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January 19, 2022

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Re:		
	Employee:	Branden Moore
	Employer:	Abercrombie Pipeline
	Date of Injury:	05/28/2020
	Date of Exam:	01/19/2022
	Claim No.:	WC608-E60694-00
	Panel No.:	2757573

QUALIFIED MEDICAL EVALUATION
in CARDIOLOGY

Dear Gentlepersons:

Thank you for the confidence expressed by my selection through the State Panel Process, pursuant to Labor Code Section 4062.2, to perform a Qualified Medical Evaluation in Cardiology of the above captioned individual, Branden Moore. I interviewed and examined Mr. Moore on January 19, 2022, in my San Clemente office, which is located at 647 De Los Mares, Suite 218, on January 19, 2022. He is a 31-year-

old construction groundman who has submitted a claim for kidney failure, nerve damage from heat stroke, muscle spasm, muscle fatigue, and burning sensation in extremities; which he alleges were caused by heat stroke while performing the duties of his employment with the Ambercombie Pipeline on May 28, 2020.

Stanley Majcher, M.D., was selected as the PQME in Internal Medicine for the purpose of evaluating this injury claim. After seeing Mr. Moore on December 16, 2020, Dr. Majcher recommended that Mr. Moore have an evaluation with another cardiologist. I therefore am performing a QME in Cardiology and deferring all other Internal Medicine issues to Dr. Majcher. On January 19, 2022, Mr. Moore's stated his cardiovascular injury is arrhythmia.

This is an ML201-95 Comprehensive Qualified Medical Legal Evaluation. I spent 1.25 hour in face-to-face interaction with Mr. Moore obtaining a history and performing a physical examination. I reviewed the provided medical records. Pursuant to Labor Code § 4062.3, a declaration and page count attestation were received. The total attestation page count is 2,010 pages.

HISTORY AS PROVIDED BY THE APPLICANT:

Mr. Moore appeared to be a credible historian.

OCCUPATIONAL HISTORY:

Prior to employment as a groundman with the International Brotherhood of Electrical Workers Local 47, Mr. Moore served in the US Marine Corps for 2-½ years. He was discharged with a disability rating for Wolff-Parkinson-White (WPW) Syndrome. Subsequently, he has received military disability ratings for tinnitus, knees and shoulders.

In September 2019, he became a groundman. The union sent him to jobs. In March 2020, he started working at Abercrombie, where he worked until he was injured on May 28, 2020. While working at Abercombie, he did not have any concurrent supplemental employment. He has been on a temporary total disability status since May 28, 2020.

HISTORY OF THE INJURY:

Prior to employment with Abercrombie and specifically prior to May 28, 2020, Mr. Moore had Wolff-Parkinson-White (WPW) Syndrome, which was cured with an

ablation procedure. He did not have subsequent arrhythmia. He did not have kidney, muscle or nerve problems. Mr. Moore had annual examinations at the La Jolla Veterans Affairs Clinic. His primary doctor is John Bas, MD.

On May 28, 2020, Mr. Moore had been working 10 hours on the Morongo Reservation performing vigorous activities installing above-ground powerlines. The peak temperature that day was 115 degrees. He intentionally hydrated. At about 5:00 pm, he began repetitively losing consciousness. He had total body cramping. The crew recognized heat stroke. They attempted cooling measures at the scene. He was transported to San Gorgonio Hospital in Banning. The diagnosis was Rhabdomyolysis and kidney failure. He was treated for a day and half. He was transferred to Loma Linda University Hospital. He was treated for another day and a half and discharged. Dr. Bas at the VA continued as his primary care doctor. Because the injury was not service connected, he was not entitled to specialty medical care.

Since the injury on May 28, 2020, Mr. Moore has had daily palpitations. He has not had racing heart or passing out. He reports that he has lost 40 pounds since the injury. In 2020, Dr. Stanley Majcher performed a PQME examination.

PAST MEDICAL HISTORY:

CHILDHOOD:	There is no history of asthma or heart murmur.
ADULT:	There is no history of asthma, diabetes, hypertension, cancer, or heart disease other than the congenital WPW.
SURGERIES:	Wolff-Parkinson-White ablation.
MEDICATIONS:	CBD drops for muscle spasms/nerve pains. (Mr. Moore does not indicate that he is taking any other medications at this time.)
DRUG ALLERGIES:	None.

FAMILY HISTORY:

Mother: deceased at 40, cause unknown.
Father: 71.

There are four siblings alive and well.

SOCIAL HISTORY:

Mr. Moore was born in California. He graduated high school in 2009. He enjoys golf, weightlifting, dirt bike riding and lodge meetings. He has been married almost 2 years and lives in Hemet with his wife, 19-month-old daughter and 7-month-old son.

TOBACCO:	Smoked cigarettes sporadically while in the Marine Corps and cigars rarely, but stopped in 2017.
ALCOHOL:	No past or current use.
RECREATIONAL DRUGS:	None.

INVENTORY OF ACTIVITIES OF DAILY LIVING:

With respect to the **claimed cardiology injury**, Mr. Moore reports:

SELF CARE: denies any difficulties with self-care.

SENSORY FUNCTION: denies any difficulties with sensory function.

COMMUNICATION: denies any difficulties with communication.

PHYSICAL ACTIVITY: denies any difficulties with physical activity.

NONSPECIALIZED HAND ACTIVITES: denies any difficulties with hand activities.

TRAVEL: denies any difficulties with travel.

SEXUAL FUNCTION: denies any difficulties with sexual function.

SLEEP: denies any difficulties with sleep.

REVIEW OF SYSTEMS:

CONSTITUTIONAL:	See History of the Injury. Constant fatigue.

	Sleep is disturbed by nocturia 3 to 4 times. No fever or chills.
HEAD:	Severe headaches. Chronic dizziness.
EYES:	Blurred vision with headaches.
EARS, NOSE AND THROAT:	Bilateral tinnitus. No change in hearing or ear pain.
NECK:	No neck pain or stiffness.
SKIN:	No itching, rashes, or sores.
HEME-LYMPHATIC:	No swollen glands, no unusual bruising or bleeding.
CARDIOVASCULAR:	See History of the Injury
RESPIRATORY:	No chronic cough or wheezing.
GASTROINTESTINAL:	See History of the Injury. Alternating diarrhea and constipation. No vomiting, rectal bleeding, or black stools.
GENITOURINARY:	Erectile dysfunction. Capable of erection, penetration and ejaculation with more effort and less pleasure.
NEUROLOGIC:	Reports memory loss "all the time": for example, forgetting why he went into a room.
MUSCULOSKELETAL:	See History of the Injury
PSYCHOLOGIC:	Depression and anxiety. Severe trouble with concentration due to fatigue.

PHYSICAL EXAMINATION:

GENERAL:	He was well developed, underweight and walked with the assistance of a cane.
VITAL SIGNS:	Pulse: 60, regular Blood Pressure: 118/72 Respirations: 26 Height: 72 inches Weight: 145 pounds BMI: 20.9
HEAD:	There was no tenderness or deformity.
EYES:	The pupils were 3 mm, equal, round, and reactive to light and accommodation.
NECK:	The carotid pulses were tapping. There were no carotid bruits. There was a full range of motion.
BACK:	No CVA tenderness.
LUNGS:	There were no rales, wheezes, or rhonchi.
HEART:	The left ventricular impulse was in the fifth intercostal space, midclavicular line. The first heart tone was normal at the apex. The second heart tone was physiologically split. There were no murmurs.
ABDOMEN:	The abdomen was soft. There was no tenderness, masses or organ enlargement.
EXTREMITIES:	The extremities showed no cyanosis, clubbing, or edema.
NEUROLOGIC EXAM:	There was no focal weakness. The gait was normal.

LABORATORY DATA:

In performance of this medical legal evaluation, the following laboratory tests were obtained, which I interpreted.

COMPLETE METABOLIC PANEL:	Abnormal: ALT 46 (nl 10-40).
CBC:	Abnormal: 3.6 (nl 3.8-10.8).
CREATINE KINASE:	Abnormal: 4292 (nl 44-196).
URINALYSIS:	Normal.

By way of submission of this report, it is recommended and assumed that Mr. Moore will be provided with all test results. I recommend that he review these test results with his private physician.

REVIEW OF RECORDS:

Schedule of Records:

San Diego Healthcare System
- Cara Eggers, Ph.D.
- Quynh-Giao Nguyen, M.D.
- Luke Hiller
- Alan Maisel, M.D.
- Michal Hose, M.D.
- David Krummen, M.D.
- Erica Moses, Ph.D.
- Debra Rice, R.N.
- Paul Krug, R.N.
- Leda Felicio, M.D.
- Anne Nisenzon
- Mohammad Siddiqui, M.D.
- Rajeev Joshi
- Robert Ross, M.D.
- Linda Ottley, N.P.
- Lenore Carlson, R.N.
- Nilsa Artesi
- Jennifer Nowaczyk

Dan Meyer, C.R.N.A.
Ronald Dueck
Melissa Tingue
Shyrl Glisan
Donna Cooper, R.N.
Stephanie Crook, M.S.N.
Sanjiv Narayan, M.D.
Denise Barnard, M.D.
Wilbur Lew, M.D.
Heather Rigney, L.V.N.
Emmanuel Espejo, Ph.D.
Margaret Matarese
Lynnetta Lester, R.N.
Kevin Lewis
Mitul Patel, M.D.
Paul Stark, M.D.
Amilcare Gentili
Cheryl Pierce
Erin Wallace
Brandon Folsom, R.N.
Richard Schulz
Joshua Bollan, M.D.
Geraldine Chang, M.D.
Alex Pearce, M.D.
Sreenath Naray
Luke Wingo, R.N.
Ali Parand, M.D.
Patrcia Hlavin, M.D.
Marcos Sandoval, R.N.
Cassidy Halle, R.N.
Ann Corbin-Fulchiron, L.C.S.W.
Roxana Aminbakhsh, M.D.
Eileen Holman, L.C.S.W.
Jasmin Lyons
Noushin Vahdat
Karen Chen
Joanne Jacalan, N.P.
Eileen Apfel, O.T.R.
Bienvenido Siy-Hian
Eliza Starr, R.N.

Justin Ly, M.D.
Matthew Sharp, M.D.
Jisha Joshua, M.D.
David Bryman
Jennifer Feneis
Mike Eskander, M.D.
William Perrine
Michael Pleban
James Ruddy, F.N.P.
John Echada
Raymond Gysler
Luella Poniktera, L.V.N.
Farshad Bahador
Felix Krainski
Gordon Ho, M.D.
Cynthia Catrell, R.N.
John Bas, M.D.
Ilyn Ballesteros-Romero, R.N.
Stella Annunziato, R.N.
Tari Long, R.N.
Ashley Buck
Natalie Sweiss, M.D.

Palomar Health
Jack Wilson, M.D.

Sharp Grossmont Hospital
Peter Colaprete
Alborz Hassankhani, M.D.
Subhash Viswanathan, M.D.
Bijan Razi, M.D.
Ryan Viets, M.D.
Joshua Doros, M.D.

TriWest Healthcare Alliance
Paul Liederman, M.D.

Rehabilitation Strategies, Inc.
Eric Prante, P.T.

iRhythm Technologies

BioTel

San Gorgonio Memorial Hospital
Amber Westbrook
Richard Preci, D.O.

Mohsin Syed, M.D.
Angela Ullon, P.A.C.
Chul Chae, M.D.
Bahij Ghazal, M.D.
Stanley Majcher, M.D.
Kenneth Garett, Ph.D.

Record Summary:

A. San Diego Healthcare System

1. C & P Examination Note, Cara Eggers, Ph.D., January 12, 2012: Military History: The patient served in the Marine Corps from 2010 to present. Highest rank he obtained is E3. He is honorably discharged. His rank at discharge is E3 or E4. His military occupational specialty is Amphibious Assault Vehicle Crewman. He did not have combat experience. He is being considered by medical board for discharge from the Marine Corps due to his heart condition. Past Medical History: Wolff-Parkinson White Syndrome is diagnosed in July 2011. Present Medical History: Insomnia: He cannot fall asleep easily; it usually takes several hours, and once he falls asleep, he wakes up multiple times feeling "excited, like something is going to happen." He states this has been a problem since a 2010 (during boot camp) and possibly before. He feels fatigued during the day; he feels he is "still awake" even when sleeping. It is not clear whether his insomnia is related at all to his heart condition, as he does report waking with racing heart and feeling "alert." Transient Alteration of Awareness: He believes this portion of the claim refers to his report that he sometimes feels like he is still awake when he is sleeping. "I feel on guard all the time, like I can't relax or sleep deeply." Anxiety: He has been deployed once to Okinawa, not in combat. His step-mother sent him Ambien while he was in Okinawa to help him sleep.

2. C & P Examination Note, Quynh-Giao Nguyen, M.D., January 12, 2012: Highest BP: 127/76. Lowest BP: 119/67. HR: 66. WT: 171. Medical History (Subjective Complaints): The patient has Wolff-Parkinson-White syndrome, fainting, and palpitations. He began experiencing palpitation, labored breathing, and chest tightness associated with running in the fall of 2010. Over the next 6 months he reports experiencing recurrent palpitations with both physical activities and at rest. He is also having associated intermittent lightheadedness and 2 syncopal episodes where he blacked out and only came to minutes later when someone lied him down on the ground. He reports having 3 episodes of left-sided

hemianopia (no vision) with left arm and leg numbness and tingling associated with palpitations, labored breathing, and chest tightness after physical activities (running) in June 2011. These symptoms resolved after a few hours and have not recurred since that time. He had a negative evaluation with carotid ultrasound and brain MRI. The claim of "transient alteration of awareness" refers to these 3 episodes, which were felt to be associated with focal brain hypoperfusion secondary to his arrhythmia. He was diagnosed with Wolff-Parkinson-White syndrome in June 2011. Cardiac ultrasound from June 2011 revealed normal left ventricular size and with an ejection fraction of 60%. No valvular abnormality was noted. He has breakthrough palpitations with associated labor breathing, chest tightness, and lightheadedness 2-3 times a week at rest and with minimal activities despite being on Flecainide since August 2011. He would lower himself to the ground and lie down with resolution of his symptoms in about 10-15 minutes. He is reluctant to undergo ablation therapy. He has not participated in physical training or exercise since June 2011. With regards to functional limitation the service member has not been able to perform command PT or work in his rank. He has some functional limitation with basic activities of daily living associated with recurrent palpitations and lightheadedness with activity, such as taking a shower. Diagnoses: 1. Wolff-Parkinson-White syndrome with recurrent palpitations, episodes of syncope and near-syncope. Estimated METS 4. He had 3 episodes of transient ischemic attacks associated with tachycardia and focal hypoperfusion in June 2011, without residual neurological deficits. He has significant functional limitation with occupational and some basic activities of daily living as described. 2. Right shoulder strain with radiographic evidence of mild sclerosis seen in the horizontal facet of the greater tuberosity. No significant functional limitation. 3. Bilateral knee patellofemoral syndrome with radiographic findings suggestive of osteochondromas. He has no significant functional limitation with occupational or daily activities at this time.

