CONFIDENTIAL REPORT

PREPARED FOR:

Jill Doe, Esq.

COMPREHENSIVE



FORENSIC MEDICAL CONSULTING

**EVALUATE | ANALYZE | IDENTIFY**

**Personal Injury Fact Sheet and Summary**

Prepared by Christine Slack RN, BSN, APRN, NP-C, CFNC

**Patient Information**

**Name**: Doe, John

**Date of Birth:** 06.13.1965

**Date of Injury:** 12.10.2018

**Date of Death:** N/A

**Primary Care Physician:** Patient is a veteran and is seen at the VA

**Treating Physicians:**

* **Dr. John Doe –** Primary Treating Physician [12.10.2018 – ongoing]
* **Dr. John Doe –**  Neurosurgery [08.18.2020] evaluated and provided opinion
* **Dr. John Doe** – Rheumatology [ongoing] Has been seeing them for years
* **Dr. John Doe –** Orthopedic [06.18.2019 - ] Generic Medical Center
* **Dr. John Doe –** Workers Compensation Accident #1 [12.10.2018 – ongoing?] Generic Medical Center
* **Dr. John Doe** - Workers Compensation Accident #2 [06.18.2019 - ongoing] Generic Medical Center
* **John Doe –** Pain Management [ - ongoing] He’s been seen by them for years
* **John Doe**  -- VA Staff Psychologist [12.31.2018 - ]MH referral to Dr Lemos-Miller
* **John Doe, PT –** Physical Therapist [12.13.2018 - ongoing]
* **John Doe, OT –** Occupational Therapist[03.19.2019 –08.13.2019]

**Records Reviewed**

|  |  |  |
| --- | --- | --- |
| **File Name/Designation** | **Relevant Pages** | **Total Pages** |
| VA RAD (1).pdf | 6 | 10 |
| S. Med Bill.pdf | 0 | 1 |
| S Med Med Record and Reports.pdf | 4 | 4 |
| PT2.pdf | 1-3,6-7,9-10, 12-13  | 17 |
| PT.pdf | 0 | 2 |
| OR Reports.pdf | 6 | 6 |
| Neuro notes.pdf | 26 | 26 |
| Misc Medical Records (PT, Radiology, etc).pdf | 41 | 41 |
| MH notes.pdf | 3 | 3 |
| LL\_MR\_2 2.3.21.pdf | 350 | 401 |
| Dr. Note and lab request.pdf | 3 | 3 |
| COS Medical 1.2(1).pdf | 62 | 62 |
| Chiro.pdf | 0 | 3 |
| Chiro\_2.pdf | 2 | 2 |
| **TOTAL** | **512** | **581** |

**Prior Medical Conditions**

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| **The Following are Prior Medical Conditions based on the review of the above records:**  |
| High Blood Pressure (mentioned in note on 12.17.2008) uncontrolled on 01.05.2015) |
| Osteoarthritis of bilateral knees (mentioned in note on 12.09.2009) |
| Right sciatica |
| PTSD (mentioned in note on 04.21.2014) |
| Lumbar spinal stenosis (mentioned in note on 09.30.2013) |
| Lumbar radiculopathy (mentioned in note on 09.30.2013) |
| Mild multilevel central & neural foraminal stenosis & facet disease (in note on 09.30.2013) |
| lumbar stenosis with history of posterior lumbar fusion |
| Impaired bladder function with incontinence (on 01.06.2017 he said he began 6 mo prior) |
| Bowel incontinence (on 08.13.2018 he reports intermittent episodes “over last few months”) |
| Bilateral shoulder impingement s/p steroid injections |
| Severe neck pain with dizziness and faint feeling when bends head forward |
| Tinnitus (mentioned in note on 04.21.2014) |
| Degenerative Disc Disease (cervical spine, lumbar spine) |
| Cervical stenosis (mentioned in note on 12.03.2015) |
| Degenerative Joint Disease (lumbar DJD without spinal stenosis on MRI 10.02.2018) (in note on 08.07.2015) |
| Degenerative Joint Disease of bilateral knees (on MRI 04.02.2009) |
| Diffuse osteoarthritis (mentioned in note on 09.30.2013) |
| Left shoulder rotator tendinopathy without tear |
| Left shoulder moderate degenerate changes of the left AC joint (mentioned in note on 11.17.2015) |
| Right shoulder moderate degenerative changes of the ac joint (mentioned in note on 11.17.2015) |
| Decreased sensation to both legs (seen documented in note on 01.06.2017) |
| Anxiety (GAD-7 score of 10 on 07.10.2018 – classified as Moderate Anxiety) |
| Depression (PHQ-9 score of 15 on 07.10.2018 –classified as Moderately Severe Depression) |
| Radiculopathy (bilateral L5 radicular symptoms… in note 10.02.2018) |
| Multilevel degenerative disc desiccation |
| C4-5 Posterior disc bulge (mentioned in MRI note on 11.17.2015) |
| C3-4 mod to severe right lateral recess & neural foraminal narrowing (mentioned in MRI note on 11.17.2015) |
| C5-6 retrolithesis of C5 on C6; mild central canal narrowing; bilateral moderate to severe lateral recess and neural foramina narrowing; (mentioned in MRI note on 11.17.2015) |
| Arthralgia ((mentioned in note on 02.11.2009) |
| Hx of prior neck injury (mentioned in PT note on 07.01.2019) |
| Scarlet Fever (mentioned in note on 11.17.2008) |
| Kyphosis |
| Polyarthralgia (mentioned in note on 10.20.2015) |
| h/o right rotator cuff tear with limited ROM (mentioned in note on 01.06.2017) |
| Left rotator cuff tear (mentioned in note on 10.20.2015) |
| Right shoulder impingement (mentioned in note on 12.15.2011) |
| Pharyngeal or upper esophageal dysphagia (mentioned in note on 12.15.2015) |

**Injuries Sustained from Accident**

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| **The Plaintiff is Claiming the Following Injuries as a result of the Accident:****(According to the medical records and discovery responses)** |
| Worsening neck pain – almost constant |
| Worsening low back pain – almost constant |
| Worsening stress and anxiety |
| Increased numbness and tingling in both arms and legs |
| Mood changes as witnessed by wife |
| Decreased strength to left arm (note on 08.03.2018 documents strength all extremities as 5/5) |
| Increased weakness to bilateral upper extremities |
| Emotional distress affecting his ability to work and straining family relationships |
| Clinically significant functional limitation resulting in inability or significantly decreased ability to perform normal, daily activities at work or at home duties (07.16.2019) |

