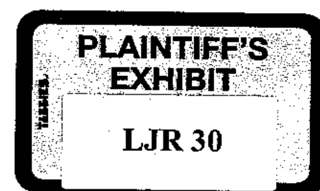
Mary E. Brothers, M.D., F.A.C.O.E.M.
Allen J. Parmet, M.D., M.P.H., F.A.C.P.M.



April 21, 2001

Amy R. Powell, Esq.
Humphrey Farrington and McClain
221 West Lexington, Ste 400
Independence, MO 60451

RE: LINDA J. REDMAN
SSN: 512-52-0440
Date of Birth: 2/17/49

Dear Ms. Powell:

At your request, I performed an Independent Medical Evaluation on Ms. Linda J. Redman in a Joplin Clinic on April 21, 2001. In addition to accomplishing a history and physical examination, I reviewed the medical records of: Dr. Beardslee, Larry Deffenbaugh, D.O., Oman Dement, M.D., Ahmed Gomaa, M.D., J. S. Grigsby, D.O., Blake Little, M.D., John Lynch, M.D., Habib Munshi, M.D., R. C. Myers, D.O., L. R. Rice, M.D., P.D. Scanlon, M.D., David Straub, M.D., Washington Unviersity, and The Mayo Clinic. My findings are as follows:

CHIEF COMPLAINT: Referred for Independent Medical Evaluation by consulting attorneys

The patient was aware of the non-confidential nature of this evaluation and that no patient/physician relationship existed.

HISTORY OF THE PRESENT ILLNESS: Ms. Redman reports that she was employed at Jasper Foods at their Popcorn Facility in Jasper, Missouri. She started work in 1995 and left in 1997, having worked a total of approximately 18 months. Her job was a production worker. She primarily sat and removed bagged microwave popcorn off one line, grouped it into three bags, and put it on another line. She began having onset of symptoms with shortness of breath and a cough in late 1996 or early 1997. She initially thought it was a cold, but her symptoms progressed. She was unable to mow a yard. She was concerned that she had heart problems and went to a cardiologist, but was told it was not her heart. Then she went to the emergency room and was initially told it was bronchitis. On subsequent visits to the emergency room, she was told it was asthma, and finally emphysema. Upon the advice of her physician, she quit work due to the progressive difficulty breathing. She has had considerable medical evaluations since that time and is currently under the care of Dr.

Munski, a pulmonologist. She has been to the Mayo Clinic in 2000 and was diagnosed with bronchiolitis obliterans. She is currently on the lung transplant list at Barnes Hospital in St. Louis having been placed there in October 2000.

She is a life-long nonsmoker and has had no prior pulmonary complaints until 1996. Her husband was a smoker and she lived with him for approximately 30 years, but was not living with him at the time of onset of the symptoms.

Currently, she is able to walk less than a block and can usually ambulate only as far as her mailbox. She normally uses oxygen 3 liters per minute and may require it 24 hours a day, although she usually does not sleep with it. She is able to go for several hours at a time without the oxygen, if she does not exert herself.

REVIEW OF SYSTEMS:

- HEENT - Reports some hearing loss and had a stapedectomy for otosclerosis some 35 years ago.
- Cardiopulmonary - See "HISTORY OF THE PRESENT ILLNESS". She also reports she had a catheterization at Mayo Clinic, which was normal.
- Gastrointestinal - Has gastroesophageal reflux. Current medications control it.
- Genitourinary - No complaints.
- Skin - Reports bruising secondary to prednisone. Minimal trauma will cause bleeding and scraping of the skin.
- Extremities - Has she cramping in her legs. She has been checked for clots but does not have them, and this is suspected to be due to side effects of prednisone and low calcium levels.
- Neuropsychiatric - Has headaches. She is using Zomig which helps. She is also anxious and was recently started on BuSpar which appears to help a little.

PAST MEDICAL HISTORY: Stapedectomy in 1965. Left foot bunionectomy and hammertoe surgery in 1999. Gravida zero.

