Medical Synopsis

Motor Vehicle Collision on XX/XX, 2018

On XXXX XXXX, 2018, Mr. Doe had an Orthopedic evaluation with XXXX, M.D., and XXXX, PA-C at Spine and Orthopedic Center of XXXX for the pain in his neck, left shoulder, low back and bilateral lower extremities. He was the driver of the vehicle which was involved in a rear-ended motor vehicle collision on XX XX, 2018. Initially, he was taken to Newton Hospital where he was evaluated and underwent radiographs of his cervical and lumbar spines as well as left shoulder. He had headaches, mid back pain and numbness in his bilateral hands. He had difficulty with grasping, lifting objects, lying on the left side, reaching overhead and placing his left hand behind his back. On assessment, he had chronic cervical and lumbar strains (whiplash injury) and left shoulder impingement. He was encouraged to continue with medications. He was recommended for physical therapy treatment and a home exercise program.

On XXXX XXXX, 2018, Mr. Doe had a follow-up with Dr. XXX and XXXX, PA-C at Spine and Orthopedic Center of XXX for the pain in his neck, left shoulder, low back and left leg. He had headaches. He had difficulty with reaching overhead and sleeping. He was recommended to have an MRI of left shoulder and lumbar spine.

From XXXX XXXX, 2018, until XXXX XXXX, 2018, Mr. Doe received multiple physical therapy sessions from XXXX, DPT at XXX Rehab for the pain in his neck, left shoulder and low back, which he rated as 2-6/10. On assessment, he had cervical radiculopathy, impingement syndrome of left shoulder, low back pain and cervical spine stenosis. His treatment comprised of range of motion exercises, bicycle ergometer, home exercise program, joint mobilization techniques, manual therapy, neuromuscular re-education, soft tissue mobilization techniques, therapeutic exercises, therapeutic activity and modalities. On XX XX, 2018, Mr. Doe had fair prognosis. He was recommended for a home exercise program. He was discharged from skilled rehabilitative therapy.

On XXXX XXXX, Mr. Doe had a follow-up with Dr. XXXX and XXXX, PA-C at Spine and Orthopedic Center of XXXX for the pain in his neck, left shoulder, low back and left lower extremity. He had numbness and tingling in the left arm. He had difficulty when seated for extended periods of time and reaching overhead. He had noticed a progression with regards to his neck pain with radiating pain throughout his left upper extremity. He was recommended to have an MRI of cervical spine and lumbar spine and physical therapy treatment.

On XXXX XXXX, Mr. Doe had a follow-up with Dr. XXXX and XXXX, PA-C at Spine and Orthopedic Center of XXXX for the pain in his neck, left upper extremity, lower back, bilateral hips and bilateral lower extremities. He had difficulty with sitting and standing for an extended period of time. He had noted improvement with regards to physical therapy treatment. He had noted a progression regarding his neck and lower back pain. He was recommended to have an MRI of cervical spine and lumbar spine. He was advised to continue physical therapy treatment.

On XXXX XXXX, 2019, Mr. Doe had a follow-up with Dr. XXXX and XXXX, PA-C at Spine and Orthopedic Center of XXXX for the pain in his neck, left upper extremity, lower back and left lower

extremity. He was recommended to have an MRI of cervical spine and lumbar spine. He was advised to continue physical therapy treatment.

On XXXX XXXX, 2019, XXXX, M.D., obtained an MRI of Mr. Doe's cervical spine at XXXX Care Centers. The study revealed multilevel disc disease and uncovertebral hypertrophy of the cervical spine, concentric disc bulge with focal central disc herniation, uncovertebral hypertrophy and bilateral neural foraminal narrowing with spinal canal stenosis at the levels of the C5-6.

On XXXX XXXX, 2019, Mr. Doe had a follow-up with Dr. XXXX and XXXX, PA-C at Spine and Orthopedic Center of XXXX for the pain in his neck, left upper extremity, lower back and bilateral lower extremities. He had headaches, numbness in the bilateral hands, heaviness and weakness in the bilateral legs. On assessment, he had a chronic cervical strain (whiplash injury), chronic lumbar strain and left shoulder impingement. He was recommended to have an MRI of the lumbar spine.

