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October 4, 2016

Perry Accardo
Law Office of Steven A. Lihosit
200 North Lasalle Street, Suite 2550
Chicago, IL

RE:	DULBERG, PAUL
DOB:	03/19/1970
Case/File No.:	0245281968.1 SKO
Location:	Illinois Bone and Joint Institute, LLC
Patient ID:	P1510776

Dear Mr. Accardo:

I was asked to perform an independent medical evaluation on Mr. Dulberg on October 4, 2016. This examination took place in my office in Glenview, Illinois.

As part of this independent medical evaluation, Mr. Dulberg's identifying documentation was obtained, xeroxed, and placed into the medical records. The information from these documents appeared to corroborate with his appropriate information.

I explained to Mr. Dulberg, with his mother Barbara as well as his attorney Randy present, the purpose of the independent medical evaluation as well as the fact that no patient-physician relationship was established with him during today's visit. Additionally, I explained to them that no treatment, outcomes or diagnoses would be discussed with him during this evaluation.

All opinions expressed in this report are made to a reasonable degree of medical and surgical certainty as a board certified orthopedic surgeon with a certificate of added qualification in hand and upper extremity surgery.

I spent 65 minutes with Mr. Dulberg in face-to-face time today obtaining a history and performing a physical examination.

HISTORY:
Mr. Dulberg is a 46-year-old right-hand dominant gentleman who previously worked in graphic design who is here for evaluation of his right upper extremity. He states that he had no symptoms referable to his right upper extremity prior to an injury that occurred in June 2011. He states he is not sure of the exact date, but on the date in question he was holding a tree branch at his neighbor's house to help David, his neighbor's son, cut the tree branch with a chainsaw. He stated he was holding a pine tree branch, which was a few inches thick, still attached to the tree and while David was cutting the branch, he inadvertently cut Mr. Dulberg's right forearm. Mr. Dulberg went to NIMC ER where the wound was irrigated and sutured. He had radiographs there which showed no fractures. He followed-up with his primary care physician, Dr. Sek, who removed the sutures two weeks later. Mr. Dulberg noticed

significant pain in his forearm after the injury. Due to persistent symptoms, Dr. Sek referred him to see Dr. Levin, who Mr. Dulberg states is a neurologist, who performed a nerve conduction study and Mr. Dulberg was told the study was normal he had no nerve injury, but was told that the superficial branches of the nerves were severed. Due to ongoing significant pain, he was referred to a hand specialist. He initially saw a hand specialist, although he is not sure of the name but per the medical records that I reviewed was Dr. Talerico, who referred him for occupational therapy. He states that he performed occupational therapy for multiple months which provided him with no benefit. He states that he was still having significant problems with his right forearm and hand and so he returned to see Dr. Levin. Dr. Levin referred him for a second opinion to see Dr. Sagerman in 2012, although he is not sure of the date. Dr. Sagerman prescribed more occupational therapy, which he states was "somewhat helpful". Dr. Sagerman also repeated the nerve studies as he stated the initial nerve study was not complete. Mr. Dulberg does not remember the date of the repeat nerve studies. Subsequently, he followed-up with. Sagerman but is not sure of the results of this nerve study, but thereafter Dr. Sagerman suggested exploring the nerve. He wanted to think about this and returned a month later after discussing this with Dr. Sek and elected to undergo surgery. He underwent surgery by Dr. Sagerman in June or July 2012 whereby he states he underwent a cubital tunnel release, and was told that the "nerve was okay." He also underwent exploration of the ulnar nerve in the forearm and tells me that Dr. Sagerman told him "this was the most scarred tissue, I have ever seen." (This is interesting as the MRI was normal and the operative report states that no scar was noted around the nerve and the muscle belly that covers the nerve was pristine only with sutures in the fascia covering the muscle). He was then enrolled in more occupational therapy, which he did for another two months. He states that this helped his forearm temporarily. He followed up with Dr. Sagerman and ultimately plateaued. His complaint at that point as well as prior to the surgery was numbness and tingling in his fourth and fifth finger as well as pain and spasms in his left forearm. Due to a plateau in his improvement after surgery, Dr. Sagerman referred him to Dr. Kujawa. Mr. Dulberg states that he was referred for "cramping" and "spasms of the muscles in the forearm." Dr. Kujawa has treated him from after this surgery until the present time. Mr. Dulberg states that Dr. Kujawa tied injecting Botox in the muscles of the forearm twice. The first time he states it provided him with no benefit and the second time he states that the muscles in his forearm got significantly weaker, which he states Dr. Kujawa confirmed that the Botox was in the correct area; however, besides having temporary weakness in the arm, did not change the cramps and spasms that he was complaining of at that time. He states that both Botox injections were performed within a year of his surgery. He has continued to follow up with Dr. Kujawa who started him on Gabapentin. He states that the Gabapentin has helped the smaller and minor cramps, spasms and pain in his forearm; however, the larger and more significant cramps and spasms in the forearm have not been affected by the Gabapentin. He sees Dr. Kujawa every six months. He did follow up to see Dr. Sagerman for left lateral epicondylitis in 2012, who performed a cortisone injection into the elbow, which cured this problem. Of note, Mr. Dulberg had previously seen Dr. Sagerman in early 2000 for "pain in the left elbow" as well as "numbness and tingling in the fingers." He underwent a cubital tunnel release on the left at that time, which helped tremendously. He currently has no similar symptoms in the left upper extremity

I asked Mr. Dulberg about a motor vehicle accident in early 2000 in which he was involved. He states he sustained a whiplash injury and he hit his left elbow against the inside of the car and developed pain in the left elbow and numbness in the fingers. He was diagnosed with left cubital tunnel syndrome. He had nerve studies and a year later underwent a cubital tunnel release. He was also diagnosed with degenerative disk disease in his cervical spine after the motor vehicle accident affecting him from C3 to C7. He takes occasional Naproxen for his neck, which he states helps somewhat. He is not sure whether the Naproxen really helps his right arm.