REVIEW OF MEDICAL RECORD: In 1982 the patient was seen at McCune Brooks Hospital for a cut finger. In 1983 she was seen there for left upper back pain and later aches and chills.

On January 20, 1996, the patient was seen in the Freeman Hospital Emergency Room by Dr. Grigsby for shortness of breath and a headache. She was wheezing on pulmonary examination and was felt to have asthmatic bronchitis. She was treated with bronchodilators and initiated on antibiotics.

On February 7, 1996, the patient was admitted to hospital with acute asthma and came under the care of Dr. Little for bronchitis. She was hospitalized February 7 through February

11. At that time, her Pulmonary Function Study demonstrated an FVC of 1.37 liters (45% of predicted), FEV_1 of 0.61 liters (24% of predicted), and $FEF_{25\text{-}75\%}$ of 0.28 liters per second (10% of predicted). She was begun on prednisone during her first hospitalization.

Dr. Little saw her in follow-up on February 23 and on February 27, decreasing her medications. He saw her for follow-up on March 5, and again on March 21, at which time her pulmonary function demonstrated FVC or 0.24 liters (75% of predicted), FEV_1 of 0.70 liters (28% of predicted and $FE_{25\text{-}75\%}$ of 0.24 liters per second (8% of predicted). He listed her as disabled. The patient was seen in emergency by Dr. Myers for acute asthma with shortness of breath and wheezing. She was treated with intravenous steroids. Dr. Little saw her the next day and noted that the "etiology of her problem is not clear to me". He noted that the asthma was causing her to be quite nervous and require anxiolytic therapy for control of her symptoms.

Dr. Little saw the patient again on April 3, noting she was disabled and also noted he had made an erroneous entry in the record and the patient was a lifelong nonsmoker, but had lived with an ex-husband, who was a smoker.

He saw her again in follow-up on April 18, noting the $alpha_1$ antitrypsin level was normal. On May 2, she was mildly anxious and on May 5, the patient was readmitted to hospital until May 15. She was admitted under the care of Dr. Little for exacerbation of chronic obstructive pulmonary disease, severe anxiety and depression. She required prednisone while hospitalized. Dr. Little saw her again on May 21 in follow-up from hospitalization and again on June 6, and on June 18, she was readmitted to hospital for three days.

Dr. Little saw her again on June 27, July 25, and September 5, in follow-up noting she was relatively stable. He saw her in follow-up on November 26 and her prednisone was decreased.

The patient was seen again by Dr. Little on February 18, 1997 in follow-up for chronic obstructive pulmonary disease and increasing shortness of breath. He saw her again on March 27, when she had bronchitis and a scheduled hysterectomy was canceled because of this. Dr. Little saw her again on April 3 for wheezing, and prescribed prednisone. He noted her symptoms were mildly diminished. She was approved for surgery. Dr. Rice admitted her for a vaginal hysterectomy on April 14.

Dr. Little saw her again on April 21 and increased her prednisone due to wheezing. He saw her again in follow-up on May 6, June 12, June 26, August 12, for wheezing and asthma. He saw her again October 7, she was doing well and stable. On October 22, she had increasing shortness of breath and again began prednisone. He saw her on December 9, she was seen in follow-up and doing well. Dr. Little continued to follow her on March 12, 1998, at which time she had some increased sputum production and she was begun on Raxar. He saw her

again on April 28 when the patient saw stable and continued to be so on June 11, July 8, and September 17.

On December 1, Dr. Straub saw the patient for allergy testing nothing she had nasal rhinitis. He noted she had nasal rhinitis. He reported on December 7 that skin testing and inhalant testing were negative. Dr. Little saw her again on December 17, 1998.

On January 7 through 12, 1999, Dr. Little hospitalized her again for asthma. On January 29, Dr. Deffenbaugh evaluated her for gastroenterology purposes, noting she had aerophagia. She had some gastroesophageal reflux, but a 24-hour pH monitor demonstrated no aspiration.

