

August 08, 2003

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CONFIDENTIAL ATTORNEY WORK PRODUCT

Re: xxxxx, xxxxx

Dear Mr. xxxxxxxx,

Thank you for allowing Medically Speaking to assist you with the medical record review concerning xxxxxx xxxxxx. **Please note, no medical records were provided for review prior to the date of loss.**

On January 27, 2002, Mr. Xxxxx was involved in a motor vehicle accident. According to the Basic Life Support Field Report (p. 2), vital signs were within normal limits with the exception of a slightly elevated blood pressure. He was found to have an abrasion to the bridge of his nose and both hands. Mr. Xxxxx was primarily complaining of left-sided chest pain with respirations in the seatbelt area. Breathing, circulation, temperature, and color were all within normal limits. The Glasgow coma score was 15 out of a possible 15 indicating Mr. Xxxxx had normal mental status. On secondary survey, chief complaints were neck and chest pain.

Mr. Xxxxx was described as a restrained driver of a vehicle with front-end damage, but no interior damage to the vehicle. The air bag deployed; however, later hospital records document no air bag deployed. **Therefore it is not entirely clear whether an air bag deployed or not.**

Mr. Xxxxx was transported to the Emergency Room at xxxxxxxx Hospital. He stated his past medical history was positive for a C5 fracture, left elbow surgery and an episode of encephalitis/meningitis. **Due to the encephalitis/meningitis, there is a chance he may have had some residual brain injury as a result of these disease processes. Unfortunately, no further information is provided to determine if Mr. Xxxxx had chronic neck pain post C5 injury or residuals as a result of the infectious process.**

According to the emergency flow sheet, oxygen saturation remained between 99% - 100%. Glasgow

coma score also remained normal throughout, with a Glasgow coma score of 15 with no documented mental status changes or other neurological changes. **This would rule out any significant claims of head injury as a result of this date of loss.**

On examination, Mr. Xxxxx complained of shortness of breath and pain on breathing. He rated his pain as moderate, at 5/10. Blood alcohol level was drawn and returned essentially negative, (p. 264). Chest x-ray at the time of admission revealed mild congestive heart failure. **Although we have no predate of loss medical records (p. 252), this finding raises questions of preexisting heart disease or other cardiac process which could be contributing to his complaints of shortness of breath residuals post date of loss.**

CT of the lungs (p. 245) showed evidence of sternal fracture. The chest was otherwise negative.

CT of the maxillofacial bones was negative (p. 246).

X-rays of the sternum revealed a fracture of the upper aspect of the sternum (p. 248).

CT and plain films of the cervical spine (p. 249-250), were essentially negative with the exception of degenerative changes.

Thoracic and lumbar spine (p. 251) was negative with the exception of degenerative changes.

CT of the brain (p. 242) was entirely normal with the exception of bilateral maxillary sinus disease.

CT of the abdomen and pelvis was essentially negative (p. 247).

Neurosurgery and cardiology consults were requested to rule out significant central nervous system condition or cardiac contusion due to the fractured sternum. In the meantime, Mr. Xxxxx was placed in an Aspen collar to protect his neck.

Post evaluation, Mr. Xxxxx was subsequently transferred to the intensive care unit. According to the nursing admission assessment, Mr. Xxxxx wore glasses and had hearing aids at home. According to the nursing admission assessment, he rated his pain between mild and severe at 2-8/9. He reported taking Advil or aspirin prior to the date of loss and Maalox occasionally once a week. **Therefore, it would appear he had some pain symptoms if he was requiring Advil or aspirin prior to the date of loss.** He gave a history of heavy alcohol consumption apparently he quit drinking 20 years previously. He also had a smoking history averaging 2½ - 4 packs per day over the previous 50 years!

While in the ICU, his Glasgow coma score and neuro checks were within normal limits. Mr. Xxxxx was placed on morphine PCA (patient controlled analgesia) for pain control. The nurse's note documented complaints of chest pain, which increased with deep breaths.

Echocardiogram was obtained to rule out cardiac contusion. The study was essentially negative for

acute findings (p. 232-234) and for signs or symptoms consistent with cardiac contusion. According to the cardiology consultation (p. 63), the monitor showed normal sinus rhythm. The chest CT showed no pericardial effusion. The EKG showed no ST or T changes and no evidence in spite of the mild congestive heart failure noted on the initial x-rays of cardiac contusion. The plan was for serial EKGs and cardiac markers for 24 hours. **Please note, cardiac markers were drawn for 24-hour period as oftentimes, cardiac enzyme elevations may be delayed post trauma.**

The cardiologist also noted (p. 37-39) Mr. Xxxxx stated his vehicle did not have air bag, which contradicts the emergency medical services records which stated the air bag did deploy. Mr. Xxxxx reported he quit smoking in April 2001, but prior to this period of time he smoked for 50 years, one to four packs per day. He told the cardiologist he was not taking any medications at home which conflicts with the nursing admission assessment in which he stated he took aspirin, Advil, or Maalox as needed. The examination revealed an oblique bruise over the right abdomen secondary to seat belt trauma.

A repeat chest x-ray showed no acute disease in the chest (p. 241).

According to the history and physical of Lisa xxxxxx, M.D. (p. 34-35), the reasons for admission were:

1. Chest contusion.
2. Sternal fracture.
3. Rule out cardiac contusion.
4. Pulmonary contusion.
5. Pulmonary effusion.
6. Nasal laceration.

Please note there is no documentation of head trauma in the initial history and physical.

According to Dr. Xxxxx's dictation, Mr. Xxxxx was driving in the rain and had some "problems with his frontal defoggers and then subsequently hit another vehicle head-on at a slight angle." **This may raise questions concerning liability or comparable negligence.** The car then spun out and proceeded to hit the median at a relatively high speed somewhere around 60 to 70 miles per hour." Mr. Xxxxx specifically denied loss of consciousness at the scene and his primary complaints were of chest pain in the sternal area with difficult respirations.

The following morning, Mr. Xxxxx reported he was feeling well except for anterior chest pain. He was alert and oriented with pupils equal and reactive to light, moving all extremities spontaneously to command with some decreased breath sounds at the bases (p. 65)

Mr. Xxxxx was seen in neurosurgical consultation by Dr. Jeffrey xxxxx (p. 20-21). The report indicated, Mr. Xxxxx was wearing a seat belt but the air bag did not deploy. He suffered blunt chest injury and was being treated for cardiac contusion. According to the history, Mr. Xxxxx was awake, alert, and fully oriented according to the pre-hospital care records, as well as post emergency

records. His neck was found to be in normal limits.

