M.D., CPE, FRSM
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Board Certified Medical Management
Diplomate American Board of Sleep Medicine
Diplomate American Board of Disability Analysis
Clinical Assistant Professor of Neurology
College

Office:

December 25, 2018
Refer to our file#:
RE:
Social Security
VA File

To Whom It May Concern:

I M.D., practice medicine in the State of and I am Board Certified by the American Board of Sleep Medicine and the American Board of Psychiatry and Neurology in Neurology.

On 12/17/2018 I personally reviewed all the records provided in their entirety, including the claimant's service records, private medical records, VA medical records, VA Claims File and sworn statements.

History: Mr. is a 33-year-old male who stands 5 feet 11 inches tall and weighs 182 pounds. He states that as recently as March 2007 he was involved in 4 IED blast episodes (at least two in which he sustained positive loss of consciousness). The claimant notes that he has had at least two grade 3 concussions. His medical history includes service-connected traumatic brain injury and posttraumatic stress disorder. The traumatic brain injury after the blasts occurred in 2006 and 2007, both while he was in the service. He entered the Marine Corps on May 23, 2005 was medically discharged on August 30, 2008. The claimant has noted problems with attention and concentration. He loses track of conversations and has problems with both short-term and long term-memory. He experiences visual blurring and he has bilateral hearing loss. He is being treated for weekly migraine headaches exacerbated by noise and light sensitivity. He is irritable and has difficulty dealing with high stimulus situations. In addition, he has difficulty with sleep, i.e. getting to and staying asleep associated with obstructive sleep apnea. At one time, he has had nightmares several times per week.

Medications: Lisinopril 10 mg q.d., citalopram 40 mg q.d., prazosin 8 mg q.d., cetirizine 10 mg q.d., methylphenidate 10 mg b.i .d.,rizatriptan 10 mg p.r.n.,fluticasone prop 50mcg(nasal inhalation qd, clindamycin phosphate 1% LOTION (topical,bid), Ketoconazole 2% cream(topical,bid),Benzoyl peroxide 5%(water based) gel topical qd,Exemestane tab 10mg po q3days,Levothyroxine 175mcg qam and

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Testosterone cyprionate 200mg (IM q 7days).

Present Clinical Problems:

1. Posttraumatic stress disorder.
2. Depression.
3. Obstructive sleep apnea.
4. Migraine headaches.
5. Memory and cognitive problems.
6. ADHD
7. Anxiety

Pertinent Medical Chart Findings:

1. Sleep apnea disability benefits questionnaire. He was diagnosed with obstructive sleep apnea dated 12/05/18.
2. Diagnostic polysomnography was performed by dated 02/11/18. The impressions were consistent with very mild obstructive sleep apnea with an AHI of 5.5, snoring was mild, and cardiac rhythm was sinus. His sleep efficiency was mildly impaired while the sleep architecture was normal. There was no periodic limb movement of sleep nor was there significant nocturnal hypoxemia. It was suggested that he try a CPAP unit.
3. He had an Epworth Sleepiness Scale of 11 out of 24 with greater than 10 being abnormal. His BMI was 28.
4. VA Problem List. Problem: Obstructive sleep apnea of adult (SCT 1101000119103). Date/Time Entered: 04/24/2018 at 1200. Provider: Location: VAMC. Status: Active.
5. VAMC Sleep Medicine Follow-Up by Dr. 04/24/18. Results of diagnostic polysomnography dated 02/11/18 discussed. Assessment: mild sleep apnea, currently untreated. It was noted that the claimant had significant sleep apnea symptomatology including socially disruptive snoring, significant sleep fragmentation with non-refreshing sleep and daytime tiredness and drowsiness. Prescribed AutoPap 6-16 cm.
6. VAMC Neurology Consult by Dr. 04/02/18. It was noted he is a 32-year-old man referred with a greater than 10 year history of headaches was referred for evaluation of headaches Impression: The claimant continues to have chronic migraine headaches related to IED blast exposures. Sumatriptan substituted for rizatriptan 10 mg p.r.n.
7. VAMC Sleep Medicine Consult 12/14/17 by PAC.

