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INDEPENDENT MEDICAL EVALUATION

PATIENT NAME: [redacted]
DATE OF BIRTH: [redacted]
DATE OF IME: January 23, 2025
DATE OF INJURY: October 13, 2023
EXAMINING PHYSICIAN: Lawrence H. Peters, M.D.
CLINIC LOCATION: 9900 Corporate Campus Dr., #2400, Louisville, KY 40223
ATTORNEY: [redacted]

INTRODUCTION: The purpose of this report is to obtain a medical history, complete a physical examination, review medical records, derive a diagnosis with prognosis, and calculate an impairment rating if indicated.

HISTORY OF PRESENT ILLNESS: Ms. [redacted] is a 66-year-old right-hand dominant female, who complains of left hand injury that occurred on October 13, 2023. The patient was working as a traveling nurse at UK Hospital. She states she fell backwards onto her wrist at work and had immediate significant pain.

The patient was sent to the emergency room, where she was diagnosed with a displaced comminuted distal radius fracture and ulnar styloid fracture, as well as a scaphoid fracture of her left upper extremity. She underwent a closed reduction in the emergency room with sedation. Of note, she apparently was given too high a dose of ketamine, which she did not tolerate very well. This was listed as an allergy, but it is not an allergy per se.

She was next evaluated on October 17, 2023 with Dr. Carrasquer at U of L. The patient presented with complaints of constant pain in the radial aspect of her wrist with significant swelling into her hand. A new splint was placed. A CT was obtained, which confirmed the comminuted non-displaced distal radial fracture and a non-displaced transverse scaphoid fracture.

The patient was referred on to Dr. Luke Robinson at Norton Louisville Arm and Hand. She was initially seen on November 1, 2023. The plan was to continue splinting with light activity.

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Ms. [redacted] had a follow-up on December 4, 2023 with Dr. Robinson. The patient now noted increasing pain in the base of her thumb, especially when using her hand. X-rays reported to show some callus formation at the distal radius, but also noted poor bone quality with osteopenia. The plan was for continued bracing and non-surgical treatment. A CT scan was to be obtained to assess scaphoid healing.

A follow-up on December 21, 2023 revealed the patient was continuing with pain and now numbness as well. A CT scan of the wrist done December 15, 2023, was noted to show a healing distal radius fracture, a scaphoid fracture with no irregularities, and osteopenia. Due to the patient's complaints of thumb pain at that point, a consideration was made of a trigger thumb and an injection was done at the office that day, which helped somewhat with physical therapy, but did not overall change her pain greatly.

A follow-up with Dr. Robinson on January 4, 2024, he noted poor grip, thumb dysfunction, feeling of weakness, tingling in her hand, and dysesthesia in her thumb. He felt she was doing poorly and considered carpal tunnel as a component of her pain. An injection was done for diagnostic and therapeutic purposes to address the possible carpal tunnel syndrome and nerve conduction and EMG studies were ordered.

EMG nerve conduction velocity studies done with Dr. Reloj on February 1, 2024, were reported as normal.

A follow-up on February 15, 2024 with Dr. Robinson, noted continued hypersensitivity and decreased range of motion in the hand, especially at the thumb. The impression was a healed distal radius fracture and suspicion of CRPS. The plan was to continue with therapy and he tried her on gabapentin. Over the next month, this was titrated upwards to 300mg t.i.d. and then stopped by the patient due to lack of efficacy and side effects. She felt somewhat sleepy.

A follow-up on April 11, 2024 with Dr. Robinson, continue with complaints of pain and dysesthesia. Noted inability to wear a glove. The patient wanted to return to work at this point. The impression was still of a healed distal radius fracture and the patient will try to return to regular duty.

A follow-up on June 13, 2024, the patient noted worsening pain that is now shooting up into her shoulder through her forearm. There was some decreased fine motor control. A pain management referral was suggested and the patient was given a trial of tramadol.

