 is a constitutively expressed enzyme in many tissues, including the gastrointestinal tract[5 6] while COX-2 is an inducible enzyme predominantly expressed at sites of inflammation.[7-11] This had led to the development of selective COX-2 inhibitors with the aim of reducing PG dependent inflammation while leaving protective gastric mucosal PG synthesis intact.

However, COX-2 is induced by many inflammatory and mitogenic stimuli,[12] and there is no reason to believe that this would not also occur in the stomach. In animal models, there is increasing evidence that COX-2 expression can be induced by mucosal injury.[13-15] Specific inhibitors of COX-2 have been reported to delay healing of erosions and ulcers in mice and rats.[13 15] Moreover, COX-2 is induced by inflammation, making it possible that this would occur with *Helicobacter pylori* infection. The aim of this study was to investigate expression, localisation, and activity of both COX-1 and COX-2 enzymes in normal gastric mucosa in *H pylori* associated gastritis and near to the rim of ulcers.

Materials and methods

HISTOLOGICAL STUDIES

Patients

Archival specimens from 30 patients with histologically confirmed gastric ulcers were retrieved. These comprised 20 specimens from gastrectomies performed for complicated ulcer disease, bleeding, or perforation and 10 from patients with active gastric ulcers at endoscopy. Eleven patients (10 surgical, one endoscopic biopsy sample) were recorded in the hospital notes as receiving NSAIDs. Surgical or endoscopic biopsy specimens were obtained both from the region adjacent to an ulcer rim and an area at least 1 cm away. Normal gastric mucosa was also obtained prospectively at routine upper gastrointestinal endoscopy from 25 patients whose drug usage and *H pylori* status (C14 urea breath test, histology, and

culture) were defined prospectively (15 *H pylori* positive, 10 *H pylori* negative). Patients studied prospectively gave informed consent for these biopsy samples. All specimens for immunohistochemistry were fixed in 10% buffered formalin, embedded in paraffin, and processed for routine histology.

Immunohistochemistry

Serial 4 µm thick sections were cut and mounted on capillary gap microscopic slides (Dako, High Wycombe, UK) for immunohistochemistry. All sections of gastric mucosa were deparaffinised and heated in citrated buffer at 102°C for 12 minutes. Immunohistochemistry was performed on an automatic machine (Dako TechMate 500) using the Dako ChemMate peroxidase labelled streptavidin/biotin technique. Sites of peroxidase activity were visualised using 3,3′-diaminobenzidine tetrahydrochloride (Dako ChemMate, Dako). The primary antibodies to COX-1 (prostaglandin H synthase 1 (ovine) polyclonal serum, Cat. No. 160107) and COX-2 (prostaglandin H synthase 2 (human) polyclonal antibody, Cat. No. 160107) were purchased from Cayman Chemical Co (Ann Arbor, Michigan, USA).

A mouse monoclonal antibody to human milk fat globule 2 (HMFG2; Novacastra Laboratories Ltd, Newcastle upon Tyne, UK) was also used. This antibody has recently been described as a specific marker of parietal cells because of its reactivity with antigen in canalicular membranes.[16] Following serial titration studies to determine optimal dilutions, COX-1, COX-2, and HMFG were routinely used at 1:500, 1:500, and 1:75 dilutions, respectively. Antigen absorption studies were performed with the sections treated in the same manner except that 95.4 µg/ml of purified ovine COX-1 antigen and 98.7 µg/ml of human COX-2 antigen (both from Cayman Chemical Co.) were added to the antibodies and incubated at 4°C for 48 hours before application. Slides were examined microscopically and scored for relative staining intensity for COX-1 and COX-2 (0–3).

Immunoelectron microscopy

Sections (15 µm) were immunostained as above and postfixed with 1% OsO_4 for one hour at room temperature. Sections were then dehydrated in serial ethanol and embedded in epoxy resin. Ultrathin sections were prepared and observed under a Jeol 1200 EX transmission electron microscope.

PREPARATION OF ISOLATED GLANDULAR EPITHELIAL CELLS

Gastric mucosal cells were obtained using a modification of a method previously described from this unit.[17] Gastric mucosal tissue was obtained from a surgical resection specimen of a 70 year old male patient undergoing surgery (*H pylori* positive, not receiving NSAIDs) for gastric cancer. Fresh specimens of non-malignant tissue taken at least 5 cm from the tumour were transferred to the laboratory and mucosal strips were dissected. Epithelial cells were removed from the basement membrane by five sequential 30 minute incubations in 1 mmol/l ethylenediaminetetra-acetic acid (EDTA; Sigma, St Louis, Missouri, USA) with continuous stirring at 37°C following a 15 minute incubation period in 1 mmol/l dithiothreitol (Sigma) at room temperature. Between each incubation, mucosal samples were washed with calcium and magnesium free Hank's balanced salt solution (HBSS; Gibco/BRL, Life Technologies, Paisley, UK). Epithelial cells detached from the mucosal samples in the last EDTA incubation were collected and washed with HBSS.

PREPARATION OF LAMINA PROPRIA CELLS

The gastric mucosal biopsy samples, completely denuded of epithelial cells, were subsequently cultured at 37°C in RPMI 1640 (Gibco/BRL) containing 10% fetal calf serum (Gibco/BRL) in 60 mm tissue culture dishes (Costar Corp., Cambridge, Massachusetts, USA) for 24 hours.[16] The cells that had migrated out of the biopsy sample and were in suspension or on the bottom of the dishes were collected by vigorous pipetting and centrifugation following incubation at 4°C for one hour. A 10^7 aliquot of these cells was resuspended in 2 ml of HBSS and incubated with fresh human serum treated zymosan (50 µg; Sigma) for 30 minutes.

Cytospin preparations of all of the above cell populations (≈50 000 cells/slide) were subsequently made, fixed with 10% buffered formalin (for epithelial cells) or acetone (for lamina propria cells), and stored at −70°C until required for immunohistochemistry.

WESTERN BLOT ANALYSIS OF COX-1 AND COX-2

Glandular epithelial cells isolated from normal gastric mucosa, as described above, were assayed for COX-1 and COX-2 by western blotting. Cells were harvested in a proteinase inhibitor cocktail (2 mmol/l *N*-ethylmaleimide, 2 mg/ml aprotinin, 4 mg/ml pepstatin, 10 mg/ml leupeptin, and 2 mmol/l phenylmethylsulphonyl fluoride) and lysed by three cycles of prompt freezing and thawing. The supernatant samples for sodium dodecyl sulphate-polyacrylamide gel electrophoresis (SDS-PAGE) were solubilised in SDS-PAGE sample buffer containing Tris HCl (62.5 mmol/l), glycerol (10%), SDS (2%), bromophenol blue (0.05%), and β-mercaptoethanol (5%), and the pH was adjusted to 6.8. Equal amounts of protein (10 µg) from each cell lysate were loaded onto 10% SDS polyacrylamide gels and electrophoresed at 200 V for two hours. The positive antigen controls were 0.5 µg of COX-1 and 0.5 µg of COX-2 (Cayman Chemical Co). After electrophoresis, the separated proteins were transferred to a nitrocellulose membrane (Amersham International, Little Chalfont, UK) in transfer buffer (48 mmol/l Tris, 39 mmol/l glycine, 20% methanol, pH 9.2) for two hours at a constant current of 20 amps and blocked in 1× Tris buffered saline containing 2.5% non-fat dry milk (Chiver and Sons Ltd, Coolock, Dublin, Ireland) for 30 minutes. The membranes were then incubated with the antibodies (diluted 1:1000) to COX-1 and COX-2 overnight at 4°C. An ABC peroxidase kit and peroxidase substrate kit (both from Vector Laboratories Ltd, Peterborough, UK) were used to detect the primary antibodies bound to the antigen.

CYCLOOXYGENASE ACTIVITY OF WHOLE MUCOSAL BIOPSY SAMPLES

Patients

All patients gave informed consent for biopsy samples to be taken for research purposes. In initial dose ranging studies, 10 antral mucosal biopsy samples were taken from eight subjects. *H pylori* was not defined in these subjects so that all samples permitted for research purposes could be used for functional assessment. Subsequently, ex vivo PGE_2 synthesis was assessed in 30 randomly selected dyspeptic patients found to be ulcer free at routine endoscopy whose *H pylori* status was established using the CLO test (15 negative, 15 positive). Patients with ulcers or erosions or who had been taking NSAIDs or ulcer healing agents in the previous 30 days were not studied.

Stimulation of PGE_2 synthesis

Three pairs of endoscopic antral biopsy specimens were preincubated in Tris saline 0.15 M, the COX-1 preferential inhibitor SC58560[18] (a gift from Searle Skokie, Illinois, USA) and the selective COX-2 inhibitor NS-398 (Cayman Chemicals),[19 20] for three, ten minute periods before PG synthesis was stimulated by vortexing for one minute.[20]This method is derived from one originally described in the rat[21] and shown, as in humans, to be sensitive to inhibition by NSAIDs and aspirin.[21 22] NS-398 is a selective COX-2 inhibitor with a reported COX-2:COX-1 IC_{50}ratio in transfected CHO cells of 8333.3.[19] SC58560 is a selective COX-1 inhibitor with a reported COX-2:COX-1 IC_{50}ratio in a recombinant enzyme system of 0.0014.[18]PGE_2 in the supernatant was measured by ELISA. In initial dose ranging studies, concentrations of 10^{-7} M and 10^{-5} M for each inhibitor were used. Based on these results, concentrations of 10^{-5} M for each drug were used in the studies relating specificity of inhibition to*H pylori* status.

CYCLOOXYGENASE ACTIVITY IN CELLS ISOLATED FROM THE GASTRIC MUCOSA

In a single experiment, epithelial cells isolated from normal human gastric mucosa were cultured for 30 minutes at 37°C in RPMI 1640 containing 10% fetal calf serum at a concentration of 5×10^6 cells/ml in the presence or absence of SC58560 or NS-398. Culture supernatant was obtained after centrifugation at 13 000 rpm at 4°C for 10 minutes and stored at −70° C until assayed for PGE_2 using a specific enzyme linked immunosorbent assay (Biotrak, Amersham International, Slough, UK).

STATISTICAL METHODS

In functional studies, analysis of variance was used to identify the influence of subject, drug, dose, and *H pylori* status on PGE_2 production. The Student's*t* test or Mann-Whitney test were used as appropriate for pairwise comparisons of both functional and immunohistochemical data.

Results

LOCALISATION OF COX-1 AND COX-2 IN NORMAL GASTRIC MUCOSA

Whole sections

In sections from normal human stomach, strong immunoreactivity was observed in the lower portion of the glandular epithelium for both COX-1 (14/15 cases) and COX-2 (12/15) (fig 1A, B). Antigen absorption studies showed that this staining was specific as preincubation with COX-1 antigen abolished COX-1 but not COX-2 immunoreactivity (fig 1C, F) while preincubation with COX-2 antigen abolished COX-2 but not COX-1 immunoreactivity (fig 1D, E). The position and morphology of the immunopositive cells in the glands suggested that these were parietal cells and this was supported by serial sections stained with haematoxylin and eosin and antibody to HMFG2 (fig 2A, B). However, some cells with apparent parietal cell position and morphology did not react with either HMFG2 or the cyclooxygenase antibodies. Electron microscopy also showed COX-1 and COX-2 immunoreactivity localised to parietal cells, demonstrated in smooth endoplasmic reticulum and canicular membranes but not in the nucleus or interior of cytoplasmic organelles such as mitochondria (fig 3A, B). Subcellular distribution of COX-1 and COX-2 enzymes in parietal cells was similar.

Download figure

Open in new tab

Download powerpoint

Figure 1

Immunohistochemistry of cyclooxygenase (COX)-1 and COX-2 enzymes in normal human gastric mucosa. Immunoperoxidase activity was positive in glandular epithelial cells when incubated with antibodies against COX-1 (A) and COX-2 (B), but negative when incubated with an anti-COX-1 antibody preabsorbed with purified COX-1 (C) and an anti-COX-2 antibody preabsorbed with purified COX-2 (D). Preincubation of COX-1 antibody with COX-2 antigen (E) and COX-2 antibody with COX-1 antigen (F) did not block staining. Original magnification: ×25 for A, C, E; ×160 for B, D, F (note, sections are not contiguous).

Download figure

Open in new tab

Download powerpoint

Figure 2

Immunohistochemical analysis of human gastric mucosa with antibodies to cyclooxygenase (COX)-1 (A) and human milk fat globule 2 (HMFG2) (B). Immunopositive cells are represented with morphological features of parietal cells (arrows). In cytospin preparations, cells with the morphological features of parietal cells demonstrated cytoplasmic immunoreactivity for HMFG2 (C), COX-1 (D), and COX-2 (E).

Download figure

Open in new tab

Download powerpoint

Figure 3

Electron photomicrography of human gastric glands stained with antibodies to cyclooxygenase (COX)-1 (A) and COX-2 (B). Immunoreactivity was localised to intracellular membrane structures (arrows), likely to be smooth endoplasmic reticulum or canicular membranes. (C, D) Western blot analysis of COX-1 and COX-2 proteins in human gastric epithelial cells. Cell lysate (10 µg, lane 4) was separated by sodium dodecyl sulphate-polyacrylamide gel electrophoresis, transferred to nitrocellulose membranes, and immunoblotted with (C) anti-COX-1 and (D) anti-COX-2 antibodies. Purified COX-1 and COX-2 standards (0.5 µg) were treated in the same way as the cell lysate and are shown on lane 2 and lane 3, respectively. Molecular weight marker for protein is shown on lane 1 with 60 kDa and 30 kDa bands present. An estimated 72 kDa protein band is seen on lanes with either COX standard or epithelial cells.

In the other layers of the stomach, there was limited immunoreactivity in the lamina propria (3/15 macrophages and 6/15 myofibroblasts) and submucosa (1/15 endothelial cells) but not the muscular layer. There was no significant difference in the proportion of immunopositive cells between antrum- and body-type mucosa for both COX-1 and COX-2. Weak positive immunoreactivity was occasionally observed in the cytoplasm of some mucus cells.

Isolated mucosal cells: immunostaining and western blot analysis

Sequential treatment with EDTA caused selective enrichment with cell, with the characteristics of parietal cells from 8% in fraction 1 to 50% in fraction 5. These cells were strongly labelled by HMFG2 antibody, supporting their identity as parietal cells (fig 2C), and that there was strong expression of COX-1 and COX-2 in the cytoplasm of the cells (fig 2D, E). Western blot analysis of lysates of the parietal cell enriched fraction showed protein bands at 72 kDa which comigrated with authentic COX-1 or COX-2 standard and reacted with antibodies to both COX-1 and COX-2 (fig 3C, D). The antibody used for COX-1 immunostaining bound to COX-1 but not COX-2 while the antibody used for COX-2 immunostaining bound to COX-2 but not COX-1. Gastric macrophages isolated from the lamina propria stimulated by in vitro phagocytosis of zymosan were shown to be immunopositive for both COX-1 and COX-2.

COX-1 AND COX-2 IN *H PYLORI* GASTRITIS: IMMUNOSTAINING

In contrast with normal gastric mucosa, in 8/10 sections of *H pylori* gastritis there was a relative increase in the intensity of staining of epithelial cells of the proliferative zone with both COX-1 (fig 4A) and COX-2 (fig 4B) antibodies. In all sections of *H pylori* associated gastritis there was an increase in the proportion of cells in the lamina propria which stained positively with both antibodies (fig 4A, B).

Download figure

Open in new tab

Download powerpoint

Figure 4

Immunohistochemistry of H pylori associated gastritis showed an increase in the relative intensity of staining of the proliferative zone of the epithelium with cyclooxygenase (COX)-1 (A) and COX-2 (B) antibodies. There was also an increase in the number of cells of the lamina propria which stained positively with COX-1 (A) and COX-2 (B) antibodies.

COX-1 AND COX-2 IN *H PYLORI* GASTRITIS: FUNCTIONAL STUDIES

Whole biopsy

Dose dependent inhibition

In preliminary dose ranging experiments, mean PGE_2 production in Tris saline was 46.4 (SD 12.3) pg/mg (n=8). This was decreased by 13.4 (10.0)% by SC58560 10^{-7} M and by 70.0 (7.1)% by SC58680 10^{-5}M. PGE_2 synthesis was not inhibited by NS-398 10^{-7} M but decreased by 35.5 (6.6)% with NC398 10^{-5} M (fig 5A).

Download figure

Open in new tab

Download powerpoint

Figure 5

(A) Dose dependent inhibition of prostaglandin E_2 (PGE_2) production by cyclooxygenase (COX)-1 inhibitor SC58560 and COX-2 inhibitor NS-398 at concentrations of 10^{-7} M and 10^{-5} M. (B) COX-1 and COX-2 inhibition of ex vivo PGE_2 production from whole biopsies by SC58560 and NS -398 at concentrations of 10^{-5} M in the presence or absence of H

pylori. *p=0.017, **p=0.002, (*)p=0.13. (C) PGE_2 production by parietal cell enriched fraction of human gastric epithelial cells (control) and its inhibition by SC58560 and NS-398 at concentrations of 10^{-6} M and 10^{-8}M.

COX-1 and COX-2 inhibition in the presence or absence of H pylori

In samples whose *H pylori*status was defined, PGE synthesis was 36.3 (16.0) pg/mg (n=14) in the absence of *H pylori* infection and increased to 62.4 (13.5) pg/mg/min (n=16, p=0.017) with *H pylori* infection. Analysis of variance showed that the two factors that significantly altered PGE_2 production by gastric mucosa were *H pylori* infection and incubation with COX inhibitors. Overall, SC58560 10^{-5} M inhibited PGE_2 synthesis by 58.1 (13.8)%, from 50.2 (10.3) pg/mg to 23.0 (5.6) pg/mg (p=0.002).

NS-398 10^{-5} M had no significant effect (PGE_2synthesis 50.7 (9.9) pg/mg). In mucosa taken from *H pylori* infected individuals, SC58560 10^{-5} M reduced synthesis significantly from 62.4 (13.5) pg/mg to 31.0 (9.3) pg/mg (p=0.002) while with NS-398, PGE synthesis was not significantly changed (61.7 (15.4) pg/mg) (fig 5B). A similar pattern was seen in*H pylori* negative individuals although the reduction by SC58560 10^{-5} M from 36.3 (15.5) to 14.0 (15.2) pg/mg was not statistically significant (p=0.13).

PGE_2 production by parietal cell enriched fraction of human gastric epithelial cells

Gastric epithelial cells enriched for parietal cells were cultured in vitro with or without selective COX inhibitors. As shown in fig 5C, the parietal cell enriched epithelial cells from fraction 5 synthesised more PGE_2 both from endogenous and exogenous arachidonic acid than those from fraction 1. Both SC5860 and NS-398 suppressed synthesis at concentrations of 10^{-6} M and 10^{-8} M.

LOCALISATION OF COX-1 AND COX-2 FROM PATIENTS WITH GASTRIC ULCER

In mucosa adjacent to gastric ulcers, active inflammation was noted in all 30 samples, including 13 with some regenerative features. COX-2 immunoreactivity was intense in cells with the morphological appearance of macrophages (27/30) (fig 6A), myofibroblasts (28/30) (fig6B), and vascular endothelial cells (18/30) (fig 6C) around the ulcer margin. Macrophages immunopositive for COX-2 (but not COX-1) were predominantly located in the lamina propria while myofibroblasts that were also immunopositive for COX-2 (but not COX-1) were localised predominantly to the ulcer base. Venular endothelial cells in the submucosa appeared to be the major type of endothelium to express COX-2 in gastric ulcer (fig 6C).

Download figure

Open in new tab

Download powerpoint

Figure 6

Immunohistochemistry of cyclooxygenase (COX)-2 enzyme in ulcerated human gastric mucosa. Immunoreactivity is seen on (A) macrophages in lamina propria proximal to the ulcer rim, (B) myofibroblasts at the ulcer base or granulation tissue, and (C) vascular endothelial cells in the submucosa next to the ulcer.

There was no significant change in COX-1 immunoreactivity in macrophages, myofibroblasts, or endothelial cells in ulcerated compared with normal tissue. However, when apparently healthy epithelial cells in intact mucosa immediately adjacent to the ulcerated area were examined, fewer were found to express COX-1 (43%) or COX-2 (43%) compared with normal tissue (93% and 80%, respectively; $p<0.01$ for both). Overall, NSAID use recorded in the hospital notes did not appear to be associated with changes in expression of COX-1 or COX-2.

Discussion

Prostaglandins are known to play a central role in protecting the gastric mucosa by virtue of their effects on mucus, bicarbonate, surface hydrophobicity, mucosal blood flow, and possible endothelial and epithelial cellular protection.[23] Abundant animal and limited human data suggest that COX-1 protein[6] and mRNA[24] predominate in gastric tissue and may account for most endogenous prostaglandin

synthesis.[6] Consistent with these observations, selective COX-2 inhibitors reduced prostaglandin levels and oedema in areas of inflammatory lesions but had no effect on either gastric mucosal prostaglandin levels or integrity.[6 25] However, other animal studies suggest that COX-2 is induced at the rim of gastric ulcers and that COX-2 inhibitors may retard healing of established ulcers.[15] The human gastric mucosa contains many cells capable of expressing COX-2[26 27] and synthesising prostaglandins,[25] raising the possibility that COX-2 could become a predominant source of prostaglandins in inflammatory gastric conditions, with the implication that COX-2 inhibitors would lose their target organ selectivity in the circumstances. Our results have confirmed that COX-1 is expressed in normal gastric mucosa where it appears to be localised principally to parietal cells. This is supported by colocalisation to cells staining for HMFG2, and by western blot, immunohistochemical, and functional studies of a parietal cell enriched fraction. It has previously been shown that isolated parietal cells from rats,[28] dogs,[29 30] rabbits,[31 32] and humans[33] can synthesis and metabolise[34] PGE_2 which may act in an autocrine manner to inhibit acid secretion.[35]

In contrast with earlier studies,[6] however, we also observed COX-2 immunoreactivity in normal gastric mucosa. This had a similar distribution as COX-1. An obvious explanation for this colocalisation would be cross reactivity between the two cyclooxygenase isoforms. However, western blotting identified both COX-1 and COX-2 in the gastric mucosa. Moreover, in antigen absorption studies, immunoreactivity of COX-2 in mucosal sections from normal human stomach was completely abolished by preincubation of COX-2 antibody with COX-2 antigen but not with COX-1 antigen and vice versa. Constitutive expression of COX-2 enzyme has in fact been shown previously in the stomach[36-39] and other tissues.[6 40 41] COX-1 and COX-2 localisation was confined to the smooth endoplasmic reticulum of parietal cells, in agreement with earlier studies.[42 43] However, the perinuclear distribution of COX-2 reported in murine 3T3 and other cells[44] was not identified in our study with human stomach. Quantitative confocal fluorescence imaging microscopy may provide more information about the intracellular distribution of COX-2 in parietal cells.

When the effect of *H pylori* on cyclooxygenase and prostaglandin synthesis was investigated, surprising and somewhat conflicting results emerged. We confirmed our previous observations that *H pylori* infection was associated with significant increases in ex vivo PGE_2 synthesis.[45] This was associated with increased immunostaining for both COX-1 and COX-2 in epithelial cells of the proliferative zone, and for COX-2 in inflammatory cells of the lamina propria, a pattern that has previously been reported.[46] We do not know if this increase is due to true induction or expansion of a population of cells that normally express COX-1. Short term in vitro challenge studies should clarify this. As with normal parietal cell staining, the apparent colocalisation of the two enzymes leaves open the possibility that, despite the controls we used, these data arose non-specifically or by cross reactivity. More confidence can be placed in the increased immunostaining for COX-2 in inflammatory cells, which appeared to be specific for this isoform. Nevertheless, inhibitor studies showed that prostaglandin production was readily suppressed by a COX-1 but not by a COX-2 inhibitor. It is possible that this could reflect reduced diffusion by NS-398,

although this has not been reported for this drug previously. Even if this were so, COX-1 remains a dominant source of prostaglandins in the presence of *H pylori*, as evidenced by the substantial inhibition achieved by the COX-1 inhibitor SC58560.

As with *H pylori* infection, COX-2 was also markedly upregulated in macrophages, myofibroblasts, and endothelial cells in granulation tissue adjacent to ulcers. These findings are consistent with previous studies on ulcerated gastric mucosa from rats and humans.[13 15 38] Availability of material prevented functional assessment of the contribution of COX-1 and COX-2 to prostaglandin synthesis at the ulcer rim. However, it will be important to assess whether COX-2 becomes the predominant source of prostaglandins in this situation as observations from elsewhere suggest that COX-2 inhibitors may impair healing of established ulcers.[13 15] Immunostaining suggested reduced cyclooxygenase expression in epithelial cells that could in theory also contribute to impaired ulcer healing.

One potential flaw with the notion that safe and effective anti-inflammatory drugs can be produced by selective COX-2 inhibition relates to the possible role of COX-1 in inflammation. In animal studies, Wallace and colleagues have reported that only doses of NSAIDs that are capable of inhibiting COX-1 have full anti-inflammatory effects.[47] Conversely however, a highly selective COX-1 inhibitor was found not to reduce inflammation.[18] Further work on both the role of COX-2 in gastric mucosal protection and of COX-1 in inflammation will be needed before the value of COX-2 inhibitors can be fully evaluated.

In this paper and elsewhere we have reported that macrophages, myofibroblasts, and endothelial cells isolated from human gastric mucosa readily express COX-2 and synthesise prostaglandins via this pathway when exposed to mitogenic or inflammatory stimuli.[26 27] Myofibroblast infiltration into the ulcer base and/or rim is a prominent phenomenon seen in granulation tissue[48 49] and myofibroblasts are believed to be important in the process of revascularisation of ulcer healing.[50] High expression of cyclooxygenase in myofibroblasts may promote cell proliferation,[51] differentiation,[52] or production of the extracellular matrix[53] which are required for wound healing. We have also reported elsewhere that human gastric endothelial cells isolated and established in culture express both COX-1 and COX-2, with increased COX-2 expression in response to mitogenic stimuli and production of PGE_2 that can be inhibited by both COX-1 and COX-2 inhibitors.[26] Prostaglandins synthesised by human gastric endothelial cyclooxygenases have potential to cause vasodilatation and angiogenesis that is inhibited by cyclooxygenase inhibitions.[26]

In summary, although there is some evidence for increased expression of COX-2 with *H pylori* infection, we were unable to show that this becomes a dominant source of prostaglandin production. Hence these results do not suggest that the gastroparing properties of COX-2 inhibitors would be lost in *H pylori* infection, and data from clinical trials confirm this.[54] In contrast, whether the intense COX-2 expression seen in macrophages, myofibroblasts, and endothelial cells close to the edge of gastric ulcers is of sufficient functional importance for COX-2 inhibitors to delay gastric ulcer healing requires further evaluation.

Acknowledgments

We are very grateful to Mr Ken Morrell and Mr Trevor Gray for technical assistance and helpful advice.

References

1. Robert A, Nezamis JE, Lancaster C, *et al.* (1979) Cytoprotection by prostaglandins in rats. Prevention of gastric necrosis produced by alcohol, HCl, NaOH, hypertonic NaCl, and thermal injury. *Gastroenterology* **77**:433–443. PubMed Web of Science Google Scholar

2. Tarnawski, Brzozowski T, Sarfeh IJ, *et al.* (1988) Prostaglandin production of human isolated gastric glands against indomethacin and ethanol injury. Evidence for direct cellular action of prostaglandin. *J Clin Invest* **81**:1081–1089. Google Scholar

3. Vane JR (1971) Inhibition of prostaglandin synthesis as a mechanism of action for aspirin-like drugs. *Nat New Biol* **231**:232–235. CrossRef PubMed Web of Science Google Scholar

4. Fellows IW, Bhaskar NK, Hawkey CJ (1989) The nature and time course of piroxicam-induced injury to human gastric mucosa. *Aliment Pharmacol Ther* **3**:481–488. PubMed Google Scholar

5. Vane J (1994) Towards a better aspirin. *Nature* **367**:215–216. CrossRef PubMed Google Scholar

6. Kargman S, Charleson S, Cartwright M, *et al.* (1996) Characterization of prostaglandin G/H synthase 1 and 2 in rat, dog, monkey, and human gastrointestinal tracts. *Gastroenterology* **111**:445. CrossRef PubMed Web of Science Google Scholar

7. Coyne DW, Nickols M, Bertrand W, *et al.* (1992) Regulation of mesangial cell cyclooxygenase synthesis by cytokines and glucocorticoids. *Am J Physiol* **263**:F97–102. Abstract/FREE Full Text Google Scholar

8. DuBois RN, Awad J, Morrow J, *et al.* (1994) Regulation of eicosanoid production and mitogenesis in rat intestinal epithelial cells by transforming growth factor-α and phorbol ester. *J Clin Invest* **93**:493–498. Google Scholar

9. Fu JY, Masferrer JL, Seibert K, *et al.* (1990) The induction and suppression of prostaglandin H2 synthase (cyclooxygenase) in human monocytes. *J Biol Chem* **265**:16737–16740. Abstract/FREE Full Text Google Scholar

10. Kargman S, O'Neill G, Vickers P, *et al.* (1995) Expression of prostaglandin G/H synthase-1 and -2 protein in human colon cancer. *Cancer Res* **55**:2556–2559. Abstract/FREE Full Text Google Scholar

11. O'Sullivan MG, Huggins EMJ, Meade EA, *et al.* (1992) Lipopolysaccharide induces prostaglandin H synthase-2 in alveolar macrophages. *Biochem Biophys Res Commun* **187**:1123–1127. CrossRef PubMed Web of Science Google Scholar

12. Herschmann HR (1996) Prostaglandin synthase 2. *Biochim Biophys Acta* **1299**:124–140. Google Scholar

13. Mizuno H, Sakamoto C, Matsuda K, *et al.* (1997) Induction of cyclooxygenase 2 in gastric mucosal lesions and its inhibition by the specific antagonist delays healing in mice. *Gastroenterology* **112**:387–397. CrossRef PubMed Web of Science Google Scholar

14. Gretzer B, Ehrlich K, Maricic N, *et al.* (1998) Selective cyclooxygenase-2 inhibitors and their influence on the protective effect of a mild irritant in the rat stomach. *Br J Pharmacol* **123**:927–935. CrossRef PubMed Web of Science Google Scholar

15. Schmassmann A, Peskar BM, Stettler C, *et al.* (1998) Effects of inhibition of prostaglandin endoperoxide synthase-2 in chronic gastro-intestinal ulcer models in rats. *Br J Pharmacol* **123**:795–804. CrossRef PubMed Web of Science Google Scholar

16. Walker MM, Smolka A, Waller JM, *et al.* (1995) Identification of parietal cells in gastric body mucosa with HMFG-2 monoclonal antibody. *J Clin Pathol* **48**:832–834. Abstract/FREE Full Text Google Scholar

17. Mahida YR, Galvin AM, Gray T, *et al.* (1997) Migration of human intestinal laminal propria lymphocytes, macrophages and eosinophils following the loss of surface epithelial cells. *Clin Exp Immunol* **109**:377–386. CrossRef PubMed Web of Science Google Scholar

18. Smith CJ, Zhang Y, Koboldt CM, *et al.* (1998) Pharmacological analysis of cyclooxygenase-1 in inflammation. *Proc Natl Acad Sci USA* **95**:13313–13318. Abstract/FREE Full Text Google Scholar

19. Kargman S, Wong E, Greig GM, *et al.* (1994) Mechanism of selective human prostaglandin G/H synthase-1 and -2 in intact cells. *Biochem Pharmacol* **48**:1605–1610. CrossRef PubMed Web of Science Google Scholar

20. Gierse JK, McDonald J, Hauser SD, *et al.* (1996) A single amino acid difference between cyclooxygenase-1 (COX-1) and -2 (COX-2) reverses the selectivity of COX-2 specific inhibitors. *J Biol Chem* **271**:15810–15814. Abstract/FREE Full Text Google Scholar

21. Whittle BJ (1981) Temporal relationship between cyclooxygenase inhibition, as measured by prostacyclin biosynthesis, and the gastrointestinal damage induced by idomethacin in the rat.

Gastroenterology **80**:94–98. PubMed Web of Science Google Scholar

22. Hawkey CJ, Hawthorne AB, Hudson N, *et al.* (1991) Separation of aspirin's impairment of haemostasis from mucosal injury in the human stomach. *Clin Sci* **81**:565–573. PubMed Google Scholar

23. Wallace JL, Bell CJ (1996) Gastroduodenal mucosal defence. *Curr Opin Gastroenterol* **12**:503–511. CrossRef Google Scholar

24. O'Neill GP, Ford-Hutchinson AW (1993) Expression of mRNA for cyclooxygenase-1 and cyclooxygenase-2 in human tissues. *FEBS Lett* **330**:156–160. PubMed Web of Science Google Scholar

25. Chan CC, Boyce S, Brideau C, *et al.* (1995) Pharmacology of a selective cyclooxygenase-2 inhibitor, L-745,337: a novel nonsteroidal anti-inflammatory agent with an ulcerogenic sparing effect in rat and nonhuman primate stomach. *J Pharmacol Exp Ther* **274**:1531–1537. Abstract/FREE Full Text Google Scholar

26. Hull MA, Brough JL, Hawkey CJ (1999) Expression of cyclooxygenase-1 and –2 by human gastric endothelial cells. *Gut* **45**:529. Abstract/FREE Full Text Google Scholar

27. Wu KC, Jackson LM, Galvin AM, *et al.* (1999) Phenotypic and functional characterisation of myofibroblasts, macrophages, and lymphocytes migrating out of the human gastric lamina propria following the loss of epithelial cells. *Gut*, (in press).. Google Scholar

28. Ota S, Razandi M, Krause W, *et al.* (1988) Prostaglandin E output by isolated rat gastric parietal cells and non-parietal epithelial cells. *Prostaglandins* **36**:589–600. CrossRef PubMed Google Scholar

29. Skoglund ML, Gerber JG, Murphy RC, *et al.* (1980) Prostaglandin production by intact isolated gastric parietal cells. *Eur J Pharmacol* **66**:145–148. CrossRef PubMed Google Scholar

30. Payne NA, Gerber JG (1987) Prostaglandin E_2 and [^{14}C] arachidonic acid release by carbachol in the isolated canine parietal cells. *J Pharmacol Exp Ther* **243**:511–516. Abstract/FREE Full Text Google Scholar

31. Ota S, Hata Y, Hiraishi H, *et al.* (1992) The effects of acid secretagogues on protective agents of gastric cells from adult rabbit in vitro. *J Clin Gastroenterol* **14 (suppl 1)** S156–S161. Google Scholar

32. Choquet A, Magous R, Bali J-P (1993) Gastric mucosal endogenous prostanoids are involved in the cellular regulation of acid secretion from isolated parietal cells. *J Pharmacol Exp Ther* **266**:1306–1311. Abstract/FREE Full Text Google Scholar

33. Schepp W, Miederer SE, Ruoff HJ, *et al.* (1986) Isolated cells from human gastric mucosa—studies on physiological and pharmacological regulation. *Klin Wochenschr* **64**:15–22. CrossRef PubMed Google Scholar

34. Kobayashi K, Higuchi K, Arakawa T, *et al.* (1992) Effect of sofalcone on localization of 15-hydroxyprostaglandin dehydrogenase, an enzyme that metabolizes prostaglandin E2, in rat gastric mucosa: An immunohistochemical study. *J Clin Gastroenterol* **14 (suppl 1)** S39–S42. Google Scholar

35. Skoglund ML, Nies AS, Gerber JG (1982) Inhibition of acid secretion in isolated canine parietal cells by prostaglandins. *J Pharmacol Exp Ther* **220**:371–374. Abstract/FREE Full Text Google Scholar

36. Iseki S (1995) Immunocytochemical localization of cyclooxygenase-1 and cyclooxygenase-2 in the rat stomach. *Histochem J* **27**:323–328. CrossRef PubMed Web of Science Google Scholar

37. Rainsford KD, Tsang S, Hunt RH, *et al.* (1995) Effects of non-steroidal anti-inflammatory drugs on prostaglandin H synthase isoenzyme 2 (cyclooxygenase 2) production by porcine gastric mucosa in organ culture. *Inflammopharmacology* **3**:299–310. Google Scholar

38. Tarnawski A, Kidao J, Jaafar S, *et al.* (1997) Expression and localization of cyclooxygenase-2 in normal and ulcerated human gastric mucosa, and in cultured human endothelial cells. *Gastroenterology* **112**:A309. CrossRef Google Scholar

39. Wong A, Fu S, Varanasi RV, *et al.* (1997) Expression of inducible nitric oxide synthase and cyclooxygenase-2 and modulation by omeprazole in Helicobacter pylori gastritis. *Gastroenterology* **112**:A332. CrossRef Google Scholar

40. Seibert K, Zhang Y, Leahy K, *et al.* (1994) Pharmacological and biochemical demonstration of the role of cyclooxygenase 2 in inflammation and pain. *Proc Natl Acad Sci USA* **91**:12013–12017. Abstract/FREE Full Text Google Scholar

41. Harris RC, McKanna JA, Akai Y, *et al.* (1994) Cyclooxygenase-2 is associated with macula densa of rat kidney and increases with salt restriction. *J Clin Invest* **94**:2504–2510. Google Scholar

42. Regier MK, DeWitt DL, Schindler MS, *et al.* (1993) Subcellular localization of prostaglandin endoperoxide synthase-2 in murine 3T3 cells. *Arch Biochem Biophys* **301**:439–444. CrossRef

PubMed Web of Science Google Scholar

43. Regier MK, Otto JC, DeWitt DL, *et al.* (1995) Localization of prostaglandin endoperoxide synthase-1 to the endoplasmic reticulum and nuclear envelope is independent of its C-terminal tetrapeptide-PTEL. *Arch Biochem Biophys* **317**:457–463. CrossRef PubMed Web of Science Google Scholar

44. Morita I, Schindler M, Regier MK, *et al.* (1995) Different intracellular locations for prostaglandin endoperoxide H synthase-1 and -2. *J Biol Chem* **270**:10902–10908. Abstract/FREE Full Text Google Scholar

45. Hudson N, Balsitis M, Filipowicz B, *et al.* (1993) Effect of *Helicobacter pylori* colonisation on gastric mucosal eicosanoid synthesis in patients taking non-steroidal anti-inflammatory drugs. *Gut* **34**:748–751. Abstract/FREE Full Text Google Scholar

46. Sawaoka H, Kawano S, Tsuji S, *et al.* (1998) *Helicobacter pylori* infection induces cyclooxygenase-2 expression in human gastric mucosa. *Prostagland Leukot Essent Fatty Acids* **59**:313–316. CrossRef PubMed Web of Science Google Scholar

47. Wallace JL, Bak A, McKnight W, *et al.* (1998) Cyclooxygenase 1 contributes to inflammatory responses in rats and mice: implications for gastrointestinal toxicity. *Gastroenterology* **115**:101–109. CrossRef PubMed Web of Science Google Scholar

48. Ryan GB, Cliff WJ, Gabbiani G, *et al.* (1974) Myofibroblasts in human granulation tissue. *Hum Pathol* **5**:55–67. CrossRef PubMed Web of Science Google Scholar

49. Nakamura M, Oda M, Inoue J, *et al.* (1995) Plasticity of myofibroblasts appearing in granulation tissues after acetic acid treatment—Effect of bFGF. *Dig Dis Sci* **40**:2477–2480. CrossRef PubMed Web of Science Google Scholar

50. Nakamura M, Oda M, Inoue J, *et al.* (1990) Roles of muscularis mucosae and myofibroblasts in the healing process of acetic acid-induced ulcer. *J Clin Gastroenterol* **12 (suppl 1)** S39–S47. Google Scholar

51. Uribe A, Alam M, Midtvedt T (1992) E2 prostaglandins modulate cell proliferation in the small intestinal epithelium of the rat. *Digestion* **52**:157–164. PubMed Web of Science Google Scholar

52. Saada J, Valentich JD, Powell DW, *et al.* (1997) Myofibroblast differentiation and the regulation of intestinal ion transport. *Gastroenterology* **112**:A398. CrossRef Web of Science Google Scholar

53. ↲ Mahida YR, Beltinger J, Makh S, *et al.* (1997) Adult human colonic subepithelial myofibroblasts express extracellular matrix proteins and cyclooxygenase-1 and -2. *Am J Physiol* **273**:G1341. Abstract/FREE Full Text Google Scholar

54. ↲ Laine L (1999) No evidence of *H. pylori*-NSAID interaction in ulcer formation: results of double-blind, placebo-controlled trials. *Gastroenterology* **116**:A993. Google Scholar

8th United European Gastroenterology Week

The UEGW abstract book (Gut 2000;**47**(suppl III)) has again been produced as a CD-ROM and can be found attached to the inside back cover of this issue.

