[redacted], M.D.
[redacted]

[redacted]

Dear Sir or Madam:

1. Thank you for the opportunity to evaluate [redacted]. Enclosed is my preliminary medical evaluation of [redacted], a summary of my findings, the resources utilized during my evaluation, a review of the pertinent clinical literature, and my opinion on the matter. [redacted] was examined at the facilities of the pretrial detention center. The examination was conducted for no fee. The examination was conducted predominantly in French. A fourth year medical student from [redacted], was in attendance for the evaluation.

I. Qualification of examiner

2. I am a licensed physician in the State of Georgia. I completed medical school at [redacted]. Currently, I am in my third year of residency training in [redacted]. I completed my Masters of Public Health Training in [redacted]. I will be joining the [redacted] faculty in [redacted]. I have completed training in evaluation of torture survivors through Physicians for Human Rights. This is my fourth evaluation of an asylum seeker.

II. Pertinent background and summary of reported symptoms

3. [redacted] describe four events in his life with pertinent physical health consequences related to his asylum application. [redacted] reported that Episode#1 occurred in October XXXX during an interrogation in the XXXX forest by the XXXX organization of XXXX. [redacted] reported that his wrists were tied together with cord. He was then suspended by his wrists from a tree without his feet touching the ground for a period of 6 hours. During that time, he reports he was beaten on the chest, back, and head. He reports that he was beaten with the butt of a Kalashnikov rifle. He reports that both sides of his head beaten, but more blows occurred to the left side. He reports that he was burned with cigarettes repeatedly on his right calf and dorsum of right foot. Mr. XXXX reports that he vomited after being hit in the abdomen. He reports the he suffered from double vision during and acutely following the beating. He reports loss of distance vision after the beating, as well. He described having a bloody nose from the beating. He reported swelling of his right foot after the cigarette burns. Mr.

XXXX reported that his hearing was decreased on the left side and described painful sensation when hearing loud noises after the beating. He also described swelling on the left side of his face near his left ear. He also reports pain near his solar plexus during deep inspiration and shortness of breath with activity. He also reported back pain when his mid-back was touched. He also described pain in his wrists after the suspension and pain in his wrists when lifting heavy objects.

4. Mr. XXXX reported that Episode #2 occurred during a protest march in March of XXXX in XXXX when he was detained with other demonstrators. During this time, he reports that he was tied to a chair for 60-90 minutes. He reports he was beaten on the chest with wooden sticks and rifle butts. He reported increased difficulty breathing during and after this event.

5. Mr. XXXX reported that Episode #3 occurred at the XXXX-XXXX border when he was detained by police on accusations of trying to flee the country. He reports he was held in a room approximately three meters by three meters with 15 other detainees for three days. He reports that he was denied food and water during this time and had no access to toilet facilities. He and other detainees urinated and defecated on the floor. During this time, he reports he was beaten with fists throughout his body including his face. He reports that he had pain all over his body during this time. He reports that his mouth bled from lacerations on his lips secondary to the beatings. He reports that his vision worsened at this time with decreased ability to see distances. He also reports that he had increasing problems breathing and pain when hearing loud noises.

6. Mr. XXXX reported that Episode #4 occurred during his sea voyage to XXXX, Georgia. Mr. XXXX reports that he had food that lasted him five days and two liters of water that lasted him one week. He reports that he drank his own urine after he finished his supply of water. He reports that his urine become red-tinged, salty, and undrinkable several days before arriving in XXXX.

III. Medical examination and current health condition

7. Mr. XXXX denies any past medical history preceding the above-described episodes. He denies any history of traumatic injury or accidental trauma except a dog bite on his right leg. His past surgical history includes appendectomy in XXXX. He denies any significant family medical history. He denies smoking, alcohol, or drug use. He denies taking medication or any medication-related allergies.

8. An extensive review of systems was performed. He complains of chronic upper back pain that worsens upon reclining. He complains of pain in his solar plexus upon deep inspiration or after exercise. He complains in his wrists particularly on his left when lifts heavy objects. He complains of ‘gas-related’ abdominal pain and constipation. He complains of difficulty with distance vision. He complains

of pain in his left ear when hearing loud noises. All other systems were reviewed and negative.