Mr. Dulberg states that he is currently able to drive, although he has to drive with his right hand at the 6 o'clock position as when he holds the steering wheel at the 10 or 12 o'clock position, he develops spasms in his forearm. He states any vibration causes spasming in his right forearm.

CURRENT COMPLAINTS WITH REGARDS TO THE RIGHT UPPER EXTREMITY:

I asked Mr. Dulberg to list all complaints referable to his right arm:

Mr. Dulberg's primary complaint is that he describes "cramps" in the forearm. He states the cramps happen at least 12 times a day. He states they frequently happen with no activities. He states the cramps last a few seconds to a few minutes. Thereafter, he notices that the fingers are weak and he frequently drops objects due to the cramps. He does not describe any finger spasms. He states that activities exacerbate the frequency and severity of the cramps "a lot." He occasionally wakes up with these symptoms at night, which he states is maybe once a week. He states the cramping is his biggest problem subsequent to the injury. He states the cramps began within six months of the injury. He states he had "a lot going on at that time" and he had to figure out what was causing his problem. When asked specifically, Mr. Dulberg states that the acute pain that he had in the forearm immediately after the injury is gone.

Mr. Dulberg's second complaint with the right arm is that he has occasional tingling in the fifth finger. It bothers him once or hen he develops these symptoms they last for a few seconds. It does not wake hir

He also describes burning in and is unpredictable, similar to the tingling in the small finger. Wh the palm begins to burn. The duration of the palmar symptoms are t. g.

He rates his pain currently as 0/10, bu urt, and rates the cramping as a 7-10/10. The pain from the cramps lasts a few secon tes.

OCCUPATION HISTORY:
Mr. Dulberg states that he has worked as a graphic designer since he was 16 years old. Subsequent to his right forearm injury, he states that he was unable to work. He tried returning to graphic design 2 months after the injury, but states that he could not type because he would develop the forearm cramps. He states any activity whether it be typing or mousing for any period of time whether it be minutes or hours, would increase his symptoms. He has no symptoms when he drives as he has modified where he grasps the steering column.

HOBBIES:
Mr. Dulberg states that he previously would fish, drive motorcycles and ATVs, canoe, camp and bicycle. He states he cannot do any of these activities as his right forearm cramps. He tried bicycling after the surgery, but he could not hold onto the handlebars without cramping. His new hobby includes maintaining a home fish aquarium. He states he is able to change the water without difficulty but his friend Mike helps him with the maintenance.

PAST MEDICAL AND SURGICAL HISTORY:
Mr. Dulberg states that he has no medical problems. He states he has no history of diabetes or thyroid

disorder. He has no history of arthritis or inflammatory arthropathy; specifically, no history of rheumatoid arthritis, gout, pseudogout, psoriasis, or colitis. He has no history of fibromyalgia. He states that he was diagnosed with anxiety and depression a year after the accident, but takes no medication for this. He does not see a psychologist.

Mr. Dulberg's only medication is Gabapentin.

Mr. Dulberg's surgeries include the right forearm wound closure in the emergency room after his right forearm chainsaw injury as well as the subsequent cubital tunnel release and ulnar nerve exploration in the right forearm. He also had a left cubital tunnel release with anterior transposition of the nerve in early 2000s.

Mr. Dulberg denies drug allergies. He has never had a bone density study and he does not have sleep apnea.

SOCIAL HISTORY:
Mr. Dulberg smokes currently 10 cigarettes a day, but previously a pack a day, since he was 18 years old. He does not consume alcohol.

PHYSICAL EXAMINATION:
On examination today, Mr. Dulberg is noted to be 5 feet 8 inches tall, weighing 165 pounds. He is in no distress today and has normal affect. He is alert and oriented. He is afebrile. He demonstrates no suspicious pain behavioral characteristics.

With regards to his right upper extremity, he is able to remove his sweater, albeit mostly using his left arm. After the examination when he put his sweater on, he was able to pull out the sleeves using his right hand, manipulating the sweeter and sleeves using his right hand normally. He holds the hand in a normal position, although the small finger is in a constantly abducted position. On inspecting of his right forearm and hand, he does have a transverse laceration in the mid forearm measuring 6 cm. The incision is healed and is stable and supple. He also has a longitudinal incision, from his surgery, over the ulnar forearm, which measures 6 cm long. This incision is healed, stable, supple and asymptomatic. He also has an incision posterior to the medial epicondyle measuring 5.5 cm, which is healed, stable, supple and asymptomatic.

With regards to his right hand, as mentioned, he holds the small finger in an abducted position. I can passively adduct the finger to sit adjacent to the fourth finger, but he cannot actively maintain this position of the small finger. He flexes the thumb normally and extends it normally. He actively flexes the index, middle and ring finger to the palm, but with active composite flexion, he lacks about 3 cm of tip to palm distance of the small finger. His hand shakes when he flexes the fingers. Am able to passively flex his small finger to his palm, which he is then able to maintain in this position, which is concerning for symptom magnification as this implies subjective voluntary manipulation. He expresses that pain does not limit his inability to flex the small finger. After performing repetitive active and passive flexion and extension motions of all fingers, he was then able to flex his small finger to his palm with 5/5 strength with no pain. He extends all fingers to neutral with robust extensor tone in the MP, PIP, and DIP joints of all digits including the thumb. He has no evidence of flexor or extensor tenosynovitis of his fingers. He has no triggering or locking of the digits. He has no trophic changes. His hair and nail growth is normal in all digits. Subjectively, he states that he is numb in the small finger and half the ring finger to touch.

