INDEPENDENT MEDICAL EXAMINATION

I have had the opportunity to examine for the purpose of independent medical examination, Mr. John Doe. He was seen in my office at 38 East 32nd Street in New York on February 26, 2015. It was reviewed with Mr.John Doe that the sole purpose for the examination was that of independent assessment and that no doctor-patient relationship was to be established. Additional records were provided for review and will be reviewed in their entirety at the end of this report.

1. BACKGROUND HISTORY: Mr.John Doe is a 25-year-old African American man without history of cigarette smoking and without previous pneumonia, pleurisy or tuberculosis exposure. Mr.John Doe as a child had repeated episodes of "bronchitis" for which he was provided an inhaler on occasion. He did not have the need for steroids, was not limited in his ability to participate in activities and was not hospitalized. He had no regular exposure to cigarette smoke and had no pets, nor had he used inhaled recreational substances at any time. He was fully physical active playing basketball on a regular basis without limitation by his respiratory status.

2. HISTORY OF ACCIDENT: The claimant worked in Housekeeping at Bellevue Medical Center without regular exposure to excessive amounts of chemicals, fumes, sprays or dust. He was regularly exposed to cleansers without respiratory or other difficulty as part of his job. On November 1, 2013, he entered a room and noted a strong and unusual smell, which he stated was related to a chemical used to sanitize dialysis machine. Nobody else was in the room at the time though he stated that other individuals had complained about the presence of that smell, and that it had not been cleaned up in a timely fashion. He became uncomfortable regarding his eyes and "lungs". From the box that was in the room, he believed the material to be acetic acid. **3.** Because he had such a great deal of difficulty with his breathing and coughing, he was hospitalized at Bellevue Hospital for two days. He was given frequent nebulizer treatments and discharged. By his description, he was seen again at Bellevue for respiratory difficulty including shortness of breath and then in a hospital closer to his home, the Franklin Division of Long Island Jewish Medical Center. He was referred to a pulmonary specialist and treated with antibiotics. He has seen

by a physician on several occasions and has been on medication since then without having tried to resume exercise.

4,5. RESPIRATORY SYMPTOMS: He wheezes and coughs with significant exertion on exposure to cold air. He uses a rescue inhaler once to twice per day on a regular basis. He has been able to resume work as a truck driver, able to work within limitations noted above.

6. PAST MEDICAL HISTORY: He is unaware of hypertension, diabetes or heart disease.

7. MEDICATIONS: He is currently on loratadine daily, theophylline (dose unknown), montelukast once daily, Ventolin two puffs each morning plus on an as needed basis, Symbicort (dosage unknown) two puffs every 12 hours, fluticasone nasal spray two sprays each nostril daily and sumatriptan.

8. FAMILY HISTORY: There is no significant pulmonary disease of symptoms in his family that he is aware of.

9. SURGICAL HISTORY: He has not had significant surgery.

10. REVIEW OF SYSTEMS: His weight has been stable. He has his eyes checked periodically and does not have glaucoma. He has not recently sinus infections or congestion. He has no palpitations and is unaware of heart murmurs. He is not aware of heartburn of indigestion, trouble swallowing or sensation of food becoming stuck. Bowel habits are regular. He has no urinary difficulties, joint aches or pain, rashes, or tingling in the hands or feet. He did not comment when asked regarding frequent headaches.

He has no medication allergies and is unaware of other allergies. He has no pets. He does not drink alcohol and as stated has not used inhaled recreational substances.

11. PHYSICAL EXAMINATION: He is well-developed muscular male without respiratory difficulty moving about the office or on dressing and undressing. Vital signs included blood pressure 124/90 taken on the right arm, heart rate was 72 and regular, weight of 195 pounds and height of 73 inches, and oxygen saturation measured on rest on air was 95%. His eyes were anicteric. His nasal mucosa was fleshy and injected without visible secretions. The pharynx was without thrush, no significant injection or secretions. The neck was without

thyroid enlargement, mass or adenopathy. Lung fields were symmetrically expanded and clear without rubs, rales, rhonchi or wheezes. The abdomen was soft and nontender. There is no clubbing, cyanosis or edema of all four extremities. Gait and station were normal as were deep tendon reflexes. There are no obvious rashes noted.

12. PULMONARY FUNCTION STUDIES: Pulmonary function testing performed at the time of the examination (Knudson) revealed a mild restrictive disorder. Spirometry revealed mild symmetric reduction of airflow with bronchodilator responsiveness. There was no secondary hyperinflation or gas trapping. It is noted that there was some difficulty with the test as the patient began to cough with forced exhalation. The contour of the flow loop suggested the presence of variable extrathoracic obstruction with upper airway flow limitation. Increased upper airway sounds were noted with repeated effort. The pulmonary diffusing capacity was within normal range.