3. X-ray of the Bilateral Knee, Luke Hiller, January 12, 2012: Impressions: 1. No acute osseous abnormality. 2. Proximal right fibular lobulated cortical irregularity and pedunculated osseous excrescence in the distal left lateral femur, both with intramedullary continuation, are suggestive of osteochondromas.

4. ECG, Alan Maisel, M.D., March 25, 2013: Ventricular Rate: 67. Interpretations: 1. Normal sinus rhythm. 2. Wolff-Parkinson-White. 3. Abnormal ECG. 4. No previous ECGs available.

5. Laboratory Reports, from March 25, 2013 to February 8, 2021: March 25, 2013 May 7, 2013 May 8, 2013 March 18, 2016 October 29, 2016 March 17, 2017 April 14, 2017 April 16, 2017 May 25, 2017 May 26, 2017 August 14, 2017 August 16, 2017 August 23, 2017 December 10, 2017 January 29, 2018 April 2, 2018 April 6, 2018 August 31, 2018 November 30, 2018 December 7, 2018 December 12, 2018 February 15, 2019 February 16, 2019 February 21, 2019 March 21, 2019: July 20, 2019 February 8, 2021 Abnormal Results: March 25, 2013, total bilirubin 0.2. March 18, 2016, eGFR 86. Albumin 5.3. Lipase 76. RBC 5.81. RDW-CV 12.4. MPV 8.7. Eosinophil # 0.0. Basophil # 0.0. UR/Protein 2+. Ketones 2+. Few epithelial cells and abundant mucus present in urine. October 29, 2016, creatinine 1.42. eGFR 73. Glucose 106. Albumin 4.8. Lipase 44. RDW-CV 12.7. MPV 8.9. Segmented neutrophil # 7.3. Basophil # 0.0. Urine slightly cloudy. UR/Protein 2+. Trace ketones present in urine. Few epithelial cells and abundant mucus present in urine. WBC/HPF 21-50. [Myocardiac] enzymes 116.2. March 17, 2017, Glucose 106. RDW-CV 12.8. Eosinophil # 0.0. Basophil # 0.0. April 14, 2017, eGFR 92. RDW-CV 12.8. MPV 9.0. Segmented neutrophil # 2.1. Eosinophil # 0.0. Basophil # 0.0. May 25, 2017, WBC 4.4. RDW-CV 12.7. MPV 8.8. Segmented neutrophil # 2.2. Eosinophil # 0.0. Basophil # 0.0. May 26, 2017, chlorine 107. WBC 4.0. RDW-CV 12.9. Segmented neutrophil # 2.0. Eosinophil # 0.0. Basophil # 0.0. TSH HS 0.45. August 14, 2017, eGFR 92. WBC 3.8. RDW-CV 12.6. MPV 8.8. Segmented neutrophil # 2.0. Eosinophil # 0.0. Basophil # 0.0. CK 726. August 16, 2017, CK 530. August 23, 2017, eGFR 82. Glucose 110. Amylase 87. WBC 4.7. RDW-CV 12.4. MPV 8.6. Eosinophil # 0.0. Basophil # 0.0. WBC/HPF 3-5. December 10, 2017, glucose 100. Lipase 75. WBC 3.8. RDW-CV 12.9. Eosinophil # 0.0. Basophil # 0.0. January 29, 2018, amylase 142. WBC 4.1. MPV 8.9. April 2, 2018, MRSA 1+. April 6, 2018, eGFR 91. WBC 4.0. MCHC 30.9. RDW-CV 12.7. August 31, 2018, chlorine 109. Glucose 103. AST 43. ALT 68. WBC 3.6. MCHC 31.5. MPV 8.8. Segmented neutrophil # 1.8. Basophil 0.0. Glucose AT 101. November 30, 2019, UR/protein 2+. Few epithelial cells and mucus are seen in urine. December 7, 2018, chlorine 108. eGFR 80. WBC 3.4. RDW-CV 12.9. March 21, 2019, amylase 108. Lipase 62. WBC 3.5. RDW-CV 12.6. MPV 8.9. Segmented neutrophil # 1.9. Eosinophil # 0.0. Basophil # 0.0. Few epithelial cells and mucus are seen in urine. July 20, 2019, carbon dioxide 23. WBC 3.4. RDW-CV 12.2. MPV 8.6. Segmented neutrophil # 1.8. Eosinophil # 0.0. Basophil # 0.0. February 8, 2021, WBC 3.8. RDW-CV 12.9. MPV 9.0. Few mucus is seen in urine. CK 473.

6. Primary Care Note, Michal Hose, M.D., March 25, 2013: BP: 121/79. HR: 81. WT: 150.6. BMI: 23. HPI: The patient has history of WPW diagnosed in military. He has had 5-6 syncopal episodes. One month ago, he had another

syncopal episode. This occurred after an argument with his girlfriend. He is usually out for "one hour." He gestured a thud in his heart and then it takes off quickly. Past Medical History: He is diagnosed of WPW in Japan in June 2011. He had syncope. He had ventricular arrhythmias (sustained) (60%-SC). He has had multiple episodes of syncope (~6) usually related to stress/exercise. He has insomnia. He sits up all night. He is on Ambien 5 mg. He is afraid to die because of WPW. Medications: Tambocor 150 mg, ASA 81 mg, and Ambien 5 mg. Social/Occupational History: He is with the Marines for 2 years. He is medically discharged. He has no combat experience. He has history of rare tobacco use. He quit tobacco use. Assessments: 1. Testicular pain. 2. Anxiety. 3. WPW. 4. HM. Plan: He is advised against driving. He is to have EKG today. He is to have Holter and ECHO per cardiology. Cardiology EP referral is to be placed.

7. PT Letter/Test Results, Michal Hose, M.D., April 1, 2013: No changes are recommended to the patient's treatment plan.

8. Holter Report, David Krummen, M.D., April 22, 2013: Minimum HR: 42. Average HR: 76. Maximum HR: 135. Interpretations: 1) Sinus rhythm with WPN and with an average HR of 76 bpm. 2) Maximum HR of 135 bpm during unknown activity 10:56 pm. 3) Minimum HR of 42 bpm during sleep 5:57 am. 4) Rare isolated premature ventricular contractions. 5) Rare isolated premature atrial contractions. 6) Duration of 22 hours with 17% tachycardia and 21% bradycardia. 7) No cardiac symptoms indicated.

9. Psychiatry Consult, Erica Moses, Ph.D., April 24, 2013: Clinical History: The patient states he has insomnia. He states he passed out and he does not know if he died, but he went to hell. He states that when he came to, he had a defibrillator on his chest. He had a sleep problem since then because he was afraid of it happening again. He states it last happened on November 4, and he just could not sleep. Sometimes in the middle of the day, he has to take a nap. He does not like taking pills because he does not want to become dependent on medication. He has been diagnosed with insomnia and Wolff-Parkinson-White. He feels like he is always apprehensive/on the alert. He has lots of thoughts running through his mind at night about not dying again. He states he does not want to go back to hell. His girlfriend reports he will kick and yell in his sleep but he cannot recall nightmares. History of Presenting Problem: His heart difficulty began in June 2011. His sleep difficulties began immediately after he left the hospital and was in recovery. He rarely drinks alcohol, and he never drinks at a higher level than he is now. He first drank when he was 17 years old. He drank 1/2 beer last weekend. He does not drink even a full beer. He has

occasional cigarette use when stressed in order to help him settle to rest. Diagnostic Impressions: Axis I: 1. Anxiety disorder not otherwise specified vs. chronic adjustment disorder with anxiety. 2. Insomnia. Axis II: Deferred. Axis III: 1. Wolff-Parkinson-White. 2. Chronic knee/elbow/back pain. Axis IV: 1. Recent cardiac episode. 2. Loss of grandmother. Axis V: Global Assessment of Functioning, current= 60.

10. Emergency Department Triage Note, Debra Rice, R.N., May 7, 2013: BP: 129/77. HR: 67. Subjective: The patient has lump to the left side of his penis and pain to his left testicle since January, which is now radiating up into abdomen since last night. He vomited once yesterday. He has urine "pressure" when urinating with slight frequency with urgency.

11. Emergency Department Note, Paul Krug, R.N., May 8, 2013: BP: 130/69. HR: 60. WT: 170.6. CC: Pain in the left testicle. Subjective: The patient has pain just above the left testicle and goes upward. He has less pain when he lies down. He passes gas. He has some hesitancy to urinate but good flow after. He has chest and abdominal pain yesterday and it is still ongoing for one and a half days. His chest pain started at the same time as the belly pain. Achy/sharp pain is just below the nipples on both sides and down into the stomach, which comes and goes with the abdominal pain that he feels below. His abdominal pain started yesterday, which is located mostly above the bladder. His chest hurts and testicle hurts when he pushes on the stomach. Constant pain comes and goes and it is rated 4/10. Nothing makes it better or worse. He has had some diarrhea over the last week every day, about less than 10 times a day. He vomited 2 days ago. He has history of WPW and tachycardia. He does have some irregular symptoms at times, but he has not had tachycardia. Medication: ASA. Social History: He smokes. [He uses marijuana]. Assessments: 1. Abdominal/chest pain with diarrhea. 2. Varicocele.

12. ECG, Leda Felicio, M.D., May 8, 2013: Ventricular Rate: 50. Interpretations: 1. Sinus bradycardia with short PR interval. 2. Wolff-Parkinson-White. 3. Abnormal ECG. 4. When compared with ECG of March 25, 2013, 14:17, bradycardia is now present.

13. Psychology Consult, Anne Nisenzon, May 14, 2013: Subjective: The patient has had a lot of anxiety and difficulty sleeping since his first tachycardia episode in June 2011. He was diagnosed with Wolff-Parkinson-White Syndrome, and has since had one other similar episode in November 2012. He described symptoms as rapid heartbeat (up to 260 bpm), light headedness, and occasional fainting.

He reported that he has had only 2 full tachycardia events, but that he occasionally has heart palpitations and sensations of skipping a beat. He noted that after his second episode, he has had very poor sleep, as he responds to the "falling feeling" with anxiety, and it "jerks" him awake. He is only getting 2-3 hours of sleep per night, and that it is often broken. He is currently taking Tambocor, Simvastatin, and Aspirin as prophylactic treatments. Diagnosis: Psychological factors affecting general medical condition (WPW syndrome). Plan: He is encouraged to speak with his cardiologist regarding cardiac rehabilitation to learn appropriate and safe rehabilitation exercises.

14. Psychiatry Attending Note, Mohammad Siddiqui, M.D., May 14, 2013: CC: Anxiety disorder. HPI: The patient has been having issues with sleep since 2011. He states, "After my first bout of tachycardia, WPW, I have vivid dreams of what happened, getting put into the back of the ambulance, waking up with the defibrillator, then I wake up with a cold sweat." He is getting about 4 hours of sleep on average per night now. He states that his anxiety is "having my palpitations again, and passing out, and having the same thing happen again, I'm 23, I'm afraid to die". Diagnostic Impressions: Axis I: 1. Anxiety disorder, not otherwise specified. 2. Insomnia. Axis II: Deferred. Axis III: 1. Wolff-Parkinson-White. 2. Chronic knee/elbow/back pain. Axis IV: 1. Recent cardiac episode. 2. Loss of grandmother. Axis V: Global Assessment of Functioning, current= 60. Plan: He has initial cardiology appointment in 2 weeks. He does not feel comfortable in initiation of any meds at this time, until cardio input.

15. Psychology Note, Anne Nisenzon, May 22, 2013: Subjective: The patient continues to have "panic" symptoms, especially at night. Diagnosis: Unchanged.

16. Psychology Note, Anne Nisenzon, May 29, 2013: Subjective: The patient has not had any anxiety attacks or difficulties falling asleep over the past week. He reported "crashing" at night, and did not have any trouble falling asleep, nor did he have any concern over his heart condition. Diagnosis: Unchanged.

17. Cardiology Note, Rajeev Joshi, May 30, 2013: BP: 129/73. HR: 92. WT: 160. HPI: The patient has several episodes of palpitations, associated with dizziness lasting about an hour, with near syncopal episodes over the past 2 years. He reports having 4 in the past 6 months. He usually lies down until the episode subsides. He has been instructed to attempt Valsalva maneuvers in the past, however, has not tried them. He has high level of anxiety. He has been on Flecainide with no relief of symptoms. Medications: Aspirin and Flecainide. Plan: He wants to proceed with an ablation.

18. ECG, Robert Ross, M.D., May 30, 2013: Ventricular Rate: 85. Interpretations: 1. Normal sinus rhythm. 2. Wolff-Parkinson-White. 3. Abnormal ECG. 4. When compared with ECG of May 8, 2013, 19:29, ventricular rate has increased by 35 BPM.

19. Urology Outpatient Note, Linda Ottley, N.P., June 7, 2013: CC: Scrotal pain. Assessment: History of varicocele vs. chronic prostatitis/chronic pelvic pain syndrome.

20. Echogram Scrotum, Luke Hiller, July 1, 2013: Impression: Unremarkable testicular ultrasound.

21. Medical Report, Leda Felicio, M.D., July 11, 2013: BP: 116/72. HR: 59. WT: 170. LVPWd: 1 cm. IVSd: 1 cm. LVIDd: 4.9 cm. BP EF (MOD): 64%. Conclusions: 1. There is normal left ventricular systolic function with no wall motion abnormalities. 2. Normal left ventricular diastolic function is observed.

22. Triage Note, Lenore Carlson, R.N., August 21, 2013: Diagnosis: Health seeking behavior as evidenced by call to TeleCare.