At the time of this examination, Mr. Xxxxx was awake, alert and oriented. He had no complaints of neck tenderness. The physical examination was essentially negative. The physician noted the CT of the head was essentially negative. CT of the cervical spine, although showed no fracture or subluxation demonstrated a significant spondylosis at the C5-C6 area with bone spur formation and degenerative changes which likely were related to the previous C5 fracture site. The impression was cervical spondylosis and degenerative changes with whiplash symptoms resolving, closed head injury with mild concussion, **even though there appears to be no evidence of concussion, it appears Dr. Xxxxx is just basing the diagnosis of concussion on the mechanism of injury.** Dr. Xxxxx gave orders to discontinue the Aspen collar, physical therapy for range of motion and occupational therapy consult. Dr. Xxxxx cleared Mr. Xxxxx for transfer out of the ICU from a neurological standpoint.

Mr. Xxxxx remained in the ICU due to pulmonary concerns. He had some difficulty voiding and in and out catheterization every six hours was ordered as needed. The nurse's notes described Mr. Xxxxx as steady on his feet, complaining of 3-4/10 mid-chest and sternal pain (p. 174).

Shortly after midnight, Mr. Xxxxx had an episode of desaturation and was placed on oxygen via nasal cannula at 2 liters. The nurse heard wheezes in all lung fields of new onset. The head of the bed was elevated and respiratory therapy treatment was started. Mr. Xxxxx had improvement in oxygen saturation and went back to sleep. Repeat chest x-ray was xxxxxly stable with no acute infiltrate.

The 0400 hours nurse's notes of January 29, 2002 (p. 174), described Mr. Xxxxx had wheezing with any exertion. The nasal cannula was changed to humidified cool mist mask and he was subsequently saturating within normal limits at 99%.

Due to elevated blood sugar noted at the time of admission, a hemoglobin A1c was performed which was a blood test that is reflective of blood sugar values over the previous three to four months. This test was only slightly elevated at 6.6 (p. 278).

Apparently a repeat chest x-ray appeared whiter and fluffy, which usually indicates fluid build up in the lungs, although there is a possibility this could be consistent with contusion, an argument can be made this was a representative of possible congestive heart failure based on the fact there were x-ray signs of mild congestive heart failure at the time of admission, and the fluid replacement being administered during this admission could surely push Mr. Xxxxx over the edge and into congestive heart failure in this setting. Incentive spirometry was ordered every hours while awake, to help inflate the lungs. The physician was advised of the x-ray findings and appropriately prescribed Lasix, a diuretic to help off load fluid. Lasix is used in the presence of pulmonary edema/congestive heart failure. Low sodium and low cholesterol diet were ordered.

At 1015 hours, Mr. Xxxxx reported mild short of breath with positive chest pain at the impact site. He was saturating within normal limits at 99% and had mild expiratory wheezing. The cardiologist reiterated there was no evidence of cardiac contusion but there “may be” pulmonary contusion and agreed with diuresis.

Mr. Xxxxx was reevaluated by the neurosurgeon (p. 67), he was described as awake and alert, having denying complaints of neck pain. His neck was nontender.

Dr. Xxxxx's note of the same date (p. 68) indicated Mr. Xxxxx was without complaints except for marked pain with respirations. She questioned the presence of mild congestive heart failure.

Cognitive evaluation was performed (p. 86-87), the study was within normal limits with no evidence of cognitive impairment as a result of the date of loss.

According to the physical therapy assessment (p. 90), Mr. Xxxxx was functioning as follows:

Bed mobility, minimal assistance. Supine to sit, minimal to moderate assistance. Transfers, contact guard assistance. Balance, good+. Mobility assistance, contact guard assistance, for 3 feet with front-wheeled walker for weightbearing. Motor: Range of motion within functional limits knee and below. Left hip flexion 4+, remaining within functional limits. Right hip strength 4, remaining within functional limits. Neck, trunk, ankle, elbow, shoulders, wrist, hands, toes within functional limits.

The following day, January 30, 2002, Mr. Xxxxx was doing “okay,” with continued complaints of mild shortness of breath. His oxygen saturation was within normal limits at 97% on the 40% face mask. He was described as “looking well.” The lungs contained expiratory wheezes. The impression was pulmonary contusion according to the cardiologist. The cardiologist felt he was okay to discharge to the floor. **Please note, the x-rays reports available do not appear to document findings consistent with pulmonary contusion and it appears on the surface these symptoms are consistent with and could very likely be related to congestive heart failure. If there are questions in this regard a chest radiology film review may be of benefit to help resolve the issue.**

According to Dr. Xxxxx' progress notes of January 30, 2002, Mr. Xxxxx complained of a stiff, but nontender neck. He continued to complain “it was hard to breathe.” Additional doses of Lasix were administered. Orders were given to transfer to the surgical floor without continuous heart monitoring. A repeat chest x-ray (p. 254) showed increasing fluid accumulation in the left hemithorax.

Dr. Xxxxx's progress note (p. 69), documented a low-grade temperature and a cough productive of yellow green sputum. She described the chest x-ray looked “wet.” Bilateral pleural effusions were present left greater than right and Mr. Xxxxx was complaining of persistent sternal pain. He was saturating, however, within normal limits at 96% to 98% on a 40% face mask with decreased lung sounds at the bases bilaterally. Mr. Xxxxx, however, was out of bed with minimal assistance with physical therapy using a front-wheeled walker for 100 feet with contact guard assistance. Sputum

cultures for sensitivity, and gram stain were sent. Mr. Xxxxx was described as having a good appetite. He continued to use the morphine PCA as needed for pain complaints.

At 1600 hours, Mr. Xxxxx was transferred out of the ICU on oxygen at 2.5 liters by nasal cannula. He was saturating within normal limits at 98%. The nurse auscultated expiratory wheezes in all lobes. Mr. Xxxxx denied complaints of pain at that time. The nurse's notes reflect Mr. Xxxxx's only complaints were pain on inspiration. He had faint expiratory wheezes bilaterally.

On January 31, 2002, Dr. Jeffery Xxxxx' note (p. 71), indicated Mr. Xxxxx described his neck stiffness was at "baseline" **confirming Mr. Xxxxx had preexisting neck stiffness and/or other neck symptomatology.**

Due to voiding difficulties, a Foley catheter, which was previously placed due to voiding difficulties, was discontinued and Mr. Xxxxx was advised that he may shower. The nurse's were also ordered to wean off the oxygen if tolerated. Mr. Xxxxx was instructed to cough and deep breathe, and use incentive spirometry. Respiratory therapy treatments continued to be performed and wheezing was still noted throughout the lung fields, which cleared with treatment. Oxygen saturation was within normal range between 96% - 100%.

Repeat chest x-ray on February 01, 2002 (p. 255), found an increase in consolidation and effusion at the left base compared to the previous study.

Dr. Jeffery Xxxxx' progress note from the above date (p. 72), indicated Mr. Xxxxx was complaining of shortness of breath. His neck was better but he still had decreased range of motion, **but given the degree of spondylosis and lack of symptomology, this was likely normal for Mr. Xxxxx.** He denied neck or arm symptoms. He was found to be stable and again his neck was noted to be at "baseline." Range of motion was within functional limits. Strength in shoulders was rated as 3+/5 bilaterally. Elbows to fingers strength was 4/5 bilaterally. The sensation was not tested. Tone was described as being within functional limits with a grip of 4/5 bilaterally. He was essentially independent with feeding, hygiene, and grooming.