13. OUTSIDE RECORDS PROVIDED FOR REVIEW

- 11.12.2013. Dr. Martin Gillman. Doctor's Progress Report. C–4.2. Diagnosis: Exposure, NAC.
- 11.18.2013. Dr. Allen Small. Diagnoses: Exposure, "chemicals," discomfort, tightness in chest, "headache".
- **11.22.2013. Shashi Patel, M.D. Pulmonary** Medicine Critical Care, Sleep Medicine Hospitalist. A consultation letter to Dr. Small describes a visit of the above date. It is stated that Mr.John Doe worked at Bellevue Hospital in the "Environmental Care Department". On 11-01-13, there were noted "fumes coming from a container, which caused irritation of the eyes" with that container placed in a garbage pail which was handled by the patient. Mr.John Doe developed irritation of his eyes, nose, throat, and chest tightness and was evaluated in the emergency room. He was given intravenous steroids, eye drops and nebulizer treatment and kept overnight and discharged. On 11.24.13, he remained symptomatic and was seen at Long Island Jewish Hospital. Because of difficulty breathing, chest tightness and phlegm, he was treated with Ventolin and prednisone at home, taken for days. The patient was seen on 11.28.2013 for "phlegm, chest tightness, difficulty breathing, nasal burning, congestion and burning in the eyes with "blurry

vision." The patient described bronchitis from early childhood to age 10 with inhaler provided with mild seasonal allergies as well. He has described again as a nonsmoker without other relevant history. There was nasal mucosa congestion and "harsh breath sounds" with moderate posttussive bronchospasm. No rales, rhonchi, or congestion were noted. The remainder of examination was normal and spirometry "shows small airways disease with 19 to 46% bronchodilator response, which is significant". It was Dr. Patel's impression that the patient "most likely had childhood asthma and has seasonal allergies, eczema, and a family history of allergies, developed the acute bronchospastic disease with rhinitis as a result of exposure to acid fumes. He prescribed Symbicort 160/4.5 two inhalation twice a day, fluticasone nasal spray and asked the patient to return for followup with a plan to use systemic corticosteroids if there is no response.

- 11.27.2013. The patient presented with headaches and facial pain.
- Doctor's Initial Report – C-4 Diagnoses: Concussion with glaucoma, concussion-brief, and concussion-moderate.
- 01.21.2014. MRI of brain without contrast revealed "no acute intracranial pathology or mass.
- 01.30.2014. Follow-up evaluation regarding "improved tremor and occasional headaches."
- **03.12.2014. Stuart Stauber, M.D.** Pulmonary Medicine. Independent Internal Medicine Evaluation. The doctor described the November 1, 2013 accident as the claimant's "face and chest" came into contact with acid after working with dumpster full of acid. The subsequent events similar to that outlined above. Mr.John Doe was at the time of that examination on albuterol inhaler, "pills," eyedrops and headache medication. Symptoms at the time of the doctor's assessment including cough, phlegm, chest tightness and shortness of breath, dry and itchy eyes, headaches and nasal burning. The examination revealed clear ENT and pulmonary findings. It was the doctor's diagnosis of "status post work-related acid exposure," posttraumatic headaches, headaches, reactive airways disease and dry eyes. It was his assessment as well that there appeared to be "a cause and effect relationship between the injury sustained and the work-related incident reported." It was his assessment that the claimant be seen by a pulmonologist once every two to three months for the next six months without need

for “any further diagnostic testing.” He was found to have a “mild temporary disability secondary to injury sustained of the work-related incident of November 1, 2013.” He stated that the claimant would be able to return to work on a full-time basis and should avoid respiratory irritants.

- **03.17.2014. Shashi Patel, M.D.** in a report to Dr. Small, it is stated that Mr.John Doe was feeling “a little better” with cough and phlegm couple of times a day with wheezing, “but much less than before.” His breathing had improved. His physical examination was unremarkable including clear lung fields. Pulmonary function studies performed on 02.14.14 revealed an FEV1 of 55% with 18% bronchodilator response. It was Dr. Patel’s impression that the patient “has developed moderately severe persistent asthma after being exposed to acid fumes at work place.” He stated that his condition “has progressively worsened and he has had three course of prednisone since November, now his condition seems to be stabilizing.” He asked that Mr. John Doe remained on Symbicort 160/4.5 to twice a day, Singulair 10 mg a day, prednisone 5 mg a day, and Claritin with fluticasone nose spray. Followup evaluation two weeks later would be performed with decision about the ability to return to work.

14. IMPRESSION: Mr. John Doe provides a history of significant exposure to noxious fumes on the date of accident outlined above. He had early on significant and pronounced upper and lower respiratory symptoms including nasal/sinus irritation and airway hyperactivity. He is maintained at the present time on numerous bronchodilators (Symbicort and theophylline) as well as anti-allergy medications (Loratadine and montelukast). The headaches and dry eyes described are outside of the expertise of this reviewer and I will not comment on those areas.

The following considerations are noted regarding his pulmonary/ respiratory status:

- There is a significant past history of respiratory symptoms predating the above event
- There are no provided pulmonary function studies for review
- There are likewise no radiographic images for review as may include or exclude bronchial tube inflammation, thickening

or damage likewise to include/ exclude lung tissue inflammation or scarring

- His initial assessment did not emphasize asthma or other respiratory findings
- He was not kept in the hospital after his initial presentation at his own institution
- Pulmonary testing performed at the time of this examination do not reveal significant airway abnormality. This would be expected even though he is on bronchodilator as he remains symptomatic
- There is suggested upper airway inflammation, as may be seen in esophageal reflux and other disorders. No GI evaluation is described.
- Additional information including spirometric findings taken early on in the claimant's history requested for review.

15. CONCLUSION: Vis-a-vis his **degree of disability**, it is at this time mild, as he is able to work as a truck driver though he should avoid exposure to noxious fumes, vapors, dust and extremes of temperature.

With the information provided, the present **treatment** should stay in place.

Regarding his **ability to return to work**, it is noted that he is working at the present time. Regarding the permanency of his disability and need for treatment, that would depend on more specific diagnosis to be determined. Such would be obtained from acquisition of earlier studies and assessment of his upper airway and restrictive disorder.

Respectfully submitted,
DK