23. Primary Care Nursing Note, Nilsa Artesi, August 27, 2013: The patient is grinding his teeth and the right side of his face is hurting. He has had nightmares since his "accident" and his heart stopped.

24. Physician History and Physical Note, Jennifer Nowaczyk, August 28, 2013: BP: 117/67. HR: 87. WT: 161. HPI: The patient has not had any palpitation episodes in the past 2 months. Medications: Aspirin 81 mg and Flecainide 150 mg.

25. ECG, David Krummen, M.D., August 28, 2013: Ventricular Rate: 83. Interpretations: 1. Normal sinus rhythm. 2. Wolff-Parkinson-White. 3. Abnormal ECG. 4. When compared with ECG of May 30, 2013, 15:29, no significant change was found.

26. Pre-Anesthetic Summary, Dan Meyer, C.R.N.A., September 9, 2013: BP: 129/94. HR: 65. WT: 170. Medications: Unchanged. Diagnosis: Wolff-Parkinson-White since June 2011.

27. Anesthesiology Attending Note, Ronald Dueck, September 9, 2013: The patient has recurrent episodes of tachycardia with dizziness for which he lies down until the tachycardia subsides. A Holter recording showed an episode at 135

BPM. He avoids strenuous exercise now due to fear of inducing tachycardia, and likely has become deconditioned, since he now experiences some dyspnea when walking uphill. However, his cardiac echo is normal. He is ASA status II.

28. Emergency Department Triage Note, Melissa Tingue, February 25, 2014: BP: 130/78. HR: 68. WT: 160. The patient was recently seen at Sharp and he was given prescription for Tamiflu and he is requesting for it to be filled.

29. Nursing Telephone Encounter Note, Shyrl Glisan, February 28, 2014: The patient is requesting Tambocor, which he states he had prescribed in military.

30. Primary Care Note, Michal Hose, M.D., March 13, 2014: BP: 139/84. Repeat BP: 120/68. HR: 81. WT: 172. HPI: The patient is being evaluated by cardiologists for WPW, and they were planning special procedure for cryoablation, but the cardiology department was waiting for special catheter to arrive. He has not heard from cardiologists yet. He avoids exercise and heavy exertion. He is having nightmares. He gets very anxious at night when he gets ready to lay down. He is afraid of going to sleep to avoid the trigger. He is still taking Flecainide. He has been getting this form prior prescription from military. The Tambocor makes him have vivid dreams. Medications: Tambocor 150 mg and ASA 81 mg. Assessments: 1. Anxiety/possible PTSD. 2. Smoking cessation. 3. WPW. 4. HM. Plan: He would need to select medications with his underlying cardiac conduction problems in mind, and that he is on Flecainide. He is advised against driving. Probe is to be done. Baseline EKG is to be obtained today.

31. Psychology Note, Anne Nisenzon, March 13, 2014: Subjective: The patient believes he may have developed PTSD following an event that occurred in 2012 when he experienced sudden heart failure and was brought back to life by heart defibrillators. He learned that day that he had developed a heart condition that could lead to sudden death in the future. He now re-experiences this event every night in the form of intense nightmares. He fears going to sleep and often does not go back to sleep after waking from the nightmare. He reports high levels of agitation and physical reactions throughout the day (heart racing, and sweating). History of Presenting Problems: He believes his symptoms have continued to exacerbate and may have recently spiked because of stress related to getting married and his wife's pregnancy with their second child. DSM 5 Diagnoses: 1. Rule out PTSD. 2. Wolff-Parkinson-White ventricular pattern.

32. ECG, Leda Felicio, M.D., March 13, 2014: Ventricular Rate: 66. Interpretations: 1. Normal sinus rhythm with sinus arrhythmia. 2. Wolff-Parkinson-White. 3.

Early repolarization. 4. Abnormal ECG. 5. When compared with ECG of August 28, 2013, 11:16, no significant change was found.

33. Cardiology Nursing Note, Donna Cooper, R.N., March 17, 2014: The patient needs refill of Flecainide.

34. Triage Note, Stephanie Crook, M.S.N., July 7, 2014: The patient has left-sided chest pain and soreness for 2 weeks that radiates to left shoulder, and he has stomach ache for 2 months. His pain has been persistent since the ablation two and a half months ago. Pain is constant dull ache, rated 5/10. Diagnosis: Acute pain.

35. Cardiology Note, Sanjiv Narayan, M.D., July 24, 2014: BP: 141/74. HR: 107. The patient presents approximately 3 months after cryoablation of his paraseptal accessory pathway. He is doing very well, with minimal palpitations. However, he still has some residual chest burning. He has seen Dr. Hassankhani who feels that a stress test would be worthwhile. Plan: Holter, echo, and stress test are offered to him. He wishes to have them done by Dr. Hassankhani.

36. ECG, Denise Barnard, M.D., July 24, 2014: Ventricular Rate: 102. Interpretations: 1. Sinus tachycardia. 2. Otherwise normal ECG. 3. When compared with ECG of March 13, 2014, 11:00, ventricular rate has increased by 36 BPM. 4. Wolff-Parkinson-White is no longer present.

37. Primary Care Note, Michal Hose, M.D., May 4, 2015: BP: 128/86. HR: 64. WT: 174.6. HPI: The patient's WPW ablation was done outside at Sharp. His heart rate is not fast now, but he gets pauses and then abnormal rhythm. He never followed up with the outside cardiologist as he could not get an appointment. He has tender swelling in abdomen. He thinks it is ingrown hair. PE: He has mild chest wall TTP when pressed in the sternum. Assessments: 1. Anxiety/possible PTSD. 2. Smoking cessation. 3. WPW. 4. Hydrocele. 5. Folliculitis. 6. HM. Plan: He is to have EKG today. ETT, Holter, and TTE are to be done. He needs a service dog in case he has an issue with his heart, and for emotional issues.

38. ECG, Wilbur Lew, M.D., May 4, 2015: Ventricular Rate: 52. Interpretations: 1. Sinus bradycardia. 2. Early repolarization. 3. Otherwise normal ECG. 4. When compared with ECG of July 24, 2014, 15:10, ventricular rate has decreased by 50 BPM. 5. QT has shortened.

39. Nursing Outpatient Note, Heather Rigney, L.V.N., May 4, 2015: The patient is having left testicle pain.

40. Psychology Group Counseling Note, Emmanuel Espejo, Ph.D., June 4, 2015: The patient participated in 90-minute session to get oriented to the Anxiety Disorders Clinic and schedule intake appointment if needed. He has sleep difficulties.

41. Psychiatry Admission Evaluation Note, Emmanuel Espejo, Ph.D., October 27, 2015: Presenting Complaints: The patient was seen for a 75-minute intake session. He met criteria for insomnia. It takes him longer than 30 minutes to fall asleep at night, that he is awake longer than 30 minutes in the middle of the night, and that he wakes up more than 30 minutes earlier than he would like in the morning. He also endorsed frequent nightmares nearly every night between 3:30-5:00 am, around the same time the traumatic event he experienced in 2011 when he collapsed and his heart stopped. He has a fear of dying since that incident and that he has a fear of falling asleep at night for fears of having the nightmare. His wife tells him he moves around in his sleep during these nightmares and he wakes up in a cold sweat. Smoking History: he previously considered himself an infrequent smoker. However, as his nightmares and sleeping difficulties have increased over the past year, he has increased his smoking to around 4 cigarettes per day. DSM-Diagnosis: 1. Insomnia. 2. PTSD. 3. Panic disorder. 4. Agoraphobia. 5. General anxiety disorder. 6. Major depressive disorder, recurrent. Plan: He requests individual psychotherapy when available for insomnia and nightmares.

42. Psychiatry Notes, Emmanuel Espejo, Ph.D., from January 15, 2016 to April 15, 2016: The patient was seen for 8 psychotherapy sessions. In the initial session he reports he has problems with nightmares and symptoms of PTSD following a tachycardia incident with stroke symptoms in 2012 (with a second event in 2014). He failed to attend a session on March 11, 2016. On his eighth session, he reported that his problems with sleep and nightmares have reduced over the past few weeks. He would like to take a break from treatment. His remaining appointments will be cancelled.

43. C & P Examination Note, Cara Eggers, Ph.D., February 3, 2016: The patient continues to have difficulty falling and staying asleep on most days. He wakes frequently during the night. He is having "sweats" at night. He takes over-the-counter Benadryl. He tries to nap during the day. He feels tense and alert much of the time. His wife tells him he talks in his sleep, punches things when he

wakes up from dreams but does not recall much about these incidents. He is often tired during the day. He has a history of taking Ambien but it was addicting to him, and he did not like the rebound insomnia and did not want to take it again. He has trouble staying awake sometimes and worries about driving because he has fallen asleep driving. Diagnosis: Unspecified anxiety disorder.

44. C & P Examination Note, Margaret Matarese, March 11, 2016: BP: 134/89. HR: 69. Medical History: The patient currently has palpitations about 1-2 times per week, lasting about 10 minutes. He has tingling on the left side and dizziness. He has syncope since the ablation once in September 2015. He reports tingling before he passed out. He did not seek care for it. Diagnosis: Ventricular arrhythmia.

45. Emergency Department Note, Lynnetta Lester, R.N., March 18, 2016: BP: 143/86. HR: 83. HPI: The patient is sitting in his car this morning when he is overcome by jitters, numbness/tingling, and sense that he could not get air. He drove home and stayed in car outside. He called 911 and is taken to Sharp, but the ED line was too long so he left without being seen and came here. Assessment: Panic attack with somatic manifestations.

46. ECG, Leda Felicio, M.D., March 18, 2016: Ventricular Rate: 72. Interpretations: 1. Normal sinus rhythm with sinus arrhythmia. 2. When compared with ECG of May 4, 2015, 11:14, no significant change was found.

47. Psychiatry Telephone Encounter Notes, from March 18, 2016 to August 15, 2018: The patient failed to attend his scheduled appointment on March 18, 2016. He had three phone calls regarding his PTSD. He could not tolerate Risperidone. He is switched to Clonidine 0.1 mg on June 2, 2017. Diagnosis: PTSD.

48. Nursing Emergency Department Note, Kevin Lewis, October 29, 2016: BP: 141/89. HR: 100. HPI: The patient has left-sided body pain (including chest, shoulder and abdomen) for 2-3 months, cough for 3 days, left flank pain and dysuria, mid chest pain for 2 years since ablation for WPW, vomiting today as he is unable to tolerate food, and diarrhea for 3 days. Impressions: 1. Gastroenteritis. 2. Patient with multiple complaints.

49. ECG, Mitul Patel, M.D., October 29, 2016: Ventricular Rate: 94. Interpretations: 1. Normal sinus rhythm. 2. When compared with ECG of March 18, 2016, 16:52, no significant change was found.

50. X-ray of the Chest, Paul Stark, M.D., October 29, 2016: Impressions: 1. Clear and well-expanded lungs. 2. Sharp costophrenic sulci and diaphragmatic contour. 3. Normal cardiovascular silhouette. 4. Normal pulmonary vessels. 5. Normal trachea. Normal hila. 6. Intact regional skeleton. Normal soft tissues and normal limited view of the upper abdomen. 7. Normal study. No pneumonia seen.

51. Nursing Emergency Department Note, Paul Krug, R.N., March 17, 2017: BP: 118/72. HR: 77. Subjective: The patient's chest pain persisted since he was seen here 1 year ago. He states, "It has never went away since my ablation years ago." He has some tingling in his fingers that is associated with hyperventilating. He has anxiety about a new symptom where he feels his ribs "popping" with certain movements. EKG is performed.

52. ECG, Leda Felicio, M.D., March 17, 2017: Ventricular Rate: 77. Interpretations: 1. Normal sinus rhythm. 2. When compared with ECG of October 29, 2016, 20:07, no significant change was found.

53. X-ray of the Chest, Amilcare Gentili, March 17, 2017: Impression: No radiographic evidence of acute cardiopulmonary disease.

54. Triage Note, Cheryl Pierce, April 14, 2017: The patient has nausea and vomiting for 2 weeks. He is unable to keep fluids down. He is also having URI symptoms. He has anal pain rated 8/10 from hemorrhoids for 3 days. It hurts for him to sit. He has left lower abdominal pain for one and a half months. He has weight loss. He becomes short of breath with exertion.

55. Emergency Department Note, Erin Wallace, April 14, 2017: BP: 112/85. HR: 67. The patient has nausea/vomiting/diarrhea and abdominal pain for 4 days after "drinking old water". He had cold sweats. He has continuous left lower quadrant abdominal stabbing pain rated 6/10 for less than 3 months that is acute. He left ED without being seen.

56. Emergency Department Note, Brandon Folsom, R.N., April 16, 2017: BP: 135/77. HR: 101. HPI: The patient has intermittent left lower quadrant and right lower quadrant abdominal pain, cramping, as well as post prandial nausea for several weeks. He also has sore throat today, and he has metallic taste in mouth. Subjective: He has sore throat for 2 weeks with nausea and brown productive cough. He has chills this morning. His tonsil is swollen. He is able to tolerate

liquids, but he has decrease in appetite. Diagnoses: 1. Abdominal pain. 2. Gastritis. Plan: He is prescribed Ranitidine and Bentyl.

57. Psychiatry Nurse Practitioner Note, Richard Schulz, April 17, 2017: Presenting Complaint: The patient is unable to sleep. History of Presenting Problems: He presented after disengaging from treatment in 2016 due to his divorce." He was overwhelmed with going through the divorce, depressed, isolated himself and did not seek treatment. He would like to reengage to focus on his insomnia and mood symptoms. He has difficulties since 2012 when he went into a dysrhythmia, became unconscious and had to be resuscitated with defibrillation. When he was stationed in Japan he was on an IED training exercise and they had to don MOPP gear (Nuclear Biologic Chemical protective clothing and masks) and perform various physical activities and became dehydrated and possibly sustained heat injury. Next morning he had weakness and altered loss of consciousness, eventually passing out. He was taken to medical and resuscitated. Since then he has been fearful of dying, and concerned about his medical condition. He has sleep maintenance disruption, generalized anxiety (fatigues, on edge, palpitations, anxiety attacks, jitteriness, insomnia, worrying about generalized things), depression (fatigued, depressed, no motivation, little enjoyment except for time with his son, loss of appetite and weight loss of 170 pounds to 140 pounds in the past 6 months), and trauma related symptoms (re-experiencing, angry outbursts, negative mood, hypervigilance, hyperarousal, nightmares every night). Medications: Dicyclomine HCl 10 mg and Ranitidine HCl 150 mg. DSM-5 Diagnoses: 1. PTSD. 2. Major depressive disorder, recurrent, moderate. 3. Rule out generalized anxiety disorder.

