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May 3, 2023

Natalia Foley, Esq.
Workers Defenders Law Group
8018 E. Santa Ana Canyon Rd. Ste 100 215
Anaheim, CA 92808

PATIENT:	Arthur Israyelyan
DOB:	August 6, 1958
OUR FILE #:	2022-174
SSN:	XXX-XX-XXXX
EMPLOYER:	Door to Door Valet Cleaners 9843 S. Santa Monica Blvd Beverly Hills, CA 90212
WCAB #:	ADJ17187099
CLAIM#:	***
DATE OF INJURY:	March 12, 2022
DATE OF 1ST VISIT:	March 22, 2023
INSURER:	AmTrust Concord P.O Box 89404 Cleveland, OH 44101
ADJUSTOR:	Iona Collier
PHONE #:	(415) 777-5557

Primary Treating Physician's Medical Legal Evaluation Report

Dear Ms. Foley,

The patient, Arthur Israyelyan, presents to my office for a primary treating physicians med-legal evaluation. I have been requested by Ms. Foley to issue a Medical Legal report to address causation.

ML 201-92: This is a Primary Treating Physician's Medical Legal Report. No medical records were reviewed in the making of this report. Medical causation has been addressed.

Job Description:

The patient began working as a general employee in 2017. His work hours were 10:00 am to 5:00 pm per day, six days a week. In his job as a general employee, he was required to perform alterations, tailors, and sewing for customers. Physically, the job required him to stand, walk, squat, stoop, bend, twist, and lift up to 50 pounds.

History of the Injury as Related by the Patient:

The patient has filed a specific trauma claim dated 3/12/2022. The patient states he worked as a tailor for Door-to-Door Valet Cleaners. He mentions that his job duties included being seated at a sewing machine and assisting customers with their tailoring needs. He mentions that on this specific dated of 3/12/2022, he accidentally punctured the posterior aspect of his right 3rd digit just above his nail with the sewing machine. He states that this caused bleeding, however, he was able to use peroxide to cleanse his finger and continue his work.

The patient states that over the course of the next few months, he began to develop discoloration of the distal end of the 3rd digit, right hand. He states that in August of 2022, he presented to the hospital given the discoloration and numbness. He was diagnosed with gangrene of the distal digit and was told he required an amputation. The patient states he underwent antibiotic therapy and took various medications which helped slowly improve the fingers condition. He mentions that he eventually underwent a wound debris of the distal end of the digit which resulted in a partial amputation. He mentions that during his hospitalization he was also diagnosed with Raynaud's phenomenon. He complained of bilateral hand multi digit pain during his hospitalization. He was discharged and continued in treatment with a rheumatologist.

On March 21, 2022, the patient underwent an angiogram for evaluation of his upper extremity vessels. He was diagnosed with poor perfusion disorder; however, the final results are pending at this time. The patient states that given his condition, he began to develop severe stress, anxiety, and depression.

Prior Treatment:

The patient does not recall the names of his previous physicians.

Previous Work Descriptions:

Prior to working at Door to Door Valet Cleaners, the patient worked at Whetherly Cleaners.

Occupational Exposure:

The patient was exposed to dust during the course of his work. The patient was not exposed to excessive noise during the course of his work. He was exposed to excessive heat or cold.

Past Medical History:

The patient was diagnosed with asthma in 2021. He has no known allergies. There is no history of prior accidents or injuries. There is no other significant medical history.

Previous Workers' Compensation Injuries:

None

Social History:

The patient is married. He has two children. He does not smoke cigarettes, drink alcoholic beverages or use recreational drugs.

Family History:

The patient's parents are deceased. He had one brother who died of a heart attack. There is no other significant family medical history.

Review of Systems:

The patient reports a complaint of shortness of breath, dizziness, wheezing, lightheadedness, eye pain, visual difficulty, sinus problems, sinus congestion, postnasal drip, jaw pain, and jaw clenching. He denies a complaint of headaches, ear pain, hearing problems, cough, throat pain, dry mouth, chest pain, palpitations, hemoptysis or expectoration. The patient denies a complaint of abdominal pain or cramping, burning symptoms, reflux symptoms, nausea, vomiting, diarrhea, constipation, weight gain or weight loss. The patient reports genitourinary complaints including urinary frequency. The patient's musculoskeletal complaints involve cervical spine pain 7/10, thoracic spine pain 8/10, lumbar spine pain 8/10, right shoulder pain 8/10, left shoulder pain 8/10, right wrist pain 5/10, left wrist pain 5/10, right hand pain 5/10, left hand pain 5/10. There is no complaint of peripheral edema or swelling of the ankles. The patient's psychosocial complaints include anxiety, depression, difficulty concentrating, difficulty sleeping, and forgetfulness. There is hair loss and dermatologic complaints. There is intolerance to excessive heat or cold. There is no complaint of fever, diaphoresis, chills or lymphadenopathy.

