Sample Report #1

PHYSICIANS LEGAL CONSULTANTS
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August 3, 2014

Tom Smith, Esq.
Law Office of Tom Smith, P.C.
123 Main Street
Denver, CO 80246

Re: KK

Dear Mr. Smith,

I have reviewed the medical records you provided concerning your client KK. This report will clarify Ms. KKôs injuries as a result of the August 6, 2013 auto crash. I will also comment on her future medical care & costs. KK is 21 years old.

Records Reviewed:

Traffic Accident Report-Parker Police Department-8-6-13

Augustine Hospital-Emergency Department-8-06-13

Romulus Hospital-Emergency Department-8-07-13

Romulus Hospital-Emergency Department-3-12-14

Westside Orthopedic Center PC-9-15-13

Neurorehabilitation Services, PC-11-11-13

S. M. W., DDS-10-4-13

Neuropsychological Partners, PC-11-1-13

E. M., O.D.-12-5-13

Western State University-Resources for Disabled Students 12-6-13

Rafael Hospital Anesthesia Center 8-11-13

Rafael Hospital Surgery Center 8-11-13

Brief History of Events:

As you know on August 6, 2013 KK was a properly restrained front passenger of her vehicle, a 2010 Subaru Outback. KKôs car was proceeding forward with a green light. The offending vehicle, a 2011Cadillac Escalade, made a left turn against a red light and KKôs car crashed into the front driverôs side of the offending vehicle. It should be noted her airbag did deploy. The right side of KKôs face and head struck the air bag. KK reports a brief loss of consciousness and post-traumatic amnesia. It is estimated that that KKôs car crashed going approximately 45 mph. The car in which KK traveled was totaled. Immediately after gaining consciousness KK reported being ñdazed and confused.ò

KK also immediately complained of right wrist pain. KK reports she stuck out her right arm to break her momentum and felt sharp right wrist pain as her arm hit the dashboard. The impact caused KKôs wrist to be ñshattered.ò She was subsequently diagnosed with a severe comminuted (a fracture in which a bone is broken, splintered, or crushed into a number of pieces) fracture of the right distal radius with fracture line extension into the radiocarpal joint.

KK was transported by ambulance to Augustine Hospital and seen in the Emergency Department. Initially, KK complained of dizziness. KK was diagnosed with ñclosed head injuryò and ñneck strain.ò In addition, as noted above she was also diagnosed with a wrist fracture.

The following day, August 7, 2013 KK returned to Augustine Emergency Department complaining of bi-temporal headache, dizziness, intermittent neck pain, nausea and vomiting. She also complained of ongoing wrist pain. KK left with a diagnosis of ñclosed head injuryò and was to follow up with Westside Orthopedic Center regarding her fractured wrist.

Ongoing Medical Problems:

It is my opinion to a reasonable degree of medical probability as a direct consequence of the August 6, 2013 auto crash KK has been left with several ongoing medical problems which are outlined below.

Traumatic Brain Injury

1. Cognitive Deficits

KK now complains of a number of ongoing cognitive deficits. She complains of memory loss, attention difficulty and rapid mental fatigue in which she ñspaces out.ò She also has difficulty with word finding, difficulty learning new material, difficulty retaining new material, decreased coordination, difficulty processing information, decreased ability in reading and spelling, easy distractibility, inability to multi-task, inability to organize thoughts and activities and a significant loss of math skills. KK feels that her loss of short term memory affects her in most of her every day activities and has disrupted just about every activity that she ñused to take for granted.ò

KK also reports the onset of difficulty falling and staying asleep since the auto crash. Her sleep disturbance has persisted.

KK was forced to change her major in college and drop her plans to major in finance. In fact, she was deemed disabled by her school, Western State University.

KK has experienced the deficits outlined above for approximately 2 years now since the accident. She reports no improvement in these cognitive problems over time. She is involved in Neuro-Psychological Rehabilitation to learn compensatory strategies to improve overall cognitive functioning. This kind of rehabilitation does not ñcureò cognitive deficits; it does help teach the impaired person to compensate with strategies known to reduce the effects of the brain injury.

It is my opinion to a reasonable degree of medical probability KK suffered a Mild Traumatic Brian Injury and subsequent Post-Concussion Syndrome as a direct result of the August 6, 2013 auto crash.

Given two years have passed since the crash, it is my opinion to a reasonable degree of medical probability that KKôs cognitive problems from her traumatic brain injury secondary to the auto crash are permanent.