58. Cardiology Telephone Encounter Note, Donna Cooper, R.N., May 17, 2017: The patient is having daily palpitations. He states it, "feels like it is going to take off, but then it doesn't." He is requesting follow-up with arrhythmia service. Holter and echocardiogram are ordered.

59. Cardiology Consult ED to CCU, Joshua Bollan, M.D., May 25, 2017: BP: 118/78. HR: 69. HPI: The patient woke up this morning with chest pain and palpitations. His chest pain feels like popping, and it is worse if he moves his arm. It is left sided, and goes to his shoulder. It is unrelated to activity. Palpitations do not feel like those he had before his ablation (where he would have a sensation of his heart racing), but feel like the palpitations he has been having "a few times a week" ever since his ablation in 2014, where he "feels like his heart is going to stop." He stated that he has come to the ED here and elsewhere for this multiple

times and is frustrated because despite all the testing, nobody has come up with an answer. When he has these episodes, he will also feel tingling in his fingers, nauseated, and lightheaded. Social History: He quit smoking 2015. He smokes marijuana occasionally for his anxiety. Recommendations: A Holter is arranged for him to get today. He may benefit from beta-blocker if he has high burden of PVCs. He is encouraged to call and schedule echocardiogram as soon as possible.

60. ECG, Leda Felicio, M.D., May 25, 2017: Ventricular Rate: 63. Interpretations: 1. Normal sinus rhythm. 2. Early repolarization. 3. When compared with ECG of March 17, 2017, 17:25, no significant change was found.

61. Holter Report, David Krummen, M.D., May 25, 2017: Interpretations: 1. Normal sinus rhythm with sinus arrhythmia with an average HR of 82 bpm. 2. Maximum HR of 130 bpm at 6:21 pm, unknown activity. 3. Minimum HR of 51 bpm at 8:56 pm, unknown activity. 4. Rare premature ventricular contractions in isolation. 5. Rare premature atrial contractions in isolation. 6. Duration of 30:36 hours recording with 15% of the total beats in tachycardia. 7. No symptoms noted on diary

62. X-ray of the Chest, Geraldine Chang, M.D., May 25, 2017: Impressions: 1. Clear and well expanded lungs. 2. Sharp costophrenic sulci and diaphragmatic contour. 3. Normal cardiac silhouette. Normal aorta. 4. Normal pulmonary vessels. 5. Normal trachea. Normal hila. 6. Intact regional skeleton. Normal soft tissues. Normal limited view of the upper abdomen. 7. Compared to a previous study from March 17, 2017, no convincing interval changes have occurred. 8. No acute cardiopulmonary disease.

63. X-ray of the Left Foot, Luke Hiller, May 25, 2017: Impressions: 1. Clear and moderately expanded lungs. 2. Sharp costophrenic sulci and diaphragmatic contour. 3. Normal sized cardiac silhouette. Normal aorta. 4. Normal pulmonary vessels. 5. Normal trachea. Normal hila. 6. Normal regional skeleton. Normal soft tissues, telemetry lines superimposed on the chest and normal limited view of the upper abdomen. 7. Compared to previous study from May 25, 2017, the lung volumes have decreased. 8. Normal bedside examination of the chest.

64. Physician History and Physical Note, Alex Pearce, M.D., May 26, 2017: BP: 128/78. HR: 78. CC: Syncope. HPI: The patient reports that he was walking to the bathroom when he felt palpitations, left sided chest pain radiating to his left arm, mild nausea, his vision narrowed and then he passed out. He hit his head, woke up on the ground. Per his girlfriend he was mildly confused for 2-5

minutes after the episode. It did not occur immediately after standing. He also reports episodes once monthly (since his ablation in 2014) where he feels palpitations like "his heart is skipping a beat" and feels like he is going to pass out. These are also associated with mild chest pain. These events are not related to a specific activity, or change in position. He cannot identify a specific trigger. He was wearing his Holter monitor when the episode occurred today. Chest pain was brief and only just prior to his syncopal episode. He does report getting palpitations sometimes when he tries to work out, so he will take it easy. PE: Cardiovascular: He has possible faint systolic murmur best heard at left lower sternal border. Assessments: 1. Syncope. 2. Atypical chest pain. 3. Anxiety. 4. Fluids, electrolytes, nutrition. 5. Venous thromboembolism pharmacologic prophylaxis. Plan: He is to be admitted to ward with telemetry. Orthostatics will be checked. He is to follow up Holter monitor results and final TTE report in the morning. He is to consider ETT in the future. He is to check urine toxicology. One additional troponin will be checked. EKG is to be repeated if he develops chest pain.

65. Emergency Department Note, Paul Krug, R.N., May 26, 2017: BP: 122/72. HR: 76. Subjective: The patient passed out. He was walking to bathroom today at 1700 when he felt nauseated with palpitations. The next thing he knew, he was on the floor. Event was witnessed by his girlfriend. "He was just groggy for a minute." He was wearing Holter monitor at time of loss of consciousness. Impressions: 1. Syncope. 2. History of WPW status post ablation. 3. Palpitations. 4. Closed head injury. Plan: He is to be admitted to telemetry by cardiology for further monitoring work-up and management.

66. CT Scan of the Head without IV Contrast, Sreenath Naray, May 26, 2017: Impression: No acute intracranial hemorrhage, mass effect or hydrocephalus.

67. ECG, Leda Felicio, M.D., May 26, 2017: Ventricular Rate: 81. Interpretations: 1. Normal sinus rhythm. 2. When compared with ECG of May 25, 2017, 05:51, no significant change was found.

68. X-ray of the Chest, Paul Stark, M.D., May 26, 2017: Impressions: 1. Clear and moderately expanded lungs. 2. Sharp costophrenic sulci and diaphragmatic contour. 3. Normal sized cardiac silhouette. Normal aorta. 4. Normal pulmonary vessels. 5. Normal trachea. Normal hila. 6. Normal regional skeleton. Normal soft tissues, telemetry lines superimposed on the chest and normal limited view of the upper abdomen. 7. Compared to previous study from May 25, 2017, the lung volumes have decreased. 8. Normal bedside examination of the chest.

69. Emergency Department Note, Luke Wingo, R.N., July 26, 2017: CC: Right ear pain. HPI: The patient has several day history of pressure, pain in his right ear and his hearing is muffled. Medication: Clonidine HCl 0.1 mg. Impression: Right otitis media.

70. Psychiatry Nurse Practitioner Note, Richard Schulz, July 30, 2017: Impression: The patient's depression is less severe than the previous 6 months due to divorce but he still has persistent depressed mood, anhedonia, and low energy, significant weight loss of 40 pounds, insomnia, and diminished ability to focus. DSM-5 Diagnosis: 1. PTSD. 2. Major depressive disorder, recurrent, moderate. 3. Rule out generalized anxiety disorder. Plan: Clonidine is increased from 0.1 mg to 2 tablets every bedtime and 1 tablet at 0800 and 1400 for trauma related symptoms.

71. Primary Care Note, Ali Parand, M.D., July 31, 2017: BP: 117/74. HR: 57. WT: 164.2. HPI: The patient continues to get intermittent palpitations, has severe episodes associated with near-syncope approximately once a month, which is often provoked by exercise, that lasts 1-2 minutes, and resolves after Valsalva maneuver. He has milder episodes with milder light-headedness that occur daily, and lasts for few seconds then resolves. Medications: Clonidine HCl 0.1 mg, and ASA 81 mg. Impressions: 1. WPW syndrome, persistent symptoms status post ablation in 2014. 2. Anxiety. 3. Chronic left knee pain. 4. Painful left varicocele. 5. Recent acute otitis media, symptoms improving.

72. Psychiatry Nurse Practitioner Note, Richard Schulz, July 31, 2017: Subjective: The patient stopped both Clonidine and Venlafaxine because he was experiencing increase in anxiety, jitteriness, and nausea that was not tolerable. He is recommended to resume Clonidine. He did tolerate Trazodone as he is able to get more sleep, but he is still having frequent nightmares. Medications: Clonidine HCl 0.1 mg, and Trazodone HCl 100 mg. DSM-5 Diagnoses: Unchanged.

73. Complete Transthoracic Echocardiogram, Leda Felicio, M.D., August 12, 2017: BP: 150/88. HR: 75. WT: 165. LV IVSd: 1.3 cm. LV IDD: 4.1 cm. LV PWd: 1.2 cm. LV Biplane Ejection Fraction: 61%. LV EF (2D): 68%. Conclusions: 1. There is normal left ventricular systolic function with no wall motion abnormalities. 2. Normal left ventricular diastolic function is observed. 3. Mild concentric left ventricular hypertrophy is observed. 4. There is mild to moderate tricuspid regurgitation. 5. Mild pulmonary hypertension is noted. 6. When compared to the previous study performed on 7/11/13, new mild left ventricular

hypertrophy, mild to moderate tricuspid regurgitation and mild pulmonary hypertension.

74. Emergency Department Note, Patrcia Hlavin, M.D., August 14, 2017: BP: 120/81. HR: 75. Subjective: The patient had a lot of dizziness and felt like he was sliding off the bed when he was not. Medications: Clonidine HCl 0.1 mg, Trazodone HCl 100 mg, and Aspirin 81 mg.

75. Emergency Department Note, Marcos Sandoval, R.N., August 23, 2017: BP: 125/94. HR: 105. HPI: The patient has continuous abdominal aching pain for 2 days rated 4/10 that is aggravated by walking and relieved by medications. Approximately 1.5 weeks ago he was cut on right finger at interphalangeal crease by a dirty scalpel in a sharps container that was at work. The scalpel that cut him was used in the autopsy of corpses. The sharp in container was from unknown corpse. He was reading a lot about needle stick injuries and got nervous today which intermittently gave him "a nervous stomach". Periumbilical abdominal discomfort occurred only when he became very anxious. He states he is a mortician and he was struck by a dirty blade 2 weeks ago. Medications: Unchanged. Impression: Healthcare related scalpel injury; abdominal pain resolved.

76. Emergency Department Note, Cassidy Halle, R.N., December 10, 2017: BP: 133/77, 126/78, 131/79. HR: 69, 72, 77. HPI: The patient says for 2 weeks he has had intermittent mid-epigastric abdominal pain, pins and needle feeling in his stomach, and this morning he woke up and was nauseated and vomited once. He has had some perirectal discomfort off and on for several days. Also today he felt lightheaded before coming to the emergency department. Now the lightheadedness is gone. He has anal burning the "past few days." Medications: Unchanged. PE: Cardiovascular: He has grade 1/6 systolic murmur along the sternal border. Impressions: 1. Rectal discomfort. 2. Nausea/vomiting, abdominal pain. Plan: He is prescribed hydrocortisone rectal suppository.

77. Mental Health Consult, Ann Corbin-Fulchiron, L.C.S.W., January 11, 2018: The patient attended anger management group as scheduled on January 10, 2018.

78. Primary Care Telephone Encounter Note, Roxana Aminbakhsh, M.D., January 12, 2018: The patient's abdominal pain is better. He has changed his diet to Mediterranean diet but he still has some intermittent abdominal pain and nausea.

79. Psychiatry Group Counseling Notes, Eileen Holman, L.C.S.W., from January 17, 2018 to February 5, 2018: The patient attended 9 sessions of anger management group counseling.

80. Administrative Note, Jasmin Lyons, March 27, 2018: The patient wants to get treated for sleep apnea because his girlfriend states that he stops breathing and he wakes up during the middle of the night.

81. Primary Care Note, Roxana Aminbakhsh, M.D., April 2, 2018: BP: 130/72. HR: 88. WT: 162.5. HPI: The patient has nausea, vomiting and diarrhea 2 days ago. He has chills and sore throat. He has chest wall pain with certain movements and he was diagnosed with costochondritis. He has history of elevated amylase/lipase. Medications: Clonidine and Trazodone. Social History: He uses marijuana for sleep. Plan: Chest x-ray is ordered.

82. Primary Care Telephone Encounter Note, Roxana Aminbakhsh, M.D., April 6, 2018: The patient came to clinic with flu type symptoms and he had lost his voice. Flu and strep throat tests are ordered. Flu test came back negative and throat culture showed MRSA. He was called today and he told that he had a staph infection on his hand 5 years ago and once in a while he gets a pustule over his abdomen (with pus).

83. X-ray of the Chest, Noushin Vahdat, May 7, 2018: Impressions: 1. Clear and well-expanded lungs. 2. Sharp costophrenic sulci and diaphragmatic contour. 3. Normal sized cardiac silhouette. Normal aorta. 4. Normal pulmonary vessels. 5. Normal trachea. Normal hila. 6. Normal regional skeleton. Normal soft tissues and normal limited view of the upper abdomen. 7. Compared to a prior study from May 26, 2017, no interval change accounting for changes in positioning. 8. Normal chest radiograph.

84. X-ray of the Left Hand, Karen Chen, May 7, 2018: Impression: No acute osseous abnormality.

85. Nurse Practitioner Note, Joanne Jacalan, N.P., May 8, 2018: BP: 113/57. HR: 80. WT: 170.4. Medications: Unchanged. Assessment: Left hand sprain status post fall.

86. Occupational Therapy Consult, Eileen Apfel, O.T.R., May 23, 2018: Assessment: Stenosing tenosynovitis primarily in palm on the leading edge of the palmar carpal ligament.

87. Triage Note, Cheryl Pierce, June 26, 2018: The patient has chest pain radiating from the mid chest to back for several months. It is a pressure sensation; however, he has no pain during triage. He has been having palpitations. He has ongoing cardiac symptoms for 4 years. He is feeling lightheaded and dizzy, and he has no palpitations. He has increased symptoms when lifting objects. He is calling today because he became diaphoretic and he felt like his heart was pounding and he became dizzy.

88. Primary Care Note, Bienvenido Siy-Hian, June 28, 2018: The patient is requesting for a choice referral for cardiology. He has not had palpitations since 2014, but his heart stops for a few seconds several times a day every day since. He gets symptomatic with it. He feels like blacking out or things closing and sweating. Medications: Unchanged.