**Additional Medical Diagnoses**

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| **Other Medical Diagnoses found in the Medical Records AFTER the Date of the Incident that are Pertinent to this Claim:** |
| Cervical strain |
| Cervical sprain |
| Cervical radiculopathy (documented in anesthesia note on 02.04.2019) |
| Cervical spondylosis C3-C4 through C6-C7 |
| Small posterior osteophyte disc complex at C3-4 (MRI 04.18.2019) |
| Mononeuropathy bilateral upper extremities (documented 02.22.2019) |
| Decreased sensation present about the left C4-5 and C6-7 nerve distributions (07.16.2019) |
| Worsening neck pain – almost constant |
| Cervical stenosis C5-6 (02.04.2019 pain clinic note) |
| Weakness in hands |
| Spinal stenosis  |
| Moderate central canal stenosis C5-6 |
| Moderate to severe bilateral neural foraminal narrowing |
| Moderate right neural foraminal narrowing  |
| Moderate central canal stenosis C4-5 |
| Moderate narrowing of neural foramen bilaterally at C4-5 |
| Neuroforaminal stenosis at C5-6 (02.04.2019 pain clinic note) |
| Cervical stenosis C5-6 (02.04.2019 pain clinic note) |
| Carpal tunnel  |
| 2.5mm posterior disc protrusion at C6-7 (MRI 04.18.2019) |
| 4mm posterior disc protrusion, narrowing thecal sac to 6mm AP at C5-6 (MRI 04.18.2019) |
| Antalgic gait |
| Muscle spasms in bilateral wrists/hands (07.16.2019) |
| Deficit to C6-T1 nerve distribution motor strength (07.16.2019) |
| Deficit to C6-T1 sensation to touch (07.16.2019) |
| Decreased upper extremity deep tendon reflexes (07.16.2019) |
| Weakness secondary to nerve root compression (07.16.2019) |
| Intractable neck pain (09.20.2019) |
| Herniations; C4 5, C5 C6, and C6 7 (09.20.2019) |
| Significant neural foraminal compromise secondary to disc herniations at C4-5, C5-C6, and C6-7 (09.20.2019) |
| At C4-5, there was a large broad base disc herniation with significant encroachment on the thecal sac and spinal cord posteriorly. (Intraoperative finding 09.20.2019) |
| There was a tear in the posterior longitudinal ligament approximately 20 degrees cephalad to caudad (Intraoperative finding 09.20.2019) |
| At cervical C5-6, there was a large tear noted in the posterior longitudinal ligament (Intraoperative Finding 9.20.2019) |
| At C6-7 collapse of the disc height (Intraoperative Finding 9.20.2019) |
| At C5-6 severe encroachment on the neural foramina bilaterally (Intraoperative Finding 9.20.2019) |
| Moderate/Severe NF narrowing at C5-6 (seen on MRI documented on 02.04.2019) |
| At C6-7 there was a large tear in the posterior longitudinal ligament (Intraoperative Finding 9.20.2019) |
| At C6-7 another broad-based significant disc herniation (Intraoperative Finding 9.20.2019) |
| Lumbar radiculopathy (documented on 08.01.2019 Pain clinic visit note) |

**Narrative Summary of the Case**

**The Facts**

# Synopsis: On December 10, 2018, client was in Long Beach for work. He is the area safety manager for Generic Construction. While working he utilizes a 2017 Ford F-150 to get from site to site. While on Anaheim or Pacific Avenue in Long Beach he was stopped at a red light. He was wearing his seat belt. He believes he was the second to third car back. The lead car wanted to turn right at the light, however, there were pedestrians crossing the street so he had to wait. As the lead car was waiting for the pedestrians to cross the street, Mr. Doe was rear ended by a Prius. Mr. Doe estimates that the Prius was traveling around 30mph. Mr. Doe reports that the impact felt like an “explosion”. The Prius hit the back of his truck with such force that the glove compartment of Mr. Doe’s truck popped open and the contents of the glove compartment were thrown about the cabin of his truck. Mr. Doe reports being jolted multiple time. The Prius was also wedged underneath the back of the trailer hitch of Mr. Doe’s work truck. In fact, as Mr. Doe attempted to drive away his truck was dragging the Prius behind him. It was documented that Mr. Doe was amnesic to the events of the collision.

# Mr. Doe reports that he experienced immediate pain in his neck, both shoulders, both arms and hands. Mr. Doe became concerned about the welfare of the other driver that he got out of his truck and went to check on the driver of the Prius. The driver was “locked up” and he told Mr. Doe that he felt “dizzy,” so Mr. Doe promptly called 911. Mr. Doe than allowed the defendant driver of the Prius to borrow his phone to call his significant other and the defendant driver was overheard, by Mr. Doe, telling his significant other that he thinks he fell asleep while driving. The accident occurred in the middle of the day. Mr. Doe estimates the time being somewhere between 11am - 1pm. The Long Beach Police Department as well as the paramedics arrived at the scene. The Long Beach Police Department arrived on the scene and began their investigation. Mr. Doe will look or the DR# or the officer’s card. A police report was filed.

# After the collision Mr. Doe drove to [ ] and was evaluated by [ ] for complaints of neck pain, lower back pain, pain in both of his shoulders, and leg pain. At this appointment Mr. Doe also reported that his legs and arms were tingling, right shoulder pain radiated to the elbow and numbness to both hands and feet. He also reported to the physician that he has previously injured the affected areas. He did specifically make note that he has been treated for a previous back injury. No specifics were given. Right shoulder pain was rated 6/10 and lumbar spine tightness rated 7/10. Pain is aggravated with movement, walking, and bending over. Mr. Doe denies weakness, bowel or bladder incontinence. Mr. Doe underwent imaging studies. Xray of right shoulder revealed Mild degenerative joint disease in the acromioclavicular joint. Xray of cervical spine revealed mild degenerative narrowing at C5-6, and mild degenerative spurring at C3 through C6. No imaging of lumbar spine found in documentation provided. He was diagnosed with acute strain pattern with paresthesias secondary to local cord compression. No concern for acute cord myelopathy or other red flags. Drug screen was done. No results found in documentation provided. His recommended work status was ‘Regular Duty’ effective the same day.

# He was seen by the Primary Treating Physician a week later, on 12.17.2018 due to lack of improvement in the pain. Mr. Doe reports the pain has worsened in the lower back, upper back, with increased stiffness. Diagnoses: (1) Strain of other muscles, fascia and tendons at shoulder and upper arm level, right arm (2) low back pain. Treatment recommended: recommend maintaining range of motion, continue OTC pain medications as previous, follow up in 2 weeks. Recommend heat or areas of stiffness. Again, his recommended work status was ‘Regular Duty’.

# On 12.27.2018 Mr. Doe was referred to the VA Mental Health Staff Psychologist for stress related insomnia. He reported restless sleep, sleeping about 4 hours a night, increasing dreams of experiences in the service, flashbacks, headaches, depression in the mornings, which has impacted his occupational functioning. His wife was present and reports that she has noticed increasing anxiety over the past few months. Feedback from work stating that he is not approachable or friendly at work. Mr. Doe indicated being “stuck in his head” a lot and was unaware of having mood changes or that his actions and behaviors have been affecting others. Mr. Doe expresses that he doesn’t want stress to negatively impact his job and was wanting to see behavioral health before fatigue impacts his judgment at work.