With regards to his right wrist, he extends his wrist normally to 60 degrees with 5/5 strength and flexes to 55 degrees with 5/5 strength, but complains of some forearm discomfort diffusely but not localized to any specific aspect of his forearm. His wrist motion parameters are symmetric. He has no pain with radial and ulnar deviation of the wrist. His passive forearm rotation is to 90 degrees of pronation and supination respectively without pain or crepitus and he actively pronates to 90 degrees with 5/5 strength without pain and actively supinates to 90 degrees with 5/5 strength with pain around the laceration over the mid medial forearm; again concerning for non-organic pathology as his supinator muscle is on the radial side (opposite to where he has pain) of his proximal forearm and he had no pain with passive pronation or supination. He has no intercarpal laxity on stress testing. He has no pain over the basilar joint of his thumb, with a negative grind and distraction test. He has a negative Finkelstein test. He has no instability of the first CMC joint. His ulna is stable and reduced. He has no ulnar-sided wrist pain. He is not tender over the radiocarpal or ulnocarpal joint.

With regards to his forearm, as mentioned, he has 2 incisions over the mid forearm, one transverse and one longitudinal as described above. The incisions are all healed and asymptomatic. He has no induration or tethering of the skin over the muscles at the site of the laceration or incision. His muscle bulk appears to be intact and appropriate. He is not tender to palpation around the muscles of the medial forearm. He is not tender to palpation over the tendons in the distal forearm or the muscles in the distal, middle, or proximal forearm ulnarly, or radially, volarly or dorsally. He is able to make a full fist, now recruiting all fingers, with good strength. His profundus tendons function normally to each finger when tested individually. His sublimis function, when tested independently, activate normally including to the small finger albeit with some discomfort in his forearm. He has no gross atrophy of the muscles in his forearm.

With regards to his elbow, he has 5.5cm incision posterior to the medial epicondyle, which is healed, stable, supple and asymptomatic. He has full elbow flexion and extension, which is symmetric and asymptomatic without crepitus. He has full forearm rotation as mentioned. He has no evidence of medial or lateral epicondylitis to palpation or with provocative testing. He has no instability of the elbow to varus or valgus stress at 30 and 60 degrees of flexion. He demonstrates no posterolateral rotatory insufficiency of the elbow to stress.

With regards to the peripheral nervous system of his right upper extremity, as mentioned, he states he has subjectively numbness in the small in ulnar half of the ring finger. His active motion was as mentioned limited in the small finger at times, but at times he had full active flexion of all fingers. With regards to the median nerve, he palmarly abducts his thumb with normal strength. Sensation was normal in the digits innervated by the median nerve. He has a negative Tinel over the carpal tunnel, and a negative wrist compression test. With regards to the ulnar nerve, he notes the aforementioned numbness. He has normal sensation over the dorsal radial and dorsal ulnar aspect of the wrist. He has normal sensation over the forearm radially and ulnarly. He was able to activate his first dorsal interosseous normally, and he abducts and adducts the fingers albeit with shaking of the hand and fingers and variable strength with abduction and adduction. At times he could abduct normally and at times he was extremely weak and this waxed and waned throughout the examination. He does hold the small finger in an abducted position, which can passively be placed back at the side of the ring finger, but then automatically assumes an abducted position. His extensor tendon functions normally and does not subluxate over the MP joint with active or passive flexion of the MP joint. He has no triggering in the small finger. He has a negative Tinel over the Guyon's canal. He has normal pulses. He has no splinter hemorrhages. He has no masses palpable around the ulnar artery at Guyon's

canal. He has a positive Tinel from 2 inches proximal to the medial epicondyle to 4 inches distal to the medial epicondyle radiating into the fourth and fifth fingers. Tinel over the forearm laceration elicit only local tingling that did not extend into the fourth and fifth fingers. Elbow flexion test elicits increased numbness and tingling in the fourth and fifth fingers. He has no instability of the ulnar nerve with elbow flexion and extension. His flexor pronator muscle bulk is asymptomatic with normal strength and without pain when stressed or with gentle and deep palpation.

Cross sectional area was measured at the level of his wrist, his mid forearm, and his proximal forearm. The values obtained at all levels were symmetric to within 1mm.

Grip strength using a Jamar dynamometer in position three on the right dominant side elicited 98 pounds of strength without pain and 80 pounds of strength without pain. On the left side, he was able to elicit 115 and 122 pounds of strength without pain. Performing rapid exchange grip strength testing, 4 times in each upper extremity, elicited up to 85 pounds of strength on the right side and 109 pounds of strength on the left side. He denied any pain or symptoms of cramping or spasming during grip despite performing the aforementioned gripping 6 times on each side.

Two-point discrimination measured with a discriminator on the right side elicited 5 mm two-point discrimination on the radial and ulnar aspect of the thumb, index, middle, and ring finger. In the small finger, he had 5 mm 2-point discrimination on the radial aspect and 6 mm on the ulnar aspect.

With regards to the left side, he has 6 cm incision over the medial elbow posterior to the medial epicondyle, which is healed and is stable and asymptomatic. He has full elbow flexion, extension, full forearm rotation. He has normal sensation in all digits. His median, and ulnar nerve motor and sensory function in his hand is normal. He has negative Tinel's over the ulnar nerve at the cubital tunnel or over the transposed ulnar nerve. He has a negative elbow flexion test.