View Abstract

Footnotes

↲†: Present address: Department of Gastroenterology, Xijing Hospital, Fourth Military Medical University, Xi'an, China

LMJ and KCW contributed equally to this work.

Footnotes

Abbreviations used in this paper:

COX
: cyclooxygenase

NSAIDs
: non-steroidal anti-inflammatory drugs

PG
: prostaglandin

HMFG2
: human milk fat globule 2

EDTA
: ethylenediaminetetra-acetic acid

HBSS
: Hank's balanced salt solution

SDS-PAGE

sodium dodecyl sulphate-polyacrylamide gel electrophoresis

Request Permissions

If you wish to reuse any or all of this article please use the link below which will take you to the Copyright Clearance Center's RightsLink service. You will be able to get a quick price and instant permission to reuse the content in many different ways.

Request permissions

Other content recommended for you

Cyclooxygenase 2-implications on maintenance of gastric mucosal integrity and ulcer healing: controversial issues and perspectives.
F Halter et al., Gut

Localisation of cyclooxygenase 1 and cyclooxygenase 2 in Helicobacter pylori related gastritis and gastric ulcer tissues in humans.
A Tatsuguchi et al., Gut

Phenotypic and functional characterisation of myofibroblasts, macrophages, and lymphocytes migrating out of the human gastric lamina propria following the loss of epithelial cells.
K C Wu et al., Gut

Effect of Helicobacter pylori colonisation on gastric mucosal eicosanoid synthesis in patients taking non-steroidal anti-inflammatory drugs.
N Hudson et al., Gut

PWE-007 Paracrine prostaglandin-E signalling modulates canine gastric epithelial cell migration
P J M Noble et al., Gut

Cdx2 expression and intestinal metaplasia induced by H. pylori infection of gastric cells is regulated by NOD1-mediated innate immune responses
MDLinx

Pirfenidone attenuates IL-1β-induced COX-2 and PGE2 production in orbital fibroblasts through suppression of NF-kB activity

October 26, 2018

TO: Disability Procedures & Services Committee
William Pryor, Chair
James P. Harris, Vice Chair
Herman Santos
Gina Zapanta-Murphy
Marvin Adams, Alternate

FROM: Ricki Contreras, Manager RC
Disability Retirement Services

FOR: November 7, 2018, Disability Procedures and Services Committee Meeting

SUBJECT: **CONSIDER APPLICATION OF DAVID PAIKAL, M.D., AS A LACERA PANEL PHYSICIAN**

On August 7, 2018, staff and Legal Counsel interviewed California Medical Evaluators regarding David Paikal, M.D., a physician seeking appointment to the LACERA Panel of Examining Physicians.

Attached for your review and consideration are:
- Staff's Interview Summary and Recommendation
- Panel Physician Application
- Curriculum Vitae
- Sample Report(s)

IT IS THEREFORE RECOMMENDED THAT THE COMMITTEE accept the staff recommendation to submit the application of David Paikal, M.D., to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

JJP:RC:mb

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

October 26, 2018

TO: Ricki Contreras, Manager
Disability Retirement Services

FROM: Tamara L. Caldwell, DRS Supervisor
Disability Retirement Services

FOR: November 7, 2018 Disability Procedures & Services Committee

SUBJECT: Recommendation for Ophthalmologist Applying for LACERA's Panel of Examining Physicians

RECOMMENDATION

Based on our efforts to provide a diverse panel of examining physicians in several geographic locations throughout Los Angeles and surrounding counties, staff recommends the Application of David Paikal, M.D. be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

On August 7, 2018, staff and Legal Counsel met with California Medical Evaluators at the LACERA offices to discuss several candidates for the LACERA Panel of Examining Physicians. California Medical Evaluators (CME) is a doctor-owned management and marketing company focused on serving the medical and legal communities. CME provides full-service administration of physician's medical-legal practices. CME was founded by Gregory Marusak, MD and Gabor Vari, MD who cumulatively span over two decades of experience in the medical-legal industry. They are both UCLA residency graduates and remain active on the UCLA faculty. Since its inception, CME has steadily grown, adding physicians, staff and offices to better serve clients and community. CME has highly experienced doctors in all specialties throughout California and pride themselves on providing a comprehensive and tailored experience for both legal and medical professionals.

Dr. Paikal is a Southern California native, who graduated high school as a valedictorian. He completed his undergraduate and medical education at UCLA, graduating at the top of his class. He then completed his ophthalmology residency at the world-class UCLA Jules Stein Eye Institute. Dr. Paikal has been practicing comprehensive ophthalmology in the LA area since 2004. He also serves as a clinical instructor at the UCLA Stein Eye Institute, where he regularly instructs medical students on their ophthalmology coursework. He also serves as a Care Harbor and Eye Care America volunteer, providing screening eye examinations for uninsured patients.

Staff reviewed the new LACERA Panel Physician Guidelines with the physician's management team, which included a lengthy discussion regarding the Rules in Evaluating Applicants, Disability Retirement Law Standards, and a thorough explanation of what is expected when preparing Panel Physician's written report for the Board of Retirement. Staff also discussed report submission timeframes, fee schedule and billing procedures, additional diagnostic testing request requirements, and advised of the requirement of maintaining a valid medical license, Board Certification, and insurance coverage. Staff also advised that all physicians must immediately report any lapses, suspensions or revocation of medical license, Board Certification, or insurance coverage, or be subject to immediate suspension or termination from LACERA Panel of Examining Physicians.

CME confirmed that they would be responsible in making sure that Dr. Paikal adhered to the rules set forth in the Guidelines and all other requirements as discussed. CME was informed that a Quality Control Questionnaire is sent to each applicant regarding their visit, which affords the applicant an opportunity to provide feedback concerning their experience during the medical appointment.

On September 21, 2018, Board Medical Advisor Vito Campese, M.D., reviewed Dr. Paikal's application and medical credential and indicated he is in agreement with submitting the Application of David Paikal, M.D. to the Disability Procedures and Services Committee for consideration.

IT IS THEREFORE RECOMMENDED THAT YOUR COMMITTEE adopt staff's recommendation to submit the Application of David Paikal, M.D. to the Board of Retirement for final approval to the LACERA Panel of Examining Physicians.

Attachments

RC:tlc:mb

David Paikal, M.D.
Office Location Details

Location	ADA Parking	ADA Restrooms	Lobby/Waiting Room Seating	Patients Per Day	Average Wait Time	Evaluation Time
16661 Ventura Blvd. Encino, CA 91316	Metered street parking and a pay to park lot with ADA compliant	Yes	12	1-5	0 – 5 Minutes	30 Minutes – 3 Hours

1. CME has 47 employees including, but not limited to, medical assistants, provider liaisons, and administrative support.
2. Bianka Kuretil will be LACERA's point of contact for scheduling appointments and addressing issues and complaints. Contact: 310-625-7475 and bkureti@calmedeval.com
3. Physician review patient history prior to examination.
4. Only CME physicians share these offices for evaluations.

LACERA

Los Angeles County Employees Retirement Association

300 N. Lake Ave., Pasadena, CA 91101 ■ Mail to : PO Box 7060, Pasadena, CA 91109-706 626/564-2419 • 800/786-6464

GENERAL INFORMATION		Date 8/14/18
Group Name: CALIFORNIA MEDICAL EVALUATORS	Physician Name: DAVID DAIKAL, MD	
I. Primary Address: 11620 WILSHIRE BLVD, SUITE 340, LA, CA, 90025		
Contact Person BIANKA KURETI	Title ACCOUNT EXECUTIVE	
Telephone: 888.853.7944	Fax 866.288.9958	
II. Secondary Address 11620 WILSHIRE BLVD, SUITE 340, LA, CA, 90025		
Contact Person DOUGLAS STODDARD	Title VICE PRESIDENT, SALES & MARKETING	
Telephone 323.6453644	Fax 213.377.5152	

PHYSICIAN BACKGROUND		
Field of Specialty OPHTHAIMOLOGY	Subspecialty	
Board Certification ☑ Yes ☐ No	License # A76744	Expiration Date 8/31/2019

EXPERIENCE
Indicate the number of years experience that you have in each category.

Evaluation Type

I. Workers' Compensation Evaluations

- ☐ Defense How Long? ____
- ☐ Applicant How Long? ____
- ☑ AME How Long? 2 years
- ☐ IME How Long? ____
- ☑ QME How Long? 2 years

II. ☐ Disability Evaluations How Long? ____

For What Public or Private Organizations?

Currently Treating? ☑ Yes ☐ No

Time Devoted to: Treatment > 30 % Evaluations ____ %

Estimated Time from Appointment to Examination

- ☒ 2 weeks
- ☐ 3-4 Weeks
- ☐ Over a month

Able to Submit a Final Report in 30 days?

☑ Yes ☐ No

LACERA's Fee Schedule

Examination and Initial Report by Physician	$1,500.00 flat fee
Review of Records by Physician	$350.00/hour
Review of Records by Registered Nurse	$75.00/hour
Supplemental Report	$350.00/hour

-OVER-

Other Fees	
Physician's testimony at Administrative Hearing (includes travel & wait time)	$350.00/hour
Deposition Fee at Physician's office	$350.00/hour
Preparation for Expert Testimony at administrative Hearing	$350.00/hour
Expert Witness Fees in Superior or Appellate Court	$3,500.00 half day $7,000 full day
Physician agrees with LACERA's fee schedule?	No
Comments	

Name of person completing this form:

BIANKA KURETI Title: ACCOUNT EXECUTIVE

(Please Print Name)

Physician Signature: _____ Date: 08/14/2018

FOR OFFICE USE ONLY Physician Interview and Sight Inspection Schedule	
Interview Date:	Interview Time:
Interviewer:	

California Medical Evaluators
11620 Wilshire Blvd., Suite 340
Los Angeles, CA 90025
Ph: 888-853-7944
Fx: 213-478-0550
info@calmedeval.com

David Paikal, M.D., QME
Ophthalmologist

EDUCATION

- **University of California at Los Angeles** *(1996)*

  Bachelor of Science in Cell and Molecular Biology, summa cumme laude

- **UCLA School of Medicine** *(2000)*

  Doctor of Medicine

RESIDENCY

- **UCLA Jules Stein Eye Institute**
  - Los Angeles, CA (2001-2004)

AWARD AND HONORS

- Stafford L. Warren Medal for outstanding achievement throughout 4 years of medical school (6/00)
- Junior AOA and AOA President of class of 2000 (03/99)
- UCLA Medical Center Student Volunteer Scholarship (06/98)
- Dionisia Bertakis Award for Outstanding Oral Presentation at the 1988 Western Student Medical Research Forum (02/99)
- Letters of Distinction in Doctoring 1 & 2 courses, Genetics course and OB/GYN and Surgery Clerkships (8/96 – 6/00)
- Phi Beta Kappa Graduate Study Award (05/96)
- UCLA Deans Honors List for 12 quarters (09/92- 06/96)
- Golden Key National Honor Society (12/94 – present)
- UCLA Honors Program (09/92 – 09/94)
- University High School Valedictorian (06/92)

RESEARCH EXPERIENCE

- Ophthalmology Research – PI Anne Coleman, MD PhD
  - Study of factors which affect the utilization of glaucoma surgeries in the Medicare population
- Ophthalmology Research – PI David A. Lee, MD
  - Study of factors which affect the proliferation of Tenon's capsule Fibroblasts
- Nephrology Research – PI Barton Levine, MD
  - Study of factors which affect phosphate reabsorption in the kidney

PUBLICATIONS

- Paikal D, Yu F, Holland GN, Coleman AL. Coding of glaucoma in uveitis patients in the Medicare database, Submitted to Ophthalmology
- Paikal D, Yu F, Coleman AL. Trends in glaucoma surgery incidence and reimbursement in the Medicare population from 1995 to 1998. Ophthalmology; 109 :1372-6, 2002

- Paikal D, Zhang G, Cheng Q, Lee DA. The effects of integrin antibodies on the attachment and proliferation of human Tenono's capsule fibroblasts. Exp Eye Res. 2000; 70:393-400

David Paikal, M.D., Q.M.E.

DIPLOMATE, AMERICAN BOARD OF OPHTHALMOLOGY
QUALIFIED MEDICAL EXAMINER

All Correspondence To:
11620 Wilshire Boulevard, Suite 340
Los Angeles, CA 90025
Tel: (888) 853-7944
Fax: (213) 377-5152

PANEL QUALIFIED MEDICAL EVALUATION IN THE SPECIALTY OF OPHTHALMOLOGY

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Employer: [redacted]
WCAB No.: [redacted]
Applicant's DOB:
Date of Injury:
Claim No.: [redacted]
Date of Evaluation:
Place of Evaluation:
Interpreter: [redacted]

Dear Parties:

Pursuant to your authorization, the applicant, [redacted] underwent a Panel Qualified Medical Evaluation, in the specialty of Ophthalmology, on [redacted], at my Pomona office. The undersigned acted in the capacity of Panel Qualified Medical Examiner, in the specialty of Ophthalmology.

I, Dr. Paikal, conducted the interview, reviewed all records, formulated the diagnosis, conclusions, and discussion. I also formulated myself the opinion on causation, disability, future care, and apportionment. The report was authored and edited by myself, Dr. Paikal. All opinions expressed are the opinions of Dr. Paikal.

Prior to the evaluation, the entire medical file made available to this physician was fully reviewed. All of the records reviewed were instrumental in this evaluator arriving at the opinions as expressed in this report.

Before I began the examination, the applicant was informed that this evaluation was being done exclusively in connection with the Workers' Compensation claim at the request of an attorney, attorneys or insurance companies, and that no treatment relationship existed. The applicant was also made aware that any communication between us is not privileged (no doctor-patient confidentiality exists) and that any information provided, as well as the results of any testing and my conclusions regarding the case, would be included in a report that may be read by people involved in the resolution and/or litigation of the claim. The applicant was advised of his or her rights pursuant to QME regulation 40. The applicant stated that the aforementioned was understood, and agreed to proceed with the evaluation. The report belongs to the party or parties requesting the evaluation.

BILLING

The report qualifies for Procedure Code **ML-104** as there are "extraordinary circumstances" relating to the medical condition for which this applicant was examined. This code best reflects the time spent and/or the complexity of this evaluation. The best proof in regard to the complexity of this evaluation is the medical/legal report which reflects the complex issues.

This is a Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances **(ML-104)**. The following complexity factors apply:

COMPLEXITY FACTORS

☐ (1) Two or more hours of face-to-face time by the physician

☒ (2) Two or more hours of record review by the physician

☐ (3) Two or more hours of medical research by the physician

☐ (4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor;

☒ (5) Six or more hours spent on any combination of three complexity factors (1)-(3), **which shall count as three complexity factors**

☒ (6) Addressing the issue of medical causation

☐ (7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), or two or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.

☐ (8) A psychiatric or psychological evaluation, which is the primary focus of the medical-legal evaluation

☐ (9) Where the evaluation is performed for injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before June 30 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.

Billed under **ML-104** time spent includes:

Face-to-face interview with the applicant:	**0.50 hours**
Review of medical records:	**7.00 hours**
Preparation, writing and editing of this report:	**2.00 hours**
Medical research:	**0.50 hours**

IDENTIFYTING DATA

The applicant is a -year-old gentleman who resides in [redacted]. He is evaluated today for a claim of injury to his vision on , while an employee of [redacted] Inc.

REVIEW OF FILE

Inadvertently contained in the medical records of [redacted], were a 2-pages report on , which was not related to the case.

NON-MEDICAL RECORD:

Defendant's Advocacy Letter, signed by, [redacted], dated

This letter was addressed to [redacted]. She was to examine the applicant on .

This matter involved an accepted injury on when applicant fell from scaffolding approximately 15 to 20 feet, landing in dirt. He was immediately taken to [redacted] where he was hospitalized for 12 days. He sustained fractures to his face and jaw, skull fractures, compression fractures in his spine, a right ankle fracture, and traumatic brain injury. He had treatment with the following doctors: [redacted] (PTP) for the neurorehabilitation, Dr. [redacted] for the orthopedic injuries, [redacted] for the neurological issues, [redacted] for dental issues, and [redacted] for neuro-psyche. The applicant had also treated with Dr. [redacted] and [redacted] for psychiatric and psychological care. The applicant had been evaluated by PQME [redacted] for the orthopedic injuries.

Attached to this letter was a Schedule of Records/Reports listing all the materials being forwarded to you for your review in connection with your examination of the Applicant and evaluation of the disputed medical issues.

It was requested that the examiner perform a thorough, thoughtful, and unbiased assessment, and address the specific following issues:
1) Please perform the evaluation in full accordance with the standards defined by the Division of Workers' Compensation (DWC) of the State of California and the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition. The evaluation should reflect a qualified independent assessment. Therefore, the history should be complete, including a report of the injury, prior status, clinical chronology, current status, and past medical history. Please compare the history provided by the examinee with the history documented in the medical records. The physical examination should document all pertinent positive, negative, and non-physiological findings. For extremity injuries, please document measurements bilaterally. Please assess whether your physical examination findings are consistent with those of other examiners. Your conclusions must be supportable.

2) As part of this evaluation it is critically important that you provide an opinion on causation of the permanent disability (L.C. §4663(b)). Please identify: a) The overall percentage of permanent disability caused by the industrial injury and b) the percentage of permanent disability due to all other factors, including prior injuries. If you cannot provide an opinion on apportionment, please state why. Per L.C. §4663(c) you are to seek help from another physician to provide the opinion or refer the employee to a physician who can make an apportionment determination. It is important that you ask the examinee if there have been any previous permanent disabilities, physical impairments, awards of permanent disability, or Compromise and Release Agreements. (L.C. §4663(d)). The response to this question must be documented.

3) In order to offer a valid and admissible apportionment opinion, you must state the following:

(a) The exact nature of the disability in as much detail as possible and set forth your reasons for such findings:

(b) You must explain how the disability is casually related to the industrial injury; how the industrial injury caused some of the percentage of permanent disability found by you; and why you have ascribed the percentage of causation to the industrial injury as opposed to nonindustrial factors;

(c) If you found that non-industrial factors caused some percentage of the permanent disability, you must explain the nature of the nonindustrial factor in as much detail as possible that is contributing to the disability, how that non-industrial factor is causing disability at the time of your P&S evaluation, and why it is responsible for the percentage of permanent disability you found.

(d) When considering non-industrial factors, you may consider pathology, asymptomatic conditions, pre-existing disability, or other factors in forming your opinion. You must state your opinion based upon and use the verbage "reasonable medical probability".

(e) Finally, when expressing an apportionment opinion, you must focus on the cause of the permanent disability, not the cause of injury.

4) In terms of the assessment of impairment, please follow the processes defined in the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, with particular reference to Chapter 2, Philosophy, Purpose and Appropriate Use of the Guides, and the applicable chapter(s). You should obtain the applicable data as discussed in the "Principles of Assessment" for each chapter and assure that the data is reliable. Prior to assessing permanent impairment, determine if maximal medical improvement (MMI) has occurred, and, if so, state when it occurred. If not, please provide an estimate of when it is likely this will occur and what will facilitate achieving MMI.

5) When rating impairment, please detail your methodology, including references to Tables, Figures and page numbers.

6) What are the current diagnoses, and which of these are associated with the referenced injury? Please discuss fully these diagnoses and their significance. If applicant has a psychological diagnosis, please fully explain how he meets each criterion for the diagnosis as per the DSMIV-TR, whether he has an Axis II diagnosis and how the Axis II diagnosis affects the Axis I diagnosis, if at all.

7) Please also fully detail applicant's current Global Assessment of Functioning, even if he is not yet permanent and stationary. Please outline why applicant is at a certain level.

8) Please disclose if you are using a computer program in assessing impairment. Please indicate the name and year of the program. Please also disclose if another person is interpreting any psychological testing completed by applicant and their qualifications.

9) Are the subjective complaints supported by objective findings? Please explain the rationale for your conclusions.

10) Are there any non-physiological findings present on examination? Please explain the rationale for your conclusions.

11) Is there evidence of dysfunctional illness behavior? Please explain the rationale for your conclusions.

12) Was the injury a new problem, an aggravation or contribution to a preexisting problem, or does this reflect a temporary exacerbation? Please present your medical conclusions, to a reasonable degree of medical certainty concerning the cause, the effect, and the relationship between the cause and effect. Please explain the rationale for your conclusions.

13) What is the prognosis? What is your basis for this prognosis? Is there an Axis II diagnosis that affects the prognosis?

14) What is the current work capacity and what is applicant's projected work capacity within the next three months? What objective findings serve as the basis for any restrictions?

15) Is the current treatment covered by MTUS Practice Guidelines? If so, is it consistent with MTUS Practice Guidelines? If not covered by MTUS, is the treatment reasonable or necessary to relieve or cure from the effects of the injury? Please explain the rationale for your conclusions.

16) Has the treatment and testing been reasonable and necessary to this point. If no, please specify.

17) Is any of the treatment inappropriate or likely to reinforce dysfunctional illness behavior? Please explain the rationale for your conclusions.

18) Would discontinuation of any of the care currently being rendered result in a deterioration of his/her function? Please explain the rationale for your conclusions.

19) What further diagnostic evaluation and/or treatment are required at this time? Please explain the rationale for your conclusions.

20) Please provide any other information that you feel would be useful in understanding this case.

Defendant's Advocacy Letter, signed by [redacted], dated _____

The examiner agreed to evaluate the applicant in the capacity as the Panel Qualified Medical Evaluator. The applicant was scheduled to be evaluated on

This matter involved an accepted injury on [redacted] when applicant fell from scaffolding approximately 15 to 20 feet, landing in dirt. He was immediately taken to [redacted] where he was hospitalized for 12 days. He sustained fractures to his face and jaw, skull fractures, compression fractures in his spine, a right ankle fracture, and traumatic brain injury. He had treatment with the following doctors: [redacted] (PTP) for the neurorehabilitation, [redacted] for the orthopedic injuries, [redacted] for the neurological issues, [redacted] for dental issues, and [redacted] for neuro-psyche. The applicant had also treated with Dr. [redacted] and [redacted], PhD for psychiatric and psychological care. The applicant had been evaluated by PQME Dr. [redacted] for the orthopedic injuries.

Attached to this letter was a Schedule of Records/Reports listing all the materials being forwarded to you for your review in connection with your examination of the Applicant and evaluation of the disputed medical issues.

It was requested that the examiner perform a thorough, thoughtful, and unbiased assessment, and address the specific following issues:

1) Please perform the evaluation in full accordance with the standards defined by the Division of Workers' Compensation (DWC) of the State of California and the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition. The evaluation should reflect a qualified independent assessment. Therefore, the history should be complete, including a report of the injury, prior status, clinical chronology, current status, and past medical history. Please compare the history provided by the examinee with the history documented in the medical records. The physical examination should document all pertinent positive, negative, and non-physiological findings. For extremity injuries, please document measurements bilaterally. Please assess whether your physical examination findings are consistent with those of other examiners. Your conclusions must be supportable.

2) As part of this evaluation it is critically important that you provide an opinion on causation of the permanent disability (L.C. §4663(b)). Please identify: a) The overall percentage of permanent disability caused by the industrial injury and b) the percentage of permanent disability due to all other factors, including prior injuries. If you cannot provide an opinion on apportionment, please state why. Per L.C. §4663(c) you are to seek help from another physician to provide the opinion or refer the employee to a physician who can make an apportionment determination. It is important that you ask the examinee if there have been any previous permanent disabilities, physical impairments, awards of permanent disability, or Compromise and Release Agreements. (L.C. §4663(d)). The response to this question must be documented.

3) In order to offer a valid and admissible apportionment opinion, you must state the following:
(a) The exact nature of the disability in as much detail as possible and set forth your reasons for such findings:

(b) You must explain how the disability is casually related to the industrial injury; how the industrial injury caused some of the percentage of permanent disability found by you; and why you have ascribed the percentage of causation to the industrial injury as opposed to nonindustrial factors;

(c) If you found that non-industrial factors caused some percentage of the permanent disability, you must explain the nature of the nonindustrial factor in as much detail as possible that is contributing to the disability, how that non-industrial factor is causing disability at the time of your P&S evaluation, and why it is responsible for the percentage of permanent disability you found.

(d) When considering non-industrial factors, you may consider pathology, asymptomatic conditions, pre-existing disability, or other factors in forming your opinion. You must state your opinion based upon and use the verbage "reasonable medical probability".

(e) Finally, when expressing an apportionment opinion, you must focus on the cause of the permanent disability, not the cause of injury.

4) In terms of the assessment of impairment, please follow the processes defined in the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, with particular reference to Chapter 2, Philosophy, Purpose and Appropriate Use of the Guides, and the applicable chapter(s). You should obtain the applicable data as discussed in the "Principles of Assessment" for each chapter and assure that the data is reliable. Prior to assessing permanent impairment, determine if maximal medical improvement (MMI) has occurred, and, if so, state when it occurred. If not, please provide an estimate of when it is likely this will occur and what will facilitate achieving MMI.

5) When rating impairment, please detail your methodology, including references to Tables, Figures and page numbers.

6) What are the current diagnoses, and which of these are associated with the referenced injury? Please discuss fully these diagnoses and their significance. If applicant has a psychological diagnosis, please fully explain how he meets each criterion for the diagnosis as per the DSMIV-TR, whether he has an Axis II diagnosis and how the Axis II diagnosis affects the Axis I diagnosis, if at all.

7) Please also fully detail applicant's current Global Assessment of Functioning, even if he is not yet permanent and stationary. Please outline why applicant is at a certain level.

8) Please disclose if you are using a computer program in assessing impairment. Please indicate the name and year of the program. Please also disclose if another person is interpreting any psychological testing completed by applicant and their qualifications.

9) Are the subjective complaints supported by objective findings? Please explain the rationale for your conclusions.

10) Are there any non-physiological findings present on examination? Please explain the rationale for your conclusions.

11) Is there evidence of dysfunctional illness behavior? Please explain the rationale for your conclusions.

12) Was the injury a new problem, an aggravation or contribution to a preexisting problem, or does this reflect a temporary exacerbation? Please present your medical conclusions, to a reasonable degree of medical certainty concerning the cause, the effect, and the relationship between the cause and effect. Please explain the rationale for your conclusions.

13) What is the prognosis? What is your basis for this prognosis? Is there an Axis II diagnosis that affects the prognosis?

14) What is the current work capacity and what is applicant's projected work capacity within the next three months? What objective findings serve as the basis for any restrictions?

15) Is the current treatment covered by MTUS Practice Guidelines? If so, is it consistent with MTUS Practice Guidelines? If not covered by MTUS, is the treatment reasonable or necessary to relieve or cure from the effects of the injury? Please explain the rationale for your conclusions.

16) Has the treatment and testing been reasonable and necessary to this point. If no, please specify.

17) Is any of the treatment inappropriate or likely to reinforce dysfunctional illness behavior? Please explain the rationale for your conclusions.

18) Would discontinuation of any of the care currently being rendered result in a deterioration of his/her function? Please explain the rationale for your conclusions.

19) What further diagnostic evaluation and/or treatment are required at this time? Please explain the rationale for your conclusions.

20) Please provide any other information that you feel would be useful in understanding this case.

Application for Adjudication of Claim, dated

It was claimed that the applicant sustained a specific injury on while employed as a Body parts injured were head, psych, jaw, neck and ankle. He fell when scaffolding collapsed and he suffered injury to his head, psyche, vision, nose, neck and right ankle.

MEDICAL RECORDS:

Doctor's Ambulance Prehospital Care Report, [redacted] - dated

Summary of Events: The applicant fell at work with chief complain of jaw pain, right ankle pain and confusion. He was placed on manual cspike. He was move to back board in full cpine then was moved to gurney. He was reassessed at emergency room to hospital. His care was given to registered nurse/trauma doctor.

History and Physical, [redacted] - dated

History of Present Trauma: The applicant fell 15 to 20 feet. He had decreased level of consciousness. He had pain on the right ankle.

Physical Examination: There was an 8 cm occipito-parietal laceration. There was tenderness over the bilateral occipital.

Trauma Team Admission Assessment, [redacted] - dated

Consultation Requested: He re quested as orthopedic consultation.

Mechanism of Injury: He fell 15 to 20 feet.

Trauma Team Admission Assessment: He was status post fell from scaffolding 15 to 20 feet. He did not recall the incident.

Trauma Report, by [redacted] M.D., dated

History of Present Illness: The applicant was brought to the trauma unit as a moderate trauma after falling 15-20 feet off scaffolding at a where he was employed as a He apparently fell onto dirt. There was no documented loss of consciousness noted field. At the time of have an alteration in his level of consciousness noted field. At the time of arrival of paramedics, he was noted to have a scalp laceration, a chin laceration, and right ankle deformity. He was placed on a backboard and in cervical collar and brought in by ambulance with vital signs stable during transport. He complained of jaw and right ankle pain on arrival.

Social History: He admitted to social alcohol consumption. His last oral intake was at 0430H in the morning on the day of his admission. Tetanus status was unknown and 0.5 cc of tetanus diphtheria toxoid was administered in the trauma unit. He was employed by [redacted]

Vitals: He had a blood pressure of 154/116 mmHg.

Physical Examination: He had an 8 cm right occipital parietal scalp laceration which was down to calvarium with active hemorrhage. He had blood in the oropharynx with open parasymphyseal fracture of the left mandible.

Consultations: Orthopedic surgical consultation was obtained from [redacted] for his right ankle fracture. Maxillofacial consultation was obtained from Dr. [redacted] for his mandibular fracture.

Impression: He was status post 15-20 foot fall off a scaffold at a work site during the course of his employment for [redacted] He sustained a blunt head trauma, cerebral concussion, and right occipital parietal 8 cm scalp laceration, cervical strain, blunt chest and abdominal trauma requiring observation to rule out internal injury, contusion and abrasion to the right anterior chest wall extending onto the base of the right neck, a 3 cm left submental laceration, trimalleolar fracture of the right ankle, contusion and abrasion to the right posterior elbow.

Plan: He was to be admitted to the trauma surgery service for pain control, wound care, and ongoing tertiary trauma assessment. He had a maxillofacial consultation from [redacted] for the open mandibular body fracture and consultation from Dr. [redacted] or orthopedic surgery for the right ankle fracture.

Consultation Report, [redacted] - [redacted], dated [redacted],

The applicant was seen for evaluation and treatment of mandibular fracture and maxillofacial surgery.

History of Present Illness: He fell from scaffolding onto the dirt earlier this morning. He was admitted to the [redacted] Trauma Surgery service for multiple traumas. He was asked to be evaluated for his mandibular fracture. His medical records were reviewed. He was interviewed in his hospital room. He was examined at bedside. He reported moderate jaw pain. He had a new-onset malocclusion and reposts that he had paresthesia at the lower lip and chin.

Social History: He consumed alcohol occasionally.

Physical Examination: There was a scalp laceration over the right posterior parietal occipital area. The laceration was currently closed and hemostatic.

There was significant edema over the submental area and also mobility of the mandibular segments at the left parasymphysis left body region.

There was mucosal laceration into the left parasymphysis body fracture of the mandible. The laceration was communicating into the mandibular fracture on the left side. There was edema and ecchymosis at the anterior floor of the mouth. The laceration was currently hemostatic without any bleeding.

There was a 2 cm laceration over the left submandibular area. The laceration appeared to be through skin and then through the platysma muscle.

Imaging: The CT scan of the facial bones appeared to show a comminuted displaced fracture of the left mandible. The fracture appeared to be extending from the left mandibular body to the right mandibular parasymphysis area.

Impression: Comminuted and displaced left mandibular body/parasymphysis fracture.

Recommendation: Risks and benefits of the surgical recommendation were also discussed in detail. He wanted to proceed with the surgical recommendation.

Medical Report, [redacted] dated

History of Present Illness: The applicant presented this morning after a fall from scaffolding while working. The scaffold was approximately 15 feet high. He was trauma activation and underwent a full trauma evaluation by [redacted] Currently he was seen resting comfortably in the trauma bar. He had pain in his jaw, neck and right ankle. A full orthopedic trauma exam was done. There was tenderness to palpation of the right clavicle. The right ankle was in splint.

Plan: Treatment options included closed treat6ment with a splint and non-weight bearing. Another options included open reduction mid internal fixation of the right ankle.

Medical Report, signed by [redacted] dated

History of Present Illness: The applicant was brought to the trauma unit as a moderate trauma after falling 15 to 20 feet off scaffolding at a
where he was employed as a He apparently fell onto dirt. There was no documented loss of consciousness, although he did have an alteration in his level of consciousness noted field. At the time of arrival of paramedics, he was noted to have a scalp laceration, a chin laceration, and right ankle deformity. He was placed on a backboard and in a cervical collar, and brought in by ambulance with vital signs stable during transport. He complained of jaw and right ankle pain on arrival.

Physical Examination: There was 8 cm right occipital parietal scalp laceration which was down to calvarium with active hemorrhage. He had blood in the oropharynx with open parasymphyseal fracture of the left mandible.

Impressions: Status post 15 t0 20 foot fall off a scaffold at work site. He sustained a blunt head trauma, cerebral concussion, and right occipital parietal 8 cm scalp laceration, cervical strain, blunt chest and abdominal trauma requiring observation to rule out internal injury, contusion and abrasion to the right anterior chest wall extending onto the base of the right neck, a 3 cm left submental laceration, trimalleolar fracture of the right ankle, contusion and abrasion to the right posterior elbow.

Plan: He was admitted to the trauma surgery for pain control, wound care and ongoing tertiary trauma assessment.

Procedure Report, by [redacted]., dated [redacted]

Procedures: The applicant underwent focused abdominal sonogram and limited cardiac ultrasound for trauma; moderate complexity repair of right occipitoparietal scalp laceration and closed reduction with manipulation of right trimalleolar ankle fracture.

Preprocedure Diagnosis: Status post 15-20 foot fall off a scaffolding with blunt chest and abdominal trauma, complex full-thickness 8 cm right occipitoparietal scalp laceration, and a right trimalleolar ankle fracture.

Postprocedure Diagnosis: Status post 15-20 foot fall a scaffolding with blunt chest and abdominal trauma, complex full-thickness 8 cm right occipitoparietal scalp laceration, and a right trimalleolar ankle fracture, no evidence of cardiac or intra-abdominal injury.

CT of the Brain without Contrast, [redacted] dated [redacted]

Impression: 1) Right posterior scalp swelling and associated laceration. Calvarium was intact. 2) No evidence for acute intracranial abnormality.

CT of the Face without Contrast, by [redacted] dated [redacted]

Impression: 1) Comminuted fracture of the anterior inferior aspect of the mandibular body on the left with extension across the mental protuberance into the anterior inferior aspect of the right mandibular body. 2) 2 mm displacement with fracture line extending between the left mandibular lateral incisor and canine tooth. 3) No other facial bone fracture was seen. 4) Globes and orbits were intact. 5) Minimal mucosal thickening at the base of the maxillary sinuses, right greater than left, without traumatic air fluid levels in the visualized paranasal sinuses.

CT of the Thoracic without IV, [redacted] dated [redacted]

Impression: Unremarkable CT examination of the thoracic spine.

CT of Abdomen and Pelvis with IV, [redacted] dated [redacted]

Impression: No CT evidence for acute injury in the abdomen or pelvis.