# On 01.03.2019 he follows up with his Primary Treating Physician where he reports that the pain in the lower neck and upper back region has worsened. He is experiencing more stiffness. He also stated that his hands feel week but “unsure if this is chronic or new.” Muscle strain is still the primary diagnosis being treated. Plan is still to continue range of motion, utilizing OTC pain medications, heat for areas of stiffness and stretching, holding each stretch for 20 seconds. Recommended work status remains at “Regular Duty”. Pain reported as 5/10.

# Mr. Doe had a MRI of his cervical spine [neck] without contrast on 01.31.2019. This reading was compared to an equivocal MRI done on 11.17.2015. Radiologist Impressions include: (1) Mild progressed posterior disc-osteophyte complex at C-6 which contributes to moderate central canal stenosis [narrowing of the spinal column that causes pressure on the spinal cord]. (2) Moderate right neural foraminal narrowing at C4-5 secondary to mildly progressed right sided uncovertebral joint spurring. (3) Remainder of the study shows no significant interval change with the cervical spine.

# Mr. Doe had a steroid injection in his neck on 02.04.2019. He reports that the injection did provide some relief but the relief only lasted two to three days. Mr. Doe was referred to chiropractic care and intervention where he underwent six sessions. The treatment was ineffective in reducing his pain. Mr. Doe was then evaluated by a pain specialist at [ ]. A nerve conduction study was done around this time which revealed carpal tunnel syndrome.

# Mr. Doe was then referred to physical therapy shortly afterwards. He participated in physical therapy three times a week for three weeks. Although he states that overall it made him feel better it would make him more sore and ultimately the treatment was ineffective in reducing his pain. He continued physical therapy for another two months, going two to three times a week. He reports the treatment was ineffective in reducing his pain.

# Pain clinic note dated 04.05.2019 reports sending referral to Pain Psych due to complaints of irritability and lack of patients [patience] with others. Affecting his marriage and life.

# On 04.18.2019 Mr. Doe had MRI of Upper Extremity and of his cervical spine. Impression of Upper Extremity: (1) Moderate age related changes at the joint in the shoulder where the collar bone and shoulder blade meet (2) Impingement of supraspinatus tendon as it passes between the acromion and humeral head (3) inflammation of the upper biceps tendon. Impression of cervical spine: (1) Arthritis from C3-4 through C6-7 (2) slipping of disc of C5 onto C6 with 4mm posterior disc protrusion, narrowing of the sheath that covers the spinal cord to 6mm, age related changes to facet joints and severe narrowing of neural foramen on both sides (3) At C4-5, a 3mm posterior osteophyte disc complex and spurring. Moderate narrowing of neural foramen on both sides (4) At C6-7 there is a 2.5mm posterior disc protrusion (5) At C3-4 there is a small posterior osteophyte disc complex. This is a significant change from MRI of his cervical spine on 01.31.2019, which only documented (1) Mild progressed posterior disc-osteophyte complex at C5-6 contributes to moderate central canal stenosis (2) Moderate right neural foraminal narrowing at C4-5 secondary to mildly progressed right-sided uncovertebral joint spurring (3) Remainder of the study shows no significant interval change with the cervical spine as detailed in the findings section, level by level, and including borderline central canal stenosis at C4-5, and moderate to severe bilateral neural foraminal narrowing at C5-6.

# On 06.18.2019 Mr. Doe was involved in another MVA. No specifics as to what happened or how it occurred. When asked how injury occurred Mr. Doe wrote “high blood pressure/ anxiety/ stress..Built up to today”. Blood pressure was documented at 201/115. Mr. Doe reports severe work related stress. Gait described as “normal without assistive devices…able to generally move with no difficulty.” Provider documents that Mr. Doe “is not fit for duty of any kind with the company at this time in his current mental state.” Mr. Doe was instructed to go to ER for severely elevated blood pressure but refused.

# Mr. Doe was then referred for an Orthopedic evaluation (likely NeuroSpine). He informs physician that he has had prior problems with the current injured body parts as a result of the military. In other documents he reveals that he was a part of the Army’s 82nd Airborne…jumping out of planes. Orthopedic physician requested authorization for chiropractic therapy, twice a week for four weeks. He also requested authorization for consultation with pain management specialist.

# On follow up Orthopedic Evaluation on 07.16.2019 Mr. Doe reports worsening muscle spasm in bilateral hands/wrists. Improvement in cervical ROM documented. Grips are weak to both hands L>R (17.2lb/27.4lb). Documentation of sensory deficit is present about the left C4-5 and C6-7 nerve distributions. Orthopedic physician reports persistent and progressive radicular pain with documented weakness secondary to nerve root compression and moderate to severe neck pain despite several sessions of conservative therapy. He also documented that Mr. Doe has clinically significant function limitation, resulting in inability or significantly decreased ability to perform normal, daily activities at work or at home duties. Provider requested authorization for anterior cervical discectomy and fusion of C4-5 and C6-7 to be followed by post operative physical therapy three times a week for four weeks. Ortho follow up on 08.19.2019 documents some improvement in cervical ROM. Neurospine physician recommended that Mr. Doe undergo a cervical fusion. Three level anterior cervical discectomy and fusion performed on 09.23.2019.

# Patient went on temporarily disability beginning on 09.23.2019.

# Mr. Doe was referred to Neurosurgery for evaluation. In document date 08.18.2020 Mr. Doe reports that he had gotten into another MVA in July 2020. This is the 3rd motor vehicle accident since 12.10.2018. Mr. Doe reports that he was the driver of a vehicle driving straight. Another car was in front of him making a left turn. Mr. Doe hit the other driver’s tail end. Mr. Doe’s car was totaled. He denies worsening pain from this collision and he didn’t require any particular treatments for this accident. Motor strength documented at 5/5 in upper and lower extremities. Continues to show weakness in grips L>R. Deep tendon reflexes normal at 2+ in upper and lower extremities.

# Documentation showing that patient received injections into his knees from 10.28.2019 to 11.12.2019 (when records end). He received 3 injections of Hyalgan, weekly for 3 weeks.

# Follow up with PCP on 12.24.2019. He is still on leave. Went on leave in Jan 2019). According to doctor’s note he is prescribed Gabapentin 400mg – 3 capsules 3 times a day [typically taken morning, afternoon and evening/bedtime]. Mr. Doe states that he is taking 4 pills /4 pills/ 2-3 pills which means he is not taking this medication as prescribed. Still having decreased function in his shoulders. Still with complaints of pain in both feet.

# Had follow up with psychologist on 01.29.2020. Psychologist reports that Mr. Doe is insightful and has worked hard in his recovery. He has also made great progress at stress management and feeling able to return to work. Psychologist has cleared him to work as early as 01.30.2020. He has follow up with physician on 02.13.2020.

# Worked with PT on 02.04.2020 at which time he states that he is only feeling discomfort, not pain. Mr. Doe does report that he still gets numbness and tingling at night but symptoms come and go. He also feels like he doesn’t have any strength in both arms. Pain Scale: Worst: 8 Best: 2 Current: 3. Neck Disability Index Questionnaire- Total Score: 23 [50 max] This is indicative of moderate (borderline severe) disability. Total %: 46% Left grip strength significantly improved from 17.2 lb on 07.16.2019 to 40lbs on 02.04.2020. Right grip strength decreased from 27.4 lbs on 07.16.2019 to 20 lbs on 02.04.2020. Continued to work with physical therapy on 02.10.2020, 02.12.2020 and 02.17.2020 with no significant improvement in pain, which was consistently reported as 5-6/10 with goal remaining at 2-3/10. He is now 14 months post subject accident and 8 months post second documented car accident.

