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RESOURCE
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November 20, 2006

Patient:
Employer:
D/I:
Claim No:
WCAB:

Ms. XXXX
XXXX
XXXX
XXXX

Mr. XXXX
XXXX
XXXX
XXXX

Dear Ms. XXXX and Mr. XXXX:

AGREED MEDICAL EVALUATION

On XXXX, I had the opportunity to interview and evaluate Mr. XXXX concerning his complaints of peptic ulcer disease and kidney stones arising as a consequence of an orthopedic injury arising out of his course of employment for XXXX in XXXX.

COMPLEXITY FACTORS AND FEE JUSTIFICATION

The revised medical-legal fee schedule indicates that ML104 may be billed if four or more complexity factors exist. The five complexity factors here are:

The revised medical-legal fee schedule indicates that ML104 may be billed if four or more complexity factors exist. The five complexity factors here are:

1. Two or more hours of face-to-face time by the physician with the patient;
2. Two or more hours of record review by the physician;

3. Two or more hours of medical research;
4. A bona fide issue of medical causation discovered in the evaluation and in any event a written request by the requesting party for discussion of the issue of medical causation;
5. A bona fide issue of apportionment discovered in the evaluation;

I verify under penalty of perjury that I spent 2.0 hours in face-to-face interview time with Mr. XXXX. I further verify that I spent 3.25 hours reviewing the medical records. I spent 2.0 hours reviewing current medical literature. I spent 4.0 hours preparing and editing this report for a total of 11.25 hours.

This report is being billed at ML104. This was clearly an extraordinarily complex medical-legal evaluation, involving renal stones, injury to the stomach and need for future medical evaluation.

GENERAL BACKGROUND & JOB DESCRIPTION

Mr. XXXX is a 25-year-old White male, born XXXX in California. Mr. XXXX graduated high school in 1991, and attended junior college for two years. In 2003, Mr. XXXX became employed as general laborer for XXXX in XXXX, California.

HISTORY OF INJURY

Mr. XXXX became employed at XXXX located in XXXX, California in 2003. Mr. XXXX worked on a full-time basis. Mr. XXXX would have one or two job responsibilities – either to drive a truck or be in the back of a semi type truck where he would load the paint to put the stripes on freeways.

On 10/03/05, Mr. XXXX went to work at 7:00 pm. That evening, Mr. XXXX and a coworker were going to work on a road off of XXXX, California. At 8:05 pm, a coworker and Mr. XXXX were putting out three signs on the freeway. Mr. XXXX loaded the first sign, and as he was walking back to his truck to put out the second sign, he was on the shoulder of the road. At that time, an individual in a motor vehicle came onto the shoulder and struck Mr. XXXX on his left side. The driver of the vehicle was going at approximately 65 mph.

Mr. XXXX states that after the accident of XXXX, he never lost consciousness and when he landed, he was half on the freeway and half on the side of the road. Mr. XXXX attempted to stand up and realized at that time that he had injured his left leg and ankle. A 911 call was made and Mr. XXXX was transferred to XXXX Hospital.

Mr. XXXX was in the hospital for approximately three days, where he had surgery on his fractured left tibia and fibula. Mr. XXXX states that when he was discharged from the hospital, he was on Celebrex. Mr. XXXX continued on Celebrex until approximately January of 2006.

Approximately two weeks later, Mr. XXXX was at home, where he lives with his fiancé in XXXX. Mr. XXXX had the onset of severe right lower back discomfort. The pain became progressive in nature and started to radiate into his lower abdomen and into the testicles. Due to the severe nature of the pain, Mr. XXXX's fiancé drove him to XXXX Hospital in XXXX, California. Mr. XXXX was seen in the emergency room, where an ultrasound was performed and he was told to have kidney stones. Mr. XXXX was given pain medication and discharged home.

Mr. XXXX was given Vicodin and discharged from the emergency room. In addition, Mr. XXXX was recommended to collect and strain his urine. Mr. XXXX states that while he was in the emergency room, he was noted to have an infection or cellulitis in his left leg, and was also given a prescription for Keflex.