CT Scan of the Lumbar Spine without Contrast, by [redacted] dated [redacted]

Impression: No CT evidence for acute fracture or subluxation in the lumbar spine.

Mount Sheet, [redacted] - [redacted]a dated [redacted]

The applicant was monitored by an electrocardiogram.

The report was poorly reproduced.

Laboratory Report, [redacted] – [redacted]a, dated [redacted]

IC was high at 0.6 (0.0-0.5).

Laboratory Report, [redacted] dated [redacted]

There was high glucose at 138.

Procedure Report, [redacted] - [redacted]a dated [redacted]

Preoperative and Postoperative Diagnosis: Right ankle fracture.

Procedure: The applicant underwent open reduction and internal fixation of the right ankle.

Intraoperative Right Ankle, by [redacted] dated [redacted]

Findings/Impression: Fluoroscopic assistance was provided for [redacted] in the operating room with a total fluoroscopic time of 25 seconds.

There were 2 spot images of the right ankle submitted for review. There was anatomic alignment of the medial malleolar fracture and the distal fibular fracture, status post ORIF. Ankle mortise was intact. There was ankle soft tissue swelling.

Intraoperative of the Right Ankle, by [redacted] dated [redacted]

Findings/Impression: Fluoroscopic assistance was provided. There were 2 spot images of the right ankle submitted. There was anatomic alignment of the medial malleolar fracture and the distal fibular fracture, status post ORIF. Ankle mortise was intact. There was ankle soft tissue swelling.

CT of the Cervical Spine without Contast, by [redacted], dated

Impression: 1) Straightening of the normal cervical lordosis, likely positional. 2) No CT evidence for acute fracture or subluxation in the cervical spine.

CT of the Chest with Contrast, by [redacted] dated

Impression: 1) No CT evidence for acute injury in the chest. 2) Incidentally noted was a 7 mm pulmonary micronodule in the posterior right upper lobe with central calcifications suggesting a benign etiology. If there was a clinical history of lung cancer risk factors, follow-up chest CT in 6 to 12 months might be considered.

Portable Chest Radiograph, by [redacted] dated

Impression: No radiographic evidence for an acute cardiopulmonary process.

Portable Chest, by [redacted] dated

Impression: 1) No acute cardiopulmonary disease. 2) Limited examination due to respiratory motion.

Right Ankle Radiographs, by [redacted] dated

Impression: 1) Suspected trimalleolar fracture. 2) Widening of the anterior ankle mortise joint space. 3) No ankle dislocation. 4) Circumferential ankle soft tissue swelling.

Right Ankle Examination, by [redacted] dated

Impression: Status post open reduction and internal fixation with the bones in near anatomic alignment.

Laboratory Report, [redacted] - a, dated

White blood cell was high at 9.4 (4.2-9.1), low red blood cell at 4.32 (4.63-6.08), low hemoglobin at 12.6 (13.7-17.3), low hematocrit at 38.2 (40.1-51.0), sigs was high at 76 (34-68), lymphs was low at 14 (22-53) and EOS was low at 0 (1-7).

Laboratory Report, [redacted] dated

There was high glucose at 132.

Procedure Report, by [redacted]., dated

Pre-Operative and Post-Operative Diagnosis: Displaced and comminuted fracture of the left side of the mandible involving the symphisis and left mandibular body.

The applicant underwent open reduction and internal fixation of left mandibular fracture.

Physician Orders, [redacted] - , dated

Post-Operative Orders: The applicant was to be transferred to 4th floor. His condition was stable. Vital signs would be monitored per protocol. He was to be on bed rest. The head of bed was to be elevated at 30 degrees.

The rest of the report is illegible.

CT of Facial without IV, [redacted] - , dated

Impression: Postoperative changes in a patient status post open reduction and internal fixation and internal fixation of mandibular fracture. No complication was seen. Alignment was anatomic.

Physician Orders, [redacted] - , dated

The applicant was to have CBC and BMP on . He was to be given Protonix 40 mg. CT scan of the facial bones without contrast was ordered. He was status post open reduction and internal fixation mandibular fracture.

The rest of the report is illegible.

Portable Chest, by [redacted] dated

Findings: Frontal view of the chest was evaluated.

Physician Orders, [redacted] - , dated

The applicant was to have physical therapy evaluation twice daily for 6 weeks.

Laboratory Report, [redacted] - a, dated (

The hematology panel showed low RBC at 3.52, hemoglobin at 10.3, hematocrit at 30.7 and lymphs at 15 and high seg 72.

Physician Orders, [redacted] - a, dated

The applicant was to be evaluated for St. [redacted] to Dr. [redacted].

The rest of the report is illegible.

Operating Room, [redacted] - a, dated

Pre-Operative Diagnosis: Left mandible fracture.

The applicant was to undergo open reduction and internal fixation left mandible fracture; irrigation and debridement of left neck wound.

Discharge Summary, by [redacted] dated

The applicant was admitted on (and was to be discharged on

Admitting and Discharge Diagnoses: 1) Status post 15-20 foot fall. 2) Blunt head trauma with traumatic brain injury. 3) An 8 cm right occipital parietal scalp laceration. 4) Open left mandibular fracture with a 3 cm left submandibular laceration. 5) Blunt chest and abdominal trauma requiring observation to rule out internal injury. 6) Trimalleolar right ankle fracture.

He underwent open reduction and internal fixation of trimalleolar right ankle fracture by [redacted] and open reduction and internal fixation of mandibular fracture by [redacted].

Reason for Admission: The applicant was brought to the trauma unit as a moderate trauma after falling 15-20 feet from scaffolding at his work site. He had altered level of consciousness in the field, had chin and scalp lacerations identified, and deformity of the right ankle. He complained of jaw and ankle pain at the time of arrival.

Hospital Course: He was admitted to the Trauma surgery service through the Trauma unit. He underwent repair of his right occipital parietal scalp laceration. Orthopedic surgical consultation was obtained for his trimalleolar fracture of the

right ankle. He had of oral maxillofacial consultation from [redacted] for the applicant's open mandibular fracture.

The applicant was admitted to the trauma surgery service and was taken to the operating room by [redacted] initially for the open reduction and internal fixation of his ankle fracture. The following day, the applicant was taken to the OR for open reduction and internal fixation of his mandibular fracture. Postoperatively, he was mobilized with the aid of physical therapy. At the time of transfer, his intermaxillary fixation had been removed. He was tolerating a dental soft diet and ambulating with a walker. He remained non-weight bearing on the right lower extremity, but had a Cam walker in place.

He was to be discharged to for rehabilitation. He would continue on a dental soft diet. He remained non-weight bearing on the right lower extremity. He was taking Lortab elixir for pain. His condition at the time of discharge was satisfactory, and there were no complications during his hospital stay.

Patient Transfer and Referral Record, [redacted] - a, dated

[redacted] was the physician in charge of the applicant and would transfer the care to [redacted].

The applicant was to follow up with [redacted] in 2 weeks and should call [redacted] for appointment.

Rehab Daily Progress Note, signed by [redacted] dated

The applicant was medically stable.

Impression: Multiple orthopedic injuries.

Plan: He was to be placed for acute rehabilitation.

Rehab Progress Note, signed by [redacted]., dated

The applicant's jaw pain was improved today; controlled with pain medications. He had no headaches.

Objective: HEENT: Eyes: Pupils were equal, round, react to light, accommodation.

Assessment: He was medically stable. He was to continue on soft diet.

Impression: Multiple orthopedic injuries.

Plan: He was to be discharged to home. He was to be placed for acute rehabilitation which included family training, trial home visit, and weekly team conference discharge.

Rehab Progress Note, signed by [redacted]., dated

The applicant's jaw pain was improved today; controlled with pain medications. He had no headaches.

Objective: HEENT: Eyes: Pupils were equal, round, react to light, accommodation.

Assessment: He was medically stable. Pain in left jaw continued to improve.

Impression: 1) Multiple orthopedic injuries, status post motor vehicle accident. 2) Left comminuted mandible fracture, status post open reduction and internal fixation. 3) Difficulty walking, non-weight bearing right lower extremity.

Plan: He was to be discharged to home. He was to be placed for acute rehabilitation which included family training, trial home visit, and weekly team conference discharge.

Rehab Progress Note, by [redacted] dated

The applicant's jaw pain was improved today; controlled with pain medications. He had no headaches.

Objective: HEENT: Eyes: Pupils were equal, round, react to light, accommodation.

Assessment: He was doing well.

Impression: 1) Multiple orthopedic injuries, status post motor vehicle accident. 2) Left comminuted mandible fracture, status post open reduction and internal fixation. 3) Difficulty walking, non-weight bearing right lower extremity.

Plan: He was to be discharged to home. He was to be placed for acute rehabilitation which included family training, trial home visit, and weekly team conference discharge.

Rehab Progress Note, signed by [redacted] dated _____

The applicant's jaw pain was improved today; controlled with pain medications. He had no headaches.

Objective: HEENT: Eyes: Pupils were equal, round, react to light, accommodation.

Assessment: He was medically stable, intermittent ankle pain. The surgical site was healed on the scalp. He was functionally improved.

Impression: 1) Multiple orthopedic injuries, status post motor vehicle accident. 2) Left comminuted mandible fracture, status post open reduction and internal fixation. 3) Difficulty walking, non-weight bearing right lower extremity.

Plan: He was to be discharged to home. He was to have family training. He was prescribed Norco for pain. He was to follow up with his primary treating physician and orthopedist. Staples were discontinued.

Audiogram, [redacted] dated _____.

Note: Normal hearing 250 to 2000, moderate loss at 4000, normal hearing at 8000 bilaterally.

Medical Report, signed by [redacted] dated _____

The applicant was seen this morning for a comprehensive hearing evaluation. He suffered a traumatic brain injury. He reported no family history of hearing loss, tinnitus, pain, pressure, ototoxic drug use or excessive noise exposure.

He underwent tympanometry which was within normal limits bilaterally.

He also underwent behavioral audiometry which showed that on the right ear, the hearing sensitivity was within normal limits from 250-2000 Hz, sloping to a moderate sensorineural hearing loss from 3000-4000 Hz and rising to within normal limits from 6000-8000 Hz. Air thresholds were consistent with those of bone. With the left ear, the hearing sensitivity was within normal limits from 250-2000 Hz, sloping to a moderate sensorineural hearing loss from 3000-6000 Hz and

rising to within normal limits at 8000 Hz. Air thresholds were consistent with those of bone.

He also had word recognition scores which showed excellent results to both ears.

Impression: The combined result of today's tests was consistent with a bilateral high-frequency moderate sensorineural hearing loss. Middle ear function, as measured using tympanometry, was within normal limits, bilaterally.

Recommendations: He was recommended to binaural Oticon Alto Pro Receiver-in-the-Ear (RITE) hearing aids and 1-year supply of batteries.

Progress Notes, signed by [redacted] dated

The applicant sustained a work-related injury while performing his usual and customary duties as a on . He fell 15-20 foot off of scaffold onto dirt without documented loss of consciousness but with altered loss of consciousness. His first memory was of walking on wall with wood on his shoulder and stepping on something that gave away. His first memory was of being in the hospital. His GCS was 15. He was brought to [redacted] and injuries included scalp and chin lacs. His had right ankle trimalleolar fracture and comminuted anterior mandibular fracture. His CT scan of the head, cervical spine, abdomen/pelvis, thoracic spine, and lumbar spine were negative. He underwent mandibular and right ankle open reduction and internal fixation. Once medically stable, he was transferred to [redacted] on for neurorehabilitation as he also demonstrated impaired cognition from trauma brain injury. He was subsequently discharged home. He enrolled in [redacted] TLC Day Treatment Program on .

Interval History: He was last seen on and returned today for follow up.

Since his last visit, he had continued with TLC day treatment, 5 full days/week and had been progressing.

Subjective Complaints: He had head pain located in right occipital area, site of impact. The right side of the neck felt "tight." He had not yet been back to Dr. [redacted] for occipital nerve blocks but today would like to defer as felt that Neurontin was also helping with this pain.

He had blurred vision. He had an appointment with [redacted] on but had to reschedule to August. The applicant stated his eyes got tired easily but had been doing visual therapy with therapists.

He had constant, increased with chewing. He was told that nerves to teeth were damaged, thus causing pain. He saw [redacted] who recommended neuro referral for anterior mandibular dysesthesias likely neuropathic. The applicant had seen [redacted] in the past. The applicant was tolerating Neurontin and stating today that area of pain and intensity of pain had decreased.

His hearing was improved with bilateral hearing aids.

He also had right foot pain.

He had impaired cognition and behavioral changes.

HEENT: Nc, healed laceration. There was tenderness over the right occipital area but without radiation.

Diagnoses: 1) Brain injury. 2) Ankle fracture. 3) Mandible fracture. 4) Neuropathic pain, jaw. 5) Impaired cognition. 6) Cognitive and behavioral changes. 7) Impaired vision.

Disability Status: He was currently on TTD until approximately

Causation: The mechanism of injury was consistent with his current impairments and disabilities.

Apportionment: He was deferred to maximum medical improvement/permanent and stationary.

Restrictions: He was not allowed to drive, go to unprotected heights, go to distracting environment and as per ortho and neuro.

Treatment Plan: He was to decrease attendance at [redacted] TLC 3 times a day per week for 4 weeks once family counseling was in place. He was to undergo counseling with psychologist/neuropsychologist. He was to continue Depakote 500 mg. He was to consider trial of Effexor in the future.

Multidisciplinary Progress Report, [redacted] dated

The applicant was initially admitted to [redacted] trauma center on after he fell 15 to 20 feet off a scaffold at the where he was employed as a . He reportedly fell onto dirt. There was no documented loss of consciousness; however, there was an alteration in his consciousness at the field. He had a scalp laceration and chin laceration as well a right ankle deformity on arrival. Further evaluation revealed that his GCS was 15.

He was able to move all extremities. He had decreased movement in the right foot and ankle secondary to a right ankle fracture - trimalleolar.

Impression: Traumatic Brain injury as a result of mechanical fall at work, comminuted fracture of the mandible, status post open reduction and internal fixation, fracture right ankle status post open reduction and internal fixation, Impaired cognitive function with decrease in orientation, memory, attention and problem solving.

Diagnosis: Trauma brain injury, posttraumatic headache- multifactorial with autonomic features, tension headache, occipital neuralgia.

Case Manager Weekly Summary: In occupational therapy, he was to be engaged in 2 English language learning classes, demonstrating increased motivation and participation with improved initiation. He was to maintain status for safe navigation within the community, however continued to require Setup for route planning and schedule reading of public transportation systems.

In physical therapy, he was to have gait velocity 1.23 m/s without SPC, improved left step length, decreased lateral trunk lean, and decreased hip external rotation. He had intermittently applied plantar strapping tape technique to right foot in order to improve midfoot stability which had in turn improved gait mechanics and his report of right ankle pain had improved.

In speech therapy, he was to recall of newly learned information within session: slight improvement at a range of 90%-95% accuracy-Mod I; Divided attention - dual cognitive moderate complex had improved to 80%-90% accuracy with Sup A within mildly distracting environments.

Safety Concerns: He required distant supervision in moderate complex problem solving due to decreased attention memory, and insight into cognitive deficits.

Neuro-optometry Consultation, by [redacted] O.D., dated .

History of Present Illness: The applicant had sustained a traumatic brain injury on when he had fallen approximately 15 to 20 feet off scaffold at a where he was employed as a . It was noted in his medical records, there was no documented loss of consciousness, however, he reported having no recall of the event other than seeing a piece of metal break and then he subsequently found that he had awoken In the hospital.

He had blurred vision. He felt his right eye was worse than his left eye. This was his first examination. He has no history of wearing glasses.

HEENT: Entering unaided distance acuities were approximately 20/30 for each eye. Near acuities was 20/50 for each eye. Static and manifest refraction were in close to revealing low myopic astigmatism and no presbyopia. Cover testing revealed orthophoric postures at both distance and near. Ocular motilities were full and symmetric. Pupils were 4 mm equal, round, and reactive to light with no APD. Visual fields by confrontation were full. Binocular function revealed 9 XOP with no hyper at distance and 9 XOP at near. Neuro-motor examination showed no head turn or tilt but good ocular cosmesis. Slit-lamp examination showed anterior chambers deep and quite. Cornea appeared clear. Conjunctivae and sclerae appeared clear. Right lens revealed lenticular changes. Left lens was clear. Intraocular pressures by Tono-Pen were right 25/27 mmHg, left 25/25 mmHg.

Impression: 1) Traumatic cataract, not significant enough to require surgery at this time. 2) Ocular hypertension.

Recommendations: He was to return to clinic in a week for a repeat intraocular pressures, pachymetry, corneoscopy, and visual field and dilated fundus examinations.

Multidisciplinary Progress Report, [redacted] dated 1.

Case Manager Weekly Summary: In occupational therapy, the applicant continued to participate in ESL programs with improved carryover of program functionality as well as increased use of simple English terms and phrases outside of structured setting.

In physical therapy, there was no change in gait velocity this reporting period, however was using SPC only for long distances to manage ankle pain since receiving orthotics. (Improved)

In speech therapy, he had improved to 100% return called for 24 hours; 0/2 completion for 72-96 hours.

Safety Concerns: He required distant supervision in moderate complex problem solving due to decreased attention, memory, and insight into cognitive deficits

Progress Notes, signed by [redacted] dated

Diagnoses: 1) Brain injury. 2) Ankle fracture. 3) Mandible fracture. 4) Neuropathic pain, jaw. 5) Impaired cognition. 6) Cognitive and behavioral changes. 7) Impaired vision.

The applicant did not have transition to 3 days/week as was unable to set up family counseling with Spanish speaking psychologist from [redacted] group until October.

Treatment Recommendations: [redacted] was to perform family counseling until [redacted] group was available so that applicant could transition to 3-day/week program. The applicant was to decrease TLC day program 3 days in a week for 4 weeks to see how he did with transition to home and outpatient therapy once family counseling was in place with [redacted]

Progress Notes, signed by [redacted]., dated .

Interval History: The applicant returned for follow up.

Subjective Complaints: He had head pain located in right occipital area, site of impact. The right side of the neck felt "tight." He had not yet been back to Dr. [redacted] for occipital nerve blocks but today would like to defer as felt that Neurontin was also helping with this pain. The applicant remained resolved with Neurontin.

He had blurred vision. He had an appointment with [redacted] on but was waiting additional testing with Humprey visual field analyzer. The applicant stated his eyes got tired easily but had been doing visual therapy with therapists.

He had constant, increased with chewing. He was told that nerves to teeth were damaged, thus causing pain. He saw [redacted] who recommended neuro referral for anterior mandibular dysesthesias likely neuropathic. The applicant had seen Dr. [redacted] in the past. The applicant was tolerating Neurontin and stating today that area of pain and intensity of pain had decreased. He had jaw pain when 1st turned on air conditioning and pain with chewing peanuts but stated was warned by dentist not to eat hard foods. He had x-rays last week and was told all was okay.

His hearing was improved with bilateral hearing aids.

He also had right foot pain.

He had impaired cognition and behavioral changes.

HEENT: Nc, healed laceration. There was tenderness over the right occipital area but without radiation.

Diagnoses: 1) Brain injury. 2) Ankle fracture. 3) Mandible fracture. 4) Neuropathic pain, jaw. 5) Impaired cognition. 6) Cognitive and behavioral changes. 7) Impaired vision.

Disability Status: He was currently on TTD until approximately

Causation: The mechanism of injury was consistent with his current impairments and disabilities.

Apportionment: He was deferred to maximum medical improvement/permanent and stationary.

Restrictions: He was not allowed to drive, go to unprotected heights, go to distracting environment and as per ortho and neuro.

Treatment Plan: He was to decrease attendance at [redacted] TLC 3 times a day per week for 4 weeks once family counseling was in place. He was to undergo counseling with psychologist/neuropsychologist. He was to continue Depakote 500 mg. He was to consider trial of Effexor in the future. He was to follow up with primary care physician. He was to have neuropsych evaluation. Broken ankle brace was replaced. He was to hold off on occipital nerve block for now. He was to have TENS unit for pain control. He had bilateral foot orthotics. He was to follow up in 6 weeks.

Multidisciplinary Progress Report, [redacted] dated

Case Manager Weekly Summary: In occupational therapy, the applicant demonstrated increase use of common English words and phrases; however, required verbal prompts to initiate within a structured setting.

In physical therapy, he was no longer using a single point cane for ambulation within the home/therapy, used only for longer distances outside of therapies for pain management 6 minute walk test: 1526 feet (75% of age/gender matched norm) (improved).

Safety Concerns: He required distant supervision in moderate complex problem solving due to decreased attention, memory, and insight into cognitive deficits.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy. He had cardio, core strength, and community/work reintegration.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy. He had community/work reintegration.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy. He had community/work reintegration.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy. He had cardio, core strength, stretching.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy. He had community/work reintegration and education.

Neurorehabilitation Primary Treating Physician Progress Report, signed by [redacted] dated

Interval History: The applicant had transitioned to TLC day treatment 3 full days/week and continued to progress.

Subjective Complaints: He had head pain located in right occipital area, site of impact. The right side of the neck felt "tight." He had not yet been back to [redacted] for occipital nerve blocks but today would like to defer as felt that Neurontin was also helping with this pain. The applicant remained resolved with Neurontin.

He had blurred vision. He had an appointment with [redacted] on [redacted] but was awaiting additional testing with Humprey visual field analyzer. The applicant stated his eyes got tired easily but had been doing visual therapy with therapists. His left eye "falls" and he had been having twitching left eyelid.

He had constant, increased with chewing. He was told that nerves to teeth were damaged, thus causing pain. He saw [redacted] who recommended neuro referral for anterior mandibular dysesthesias likely neuropathic. The applicant had seen [redacted] in the past. The applicant was tolerating Neurontin and stating today that area of pain and intensity of pain had decreased. He had jaw pain when 1st turned on air conditioning and pain with chewing peanuts but stated was warned by dentist not to eat hard foods. He had x-rays last week and was told all was okay.

His hearing was improved with bilateral hearing aids.

He also had right foot pain.

He had impaired cognition and behavioral changes.

HEENT: Nc, healed laceration. There was mild left lower medial eyelid twitching.

Diagnoses: 1) Brain injury. 2) Ankle fracture. 3) Mandible fracture. 4) Neuropathic pain, jaw. 5) Impaired cognition. 6) Cognitive and behavioral changes. 7) Impaired vision.

Disability Status: He was currently on TTD until approximately February 10, 2015.

Causation: The mechanism of injury was consistent with his current impairments and disabilities.

Apportionment: He was deferred to maximum medical improvement/permanent and stationary.

Restrictions: He was not allowed to drive, go to unprotected heights, go to distracting environment and as per ortho and neuro.

Treatment Plan: He was to continue with attendance at [redacted] TLC 3 times a day per week for 4 weeks. He was to undergo counseling with psychologist/neuropsychologist. He was to follow up with [redacted] for current visual issues. The applicant was to continue Depakote 500 mg. He was to consider trial of Effexor in the future. He was to follow up with primary care physician and all specialists. He was to have neuropsych evaluation. Broken ankle brace was replaced. He was to hold off on occipital nerve block for now. He was to have TENS unit for pain control. He had bilateral foot orthotics. He was to follow up in 6 weeks. He was given trial of Amantadine.

Team Conference Note, signed by [redacted], M.D., dated [redacted]

The applicant was initially admitted to [redacted] Trauma Center on [redacted] after he fell 15-20 feet off a scaffold at the [redacted] where he was employed as a [redacted]. He reportedly fell onto dirt. He had alteration in his consciousness at the field. He had scalp laceration and chin laceration as well as right ankle deformity on arrival. His GCS was 15. He was able to move all extremities. He had decreased movement in the right foot and ankle secondary to a right ankle fracture – trimalleolar.

Impression: Traumatic brain injury as a result of mechanical fall at work, comminuted fracture of the mandible, status post open reduction and internal fixation, fracture right ankle status post open reduction and internal fixation, impaired cognitive function with decrease in orientation, memory, attention and problem solving.

Case Management:

Discharge Plan: He was presently at home with family.

Safety Issues: At present time, he did not present with significant behaviors that placed him at risk. He appeared to have a functional understanding with regard to his limitations, and did not exhibit significant impulsive behaviors.

Physical therapy: He had improved to be Independent with structured strengthening and endurance program at TLC and in the outpatient fitness center, with no cues required for safety or proper use of familiar exercise equipment Min A at community gym for general fitness program.

He was no longer using a cane for short distance ambulation within the home and community secondary to improved right ankle stability and decreased right ankle pain.

Safety Issues: Decreased safety awareness.

Occupational Therapy: He progressed to Setup in transportation group, bus outing. He was able to plan and complete simple one transfer bus route within a small group and was moderated I for carry over of schedule reading strategies.

He demonstrated improved thought organization, sequencing and communication skins for collaborative woodshop activity.

He self-initiated usage of simple English words and phrases in structured and unstructured settlings. Demonstrating increased carry over, motivation and participation within ESL group.

In speech therapy, he recalled of events post 24 hours. He completed 2/2 calls post 5 hours from zero completed last reporting period. He was independently initiating use of trained compensatory strategies during most memory activities.

Safety Issues: He had reduced initiation of requests for assistance when needed.

In Neuropsychology, he presented with somewhat stable cognitive functioning. However, while he was showing some improvement in memory and initiation there continue to be challenges with social emotional regulation. These were particularly problematic in the home, interacting with this family.

He was much motored in participating in therapy; however, while he was able to identify how others would benefit from therapy. It was more difficult for him to identify that in his own behavior. Family therapy continued to be an area of need that was being coordinated. He continued to require support with regard to establishing and maintaining a productive day.

He did not present as an imminent danger to himself or others. He had functional insight as to the nature and extent of his injury, and did not exhibit impulsive behaviors that warrant 1:1 or a highly structured level of supervision. Again, family therapy was strongly recommended in order to support his success as he transitioned to less intensive levels of therapy.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy

Neurorehabilitation TLC Team Conference Note, signed by [redacted] M.D., dated

Diagnoses: 1) Brain injury. 2) Ankle fracture. 3) Mandible fracture. 4) Neuropathic pain, jaw. 5) Impaired cognition. 6) Cognitive and behavioral changes. 7) Impaired vision.

The applicant was asking for MWF as felt 4 days in a row with wife at home was too much.

Treatment Recommendations: He was to continue with TLC Day program 3 days/week for 3-4 weeks. [redacted] was to continue with family counseling until [redacted] group was available for regular family counseling sessions. The staff was to identify structure productive day activities for the 2 days that the applicant was not at day program. The applicant was to consider computer-based cognitive programs such as lumosity as an adjunct to speech therapy. He would need advice to access these types of program.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy

Physical Therapy Daily Notes, [redacted] dated [redacted].

The applicant underwent physical therapy

Physical Therapy Daily Notes, [redacted] dated [redacted].

The applicant underwent physical therapy

Physical Therapy Daily Notes, [redacted] dated [redacted]

The applicant underwent physical therapy

Physical Therapy Daily Notes, [redacted] dated [redacted].

The applicant underwent physical therapy

Physical Therapy Daily Notes, [redacted] dated [redacted].

The applicant underwent physical therapy

Psychodiagnostic Consultation, signed by [redacted] Ph.D., dated [redacted]

Reason for Referral: The applicant was referred for a neuropsychological evaluation in order to assess his current level of cognitive functioning and to provide recommendations for treatment.

History of Present-Illness and Background Information: He worked for [redacted] as a [redacted]. His duties included finishing and touching up, "I did all kinds of things at the [redacted]."

While performing his usual and customary duties, he was setting up a scaffold, "When I stepped on the scaffold, something broke. The next thing I know is waking up at the hospital."

He believed that he was unconscious for several hours, but he was not sure. His first memory after the accident was waking up at the hospital, "I was very afraid and angry at the same time. I didn't know why that had to happen to me." He remained hospitalized for about two weeks, before being transferred to [redacted] where he remained for another 2 weeks before being discharged home. He was followed up by a neurologist, an orthopedic doctor, and a temporomandibular joint pain specialist. He was referred to [redacted] Hospital in [redacted]. [redacted] became his Primary Treating Physician. The applicant had been attending

the TLC program as an outpatient from 9:00 AM – 3:00 PM. [redacted] prescribed medications for pain and for mood.

The applicant denied having any surgeries since he was discharged from the hospital. He had a temporomandibular joint reconstruction when he was first hospitalized. He had received bilateral hearing aids ( ).

He saw the temporomandibular joint pain specialist every 6 weeks. He was precluded from eating hard foods (i.e., nuts, etc.).

Of note, he denied any Emergency Room visits or hospitalizations since he was discharged from [redacted] Hospital.

Subjective Complaints: He had blurry vision, diplopia, sensory neural hearing loss, using hearing aids; temporomandibular joint pain, which increased with low temperatures which he rated the pain at 3/10; intermittent lower back pain which he rated at 3/10, right ankle pain which he rated at 5/10, initial insomnia, loss of libido, depression and sadness over his limitations, anxiety about his finances and his future, irritability, marital discord to above, decreased concentration, memory problems, problems with planning and organizing, difficulties completing projects, word finding difficulties, impulsivity, and personality change.

Occupational History: He began working as a child, helping his father in the family farm. When he came to the States he learned carpentry from his brothers, "I have worked as a ever since I came to the states." He had worked for multiple employers. He had been working for for approximately a year at the time of the accident.

Medical History: He denied any history of heart disease, high blood pressure, diabetes, high cholesterol or any other chronic illnesses. He denied any prior history of motor vehicle accidents, loss of consciousness, traumatic brain injuries, seizures or any other neurological problems. He also denied any prior history of orthopedic injuries, falls or back injuries. He reported that he was in very good health prior to the accident.

Health Habits: He admitted to drinking beer on a social basis. He denied smoking at this time; however, he used to smoke up to the time of his accident ("I smoked 2 packs a week. "). He denied the use of drugs, but admitted to drinking 3 cups of coffee a week. Before the accident, he used crystal meth up to 4 times a week. He reported that he used for 3 months at the time he was arrested and had to undergo rehabilitation. He also admitted to using THC when he lived in Mexico as an adolescent.

Summary and Conclusion: It was evident that the he was experiencing significant emotional dysregulation at home which was causing havoc with the family. The wife was very concerned and scared given his impulsivity and anger outbursts.

On current evaluation, he was only willing to admit to moderate depression. However, this was a self-report measure and he had little insight. On the SCL-90-R he had much more elevated scores, indicating that he was experiencing significant internal turmoil. However, a comprehensive detailed neuropsychological evaluation was clearly in order as he more likely than not had significant behavioral and emotional issues which would impact his recovery process.

Diagnoses: Axis I - cognitive Disorder Not otherwise Specified (Post-concussive syndrome). Personality change due to traumatic brain injury. Mood disorder secondary to traumatic brain injuries, with mixed depressive and anxious features. Axis II – No diagnosis. Axis III – Traumatic brain injury. Axis IV – Financial problems, litigation. Axis V – GAF = 50.

Disability Status: He was totally temporarily disabled on a neuropsychological basis.

Causation: It was within reasonable psychological certainty that the primary diagnosis was entirely industrially caused. Absent the injury of
he would not be experiencing any emotional or psychological problems at this time. The industrial injury was the substantial and preponderant cause of his neuropsychological diagnoses and disability as to all factors combined.

Apportionment: Apportionment was not indicated at this time, as there was no permanent disability to apportion.

Treatment Recommendations: He was recommended 12 individual psychotherapy with cognitive behavioral therapy emphasis; 12 sessions of family therapy, psychiatric consultation and comprehensive neuropsychological evaluation.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy.

Workers' Comp Report, by [redacted] dated

History of Present Illness: The applicant had sustained a traumatic brain injury on that resulted from a fall while at work. He was last seen at this clinic on to follow up for ocular hypertension. At that time, they

had requested additional visual field testing which had not yet been completed. Today, he complained of blurred vision with mild pressure and eye strain. Currently, he was participating in rehabilitation at TLC 3 days a week. Additionally, when asked about his family history if it was positive for glaucoma, he reported that he did not know if any of the family members had glaucoma.

Examination Findings: Unaided distance acuities were right 20/50, left 20/40. Near unaided acuities were right 20/40 and left 20/25. Subjective refraction revealed change from his baseline readings and currently read at right -0.75 minus a quarter at 75, left minus a quarter minus a quarter axis 40 with best corrected acuities of 20/20 for each eye. Intraocular pressure was again rechecked with the following readings: Right 26, 24 and 26. Left 21, 22 and 24.

Recommendations: He was prescribed single vision distance glasses. He was given schedule for extended visual fields (SIT A 24-2).

Medical Report, [redacted] dated

The applicant came for follow up of right bimalleolar ankle fracture. He fell approximately 15 feet from a scaffold and was treated for multiple injuries, including a right ankle fracture. He was currently being treated in Rehabilitation for cognitive difficulties. He had been participating in physical therapy thrice a week, ambulating with Cam walker, without assistive device. He had intermittent pain in lateral aspect of ankle. He described the pain as weakness and snapping.

Assessment/Plan: He was status post open reduction and internal fixation right ankle fracture 6 months ago.

It was discussed to him symptoms consistent with peroneal tendon inflammation and irritation, treatment options including continued observation, physical therapy, and removal of hardware; and the possibility that removal of hardware could improve symptoms, but possibility that symptoms might not resolve.

He was to continue ambulating as tolerated.

Risks associated with ankle fractures, including chronic ankle pain and swelling, limp, early degenerative changes, symptomatic hardware were reviewed. Ankle strengthening and range of motion exercises were provided.

Team Conference Note, [redacted] dated _____.

Case Management: At the present time, the applicant did not present with significant behaviors that place him at risk. He appeared to have a functional understanding with regard to his limitations, and did not exhibit significant impulsive behaviors.

With regard to physical therapy, he had improved ankle stability and balance noted as BESS (Balance Errors Scoring System) score improved from 31 errors to 27 errors, however still above norm of less than 12 errors. He had improved endurance as distance ambulated in 6-minute walk test increased to 1705 feet, however still only at 84% of age/gender matched norm. Gait velocity was improved from 1.25 m/sec to 1.67 m/sec without an AD (>1 00% norm).

Other: He continued to be limited in ambulation distance due to right ankle pain (2-3/10) secondary to Achilles and peroneal tendinopathy. He required moderate cues for initiation and completion of proper eccentric strengthening, stretching, and core stabilization/proximal hip stability exercise program.

With regard to occupational therapy, he had increased carry over and initiation of simple English phrases with staff. He was able to communicate 30% of all needs when speaking English. He completed 2 simulated drives going over the speed limit 4x, off the road at 12x and completed divided attention. He responded with 10/12 correct. He completed money management with checkbook balance, unit pricing and tax calculation with minimum A Exploration of volunteer services for productive day with future transition. He required maximum/moderate A for initiation and problem solving.

With regard to speech therapy, he had breakdown in accuracy and increased frustration occurred within unstructured activities and situations. He had benefits from continued daily structure and training in order to promote safety, cognitive efficiency, and success.

With regard to neuropsychology, from a neuropsychological perspective, he presented with somewhat stable cognitive functioning. However, while he was showing some improvement in memory and initiation there continued to be challenges with social emotional regulation. These were particularly problematic when in the home, interacting with this family. He was much motored in participating in therapy; however, while he was able to identify how others would benefit from therapy, it was more difficult for him to identify that in his own behavior. Family therapy continued to be an area of need that was being coordinated. He continued to require support with regard to establishing and maintaining a productive day. From a neuropsychological perspective, he did not

present as an imminent danger to himself or others. He had functional insight as to the nature and extent of his injury, and did not exhibit impulsive behaviors that warrant 1:1 or a highly structured level of supervision. Again, family therapy was strongly recommended in order to support his success as he transitioned to less intensive levels of therapy.

Medication Substantiation for Continued Length of Stay: He was to continue with attendance at [redacted] TLC 3 days/week for 4 wks. He was to undergo counseling with psychologist or neuropsychologist. He was to follow up with Dr. [redacted] for current visual issue. The applicant was to continue with Depakote 500 mg. He was to consider a trial of Effexor as well in the future. He was to follow up with primary care physician and all specialists. He was to have neuropsych evaluation.

e Note dated

Diagnoses: 1) Brain injury. 2) Ankle fracture. 3) Mandible fracture. 4) Neuropathic pain, jaw. 5) Impaired cognition. 6) Cognitive and behavioral changes. 7) Impaired vision.

Current Status: The applicant right ankle was improving. He had increasing endurance. He was recommended Achilles' tendinopathy program by his orthopedist. He was on possible removal of plate per his orthopedist.

Treatment Recommendations: He was on transition to TLC Day Program 2 days per week for 3 to 4 weeks. He was to continue family counseling.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy

Speech Therapy Daily Notes, [redacted] dated

The applicant underwent speech therapy.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy.

Speech Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy.

Speech Therapy Daily Notes, [redacted] dated

The applicant underwent speech therapy.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Physical Therapy Daily Notes, [redacted] date

The applicant underwent physical therapy

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy.

Speech Therapy Daily Notes, [redacted] dated

The applicant underwent speech therapy.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Speech Therapy Daily Notes, [redacted] dated

The applicant underwent speech therapy.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Speech Therapy Daily Notes, [redacted] dated

The applicant underwent speech therapy.

Speech Therapy Daily Notes, [redacted] dated

The applicant underwent speech therapy.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy

Speech Therapy Daily Notes, [redacted] dated

The applicant underwent speech therapy/

Progress Report, Restore Rehabilitation dated

Diagnosis: 1) Traumatic brain injury. 2) Comminuted fracture of the mandible, status post open reduction and internal fixation. 3) Fracture, right ankle, status post open reduction and internal fixation. 4) Impaired cognitive function, with decrease in orientation, memory, attention and problem solving.

Vocational Activity: The applicant remained TID.

