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October 26, 2022

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RE:	Adel Hanna vs. California Institution for men
WCAB Case No:	ADJ 15547699
Claim No.:	06675270
Panel No.:	7490085
Date of Injury:	CT: 12/01/16 - 12/05/21
Date of Service:	10/26/22
Location:	9555 Foothill Blvd., Suite A, Rancho Cucamonga, CA 91730

PANEL QUALIFIED MEDICAL EVALUATION

Thank you for asking me to see and evaluate Adel Hanna in the capacity of a Panel Qualified Medical Examiner in the field of internal medicine. I had the opportunity to obtain a history and perform a comprehensive assessment on Adel Hanna in my office in Rancho Cucamonga, California on October 26, 2022. This was a comprehensive assessment and 55 minutes of face-to-face time was required for the assessment. Additionally, medical records were reviewed, which are attested to consist of 61 plus 695 pages. This report is billed as ML201-95 with a total of 756 pages.

BACKGROUND INFORMATION: Adel Hanna has alleged an injury to his eye, right ear, right internal organs, soft tissue, neck, lungs, chest, ribs, knee right, mental, abdomen/groin, shoulders, lower back area, lower legs on 12/05/21, while employed by California Institution for Men as a chief Psychiatrist, hired on 06/26/00. I am asked to provide a detailed medical and employment history, provide a diagnosis, discuss future medical care, period of TTD, causation, and apportionment as appropriate.

I have also reviewed the DWC Form 1a, which lists CT injury 12/01/16 to 12/05/21 to circulatory system, digestive system, and hernia, as well as patella lower extremities and back.

HISTORY OF PRESENT ILLNESS/INJURY: Dr. Adel Hanna is a 76-year-old male. He used to be a thoracic surgeon in his native country, but has been practicing as a psychiatrist now for decades while in the US. He has been employed at CDCR as a psychiatrist for over 22 years. Dr. Hanna started as a staff psychiatrist, but then later on became a chief psychiatrist. His responsibilities were predominantly administrative at that time, and he would work with other psychiatrists, dealing with difficult cases and helping with policy and decisionmaking. He states that the first 20 years of his career at CDCR was very rewarding and fulfilling, and he had no psychiatric concerns, anxiety or stress at his place of work.

Dr. Hanna reports that he has a history of hypertension that apparently resolved many years ago. Per records, he was on Diovan in 2005; however, in 2008, he was no longer on it. He was taking a betablocker only for migraine prophylaxis. He reports that he had previous admissions for heart disease, as he would have occasional episodes of chest pain. However, he had a complete workup in the past that was negative, including a coronary angiogram. Dr. Hanna also reports that he has a remote history of a hiatal hernia, which required a Nissen fundoplication. This was complicated by an empyema, requiring chest surgery as well. This occurred more than 40 years ago. He also reports a remote history of an inguinal hernia, repaired more than 40 years ago. This was years before he began employment at CDCR. Dr. Hanna reports therefore that when he began employment with CDCR 22 years ago, he had no known medical illnesses, except for a remote history of hypertension that resolved, and a history of previous hiatal hernia/Nissen fundoplication complicated by empyema, and a history of inguinal hernia that had been repaired.

Dr. Hanna reports that his work was congenial and well, and he would work typically either 8:00 am to 4:00 pm or 7:00 am to 3:00 pm, five days a week. He would work in person, and he would evaluate patients as needed. As discussed above, his work was predominantly more administrative in nature. Dr. Hanna reports that he had stellar recommendations and evaluations until 2020. In 2020, he states that there was an executive decision by Sacramento that the chief psychiatrist cannot be reporting to the chief of mental health, which, at that time, was a psychologist. Sacramento decided that Dr. Hanna would report directly to the CEO. Per Dr. Hanna, this caused a bit of conflict between him and the chief psychologist, who, at that time, was the chief of mental health. Dr. Hanna continued to work without issue; however, noted that in early 2020, he felt that there was a move to have him removed. He states he overhead a conversation where an individual was talking about writing him up, so that he could be eliminated. He also noticed that he had started having poor work performances. Dr. Hanna felt that this was an issue for him, as he had worked without issue for the last 20 years and had stellar performances. He has felt this disrupted his sleep, and he started having thoughts about this. He

felt sad and anxious. In the past, he was never hypertensive; however, he noted that his blood pressure would start creeping up; although, he is unable to recall the blood pressure values.

Dr. Hanna then reports that he had an admission to a local hospital in June 2020, at which time, again, he was not found to have coronary artery disease. Medical records confirm this history. Dr. Hanna reports that over the next year or so, he has had subsequent evaluations at hospitals and has been found to have coronary artery disease, and also required to have cardiac stents placed. He states he has had four stents placed total. I reviewed the records, and I do not see any such records being sent to my attention.

Dr. Hanna denies being a smoker. He states he had two brothers who died in their 80s, and he suspects they may have had heart disease, but he is unaware of any known history of cardiac disease in his family. At this time, he states that he has no issues with heartburn. He has no issues with his hernia. He has no chest or rib pain. His main issues are his hypertension and CAD. He denies a history of asthma, although medical records indicate a history of exercise-induced asthma in the past, also.

Medical records from Dr. Khabibulina indicates that the patient reported a brother died at age 50 and a second brother died at age 65 from heart attack. Therefore, there is clearly a history of heart disease in the family. Also, he is noted to be on amlodipine on 06/01/20. Therefore, there is some history of previous antihypertensive usage before his reported CAD, as well.

WORK HISTORY: Discussed above.

PAST MEDICAL HISTORY: Hypertension, diagnosed formally in the last several years, although there is a history that he was on Diovan in 2005. Records indicate that he was no longer on antihypertensive as of 2008, except for a betablocker for migraine prophylaxis.

PAST SURGICAL HISTORY: 1) Coronary artery disease status post PCI x4. 2) Inguinal hernia repair more than 40 years ago. 3) History of Nissen fundoplication and thoracic surgery for empyema more than 40 years ago.

HOME MEDICATIONS: Brilinta, Lipitor, nitroglycerin, and Norvasc 10 mg daily.

ALLERGIES: Reglan.

SOCIAL HISTORY: He is married and has three children. He denies alcohol, tobacco, substance abuse, or marijuana.

FAMILY HISTORY: Discussed above. There is no definitive history of CAD.

REVIEW OF SYSTEMS:

A ten point review of systems for internal medicine was conducted. Relevant positives and negatives are noted in the body of this report.

PHYSICAL EXAMINATION:

Vital Signs: Blood pressure: 140/90. Heart rate: 84. Respirations: 18. O2 saturation is 98% on room air. Weight: 198 pounds. Height: 67 inches.

HEENT: Head examination reveals that the head is normocephalic, atraumatic without deformity or unusual swelling. Pupils are round, reactive to light and accommodation normally. There is no nystagmus, lid lag or exophthalmos. Nasal mucosa is pink. Vision is normal.

Chest and Lung: Reveals clear, normal, symmetrical breath sounds with no adventitious sound. Expansion is normal. There are no surgical scars.

Cardiovascular: Reveals normal S1, S2 without murmurs, rubs or clicks.

Abdomen: Soft with no tenderness or organomegaly.

Musculoskeletal: There is no tenderness to palpation. Range of motion is normal.

Extremities: There is no cyanosis, peripheral edema, or clubbing. There is no evidence of insufficiency or skin changes. Pedal pulses are strong and bounding.

Neurological: Cranial nerves II to XII are intact. Gait is normal without ataxia. DTRs are normal. Babinski is downgoing.

