

1.MEDICAL RECORDS REVIEW

1.1 Sources

For the purpose of determining Mr. Anamika Dafferty's future medical requirements, I have had the opportunity to review and give consideration to the following medical records:

1. Acadian Ambulance Services (Medical & Billing) - Lafayette, Louisiana
2. Ochsner Medical Center-Baton Rouge (Medical & Billing) - Baton Rouge, Louisiana
3. Art Tail, Ph.D. (Medical & Billing) - Big Cave, Texas
4. TTT Memorial Westside (Medical & Billing) - Las Dentas, Texas
Donald Duck, M.D.
5. MRI & Diagnostic Clinic (Medical & Billing) - Big Cave, Texas
6. The Nerve Clinic (Medical & Billing) - Disneyland, Texas
Boris Doctor, M.D.
7. Blackcircle Chiropractic Wellness and Rehab LLC
Bruce Lee, D.C.
8. Simple Heart Care (Medical & Billing) - Houston, Texas
Lou Mouse, M.D.
9. General Hospital of Black Hill (Medical & Billing) - Black Hill, Texas
Donald Duck, M.D.
10. Bayou Anesthesia and Pain Services, PA (Billing) - Spring, Texas
11. Best Choice Anesthesia (Billing) - Houston, Texas
12. Dream Pharmacy Memorial (Billing) - Houston, Texas
13. Dorsey Chiropractic (Billing) - Greenville, Mississippi
14. Louisiana Identification Card of Mr. Anamika Dafferty (Document)
15. Memorial Compounding Pharmacy (Billing) - Houston, Texas Ochsner
16. Emergency Physicians (Billing) - New Orleans, Louisiana

1.2 Summary of Medical Records

On June 13, 2013, Acadian Ambulance Services records indicate Mr. Anamika Dafferty was complaining of low back pain and minor burn to back of head secondary to a fall while running from an explosion. Examination revealed lower back pain, and 1st degree burns to back of head. Mr. Dafferty was provided an impression of trauma injury and was transported to Ochsner Medical Center of Baton Rouge. (**SAMPLE-** [page 3](#))

Also on this date, upon arrival to the Emergency Department of Ochsner Medical Center-Baton Rouge, Mr. Dafferty was complaining of left posterior neck burn and mid back pain with an intensity of 5/10 secondary to an explosion. Examination revealed burn to inferior/posterior aspect of left ear. Mr. Dafferty was provided a clinical impression of burn and was discharged home in good condition. (**SAMPLE-** [page 5](#))

On June 24, 2013, Mr. Dafferty underwent a Psychological evaluation performed by **Arthur Potter, Ph.D.** and provided diagnoses of Axis I: Acute Stress Disorder (ASD), Axis III: lower back pain or neck pain. Dr. Potter recommended cognitive behavioral therapy (CBT), education and normalization and indicated Mr. Dafferty might require psychiatric consultation for appropriate psychotropic. (**SAMPLE-** [page 7](#))

On June 25, 2013, Mr. Dafferty had an office visit with **Donald Duck, M.D.** for low back pain, stiffness, tingling and numbness in both legs, more to the left, radiating down to the left knee, stiffness in the neck and shoulders and severe headaches secondary to an explosion at work. Mr. Dafferty reported he felt a burning sensation in the head and a headache soon after the explosion, also had a previous head injury in 1976, when was hit by a rock and had a slight