According to the nurse's notes, Mr. Xxxxx was described as being "hard of hearing." There was no indication if his hearing aids were brought to the hospital for his use. The nurse's apparently had tried to wean the oxygen off and Mr. Xxxxx had a drop in oxygen saturation to only 91% on room air. He was placed back on 2 liters and was saturating at 97%. Wheezing and rhonchi were present in all lung fields. He was helped up to the chair and was described as being a little weak on his feet and the nurse did not feel he was safe for a shower at the current time due to the weakness, as well as drop in oxygen saturation when the oxygen was removed.

The occupational therapist (p. 179) described Mr. Xxxxx as easily short of breath or desaturates. He was requiring oxygen at 2 liters/minute by nasal cannula. He was placed up in the chair. In spite of the shortness of breath, he was able to transfer to the bed with standby assistance and ambulate 300 feet with a front-wheeled walker with oxygen at 4 liters/minute. Mr. Xxxxx reported pain levels in the range of 3-5/10 while on the PCA (p. 180).

The nurse's notes in the early morning hours of February 02, 2002 (p. 180-181), reflect wheezes throughout the lungs fields. Mr. Xxxxx continued to receive respiratory therapy treatments every four hours and was encouraged to cough and deep breathe. He was saturating between 94% and 96% (normal) on 3 liters of oxygen. He continued to have a productive cough. He denied shortness of breath at rest. Mr. Xxxxx reported he was feeling better. The plan was to discontinue the morphine PCA and start oral pain medications.

The echocardiogram was repeated (p. 236-237) and again negative for acute changes. Repeat chest x-ray was stable showing a small left pleural effusion (p. 256).

With physical therapy (p. 180), Mr. Xxxxx required essentially contact guard - minimal assistance and was able to ambulate for 300 feet with a front-wheeled walker. Occupational therapy (p. 180) issued Mr. Xxxxx a Reacher for socks and lower body dressing and toileting. He essentially required minimal assistance for lower body dressing, standby assistance for toileting, and was independent with perineal care.

On February 03, 2002, orders were given to begin discharge planning. Mr. Xxxxx was afebrile. Vital signs were stable and his chest was clear (p. 73).

According to the nurse's notes, Mr. Xxxxx had ambulated 500 feet x 1 with a front-wheeled walker and contact guard assistance to the bedside chair with standby assistance. Mr. Xxxxx complained of discomfort in the lungs and chest but refused any pain medication. Lung sounds were diminished in the bases and wheezes were noted on the left side. He complained of some shortness of breath on exertion with a productive cough of thick yellow green secretion. Chest x-ray showed bilateral pleural effusions and infiltrates, left greater than right.

According to the physician's progress notes (p. 74), Mr. Xxxxx was described as doing well; however, was still having episodes of shortness of breath. Apparently, he was refusing his nebulizer treatments, which caused an increase in symptoms. The lungs were noted to have a few rhonchi, left greater than right. The physician advised to increasing activity. There was some speculation on the above date that Mr. Xxxxx would require oxygen for home use.

The physical therapist (p. 182) indicated Mr. Xxxxx was able to transfer in and out of bed with standby assistance. He ambulated 270 feet with a front-wheeled walker on oxygen of 4 liters of oxygen. He was slightly short of breath with ambulation. Oxygen saturation prior to ambulation was 91% and after ambulation 95% while on oxygen.

On February 04, 2002, the nurse's notes at 1245 hours (p. 182) reflected Mr. Xxxxx was on 2 liters of oxygen with head at the bed elevated. He was short of breath and unable to speak a complete sentence clearly because his respirations were labored. Respiratory therapy was notified and stated Mr. Xxxxx had denied treatment earlier that morning. The nurse stressed to Mr. Xxxxx the necessity of treatment and he complied. Post treatment, he was under less stress with breathing with oxygen saturation at 94%. However, he continued with shortness of breath. He complained of pain

in the anteroposterior area of the chest with stabbing pain. Vicodin was given with relief.

Pulmonary consultation was requested and performed by Dr. George XXXXXXXXX on February 05, 2002 (p. 40-42). According to the pulmonary consultation (p. 40-42) the impression was:

1. Blunt chest trauma.
2. Sternal fracture.
3. Pleurisy.
4. Left pleural effusion.
5. Tobacco abuse.
6. Reactive airway disease with significant restrictive dysfunction related to above.

According to this consultation, the day prior, Mr. XXXXX developed a bout of pleuritic chest pain in the left scapula and some vague pain noted in the left anterolateral chest. Initially, the anteromedial chest pain was reproduced by an external chest wall pressure. He episodically felt dyspneic (breathless) as if there was mucus stuck in the middle of his windpipe that he was unable to clear. He occasionally coughed producing yellowish mucus. He stated prior to the hospitalization, he was on no medications. While hospitalized, he was receiving Vicodin for pain, Protonix for stomach prophylaxis, oxygen, and inhaled therapy from IPPB. He gave an additional surgical history of hemorrhoidectomy, which was something that he did not mention previously.

On examination, he was saturating within normal limits. However, throughout the conversation, he intermittently desaturated while talking and felt somewhat dyspneic (breathless). He had occasional use of accessory muscles with respirations, increased anterior posterior diameter, and mild prolongation of the expiratory phase. Breath sounds were diminished at 1/4th of the way up on the left with dullness to percussion and decreased diaphragmatic excursion, left greater than right. There was some anterior chest wall tenderness in the region of manubrium sterni.

Respiratory cultures were unremarkable, consistent with normal flora. Chest x-ray showed borderline cardiomegaly (enlargement of the heart) with mild flattening of the diaphragm with haziness at the left base. CT scan confirmed presence of bilateral effusion left greater than right.

In summary, Mr. XXXXX was noted to have dyspnea and an ineffective cough.

The subsequent occupational therapy note (p. 183), documented Mr. XXXXX required standby assistance to the edge of bed and verbal cues for lower body dressing. He was noted to have decreased shortness of breath with activities of daily living but was still on 3 liters of oxygen. With physical therapy, he was ambulating for 400 feet with a front-wheeled walker with oxygen of 4 liters. Repeat chest x-ray was thought to show a small left-sided pneumothorax, which was not confirmed on later CT.

At 0145 hours on the morning of February 05, 2002 (p. 183), Mr. XXXXX was medicated with Vicodin for complaints of chest pain with relief. He was described as sleeping at long intervals. He continued to receive respiratory therapy every four hours. Oxygen saturation was ranging from 95% to 97% (normal). Lung sounds improved with treatment.