REVIEW OF MEDICAL RECORDS

04/15/05 – Ashok Madahar, M.D. – Chino Valley Medical Center – Emergency Room Report. History of Present Illness: The patient, a 59-year-old Caucasian male, who while attending this morning, had a substernal pressure type sensation radiating to his jaw and the right arm. He looked pale and sick to the staff members. They told him to go home. He went home and rested, and tried to fall asleep, but the pain continued rating from 4-7/10. He thought it was his initial hernia and took Mylanta without any relief. Then the pain continued, and eventually, he decided to get an electrocardiogram done. He is a psychiatrist. He had an electrocardiogram, which was read as normal, but the symptoms continued. His coronary risk factors are positive for his age, male gender, past smoking, hypertension, and strong family history. Three brothers died of sudden death and one brother had a quadruple bypass. Three of them were younger than him. His cholesterol is normal. **Medical History:** Significant for hypertension, migraine headaches, and hiatal hernia. **Allergies:** Reglan. **Current Medications:** Diovan. **Vital Signs:** Blood Pressure 132/72. Pulse 71. Respirations 20. Temperature 97.5. **Interim Diagnostic Impression:** Chest pain. **Medical Decision Making:** His history is of classic angina. An electrocardiogram done at the facility where he was working showed possibly an old inferior myocardial infarction, otherwise unremarkable. Electrocardiograms done here have similar changes, but nothing acute. A cardiac workup has been initiated. He will be treated with sublingual nitro, nitro paste, and aspirin. Supplemental oxygen has been placed. **Final Disposition:** He will require admission for ongoing evaluation of his symptoms.

04/15/05 – Ashok Madahar, M.D. – Chino Valley Medical Center – Disposition and Admission Report. The patient is feeling better and 100% pain-free after nitroglycerin. At this time, his blood pressure is normal. Heart rate is 58, in sinus rhythm and saturation is 98%. **Diagnostic Impression:** 1) Chest pain, rule out unstable angina. 2) Hypertension, controlled. 3) Past tobacco use. His pulse oximetry was 97% on room air and is normal. He is in sinus rhythm with no ectopy; a normal rhythm. **ECG Interpretation:** ECG done at 0050 hours revealed a heart rate of 69. He is in sinus rhythm with no ectopy. Intervals are normal. Axis is normal. No QRS configuration abnormality. He has Q waves in leads II, III and aVF and a subtle upward curving of the ST segment, which is nonspecific, but comparable to the ECG done about 3 hours ago, a borderline ECG.

04/15/05 – James Lally, M.D. – Chino Valley Medical Center – History and Physical Report. History of Present Illness: The patient has chest pain that started at 9:30 a.m. on 04/14/05. His chest pain was intermittent but continued to become progressively worse. His chest pain was 7/10 and was sharp in nature. He has a strong family history of myocardial infarction, so he sought medical attention. **Medical History:** Significant for cholecystectomy in 1987 and hiatal hernia in 1994 with Nissen fundoplication in 1994. **Medication:** Diovan 80 mg. **Social History:** He denies tobacco use; he quit 21 years ago. He drinks alcohol once per month and 2 caffeinated beverages per day. He denies recreational drug use. **Family History:** Significant for myocardial infarction and diabetes mellitus type 2. **Review of Systems:** Positive for intermittent chest pain, history of gastroesophageal reflux disease, and sliding hiatal hernia. **Vital Signs:** Blood Pressure 102/70. Temperature 97.7. Pulse 61. Respirations 18. Height 5'8". Weight 164 pounds. **Physical Examination:** Unremarkable. **Assessment:** 1) Chest pain, rule out acute coronary syndrome. 2) Hiatal hernia. 3) History of Nissen fundoplication repair. 4) Hypertension. 5) Dehydration. **Plan:** 1) Prescribed Diovan 80 mg. 2) IV fluids.

04/15/05 – Curtis Handler, M.D. – Chino Valley Medical Center – Diagnostic Imaging Report. Procedure: Portable Chest X-ray. **Impression:** 1) No acute abnormality is demonstrated. 2) Right base fibrosis and pleural thickening. 3) Bibasilar atelectasis.

04/15/05 – Chino Valley Medical Center – ECG, 0050 hours. Impression: 1) Normal sinus rhythm, rate 69. 2) Normal ECG.

04/15/05 – Chino Valley Medical Center – ECG, 2201 hours. Impression: 1) Normal sinus rhythm, rate 74. 2) Normal ECG.

04/15/05 – Chino Valley Medical Center – Laboratory Report. Abnormal Results: WBC 3.9 L. BUN 210 H. AST/SGOT 14 L. Alkaline phosphatase 49 L. Cholesterol 134 L. HDL 31 L. Magnesium 2.5 H.

04/15/05 – James Lally, M.D. – Chino Valley Medical Center – Discharge Summary Report. Hospital Course: The patient was admitted to the direct observation unit, on telemetry, and started with chest pain protocol. His pain remained decreased once on the floor with 2-3/10. Cardiac enzymes were negative x 2 sets as previously described. ECG remained in normal sinus with no acute changes. He was reevaluated and found to be stable for discharge. He is to follow

up with his primary care physician. He is advised on low cholesterol and low-sodium diet. Activity as tolerated. He is to continue with his previous home medications.

06/15/07 – Illegible Signature – Chino Valley Medical Center – History and Physical Report. Chief Complaint: The patient presents with heartburn. He was status-post screening colonoscopy. He has a history of colon polyps. **Vital Signs:** Blood Pressure 130/70. Temperature 98. Pulse 80. Respirations 14. **Diagnoses:** 1) Gastroesophageal reflux disease. 2) Chest pain. 3) Colon polyps.

06/15/07 – Umesh Shah, M.D. – Chino Valley Medical Center – Operative Report. Procedures Performed: 1) Upper GI endoscopy with biopsy. 2) Colonoscopy with polypectomy. **Impression:** Status post fundoplication. Some erosion at the GE junction on the retroflex view. This is probably traumatic. **Plan:** Await the pathology report for H. pylori and treat appropriately if positive. There are no inflammatory changes in the esophagus. Atypical chest pain, difficult to explain for now.

06/15/07 – Robert Bearman, M.D. – Chino Valley Medical Center – Pathology Report. Diagnosis: Colonoscopy of right large intestine reveals tubular adenoma.

11/19/08 – James Lally, M.D. – Chino Valley Medical Center – History and Physical Report. History of Present Illness: The patient presented with abdominal pain and nausea for 2 days. He states his abdominal pain is 5/10, which is also accompanied by chills, fever, dizziness, diarrhea, and generalized body ache. He was unable to tolerate food or drink for 2 days due to nausea, vomiting, and diarrhea. He has had no urinary output for 2 days either. He describes the abdominal pain as continuous cramping and generalized everywhere. Also, he tried Tylenol to control his fever. He has a history of depression and migraine. **Medications:** Atenolol 50 mg, Lexapro 15 mg, Zomig 2.5 mg, and Tylenol 500 mg. **Review of Systems:** Positive for fever, chills, fatigue, migraine, high frequency hearing loss in the right ear, sore throat, nonproductive cough, food intolerance, nausea, vomiting, abdominal pain, decreased appetite for 2 days, generalized body aches, and history of depression. **Vital Signs:** Blood Pressure 131/88. Temperature 98.5. Pulse 90. Respirations 20. Weight 167. **Physical Examination:** Abdominal tenderness is noted. **Diagnoses:** 1) Intractable acute abdominal pain. 2) Small bowel obstruction. 3) Intractable acute nausea and diarrhea. 4) Dehydration. 5) Migraines. 6) Depression. 7) Possible acute/chronic systolic/diastolic heart failure. **Plan:** 1) Order laboratory tests and echocardiogram. 2) IV Toradol 30 mg, IV ampicillin 1 mg, atenolol 50 mg, IV Benadryl 25 mg, and IV Protonix 40 mg. 3) Consult Dr. Quianzon for small bowel obstruction and Dr. Amin for patient's care and management for abdominal pain. 4) Admit to med-surg. 4) Hydrate at 100 ml/hour NS, NG tube, and intermittent suction. 5) Surgical consult.