concussion. Examination revealed quite a lot of tenderness over the muscle masses on the left side and in the trapezius muscles on the left side, less on the right side, was able to turn a little bit more to the left than to the right, when got to 30 degrees to the right, a lot of pulling on the left side and a lot of spasm and pain, hyperextension was not possible, decreased flexion, muscle spasm was more on the right side, grip measured 13 on the right and 11 on the left, pinch was 7 on the right and 3 on the left, moderate low back distress, loss of normal lumbar lordosis when standing, tenderness in the lower lumbar and lumbosacral areas, tenderness over both sacroiliac joints, more to the left than to the right, more tenderness and spasm in the muscle masses on the left side, could bend forward to 45 degrees, could not hyperextend, limited lateral motion, spasm on the left side more so than anywhere else, positive straight-leg raising on the left side at about 40-50 degrees and on the right side at about 60-70 degrees. Dr. Duck reviewed x-rays of the cervical spine, which revealed some straightening of the normal cervical lordosis, neuroforamen were open, full range of motion in the cervical spine in all planes with no complaints of pain at the extremes of motion, no evidence of an arthritic or degenerative process, and a very minimal degeneration at C6-C7 and x-rays of the lumbosacral spine, which revealed 5 lumbar vertebrae in normal alignment, no congenital anomalies, no evidence of spondylolysis or spondylolisthesis, no evidence of trauma to the bony parts of the lumbar spine, and evidence of narrowing at L5-S1. Dr. Duck provided diagnoses of cervical strain, lumbosacral strain, and possible herniated nucleus pulposus. Dr. Duck prescribed Medrol Dosepack, Celebrex 200 mg, Robaxin 750 mg, and Fiorinal, recommended physical therapy, MRI's of the cervical and lumbosacral spine and provided neck and back booklet. (SAMPLE- page 14)

An MRI of the cervical spine performed at **Memorial MRI & Diagnostic** revealed spondylotic osteophytes anteriorly at C4-C5, C5-C6, and C6-C7, no fracture, dislocation, epidural hematoma or neoplastic process, intact odontoid process, cervical spinal cord did not show any evidence of laceration injury, hematomyelia, myelomalacia, or mass lesion, at C2-C3 and C3-C4, posterior protrusion-subligamentous disc herniation in the central and paracentral region measuring 3 mm in AP diameter, indenting the thecal sac, not reaching the spinal cord, at C4-C5, posterior protrusion-subligamentous disc herniation in the central and paracentral region extending more to the right lateral aspect measuring 2.3-2.5 mm in AP diameter, indenting the thecal sac, touching the spinal cord, at C5-C6, posterior protrusion-subligamentous disc herniation in the central and lateral aspect in both sides measuring 2.8-3.7 mm in AP diameter, indenting the thecal sac, indenting the spinal cord, causing marked foraminal stenosis bilaterally, at C6-C7, posterior bulging disc measuring 1.6 mm in AP diameter, indenting the thecal sac, not reaching the spinal cord and normal C7-T1. (SAMPLE- page 3)

Also on this date, an MRI of the lumbar spine revealed osteophytes at multiple levels, at L3-L4, a large spur anteriorly, no fracture, dislocation, spondylolisthesis, epidural hematoma, or neoplastic process, conus was normal, located at T11-T12, at L1-L2, and L2-L3, discs were normal, at L3-L4, mild narrowing of the disc space, mild decreased signal of the disc indicative of dehydration and desiccation, broad-based posterior protrusion-subligamentous disc herniation in the central and lateral aspect in both sides measuring 3-3.3 mm in AP diameter, mildly indenting the thecal sac, at L4-L5, mild decreased signal of the disc indicative of early dehydration and desiccation, disc space was not narrowed, broad-based posterior protrusion-subligamentous disc herniation in the central and lateral aspect in both sides but more prominent in the central and paracentral region, right more than left, measuring 3.5-3.7 mm in anteroposterior (AP) diameter, mildly indenting the thecal sac, a tear in the posterior annulus fibrosus in the central and right paracentral region, hypertrophic changes in the facet joints, slight to moderate inferior neural foraminal stenosis bilaterally at that level, right more than the left, at L5-S1, no evidence of disc herniation or spinal stenosis, and hypertrophic changes in the facet joints. (SAMPLE- page 5)