The mechanism of action of injury is that when a person has a whiplash event or directly hits their head, there is a coup/contacoup event in which the brain moves back and forward inside of the skull with enough force to cause shearing of the brainôs nerve cells as well as causing a contusion (bruising) of brain tissue. This type of shearing of nerve cells is felt to be tearing of the axonal part of the nerve which disrupts normal electrical brain activity. Clinically this circumstance is noted as a concussion. The area of the brain that is damaged can cause biochemical and structural brain changes that can be permanent which is the case for KK. In the August 6, 2013 accident KK sustained a traumatic brain injury resulting in Post-Concussion Syndrome with several sequelae.

KK denies any of these cognitive problems before the auto crash. As noted in the medical record KK did have a previous concussion in March 2007, however she made a full and complete recovery from that concussion in a relatively short period of time.

It is well documented in the medical literature that cognitive loss is a common symptom of Post-Concussion Syndrome. KK has multiple cognitive complaints.

In 2007 Freeman et al. in *Whiplash and Causation* demonstrate a practical method for individual clinicians to determine causation following traumatic injury. According to a 2009 follow-up journal article by Freeman et al. titled *A Systematic Approach to Clinical Determinations of Causation in Symptomatic Spinal Disc Injury following Motor Vehicle Crash Trauma* KK meets traumatic injury symptom causation requirements for her cognitive loss.

Freeman et al. report that there are three criteria that must be met. First, there must be a biologically plausible or possible link between the exposure and the outcome. In the auto accident KK was thrown forward and back resulting in whiplash (exposure). The medical literature makes it clear whether she lost consciousness is inconsequential to making a diagnosis of TBI. Lovell et al. in a 2010 article in Clinical Journal of Sport Medicine titled *Does Loss of Consciousness Predict Neuropsychological Decrements After Concussion* report ñthere were no significant differences found between LOC, no LOC or uncertain LOC groupsò referring to the severity of TBI symptoms.

Clearly, the auto crash of August 6, 2013 (exposure) creates the link between the accident and the onset of KKôs TBI symptoms (outcome). KK complained of cognitive difficulties not described before the accident.

Second, there must be a temporal relationship between the exposure and the outcome. Starting immediately after the accident (exposure) KK complained of experiencing the cognitive symptoms outlined above (outcome). She has continued to consistently report these symptoms to her treating physicians. In fact, KK felt her cognitive symptoms worsened over time.

It is well described in the literature that there are at least two explanations for the ñworseningò of cognitive symptoms over time. It is not uncommon for an individual to under report cognitive loss in the days, weeks or even months after a traumatic brain injury as well as present with the late onset of cognitive loss symptoms. In addition, cognitive symptoms are often masked by more immediate patient & physician concerns such as pain and other symptoms that are immediately of more concern and difficulty. In this case KKôs wrist pain and fracture were most prominent in her mind.

The symptoms of cognitive loss can be confusing to the patient and misinterpreted by the patient and doctors alike. LM Ryan and DL Warden in a 2003 article in *International Review of Psychiatry* **15** (4): 310-316 titled *Post Concussion Syndrome* report ñsymptoms such as noise

sensitivity, problems with concentration and memory, irritability, depression, anxiety, fatigue and poor judgment may be called ólate symptomsô because they generally do not occur immediately after the injury, but rather days or weeks after the accident.ò

In a 1995 paper by P. Karzmark; K. Hall; and J. Englander titled *Late-Onset Post-Concussion Symptoms after Mild Brain Injury: The Role of Premorbid, Injury-Related, Environmental, and Personality Factors* the authors discuss the factors that contribute to late onset symptoms.

The third criterion states there must not be a more likely or probable alternative explanation for the symptoms. It is my opinion there is not a more likely or probable explanation for KKôs cognitive loss.

Verbatim Notes from her providers substantiate this conclusion:

M E, M.D.

8-06-13

Discharge diagnosis: Closed head injury.

D R, M.D.

8-07-13

She returns now stating that she has developed a bi-temporal headache associated with dizzinessé also complaining of intermittent neck and abdominal pain.

Discharge diagnosis: Closed head injury

J W, M.D.

10-23-13

KK noted head and neck pain. Since the accident she has had short-term memory problems. It is hard for her to concentrate. She has trouble with simple math problems. She forgets names and conversations.

Diagnosis: Grade 3 concussion

D H, Ph. D.

3-20-14

Below average attention, concentration and fine discrimination. Below average motor speed,

impairment of verbal learning, below average retention of newly learned information, mild to moderate impairment of learning complex nonverbal information, moderate to severe impairment of language comprehension.

2. Mood Disorder

KK reports ongoing chronic anxiety made worse by traveling in a car. She also has ongoing irritability and emotional lability. She complains of post-accident intermittent depressed mood. KK reports ñI get worked up a lot easier.ò She goes on to state ñMy emotions take control of me.ò Initially KK noticed she felt depressed, however, her ongoing mood problems are anxiety and emotional lability. She denies any of these mood problems prior to the accident.

