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February 3, 2023

Natalia Foley, Esq.
Workes Defenders Law Group
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Anaheim Hills, CA 92808

PATIENT:	Marvetta Johnson
DOB:	December 11, 1967
OUR FILE #:	210292
SSN:	XXX-XX-7076
EMPLOYER:	Los Angeles County Probation Department 9150 E. Imperial Hwy Downey, CA 90242
WCAB #:	ADJ14891825
CLAIM#:	Unavailable
DATE OF INJURY:	CT June 1, 2019 to June 22, 2021
DATE OF 1ST VISIT:	September 1, 2021
INSURER:	Sedgwick CMS P.O. Box 51350 Ontario, CA 91761
ADJUSTOR:	Christine Rowney
PHONE #:	***

Primary Treating Physician's Permanent and Stationary Report

Dear Ms. Foley,

I examined Ms. Johnson most recently on 2/3/23 in the capacity of primary treating physician for permanent and stationary status.

Job Description:

The patient began working as a senior detention services officer for the Los Angeles County Probation Department in November 2008 and she continues to be employed by the county. At this time, she is not working. Her work hours were from 6:00 am to 2:00 pm, five days per week. Her job duties involved supervising the detention service officers who supervise the youth inmates, assure daily

operations are handled in a safe manner, and when problems arise she is to attempt to resolve them. Physically, the job required for her to stand, squat, bend, walk, stoop, kneel and twist. She was also required to lift 25 or more pounds weight.

History of the Injury as Related by the Patient:

The patient has filed a continuous trauma injury between the dates of June 1, 2019 and June 22, 2021, for injuries that she sustained during the course of her employment.

The patient worked for the Los Angeles County Probation Department as senior detention services officer. She would supervise the youth detention center. She would secure proper operation of the facility. She mentions that she sustained injuries on a cumulative trauma basis. She initially complained of musculoskeletal injuries due to the detainment of a youth. She had to provide force at times and often causing injuries to the cervical and lumbar spine, left shoulder, left elbow, left hip and left knee. She also states that she was often on her feet on a concrete floor and over time she began to develop pain in both ankles and feet.

The patient states that in August 2019, she was involved in an incident at the workplace where some of the doors were left open at the detention center. When she noticed this, she noticed two minors that were out of their rooms and they began to attack her. She locked herself in one of the offices and called for help for approximately 45 minutes. She was not able to get help and called 911 for assistance eventually having officers show up at the detention facility. She states that since that time she has had been under a significant amount of stress from her superiors and the facility individuals as calling officers is considered an embarrassment to the detention center. She mentions that she continued working until March 2021, when she was no longer able to continue working.

The patient was diagnosed with diabetes mellitus type II in 2008 and hypertension in that same year. However, since sustaining her injuries, she has worsening blood sugar and blood pressure levels. She often complains of increased anxiety and stress including posttraumatic stress from the incident that occurred in August 2019.

The patient states that the facility was often short staffed. This caused a significant burden on the patient.

The patient worked in a closed facility and was often exposed to asbestos, as the facility was an old building. Overtime she began to develop sinus problems and sinus congestion. She also complained of shortness of breath often.

Prior Treatment:

The patient has been under the care of Dr. Powks, orthopedist and Dr. Eric Gofnung, chiropractor. She has received physical therapy treatments.

Previous Work Descriptions:

Prior to working at the Los Angeles County Probation Department, the patient worked at the County of Los Angeles Department of Social Services.

Occupational Exposure:

The patient was exposed to dust during the course of her work. The patient was not exposed to excessive noise during the course of her work. She was exposed to excessive heat and cold.

Past Medical History:

The patient was diagnosed with hypertension and diabetes mellitus in 2008. She underwent partial hysterectomy in 2019. She underwent cesarean section in 1990. She had a breast reduction performed in 1994, cholecystectomy in 2011/2012 and left shoulder rotator cuff repair in 2011/2012. She denies any other history of previous medical or surgical conditions. She has no known allergies. There is no history of prior accidents or injuries. There is no other significant medical history.

Previous Workers' Compensation Injuries:

The patient has filed several claims for workers' compensation benefits in the past some of which included the years 2008, 2019, 2020 and 2021.

Social History:

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

Family History:

The patient's mother is alive with a history of suffering a minor stroke. Her father died of natural causes. She had two brothers and two sisters. One brother died of unknown cause. The remaining siblings are alive and well. There is no other significant family medical history.