9. Physical Exam:

    a. **Head-ears-eyes-nose-throat**: Normocephalic, atraumatic, decreased ability to open his mouth, normal dentition, posterior oropharynx was clear of any lesions, left temperomandibular joint was tender to palpation, tympanic membranes had evidence of scarring at the periphery bilaterally, no lymphadenopathy, sclera non-injected and non-icteric.
    b. **Neurological**: Cranial nerves two through twelve were grossly intact with the exceptions that Mr. XXXX reported some pain and difficulty with eye movements of vertical tracking with no diplopia and decreased hearing on the left side. Strength was intact throughout with the exception his left grip strength decreased relative to his right grip strength. He also had decreased dorsal flexion of the wrist bilaterally, worse on the left. Sensation to light touch and two-point discrimination were intact in the medial, ulnar, and radial distributions but diminished in the palmar aspect of the left forearm. Deep tendon reflexes, temperature sense, and vibration were intact throughout. Gait was normal.
    c. **Chest**: Normal inspection, easy work of breathing, equal rise bilaterally, non-tender, no rashes noted. Clear to auscultation bilaterally with no wheeze, rales, or rhonchi. Mr. XXXX reported substernal pain with deep inspiration. Pain was not reproducible with palpation.
    d. **Back**: Normal inspection. No rashes or other lesions noted. Mr. XXXX was tender to palpation in the area of the fourth thoracic vertebrae.
    e. **Cardiovascular**: Regular rate and rhythm. Strong pulses throughout. No jugular venous distension or peripheral edema.
    f. **Abdomen**: Positive bowel sounds, soft, nondistended. Well-healed appendectomy scar noted. Mild tenderness to palpation in the area of the appendectomy scar.
    g. **Skin**: Several well-healed scars were noted. 1. Right eye lateral to the canthus, linea and well healed, approximately one centimeter by two millimeters (Refer to Image 1). 2. Right calf, irregular shape with centrally spared area, approximately 7x3 centimeters (Refer to Image 2). 3. Dorsum of right foot, irregularly shaped, approximately two centimeters by one centimeter (Refer to Image 3). 4. 2x2 circular scar on the anterior aspect of right leg.

10. The 36 item health survey (SF-36, item attached) was administered to calculate Mr. XXXX's health functioning. He received a 50 for physical functioning (mean 70, SD 27). For physical role functioning he received a 0 (mean 52, SD 40). For emotional role functioning, he received a 33 (mean 65, SD 40). For energy level, he received a 43 (mean 52, SD 22). For emotional well-being, he received a 19 (mean is 70, SD is 21). For social functioning, he received a 12 (mean 78, SD

25). For pain, he received a 70 (mean 70, SD 25). For general health he received a 35 (mean 56, SD 21). On all scales, the lower the score, the greater the impairment. Mr XXXX's impairment was severe (greater than 1 SD below the mean) in physical role functioning, emotional well-being, social functioning, and general health.

VII. Medical opinion

11. Regarding reliability of interview, please see attached credibility checklist (Hanscom et al. 2001). Mr. XXXX was found believable and to manifest behavior highly consistent with his description of events.
12. Mr. XXXX complains of pain on hearing loud noises in his left ear. This complaint, termed hyperacusis, can be the result of tramautic sensorineural injury to the acoustic nerve. Hearing loss is also a common result of traumatic injury to the hearing apparatus. These findings are common in people who report telefono (repeated blows to the ears). Coupled with objective evidence of decreased hearing on the left and scarring of the tympanic membrane, it is reasonable to conclude that Mr. XXXX's hyperacusis and hearing loss are consistent with his description of sustaining significant traumatic injury to the left side of his head and his left ear.
13. Mr. XXXX also has difficulty fully opening his mouth with tenderness over his left temperomandibular joint. The etiology of this complaint is not clear. The differential diagnosis in this case would include arthritis, often caused by bruxism (teeth-grinding) but also commonly caused by trauma, as well as several other, more rare problems including synovitis, scleroderma, and congenital defects in connective tissue. Given that Mr. XXXX does not exhibit signs or symptoms of these other rare conditions and his teeth show no signs of bruxism, it is reasonable to conclude that his jaw pain and difficulty opening his mouth are a result of traumatic arthritis in his temperomandibular joint.
14. Mr. XXXX complains of chest pain, particularly with deep inspiration. There are numerous possible causes in the differential diagnosis for this complaint, including traumatic arthritis, costochondritis, acid reflux, pleurisy, and other lung disorders. Mr. XXXX's complaints might also be the result of anxiety and his depression and PTSD as diagnosed in a separate evaluation.
15. Mr XXXX has several scars, some of which he reports sustaining during the events described above. The scars on his calf and his right foot, which he reports being caused by cigarette burns, are consistent with the history he reports. The scar on his calf, with its area of central sparing, is less likely to have resulted from another traumatic mechanism, given that this likely would have affected all of the involved tissue. The scar is plausibly the result of a several conglomerated smaller injuries such as burns from a cigarette. The scars on the foot are also consistent with cigarette burns. Both scars appear to be of the appropriate age in relation to when he sustained the reported injuries.

Thank you again for the opportunity to examine Mr. XXXX. Please contact me if I may be of any additional assistance in his case. I declare under penalty of perjury that the foregoing is true and correct.

_____

[redacted], M.D., M.P.H.