agile OCCUPATIONAL MEDICINE

1710 Churn Creek Rd.
Redding, CA 96002 - 0236
PH: 530 646-4242
FAX: 530 255-4934

PROGRESS NOTE

Patient First Name:	Patient Last Name:	Date of Birth:	Sex:
Eric	Linch	07-20-1971	Male
Attending Provider:	**Referring Provider:**	**Visit Date:**	**Chart No.:**
Shirin Alonzo, MD, MPH		11-16-2023	SCL02684
Insurance:	**Employer:**	**Claim Number:**	**Date of Injury:**
State Fund	California Dept of Justice	06879080	04-21-2022
Appointment Location:		**Appointment Location Address:**	
Agile Occupational Medicine, Redding		1710 Churn Creek Rd., Redding CA 96002 - 0236	

History of Present Illness
Patient is a 52 year old male.
52 year old male in law enforcement with cumulative injury from over 20 years in law enforcement. He has two separate cases. One includes multiple musculoskeletal claims, and another is for his shortness of breath with exertion and chest tightness.

Today, he presents for follow-up of dyspnea on exertion/shortness of breath. Unfortunately, he has been diagnosed only with "asthma," however, after review of all his medical documents, I do not see evidence that he has "asthma." Furthermore, he has been given albuterol inhaler trial which does not alleviate his symptoms. He does, however, endorse chronic symptoms of shortness of breath with exertion and heart palpitations. Patient likely has cardio-pulmonary chronic disease that is causing his symptoms, and are a result of his cumulative exposures and traumas in law enforcement.

Poor sleep function has been reported prior. He sleeps about 4-5 hours per night, and naps during the day. During his QME with cardiologist patient reported being "tired and worn out." The job duties that the patient has experienced are known to cause cardio-pulmonary diseases.

LUNGS. Patient has over 20 years intermittent exposure to smoke (in casino, and also in meth lab). Patient is ex tobacco smoker for about 20 years 1/2 PPD, quit 10 years prior. He continues with dizziness, chest tightness, and dyspnea on exertion. A lung scan obtained through the VA shows lung scarring as well as scattered calcified granulomas. Given patient's environmental work-related exposures, it is possible that he has interstitial lung disease.

Chronic fatigue as a result of long shifts, overtime, irregular shift schedule can lead to sleep disorders, including obstructive sleep apneal, moderate to severe insomnia, and shift work disorder (defined as "excessive wake time sleepiness and insomnia associated with night work.)

The patient has Obstructive Sleep Apnea and he states he uses a CPAP, and was diagnosed about 10 years prior.

Prior pulmonary diagnostics:

10/6/2022: Patient performed PFTS at the VA with pre and post albuterol testing. Per the report findings, patient had "mild obstructive pattern with significant improvement in FEV1 and FVC with albuterol. Total lung capacity was normal, and air trapping was present on lung volumes. DLCO is normal." The flow volume loops were not submitted for review, so accuracy of testing is unknown.

8/14/2023: CT Chest, low dose (obtained at VA by PCP for lung cancer screening)
Lungs - mild bibasilar scarring or atelectasis. Scattered calcified granulomas. No suspicious pulmonary nodules or masses.

#CARDIOVASCULAR: Given patient's long-time service commitment in law enforcement, and history of extreme stressful working conditions, disruptions in sleep/wake cycle, long work hours, high levels of stress, patient has work-related cardiovascular disease. He has hypertension, abnormal heart beats, elevated cholesterol, and plaques in his arteries.

Cardiology QME did not accurately assess patient's cardiovascular status, and stated that patient did not have cardiovascular disease. This is incorrect, as patient has documented hypertension with anatomical findings on echocardiogram, coronary atherosclerosis as evidence on imaging, as well as abnormal EKGs that are concerning, and multiple arrythmias (including premature atrial complexes and premature ventricular complexes). Furthermore, the QME inaccurately states that the patient had a pharmacological exercise stress test. However, this is not correct, as the patient only had a pharmacological Lexiscan Stress Test and no EKG reports during the stress test dated 3/23/2023 were submitted to cardiologist for review.

Upon review of all of patient's external documents and relevant QMES (of note, no PCP records were submitted for review), this patient has coronary artery disease as evidenced on Low Dose CT scan performed at the VA on 8/14/2023. He also has evidence of chronic hypertension on his echocardiogram from 11/20/2022. He has been diagnosed with hypertension by his PCP. Upon review of Blood pressure measurements at AGILE, he has hypertension. He also has been prescribed low-dose Lisinopril 5 mg by his PCP which he admits to taking intermittently. His chronic hypertension is likely due to chronic pain from his work-related musculoskeletal injuries, the use of chronic NSAIDs for his work-related pain, as well as stress induced work-related hypertension.