Review of Systems:

The patient complains of headaches, dizziness, lightheadedness, visual difficulty, ear pain, sinus problems, sinus congestion, jaw pain, jaw clenching, dry mouth, chest pain, palpitations, and shortness of breath. She denies a complaint of cough, throat pain, postnasal drip, wheezing, hemoptysis or expectoration. The patient complains of abdominal pain, reflux symptoms, nausea, constipation and 50 pound weight gain. She denies a complaint of vomiting or diarrhea. The patient complains of urinary frequency and urgency. She denies urinary tract infections. She does complain of sexual dysfunction. The patient's musculoskeletal complaints involve cervical spine pain 7/10, lumbar spine pain 9/10, left shoulder pain 8/10, left elbow pain 7/10, left hip pain 9/10, left knee pain 7/10, left ankle pain 7/10, and bilateral foot pain 8/10. There is a complaint of peripheral edema and swelling of the ankles. The patient's psychosocial complaints include anxiety, depression, difficulty concentrating, difficulty sleeping, difficulty making decisions and forgetfulness. There is a complaint of hair loss from the scalp. There are no dermatologic complaints. There is intolerance to excessive cold. There is no complaint of fever, diaphoresis, chills or lymphadenopathy.

Activities of Daily Living Affected by Workplace Injury:

The patient has much difficulty with sleep because of her musculoskeletal pain. She is unable to find a comfortable position to sleep in. She has problems with bathing, dressing, and self-grooming because of difficulty lifting her upper extremities. She also has problems with climbing stairs, performing housework and driving. She denies any problems with toileting, walking, shopping, or cooking.

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 Meloxicam 15 mg daily, insulin NPH 20 units AM and 15 units HS, Flonase nasal spray 2 sprays in each nostril, Escitalopram 5 mg two tablets daily, Diclofenac Sodium topical gel to apply 4 times daily, Rosuvastatin 10 mg daily, Lisinopril/HCTZ 20-25 mg daily, Metformin 750 mg two tablets PM, Atenolol 25 mg daily, Glipizide XL 10 mg 2 tablets before breakfast, Pioglitazone 45 mg daily, an Albuterol inhaler 90 mcg 2 puffs 4 times daily, Duloxetine 60 mg daily, and Gabapentin 300 mg TID.

Physical Examination:

The patient is a right handed 53-year-old alert, cooperative and oriented African/American female, in no acute distress. The following vital signs and measurements are taken today on examination: Weight: 230 pounds. Blood Pressure: 124/59. Pulse: 60. Respiration: 16. Temperature: 90.5 degrees F. There were no abnormalities of the skin detected. 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. 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. 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. The abdomen is globular, with epigastric tenderness and without organomegaly. Normoactive bowel sounds are present.

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, with epigastric tenderness and 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 of the left side of the cervical and thoracic spine and tenderness of the lumbar paraspinal musculature. There is tenderness of the left shoulder, medial and lateral aspect of the left elbow and left wrist. Tinel's is positive at both wrists. There is tenderness at the base of the 4th digit of the right hand. There is tenderness of the left knee.

Range of Motion Testing:

Cervical Spine:	Normal
Flexion	50/50
Extension	60/60
Right Rotation	80/80
Left Rotation	80/80
Right Lateral Flexion	45/45
Left Lateral Flexion	45/45

Thoracic Spine:

Flexion	60/60
Right Rotation	30/30
Left Rotation	30/30

Lumbo-Sacral Spine:

Flexion	60/60
Extension	25/25
Right Lateral Flexion	25/25
Left Lateral Flexion	25/25

Shoulder:	*Right*	*Left*
Flexion	180/180	160/180
Extension	50/50	40/50
Abduction	180/180	150/180
Adduction	50/50	40/50
Internal Rotation	90/90	70/90

External Rotation	90/90	70/90
Hips:	*Right*	*Left*
Flexion	140/140	140/140
Extension	0/0	0/0
Abduction	45/45	45/45
Adduction	30/30	30/30
Internal Rotation	45/45	45/45
External Rotation	45/45	45/45
Elbow:	*Right*	*Left*
Flexion	140/140	140/140
Forearm	*Right*	*Left:*
Pronation	80/80	80/80
Supination	80/80	80/80
Wrist:	*Right*	*Left*
Dorsiflexion	60/60	60/60
Palmar Flexion	60/60	60/60
Radial Deviation	20/20	20/20
Ulnar Deviation	30/30	30/30
Knee:	*Right*	*Left*
Flexion	130/130	130/130
Ankle/Foot:	*Right*	*Left*
Dorsiflexion	15/15	15/15
Plantar Flexion	40/40	40/40
Inversion	30/30	30/30
Eversion	20/20	20/20

<u>Neurological Examination:</u>

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.