Approximately 24-48 hours after Mr. XXXX left the emergency room for his kidney stones, he had the onset of nausea and vomiting. Mr. XXXX had recurrent vomiting and states it was coffee grounds like in consistency.

Mr. XXXX then returned to the emergency room at XXXX Hospital. Mr. XXXX states that at this time x-rays were done and he was told to have "an ulcer". He was given medication to take at home. Over the next three days, Mr. XXXX had persistent nausea and vomiting at home, requiring three separate visits to the emergency room. During these visits, Mr. XXXX was given various tests and was also given suppositories.

After the third visit to the emergency room, Mr. XXXX states his symptoms improved. Mr. XXXX has had continued abdominal discomfort, but has not required any more emergency room visits, has not seen a gastroenterologist and has not had endoscopy.

In 2006, there have been no more visits to the emergency room for back pain, kidney stones or difficulty with urination.

Mr. XXXX continues under the care of Dr. XXXX for his orthopaedic injury, and this is not subject of this report.

CURRENT COMPLAINTS

1. Mr. XXXX states his appetite is good. He has had no recurrent nausea or vomiting. Mr. XXXX has gained approximately 35 pounds due to his inactivity after his accident.
2. Mr. XXXX has persistent retrosternal burning pain. Mr. XXXX dates the onset of this pain to October of 2005. The discomfort is a burning chest discomfort which occurs 3-4 times a day, is aggravated by various juices or spicy foods. Mr. XXXX may awaken from sleep with severe

retrosternal burning pain, and has been treating himself with Tums. Mr. XXXX has not had antacids or H-2 blockers.

3. There have been no black stools or melena. There is no history of recurrent dysuria or hematuria or passage of any additional stones.

CURRENT MEDICATIONS

Keflex for recurrent cellulitis of the left leg.

Vicodin 6-8 tablets qd for pain.

In the past, Mr. XXXX has been on various anti-inflammatories, including Naprosyn, but not at the present.

PAST MEDICAL HISTORY

Surgical: Status post right shoulder surgery after football injury in 2001. Left tibia and fibular shaft fractures closed with intramedullary fixation of the left tibial shaft fracture, 10/04/05. Left distal tibia and left distal fibula osteotomy and application of talar spacial frame, 8/21/06.

Medical: No history of diabetes, tuberculosis, hypertension or myocardial infarction. There was no prior history of peptic ulcer disease or kidney stones prior to the injury of 10/03/05.

Drug Allergies: No known drug allergies.

FAMILY HISTORY

Mother - Age 47, alive and well.

Father - Age 47, alive and well.

Siblings- Three brothers and three sisters, alive and well.

Children- None.

No family history of peptic ulcer disease, kidney stones or endocrine disorders.

SOCIAL HISTORY

Mr. XXXX is single and resides with his fiancé in XXXX, California.

Smoking: None.
Alcohol: In the past, an occasional beer on a social basis.

REVIEW OF SYSTEMS

HEENT: Negative sinus problems, swallowing problems, vision problems, or hearing problems.
LUNGS: Negative cough. Negative wheeze.
HEART: Negative palpitations or irregularities.

MEDICAL RECORD REVIEW

10/03/05 Dr. XXXX. Consultation. 24-year-old employee of XXXX involved in an accident in which he was struck by a car while walking on the shoulder of Interstate 80. It was witnessed that the car was traveling around 40 mph. Patient has complained of severe left leg pain. Negative for loss of consciousness. He has had no recent illness or systemic illness. He denies any other extremity complaints, other than the left leg. No known drug allergies. Previous surgeries include: Arthroscopic procedure right shoulder. Impression: Acute left tibia and fibular shaft fracture, closed.

10/04/05 Dr. XXXX. Operative report. Procedure: Left tibia and fibular shaft fractures closed with intramedullary fixation of the left tibial shaft fracture.

10/03/05 24-year-old male worked for XXXX. Struck by a car. Status post motor vehicle crash. Closed fib/tib fracture.

10/03/05 Chest x-ray. No definite left rib fractures. Left clavicle fracture.

10/03/05 X-ray. Acute comminuted distal tibial and fibular fracture.