89. Emergency Department Note, Eliza Starr, R.N., July 7, 2018: BP: 131/69. HR: 105. CC: Chest congestion and cough. Medication: Aspirin 81 mg. Assessment: Bronchitis/upper respiratory infection with mild reactive airways.

90. X-ray of the Chest, Justin Ly, M.D., July 8, 2018: Impressions: 1. Clear and well-expanded lungs. Sharp costophrenic sulci. 2. Normal cardiovascular silhouette. 3. Normal trachea, hila, and pulmonary vasculature. 4. Intact regional skeleton. 5. Compared to a prior study, no change. 6. No radiographic evidence of acute cardiopulmonary process.

91. Primary Care Note, Bienvenido Siy-Hian, July 13, 2018: BP: 106/75. HR: 80. WT: 169. BMI: 23. Medication: Unchanged. Impressions/Assessments: 1. Right shoulder pain.2. Left knee pain.

92. X-ray of the Left Knee, Matthew Sharp, M.D., July 13, 2018: Impression: No radiographic evidence of acute osseous abnormality.

93. Sleep Medicine Consult, Jisha Joshua, M.D., August 24, 2018: HPI: The patient has been having insomnia. He has been going to bed at 8 pm but only falls asleep at 1 am. He then has episodes of choking and apneas witnessed by his girlfriend. He wakes up at around 3-4 pm after he gets nightmares. He then feels fatigued and sleepy throughout the day. He also has snoring. He has headache on waking up. Medications: Clonidine HCl 0.1 mg and Aspirin 81 mg. Assessment: Obstructive sleep apnea screen. Plan: Home sleep test is ordered. He is agreeable to using CPAP if he is found to have obstructive sleep apnea. He is advised regarding sleep hygiene and bedroom time restriction.

94. Complete Transthoracic Echocardiogram, Robert Ross, M.D., August 24, 2018: BP: 143/84. HR: 65. WT: 165. LV IVSd: 1.33 cm. LV IDD: 4.08 cm. LV PWd: 1.27 cm. LV Biplane Ejection Fraction: 61.7%. LV EF (2D): 57.93%. Conclusions: 1. There is normal left ventricular systolic function with no wall motion abnormalities. Mild concentric left ventricular hypertrophy is observed. 2. Normal left ventricular diastolic function is observed. 3. The right ventricle is slightly dilated with mildly reduced function noted on some views. 4. The tricuspid valve leaflets are moderately thickened. The septal leaflet appears significantly underdeveloped and tethered to septum. 5. There is moderate to severe tricuspid regurgitation. 6. Mild pulmonary hypertension is noted. 7. When compared to the previous study performed on August 12, 2017, mild to moderate tricuspid regurgitation has increased to moderately severe. Appearance of TV is same, as is RV. TV appeared more mobile in 2013 echo but RV same then.

95. Attending Emergency Department Note, David Bryman, August 31, 2018: BP: 121/78. HR: 61. HPI: The patient awoke today with photophobia, nausea and headaches. He has not been sleeping well and he has had this several times in the past. He had some right sided pain at the chest worse with moving "not cardiac". He states that has since resolved and it was present when he rolled over this morning. Medications: Clonidine HCl 0.1 mg and Aspirin 81 mg.

96. X-ray of the Chest, Jennifer Feneis, August 31, 2018: Impression: No evidence of acute cardiopulmonary disease.

97. Cardiology Arrhythmia Consult, Mike Eskander, M.D., September 10, 2018: BP: 129/75. HR: 74. Subjective: The patient presented to establish care. He is with WPW and status post ablation of pathway by Dr. Hassankhani in 2014 in Grossmont Hospital. He was first became aware of this diagnosis in 2011 when he was in Okinawa, Japan when he felt "fluttering" in his heart when he was carrying a friend. The day after he experienced "stroke-like symptoms" and hemiparesis he was given glucose. He had syncope and he was taken to a hospital and underwent testing. He was airlifted to US hospital Wounded Warriors for several weeks but he did not want to get the ablation. He got out of the military and he was awaiting cryoablation in the VA though he did not receive the ablation. In 2014, he experienced another syncopal episode and he was taken Grossmont hospital and underwent ablation "16 points" with Dr. Hassankhani. He continued to have skipped heart beats almost immediately after the ablation. He was afraid of returning to the VA due to his prior experiences. He continued to take ASA 81mg daily. It is difficult for him to exercise due to palpitations

though no rapid heart rates and he has had episodes of near syncope nearly twice a week. He was previously on Flecainide previously and it did help him somewhat though not completely. Medications: Unchanged. ECG: NSR, PR 146ms QTc 369ms, no pathway. Diagnostic Assessments: 1. WPW syndrome (Anteroseptal on 2013 ECG) status post ablation by Dr. Hassankhani on April 14, 2014. 2. Palpitations with syncope and near syncope. Recommendation: Event monitor is recommended.

98. Sleep Medicine Note, William Perrine, September 10, 2018: The patient was introduced to the home sleep recorder type 3. He is instructed to return the sleep recorder the next business day.

99. CPRS Sleep Study Interpretation, Michael Pleban, September 10, 2018: Data Summary: 1. No significant elevation of the apnea hypopnea index was observed. (AHI 3.8/hr., supine AHI 2.8/hr., prone AHI 0.0/hr., left AHI 7.2/hr., right AHI 4.5/hr., normal < 5/hr.) Events observed were mostly obstructive hypopneas. Some central events seen appeared to be post arousal and sleep onset. ODI was 5.3/hr. No significant snoring was recorded. 2. Body position (supine/non-supine %): 49/51. 3. No significant oxyhemoglobin desaturation was seen. Average oxygen saturation: 94.9%. Baseline saturation: 95%. Nadir saturation: 89%. Average lowest desaturation: 92.6%. T<90: 0.1%.

100. Sleep Medicine Diagnostic Study Report, Michael Pleban, September 11, 2018: Impression: No significant obstructive sleep apnea. Recommendations: 1. The patient is to avoid alcohol before bedtime. 2. If clinically indicated he should stop driving until sleepiness has resolved. 3. He is to follow up with Dr. Joshua to go over basic sleep hygiene, especially keeping a regular sleep schedule that allows for 7-9 hours of sleep nightly.

101. Primary Care Note, James Ruddy, F.N.P., October 2, 2018: BP: 109/63. HR: 73. WT: 167.2. BMI: 23. Medications: Unchanged. Diagnoses: 1. Bilateral knee pain. 2. Ankle pain, normal exam. 3. Foot pain, normal exam. 4. Chronic low back pain.

102. Orthotics Prosthetics Consult, John Echada, October 17, 2018: The patient is fitted with hinged knee support.

103. Nurse Practitioner Note, James Ruddy, F.N.P., November 15, 2018: BP: 130/69. HR: 78. WT: 169.9. Medications: Unchanged. Diagnosis: Poor fitting dental retainer.

104. Psychiatry Nurse Practitioner Note, Richard Schulz, November 29, 2018: Diagnosis: PTSD. Plan: The patient is prescribed Clonidine 0.2 mg at bedtime, 0.1 mg at 0800 and 1400, and Trazodone 200 mg every bedtime.

105. Emergency Department Triage Note, Cassidy Halle, R.N., November 30, 2018: BP: 126/75. HR: 73. Medications: Clonidine HCl 0.1 mg and Aspirin 81 mg. Impression: STD check for gonorrhea/chlamydia.

106. Addendum, Mike Eskander, M.D., December 28, 2018: The patient continues to have palpitations with near syncope, more frequently now that he is sick with the flu. He was not aware that he had to wear the monitor that was mailed to him. A monitor will be re-ordered in 14 days he is to wear it.

107. Nurse Practitioner Note, James Ruddy, F.N.P., January 9, 2019: BP: 107/66. HR: 76. WT: 158. Medications: Unchanged. Diagnoses: 1. Sinus headache with congestion. 2. Anxiety, (PTSD) and somatic pains. 3. Mild intermittent asthma per patient history.

108. Sleep Medicine Note, Jisha Joshua, M.D., January 25, 2019: BP: 122/83. HR: 71. HPI: The patient he continues to have insomnia, mainly early awakenings. He has now been going to bed at 10 pm (before it was 8pm), he is able to fall asleep but wakes up around 3-4. He is woken up by nightmares from PTSD as well as from his history of cardiac arrest from WPW. He also gets palpitations and is going to get a Holter today. He is on Clonidine and Trazodone for sleep from his psychiatrist. He was started on Duloxetine by his PCP and asked to increase dose by his psychiatrist but he has not been taking it. He then feels fatigued and sleepy throughout the day; however, he does not take any daytime naps. Medications: Unchanged. Assessment: OSA screen. Plan: He is advised regarding sleep hygiene and bedroom time restriction. He is asked to delay going to bed until 12 am if possible to hopefully wake up around 5-6 am. He is to let MHP know that he is no longer taking Duloxetine. He could also try Prazosin for nightmares. He is to have evaluation by cardiologists for palpitations with Holter. Cognitive behavioral therapy for insomnia is discussed.

109. Cardiology Diagnostic Study Consult, David Krummen, M.D., February 5, 2019: The patient had a minimum HR of 48 bpm, max HR of 188 bpm, and average HR of 85 bpm. Predominant underlying rhythm was sinus rhythm. Isolated SVEs were rare (<1.0%), and no SVE Couplets or SVE Triplets were present. Isolated VEs were rare (<1.0%), and no VE Couplets or VE Triplets were present.

110. Nurse Practitioner Note, Raymond Gysler, February 15, 2019: BP: 111/79. HR: 72. WT: 159. BMI: 22. Medications: Unchanged. Assessment: Open sore on the side of penis.

111. Office Visit, Luella Poniktera, L.V.N., March 21, 2019: BP: 104/63. HR: 76. WT: 153. BMI: 21. HPI: The patient has history of abdominal pain, nausea vomiting, and intermittent rectal bleeding for 2 weeks. The pain is located to the left side of his abdomen. He has intermittent episodes of nausea and vomiting with referred pain to his rectal area. He has a history of hemorrhoids and occasionally bleeding noted on toilet paper. He has been on a juice fast over the past 4 days. The pain is worse with lying down. Stools are inconsistent and he has a history of diarrhea. Medications: Unchanged. Assessments: 1. Abdominal pain. 2. Bilateral shoulder pain. 3. Sternal mobility. 4. Low back pain. Plan: Labs and imaging are pending for abdominal pain.

112. X-ray of the Abdomen, Farshad Bahador, March 21, 2019: Impression: 1. Unremarkable bowel gas pattern. 2. Lung bases are clear. 3. No abnormal calcifications noted. 4. The regional bony structures demonstrate no acute osseous abnormalities. Round calcifications in the pelvis likely represent phleboliths.

113. Cardiology Note, Felix Krainski, April 1, 2019: BP: 111/74. HR: 108. WT: 161.5. CC: Presyncope and palpitations. HPI: The patient continues to take ASA 81mg daily. It is difficult for him to exercise due to palpitations though he no rapid heart rates and he has had an episodes of near syncope nearly twice a week. He underwent Ziopatch on January 25, 2019, but only wore it for 2 days as it fell off. He has sweating at night. Ziopatch shows SR and appropriate episodes of sinus tachycardia. On January 22, 2019, he has episode of presyncope, feeling jittery and almost passing out when he was walking over to his neighbor's house. Medications: Unchanged. Assessments: 1. WPW syndrome. 2. Palpitations with syncope and near syncope. Recommendation: He is to repeat event monitor now with Lifewatch.

114. Holter-Event Monitor Consult, David Krummen, M.D., May 7, 2019: HR: 110. Preliminary Findings: Sinus tachycardia. Comments: Transmission contains 1 recorded event. This transmission may contain artifact and/or an impedance check.

115. Holter-Event Monitor Consult, Gordon Ho, M.D., May 28, 2019: Enrollment Period: April 27, 2019, to May 26, 2019. Total: 30 days. Narrative

Summary: The patient was monitored for 699:44 hours, of which 21:39 hours were usable. Average heart rate for the monitored period was 89 bpm. Tachycardia was present for 13% of the readable data. Bradycardia was present for 0% of the readable data. No pause(s) noted of 3 seconds or longer.

116. Nursing Telephone Encounter Triage Note, Cynthia Catrell, R.N., June 14, 2019: Assessments: 1. Upper respiratory symptoms with nasal congestion secondary to viral illness versus allergic rhinitis. 2. Neck pain and likely trapezial strain.

117. Nursing Telephone Encounter Triage Note, Cynthia Catrell, R.N., June 20, 2019: Assessments: 1. Lab work requested. 2. Testicular mass and pain.

118. Primary Care Note, John Bas, M.D., July 8, 2019: BP: 126/76. HR: 79. WT: 159. BMI: 22. HPI: The patient was seen in the emergency room at Sharp Grossmont Hospital on July 6, 2019. He was at home noting an acute episode of diaphoresis and palpitations. He went to the emergency room for evaluation. He was released home. EKG was performed today otherwise noting normal sinus rhythm without acute changes. He is also requesting a repeat sleep study. He has had a history of abdominal pain accompanied with diarrhea and a history of hemorrhoids which has since resolved. Medications: Clonidine HCl 0.1 mg, Prednisone 20 mg, and Aspirin 81 mg. Assessments: 1. Palpitations. 2. Abdominal pain/hemorrhoids. 3. Question of sleep apnea. 4. Left testicular pain. Plan: Attempt will be made to obtain discharge summary from Grossmont hospital for palpitations. Referral to sleep clinic will be reviewed.

119. Attending Emergency Department Note, David Bryman, July 20, 2019: BP: 132/82. HR: 66. CC: Bumps in groin area. HPI: The patient noticed swollen lumps at groin for a few weeks. He also has loose stools at times. Medications: Clonidine HCl 0.1 mg, colon electrolyte lavage PWD for solution, and Aspirin 81 mg. Impression: Small palp nodes at inguinal region.