Repeat chest x-ray showed bilateral consolidation and effusions left greater than right (p. 260). At 0900 hours (p. 74), Mr. Xxxxx seemed short of breath. Due to symptoms and question of possible pneumothorax, arterial blood gases, chest x-ray and pulmonary evaluation were ordered.

The pulmonary consult was performed by Dr. XXXXXXXXX. He ordered a ventilation perfusion scan to rule out pulmonary embolism (blood clot) as the cause of the symptoms. He also ordered pleural fluids for culture and sensitivity. Lovenox was ordered as a blood thinner in case there was a pulmonary embolism. Xopenex and Atrovent every four hours were ordered for respiratory therapy treatments by hand held nebulizer along with Mucomyst 1 cc 10% every treatment.

Interventional radiology performed an ultrasound of the chest; however, no significant drainable fluid collection was found on the either side. High resolution lung scan showed bilateral pleural effusions, bibasilar atelectasis, and fractured sternum with no evidence of pneumothorax. Bilateral lower extremity venous ultrasound turned out normal (p. 261). Ventilation perfusion scan returned with low probability for pulmonary embolism (p. 262). Spirometry (p. 238) reflected a mild obstructive defect with significant response to bronchodilators. There was moderate reduction in vital capacity.

In spite of the above complaints, Mr. Xxxxx ambulated independently with physical therapy 300 feet with standby assistance with oxygen of 4 liters. His gait was steady. He complained of some shortness of breath with ambulation. Saturation before ambulation was 95% and after ambulation with oxygen saturation was 91%. The nurse's notes reflect Mr. Xxxxx complained of some increased shortness of breath with activities.

Advair was added to the medication regimen on February 06, 2002 (p. 58). Mr. Xxxxx continued to complain of severe dyspnea (breathlessness) and orthopnea (positional shortness of breath). Dr. XXXXXXXXX diagnosed pneumonia, pleurisy, and hypoxia (p. 77). Nevertheless, the note of p. 78 documented Mr. Xxxxx was actually better, tolerating his diet, although he still had some shortness of breath. Mr. Xxxxx was medicated for pain at 0700 hours with good relief. He continued with wheezes in the upper anterior chest and crackles audible throughout all lobes. The oximetry was ranging between 93% - 95% (normal).

The physical therapist found Mr. Xxxxx was ambulating independently for 600 feet with an assistive device slightly short of breath with ambulation. Mr. Xxxxx was discharged from physical therapy on February 07, 2002. Discharge planning was initiated for possible oxygen requirement post discharge. Vicodin was effective for relief of sternal pain.

On February 07, 2002, orders were given to wean the oxygen and continue with the albuterol as needed. According to the nurse's notes on a pain scale from 1 to 10, Mr. Xxxxx reported his pain as 6/10. He continued to complain of pain in the chest and sternum area. He received relief from the medications. It appears that sternal pain was basically Mr. Xxxxx's only pain complaint.

Mr. Xxxxx was taught by respiratory therapy how to use the respiratory inhalers. An ambulating desaturation study was ordered. PaO₂ returned at 53 (low) with saturation low at only 88%. It was felt Mr. Xxxxx qualified for home oxygen use at 2 liters/minute.

On February 08, 2002, Mr. Xxxxx was discharged to home. Since he had no insurance he would be responsible for the \$197 cost of the oxygen setup for home use. He was also given a voucher for \$100 to put towards his medications.

According to the discharge summary (p. 30-31), Mr. Xxxxx was discharged with Darvocet-N 100 for pain, oxygen 2 liters by nasal cannula, Advair, bronchodilator, steroid, and albuterol. Home care was arranged for delivery of oxygen through Option I.

A repeat chest x-ray on February 11, 2002 showed no significant pleural effusion on either side (p. 263). **There is no associated office visit associated with this film.**

On February 18, 2002, Mr. Xxxxx was evaluated by Dr. Lisa Xxxxxx. Mr. Xxxxx reported (p. 334), shortness of breath with walking as well as with activity. He continued to complain of chest wall tenderness centrally left and right with positive chills. Bending over "hurt." He was eating okay, but had lost 8 pounds since the accident. Breath sounds were distant, but clear lungs bilaterally. The assessment was consistent with pulmonary contusion and sternal fracture. He would follow up with the pulmonologist closer to home.

Mr. Xxxxx presented to University of California, Irvine on March 26, 2002 (p. 347), for evaluation. He was now reporting a closed head injury and was "feeling well," but complaining of "stuttering voice since accident." He now denied shortness of breath or chest pain. **A follow-up chest x-ray showed resolving pleural effusion. He was advised neurology follow-up. Please note, this is the first mention of stuttering post date of loss. The hospital admission records reflected no significant head trauma as a result of the date of loss and all central nervous system assessments were negative immediately post date of loss.**

The following day, Mr. Xxxxx was seen for a pulmonology visit (p. 351). He admitted to a tobacco history and reported shortness of breath and needing oxygen. **He denied shortness of breath according to the previous visit.** He also was complaining of stuttering when he talked. He claimed the stuttering had been present since the motor vehicle accident. While talking oxygen saturation was 98 to 99% (normal.) He denied a past medical history. He now reported being short of breath only with talking. He denied chest pain with exertion. Pulse oximetry was 99% on room air at rest, not talking, and talking, and 95% with exertion. The assessment was shortness of breath of questionable etiology. He was advised to discontinue the oxygen and referred to neurology for evaluation of the stuttering. Ibuprofen was ordered 90 tablets one three times per day as needed, (p. 434). A repeat chest x-ray (p. 425) showed the following:

Pleural calcification on diaphragmatic pleural surface left lung, which may be related to previous asbestos exposure. Correlate clinically, no evidence of acute cardiopulmonary disease appreciated.

On April 02, 2002, xxxxxx I picked up the oxygen supplies (p. 326).

A pulmonary function test from April 08, 2002 (p. 403) found mild restriction.

Mr. Xxxxx failed to keep his April 22, 2002 appointment (p. 360).

On May 08, 2002, Mr. Xxxxx was seen for pulmonary evaluation (p. 362) for complaints of shortness of breath and “stutter.” Spirometry was consistent with obstruction. He had expiratory wheezing audible without auscultation (using a stethoscope). The impression was acute bronchitis/bronchospasm, COPD, and stutter consistent with anxiety due to the accident. Prednisone was initiated on sliding scale with antibiotics and Serevent. He was advised to follow up in three to four weeks.

The attending physician note from the above exam, documented oxygen saturation was 95 to 99% on room air. Mr. Xxxxx claimed he had a bruise to his heart and lungs; **however, a bruise to the heart is not supported by the hospital records.** He complained of positive shortness of breath mainly with exertion and talking but the symptoms resolved with rest. He denied shortness of breath with walking. He claimed stuttering since the accident. Wheezing since the accident was described as “rare.” He complained of positive chest pain with rest that was sharp for minutes at a time. Interestingly, he reported positive asbestos exposure. The physician felt some of the symptoms maybe related to chronic obstructive pulmonary disease due to his cigarette smoking.