10/05/05 Dr. XXXX. Discharge summary. 24-year-old male worked for subcontractor for XXXX. Struck by a car on the freeway with an isolated tib/fib fracture. Surgery on 10/04/05 by orthopaedics, did well. Ambulated with physical therapy. He will be started on Coumadin for deep venous thrombosis prophylaxis as an outpatient. He was managed by mouth pain medications and is being discharged home on 10/05/05.

10/09/05 Dr. XXXX. Doctor's report of injury. Patient comes in after being hit by a car on 10/03/05 with a very severe fracture of his left tib/fib. Treated with surgery by Dr.

XXXX and has been on Norco pain tabs ever since. He has been staying with his mother in XXXX. He has run out of pain medications. Physical exam: Patient is a young male in a wheelchair. His left leg is wrapped. There is ecchymosis down to the foot. He was given Norco 10/325, 20 tablets. Follow up with orthopaedist.

- 10/16/05 Emergency Room note from XXXX Hospital. This is a handwritten note, which is very difficult to read, almost illegible. Patient was treated with intravenous fluids and various pain medications. Diagnosis: Acute right-sided uretal lithiasis and anemia.
- 10/16/05 Doctor's report of injury. Chief complaint: Sudden onset of abdominal pain. Right uretal lithiasis. Cellulitis left foot. This patient's complaints are related to the kidney stone. Asked, are your questions consistent with the account of injury or illness? Answer was unsure. Treatment rendered: Medications.
- 10/16/05 X-ray report. No evidence of acute cardiopulmonary disease.
- 10/17/05 XXXX Hospital. Second CT scan of abdomen and pelvis without contrast. There is a 1 mm uretal calculus at the right uretal vesicle junction with associated minimal perinephria extending. The region of the appendix is not identified. In the upper abdomen, the liver, stomach, spleen, pancreas and gallbladder have a normal CT appearance. Impression: Punctate right uretal stone with distal uretal associated with mild hydronephrosis and hydronephrosis. No convincing evidence for appendicitis; however, appendix not discreetly identified. Appendicitis could not be absolutely excluded.
- 10/17/05 Flat plate of the abdomen. No acute chest or abdominal masses demonstrated.
- 10/17/05 Laboratory data revealed a normal bilirubin, SGOT and SGPT. Calcium 9.3. Serum amylase 52, serum lipase 22. Hemoglobin 12.7.
- 10/17/05 Renal ultrasound. Right kidney measured 12 x 6.2 x 5.9 cm. The left kidney measured 10.8 x 6 x 6.3 cm. There is mild hydronephrosis on the right. A small amount of free fluid was present in Morrison's pouch. There was no evidence of right uretal jet. The left uretal jet was identified. Renal blood flow was normal. Impression: Mild right-sided hydronephrosis with absent right uretal jet. A uretal obstruction is suggested. Small amount of fluid in Morrison's pouch.
- 10/17/05 X-ray. Normal venous duplex exam of left lower extremity.
- 10/17/05 CT of abdomen and pelvis. Lung bases were clear. The adrenal glands of normal size. Punctate calcifications are present in the right kidney which shows mild to moderate hydronephrosis and some perirenal fluid. Punctate calcifications are also present centrally in the left kidney. Aorta and vena cava are normal. Scans through the pelvis

show a punctate calcification near the right ureteral vesical junction or just within the bladder. Prostate is normal. Impression: Obstructing punctate calculus in the right ureteral vesicle junction with upstream hydronephrosis.