11/19/08 – Peter Phan, M.D. – Chino Valley Medical Center – Diagnostic Imaging Report. Procedure: CT – Abdomen and Pelvis. **Impression:** 1) Findings consistent with small bowel obstruction with a transition point in the right mid abdomen. 2) Status post cholecystectomy. 3) Normal appendix is identified. 4) Tiny nonspecific free pelvic fluid. 5) Scattered diverticula are seen in the sigmoid colon without CT evidence for acute diverticulitis.

11/19/08 – Peter Phan, M.D. – Chino Valley Medical Center – Diagnostic Imaging Report. Procedure: X-ray – Chest, 1 view. **Conclusion:** Bibasilar discoid atelectasis.

11/19/08 – Gary Harris, M.D. – Chino Valley Medical Center – Diagnostic Imaging Report. Procedure: Supine portable AP chest/abdomen. **Impression:** 1) Nasogastric tube in place with its tip near the region of the EG/junction gastric fundus; recommend advancing the tube from 6 cm to 8 cm. 2) Finding suggestive of a distal small bowel obstruction.

11/19/08 – Chino Valley Medical Center – ECG. Impression: 1) Normal sinus rhythm, rate 89. 2) Normal ECG.

11/19/08 – Chino Valley Medical Center – Laboratory Report. Abnormal Results: Potassium 3.4 L. Creatinine 22.0 H. Calcium 8.4 L. AST/SGOT 13 L. Alkaline phosphatase 42 L. Cholesterol 110 L.

11/20/08 – Mukesh Amin, M.D. – Chino Valley Medical Center – Consultation Report. History of Present Illness: The patient was essentially admitted with abdominal pain and nausea for 2 days, chills, fever, dizziness, and some generalized body aches. The abdominal pain was continuous. He was admitted and found to have a small bowel obstruction. A nasogastric tube was placed and intravenous Protonix was started and ampicillin. **Medications:** Atenolol, Lexapro, Zomig, and Tylenol. **Review of Systems:** Positive for sore throat, high frequency hearing loss, and mild body aches. **Vital Signs:** Blood Pressure 118/82. Pulse 94. Respirations 18. Temperature 99.7. **Physical Examination:** Unremarkable. **Assessment:** 1) Abdominal pain, small bowel obstruction. 2) Dehydration, azotemia. 3) Depression. 4) Migraine. **Plan:** 1) Agree with the current treatment. 2) IV fluids. 3) Add IV KCl 40 mEq. 4) Order laboratory tests.

11/20/08 – Illegible Signature – Chino Valley Medical Center – Progress Report. Subjective: The patient complains of a slight throat and epigastric discomfort starting with nasogastric tube placement. A nasogastric tube was set to low intermittent suction. **Vital Signs:** Blood Pressure 112/70. Pulse 81. Respirations 18. Temperature 97.5. **Assessment:** 1) Distal small bowel obstruction. 2) Acute intractable abdominal pain secondary to distal small bowel obstruction. 3) Acute intractable nausea and diarrhea. 4) Epigastric pain/esophagitis. 5) Bibasilar discoid atelectasis. 6) Electrolyte imbalance. **Plan:** 1) Repeat KUB in the morning. 2) NPO after midnight. 3) Continue medications.

11/20/08 – Peter Phan, M.D. – Chino Valley Medical Center – Diagnostic Imaging Report. Procedure: X-ray – Abdomen/KUB. **Impression:** Slight improvement in distal small bowel obstruction. The feeding tube tip is in the distal stomach/duodenum.

11/20/08 – Chino Valley Medical Center – Laboratory Report. Abnormal Results: WBC 3.0 L. Hemoglobin 12.9 L. Hematocrit 39 L. RDW 14.7 H. Monocytes% 10.9 H. Neutrophils# 1.3 L. Phosphorus 2.3 L. Cholesterol 110 L. Ketones 2+ H. Urine bilirubin 1+ H. Icto / Positive.

11/21/08 – Illegible Signature – Chino Valley Medical Center – Progress Report. Subjective: The patient is resting comfortably. He had no new complaints overnight. **Vital Signs:** Blood Pressure 118/74. Pulse 67. Respirations 20. Temperature 97.8. SpO2 98%. **Assessment:** 1) Distal small bowel obstruction. 2) Acute intractable abdominal pain secondary to small bowel obstruction. 3) Acute intractable nausea and diarrhea, resolving. 4) Bibasilar discoid atelectasis. 5) Electrolyte imbalance. 6) Migraine headache. 7) Dehydration. **Plan:** 1) CT scan of the abdomen/pelvis. 2) Continue medications.

11/21/08 – Fahim Gheybi, M.D. – Chino Valley Medical Center – Diagnostic Imaging Report. Procedure: X-ray – Abdomen. **Impression:** Slight decrease in small bowel ileus pattern.

11/21/08 – Steven Cobb, M.D. – Chino Valley Medical Center – Diagnostic Imaging Report. Procedure: CT – Abdomen and Pelvis. **Impression:** 1) The nasogastric tube terminates in the descending duodenum. 2) There is no pattern of small bowel obstruction. 3) There is a lack of distention versus thickening to the wall of the sigmoid colon without marked adjacent inflammatory change.

11/21/08 – Chino Valley Medical Center – Laboratory Report. Abnormal Results: WBC 3.4 L. Hemoglobin 12.8 L. Hematocrit 38 L. Glucose 70 L. Calcium 7.9 L. Phosphorus 1.8 L.

11/21/08 – Daljinder Takhar, D.O. – Chino Valley Medical Center – Discharge Summary Report. Discharge Diagnoses: 1) Intractable acute abdominal pain. 2) Acute small bowel obstruction. 3) Intractable acute nausea, vomiting, and diarrhea. 4) Dehydration. 5) Migraine. 6) Depression. 7) Possible acute/chronic systolic/diastolic heart failure. **Hospital Course:** The patient came in complaining of diffuse and cramping abdominal pain for 2 days with chills, fever, dizziness, and diarrhea. He was admitted to medical/surgical with nasogastric tube placement in the emergency room with intermittent loss of low suction. He was put on NPO and IV fluid 100 ml/hour of normal saline with Zofran 4 mg IV, morphine 2 mg IV, Ativan 1 mg IV, Protonix 40 mg IV daily, Ambien 5 mg, Toradol 30 mg, ampicillin, atenolol 50 mg, and Benadryl. Dr. Oh was consulted for small bowel obstruction and he recommended NPO, nasogastric tube suction out-of-bed, and deep vein thrombosis prophylaxis. The patient tolerated a full liquid diet starting on the discharge date and per Dr. Oh, the patient was okay to be discharged. The patient was also given Ativan 2 mg, K-Phos 2 mEq in 2 liters of normal saline, Gaviscon 15 mL, and Cepacol. He was given an incentive spirometer for bibasilar discoid atelectasis, out-of-bed, and decreased IV fluid to 90 ml/hour of normal saline because his BUN and creatinine were improving with less dehydration. Also, the sodium phosphate rider was given 40 mEq in 250 mL per normal saline due to his low phosphate. A nasogastric tube was removed on 11/21/08 at 1000 hours, which he tolerated well. A repeat CT showed no apparent small bowel obstruction. Upon discharge, his vitals were temperature 98.6 degrees, heart rate 62, respirations 20, blood pressure 137/91, and saturation 96% on room air with no pain. At this point, he has no nausea, or vomiting, and tolerates a full liquid diet without any complications. He was agreeable to being discharged. He got better with the hospital course. There was no cp, abdominal pain, or headache upon discharge, and his dehydration was resolved. **Diet:** Full liquid to a regular diet as tolerated. **Activity:** As tolerated. **Medications:** Atenolol 50 mg, Lexapro 15 mg, Zomig 2.5 mg, and Tylenol 500 mg.