It appears the symptoms of shortness of breath have changed and progressively increased since the first denial of pulmonary symptoms at the time of the first post hospitalization follow-up. Mr. Xxxxx has a significant pulmonary history in spite of his denials, in the sense that he has both asbestos exposure and smoked excessive amounts of cigarettes; up to 4 packs per day! Given the asbestos history, one wonders if he filed any claims for compensation through the military or privately. If so, then there may be some previous medical information to use to compare with his current complaints.

On May 10, 2002, Mr. Xxxxx now claimed worsening hearing loss in the left ear (p. 363). He complained of decreased hearing in the left ear and tinnitus (ringing in the ear) since the motor vehicle accident. He apparently had a post concussion head syndrome and was alleging head trauma, stuttering and hearing loss. **Please remember, Mr. Xxxxx was described as hard of hearing and admitted to having hearing aids pre date of loss, therefore he had a significant history of decreased hearing prior to the date of loss. Since it does not appear there was any significant head injury, the etiology of decreased hearing is not clear, as it would relate to the date of loss. Since we know he has hearing aids, we know he had to have had an audiology exam. These tests should be obtained to compare with the current testing.**

Mr. Xxxxx had stated he just walked “40 minutes.” The chest pain was described as being similar to gastroesophageal reflux disease and Zantac was prescribed. **Gastroesophageal reflux is not related to the date of loss. We know he had similar problems pre date of loss as he admitted to taking Mylanta.**

As we know in retrospect the Xxxxx's were having a stressful home life due to problems with their son this could easily explain any exacerbation of reflux symptoms.

Please note on May 12, 2002, his son was arrested and his wife was hospitalized for a ruptured cerebral artery aneurysm.

Mr. Xxxxx was evaluated by audiology on May 20, 2002 (p. 365). He reported "new decreased" hearing in the left greater than right ear. He complained of occasional tinnitus, 5 minutes to 3 hours on the left side and dizziness when he lay down, along with right ear pressure. The testing found a moderate to profound sensorineural hearing loss in both ears, right greater than left and he was referred for further evaluation. There is no indication he told the audiologist he had hearing aids prior to the accident. As noted above, there are prior audiology records which should be obtained for review and comparison. In addition, the left ear was his primary complaint, but on testing the right ear was worse than the left. Again there was no significant evidence of head injury and there is no way to confirm the tinnitus and dizziness is related to the date of loss, particularly since he had no similar complaints until 4 months post date of loss. These symptoms could also be due to cervical sprain strain however, Mr. Xxxxx admitted his neck was at baseline with in a couple of days post date of loss. Other possibilities include, the gastroesophageal reflux is severe enough to be causing acid irritation of the throat leading to swelling and irritation of the ear canals, or the symptoms are related to upper respiratory congestion. The symptoms could also be stress related given his wife's lengthy hospitalization.

On May 30, 2002, Mr. Xxxxx presented for an eye examination. He was requesting a new prescription. It does not appear he is claiming this visit as related to the date of loss.

On June 12, 2002, Mr. Xxxxx returned for follow-up. He continued to complain of shortness of breath in spite of inhalers. He was requesting to see an ENT for "hearing loss." Examination revealed there were no wheezes in the lungs and tympanic membranes were normal. The impression was COPD and hearing loss. Please note, there is no mention of accident related problems just chronic obstructive pulmonary disease and hearing loss, which we know is a chronic problem prior to the date of loss. Mr. Xxxxx was advised to continue his medications, pulmonary function test, labs, ENT consultation, and hearing aids. He continued to complain of stuttering, which had improved over the last one and a half to two months and hearing loss, which he alleged progressively worsened since the January 2002 accident. Labs were ordered, but the PSA, lipids, CBC, and chem panel ordered at the time of his visit are not related to the date of loss.

On June 19, 2002, the records (p. 371), document Mr. Xxxxx had "questionable" shortness of breath with chronic bronchitis/bronchospasm. He denied a past medical history other than the motor vehicle accident. He complained of being short of breath even with walking; however, in prior records he denied short of breath with walking and had reported he walked 40 minutes! He was saturating 95 to 99% on room air, which was within normal limits. Again it appears with each visit, instead of improving his respiratory status was deteriorating.

Pulmonary function tests were performed (p. 407-409), and consistent with chronic obstructive

pulmonary disease. Arterial blood gases were normal. **Given his excessive smoking history and asbestos exposure, the diagnosis of COPD is not surprising.**

The attending physician documentation (p. 371) indicated Mr. Xxxxx's shortness of breath was currently at "baseline." The shortness of breath occurred with walking and talking. He complained of pain, he rated at 1.5/10 in the left chest, which occurs at night. **This pain was previously attributed to gastroesophageal reflux. Nevertheless, the pain levels are apparently not significant and this is supported by the fact no analgesics had been prescribed since the first UCI visit and there is no documentation he was requiring over the counter analgesics.** He complained of a rare cough productive of gray sputum. He was off the oral prednisone and using Combivent and Advair. The pulmonary function test revealed moderate obstruction with positive reversibility of "unclear etiology." The echocardiogram post motor vehicle accident was within normal limits. The plan was to consider an exercise test; however, it was felt Mr. Xxxxx had few signs and symptoms consistent with congestive heart failure/cardiac disease. Obviously the physicians were not aware the chest x-ray obtained in the ER immediately post accident was consistent with mild congestive heart failure.

Mr. Xxxxx was reevaluated on June 28, 2002. Now he was asserting questionable loss of consciousness post motor vehicle accident. **He claimed to have started stuttering on February 06, 2002, which was not the case since there is no documentation in the hospital records he began stuttering, nor was he having any speech problems during the hospital admission post date of loss.** He claimed that stuttering had improved since the accident and reported positive history of stuttering in childhood. Mr. Xxxxx reported he smoked, quitting approximately a year ago and 15 years ago quit drinking, but had been drinking up to two six packs a day. The neurological examination was essentially negative. The differential diagnosis included axonal injury versus stress and anxiety and he was advised seeing psychiatry for anxiety and was discharged from the neurology clinic.

The attending physician's note is somewhat difficult read due to light photocopy; however, again Mr. Xxxxx now claims to be alleging loss of consciousness post motor vehicle accident, **which is not supported by any of the medical records provided prior to this point in time.** He claimed he began stuttering one-week post accident with brief vertigo when he lies down, not associated with movement. He also reported complaints of shortness of breath and hearing loss related to the motor vehicle accident. His social history was described as significant for his wife having an aneurysmal rupture recently. **I would attempt to pin Mr. Xxxxx down as to exactly when the stuttering began to compare with the timing of the aneurysmal rupture to determine a relationship.** The physician wrote, he had reemergence of stuttering after motor vehicle accident, which was more likely related to anxiety and stress than to any organic brain disease. No further neurological evaluation was indicated and he again was discharged from the neurology clinic.