[redacted]

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Assessment: sleep disorder, sleep onset and maintenance insomnia, esophageal reflux with poor diet compliance or allergic rhinitis. Prescribed fluticasone prop 50mcg b.i .d. Scheduled for split night polysomnogram.

8. Report of a periodic physical examination ICO CPL [redacted] USMC (TRET) performed by Dr. [redacted], 02/26/2014 at [redacted] It is stated that since placement on the TDRL, the claimant has continued to have headaches largely without change. The patient's condition has stabilized. The prognosis for recovery is poor. The patient is mentally competent. The degree of civilian, social and occupational impairment is moderate.
9. I reviewed his chronological record of medical care dated 10/09/07. Diagnoses were posttraumatic stress disorder, combat stress, traumatic brain injury, and depression.
10. Neuropsychological evaluation performed by [redacted] a Clinical Neuropsychologist dated 10/15/07 and 11/08/07. The claimant felt he appeared to have far more difficulty with executive type functions. It is stated that the claimant presented the picture of an individual who was quite depressed and aware of a need for help. His self-esteem was poor and the claimant felt ineffectual and powerless to change the direction of his life. He was feeling discomforting levels of anxiety and tension. Overall, it was felt that the current evaluation was consistent with the presence of impaired attention, concentration and decreased memory. He presented with significant depression as well as tension and anxiety surrounding previous events. The pattern was consistent with the presence of posttraumatic stress disorder and/or major depression. It was stated that the claimant would benefit from continued followup with a mental health professional.
11. [redacted] Hospital Speech Language Therapy evaluation 03/05/2008. It was noted that the claimant had deficit in areas which included recall and word retrieval. The claimant also reported difficulty absorbing information when reading and become easily distracted and difficulty finding his way around new places.
12. Health record chronological record of medical care on 04/14/2008 at the neurology clinic. It was noted he is a 22-year-old man with a history of blast exposure seen today in followup. He continues to have headaches, disturbed sleep, problems with memory and mood. At that time he was on Topamax 25 mg q.4h. h.s. and Fioricet p.r.n.
13. Findings of the physical evaluation board proceedings, 06/10/2008. Category 1, unfit condition, sleep disorder, mood disorder, traumatic brain injury, postconcussive syndrome, cognitive changes, headaches with mixed features including migraine. It is noted that disability may be permanent; all board members concurred.
14. Naval Hospital Camp [redacted] on 03/06/2008 automated medical sheet. Diagnoses:

[redacted]

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Migraine unspecified without intractable migraine, mild cognitive impairment, headache, postconcussion syndrome, intracranial injury of other and unspecified nature without mention of open intracranial wound with loss of consciousness.

15. Abbreviated medical evaluation report 10/10/2007- concussion with loss of consciousness.
16. Marine Corps Recruit Depot [redacted], Recruit Screening Exam, 05/24/2005. No significant interval/ non-disclosed medical history. General: Alert, oriented, no apparent distress, no gross evidence of undocumented health condition. No evidence of communicable infection or significant medical problems. Recommend SNM begin basic training
17. [redacted] Meps, Report of Medical history, 02/26/2005.
18. Medical Prescreen of Medical History Report. 02/24/2005.
19. Sworn Declarations:
    a. [redacted] who noticed that he had snoring at night.
    b. [redacted] in 2008; the claimant came to stay with [redacted] and was noted to have snoring.
    c. [redacted], it is stated the claimant got hurt by a couple of IED blast that destroyed the Humvee he was driving. After the blasts, he became lethargic and irritable all the time and began snoring obnoxiously loud every night. He would sometimes stop breathing in the middle of the night and made gagging sounds.
    d. [redacted], after the claimant got knocked out by the first IED he started sounding like he was choking all the time during sleep and started snoring very loud. His roommates had to leave the room.
    e. It is stated by [redacted] that without the use of my prescribed APAP I wake up gasping for air every night multiple times per night. These occurrences coincided with getting hurt by an IED blast that destroyed my truck and made me lose consciousness. He states he has poor stamina and poor concentration and poor memory retention daily. He noticed this phenomena beginning in November 2006 prior to being prescribed Ritalin.