# On 08.18.2020 Mr. Doe was evaluated by Neurosurgery for evaluation of symptoms. Mr. Doe reported: neck pain with radiation to both arm down to fingertips R>L, numbness, weakness, tingling and burning sensation in neck and both arm down to fingertips R>L, spinal stenosis in lumbar spine, shooting pain down to both legs, urinary urgency, bowel and bladder incontinence (twice a week since accident), increased neck pain with sneezing and coughing, has to brace himself when driving over a bump, buckling in both legs, balance issues, he has to constantly lean on surfaces for support with increasing lower back pain with more frequent radiation into right leg, history of radiation to right leg, more frequent and worse radiation of pain and increased weakness in legs since the subject accident, muscle loss in right calf, difficulty performing self cares, difficulty with intercourse, difficulty bending, twisting, lifting above arm and shoulders, pain in shoulder and both hands keep him awake at night, pain when moving from lying to standing, pain increases with writing and typing, can’t hold onto objects, dropping his phone all the time, recently started having trouble driving, prior history of low back pain with right sided sciatica, prior history of lumbar stenosis, prior history of left knee pain, requiring cane for past 10-15 years, excessive sleeping, trouble with bowel movements, weakness and numbness of extremities, trouble starting and stopping urine flow, trouble controlling mood, decreased range of motion to neck: flexion, lateral rotation, neck extension causes pain, decreased lateral bending to right, flexion to lumbar spine with pain in lumbosacral region. Physical exam reveals positive straight leg raise. Motor strength in arms and legs is 5/5. Positive Tinel test. Deep tendon reflexes symmetric and 2+ (normal) in both arms and legs. Antalgic gait. Based upon records review, history and physical exam the neurosurgeon gave his opinion that the subject collision is directly responsible for Mr. Doe’s injuries with cervical, lumbar spine and bilateral shoulder injury, aggravation of underlying degenerative joint disease in his shoulders and aggravation of his lumbar spine degenerative disc disease condition. He states that Mr. Doe will require future medical care in many forms include doctor visits, multiple therapies, imaging and procedure. He gave his opinion that Mr. Doe is permanently totally disabled in terms of performing tasks requiring repetitive bending, lifting, twisting, pushing, pulling or stooping. He has a difficulty with past requiring him to be in a seated position for more than 2 hours at a time continuously. He is unable to perform tasks requiring balancing or requiring working at heights. He will require appropriate vocational rehabilitation evaluation to determine his work capacity.

# Discussion of Claims and Injuries

# Worsening neck pain

# Numbness and tingling in both arms

# Decreased strength to left arm (note on 08.03.2018 documents strength all extremities as 5/5)

# Mood changes documented as witnessed by wife

# Worsening low back pain – almost constant

# Weakness in legs

# Pain radiating down into both legs

# Worsening stress and anxiety – affecting work and relationships

# WORSENING NECK PAIN w/RADIATION TO BOTH ARMS/ WEAKNESS TO BUE/ NUMBNESS & TINGLING TO BUE: The constant pain in his neck has not only affected him physically but also emotionally. In a physical medicine rehab note dated four months prior to the subject accident his arm strength in both arms was documented as 5/5 [please refer to note on 08.03.2018], which is a normal finding without deficits. From the beginning he has rated his neck pain at 6/10 and it rarely dropped below this throughout the entirety of the provided documentation. The accident occurred on 12.10.2018. Just two weeks later, in a document dated 12.27.2018, Mr. Doe was requesting a referral to Mental Health Services. Crisis evaluation was immediately performed. He was not found to be a danger to himself or others. He was seen by a psychologist just a few days later. He reported feeling restless at night, thrashing in his sleep with an inability to sleep more than 4 hours at night, having increased dreams of his experiences in the military, sleep impairment, and depression. He reports that these have impacted his occupational functioning. His wife reports seeing mood changes. Mr. Doe was unaware of any changes to his mood. It was even reported that his coworkers described him as unapproachable and unfriendly at work. Mr. Doe reports that he is often “stuck in his head.” He expressed concern over the possibility of increased stress and fatigue, from lack of sleep, negatively affecting his job. He requested to see behavior health. He was put on several new medications, some of which, can cause drowsiness or sedation and even mood changes. Sleep deprivation can also affect his mood. The only medical interventions for pain were OTC pain medications, specifically Tylenol as he cannot take NSAIDS, stretches and heat. Mr. Doe takes the train to work. By the time he gets off the train not only is his neck in constant pain but his right arm will be numb. By Jan 2019 he was beginning to experience both of his hands going numb and headaches. Pain at that time 5/10. MRI of cervical spine revealed mildly progressed posterior disc osteophyte [bone spurs found in the cervical spine that come due to natural aging over time or in response to spinal joint instability] at C5-6 which is contributing to moderate central canal stenosis [narrowing which can cause pain or numbness in arm]. Mr. Doe did receive an epidural steroid shot in his neck on 02.04.2019. Two weeks afterwards his pain was still rated at 7/10. He had been working with physical therapy which has made him feel better but he immediately become more sore. By March 2019 pain remained persistent and still rated at 6/10. He also noticed that the pain is accompanied by numbness and tingling in his arms. He continued to work with physical therapy. In a documented visit to the pain clinic Mr. Doe reports that he is starting to become more irritable and losing his patience. His condition is beginning to affect his marriage and his life. He was referred to pain psych. On 04.18.2019 MRI revealed some significant changes in his cervical spine including: (1) arthritis from C3-4 through C6-7 (2) 4mm posterior disc protrusion at C5-6 (3) narrowing of the sheath that covers the spinal cord to 6mm (4) uncovertebral spurring and degenerative changes in the facet joint with severe narrowing of neural foramen on both sides at C5-C6 (5) 3mm posterior osteophyte disc complex and uncovertebral spurring at C4-5 (6) Moderate narrowing of neural foramen on both sides at C4-5 (7) 2.5mm posterior disc protrusion at C6-7 (8) small posterior osteophyte disc complex at C3-4. Pain 4-5/10. He was referred to Ortho Spine due to lack of progress. In May 2019 he attempted to work in his yard. This led to severe pain which kept him in bed for a couple of days. Mr. Doe is also expressing depression. He continues to have family issues specifically naming marriage and daughter. Mr. Doe was involved in another motor vehicle accident on 06.18.2019. A Patient Injury Form dated 06.18.2019 was filled out. No specific details about the accident were found but when asked to describe how the accident happened Mr. Doe responds “High blood pressure/ Anxiety/ Stress..Built up to today”. He reports that he had a heated conversation with his supervisor regarding him working from home. They want him to stop working from home but Mr. Doe told his employer that “it would be difficult due to the sedating nature of multiple medications he has been prescribed by the [ ] hospital system.” Also of note, on this particular form Mr. Doe lists his marital status as ‘single’ while on his last injury report he lists his marital status as ‘married’. Provider states,” It is my opinion that the patient is not fit for duty of any kind with the company at this time in his current mental state.” In July 2019 you begin to see documentation of worsening muscle spasms, numbness and tingling in both hands and feet, weakened grips, worsening weakness to both arms L>R. Mr. Doe was referred to Ortho Spine. Evaluation was done on 07.16.2019. In that note provider documents “a sensory deficit is present about the left C4-5 and C6-7 nerve distributions… as well as deficit to C6-T1 nerve distribution motor strength as well as sensation to touch, as well as decreased upper extremity deep tendon reflexes… persistent and progressive radicular pain with documented weakness secondary to nerve root compression and moderate to severe neck pain, despite several sessions of conservative therapy…has clinically significant functional limitation, resulting in inability or significantly decreased ability to perform normal, daily activities at work or at home duties.” Pain in shoulder and both hands kept him up at night; pain increases with writing and typing; Mr. Doe can’t hold on to objects.. he reports “I've dropped my phones so many times”; started having trouble driving.. got into another car accident in July 2020; continued weakness and numbness of extremities; trouble concerning fluctuating mood [there is medical documentation reporting that instability in the cervical spine can negatively change personality]; continued decreased range of motion to neck on all planes; positive Tinel test indicative of nerve damage. He never met his pain goal of 2-3/10. After seven long months Mr. Doe was getting prepared for surgical intervention. On 09.30.2019 Mr. Doe underwent a three level anterior cervical discectomy and fusion. He continue to suffer a number of symptoms following the surgery.