10/23/14 – Jorge Perez, M.D. – Chino Valley Medical Center – Emergency Room Report. History of Present Illness: The patient presented with an intermittent frontal headache for 3 weeks, but worse in the last 3 days. He feels nauseous, but he has had no vomiting. He states the pain decreased with Tylenol and then returned. He used to have a history of migraine headaches for 40 years but has not had any migraines for the last 3 years. When initially started having the migraines, he used to have them every week, then it became every month, then every 6 months, and then discontinued approximately 3 years ago. He does take atenolol prophylactically for migraine headaches. **Medications:** Atenolol. **Vital Signs:** Blood Pressure 179/105. Pulse 60. Respirations 16. Temperature 97.8. Physical Examination: Unremarkable. **Diagnoses:** 1) Intractable headache. 2) Sinusitis. 3) Neutropenia. 4) Hypertension. **Emergency Department Course:** He was initially treated with morphine 4 mg IM and Compazine 5 mg IM. He did have an improvement in symptoms. He states that he was feeling more comfortable. He received IV antibiotics for sinusitis given that he has had progressive symptoms. He still has a mild headache. Therefore, an IV of normal saline was established. He was hydrated with normal saline at 100 mL per hour. He was given Unasyn 3 g IV and fentanyl 25 mcg IV. A repeat neurological examination at approximately 1140 hours revealed he is neurovascularly intact with a non-focal examination. No meningism signs or symptoms. No clinical toxicity. It appears that his symptoms may be secondary to the sinusitis noted in the CT scan. He does have pansinusitis, which is most likely contributing to his headache.

12/23/14 – William Dalrymple, M.D. – Chino Valley Medical Center – History and Physical Report. History of Present Illness: The patient was brought in with severe headache for the past 3 days, located bilaterally and diffusely throughout the head, rated 9/10. Headaches have been intermittent. His most recent headache occurred at work and was severe for 15 minutes and the pain became more tolerable. **Medications:** Atenolol 50 mg, baby aspirin 81 mg, and Tylenol. **Vital Signs:** Blood Pressure 179/105. Temperature 97.8. Pulse 60. Respirations 16. Weight 172 pounds. **Assessment:** 1) Intractable headaches, rule out mass, vasculitis, and aneurysm. Possible migraine exacerbation versus sinusitis. 2) History of migraines. 3) Gastroesophageal reflux disease. 4) Sinusitis. 5) Allergic rhinitis. 6) Asthma. **Plan:** 1) Admit on telemetry. 2) Consult neurology. 3) Order MRI of the brain and magnetic resonance angiography. 3) Pain control and restart of home medications.

12/23/14 – James Lally, M.D. – Chino Valley Medical Center – Diagnostic Imaging Report. Procedure: MRI – Brain. **Impression:** 1) Intracranially, no acute process or suspicious space-occupying mass lesion is seen. A small amount of T2 FLAIR hyperintensity of the periventricular white matter favors mild chronic small vessel ischemic change. 2) Extensive paranasal sinus disease. This includes an air-fluid level within the right maxillary sinus, a finding which can be seen with acute sinusitis.

12/23/14 – Steven Cobb, M.D. – Chino Valley Medical Center – Diagnostic Imaging Report. Procedure: CT – Head. Impression: No acute intracranial abnormality. There is evidence of pansinusitis.

12/23/14 – Curtis Handler, M.D. – Chino Valley Medical Center – Diagnostic Imaging Report. Procedure: MRA – Brain. Impression: The visualized major intracranial arterial

structures show no aneurysm or hemodynamically significant stenosis. It is noted that the intracranial vertebral arteries and the lower half of the basilar artery are not captured in the field of view on this examination.

12/23/14 – Chino Valley Medical Center – Laboratory Report. Abnormal Results: WBC 3.6 L. RBC 6.16 L. Hematocrit 53 H. RDW 14.7 H. Neutrophils# 1.6 L. Globulin 3.7 H. Phosphorus 2.4 L.

12/24/14 – Jeffrey Ries, D.O. – Chino Valley Medical Center – Consultation Report. History of Present Illness: The patient, a 68-year-old physician from the California Institute for Men where he serves as a chief psychiatrist, has had a severe headache for the past 3 days, which seems to be located bilaterally and diffusely throughout the head. The headaches have been daily. He states that he may have had them longer than this time. Most of these headaches have occurred while he is at work. He does have a history of migraine headaches. He has had migraines since he was in his 30s. He takes prophylactic propranolol for this. He presented because the headache would not dissipate. He had not taken any true migraine medication, although he was taking Excedrin and was taking Tylenol as well as ibuprofen, which provided temporary relief. He does have a history of chronic sinus infection. **Vital Signs:** Blood Pressure 142/80. Temperature 98.2. Pulse 67. Respirations 18. **Impression:** 1) Suspect chronic sinusitis as the cause of the current headache. Another possibility would be a muscular based headache. 2) Essential hypertension with fluctuation of blood pressure may have been related to pain. 3) History of migraine. 4) Gastroesophageal reflux disease. **Recommendations:** 1) Treat for chronic sinus. 2) Observe for future blood pressure elevations. 3) Reassess the future direction of headache control.

12/24/14 – Chino Valley Medical Center – Laboratory Report. Abnormal Results: WBC 4.0 L. RDW 15.1 H.

12/24/14 – William Dalrymple, M.D. – Chino Valley Medical Center – Discharge Summary Report. Discharge Diagnoses: 1) Intractable headache likely secondary to acute on chronic sinusitis. 2) History of migraines. 3) Gastroesophageal reflux disease. 4) Chronic sinusitis. 5) History of exercise-induced asthma. **Hospital Course:** The patient presented with an intermittent headache for 3 weeks recently worsening. He has a history of migraine headaches but stated this headache was different from his migraines. He had a CT scan of the head that showed evidence of moderate to severe mucoperiosteal thickening involving the ethmoid air cells and left frontal sinus. Moderate mucoperiosteal thickening involving the right maxillary sinus. An MRI brain showed complete opacification of the left frontal sinus. Near-complete opacification of the bilateral ethmoid air cells. Mucosal thickening of the bilateral maxillary sinuses with superimposed mucous retention cysts, right greater than left. Dr. Ries (neurology) was consulted and suggested the etiology of the headache was from his acute on chronic sinusitis. The patient's vitals remained stable and he is stable for discharge to home. He will be given prescriptions for Augmentin, prednisone, and intranasal glucocorticoid.

06/01/20 – Francisco Ornelas, M.D. – Chino Valley Medical Center – Emergency Department Physician Documentation. History of Present Illness: The patient had substernal chest tightness and pressure with radiation to the left shoulder, left arm, and jaw for 1 hour at

rest, associated with nausea but no vomiting or diaphoresis. He is an ex-smoker but stopped over 40 years ago. He does have a history of hypertension. There is a significant family history of heart disease. He had 1 brother who died at almost 50 years old and a second brother who died at 65 years old from a heart attack. He had a cardiac catheterization about 5 or 6 years ago and he showed mild disease but no stents were placed. He denies hypercholesterolemia. He denies drug use. He is not diabetic. He was given 2 nitro in the field and he took aspirin at home. Currently, he rates his pain as a 5/10 but is declining any additional medication. **Vital Signs:** Blood Pressure 105/69. Pulse 74. Respirations 18. Temperature 98.3. SpO2 95%. **Physical Examination:** Unremarkable. **Diagnoses:** 1) Chest pain. 2) Hypokalemia. **Plan:** The patient was placed under observation status for ongoing evaluation and risk stratification of acute chest pain. He is admitted to telemetry by Dr. Crudo.

