Jonathan S. Rutchik, MD, MPH
Neurology and Electromyography
Occupational and Environmental Medicine
Diplomat of the American Board of Psychiatry and Neurology (Neurology)
Diplomat of the American Board of Preventive Medicine (Occupational and Environmental Medicine)
http://www.NEOMA.com
20 Sunnyside Avenue, Suite A-321
Mill Valley, Ca 94941 PHONE: 415-381-3133
Email:jsrutch@neoma.com FAX: 415-381-3131
CALIFORNIA STATE QUALIFIED MEDICAL EXAMINER
San Francisco, Richmond, Petaluma, Sacramento and Arcata, California

January 14, 2005

Lupe ZZZZZZ
ZZZZZZZZZZZZZZZ
PO Box 5432
Cincinnati, OH 45201

Anne AAAAAAAAA
Attorney at Law
BBBBBBB
PO Box 14459
CCCCC

Re: Susan XXXXXXXXXxx
Date of Birth: 3/26/73
Employer: DDDDDDDDDDD
Great American Ins. Group
Claim number: 497666hhh500646
49750085
Date of Injury: 1/28/04, 5/7/04

DEFENSE QUALIFIED MEDICAL LEGAL EVALUATION

I had the pleasure of evaluating Susan ZZZZZZ in my Petaluma office on January 14, 2005, for the purpose of a Defense Qualified Medical Legal Evaluation. I am in receipt of a cover letter from the attorney Anne Hernandez dated November 5, 2004. I have examined the above referenced claimant.

Not only does this report address causation and apportionment it also entails _____ hours of face to face time, _____ hours of medical record review including placing the medical records in chronological order. _____hours of medical research and _____hours of report preparation. I have been given authorization by _____ to perform _____studies. You will also find these studies and my medical opinion in the body of this report. EMG NCV testing will also be billed.

This report is submitted as an ML103, Medical-Legal Evaluation pursuant to 8 Cal. Code Regs. Section 9795(b) and (c), with justification factors (2), (6) and (7), within the context of subdivision (b). Complexity is further reflected by the involvement of multiple body parts, with treatment with multiple specialists with widely divergent opinions.

HISTORY AS EXPLAINED BY THE PATIENT :

The patient is a 31-year-old righthanded female who state of birthdays March 26, 1973. She explains that she injured her head, neck, shoulders, arms and hands on January 28, 2004. She explains that she was working for the XXXXXXXX Lodge in little river California. Her job there was the concierge, practice server, housekeeper and also maintenance person.

She explains that on that date that approximate 5 p.m. she took out the office trash. There was trash cans outside against the wall of the lodge. She reports that I she was placing the bag into the trash can, he would embrace that was hanging on the wall slipped from its cloak and crashed down on her head. The brace was made up of four to inch by 4 inch wooden planks that weighed approximately 20 pounds in total.

Between January and May of 2004, she did not see a doctor. She had complaints of pain and tingling and numbness in her arms and shoulders and neck and head. She continued to work.

In May, she dropped a tray of dishes while serving breakfast since her hands were tingling. She had pain and numbness and tingling. Her boss had called and she told him what had happened. She told him that she dropped a tray since she had pain and tingling in her arms and neck.

She then went to see a Dr. Jonas in Mendocino Coast Hospital in Occupational Medicine. Initially they were concerned with carpel tunnel but were concerned with her neck pain. She had a test that was negative. She had a nerve test in Santa Rosa in May of 2004. This was reported to be negative. They referred her to hand therapy but stopped after the nerve test was normal. They then asked about any head injuries. She then remembered that she had the injury in January to her head and neck. They then referred her to a neurologist. She was referred to a neurosurgeon, Dr. Pompalompu in Santa Rosa. He was difficult and asked difficult questions. He examined her and pushed on her lower back. She experienced some lower back pain then. She reports that he was rough with

her. She continues to experience lower back pain. She denies any prior lower back pain. She had already had an MRI of the brain and cervical spine. These were normal.

She returned to work immediately. She was doing modified duty but 6 days per week. She did seating and taking orders. She then realized she was getting worse. Dr. Kimbro then wrote that she should work only 5 days. She had a note that stated she should not serve breakfast and only work 5 days per week. She then was not offered modified duty. She was told they could not accommodate her. This was June 3, 2004. The next day, she resigned when she saw her job asdvertised in the newspaper.

She did not work until August 30, 2004. She was not offered modified duty by the lodge. She chose a lighter duty job. She went to work as teacher's aide at Albion School. This does not require any lifting. The hours and pay are less.