Special Diagnostic Testing:

A pulmonary function test is performed revealing an FVC of 1.26 L (35.1%), an FEV 1 of 1.17 L (41.4%), and an FEF of 1.51 L/s (56.0%). There was a 33.5% increase in FVC, a 41.6% increase in FEV 1, and a 28.1% increase in FEF after the administration of Albuterol.

A 12-lead electrocardiogram is performed revealing sinus bradycardia and a heart rate of 52 per minute.

A pulse oximetry test is performed today and is recorded at 98%.

Laboratory Testing:

A random blood sugar is performed today and is recorded at 245 mg/dL. The urinalysis performed by dipstick method was reported as 1+ protein.

Subjective Complaints:

1. Headaches
2. Dizziness
3. Lightheadedness
4. Visual difficulty
5. Ear pain
6. Sinus problems
7. Sinus congestion
8. Jaw pain
9. Jaw clenching
10. Dry mouth
11. Chest pain
12. Palpitations
13. Shortness of breath
14. Abdominal pain
15. Reflux symptoms
16. Nausea
17. Constipation
18. 50 pound weight gain
19. Urinary frequency and urgency
20. Sexual dysfunction
21. Cervical spine pain
22. Lumbar spine pain
23. Left shoulder pain
24. Left elbow pain
25. Left hip pain
26. Left knee pain

27. Left ankle pain
28. Bilateral foot pain
29. Peripheral edema and swelling of the ankles
30. Anxiety
31. Depression
32. Difficulty concentrating
33. Difficulty sleeping
34. Difficulty making decisions
35. Forgetfulness
36. Hair loss from the scalp
37. Intolerance to excessive cold

Objective Findings:

1. Epigastric tenderness
2. Tenderness of the left side of the cervical and thoracic spine and tenderness of the lumbar paraspinal musculature
3. Tenderness of the left shoulder, medial and lateral aspect of the left elbow and left wrist
4. Tinel's is positive at both wrists
5. Tenderness at the base of the 4th digit of the right hand
6. Tenderness of the left knee
7. An x-ray of the chest (two views) reveals increased bronchial markings bilaterally.
8. An x-ray of the left shoulder (two views) reveals mild osteoarthritic changes of the AC and glenohumeral joints.
9. An x-ray of the left elbow (two views) reveals mild degenerative joint disease along with an osteophyte at the olecranon process.
10. An x-ray of the left hip (two views) reveals degenerative joint disease that is mild to moderate.
11. An x-ray of the left knee (two views) reveals degenerative joint disease of a mild degree.
12. A pulmonary function test revealing an FVC of 1.26 L (35.1%), an FEV 1 of 1.17 L (41.4%), and an FEF of 1.51 L/s (56.0%). There was a 33.5% increase in FVC, a 41.6% increase in FEV 1, and a 28.1% increase in FEF after the administration of Albuterol.
13. A 12-lead electrocardiogram revealing sinus bradycardia and a heart rate of 52 per minute.
14. A pulse oximetry test is recorded at 98%.
15. A random blood sugar is recorded at 245 mg/dL.
16. The urinalysis is reported as 1+ protein.