QuickDASH score completed by Mr. Dulberg today elicited a score of 38. He completed all 11 items. Given his physical examination, I was quite surprised by high QuickDASH score. I therefore asked him about each of the items. He states he cannot open a jar with his right hand because he develops cramping and he has weakness when he twists the lid of a jar. He states that he develops cramping within seconds of twisting the jar. He states he cannot do household chores or carry a shopping bag for the same reason. He stated that he had severe difficulty washing his back, scored at 4/5, and when I asked him about this, he states that he had made an error and in fact he had no difficulty with this activity. He also stated severe difficulty when using a knife to cut food or perform any recreational activities. He notices severe difficulty with most activities throughout the week and noted that tingling in his arm was a moderate problem. He stated he had mild difficulty in the last week sleeping at night.

MEDICAL RECORD REVIEW:
As part of this independent medical evaluation, I was forwarded about 8 inches of medical records to review. The medical records that were forwarded to me for review included the following:

1. Medical records from Centegra Northern Illinois Medical Center.
2. Medical records from Moraine Emergency Physicians.
3. Medical records from Open Advanced MRI of Round Lake.
4. Medical records from Associates of Neurology.
5. Medical records from McHenry Radiologists Imaging.
6. Medical records from Neuroscience Institute.

7. Medical records from Hand Surgery Associates.
8. Medical records from Alexian Brothers.
9. Medical records from MidAmerica Hand to Shoulder Clinic.
10. Deposition transcript of Mr. Dulberg, Dr. Talerico, Dr. Levin, Dr. Ford, Dr. Sagerman and Dr. Kujawa as well as the plaintiff's answers to all the questions.

NIMC:
According to the medical records from Centegra Northern Illinois Medical Center, Mr. Dulberg was seen in the emergency room on June 28, 2011. According to the emergency room admission assessment he was seen stating that he had a chain saw injury to the right arm 15 minutes ago and he was feeling lightheaded. He is noted to smoke a pack a day. He is alert and oriented x3. He was accompanied by a coworker with the laceration by chainsaw to the right forearm. He had radiographs, which showed no bony abnormalities other than a soft tissue injury. The wound was irrigated and cleaned and sutured. He had 3 subcutaneous stitches placed of 4-0 Vicryl and 11 4-0 Prolene sutures placed in the skin. He was given discharge instructions for follow-up. He was discharged home.

According to the radiologist's report of radiographs performed of the right forearm dated June 28, 2011. The findings were dictated as two views of the right forearm, which demonstrated a deep laceration on the ventral aspect of the mid forearm, best visualized on the lateral view. No fractures or radiopaque foreign body is identified.

According to the Moraine emergency room physician records, Mr. Dulberg was seen on November 11, 2005 for right foot injury. He states he was fighting with home invaders at that time.

He was seen again on June 28, 2011 for the aforementioned chainsaw injury, which has previously been described above.

Dr. Talerico:
According to the medical records from MidAmerica Hand to Shoulder, Mr. Dulberg was seen by Dr. Talerico on December 2, 2011. His history is a 41-year-old male, right hand dominant, referred by Dr. Levin, MD, neurologist, for evaluation of an injury sustained to the right medial forearm in June 2011. He was using a chainsaw when he accidentally struck the volar medial aspect of his right forearm in roughly the mid forearm range with a chain saw. He had a large open wound down to muscle. He was seen in the emergency department where the wound and muscle were sewn together and the skin was closed. He followed up with his PCP and was noted to have persistent pain, which he describes as intermittent and shooting in character radiating from the laceration site. He occasionally has intermittent numbness and tingling in the ring and small finger. He reports grip weakness and no endurance with wrist flexion and gripping. He has not had therapy. He had nerve studies performed by Dr. Levin in August 2011, which per the patient, were normal. Did not have the study available. He is not working, but he is a graphic designer by training. He uses a computer mouse for 20 minutes causing significant forearm pain. He previously had an ulnar nerve transposition on the left side. He is single. Smokes everyday. He has a family history of diabetes. ROS negative. Examination showed him in no distress. Examination of the right upper extremity reveals his elbow has normal, painless range of motion. He has no focal tenderness to palpation. His collateral ligaments are intact. Forearm compartments are soft. He has a well-healed transverse laceration at the volar medial forearm level. There is no erythema, drainage, or fluctuance at the level of the laceration. He has no tenderness to palpation. He has some apparent muscle incongruity. Distally, his hand demonstrates no atrophy. He has 5/5 intrinsic strength, 5/5 APB strength. He can make a full fist with full extension of all digits. He

does not demonstrate a clawed position. He has a negative Froment's sign. He has a positive Wartenberg's sign. Wrist flexion and extension 5/5 strength. He has a palpable FCU and ECU tendon at the level of the wrist. He has appropriate tension. No radiographs performed. Dr. Talerico wanted to get the nerve studies. His complaints appear to be "likely muscular origin." He may have some "superficial sensory complaints as well." Dr. Talerico did not feel that he required surgical intervention. He was recommended occupational therapy to work on strengthening and conditioning of his forearm muscles. They can also perform pain modalities and he was told to follow up in four to six weeks and the nerve studies would be obtained.

He was seen back on January 6, 2012 for right forearm pain. He does not feel the occupational therapy is helping. He complains of pain/soreness and loss of strength. His history is reiterated. He has attended one or two sessions of therapy thus far. Nerve studies were obtained. He feels he is getting weaker. He feels a burning in the forearm. He asked about disability paperwork. Examination is unchanged. Of note, at this visit that he had no intrinsic or thenar atrophy with 5/5 intrinsic strength. His FDP to the small finger had 5/5 strength. He had light touch, which was intact to all digits. Nerve studies were reviewed, which were normal. No evidence of ulnar nerve injury. Given the location of the injury, this is the only significant problem that Dr. Talerico could imagine from this wound. He has no evidence of nerve or tendon injury. "He may have some residual soreness and some superficial sensory abnormalities, but this should improve over time." Dr. Talerico suggested he continued therapy with no need for surgical intervention. He felt he did not have anything further to offer.