Action Plan: Obtained was RFA for continued comprehensive treatment program 3 days per week orthotics, TENS unit, ad neuropsychological counseling. He was to continue to maintain contact with [redacted] to address ongoing treatment needs and progress and comprehensive brain injury program. He was to follow-up with claim examiner to determine if the modified duty physician available and help with the transition beck to work environment. He was to maintain contact with Dr. [redacted] office to obtain status on counseling and projected need for additional visit. He was to attend with Dr. [redacted] and facilitate all medical reports being forwarded to Dr. [redacted] He was to continue schedule transportation and translation for all medical appointments.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy

Speech Therapy Daily Notes, [redacted] dated

The applicant underwent speech therapy.

Speech Therapy Daily Notes, [redacted] Hospital, dated

The applicant underwent speech therapy.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy.

Speech Therapy Daily Notes, [redacted] dated

The applicant underwent speech therapy.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Speech Therapy Daily Notes, [redacted] dated

The applicant underwent speech therapy.

Physical Therapy Daily Notes, [redacted] dated

The applicant underwent physical therapy.

Speech Therapy Daily Notes, [redacted] dated

The applicant underwent speech therapy.

Plan of Treatment/Ongoing, signed by [redacted] dated

At this time, home and community rehabilitation remained most appropriate for the applicant to be able to return to more independence. He continued to work a 2-hour shift at [redacted] once a week. He was able to complete without indirect supervision of therapist 2 times this reporting period. He reported fatigue and needed for rest after return home and continued difficulty with pre- planning and initiation. He declined to use strategy of checklist to be prepared for volunteering. He continued to need encouragement to try new activities, tended to change the plans of the session to something he was familiar with and not as physically active, and had not met the 6-8 hours of productive activity without rest breaks. During this last reporting, his treatment team had tried to emphasize the importance of having a routine and plans for the day (while in therapy but more importantly after [redacted]). His wife [redacted] was worried about his level of initiation and carryover and going back to his isolative ways and with increased anger and depression. He was not able to verbally express his plans and how he currently spent his free time. He was able to participate in cognitive tasks /tabletop activities for 2 hours without rest breaks but lacks initiation, eye contact

and confidence in the community setting when interacting with strangers/store employees. He needed lots of encouragement from his therapy team to practice community-social interactions (maintains the passive role).

Recommendations/Plan: Ongoing home and community program to include physical, speech, and recreational therapies, clinical social worker and clinical coordination for up to 14 hours per week for additional 4 weeks. Occupational therapy would be discharged as of .

Physical Therapy Daily Notes, [redacted] dated .

The applicant underwent physical therapy.

Occupational Therapy Daily Notes, [redacted] dated .

The applicant underwent occupational therapy.

Neurorehabilitation Primary Treating Physician Progress Report, signed by [redacted] M.D., dated .

Interval History: The applicant returned for follow-up visit.

He had transitioned to blended program with TLC Day Treatment 3 full days per week and RWW 2 days per week and continued to progress. He had not been on medication for 1 month due to lack of authorization.

Subjective Complaints: He complained of jaw and teeth pain that was increased with chewing. He was told that the nerve to the teeth were damaged thus causing pain. He was recommended neuro referral for anterior mandibular dysesthesia likely neuropathic by Dr. [redacted] He was tolerating Neurontin with decreased pain. He had increased jaw pain when first turn on air conditioning and chewing peanuts. He underwent x-rays and was told it was okay.

He complained of right foot pain secondary to trimalleolar fracture. He was status post ORIF. The pain was localized to the lateral malleolus and posterior ankle with prolonged ambulation and going upstairs. It was unchanged and did not allow to go over 5/10. His ankle brace was broken and still had not been fixed as requested on TENS unit helped with pain. Orthotic insert decreased pain and ankle brace allowed flexibility. He was still waiting replacement brace due to issues with orthoptist. His pain was unchanged even without Neurontin.

He complained of pain on the right occipital area at the site of impact. His right neck was tight. He had not yet been back to neurologist for occipital nerve block but would like to defer as he felt that Neurontin was also helping with his pain. He remained resolved even without Neurontin.

He complained of blurred vision. He had appointment with [redacted] on . but was waiting additional testing with Humprey visual fold analyzer. His eyes got tired easily but had been having twitching of the left eyelid. He was still waiting authorization for glasses.

He complained of decreased STM, focus, attention, and multitasking. He felt as if he was improved with ST but still with deficits.

He had temper prior to injury but it was much worse now. He complained of increased irritability, and decreased frustrations tolerance. He hurt people without knowing it and spent all day apologizing. His wife reported angry outburst with destruction of TV and daughter's room. At his last visit, he and his wife stated that he was better but still prone to hurtful outburst and wife did not know how to handle it. Previously verbalized fear of increased tension at home but this had not decreasing to 3-day program at TLC. He started counseling session with Dr. [redacted] prior to irritability even without Depakote. He was utilizing coping strategies from Dr. [redacted].

His hearing was improved with bilateral hearing aids.

Diagnosis: 1) Status post fall with traumatic brain injury. 2) Right ankle fracture, status post ORIF. 3) Mandibular fracture status post ORIF.

Disability Status: He was currently TTD until approximately

Causation: The mechanism of injury was consistent with current impairment and disabilities.

Restrictions: He was not to drive. He should not be on unprotected heights and distracting environments.

Treatment Plan: He was to continue with [redacted] TLC 3 days per week until with plans to transition to 2 days per week with RWW 3 days per week. He was recommended to undergo counseling with psychologist or neuropsychologist. He was to follow-up with [redacted] He was to stop Depakote and Neurontin. He was to follow-up primary care physician and all specialist. He was recommended to replace broken ankle brace. He was to use TENS unit. He was recommended trial of Amantadine.

Occupational Therapy Daily Notes, [redacted] dated _____.

The applicant underwent occupational therapy.

Medical Report, **Group dated** _____.

Initial family session was conducted with the applicant, his wife [redacted], daughter [redacted] Main issue identified was applicant's anger and its impact on the family. Psychoeducation on TBI was provided. Family aided to identify treatment goals. These included re-establishing family harmony (e.g., improving relationships) and increasing activity. Steps to meet these goals were written out as family rules. His triggers that impacted his anger were identified. Strategies he learned from previous psychologist [redacted] were reviewed and shared with family (e.g., deep breathing).

The applicant was to follow up in a week.

Team Conference Note, signed by [redacted] dated _____,

Physical Therapy: The applicant continued to be limited in ambulation distance due to right ankle pain (2 to 3/10) secondary to Achilles and peroneal tendinopathy. Gait deviations persisted including decreased right lower extremity stance time, bilateral Trendelenburg due to hip abductor weakness, decreased right lower extremity shock absorption, and pain with ambulation. Completing paperwork was to use outpatient gym facilities independently on/off therapy time.

Occupational Therapy: He was independent with initiating and setting up of Roselta Stone and continued to self-initiate usage of words and common English phrase.

Productive week plan continued with emphasis on Holiday activities. He was structured of 14 days good time management and thought organization.

He remained independent with all construction and assembly tasked with increased abstract thinking and functional problem solving.

Speech Therapy: Breakdown in accuracy and increased frustration occurred within unstructured activities and situations. He benefitted from continued daily structure and training in order to promote safety, cognitive efficiency, and success.

Neuropsychology: He remained stable and did not present as an imminent danger to himself or others. He had functional insight as lo the nature and extent of his

injury, and did not exhibit impulsive behaviors that warrant 1:1 or a highly structured level of supervision. Marital and family therapy continued to be an area of need to assist with providing emotional stability in the home, which should also decrease occurrence of crisis situations.

Physician Note: Transition from TLC day treatment program with Rehab Without Walls and then solely to RWW for reintegration for community and structured day activities.

Medical Substantiation: He was to continue with [redacted] TLC 3 days per week until [redacted] with plans to transition to 2 days per week with RWW 3 days per week. He was recommended to undergo counseling with psychologist or neuropsychologist. He was to follow-up with [redacted] He was to stop Depakote and Neurontin. He was to follow-up primary care physician and all specialists. He was recommended to replace broken ankle brace. He was to use TENS unit. He was recommended trial of Amantadine.

Physical Therapy Daily Notes, [redacted] dated [redacted]

The applicant underwent physical therapy.

Occupational Therapy Daily Notes, [redacted] dated [redacted]

The applicant underwent occupational therapy.

Speech Therapy Daily Notes, [redacted] dated [redacted]

The applicant underwent speech therapy.

Physical Therapy Daily Notes, [redacted] dated [redacted]

The applicant underwent physical therapy.

Occupational Therapy Daily Notes, [redacted] dated [redacted]

The applicant underwent occupational therapy.

Physical Therapy Daily Notes, [redacted] dated [redacted]

The applicant underwent physical therapy.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Speech Therapy Daily Notes, [redacted] dated

The applicant underwent speech therapy.

Medical Report, Persona Neurobehavioral Group dated

The applicant's wife, [redacted], was upset and almost cancelled session due to applicant not following-through with strategies. He was disappointment that he was unable to grasp education received from this and previous treatment (e.g., [redacted] Psychoeducation was provided on trauma brain injury, cognitive deficits, pain, depression, and anxiety. An argument yesterday precipitated these concerns. Each family member was asked to give their perspective to help understand their thoughts, feelings, and actions. Overall, there was a consensus that they had not followed through as a family with communication strategies. They were assisted in prioritizing and applying strategies consistently.

Plan: He was to follow up next week.

Progress Report,] dated

Medical Status Overview:

Diagnoses: 1) Traumatic brain injury. 2) Comminuted fracture of the mandible, status post open reduction and internal fixation. 3) Fracture, right ankle, status post open reduction and internal fixation. 4) Impaired cognitive function, with decrease in orientation, memory, attention and problem solving.

The applicant underwent closed reduction with manipulation of right trimalleolar ankle fracture, focused abdominal sonogram and limited cardiac ultrasound for trauma, and moderate complexity repair of right occipitoparietal scalp laceration.

Medical Activity: He continued to participate at [redacted] 3 days a week until . Then he started participating full time with as of which was now based out of his home.

The recommendation plan from included ongoing home and community program with physical, occupational, speech and recreational therapies, clinical social worker and clinical coordination for up to 20 hours per week for additional 4 weeks.

Discharge plan: In 10-12 weeks, the treatment team would begin exploring productive day activities in was local area such as volunteer opportunities, local community and recreational centers in area to increase daily activity participation. The treatment team would also provide additional education and training for his caregivers due decreased mental flexibility and becoming overwhelmed in high distracting environments. Introduce local Spanish support groups in area for ongoing family education through [redacted] support group.

Subjective Complaints: He had stable jaw and teeth pain even without Neurontin. He had right foot pain. He had head pain located in right occipital area, site of impact. The right side of the neck felt tight. He had not yet been back to neuro, Dr. [redacted] for occipital nerve blocks, but would like to defer as felt that Neurontin was also helping with his pain. The applicant remained resolved even without Neurontin. His eyes got tired easily but had been doing visual therapy with therapists. He stated his left eye fell and he had been having twitching left eyelid. Glasses had been authorized. He had impaired cognition, behavioral changes. He had improved with hearing aids.

Treatment Plan: He was to have transition to [redacted] for ongoing cognitive therapy. He was to continue to undergo counseling with psychologist or neuropsychologist. He was to follow up with Dr. [redacted] It was okay to stop Depakote and Neurontin. The applicant was to follow up with primary care physician and all specialists. TENS unit was utilized. Bilateral foot orthotics was given. He was to follow up in 6 weeks. He was recommended a trial of Amantadine. He was to continue transition to home and community reintegration with RWW.

Vocational Activity: He remained TTD.

Action Plan: He was to continue to maintain contact with [redacted] to address ongoing treatment needs and progress and comprehensive brain injury program. He was to follow-up with claims examiner to determine if the modified duty physician available and help with the transition back to work environment if applicable. He was to maintain contact [redacted] office to obtain status on counseling and projected need for additional visit. The applicant was to facilitate and schedule next appointment with [redacted] The applicant was to continue to schedule transportation and translation for all medical appointments.

Medical Report, [redacted] Group dated [redacted]

The applicant and his wife reported improvements within the last week. The children were listening better. There were no arguments but the family was not

participating in more positive interactions, as they did prior to his injury. He was now working with and therapy time has reduced. He was sleeping more and was less motivated. He might require more structure at home but in the meantime changes to his therapies would be made. The children's motivation could also be variable and likely impacted by anxiety and fear ("something happened if my parents are gone too long.") since his injury. Brandon, especially seemed to detach himself more from his family.

Plan: The applicant was to follow up next week.

Medical Report, Group dated

There had been no major changes from last session. The family did attempt to spend time together except for . The need to spend time together on an enjoyable activity for all was emphasized. Variable motivation appeared to be an issue for patient and children. An increase in structure was recommended, especially for the applicant. Psychoeducation on TBI was reviewed, as all family members except him like to spend time with their extended family. He became irritable and fatigue with triggers, such as loud noise and too much activity suggestions (e.g., limit time) were provided in order for him to participate cordially in family events without increased irritability and worry from wife and children.

He was to follow up in a week.

Psychotherapy Session Note, signed by [redacted] Ph.d., dated

The applicant underwent psychotherapy session.

Medical Report, up dated

The applicant underwent psychotherapy session.

Progress Report, signed by [redacted] M.D., dated

The applicant would need interpreter and transportation to program. He would be staring to at

Progress Report, Restore Rehabilitation dated

Diagnosis: 1) Traumatic brain injury. 2) Comminuted fracture of the mandible, status post open reduction and internal fixation. 3) Fracture, right ankle, status

post open reduction and internal fixation. 4) Impaired cognitive function, with decrease in orientation, memory, attention and problem solving.

Vocational Activity: The applicant remained TID.

Action Plan: He was to continue to maintain contact with to address ongoing treatment needs and progress and comprehensive brain injury program. He was to follow-up with claims examiner to determine if the modified duty physician available and help with the transition back to work environment if applicable. Facilitate coordination of gym membership and payment to fitness center. To be obtained was report from Dr. [redacted] to determine progress in family counseling. Facilitate scheduling of appointment with Dr. [redacted] his primary care physician. He was to continue to schedule transportation and translation for all medical appointments.

Neurorehabilitation Primary Treating Physician Progress Report, signed by [redacted] M.D., dated

Interval History: Since the last visit, the applicant had transitioned to home and community reintegration program 5 days per week. There was initial decline with increased daytime sleeping due to unstructured day and due to wife needing house to be quiet as she worked at home. He was now in the process of setting up structured day activities. He had also started psychological adjustment counseling and family counseling. He was not able refill Amantadine and felt increased cognitive problems but that it might be 2/2 transitioning to home.

Subjective Complaints: He complained of jaw and teeth pain that was increased with chewing. He was told that the nerve to the teeth were damaged thus causing pain. He was recommended neuro referral for anterior mandibular dysesthesia likely neuropathic by Dr. [redacted] He was tolerating Neurontin with decreased pain. He had increased jaw pain when first turn on air conditioning and chewing peanuts. He underwent x-rays and was told it was okay.

He complained of right foot pain secondary to trimalleolar fracture. He was status post ORIF. The pain was localized to the lateral malleolus and posterior ankle with prolonged ambulation and going upstairs. It was unchanged and did not allow to go over 5/10. His ankle brace was broken and still had not been fixed as requested on TENS unit helped with pain. Orthotic insert decreased pain and ankle brace allowed flexibility. He was still waiting replacement brace due to issues with orthoptist. His pain was unchanged even without Neurontin.

He complained of pain on the right occipital area at the site of impact. His right neck was tight. He had not yet been back to neurologist for occipital nerve block but would like to defer as he felt that Neurontin was also helping with his pain. He remained resolved even without Neurontin.

He complained of blurred vision. He had appointment with [redacted] on but was waiting additional testing with Humprey visual fold analyzer. His eyes got tired easily but had been having twitching of the left eyelid. He was still waiting authorization for glasses.

He complained of decreased STM, focus, attention, and multitasking. He felt as if he was improved with ST but still with deficits.

He had temper prior to injury but it was much worse now. He complained of increased irritability, and decreased frustrations tolerance. He hurt people without knowing it and spent all day apologizing. His wife reported angry outburst with destruction of TV and daughter's room. At his last visit, he and his wife stated that he was better but still prone to hurtful outburst and wife did not know how to handle it. Previously verbalized fear of increased tension at home but this had not decreasing to 3-day program at TLC. He started counseling session with [redacted]s prior to irritability even without Depakote. He was utilizing coping strategies from [redacted]

His hearing was improved with bilateral hearing aids.

Diagnoses: 1) Cognitive and behavioral changes. 2) Impaired cognition. 3) Neuropathic pain, jaw. 4) Impaired vision. 5) Brain injury. 6) Ankle fracture. 7) Mandible fracture.

Disability Status: He was TTD until .

Restrictions: He was not to drive. He should not be on unprotected heights and distracting environment.

Treatment Plan: He was to continue with 5 days per week and counseling with psychologist or neuropsychologist. He was to follow-up with Dr. [redacted] and primary care physician. He was strongly recommended replacement of ankle brace. He was to attend program. His Amantadine was refilled. Requested was authorization for gym membership.

Psychotherapy Session Note, [illegible] dated [illegible]

The applicant underwent psychotherapy session.

Psychotherapy Session Note, [illegible] dated [illegible]

The applicant underwent psychotherapy session.

Psychotherapy Session Note, signed by [redacted], Ph.d., dated [illegible]

The applicant underwent psychotherapy session.

Plan of Treatment/ongoing, signed by [redacted] B.A., dated [illegible]

Recommendations: The applicant ongoing home and community program to include physical, occupation, speech and recreational therapies, clinical social worker and clinical coordination for up to 20 hours per week for additional 4 weeks.

Psychotherapy Session Note, [illegible] l Group dated [illegible]

The applicant underwent psychotherapy session.

Progress Report, [illegible] dated [illegible]

Diagnosis: 1) Traumatic brain injury. 2) Comminuted fracture of the mandible, status post open reduction and internal fixation. 3) Fracture, right ankle, status post open reduction and internal fixation. 4) Impaired cognitive function, with decrease in orientation, memory, attention and problem solving.

Vocational Activity: The applicant remained TID.

Action Plan: He was to continue to maintain contact with Rehab Without Walls to address ongoing treatment needs and progress and comprehensive brain injury program. He was to follow-up with claims examiner to determine if the modified duty physician available and help with the transition back to work environment if applicable. Facilitate coordination of gym membership and payment to fitness center. To be obtained was report from [redacted] to determine progress in family

counseling. Facilitate scheduling of appointment with Dr. [redacted] his primary care physician. He was to continue to schedule transportation and translation for all medical appointments.

Psychotherapy Session Note, [redacted] dated [redacted]

The applicant underwent psychotherapy session.

Neurorehabilitation Primary Treating Physician Progress Report, signed by [redacted] M.D., dated [redacted]

Interval History: The applicant continued with home and community reintegration program 5 days per week and had also been attending [redacted] program 2 days per week. Volunteer activities with society and were being coordinated. The gym that gave him the pass never received payment from WC insurance. He continued to see psych every week and had received glasses. He still reports decline with increased daytime sleeping despite structured day.

Subjective Complaints: He complained of jaw and teeth pain that was increased with chewing. He was told that the nerve to the teeth were damaged thus causing pain. He was recommended neuro referral for anterior mandibular dysesthesia likely neuropathic by Dr. [redacted] He was tolerating Neurontin with decreased pain. He had increased jaw pain when first turn on air conditioning and chewing peanuts. He underwent x-rays and was told it was okay.

He complained of right foot pain secondary to trimalleolar fracture. He was status post ORIF. The pain was localized to the lateral malleolus and posterior ankle with prolonged ambulation and going upstairs. It was unchanged and did not allow to go over 5/10. His ankle brace was broken and still had not been fixed as requested on TENS unit helped with pain. Orthotic insert decreased pain and ankle brace allowed flexibility. He was still waiting replacement brace due to issues with orthoptist. His pain was unchanged even without Neurontin. He was still waiting replacement of brace due to issues with orthopedist.

He complained of pain on the right occipital area at the site of impact. His right neck was tight. He had not yet been back to neurologist for occipital nerve block but would like to defer as he felt that Neurontin was also helping with his pain. He remained resolved even without Neurontin.

He complained of blurred vision. He had appointment with [redacted] on [redacted] but was waiting additional testing with Humprey visual fold analyzer. His eyes got tired easily but had been having twitching of the left eyelid. He was still waiting authorization for glasses.

He complained of decreased STM, focus, attention, and multitasking. He felt as if he was improved with ST but still with deficits.

He had temper prior to injury but it was much worse now. He complained of increased irritability, and decreased frustrations tolerance. He hurt people without knowing it and spent all day apologizing. His wife reported angry outburst with destruction of TV and daughter's room. At his last visit, he and his wife stated that he was better but still prone to hurtful outburst and wife did not know how to handle it. He was seeing [redacted] for both individual and family counseling. Psychiatry appointment with [redacted] was canceled as he closed his practice. He had not seen any psychiatrist.

His hearing was improved with bilateral hearing aids.

His endurance was decreased since he stopped day program but it was boring at home and had to be quiet as his wife works at home thus he just sleep.

He complained of anxiety and shortness of breath when his wife drives and steps on the brakes and when his neighbor barked.

He complained of waking up frequently with difficulty breathing ever since leaving Day Program. He had gained 20 pounds since his injury.

Diagnoses: 1) Brain injury, sequelae. 2) Cognitive and behavioral changes. 3) Impaired cognition. 4) Neuropathic pain. 5) Impaired vision. 6) Ankle fracture. 7) Mandible fracture. 8) Depression. 9) OSA (obstructive sleep apnea).

Disability Status: He was TTD until approximately [redacted].

Restrictions: He was not to drive. He should not be on unprotected heights and distracting environment.

Treatment Plan: He was to continue with 5 days per week and counseling with psychologist or neuropsychologist. He was referred to psychiatrist. He was to follow-up with [redacted] and primary care physician. He was strongly recommended replacement of ankle brace. He was to continue to attend program. His Amantadine was refilled. He was on trial of Lexapro 10 mg. Requested was authorization for gym membership.

Psychotherapy Session Note, [redacted] dated [redacted]

The applicant underwent psychotherapy session.

Plan of Treatment/ongoing, signed by [redacted] B.A., dated [redacted]

The applicant was recommended ongoing home and community program to include physical, occupational, speech, and recreational therapies, clinical social worker and clinical coordination for up to 20 hours per week for additional 4 weeks.

Neurorehabilitation Primary Treating Physician Progress Report, signed by [redacted] dated [redacted]

Interval History: The applicant continued with home and community reintegration program 5 days per week and had also been attending 2 days per week and took ESL 2 days per week. He has started volunteer activities with and the gym that gave him the pass still had not received payment from the insurance. He continued to see psych every week and had received glasses. He was tolerating medications.

Subjective Complaints: He complained of jaw and teeth pain that was increased with chewing. He was told that the nerve to the teeth were damaged thus causing pain. He was recommended neuro referral for anterior mandibular dysesthesia likely neuropathic by [redacted] He was tolerating Neurontin with decreased pain. He had increased jaw pain when first turn on air conditioning and chewing peanuts. He underwent x-rays and was told it was okay.

He complained of right foot pain secondary to trimalleolar fracture. He was status post ORIF. The pain was localized to the lateral malleolus and posterior ankle with prolonged ambulation and going upstairs. It was unchanged and did not allow to go over 5/10. His ankle brace was broken and still had not been fixed as requested on TENS unit helped with pain. Orthotic insert decreased pain and ankle brace allowed flexibility. He was still waiting replacement brace due to issues with orthoptist. His pain was unchanged even without Neurontin. He was still waiting replacement of brace due to issues with orthopedist.

He complained of pain on the right occipital area at the site of impact. His right neck was tight. He had not yet been back to neurologist for occipital nerve block

but would like to defer as he felt that Neurontin was also helping with his pain. He remained resolved even without Neurontin.

He complained of blurred vision. He had appointment with [redacted] on [redacted] but was waiting additional testing with Humprey visual fold analyzer. His eyes got tired easily but had been having twitching of the left eyelid. He was still waiting authorization for glasses.

He complained of decreased STM, focus, attention, and multitasking. He felt as if he was improved with ST but still with deficits.

He had temper prior to injury but it was much worse now. He complained of increased irritability, and decreased frustrations tolerance. He hurt people without knowing it and spent all day apologizing. His wife reported angry outburst with destruction of TV and daughter's room. At his last visit, he and his wife stated that he was better but still prone to hurtful outburst and wife did not know how to handle it. He was seeing [redacted] for both individual and family counseling. Psychiatry appointment with [redacted] was canceled as he closed his practice. He had not seen any psychiatrist.

His hearing was improved with bilateral hearing aids.

His endurance was decreased due to less sleep in daytime since he started medications but still had mental and physical fatigue post classes and volunteer activities.

He complained of anxiety and shortness of breath when his wife drives and steps on the brakes and when his neighbor barked.

He complained of waking up frequently with difficulty breathing ever since leaving TLC Day Program. He had gained 20 pounds since his injury.

Diagnoses: 1) Brain injury. 2) Ankle fracture. 3) Fracture of mandible. 4) Visual impairment. 5) Cognitive and behavioral changes. 6) Impaired cognition. 7) Neuropathic pain syndrome (non-herpetic). 8) Generalized anxiety disorder. 9) OSA (obstructive sleep apnea). 10) Depression.

Disability Status: He was TTD until approximately [redacted].

Restrictions: He was not to drive. He should not be on unprotected heights and distracting environment.

[redacted]

Treatment Plan: He was to continue with 5 days per week and counseling with psychologist or neuropsychologist. He was referred to psychiatrist. He was to follow-up with [redacted] and primary care physician. He was strongly recommended replacement of ankle brace. He was to continue to attend program. He was to undergo sleep study to rule out possible obstructive sleep apnea. His attorney was to obtained authorization for gym pass and right lower extremity brace.

Psychotherapy Session Note, [illegible] dated [illegible]

The applicant underwent psychotherapy session.

Progress Report, [illegible] dated [illegible]

Diagnosis: 1) Traumatic brain injury. 2) Comminuted fracture of the mandible, status post open reduction and internal fixation. 3) Fracture, right ankle, status post open reduction and internal fixation. 4) Impaired cognitive function, with decrease in orientation, memory, attention and problem solving.

Vocational Activity: The applicant remained TID.

Action Plan: He was to continue to maintain contact with [illegible] to address ongoing treatment needs and progress and comprehensive brain injury program. He was to follow-up with claims examiner to determine if the modified duty physician available and help with the transition back to work environment if applicable. He was to continue to follow-up with [redacted] He was to continue schedule transportation and translation for all medical appointments.

Psychotherapy Session Note, [illegible] dated [illegible]

The applicant underwent psychotherapy session.

Progress Report, signed by [redacted] B.A., dated [illegible]

Plan: He recommended ongoing home and community program to include physical, occupational, speech, and recreational therapies, clinical social worker and clinical coordination for up to 20 hours per week for additional 4 weeks.

Requested was 4 additional weeks of services.

[redacted]

Psychotherapy Session Note, [redacted] lated [redacted]

The applicant underwent psychotherapy session.

Psychotherapy Session Note, [redacted] lated [redacted]

The applicant underwent psychotherapy session.

Progress Report, [redacted] lated [redacted]

Diagnosis: 1) Traumatic brain injury. 2) Comminuted fracture of the mandible, status post open reduction and internal fixation. 3) Fracture, right ankle, status post open reduction and internal fixation. 4) Impaired cognitive function, with decrease in orientation, memory, attention and problem solving.

Vocational Activity: The applicant remained TID.

Action Plan: He was to continue to maintain contact with
to address ongoing treatment needs and progress and comprehensive brain injury program. He was to follow-up with claims examiner to determine if the modified duty physician available and help with the transition back to work environment if applicable. He was to continue to follow-up with Dr. [redacted] He was to continue schedule transportation and translation for all medical appointments.

Neurorehabilitation Primary Treating Physician Progress Report, signed by [redacted] dated [redacted].

Interval History: Interval History: Since the last visit, staff and the applicant reports difficulty getting things authorized and getting responses or assistance from the case manager. They reported that their calls were not returned and he was still not able to enroll in gym program (the gym that gave him the pass still had not received payment from the insurance), obtain sleep study, or see pulmonology as recommended at prior visit. As well, insurance had stopped authorizing his medications and he had been out for 2 weeks. His attorney had not gone to court to get compliance with some of these recommendations. He had just received a new ankle brace 3 weeks ago (approximately 10 months since 1st request) and he only received it due to persistence of staff making near daily calls to adjustor and orthotist.

He continued with home and community reintegration program 5 days week and had also been attending program 2 days week and took ESL 2

day's week though both the [redacted] and ESL classes were currently on vacation until . He continued to volunteer for and had just been cleared for He continued to see psych every week.

Subjective Complaints: He complained of jaw and teeth pain that was increased with chewing. He was told that the nerve to the teeth were damaged thus causing pain. He was recommended neuro referral for anterior mandibular dysesthesia likely neuropathic by Dr. [redacted] He was tolerating Neurontin with decreased pain. He had increased jaw pain when first turn on air conditioning and chewing peanuts. He underwent x-rays and was told it was okay.

He complained of right foot pain secondary to trimalleolar fracture. He was status post ORIF. The pain was localized to the lateral malleolus and posterior ankle with prolonged ambulation and going upstairs. It was unchanged and did not allow to go over 5/10. His ankle brace was broken and still had not been fixed as requested on . TENS unit helped with pain. Orthotic insert decreased pain and ankle brace allowed flexibility. He was still waiting replacement brace due to issues with orthoptist. His pain was unchanged even without Neurontin. He was still waiting replacement of brace due to issues with orthopedist.

He complained of pain on the right occipital area at the site of impact. His right neck was tight. He had not yet been back to neurologist for occipital nerve block but would like to defer as he felt that Neurontin was also helping with his pain. He remained resolved even without Neurontin.

He complained of blurred vision. He had appointment with [redacted] on but was waiting additional testing with Humprey visual fold analyzer. His eyes got tired easily but had been having twitching of the left eyelid. He was still waiting authorization for glasses.

He complained of decreased STM, focus, attention, and multitasking. He felt as if he was improved with ST but still with deficits.

He had temper prior to injury but it was much worse now. He complained of increased irritability, and decreased frustrations tolerance. He hurt people without knowing it and spent all day apologizing. His wife reported angry outburst with destruction of TV and daughter's room. At his last visit, he and his wife stated that he was better but still prone to hurtful outburst and wife did not know how to handle it. He was seeing [redacted] for both individual and family counseling. Psychiatry appointment with [redacted] was canceled as he closed his practice. He had not seen any psychiatrist.

His hearing was improved with bilateral hearing aids.

His endurance was decreased due to less sleep in daytime since he started medications but still had mental and physical fatigue post classes and volunteer activities.

He complained of anxiety and shortness of breath when his wife drives and steps on the brakes and when his neighbor barked.

He complained of waking up frequently with difficulty breathing ever since leaving TLC Day Program. He had gained 20 pounds since his injury.

Diagnoses: 1) Ankle fracture, right, sequelae. 2) Fracture of mandible. 3) Visual impairment. 4) Cognitive and behavioral changes. 5) Impaired cognition. 6) Neuropathic pain syndrome (non-herpetic). 7) Generalized anxiety disorder. 8) OSA (obstructive sleep apnea). 9) Depression. 10) Neuropathic pain. 11) Impaired vision. 12) Obstructive sleep apnea. 13) Brain injury.

Disability Status: He was TTD until approximately .

Restrictions: He was not to drive. He should not be on unprotected heights and distracting environment.

Treatment Plan: He was to continue with 5 days per week and counseling with psychologist or neuropsychologist. He was referred to psychiatrist. He was to follow-up with [redacted] and primary care physician. He was strongly recommended gym program be reimbursed and authorized. He was to continue ESL and program. He was recommended sleep study. He was recommended be assigned a responsive care manager.

Psychotherapy Session Note lated

The applicant underwent psychotherapy session.

Progress Report, signed by [redacted] B.A., dated

The applicant was recommended ongoing home and community program to include physical, occupational, speech, and recreational therapies, clinical social worker and clinical coordination for up to 20 hours per week for additional 4 weeks.

Psychotherapy Session Note, dated

The applicant underwent psychotherapy session.

Psychotherapy Session Note, dated

The applicant underwent psychotherapy session.

Psychotherapy Session Note, dated

The applicant underwent psychotherapy session.

Progress Report, dated .

Diagnosis: 1) Traumatic brain injury. 2) Comminuted fracture of the mandible, status post open reduction and internal fixation. 3) Fracture, right ankle, status post open reduction and internal fixation. 4) Impaired cognitive function, with decrease in orientation, memory, attention and problem solving.

Vocational Activity: The applicant remained TTD.

Action Plan: Identify psychiatrist for medication management. He was to attend appointment with [redacted]

Psychotherapy Session Note, dated

The applicant underwent psychotherapy session.

Progress Report, signed by [redacted] B.A., dated

The applicant was recommended ongoing home and community program to include physical, occupational, speech, and recreational therapies, clinical social worker and clinical coordination for up to 20 hours per week for additional 4 weeks.

Psychotherapy Session Note, dated

The applicant underwent psychotherapy session.

Progress Notes, signed by [redacted] M.D., dated

The applicant was recommended ongoing home and community program to include physical, occupational, speech, and recreational therapies, clinical social worker and clinical coordination for up to 20 hours per week for additional 4 weeks.

Requested was 4 additional weeks of services for up to 14 hours per week.

Psychotherapy Session Note, dated

The applicant underwent psychotherapy session.

Medical Report, signed by [redacted] B.A., dated

The applicant was discharge from

Neurorehabilitation Primary Treating Physician Progress Report, signed by [redacted] M.D., dated

Interval History: The applicant had completed and had resumed program of 2 times a week, gym 3 times a week, and ESL classes 4 times a week. He had stopped going to [redacted] due to low back pain and had never started volunteering at [redacted]. At [redacted], he was volunteering by stocking things in a warehouse, approximately 5 to 20 pounds. He was responsible for scheduling [redacted] and ESL and that his wife scheduled the doctor appointments. He had no longer sees Dr. [redacted] and has not had authorization to continue with Provigil.

He was unable to obtain permit for driving evaluation due to outstanding tickets.

Subjective Complaints: He complained of jaw and teeth pain that was increased with chewing. He was told that the nerve to the teeth were damaged thus causing pain. He was recommended neuro referral for anterior mandibular dysesthesia likely neuropathic by Dr. [redacted] He was tolerating Neurontin with decreased pain. He had increased jaw pain when first turn on air conditioning and chewing peanuts. He underwent x-rays and was told it was okay.

He complained of right foot pain secondary to trimalleolar fracture. He was status post ORIF. The pain was localized to the lateral malleolus and posterior ankle with prolonged ambulation and going upstairs. It was unchanged and did not allow to go over 5/10. His ankle brace was broken and still had not been fixed as

requested on . TENS unit helped with pain. Orthotic insert decreased pain and ankle brace allowed flexibility. He was still waiting replacement brace due to issues with orthoptist. His pain was unchanged even without Neurontin. He was still waiting replacement of brace due to issues with orthopedist.

He complained of pain on the right occipital area at the site of impact. His right neck was tight. He had not yet been back to neurologist for occipital nerve block but would like to defer as he felt that Neurontin was also helping with his pain. He remained resolved even without Neurontin.

He complained of blurred vision. He had appointment with [redacted] on . but was waiting additional testing with Humprey visual fold analyzer. His eyes got tired easily but had been having twitching of the left eyelid. He was still waiting authorization for glasses.

He complained of decreased STM, focus, attention, and multitasking. He felt as if he was improved with ST but still with deficits.

He had temper prior to injury but it was much worse now. He complained of increased irritability, and decreased frustrations tolerance. He hurt people without knowing it and spent all day apologizing. His wife reported angry outburst with destruction of TV and daughter's room. At his last visit, he and his wife stated that he was better but still prone to hurtful outburst and wife did not know how to handle it. He was seeing Dr. [redacted] for both individual and family counseling. Psychiatry appointment with Dr. [redacted] was canceled as he closed his practice. He had not seen any psychiatrist.

His hearing was improved with bilateral hearing aides.

His endurance was decreased due to less sleep in daytime since he started medications but still had mental and physical fatigue post classes and volunteer activities.

He complained of anxiety and shortness of breath when his wife drives and steps on the brakes and when his neighbor barked.

He complained of waking up frequently with difficulty breathing ever since leaving TLC Day Program. He had gained 20 pounds since his injury.

Diagnoses: 1) History of traumatic brain injury. 2) Closed right ankle fracture, sequelae. 3) Brain injury, without loss of consciousness, sequelae. 4) Ankle fracture, right, sequelae. 5) Fracture of mandible, sequelae. 7) Cognitive and

behavioral changes. 8) Impaired cognition. 9) Neuropathic pain syndrome. 10) Generalized anxiety disorder. 11) Obstructive sleep apnea syndrome. 12) Depression. 13) Impaired vision.

Disability Status: He was TTD until approximately .

Restrictions: He was not to drive. He should not be on unprotected heights and distracting environment.

Treatment Plan: He was to continue with program, ESL classes, and gym. He was encourage to increase volunteering. He was waiting authorization for neuropsychologist. He was to follow-up primary care physician and specialists. He was to continue gym program. He was to continue with ESL and Mt SAC ABI program. He was waiting pulmonologist consultation. His attorney was to advance payment for outstanding ticket.

Sleep Consultation, signed by [redacted] M.D., dated .

The applicant complained of excessive daytime sleepiness. He had a traumatic brain injury approximately 4 months ago. At that time, he hit his head and also broke his jaw. After this accident he had been extremely sleepy during the day and initially was treated with Provigil. He was on this medication for about 3 months and then this medication was discontinued. When this was discontinued, he relapsed and had severe excessive daytime sleepiness and was therefore restarted on this medication. He was also on antidepressants as well. He snores and woke up at night gasping for air. He did have nightmares.

Impression: 1) Hypersomnia with obstructive sleep apnea. 2) History of traumatic brain injury. 3) Depression.

Recommendations: He was recommended to undergo a nocturnal polysomnogram. He was recommended that he avoid driving and operating machinery in the absence of sustained vigilance and avoid alcohol and sedative hypnotics.