- 10/18/05 Urinalysis dipstick. Glucose negative. Bilirubin negative. Ketones negative. Protein negative. Blood negative.
- 10/18/05 Calcium 9.1, BUN 12, creatinine 1.3.
- 10/20/05 Dr. XXXX. Emergency Room. Handwritten note. Two weeks status post tibial nail. Only problem equals kidney stones. Exam: Wounds, abrasions all healed. Fifty percent weightbearing limit until 11/01/05. May drive automatic car.
- 10/20/05 X-ray posterior tibia and fibular fracture.
- 10/20/05 X-ray follow up. No significant change in healing of intramedullary fracture.
- 11/17/05 Healing surgical left tibial fracture.
- 1/10/06 Dr. XXXX, orthopaedist. 25-year-old male examined on 1/10/06 after second opinion consultation regarding recent industrial injury. Patient continues to have ongoing pain. He apparently has denied allergic medication reaction. Medications included Tylenol 500 mg tablets up to eight a day, Os-cal and Vicodin. Impression: Healing fracture. Status post closed IM rodding with posterior distal interlocks.
- 1/12/06 Dr. XXXX. Over three months internal fixation left tibial fracture, work related injury. Returns for routine follow up with a continued complaint of mild to moderate discomfort in the area of his fracture. He has continued to take Vicodin, occasionally having some trouble sleeping as well. Patient will be referred to physical therapy. Have encouraged him to stop taking Vicodin and a prescription is written for ibuprofen 400 mg every 4-6 hours for pain.
- 1/17/06 XXXX. One and a half months status post tibial fracture. Walking with boot. Exam: Left ankle aligned. Good bone motion. Radiographic alignment assessable. Fixation intact. Tibial fracture. Treated with Vicodin and ibuprofen 400 mg.
- 1/31/06 Exam for second opinion on 1/10/06. He has undergone internal fixation of his fracture of left distal fibula. Currently he remains temporarily disabled. Continues to have atrophy of the calf. Impression: Industrial injury with fracture, status post closed intramedullary rodding.
- 1/31/06 Dr. XXXX. Will have his radiographs reviewed by trauma surgeon. At this point, uncertain regarding clinical findings. He may require further reconstructive surgery.

- 2/09/06 Dr. Holmes, orthopaedic surgeon. Mr. Hewitt is an otherwise healthy 25-year-old male who unfortunately was involved in a work related pedestrian versus automobile accident on 10/03/05. He was taken to Sutter Roseville. He underwent successful intramedullary nailing of the left distal one-third of the tib/fib fracture by Dr. Gregory. Over the last 6-8 weeks he has been progressively weighting on his left leg. Mr. Hewitt is taking Vicodin and Naprosyn for his discomfort. Review of systems listed on patient's permanent medical record reviewed by me: Denies any chest pain, shortness of breath, nausea, vomiting, diarrhea or constipation. He walked using a cane, with left-sided antalgic gait. Plan: Mr. Hewitt's fracture appears to be healing without complication. I have discussed further conservative therapy.
- 3/02/06 Dr. Fassero. 25-year-old male employed at Central Striping, was examined for continuing care. He had an industrial injury to the left lower extremity on 10/03/05. He has undergone an internal fixation of fractures of his left tibia and fibula. Now has pain over the lateral ankles. On examination, he ambulates cautiously on the left lower extremity. He is discouraged at this point. He feels he has made little progress. Impression: Industrial injury with fracture left distal tibia and fibula. Status post IM rodding with proximal distal interlocks. Residual malunion with left foot and ankle in valgus position. Patient is very discouraged at this time. He remains temporarily disabled.
- 3/22/06 Dr. Holmes. Returns for evaluation of his tib/fib fracture. Healed distal one-third fracture. I am not able to fully explain his complaints of moderate to severe pain in his left leg.
- 6/29/06 Dr. Fassero. He was last interviewed on 3/02/06 and remains on temporary disability. On his last visit, he was very discouraged. He was seen by Dr. Holmes for second opinion. Pertinent interim history: He has been working out more, riding an exercise bicycle. He uses a cane outdoors. He seemed to ambulate better than at the last visit. Industrial injury with fractures.
- 6/30/06 Dr. Fassero. He was examined by me on 6/29/06. He sustained an injury on 10/03/05. Last interview 3/20/06 he was very discouraged. Impression: Industrial injury, fractures left tibia and fibula. Status post intramedullary rodding. I have agreed to give him a handicap sticker and renewed his prescriptions for Vicodin and Celebrex which he has been taking daily.
- 7/20/06 Dr. Holmes. Follow up for reevaluation. Severe pain in his left leg. He is walking with a significant limp. Diagnosis: Left tibia malunion. Surgery tentatively scheduled for 8/21/06.
- 8/15/06 Mr. Hewitt is scheduled for left tibial osteotomy.