Diagnoses:

1. MUSCULOSKELETAL INJURIES INVOLVING CERVICAL AND LUMBAR SPINE, LEFT SHOULDER, LEFT ELBOW, LEFT HIP, LEFT KNEE AND BILATERAL FEET
2. CERVICAL SPINE SPRAIN/STRAIN
3. LUMBAR SPINE SPRAIN/STRAIN
4. TORN ROTATOR CUFF, LEFT SHOULDER, STATUS POST CUFF REPAIR SURGERY (2011/2012)
5. EPICONDYLITIS LEFT ELBOW
6. TENDINOSIS LEFT HIP
7. INTERNAL DERANGEMENT LEFT KNEE
8. COMPENSATORY RIGHT KNEE PAIN DUE TO LEFT KNEE INJURY
9. BILATERAL ANKLE SPRAIN/STRAIN
10. NEUROPATHIC PAIN BILATERAL FEET
11. STATUS POST PARTIAL HYSTERECTOMY (2019)
12. STATUS POST BREAST REDUCTION (1994)
13. STATUS POST CHOLECYSTECTOMY (2011/2012)
14. HYPERTENSION (2008) AGGRAVATED BY WORKPLACE INJURY
15. DIABETES MELLITUS TYPE II (2008) AGGRAVATED BY WORKPLACE INJURY
16. REACTIVE AIRWAY DISEASE DUE TO OCCUPATIONAL EXPOSURES TO DUST AND ASBESTOS
17. OCCUPATIONAL EXPOSURES TO DUST AND ASBESTOS
18. HEADACHES
19. DIZZINESS/LIGHTHEADEDNESS
20. VISUAL DIFFICULTY
21. TMJ SYNDROME
22. BRUXISM
23. XEROSTOMIA
24. CHEST PAIN
25. HEART PALPITATIONS
26. SHORTNESS OF BREATH
27. GASTRITIS/GERD SECONDARY TO NSAID MEDICATIONS
28. IRRITABLE BOWEL SYNDROME MANIFESTED BY CONSTIPATION
29. 50+ POUND WEIGHT GAIN
30. URINARY FREQUENCY AND URGENCY
31. SEXUAL DYSFUNCTION
32. ANXIETY DISORDER
33. POSTTRAUMATIC STRESS DISORDER
34. DEPRESSIVE DISORDER
35. SLEEP DISORDER
36. DIFFICULTY WITH DECISION MAKING
37. DIFFICULTY WITH CONCENTRATION
38. FORGETFULNESS

39. ALOPECIA
40. INTOLERANCE TO EXCESSIVE COLD

Discussion:

The patient worked as a Senior Detention Officer for the Los Angeles County Probation Department and she supervised the staff and youths at the center. It was her job to secure proper operation of the facility. In August 2019, she noticed an open door and that some of the youths were out of their rooms who were trying to assault the patient. She closed the door and called for help, which never came. She then called 911 for officers to assist her. She states that since that time she has had been under a significant amount of stress from her superiors and the facility individuals as calling officers is considered an embarrassment to the detention center. As of March 2021, she was no longer able to continue working.

The patient was diagnosed with diabetes mellitus type II in 2008 and hypertension in that same year. However, since sustaining her injuries, she has worsening blood sugar and blood pressure levels. She often complains of increased anxiety and stress including posttraumatic stress from the incident that occurred in August 2019.

The patient worked in a closed facility and was often exposed to asbestos, as the facility was an old building. Overtime she began to develop sinus problems and sinus congestion. She also complained of shortness of breath often.

The patient's work required her to engage in activities that required bending, stooping, squatting, and physically restraining individuals, all of which contributed to her musculoskeletal pain. These activities put strain on the muscles which can lead to the muscles becoming overstretched or torn, resulting in pain, aching or mobility loss. Tendons and ligaments can also become worn down over time due to repetitive lifting, resulting in weak and inflamed joints[1]. The medical literature and epidemiological research confirm that such occupational factors make an individual susceptible to developing musculoskeletal injuries from repeated physical stress. This appears to be the case with Ms. Johnson. In my opinion, the patient's work activities were of sufficient frequency, intensity, and duration to result in her degenerative state.

The patient began to take pain medications such as Meloxicam to manage her musculoskeletal pain. Meloxicam falls into the category of nonsteroidal anti-inflammatory drugs (NSAIDs) which are among the most commonly used drugs in the world. While they work well to relieve pain, they have been shown to have adverse side effects. NSAIDs have been shown to impact gastrointestinal motility by reducing the lower esophageal sphincter (LES) pressure which is responsible for preventing the backflow of stomach acid into the esophagus. The impairment of the LES enables gastric fluid to enter the esophagus, leading to

gastroesophageal reflux. In my opinion, progressive chronic use of NSAIDs has resulted in the patient's GERD. Additionally, NSAIDs have shown to have other consequences on the gastrointestinal system. The main cause of the negative effects of NSAIDs relies on the inhibition of the cyclooxygenase (COX) enzymes. These enzymes are responsible for synthesizing a group of lipids called prostaglandins which work to regulate inflammation and prevent stomach acids from eating away at the gastric mucosa. Using NSAIDs over a long period of time lowers prostaglandin levels, which leads to gastric mucosa irritation which results in IBS and plays a role in GERD as well[2].