Repeat echocardiogram on July 03, 2002 (p. 413), was essentially negative for acute changes. **There is, and has been no evidence of heart problems related to the date of loss.**

Mr. Xxxxx returned on August 16, 2002 (p. 376), continuing to complain of increased dyspnea on exertion and stuttering speech. The assessment was underlying chronic obstructive pulmonary disease compounded by bronchospasm and probable allergic rhinitis (allergy symptoms). He stated

the shortness of breath was unchanged since the initial presentation, with little relief from Advair and Combivent. He was also found to have nasal congestion, cough, dyspnea on exertion, and shortness of breath when talking. The examination revealed signs and symptoms consistent with allergic symptomology. Flonase was ordered for nasal congestion.

The August 21, 2002, note from University of xxxxxxxxxxxx xxxxxx Medical Center (p. 378-379), documented referral to pulmonary to evaluate Mr. Xxxxx's shortness of breath. He was noted to be a smoker with shortness of breath "out of proportion" to lung and heart disease. **However, please note that other than an echo, no other cardiac work-up had been undertaken according to the available records. One could have a normal echo and still have coronary artery disease. The physician made a point of recording Mr. Xxxxx was in litigation from the motor vehicle accident, which appears to intimate this may explain the continued complaints of shortness of breath in the face of an essentially negative exam.**

On August 29, 2002, Mr. Xxxxx was again found to have an elevated random blood sugar. He denied signs and symptoms consistent with diabetes. **However, was diagnosed with diabetes mellitus and referred to the diabetes mellitus education clinic. He had an elevated blood sugar on admission to the hospital. Diabetes, particularly untreated (since he stated he had no medical care for a prolonged period of time prior to the date of loss) can accelerate coronary artery and peripheral artery disease, cause retinal (eye) problems and multiple other serious consequences.**

On September 25, 2002, Mr. Xxxxx returned to the University of xxxxxxxxxxxx, xxxxxx (p. 382), requesting to have disability forms filled out. He claimed "severe COPD" was his disability; however, he was not oxygen dependent, not steroid dependent, and had no objective disability on pulmonary exam or pulse oximetry. He claimed limited walking produced significant dyspnea. **These symptoms yet again seem to have worsened. He is worse now than immediately post DOL. One wonders if part of the motivation for permanent disability is due to the severe problems and permanent disability suffered by his wife.** Mr. Xxxxx was referred to pulmonary as the physician essentially refused to fill out the disability forms in the face of no objective evidence of pulmonary disability.

It appears we are missing medical records, as on September 30, 2002, Mr. Xxxxx underwent an ophthalmology examination and the medications section now included Zestril, which is a blood pressure medication and it is not clear who prescribed this medication or when it was prescribed. Concerning pulmonary symptoms, other than the visit for the disability papers to be filled out, it appears there is a gap in medical visits between August 29, 2002 and December 17, 2002 (p. 386),

On December 17, 2002, Mr. Xxxxx returned complaining of shortness of breath with or without activity. He now admitted having sustained no significant head trauma, but had a chest contusion and thereafter developed persistent shortness of breath, which is worse when he gets upset or angry or with bending over. He also developed stuttering. Pulmonary function test revealed obstructive and restrictive changes. He stated the Advair and Combivent were not helpful. Examination revealed positive accessory muscle use, bilateral expiratory wheeze, lungs with dry crackles, and persistent shortness of breath. The shortness of breath was noted to persist with rest, mild and

increased with exertion, but there was no exercise limitation secondary to the shortness of breath. The physician questioned an anxiety component. He also complained of chest pain, which was felt to be non-cardiac. The plan was to rule out interstitial lung disease with a high resolution CT scan and possible trial of prednisone.

The available medical records end on March 31, 2003 (p. 387). Mr. Xxxxx failed to keep his appointment on this date. Therefore, it is unknown if he had the high resolution CT scan, what the study showed, if any diagnosis had been made and if the diagnosis could be related residuals from the date of loss, versus 50 years of smoking between 2½ to 4 packs of cigarettes per day and asbestos exposure.

DISCUSSION

The medical records provided for review unfortunately contain no predate of loss medical records. According to the available information, Mr. Xxxxx has a medical history positive for C5 fracture, degenerative and spondylitic changes at the cervical spine, significant smoking and alcohol abuse, asbestos exposure, elbow surgery, hemorrhoidectomy, hearing loss, encephalitis/meningitis and stuttering as a child.

The immediate post date of loss medical records reflect Mr. Xxxxx's primary complaints centered on chest pain and neck pain. Mr. Xxxxx was admitted to the intensive care unit, but discharged to a regular unit on January 30, 2002. He was discharged from the hospital on February 8, 2002.

Neck pain

The neck pain essentially resolved to baseline within a couple of days post date of loss. He was apparently symptomatic to the neck prior to the date of loss. He was taking aspirin and Advil for unknown pain complaints. He had a history of C5 fracture and radiological evidence of spondylosis and degenerative changes.

Head Injury

In spite of admission diagnosis of closed head injury, there does not appear to be any significant indication this was actually the case. There is no convincing evidence in the medical records provided of a head injury. Mr. Xxxxx had no loss of consciousness, Glasgow coma scores were within normal limits, and all serial neurological testing and assessments were within normal limits. Cognitive assessment by speech therapy was also essentially negative. Head CT was negative. He had a history of encephalitis/meningitis which may have left some residuals. Since there is no evidence of significant head injury this would speak against a head injury as the etiology of the stuttering.

Pulmonary Issues

There was question of pulmonary contusion; however, it is not entirely clear based on the

radiological reports and clinical picture that Mr. Xxxxx had a definite pulmonary contusion as a result of the date of loss. The initial chest film did show signs and symptoms consistent with mild congestive heart failure, which evidently pre-existed his accident. Repeat films described more of a fluffy infiltrate type of picture, which is usually more consistent with congestive heart failure/pulmonary edema type of problems. He was diuresed on multiple occasions in attempts to off load fluid and subsequently improved the lung condition to some degree. He was placed on aggressive pulmonary toilet and his primary complaints continued to be pulmonary throughout the admission. Due to decreases in oxygen saturation, Mr. Xxxxx was discharged on February 08, 2002 with continued oxygen requirement. Home oxygen therapy was recommended and provided post admission.

Mr. Xxxxx followed up in the University of xxxxxxxxxxx, xxxxxx. The first visit was on March 26, 2002. Interestingly enough, in one section he denied shortness of breath or chest pain. According to another note, Mr. Xxxxx reported shortness of breath and oxygen requirement. While talking, his oxygen saturation was 98% to 99% and while ambulating in the clinic, he was saturating between 95% and 96%. He claimed to be short of breath only with talking at this point in time. Yet clearly, his oxygen saturation was within normal limits at this point in time. The home oxygen was discontinued. Mr. Xxxxx was given a pulmonary referral.