Per the ACA/AHA (American Cardiology Association and American Heart Association) 2023 guidelines, a diagnosis of hypertension is made when the blood pressure measurement is greater than 120/80. Prior to 2023, hypertension diagnosis was when blood pressure measurement was greater than 130/80.

Prior Cardiovascular Diagnostics:
8/14/2023: CT Chest, low dose (obtained at VA by PCP for lung cancer screening)
Mediastinum: Aortic and coronary artery atherosclerosis.

3/23/2023: Nuclear Medicine Stress Test, LV ejection fraction 58%. Patient only achieved 66% of age predicted maximum heart rate. The patient did develop symptoms during the procedure. Specific symptoms included shortness of breath. He did not have ST changes or evidence of myocardial ischemia.
- Of note, this is not an accurate test since patient's target heart rate of 85% was not achieved as he developed shortness of breath. Furthermore, a common side effect of the Lexiscan (Regadenason) IV chemical infusion is shortness of breath. Thus, his stress test is limited and cannot be interpreted accurately.

There are significant differences between the two EKGs provided to the QME cardiologist:
1/9/2023 EKG - low voltage is present now in multiple leads, The patient has absent q waves in leads 5 and 6 on both EKGs which are abnormal.

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11/20/2022 Echocardiogram (via Dr. Khan at the Cardiovascular Center): LV normal with mild concentric

hypertrophy. LV ejection fraction is 60- 65%. Aortic valve mildly sclerotic without stenosis. Mild mitral annual calcification.

1/11/2021: Echocardiogram (at the VA by PCP):
- Ejection fraction 50-55%. Left ventricular systolic function is low normal. Normal left ventricular diastolic function.
- Trace mitral regurgitation
- Trace pulmonic regurgitation. The pulmonic valve leaflets are thin and pliable, valve motion is normal.

12/11/2020: Zio XT Patch 14 day continuous holter, done for symptoms of palpitations
- Numerous triggers (67) with unifocal PVCs, PACS, sinus, artifact. PVCs and PAC occur without triggering also.
- Underlying rhythym was sinus rythym
- Isolated SVEs were rare (<1%, 28), SVE triplets were rate (< 1.0%, 1), and now SVE couplets.

SVE = supraventricular ectopics
VE = ventricular ectopics
"Suggest: AS patient appears to be very sensitive to PVCs and PACS, best to avoid all stimulants, pseudoephedrine, cyclobenzaprine may be associated with tachycardia. If needed, small dosages of beta blocker may be tried. "

Patient had been on cyclobenzaprine for back pain. This can cause heart palpitations. Additionally, stress, poor sleep, caffeine, can also cause heart palpitations. Patient had been on Sudafed by ENT for bilateral eustachian tube dysfunction. Patient states he never used Sudafed long-term, so this is not likely a cause of his palpitations. Last labs PCP 12/2022: normal electrolytes, normal CBC, normal thyroid function tests.

Prior QMEs:
Asthma QME 8/2023
Cardiovascular QME 8/12/2023, per patient, supplemental information from PCP was sent 8/22/2023. QME by family medicine/occupational medicine Dr. Donald Lee
9/15/2023 - QME by family medicine/occupational medicine Dr. Donald Lee, requesting audiology eval and PFTs

PMH includes:
hyperlipidemia, on lipitor
allergic rhinitis
nasal obstruction, nasal septal perforation, status post rhinoplasty (not work-related)
sleep apnea, uses cpap (uses consistently)
thyroid nodule, s/p biopsy with benign pathology
hypertension, on lisinopril intermittently

Past Medical History
No Known Past Medical History

Surgical History
left shoulder surger: 11/21 by Matt Paul at Mercy. right knee surgery: 9/9/22 by Matt Paul at Mercy.

Allergy
No Known Drug Allergies.

Current Medication

daily vitamin
Lipitor
vit d

Social History
Work History: He is employed - full time. He has been in the current profession for years.
Use of Drugs/Alcohol/Tobacco: Never drinks any alcohol. Smoking Status (MU) former smoker. Reports consuming caffeine/caffeinated drinks few times per week. He has never used any illicit drugs. He denies using street drugs with a needle.