Since then she has continued to see doctors at the Occupational Medicine clinic, Dr. Kimbro. She goes there once per week. Her doctor requested acupuncture. This was cancelled after 6 visits. Her acupuncturist agreed to continue to other 4 visits. She finished the 10th visit in November. She has continued with her twice, paid by herself, since December.

She also is getting full body massage, paid for by herself. She was told workers compensation did not cover that. She goes once to twice per month.

She is told that she is waiting for an FCE before her doctor renders her P and S.
She feels about 75- 80% better.

She is taking Flexeril, taking about ¼-1/2 pill per night, three times per week.

She saw Dr. Bronshvag in October 2004. He did not review medical records. She plans to have reexamination in late January.

OCCUPATIONAL HISTORY:

She began working December 2002 at this lodge. She had no problems with injuries or behavioral issues between that date and January 2004.

Before that she worked at Senior Apartments in Santa Rosa as a manager. She was a leasing consultant and then moved up. She worked for them for 2 ½ years. She had no injuries while working for this company.

She worked at Yosemite national Park for five one half years as a reservation agent. She had no worker injuries while working for that organization.

Her job included taking orders at breakfast, serving and busing tables, cleaning the lodge, changing beds and cleaning bathrooms in the lodge. She also worked at the front desk and took reservations and also maintained the spa and the koi pond.

She did do some lifting; five to 20 pounds every day. She worked six days a week and for six hours each day.

SECOND JOBS:

She had no second jobs will working at the lodge.

PAST MEDICAL HISTORY

She reports that she slipped outside the spa of the lodge in 2003. She did not see a doctor. She had a bruise on her right knee, but did not miss any work.

She has no other medical history.

She occasionally drinks alcohol and does smoke occasionally.

CURRENT MEDICATIONS

Flexeril, one quarter to one half pill at night. She has been taking this medication since June 2004. This does started at three times per day of one pill.

CURRENT COMPLAINTS/STATUS

She has occasional right wrist and hand pain. This worsens when she uses the hand to open a jar or open the car door. At it worst, it is a 5-6/10. This lasts for a minute after the offending activity.

She explains that she has pain and tingling in her neck, arms, right wrist and hand. She also has swelling in the right hand.

The pain in the neck is not a sharp pain. She has aching when she turns her head or puts the head back. She feels that this is limiting since it hangs around. It limits her from being active. She needs to stop stretching due to the pain. She gets some pain while working, but she is able to do the job.

In order of severity, her pain in her right hand is the most severe. Pain behind her left ear is related to her neck pain and is the next most severe issue. She wakes up in the morning with this pain. She also gets pain in the neck is the next most severe.

She also has pain in the lower back occasionally. She feels this once or twice per week. She cant bend down at the waist. She can't do stretches. She felt this pain after the neurosurgeon pushed on her back.

She feels that she is limited from twisting and bending at the waist. She did get pain radiating to the right thigh. She has not felt this in three weeks. She denies any other symptom into her right leg.

She also notes pain behind her left here and also in the right side of her lower back.

She feels that she is 75 -80 percent better. She feels that she cannot do her old job; she could not do the vaccuming or changing beds or serving breakfast.

She also sees spots since after the accident in January 2004. She does see spots still. She has seen an eye doctor in December 2004 who told her she has no detached retina.

CURRENT TREATMENT PROGRAM

She is doing massage and acupuncture once per month. She is also doing stretching 1-2 times per day and taking Flexeril.

She does walks on the beach.

She is doing some gardening now, planting a flower occasionally.

She is now working in a less strenuous position.

UPPER EXTREMITY AND UPPER BACK EXAMINATION

GENERAL DESCRIPTION:

The patient's self reported height and weight was 5'2 ½ and 130 lbs

The patient was able to undress and get on and off the examining table without assistance.

The patient was visibly nervous and anxious during the historical portion of the evaluation.

INSPECTION:

The normal cervical curve was present.
Flexion, extension, lateral flexion and rotation to the left and right was normal for the cervical spines all were painful; the most painful was lateral flexion to the left and rotation. Tinel's sign was normal for the ulnar groove and the wrist bilaterally.
Phalen's sign was normal at the wrists bilaterally.

Pain was noted on light palpation. The patient reported pain upon extremely light touching of her neck region and behind her left ear.