On January 19, 1999, Dr. Little saw the patient in follow-up following hospitalization. On January 29, 1999, Dr. Deffenbaugh performed a gastroenterological evaluation noting she had some reflux, but this was not significant with regard to her pulmonary disease, on a 24-hour pH monitor.

Dr. Little saw the patient April 22, at which time she had increasing shortness of breath. She was seen again on June 29, September 21, and December 16, the latter following her admission to hospital by Dr. Little on December 7 through December 11, 1999. He saw her in follow-up on December 16, 1999.

On November 11, 1999, Dr. Dement performed a bone density examination demonstrating osteoporosis.

December 31 through January 1, Dr. Little again admitted her to hospital for asthma. Dr. Little saw her again in follow-up on January 13 and on February 10, 2000 when she was being followed for severe chronic obstructive pulmonary disease. He decreased her prednisone slightly at that time.

On June 5, 2000 Dr. Scanlon saw her at the Mayo Clinic. Exercise spirometry demonstrated a resting oxygen saturation of 94% on room air with a resting pulse of 102. At 2.3 miles per hour she desaturated to 90% and her pulse went to 124. FVC was 2.28 liters (74% of predicted), FEV_1 of 0.80 liters (31% of predicted), and $FEF_{25-75\%}$ was 0.03 liters (11% of predicted). She had abnormal exercises spirometry.

She was diagnosed with bronchiolitis obliterans "in association with her exposure to the popcorn plant from 1994 to 1997".

On October 31, 2000, Dr. Lynch saw her at Washington University, noting her onset of bronchiolitis obliterans which was "presumably secondary to occupational exposure". He felt there was no contraindication to a lung transplant. She had further evaluation, including a

cardiac catheterization on November 1 by Dr. Beardslee, which demonstrated no significant coronary artery disease. On November 11, Dr. Lynch stated she would eventually need a lung transplant.

On December 21, 2000, Lee Rice, M.D., performed a bone density scan, which demonstrated osteoporosis.
Dr. Munshi saw the patient and admitted her to hospital February 16 to February 20, 2001. She was in respiratory distress with anxiety. Dr. Munshi followed her up for severe chronic obstructive pulmonary disease and bronchiolitis obliterans requiring prednisone. On February 22, March 21, April 11, May 16, and June 20, 2001, the patient was also evaluated by Ahmed Gomaa, M.D., of the Division of Respiratory Disease Studies, National Institute for Occupational Safety and Health and he reported that she had "very severe airway obstruction".

SOCIAL HISTORY: Born in Joplin, Missouri and attended tenth grade. She has no military service and no foreign travel. She denies the use of tobacco, alcohol, or recreational drugs.

WORK HISTORY: Employed at Safeway as a cheese packer and scaler for 23 years until 1994. From 1995 to 1997, worked in production at Jasper Foods.

FAMILY HISTORY: Father deceased age 61 of heart disease. Mother deceased age 72 of heart disease. Brother deceased age 61 of heart disease. Two brothers, three sisters, alive and well.

MEDICATIONS: Prednisone 40 mg alternating with 20 mg daily, BuSpar 15 mg t.i.d., Bactrim 1 daily, Glucotrol 1 daily, Ranitidine 1 tablet daily, Clonidine 1 daily, Singulair, Premarin, Flovent, Serevent inhalers, albuterol breathing treatment q. 6 hr., oxygen 3 liters per minute.

ALLERGIES: Ceftin, Floxin, Levaquin, and Biaxin cause hives and dyspnea.

PHYSICAL EXAMINATION: Well-developed, well-nourished, Caucasian female in no acute distress. Oriented times three. Alert and cooperative

Height - 62 inches. Weight - 160 lb. Blood pressure - 140/92. Pulse - 80 beats per minute and regular.