The stress the patient has experience can be attributed to her diagnosis of irritable bowel syndrome (IBS) as well. IBS and psychological distress are often comorbid. The prevalence of one or more psychiatric disorder in patients with IBS commonly ranges from 40%-60%. Stress releases hormones, including corticotropin-releasing factor (CRF). This hormone affects the composition and growth of the gut's healthy bacteria which are essential for maintaining healthy bowl function[3]. Additionally, it has been found that in IBS, alterations of the autonomic nervous system, which is activated by stress, are likely to play a role in altered bowel habits and alterations in gastric emptying. Evidence for such enhanced responsiveness of autonomic responses in IBS includes increased responses of colonic motility in response to stress as well as food intake and delayed gastric emptying in patients[4].

The patient also developed high blood pressure, also known as hypertension, and this was aggravated in response to her elevated stress levels. Stress brings about heightened cortisol levels and blood pressure. It is generally accepted that chronic psychological stress induces hyperactivity of the hypothalamic pituitary adrenal (HPA) axis of the neuroendocrine system. This leads to excess amounts of glucocorticoid hormones which increases sugar formation in the liver as well as insulin resistance. The increase in systemic glucocorticoids also results in water and salt retention in the kidneys, thus raising systemic blood pressure[5]. The patient's musculoskeletal pain resulted in decreased mobility and weight gain, and the relationship between heightened blood pressure and obesity is well established. Overweight individuals have higher levels of cholesterol in the bloodstream which can result in buildup in vascular walls. This limits blood flow and increases blood pressure[6]. The patient's hypertension is also a contributing

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[1]El-Tallawy, S.N., Nalamasu, R., Salem, G.I. *et al.* Management of Musculoskeletal Pain: An Update with Emphasis on Chronic Musculoskeletal Pain. *Pain Ther* 10, 181–209 (2021).
[2]Akarca, U. Gastrointestinal Effects of Selective and Non-selective Non-steroidal Anti-inflammatory Drugs. *Current Pharmaceutical Design*. 2005; 11(14): 1779-1793.
[3]Qin HY, Cheng CW, Tang XD, Bian ZX. Impact of psychological stress on irritable bowel syndrome. *World J Gastroenterol*. 2014 Oct 21;20(39): 14126–14131.
[4]Emeran A. Mayer,Bruce D. Naliboff, Lin Chang, and Santosh V. [4]Coutinho. V. Stress and irritable bowel syndrome. *American Journal of Physiology-Gastrointestinal and Liver Physiology, Volume 280, Issue 4*. 2001. G519-G524.
[5]Peter, R., Westerholm, P., et al. Does a Stressful Psychosocial Work Environment Mediate the Effects of Shift Work on Cardiovascular Risk Factors? *The Scandinavian Journal of Work, Environment, and Health*. 1999; 25(4): 376-381
[6]Jiang, S. Z., Lu, W., Zong, X. F., Ruan, H. Y., & Liu, Y. (2016). Obesity and hypertension. *Experimental and therapeutic medicine*, *12*(4), 2395–2399.

factor to her headaches. Hypertension causes changes in blood flow (from constriction of vasculature), affecting the amount of blood that travels to the brain, and constricted blood flow to the brain can cause headaches. Additionally, narrowing of blood vessels can increase the pressure in the brain's blood vessels. This also can lead to headaches[7].

The patient's stress from her work and pain can also be a contributing factor to her aggravation of diabetes. High blood sugar is a defining characteristic of II diabetes, as cells of individuals with type II diabetes resist insulin. Insulin is released by the pancreas in response to increased glucose levels in the blood and it serves to help glucose enter the body's cells from the blood stream. When an individual experiences stress, cortisol is released from the adrenal glands[8]. Cortisol works to increase glucose (sugars) in the blood stream. The patient's increased stress levels resulted in cortisol release, which increased the patient's blood sugar levels[9]. Due to her type II diabetes, insulin was not able aid in moving sugar from the bloodstream to the body's cells, resulting in hyperglycemia (high blood sugar levels). Additionally, the patient's injuries sustained at work affected his ability to engage in physically activity. As a result, the patient has gained weight. Studies have shown that in individuals with higher levels of body fat, the amount of proinflammatory substances, hormones and other substances involved in the development of insulin resistance are increased, leading to the development of diabetes[10].