On July 24, 2013, Mr. Dafferty had an office visit with **Igor Cherches, M.D.** for daily, constant severe headaches, significantly increased after explosion 6 weeks ago, reported pain in the left occipital, radiating to the left temporal parietal regions to the left retro-orbital area, photophobia and sonophobia, had intermittent low back pain since the accident, radiating to bilateral buttocks, hamstrings and bilateral quadriceps, exacerbated by standing and walking and relieved by sitting down. Dr. Cherches noted Mr. Dafferty had chronic history of headaches from the age of 13 seemingly following a traumatic head injury, severe headaches would occurred 2-3 times per week, was on social security disability for several years until early 20s, headaches spontaneously improved in mid 20's, did well until April 2013 when started a

job at a chemical refinery, was exposed to multiple chemicals and smells, started to notice a gradual increase in headache frequency and Advil gave transient relief of pain. Dr. Cherches provided assessments of chronic migraine without aura, with intractable migraine, so stated, with status migrainosus, chronic headaches, significantly exacerbated by plant explosion and exposure to chemicals or smoke on a background of chronic headaches that otherwise seemed to be consistent with vascular headaches, and reported Mr. Dafferty had a nonfocal neurologic examination at that time. Dr. Cherches recommended reviewing an MRI of the brain, labs, physical therapy for the low back pain, if not better with therapy then MRI of the lumbar spine, prescribed Pamelor capsule 10 mg, to be titrated up to 30 mg, Cambia on an as needed basis, and advised to follow up in 3 months. (SAMPLE- page 3)

On July 30, 2013, Mr. Dafferty had a follow up visit with Dr. Cupic for pain in the neck and low back mostly on the right side. Dr. Cupic reviewed MRI's of the cervical and lumbosacral spine and provided diagnoses of cervical disc disease and lumbosacral disc herniation. Dr. Cupic recommended physical therapy and prescribed Flexeril 10 mg and Naprosyn 500 mg. (SAMPLE- page 20)

On August 5, 2013, Mr. Dafferty had an office visit with **Khanh Le, D.C.** for pain and stiffness in the neck, upper back and low back areas, numbness and tingling radiating down the shoulders, secondary to a fire explosion and fall on June 13, 2013. Examination revealed decreased range of motion in the cervical, thoracic and lumbar area as well as pain upon palpation. Dr. Le provided diagnoses of cervical radiculitis, cervicgia, thoracic pain, lumbalgia, tingling/numbness/burning, muscle spasms, post traumatic headaches and anxiety. Dr. Le recommended chiropractic care physical therapy 3 times per week and reevaluate after 12 visits or 1 month, physical medicine and rehabilitation, joint mobilization to affected areas and indicated might take over the counter pain medications if needed. (SAMPLE- page 3)

An records indicate Mr. Dafferty was first seen for therapy at **Greenspoint Chiropractic Wellness and Rehab** and last seen for therapy on September 12, 2013. (SAMPLE- page 43)

On August 26, 2013, records indicate Mr. Dafferty was first seen for Psychotherapy with Dr. Tarbox and was last seen for psychotherapy on July 29, 2014. (SAMPLE- page 10)

On September 4, 2013, Mr. Dafferty had a follow up visit with Dr. Cupic for pain and discomfort in the neck and low back. Dr. Cupic noted Mr. Dafferty was almost 3 months status post injury, had not gotten any better, was still going to physical therapy, continued to have pain and discomfort in the neck and the low back, also had some thoracic problems, pain in the neck was going down into the right upper extremity and in the low back, mainly on the right side. Dr. Cupic provided diagnoses of cervical, thoracic and lumbosacral strain, disc protrusions at C4-C5, C5-C6 and C6-C7 with the worst being at the C5-C6, herniated nuclear pulposus at C5-C6 and L4-L5 and degenerative disc disease at L3-L4 and L4-L5. Dr. Cupic recommended continuing conservative treatment, indicated surgery was one of the possibilities in the future, referral to urologist and a neurologist for further evaluation of problems with erections and vision, prescribed Celebrex 200 mg and advised to follow up in 6-8 weeks. (SAMPLE- page 26)