From XXXX XXXX, 2018, until April 6, 2019, Mr. Doe received multiple physical therapy sessions from XXXX, DPT, XXXX, PTA and XXXX, PT, DPT at XXXX Rehab for the pain in his neck and low back, which he rated as 3-8/10. His treatment comprised of range of motion exercises, home exercise program, joint mobilization techniques, manual therapy, neuromuscular re-education, soft tissue mobilization techniques, therapeutic exercises, therapeutic activity and modalities. On XXXX, 2019, Mr. Doe had good prognosis. He was discharged from physical therapy due to insurance visit limitations.

On XXXX XXXX, 2019, XXXX, M.D., obtained an MRI of Mr. Doe's lumbar spine at XXXX Care Centers. The study revealed straightening of the lumbar lordosis, degenerative changes of the lumbar spine, central disc protrusion at the levels of the L5/S1, disc bulge with bilateral foraminal stenosis impinging the L5 nerve roots, central disc protrusion at the levels of the L4/5 with bilateral foraminal stenosis, right foraminal disc protrusion at the levels of the L3/4 with central stenosis and foraminal stenosis.

On XXXX XXXX, 2019, Mr. Doe had a follow-up with Dr. XXXX and XXXX, PA-C at Spine and Orthopedic Center of XXXX for the pain in his neck, left shoulder, low back and bilateral legs. He had difficulty with prolonged sitting, standing and ambulating as well as sleeping and rising from a seated position. He had decreased quality of life due to his condition, which adversely affected most of his activities of daily living. He was advised to continue home exercise program.

On XXXX XXXX, 2019, Mr. Doe had a follow-up with Dr. XXXX and XXXX, PA-C at Spine and Orthopedic Center of XXXX for the pain in his neck, left shoulder, and low back and bilateral lower extremities. He had numbness, tingling and weakness in his bilateral legs. On assessment, he had a chronic cervical strain (whiplash injury), chronic lumbar strain and left shoulder impingement. He was recommended the following: Lumbar epidural steroid injection, lumbar spinal fusion surgery and encouraged to continue with home exercise program.

On XXXX XXXX, 2019, Mr. Doe underwent epidural steroid injection of the lumbar spine at the levels of the L5-S1. The procedure was performed by Dr. XXXX at Surgical Center at XXXX

On XXXX XXXX, 2019, Mr. Doe had a follow-up with Dr. XXXX and XXXX, PA-C at Spine and Orthopedic Center of XXXX for the pain in his neck, left shoulder and low back. He had numbness in

the left hand. He had numbness and tingling in the left foot and left calf. He was recommended for second lumbar epidural steroid injection. He was encouraged to continue with home exercise program.

On XXXX XXXX, 2020, Mr. Doe had a follow-up with Dr. XXXX at Spine and Orthopedic Center of XXXX for the pain in his low back. He was scheduled for an anterior lumbar interbody fusion/posterior spinal decompression fusion at the levels of the L5-S1 on XXXX, 2020.

On XXXX XXXX, 2020, Mr. Doe presented to XXXX, D.O., at Spine and Orthopedic Center of XXXX . On assessment, he had degenerative disc disease of the lumbar spine. He was recommended for anterior lumbar interbody fusion and posterior spinal decompression fusion surgery.

Hospitalization at XXXX Hospital from XXXX XXXX, 2020, until XXXX XXXX, 2020

On XXXX XXXX, 2020, Mr. Doe was examined by Dr. XXXX. for the pain in his low back and bilateral lower extremities. On assessment, he had herniated nucleus pulposus at the levels of the L5-S1 with radiculopathy. He underwent anterior lumbar discectomy and fusion at the levels of the L5-S1 with partial corpectomies of L5 and S1 vertebral bodies and placement of an interbody fusion device with anterior spinal instrumentation at the levels of the L5-S1. The intra-operative fluoroscopy/X-ray of the lumbar spine revealed well-seated interbody cage device with associated diverging intrinsic screws projecting over the respective height-restored disc interspace, no immediate hardware complication and operative segment anatomic alignment. Percocet was prescribed. He was recommended to have a post-procedure X-ray of the lumbar spine to assess adequacy of hardware placement and operative segment alignment. He was advised to walk daily for exercises and to follow-up in 7-10 days. He was discharged home.