The stress the patient experiences can also be linked to her headaches. Stress and headaches are connected, as stress is thought to play part in headache disorder onset in predisposed people. It has also been found to trigger or worsen individual headache episodes in those with headaches and heighten the progression of a headache disorder. Through aggravating headache disorder progression, stress is believed to be a major factor in converting headaches from episodic to chronic[11]. The patient's difficulty with sleep can also be attested to her musculoskeletal pain. It is estimated that over 50 million Americans are affected by chronic pain and that as many as 70% of these patients complain of poor sleep. In clinical samples, 51% of patients experiencing chronic lower back pain report impaired sleep, and 70% in a mixed group of patients attending a pain clinic reported the same. It has also been found that patient's medical history often displays that a stress-related incident precedes insomnia, and that pain frequently

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[7]Hypertension and Headache: A Comprehensive Review. American Journal of Hypertension. 2011;24(2):163-172.
[8]Santwana Padhi, Amit Kumar Nayak, Anindita Behera, Type II diabetes mellitus: a review on recent drug based therapeutics, *Biomedicine & Pharmacotherapy*, Volume 131, 2020, 110708, ISSN 0753-3322.
[9]Sandra Zänkert, Brigitte M. Kudielka, Stefan Wüst, Effect of sugar administration on cortisol responses to acute psychosocial stress, *Psychoneuroendocrinology*, Volume 115, 2020, 104607, ISSN 0306-4530.
[10]Al-Goblan, A. S., Al-Alfi, M. A., & Khan, M. Z. (2014). Mechanism linking diabetes mellitus and obesity. *Diabetes, metabolic syndrome and obesity : targets and therapy*, *7*, 587–591.
[11]Timothy Houle PhD, Justin M. Nash PhD. Stress and Headache Chronification. *Headache: The Journal of Head and Face Pain, Volume 63, Issue 1*. 2023; 1: 1-182.
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leads to the insomnia becoming chronic[12]. There was a positive correlation between perceived stress levels and urinary incontinence symptoms, and its impacts on quality of life among overactive bladder patients[13]. This is the case with Ms. Johnson.

As a result of the psychological stress from the industrial injuries sustained, the patient developed alopecia (hair loss). The stress hormone, cortisol, is known to affect the function and cyclic regulation of the hair follicle. When cortisol is present at high levels it has been demonstrated to reduce the synthesis and accelerate the degradation of important skin elements, namely hyaluronan and proteoglycans by approximately 40%[14]. This is the case with Ms. Johnson.

Given the history and work environment that the patient described, exposure to dust would be unavoidable for someone in her line of work, and this led to multiple ailments. The dust and chemical exposure the patient experienced can also be linked to her reactive airway disease (RAD). RAD is a term used to describe a group of respiratory symptoms that occur in response to various triggers such as dust which can contribute to RAD by irritating the airways and triggering an inflammatory response. The inflammation causes constriction of the airways which leads to shortness of breath[15].

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.

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[12]Frederic Stiefel Daniele Stagno. Management of Insomnia in Patients with Chronic Pain Conditions. *Therapy in Practice.* 2012 (8): 285-296

[13]Lai H, Gardner V, Vetter J, Andriole GL. Correlation between psychological stress levels and the severity of overactive bladder symptoms. BMC Urol. 2015;15:14. Published 2015 Mar 8. doi:10.1186/s12894-015-0009-6

[14]J Drugs Dermatol. 2016 Aug 1; 15(8): 1001-4.

[15]Arif, T., Malik, J. A., & Shoib, S. (2013). First reported case of reactive airway dysfunction syndrome in a laborer due to porcelain tile dust. *Iranian journal of medical sciences*, *38*(2), 132–134.

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's status is not expected to improve significantly for the foreseeable future. The patient has now reached a point of maximal medical improvement (MMI) and can now be considered permanent and stationary (P&S) as of 2/3/23 for rating purposes.