06/01/20 – Zarina Khabibulina, M.D. – Chino Valley Medical Center – History and Physical Report. History of Present Illness: The patient presents with substernal chest tightness and pressure with radiation to the left shoulder, left arm, and jaw for 1 hour at rest, associated with nausea. **Review of Systems:** Positive for chest pain/pressure. **Medications:** Aspirin 81 mg, atenolol 100 mg, and amlodipine besylate 5 mg. **Vital Signs:** Blood Pressure 105/69. Pulse 74. Respirations 18. Temperature 98.3. **Assessment:** 1) Chest pain, rule out ACS vs. GERD. 2) Hypokalemia. 3) Mild dehydration. 4) Hypertension, controlled. 5) History of migraines. 6) DVT prophylaxis. **Plan:** 1) Order chest x-ray, electrocardiogram, echocardiogram, and laboratory tests. 2) Metoprolol 12.5 mg, nitroglycerin, aspirin 81 mg, lisinopril 5 mg, atorvastatin 10 mg, omeprazole 20 mg, and Tums. 3) Consult cardiology.

06/01/20 – Sushma Thiruvoipati, M.D. – Chino Valley Medical Center – Progress Report. Subjective: The patient reports chest pain is alleviated. He reported that he has had a lot of work stress lately as he is the chief psychiatrist for 4 prisons in the area and 457 prisoners of his patients have COVID-19. He was tested 4 days ago and was found to be negative. **Review of Systems:** Positive for fatigue. **Vital Signs:** Blood Pressure 110/65. Pulse 60. Respirations 17. Temperature 97.4. **Assessment:** 1) Chest pain, rule out ACS vs. GERD. 2) Hypokalemia. 3) Mild dehydration. 4) Hypertension, controlled. 5) History of migraines. 6) DVT prophylaxis. **Plan:** 1) Pending echocardiogram. 2) Pending consultations with psychiatry and cardiology.

06/01/20 – William Paik, M.D. – Chino Valley Medical Center – Diagnostic Imaging Report. Procedure: X-ray – Chest, 1 view. **Impression:** 1) Bibasilar atelectasis. 2) Trace right pleural effusion is not excluded. 3) Probable right upper lobe scarring. 4) Stable elevation of the right hemidiaphragm.

06/01/20 – Stanley Chou, M.D. – Chino Valley Medical Center – Diagnostic Imaging Report. Procedure: Comprehensive 2-Dimensional, Doppler and Color – Flow Echocardiogram. **Vital Signs:** Blood Pressure 123/72. Pulse 64. **Indication:** Chest pain and hypokalemia. **Findings:** Left ventricle is normal in size. The left ventricular systolic function is normal. The left ventricular ejection fraction is within the normal range. There are upper limits of normal left ventricular wall thickness. There is normal LV segmental wall motion. Transmitral Doppler flow pattern suggests impaired LV relaxation. LVEF is 60-65%. The right ventricle is normal in size. The right ventricular systolic function is normal. The left atrium size is normal. The right atrium size is normal. The aortic valve is mildly sclerotic. There is no

aortic valvular stenosis. Mild aortic regurgitation. The mitral valve is normal in structure. Noted in color, but no velocity available/possible. The tricuspid valve is normal in structure. Mild tricuspid regurgitation. The RVSP is 26 mmHg plus right atrial pressure. The pulmonary valve is normal in structure. There is no pulmonic valvular regurgitation. The aortic root is normal in size. The IVC was not visualized. There is no pericardial effusion. Study quality is adequate. **Conclusion:** 1) The left ventricle is normal in size and systolic function. 2) Estimated left ventricular ejection fraction of 60-65%. 3) Grade 1 diastolic dysfunction.

06/01/20 – Chino Valley Medical Center – ECG. Impression: Sinus rhythm.

06/01/20 – Chino Valley Medical Center – Laboratory Report. Abnormal Results: RDW 16.0 H. BUN 19.0 H. Chloride 108 H. Calcium 8.3 L. AST/SGOT 11 L. Alkaline phosphatase 35 L. T3 uptake 32 L.

06/02/20 – Stanley Chou, M.D. – Chino Valley Medical Center – Procedure Report. Procedure: Lexiscan SPECT. **Indication:** Chest pain. **Findings:** Resting ECG showed normal sinus rhythm. Stress ECG without ischemic ST changes or arrhythmia. **Conclusion:** Normal Lexiscan stress ECG results.

06/02/20 – Kevin Bui, M.D. – Chino Valley Medical Center – Myocardial Perfusion Study with SPECT. Clinical History: Chest pain. **Conclusions:** 1) No evidence of myocardium ischemic risk. 2) The left ventricular ejection fraction is 71%.

06/02/20 – Chino Valley Medical Center – ECG. Impression: 1) Sinus rhythm. 2) Borderline prolonged PR interval. 3) Baseline wander in lead(s) V1.

06/02/20 – Chino Valley Medical Center – Laboratory Report. Abnormal Results: WBC 4.1 L. RDW 16.4 H. Calcium 8.4 L.

06/03/20 – Chino Valley Medical Center – Laboratory Report. Abnormal Results: WBC 3.9 L. RDW 15.9 H.

06/03/20 – Andrea Glover, N.P. – Chino Valley Medical Center – Discharge Summary Report. Discharge Diagnoses: 1) Chest pain, rule out ACS vs. GERD, resolved. 2) Hypokalemia, resolved. 3) Mild dehydration. 4) Hypertension, controlled. 5) History of migraines. 6) DVT prophylaxis. **Hospital Course:** The patient was admitted for chest pain and hypokalemia. He received cardiology consult with Dr. Chou. Potassium was replaced and hypokalemia resolved. Troponins x 2 were negative, trending every 8 hours. His electrocardiogram showed normal sinus rhythm without acute ischemic changes. His chest pain was ruled out for myocardial infarction; a constellation of symptoms suggests secondary to stress. He received a stress test with no evidence of myocardium at ischemic risk. The left ventricular ejection fraction is 71%. A psychiatry consultation is pending. He has been under an extreme amount of stress and is requesting to speak with a psychiatrist. He is clear for discharge. He is ambulating without assistance and is tolerating his diet.

06/05/20 – Zaheib Idrees, D.O. – Chino Valley Medical Center – Consultation Report. History of Present Illness: The patient was admitted to Chino Valley Medical Center due to chest pain. He had a full cardiac workup, which has been negative thus far. He had increasing anxiety and stress. He reports that he has been having a significant amount of stress at his work at the Chino prison. He has been doing well there and that he enjoys his job until a recent change of supervisors. He was previously reporting to the chief psychologist and receiving his evaluation and critique and feedback from this individual and he reports that he was doing well and had an open discussion and relationship with this person; however, recently over the past 2 months, his reporting person has changed to the CEO of the prison. This has been causing an immense amount of stress for him. Prior to this, he was doing well; tolerating stress well. He reports that if his reporting person changes to a different person other than the CEO, he feels that his anxiety will resolve and he will no longer have severe stress, anxiety, insomnia and chest pain. **Provisional Diagnosis:** Adjustment disorder with depressed mood and anxious distress, rule out major depression with anxious distress. **Treatment Plan:** 1) He does not meet LPS hold criteria. 2) Prescribed Ambien CR 6.25 mg. 3) Remain off work for the next 2 months.

12/15/21 – Workers' Compensation Claim Form. Date of Injury: CT 12/01/16 to 12/05/21. The claimant reports stress and strain due to repetitive work, and prolonged occupational exposure to industrial air pollution, causing injuries to the neck, shoulder, lower back, chest pain, eye, ear, and other bodily systems.