Upper Extremity: Range of Motion

Neck forward flexion	50
Neck extension	60
Lateral flexion	45
Lateral rotation	80
Shoulder abduction	170
Shoulder extension	30
Shoulder internal rotation	60
Shoulder external rotation	80
Elbow flexion	135
Elbow extension	180
Forearm pronation	75
Forearm supination	85
Wrist flexion	70
Wrist extension	65
Wrist radial deviation	20
Wrist ulnar deviation	40

MOTOR EXAMINATION:

Full power, 5/5 of upper, both proximal and distal bilaterally.

No weakness was noted for small muscles of the hands including interossei and abductor pollicis brevis. No atrophy or abnormal tone was noted.

Circumferential measurements in centimeters: **Upper Extremities**

	RIGHT	**LEFT**
Above elbow	27.5	27.5
Below elbow	23	23.5
Wrist	14.5	14.5

Jamar dynamometer testing in pounds revealed the following:

	RIGHT	**LEFT**
Grip test one	22	27
Grip test two	19	29
Grip test three	22	25

Effort was fair

Jamar pinch grip dynamometer testing in pounds revealed the following:

	RIGHT	**LEFT**
Grip test one	4	5.5

Grip test two	5	6
Grip test three	4.5	5

Effort was fair

SENSORY EXAMINATION:

Normal for light touch, pinprick, temperature, vibration and joint position sense bilaterally in the upper in the cervical dermatomes C5-T1, median, ulnar and radial nerve distributions.

REFLEX EXAMINATION:

Reflexes appear to be symmetrical but reflexes appear to be mildly diminished throughout for Biceps, triceps and brachioradialis for the upper extremities bilaterally.

LOWER EXTREMITIES AND BACK EXAMINATION

INSPECTION

The lumbar spine revealed a normal curvature. No scars were noted.

Flexion and extension of the torso led to pain. Due to the patient's reporting of lumbar pain after being examined by the neurosurgeon, I elected not to attempted to palpate the lower spine.

Rotation to the left and flexion to the left did lead to pain. Normals are listed below. Normal arches of the feet are noted.

Lower Back Evaluation: Range of Motion

	RIGHT
Forward flexion of torso	45
Extension of torso	15
Lateral flexion	20
Lateral rotation	20
Hip flexion	110
External rotation	50
Internal rotation	35
Hip abduction	50
Hip adduction	30
Knee flexion	130
Knee extension	180
Ankle flexion	50
Ankle extension	15

MOTOR

The motor power appears to be full. There is good bulk and good tone.

Circumferential measurements in centimeters: **Lower Extremities**

	RIGHT	**LEFT**
Above knee	46	45
Below knee	34	33
Ankle	21	21

SENSORY

The sensory examination does in fact appear to be normal to pin prick, light touch and temperature. There is no evidence of stocking or glove distribution of deficits.

REFLEXES

Reflexes are +2 at the knees and +1 at the ankles. Toes are both down going.

GAIT AND COORDINATION

The patient is able to walk well. The patient is able to walk on heels and toes.

NEUROPHYSIOLOGICAL TESTING

Testing of the upper extremities did reveal borderline median sensory slowing and asymmetrical sensory studies for the median nerve at the wrist suggestive of a mild CTS on the right. The left was suggestive as one of three comparison studies was asymmetrical.

The patient tolerated the procedure but after the procedure was visibly anxious.

REVIEW OF RECORDS

Date	**Description**	**Comments**
December 14, 2004	Industrial status form, Mendocino Coast district hospital	Return to work on December 14 with limited use of right and left hands, arm. Return for recheck an attempt to get functional evaluation. Diagnosis is bilateral upper extremity neuropathy.
November 11, 2004	Mendocino Coast district hospital, occupational medicine	Continued upper extremity numbness and tingling. Lumbar pain, present times four months. Continue acupuncture, modified duty, Flexeril. Return to modified duty on November 11, 2004. No lifting more than 25 pounds, and repetitive bending or overhead lifting.
November 10, 2004	Dr. Bronshvag, qualified medical examination	Physical examination revealed incomplete effort for grip strength bilaterally. Discussion mentions a head blow, in January 2004 and incremental worsening of symptoms since. Also it mentions spots before the eyes since February 2004, eye exam being grossly