On April 02, 2002, his oxygen saturation was clearly within normal limits on room air. The oxygen supplies were returned. Pulmonary function test on April 08, 2002, showed mild restriction.

Mr. Xxxxx was seen for pulmonary consultation on May 08, 2002, at the University of xxxxxxxxxxx, xxxxxx (p. 362). At that time, he had audible expiratory wheezing and was diagnosed with acute bronchitis/bronchospasm, COPD. Antibiotics and steroid taper were prescribed to see if his symptoms improve.

When he returned on May 10, 2002, he stated he just walked 40 minutes.

On June 19, 2002, he now claimed shortness of breath even with walking which was previously denied. However, he was still saturating between 95% - 99%. Pulmonary function tests were

consistent with chronic obstructive pulmonary disease. There was no documentation of an acute component on these studies.

Of particular interest, at the June 19, 2002 visit, the physician considered exercise test, "but patient with few signs and symptoms consistent with congestive heart failure/cardiac disease. Again, as noted in the body of this report, the physician was obviously unaware that the initial chest x-ray post trauma was consistent with mild congestive heart failure (CHF). CHF occurs when the heart muscle is not pumping efficiently causing fluid to accumulate in the lungs. His ejection fraction (left ventricle pumping) on echo was within normal limits, yet he still had x-ray evidence of mild CHF.

The August 16, 2002 evaluation (p. 376) essentially attributed the respiratory symptoms to underlying COPD (chronic obstructive pulmonary disease – common in smokers) compounded with

bronchospasm as well as allergic rhinitis.

On August 21, 2002, the physician felt Mr. Xxxxx's complaints of shortness of breath were "out of proportion" to his heart and lung disease. He further noted Mr. Xxxxx was currently in litigation concerning the motor vehicle accident, and was requesting pulmonary consultation for evaluation of the shortness of breath.

At the time of the August 21, 2002 visit (p. 379), Mr. Xxxxx minimized his cigarette use claiming he smoked one pack per day. Earlier records clearly indicated he smoked on an average 2½, to as many as four packs per day.

On September 25, 2002 (p. 382), Mr. Xxxxx returned requesting disability forms be filled out and the physician noted he "claims severe COPD" is his disability; however, he is not oxygen or steroid dependent." He was now reporting any limited walking produced significant dyspnea; however, on previous visits he admitted to walking up to 40 minutes and claimed walking did not aggravate his shortness of breath. The physician was concerned, as he had no objective disability on pulmonary examination, or pulse oximetry. He referred Mr. Xxxxx to the pulmonary service to if see the disability could be proven.

There is essentially four months gap when he returned in mid December 2002 (p. 386), complaining of shortness of breath "now with and without activity." He claimed his shortness of breath got worse when he was upset, angry or bending over which leads one to wonder if these symptoms are related to anxiety, stress, or reflux. The examination, however, did reveal some bilateral expiratory wheeze with positive accessory muscle use and persistent shortness of breath. The plan was to rule out interstitial lung disease; however, no further medical records were provided for review to determine if the testing was performed, whether any objective signs of disability could be found and if it could be due to the accident. The physician again questioned anxiety component and felt the chest pain complaints were not consistent with a cardiac etiology.

In previous cases where patients have had acute lung trauma, I have been told by a pulmonology expert that usually this goes on to resolve without any permanent lung damage. However, in this case, it was advised that the chest x-rays be obtained for review to determine whether there was evidence of actual pulmonary contusion or if the findings during his admission were more consistent with congestive heart failure. Given the seriousness of the wife's problems, which will be discussed in a separate report, it is entirely possible given the onset of stuttering that the continued shortness of breath and increasing shortness of breath may be related to anxiety reaction due to problems occurring with the wife.

Pain

At the time of the admission, he was placed on patient controlled analgesia, morphine. The PCA was discontinued on February 02, 2002, and oral narcotic analgesics were prescribed. He was discharged with a prescription for Vicodin. At the first UCI visit he was given a prescription for 90 Ibuprofen tablets. There are no further prescriptions for analgesics, speaking against any significant

pain complaints related to the date of loss.

Hearing Loss

Mr. Xxxxx admitted having hearing aids at the time of admission and apparently the hearing aids were not with him. The occupational therapist had remarked that Mr. Xxxxx was hard of hearing. He had no complaints of tinnitus during this admission. There were no complaints of increased hearing loss.

When he returned on May 10, 2002, he was now complaining of decreased hearing on the left attributed to the motor vehicle accident. He was now alleging decreased hearing in the left ear and tinnitus since motor vehicle accident. He was also reporting head trauma, but again there really is no evidence of significant head trauma in the post accident records.

Mr. Xxxxx was seen by audiology and was alleging “new” decreased hearing in the left ear greater than right ear with occasional tinnitus lasting between 5 minutes to 3 hours on the left and dizziness when he would lie down. He was found to have moderate to profound sensorineural hearing loss in both ears right greater than left. The results were worse with testing on the opposite ear than the ear he was complaining of. Again, we need to obtain predate of loss medical records from his previous audiologist, to determine his hearing prior to the date of loss. Since he was wearing hearing aids prior to the date of loss, there must be records somewhere concerning his hearing function to compare with the current study.

Chest pain

There was no evidence of cardiac contusion post date of loss. He was found to have a fracture of the upper portion of the sternum. On May 10, 2002, the chest pain was attributed to gastroesophageal reflux symptoms and not the date of loss. In June, 2002, he reported chest pain rated as 1.5/10 on the left chest occurring at night, the physician did not attribute this to cardiac pain. Of particular interest, at the June 19, 2002 visit, the physician considered exercise test, “but patient with few signs and symptoms consistent with congestive heart failure/cardiac disease. Again, as noted in the body of this report, the physician was obviously unaware that the initial chest x-ray post trauma was consistent with mild congestive heart failure.

In December 2002, Mr. Xxxxx was now on blood pressure medication, although it is not clear who prescribed this medication. The physician wrote (p. 386), the chest pain complaints were not consistent with a cardiac etiology. Please note, given he is diabetic, hypertensive, has chest pain, and had radiological evidence of mild congestive heart failure, which may have progressed to florid CHF during the admission, one must at least consider the possibility the chest pains may be related to a cardiac etiology. He was not evaluated by a cardiologist as far as we know. CHF occurs when the heart muscle is not pumping efficiently causing fluid to accumulate in the lungs. His ejection fraction (left ventricle pumping) on echo was within normal limits, yet he still had x-ray evidence of mild CHF.

Stuttering

Post admission, Mr. Xxxxx followed up in the University of xxxxxxxxxxx xxxxxx. The first visit was on March 26, 2002. He was now complaining of stuttering voice “since accident.”