On September 12, 2013, Dr. Le issued a Final Examination Narrative indicating Mr. Dafferty was being treated for injuries suffered from a fire explosion incident occurred on June 13, 2013 and was last seen for care on September 12, 2013. Dr. Le provided final diagnoses of lumbar and cervical disc disorder, thoracic pain, tingling, numbness and burning, muscle spasms, sleep disturbance, post traumatic headaches and anxiety. Dr. Le indicated Mr. Dafferty would follow up with an orthopedic specialist and future treatment might include chiropractic care and the estimated cost would be \$5000.00. (SAMPLE- page 4)

On October 16, 2013, Mr. Dafferty had a follow up visit with Dr. Cupic for continued pain in the cervical area with radiation into both shoulders, pain in the right upper arm and low back. Dr. Cupic noted Mr. Dafferty had been to Primary Care Physician who had given him multiple medications such as Flexeril, Robaxin and Parafon Forte, but this had been given to him all at one time. Dr. Cupic prescribed Naprosyn 500 mg and Flexeril 10 mg, recommended consultation with a neurologist for persistent headaches, not to take medications from Primary Care Physician, to stop taking the anti-

inflammatory medications Celebrex, Relafen, and the medications for spasm, Flexeril, Robaxin, and Parafon Forte, indicated all these were all same types of drugs and Mr. Dafferty was getting a double dose of medication for inflammation and a triple dose of medication for spasms by taking all these drugs at the same time and advised to continue exercises. (SAMPLE- page 32)

On October 25, 2013, Mr. Dafferty had a follow up visit with Dr. Cherches for right-sided neck pain radiating to the right trapezius and occasionally to the right shoulder, patchy numbness in the right upper extremity. Dr. Cherches noted Mr. Dafferty's headaches were significantly better with initiation of Nortriptyline 30 mg, but was still experiencing mild headaches about 3 times per week, usually aggravated by stress, low back pain was better, was continuing to do strengthening exercises, Robaxin gave some transient mild relief of symptoms, pain was relieved by heating pad and hot shower, did not do blood work after the previous visit and results of MRI of the brain was not available. Dr. Cherches provided an additional assessment of neck pain. Dr. Cherches recommended reviewing metabolic work up and MRI of the brain, to review recent MRI of the cervical spine, continue strengthening exercises and Robaxin as needed, and advised to follow up in 6 months. (SAMPLE- page 6)

On November 13, 2013, Mr. Dafferty had a follow up visit with Dr. Cupic for continued problems with neck, right shoulder and low back and headaches. Mr. Dafferty reported low back pain was worse, mainly on the right side, neck pain was also mainly on the right side radiating into the right shoulder down into right elbow. Dr. Cupic prescribed Parafon Forte and Clinoril 200 mg and provided shoulder booklet. (SAMPLE- page 38)

On January 7, 2014, Mr. Dafferty had a follow up visit with Dr. Cupic for pain in the mid line of the cervical spine, more to the left than to the right, radiating into both shoulders, numbness in both hands, low back pain with some radiation into the buttock areas on both sides and upwards into the thoracic area with an intensity of 6/10. Dr. Cupic opined medications did not help Mr. Dafferty much and the pain was about 6-7/10 and prescribed a specialty-made compound, which had components made of anti-inflammatory and pain medications. (SAMPLE- page 8)

On February 18, 2014, Mr. Dafferty had a follow up visit with Dr. Cupic, who noted sharp pain in the lower back radiating at times to legs, low back pain was little bit worse, neck pain was radiating into right upper extremity, numbness in the right hand, numbness from time to time on the left side as well, rated pain as 5-6/10 on the right side and compound cream was helping somewhat. Dr. Cupic recommended to continue exercise, prescribed Flexeril 10 mg and Naprosyn 500 mg and advised to follow up in 6-8 weeks. Dr. Cupic indicated if Mr. Dafferty did not respond to conservative measures then might consider surgical procedure. (SAMPLE- page 43)

On April 7, 2014, Mr. Dafferty had a follow up visit with Mr. Cherches, for continued generalized mild headaches 3-5 times daily, felt very stressed out, related headaches to the times when he was very nervous and depressed, mild soreness on the right side of the neck, overall had been stable for 6 months and was compliant with Nortriptyline 30 mg. Dr. Cherches recommended rest and exercise, increase Nortriptyline to 50 mg and advised to follow up in 6 months. (SAMPLE- page 10)