Dr. Sek:
According to the medical records from Dr. Frank Sek, Mr. Dulberg had been seen since 1978. These are handwritten notes and difficult to decipher, but he was seen multiple times in 1984 and 1985 for lower extremity injuries. In 1984 and 1985, he injured his right thumb playing football. His x-rays were negative. He was seen again in 1998 for a fever and in 2002 for low back pain as well as pain in the trapezius after an auto accident 6 days prior. He went to NIMC ER. X-rays of the neck reported as a fracture and he went back for a CT scan, which was negative. He is taking Tylenol and Skelaxin. He has tenderness in the left trapezius and the left lower chest and lumbar area. He was seen again in March 2002, for pain in his back, and later in March 2002 for pain in his lumbar spine.

He was seen again on March 19, 2002 for the same problems in the lumbar spine and then on March 25, 2002 with pain in his buttock and leg with numbness and tingling in his left foot. He was seen back on March 30, 2002 for similar symptoms. He was seen back on April 6, 2002 for pain in his upper trapezius and his lumbar area. He was seen back on April 13, 2002 for spasms in his neck 3 days ago. He was seen back on April 20, 2002 for spasms in his left upper trapezius. On April 27, 2002, he was feeling better with "minor spasms here and there." On May 4, 2002, seen for spasms in the low back and left trapezius. On May 11, 2002, he was seen for muscle spasm again. On May 25, 2002, he was seen for pain in his buttock and leg. He was seen back on June 8, 2002 for similar symptoms. On June 13, 2002, he was released for office work. On June 22, 2002, he was seen for a "pinching sensation in the left upper trapezius and soreness in the lumbosacral area and buttock." On July 6, 2002, he was seen again for similar symptoms and then on April 27, 2007 for headache.

On July 1, 2011, he was seen after his forearm chainsaw injury that occurred on June 28, 2011. He was on Cefadroxil and Norco. His right forearm was slightly swollen and tender. On July 8, 2011, he was seen for suture removal. On January 14, 2012, he was seen because he was feeling depressed as his right hand is weak. On February 13, 2012, he was seen after an MRI of his right forearm was

negative. He was seen on April 24, 2012 for non-arm issues. On August 6, 2012, he was seen after surgery on his right arm.

Mr. Dulberg had an MRI of his low back, ordered by Dr. Sek on April 12, 2002. This is documented as a normal MRI of his lumbar spine.

Nerve studies performed on May 29, 2002 were performed of the left upper extremity. These nerve studies revealed cubital tunnel syndrome without denervation in the ulnar innervated muscles. Of note, the EMG component of the study was completely normal.

Nerve studies performed on December 23, 2002 by Dr. Grobman for persistent left hand symptoms with the previous study of May 29, 2016 showing ulnar neuropathy. The results of this study revealed left ulnar neuropathy at the elbow. .

MRI of the cervical spine was performed on September 5, 2012. Per the radiologist, showed multilevel degenerative disk disease, and a possible atypical hemangioma.

He had radiographs of his right foot performed on November 11, 2005.

Medical records from Michael Grobman are present within Dr. Sek's notes. Dr. Grobman saw Mr. Dulberg on May 8, 2002, for pain and sensory disturbances since a motor vehicle accident. He is noted to be a 32-year-old right-hand dominant gentleman with no significant medical history. He was involved in an MVA on March 1, 2002. He states he stopped to make a turn and another car tried to pass him and then turned back quickly into his lane. The other car's front passenger side impacted into his rear driver's side. He states he had turned all the way towards the left to find the car that was passing him. He states his left arm was between his seat and the door frame. His neurological examination did not show any weakness in his upper extremity with normal reflexes. He was diagnosed with musculoskeletal pain due to a flexion/extension injury and sensory disturbance in the left arm consistent with ulnar neuropathy described as due to the position of the arm at the time of accident, and is likely to be directly related to the accident. He also has sensory disturbances in his left leg consistent with an L5 radiculopathy.

Hand Associates:
According to the medical records from Hand Associates, Mr. Dulberg was seen by Dr. Sagerman on February 27, 2012. He was seen for consultation with regards to his right arm. He sustained a laceration to his forearm from a chainsaw accident on June 28, 2011. He developed symptoms of numbness in the small finger with weakness. He has treated with therapy. He had an EMG and MRI scan. Past medical history remarkable for arthritis and cervical disk disease. He is taking naproxen, Tramadol, Cyclobenzaprine, and Fluoxetine. Examination shows a 7 cm transverse scar at the ulnar aspect of the mid forearm. He has local tenderness and sensitivity to percussion with positive Tinel's sign and paresthesia radiating into the small finger. He has sensitivity at the cubital tunnel. Wrist and elbow motion are unrestricted. No atrophy. He is unable to adduct the small finger. Flexion strength is normal. Sensation is decreased to light touch in the small finger only with inconsistent two-point discrimination. Radiographs of the right forearm performed on June 20, 2011 were reviewed with no fractures or foreign body. MRI form of the right forearm performed on February 3, 2012 was reviewed with no abnormality seen. Nerve studies performed by Dr. Levin on August 10, 2011 showed no evidence of neuropathy. He was diagnosed with a right forearm laceration with probable partial ulnar nerve injury. He was referred for additional nerve study testing. He was told that he may need surgery.

He was seen back on April 2, 2012 after the nerve study was repeated on March 13, 2012. The records state that this shows no evidence of neuropathy. The EMG portion showed no denervation and the ulnar nerve conduction was within normal limits. Examination was unchanged. Treatment options were discussed with him and he does not wish to pursue with surgery. He was therefore prescribed physical therapy, told to follow up in six weeks or p.r.n.