Activities of Daily Living Affected by Workplace Injury:

The patient reports problems with sleeping, bathing, dressing, walking, hobbies, climbing stairs, shopping, cooking, driving.

Review of Records:

Please note that if medical records have been received for review, they will be reviewed and commented upon in a subsequent communication.

Current Medications:

The patient currently takes Sildenafil 20mg QD, Baby aspirin 81mg TID, Atorvastatin 40mg QD,

Physical Examination:

The patient is a 64-year-old alert, cooperative and oriented Armenian American male, in no acute distress. The following vital signs and measurements are taken today on examination: Weight: 178 pounds. Blood Pressure: 1111/78. Pulse: 73. Respiration: 17. Temperature: 98.4 degrees F.

Skin:

No abnormalities were detected.

Head:

The patient's head is normocephalic and atraumatic. The patient's facial muscles show good contour and symmetry. There is no scleral icterus and no tenderness of the skull noted on examination.

EENT:

Pupils are equally reactive to light and accommodation. Extraocular movements are intact. The throat is clear. Hearing appears to be uninvolved. The nasal passages are clear and the mucosa is normal in appearance. The patient's neck is overall supple with no evidence of lymphadenopathy, thyromegaly or bruits.

Thorax:

The patient exhibits good bilateral rib excursion during respiration. Lungs are clear during percussion and auscultation. The heart reveals a regular rate and rhythm and no murmurs are noted.

Abdomen:

The abdomen is globular, non-tender without organomegaly. Normoactive bowel sounds are present.

Genitalia and Rectal:

Examination is deferred.

Musculoskeletal Examination:

The patient is ambulatory. There are no grossly visible abnormalities of the upper or lower extremities or the axial skeleton. There are no deformities. There is tenderness or myospasm of the cervical, thoracic or lumbar paraspinal musculature. Distal amputation of the 3rd digit, right hand. Tremor noted of bilateral hands

Neurological Examination:

Cranial nerves 2-12 are intact. Deep tendon reflexes are 2+ bilaterally. Superficial reflexes are found to be within normal limits. There are no abnormal reflexes detected and there is no abnormality of sensation or coordination. Numbness noted of tips of all digits, both hands

Special Diagnostic Testing:

A pulmonary function test is performed revealing an FVC of 1.91 L (37.0%) and an FEV 1 of 1.34 L (34.8%). There no change after the administration of Albuterol.

Subjective Complaints:

1. Shortness of Breath
2. Erectile Dysfunction
3. Dizziness
4. Wheezing
5. Sexual Dysfunction
6. Lightheadedness
7. Eye Pain
8. Anxiety
9. Visual Difficulty
10. Depression
11. Difficulty Concentrating
12. Sinus Problems
13. Difficulty Sleeping
14. Sinus Congestion

15. Difficulty Making Decisions
16. Forgetfulness
17. Hair Loss
18. Postnasal Drip
19. Skin Issues
20. Jaw Pain
21. Intolerance to Heat/Cold
22. Jaw Clenching
23. Urinary Frequency

Objective Findings:

1. Tenderness noted to the paravertebral of the cervical spine and lumbar spine
2. Distal amputation of the 3rd digit, right hand
3. Numbness noted of tips of all digits, both hands
4. Tremor noted of bilateral hands
5. A pulmonary function test is performed revealing an FVC of 2.78 L (53.8%) and an FEV 1 of 1.79 L (46.4%). There was a 13.0% increase in FVC after the administration of Albuterol.
6. A 12-lead electrocardiogram is performed revealing sinus arrythmia and a heart rate of 65 per minute.
7. A pulse oximetry test is performed and is recorded at 99%.
8. Jamar Test: Rt. 1. 7.9kg 2. 9.2kg 3. 11.3kg Lft. 1. 8.3kg 2. 6.0kg 3. 6.7kg
9. Vision Test with glasses: OU: 20/25 OD: 20/30 OS: 20/30
10. An audiogram is performed and reveals the following:

	1,000 Hz	2,000 Hz	3,000 Hz	4,000 Hz
Right:	15	15	15	40
Left:	15	15	15	30

11. A random blood sugar is performed and is recorded at 109 mg/dL.

Diagnoses:

1. CERVICAL SPINE STRAIN/SPRAIN
2. THORACIC SPINE STRAIN/SPRAIN
3. LUMBAR SPINE STRAIN/SPRAIN
4. RIGHT SHOULDER STRAIN/SPRAIN
5. LEFT SHOULDER STRAIN/SPRAIN
6. RIGHT WRIST STRAIN/SPRAIN
7. LEFT WRIST STRAIN/SPRAIN
8. RIGHT HAND STRAIN/SPRAIN

9. LEFT HAND STRAIN/SPRAIN
10. GANGRENE INFECTION OF THIRD DIGIT, RIGHT HAND, RESULTING IN PARTIAL DISTAL AMPUTATION
11. PARESTHESIA OF DISTAL ENDS OF ALL DIGITS, BOTH HANDS
12. RAYNAUD'S PHENOMENON
13. BRUXISM
14. SHORTNESS OF BREATH
15. ERECTILE DYSFUNCTION
16. DIZZINESS
17. WHEEZING
18. SEXUAL DYSFUNCTION
19. LIGHTHEADEDNESS
20. EYE PAIN
21. ANXIETY DISORDER
22. POST TRAUMATIC STRESS DISORDER DUE TO PARTIAL AMPUTATION OF FINGER
23. VISION DISORDER
24. DEPRESSIVE DISORDER
25. DIFFICULTY CONCENTRATING
26. SINUS PROBLEMS AND CONGESTION
27. DIFFICULTY MAKING DECISIONS
28. FORGETFULNESS
29. ALOPECIA
30. POSTNASAL DRIP
31. SKIN ISSUES
32. TMJ SYNDROME
33. INTOLERANCE TO HEAT/COLD
34. JAW CLENCHING
35. URINARY FREQUENCY

Discussion:

The patient has filed a specific trauma claim dated 3/12/2022. The patient states he worked as a tailor for Door-to-Door Valet Cleaners. He mentions that his job duties included being seated at a sewing machine and assisting customers with their tailoring needs. He mentions that on this specific dated of 3/12/2022, he accidentally punctured the posterior aspect of his right 3rd digit just above his nail with the sewing machine. He states that this caused bleeding, however, he was able to use peroxide to cleanse his finger and continue his work.

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medications which helped slowly improve the fingers condition. He mentions that he eventually underwent a wound debris of the distal end of the digit which resulted in a partial amputation. He mentions that during his hospitalization he was also diagnosed with Raynaud's phenomenon. He complained of bilateral hand multi digit pain during his hospitalization. He was discharged and continued in treatment with a rheumatologist.

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In my opinion, it is within a reasonable degree of medical probability that the (conditions) the patient developed while working at (place of employment) contributed to the onset of (blank) which led to the onset of (blank). At this time, and with the currently available medical evidence, it would appear that (patient's name) ailments have industrial causation.

Please be advised that the listed diagnoses represent medical diagnoses and/or a differential diagnosis to a reasonable degree of medical probability based on the history provided to me by the patient and the findings of my examination. I believe that some of these diagnoses are industrial in origin and are either initiated or aggravated by the patient's employment and are, therefore, industrial in origin. Some diagnoses are non-specific and will require further evaluation. I reserve the right to alter my opinions based upon receipt of additional information in the form of prior medical records or other documentary evidence that relates to this case. Please be advised that the denial of the claim by the employer will affect my ability to either confirm or reject any of the stated diagnoses, which will also affect my ability to provide evidentiary support for my opinions. Treatment authorization, if already approved, is appreciated. If treatment has not yet been approved, it is hereby requested.

The various diagnoses listed appear to be consistent with the type of work that would typically cause such abnormalities. I, therefore, believe that the diagnoses listed thus far are AOE/COE.

The patient has not attained maximum medical improvement and therefore impairment cannot be rated at this time. A permanent and stationary report will be provided when the patient reaches maximum medical improvement.

Attestation:

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.

I further declare under penalty of perjury that I, Koruon Daldalyan, M.D., personally performed the evaluation of this patient and the cognitive services necessary to produce this report. The evaluation was performed at the above address. The time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

The laboratory tests, if taken, were performed by Quest Diagnostics or Metro Lab in Encino, CA.

The history was obtained from the patient and the dictated report was transcribed by Hazel Babcock, transcriptionist.

I further declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this patient or the preparation of this report. This attestation is effective as of January 1, 2020.

Based on Labor Code Statute 4628, a fee of $64.50 per page for a total of 10 pages has been added to cover reasonable costs of the clerical expense necessary to produce this report.

Should you have any questions or concerns regarding the evaluation or treatment provided to this patient or this report, please feel free to contact me.

Sincerely,

Koruon Daldalyan, M.D.
Board Certified, Internal Medicine