On April 22, 2014, Mr. Dafferty had a follow up visit with Dr. Cupic, for continued neck and low back pain with an intensity of 6/10, and discomfort in the right shoulder. Dr. Cupic opined pain in the right shoulder more than likely, was radiating from the neck and was not in the shoulder, proper. Dr. Cupic recommended continuing exercise, prescribed specialty-made lipoderm-based anti-inflammatory/pain compound cream which had components made of Meloxicam, Flurbiprofen, Tramadol, Cyclobenzaprine and Bupivacaine medications and advised to follow up in 6 weeks. Dr. Cupic stated did not do an MRI of the right shoulder as he believed the pain in the right shoulder was mainly posterior and was coming from neck and considered watching that. (SAMPLE- page 48)

On June 3, 2014, Mr. Dafferty had a follow up visit with Dr. Cupic, for continued pain in the cervical spine rated as 5/10, lower back pain rated as 6-7/10 going down into the right leg, numbness and tingling down into the toes, and reported specialty made lipoderm-based compound cream was helping. Dr. Cupic recommended a 1-level laminectomy,

discectomy and fusion at L4-L5 on the following week, due to the severity and duration of the symptoms and lack of improvement with conservative treatment, also explained the significance and negative effects of smoking as it lowers the rate of fusion from close to 90% to around 50%. ([SAMPLE- page 53](#))

On June 10, 2014, Mr. Dafferty underwent a Cardiology consultation with **Luis A. Campos, M.D.** for evaluation of preoperative electrocardiogram (EKG) and surgical clearance and had been referred because of an abnormal EKG. Dr. Campos reviewed an electrocardiogram, which revealed large septal Q waves I and a VL with typical changes of LVH and a QS pattern in VI, consistent with left ventricular hypertrophy. Dr. Campos reported blood pressure taken by the office staff was 134/90, was 130/80 when taken by Dr. Campos on that day and was compatible with being somewhat nervous at coming to see a physician. Examination revealed PMI between 4th and 5th intercostals space and prominent sustained apical impulse. Dr. Campos provided assessments of abnormal EKG, left heart failure, benign hypertension, left ventricular hypertrophy and labile hypertension. Dr. Campos recommended monitoring blood pressure on a regular basis postoperatively, counseled on the benefits of AHA-step II diet less than 40 g fat, less than 10 g saturated fat, greater than 30 g soluble fiber, NAS diet-2-3 g sodium and advised to follow up on an as needed basis. ([SAMPLE- page 3](#))

On June 11, 2014, Mr. Dafferty was admitted and underwent bilateral hemilaminectomy with decompression of neural elements at L4-L5, transforaminal interbody arthrodesis via right foramen L4-L5, utilization of structural mechanical implant for spinal arthrodesis (X-spine Calix T), use of auto and allograft for anterior and posterior fusion, nonsegmental internal fixation L4-L5 utilizing the X-spine X-press screw fixation system, posterolateral fusion bilateral L4-L5 and use of fluoroscopy for intraoperative guidance performed at **University General Hospital** by Dr. Cupic without complications. ([SAMPLE- page 47](#))

On June 12, 2014, Mr. Dafferty underwent a Physical Therapy evaluation with short term goals of supervised bed mobility, transfers, gait, to be achieved in 5 days, and long term goals of moderate independence with bed mobility, transfers and rolling walker/gait to be achieved in 10 days. Records indicate Mr. Dafferty was last seen for therapy on June 13, 2014. ([SAMPLE-page 58/ page 30](#))

On June 13, 2014, Mr. Dafferty was discharged from University General Hospital by Dr. Cupic and prescribed Cipro 500 mg, Flomax 0.4 mg and advised to follow up with Dr. Anhalt, a urologist, and Dr. Elhafi on June 16, 2014, and Dr. Cupic on June 16, 2014 or June 17, 2014. Dr. Cupic reported Mr. Dafferty was discharged with a Foley because on 2 trials he was not able to void. ([SAMPLE- page 75](#))