He was seen back Dr. Sagerman on May 14, 2012. He has persistent pain with use of his arm, especially with gripping activities. He had additional therapy, which has been beneficial. He has no change in his symptoms of numbness, which is bothersome. His function is limited due to his pain. Examination unchanged. He has full finger composite flexion with no triggering or locking and no clawing. Wartenberg sign positive. Intrinsic strength is slightly weak. His possible surgical options were discussed and he was suggested to see Dr. Biafora for a second opinion.

Mr. Dulberg saw Dr. Biafora for a second opinion on May 17, 2012. His history is outlined. His examination is similar to that described by Dr. Sagerman. It was noted that he has good strength in the first dorsal interosseous with negative Froment's test, positive Wartenberg's sign. He has full digital motion. He has pain at the scar in his most distal and ulnar border with resisted DIP flexion of the small finger. FCU function is intact, however, with pain at the scar. Nerve studies have been reviewed. He has a positive Tinel around the scar. He has tenderness at the scar to deep palpation on his most ulnar and distal border near the ulna. He is assessed as being almost a year after forearm laceration with probable partial ulnar nerve injury with ulnar neuritis. Surgery was discussed with him.

He was seen back by Dr. Sagerman on June 6, 2012. He has no change in his symptoms. His medication interferes with his functioning. He wanted to proceed with surgery. It was noticed that his scar is stable with tenderness and sensitivity to percussion. He has pain with gripping localized to the forearm region with increased numbness in the ring and small finger with weakness of his grip. His prognosis was noted to be guarded in terms of symptom improvement. He was told to discuss his side effects from the Neurontin with his neurologist. He was scheduled for surgery.

He was seen back on July 11, 2012. He has had surgery. His wounds were healing. Operative findings were reviewed. He was given a prescription for therapy for motion.

He was seen back on July 23, 2012, recovering appropriately after surgery.

He was seen back on July 30, 2012. He is noted to be doing well. His arm feels better. His hand function is increased and he feels his symptoms improved. Examination showed mild diffuse swelling from the scar, but no evidence of infection. Wrist, elbow, and finger motion is satisfactory. Sensation is intact in all distributions. He has improved independent finger flexion compared to his preoperative function. He was told to continue therapy and follow up in a month.

He was seen back on August 27, 2012. He is described as doing well, but his elbow is sore. He is doing therapy. His grip strength is increased. His hand function has improved. Examination shows mild tenderness around the incisions. Elbow and wrist motion unrestricted. He has no ulnar nerve subluxation. Intrinsic strength is increased. Sensation is intact in all distributions. He was continued in therapy for scar management and strengthening. He was told to advance activities. He was limited in work in terms of limited forceful gripping and no lifting, pushing or pulling.

He was seen back on October 22, 2012. His function improved. He is doing therapy. Sensation has improved. He grasps objects better than before surgery. Examination is essentially unchanged. He could maximally grip 112 pounds according to the most recent therapy report. He has less pain with gripping, but tenderness at the dorsal aspect of the forearm scar. He was told to continue home exercises. He is currently unemployed and wanted to pursue with disability. He was told to follow up in six weeks.

Dr. Kujawa:
According to the medical records from Alexian Brothers Neurosciences Institute, Mr. Dulberg was seen on September 25, 2013 documented as being a 43-year-old male with a history of depression as well as an MVA over 10 years ago with resultant cervical DJD and left ulnar nerve transposition, BPH, and migraines. He was seen for evaluation of his right arm dystonia. He had significant trauma to his right forearm after a chainsaw accident two years ago after he was holding a branch when the arm was nearly severed by his neighbor using a chainsaw. Fortunately, the bone was not damaged. He has complaints of burning pain in his right forearm that is worse when he tried to stop Gabapentin. Second complaint is "curling" on his right hand with activity, which started approximately 18 months ago, lasts several minutes, and can occur independent of forearm pain, but usually follows pain episodes. Curling occurs many times a day and can awaken him at night. He also complains of numbness in the medial aspect of the forearm and intermittent tingling. Examination showed he has 5/5 motor in all extremities except right hand grip is 4/5. He has sustained (several minutes) involuntary flexion of the right wrist and three to five fingers at the PIP joint after voluntarily clenching of the fist. Sensation not tested. Diagnosed with posttraumatic dystonia of the right upper extremity and chronic pain syndrome that may be related to intermittent right hand dystonia. He was managed with Gabapentin and was suggested to have Botox injections. There are multiple handwritten notes as well, which are difficult to decipher.

Mr. Dulberg was seen on February 6, 2014 by Dr. Kujawa. The chief complaint is that he has "organic writer's cramp." He is here for follow-up from his initial intake on September 25, 2013. He wants to proceed with Botox injections. He has right forearm pain only with activity, not worse since he stopped Neurontin. He ran out. He drops objects (dinner plates), occasionally has difficulty using utensils. He has migraines much improved after Zomig nasal spray. His problem is that he has organic writer's camp and acquired torsion dystonia. He is also diagnosed as having chronic pain syndrome that may be related to intermittent right hand dystonia. He was given Botox.

Neurology:
I reviewed the medical records from Associates in Neurology. This includes the multiple nerve studies as well as cervical spine MRI. He had a brachial plexus MRI performed on August 26, which was normal. Nerve studies from 2002 are present. MRI of his forearm from January 3, 2012 is present, which was documented as normal. Nerve studies from March 13, 2012, which are documented as normal are present.

He was seen by Dr. Grobman on May 8, 2002 after his motor vehicle accident not pertaining to the right side. He has multiple handwritten notes, prior to this, which are hard to decipher.

It would appear Mr. Dulberg was seen by Dr. Grobman on February 4, 2003. He was diagnosed with ulnar neuropathy at the elbow. It was felt that he could return to work with lifting restrictions.