Apportionment:

This is to certify that I have reviewed Labor Code sections 4663 and 4664 in rendering my opinion on apportionment or lack thereof.

Regarding the apportionment of the patient's left shoulder disabilities and cervical and lumbar spine impairments, 70% is apportioned to the industrial cumulative stress, and 30% is apportioned to the non-industrial natural degenerative changes. The basis for this decision is the frequency and duration of shoulder and back stress related by the patient, and the available medical evidence.

Regarding the apportionment of the patient's GERD and IBS, 80% is apportioned to industrial factors, and 20% is apportioned to non-industrial factors. The basis for this decision is the musculoskeletal problems that were caused by the industrial injuries sustained, the fact that the patient was taking NSAIDs, the known adverse gastrointestinal side effects of NSAIDs, and the absence of any medically significant gastrointestinal history.

Regarding the apportionment of the patient's hypertension, 60% is apportioned to industrial factors, and 40% is apportioned to non-industrial factors. The basis for this decision is the psychological stress that the patient described, the medical literature that describes the relationship between psychological stress and the onset of hypertension, and the available medical evidence at this time.

Regarding the apportionment of the patient's reactive airways disease, 80% is apportioned to industrial factors, and 20% is apportioned to non-industrial factors. The basis for this decision is the patient's frequent exposure to dust while working, the medical literature describing the relationship between such exposures to RAD, and the absence of any medically significant respiratory history.

Regarding the apportionment of the patient's diabetes, 60% is apportioned to industrial factors, and 40% is apportioned to non-industrial factors. The basis for this decision is the psychological stress that the patient described, the medical literature that describes the relationship between psychological stress and the onset of diabetes, and the available medical evidence at the time.

Regarding the apportionment of the patient's sleep impairment, headaches, alopecia, and urinary impairment (frequency & urgency) 90% is apportioned to industrial factors, and 10% is apportioned to non-industrial factors. The basis for this decision is the duration, frequency, and intensity of the musculoskeletal injuries reported by the patient, the known adverse side effects of psychological stress sustained, and the available medical evidence.

Permanent Impairment Ratings:

According to According to the AMA Guidelines 5th Edition, Table 5-9 Impairment Classification for Asthma Severity and Table 5-10 Impairment Ratings for Asthma, both on page 104, the patient's RAD qualifies for a total asthma score of 9 (FEV_1 was 41.4% of predicted with a 41.6% of FEV_1 change and daily use of bronchodilators), corresponding with a 50% WPI.

According to the AMA Guidelines 5th Edition, Table 6-3 Criteria for Rating Permanent Impairment Due to Upper Digestive Tract (Esophagus, Stomach and Duodenum, Small Intestine, and Pancreas) Disease on page 121, the patient's NSAID-induced GERD and IBS warrant a Class II rating (symptoms of upper digestive tract disease, continuing treatment required), corresponding to a 15% WPI.

According to the AMA Guidelines 5th Edition, Table 10-8 Criteria for Rating Permanent Impairment Due to Diabetes Mellitus on page 231, the patient's diabetes warrants a Class II rating (Type II diabetes mellitus requiring medication), corresponding to a 10% WPI.

According to the AMA Guidelines 5th Edition Table 7-1 Criteria for Rating Permanent Impairment Due to Upper Urinary Tract Disease on page 146, the patient's urinary impairment (frequency and urgency) warrants a moderate Class I impairment rating, equating to a 10% WPI.

According to the AMA Guidelines 5th Edition, Table 13-4 Criteria for Rating Impairment Due to Sleep and Arousal Disorders on page 317, the patient's sleep impairment warrants a high Class I rating (reduced daytime alertness, mild interference of activities of daily living), corresponding to a 9% WPI.

According to the AMA Guidelines 5th Edition, Table 4-2 Classification of Hypertension in Adults and Table 4-1 Criteria for Rating Permanent Impairment Due to Hypertensive Cardiovascular Disease both on page 66, the patient's hypertension qualifies for a Class I rating (normal blood pressure with hypertensive medications), corresponding to a 9% WPI.

According to the AMA Guidelines 5th Edition, Table 8-2 Criteria for Rating Permanent Impairment Due to Skin Disorders on page 178, the patient's alopecia

qualifies for a high Class I rating (signs and symptoms are continuously present, requires intermittent treatment) equating to a 7% WPI.