120. X-ray of the Chest, Paul Stark, M.D., July 20, 2019: Impressions: 1. Clear and well-expanded lungs. 2. Sharp costophrenic sulci and sharp diaphragmatic contour. 3. Normal sized cardiac silhouette. Normal aorta. 4. Normal central pulmonary arteries and normal peripheral pulmonary vessels. 5. Normal trachea and normal bronchi. 6. Normal regional skeleton. Normal soft tissues and normal limited views of the upper abdomen. 7. Compared to previous study from August 31, 2018, no interval changes have occurred. 8. Normal study. No evidence for enlarged mediastinal or hilar lymph nodes seen.

121. CT Scan of the Abdomen and Pelvis with Contrast, Farshad Bahador, July 20, 2019: Impression: No acute abnormality of the abdomen or pelvis. No pathologically enlarged lymph nodes seen.

122. Nursing Telephone Encounter Triage Note, Cynthia Catrell, R.N., October 22, 2019: The patient would like a consult for carpal tunnel testing.

123. Triage Note, Ilyn Ballesteros-Romero, R.N., October 27, 2019: Assessment: Red swollen rash on groin for 3 days.

124. Triage Note, Ilyn Ballesteros-Romero, R.N., October 30, 2019: The patient went to urgent care a few days ago regarding bumps on genital area and he was diagnosed with folliculitis and given antibiotics.

125. Emergency Department Triage Note, Stella Annunziato, R.N., November 22, 2019: BP: 114/74. HR: 84. Subjective/CC: The patient had brownish/yellow fluid dripping from his nose this morning.

126. Primary Care Telephone Encounter Note, John Bas, M.D., November 25, 2019: The patient has recent upper respiratory infection requiring ER management.

127. Triage Note, Tari Long, R.N., February 6, 2020: The patient states he was diagnosed with Pityriasis rosea.

128. Nursing Telephone Encounter Triage Note, Cynthia Catrell, R.N., February 27, 2020: Impressions: 1. Cystic fibrosis. 2. Pityriasis rosea.

129. Nursing Telephone Encounter Note, Cynthia Catrell, R.N., June 1, 2020: The patient reported muscle cramps and syncopal episode. He is admitted to San Gorgonio Hospital in May 28. He is referred to Loma Linda VA. He is diagnosed with acute kidney injury secondary to dehydration, volume loss, also resulting in rhabdomyolysis.

130. Primary Care Telephone Encounter Note, Ali Parand, M.D., June 1, 2020: The patient is discharged from LLVA on Saturday after being hospitalized for 2 days for rhabdomyolysis/acute kidney injury due to heat exhaustion while working as a grounds man for Edison. He is requesting to remain off of work until he recovers. He is concerned about risk of repeat heat exhaustion. He says that the company he was working for overworked him. Impression: Status post

heat exhaustion, rhabdomyolysis/acute kidney injury. Plan: Chemistry panel is to be repeated. Letter is signed per his request.

131. Primary Care Telephone Encounter Note, Ali Parand, M.D., June 21, 2020: The patient still has occasional myalgias.

132. Nursing Telephone Encounter Triage Note, Cynthia Catrell, R.N., June 26, 2020: The patient is improving, but he has ongoing pain and he is requesting a letter from PCP to excuse him from work until August 1, 2020. He is still waking up with stabbing back pain and pressure, and he has bilateral low back pain near "my kidneys" throughout the day. He still feels nauseous, but mostly when stabbing pain occurs which is when lying down.

133. Primary Care Telephone Encounter Note, Ali Parand, M.D., June 26, 2020: Impressions: 1. Persistent bilateral mid-back pain, now with left groin pain and dysuria, rule out nephrolithiasis. 2. Left forearm superficial venous thrombosis.

134. Primary Care Nursing Note, Ashley Buck, September 22, 2020: The patient wanted to inform team he was going to start filling out state disability regarding his kidney issue that is ongoing. He requested to schedule VVC with Dr. Bas because he has ongoing kidney pain. He would like the doctor to write medical note for his current ongoing lawsuit against his job.

135. Primary Care Note, John Bas, M.D., September 22, 2020: HPI: In May, the patient was establishing electrical lines and working in the heat. Subsequently, he developed heat stroke; rhabdomyolysis; and acute kidney injury. He was seen in the emergency room and later transferred requiring ICU level care. He attempted to apply for a workers compensation claim but it was denied due to the lack of sufficient paperwork submitted at the time of his hospitalization. He continues to note kidney related pain, lethargy and intolerance to heat. Medication: Aspirin 81 mg. Diagnosis: History of recent heat injury with subsequent rhabdomyolysis and kidney injury. Plan: He is to continue with plan of care as outlined previously at the time of his discharge. Labs to include serum electrolytes and renal function testing are to be repeated.

136. Primary Care Note, John Bas, M.D., March 5, 2021: CC: Follow-up examination for history of prior acute rhabdomyolysis with abnormal LFTs due to exertional heat stroke, acute kidney injury, presyncope, and palpitations; in the setting of prior WPW. Medication: Unchanged. Assessments: 1. History of

heat stroke. 2. Acute renal failure syndrome. 3. Non-traumatic rhabdomyolysis. Plan: The patient is to follow up with renal as directed.

137. Nephrology Consult, Natalie Sweiss, M.D., March 11, 2021: HPI: The patient was previously seen by nephrology in the past and he is requesting follow-up. He has back pain and "tightness" muscle twitches when he lays flat. He calls this kidney pains. He also notices that he has more difficulty holding his urine. He thinks he is drinking the same amount. Assessments: 1. Acute kidney injury secondary to rhabdomyolysis. 2. Low back pain. Plan: It is discussed to him that there is no evidence of ongoing kidney disease. He is okay to check renal ultrasound.

B. Palomar Health

1. Emergency Department Physician Note, Jack Wilson, M.D., February 10, 2013: BP: 131/86. HR: 82. CC: Large mass hangs down over left testicle when the patient stands up. Diagnoses: 1. Epididymitis. 2. Probable varicocele.

2. Laboratory Report, February 10, 2013: Urinalysis is unremarkable.

C. Sharp Grossmont Hospital

1. Emergency Services Report, Peter Colaprete, April 12, 2014: BP: 136/68, 162/88. HR: 59. HPI: The patient is diagnosed with Wolff-Parkinson-White syndrome in 2012. At around 12:00 noon today, he was cooking when he felt lightheaded and possibly passed out, falling onto the arms of his wife. He felt very tired, and he had some sharp chest pain intermittently. Medics were called and he was brought here. At this time, he just feels weak. His rapid sugar in the field was 65. Medications: Aspirin 81 mg, Tambocor 150 mg, and Temazepam 15 mg. Objective: He is placed on cardiac monitor, which showed a sinus rhythm with wide QRS complexes. EKG showed sinus bradycardia at 59 with obvious Wolff-Parkinson-White with delta waves, left axis, ST-segment elevation in V3, V4. QRS duration was 134 milliseconds, QTc 405 milliseconds. Prior cardiogram in February of this year was similar except for the elevation in V4 today, which could be positional. Final Impressions: 1. Syncope versus presyncope. 2. History of Wolff-Parkinson-White, possible arrhythmia. 3. Acute chest pain, rule out coronary ischemia. Plan: He is admitted to telemetry, Dr. Abdulhadi. He is given Tambocor 150 mg.

2. Laboratory Reports, from April 12, 2014 to March 1, 2018: April 12, 2014, WBC 3.1. MPV 5.9. April 13, 2014, WBC 4.0. MCHC 31.7. MPV 5.8. Anion gap 13. March 1, 2018, anion gap 14. ALT 13. MPV 7.1.

3. EP Study with Radiofrequency Catheter Ablation of 2 Accessory Pathways, Alborz Hassankhani, M.D., April 15, 2014: Pre-operative Diagnosis: Wolff-Parkinson-White syndrome and syncope. Post-operative Diagnoses: WPW with ORTs involving multiple accessory pathways: 1. Right-sided posteroseptal (CS9, 10) bi-directionally conducting pathway, with ORT (TCL = 400 msec); successfully ablated. 2. Left-sided posteroseptal pathway (CS5,6); successfully ablated via the CS approach. 3) Atrial Flutter – status post successful isthmus ablation with bidirectional block (there was 1:1 conduction with AFL with CL = 245 msec). 4) Paroxysmal AF. Procedures Performed: 1. Comprehensive EP study with mapping. 2. Placing a catheter in the coronary sinus for LA mapping and recording. 3. Infusion of isoproterenol in attempt to induce and maintain tachycardia. 4. Radiofrequency catheter ablation of the 2 accessory pathways for ORT/WPW syndrome. 5. RFCA of RA isthmus. 6. Fluoroscopy with supervision and interpretation. 7. Conscious sedation. Conclusions: 1. WPW syndrome with multiple pathways. a. Right posteroseptal: In the vicinity of the CS ostium (ablated from the right side). b. Left mid-posterior (CS5,6): ablated from within the CS. 2. AP#1: Right posteroseptal pathway participated in ORT (TCL = 400 msec). a. Earliest retrograde fusion CS Os (CS9,10). b. It was a bidirectionally-conducting pathway. 3. AP#2: Left mid-posterior pathway did not appear to participate in SVT. a. Antegrade fusion In CS6. b. Persistence of antegrade conduction upon adenosine testing. 4. AFL with 1 :1 conduction and pre-excitation (with shortest R·R interval 240 msec). 5. Paroxysmal AF. 6. Dual AV node physiology. Plan: He is to bedrest for 4-6 hours. Ambulation will be tried, and if all goes well, he will be discharged to home.

4. ED Note, Subhash Viswanathan, M.D., March 1, 2018: BP: 147/74. HR: 86. CC: Chest pain. Impressions: 1. Costochondritis. 2. Benign headache.

5. 12 Lead ECG, Bijan Razi, M.D., March 1, 2018: Ventricular Rate: 84. Interpretations: 1. Normal sinus rhythm with sinus arrhythmia. 2. Possible Left atrial enlargement. 3. Borderline ECG. 4. When compared with ECG of March 18, 2016, 15:14, no significant change was found.

6. CT Scan of the Head without IV Contrast, Ryan Viets, M.D., March 1, 2018: Impression: 1. No acute intracranial abnormality.

7. X-ray of the Chest, Ryan Viets, M.D., March 1, 2018: Impression: 1. No acute cardiopulmonary disease.

8. ED Note, Joshua Doros, M.D., July 7, 2019: BP: 115/58. HR: 77. Triage Narrative: The patient presents to ED with palpitations, vomiting and chills. He felt "off" but then approximately 1 hour ago he was sitting down and felt sudden onset of pain in chest and vomited 4-5 times. He has history of WPW and had an ablation 5 years ago. Occasionally he gets palpitations but this time if felt different. He has mild shortness of breath. Pain to mid chest is rated 5/10 and it is burning in sensation. He admits to one whiskey drink prior to arrival. CC: Palpitations. HPI: He has intermittent palpitations for the last few days. He feels that he is very tachycardic. He occasionally gets palpitations and chest pain; however, this time is different. He did drink a little bit of alcohol just before symptoms started earlier tonight. Medical Decision Making: He appeared well and vitals were stable upon arrival. Exam otherwise is benign. EKG showing delta wave however otherwise normal. He was not tachycardic. He was placed on a cardiac monitor; chest x-ray and blood work was ordered. He was also given fluid Zofran GI cocktail and Pepcid for symptoms. Chest x-ray did not appear abnormal. Blood work was grossly normal. He fell asleep and felt much better. He did admit that he has been very anxious recently and he has been under a lot of stress. He also has been having nightmares and other symptoms of PTSD. He was instructed to follow-up with his primary doctor and his cardiologist. He does report that he has a cardiology appointment coming up. Impressions: 1. Palpitations. 2. Anxiety/PTSD. Plan: He is discharged.

D. TriWest Healthcare Alliance

1. Initial Evaluation Report, Paul Liederman, M.D., March 23, 2016: DSM-V Diagnoses: 1. Bipolar disorder. 2. PTSD. 3. Panic disorder.

2. Progress Note, Paul Liederman, M.D., March 23, 2016: The patient has PTSD, dreams of dying, flashbacks, and mood swings. The rest of the note is illegible.

3. Progress Note, Paul Liederman, M.D., Undated: DSM-V Diagnoses: Axis I: 1. Bipolar disorder. 2. PTSD. 3. Panic disorder. Axis II: [Illegible]. Axis III: 1. Wolff-Parkinson-White. 2. History of ablation. Axis IV: [Illegible]. Axis V: GAF 60. The rest of the note is illegible.

E. Rehabilitation Strategies, Inc.

1. Initial Evaluation, Eric Prante, P.T., October 30, 2018: Complaint: The patient has left knee pain. He was injured in 2011 while active on duty when he jumped off of a tank. Diagnosis: Patellofemoral disorders, left knee.

F. iRhythm Technologies

1. ECG Events, from January 25, 2019 to January 28, 2019: Preliminary Findings: The patient had a minimum HR of 48 bpm, maximum HR of 188 bpm, and average HR of 85 bpm. Predominant underlying rhythm was sinus rhythm. Isolated SVEs were rare (<1.0%), and no SVE Couplets or SVE Triplets were present. Isolated VEs were rare (<1.0%). and no VE Couplets or VE Triplets were present.

G. BioTel

1. MCT 3-Lead ACT End of Service Report, June 7, 2019: Enrollment Period: April 27, 2019, to May 26, 2019. Narrative Summary: The patient was monitored for 699:44 hours, of which 21:39 hours were usable. Average heart rate for the monitored period was 89 BPM. Tachycardia was present for 13% of the readable data; bradycardia was present for 0% of the readable data. No pause(s) noted of 3 seconds or longer.

H. San Gorgonio Memorial Hospital

1. ED Triage Report, Amber Westbrook, May 28, 2020: BP: 116/74. HR: 77. WT: 175. CC: Syncope. Patient Narrative: The patient had syncopal episode 2 hours ago. He has cramping all over and chest pain. He is very weak. Pain Assessment: He has cramping pain rated 10/10 in his entire body.

2. Emergency Department Record, Richard Preci, D.O., May 28, 2020: HPI: The patient has muscle cramps and syncopal episode for 2 hours. He is a power line worker. He was working outside when at 1600 he was on Facetime with his wife and he was not feeling well. He sat in his car and he proceeded to vomit. Afterward, he walked outside and had a syncopal episode. He woke up on the ground with his legs over the forklift. Shortly after, his abdomen, arms and legs began to cramp. Clinical Impressions: 1. Rhabdomyolysis. 2. Acute kidney injury. Plan: He will be admitted for further evaluation.