Psychological Evaluation Report, signed by [redacted], Ph.D., dated .

Reason for Referral: The applicant was referred for a psychodiagnostic evaluation by his Nurse case Manager and Adjuster, in order to assess his current level of emotional functioning and to provide recommendations for treatment.

History of Present Illness and Background Information: He was employed by [redacted] as a carpenter at the time of his industrial accident. Details of his injury had been provided in the prior report.

Interim history revealed that he was under the care of Rehab without walls, which consisted of teaching him independent living skills. "I had a speech therapist, a social worker, a recreational therapist, an occupational and a physical therapist." He learned to become more independent as a result of his treatment and that he was able to learn coping skills. His treatment ended approximately a month prior to this evaluation.

Currently, he attended [redacted] Acquired Brain Injury Program. "I go two hours a day, two days a week [Mondays and Wednesdays]." He was learning cognitive coping strategies. He was also taking ESL classes, from Monday through Thursday between 6:00-8:00 PM.

His Primary Treating Physician, [redacted] saw the applicant on a monthly, basis. "She gives me medication for my depression." He had ongoing treatment with his temporomandibular joint pain specialist. "I saw him about 15 days ago, and my next appointment is in four months."

The applicant reported that he continued to experience problems with his wife because he did not have control of his reactions. "We are usually fighting all the time." He remained symptomatic, which caused him great sadness and distress.

Subjective Complaints: He had headaches, triggered by sunlight, localized in the frontal area. This would occur about twice a week and lasted 2-3 hours, with the pain rated at 8/10. He had blurry vision, he could not see without the assistance of his glasses. He had diplopia, especially when he was fatigued. He had photosensitivity. He had bilateral sensory neural hearing loss; he used hearing aids. He had vertigo, he experienced balance problems when he used a treadmill. He had temporomandibular joint pain, increased with low temperatures; pain rated as 3/10 on a regular basis, but it could increase to 7/10. He had numbness of the lower lip and gums below the 4 lower teeth; this was constant. He had occasional drooling and dropping of food from his mouth while eating. He had lower back pain. He had right ankle pain. He had hypesomnia during the day. He had nightmares of having an accident. He had fatigues during the day. He had loss of libido. He had depression and sadness. He had anxiety. He had personality change. He had irritability. He had word finding difficulties. He had decreased concentration. He had memory problems.

Diagnoses: 1) Diffuse traumatic brain injury with altered of consciousness, as per medical records. 2) Major neurocognitive Disorder with behavioral disturbance.

3) Other chronic Pain. 4) Pain disorder related to psychological factors. 5) Mood Disorder due to traumatic brain injury, with depressive features. 6) Personality change due to traumatic brain injury. 7) Sleep disorder due to traumatic brain injury, as per medical records. 8) Unspecified disorder of binocular vision, as per medical records. 9) Temporomandibular joint disorder, unspecified, as per medical records. GAF = 57.

Whole person impairment Index: A GAF of 57 was equivalent to a WPI of 20%. The impairment was expressed in the whole person, because it was affecting his family/home life, as well as his recreational, social, occupational and sexual life, his self-care and life support activities.

According to Table 13-8 of the AMA Guides, 5th Edition, his impairment due to emotional and behavioral disorders met criteria for Class 2 or moderate impairment. He was given 29% whole person impairment.

He should undergo a formal polysomnogram to address his sleep disturbance and to determine his disability resulting from this problem.

Disability: He had now reached a level of Maximal Medical Improvement on a Psychological basis as of the date of this evaluation. He was totally temporarily disabled from the time of his injury up to August 17, 15, when he became Permanent and Stationary.

Causation: Based on the preponderance of the evidence, it was within reasonable psychological certainty that the primary diagnosis was entirely industrially caused. Absent the injury of October 17, 2013, he would not be experiencing any emotional or psychological problems at this time. The industrial injury was the substantial and preponderant cause of his psychological diagnoses and disability as to all factors combined.

Apportionment: There was no apportionment to either non-industrial or pre-morbid injuries.

Objective Factors of Disability: He had moderate depression, mild hopelessness, moderate anxiety, and severe internal turmoil as per the MMPI-2 with strong focus on somatization.

Subjective Factors of Disability: He had headaches, blurry vision, diplopia, photosensitivity, bilateral sensory neural hearing loss, vertigo, temporomandibular joint pain, numbness of the lower lip and gums below the 4 lower front teeth, occasional drooling, occasional dropping of food from his mouth while eating, lower back pain, right ankle pain, hypersomnia during the day, nightmares of

having an accident, fatigues during the day, loss of libido, depression and sadness, anxiety, personality change, irritability, word finding difficulties, decreased concentration, and memory problems.

Vocational Rehabilitation: He was a QIW; therefore vocational Rehabilitation was indicated in this case from a psychological perspective.

Future Treatment: He should have access to individual psychotherapy with a bilingual/bicultural clinician at the rate of 100 sessions over his lifetime. He should have marital/conjoint therapy with his wife to address issues of marital adjustment given his personality changes. A set of 24 sessions over his lifetime is indicated. He would need ongoing psychiatric treatment. He should meet with a psychiatrist at the rate of once every 2 months for the next 3 years, with re-evaluation thereafter. Treatment for all other medical issues was deferred to Dr. [redacted] and the appropriate specialists.

Occupational Therapy Daily Notes, [redacted] dated 1

The applicant underwent occupational therapy.

Occupational Therapy Daily Notes, [redacted] dated

The applicant underwent occupational therapy.

Sleep Consultation, signed by [redacted] M.D., dated

The applicant came for nocturnal polysomnogram.

Impressions: Axis A- 1) Primary snoring. 2) Hypersomnia, unspecified. Axis B- Procedure: Nocturnal polysomnogram. Axis C- Diagnosis: Traumatic brain injury and depression.

Recommendations: He was to continue Modafinil. He was recommended further evaluation for possible nocturnal insomnia and was to continue to avoid driving and operating heavy machinery.

Initial Psychological Evaluation Report, signed by [redacted] Ph.D., dated

Introduction: The applicant had been living continuously in the United States since He reportedly began his employment with [redacted] in

approximately as a full-time . He claimed good physical and psychological health when he took the job.

He denied any work-related performance, productivity, attendance, interpersonal, disciplinary or injury problems prior to the current industrial period in question) when he fell from scaffolding sustaining multiple physical, psychological, and cognitive-related injuries, was hospitalized for several days and then was placed for treatment and rehabilitative purposes in the brain injury program at . He had further received treatment via the program he referenced as "without walls" while he also was currently attending classes at College which records reference as an Acquired Brain Injury Program.

He had worked in no capacity since He was currently receiving Disability Benefits from the insurance carrier. He lived with his wife and their 2 children in . Finances were strained. He described wide-ranging physical/emotional/cognitive symptoms/impairments. He did receive individual psychotherapy as well as conjoint/family psychotherapy with Dr. [redacted] The applicant had been prescribed psychotropic medicine.

Current Cognition: He last worked in any capacity on He stated he was currently receiving Disability Benefits from the insurance carrier. His wife worked full-time.

He acknowledged noteworthy financial difficulties and stated that while his wife was managing all finances presently, it was his understanding that household income was insufficient to cover basic monthly overhead.

As for his current physical condition, he reported chronic right foot pain rated as a "2-6"/1 0 with cracking and numbness in the right foot, particularly when he ambulated.

He next reported chronic jaw pain rated as a "4-7/1 0 with problems chewing.

He then reported recurrent (though not necessarily chronic and unremitting) low back pain rated as a "6"/10.

He was diagnosed with hypertension and estimated this was perhaps 2 years ago.

While reporting spontaneously, he denied any other acute or chronic physical symptoms or conditions and a basic routine systems review was negative.

His primary treating physician through the Workers' Compensation System was Dr. [redacted] with whom the applicant had good attendance at follow up scheduled once monthly at present.

The applicant provided 2 bottles of medication: Modafinil 100 mg and Escitalopram 10 mg. He stated that his wife managed his medication and he took it otherwise with good compliance.

He had neither medical insurance coverage nor a primary care physician.

When asked specifically, he denied any current treatment via physical therapy, chiropractic, acupuncture or related modalities.

As for his current psychological condition, he described chronically depressed mood. He acknowledged high levels of recurrent anger, though adamantly denied any violent acting out. He did become verbally abusive and following this, he felt notably guilty. He tended to be withdrawn socially. He said his self-esteem was quite low. He described memory problems particularly for recent events. He described chronically anxious mood associated with nervousness, tension, and wide-ranging worry.

When asked specifically, he acknowledged recurrent feelings of hopelessness, word finding problems, "panic attacks" in public places and some avoidance of groups of people as a result, as well as diminished concentration.

He specifically denied, when asked, overall feelings of helplessness, self-deprecation and anhedonia. He did acknowledge occasional passive suicidal ideation, adamantly denying any plan or intent to harm himself as well as any past history of self-harm.

He said his appetite varied. He described 1 hour of sleep onset delay on average secondary to affective distress and occasional middle sleep insomnia. He otherwise described, to some degree, hypersomnia, claiming that he remained in bed on the average of 10 hours a day. When asked specifically, he acknowledged having nightmares, currently on the average of one every other week. He denied noteworthy energy problems during the day, when asked specifically, though did acknowledge nodding off on the average of twice weekly, typically in front of a television. He said his libido was notably diminished.

He had received 12 sessions of individual psychotherapy and 12 sessions of conjoint/family psychotherapy under the direction of psychologist, Dr. [redacted] last attending such a session an estimated 2 ½ months ago. The applicant did state that he derived what he had experienced as lasting benefits from these sessions.

He had been married once, for years and continuing. His wife was years old. She worked full time for currently from the family home, where she could provide assistance to him as needed. There were no known industrial problems. She was said to be in generally good health. There had been marital strain post his injury as he stated he was very argumentative and given to anger, though he adamantly denied any physical acting out. There had been no history of marital separations or violence.

The couple had 2 children. Their -year-old son was a senior in high school while their -year-old daughter was also in high school, though the applicant did not know her grade level. Both were performing adequately academically, though he did acknowledge that they seemed to have better academic performance prior to his injury. He stated he was given to verbalizing anger at the children, though again denied any physical acting out of any sort at any time. He denied that either of his children have any noteworthy health, behavior, developmental, social, substance abuse, legal or gang related problems.

His mother was years old and lived in . He did maintain regular contact with her. She was being treated for diabetes mellitus, though was otherwise said to be in good health without any noteworthy relationship or welfare problems.

He estimated his father died about 10 years ago secondary to a stroke. The applicant did not know his father's age at the time of death.

The applicant had 12 siblings, all living either in or . This included 4 sisters and 8 brothers. He did maintain contact with all of his siblings and denied any known significant health, relationship or welfare concerns regarding any of them.

He denied any clear, obvious biologic family history of mental illness or substance abuse.

He regularly maintained his hygiene. He estimated he did not change out of bedclothes on the average of once weekly. He did perform chores and fixes meals around the household. He watched television very regularly without comprehension problems, though he was distractible. He maintained contact with family (as described above).

He would occasionally go on a social outing, typically to a restaurant with his wife and possibly their children. He stated he would occasionally get on the internet via his SmartPhone.

He was currently attending College where he was taking 3 separate classes including English as a Second Language 4 times weekly. He stated that the other 2 classes were primarily to assist him in increasing his ability to focus and concentrate. He had good attendance at this program. He had had no noteworthy industrial problems with any of his fellow students nor any of the instructors. There was no homework, per his account. He had performed within the average range on tests. He then stated that once a week he had been doing some volunteer work at a store. He had been able to do this adequately. This took about 2 hours of his time on a weekly basis.

He must be transported on outings by others. He was not currently supervising his children in any regard, "because my feelings are too high." His wife handled all financial matters. His wife managed all of his medications. There were no pets. He had no friends with whom he was currently in contact.

He did not smoke cigarettes. He would drink "a couple of beers" on a social basis only. He did not currently use illicit drugs. He was not licensed for medical marijuana. He did state that he had previously used methamphetamine and was arrested some 4 years ago, being briefly jailed at the time, and subsequently completing all of his legal requirements. He had been entirely clean from this and all other drugs since then.

He denied any personal history of injurious motor vehicle accidents, past psychologic/psychiatric evaluation or treatment, prior Workers' Compensation claims, bankruptcy, and eviction. While he also denied any history of major surgeries, records (reviewed in Section IV of this report) do indicate he had undergone surgical interventions.

History of Present Illness: According to him, he began working with [redacted] in approximately as a full-time He did not currently recall where the company's headquarters was located.

He claimed good physical and psychological health when he took the job.

His primary duties were to prepare areas for drywall installation and this involved multiple physical activities.

His work schedule was Monday through Friday, 7:00 A.M. to 3:30 P.M. He was afforded a 30-minute lunch and two 15-minute breaks. He denied overtime.

There was no work-related performance, productivity, attendance, interpersonal, disciplinary, injury or other problems with his employer prior to the current industrial period in question:

The company had been working for about 3 months at a location in Irvine on a housing project. On [redacted] pproximately 1 hour into his workday, he explained, "I was putting together a scaffold for protection. I jumped and the scaffold broke." He subsequently fell to the ground, though did not estimate how many feet he fell.

He recalled injuring his right foot, jaw and head. He did appear to claim loss of consciousness stating that he next became aware of being in a hospital in [redacted] a (name unrecalled). He explained, "It's a trauma center. I don't know the name. I was there for two weeks. I was transfer to [redacted] in [redacted] ı for two weeks. I was in a wheelchair. They would show me how to get to the bathroom and dress myself I had physical therapy. They transferred me to [redacted] ı."

In this regard that he had sustained multiple physical injuries, primarily to the right foot and jaw, though he was not certain if he injured his low back in the fall or if this injury occurred due to altered ambulation arising from the right foot injury (records reviewed in detail in Section IV of this report, indicated he had wide-ranging injuries and underwent multiple surgeries, though he did not provide this history during our examination, despite being asked).

He did state that his treatment at [redacted] was as an outpatient basis, continuing for, "A little more than a year. I went to another program [Without Walls] where I got five different therapies [including physical therapy, speech therapy and psychotherapy]. He stated that this treatment occurred at his home and or upon being transported from his home to "different locations" where various therapies were administered.

He had retained an attorney, [redacted]

Early on, post injury, the applicant was referred to primary treating physician, Dr. [redacted] who, in turn referred him to [redacted] and to psychologist, [redacted]. The applicant said regarding Dr. [redacted] the applicant was provided with 12 individual psychotherapy sessions and 12 sessions of conjoint/family psychotherapy.

As for his psychological condition, he recalled immediate onset of anger, verbal outbursts followed by guilt, depression, anxiety, and wide ranging cognitive difficulties (all as described in detail in Section II of this report).

He then recalled that some 3 months ago he started courses at
College including English as a Second Language and courses to assist in his overall cognitive functioning (records indicate that this is an acquired brain injury program).

He could not provide more specific information. He had improved over time with regard to activities of daily living and did derive benefit from the psychological treatment given to him through the office of [redacted]

Diagnoses: Axis I - Major Depressive Disorder, Single Episode, Moderate, with Anxiety. Neurocognitive Disorder, per limited records currently available. Axis II – No diagnosis. Axis II – Diagnosis deferred. Pending receipt were medical records.

Based on his actual mental status, direct observations during this examination, psychological test results, his spontaneous account, and limited records, he was diagnosed on Axis I with a Major Depressive Disorder, Single Episode, Moderate, with Anxiety. Symptoms included depressed mood, social withdrawal, diminished self-esteem, feelings of hopelessness, appetite disturbance, hypersomnia, diminished libido, angry outbursts followed by guilt (which may well be an aspect of his Neurocognitive Disorder, discussed below), anxious mood, nervousness, tension, wide-ranging worry, some avoidance behavior of crowds, and recurrent passive suicidal ideation, he adamantly denying any plan or intent to harm himself nor any past history of attempted self harm. His affect at the time of this examination was restricted and his mood was clearly dysphoric with associated worry.

Based on limited records currently available (and pending receipt of all relevant records) as well as direct observations of the patient, he was assessed with a Neurocognitive Disorder reflecting diminished concentration, distractibility, memory problems, word finding problems, latency in responding to questions, and slowed overall cognitive functioning.

There was no evidence of a Personality Disorder on Axis II. He had met most developmental milestones adequately from a mental and emotional perspective. He had shown the ability to form relationships as was clearly evident by his 19-year and continuing marriage. He had shown the ability to work productively as evident by a long history of work in the construction field.

Final and definitive diagnosis and discussion of his wide ranging physical condition on Axis III was deferred to the appropriate medical specialists and pending receipt of a full medical file. Per the psychological report of [redacted] Ph.D., he reviewed records from primary treating physician, [redacted], who was said to have diagnosed the applicant as follows: right ankle fracture, sequelae; mandible fracture, sequelae; visual impairment; cognitive and behavioral changes; impaired cognition; neuropathic pain syndrome (non herpetic); Generalized Anxiety Disorder; obstructive sleep apnea syndrome;

Depression; neuropathic pain; impaired vision; and brain injury involving loss of consciousness, sequelae (HCC), per report dated .

Periods of Temporary Psychological Disability: It appeared, from the evidence currently available, that the applicant has been temporarily totally disabled on a psychological/neurocognitive basis since very substantial injuries sustained on . He was considered to have reached maximal medical improvement by psychologist, [redacted] Ph.D., . Nonetheless, it was not clear as yet to this examiner if the applicant remained temporarily totally disabled or had, in fact, reached maximal medical improvement. Additional records would assist in making this distinction. In any event, he certainly manifested various impairments associated with his psychological illness. These included concentration/attention problems with noteworthy levels of distractibility. His productivity was diminished overall. He had no gainful employment since the date of injury. His wife managed his medications and handled all financial matters. He reportedly was dependent on others for transportation. He was given to angry outbursts followed by guilt, though adamantly denied any physical violence. There was some degree of fatigue and hypersomnia. To his credit, he was attending College where he was said, by [redacted] to be participating the acquired brain injury program at College. A discussion of temporary disability from a purely physical point of view was deferred to the appropriate medical specialists.

Current Disability Status: It could not yet be formally determined whether the applicant had, in fact, reached a level of maximal medical improvement psychologically. Once critical records were forwarded, this would be addressed further.

Medical Causation/Apportionment: It was quite clear that an industrial fall with wide-ranging injuries sustained during the course of his usual and customary work duties on while employed at [redacted] was the direct and predominant cause (greater than 50% AOF/COE) of his overall psychological illness. Based on his account and limited records currently available, he had received extensive psychological and cognitive intervention thus far via programs at [redacted] and the aforementioned acquired brain injury program at College. The applicant remained notably symptomatic emotionally and neurocognitively. Only when his psychological condition was formally deemed to have reached maximal medical improvement could a final assessment of any possible factors of apportionment be undertaken.

Recommendations: Based on the information currently available, and pending receipt of additional requested information at which time [redacted] reserved the right to make changes in treatment recommendations, the following were current

treatment recommendations: the applicant should have 12 weekly sessions of psychotherapy of a supportive and behavioral nature aimed specifically at managing his anger so as to minimize adverse effects on his immediate family. Six of these 12 sessions should be conjoint in which both the applicant and his wife attend the session. He certainly needed appropriate psychotropic medicines. This would be best assessed by a psychiatrist familiar with treating brain injured patients. In this regard, he should have an evaluation for and prescription of appropriate psychotropic medicines and follow up with the treating psychopharmacologist on 5 subsequent occasions. After he had completed the 12 total sessions of psychotherapy, he should be seen again for formal psychological reassessment. In the interim, it was presumed that all relevant records would be forwarded. Prognosis was substantially guarded.

Driving Evaluation Summary, [redacted] dated

Driving Evaluation Summary: The applicant vision and physical function appeared within normal limits. He was recommended distance glassed be rechecked. His right foot pain did not affect his driving function. His visual processing was tested slow. His main problem seemed to be confidence due to both his injury and his long off from driving. He was recommended 8 hours training.

Impairment Rating Report, signed by [redacted], M.D., dated

GAF rating = 57 with whole person impairment of 20%; central and peripheral nervous system 22%; and pain 3%.

Calculated total whole person impairment was 39% from neurorehabilitation standpoint.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated

Interval History: The applicant was last on where he was made permanent and stationary. Since the last visit, patient has been stable. He continues to attend program 2 hours per day 2 days per week, ESL classes 2 hours per day 4 days per week, and gym 1 to 2 hours per day 3 to 4 days per week. He was not volunteering. He had been able to obtain his medications. He needed gym membership renewal. He still had not yet seen psychiatrist and his psychological sessions have ended without authorization for extension. He needed paper work to be filled out to undergo driving test at DMV.

Subjective Complaints: He complained of jaw and teeth pain, right foot pain, right occipital area pain, blurred vision, impaired cognition, behavioral changes, hearing problems, anxiety, and sleep disturbance.

Diagnoses: 1) Traumatic brain injury without loss of consciousness. 2) History of traumatic brain injury. 3) Closed right ankle fracture, sequelae. 4) Brain injury, without loss of consciousness, sequelae. 5) Visual impairment. 6) Cognitive and behavioral changes. 7) Impaired cognition. 8) Neuropathic pain syndrome. 9) Generalized anxiety disorder. 10) Obstructive sleep apnea syndrome. 11) Depression, unspecified type. 12) Closed fracture of mandible, unspecified site, sequelae. 13) Ankle fracture, right, sequelae. 14) Impaired vision. 15) Neuropathic pain. 16) Obstructive sleep apnea. 17) Fracture of mandible, unspecified, sequelae.

Disability Status: He was considered permanent and stationary and had reached maximum medical improvement from neurorehabilitation and neurocognitive standpoint.

Causation: The mechanism of injury resulted in his current disabilities and impairments.

Restrictions: He was not to drive, no unprotected heights, and no distracting environment.

Treatment Plan: He was to continue with program, ESL classes and gym. He was to renew gym membership. He was still waiting psychiatric consultation. He was recommended to continue with adjustment counseling. He was to follow-up Dr. and all specialists. He was to continue with translator and transportation for medical appointments. He was to continue Provigil and Lexapro. He was to undergo driving test. He was to follow-up in 3 months.

Complex Comprehensive Orthopedic Qualified Medical Evaluation, signed by dated

The applicant worked for as a for approximately year, from to During the course of his employment, he sustained injury to his head, jaw and right ankle.

On , he was working on the roof of a 2-story home, transferring material to a co-worker who was standing on the scaffolding, adjacent to the roof. When he stepped onto the scaffolding, it suddenly broke and collapsed onto the ground, causing the worker to fall approximately 15 to 20 feet. He did not have any recollection of falling, but stated that he woke up in the emergency

room. He stayed at that hospital for approximately 3 weeks due a fractured jaw and right ankle, and a scalp laceration and head trauma. His treatment there consisted of right ankle surgery and jaw surgery. He did recall what kind of tests he underwent there or any other type of treatment performed.

Near the beginning in [redacted], he was transferred to [redacted] Hospital for approximately 2 weeks. During his stay there, he underwent daily occupational therapy and began seeing [redacted] a neurologist. The applicant was then discharged to home, and began daily treatment at [redacted] consisting of occupational, physical, and speech therapy lasting approximately 18 months. He did not remember any of the names of his treating providers at that time except for his primary doctor. He also began seeing an orthopedic physician at that time, who dispensed an ankle brace.

He developed low back pain after leaving [redacted] due to the activities that were required of him, but that he did not believe it was not caused by the accident.

In approximately the beginning of , he retained services from an attorney.

After completing the 18 months of therapy, his care was transferred to a service called Rehab without Walls) which was a daily program to help him become reintegrated into regular, daily activities. He did this program for one year, and was then phased out. He was subsequently placed a college class that is designed for patients recovering from head injuries.

His current treatment program consisted of the college class 2 times a week, regular visits with his [redacted] monthly visits with the psychiatrist as well as the ENT for the jaw injury. The applicant recently saw an orthopedic physician to get his right ankle brace replaced. He was currently taking Modafinil, Escitalopram, and over-the-counter Advil or Tylenol. He was also pending authorization for family counseling.

He had frequent, moderate, aching headaches, slight to moderate, constant jaw pain) slight to moderate, aching and dull ankle pain, and moderate and aching low back pain. He stated that resting and less movement provided relief, and that prolonged walking or standing caused him increased low back pain. He reported that constant chewing of hard food aggravated his jaw pain. He was not currently working and had not worked since his date of injury. Lower back started at [redacted] during Rehab and also developed Vision and hearing loss and memory loss.

He reported a history of depression. He reported undergoing mandibular and right ankle surgery in . He was currently taking Modafinil and Escitalopram.

Current Complaints: He currently complained of frequent, moderate, aching headaches, slight to moderate, constant jaw pain, slight to moderate, aching and dull ankle pain, and moderate and aching low back pain. He stated that resting and less movement provided relief, and that prolonged walking or standing caused him increased low back pain. He reported that constant chewing of hard food aggravated his jaw pain. He was not currently working and had not worked since his date of injury.

Diagnoses: 1) Status post internal fixation of jaw. 2) Hearing and vision loss. 3) Laceration head. 4) Status post internal fixation of right ankle.

Discussion and Causation: It was opined that he had sustained significant trauma injury affecting his brain function and eyesight and hearing and lower extremity.

This qualified medical examiner was able to combine all impairments as per the losses mentioned above pursuant to the specific injury of upon receipt of specific detailed impairment ratings specifically from the eye and the hearing Dr. pertaining to the losses incurred.

This undersigned would comment at this time only as pertaining to the orthopedic complaints and the loss of cognition pending receipt of specific comments regarding the others.

It was reasonable to assume that this applicant's condition would not significantly change in the foreseeable future therefore might be considered permanent and stationary at this time of . for rating purposes with injuries as documented in orthopedics for his right ankle and secondarily pain in his back.

Subjective Factors of Disability: He had constant slight to moderate pain in the right ankle pain on palpation occasional lower back pain and pain in the jaw.

Objective Factors of Disability: X-ray findings of internal fixation of the John the right ankle. He had arthritic changes as a narrowing of the joint of the right ankle. He had decreased range of motion in the right ankle. He had scars from internal fixation of right ankle. He had slight decreased sensation right ankle. He had use of hearing aids status post injury. He had claimed loss of vision subsequent to injury. He had temporary loss of consciousness was subsequent cognition difficulties.

Work Restrictions: He had a work restriction precluding repetitive squatting climbing walking on uneven terrain or at heights.

Impairment Ratings: The impairment rating on him was consistent with AMA Guides report this undersigned provided for which allowed for the orthopedic impairment at 14% for the loss of range of motion of the right ankle as per chapter 17 page 533 and 538 figure 17/5.

The peripheral sensory loss as noted was consistent with chapter 17 pages 515 552 table 17/37 and 16 at 4% lower extremity. The peripheral motor loss was consistent with chapter 17 pages 550 through 552 table 17/37 at 13% lower extremity.

The sensory loss associated with the status post head trauma was consistent with class I impairment at 14% whole person as per table 15/2 page 309 of the AMA guide 5th edition.

Converting lower extremity to hold person by factor 0.4 then combining all of the above provided for 23% whole person impairment.

This was to be combined with impairments of the jaw, eyes and ears loss of function consistent with the injury.

Apportionment: A 100% of the above-mentioned impairment was due to the ill effects of the specific injury occurring on

Vocational Rehabilitation/Job Displacement Benefits: Job displacement benefits were provided to injured workers who were unable to obtain employment within the above-mentioned work restrictions. At that time the disability evaluation unit of the state of California would provide for impairment related educational vouchers in parallel to the level of impairment/disability.

Future Medical Care: He was to have surgical removal of hardware from the jaw and right ankle if and when indicated. He was to have pain medication and integrative pain management control. He was prescribed psychotropic medication. He was to use right ankle brace. He was to consult with ortho and neurologist. He was to have physical therapy 2 visits.

Comprehensive Orthopedic Supplemental Report, signed by [redacted], D.O., dated

Discussion: [redacted] did not change his previous opinion.

Psychotherapy Session Note, signed by [redacted], Ph.D., dated .

The applicant underwent psychotherapy session.

Caldwell Report, by [redacted] Ph.D., dated .

The applicant underwent MMPI-2.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated

Interval History: The applicant continued to attend [redacted] program, ESL classes and gym. He had resumed volunteering in a second hand store. He had seen psychiatrist and psychologist and was on new medication regiment. His gym membership was being worked on by case manager.

Subjective Complaints: He complained of jaw and teeth pain, right foot pain, head pain locate at the right occipital area, blurred vision, impaired cognition, behavioral changes, anxiety, sleep disturbance.

Diagnoses: 1) History of traumatic brain injury. 2) Close right ankle fracture, sequelae. 3) Visual impairment. 4) Cognitive and behavioral changes. 5) Impaired cognition. 6) Neuropathic pain syndrome (non-herpetic). 7) Generalized anxiety disorder. 8) Depression, unspecified type. 9) Fracture of mandible of other site, sequelae.

Disability Status: He was considered permanent and stationary.

Causation: The mechanism of injury resulted in his current disabilities and impairments.

Restrictions: He was not to drive, no unprotected heights, and no distracting environment.

Treatment Plan: he was to continue with [redacted] program, ESL classes, volunteer work and gym. He was to continue psychiatric treatment and psychologist counseling. He was to follow-up [redacted] and specialists. He was to continue translator and transportation for medical appointment. He was to wait driving test. He was referred to orthotist.

Comprehensive Medical-Legal Psychiatric Evaluation Report, signed by [redacted] M.D., dated _____

Current Complaints: The applicant had been experiencing psychiatric and emotional problems. He suffered from anxiety, anger, depression, sadness and fear.

He slept well; however, he had nightmares regarding his accident about 3 to 4 times monthly.

He noted he had a good appetite and fair energy level. He was able to finish his routine chores and responsibilities and said his sex drive was fair.

Currently, he described his overall mood as sad, irritable, fearful, nervous, upset with severe temper, and he lacked desire to do anything. He was currently able to work.

History of Present Illness: He was seen for a psychiatric- evaluation on _____. He was status posttraumatic brain injury. He also broke his jaw, neck, and back, and also had a right ankle fracture.

His job was to install scaffolds. He was traumatized while performing his job in _____ while he was installing the scaffolds. He reports falling and in the process had a traumatic brain injury and injury to his neck and back, fractured his right ankle, and also broke his jaw, which had to be repaired. Currently, he reported labile mood and irritability. He reported problems managing his anger. He had anxiety and fearfulness. He had periodic symptoms of confusion and excessive sleepiness. He also reported his muscles had become weak. He had problems focusing and concentrating, with a history of lapses of memory.

He denied symptoms related to thought disorder, ideas of reference, or prominent delusion. He had a problem managing his anger. He was being irritable. He was having a fear of heights and of crowded places. He periodically felt like he wanted to give up but denied specific suicide plan. He had recurrent intrusive thoughts, memories, and flashbacks of the trauma of the accident.

He was being referred for the management of the above psychiatric symptoms.

He had been suffering from the above psychiatric symptoms since the date of injury, _____.

He was currently on Modafinil, Amiodarone, Advil, and Tylenol.

Diagnoses: Axis I – Mood disorder due to a general medical condition. Anxiety disorder due to a medical condition. Rule out posttraumatic stress disorder, chronic. Rule out dementia due to a medical condition. Axis II – No diagnosis. Axis III – History of traumatic brain injury. History of injury to the neck and back. History of fractured jaw. History of fractured right ankle. Deferred to the appropriate specialists. Axis IV- Severity of current psychosocial stressor due to work-related traumatic injury, Moderate to severe. Axis V – GAF = 39.

Summary and Conclusions: In the case of him, an assessment of Mood disorder due to a general medical condition; Anxiety disorder due to a medical condition; Rule out posttraumatic stress disorder, chronic; and rule out dementia due to a medical condition was offered on Axis I on the basis of his history, mental status examination, review of medical records, and psychological testing. He remained temporarily totally disabled.

Temporary Disability: He remained temporarily totally disabled psychiatrically on an industrial basis.

Causation: His work injury contributed at least 51% to his psychiatric condition and was the predominant cause of his disability.

Medical Care: He required treatment both with medication and psychotherapy.

Ability to Work: He was unable to work in his former capacity.

Psychotherapy Session Note, signed by [redacted] Ph.D., dated

The applicant underwent psychotherapy session.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated

Interval History: The applicant continued to attend program, ESL classes and gym. He had stop volunteering. He continued to see psychiatrist and psychologist. He had another child.

Subjective Complaints: He complained of jaw and teeth pain, right foot pain, head pain located at the right occipital, blurred vision, impaired cognition (resolved with new glasses), impaired cognition, behavioral changes, hearing problems, anxiety, and sleep disturbance.

Diagnoses: 1) history of traumatic brain injury. 2) Closed right ankle fracture, sequelae. 3) Visual impairment. 4) Cognitive and behavioral changes. 5) Impaired cognition. 6) Neuropathic pain syndrome. 7) Generalized anxiety disorder. 8) Depression, unspecified type. 9) Fracture of mandible of other site. 10) Traumatic brain injury, without loss of consciousness. 11) Ankle fracture, right, sequelae. 12) Impaired vision. 13) Neuropathic pain.

Disability Status: He was considered permanent and stationary.

Causation: The mechanism of injury resulted in his current disabilities and impairments.

Restrictions: He was not to drive, no unprotected heights, and no distracting environment.

Treatment Plan: He was to follow-up with [redacted] to obtain psych clearance. He needed to be assigned to another psychiatrist. He was to continue with [redacted] program, ESL classes, volunteer work and gym. He was to follow-up Dr. [redacted] and specialists. He was to continue translator and transportation for medical appointment. He was to wait driving test.

Primary Treating Physician's Progress Report, signed by [redacted], Ph.D., dated [redacted].

Subjective Complaints: The applicant was taking Clonazepam, Prazosin, Topiramate, and Quetiapine. Initially his medications caused increased nightmares. His nightmares were work-related. It occurred once a week to once every 2 weeks. He also reported post-traumatic stress disease symptoms including jumpiness and somatic complaints. He reported anxiety regarding upcoming events including studying for citizenship and driving test. He did not pass his written driver's test. He had financial stressors. He felt anger and irritability were decreasing but could impact his ability to parent.

Diagnoses: 1) Diffuses traumatic brain injury with altered consciousness. 2) Mild neurogenic disorder with behavioral disturbance. 3) Other chronic pain. 4) Pain disorder related to psychological factors. 5) Mood disorder due to traumatic brain injury, with depressive features. 6) Personality change due to traumatic brain injury. 7) Sleep disorder due to traumatic brain injury. 8) Unspecified disorder of binocular vision. 9) Temporomandibular joint disorder.

Treatment Plan: Requested was 6 psychotherapy sessions provided on a bi-monthly basis. A transfer of care was also requested to [redacted] Ph.D.

Work Status: He was totally temporarily disabled from the time of his injury up to , when he became permanent and stationary.

Psychiatric Progress Note, signed by [redacted] M.D., dated

Current Progress: The applicant was suffering from aftermath of his injury. He also had history of injury to his neck and back. He fractured his jaw and right ankle. Current psychiatric symptoms included anxiety, panic attack, preoccupation with labile mood, irritability, racing thought, agitation, problem managing anger, chronic insomnia, recurrent intrusive thoughts and memories and flashbacks of trauma related incident. His disability status remained temporary total.

Treatment Plan: He remained on Clonazepam 0.5 mg, Topamax 25 mg, Seroquel 25 mg, and Prazonin 1 mg. He could drive with his significant other person sitting near him, also was very cautioned not to drive when he felt sedated or when he felt confused.

Comprehensive Progress Note, signed by [redacted], M.D., dated

Current Progress: The applicant was suffering from mood disorder due to medical condition and chronic post-traumatic stress disorder. His symptoms were in reaction to work-related injury and other multiple bodily injuries from which he had recovered. He currently still had fluctuation in mood irritability, anxiety, racing thought, agitation, insomnia and problem modulating anger.

Treatment Plan: He was responsive to Seroquel 25 mg, Prazonin 1 mg, Clonazepam 0.5 mg, and Topamax 25 mg. He was cleared to drive.

Team Conference Note, signed by [redacted] Undated.

Medical Substantiation: He was to continue attendance at [redacted] TLC 3 days a week for 4 weeks. He was recommended to undergo counseling with psychologist or neuropsychologist. He was to follow-up [redacted]. He was to continue follow-up with specialist. He was to undergo neuropsych evaluation.

Medical Report, , undated.

Assessment: The applicant was medically stable with intermittent ankle pain. The surgical site on the scalp had healed. He was functionally improved.

Impressions: 1) Multiple orthopedic injuries status post MVA. 2) Left comminuted mandible fracture, status post ORIF. 3) Difficulty walking, non-weight bearing right lower extremity.

He was discharged home.

That completes the review of records.

HISTORY OF PRESENT ILLNESS

The applicant states that on the date of injury, he was working on the second floor, in the process of making a scaffold, when he fell approximately 18 feet. He states that he lost consciousness, and woke up in the hospital. He is not sure how many days he was in the hospital, but states that he had several procedures done on him, including: mandibular surgery, suturing the back side of his head, and a procedure on his right foot. It was not until he was in a rehabilitation facility, approximately 2 months after the original injury that he noticed ocular symptoms which included: blurry vision bilaterally, fatigued vision, double vision, and burning in both eyes. He adds that these symptoms have gotten better since the injury.

He has seen an eye doctor on two occasions since this injury. He states that the eye doctor told him he has a cataract and prescribed him glasses, which he wears on occasion. He feels that from a visual standpoint he is able to work.

JOB DESCRIPTION

The applicant worked as a carpenter; he was in charge of the wooden structures of houses.

CURRENT VISION COMPLAINTS

He complains of blurry vision, especially in the right eye, as well as intermittent burning sensation in both eyes. He also experience light sensitivity at night.

PAST MEDICAL HISTORY

Denies

SOCIAL HISTORY

No tobacco, occasional alcohol; currently not working

MEDICATIONS

For anxiety

ALLERGIES

Denies

PAST OCULAR HISTORY

Denies

EXAMINATION

Visual acuity with correction in the right is 20/40, and in the left eye is 20/20, and in both eyes is 20/20. Refraction did not improve vision in the right eye.