		normal. Also a mention of a complaint of right leg and lower back discomfort since the nerve surgical exam on August 2004. Dr. B's plan was to wait for the medical records and to reevaluate the patient again.
October 27, 2004	Mendocino Coast hospital	Right upper extremity neuropathy.
September 3, 2004	Dr. Kimbrough	Patient is waiting for a neurologist to evaluate the patient.
August 27, 2004	Mendocino Coast district hospital	Feeling better, pain that is bad. Still feels tingling and numbness. Their surgical consultation suggests symptoms are stress-related and not necessarily work related. Diagnosis is myofacial pain syndrome and cervical sprain. Medications include Vioxx and Flexoril. Instructions are to be off work, continue acupuncture.
August 13, 2004	Mendocino Coast hospital, occupational medicine	Off work through August 27, 2004. No mention of new lumbar pain.
July 19, 2004	Dr. Puplampu, neurosurgeon, qualified medical examination	Patient sustained a sudden concurrence of head injury. There is not lost consciousness. She developed headaches and neck pain which have gone on to a bizarre complex of symptoms at this time. Our sensory examination did not conform to any particular physiologic pattern and her motor examination does not show any civic weakness. She did have hyperflex is a noted. Brain imaging studies as well as EMG do not show any evidence of pathology. Is my opinion that the patient's complex symptoms appear to be related to stress and hypertonia. She could be a candidate for acupuncture treatment. In she should be permanent and stationary in another 2-3 months. She could return to work without any forceful gripping.
July 13, 2004		Neuropathy bilateral upper extremities.
July 1, 2004	Cat scan of the brain	Normal.
June 24, 2004	Mendocino Coast hospital, occupational medicine	Reject neuropathy bilateral upper chimneys
June 15, 2004	Mendocino Coast hospital, occupational medicine	Reject numbness and weakness in hands. Also pain in the shoulder reading to head and torso.
June 14, 2004	MRI of the cervical spine	The cervical did in six disc is smaller than the other disks, which is most likely congenital. Otherwise there are no other abnormalities

June 8, 2004	X-ray of the cervical spine	Partial congenital fusion of the cervical fifth and sixth vertebrae.
June 8, 2004	Mendocino Coast hospital, occupational medicine	Recheck.
June 3, 2004	EMG of the upper extremities.	Minimal nonspecific findings which could represent nerve root irritation at the cervical fifth six bilaterally.
June 2, 2004	Mendocino Coast hospital, occupational medicine	Recheck weakness in tremor and numbness.
May 27, 2004	Mendocino Coast hospital, occupational medicine	Reject numbness and weakness in bilateral hands.
May 21, 2004	Mendocino Coast hospital, occupational medicine	Reject numbness and weakness
May 7, 2004	Doctors first report, Dr. Kraut	As I carried a small tray of dishes, I felt a sudden sharp pain in my hands and wrists and numbness that ran for my fingertips to my neck caused me to drop the tray. Tingling numbness in the first three digits, and weakness in pain shooting up my arms to my neck. Diagnosis is bilateral carpal tunnel syndrome right greater than left. Treatment plan is for occupational therapy and modified duty and recheck.

COMMUNICATION WITH PROVIDER(S):

None

DIAGNOSIS

1. Bilateral hand pain, mild CTS as noted on today's NCV testing.
2. Left sided pain behind her ear.
3. Neck pain, right side that radiates to the left.
4. Lower back pain.
5. Spots in her vision, which have been evaluated.

SUMMARY IN BRIEF

This 31-year-old righthanded female was in her usual and normal state of health until January 28, 2004 when she was head in a head by four wooden planks while taking out

the trash at work. She felt neck pain in hand numbness and tingling over the next five months. She worked in a bed-and-breakfast Lodge as the server, concierge, and housekeeper. She did not report this to a physician or supervisor nor her pain. She remarks that she was afraid to lose her job. Five months later, In May 2004 she dropped plates while serving breakfast when she felt tingling and numbness in her hands. She was referred to physicians in Mendocino near where her job was. Doctors their assessed her for bilateral hand pain and referred her to occupational therapy. She also had nerve and muscle testing and an MRI of the neck. At some point the nerve and muscle testing ruled out carpal tunnel syndrome and the hand therapy was stopped. Further questioning lead to the discovery that she had had a prior head and neck injury. The patient reports that the Doctors suspected this is related to her neck pain and hand numbness. It appears that a neurological consultation was requested, at that the insurance company referred the patient to a neurosurgeon who felt that the patient's symptoms were mainly stress-related. No mention of the head trauma or the specific events of the head and neck pain where mentioned in the record from the Occupational Medicine physician. The neurosurgical consultation in July 2004, did mention the issue of the head trauma from the January accident.

Also, the patient reports that she developed lower back pain after she was roughly handled by the neurosurgeon. No mention of lower back pain exists in the record until November 2004 and no mention of the uncomfortable experience or the inciting events from that doctor visit are documented.