12/15/21 – Application for Adjudication of Claim. Date of Injury: CT 12/01/16 to 12/05/21. The applicant, who was employed with the California Institution for Men as a chief psychiatrist, reports stress and strain due to repetitive work, prolonged occupational exposure to industrial air pollution, repetitive physically traumatic activities extended over a period of time, the combined effect of which caused disability to the neck, shoulder, lower back, chest pain, eye, ear, and other bodily systems.

01/26/22 – Amended Application for Adjudication of Claim. Date of Injury: CT 12/01/16 to 12/05/21. The applicant, who was employed with the California Institution for Men as a chief psychiatrist, sustained injuries to the neck, shoulder, lower back, chest pain, eye, ear, and other bodily systems. The claim is amended to include the circulatory system, digestive system, knee patella, lower extremities, hernia, and back.

Blood Pressure Readings Extracted from Medical Records

Date	Blood Pressure	Wt.	Physician/ Facility	Medications With Doses
04/15/05	132/72		Dr. Madahar	Diovan
04/15/05	102/70		Dr. Lally	Diovan 80 mg
06/15/07	130/70		Chino Valley Medical Center	
11/19/08	131/88		Dr. Lally	Atenolol 50 mg, Lexapro 15 mg, Zomig 2.5 mg, and Tylenol 500 mg.
11/20/08	118/82		Dr. Amin	Atenolol, Lexapro, Zomig, and Tylenol.
11/20/08	112/70		Chino Valley Medical Center	
11/21/08	118/74		Chino Valley Medical Center	
11/21/08	137/91		Dr. Takhar	Atenolol 50 mg, Lexapro 15 mg, Zomig 2.5 mg, and Tylenol 500 mg.
10/23/14	179/105		Dr. Perez	Atenolol; given Unasyn 3 g IV and fentanyl 25 mcg IV.
12/23/14	179/105		Dr. Dalrymple	Atenolol 50 mg, baby aspirin 81 mg, and Tylenol.
12/24/14	142/80		Dr. Ries	Excedrin, Tylenol, and ibuprofen.
06/01/20	105/69		Dr. Ornelas	
06/01/20	105/69		Dr. Khabibulina	Aspirin 81 mg, atenolol 100 mg, and amlodipine besylate 5 mg.
06/01/20	110/65		Dr. Thiruvoipati	
06/01/20	123/72		Dr. Chou	

RESULTS OF LAB TESTING:

CBC and blood chemistries were obtained.
Results are normal.

IMPRESSION:

1. Coronary artery disease (CAD).
2. Hypertensive cardiovascular disease.
3. Upper digestive tract disorder.
4. Hernia.

DISCUSSION:

1. **Coronary artery disease**:

   Dr. Hanna has been found to have coronary artery disease and has required cardiac stenting. I am requesting these records to be sent to my attention, so I may confirm the historical narrative provided by Dr. Hanna to me. In the absence of medical records confirming this history, this would be considered only a preliminary assessment regarding the CAD.

   Impairment Rating:

   Using the AMA Guides to the Evaluation of Permanent Impairment Fifth Edition, Page 36, Table 3-6a, it is my opinion that Dr. Adel Hanna has Class 2 Impairment of the Whole Person, 20%, due to coronary heart disease. He has had coronary angioplasty; however, at this time, does not appear to have any significant use of medications to prevent angina or CHF.

   Causation:

   Causation is industrial.

   The traditional risk factors for coronary artery disease are high LDL cholesterol, low HDL cholesterol, high blood pressure, family history, diabetes, smoking, being post-menopausal for women and being older than 45 for men. Obesity may also be a risk factor. The risk factor is that Dr. Hanna is hypertension, which, in my opinion, as discussed below, has been aggravated by stress at his place of work.

   Psychosocial factors may also contribute to the early development of atherosclerosis. The link between psychologic stress and atherosclerosis may be both direct, via damage of the endothelium, and indirect, via aggravation of traditional risk factors such as smoking, hypertension, and lipid metabolism. (Rozanski A. Impact of psychological factors on the pathogenesis of cardiovascular disease and implications for therapy. Circulation. 1999;99(16):2192).

   Human studies of stress and coronary atherosclerosis suggest that more extensive atherosclerosis is seen in patients with type A personality. (Krantz DS. Extent of coronary atherosclerosis, type A behavior, and cardiovascular response to social

interaction. Psychophysiology. 1981;18(6):654). Stronger epidemiologic studies have linked psychosocial factors such as bereavement, loss of job, and depression with hard end points such as myocardial infarction and sudden death. One study which followed 1592 men and women for five years reported that the personality trait of submissiveness, a marker for type B behavior, was protective against nonfatal and total myocardial infarction, particularly in women (relative risk 0.59 and 0.69, respectively). (Whiteman MC. Submissiveness and protection from coronary heart disease in the general population: Edinburgh Artery Study. Lancet. 1997;350(9077):541.).

The association between psychosocial factors and the presence of asymptomatic coronary heart disease is uncertain. One study evaluated 630 active-duty army personnel, aged 38 to 45, without known coronary disease who underwent electron beam computed tomography; there was no correlation between the presence of coronary artery calcification and prior or current psychiatric disorders, such as anxiety, hostility, and stress. (O'Malley et al. Lack of correlation between psychological factors and subclinical coronary artery disease. N Engl J Med. 2000;343(18):1298). In contrast, another study of 1305 men with a mean age of 62 found that symptomatic depression, as measured by the Minnesota Multiphasic Personality Inventory, was associated with an increased risk of coronary heart disease and angina pectoris. (Sesso HD et al. Depression and the risk of coronary heart disease in the Normative Aging Study. Am J Cardiol. 1998;82(7):851).

The association of psychosocial factors and coronary heart disease may be especially prominent in individuals at high risk for the development of coronary disease. As an example, the Family Heart study of 2300 subjects at high risk, based upon the age of onset of coronary heart disease in biologically related family members, found that, after controlling for other risk factors, hostility was associated with a history of revascularization in high risk men (odds ratio 1.21) and a history of myocardial infarction in high risk women (odds ratio 1.39). (Knox SS et al. Hostility, social support, and coronary heart disease in the National Heart, Lung, and Blood Institute Family Heart Study.Am J Cardiol. 1998;82(10):1192).

Psychosocial factors may also promote atherosclerosis via an effect on traditional risk factors. As examples, cigarette smokers typically increase their consumption in response to stress, and the serum cholesterol levels have been shown to rise in stressful situations.

As discussed above, it is my opinion that psychological factors contribute to the development of CAD.

Apportionment:

As per SB 899 and Labor codes 4663 and 4664, and mindful of the Escobedo and Benson decisions, apportionment to causation of impairment/disability is considered. I will apportion 25% to hyperlipidemia, however I will need to confirm if he was hyperlipidemic before undergoing PCI. Medical records are requested.

I will apportion 75% to hypertensive cardiovascular disease. Of this apportionment, I will apportion 50% to aggravation due to work factors (including psychological factors) and 50% to age-related factors. Therefore, 25% is nonindustrial due to hyperlipidemia (if found), 37.5% nonindustrial due to age-related factors, and 37.5% due to aggravation of hypertension due to industrial factors.

2. **Hypertensive cardiovascular disease**:

Dr. Adel Hanna is now hypertensive. He is taking Norvasc for blood pressure control. Today, his blood pressure is considered to be high-normal.

Impairment Rating:

Using the AMA Guides to the Evaluation of Permanent Impairment Fifth Edition, Page 66, Table 4-2, with a blood pressure considered Stage 1, it is my opinion that Dr. Hanna has 12% WPI secondary to hypertensive cardiovascular disease. He has Stage 1 hypertension on medications.

Dr. Hanna reports that he has had an echocardiogram, which does not show evidence of LVH. His echocardiogram, which I reviewed, also did not show LVH. Therefore, there is no need for LVH assessment for impairment rating for hypertension.

Causation:

Causation is industrial.