Pupils were equally round and reactive to light in both eyes; no afferent pupillary defect was noted in either eye.

Visual fields were full to confrontation in both eyes.

Ocular motility was within normal limits in both eyes.

Intraocular tension was 18 in both eyes by applanation.

Lids and lashes were within normal limits in both eyes.

Sclera and conjunctiva were within normal limits in both eyes.

Corneas were clear in both eyes.

Irises were regular and round in both eyes.

Anterior chambers were deep and quiet in both eyes.

Lens examination in the right eye was remarkable for a moderate paracentral cortical cataract; lens exam in the left eye was within normal limits.

Dilated fundus exam revealed normal disc, macula, vessels, and periphery in both eyes.

[redacted]

IMPRESSION

1. Traumatic cataract right eye

DISCUSSION

The applicant's visual impairment is caused by the cataract in the right eye. The relevant question to be addressed is whether his work-related trauma of [redacted] is responsible for this cataract. An attached article entitled "Traumatic Cataract: A Review" by Emily Jacobs et al in the Journal of Ocular Biology (May 2016) describes the etiology and management of traumatic cataracts. According to this article, blunt or penetrating ocular trauma causes damage to the lens, bringing about a traumatic cataract. Our applicant clearly didn't have penetrating ocular trauma to his right eye, and my review of medical records did not reveal any mention of signs of blunt ocular trauma to the right eye as the applicant was being cared for on an emergency basis for the traumatic injury in question. That said, the applicant's traumatic injury was fairly catastrophic, involving multiple body parts, involving the back and front of his head, and requiring various types of surgery; it is conceivable that during this traumatic injury, a more subtle but blunt trauma did occur to the right eye as well.

Furthermore, I reviewed the medical literature to see whether traumatic cataract may occur in the setting of head trauma, but without direct ocular trauma. In fact, such a case report is described and attached; it is entitled "Cataract Formation without Specific Ocular Trauma after Traumatic Brain Injury: A Case Report" by Carol Li, et al, published in the International Journal of Physical Medicine and Rehabililation (2016).

To summarize, the catastrophic nature of the applicant's injury, in conjunction with his young age (which goes against pre-existing cataract), and my review of relevant literature lead me to believe there is a reasonable medical probability that the applicant's cataract in the right eye is a direct result of his traumatic work-related injury of [redacted]

CAUSATION

It is medically reasonable that the applicant's work related injury of [redacted] caused a traumatic cataract of the right eye.

PERMANENT AND STATIONARY STATUS

At this time, the applicant is at permanent and stationary status with regards to the traumatic cataract of the right eye.

IMPAIRMENT

Visual impairment is assessed utilizing guidelines provided by the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, Chapter 12, and the Visual System. Using Tables 12-2 and 12-3 on page 284, we arrive at a functional acuity score of 97, which correlates with an impairment rating of ***3%***. According to Table 12-4 on page 285, this places our applicant in Class 1 of Visual Impairment, within the range of normal vision.

APPORTIONMENT

100 percent of the applicant's visual impairment may be apportioned to the traumatic cataract brought about by the industrial trauma of [redacted].

ABILITY TO WORK

According to Table 12-10 on page 298, our applicant's visual impairment places him in class 1 of whole person impairment, with reserve capacity, and normal or near-normal ability to perform activities of daily living. From a visual standpoint, I believe the applicant may return to his occupation without restriction.

FUTURE CARE

The applicant should have annual examinations to monitor the status of his right-sided cataract on an industrial basis. Should the cataract progress, causing further decrease in the visual acuity of the right eye, and interfering with the applicant's activities of daily living, it would be reasonable to perform cataract surgery, once again on an industrial basis

[redacted]

SPECIAL COMMENTARY

The above responses and opinions are based on reasonable medical probabilities, as viewed from the perspective of available documentation and information submitted to this examiner, including the applicant's direct anamnesis.

Thank you for the opportunity of serving as Qualified Medical Examiner, in the specialty of Ophthalmology, for this most interesting case and condition.

Sincerely,

_____

David Paikal, M.D., Q.M.E.
Diplomate, American Board of Ophthalmology

Attachments:
1. Appendix A: Declaration
2. Appendix B: Medical Research

APPENDIX A - DECLARATION

Pursuant to AB 1300, LC Sec. 5703, I have not violated Labor Code section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

DATE OF REPORT:

Dated this at

David Paikal, M.D., Q.M.E.
Diplomate, American Board of Ophthalmology

International Journal of Physical Medicine & Rehabilitation

Li et al., Int J Phys Med Rehabil 2016, 4:5
DOI:10.4172/2329-9096.1000357

Case Report Open Access

Cataract Formation without Specific Ocular Trauma after Traumatic Brain Injury: A Case Report

Carol Li, Sandra Fox and Blessen C Eapen*

Blessen C Eapen, Department of Rehabilitation Medicine, University of Texas Health Science Center, San Antonio, USA

***Corresponding author:** Blessen C Eapen, Department of Rehabilitation Medicine, University of Texas Health Science Center, San Antonio, USA, Tel: +1-584-4662; E-mail: blessen.eapen2@va.gov

Received date: July 01, 2016; **Accepted date:** July 26, 2016; **Published date:** July 29, 2016

Case Report

29 year-old African American male with no significant past medical history was a restrained driver involved in a motor vehicle side collision sustaining primarily left sided cranial injuries including left zygomatic and greater wing of sphenoid bone fractures, left frontal and temporal lobe epidural hematomas with 4mm shift and subsequent left temporal bone fracture requiring emergent evacuation and craniotomy. Patient was diagnosed with severe traumatic brain injury (TBI) and sustained multiple fractures involving pelvis, cervical, thoracic spine, and face but no reports of specific ocular injuries. During the patient's three-month inpatient neurorehabilitation stay at the VA Polytrauma Center, the patient was followed extensively by an interdisciplinary team including neuro-optometrist and vision rehabilitation specialists. A dilated fundus exam was completed 4 weeks after initial injury, and dot hemorrhages were identified in the inferior retina of right eye, suggesting trauma force to this eye.

A second dilated fundus exam was repeated 2 months after initial injury, and residual exudates from prior dot hemorrhages were again seen in the inferior retina of right eye in addition to cataract formation (Figures 1 and 2). Though patient sustained mostly left sided injuries as listed above, patient also sustained a fracture of the clivus with initial MRI brain demonstrating a small area of infarction to the right temporal lobe near upper brainstem. Given the anatomical proximity of clivus to the retina and basilar artery's connection to posterior cerebral artery, this may suggest a vascular etiology rather than the typical blunt force trauma etiology for patient's right ocular findings. Based on the severity of patient's injury and the absence of premorbid or family history of ocular pathology, this cataract finding is likely related to patient's TBI.

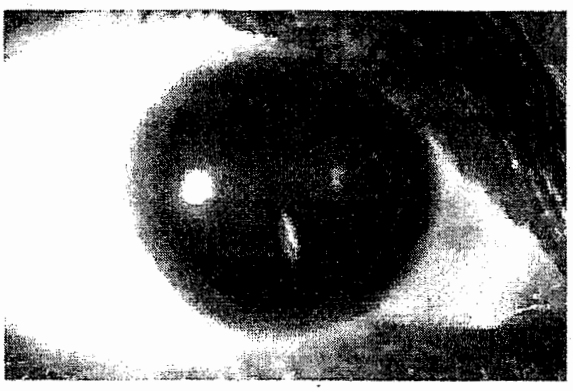


Figure 1: Retina of Eye.

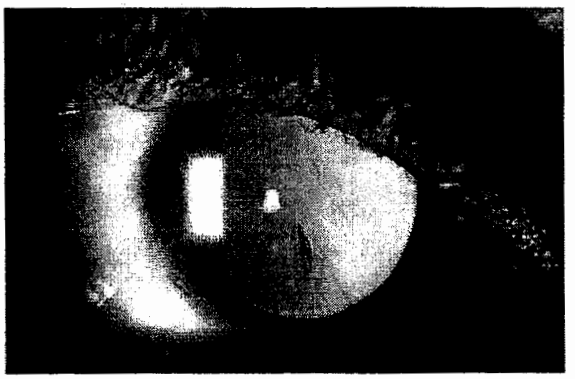


Figure 2: Photosensitivity.

Patient did not have any subjective symptoms other than dry eyes and photosensitivity. Patient did not have any complaints of eye pain, disruption in extraocular movements or diplopia. On initial exam, patient had slight nasal deviation of right eye, exhibited difficulty with smooth pursuit and saccadic movements of bilateral eyes leading to omission and addition reading errors, and had poor depth perception. All occulomotor skills improved and abnormal eye movements resolved with weekly vision rehabilitation. Given that patient's cataract was in the inferior temporal region of retina, functional vision was left intact.

It is well known that brain injury of all severities can cause visual disturbances and abnormalities. Current literature mainly addresses traumatic cataracts as a result of penetrating injuries as it is the leading cause of monocular blindness in pediatric age groups, and is more often associated with worse prognosis [1-3]. Cataracts are common after direct trauma, specifically blunt and open globe trauma and predominantly in males as reported in both pediatric and adult literature. However, non-perforating trauma such as concussive injuries to the orbit, head or body can also cause cataract formation [4,5]. There is limited information in regards to timeline of cataract formation after trauma. In adults, increasing age is the primary risk factor for cataract formation; however, certain military members, especially Marine Corps and Army, have higher incidence of traumatic cataracts due to occupational exposure [4]. Demographically, incidence rate is higher in black and non-Hispanic service members [4]. Given that this patient was also a service member, he may have other occupational exposure that may have put him at risk for cataract formation. However, in setting of known brain injury, etiology of patient's cataract is likely traumatic, though the mechanism may be

more indirect as most of his injuries are left sided. Additionally, the location of this patient's cataract is inferior, which differs from the more common anterior, segmental or subcapsular location [5]. To the authors' knowledge, this is the first case of unilateral traumatic cataract in the setting of traumatic brain injury without a specific associated ocular trauma. Findings from this case emphasize the importance of conducting visual screening to include a fundoscopic eye exam even if patient is generally asymptomatic. This becomes even more important in cases when patients with severe traumatic brain injuries may not have the communication abilities or cognition to convey symptoms. Early identification of cataract can facilitate management and maximize vision outcomes. Traumatic cataracts may lead to lens opacification, which can progress to decreased light perception and vision loss [5]. Fortunately in this case, there was no effect on functional vision given location of cataract, and patient will require periodic monitoring; however, removal of the cataract by a retinal surgeon may be necessary in the future to prevent known complications like retinal detachment. Additional research is needed to explore the incidence and overall prognosis of this condition in TBI populations.

References

1. Zhu L, Wu Z, Dong F, Feng J, Lou D, et al. (2015) Two kinds of ocular trauma score for paediatric traumatic cataract in penetrating eye injuries. Injury 46: 1828-1833.
2. Ventura RE, Balcer LJ, Galetta SL (2014) The Neuro-ophthamology of head trauma. Lancet Neurology 13:1006-1016.
3. Shah MA, Shah SM (2011) Morphology of Traumatic Cataract. British Jounrnal of Ophthalmology 1: 1-7.
4. Emasealu OV, Dorsey KA, Nagarajan S (2014) Surveillance of cataract in active component service members, US Armed Forces 2000-2013. MSMR 21: 10-3.
5. Gombos Dan S, Gombos, George M, (2008) Roy and Fraunfelder's Current Ocular Therapy. Page no 560-562.

Avens Publishing Group

J Ocular Biol

May 2016 Vol.:4, Issue:1

Traumatic Cataract: A Review

Keywords: Traumatic cataract, Ocular trauma; Intraocular lens; Capsular tears

Abstract

Purpose: Cataract formation is common following ocular trauma and is a major cause of vision loss worldwide. The purpose of this review article is to discuss the current approaches to treatment of traumatic cataracts.

Methods: Review of the recent literature regarding traumatic cataract was performed.

Results: The mechanisms behind cataract formation, as well as surgical indications, surgical planning and approach in the acute setting are discussed.

Conclusions: Uniformity in the classification and reporting of surgical results is needed to provide better care to patients with traumatic cataracts.

Open Access Review Article

Journal of Ocular Biology

Emily J. Jacobs* and Bradford L. Tannen

Department of Ophthalmology, Icahn School of Medicine, Mount Sinai, USA

***Address for Correspondence**

Emily J. Jacobs, M.D, Department of Ophthalmology, Icahn School of Medicine, Mount Sinai, One Gustave L. Levy Place, Box 1183, New York NY 10029, Tel: 212-241-6752; Fax: 212-241-5764; Email: emily.jacobs@mountsinai.org

Submission: 23 Mar, 2016
Accepted: 26 Apr, 2016
Published: 03 May, 2016

Introduction

Ocular trauma is frequently associated with the formation of a traumatic cataract [1-3]. Both blunt and penetrating trauma can cause damage to the crystalline lens. Cataract is estimated to occur in up to 65% of eye trauma cases, and is a major cause of acute and longstanding visual loss worldwide [1,4].

Cataract Formation

Opacification of the crystalline lens may occur immediately after trauma or may not appear for years [5]. The type of cataract formed is related to the nature and extent of the trauma [6]. The morphology of cataracts formed due to penetrating trauma is typically related to the size of the opening in the lens capsule. No standard morphologic classification exists [7]. Large capsular openings may cause the entire lens to rapidly become cataractous, while smaller openings may self-seal leaving only a focal opacity localized to the site of penetration. Cataracts may also form without any loss of capsular integrity due to forces of the original trauma or subsequent inflammation. Anterior subcapsular cataracts are formed when damage to the lens causes peripheral epithelial cells to undergo fibrous metaplasia, which creates an anterior fibrous plaque. Cataracts formed from blunt trauma often have a rosette or flower-shaped appearance, the petals of which correspond to sectors of cortical opacity [8]. Posterior subcapsular cataracts are also commonly associated with trauma [9].

Acute Assessment

In the setting of acute ocular trauma, a thorough assessment is made to determine the extent of ocular injury. This includes visual acuity, pupils, intraocular pressure, slit lamp biomicroscopy, dilated fundus examination, and ancillary imaging depending on the nature of the injury (frequently CT scan and B scan ultrasound). Obvious signs of zonular damage such as phacodonesis, iridodonesis, vitreous prolapse and lens subluxation should be looked for but may not be present. Subtle signs may include visibility of the lens equator during eccentric gaze, decentered nucleus in primary position, iridolenticular gap, changes in the contour of the lens periphery and focal iridodonesis [10]. The initial task is to determine whether a surgical or other acute emergency exists.

Surgical Indications and Timing

In the acute setting, surgery to remove a traumatic cataract has not traditionally been recommended [11]. Where a penetrating or perforating globe injury is present, the standard recommendation is primary globe closure, followed later by a "secondary" procedure to remove the cataract and place an intraocular lens (IOL). There are several advantages to this approach [12]. First, in the acute setting, the degree of cataract and its visual significance may not be readily apparent. Even with penetrating injuries that clearly involve the lens capsule; a small focal opacity may ultimately be visually insignificant once the eye has healed from the initial trauma [11]. Second, a "primary" procedure in conjunction with globe repair may not allow for a thorough assessment of associated injuries to the adjacent ocular structures, which are critically important in pre-operative cataract surgical planning. The surgery itself may be made technically more difficult due to poor visualization from resulting media opacities in the cornea, anterior and posterior segments. A primary approach may also limit an adequate assessment of retinal or optic nerve damage that, if severe, may make cataract surgery inconsequential. In addition, calculations for placement of an IOL and decisions about the type of lens and positioning may be compromised in the acute setting. One study has shown significant improvement in visual acuity in patients with open globe injury, following placement of a secondary IOL. The subsequent IOL implantation was performed at a mean of 4.63 months following the last surgical procedure related to the initial ocular injury [13]. Finally, a non-ideal operating room setting may have to be used with less experience staff, particularly when performed outside of standard operating hours, as is often the case with penetrating globe repair. Despite the above, and although no clear consensus exists, primary cataract removal in the acute setting may be preferred in certain situations and has been more frequently proposed in recent literature [3-4,7,14,15]. Some studies have shown a relationship between earlier surgical intervention and visual outcome [16]. In the acute setting, extensive lens capsular rupture can release flocculent cortical material into the anterior chamber. This may cause a significant inflammatory response and intraocular pressure elevation, which can improve with primary cataract removal

ISSN: 2334-2838

[1]. Another benefit of primary removal is earlier direct visualization of the posterior segment and optic nerve. In these settings, primary cataract removal combined as necessary with limited anterior vitrectomy may be preferred. Whether to also place an IOL during primary cataract removal is subject to debate, but favorable outcomes have been shown in several small case series where primary cataract removal with IOL placement was performed [4].

Considerations in Children

Children account for approximately one third of serious eye injuries [7,17]. In pediatric patients, consideration must be given to the timing of clearing the visual axis to prevent stimulus deprivation amblyopia, especially in children less than 5 years old. Cataract surgery should be performed within one year of the ocular trauma, as the risk of amblyopia can significantly increase with longer delay [18]. In addition, in pediatric eyes, a swollen cataractous lens can lead to pupillary block, which further supports prompt extraction to prevent phacomorphic glaucoma. Primary cataract removal, therefore, with or without IOL placement, may be more of a consideration in these cases [19]. Posterior capsule opacification (PCO), however, develops faster in eyes with traumatic cataract. Primary posterior capsulectomy and vitrectomy should therefore be considered for children having traumatic cataract surgery [20]. Other common complications include high positive pressure during surgery and fibrinous uveitis [21]. Epilenticular IOL implantation is one option that can help avoid these common complications, and studies have obtained clear visual pathways and improved visual acuity using this technique [21].

Of note, the use of contact lenses for unilateral aphakia is not an option for children in many parts of the world due to cost, inadequate sanitation and lack of availability. One study of children in sub-Saharan Africa supports the use of posterior chamber IOLs as the standard of care in all children older than the age of two, as this produces the best visual acuity results [22]. The same study reported that IOLs placed in the capsular bag were significantly less likely to require capsulotomy in the future, further decreasing the risk of amblyopia from the development of PCO. In cases from India where the posterior segment was not involved, it was shown that, following extracapsular CE with PCIOL implantation, visual acuity in children was better following blunt trauma versus penetrating trauma [23]. Of course, the presence of a non-congenital cataract in a child with a vague history of trauma should also raise the suspicion of possible child abuse.

Surgical Planning and Ancillary Testing

Cataract surgery for traumatic cataracts is frequently more complex than standard cataract surgery. This is due to associated damage to the lens capsule and zonules, the presence of synechiae and reduced media clarity leading to the increased risk of intra-operative lens dislocation, capsular rupture and vitreous loss. Thorough preoperative assessment and planning is key to achieving successful surgical outcomes. In the acute setting, where significant corneal and other media opacities obscure visualization, CT imaging may be helpful in initially suggesting the presence of a traumatic cataract [19,24]. Anterior and posterior lens-capsular tears can occur simultaneously or separately [25]. Traditional B scan ultrasound is helpful in identifying a broad range of ocular pathology, but lacks the resolution to image the integrity of the posterior capsule or zonular structures [26]. Alternatively, ultrasound echography using a 20-MHz frequency is an effective imaging modality for detection of occult posterior lens capsular rupture [26,27]. Ultrasound biomicroscopy is an effective method for identifying occult zonular damage in patients with anterior segment trauma [28], and may also be helpful in identifying small occult posterior capsular ruptures [29]. More recently, anterior segment OCT and Scheimpflug imaging [30,31] have been useful in determining the presence and extent of posterior capsular rupture and zonular integrity. These modalities, when available, have the advantage over ultrasound modalities of being noncontact. The disadvantage, however, is that they are limited by optical clarity that is often compromised after ocular trauma. Scheimpflug imaging has also demonstrated utility in localizing intraocular foreign bodies [32].

IOL Calculations

In the acute setting one may not be able to obtain accurate IOL calculations. Options include using data from the traumatized eye (where able), the fellow eye, or deferring IOL placement to a later secondary procedure. Several small studies show that acceptable IOL calculations can be obtained from the fellow eye in most cases. One study of 30 patients with open globes found that it was more accurate to use biometry of the injured eye after primary repair than to use the fellow eye for IOL calculations [15]. Some have suggested a role for light adjustable IOLs where the power can be changed post implantation to improve refractive outcomes in difficult cases such as trauma [33].

Surgical Approach

The choice of surgical approach is dependent on, among other things, the expertise and preferences of the surgeon, the status of the capsular bag, zonular support, synechiae and the presence of vitreous prolapse. A prospective randomized controlled trial of 120 patients has shown that performance of posterior capsulectomy and anterior vitrectomy as part of the primary procedure improves the final visual outcome. Therefore, this might be considered when forming the surgical approach [34]. In eyes with concomitant posterior segment abnormalities, pars plana lensectomy can be used to remove the traumatic cataract at the time of repair of the posterior pathology. This approach, however, has been associated with an increased risk of complications, including macular pucker, cystoid macular edema and secondary glaucoma [35]. In addition, general anesthesia is frequently preferred in the setting of open globe injuries, uncooperative patients, complex multi-step procedures and pediatric patients.

Pre-existing Anterior Capsular Tears

Pre-existing tears in the anterior capsule can usually be outlined using trypan blue staining. Capsulorhexis may be performed as in routine cataract surgery, with preference towards a complete circular capsulorhexis over a can-opener type opening. In some cases, a thick fibrotic capsule may require vannas scissors. It is important to avoid injuring the zonules, which may be aided by the use of flexible iris retractors to fixate the capsule and/or placement of a fixated capsular tension ring. In a few cases, femtosecond laser-assisted capsulorhexis has been performed in the setting of trauma and may prove beneficial

ISSN: 2334-2838

in achieving a more predictable capsulorhexis and in reducing zonular stress [36].

Pre-existing Posterior Capsular Tears

The management strategies for preexisting posterior tears depend on the type and size of the tear [22]. In Type 1 tears, which develop over time, the margins of the tear are thickened and fibrosed and the size of the tear is less prone to extension with irrigation. Type 2 tears are present when surgery is performed soon after the trauma. They have thin, transparent margins that may rapidly enlarge during irrigation-aspiration. Tears larger than 6mm are generally unable to support an in-the-bag IOL.Successful outcomes have been described using both posterior and anterior approaches. When using an anterior approach, precautions must be taken to not further hydrate the vitreous and extend the size of preexisting posterior tears. The methods for this are thoroughly addressed in the literature, but generally involve prevention of lens matter mixing with vitreous, establishment of a semi-closed system, dry aspiration techniques, meticulous control of infusion and anterior vitrectomy. Phacoemulsification, when used, is done with low flow rate and low ultrasound settings. Identification and thorough removal of vitreous prolapsed into the anterior chamber may be aided by the use of triamcinolone staining [37,38].

Zonular Support and IOL Positioning

Compromised zonular support may increase surgical complexity and lead to inadequate support for placement of an in-the-bag IOL. Pre-existing zonular compromise can easily be further weakened during surgery, particularly during capsulorhexis and cortical removal. Capsular tension rings (CTR) may be beneficial both as a support tool during surgery or as a long-term implant device for IOL fixation [39]. Preservation of the capsular bag, even in cases of traumatic subluxation, has been successfully demonstrated using fixated CTR [40,41].In the presence of a small posterior capsular tear with capsular support, a foldable IOL can be placed in the bag [42]. Where capsular support is adequate, a three-piece IOL can also be positioned in the ciliary sulcus [43]. It has been shown; however, that improvement in visual acuity is statistically significantly higher when the IOL is placed in the bag compared to in the sulcus [44]. One explanation for this finding is those sulci IOLs incite a greater inflammatory response. When capsular support is not adequate, other options include an anterior chamber IOL, as well as iris and scleral suture fixated IOLs. In addition, newer techniques for glued sutureless scleral-fixated IOLs appear promising [45,46].

Outcomes and Unresolved Questions

Visual gain after traumatic cataract surgery is complex, dependent on many factors, and largely unpredictable. Utilization of the Ocular Trauma Score to predict visual acuity remains controversial as a recent study of 80 patients did not support its usefulness [44]. A lack of uniformity in the classification and reporting of most results limits their usefulness in addressing several unresolved questions, including: (1) primary vs. secondary cataract removal, (2) primary vs. secondary IOL placement, and (3) optimal surgical approaches. Methods to standardize classification and reporting of results in traumatic cataract outcomes are important steps to answering these unresolved questions, and, ultimately, to providing better care to patients with traumatic cataract [47-51].

References

1. Insler MS, Helm CJ (1989) Traumatic cataract management in penetrating ocular injury. CLAO J 15: 78-81.
2. Viestnez A, Kuchel M (2001) Retrospectice analysis of 417 cases of contusion and rupture of the globe with frequent avoidable causes of trauma: the Erlangen Ocular Contunsion-Registry (EOCR) 1985 - 1995. Klin Monbl Augenheilkd 218: 662-669.
3. Agarwal A, Kumar DA, Nair V (2010) Cataract surgery in the setting of trauma. Curr Opin Ophthalmol 21:65-70.
4. Moisseiev J, Segev F, Harizman N, Arazi T, Rotenstreich Y, et al. (2001) Primary cataract extraction and intraocular lens implantation in penetrating ocular trauma. Ophthalmology 108:1099-103.
5. Cameron JD (2006) Surgical and nonsurgical trauma. Chapter 6.
6. Diseases of the Lens. Duane's Clinical Ophthalmology, Volume 1, Chapter 71.
7. Shah M, Shah S, Upadhyay P, Agrawal R (2013) Controversies in traumatic cataract classification and management: a review. Can J Ophthalmol 48: 251-256.
8. Asano N, Schlötzer-Schrehardt U, Dörfler S, Naumann GO (1995) Ultrastructure of contusion cataract. Arch Ophthalmol 113: 210-215.
9. Wong TY, Klein BE, Klein R, Tomany SC (2002) Relation of ocular trauma to cortical, nuclear and posterior subcapsular cataracts: the Beaver Dam Eye Study. Br J Ophthalmol 86: 152-155.
10. Marques DM, Marques FF, Osher RH (2004) Subtle signs of zonular damage. J Cataract Refract Surg 30: 1295-1299.
11. Kwitko ML, Kwitko GM (1990) Management of the traumatic cataract. Curr Opin Ophthalmol 1: 25-27.
12. Kuhn F (2010) Traumatic cataract: what, when, how. Graefes Arch Clin Exp Ophthalmol 248: 1221-1223.
13. Chuang LH, Lai CC (2005) Secondary intraocular lens implantation of traumatic cataract in open-globe injury. Can J Ophthalmol 40: 454-459.
14. Rumelt S, Rehany U (2010) The influence of surgery and intraocular lens implantation timing on visual outcome in traumatic cataract. Graefes Arch Clin Exp Ophthalmol 248: 1293-97.
15. Kuhn F, Mester V (2002) Anterior chamber abnormalities and cataract. Ophthalmol Clin North Am 15: 195-203.
16. Shah MA, Shah SM, Shah SB, Patel UA (2011) Effect of interval between time of injury and timing of intervention on final visual outcome in cases of traumatic cataract. Eur J Ophthalmol 21: 760-765.
17. Ram J, Verma N, Gupta N, Chaudhary M (2012) Effect of penetrating and blunt ocular trauma on the outcome of traumatic cataract in children in northern India. J Trauma Acute Care Surg 73: 726-730.
18. Gradin D, Yorston D (2001) Intraocular lens implantation for traumatic cataract in children in East Africa. J Cataract Refract Surg 27: 2017-2025.
19. Taslakian B, Hourani R (2013) Don't forget to report "simple" finding on CT: the hypodense eye lens. Eur J Pediatr 172: 131-132.
20. Trivedi RH, Wilson ME (2015) Posterior capsule opacification in pediatric eyes with and without traumatic cataract. J Cataract Refract Surg 41: 1461-1464.
21. Kamlesh, Dadeya S (2004) Management of paediatric traumatic cataract by epilenticular intraocular lens implantation: long-term visual results and postoperative complications. Eye (Lond) 18: 126-130.
22. Vajpayee RB, Sharma N, Dada T, Gupta V, Kumar A, et al. (2001) Management of Posterior Capsular Tears. Surv Ophthalmol 45: 473-488.
23. Brar GS, Ram J, Pandav SS, Reddy GS, Singh U, et al. (2001) Postoperative complications and visual results in uniocular pediatric traumatic cataract. Ophthalmic Surg Lasers 32: 233-238.

ISSN: 2334-2838

24. Boorstein JM, Titelbaum DS, Patel Y, Wong KT, Grossman RI (1995) CT diagnosis of unsuspected traumatic cataracts in patients with complicated eye injuries: significance of attenuation value of the lens. AJR Am J Roentgenol 164: 181-184.

25. Banitt MR, Malta JB, Mian SI, Soong HK (2009) Rupture of anterior lens capsule from blunt ocular injury. J Cataract Refract Surg 35: 943-945.

26. Perry LJ (2012) The evaluation of patients with traumatic cataracts by ultrasound technologies. Semin Ophthalmol 27: 121-124.

27. Tabatabaei A, Kiarudi MY, Ghassemi F, Moghimi S, Mansouri M, et al. (2012) Evaluation of posterior lens capsule by 20-MHz ultrasound probe in traumatic cataract. Am J Ophthalmol 153: 51-54.

28. McWhae JA, Crichton AC, Rinke M (2003) Ultrasound biomicroscopy for the assessment of zonules after ocular trauma. Ophthalmology 110: 1340-1343.

29. Kucukevcilioglu M, Hurmeric V, Ceylan OM (2013) Preoperative detection of posterior capsule tear with ultrasound biomicroscopy in traumatic cataract. J Cataract Refract Surg 39: 289-91.

30. Grewal DS, Jain R, Brar GS, Grewal SP (2008) Posterior capsule rupture following closed globe injury: Scheimpflug imaging, pathogenesis, and management. Eur J Ophthalmol 18: 453-455.

31. Grewal DS, Jain R, Brar GS, Grewal SP (2009) Scheimpflug imaging of pediatric posterior capsule rupture. Indian J Ophthalmol 57: 236-238.

32. Singh R, Ram J, Gupta R (2015) Use of Scheimpflug imaging in the management of intra-lenticular foreign body. Nepal J Ophthalmol 7: 82-84.

33. Rocha G, Mednik ZD (2012) Light-adjustable intraocular lens in post-LASIK and post-traumatic cataract patient. J Cataract Refract Surg 38: 1101-1104.

34. Shah MA, Shah SM, Patel KD, Shah AH, Pandya JS (2014) Maximizing the visual outcome in traumatic cataract cases: The value of a primary posterior capsulotomy and anterior vitrectomy. Indian J Ophthalmol 62: 1077-1081.

35. Tewari HK, Sihota R, Verma N, Azad R, Khosla PK (1988) Pars plana or anterior lensectomy for traumatic cataracts? Indian J Ophthalmol 36: 12-14.

36. Nagy ZZ, Kránitz K, Takacs A, Filkorn T, Gergely R, et al. (2012) Intraocular femtosecond laser use in traumatic cataracts following penetrating and blund trauma. J Refract Surg 28: 151-153.

37. Wu MC, Bhandari A (2008) Managing the broken capsule. Curr Opin Ophthalmol 19: 36-40.

38. Praveen MR, Shah SK, Vasavada VA, Dixit NV, Vasavada AR, et al. (2010) Triamcinolone-assisted vitrectomy in pediatric cataract surgery: intraoperative effectiveness and postoperative outcome. J AAPOS 14: 340-344.

39. Hansanee K, Ahmed II (2006) Capsular tension rings: update on endocapsular support devices. Ophthalmol Clin North Am 19: 507-519.

40. Chee SP, Jap A (2011) Management of traumatic severely subluxated cataracts. Am J Ophthalmol 151: 866-871

41. Buttanri IB, Sevim MS, Esen D, Acar BT, Serin D, et al. (2012) Modified capsular tension ring implantation in eyes with traumatic cataract and loss of zonlular support. J Cataract Refract Surg 38: 431-436.

42. Blum M, Tetz MR, Greiner C, Voelcker HE (1996) Treatment of traumatic cataracts. J Cataract Refract Surg 22: 342-346.

43. Pandey SK, Ram J, Werner L, Brar GS, Jain AK, et al. (1999) Visual results and postoperative complications of capsular bag and ciliary sulcus fixation of posterior chamber intraocular lenses in children with traumatic cataracts. J Cataract Refract Surg 25: 1576-1584.

44. Serna-Ojeda JC, Cordova-Cervantes J, Lopez-Salas M, Abdala-Figuerola AC, Jimenez-Corona A, et al. (2015) Management of traumatic cataract in adults at a reference center in Mexico City. Int Ophthalmol 35: 451-458.

45. Agarwal A, Kumar DA, Jacob S, Baid C, Srinivasan S (2008) Fibrin glue-assisted sutureless posterior chamber intraocular lens implantation in eyes with deficient posterior capsules. J Cataract Refract Surg 34: 1433-1438

46. Saleh M, Heitz A, Bourcier T, Speeg C, Delbosc B, et al. (2013) Sutureless intrascleral intraocular lens implantation after ocular trauma. J Cataract Refract Surg 39: 81-86.

47. Shah MA, Shah SM, Shah SB, Patel CG, Patel UA (2011) Morphology of traumatic cataract: does it play a role in final visual outcome? BMJ Open.

48. Shah MA, Shah SM, Applewar A, Patel C, Patel K (2012) Ocular Trauma Score as a predictor of final visual outcomes in traumatic cataract cases in pediatric patients. J Cataract Refract Surg 38: 959-965.

49. Shah MA, Shah SM, Applewar A, Patel C, Shah S, et al. (2012) Ocular Trauma Score: a useful predictor of visual outcome at six weeks in patients with traumatic cataract. Ophthalmology 119: 1336-1341.

50. Shah MA, Shah SM, Shah SB, Patel CG, Patel UA, et al. (2011) Comparative study of final visual outcome between open- and closed-globe injuries following surgical treatment of traumatic cataract. Graefes Arch Clin Exp Ophthalmol 249: 1775-1781.

51. Agrawal R, Shah M, Mireskandari K, Yong GK (2013) Controversies in ocular trauma classification and management: review. Int Ophthalmol 33:435-445.

David Paikal, M.D., Q.M.E.

DIPLOMATE, AMERICAN BOARD OF OPHTHALMOLOGY
QUALIFIED MEDICAL EXAMINER

All Correspondence To:
11620 Wilshire Boulevard, Suite 340
Los Angeles, CA 90025
Tel: (888) 853-7944
Fax: (213) 377-5152

PANEL QUALIFIED MEDICAL EVALUATION
IN THE SPECIALTY OF OPHTHALMOLOGY

[redacted]

[redacted]

[redacted]

[redacted]

Re: [redacted]
Employer:
WCAB No.:
Applicant's DOB:
Date of Injury:
Claim No.:
Date of Evaluation:
Place of Evaluation:

Interpreter:

Dear Parties:

Pursuant to your authorization, the applicant, [redacted] underwent a Panel Qualified Medical Evaluation, in the specialty of Ophthalmology, on , at my El Monte office. The undersigned acted in the capacity of Panel Qualified Medical Examiner, in the specialty of Ophthalmology.

I, Dr. Paikal, conducted the interview, reviewed all records, formulated the diagnosis, conclusions, and discussion. I also formulated myself the opinion on causation, disability, future care, and apportionment. The report was authored and edited by myself, Dr. Paikal. All opinions expressed are the opinions of Dr. Paikal.

Prior to the evaluation, the entire medical file made available to this physician was fully reviewed. All of the records reviewed were instrumental in this evaluator arriving at the opinions as expressed in this report.

Before I began the examination, the applicant was informed that this evaluation was being done exclusively in connection with the Workers' Compensation claim at the request of an attorney, attorneys or insurance companies, and that no treatment relationship existed. The applicant was also made aware that any communication between us is not privileged (no doctor-patient confidentiality exists) and that any information provided, as well as the results of any testing and my conclusions regarding the case, would be included in a report that may be read by people involved in the resolution and/or litigation of the claim. The applicant was advised of his or her rights pursuant to QME regulation 40. The applicant stated that the aforementioned was understood, and agreed to proceed with the evaluation. The report belongs to the party or parties requesting the evaluation.

BILLING

The report qualifies for Procedure Code **ML-103** as there are "extraordinary circumstances" relating to the medical condition for which this applicant was examined. This code best reflects the time spent and/or the complexity of this evaluation. The best proof in regard to the complexity of this evaluation is the medical/legal report which reflects the complex issues.

This is a Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances **(ML-103)**. The following complexity factors apply:

COMPLEXITY FACTORS

☐ (1) Two or more hours of face-to-face time by the physician

☒ (2) Two or more hours of record review by the physician

☐ (3) Two or more hours of medical research by the physician

☒ (4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor;

☐ (5) Six or more hours spent on any combination of three complexity factors (1)-(3), **which shall count as three complexity factors**

☒ (6) Addressing the issue of medical causation

☐ (7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), or two or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.

☐ (8) A psychiatric or psychological evaluation, which is the primary focus of the medical-legal evaluation

☐ (9) Where the evaluation is performed for injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before June 30 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.

Billed under **ML-103** time spent includes:

1. Face-to-face interview with the applicant: **0.50 hours**
2. Review of medical records: **4.00 hours**
3. Preparation, writing and editing of this report: **1.50 hours**

[redacted]

IDENTIFYTING DATA

Mr. [redacted] is a -year-old Hispanic gentleman who resides in ....., . He is evaluated today for a claim to continuous trauma to the eyes from through , during his tenure as an employee of [redacted] Corp.

REVIEW OF FILE

NON-MEDICAL RECORDS:

Qualified Medical Evaluation, signed by and dated

The examiner had been selected as the examining physician from Panel no.

The applicant claimed continuous trauma to the eyes from rough . The claim had been accepted for the neck, low back, and shoulders pursuant to the Agreed Medical Evaluation report of Dr. [redacted]

A complete copy of the medical file was provided for the examiner's review. He was to address the questions as indicated in this letter.