Discussion: The claimant has documented posttraumatic stress disorder, migraine headaches, depression, anxiety, obstructive sleep apnea, ADHD and traumatic brain injury. He takes appropriate medication for these clinical problems. It should be noted that a traumatic brain injury caused by an IED can cause disruption of neurotransmitter tracts in the central nervous system and brainstem. Serotonin is produced in the raphe nuclei part of the reticular activating system which controls the sleep-wake cycle. Loss of serotonin can cause depression produced by depressive waves emanating from the brainstem to the cortex. He takes an antidepressant,

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citalopram, for this problem. In addition, he takes rizatriptan for migraine headaches caused by severe vasodilatation secondary to changes in the transmission of dopamine and monoamines from the brainstem. He also takes Ritalin for ADHD to replace norepinephrine products produced in the brainstem and cerebral cortex. Likewise, trauma to the brainstem and reticular activating system can severely disrupt the sleep-wake cycle. Multiple groups of neurons in the basal forebrain, hypothalamus and brainstem regulate arousal, non-rapid eye movement and REM sleep and transitions between these different stages. The loss of monoaminergic influences during REM sleep can contribute to reduced tone of muscles opening the upper airway and thus increase susceptibility to obstructive sleep apnea.

The sleep-wake cycle originates from a central pattern generated and located in the lower brainstem. Traumatic disruption of these nuclei in the lower brainstem would affect the normal sleep-wake cycle and certainly be a cause of obstructive sleep apnea.

The brainstem contains several critical areas involving control of behavioral arousal, sleep-wake cycle, cardiovascular function and respiration as well as sleep and arousal associated with profound changes in arterial pressure, heart rate, and respiration. Signals from the brainstem areas controlling these functions promote arousal from sleep. These interactions involve neurons distributed throughout the rostrocaudal extent of the brainstem. Trauma to delicate areas of the brainstem from an IED could certainly cause disruption of critical nuclei causing obstructive sleep apnea.

In my professional opinion, based on the evidence reviewed, it is at least likely as not that the veteran's current Obstructive Sleep Apnea is the direct result of his service connected Traumatic Brain Injury (TBI) or IED blast exposures. Furthermore, the veteran's current medical diagnosis of Obstructive Sleep Apnea is as least as likely as not related to the historical symptomology that the veteran and those around him observed during his military service and the symptomology documented in his service medical records. There was no evidence of risk factors or a pre-existing disposition to obstructive sleep apnea prior to entering service.

References:

1. Saper CB, Fuller PM. Wake-sleep circuitry: An overview. Current Opinion in Neurobiology 2017; 44: 186-192.
2. Del Negro CA, Funk GD, Feldman JL. Breathing Matters. Nat Rev Neuroscience. 218; 19: 351-367.
3. Chamberlain NL. Brain circuitry mediating arousal from obstructive sleep apnea. CURR OPIN Neurobiology 2013; 23: 774-779.

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I certify and confirm that being a practitioner duly licensed to practice medicine in the State of New York, under the penalties of perjury and pursuant to CPLR 2106, do hereby affirm the contents of the above report are my own. The statements contained herein are true and accurate to the best of my knowledge under the penalties of perjury. No doctor-patient relationship exists or is implied by this chart review and no treatment was specifically suggested.

Yours truly,

, M.D., CPE

Date dictated: 12/25/18
Date transcribed: 12/26/18

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01/08/16

CURRICULUM VITAE

[redacted]

[redacted]

MEDICAL EDUCATION

[redacted]

[redacted]

INTERNSHIP:

[redacted]

[redacted]

RESIDENCY:

[redacted]

[redacted]

OTHER TRAINING:

[redacted]

BOARD CERTIFICATION:

[redacted]

[redacted]

BOARD CERTIFICATION(continued)

HOSPITAL APPOINTMENTS:

MEDICAL SOCIETIES:

[redacted]

[redacted]

HOSPITAL COMMITTEES:

[redacted]

[redacted]

CREDENTIALS COMMITTEE:

DIPLOMATE:

LICENSURE:

EPILEPSY FOUNDATION OF THE HUDSON VALLEY, INC.

[redacted]

PHYSICIAN ADVISORY BOARDS

[redacted]

PUBLICATIONS:

[redacted]

AWARDS:

[redacted]