Hypertension is divided into two classes, essential hypertension and secondary hypertension. Secondary hypertension is hypertension due to specific identifiable etiology such as an endocrinologic abnormality, blood vessel malformation or vasoactive chemical-producing tumor.

There are risk factors for essential hypertension. Those risk factors include genetic loading (family history), obesity, high salt intake, alcohol abuse, sleep apnea, and age. Those conditions that predispose to atherosclerosis, such as diabetes, hypercholesterolemia, and tobacco, are thought to predispose to hypertension; however, the Surgeon General's report on the risk from tobacco use does not include tobacco as a cause of hypertension. Biochemical changes in the muscular layer of the blood vessels that occur with age cause a loss of elasticity and elevation of the systolic blood pressure. In the United States there is a linear increase in blood pressure by age, reaching 34% at age 50.

Short sleep duration has been associated with a variety of adverse cardiovascular outcomes in large cross-sectional and prospective observational studies.

The medical literature is undivided in the opinion in the knowledge that NSAID medications have a variety of adverse effects from a cardiovascular standpoint that can

both raise the blood pressure and affect overall cardiovascular risk. In an article by Warner T. D. Mitchell, J.A., the others conclude that all NSAIDS in doses that adequately reduce inflammation and pain, can increase blood pressure in both normotensive and hypertensive individuals. (Warner et al. COX-2 selectivity alone does not define the cardiovascular risks associated with NSAID drugs, Lancet 2008; 371:270).

Although there is not a medical consensus that psychosocial stress is a risk factor for hypertension, there is a large body of peer reviewed medical literature that suggests psychosocial stress is a contributing factor. There is also a body of medical literature that tends to refute this theory. It has been long observed that rural dwellers have lower blood pressure than urban dwellers. A study of Samoan villagers living a traditional life showed them to have average systolic blood pressures of 110, whereas the same population who had become students, sedentary workers and laborers had average blood pressure of 122 (James GD, et al. Differences in catecholamine excretion rates, blood pressure, and life style among young Western Samoan men. *Hum Biol* 1985;57:635). A study of Italian nuns in a secluded order compared with age-matched control subjects demonstrated an emergence of hypertension in the control subjects over 20 years as compared to normal blood pressure in the nuns over the same period of time (Timio M. Blood pressure trends and psychosocial factors: the case of nuns in a secluded order. *Acta Physiol Scand Suppl* 1997;640:137).

Work-related stress has also been implicated in the development of hypertension. The most compelling study was the Air Traffic Controllers Study of 1974 to 1978, published in *Psychosomatic Medicine*. In this study, work-related stress was measured by the average number of airplanes managed by a controller at one time. There was a direct correlation with the stress and the level of blood pressure, although not necessarily hypertensive. A follow-up to the Air Traffic Controllers Study 20 years later (*Psychosomatic Medicine*, 2004) demonstrated that air traffic controllers with higher stress levels and higher reactivity to stress had a higher incidence of hypertension. The Cornell Work Site Study published in *JAMA* in 1992 revealed that individuals with hypertension were three times more likely to be in high stress jobs. A conflicting finding was observed by J.P. Fauvel in the *Journal of Hypertension,* published in 2004.

Dr. Fauvel found that neither high stress nor high reactivity to stress increased the incidence or progression of hypertension over a five-year period of evaluation. The available medical literature is suggestive that hypertension is related to the inherent stresses of living in a complex society. It may be further exacerbated by exposure to additional stress in the workplace. The incidence of hypertension in Western civilization is approximately 20%. The incidence of hypertension in stressful work is not as well defined. It is abundantly clear that not all individuals exposed to stress develop hypertension.

Apportionment:

As per SB 899 and Labor codes 4663 and 4664, and mindful of the Escobedo and Benson decisions, apportionment to causation of impairment/disability is considered.

Apportionment is in order, as Dr. Adel Hanna has had a previous history of hypertension; however, that resolved. I will apportion 50% to age-related factors due to age-related hardening of arteries. I will apportion 50% to aggravation of hypertension due to industrial factors of stress at his place of his work. Dr. Adel Hanna clearly reports that he noticed his blood pressure creeping up after the period of stress began in 2020. He was never on antihypertensive medication before; however, he is now on Norvasc 10 mg daily. Therefore, 50% is industrial and 50% is nonindustrial.

Future Medical Care:

Future medical care for the treatment of hypertension is indicated on an industrial basis. He will require medical supervision of a doctor skilled in the treatment of hypertension semiannually and more frequently as indicated by control of blood pressure and the development of complications. He will require surveillance for progression of disease in the form of appropriate testing including, but not limited to, blood chemistries, electrocardiogram, echocardiogram, and EKG stress testing on an annual basis. He will require medication as appropriate.

3. **Upper digestive tract disorder**:

Dr. Hanna had a history of a hiatal hernia that has resolved after Nissen fundoplication. At this time, he has no symptoms of an upper digestive tract disorder. It is my opinion at this time that without any symptoms or medication use for hiatal hernia/upper digestive tract disorder, Dr. Hanna does not have a ratable upper digestive tract disorder.

Causation:

Causation is nonindustrial.

Apportionment:

As per SB 899 and Labor codes 4663 and 4664, and mindful of the Escobedo and Benson decisions, apportionment to causation of impairment/disability is considered. I find no factors responsible for industrial apportionment.

Future Medical Care:

None required.

4. **Inguinal hernia**:

Dr. Hanna has had a previous inguinal hernia repair. This was more than 40 years ago, and is considered nonindustrial. At this time, he has no symptoms from this condition, as this resolved completely. It is my opinion that he has 0% WPI secondary to hernia.

Causation:

Causation is nonindustrial.

Apportionment:

As per SB 899 and Labor codes 4663 and 4664, and mindful of the Escobedo and Benson decisions, apportionment to causation of impairment/disability is considered. I find no factors responsible for industrial apportionment.

Future Medical Care:

None required.

Thank you for asking me to see and evaluate Dr. Adel Hanna.

Syed O. Tirmizi, M. D. FCCP
Diplomate, American Board of Internal Medicine
Diplomate, American Board of Internal Medicine, Pulmonary Disease
Diplomate, American Board of Internal Medicine, Critical Care Medicine
Diplomate, American Board of Internal Medicine, Sleep Medicine
Diplomate, American Board of Sleep Medicine
Qualified Medical Evaluator #945518 State of California

RE: Adel Hanna
Date: October 26, 2022

Omar Tirmizi, M.D. F.C.C.P.
A Professional Corporation
Telephone Number 310-556-0702 Fax number 310-556-8464

DISCLAIMER

Pursuant to WCAB Rule 10606, the patient's history and physical examination was performed in its entirety by the undersigned. Assistance was obtained from Betty Wolf for transcription. The diagnostic impression, conclusions, and recommendations are exclusively mine. The report was transcribed directly from my dictation. The examination took place at my office, indicated in the body of the report; and was performed on the date indicated on the report. Vital signs were obtained by medical assistant Estiven Meza and verified by myself. Additional diagnostic testing where indicated was conducted by Karen Nolasco (PFT), Dena Masangkay (Ultrasonography), Jasmine Contreras (Echocardiography) and Estiven Meza (Venipuncture)

DECLARATION PURSUANT TO AB3660
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 for information I have indicated I have 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.

DECLARATION PURSUANT TO SECTION 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. Under penalty of perjury, I declare that I have not violated Section 139.3 in terms of receiving money, compensation, or other inducement for this referred examination. Laboratory specimens are analyzed limited to blood chemistries and hematology at Omar Tirmizi MD, Clinical Laboratory located in my office in Culver City, or in standard reference lab. I further declare that I have no financial interest or refer to an outside clinical laboratory, diagnostic procedures, physician or home infusion therapy, rehabilitation, psych diagnostic testing or radiation oncology for either treatment or medical purposes, with the sole exception of referral to Los Angeles Sleep Disorder Group dba Sunset Sleep Lab, in Culver City, CA where I have potential financial interest.