Uncorrected distant visual acuity is 20/20 O.S., 20/40 O.D., Corrected near visual acuity 20/20 O.U.

The patient had moon facies and central obesity with a general Cushingoid appearance.

The eyes demonstrated the pupils to be equal, round, and reactive to light. The cornea and media were clear and fundi benign. The ears demonstrated the external auditory canals to be clear and the right tympanic membrane was scarred, compatible with reported otosclerotic surgery. The nose was patent and the pharynx clear. Thyroid was normal to palpation.

The lungs were clear to auscultation. The patient was able to speak in short, choppy sentences, stopping frequently for breath. There was no use of secondary muscular or flaring of the nares.

The heart demonstrated regular rate and rhythm without murmurs, gallops, or rubs. Carotid uptakes were normal. The abdomen was protuberant without masses or organomegaly.

Examination of the skin demonstrated multiple ecchymoses and contusions of the upper extremities. The upper extremities were thin, but otherwise demonstrated normal range of motion and dexterity. Motion of the cervical and lumbar spine were generally normal. The lower extremities were thin, but demonstrated normal range of motion at the hips, knees and ankles. A surgical scar was present over the left first metatarsal with a recurrent bunion and an overlapping second toe.

Gait and statin were normal.

Deep tendon reflexes were +2 at the biceps, triceps, patellae and Achilles tendon.

Babinski's sign was absent. Romberg's test was normal.

Pulmonary Function Studies demonstrated an FVC of 2.34 liters (80% of predicted), FEV_1 of 0.87 liters (36% of predicted),. and $FEF_{25\text{-}75\%}$ of 0.28 liters per second (10% of predicted).

PULMONARY FUNCTION TEST:

	1996 Feb 9	1996 Mar 21	2000***	2000** Jun 5	2000* Nov 6	2001* Nov 1
FVC (L)	1.37 (45%)	2.24 (75%)	1.70 (56%)	2.28 (74%)	2.26 (70%)	1.91 (56%)
FEV_1 (L)	0.61 (24%)	0.70 (28%)	0.60 (25%)	0.80 (31%)	0.73 (28%)	1.23 (45%)
$FEF_{25\text{-}75}$ (L/S)	0.28 (10%)	0.24 (8%)	0.26 (9%)	0.30 (11%)		
DLCO %			80%			

	2001* Apr 20	2001 Apr 21	2001 Feb 20
FVC (L)	2.57 (80%)	2.34 (80%)	1.91 (66%)
FEV_1 (L)	0.39 (36%)	0.87 (36%)	0.84 (35%)
FEF_{25-75} (L/S)		0.28 (10%)	0.25 (9%)
DLCO %			46%

*Performed by National Institute for Occupational Safety and Health
**Performed by Mayo Clinic
***Performed by Washington University

DIAGNOSIS:

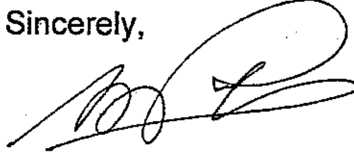
1) Bronchiolitis obliterans. This condition is causally related to occupational exposure to environmental toxins while employed at Jasper Foods from 1995 through 1997.
2) Osteoporosis. This condition is in part due to the fact that the patient is postmenopausal, but the majority of the effects are due to the patient's required use of steroids for control of her pulmonary condition.

DISABILITY:
This patient is permanently and totally disabled and is unemployable within the scope of the national economy. She will continue to require life-long medical care up to and including a lung transplant. Without this procedure, her life expectancy is greatly reduced. Even if successful, a lung transplant would not enable Ms. Redman to return to employment.

The above findings are made to a reasonable degree of medical certainty.

Thank you for the opportunity to participate in the evaluation of this interesting patient. If you have any questions, please do not hesitate to contact me.

Sincerely,



Allen J. Parmet, M.D., M.P.H., F.A.C.P.M.

AJP/ldh:jg

c: Theodore Green, Esq.
Jace Kentner, Esq.