He was seen back on July 28, 2011 by Dr. Levin. His history of left cubital tunnel syndrome in 2002 was outlined. He states he became asymptomatic by 2007 and he never had difficulty in the right arm.

He states a month prior he was involved in a chainsaw injury as mentioned above. He went to NIMC ER where he had stitches. He had "very significant pain, but as the pain was getting better, he started noticing that he had numbness in the fifth digit and in the inner aspect of his forearm. He has not been dropping things. It was mostly just a tingling and numb feeling. He denies previous symptoms. Examination showed a healed scar in his right forearm with decreased light touch, pinprick, and temperature in the ulnar distribution of the right arm. Strength is normal. It was felt that he had a branch neuropathy of the sensory nerves. He was suggested to undergo nerve studies and see a hand surgeon.

Rehab:
I reviewed the medical records from Fox Lake dynamic hand therapy, which are extensive.

Diagnostic tests relevant to the right arm:
MRI performed at Open Advanced MRI on February 3, 2012 of the right forearm with and without intravenous contrast showed no forearm abnormality appreciated. The radiologist states that this does not exclude the possibility of ulnar nerve impingement, but there is no gross mass or abnormal infiltration along the expected course of the ulnar nerve. No obvious tendon or muscle abnormality appreciated at this time.

Nerve conduction studies performed on August 10, 2011 by Associates in Neurology were reviewed. The conclusion is that there is no evidence of nerve dysfunction

Nerve conduction studies performed on March 13, 2012 by Associates in Neurology were reviewed. This is both a nerve conduction study and an EMG. Both components are noted to be normal with no evidence of ulnar nerve dysfunction.

Operative report:
An operative report was authored by Dr. Sagerman with a preoperative diagnosis of right cubital tunnel syndrome and right ulnar nerve injury at the forearm. Dr. Biafora assisted with the procedure. The procedure was a right cubital tunnel release and right ulnar neurolysis of the forearm. The patient underwent a standard cubital tunnel release with no documented gross abnormalities noted except "the nerve was mobilized from adhesions". A longitudinal incision was made over the ulnar aspect of the mid forearm. He was noted to have some retained suture material that was removed (interesting as per the ER note, he had Vicryl placed which usually dissolves over 3 months). The muscle fibers were found to be in continuity. The ulnar nerve was exposed in its normal position. The nerve was dissected proximally and distally and was completely intact with no visible scarring or adhesions.

Depositions:
I reviewed the discovery deposition of Marcus Talerico taken on October 16, 2013. It should be noted that on page #10, when asked about the physical examination, Dr. Talerico states it was basically a normal exam except for the fact that he has a well-healed laceration in the area of the forearm where the chainsaw hit him. He had some apparent muscle incongruity meaning some scarring of the muscle belly level deep to the skin. He had no tenderness to palpation in the forearm. He has intact strength with normal wrist flexion and extension strength with normal grip strength and normal intrinsic strength. He had a negative Froment's sign. He has a positive Wartenberg's sign documented on page 12. Dr. Talerico states that a Wartenberg's sign is an objective test. On page #13, Dr. Talerico states that he had a healed laceration in the forearm with no appreciable nerve, tendon or artery injury. He had some scarring and he suggested he do therapy. He felt that he might have had a superficial sensory

complaint given the history. On page 17, Dr. Talerico did not feel he was suffering from any type of disability. He felt he had some scarring in the forearm and he had a lot of complaints, but Dr. Talerico did not feel he had any real objective findings that he could come up with a diagnosis that he could treat. Dr. Talerico states on page #19 that he felt that he had a laceration to the muscle belly of his forearm that healed and he did not have any objective weakness or real abnormalities other than his subjective complaints of shooting, burning pain in the forearm area.

Dr. Karen Levin's, deposition taken on October 1, 2013 was reviewed. It would appear that she is a neurologist. On page 12, Dr. Levin outlines the subjective numbness that he had to touch. On page 24, Dr. Levin states that cutting the nerve can cause permanent numbness. On page 32, Dr. Levin states that the MRI of the forearm was negative. She states "I don't know why the patient has continued symptoms, not sure why he bends his little finger. Things get worse with pain in the entire arm. I suggested he get a third opinion with Dr. Scott Sagerman." On page 46. Dr. Levin states that she was confused on August 14, 2013. She did not know why he was still having these dystonia symptoms. He was placed back on Gabapentin and sent back to the hand surgeon.

The deposition of Dr. Ford taken on November 20, 2013 was reviewed. Dr. Ford is an emergency department physician.

I reviewed the deposition of Dr. Scott Sagerman taken on October 15, 2013. Dr. Sagerman states on page 39 that Mr. Dahlberg has some scarring of the ulnar nerve to the floor of the cubital tunnel and local constriction at the flexor pronator aponeurosis. This relates to his cubital tunnel syndrome. On page 41, Dr. Sagerman states that the laceration from the chain saw was "relatively deep - below the skin, below the fat, and into the muscle covering "but the muscle fibers were intact. There was suture material, presumably from where the laceration was originally repaired at the time of the injury. The nerve was not cut or visibly scarred in that area". Dr. Sagerman opined on page 41 that the scarring from the laceration would account for his symptoms, but fortunately the nerve itself was not cut.

I reviewed the deposition of Dr. Kathy Kujawa performed on July 23, 2014. She is a neurologist with an apparent specialty in movement disorders. Dr. Kujawa states on page 18 that after the injury she felt the brain is trying to rewire itself. Not only is the brain trying to rewire itself, the nerves are trying to regrow. Any nerves can regrow, but very slowly. Unfortunately, a lot of times the connections made are incorrect to the wrong muscle and to the wrong place. "So the man may say voluntary I want to squeeze my hand and the wrong muscle contracts, if they can contract at all." She felt these were permanent deficits.