3. History and Physical, Mohsin Syed, M.D., May 28, 2020: HPI: The patient is working in the heat for several hours without adequate hydration and fainted twice and he has since felt much weaker with cramping of his muscles and he was also confused. He was brought to the emergency department where he appeared dehydrated and was given 3 L of IV fluids. His initial labs demonstrated prerenal acute kidney injury and elevated CPK over 1100 Creatinine 1.2. Repeat labs showed improvement in his BUN/creatinine but worsening of the CPK (3434). He feels better after having receiving fluids but he still feels weak. He is being admitted for further evaluation. Past Medical/Surgical History: He had cardiac ablation for WPW in 2014. He has WPW. Family History: Positive for HTN. Assessments: 1. Acute kidney injury secondary to dehydration, volume loss, also resulting in rhabdomyolysis. 2. Syncope, likely secondary to above. Plan: He will be admitted for IV fluid resuscitation and follow-up of his labs. He should stay well hydrated and out of the sun. He will be monitored on telemetry.

4. ECG, Angela Ullon, P.A.C., May 28, 2020: Ventricular Rate: 61. Interpretations: 1. Sinus rhythm with marked sinus arrhythmia. 2. Moderate voltage criteria for LVH, may be normal variant. 3. Early repolarization. 4. Borderline ECG.

5. CT Scan of the Head without IV Contrast, Chul Chae, M.D., May 28, 2020: Impression: No acute abnormality of the head.

6. X-ray of the Chest, Chul Chae, M.D., May 28, 2020: Impression: No acute abnormality of the chest.

7. Laboratory Report, May 28, 2020: WBC 13.1. RBC 6.01. Hemoglobin is 13.4 at 06:30, and 16.9 at 19:35. Neutrophil % is 75.9 at 06:30, and 73.9 at 19:35. Lymphocyte % is 14.5 at 06:30, and 17.0 at 19:35. Neutrophil 9.7. Monocyte is 0.9 at 06:30, and 1.1 at 19:35. Chlorine is 108 at 12:07, and 109 at both 06:30 and 22:04. Carbon dioxide 20. Anion gap is 4 at 12:07, and 17 at 19:35. Glucose 121. BUN is 18 at 12:07, and 26 at 19:35. Creatinine is 2.8 at 19:35, and 1.9 at 22:04. Calcium is 7.8 at both 12:07 and 06:30, 10.3 at 19:35, and 6.2 at 22:04. CPK is 3434.0 at 12:07, 2574.0 at 06:30, 1160 at 19:35, and 1268.0 at 22:04. CKMB is 11.5 at 12:07, 9.3 at 06:30, 6.7 at 19:35, and 6.7 at 22:04. Albumin 5.6. Total protein 10.0. AST (SGOT) is 72 at 12:07, 58 at 06:30, and 51 at 19:35. Potassium 3.0. Nitrite positive in urine.

8. Progress Note, Bahij Ghazal, M.D., May 29, 2020: BP: 113/83. HR: 85. WT: 154. Interval History: The patient was seen and examined. He is doing better

clinically. Inpatient Medication: Nitroglycerin 0.4 mg, Assessments: Unchanged. Plan: IV fluid resuscitation, monitoring and hydration will be continued. He is stable for transfer to VA.

9. Discharge Summary, Bahij Ghazal, M.D., May 29, 2020: Hospital Course: The patient is a VA patient and VA accepted him and wanted to take him to their hospital. He was transferred to the VA hospital and care will continue over there. Final Diagnoses: 1. Acute rhabdomyolysis. 2. Acute renal failure. 3. Syncope. 4. History of Wolff-Parkinson-White.

10. ECG 01:31:49, May 29, 2020: PR: 0.16. QRS: 0.08. HR: 87.

11. ECG 04:00:17, May 29, 2020: PR: 0.14. QRS: 0.10. HR: 90.

12. ECG 08:00:00, May 29, 2020: PR: 0.16. QRS: 0.09. SR: 81.

13. ECG 12:00:00, May 29, 2020: PR: 0.16. QRS: 0.09. SR: 84.

I. Stanley Majcher, M.D.

1. Initial Internal Medicine Panel Qualified Medical Evaluation, December 16, 2020: BP: 131/89. HR: 69. WT: 160. Injured Body Parts: Virtually total body associated with heat stroke/rhabdomyolysis, kidney failure, and other internal organ failure. Job Description/Mechanism of Injury: The patient was hired at Abercrombie Pipeline Company in March 2020. He was employed as a grounds man who worked 80 hours per week and at times even more. His work activities involved heavy lifting. He would run powerlines, dig ditches six feet deep two to three times per day, and lift items which weighed 100 pounds or at times more. Health Issues Prior to Date of Injury May 28, 2020: He has a history of a congenital abnormality which had been detected during his career in the United States Marine Corp. His heart condition is Wolffe-Parkinson-White syndrome. Eventually he required surgical intervention in the form of ablation. Ablation had been completed several years prior to date of hire. His estimate is 2015. Prior to his date of hire, his medications included Tambocor 150 mg twice daily. Issues Regarding Specific Injury May 28, 2020: He was working at the Morongo Reservation in Redlands and he indicates the temperatures were somewhere between 115 and 119 degrees. He started work at 5:30 am. He was performing his usual duties. At approximately noon, he noted severe pain in the area of his urinary bladder, flanks, and entire abdomen. He tried to consume water, which did not relieve his symptoms. Thereafter, he developed a series of complications

including cramps involving virtually every muscle in his body, confusion, dizziness, and recurrent episodes of syncope. Despite his symptoms which occurred at noon, he continued to work. At approximately 5:30 pm, the first episode of syncope occurred, notably fainting. The employer did not arrange for paramedics to be called and instead the patient was taken to a gas station where he was given water, which did not relieve his symptoms. Total body cramps progressed in severity and his symptoms were intense. He noted severe pain involving his calves. A coworker tried to massage his calves without relief. He had another episode of fainting. Eventually, a coworker transported him to San Joaquin Hospital, where he was hospitalized for one and one-half days before being transferred to V.A. hospital Loma Linda University Medical Center. At that center, he was apparently treated for rhabdomyolysis, kidney failure and other complications related to heat stroke. Current Status: The applicant is being treated at VA hospital in Loma Linda. Currently, he has intense pain involving virtually every part of his body, particularly the muscles of the abdomen and urinary bladder area. He has had recurrent episodes of loose bowel movements. He has severe epigastric pain. He is extremely sensitive to the sun whereby he develops vomiting and nausea. He has generalized headaches. His sleep pattern is interrupted. He estimates that he gets approximately two hours of sleep per night. He has severe flank pain. He has severe muscle pain and tenderness. His physicians at Loma Linda advised him he is not capable at this time of resuming his work activities. Physical Examination: Abdomen: Severe tenderness throughout the abdomen. Bowel sounds decreased but present. Standard/ Special Internal Medicine Diagnostic Studies: 1. Electrocardiogram - consistent with Wolffe-Parkinson-White syndrome, regular sinus rhythm. 2. Rhythm strip - no industrial abnormalities. 3. Pulse oximetry - normal room air at 98%. 4. Echocardiogram - atherosclerosis involving mitral and aortic valves. No evidence of left ventricular hypertrophy or diastolic dysfunction. 5. Thyroid ultrasound screen - congenital cysts, nonindustrial. 6. Carotid artery ultrasound screen - atherosclerosis, no industrial issue. 7. Abdominal aortic ultrasound screen - atherosclerosis, no industrial issue. 8. Gallbladder ultrasound screen - no industrial abnormalities. 9. Peripheral artery Doppler lower extremities - atherosclerosis, no industrial issue. 10. Peripheral venous Doppler lower extremities - no industrial abnormalities. 11. Doppler arterial bilateral upper extremities. Diagnoses: 1. History of rhabdomyolysis (severe muscle injury). 2. History of kidney failure. 3. History of multiple episodes of fainting and other generalized symptoms associated with industrial injury on May 28, 2020. Causation: Medical facts are consistent with industrial injury caused by heavy work in an atmosphere of high temperatures and inadequate fluid intake resulting particularly in damage to body muscles, kidneys, and other parts of his

body associated with the underlying injuries caused by the muscle and kidney injuries. Disability Status: The patient is temporarily totally disabled. Date when his condition will be MMI cannot be estimated. He is recommended that he continue to be followed at the VA hospital or by a private nephrologist. Apportionment: Not applicable to non-industrial factors at this time. Future Medical Care: He does require medical treatment to cure or relieve the effects of the industrial injury. Options are to continue treatment at the VA hospital, but if the VA hospital specialists are reluctant to treat him for work-related injuries, he is to be referred on an industrial basis to a nephrologist. Miscellaneous Remarks: The applicant emphasized that he does want to continue with his usual type of work, but he does not want to return to the prior employer because he feels that the employer was not sensitive to his major problems occurring at the workplace.

2. Supplemental Internal Medicine Panel Qualified Medical Evaluation Report, April 20, 2021: In regard to the patient's history of chest palpitations, he is recommended to have an evaluation with another cardiologist.

3. Internal Medicine Panel Qualified Medical Re-Evaluation, July 8, 2021: BP: 141/79. HR: 92. WT: 150. Mechanism of Injury: The patient has a history of industrially related injury associated with a heat stroke whereby he had been working at Morongo Reservation Redlands where temperatures were somewhere between 115 and 119 degrees. As a result of heat exposure, he developed numerous subjective complaints related to this heat stroke. Insomnia is detected in 2010. He does not know the results of his consultation with a nephrologist. He noted a 20 pound weight loss. His subjective issues are unchanged. Physical Examination: Abdomen: Severe tenderness involving the epigastric area, right upper quadrant, left lower quadrant and right lower quadrant. Internal Medicine Diagnostic Studies: l. EKG consistent with Wolff-Parkinson-White syndrome – non-industrial. 2. Rhythm strip consistent with Wolff-Parkinson-White syndrome – non-industrial. 3. Thyroid ultrasound scan reveals congenital cysts – non-industrial. 4. Echocardiogram reveals left ventricular hypertrophy with criteria of interventricular septum and left ventricular posterior wall measuring 1.1 cm with normal up to 1.0 cm; non-industrial atherosclerosis of mitral and aortic valves. The abnormalities are related to the applicant's nonindustrial congenital Wolff-Parkinson-White syndrome. 5. Abdominal aorta ultrasound screen reveals non-industrial atherosclerosis. Diagnosis: Heat stroke/rhabdomyolysis. Discussion: Currently, the doctor's opinions and conclusions are basically the same, notably industrial injury caused by heat stroke involving his muscles and kidneys. Currently, the

patient has diffuse muscle pain and his last laboratory report reveals evidence of muscle injury as of March 5, 2021. At this time the medical records refer to resolution of any kidney injury and the doctor do not believe a follow-up evaluation by a nephrologist is necessary. The only issue that remains to be resolved is the extent of whole person impairment because of the patient's persistent subjective and objective findings, notably continuous elevation of the CPK level.

J. Kenneth Garett, Ph.D.

1. Psychological Evaluation, June 4, 2021: On May 28, 2020, the patient experienced a work related injury. He passed out while working on a forklift. He was suffering from dehydration and indicated that he had been working ten hour days consecutively for the past six days. He was taken to San Gorgonio Hospital in Banning and then transferred to the Veterans Hospital where he remained for three days. He experienced physical damage to his kidney, bladder, and intestines and has been suffering from chronic physical weakness and has not returned to work. He also claims that he is experiencing severe difficulties coping with heat. He also has severe sleep deprivation and ongoing palpitations. He has lost 30 pounds over the last year. He has chronic sleep deprivation which makes him tired when he wakes in the morning. Probable Diagnoses: 1. Major depressive disorder. 2. Generalized anxiety disorder with panic. 3. Chronic sleep deprivation.4. Chronic issues with his kidneys, bladder, and intestines due to episode of one year ago. Recommendation: He may benefit from sleep medication, possibly a sleep medication which could also function as an antidepressant would be appropriate.

FINDINGS AND DISCUSSION:

Brandon Moore is a 31-year-old construction groundman whom I was asked to evaluate from a Cardiology perspective consequent to injuries resulting from heat stroke that occurred on May 28, 2020. His current complaints are kidney, muscle, nerve and arrhythmia injury. I obtained a complete history and performed a physical examination. I reviewed the provided medical records. That file does not contain the medical records from Loma Linda University Hospital Medical Center or from the VA Hospital, where he was treated for the acute injury after the date of injury, May 28, 2020. He was referred to Stanley Majcher, MD, for a Panel QME in Internal Medicine. Dr. Majcher recommended that Mr. Moore be seen by another cardiologist with regard to the palpitations. Dr. Majcher indicated his opinion that the only issue that remains to be resolved is the extent of whole person impairment relative to Mr. Moore's

persistent subjective and objective findings, notably continuous elevation of the CPK level.