On May 08, 2002 (p. 362), the stuttering was thought to be related to anxiety. Mr. Xxxxx was seen for neurological consultation for stuttering on June 28, 2002 (p. 373). According to this note, he alleged the stuttering began on February 06, 2000, but this does not appear to be consistent with the available medical records. In any event, differential diagnosis included axonal injury versus stress and anxiety. The physician primarily felt the symptoms were related to anxiety particularly due to the wife having a recent aneurysmal rupture and referred Mr. Xxxxx to psychiatry. Mr. Xxxxx admitted a history of stuttering as a child. It is not all that unusual for people who have a history of stuttering for this to become exacerbated during times of stress or anxiety.

Diabetes

On August 29, 2002, Mr. Xxxxx was diagnosed with diabetes mellitus, which can significantly affect the heart, eyes, and blood vessels causing acceleration of cardiovascular disease.

Diane Xxxxx

When comparing Mr. xxxxxx Xxxxx’s records with xxxxxx Xxxxx’s records, the following is noted:

1. Two days prior to the aneurysmal rupture, Mr. Xxxxx stated he just walked “40 minutes.” He complained of decreased hearing in the left ear and tinnitus since the motor vehicle accident. He also complained of stuttering and chest pain similar to gastroesophageal reflux disease and Zantac was prescribed.
2. The son was apparently arrested causing a hypertensive crisis and subsequent aneurysmal rupture with intracranial bleeding. Ms. xxxxxx Xxxxx was hospitalized initially on May 12-21, 2002, and again on May 22, 2002 for ruptured arteriovenous malformation and discharged on June 02, 2002.
3. On June 12, 2002, Mr. xxxxxx Xxxxx presented with continued complaints of shortness of breath. Examination revealed clear lungs. He was referred to the pulmonary clinic. On June 19, 2002, pulmonary function tests were consistent with COPD with response to bronchodilators. He complained of shortness of breath with walking and talking.
3. On June 28, 2002, he and xxxxxx Xxxxx were both seen at the University of xxxxxxxxxxx xxxxxx Clinic. He was seen for neurological consultation. He reported his stuttering had improved. Neurological examination was within normal limits. The physician primarily felt the symptoms were related to anxiety and discharged him from the neurology clinic and advised him to follow up with psyche. According to the records of xxxxxx Xxxxx, Ms.

Xxxxx complained of some mild residual unsteadiness on her feet.

4. On July 27, 2002, Ms. Diane Xxxxx was readmitted to the University of xxxxxxxxxxxx, xxxxxx, in an essentially comatose state. Ms. Xxxxx underwent multiple procedures and treatments and was discharged with fairly significant residuals on August 30, 2002. Signs and symptoms were consistent with CVA. Mr. Xxxxx was evaluated in the clinic on August 16, 2002, essentially partway through his wife's admission to the hospital complaining of increasing dyspnea on exertion and stuttering speech. The physician felt at that time there was an allergy component related to the shortness of breath; however, arguably, Mr. Xxxxx was noted to have significant amount of stress concerning the problems with xxxxx Xxxxx.
5. Mr. Xxxxx was seen on August 21, 2002, denying shortness of breath stating he can "walk for miles but with more short of breath than usual, also with talking." The noted documentation involved the litigation secondary to the motor vehicle accident. He minimized his tobacco use stating he smoked one pack per day when asked clearly not consistent with previous medical records.
6. On August 29, 2002, Mr. Xxxxx was diagnosed with diabetes mellitus, all significant stressors. His wife was transferred to a nursing home on August 30, 2002.
7. Mr. Xxxxx was evaluated on September 23, 2002 at the xxx Clinic again continuing to have significant residuals.
8. Mr. Xxxxx presented two days later on September 25, 2000, requesting his disability forms be filled out claiming severe COPD was his disability. Even though, he was not oxygen or steroid dependent and had no objective signs or symptoms of disability. One of course has to

wonder if the condition what the wife had prompted the need for disability as well as perceived problems related to the date of loss.
9. The medical records of xxxxx Xxxxx indicate multiple visits and treatments through December 2002. She had been discharged from the nursing home. Ms. xxxxx Xxxxx was complaining of knee pain, shoulder pain, and continued to have neurological residuals as a result of her ruptured aneurysm
10. The following day, December 17, 2002, Mr. Xxxxx returned complaining of shortness of breath with and without activity. The symptoms became worse when he got upset, angry or with bending over. He continued to complain of stuttering. The physician wanted to rule out interstitial lung disease and ordered a high resolution CT scan and a trial of prednisone; however, no further medical records were provided for review. Therefore, an anxiety component or stress component may be an entirely possible etiology of Mr. Xxxxx's condition, as Ms. Xxxxx was certainly disabled.

SUMMARY

- Motor vehicle accident.
- The patient claims problems with defoggers on car immediately prior to the accident.
- Fractured sternum.
- Mild congestive heart failure at the time of admission. No confirmed documentation of pulmonary contusion on x-rays.
- No evidence of cardiac contusion.
- Shortness of breath with oxygen requirement and decreased oxygen saturation with wheezes on wet lungs, which could be due to congestive heart failure and/or pulmonary contusion.
- The patient required oxygen post discharge thru March 26, 2002.
- Oxygen supplies returned on April 2002.
- Stuttering in childhood with claimed onset occurring during the admission and post date of loss. The occurrence of stuttering during this admission was not confirmed. Cognitive evaluation was within normal limits.
- Likely etiology of recurrence of stuttering could be anxiety component due to wife's multiple medical problems.
- Complaints of neck tenderness immediately post date of loss resolved in approximately two days resolved to baseline approximately two days.
- Mr. Xxxxx was hard of hearing and wore hearing aids prior to the date of loss. Allegations of decreased hearing post date of loss not substantiated based on the available medical records.
- Apparent resolution of sternal chest pain. Only one prescription for ibuprofen in the medical records, post date of loss.
- Mr. Xxxxx was taking Advil or aspirin along with Maalox prior to the date of loss. Pain complaints, unknown.
- Mr. Xxxxx had no medical insurance prior to the date of loss.
- Post date of loss with the availability of medical insurance, Mr. Xxxxx seems to be trying to

take care of likely chronic medical problems he had prior to the date of loss, but neglected since he did not have medical insurance which includes ophthalmology, audiology, and unknown if pulmonary or cardiac component.

- Chest pain, thought to be related to gastroesophageal reflux/noncardiac etiology.
- Concerns by physicians of shortness of breath out of proportion to objective findings.
- Physicians concerned litigation responsible for above concerns.
- Likely anxiety component for residuals.

When the missing records have been obtained they can be added to the reports. After the depositions are done, these can be compared to the medical records and impeachment charts created for use at settlement conferences or trial.

If you should have questions or concerns, please do not hesitate to call.

Sincerely,

Kerrie E. Bradshaw, R.N., B.S.N.
Executive Director of Consulting

KEB/ms
Enclosure