- 8/17/06 Dr. Holmes. Preop history. History of distal tibial fracture October 2005. Past medical history unremarkable. Review of systems: Denies any chest pain, shortness of breath, nausea, diarrhea, dizziness or paresthesias. He has no recent fevers or weight changes. Impression: Left tibial malunion.
- 8/21/06 Dr. Holmes. Operative report. Left distal tibia and left distal fibula osteotomy and application of talar spacial frame.
- 8/31/06 Dr. Holmes. Returns to office to recheck left leg status. Status post total osteotomy with placement of talar spacial frame. Diagnosis: Status post tib/fib osteotomy with placement of talar spacial frame.
- 9/12/06 Dr. Holmes. Returns for follow up. Given prescription for Keflex to use over the next 10 days.
- 9/21/06 Dr. Holmes. Returns for follow up. He has been doing quite well status post surgery. He was slowly advanced to weightbearing.
- 10/12/06 Dr. Holmes. Returns two months status post surgery. He is walking on the left side. He is doing quite well. He will continue full weightbearing.

PHYSICAL EXAM

On physical exam, Mr. Hewitt is a well-developed, well-nourished male in no acute distress. Blood pressure is 120/78. Pulse rate is 72 and regular. Weight 230 pounds.

- HEENT: Tympanic membranes clear. Extra ocular movements intact. Pupils equally reactive to light. Fundi and discs benign. Pharynx clear. Neck supple. No temporal artery tenderness. Eyes, ears, nose and throat were clear. Teeth were in good repair. No lymphadenopathy.
- LUNGS: Clear.
- HEART: S1, S2 regular. No rubs, murmurs, gallops, or clicks.
- ABDOMEN: Soft, slightly obese with good bowel sounds. Negative hepatosplenomegaly. Liver and spleen not palpated. No masses or bruits.
- EXTREMITIES: Negative atrophy, joint deformity, cyanosis, clubbing or edema. Peripheral pulses were full.

LEFT LEG: There is a left knee incision measuring approximately 5 cm. On his left leg, there is a halo insert into his left leg and ankle.

MUSCULO-SKELETAL: Back was not tender.

NEUROLOGICAL: Upper extremity/lower extremity strength five out of five. Deep tendon reflexes brisk and symmetrical. Cranial nerves II-XII were intact. Gait and coordination within normal limits. Sensation was intact.

DIAGNOSES

1. Industrial orthopaedic injury, 10/03/05, arising out of and during the course of his employment.
2. Left tibia and fibular shaft fractures closed with intramedullary fixation of the left tibial shaft fracture, 10/04/05.
3. Left distal tibia and left distal fibula osteotomy and application of talar spacial frame, 8/21/06.
4. Right-sided uretal lithiasis with evidence of hydronephrosis.
5. Symptoms of gastroesophageal reflux disease.

DISCUSSION

I have examined Mr. Derrick Hewitt for an Agreed Medical Examination report.

I have received a letter dated 10/27/06 from State Compensation Insurance Fund, Ms. Tasha King, stating that Mr. Hewitt sustained lower left leg injury on 10/03/05 while employed by Central Striping as a construction laborer. He also has alleged an injury on 10/03/05 to his internal organs while employed by Central Striping, and I refer to applicant attorney, Mr. Brasher's letter of 10/09/06. Enclosed was a complete medical file.

I have also received a letter dated 11/01/06 from applicant counsel Mr. Jeremy Brasher that states, by way of introduction, Mr. Hewitt suffered industrial injury to his left lower extremity and psyche on 10/03/05 in his capacity as a laborer for Central Striping when he was hit by a passing car on a freeway while performing his job duties. Mr. Hewitt alleges that he developed kidney stones and an ulcer as sequelae or compensable consequence injuries. The leg injury has been accepted. All other body parts are denied. We would like you to focus solely on the kidney stones and ulcer sequelae.

Mr. Hewitt became employed at Central Striping Service in Rancho Cordova in 2003. On 10/03/05, Mr. Hewitt had a work related injury when he was hit by a vehicle during the course of his employment. As a consequence of this injury, Mr. Hewitt was admitted to the hospital on 10/03/05 and was discharged on 10/05/05 after he had the surgical procedure of the left tibial and fibular shaft fractures.