# On 08.18.2020 Mr. Doe was evaluated by Neurosurgery for evaluation of symptoms. Mr. Doe reported: neck pain with radiation to both arm down to fingertips R>L, numbness, weakness, tingling and burning sensation in neck and both arm down to fingertips R>L, increased neck pain with sneezing and coughing, has to brace himself when driving over a bump, difficulty performing self cares, difficulty with intercourse, difficulty bending, twisting, lifting above arm and shoulders, pain in shoulder and both hands keep him awake at night, pain when moving from lying to standing, pain increases with writing and typing, can’t hold onto objects, dropping his phone all the time, recently started having trouble driving, weakness and numbness of extremities, trouble controlling mood, decreased range of motion to neck: flexion, lateral rotation, neck extension causes pain. Motor strength in arms and legs is 5/5. Positive Tinel test indicating damage to the median nerve.

# WORSENING LOW BACK PAIN w/ RADICULOPATHY/ WEAKNESS IN BOTH LEGS/ BOWEL & BLADDER INCONTINENCE: Mr. Doe has acknowledged a prior history of chronic back pain. But since the subject accident on 12.10.2018 the pain in his legs has worsened and impairing his functional ability. He was regularly documented as saying that it was constant. Just two weeks later, in a document dated 12.27.2018, Mr. Doe was requesting a referral to Mental Health Services. Crisis evaluation was immediately performed. He was not found to be a danger to himself or others. He was seen by a psychologist just a few days later. He does report having increased dreams of his experiences in the military, sleep impairment, and depression. He reports that these have impacted his occupational functioning. His wife reports seeing mood changes. Mr. Doe was unaware of any changes to his mood. It was even reported that his coworkers described him as unapproachable and unfriendly at work. Mr. Doe reports that he is often “stuck in his head.” He expressed concern over the possibility of increased stress and fatigue, from lack of sleep, negatively affecting his job. He requested to see behavior health. He was put on several new medications, some of which, can cause drowsiness or sedation and even mood changes. Sleep deprivation can also affect his mood. The only medical interventions for pain were OTC pain medications, specifically Tylenol as he cannot take NSAIDS, stretches and heat. In note by primary treating physician it was documented that over all symptoms are the same as prior there was a different quality of radiation of pain from his lower back. He worked with physical therapy off and on for quite some time. Pain clinic note documents that he was scheduled for a steroid injection in his neck mentioned that they “consider switch to LESI [steroid injection in his lower back]… today his neck pain is more consistent/worse than his back and can do the other location the following month.” His back pain seems to take a back seat to the neck pain despite Mr. Doe mentioning how it has been affecting his life. In a primary care note dated 05.13.2019 he mentioned how working in the yard and mowing his lawn resulted in “serve pain, particularly in his lower back and ankles. He was hardly able to get out of bed for a couple of days. He feels the pain has not let up…” . Mr. Doe is also expressing depression. He continues to have family issues specifically naming marriage and daughter. In July 2019 it was documented that Mr. Doe had complaints of numbness in both of his feet coupled with tingling sensations. There were no discussions regarding treatment options suggested for his back. In consultation note by neurosurgery it was referenced that Mr. Doe did have a steroid injection in his back in the area of L5-S1on 08.01.2019. It wasn’t until reading the evaluation by neurosurgery that it was clear just how severe Mr. Doe’s back injury was and how extensively it was affecting his life. It was documented in the 08.18.2020 consultation note by neurosurgery that patient had the following complaints: pain was constant in his lower back at 4/10 with intermittent pains that Mr. Doe reported as 10/10 intensity, pain was aggravated with any activity or activities of daily living and only temporarily relieved by rest; shooting pain down both legs, weakness to both legs.. buckling in both legs with balance issues, bowel and bladder incontinence.. twice a week since the accident, he has to constantly lean on surfaces for support with increasing lower back pain with more frequent radiation into his right leg, difficulty walking up stairs and climbing ladders, difficulty getting up from lying down, more frequent and worse radiation of pain and increased weakness in legs since the subject accident, muscle loss in right calf, difficulty with intercourse, difficulty bending, pain with moving from lying to standing, weakness and numbness of extremities, trouble starting and stopping urine flow, decreased lateral bending to right, flexion to lumbar spine with pain in lumbosacral region. Physical exam reveals positive straight leg raise. Antalgic gait, favoring the left leg when walking. The majority of these symptoms weren’t mentioned in the few medical progress notes dated prior to the accident. Some were denied as occurring. Which is surprising because some of these symptoms are suggestive of something quite concerning. The only MRI of Mr. Doe’s lumbar spine that were included in the medical notes was done prior to the accident and the findings of that MRI are inconsistent with the symptoms described by neurosurgery on 08.18.2020. The progress note from the pain clinic on 02.04.2019 documented the last steroid injection given to Mr. Doe’s lumbar spine was 04/14. This would imply that Mr. Doe wasn’t struggling in the same way that he is currently struggling. In the months leading up to the accident Mr. Doe was exhibiting symptoms that medical providers expressed concern over the possibility of cauda equina, which is a very serious condition. An MRI was done which revealed that he wasn’t suffering from cauda equina but in the neurosurgery note from 08.08.2020 Mr. Doe told this provider that he was having “bowel and bladder incontinence.. twice a week since the accident.” There were three progress notes where it was documented that Mr. Doe “denies bowel and bladder incontinence: 12.10.2018, 01.03.2019, 07.01.2019. Other than the progress note from the neurosurgery consultation there doesn’t seem to be anyone asking him about this. That is quite concerning considering the symptoms described by neurosurgery on 08.18.2020.