On the same day, at 8:41 p.m., Mr. Doe had a history and physical examination with XXXX, M.D., for the pain in his low back. On assessment, he had herniated nucleus pulposus of the lumbosacral spine, status post transforaminal lumbar interbody fusion. He was recommended the following: Monitor neuro checks and urine output, gastrointestinal prophylaxis with Protonix, deep vein thrombosis prophylaxis with Venodynes and patient controlled analgesia for pain.

On XXXX XXXX, at 8:42 p.m., Mr. Doe was examined by Dr. XXXX, for the pain in his low back. Oxycodone and Flexeril were given. He was recommended physical therapy treatment.

On XXXX XXXX, 2020, at 11:09 a.m., Mr. Doe was examined by XXXX, M.D. and XXXX, RN. The surgical site with staple was dry and intact. The pain in his low back was controlled with medication regimen. Percocet and Colace were given. He was given a lumbar brace. Dr. XXXX advised to elevate the head of the bed to 30 degrees, out of bed as desired and to ambulate. He was scheduled to discharge home.

From XXXX XXXX, 2020, until May 13, 2020, Mr. Doe received physical therapy sessions from XXXX, PT and XXXX, PT status post lumbar spine surgery. He required assistance with bed mobility, transfers, gait, stairs, sitting and standing. His treatment comprised bed mobility training, gait training, range of motion exercises, endurance training, transfer training, therapeutic exercises, balance training and patient/family education and training. On May 13, 2020, Mr. Doe was independent with all aspects of functional mobility, including bed mobility, transfers and ambulation. Overall, he demonstrated fair balance and good safety awareness. He was discharged from physical therapy.

On XXXX XXXX, 2020, at 8:44 p.m., Mr. Doe was examined by Dr. XXXX. He was discharged to home in stable condition.

On XXXX XXXX, 2020, Mr. Doe had a history and physical examination with Dr. XXXX for wound infection. On assessment, he was status post transforaminal lumbar interbody fusion with a wound infection. He was medically cleared for wound washout and surgery.

Hospitalization at XXX System-XXX Medical Center from XX XX, 2020, until XX XX, 2020

On XX XX, 2020, Mr. Doe presented to XXXX, D.O., and XXXX, PA-C for the pain and skin infection on the low back, which he rated as 5/10. He reported he had surgery on his lumbosacral spine on XXXX, 2020. He has recovered well since the surgery and had his sutures removed. However, Mr. Doe stated that he had increased pain at the surgical site associated with drainage from the wound, fevers, chills, dizziness and lightheadedness. The CT scan of the lumbar spine revealed laminectomy defect and intervertebral disc spacer device at the levels of the L5-S1 and multilevel degenerative joint disc disease. He took Tylenol. On assessment, he had Cellulitis of lower back and sepsis. Initially, he was treated with normal saline 1 liter intravenous fluid and Morphine 2 mg intravenous push. He was administered with Vancomycin 1,000 mg, Dextrose 5%, Iohexol 300 mg and Zosyn 4.5 g. His condition was guarded and admitted to the XXXX Center.

On the same day, at 7:25 p.m., Mr. Doe had a history and physical examination with XXXX, D.O., for the pain in his low back. He had bleeding at the surgical site in the low back. In the emergency room, he was given Vancomycin and Zosyn intravenously. He also received Morphine intravenously, which helped him with the pain control. On assessment, he had cellulitis. He was admitted to the medical floor. He was advised the following: Continue IV Vancomycin, IV Zosyn and outpatient medications, transfer to Dr. XXXX at XXXX Hospital for wound debridement on XXXX, 2020 and place on sequential compression devices.