The examiner was to address the following issues:

1) Your diagnosis and prognosis;

2) Your objective findings;

3) The applicant's subjective complaints and whether the subjective complaints are supported by the objective evidence of injury;

4) Status: Please indicate whether this individual's condition is temporary or permanent and stationary for rating purposes. Please also state the date(s) said condition(s) became permanent and stationary;

5) Permanent Disability: Please indicate what, if any, disability this individual has. Please describe any disability with language in accordance with the Worker's Compensation guidelines. When assessing permanent disability please assess disability pursuant to the AMA Guides for assessing disability after January 1, 2005.

7) Apportionment: If there is disability as a consequence of this individual's employment, please comment on whether there is apportionment to pre-existing industrial or non-industrial causes, or both. Please state the basis upon which you find apportionment is or is not applicable;

8) If there is apportionment based on a progressive disease process theory, please indicate the level of disability solely attributed to that disease process absent the claimed industrial injury;

9) Rehabilitation: If there is disability, please state the extent and/or what relationship, if any, said disability has to this individual's continued employment at the job held on the date of injury;

10) Please indicate what, if any, prophylactic work restrictions, or other specific work restrictions, you would place on this individual with respect to the applicant's occupation and ability to compete in the open labor market because of the claimed industrially caused disability;

Medical Treatment Past/Future:

11) Please indicate what, if any medical care may or will be required in the future to cure or relive this individual of the effects of the injuries. Please include your recommendations regarding medication, frequency and duration of medical care, etc.

He was authorized to conduct such diagnostic tests as he deemed necessary and appropriate to effectuate his determination of this individual's condition as it relates to the claimed industrial disability.

He was to comment on all aspects of this individuals' current condition, within his specialty, with particular emphasis on causation, apportionment, the date applicant became permanent and stationary and whether the treatment received was necessary and if not, why not.

Application for Adjudication of Claim, dated _____

The applicant suffered a cumulative injury while employed as a carpenter from to As a result of activities and conditions at work, he developed injury to the hands, wrists, feet, knees, hips, eyes, ears, and mouth. He also developed diabetes, high blood pressure, stress, psyche problem, and nervous system problem.

Workers' Compensation Claim Form (DWC 1), dated

The applicant suffered a cumulative injury while employed from to . He injured his neck, back, shoulders, arms, wrists, hands, feet, knees, hips, eyes, ears, mouth, and developed nervous system problem, diabetes, high blood pressure, stress, and psyche problem as a result of activities and conditions at work.

Deposition of [redacted] dated

The applicant had had been married for years. He was still married to [redacted] He was currently taking medication. He was taking Ranitidine for his stomach which was prescribed by a doctor at a clinic in he had for three to four years. He last took Ranitidine yesterday. The next medication he took was Atenolol, which was also prescribed by the doctor in . This was for high blood pressure. He took that pill daily and he had last taken it yesterday. He also took Simvastatin for his cholesterol. This was also prescribed by the doctor in . He had been taking this for one year. He last took it yesterday. He also took medication for sleep, which he had been taking for a year but he did not take it every day. He took it two to three times per week. He was also taking pain medication, which he had been taking for one year. He last took the pain medication yesterday. He took this two to three times per week.

He lived on [redacted]. He had lived at this address for two years with his wife and son, years old. He drove a small car, a Nissan. His son gave him a ride to the deposition today. He was born in and had lived there for years. He moved to in The highest level of school he completed was He went to school in He was not currently working. He was fired in from [redacted] He worked two weeks in for a construction company, in He did small cabinets while he worked there. He was paid by check. He received two checks. He was paid weekly. He was paid for 30 hours a week. He stopped working because his body was hurting when he tried to work. He could not concentrate on what he was doing because of pain.

His daughter helped to support him. She helped him to pay for the rent. She had been helping him for two months. The applicant had one child in who was years old, [redacted], who had a different mother than his other two children. The last time he saw [redacted] was in He went to for 16 days. The applicant had not been to for two months. He was on welfare. He received dollars a month.

After he was fired, he was supporting himself with unemployment. This stopped in . His wife did not work. His son gave him for food. He

started working at [redacted] in . The last day he worked was on . He worked there Monday through Friday and half days on Saturdays sometimes. He was paid every two weeks. His supervisor was [redacted] at first and then it was [redacted] His job was to watch all of the workers cutting the wood, making the molds, making the doors, make base molding, and crown molding. These were his duties his entire time he worked there. He had to separate wood that arrived on the truck. He used his hands and tools such as a table saw, planers, shapers and routers. He used machines at work. He used safety equipment such as goggles for the eyes but not for the ears. He also used a face mask.

He was fired at [redacted] He did not know why he was fired. One day, he arrived and then he was given his check and told there was no more work for him.

The pain in his back started at . At the same time his back pain started, he also had shin pain. He also felt pressure at work because he had to do everything. If there were 10 or 15 people waiting for work, he had to prepare everything for them so they would not have to do it. He had pressure from the owner of the shop as well. He stated the owner treated him very badly. He was yelled at daily. He would get yelled at if someone else did something wrong. In , the applicant's face became twisted. This lasted for three months. This occurred again later on and lasted three to four months. His right side of his face was crooked and twisted. His mouth was moved to the right. The second this occurred was three to four years later. He was treated at [redacted] for this condition. The doctor told him the twisting in the face was because of so much stress that he needed to relax. The doctor wanted to give him disability but he was not given permission at work. He still had to work in this condition.

The applicant also had right and left shoulder pain as well as hand and shin pain. The pain started in The applicant complained of lower extremity pain from the thighs down to right below the knees. He complained of lower back pain. He did not miss time from work for these injuries. His shoulder pain began in His hand pain began in or . In or , he went to get a piece of wood and it slipped and then pain started. The piece of wood slipped and hit him on his right hip. At this point, he already had back pain. He believed his pain was from lifting so much. He was injured in or when a piece of plywood scraped him and blood came out. His nail on his big toe on the left foot got black and fell off. He did not go to the doctor for this. He continued working that day and it took a month to recover. He took Tylenol and Advil for pain.

He worked from to his last day of regular duties with the pain to all these body parts. He took Tylenol and Advil. He also had problems with ears. His left ear was hurting and he heard bells and could not hear well. He went to the doctor and he was told his ears were bad. He was sent to see a specialist by Dr. [redacted]

He also complained of stomach issues, which started three or four years ago. He went to the doctor for this two years ago and was given medication to protect his stomach. He was also told he had problems swallowing. He was asked if he had stress in regards to his stomach issues. He also complained of headaches. He had told Dr. [redacted] he had headaches. He also had issues with his eyes. When he would work, he would cut and the dust would get in and his eyes would tear from so much dust. He went to the eye doctor and was given glasses and eye drops.

He told his boss, [redacted] about his multiple problems. His boss would just laugh and tell the applicant he was old already. The applicant was seeing a psychologist. His last appointment was last month. His psych complaints were depression and stress. He also experienced anxiety. He had depression before he was terminated because of the many years of mistreatment from the gentleman who made him feel very low. This started many years ago. He felt afraid. His self-esteem was very low. He was anxious. He did not seek treatment. His anxiety and depression started years ago, around six to seven or more years ago. His stress started many years ago as well. He drank very little alcohol. He drank two times a month. He had stress on Sunday afternoons when he thought about going to work on Monday. When trying to relax and reduce his stress, he would go to church with his family on Sunday and this relaxed him a lot. He did not tell his wife about these feelings because he did not want to worry her. He was stressed from using a dangerous machine at work. When he was feeling very stressed because of work or having a lot of anxiety, he still worked. He would get screamed at if someone did not do their job well. He was the one who decided what those employees did. He did not know when his depression started because he did not know what kind of illness that was. He did not know until he talked to his doctor, the psychologist. This was the psychologist he was currently treating with.

He had felt depressed since he stopped working. Remembering his work made him depressed. Remembering how he was treated made him depressed. The treatment with the psych doctor helped him. When he was speaking to her, he was happy. He felt happy when he left. But the symptoms would return four or five hours later. He did talk to his supervisor about his depression, anxiety or stress. His problems with sleep began five years ago. He would have troubles falling asleep. Once he fell asleep, he would not awaken. Lately however, the pain in his right shoulder woke him up. He was woken up from pain two times a night. He had difficulty falling asleep three or four times a week.

The applicant's father was still alive and living in [redacted]. The applicant felt he had the best father in the world and they had the best relationship. His mother passed away when he was two years old. His father remarried and the applicant got along with his stepmother. The psych doctor gave the applicant advice on how to relax himself. She told him to go walking. The sessions were 20 minutes. The

applicant had a very good relationships with his children. The applicant's wife had diabetes.

The applicant had been told he had diabetes and high blood pressure. He had been told he had to lose weight. He had been told he had high cholesterol as well. He had to go in a month to see a specialist because he had trouble swallowing. He had been put on a diabetic diet and had been on this diet for a year and a half. He had lost three to four pounds but he needed to lose seven pounds. He helped his wife wash the dishes. He walked with his wife. He stood three or four times during the deposition because he was tired of being seated and had a backache.

MEDICAL RECORDS:

Consultation Request, [redacted] - [redacted] Illegible Signature, dated [redacted]

The applicant had Bells palsy.

Provisional Diagnosis: Bells palsy.

Electrocardiogram, signed by [redacted] M.D., dated [redacted]

The applicant complained of chest pain.

Conclusion: Borderline. Minimum voltage criteria for LV enlargement, might be normal variant.

Physician Documentation, [redacted] - [redacted] dated [redacted]

The applicant complained of wrist pain. His work involved making cabinets and using his hands a lot. He had pain with movement of the wrist. He complained of right hip pain.

Medications: The applicant was on Tylenol and Advil.

Assessment: Tenosynovitis of right wrist and likely bursitis of right hip bursa.

Plan: Motrin and ice application were prescribed.

X-ray of the Left Foot, signed by [redacted], M.D., dated [redacted].

Impression: Normal exam.

Patient Health Questionnaire, [redacted] Inc., dated

The applicant is allergic to Penicillin. He drank alcoholic beverages.

History and Physical Report, [redacted] Inc., Illegible Signature, dated

The applicant presented for complete check up and blood test.

Medical History: He has a medical history of gout.

Social History: He smoked tobacco every day. He denied drinking alcoholic beverages or using drugs.

Family History: He has a family history of diabetes mellitus.

Diagnoses: 1) Complete physical exam. 2) GERD. 3) Chronic obstructive pulmonary disease. 4) History of gout.

Plan: X-ray of the chest, and laboratory tests were requested.

Laboratory Report, Laboratory, Inc., dated)9.

Hemoglobin was 15. Creatinine was 0.8. AST was 29. ALT was 48. Total bilirubin was 0.9. Alkaline phosphatase was 79.

Laboratory Report, [redacted], Inc., dated

Glycohemoglobin A1C was 6.3.

Progress Note, [redacted] Inc., Illegible Signature, dated

Chief Complaint: The applicant complained of coughing and back pain.

Subjective: His cough was not getting better. He was a smoker.

Assessment: 1) Community-acquired pneumonia. 2) Tobacco abuse.

Plan: Z-pack was prescribed.

Progress Note, [redacted] Inc., Illegible Signature, dated _____.

The applicant was seen for follow-up. He was feeling much better status post antibiotic treatment. He was still smoking.

Assessment: 1) Pneumonia. 2) Hypertriglyceridemia. 3) Tobacco abuse.

Plan: Lipid test was requested.

Progress Note, [redacted] Inc., Illegible Signature, dated _____

Chief Complaint: The applicant complained of low back pain.

Assessment: Back pain.

Plan: Baclofen and Naproxen were prescribed. Back exercise was recommended.

Medical Report, signed by [redacted] P.A., dated _____

History of Present Illness: The applicant presented with cough, runny nose, congestion, and sore throat.

Assessment: 1) Upper respiratory infection. 2) Tobacco use.

Plan: Recheck of blood pressure, supportive measures, and tobacco cessations were recommended. Triaminic Day Time Cold and Cough was prescribed.

Medical Report, signed by [redacted] P.A., dated _____

Chief Complaint: The applicant complained of pain in the feet.

Assessment: 1) Plantar fascitis bilateral foot. 2) Tinea pedis. 3) Hypertension. 4) Tobacco use – 30-pack year history.

Plan: Recheck of blood pressure, laboratory tests, supportive measures, and tobacco cessations were recommended. Benazepril was prescribed.

Medical Report, signed by [redacted] P.A., dated _____

Chief Complaint: The applicant complained of cough and chest congestion.

History of Present Illness: He had had cough for 3 weeks. He had runny nose, congestion, tactile temperature, and green phlegm. He was smoking 8 cigarettes per day. He stopped taking blood pressure medication 1 month ago.

Assessment: 1) Bronchitis. 2) Hypertension – uncontrolled. 3) Tobacco use – 30-pack year history. 4) Overweight.

Plan: Recheck of blood pressure, laboratory tests, x-ray of the chest, diet, exercise, and tobacco cessations were recommended. Hydrochlorothiazide, Mucinex, and Zithromax Z-pak were prescribed.

Medical Report, signed by [redacted] P.A., dated _____

Chief Complaint: The applicant was seen for follow-up regarding his blood pressure.

History of Present Illness: He had not been taking his blood pressure medications and did not complete the laboratory tests. He continued to smoke 10 cigarettes per day. His cough had resolved.

Assessment: 1) Bronchitis – resolved. 2) Hypertension – controlled. 3) Tobacco use – 30-pack year history. 4) Overweight.

Plan: Rechecks of blood pressure, laboratory tests, supportive measures, tobacco cessation, and weight management were recommended. Aspirin and Hydrochlorothiazide were prescribed.

Laboratory Report, [redacted], dated _____

Hemoglobin was 16. Creatinine was 0.78. Total bilirubin was 0.7. Alkaline phosphatase was 83. AST was 20. ALT was 23.

Medical Report, signed by [redacted] P.A., dated _____

The applicant presented for discussion of blood test result.

Assessment: 1) Hypertension – controlled. 2) Tobacco use. 3) Overweight. 4) Alcohol abuse. 5) Prediabetes. 6) Dyslipidemia.

Plan: Rechecks of blood pressure, referral to healthy living classes, supportive measures, tobacco cessation, alcohol cessation, DASH diet, weight management,

and referral to an ophthalmologist were recommended. The Hydrochlorothiazide was changed to Lisinopril. Lovastatin was prescribed.

X-ray of the Right Shoulder, signed by [redacted], M.D., dated _____

Impression: Suggestion of calcific tendinosis of the supraspinatus or long head of the biceps.

X-ray of the Pelvis and Right Hip, signed by [redacted], M.D., dated _____

Impression: Normal.

Medical Report, signed by [redacted], M.D., dated

Medical History: The applicant had hypertension and GERD. He was not taking his medications regularly.

Social History: He smoked cigarettes. He denied drinking alcoholic beverages or using drugs. He was married and had 2 kids. He completed 12th grade. He worked as a carpenter.

Subjective: He complained of reduced hearing in both ears. He complained of pain in the right shoulder and right hip.

Assessment: Routine health maintenance, hypertension, reduced hearing in ears, right shoulder and right hip pain, GERD, normal BMI, chronic smoker, and refractive error.

Plan: Audiometry, vision test, healthy heart diet, weight loss, exercise, laboratory tests, and x-ray of the right hip and shoulder were requested. The applicant was to avoid greasy foods. He was recommended to stop smoking. He was prescribed Tylenol, Tramadol, Omeprazole, and Atenolol. He was referred to an ENT specialist.

Laboratory Report, [redacted], dated _____

Creatinine was 0.77. Alkaline phosphatase was 64. Total bilirubin was 1.4. ALT was 27. AST was 20. Hemoglobin was 15.1. TSH was 2.28.

Medical Consultative Report Internal Medicine Initial Consultation, signed by [redacted], M.D., dated

Chief Complaint: The applicant presented for evaluation regarding his hypertension, gastritis, insomnia, and headaches.

Job History: He was employed as a at [redacted] Corporation. He worked 9 to 10 hours a day, 60 to 65 days per week. He was responsible for assembling and cutting wood for making cabinets and couches. Physically, his job required standing, walking, lifting, carrying, bending and twisting at the neck and waist, gripping, grasping, fine manipulation, pushing, pulling, reaching, lifting and carrying.

Injury History: He was unsure of the exact date when he first noticed his symptoms but stated that in 2000, the pain in his knees, shoulders, arms and hips worsened that he reported them to his boss, [redacted] He continued working with persistent pain. In 2005, he developed blurry vision in both eyes. In 2007, he noticed having difficulty hearing, which he attributed to exposure to noise from machines and tools at work. In 2009, he noted the onset of pain in his neck, back, hands, and feet. He reported his symptoms again to his boss. In 2012, he developed problems with sleep due to pain and stress at work. He continued working with pain until he was terminated on January 8, 2014 when he was told that there was no more work available.

History of Current Illness: He was injured through repetitive motion carrying heavy objects. He slept approximately six hours every night and had problems staying asleep. He was taking medication for this at this time. He had heartburn but denied nausea, vomiting, constipation, diarrhea and melena. He had bilateral temporal headaches and occipital region headaches without photophobia, blurred vision, dizziness or syncope. He had developed bilateral calf pain when walking but denied edema and coldness to extremities.

Medical History: He had had hypertension for 3 years. This increased after his injuries.

Social History: He smoked cigarettes. He drank alcoholic beverages.

Allergies: He is allergic to Penicillin.

Medications: The applicant was on Atenolol, unknown sleep aid, Prilosec, unknown pain medication, and Tylenol ES.

Impression: 1) Hypertension. 2) Gastritis. 3) Insomnia. 4) Headache.

Plan: The applicant would continue treatment with his PCP for hypertensive treatment. He would continue taking his current medications. EKG, echocardiogram, ultrasound of the lower extremities, and recheck were requested.

Psychiatric Evaluation (Incomplete Report), signed by [redacted], M.D., Ph.D.,

Causation: The primary stressors for the applicant appeared to have been the harassment he experienced during the course of his employment at [redacted] and the injuries he sustained while working there. While the exact severity of his orthopedic symptoms remains to be determined, it was apparent that the applicant felt they were significantly impacting his life. When physical injuries were sustained, there could be significant psychological consequences as the individual faces a loss of autonomy, worries about their future limitations, and realized they were facing the unknown. Typically self-confidence and self-esteem diminished as they struggle to come to grips with their reduced capabilities. His symptoms of anxiety and depression represent, in part, a psychological reaction to his physical injuries.

The applicant also reported being subjected to the harassment of his employer over a course of many years. This caused him to feel anxious and depressed. At some point, he sought medical treatment when his face "pulled," and he was told he needed to relax, suggesting the stress he was experiencing was substantial. He felt that he was being subjected to the harassment by his supervisor, and was being disrespected and mistreated. He also reported working long hours under considerable stress. Those factors were detrimental to his job environment, and he felt hopeless and helpless about being able to resolve the problem and assert some measure of control into his work environment. Work stress models, such as the Karasek model, suggested that lack of job control interacted with the level of demand in affecting job strain. Circumstances such as those experienced by the applicant led to an unacceptably high level of stress at work and not surprisingly to the development of psychological symptomatology such as depression and anxiety. When mental health outcomes were reported via self-report, there was commonly a significant association with perceived job strain and control. Several studies had linked job control to depression in Europe and Japan, and job strain to depression in Poland and the Czech Republic. A Belgian study showed an association between job control and depression and anxiety.

Given the duration of the stress experienced by the applicant because of harassment, it was not surprising that he had developed symptoms of depression and anxiety. The experience of stress caused the applicant to develop symptoms of mental disorder. Specifically with respect to anxiety disorders, there was

evidence that indicated traumatic life events and stress were etiologically significant. In terms of environmental factors, it was thought that particularly important were stressors connected with an alteration in the level of expectations placed on the individual, such as in the applicant's case (Kaplan and Sadock's Comprehensive Textbook of Psychiatry. Seventh Edition, Ch 15.5: Anxiety Disorders).

With respect to causation of primary insomnia, the DSM-IV-TR noted (page 601): "Most cases have a fairly sudden onset at a time of psychological, social, or medical stress. Primary Insomnia often persists long after the original causative factors resolve, due to the development of heightened arousal and negative conditioning." It noted that individuals who suffer a painful injury can develop negative associations for sleep which can persist beyond the convalescent period. Similarly, insomnia that occurred during the course of a psychological disorder may persist long after resolution of the psychological disorder.

It should be noted that the applicant did not report a history of unusual anxiety or depression, and denied having had any prior psychological treatment. He denied having had any problems in the past in his personal life or at work related to psychological symptoms. Based on the reported history it appeared that the applicant developed psychological symptomatology in the context of a general feeling of stress because of the unreasonable behavior of the employer while he was experiencing the pain and impairment of his physical injuries.

He denied having experienced any other sources of stress in the time frame which would be relevant with respect to his psychological condition. The evidence indicated that absent the work-related events the applicant would not be experiencing any psychological symptomatology or disability. Considering all factors, the predominant cause, as to all causes combined of the applicant's psychological condition was the harassment he experienced at work over a period of many years. A lesser, though significant cause, was the physical injuries he sustained. Finally, the unexpected termination of his employment probably somewhat exacerbated or aggravated his symptoms.-

Disability Status: Emotionally, the applicant presented as being both depressed and anxious. There was irritability, and he appeared agitated and restless. He reported a general feeling of paranoia or suspiciousness, probably related to his experience with Mr. [redacted] The psychological test results were consistent with the presence of clinical levels of depression and anxiety, although the defensiveness described above made it difficult to assess the exact level of the severity of the symptoms. His psychological test results appeared to reflect a mixture of genuine distress with an effort on his part to deemphasize his problems.

His cognitive functioning was being impacted by his psychological condition, with the applicant stating that he experienced problems in areas such as concentration and making decisions. Even in the limited environment of the mental status examination his concentration appeared somewhat impaired. Any cognitive deficiencies which were present were even more apt to be apparent in real world situations where there was a higher level of stress, more distractions and competing sensory inputs. The applicant currently was able to perform some basic and instrumental activities of daily living. He was able to maintain some of his adaptive living skills. He was able to articulate and communicate thoughts, ideas and needs, and discusses his current concerns, but with irritability and agitation.

Due to his psychological symptomatology, his coping skills were now more fragile, and it was now more difficult for him to cope with stressors in the environment, or to deal effectively with people.

When this examiner asked the applicant if he had any emotional problems which would impair his ability to work, he responded that he did because his nervousness, anxiety, and fearfulness impaired his concentration and made him worried that he would make mistakes. The physical pain he experienced also distracted him from work duties. While he was not qualified to assess the presence or absence of psychopathology, his opinion as to his ability to work was relevant. The AMA Guides noted: "The individual's own description of his or her functioning and limitations is an important source of information." His opinion was consistent with the results of this examiner's evaluation.

The applicant presented with continued distress and he was not at maximum medical improvement. There was a good chance that he would show improvement with appropriate treatment. He was not considered temporarily totally disabled from a strictly psychiatric perspective. There had been no periods of temporary total disability from a psychiatric perspective. His work status was deferred to the primary treating physician. Current Global Assessment of Functioning was 61.

Psychiatric treatment, supportive therapy, ventilatory therapy, psychopharmacological evaluation, and cognitive behavioral therapy were recommended. Celexa, Abilify, Wellbutrin, Xanax, were Ambien prescribed.

Although the applicant's condition was not at maximum medical improvement, from a vocational rehabilitation perspective it was likely that if he recovered sufficiently from an orthopedic perspective to be able to successfully return to work at his former position as a carpenter and manager, he would be able to do so from a psychological perspective. However, it was not clear that he would be able to return to work with Mr. [redacted] whom he identified with substantial harassment over the years. If able to return to work and sustain employment over time, a

successful return to work could be an important factor in improving his psychological condition and strengthening damaged self-esteem and self-confidence.

Pages 1-22 are missing.

Medical Report, signed by [redacted] M.D., dated _____

Subjective: The applicant was seen for follow-up for discussion of lab result and x-ray result of the right hip and right shoulder. He needed refill of medications.

Assessment: Hypertension, dyslipidemia on diet, GERD, right shoulder and right hip pain.

Plan: Healthy heart diet and laboratory tests were requested. Tramadol and Vitamin D3 were prescribed.

Medical Report, signed by [redacted], O.D., dated _____

The applicant presented for an annual eye exam.

History of Present Illness: He complained of decreased NVA of both eyes. He had hypertension. His father was blind in both eyes that occurred years after cataract surgery.

Basic Components: Visual acuity of right eye was 20/30. Visual acuity of left eye was 20/30-3.

Anterior Segment: Both Eyes: Abnormal; narrow angles by VH, confirmed by gonio.

Lens: Right Eye: Clear. Left Eye: Aphakic.

Disc: Right Eye: Thinner inferiorly.

Age-Related Macular Degeneration: Severity: Macular thickening or hemorrhage.

Diabetes Care (Diabetic Retinopathy): Severity: Presence of macular edema.

Assessment: 1) Narrow angles x OU. 2) Hyperopia/presbyopia x OU.

Plan: The applicant was referred to Dr. [redacted] for evaluation/management.

Permanent and Stationary Otolaryngological Medical/Legal Evaluation, [redacted], M.D., dated

The applicant presented for evaluation regarding his cumulative injury that occurred while working at [redacted] Corporation from / to

Job Description/History of Work-Related Injury: At the time of his work-related injury sustained while he was employed at [redacted] he was employed there in the capacity of a carpenter. He described his job duties as working where he would cut wood, prepare pieces of wood to be assembled using power tools, and work with heavy machinery, table saws, shapers and routers. His job duties necessitated the performance of frequent bending, stooping, pushing and pulling maneuvers. He worked eight hours a day, five days a week. He also indicated that during the course of his normal employment. He had been constantly exposed to a lot of noise originating from working heavy machinery and power tools. He had been provided with ear protection, and he was using ear protection most of the time, however, occasionally he was working without ear protection, because he had to listen to the instructions. He initially became employed in , and since the year he became aware of hearing deterioration, and he developed intermittent ringing in the ears. He believed that the exposure to loud noise affected his ears. He was referred to this office for evaluation of his hearing problems.

Present Complaints: The applicant complained of hearing loss and ringing in the ears.

Medical History: He has a medical history of hypertension.

Medications: The applicant was taking blood pressure medication.

History of Previous Employment: He worked for the same employer since and he discontinued his employment in

Impression: The applicant had a moderate severe bilateral sensorineural hearing loss and intermittent tinnitus.

There is/are missing page/s.

Progress Report of Secondary Treating Physician, signed by [redacted] L.Ac., dated

The applicant had back pain. He was not currently working.

Diagnosis: Per PTP diagnoses.

Treatment Plan: Acupuncture, electroacupuncture, infrared, and manual therapy were recommended.

Adult Primary Care Outpatient Provider Note, signed by [redacted], M.D., dated [redacted].

The applicant presented for medication refill. He had tinging in the hands.

Medications: The applicant was on Acetaminophen, Atenolol, Gabapentin, Tramadol, Vitamin D3, and Zantac.

Allergies: He is allergic to Omeprazole and Penicillin.

Assessment: Hypertension/refill.

Plan: Atenolol, Gabapentin, and Ranitidine were prescribed.

Consulting Treating Physician's Progress Report, signed by [redacted], M.D., Ph.D., dated [redacted]

Subjective: The applicant complained of pain in the right shoulder and low back. He had tingling in the right hand. He slept for 5 hours. He took sleep medications.

Diagnoses: 1) Depressive disorder NOS. 2) Anxiety disorder NOS.

Treatment Plan: Psychotherapy was recommended. Xanax and blood pressure medications were prescribed.

Progress Report of Secondary Treating Physician in the Field of Acupuncture, signed by [redacted], L.Ac., dated [redacted]

The applicant was seen for follow-up. His pain symptom had improved as well as his overall strength, stress level, and VAS pain score.

Treatment Plan: Electroacupuncture, infrared, and manual therapy were recommended.

Department of Emergency Medicine Record, [redacted] - [redacted] dated [redacted].

The applicant had mild right lower quadrant pain. He had vomiting with blood this morning.

Discharge Impression: Abdominal pain – resolved.

The rest of the note is illegible.

Adult Primary Care Outpatient Provider Note, signed by [redacted], M.D., dated [redacted].

Chief Complaint: The applicant complained of abdominal pain and lots of gas.

History of Present Illness: He complained of bloating in his stomach with acid problem. He gained weight lately.

Medical History: He has a medical history of GERD, hip pian, hypertension, hyperlipidemia, shoulder pain, and tobacco use.

Medications: The applicant was on Acetaminophen, Atenolol, Gabapentin, Tramadol, Vitamin D3, and Zantac.

Assessment: Hypertension. 2) Overweight. 3) GERD. 4) Hip pain. 5) Hyperlipidemia. 6) Shoulder pain.

Plan: EKG, laboratory tests, and RF upper GI were requested. Atenolol, Gabapentin, and Ranitidine were prescribed.

Electrocardiogram, [redacted], dated [redacted]

Interpretation: 1) Sinus bradycardia with sinus arrhythmia. 2) Otherwise normal ECG.

Consulting Treating Physician's Progress Report, signed by [redacted], M.D., Ph.D., dated [redacted]

Subjective: The applicant had no money. His daughter used to help him financially. He had pain in the right shoulder and right side of the low back. He was worried that he would not able to walk secondary to low back pain.

Diagnoses: 1) Depressive disorder NOS. 2) Anxiety disorder NOS.

Treatment Plan: Psychotherapy was recommended. Xanax and blood pressure medications were prescribed.

Work Status: The applicant was off work.

Consultation Note, signed by [redacted], M.D., dated [redacted]

The applicant has a history of hypertension. He complained of abdominal discomfort after eating meals with gas for a few months. The upper GI showed esophageal dysmotility and duodenal diverticula and recommended for GI consultation for further evaluation.

RF Upper GI, signed by [redacted], M.D., dated [redacted]

Impression: 1) Esophageal dysmotility with stasis and tertiary contractions/spasms in the lower two-thirds of the esophagus. No evidence of achalasia. The applicant was able to clear the contrast bolus after several swallowing attempts. No evidence of gastroesophageal reflux. 2) Suggestion of duodenal diverticula within the third portion of the duodenum.

Adult Primary Care Outpatient Provider Note, signed by [redacted], N.P., date[redacted]

Chief Complaint: The applicant complained of abdominal discomfort.

History of Present Illness: He had abdominal discomfort after eating meals. His doctor ordered upper GI before. His discomfort went away and upper GI was cancelled. The pain returned and he wanted to have the test.

Medications: The applicant was on Acetaminophen, Atenolol, Gabapentin, Tramadol, Vitamin D3, and Zantac.

Assessment: Dyspepsia.

Plan: Laboratory tests and RF upper GI were requested.

Secondary Treating Physician's Progress Report, signed by [redacted], M.D., Ph.D., dated [redacted]

Subjective: The applicant still had headaches. The Tylenol helped. The medicine helped him to relax. The applicant had limited range of motion in the right shoulder.

Diagnoses: 1) Depressive disorder NOS. 2) Anxiety disorder NOS.

Treatment Plan: Psychotherapy was recommended. Xanax and blood pressure medications were prescribed.

Work Status: The applicant was off work.

Laboratory Report, [redacted] dated

Hemoglobin was 14.9. Creatinine was 0.66. Alkaline phosphatase was 82. AST was 29. ALT was 36. Total bilirubin was 0.9.

Primary Treating Physician's Permanent and Stationary Evaluation, signed by [redacted] M.D., dated

History: The applicant noticed the gradual onset of pain in his shoulders, arms, hips and knees around the year He reported his symptoms to his boss, [redacted] In his symptoms continued and he also began to have trouble and discomfort in both of his eyes, including blurred vision.

In , he began to have a difficult time hearing. He believed it was due to the daily use of machinery and tools used to assemble, make, and cut cabinets and couches. He did not report these symptoms, but he continued working.

In , he noticed the onset of pain in his neck, back, wrists, hands, hips, and feet. He again reported his symptoms to his boss, [redacted] He also began to have a difficult time sleeping and had noticed the onset of stress and anxiety as well.

He received no offers of medical treatment from his employer. He eventually went on his own volition to [redacted]. For whatever reason, they only addressed his feet. He continued to work until , when he was told by his employer that there was no more work for him.

Review of Job Description/Vocational Activities: At the time of the injury, he worked as a at [redacted] Corporation. He began working in and last worked on . His job responsibilities included cutting, carrying, and assembling wooden cabinets and making couches. He also had to lift and carry the cabinets and couches to load them onto delivery trucks. He used various hand and power tools, including a table saw, grinder, and sander. Physically, he was required to be walking, standing, bending the neck and waist,

climbing, lifting, carrying, stooping, kneeling, climbing, twisting the neck and waist, reaching at all levels, power gripping and grasping, and pushing and pulling.

Interim History/Treatment Course: The applicant had attended the course of treatment on a regular and consistent basis, as instructed, and had shown a gradual improvement of the presenting symptomatology. During the treatment course, he underwent drug compliance and diversion screen (s), to help assess his compliance and to identify signs of the possibility of drug diversion and drug-drug interactions. Drug classes tested included Opiates, Narcotic/Analgesics, Benzodiazepines, Muscle Relaxants, Antidepressants, and other commonly prescribed medications. A drug-drug interaction was also performed as part of this screen.

Present Complaints: The applicant had pain in the neck, shoulders, wrists, low back, hips, knees, and ankles. He had hearing difficulties, anxiety, depression, stress, and sleep difficulties. He had difficulty performing his activities of daily living.

Final Diagnostic Impression: 1) Cervical spine musculoligamentous injury without discopathy. 2) Cervical spine sprain/strain. 3) Lumbar spine musculoligamentous injury with discopathy. 4) Discogenic low back pain. 5) Lumbar spine sprain/strain, myositis, myalgia. 6) Right shoulder impingement syndrome. 7) Right shoulder rotator cuff tear. 8) Bilateral subacromial bursitis. 9) Bilateral shoulder strain, myositis. 10) Bilateral hip sprain/strain. 11) Bilateral knee sprain. 12) Bilateral chondromalacia patella. 13) Right patellar tendinitis. 14) Binaural hearing impairment [redacted], M.D.).

Discussion/Causation: There was causal relationship between the history of injuries as provided by the applicant, and the injuries sustained while performing his regular duties. The applicant's presenting complaints, need for treatment, residual symptoms, and permanent impairment/disability were secondary to the occupational injury.

Permanent and Stationary (MMI) Status: From through the applicant had remained under our supervision, and had attended a supervised course of conservative care and treatment. It was this examiner's opinion that, as of the applicant's condition or state was well-stabilized and unlikely to change in the next year with or without medical treatment. Although it was anticipated that over time, there might be some change in the applicant's condition, further recovery or deterioration was not anticipated. This examiner opined that the applicant's condition had reached a permanent and stationary (MMI) status for rating purposes. Based on review of the medical records, the history from the applicant, the physical examination and the results of the diagnostic tests, the applicant had the following impairment rating:

Impairment Rating According to AMA Guides, Fifth Edition: Based on the AMA Guides to the Evaluation and Permanent Impairment, 5th edition, Chapter 15, pages 417-22; page 417, Figure 15-15, page 418, Table 15-12 page 419, Figure 15-16, page 420, Table 15-13, and page 421, Figure 15-14 and Table 15-14, there was tenderness and spasm of the cervical paravertebral muscles; total WPI regarding the cervical spine was 7%. From page 404, table 15-7, II, B, there were 2 disc levels affected in the cervical spine, this equated to 4% and 1% for each additional level (4 + 1) = 5%. The total WPI = 7 + 5 = 12% WPI.

Based on the AMA Guides to the Evaluation and Permanent Impairment, 5th edition, Chapter 15, pages 405-409, page 405, Figure 15-8, page 407, Table 15-8, page 409, Figure 15-9, page 409, Table 15-9, there was tenderness and spasm of the lumbar paravertebral muscles and decreased range of motion. Total WPI was 13%. From page 404, table 15-7, II, C, there were 2 disc levels affected in the lumbar spine. This equated to 7% and 1% for each additional level (7 + 1) = 8%. The total WPI = 13 + 8 = 21%.

Combined Spinal Impairment Rating: Per combined values chart, page 604, 13% WPI cervical spine, combined with 21% WPI lumbar spine= 31% combined whole person spine impairment rating.

Right Upper Extremity Impairment Rating: The applicant had 13% right upper extremity (shoulder) impairment (figures 16-40, 16-43, and 16-46, pages 476, 477, and 479). He had 7% right upper extremity (wrist) regional impairment (Figure 16-28 and 16-31, pages 467 and 469).

Combined Right Upper Extremity Impairment Rating: Combining right upper extremity impairment ratings, the applicant had an 18% upper extremity impairment, 13% upper extremity regional impairment (shoulder), combined with 5% upper extremity regional impairment (wrist).

Per table 16-3, page 439, 18% upper extremity impairment converted to 11% WPI.

The applicant had 2% left upper extremity (shoulder) impairment (figures 16-40, 16-43, and 16-46, pages 476,477, and 479).

The applicant had 7% left upper extremity (wrist) regional impairment (Figure 16-28 and 16-31, pages 467 and 469).

Combined Left Upper Extremity Impairment Rating: Combining left upper extremity impairment ratings, the applicant had a 9% upper extremity impairment. 2% upper extremity regional impairment (shoulder), combined with 7% upper

extremity impairment (wrist). Per table 16-3, page 439, 9% upper extremity impairment converted to 5% WPI.

Total Upper Extremity Impairment Rating: Per combined values chart, page 604: 11 + 5 = 15% whole person impairment.

Right Lower Extremity Impairment Rating: The applicant had 4% right lower extremity (knee) regional impairment (Table 17-10, page 537).

The applicant had 1% right lower extremity (ankle/foot) regional impairment (table 17-11, table 17-12, page 537).

Combined Right Lower Extremity Impairment Rating: Combining right lower extremity impairment ratings, the applicant had 5% lower extremity impairment, 4% lower extremity regional impairment (knee), combined with 1% lower extremity impairment (ankle/foot). Per table 17-3, page 527, 5% lower extremity impairment converted to 3% WPI.