The medical records confirm that Mr. Hewitt was evaluated in the emergency room on 10/16/05.

- 10/16/05 Emergency Room note from Marshall Hospital. This is a handwritten note, which is very difficult to read, almost illegible. Patient was treated with intravenous fluids and various pain medications. Diagnosis: Acute right-sided ureteral lithiasis and anemia.

- 10/16/05 Doctor's report of injury. Chief complaint: Sudden onset of abdominal pain. Right ureteral lithiasis. Cellulitis left foot. This patient's complaints are related to the kidney stone. Asked, are your questions consistent with the account of injury or illness? Answer was unsure. Treatment rendered: Medications.

- 10/17/05 Mercy General Hospital. Second CT scan of abdomen and pelvis without contrast. There is a 1 mm ureteral calculus at the right ureteral vesicle junction with associated minimal perinephria extending. The region of the appendix is not identified. In the upper abdomen, the liver, stomach, spleen, pancreas and gallbladder have a normal CT appearance. Impression: Punctate right ureteral stone with distal ureteral associated with mild hydronephrosis and hydronephrosis. No convincing evidence for appendicitis; however, appendix not discreetly identified. Appendicitis could not be absolutely excluded.

- 10/17/05 Laboratory data revealed a normal bilirubin, SGOT and SGPT. Calcium 9.3. Serum amylase 52, serum lipase 22. Hemoglobin 12.7.

- 10/17/05 Renal ultrasound. Right kidney measured 12 x 6.2 x 5.9 cm. The left kidney measured 10.8 x 6 x 6.3 cm. There is mild hydronephrosis on the right. A small amount of free fluid was present in Morrison's pouch. There was no evidence of right ureteral jet. The left ureteral jet was identified. Renal blood flow was normal. Impression: Mild right-sided hydronephrosis with absent right ureteral jet. A ureteral obstruction is suggested. Small amount of fluid in Morrison's pouch.

These findings from the emergency room reveal a CT scan with evidence of calcifications in the right kidney, the findings of moderate hydronephrosis. Punctate calcifications were also present in the left kidney.

Mr. Hewitt states that he was sent home from the emergency room and was told to strain his urine, but he never collected a stone. There is a report of a normal serum calcium in the chart.

Kidney calcifications are usually related to disorders in mineral metabolism, either serum calcium, phosphorous or uric acid. These disorders in calcium metabolism can be related to diseases of the parathyroid gland and may require periodic serum calcium and measures or parathyroid hormone levels. In addition, this has been associated with disorders of vitamin D metabolism. It has also been associated with abnormalities in phosphorous metabolism.

There are multiple causes related to this, which can also include inherited causes of metabolism, also hypercalcemia or excess calcium in the urine. Kidney stones have also been secondary to chronic disorders of uric acid metabolism.

These kidney stones or calcifications usually do not cause pain. When this calcification or crystal material moves into the urinary tract, this can cause recurrent pain, in addition to nausea and vomiting. Usually these stones may be small and only found on routine examination. The most common types of stones are calcium. However, kidney stones form when there is a high level of calcium, oxylate or uric acid in the urine. Approximately 85% of stones are calcium.

Findings of hydronephrosis or dilation of the ureter, as with Mr. Hewitt, suggests that these stones have been present and causing symptoms of obstruction.

The unilateral nephrosis is associated with the unilateral obstruction secondary to evidence of calcifications and the possibility of obstruction to his ureteral canal.

In reference to this finding of calcifications, with mild hydronephrosis on the right is a nonindustrial condition of kidney stones, which were not secondary to his work related injury.

GASTROINTESTINAL:

Mr. Hewitt has also filed a claim for injury to his stomach. During his interview, Mr. Hewitt stated that he had a possible "upper GI series" and was told to have peptic ulcer disease. Review of the medical records did not confirm the findings of either an upper GI series, evaluation by a gastroenterologist or an endoscopic procedure.