I reviewed the deposition of Mr. Dulberg performed on January 24, 2013.

DISCUSSION: Mr. Dulberg is a 46-year-old right-hand dominant unemployed, graphic designer who on June 28, 2011 sustained a laceration to the ulnar aspect of his right midforearm. He was seen in the emergency room where the laceration was cleaned and sutured. He had 3-0 Vicryl sutures and 11 Prolene sutures in the skin. After the injury, he saw his primary care physician, followed by multiple hand surgeons. He initially saw Dr. Talerico who felt that his symptoms were not substantiated by his physical examination. He had two sets of nerve conduction studies with the second set including an EMG component, which were negative for any ulnar nerve injury. Dr. Talerico did not feel any surgery would be helpful. He had an MRI with and without IV contrast of his right forearm, which showed no gross abnormalities. Ultimately he saw Dr. Sagerman for another opinion who, after no benefit with further occupational therapy, performed a cubital tunnel release and explored his ulnar nerve in his mid

forearm. He did find some adhesions in the cubital tunnel, which Dr. Sagerman opined is what one sees in cubital tunnel syndrome. As to the area of the forearm laceration, the muscle belly was noted to be intact and there was noted to be no injury, nor scar around the ulnar nerve. Mr. Dulberg had previously had his contralateral cubital tunnel release performed multiple years prior after a MVA. Mr. Dulberg currently has multiple symptoms that I cannot substantiate based on his physical examination or the medical records. His primary problem is that he describes cramps in his forearm. He states these occur at rest and with activities multiple times a day and are significantly exacerbated by activities. Despite seeing him and personally interacting with him for over an hour in the office today and having him perform multiple activities including squeezing a Jamar dynamometer at least six times on either side, I could not elicit any cramping or spasms in his forearm. Additionally, he had multiple red flags for symptom magnification, including shaking and weakness with abduction and adduction of his fingers, which waxed and waned. He could only actively flex his small finger to his palm; however, passively I could flex his small finger easily and pain-free to his palm, which he could then maintain, as well as after multiple flexion and extension movements of his fingers, he was able to flex his small finger to his palm actively. He describes weakness in his hand and states that he can't type or perform most activities. His examination showed that his grip strength on the right was between 80, 85, and 98 pounds, with no pain in his forearm and no spasming or cramps. His scar was not sensitive or tender and he demonstrated no irregularity in the area. The cross sectional area of his wrist, his mid forearm, and his proximal forearm were symmetric, which would not be the case had he injured the muscle, or nerve and if he was not using his arm normally.

I do feel that Mr. Dulberg sustained a laceration to the right forearm, which did not involve the muscle belly or the ulnar nerve, as proven on MRI, nerve studies and operative exploration. I do not feel that his current symptoms are supported by his physical examination. A laceration as described would not cause focal dystonic signs based on the fact that it did not involve any motor nerve fibers or muscle fibers.

Summary:
I believe that Mr. Dulberg sustained a forearm laceration involving the right mid forearm in the injury on June 28, 2011. This required emergency room care with irrigation and suture. Thereafter, he has developed multiple symptoms, which I cannot base on local anatomy or structural pathology in his right forearm. He has focal dystonic symptoms, which I disagree with Dr. Kujawa, as are not related to any structural abnormalities in his arm. As documented on his nerve studies his motor and sensory nerves were intact in the entire forearm. His muscle belly was intact as proven on MRI as well as seen at the time of surgery. Multiple physicians had stated that the muscle belly and/or sensory nerve branches has caused his problems, but in fact his muscle belly was never violated at the time of the injury as proven by the MRI and found at the surgery performed by Dr. Sagerman. Additionally, his ulnar nerve was found not to be injured by the chainsaw, also based on 2 sets of nerve studies and operative exploration. I believe the reason the providers made the statements above is because there was no structural cause for his symptoms. Obviously, Mr. Dulberg did have a peripheral superficial sensory nerve laceration, based on the fact that he had a laceration just as any laceration or surgery would violate the superficial sensory nerves to the skin. These would heal and stabilize, which they have based on his examination today. On his current examination, he demonstrates no evidence or muscle or nerve dysfunction around the laceration area and no evidence of any residual sensory dysfunction.

I believe that medical treatment that he received was necessitated by the accident. Subsequent treatment has been based on the temporal relationship between his symptoms and the injury, yet he currently has obvious nonorganic findings. He relates the focal dystonia to the accident; however, from

a structural standpoint his focal dystonic symptoms have nothing to do with his structure in his forearm. Nothing in his forearm could account for his symptoms.

As to any preexisting medical problems, Mr. Dulberg's has a history of prior left cubital tunnel syndrome, which has been attributed to a motor vehicle accident. He developed cubital tunnel syndrome on the right side after a forearm laceration, distant to the cubital tunnel. He does have a strong smoking history. Chronic smoking has been associated with nerve pathology, diminished capacity for nerves to heal and increased risk of nerve irritation.

1. ***What if any disability relates to the accident?***

   I feel Mr. Dulberg was debilitated for four to six weeks after the accident. After the laceration had healed, his symptoms began to be nonorganic, as described by Dr. Talerico in his deposition

2. ***What if any permanency is related to the accident?***

   At the present time from a structural standpoint, Mr. Dulberg has no structural deficit in his right upper extremity. He has no structural cause in his right arm that is causing him any dysfunction. The described focal dystonic symptoms are not due to any structural pathology within his upper extremity.

If you have any questions beyond the scope of this report, please do not hesitate to contact me.

Sincerely,

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Trained, certified and credentialed in Permanent Impairment rating
According to the AMA Guides to the Evaluation of Permanent Impairment 6th Edition

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