Syed O. Tirmizi, M. D. FCCP
Diplomate, American Board of Internal Medicine
Diplomate, American Board of Internal Medicine, Pulmonary Disease
Diplomate, American Board of Internal Medicine, Critical Care Medicine
Diplomate, American Board of Internal Medicine, Sleep Medicine
Diplomate, American Board of Sleep Medicine
Qualified Medical Evaluator #945518 State of California

 10/27/2022 08:08:56 AM

Report Status: Final
HANNA, ADEL S

Patient Information	Specimen Information	Client Information
HANNA, ADEL S **DOB: 03/29/1946 AGE: 76** Gender: M Phone: 949.244.7759 Patient ID: 03291946HA Health ID: 8573030750024033	Specimen: ZD055469M Requisition: 0004034 Collected: 10/26/2022 Received: 10/26/2022 / 22:28 PDT Reported: 10/27/2022 / 03:10 PDT	Client #: 90230039 BH080000 TIRMIZI, OMAR MORRISON MD ALLAN 4340 OVERLAND AVE CULVER CITY, CA 90230-4117

Test Name	In Range	Out Of Range	Reference Range	Lab
LIPID PANEL, STANDARD				
CHOLESTEROL, TOTAL	96		<200 mg/dL	EN
HDL CHOLESTEROL	52		> OR = 40 mg/dL	EN
TRIGLYCERIDES	57		<150 mg/dL	EN
LDL-CHOLESTEROL	31		mg/dL (calc)	EN

Reference range: <100

Desirable range <100 mg/dL for primary prevention; <70 mg/dL for patients with CHD or diabetic patients with > or = 2 CHD risk factors.

LDL-C is now calculated using the Martin-Hopkins calculation, which is a validated novel method providing better accuracy than the Friedewald equation in the estimation of LDL-C.
Martin SS et al. JAMA. 2013;310(19): 2061-2068 (http://education.QuestDiagnostics.com/faq/FAQ164)

Test Name	In Range	Out Of Range	Reference Range	Lab
CHOL/HDLC RATIO	1.8		<5.0 (calc)	EN
NON HDL CHOLESTEROL	44		<130 mg/dL (calc)	EN

For patients with diabetes plus 1 major ASCVD risk factor, treating to a non-HDL-C goal of <100 mg/dL (LDL-C of <70 mg/dL) is considered a therapeutic option.

Test Name	In Range	Out Of Range	Reference Range	Lab
COMPREHENSIVE METABOLIC PANEL				EN
GLUCOSE	98		65-99 mg/dL Fasting reference interval	
UREA NITROGEN (BUN)	16		7-25 mg/dL	
CREATININE	0.84		0.70-1.28 mg/dL	
EGFR	90		> OR = 60 mL/min/1.73m2	

The eGFR is based on the CKD-EPI 2021 equation. To calculate the new eGFR from a previous Creatinine or Cystatin C result, go to https://www.kidney.org/professionals/kdoqi/gfr%5Fcalculator

Test Name	In Range	Out Of Range	Reference Range	Lab
BUN/CREATININE RATIO	NOT APPLICABLE		6-22 (calc)	
SODIUM	141		135-146 mmol/L	
POTASSIUM	4.2		3.5-5.3 mmol/L	
CHLORIDE	106		98-110 mmol/L	
CARBON DIOXIDE	28		20-32 mmol/L	
CALCIUM	9.7		8.6-10.3 mg/dL	
PROTEIN, TOTAL	7.4		6.1-8.1 g/dL	
ALBUMIN	4.5		3.6-5.1 g/dL	
GLOBULIN	2.9		1.9-3.7 g/dL (calc)	
ALBUMIN/GLOBULIN RATIO	1.6		1.0-2.5 (calc)	
BILIRUBIN, TOTAL	0.9		0.2-1.2 mg/dL	
ALKALINE PHOSPHATASE	52		35-144 U/L	
AST	17		10-35 U/L	
ALT	23		9-46 U/L	
HEMOGLOBIN A1c		**5.8 H**	<5.7 % of total Hgb	EN

For someone without known diabetes, a hemoglobin A1c value between 5.7% and 6.4% is consistent with

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 10/27/2022 08:08:56 AM

Report Status: Final
HANNA, ADEL S

Patient Information	Specimen Information	Client Information
HANNA, ADEL S **DOB: 03/29/1946 AGE: 76** Gender: M Patient ID: 03291946HA Health ID: 8573030750024033	Specimen: ZD055469M Collected: 10/26/2022 Received: 10/26/2022 / 22:28 PDT Reported: 10/27/2022 / 03:10 PDT	Client #: 90230039 TIRMIZI, OMAR

Test Name **In Range** **Out Of Range** **Reference Range** **Lab**

prediabetes and should be confirmed with a follow-up test.

For someone with known diabetes, a value <7% indicates that their diabetes is well controlled. A1c targets should be individualized based on duration of diabetes, age, comorbid conditions, and other considerations.

This assay result is consistent with an increased risk of diabetes.

Currently, no consensus exists regarding use of hemoglobin A1c for diagnosis of diabetes for children.

Test Name	In Range	Out Of Range	Reference Range	Lab
CBC (H/H, RBC, INDICES, WBC, PLT)				EN
WHITE BLOOD CELL COUNT	4.9		3.8-10.8 Thousand/uL	
RED BLOOD CELL COUNT	5.17		4.20-5.80 Million/uL	
HEMOGLOBIN	14.4		13.2-17.1 g/dL	
HEMATOCRIT	44.1		38.5-50.0 %	
MCV	85.3		80.0-100.0 fL	
MCH	27.9		27.0-33.0 pg	
MCHC	32.7		32.0-36.0 g/dL	
RDW	13.0		11.0-15.0 %	
PLATELET COUNT	197		140-400 Thousand/uL	
MPV	11.1		7.5-12.5 fL	

PERFORMING SITE:

EN QUEST DIAGNOSTICS-WEST HILLS, 8401 FALLBROOK AVENUE, WEST HILLS, CA 91304-3226 Laboratory Director: TAB TOOCHINDA,MD, CLIA: 05D0642827

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HANNA, Adel 622256 OT QME 79313

State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

Case Name Adel Hanna v CALIFORNIA INSTITUTION FOR MEN

Claim No. 06675270 **EAMS or WCAB Case No. (if any):** ADJ15547699

I, Victoria Montes declare:

1. I am over the age of 18 and I am not a party to this case.

2. My business address is: **Arrowhead Evaluation Services 1680 Plum Lane, Redlands, CA 92374**

3. On the date shown below, I served this Comprehensive Medical-Legal Report with the original, or a true and correct copy of the original, comprehensive medical-legal report, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope addressed to the person or firm named below, and by:

A depositing the sealed envelope with the U.S. Postal Service with the postage fully prepaid.

B placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U.S. Postal Service in a sealed envelope with postage fully prepaid.

C placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.

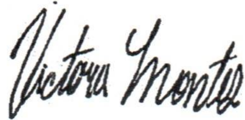
D placing the sealed envelope for pick up by a professional messenger services for service. (Messenger must return to you a completed declaration of personal service.)

E personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of Service *(For each addressee, Enter A - E as appropriate)*	***Date***	***Addressee and Address***
A	11-23-2022	Diana Munoz, SCIF SENT ELECTRONICALLY - SENT ELECTRONICALLY
A	11-23-2022	Natalia Foley WORKERS DEFENDERS LAW GROUP 751 South Weir Canyon Road STE 157-455, Anaheim, California 92808

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Declarant



Print Name

Victoria Montes