Mr. Hewitt continued to be evaluated after his October visits for his orthopaedic injuries and recurrent cellulitis. Review of the medical records confirms that Mr. Hewitt has been treated with ibuprofen and with Celebrex. The medical records also state, as of 2/09/06 in a report by Dr. Holmes, that Mr. Hewitt was not complaining of any vomiting, diarrhea, constipation or any symptoms of a gastrointestinal nature. In June of 2006, Mr. Hewitt was continued on Celebrex, however, still there is no confirmation of any gastrointestinal symptoms.

Mr. Hewitt had a second surgery by Dr. Holmes in August of 2006, with no complaints of nausea, vomiting or hematemesis. However, Mr. Hewitt states that he has had recurrent symptoms of heartburn since October of 2006.

These symptoms are suggestive of gastroesophageal reflux and can be a complication of use of his nonsteroidal agents.

As of the date of review of these medical records, there is no objective confirmation of injury from nonsteroidal agents, however, this is a well known cause of esophagitis, esophageal erosions, duodenal ulcer and gastritis.

In view of this, I would recommend that Mr. Hewitt have further medical evaluation, specifically evaluation by a gastroenterologist and/or empiric treatment with antisecretory medications.

In summary, Mr. Hewitt has had an accepted orthopaedic injury due to his being struck by an automobile on 10/03/05. Review of the medical records does reveal a renal ultrasound with chronic calcifications and hydronephrosis. This is a nonindustrial condition.

In reference to the complaints of gastrointestinal injury, Mr. Hewitt has subjective complaints with no objective findings. However, due to the fact that there are clinical symptoms of gastroesophageal reflux and there were no prior symptoms before the industrial accident, this would be an industrial condition which requires further medical evaluation.

If additional information becomes available at a later date, then supplemental reports can be issued as required to assess these factors. Such information may or may not change the opinions rendered in this evaluation. The above analysis is based upon the subjective complaints, the history given by the applicant, the review of medical records and tests provided, the physical findings and review of the appropriate medical literature. It is assumed that the material provided is correct.

The examiner's opinions are based upon reasonable medical probability and are totally independent of the requesting party. Medicine is both an art and science. There is no guarantee that the applicant will not be re-injured or suffer additional injury or disease. If applicable, the employer should follow the process established in the Americans with Disabilities Act, Title 1. The opinions expressed here do not constitute a recommendation that specific claims or administrative functions be made or enforced.

This evaluation is definitely not meant for use in any other civil proceedings. The medical issues discussed are approached solely from the perspective of a licensed Qualified Medical Evaluator writing an industrial evaluation report for the California workers' compensation system. For this reason, when medical issues pertaining to the applicant arise in a different legal forum, such as a civil suit, obtaining a separate medical legal report to evaluate such medical issues from a different perspective would be mandatory.

DISABILITY STATUS/DATE OF MAXIMAL MEDICAL IMPROVEMENT

Mr. Hewitt has had no time of total and temporary disability either secondary to his alleged injury to his kidneys or stomach, i.e. peptic ulcer disease.

Mr. Hewitt's injury to his kidneys, i.e., kidney stones, is nonindustrial in nature.

In reference to Mr. Hewitt's complaints of gastrointestinal symptomatology, this will require further treatment and evaluation. It has not caused any total or temporary disability, however, Mr. Hewitt as of this time is not considered permanent and stationary or ratable from this potential injury to his gastrointestinal tract.

FACTORS OF DISABILITY

SUBJECTIVE:

1. Persistent retrosternal burning pain requiring the use of frequent Tums.
2. Appetite good with no recurrent nausea or vomiting.

OBJECTIVE:

- 10/17/05 Renal ultrasound. Right kidney measured 12 x 6.2 x 5.9 cm. The left kidney measured 10.8 x 6 x 6.3 cm. There is mild hydronephrosis on the right. A small amount of free fluid was present in Morrison's pouch. There was no evidence of right uretal jet. The left uretal jet was identified. Renal blood flow was normal. Impression: Mild right-sided hydronephrosis with absent right uretal jet. A uretal obstruction is suggested. Small amount of fluid in Morrison's pouch.
- 10/17/05 CT of abdomen and pelvis. Lung bases were clear. The adrenal glands of normal size. Punctate calcifications are present in the right kidney which shows mild to moderate hydronephrosis and some perirenal fluid. Punctate calcifications are also present centrally in the left kidney. Aorta and vena cava are normal. Scans through the pelvis show a punctate calcification near the right uretal vesical junction or just within the bladder. Prostate is normal. Impression: Obstructing punctate calculus in the right uretal vesicle junction with upstream hydronephrosis.