Left Lower Extremity Impairment Rating: The applicant had 4% left lower extremity (knee) regional impairment (Table 17-10, page 537).

He had 1% left lower extremity (ankle/foot) regional impairment (table 17-11, table 17-12, page 537).

Combined Left Lower Extremity Impairment Rating: Combining left lower extremity impairment ratings, he had a 5% lower extremity impairment, 4% lower extremity regional impairment (knee), combined with 1% upper extremity impairment (ankle/foot). Per table 17-3, page 527, 5% lower extremity impairment converted to 3% WPI.

Total Lower Extremity Impairment: Per combined values chart, page 604: 3 + 3 = 6% WPI.

Hearing Impairment: From an ENT perspective and rated with a 10% whole person impairment (Chapter 11, Table 11-1. 11-2, and 11-3. Binaural hearing impairment calculated to be 27.5%, which equaled 10% WPI). Per K. C. Salkinder, M.D.

[redacted] Decisions: With respect to the applicant, this examiner found that the AMA Guides had provided reasonable provisions for offering the applicant an impairment rating on the musculoskeletal conditions that this examiner had been asked to address. With the information that this examiner had been provided, the impairment ratings derived from the AMA Guides appeared to

be a reasonable, equitable, accurate, and proportionate rating. Further, the anatomic consideration along with activities of daily living impacted that underlie the impairment ratings offered in the AMA Guides appeared to have an equal impact on activities both inside and outside the work environment. Any determination of diminished future earnings capacity was outside of this examiner's area of expertise and might require analysis by a vocational rehabilitation expert.

Total Combined WPI Rating: Based exclusively on the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition directives (and using the Combined Values Chart, pages 604 through 606), it was the opinion of this examiner that the applicant had a total combined whole person impairment rating of 5O% (31% WPI spine, combined with a 15% WPI upper extremity, combined with a 6% WPI lower extremity, and with an added 10% WPI due to hearing impairment). As noted above, in the case of the applicant, it was the opinion of this examiner that the above permanent impairment rating award was equitable, proportioned, and an accurate measure of the applicant's permanent disability.

Work Restrictions: The applicant had work restrictions of No lifting or carrying more than 15 pounds, no repetitive bending, stooping, or lifting, no work at or above shoulder level, no repetitive reaching, and no prolonged standing or walking.

Future Medical Care: The applicant should be afforded access to a medical doctor for medication and should be afforded 24 visits of therapy (4-6 visits per flare up) which may consist of physical therapy, chiropractic treatment, and acupuncture. He should be afforded further diagnostic testing if indicated. He should have access to pain management consultation for possible injections into lumbar spine and right shoulder. He should have access to orthopedic consultation for right shoulder surgery. He should have access to ENT consultation if indicated.

Apportionment: This examiner would apportion 30% of the applicant's cervical and lumbar spine impairment and bilateral knee impairment to degeneration and 70% to the continuous trauma injury of [redacted] to [redacted]. This examiner would apportion 100% of the applicant's bilateral shoulder and ankle impairment to the continuous trauma injury of [redacted] to [redacted]

Vocational Rehabilitation/Voucher Program: No formal job analysis, or DWC Form RU-91 had been provided to this examiner to determine if, in fact, the applicant would be able to return to their former employment duties. However, the applicant had provided information with regards to the usual job duties and physical activity requirements. If the applicant's employer could provide him with work activities within the present physical capabilities, then the applicant would

be able to return to pre-injury work duties, and would not be considered an appropriate candidate for the voucher program. However, if he could not go back to work with above restrictions, or if the employer could not provide work activities within the present physical capabilities, then the applicant was an appropriate candidate for the voucher program.

Adult Primary Care Outpatient Provider Note, signed by [redacted] M.D., dated

The applicant presented for discussion of lab results.

History of Present Illness: He wanted for medication for insomnia. He complained of erectile dysfunction.

Medical History: He has a medical history of erectile dysfunction, GERD, hip pain, hypertension, hyperglycemia, hyperlipidemia, insomnia, overweight, shoulder pain, and tobacco use.

Medications: The applicant was on Acetaminophen, Atenolol, Gabapentin, Simvastatin, Tramadol, Vitamin D3, and Zantac.

Assessment: 1) Hyperlipidemia. 2) Erectile dysfunction. 3) Hyperglycemia. 4) Insomnia NOS. 5) GERD.

Plan: Laboratory tests were requested. Atenolol, Hydroxyzine, Ranitidine, and Simvastatin were prescribed.

Medical Consultative Report, signed by [redacted] M.D., dated

The applicant presented for final rating for internal medicine disorders.

Job History: He was employed as a at [redacted] Corp. He worked 9 to 10 hours a day, 60 to 65 days per week. He was responsible for assembling and cutting wood for making cabinets and couches.

Injury History: He was unsure of the exact date when he first noticed his symptoms but states that in , the pain in his knees, shoulders, arms and hips worsened that he reported them to his boss, [redacted] He continued working with persistent pain. In , he developed blurry vision in both eyes. In , he noticed having difficulty hearing which he attributed to exposure to noise from machines and tools at work. In , he noted the onset of pain in his neck, back, hands, and feet. He reported his symptoms again to his boss. In , he

developed problems with sleep due to pain and stress at work. He continued working with pain until he was terminated on [redacted] when he was told that there was no more work available.

Medications: The applicant was on Atenolol, Prilosec, unknown sleeping medication, Tylenol, and Tramadol.

Impression: 1) Hypertension. 2) Diabetes. 3) Gastritis.

Discussion: Hypertension: The applicant has no history of hypertension prior to the injury. His hypertension did not start until the last year. Apparently, the stress from his injury became overwhelming. He was placed on Atenolol, and on Atenolol, he had done well and his blood pressure had remained under good control. He denied chest pain, shortness of breath, pedal edema or blurred vision. His physical examination was without significant abnormalities.

He had an echocardiogram done in [redacted]. It showed mild left ventricular hypertrophy with an ejection fraction of 37% which was normal. The applicant had no signs or symptoms of heart failure such as shortness of breath, orthopnea, dyspnea on exertion or pedal edema. His blood and urine tests showed no evidence of renal or other end-organ damage.

Based on the AMA Guides to the Evaluation and Permanent Impairment, 5th edition, this qualified him for a Class 3 impairment because there was left ventricular hypertrophy, but no evidence of heart failure or other end organ damage.

MMI: The applicant's condition had reached MMI from an internal medicine standpoint.

Impairment Rating: Based on the AMA Guides, page 66, Table 4-2, he qualified for Class Ill, 30%-49% Impairment of the Whole Person. This examiner would give the final rating as follows: this examiner would divide the 30%-49% 19 point spread equally. For mild LVH, he would give 30-35%, for moderate LVH, he would give 36-42%, and for severe LVH, he would give 43-49%. He would give the applicant a 33% impairment of the whole person. This score should be combined with the other ratable categories.

Factors of Disability: Hypertension.

Causation: As noted in the discussion, the cause of his hypertension was within medical certainty related to the stress from his injury. He did not have a prior history of hypertension.

Apportionment: The only risk factor that he had for hypertension was a family history, but that was not enough to say that he was going to get hypertension. Therefore, apportionment was 100% due to the injury.

Future Medical Treatment: The applicant should be provided future medical treatment including doctor visits, medication, and treatment for his hypertension and any complications that might arise from hypertension including but not limited to coronary artery, cerebrovascular and renal diseases.

Work Restrictions: None from an internal medicine standpoint.

Diabetes: The applicant had borderline diabetes up until recently and the last time his blood test was done two months ago was borderline with hemoglobin A1c of 5.7. Now, his hemoglobin A1c was 6.3 with a glucose of 120. In the last several months, he had been under an incredible amount of stress because of financial problems secondary to his lack of work due to his injury. He did not have a family history of diabetes.

Based on the AMA Guides, this qualified him for a Class II, 6%-10% impairment of the whole person because of the fact that he needed medication to control his diabetes.

Maximum Medical Improvement: His condition had reached maximum medical improvement from an internal medicine standpoint.

Impairment Rating: Based on the AMA Guides, page 231, Table 10-8, he qualified for Class 6%-10% Impairment of the Whole Person. This examiner would give him a 7% impairment of the whole person. This score should be combined with the other ratable categories.

Factors of Disability: Diabetes.

Causation: As noted in the discussion, the cause of his diabetes was within medical certainty related to the stress from his injury. He did not have history of a full blown diabetes although he did have borderline diabetes.

Apportionment: As per the above, since the diabetes seemed to be caused by the stress from his injury, there would be no apportionment.

Future Medical Treatment: The applicant should be provided future medical treatment including doctor visits, medication, home glucose monitoring equipment and treatment for his diabetes and any related complications including but not

limited to coronary artery disease, peripheral vascular disease, and renal dysfunction and vision problems.

Work Restrictions: None from an internal medicine standpoint.

Gastritis: The applicant was no longer having gastritis. He was having gastritis earlier in the course of his treatment when he was taking non-steroidal anti-inflammatory medications. He stopped taking them and since then, his symptoms of gastritis had gone away. He now only got gastritis when he ate spicy foods. This would not be rated.

In summary, he had new onset diabetes and new onset hypertension, all because of the stress from his injury. These were both rated as above.

This report was subject to change if the applicant's condition changes.

Almaraz-Guzman: This examiner found that the AMA Guides provided an accurate impairment rating on the internal medicine conditions that he had been asked to address. Further, the anatomic considerations along with activities of daily living impacted that underlie the impairment ratings offered in the AMA guides appeared to have an equal impact on activities both inside and outside the work environment.

Agreed Medical Evaluation in Orthopedics, signed by [redacted] M.D., dated [redacted]

The applicant presented for evaluation regarding his orthopedic complaints involving his neck, shoulders, arms, hands, wrists, low back, hips, knees, and feet. He was claiming that he developed nonorthopedic symptoms including headaches, high blood pressure, diabetes, eyes/mouth/ear complications, nervous and circulatory system problems, and psychiatric symptoms.

Job Description: He began working at [redacted] Corporation on April 1, 1985 and worked as a [redacted] at the time of his injury. His job duties involved constructing, erecting, installing, and repairing structures and fixtures of wood, plywood, and wallboard, using [redacted]'s hand tools and power tools. His job also included to shape or cut materials. His job required finger manipulation, gripping, grasping, pulling, pushing, reaching, bending, stooping, twisting, squatting, kneeling, sitting, standing, walking, and climbing. He drove a forklift.

Current Work Status: His final day at [redacted] Corporation was on [redacted] when he was terminated from employment. He was TTD per the instructions of Dr. [redacted] from [redacted]. He denied

working for a subsequent employer or earning cash on the side for financial reasons. He was unable to work due to ongoing pain in affected areas. He was not receiving workers' compensation benefits and had recently filed for social security benefits.

History of Injury: He had difficulty recalling prior events that occurred prior to this examination, including dates, doctor's names, and types of treatment.

Prior to the orthopedic industrial injury, he had no symptoms affecting the relevant body parts. He was not following prior work restrictions. He was not self-limiting work activities or receiving ongoing medical attention for the affected areas. He did not injure the relevant areas.

He sustained a cumulative injury from to

He first noted the onset of stress in or and he attributed this to his work-related duties. He felt the repeated episodes of harassment by his coworkers/managers and overload of work was the cause of the onset symptoms. That same year, he developed paralysis in the facial area.

He did report the onset of symptoms to his employer, but was not referred to an industrial clinic. He sought medical care on a private basis at [redacted] Hospital. Treatments consisted of a consult with a doctor. He continued to work in hope that his symptoms would improve. After a month or two, his facial area recovered. In , he developed paralysis once again in the facial area. He did not seek medical care on this occasion and continued to work. He had symptoms of paralysis for 3 months.

By or , he developed pain in the neck, shoulders, arms, hands, wrists, low back, hips, knees, and feet. He attributed the pain and symptoms due to heavy lifting, bending, heavy pushing, repetitive hand use, kneeling, and stooping, squatting, and constant standing. He reported the injuries to his employer but was not referred to an industrial clinic. He self-treated with Bengay lotion and multiple supports for the affected areas. During this time, he did not lose time off work and continued to work with no restrictions.

He was terminated on and he was told that there was no more work available for him. Thereafter, he received unemployment benefits for 6 months following his termination.

He was not under the care of any medical doctors regarding his injuries. He followed up with his private physician for monthly check-ups.

Treatment: In [illegible] or [illegible], he retained an attorney who referred him to Dr. [redacted]

He was seen for periodic exams once a month and attended therapy twice a week.

He was referred to Dr. [redacted] to address his psychiatric symptoms that he developed post termination. He was seen for counseling evaluations once a month.

He was referred to an internist, Dr. [redacted]. Treatment consisted for exams and alb work. Dr. [illegible] diagnosed him with stomach complications and diabetes.

The applicant had been referred to many physicians to address complications to his ears and mouth.

He was not waiting for further medical attention and he was not presently working. He denied any prior injuries to the affected areas.

Current Orthopedic Complaints: He had pain in the neck radiating to the shoulders. He had pain in the shoulders, forearms, wrists, and hands. He had low back pain radiating to the legs. He had pain in the right hip, knees, ankles, and feet.

Medications: The applicant was taking medications for pain, high blood pressure, high cholesterol, and sleep problem.

Impression: 1) Musculoligamentous strain of cervical spine, rule out cervical radiculopathy. 2) Right shoulder painful motion, rule out rotator cuff tear. 3) Left shoulder, no current evidence of clinical abnormalities. 4) Chronic low back strain, rule out lumbar radiculopathy. 5) Right outer hip pain, rule out soft tissue strain. 6) Right and left knee, ankle, and foot, no current evidence of clinical abnormality.

Discussion: Soft tissue ultrasound of the shoulders and pelvis, and electrodiagnostic studies of the upper and lower extremities were requested.

MMI Status: This would be discussed at the time of follow-the up evaluation.

Causation of Injury: Once this examiner had reviewed the medical records, he would further comment on the issue of causation.

Causation of Disability/Impairment: This would be discussed at the time of follow-up evaluation.

Apportionment: This would be discussed at the time of follow-up evaluation.

Impairment Rating: This would be discussed at the time of follow-up evaluation.

Future Medical Care: This would be discussed at the time of follow-up evaluation.

Work Status: The applicant was precluded from heavy lifting, repetitive or prolonged overhead work, repetitive lifting, repetitive bending, stooping, twisting, squatting, or turning. He was also precluded from standing or waking more than ?? per hour, repetitive walking over uneven surfaces, climbing ladders, and working at unprotected heights.

Ultrasound of the Right Shoulder, signed by [redacted], M.D., dated

Impression: 1) Full thickness rotator cuff tear (supraspinatus). 2) Moderate subacromial-subdeltoid bursitis. 3) Long head biceps tendinosis. 4) Moderate acromioclavicular joint degenerative joint disease.

Ultrasound of the Left Shoulder, signed by [redacted], M.D., dated

Impression: 1) High-grade partial thickness rotator cuff tear/supraspinatus. 2) Long head biceps tenosynovitis. 3) Moderate acromioclavicular joint degenerative joint disease/subacromial narrowing.

Ultrasound of the Hips/pelvis, signed by [redacted], M.D., datec

Impression: 1) Right femoroacetabular mild-moderate degenerative joint disease/articular cartilage loss femoral head. 2) Right anterior labrum fraying/degeneration (no distinct tear). 3) Bilateral pelvis satisfactory.

Agreed Medical Reevaluation in Orthopedics, signed by [redacted] M.D., dated

Interim History: Since the last evaluation, there had been no further treatment. The applicant had not seen any doctor. He had not worked since
Overall, there had been no improvement in his condition. He was taking medication for high blood pressure, sleep problem, and hypocholesterolemia.

Current Orthopedic Complaints: He had pain in the neck radiating to the shoulders. He had pain in the shoulders radiating to the arms and hands. He had

low back pain radiating to the legs. He had pain in the right hip, knees, ankles, and feet.

Impression: 1) Musculoligamentous strain of cervical spine. 2) Right shoulder painful motion, rule out rotator cuff tear. 3) Left shoulder partial thickness rotator cuff tear, clinically asymptomatic. 4) Chronic low back strain. 5) Right outer hip pain with no structural abnormality. 6) Right and left knee, ankle, and foot, no current evidence of clinical abnormality.

Discussion: The applicant's condition had reached a plateau and should be considered permanent and stationary.

MMI Status: The applicant's condition had attained MMI.

Causation of Injury: The applicant worked as a for years from to This type of work over this period caused an overuse strain injury to his neck, shoulders, and low back.

The left shoulder injury had improved clinically. Although the ultrasound showed a partial thickness tear, clinically the applicant had no significant abnormal findings on exam.

Causation of Disability/Impairment: The applicant's current neck, right shoulder, and low back condition/disability/impairment was caused by the continuous trauma of his work through his last day on .

Apportionment: 100% of the applicant's current neck, right shoulder, and low back condition/disability/impairment was apportioned to the continuous trauma of his work through

Impairment Rating: Based on the AMA Guides to the Evaluation and Permanent Impairment, 5th edition, the applicant had a total WPI of 18%, with respect to his cervical spine, right shoulder, and lumbar spine injuries.

Summary of WPI Rating per Body Part: Cervical Spine: 6% WPI. Right Shoulder: 6% WPI. Lumbar Spine: 6% WPI.

Future Medical Care: Motrin, Advil, Aleve, or similar type antiinflammatory medications as well as occasional use of muscle relaxants, such as Soma, Skelaxin, or similar type medications were recommended. The applicant should be seen by a physician specializing in spine injuries. Physiotherapy was requested. The applicant would be considered as a candidate for right shoulder rotator cuff repair.

He would also be considered as a candidate for shoulder subacromial decompression and postoperative physical therapy.

Work Status: The applicant was precluded from heavy lifting, repetitive or prolonged overhead work, repetitive lifting, and repetitive bending, stooping, twisting, squatting or turning.

Periods of TTD: The applicant was terminated on . Subsequently, he would not have been able to perform similar work in the open labor market and therefore should have been considered TTD through today.

Comprehensive Medical-Legal Discharge Report: Psychiatry, signed by [redacted], M.D., Ph.D., dated .

The applicant was examined on .

Applicant Identification: He worked as a at [redacted] from until

Summary of Prior Exam Findings: This examiner diagnosed depressive disorder not otherwise specified, anxiety disorder not otherwise specified, and rule out dyssomnia not otherwise specified. Considering all factors, the predominant cause, as to all causes combined, of the applicant's psychological condition was the harassment he experienced at work over a period of many years. A lesser, though significant cause, was the physical injuries he sustained. Finally, the unexpected termination of his employment probably somewhat exacerbated or aggravated his symptoms. He presented with continued distress and he was not at maximum medical improvement. Treatment was recommended. He was not considered temporarily totally disabled from a strictly psychiatric perspective. There had been no periods of temporary total disability from a psychiatric perspective. His work status was deferred to the primary treating physician. Current Global Assessment of Functioning was 61.

Applicant's Report of Interim History: With respect to his physical symptoms, despite having received conservative treatment since , his symptoms had not changed substantially. He did not report any significant changes in his non-work related medical history since

This examiner had provided a brief course of psychotherapy and prescribed Xanax. Despite the treatment, he continued to experience anxiety, although he had stated at times that he felt it was diminishing. He continued to worry, wondering if he would be able to work again and how he would earn an income. There was ongoing difficulty with falling asleep, largely because of ruminations about his

situation. Staying asleep was made difficult because of tile pain he was experiencing. The applicant did not feel that his depression had improved substantially, stating that he just generally felt he was having a difficult time adjusting to his circumstances. He was depressed because he had worked for many years with the same routine and was now unable to work at all. In general, he felt discouraged. He noticed that he was losing weight and over time his energy level continued to decline. His reported weight decreased from to since he was seen in . He just found it very difficult to understand how he could move forward with his life.

He continued to live with his wife and son. They were not currently having any significant problems in the household relationships, and his wife and son were doing well.

He had not worked for any employer since he stopped working at [redacted] and had not sought employment.

When asked if he had experienced any non-work concerns or problems since the time of his initial evaluation, he responded that he had not.

Presenting Complaints: He had pain in the neck, back, shoulders, arms, wrists, hands, knees, hips, and feet. He had numbness and swelling in the wrists and hands. He had difficulty swallowing, vision problems, headaches, high blood pressure, hearing problems, and insomnia.

Current Treatment: The applicant was being treated by Dr. [redacted] and by his personal physician. He had received a brief course of psychotherapy.

Medications: The applicant was on Atenolol, Hydroxyzine, Simvastatin, Tramadol, and Xanax.

Diagnoses: Axis I: 1) Depressive disorder not otherwise specified. 2) Anxiety disorder not otherwise specified. Axis II: Deferred. Axis III: Organic complaints were deferred to the appropriate medical specialists.

Discussion: The applicant had sustained psychiatric injury as a result of his employment.

Causation: This examiner's opinions with respect to causation were unchanged from the initial report.

Disability Status: Emotionally, the applicant continued to present as being depressed and anxious. Despite the defensiveness on the MMPI-2, scale 2

(Depression), was extremely elevated. He also reported having a feeling of paranoia. The psychological test results were consistent with the presence of significant levels of depression and anxiety, although the defensiveness described above made it difficult to assess the exact level of the severity of the symptoms.

The applicant's cognitive functioning was being impacted by his psychological condition, with the applicant stating that he experienced difficulties in areas such as making decisions and memory. However, in the limited environment of the mental status examination his general intellectual functioning was grossly intact. Any deficiencies were more apt to be apparent in real world situations where there was a higher level of stress and there were more distractions and competing sensory inputs. The applicant currently was able to perform most basic and instrumental activities of daily living. He was able to maintain most of his adaptive living skills. He was able to articulate and communicate thoughts, ideas and needs, and discusses his current concerns.

Due to his ongoing psychological symptomatology the applicant's coping skills were now more fragile, and it was now more difficult for him to cope with stressors in the environment, or to deal effectively with people. There would be more vulnerability to criticism and rejection as he struggled with self-esteem and self-confidence issues, and feelings of self-doubt and uncertainty about his abilities. This was objectively reflected in his low Ego Strength score (ES) on the MMPI-2 despite the presence of defensiveness. A low Ego Strength score suggested difficulty in day-to-day functioning and immediate practical self-sufficiency.

Although the applicant presented with continued distress at this time, his condition should be considered permanent and stationary, at maximum medical improvement, on the basis that it was unlikely to significantly improve in the short term. The applicant's mental condition had gradually plateaued and reached maximal medical improvement as of the date of this evaluation.

In terms of Global Assessment of Functioning, this examiner estimated that the applicant' GAF=63 (11% Whole Person Impairment). He had placed the applicant at the lower end of the range 61-70 because the applicant's symptoms were more severe than was typical for this range.

Apportionment was as Follows: Harassment at Work: 55%. Orthopedic Injuries: 25%. Termination of Employment: 20%.

Future Medical Care: Because greater than 50% of the applicant's emotional suffering was a result of his work experience, this examine was following the MTUS guidelines in recommending psychiatric treatment. The treatment he was proposing was an additional four sessions of supportive and cognitive behavioral

psychotherapy to aid in consolidating the applicant's improvement to date. This was important because efforts directed solely to the management of possible pain generators without addressing psychosocial factors might result in a suboptimal outcome. The goal of treatment would be to achieve a greater level of adjustment and outcome by encouraging him to resume activities as able and help him with the return to work process. This would serve to bolster his self-confidence and self-esteem. The applicant should have access to Xanax or similar anxiolytic as needed for a period of one year. Medication management could be handled on a quarterly basis.

Vocational Rehabilitation: If the applicant recovered sufficiently from an orthopedic perspective to be able to successfully return to work at his former position, he should be allowed to attempt to do so from a psychological perspective. If sustained over time, a successful return to work could be an important factor in improving the applicant's psychological condition and strengthening damaged self-esteem and self-confidence.

State Qualified Medical Evaluation Report for Psychological Disability, signed by [redacted], Ph.D., dated

The applicant was examined on The interpreter had difficulty keeping the applicant focused and attentive and that he had a tendency to ramble in answering the questions. The applicant also reported hearing problems, which compounded the comprehension problems. He appeared to be a poor historian.

Employment Details: He worked at [redacted] Corporation as a from until . His main duties included receiving wood and placing it into a dolly and then cutting it in different lengths and widths and leaving wood ready to be assembled. He also had to lift big pieces of wood and place them into the machine to cut them to different sizes. He denied that his duty was changed over the years of his employment. He was doing the same job for years. He normally worked at 7:00 a.m. to 4:00 or 5:00 p.m., 8 to 9 hours per day. He worked 5 ½ days per week and 5 ½ days in a row. He had 30-minute lunch break and more recently 45 minutes, and 15-minute rest break (for the last four years but not before). He was paid $ per hour plus $ monthly in cash. He denied that he had more than one employer when he was injured and he was not working anymore for the same employer since his work injury occurred. He had no new employer.

History of Present Illness: He first felt pain in the right shoulder. He reported this to his boss and he requested to take a short break. Sometimes, his boss would get mad and would yell to the applicant. The applicant was accused that he was lying.

Later, his hip started to get hurt but he did not remember when. He also indicated about 3 or 4 times he got facial affection (paralysis) as if having a stroke.

His physical injury came on gradually. He realized he was injured in

His claim was a repetitive cumulative trauma injury. He did not remember many of specific incidents but there were "several" incidents. He reported that the stress from the owner to get the production out contributed to his mental health problems. He reported that sometimes the wood would not get out on time and the owner would yell at him and demand that he should get to production right away. Sometimes if the measurements would be different from what the customer wanted and needed, though he asserted he had followed the instructions he was given, the owner would then get mad and yell. He would have stress due to coping with rush orders and for "many other reasons." He reported that he had no treatment while he was still working.

Psychological Response to Alleged Injury Situation: The applicant reported that his problem with his mood caused him severe distress as it caused him nightmares and he could not sleep well. He reported that he was stressed and he was worried almost all the time. He stated that his problem with anxiety causes him moderate distress. He indicated that he did not know what to do job-wise. He could not do carpentry any longer because it was too heavy. He indicated that he did not know if he would go to school, he did not know what to study. He related that his problem with sleep caused him moderate distress. He wished he could sleep better. His thinking as he goes to sleep was a problem. When he went to bed, he could not fall asleep and when he fell asleep he woke up. He explained that his problem with his experience of trauma caused him severe distress. He wished he did not remember the moments of verbal abuse, but he could not stop thinking about those events. His problem with sexual problems caused him mild distress. He tried not to even think about it, but sometimes it did bothers him. Furthermore, in dealing with the problems he had, he reported that he did not know what to do and he just took pills to sleep but that was about it.

History of Mental Health Problems since Alleged Injury: The applicant reported that his overall mental and emotional problems cause him severe distress which began in about 2011.

History of Treatment since Alleged Injury: The applicant first sought treatment for his injury by drinking tea and over-the-counter pills to help him sleep in 2012. He was not sent by his employer for treatment. He sought treatment on his own. He initially went to the [redacted] Hospital in [redacted] for the facial problems; paralysis or weakness of the muscles. He was not admitted and he was given medication to relax the muscle. The doctor told him that it was due to nerves

and too much stress. He was told that he would need more treatment including therapy but his work activities were not modified.

He was seen by Dr. [redacted], general practitioner, in [redacted] in [redacted]. He had physical examination and was given sleeping pills. He was told that he was suffering from stress. He had stopped treating with this doctor. He noted that he was not taken off work and was not referred anywhere else.

He was seen by a doctor (unknown specialty) at [redacted] in [redacted] from [redacted] to [redacted] He was seen for physical examination only. The doctor told him that he was overworked. He had no improvement. He stopped treating with this doctor. He noted that he was not taken off work and his work activities were not modified. He was referred to an ear doctor and to an eye doctor.

He then went to a general practitioner in [redacted] Clinic in [redacted] for [redacted] to [redacted] times. He reported that he was seen for physical examination and laboratory work. He was treated for high blood pressure, high cholesterol and pre-diabetes. He started his treatment in [redacted] and it was still ongoing for control of his high blood pressure, cholesterol and pain. He noted that he was not taken off work and his work activities were not modified. He was referred to an ear and eye specialist.

He was seen by Dr. [redacted] (?), chiropractor in [redacted] from [redacted] to [redacted]. He had chiropractic therapy three times per week. He had a total of 150 visits. He was told he had a torn tendon in the right shoulder and the disc in his neck was bad. He noted that he was not taken off work and his work activities were not modified. He was not referred anywhere else.

He had received much benefit from medications, and some benefit from injections, chiropractic care, electrical stimulation (TENS unit) and physical therapy. He had no benefit from surgery. He rated his compliance with treatment recommendations as "excellent."

Medications: The applicant was on Amlodipine, Ranitidine, Pravastatin, Gabapentin, and Hydroxyzine.

Medication taken on the day of Interview: The applicant had taken medication for high blood pressure only.

Subjective: The applicant had pain in the right shoulder, right hip, low back, neck, head, and feet.

Account on Current Mental Health: He was quiet, shy, incompetent, having horrible thoughts, anxious, panicky, unconfident, easygoing, friendly, depressed, confused and intelligent. His main strength was being intelligent. His main weakness was depression.

Diagnosis Using DSM-V: 1) Adjustment disorder with mixed anxiety and depressed mood. 2) Other problem related to employment. 3) Low income. 4) GAF Score: 62.

Summary and Discussion: Apportionment was 100% due to the injury.

Results of the Interview: During this examination, the applicant's symptoms were reported to be depressed mood, loss of energy, feelings of excessive sadness, decreased of appetite, weight loss (5 pounds over two years), anxiety, fearfulness, hard to control worrying, muscle or physical tension, stress, marked inability to cope and grinding teeth at night. The applicant's anxiety and depressive episode was reported by him to have started about 6 to 7 years ago and lasted until this date. He said they last for periods but not the whole of the day more days that not and vary in intensity. He believed these symptoms were poorly controlled. His anxiety and depressive episode were related to pain, disability and work stress. He further reported sleep disturbance, including insomnia (4-6 hours per night), difficulty falling asleep, difficulty staying asleep, frequently waking (2-3 times per night), and low energy and day time fatigue. These symptoms were said to have been present 10 years ago and he believed his symptoms were poorly controlled. He believed that his sleep disturbance was related to pain, disability, depression, stress and anxiety. He reported sexual dysfunction including decreased libido and lack of erection. These symptoms were said to have lasted for 5-6 years and he believed these symptoms were poorly controlled. He believed that his sexual dysfunction symptoms were related to stress and anxiety.

Conclusion: Based upon reported symptoms the applicant met the threshold for chronic adjustment disorder based upon the development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within three months of the onset of the stressor(s). These symptoms or behaviors were clinically significant as evidenced by marked distress that was in excess of what would be expected from exposure to the stressor and/or significant impairment in social or occupational functioning. The stress-related disturbance did not meet the criteria for another specific Axis I disorder and was not merely an exacerbation of a preexisting Axis I or Axis II disorder nor do the symptoms represent Bereavement. GAF score was 62.

Causation: The applicant's claim was for a continuous trauma case so, there were no "sudden and extraordinary events of employment." There was no evidence

other than the word of the employee that the employer had notice of the psychiatric injury. There was no evidence in the employee's medical records, prior to notice of termination or layoff of evidence of treatment of a psychiatric injury. No trier of fact had made a finding of sexual or racial harassment. There was no evidence that the date of injury, as specified in Section 5411 or 5412, if subsequent to the date of the notice of termination or layoff, but prior to the effective date of the termination or layoff. Therefore, this examiner could only conclude that the case for a primary psychiatric injury was unproven by a preponderance of the evidence. However, with respect to a psychiatric injury secondary to his physical injuries, it would seem that there was a case to be made. The applicant did not have a pre-existing, non-industrial, depressive clinical diagnosis. Absent any medical documentation to the contrary, there was no evidence that the applicant had ever experienced feelings of depression or anxiety which had impacted his ability to function. It appeared that the actual events of employment were the predominant, greater than 50%, cause of the applicant's current psychiatric injuries secondary to the physical injuries if such were found to be industrial in origin. Within reasonable medical probability, the actual events of employment were predominant to all the causes combined to have produced a psychiatric injury. This injury met the requirements under section 3208.3 for predominant cause.

Temporary Disability Status: The applicant had never been temporarily totally disabled on an industrial psychological basis.

Permanent and Stationary: The applicant's condition had not yet reached maximal medical improvement; and therefore, was not yet permanent and stationary.

Permanent Disability Status: Permanent disability was deferred as the applicant's condition was not yet permanent and stationary.

Apportionment: At this point, the applicant's condition was not yet permanent and stationary; therefore, a discussion of apportionment would be premature.

Recommendations: Cognitive behavioral therapy was recommended. This examiner would recommend discontinuing psychotherapy.

Summary of Referral Questions: The applicant was diagnosed with adjustment disorder. The work exposure caused the impairment. He was not deemed permanent and stationary. He was not totally disabled on a psychiatric basis. Disability status was deferred until the applicant had reached MMI. Homecare was not warranted in this case. This examiner would recommend 6 to 10 individual sessions over 6 to 10 weeks. The applicant's condition was not yet permanent and stationary; therefore, a discussion of apportionment would be

premature. No vocational rehabilitation was warranted in this case. The applicant was cleared to return to work on a psychiatric basis.

Department of Emergency Medicine Record, [redacted] - [redacted] Undated.

The applicant had problem in the right eye. He had chest pain.

Medications: He was not taking any medications.

Discharge Impression: Bell's palsy.

The rest of the note is illegible.

That completes the review of records.

HISTORY OF PRESENT ILLNESS

The applicant states that during his tenure as an employee of [redacted] Corp., he was exposed to lots of dust which caused him significant ocular irritation. He states that he would wear eye protection while he worked, but sometimes, he would have to remove his eye protection to work because it would get fogged up when used in conjunction with a mask.

The applicant states that we was terminated from his work in ' He feels that at this time, he is unable to return to his customary duties both because of orthopaedic limitations and because of his ocular issues.

JOB DESCRIPTION

The applicant worked as an employee of [redacted] Corp., involved in furniture manufacturing. His job duties included cutting wood, lifting, carrying, assembly of furniture, carpentry, and use of various tools and machines.

CURRENT VISION COMPLAINTS

At this time, the applicant complains of dryness and redness in his eyes as well as his eyes feeling tired.

PAST MEDICAL HISTORY

Diabetes, Hypertension, Cholesterol, Stomach issues

PAST OCULAR HISTORY

Possible glaucoma; Use of OTC readers; use of artificial tears; no previous eye surgery

SOCIAL HISTORY

Positive for smoking, occasional alcohol; currently not working.

OCULAR MEDICATIONS

Artificial tears

ALLERGIES

Penicillin

EXAMINATION

Visual acuity without correction is 20/50 right eye, 20/50 left eye, and 20/50 both eyes. Refraction in the right eye is +0.50, and refraction in the left eye is -0.50. Best-corrected vision is 20/30 in the right eye, 20/20 in the left eye, and 20/20 in both eyes.

Pupils were equally round and reactive to light, without afferent pupillary defect

Visual fields were full to confrontation in both eyes.

Ocular motility was within normal limits in both eyes.

Intraocular tension was 19 in the right eye and 20 in the left eye by applanation.

Lids and lashes were remarkable for bilateral blepharitis.

Sclera and conjunctiva were within normal limits in both eyes.

Corneas were clear in both eyes.

Irises were regular and round in both eyes.

Anterior chambers were deep and quiet in both eyes.

Lens examination revealed early nuclear cataracts in both eyes

Dilated fundus exam revealed normal macula, vessels, and periphery in both eyes. Moderate optic nerve head cupping was noted bilaterally.

IMPRESSION

1. Blepharitis/ocular surface disease
2. Early cataracts both eyes
3. Refractive error both eyes
4. Glaucoma suspect both eyes

DISCUSSION

The applicant's diagnoses of early cataracts, refractive error (the need for glasses), and borderline glaucoma (glaucoma suspect) have no relationship to his work.

The applicant's diagnosis of blepharitis (inflammation of the eyelids, which often manifests as ocular irritation and redness) is also unlikely to have been caused by his work, given that his ocular irritation persists despite his not having worked for some time, and also given that blepharitis is a fairly common ocular disorder in the general population. That said, given that the applicant's work environment was full of dust, it is medically reasonable that his blepharitis would become aggravated in such an environment.

CAUSATION

As discussed above, it is medically reasonable that the applicant's ocular irritation (diagnosis of blepharitis) was exacerbated by his work environment.

I find no causative relationship between the applicant's work and his diagnoses of: early cataracts, refractive error, or borderline glaucoma.

PERMANENT AND STATIONARY STATUS

At this time, from a visual standpoint, the applicant is permanent and stationary.

IMPAIRMENT

The applicant's only ocular diagnosis related to industrial causation is the blepharitis, which has not caused any ratable visual impairment.

APPORTIONMENT

Discussion of apportionment is moot, as there is no industrial visual impairment.

ABILITY TO WORK

From a visual standpoint, the applicant may return to his job duties without restriction. He should use eye protection to limit ocular dust exposure as much as possible.

FUTURE CARE

Initial treatment of blepharitis generally involves patient education on lid hygiene (such as warm compresses and lid scrubs) and lubricating drops. The applicant should be afforded twice yearly eye examination to be certain these measures are adequate.

SPECIAL COMMENTARY

The above responses and opinions are based on reasonable medical probabilities, as viewed from the perspective of available documentation and information submitted to this examiner, including the applicant's direct anamnesis.

Thank you for the opportunity of serving as Qualified Medical Examiner, in the specialty of Ophthalmology, for this most interesting case and condition.

Sincerely,

_____
David Paikal, M.D., Q.M.E.
Diplomate, American Board of Ophthalmology

Attachments:
1. Appendix A: Declaration

[redacted]

APPENDIX A - DECLARATION

Pursuant to AB 1300, LC Sec. 5703, I have not violated Labor Code section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

DATE OF REPORT:

Dated this day of at

David Paikal, M.D., Q.M.E.
Diplomate, American Board of Ophthalmology