Patient initially returned back to work after the accident in May 2004 to modified duty. She continued to work six days a week but did not serve breakfast. After some period, she realized that she was getting worse and returned back the physician. He reduced her to only five days per week, but the the Lodge could not accommodate her. She last worked in June 3, 2004. Realizing that the lodge was interviewing new workers for her job, she resigned. By the end of August 2004 she found a much lighter duty job as a teacher's aide in Mendocino. She able to work in this position.

She also has completed 10 visits with an acupuncturist. Her physician arranged for these visits but it appears that they were stopped after six. She paid for the last four out of her own pocket. She also has gone twice in the last two months. She also began going to massage therapist once per month and pays for that out of her own pocket. She has been stretching each day and feels that she is approximately 75- 80% of what she was prior to the injury.

The patient did see Dr. Bronshvag as an applicant QME. Dr. B. did not have the medical records and so did not opine on causation. Is noted that the physical exam did suggest poor effort, specifically the section on grip strength.

Today, she complaints of bilateral hand pain as well as left sided neck pain and pain behind the left ear. She also complains of some mild and less frequent Lower back pain which developed after she visited with the neurosurgeon who pushed upon her Lower back. She also complains of some spots in her vision. She mentions that she did finally

see an eye doctor who told her that she did not have a detached retina. The hand pain is limiting to the extent where she has more pain when she twists open jars or opens car doors. The lower back pain is less frequent but does limit her from bending or twisting, she reports.

Examination reveals a nervous and anxious female. She has tenderness in her neck to very light palpation. ROM of the neck leads to pain. She also reports pain on ROM of the lumbar spine, though muscle power and sensory exam are normal. Reflexes are symmetrical but she did have hyperreflexia noted in the knees; the ankles were +2 and no clonus was noted.

She complained of pain upon performing SLR testing and bending also.

TEMPORARY TOTAL DISABILITY

She was out of work between June 3 and August 30, 2004.

PERMANENT AND STATIONARY STATUS

I feel that she is P and S as of the date she began her new position at the school, August 30, 2004.

OBJECTIVE FACTORS OF DISABILITY

None

SUBJECTIVE FACTORS OF DISABILITY

For hand pain, occasional slight to moderate when exerting herself.

For neck and pain behind her ear, she has occasional slight to moderate pain.

For her lower back pain, she has occasional mild pain.

Overall, her complaints of pain, are out of proportion to her injuries described.

PERMANENT DISABILITY

I feel that this should be based on her subjective complaints and work preclusions; she is limited from prolonged forceful gripping. Regarding her neck, she is limited from prolonged extension and flexion of the neck.

Regarding her lower spine on a non industrial level, she appears limited from very heavy lifting.

CAUSATION

Regarding the bilateral hand pain, I feel this is industrial and cumulative for the period of time prior to May 2004.

For her neck pain, I do feel that this is industrial and related to her traumatic event of January 28, 2004.

For her lower back pain, I identify no medical record or notation from any physician to support that an industrial injury has occurred. Inconsistencies in the record are present.

APPORTIONMENT

I feel the lower back pain disability is entirely apportioned to a non industrial injury. No medical records from her primary treating physician substantiate her history of lower back pain that began after she was seen by Dr. Paplampu. If further medical records, become available I would reserve the rights to change my opinion.

FUTURE MEDICAL CARE

Conservative care, including anti-inflammatory medications, a gym membership to perform exercises that she has learned from the occupational therapist for her hands and neck. I do feel she is entitled to 2- 4 visits to a occupational therapist to teach her exercises that she can do on her own, in a gym membership. A 6 month membership should suffice.

Regarding the CTS diagnosis, she may need further NCV studies in 6 months to 1 years time, if she does not improve.

RETURN TO WORK/VOCATIONAL REHAB STATUS

She is able to perform the duties of her present position.

Consistent with WCAB Rule 16063, I certify that the history and physical examination was conducted and dictated in its entirety by Jonathan S. Rutchik, MD, MPH. All conclusions and opinions within this report are solely mine.

This report is for medical-legal assessment and is not to be construed as a complete physical examination for general health purposes. Only those symptoms which I believed to have been involved in the injury or might relate to the injury, have been assessed.

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 to 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. The foregoing declaration is dated and signed in Mill Valley.

In accordance with Labor Code 5703 (a) (2), there has not been a violation of Labor Code 139.3 and the contents of this report are true and correct to the best of my knowledge. This statement is made under penalty of perjury. Pursuant to 8 Cal. Code Regs. Section 49.2-49.9, I have complied with the requirement for face to face time with the patient in this evaluation.

Very truly yours,

Jonathan S. Rutchik, MD, MPH
Board Certified in Occupational and Environmental Medicine
Board Certified in Neurology