# WORSENING ANXIETY AND STRESS: Although Mr. Doe does have a history of anxiety documented prior to the accident it there was nothing documented to suggest that he was struggling in his relationships with his wife, daughter or with his supervisor at work. But there are several instances documented following the accident that worsening stress was affecting his relationships with others. In a progress note dated 12.31.2018 his psychologist documented that Mr. Doe had reported how his mental health decline has impacted his occupational functioning. It was also affecting his mood as documented in that same note that his coworkers didn’t find him approachable or friendly. Mrs Doe was even documented as noticing changes in his mood and increasing anxiety. Mr. Doe verbalized not wanting stress to negatively impact his job and being unaware of changes to his mood and being unaware of how it was affecting those around him. Mr. Doe also correlates anxiety as a contributing factor to the motor vehicle accident which occurred on 06.18.2019. Just six months following the subject accident on 12.10.2018. It was also at this time that Mr. Doe lists his marital status as ‘single’ while on his previous injury report he lists his marital status as ‘married’. The treating provider also documented,” It is my opinion that the patient is not fit for duty of any kind with the company at this time in his current mental state.” In a progress noted dated 09.16.2019 his psychologist documents that Mr. Doe has “been off work for approximately 9 weeks on a leave of absence. He was seen on 09/16/2019, and he needs to stay on stress related leave for approximately another week.” He was scheduled for surgery on his neck shortly afterwards and the psychologist did “anticipate that his stress will be adequately resolved such that he will be ready to return to work after recovery from the neck surgery.” In documentation dated 10.04.2019 Mr. Doe was expected to be on temporary disability from “09/20/219 [day of surgery] through 10/03/19”. In documentation dated 10.09.2019 it was stated that Mr. Doe would remain off work until 11.19.2019. Documentation date 01.28.2020 reported a “return to modified work on 1-29-20.” In documentation dated 01.29.2020 his psychologist documented “it is my professional opinion that he is able to return to work as of January 30, 2020. In the evaluation report from neurosurgery on 08.18.2020 it lists “short term memory issues and cognitive issues” under the chief complaint. There were no other references made to this in the records provided. Could it be related to age.. stress and anxiety.. medications.. the accident? Difficult to say without looking at all of his records. These were not diagnoses listed in his prior history or mentioned in any of the records provided. Would be interested in seeing what Mr. Doe was meaning by this.

# Discussion of Diagnoses

# Cervical strain -- A strain is an injury to muscles or tendons

# Cervical sprain – A sprain is an injury to the ligaments and capsule of a joint in the body.

# Cervical Radiculopathy – Cervical radiculopathy is caused by a pinched nerve in your cervical spine (your neck). More specifically, it happens when one of your nerve roots (where your nerves join your spinal column) is compressed or irritated. Radiculopathy will cause the area around your pinched nerve to feel painful, numb or tingly.

# Cervical Spondylosis – Cervical spondylosis, sometimes called arthritis of the neck, is a general term for wear and tear that affects your cervical spine. If you have cervical spondylosis, your neck may ache, hurt or feel stiff. Healthcare providers can’t cure cervical spondylosis, but they can keep it from getting worse. Just as important, there are things you can do to protect your neck.

# Small posterior osteophyte disc complex – Disc osteophyte complex is the development of osteophytes (bone spurs) affecting more than one intervertebral disk or spinal vertebrae. Osteophytes or bone spurs develop in the musculoskeletal system due to normal wear and tear as you age.

# Mononeuropathy bilateral upper extremities – Mononeuropathy is damage that happens to a single nerve, usually one that is close to the skin and near a bone. One of the best known forms of mononeuropathy is carpal tunnel syndrome. Treatments range from relieving the pressure on the nerve to analgesics and steroid injections to surgery. Carpal tunnel is most common form of mono neuropathy.

# Cervical stenosis – Cervical spinal stenosis is a broad term which refers to a range of symptoms which can result from the narrowing of the spinal canal in the neck. This may be due to age, injury, or degeneration.

# Spinal stenosis – Narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal nerves leave the spinal column.

# Grade 1 retrolisthesis of C5 on C6 – Retrolisthesis is a medical term used to describe a condition in which one vertebra in the spine slips backward in relation to the vertebra below it. This is the opposite of anterolisthesis, where the vertebra slips forward.

# Central canal stenosis – The spinal is a long tunnel that runs down the center of the spine. This canal sits directly behind the bony blocks, or vertebrae, which forms the spine. It contains the spinal cord and nerve roots. When the spinal canal is narrowed, the spinal cord and nerve roots may be compressed. This is referred to cervical canal stenosis.

# Neural foraminal narrowing (stenosis) – Nerves run from all parts of the body to the spinal canal and continue up the spinal cord to the brain. The nervous system responds to information from the senses and triggers reactions. Neural foraminal stenosis occurs when the foramen of the neck (cervical stenosis) compress or narrow, trapping the nerve root. Neural foraminal stenosis refers to the narrowing of the small openings between the vertebra in the spine which nerve roots pass through.

# Carpal tunnel – Carpal tunnel syndrome is when the median nerve is compressed as it passes through the carpal tunnel. The carpal tunnel is an opening in your wrist that is formed by the carpal bones on the bottom of the wrist and the transverse carpal ligament across the top of the wrist. The median nerve provides sensory and motor functions to the thumb and 3 middle fingers. If it gets compressed or irritated, you may have symptoms which can include: loss of strength in hand, sensation of pins and needles in the hand, forearm tenderness, pain radiating up the arm, weak grip strength, pain during the night starting gradually.

# Posterior disc protrusion (bulge) – A bulging disc in the neck occurs when a spinal disc weakens and encroaches on the spinal cord. This can cause pain in the neck, shoulders, arms, and back. Treatment can depend on how serious it is. These structures in the spine tend to weaken over time, so aging can increase the risk of a bulging disc in the neck. These structures in the spine tend to weaken over time, so aging can increase the risk of a bulging disc in the neck.

# Muscle spasms – involuntary contractions, or tightening, of your muscles. Spasms usually accompany other symptoms like neck pain and stiffness. Neck sprains and strains are the most common causes, but injuries and more serious conditions can also cause spasms.

# Nerve distribution – The peripheral nervous system consists of the nerves that branch out from the brain and spinal cord. These nerves form the communication network between the CNS and the body parts. The peripheral nervous system is further subdivided into the somatic nervous system and the autonomic nervous system

# Decreased upper extremity deep tendon reflexes – The reflex exam is fundamental to the neurological exam and important to locating upper versus lower motor neuron lesions. Similar to motor and sensory tests, specific reflexes are activated at specific spinal levels. There are five deep tendon reflexes and a number of superficial and visceral reflexes covered here. Hyporeflexia happens when your skeletal muscles have a decreased or absent reflex response. An absent reflex response is also called areflexia. A reflex is an involuntary (automatic) action your body does in response to something. Reflexes protect your body from things that can harm it. Hyporeflexia results from any interruption of the reflex arc, which has a sensory part, a central part (spinal cord) and a motor part. Damage to any of the parts (sensory nerves, spinal cord or motor nerves) can potentially cause hyporeflexia. If the damage is to your motor nerves or motor nerve cells, it’s called a lower motor neuron lesion.