She was seen by Dr. Brandon Sutton at the Ohio Valley Pain Institute on August 29, 2024. He reviewed the previously mentioned history and noted worsening pain with description of having "thousands of pins and needles" through her hand. The pain was noted to extend from her fingers through her hand, arm, and to the shoulder. It was worse distally. There were color changes noted of reddishness and purple, hypothermia and cold sensation, and decreased range of motion. The patient also reported decreased significant quality of life and difficulty with ADLs, as well as emotional stress.

The patient at this point failed extensive physical therapy and gabapentin. The examination at that time showed significant swelling and waxy appearance in the fingers and painful range of motion of the hand, wrist, and fingers. Range of motion was minimally decreased in the shoulder and elbow that was painful. Neurological examination was normal. The examining physician noted severe allodynia. The impression was of a diagnosis of CRPS type 1 that had failed conservative treatment. The patient did not want to use any analgesics and had already failed anti-convulsive medications. A stellate ganglion block was suggested and a discussion was had with the patient regarding the possibility of spinal cord stimulation. The plan was to schedule for a stellate ganglion and to get an MRI of the patient's cervical spine to assess for possible spinal cord stimulator placement in the future.

The patient followed up with Dr. Sutton on October 14, 2024. The history was mostly the same. She had been treated at this point due to waiting for clearance. The stellate ganglion block was done on October 22, 2024 with ultrasonic guidance. It was uncomplicated.

A follow-up with Dr. Sutton on November 25, 2024, the patient noted 80% improvement for approximately a week. She was very happy with this change during that time and had maintained about 50% improvement for three weeks afterwards. At this follow-up appointment, the patient was back to her baseline complaining of burning, severe hypersensitivity, color changes, and hypothermia. She was very frustrated by the lack of response to the single injection. The plan at that point was to continue working towards a spinal cord stimulator trial. She was also given a low dose of hydrocodone 5mg, which she could take up to twice a day. She uses this infrequently.

A follow-up with Dr. Sutton on December 23, 2024, the history was consistent with the same symptoms. The patient was also complaining of feeling worse due to cold weather and being limited in her ADLs. At this point, spinal cord stimulation had not been approved. The patient stated this had been attempted through both her private insurance and Workers' Compensation. There was no plan for further stellate ganglion injections at this point due to denial based on the lack of long-term improvement with the first single injection. The plan was to continue to wait approval for a spinal cord stimulator, treat the patient with low dose analgesics, and consider a repeat stellate ganglion block.

In addition to the treatment via Dr. Sutton, the patient also had an IME on September 7, 2024 with Dr. Thomas Gabriel. His exam was focused mainly on an orthopedic injury. He appeared to have found that treatment and diagnosis was appropriate for the wrist fracture and noted the suspicion of CRPS and agreed with the role of a stellate ganglion block, but deferred to the role of spinal cord stimulation. He okayed a trial of return to work. At that point, he gave an impairment rating of 4% of the whole person based on orthopedic issues and focused mainly around the loss of range of motion in her left thumb and index finger.

In addition to the aforementioned findings from her treating physicians, the patient states that she had an onset of pain and dysesthesia throughout her entire hand and fingers within a few weeks of the injury. She also noted hyperthermia, color changes with mottling and purple discoloration, which also occurred after a few weeks. These symptoms continued to worsen over the ensuing months and she did not feel that the physical therapy was any help with her pain, though it did help her to maintain her range of motion. Of note, the patient continues range of motion exercises on her own.

Treatments included anti-inflammatories, which is intolerant due to GI issues and gabapentin which did not help at a dosage up to 300mg t.i.d. and was poorly tolerated. She did not want Lyrica, which had been suggested. Hydrocodone 5mg had been used infrequently when her pain was very bad. She noted that her sleep was also very bad due to pain and dysesthesia. She rates her pain as a 6/10 daily and it can get up to a 10/10.