Prior to employment with Abercombie Pipeline, Mr. Moore was diagnosed with Wolff-Parkinson-White syndrome (WPW) (arrhythmia) while he was serving in the United States Marine Corps. In 2012, he was having recurrent arrhythmia, syncopal episodes, insomnia and daytime fatigue (Records A1, A2). On April 24, 2013, Erica Moses, PhD, diagnosed him with 1. Anxiety disorder, not otherwise specified vs. chronic adjustment disorder with anxiety 2. Insomnia, GAF 60 (Record A9). On July 11, 2013, an echocardiogram revealed normal left ventricular systolic function with no wall motion abnormalities (Record A21). On April 15, 2014, Alborz Hassankhani, MD, performed a WPW ablation at Sharp Grossmont Hospital (Record C3). On October 27, 2015, Emmanuel Espedo, PhD, diagnosed 1. Insomnia. 2. PTSD. 3. Panic disorder. 4. Agoraphobia. 5. General anxiety disorder. 6. Major depressive disorder, recurrent (Record A41). On March 11, 2016, Mr. Moore complained of palpitations 1-2 times a week (Record A44). On March 17, 2017, Mr. Moore presented to the emergency room for acute gastroenteritis. He also complained of chest pains that never went away since his WPW ablation (Record A51). On April 17, 2017, Richard Schultz, Psych NP, reported that he was having sleep maintenance disruption, generalized anxiety (including palpitations), depression including loss of appetite and weight loss of 170 pounds to 140 pounds in the past 6 months (Record A57). On May 25, 2017, Mr. Moore complained of palpitations (Record A59). A 30-hour Holter recorder showed no ectopic complexes. 15% of the recording time the patient was in tachycardia. The maximum heart rate was 130 bpm. No symptoms were reported in the Holter diary (Record A61). The patient returned on May 26, 2017. He reported that he had passed out the previous day while he was wearing the Holter recording. He complained of palpitations (Record B65). On August 12, 2017, a Complete Transthoracic Echocardiogram revealed normal left ventricular systolic function with no wall motion abnormalities, normal left ventricular diastolic function, mild concentric left ventricular hypertrophy, mild to moderate tricuspid regurgitation, and mild pulmonary hypertension. When compared to the previous study performed on July 11, 2013, there was new mild left ventricular hypertrophy, mild to moderate tricuspid regurgitation and mild pulmonary hypertension (Record A73). On June 28, 2018, Mr. Moore reported that he had not had palpitations since his ablation in 2014, but his heart stops for a few seconds several times a day every day since (Record A88). On August 24, 2018, an echocardiogram showed moderately severe tricuspid regurgitation and mild pulmonary hypertension (Record A94). On September 10, 2018, Mr. Moore reported to cardiologist Mike Eskander, MD, that he continued to have skipped heart beats almost immediately after the ablation. He had had episodes of near syncope twice a week (Record A97). On February 5, 2019, an EKG event recorder revealed isolated supraventricular (SVEs) and

isolated rare ventricular ectopic (VEs) (Record A109). A Holter Event Monitor from April 27, 2019, through May 26, 2019, was normal except for tachycardia being present 13% of the time (Record A115). On July 8, 2019, Mr. Moore reported that he had presented to Sharp Grossmont Hospital because of diaphoresis (sweating) and palpitations (Record A118).

All of the above-outlined medical documentation predates the incident at issue that occurred on May 28, 2020. On that date, Mr. Moore was transported to San Gorgonio Memorial Hospital following a syncopal episode at work. His creatinine was 2.8 (normal 0.5-1.4) but returned to normal (1.2). His CPK rose to 3434 (nl 39-308) (Record C7).

As noted above, following initial post-injury evaluation at San Gorgonio Memorial Hospital, Mr. Moore was transported to Loma Linda University Medical Center and then to the VA Hospital. The only records of treatment available to me following the heat stroke are records from San Diego Healthcare System from June 2020, September 2020, and March 2021 (Records A129-A137); and the reports of Internal Medicine QME Stanley Majcher, MD, who initially evaluated Mr. Moore on December 16, 2020, for "virtually total body associated with heat stroke/rhabdomyolysis, kidney failure and other internal organ failure." In his July 8, 2021, report of reevaluation, Dr. Majcher referenced diagnostic studies to include EKG and echocardiogram findings consistent with prior EKGs and echocardiograms (Record Section I).

At the time of this QME examination, Mr. Moore complains that he has daily skipped heartbeat. He does not have episodes of rapid heartbeat.

In my opinion, Mr. Moore had a curative WPW ablation procedure for cardiac arrhythmias in 2014. Since the procedure, he has complained of palpitations. Through April 2019 specifically, multiple extended EKG monitoring tests did not demonstrate **objective** evidence of arrhythmia corresponding to Mr. Moore's **subjective** palpitations; nor did the reference to EKG testing within the July 8, 2021, report of Dr. Majcher.

The significantly elevated CPK associated with rhabdomyolysis would reasonably represent the effect of skeletal muscle injury/damage resulting from dehydration due to heat stroke, not as a result of a cardiac etiology. However, elevated CPK level due to heat stroke should normalize following hydration. The cause of the continuing CPK elevation is not clear. The echocardiogram findings of mild LVH, moderately severe tricuspid regurgitation and mild pulmonary hypertension do not explain the CPK elevation or the continuing subjective experience of palpitations.

In summary, based on the preponderance of evidence currently available, I cannot at this time provide a reasonably medically probable explanation, from a Cardiology standpoint, for Mr. Moore's continuing subjective experience of palpitations or for the continuing significantly elevated CPK. I also do not currently have a reasonably medically probable basis to conclude that Mr. Moore sustained a cardiac injury as a result of the heat stroke. As indicated, the most reasonably medically probable explanation for the elevated CPK following heat stroke would be as a consequence of skeletal muscle injury/damage resulting from the heat stroke.

For completeness, to rule out a cardiomyopathy as causing or contributing to the CPK elevation, I would request authorization to obtain a Cardiac MRI with gadolinium.

In addition, as noted above, I do not have the medical records from Loma Linda University Hospital Medical Center or the records from the Veterans Administration Hospital, where Mr. Moore was treated for the acute injury after his initial post-injury evaluation at San Gorgonio Memorial Hospital on the date of the incident, May 28, 2020; and I would request that those records be subpoenaed for my review. Upon performance of the Cardiac MRI with gadolinium and an opportunity to review the additional records of treatment, I can issue a supplemental report discussing whether and how the additional information might impact my opinions in this case.

If and when I may be of any further assistance in the evaluation of this individual, please do not hesitate to contact me.

DISCLOSURE:

I declare under penalty of perjury that the names and qualifications of each person who performed any services in connection with this report, including diagnostic studies, other than clerical preparation, are as follows: EDATA assists in excerpting from the medical records, with the records being reviewed by me personally. Laboratory services are performed by Cedars-Sinai Clinical Laboratory and/or Quest Diagnostics. EKG, pulmonary function testing and EKG stress testing are performed by Erika Aguirre, Kahlia Bundle, Nancy Hernandez, and/or Arusyak Sahakyan under my supervision. Arusyak Sahakyan, RDSC at COR Medical Group, an IAC accredited echocardiography laboratory, records the echocardiogram and or vascular sonar studies, which I interpret. Prior to me obtaining a complete history Linda Muratalla assisted the applicant in completing a 12-page questionnaire, which I reviewed with the applicant. I wrote this report. My report was then reviewed for clarity and completeness as well as for compliance with the Labor Code and the rules of the Administrative Director by Walter Colvin. Any potential questions were then brought to my attention for my clarification and/or completion. By my signature, I certify that all findings, opinions and conclusions expressed in this report are mine and were derived by me from my personal examination of the patient.

The evaluation performed and the time spent performing such evaluation was in compliance with the guidelines established by the Division of Workers' Compensation Medical Unit or the Administrative director pursuant to paragraph (5) of subdivision (j) of Section139.2.

Pursuant to Labor Code Section 4628 (k), it is to be known that I devote at least one-third of my total practice time to providing direct medical treatment and I have served as an Agreed Medical Evaluator (AME) on eight (8) or more occasions in the last 12 months.

Pursuant to Labor Code 5703 (a) (2), I declare under penalty of perjury that there has been no violation of Labor Code 139.3.

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

Signed in the County of Los Angeles,

J Caren, M.D. 2/21/22

Jeffrey F. Caren, M.D., F.A.C.C. Date

Sincerely,

Jeffrey F. Caren, M.D., F.A.C.C.

Assistant Clinical Professor of Medicine,
David Geffen School of Medicine at UCLA
Attending Cardiologist,
Cedars-Sinai Smidt Heart Institute

JFC

cc:

Branden Moore
292 Finnhorse Street
Hemet, CA 92545

Quest Diagnostics

Report Status: Final

MOORE, BRANDEN

Patient Information	Specimen Information	Client Information
MOORE, BRANDEN **DOB: 05/12/1990 AGE: 31** Gender: M Fasting: N Phone: 313.720.5458 Patient ID: 05121990BM Health ID: 8573029381941193	Specimen: ZD681083G Requisition: 0001175 Collected: 01/27/2022 / 09:47 PST Received: 01/28/2022 / 06:02 PST Reported: 01/28/2022 / 18:33 PST	Client #: 90048133 MAIL000 CAREN, JEFFREY F COR MEDICAL GROUP 8635 W 3RD ST STE 890W LOS ANGELES, CA 90048-6101

COMMENTS: FASTING:NO

Test Name	In Range	Out Of Range	Reference Range	Lab
COMPREHENSIVE METABOLIC PANEL				EN
GLUCOSE	80		65-139 mg/dL Non-fasting reference interval	
UREA NITROGEN (BUN)	15		7-25 mg/dL	
CREATININE	1.08		0.60-1.35 mg/dL	
eGFR NON-AFR. AMERICAN	91		> OR = 60 mL/min/1.73m2	
eGFR AFRICAN AMERICAN	105		> OR = 60 mL/min/1.73m2	
BUN/CREATININE RATIO	NOT APPLICABLE		6-22 (calc)	
SODIUM	140		135-146 mmol/L	
POTASSIUM	4.4		3.5-5.3 mmol/L	
CHLORIDE	106		98-110 mmol/L	
CARBON DIOXIDE	28		20-32 mmol/L	
CALCIUM	9.3		8.6-10.3 mg/dL	
PROTEIN, TOTAL	6.9		6.1-8.1 g/dL	
ALBUMIN	4.5		3.6-5.1 g/dL	
GLOBULIN	2.4		1.9-3.7 g/dL (calc)	
ALBUMIN/GLOBULIN RATIO	1.9		1.0-2.5 (calc)	
BILIRUBIN, TOTAL	0.4		0.2-1.2 mg/dL	
ALKALINE PHOSPHATASE	68		36-130 U/L	
AST		**46 H**	10-40 U/L	
ALT	21		9-46 U/L	
PROTEIN, TOTAL W/CREAT, RANDOM URINE				EN
CREATININE, RANDOM URINE	187		20-320 mg/dL	
PROTEIN/CREATININE RATIO	64		22-128 mg/g creat	
PROTEIN/CREATININE RATIO	0.064		0.022-0.128 mg/mg creat	
PROTEIN, TOTAL, RANDOM UR	12		5-25 mg/dL	
CREATINE KINASE, TOTAL		**4292 H**	44-196 U/L Verified by repeat analysis.	EN
CBC (INCLUDES DIFF/PLT)				EN
WHITE BLOOD CELL COUNT		**3.6 L**	3.8-10.8 Thousand/uL	
RED BLOOD CELL COUNT	5.22		4.20-5.80 Million/uL	
HEMOGLOBIN	14.6		13.2-17.1 g/dL	
HEMATOCRIT	43.4		38.5-50.0 %	
MCV	83.1		80.0-100.0 fL	
MCH	28.0		27.0-33.0 pg	
MCHC	33.6		32.0-36.0 g/dL	
RDW	12.8		11.0-15.0 %	
PLATELET COUNT	267		140-400 Thousand/uL	
MPV	9.6		7.5-12.5 fL	
ABSOLUTE NEUTROPHILS	1969		1500-7800 cells/uL	
ABSOLUTE LYMPHOCYTES	1192		850-3900 cells/uL	
ABSOLUTE MONOCYTES	396		200-950 cells/uL	
ABSOLUTE EOSINOPHILS	22		15-500 cells/uL	
ABSOLUTE BASOPHILS	22		0-200 cells/uL	
NEUTROPHILS	54.7		%	
LYMPHOCYTES	33.1		%	
MONOCYTES	11.0		%	

TC

Patient Information	Specimen Information	Client Information
MOORE, BRANDEN **DOB: 05/12/1990** **AGE: 31** Gender: M Fasting: N Patient ID: 05121990BM Health ID: 8573029381941193	Specimen: ZD681083G Collected: 01/27/2022 / 09:47 PST Received: 01/28/2022 / 06:02 PST Reported: 01/28/2022 / 18:33 PST	Client #: 90048133 CAREN, JEFFREY F

Test Name	In Range	Out Of Range	Reference Range	Lab
EOSINOPHILS	0.6		%	
BASOPHILS	0.6		%	
URINALYSIS REFLEX				EN
COLOR	YELLOW		YELLOW	
APPEARANCE	CLEAR		CLEAR	
SPECIFIC GRAVITY	1.023		1.001-1.035	
PH	5.5		5.0-8.0	
GLUCOSE	NEGATIVE		NEGATIVE	
BILIRUBIN	NEGATIVE		NEGATIVE	
KETONES	NEGATIVE		NEGATIVE	
OCCULT BLOOD	NEGATIVE		NEGATIVE	
PROTEIN	NEGATIVE		NEGATIVE	
NITRITE	NEGATIVE		NEGATIVE	
LEUKOCYTE ESTERASE	NEGATIVE		NEGATIVE	
C-REACTIVE PROTEIN	0.6		<8.0 mg/L	EN

PERFORMING SITE:

EN QUEST DIAGNOSTICS-WEST HILLS, 8401 FALLBROOK AVENUE, WEST HILLS, CA 91304-3226 Laboratory Director: TAB TOOCHINDA,MD, CLIA: 05D0642827

State of California

DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT

AME or QME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

Case Name : Branden Moore *(employee name)* v Ambercrombie Pipeline *(claims administrator name, or if none employer)*

Claim No. : WC608-E60694-00 **EAMS or WCAB Case No. (*if any*) :** _____

I, Kahlia Bundle *(Print Name)*, declare:

1. I am over the age of 18 and not a party to this action.
2. My business address is : 8635 West 3rd Street, Suite 890W, Los Angeles, CA 90048
3. On the date shown below, I served the attached original, or a true and correct copy of the original, comprehensive medical-legal report on each person or firm named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

   A — depositing the sealed envelope with the U.S. Postal Service with the postage fully prepaid.

   B — placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U.S. Postal Service in a sealed envelope with postage fully prepaid.

   C — placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.

   D — placing the sealed envelope for pick up by a professional messenger service for service. (Messenger must return to you a completed declaration of personal service.)

   E — personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of Service: *(For each addressee, enter A-E as appropriate)*	Date Served:	Addressee and Address Shown on Envelope:
B	2/21/22	Branden Moore, 292 Finnhorse Street, Hemet, CA 92545
B	2/21/22	Liberty Mutual, P.O. Box 779008, Rochlin, CA 95677
B	2/21/22	Brett Sherry, Esq., Koszdin, Fields, Sherry & Katz, 6151 Van Nuys Blvd, Van Nuys, CA 91401
B	2/21/22	Nicolett Ybarra, Esq., Law Offices of Muhar, Garber, Av & Duncan, P.O. Box 7218, London, KY

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date : February 21, 2022

Kahlia Bundle *(signature of declarant)*

Kahlia Bundle *(print name)*

QME Form 122
Rev. February 2009