On June 18, 2014, Mr. Dafferty had a follow up visit with Dr. Cupic, who noted Mr. Dafferty was doing very well status post lumbar laminectomy, discectomy and fusion with instrumentation and interbody fusion at L4-L5, went to see Dr. Anhalt, Foley catheter was removed and was able to void after that. Dr. Cupic reviewed x-rays of the lumbosacral spine, which revealed excellent position of the screws, no evidence of loosening and excellent position of the interbody bone graft and provided an additional diagnosis of status post one-level lumbar laminectomy, discectomy and fusion with instrumentation and interbody fusion at L4-L5 on June 10, 2014. Dr. Cupic recommended to continue walking with a walker, not to do any bending, lifting or twisting, advised to follow up on June 25, 2014 and considered removing staples at that time. ([SAMPLE- page 59](#))

On June 25, 2014, Mr. Dafferty had a follow up visit with Dr. Cupic, who noted Mr. Dafferty had some problems with constipation since surgery. Dr. Cupic recommended to increase activities with low back, prescribed Miralax 17 g and advised to follow up in 6 weeks. (**R00075 - R000154 A. Dafferty_ Mermorial Bone & Joint Clinic_Medical-** page 63)

On July 30, 2014, Mr. Dafferty had a follow up visit with Dr. Cupic, who noted Mr. Dafferty was about 1 year post-injury and 6 weeks post-op. Dr. Cupic reviewed x-rays of the lumbosacral spine, which revealed the screws to be in perfect position at L4-L5, no evidence of any type of loosening, and no evidence of any problems with interbody bone graft. Dr. Cupic recommended to continue to wear the brace all of the time, not to do any bending or lifting, to do some walking and

advised to follow up in 6-8 weeks. (SAMPLE- page 67)

On September 9, 2014, Mr. Dafferty had a follow up visit with Dr. Cupic for some pain and discomfort on the right side. Dr. Cupic reported Mr. Dafferty was about 3 months post-surgery and rated back pain as 0/10. Dr. Cupic reviewed x-rays of the lumbosacral spine, which revealed excellent fusion and placement of the screws, no evidence of any type of loosening and excellent placement of the interbody bone graft. Dr. Cupic recommended continuing to wear brace for another 6 weeks and to be weaned away from the brace after that, always to have the brace on while outside or in the car, start physical therapy and exercises at home around 1st of November and advised to follow up in 2 months. (SAMPLE- page 71)

On October 20, 2014, Mr. Dafferty had a follow up visit with Dr. Cupic for worsening neck pain with an intensity of 6-7/10 and rated lumbar spine pain as 3-4/10. Mr. Dafferty reported low back pain was much better, still had some pain in the lower back, but leg pain was much better. Dr. Cupic recommended to increase his activities, start some gentle exercises and physical therapy sometime next month, surgery for cervical spine, continue to take pain medication, and advised to follow up in a couple of months. Dr. Cupic indicated Mr. Dafferty was to go 1 hour per day without the brace for a couple of weeks, then 2 hours per day and continue until no longer wearing the brace. Dr. Cupic explained the significance and negative effects of smoking as it lowers the rate of fusion from close to 90% to around 50% and if Mr. Dafferty did not get better would probably schedule cervical neck surgery in January 2015. (SAMPLE- page 8)

On December 8, 2014, Mr. Dafferty had a follow up visit with Dr. Cupic, who noted Mr. Dafferty's low back continued to improve, but neck was not getting any better. Dr. Cupic recommended C5-C6 surgery, and to increase activities. (SAMPLE- page 13)

Undated, Dr. Cupic issued a correspondence indicating the estimated cost for 2 level lumbar laminectomy discectomy with posterior instrumentation and interbody fusion was \$55,100.00 including the surgeon's fees along with the assistant surgeon and the 2nd surgical assistant. (SAMPLE- page 8)

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