The patient's pain complaints currently are significant allodynia through the fingers and hand. The pain becomes slightly less severe through the upper arm to her shoulder, though there is dysesthesia all the way to the shoulder, which worsens at times with activity. There was mild mottling present. This got worse during the time of her exam. The patient reported some nail changes, which are difficult to assess due to the fact that she was wearing fake nails. There were some shiny waxy changes to her skin. There was some muscle wasting in the palmar aspect of her hand and decreased range of motion due to pain and decreased grip strength. The patient noted that she avoids ADLs that require the use of her left hand.

PHYSICAL EXAMINATION: The patient is alert, oriented, cooperative, and non-antalgic. She does hold her hand somewhat protectively.

Cervical spine was nontender. She had a full range of motion. There was no myofascial tenderness, spasm, or trigger points appreciated.

Right upper extremity examination was entirely normal for full range of motion, normal reflexes, normal sensation, and muscle strength.

Examination of the left upper extremity showed normal reflexes at the biceps, triceps, and brachioradialis. Sensation was intact throughout her upper extremity, though she had the noted hypersensitivity and allodynia was more significant distally in her hand. The hand was cool to touch as compared to her right hand. There was muscle wasting in the palmar aspect of her hand and mild mottling. Pulses were normal.

JOINT RANGE OF MOTION EXAMINATION: At the time of this exam, the range of motion in her fingers was measured as normal on the left.

Left wrist range of motion showed ulnar deviation to 15 degrees, radial deviation to 20 degrees, flexion 30 degrees, and extension 30 degrees.

Left shoulder abduction was 160 degrees, adduction was 50 degrees, flexion was 140 degrees, extension was 50 degrees, internal rotation was 50 degrees, and external rotation was 70 degrees.

MEDICAL RECORDS REVIEWED:

1. Norton Louisville Arm and Hand, Dr. Luke Robinson, notes from November 1, 2023, November 22, 2023, December 21, 2023, January 4, 2024, February 15, 2024, April 11, 2024, and June 13, 2024.
2. Ohio Valley Pain Institute, Dr. Brandon Sutton, dates seen August 29, 2024, October 14, 2024, October 22, 2024, November 25, 2024, and December 23, 2024.
3. Dr. Noel Reloj, EMG nerve conduction velocity study, February 1, 2024.
4. Kentuckiana Hand Surgery, Dr. Thomas Gabriel, IME, dated September 11, 2024.

IMPAIRMENT RATING: Using the AMA *Guides to the Evaluation of Permanent Impairment*, 5th Edition, the impairment rating at this point is based on the patient's current condition. She likely needs further treatment and is not at MMI. Impairment rating is based on a combination of the pain associated with her diagnosis of CRPS type 1 and associated decreased range of motion affecting most significantly her wrist and shoulder. The process used is as described in Section 16.5e on Pages 495-497 of the Guides.

Left wrist, using Figure 16-31 on Page 469, ulnar deviation at 15 degrees gives a 3% impairment and radial deviation at 20 degrees is 0%. Using Figure 16-28 on Page 467, wrist flexion of 30 degrees gives an impairment of 5% and extension of 30 degrees gives an impairment of 5%. Additively, this is 13% of the upper extremity.

Left shoulder examination using Figure 16-40 on Page 476 for flexion and extension, flexion at 140 degrees gives a 3% impairment and extension of 50 degrees gives a 0% impairment. Using Figure 16-43 on Page 477, abduction at 160 degrees gives a 1% impairment and adduction at 50 degrees gives a 0% impairment. External rotation was 50 degrees, giving 1% impairment and internal rotation was 70 degrees, giving 1% impairment based on Figures 16-46 on Page 479. Adding these motion impairments together gives a 6% impairment of the upper extremity.

The combined upper extremity impairment for wrist and shoulder deficits is 13 and 6, giving a value of 18%.