# Weakness secondary to nerve root compression – Your motor nerves control your muscles. Nerve compression syndromes can result from pressure on a peripheral nerve. You may have limb weakness, numbness, pain or tingling.

# Intractable neck pain – Intractable is an adjective meaning not easily controlled or directed; not docile or manageable; stubborn; obstinate. In this case it is referring to neck pain that is not easily controlled.

# Disc herniation – Each disc contains a soft inner substance with a surrounding outer layer, which maintains the structure of the disc. A herniated disc occurs when damage to the outer layer causes the inner substance to leak out of the disc. The causes of bulging or herniated discs include sudden or long-term trauma.

# Collapse of disc height – Weakened or torn annulus fibrosus can cause discs to bulge or become herniated. This causes the disc to lose its normal height and "collapse." Both of these conditions may cause pressure upon adjacent nerve roots. This can cause symptoms including numbness, tingling, weakness or pain.

# Lumbar radiculopathy – Cervical radiculopathy is caused by a pinched nerve in your cervical spine (your neck). More specifically, it happens when one of your nerve roots (where your nerves join your spinal column) is compressed or irritated. Radiculopathy will cause the area around your pinched nerve to feel painful, numb or tingly

# Uncovertebral joint spurring - The neck is made up of seven stacked bones — the cervical vertebrae. The cervical disks lie between these bones, acting as shock absorbers and allowing for flexibility in the neck. Uncovertebral joints are small joints that sit on each side of the cervical disks. They are not present at birth. They develop as a person grows. The uncovertebral joints allow for flexibility, movement, and stability within the neck and limit sideways movement. Additionally, the uncovertebral joints work to protect the spinal disks and prevent slipped disks. Another function of these joints is to protect the intervertebral foramen. This is the passageway between vertebrae that allows nerve roots to travel through the spinal cord. The degeneration typically begins when a person is in their 20s. It becomes more severe when people are beyond their 70s. A 2022 study suggests that the following factors may affect the rate of degeneration: sex, age, history of neck trauma.

# Legal Nurse Discussion and Opinion Based on the Medical Records Provided

# Based on the review of the medical records made available to this writer, it is my opinion that Mr. Doe’s current complaints and problems are related to the injuries he sustained as a result of the initial motor vehicle accident which occurred on 12.10.2018.

# There are many that might focus on the size of the truck vs the size of the car or feel as if going 30mph isn’t fast enough to cause symptoms as severe or longstanding as Mr. Doe is reporting. In reality, many whiplash injuries from motor vehicle accidents occur at speeds as low as five to 10 mph. Although neck pain is common immediately after a whiplash injury, some people don’t experience pain until a few hours, days or even weeks later. Severity can often depend on whether the injured was wearing a seatbelt. It was documented that Mr. Doe was wearing a seatbelt at the time of the accident. A delay in seeking treatment can alter the course of recovery. Documentation has shown that Mr. Doe was seen immediately afterwards and was compliant with whatever treatment was offered at that time and throughout all records provided.

#  Older people, and those who already have neck problems such as arthritis, may experience more serious whiplash than a younger person. As people get older, their movement is more limited, their bones are less dense, their muscles lose flexibility and strength, and their discs and ligaments are not as stretchy. So when their neck whips back and forth, there’s more potential for damage. Mr. Doe does have a documented history of prior neck and back injuries with treatment. But, Mr. Doe has imaging reports and provider notes to support the fact that although he did have an existing back or neck problem these problems were stable. A Lumbar MRI done on 09.04.2018 documented “multilevel chronic degeneration without significant central spinal canal narrowing. Without significant changes at L1-2 there is a disk extrusion. Neural foramina otherwise without significant change since prior study”, which is documented as 11.17.2015. Mr. Doe was able to function in the work place, he was able to tend to his activities of daily living, his anxiety and stress levels were never documented as causing friction in his personal or professional relationships. These symptoms and problems started to occur after the accident on 12.10.2018.

# Numerous studies have indicated that preoperative depression and anxiety affect surgical outcomes and patient satisfaction. They are associated with poorer patient reported outcomes following cervical spine surgery. The negative effects of depression and anxiety on surgery outcomes may currently be underestimated, since mental health status is not evaluated routinely in clinical practice. Mr. Doe has a preoperative diagnosis of depression and anxiety. There was no indication in his records that his anxiety or depression weren’t controlled. This is why it is beneficial for spine surgeons to identify cervical degenerative disc disease patients who are susceptible to depression and anxiety. There is no documentation supporting that this was ever addressed prior to, or following surgery.

# Mr. Doe did everything he should’ve been doing. He wasn’t documented as driving recklessly. He was simply stopped at a light waiting for his turn to go. He was wearing his seatbelt as required by law. He had participated in every medical intervention he was offered in order to keep his conditions stable. All of that effort was all for not on the day that that Prius rear ended him. It is also my opinion that Mr. Doe will certainly require future, lifelong, medical care ranging from mild and conservative to more complex surgical interventions. The Eggshell Plaintiff doctrine dictates that the liable parties involved are responsible for the entirety of the harm they inflict, regardless of what vulnerabilities existed prior to the subject accident. Despite a victim’s heightened susceptibility because they have conditions that were present prior to the accident the parties at fault remain responsible for these newly added consequences.

# Legal Nurse “Next Step” Recommendations

#  Please schedule a call with our LNC after you review to discuss this case.

# Medical Record Retrieval: video footage of accident; old records focused on his neck and back

# Please have your firm request the medical records listed below:

|  |  |  |  |
| --- | --- | --- | --- |
| Record Type and Date | Facility | Date Requested | Date Received  |
| Psychotherapist’s dictated notes – curious if he was ever prescribed anything new for the increasing anxiety | Unknown – possibly VA |  |  |
| Results of post-accident drug test | Worker’s Comp |  |  |
| Long Beach Police Records | Long Beach Police Dept |  |  |
| Investigation report with details of the of accident.. speed of Prius | Long Beach Police Dept |  |  |
| EMS records | EMS |  |  |
| ER records | Generic Hospital |  |  |
| Military records – how much jumping did he do and how long; any treated injuries? | VA |  |  |
| Primary Care Provider for documentation of anxiety and depression timeline | Possibly VA vs Private sector |  |  |
| MRI of cervical spine prior to 12.10.2018 | Possibly VA |  |  |
| Rehab Therapy Notes prior to 12.10.2018 to compare ROM | Possibly VA or occupational medicine |  |  |
| Driving records / police records | DMV – how many past accidents Mr. Doe was involved in  |  |  |
| MRIs of Lumbar spine past and present | Possibly VA |  |  |
| Records discussing his back pain and conditions associated with it. There was very little included in these documents. | PCP, pain clinic, radiology |  |  |