On the same day, at 9:30 p.m., Mr. Doe had an Infectious Disease consultation with XXXX, M.D., for the pain in his low back. The wound culture revealed white blood cells, few epithelial cells, gram positive cocci in clusters, few gram positive bacilli, mixed bacterial flora and staphylococcus aureus. He was advised to continue Vancomycin and Zosyn.

On XX XX, 2020, Mr. Doe was examined by Dr. XXXX for the pain in his low back. On assessment, he had cellulites of the lower back and sepsis. Acetaminophen 325 mg, Docusate Sodium 100 mg, Ondansetron 4 mg and Sennosides 8.6 mg were prescribed. He was advised to continue Amlodipine 5 mg, Atorvastatin 10 mg, Oxycodone-Acetaminophen 5-325 mg and Ramipril 5 mg. In a stable condition, he was transferred to XXXX Hospital short-term acute inpatient facility/hospital care.

Hospitalization at XXXX Hospital from XX XX, 2020, until XX XX, 2020

On the same day, at 1:15 p.m., Mr. Doe was examined by XXXX, M.D. for Cellulitis of the lower back. He was evaluated by Dr. XXXX in the emergency room. IV fluids and Zosyn were given. On assessment, he had wound infection status post lumbar laminectomy. Clean and dry dressing was applied to the lower back. He was admitted to MedSurg floor to Dr. XXXX

On XX XX, 2020, at 11:18 a.m., Mr. Doe had an Infectious Disease consultation with XXXX, M.D., for lower back cellulitis. He had post-surgery pain in the low back. On assessment, post-operative infection status post transforaminal lumbar interbody fusion. He was recommended for wound debridement. He was advised to continue IV antibiotics and wound care.

From XX XX, 2020, until XX XX, 2020, Mr. Doe had multiple inpatient evaluations done by Dr. XXXX for wound infection of the lower back. He complained of the pain in his low back, which he rated as 1-8/10. The wound culture was positive for methicillin-susceptible staphylococcus aureus. The post-operative wound culture revealed rare white blood cells, few gram positive cocci and moderate growth of growth of staphylococcus aureus. He was administered with Oxycodone HCL 5 mg/APAP 325 mg, Percocet. Mechanical intermittent pneumatic compression device was applied. He was given pillow support for comfort. Heplocks were removed and dressing applied. On assessment, he had methicillin-susceptible staphylococcus aureus wound status post debridement. He was improved status post wound washout. He was encouraged to get out of bed and ambulate. He was advised to continue IV antibiotics, wound care and to follow-up with primary physician. On XXXX, Mr. Doe was discharged home in good condition.

On XX XX, 2020, XXXX, M.D., obtained an X-ray of Mr. Doe's lumbar spine at Radiology XXXX. The study revealed disc spacer with orthopedic screws at the levels of L4-5, disc space narrowing at the levels of L1-2 and L2-3 and disc space narrowing at the levels of L3-4.

On XX XX, 2020, Mr. Doe had a follow-up with Dr. XXXX and XXXX, PA-C at Spine and Orthopedic Center of XXXX for the pain in his neck, left shoulder, left lower extremity and left buttock, which he rated as 4/10. He continued to have decreased quality of life due to his symptoms and injuries. On assessment, he had a multilevel disc disease in the cervical spine and status post anterior and posterior spinal fusion at the L5-S1 level required postoperative irrigation and debridement for a complex postoperative deep wound infection, which was fully healed. He had failed a very long course of conservative care. With regards to his lower back, he was encouraged to continue over-the-counter medication for his pain as needed. His lumbar spine condition was permanent and may require further lumbar fusion surgery in the future. With regards to his neck, he was recommended for cervical epidural steroid injections as well as anterior cervical discectomy and fusion surgery at the level of C5-C6. He was advised to continue home exercise program. Dr. XXXX opined that Mr. Doe's condition, injuries, treatment and surgery were causally related to the motor vehicle collision on June 14, 2018. He also opined that Mr. Doe's prognosis was guarded with significant residual sequelae from the collision on XX XX, 2018, interfere with his activities of daily living, and require continued and ongoing treatment in the future, including surgery.