The upper extremity impairment due to sensory deficits and pain associated with CRPS was calculated using Table 16-10 on Page 482. The patient's symptom complex was consistent with a grade-2 rating in the low range of 60%.

The 60% rating from Table 16-10 and the 18% upper extremity rating, based on the wrist and shoulder dysfunction was then applied to the Combined Values Chart on Page 604. This gave a combined value of 67%. This 67% was then applied to Table 16-3 on Page 439 for conversion to whole person impairment. The 67% impairment was consistent with a 40% whole person impairment. This encapsulates the limitations of her shoulder and wrist range of motion and the pain associated with her diagnosis of CRPS, if no further treatment is anticipated.

IMPRESSION: Healed distal radius and scaphoid fracture with CRPS type-1. The patient's diagnosis is based on use of the Budapest criteria for which the patient has symptoms and findings consistent with that diagnosis.

CONCLUSIONS AND RECOMMENDATIONS: At this point, the patient would be at MMI as of December 23, 2024. This date is based on the fact that at that point, further treatment in the realm of repeat stellate ganglion blocks or spinal cord stimulation had been denied by her Workers' Compensation carrier. This MMI date is based on the assumption that no further treatment is anticipated due to lack of approval.

With regard to restrictions for Ms. [redacted] if no treatment is forthcoming, these restrictions would include no lifting greater than five pounds with her left hand occasionally, no repetitive use of the left upper extremity for fine manipulation, and no repetitive flexion or extension of the shoulder or elbow on the left. Additionally, the patient should not push or pull greater than 30 pounds with both upper extremities and only occasionally.

With regard to further treatment, based on this patient's diagnosis of CRPS, there are a number of options available:

1. Repeat stellate ganglion block. This patient had a fairly good response for a week of 80% improvement and three weeks of 50% improvement. This actually is above average for the initial single injection. Typically, a response like this would have been followed up by repetitive injections. There was no specific number. The number of injections are based more on response. If she continues to respond, this may be a permanent modality of treatment. Some patients even do very well and need an intermittent injection every 6 to 18 months if symptoms recur.
2. Spinal cord stimulation is a definite option for this patient based on her diagnosis and failure of other modalities. A trial period with a temporary placement of leads would first be attempted. If this was successful, then permanent implantation could be considered.
3. Ketamine infusions have gained popularity based on efficacy for the treatment of CRPS symptoms in many patients. This patient does not actually have an allergy to ketamine. She was likely given a dose that was in excess of what was needed due to problems when she was having her wrist set. Ketamine infusions have definitely shown efficacy in treating patients with CRPS symptoms.
4. With regards to medical management, the patient has been on low-dose hydrocodone and there is a discussion of trialing low-dose oxycodone as an analgesic. The patient states that these analgesics have been helpful when the pain becomes very severe. She is very aware of possible issues with narcotics due to a history of family members with problems and strongly wants to avoid their use at all times when she is able. However, at times it has been the only thing to give her relief when the pain has been very severe.
5. The patient should continue with her home exercise program that she does to maintain her range of motion. This has been fairly effective and I do not think that she needs any further therapy at this point.

In my opinion, the patient may continue employment based on the above restrictions. At this point, she has worked as a traveling nurse and she currently is able to accomplish the required tasks working within the above-noted restrictions. Other employment possibilities as a traveling nurse obviously can change based on the requirements put forth by her potential employers.

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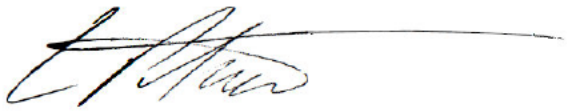
Prior to the interview and examination, the patient was apprised as to the role of an Independent Medical Examination and the fact that it does not constitute a patient/physician relationship. The role of the exam is to assess treatment, determine diagnosis and impairment, and comment on future treatment indications or options.

All findings are based on accepted medical criteria and are consistent with best practices.

Sincerely,



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