# Expert Location and Screening:

# Recommend an expert on whiplash in a patient with pre-existing medical conditions similar to Mr. Doe

# Recommend an expert on the effects of cervical instability on mood changes specifically anxiety and depression

# Expert on the affects of preoperative conditions such as anxiety and depression on the clinical outcome of chronic pain patients undergoing surgical repair on the spine

# NNC can help find and facilitate experts for your case.

# Research and Summarization of Authoritative Literature: (If you feel like in depth research should be done on the subject matter to strengthen the case please state so)

# [*https://caringmedical.com/prolotherapy-news/dissociation-anxiety-depression-uncontrolled-emotion-cervical-spine-instability-patients/#:~:text=Part%201%3A%20Personality%20changes%20and,discussed%20by%20Ross%20Hauser%2C%20M.D*](https://caringmedical.com/prolotherapy-news/dissociation-anxiety-depression-uncontrolled-emotion-cervical-spine-instability-patients/#:~:text=Part%201%3A%20Personality%20changes%20and,discussed%20by%20Ross%20Hauser%2C%20M.D)*.*

# [*https://pubmed.ncbi.nlm.nih.gov/16094160/*](https://pubmed.ncbi.nlm.nih.gov/16094160/)

# [*https://journals.lww.com/clinicalpain/abstract/2006/06000/the\_association\_between\_anxiety\_and\_chronic\_pain.12.aspx*](https://journals.lww.com/clinicalpain/abstract/2006/06000/the_association_between_anxiety_and_chronic_pain.12.aspx)

# [*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9853204/*](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9853204/)

# [*https://pubmed.ncbi.nlm.nih.gov/20671380/*](https://pubmed.ncbi.nlm.nih.gov/20671380/)

# [*https://pubmed.ncbi.nlm.nih.gov/33424749/*](https://pubmed.ncbi.nlm.nih.gov/33424749/)

# [*https://centenoschultz.com/condition/craniocervical-instability/*](https://centenoschultz.com/condition/craniocervical-instability/)

# *https://centenoschultz.com/symptom/brain-fog/*

# Possible Defenses:

# *PRE-EXISTING CONIDITIONS*: Mr. Doe has a long standing, well documented history of chronic back pain, neck pain, bilateral knee pain, numbness and tingling to extremities, decreased sensation to both hands and feet, multiple therapies including physical therapy, occupational therapy, rehab, various types of pain medications, injections in knees, injections in his back, simple procedures, complex surgeries etc. Mr. Doe is documented as reporting that he was a paratropper in the military with over 300 jumps out of an airplane, then did a lot of lifting with 105lb rounds. He admits that his chronic pain started in his early 20s. Some could argue that it was only a matter of time before Mr. Doe would begin to experience his current symptoms. Even he foresaw this. In note dated 07.10.2018, five months prior to accident, he verbalizes “fear of unknown debilitating back and neck issues.” Complaints of bilateral lower extremity numbness and tingling documented as far back as 2010. Presence of peroneal sensory neuropathy was also found in documentation in 2010. Diagnosis of right shoulder impingement was documented in 2011. Numbness in both legs from mid/lower thigh down documented in 2013. Spinal stenosis, mild, found in documentation in 2013. Leakage of urine and stool found in documentation from 2013. Pain consultation at the end of 2013 documents that Mr. Doe periodically fell because his feet are so numb that he can’t recognize where his legs are.

# *OBESITY*: Mr. Doe has a documented history of obesity. Most people would agree that it’s common knowledge that the more weight you carry on your body the more wear and tear you have on your joints. There are several medical progress notes that discuss weight loss with Mr. Doe but you don’t see any documented weight loss in those records provided.

# *HISTORY OF ANXIETY:* Numerous studies have indicated that preoperative depression and anxiety affect surgical outcomes and patient satisfaction. It has been documented that depression and anxiety have been reported as risk factors for complications, readmission, and revision following cervical spine surgery. In addition, mental stress related symptoms, including depression and anxiety, are associated with changes in masticatory muscle symmetry, indicating that mental state is related to muscle function. In a VA Mental Health Note dated 07.10.2018 Mr. Doe was found to have a GAD-7 score of 10 indicative of moderate anxiety. In that same note Mr. Doe was found to have a PHQ-9 Depression Scale Score of 15 indicating moderately severe depression. He had been referred to the VA Mental Health for anxiety and depression. His anxiety and stress eventually led to Mr. Doe having a second motor vehicle accident on 06.18.2019. Defense could argue that it was Mr. Doe’s lack of taking into account his long standing history of anxiety and depression that led to his poor post operative conditions. If someone had been more conscious of this and monitored him closely prior to, and following, the surgery perhaps the pain and physical limitations would not have been so life altering.

# *NONCOMPLIANCE/ABUSE:* This may be a bit of a stretch as there is little documentation to make a strong case but it can be added as an adjunct piece of evidence. In a Physical Rehab note dated 07.19.2019 it documents that Mr. Doe no-showed [didn’t show up] for TaiChi twice. This is part of his occupational therapy. He was discharged from class due to this. Did he take his therapy seriously or decided to pick and choose which ones he thinks he should be doing? In a PCP visit note dated 12.24.2019 Mr. Doe’s PCP notes that he had to remind Mr. Doe what his maximum allowed daily dose of gabapentin is. According to this note he had previously been prescribed Gabapentin 400mg and instructed to take 3 capsules TID [3 times a day – typically morning, mid afternoon, and evening/bedtime]. This would equate to Mr. Doe taking 3600mg/24 hours. Mr. Doe admits that he has been taking 4 pill in his first [AM] dose, then another 4 pills in his second [midafternoon] dose and then 2-3 pills in his third [evening/bedtime] dose. This would equate to 4000-4400mg/ 24 hrs. Mr. Doe is not taking medications as prescribed. This is not only illegal but unsafe as well. This is another sign of defiance. He is deliberately defying a doctor’s order and openly admitted it to his PCP. Is he claiming more pain than is present to obtain more medication?

# *MULTIPLE CAR ACCIDENTS:* The subject accident occurred on 12.10.2018. Mr. Doe was involved in a second motor vehicle accident (MVA) on 06.18.2019 which he attributed to high blood pressure, anxiety and stress. Mr. Doe was taking a lot of medications, some of which have side effects of sedation/drowsiness. On of those medications is Gabapentin, which was mentioned above, as being taken inappropriately. Were medications a factor in this second accident? Did Mr. Doe allow his stress and anxiety to take over and he began driving recklessly or aggressively? In addition to this second MVA, Mr. Doe was involved in a third MVA that was documented as occurring in July 2020. There were no details or a documented report. It was documented by neurosurgery during his consultation on 08.18.2020. So Mr. Doe was involved in three separate MVAs in 19 months. Either he's the unluckiest driver in town or his actions played a part in the cause of some of the MVAs. What did his driving history look like prior to 12.10.2018?