According to the AMA Guidelines 5th Edition, Table 13-11 Criteria for Rating Impairment of Cranial Nerve Vs (Trigeminal Nerve) on page 331, the patient's chronic headaches qualify for a low Class I rating (mild facial neuralgic pain, intermittent frequency, mild interference with activities of daily living), equating to a 5% WPI.

According to the AMA Guidelines 5th Edition, Table 15-5 Criteria for Rating Impairment Due to Cervical Disorders on page 392, the patient's cervical spine impairment warrants a low DRE Cervical Category II rating of 5% WPI.

According to the AMA Guidelines 5th Edition, Table 15-3 Criteria for Rating Impairment Due to Lumbar Spine Injuries on page 384, the patient's lumbar spine impairment warrants a low DRE Lumbar Category II rating of 5% WPI.

According to the AMA Guidelines 5th Edition, Table 16-18 Maximum Impairment Values for the Digits, Hand, Wrist, Elbow, and Shoulder Due to Disorders of Specific Joints or Units on page 499, and Table 16-19 Joint Impairment from Synovial Hypertrophy on page 500, the patient's left shoulder (glenohumeral joint, 60% upper extremity) injury warrants mild classification, corresponding to a 10% joint impairment. The left shoulder impairment is equivalent to a 6% upper extremity impairment (60% x 10% = 6%).

According to the AMA Guidelines 5th Edition, Table 16-3 Conversion of Impairment of the Upper Extremity to Impairment of the Whole Person on page 439, the patient's upper extremity impairment corresponds to a 4% WPI.

For chronic pain, we will be adding 3% WPI, which was adopted from the AMA guidelines 5th edition, chapter 18.

According to the Combined Values Chart of The AMA Guides, page 604-605, the patient's whole-body impairment is 71% (50% + 15% + 10% + 10% + 9% + 9% + 7% + 5% + 5% + 5% + 4% + 3%).

Work Restrictions

For the patient's complaints of lumbar and cervical spine pain, she should be precluded from work involving heavy lifting, repetitive pushing, pulling, stooping, or overhead work with the upper extremities.

For the patient's complaints of left upper extremity pain, she should be precluded from repetitive overhead work, heavy lifting, rapid repetitive gross motor activity,

pushing, pulling, and activities that require flexion, extension, and twisting of the upper extremities.

For the patient's hypertension, she should be precluded from work in emotionally stressful environments, work that involves frequent to constant deadlines, work that involves reasonably probable exposure to significant psychological trauma (violence, crime, death, disease), and occasional to frequent undue stress from co-workers and management.

Vocational Rehabilitation:

If the above work restrictions cannot be met, then the patient should be considered a Qualified Injured Worker (QIW) and should have access to vocational rehabilitation.

Future Medical Care:

Provisions for future medical care for the patient's lumbar and cervical spine and left shoulder is indicated. She should be allowed office visits with her primary care physician in the event of future flare ups of her symptoms. Necessary and appropriate should include physical therapy sessions (as recommended by the California MTUS Guidelines) for the lumbar and cervical spine and left shoulder (twice per week, for 4 weeks), the use of NSAID medications, and follow up with a pain management specialist for epidural steroid injections. Surgical intervention is not anticipated at this time.

Future medical care for the patient's hypertension is indicated. The patient should be seen by an internist, or her primary treating physician, on an industrial basis approximately 4-6 times per year. Medically necessary and appropriate treatment for the patient's hypertension should include regular hyperglycemic testing (lab work ups including: hemoglobin A1C, fasting glucose, and comprehensive metabolic panels), education on diet changes, home exercise for weight management, and annual cardiovascular testing (electrocardiogram, cardio-impedance testing, lab work up); she will also require lifelong access to anti-hypertensive medications.

Future medical care for the patient's GERD is indicated. Medically necessary and appropriate treatment should include follow ups with an internal medicine specialist (or her primary treating physician) for any flare-ups of her GERD symptoms, H2 blockers or proton pump inhibitors (Omeprazole 20 mg QD), and selective opioid antagonists (Naloxegol) and suppositories (Dulcolax) on an industrial basis for life.

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. X-rays, if taken, were administered by Jose Navarro, licensed x-ray technician #RHP 80136, and read by me. The chiropractic care and physical therapy treatments are provided under the direction of Ara Tepelekian, D.C.

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 13 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