Vitals
Pain scale was 5 out of 10.
Weight: 230.00 lbs.
Height: 75.00 inches.
Temperature: 97.80 F.
Pulse: 92 per min.
Pulse rhythm regular: Yes
Respiration: 16 breaths per min.
BMI: 29.
BP Systolic: 118 mm Hg.
BP Diastolic: 72 mmHg.
Pulse Oximetry: 95

QME reports in docs
No changes since last visit.
Asking about a disability form if it ever made it to you? A calpers form?

Physical Examination

Gen: NAD, pleasant

CHEST EXAM (exam done 10/4/2023, not repeated today)
A. VISUAL INSPECTION: Chest exam reveals no cyanosis, no gross deformity, no swelling, No ecchymosis, or any skin lesion. Normal breathing.
B. AUSCULTATION: Lungs are clear to auscultation bilaterally. Heart is regular rate and rhythm without murmurs, gallops, or rubs noted.
C. PALPATION: Chest wall is not tender to palpation.

Orders: Spirometry/PFT with Pre/Post Bronchodialator:needs repeat PFTS with albuterol

Assessment and Plan
ICD: Interstitial lung disease (J84.9)
Assessment: 52 year old male in law enforcement with cumulative injury from over 20 years in law enforcement. He has two separate cases. One includes multiple musculoskeletal claims, and another is for his shortness of breath with exertion and chest tightness. To date, he does not have an accurate diagnosis or treatment plan of his concerning symptom of shortness of breath with exertion.

Today, he presents for follow-up of dyspnea on exertion/shortness of breath. Unfortunately, he has been diagnosed only with "asthma," however, after review of all his medical documents, I do not see evidence that he has "asthma." Furthermore, he has been given albuterol inhaler trial which does not alleviate his symptoms. He

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hypertension, on lisinopril intermittently
Plan: #Lungs: Per AOECM guidelines, patient meets criteria for occupationally related interstitial lung disease. Patient has what appears to be chronic granulomatous changes on low dose CT scan and evidence of lung scarring, which is likely causing his mild obstruction in previous PFT. This is likely due to exposures. Furthermore, his sleep disorder is likely due to chronic fatigue caused by his employment.
- He needs an appropriate pulmonary consultation for complete evaluation and correct diagnosis of lung disease, as well as a pulmonary sleep medicine consult to correctly evaluate his sleep disorder. He should have an evaluation for pulmonary hypertension given his co-morbidities and symptoms
- He needs an appropriate CT chest with and without contrast to properly evaluate degree of inflammation/fibrosis of lungs
- He needs repeat pulmonary function tests, as recommended by most recent QME Dr. Lee

#CV: Patient with long-standing hypertension, hyperlipidemia, heart arrythmia (PACS/PVCs) and coronary artery disease.
- Coronary Artery Calcium CT Scan to obtain accurate diagnosis of degree of coronary artery disease as his previous stress tests were not able to be interpreted due to not achieving target heart rate
- Will do repeat EKG next time patient is in clinic
- Recommend updated Z-patch Holter monitor to assess for current status of heart arrythmia given that last diagnostic evaluation was three years prior, and patient continues with persistent palpitations (defer to cardiology to order)
- Refer to cardiology for second opinion of abnormal findings including prior abnormal EKGS and abnormal Hotler monitor; and for management and recommendations

ICD: Exposure to chemical inhalation (Z77.098)
ICD: Abnormal PFTs (pulmonary function tests) (R94.2)
ICD: Chronic hypertension (I10)
ICD: Concentric left ventricular hypertrophy (I51.7)
ICD: Abnormal EKG (R94.31)
ICD: Heart palpitations (R00.2)
ICD: Premature atrial complexes (I49.1)
ICD: Ventricular premature complexes (I49.3)
ICD: Chronic fatigue (R53.82)
ICD: Obstructive sleep apnea (G47.33)
ICD: Sleep disorder, circadian, irregular sleep-wake type (G47.23)
ICD: Coronary atherosclerosis due to lipid rich plaque (I25.10)
ICD: Other hyperlipidemia (E78.49)
ICD: Dyspnea on exertion (R06.09)

CPT Codes:
Office O/p Est Hi 40-54 Min (99215)
WC002 (WC002)

HCPC Codes:
Prolong outpatient office services (G2212)

E and M Time Factor/ Medical Decision Making Notes:
40-54

I spent over 3 hours with the patient today face-to-face encounter, after hours phone call, chart review, reviewed over 100 pages of documents, patient prognosis and medical decision making.

Follow up: -