WORK RESTRICTIONS/PERMANENT DISABILITY/IMPAIRMENT

Discussion utilizing California Schedule for Rating Permanent Disabilities (April 1997) and/or IMC guidelines for evaluation of cardiac and pulmonary disability (July 1998).

Discussion utilizing AMA Guides to the Evaluation of Permanent Impairment, 5th edition.

Mr. Hewitt will require continued evaluation of his gastrointestinal tract.

Based on this evaluation and the current available medical records, there is no work restriction or disability on an internal medicine basis due to his gastrointestinal symptoms.

In reference to his kidney symptomatology, there is no disability, and this is a nonindustrial medical condition.

APPORTIONMENT OF PERMANENT DISABILITY BASED ON CAUSATION

(Relying on guidelines set forth in Escobedo vs. Marshalls; and CNA Insurance Inc. WCAB en banc. 4/19/05.)

SEC. 34. Labor Code Section 4663

(c) In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.

SEC. 35. Labor Code Section 4664

(a) The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.

(b) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof.

As there is no evidence of internal medicine industrial injury, apportionment is not applicable.

VOCATIONAL REHABILITATION

Mr. Hewitt is not considered a qualified injured worker in terms of his internal medicine complaints of damage to his kidneys or peptic ulcer disease.

FUTURE MEDICAL CARE

In reference to Mr. Hewitt's injury to his kidneys, this is nonindustrial and all future medical care is to be obtained on a nonindustrial basis.

Mr. Hewitt has symptoms of gastroesophageal reflux, which had potential causation secondary to use of nonsteroidals to treat his industrially related orthopaedic injury. Mr. Hewitt warrants provision of antacids and antisecretory medication, especially with the use of his nonsteroidals. In addition, due to

his persistent complaints, Mr. Hewitt warrants an evaluation by a gastroenterologist to determine if this is secondary to esophageal reflux disease, gastritis or peptic ulceration as a potential complication from his long-term use of nonsteroidal agents.

If you have any other questions, please feel free to contact me.

END OF REPORT

DECLARATION/SIGNATURE PAGE

I personally took the history from the applicant on the date indicated at the beginning of the report in the medical-legal office located at 1498 Solano Ave, Albany, California, performed the physical examination, reviewed the medical records and prepared this report entirely myself. The medical-legal opinions expressed in this report are solely my own. If medical testing is required, authorization will be requested first and the tests will be performed by an outside hospital or medical entity completely unaffiliated with myself. The results of any medical testing will be addressed by an appropriate supplemental report. For QME reports, additional medical records may be requested and reviewed.

For AME reports, if either additional medical records or medical testing are required to complete the report, a request will be made simultaneously to both requesting parties to avoid the prohibition on ex parte communications for AMEs.

I declare under penalty of perjury that the information obtained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to the information that I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true to the best of my knowledge.

The evaluation of this applicant and the time spent performing the evaluation was in compliance with the guidelines established by the Administrative Director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code or any other relevant sections or revisions of the Labor Code.

I further declare under penalty of perjury that I have not knowingly violated the provisions of the California Labor Code Section 139.3 with regards to the evaluation of this applicant or the preparation of this report. I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred exam or evaluation.

In summary, I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. All statements on this declaration page are made under penalty of perjury.

**PERSONALLY DICTATED, REVIEWED, EDITED AND MEDICAL LEGAL OPINION
VERIFIED AS ATTESTED HERETO BY MY ORIGINAL SIGNATURE:**

Signed: ___/___/200_ in _____, California, County of _____.

David B. Waldman, M.D.
Diplomate, American Board of Internal Medicine
Diplomate, American Board of Gastroenterology