Given two years have passed since the crash; it is my opinion to a reasonable degree of medical probability that KKôs Mood Disorder is permanent. She may get some symptomatic relief from medications; however, her Mood Disorder is permanent.

Depression is one of the most common problems of TBI. Jorge et al. in Archives of General Psychiatry Vol. 61, No. 1, Jan. 2004 state ñMajor depressive disorder was observed in 30 (33%) of 91 patients during the first year after sustaining a TBI. Major depressive disorder was significantly more frequent among patients with TBI than among the controlsé Major depression is a frequent complication of TBI that hinders a patient's recovery. It is associated with executive dysfunction, negative affect, and prominent anxiety symptoms. The neuropathological changes produced by TBI may lead to deactivation of lateral and dorsal prefrontal cortices and increased activation of ventral limbic and paralimbic structures including the amygdala.ò

3. **Generalized Fatigue**

Since the accident KK reports generalized fatigue in addition to experiencing rapid mental fatigue. She states ñI always feel tired in the morning no matter how much sleep I get.ò The fatigue occurs daily and KK reports never having chronic fatigue before the auto crash.

It is my opinion to a reasonable degree of medical probability that KKôs chronic fatigue is post-traumatic, related to her brain injury and permanent. In fact, chronic physical and/or mental fatigue is a hallmark problem of Traumatic Brain Injury. I can supply you with the medical literature if you so request.

4. Post-Traumatic Headaches

KK reports the onset of headaches immediately after the accident. Initially the headaches were constant now KK reports she gets 6-7 ñbad headachesò per month. The headaches are characterized by intense bilateral temporal pain radiating posteriorly, with pain worse on the right side. She describes the pain as ñsharp and crushing, like being punched in the head.ò KK reports the severe headaches rate 7/10 on a pain rating scale.

It is my opinion to a reasonable degree of medical probability that KKôs headaches are post-traumatic, related to her brain injury and permanent. It is an unfortunate yet common problem for victims of head injury. In fact, post-traumatic headaches are the most common residual problem with traumatic brain injury. There is ample evidence in the medical literature to support this opinion. Again, I can provide you with articles if needed. KK is not financially able to get medical follow up for the headaches and I believe she would benefit from treatment and get some symptomatic relief from medications.

Verbatim Notes from her providers substantiate this conclusion:

J W, M.D.

10-23-12

She gets headaches. They may be too severe, but constant. She has the less intense ones daily, but the shooting pain types several times per week.

Diagnosis: Post traumatic cervical whiplash, headaches, right jaw involvement.

1-23-13

Headaches: Several per week. No clear precipitants.

J W, M.D.

10-23-12

Post-traumatic adjustment disorder with depression, anxiety.

D H, Ph. D.

3-20-13

Persistent problems with fatigue, irritability and emotional lability.

Temporal Mandibular Joint Disorder (TMJ)

KK reports the onset of bilateral jaw pain since the accident. She continues to experience pain with chewing, more so on the right-side. She states ñmy jaw gets tired too quickly.ò She reports eating is more a task than a pleasure. KK states ñitôs always pretty uncomfortable.ò Normal talking will create pain she says which rates a 3/10. When using her jaws more consistently, for example eating a full meal, her pain can be as high as 8/10.

It is my opinion to a reasonable degree of medical probability that KKôs TMJ Disorder is post-traumatic and related to the auto crash.

Verbatim Notes from her providers substantiate this conclusion:

S W, DDS, MPS

9-21-13

Assessment: Diagnosis is trauma to the TM joints, cervical and masticatory myalgia, synovitis of the temporomandibular joints and temporal tendonitis, all of traumatic etiology.

Comminuted Fracture of the Right Distal Radius with Ongoing Pain & Sensory Loss in the Right Upper Extremity

KK reports in addition to chronic pain she also continues to experience paresthesias, specifically numbness and loss of sensation, in the right upper extremity. KK reports the sensation loss and numbness start in the right hand palm and radiate into the right wrist itself. As with the problems related to pain, KK has been forced to give up many activities because of this nerve damage problem. KK was an avid piano and guitar player and can no longer play either instrument. She also has to be very careful in picking up objects as she does not have the sensory feedback to hold objects in her right hand.

Verbatim Notes from her providers substantiate this conclusion:

Westside Orthopedic ï Dr. H.H.
8-9-13
Fracture right distal radius. Maintain R arm splint until follow-up.
RT wrist to mid forearm. No priors.
Severely comminuted, mildly impacted fracture of the distal radius with fracture line extension into the radiocarpal joint.
Rafael Hospital Surgery Center 8-11-13
Planned procedure: ORIF R distal radius fracture.
Open reduction and internal fixation, right distal radius fracture.
21-year-old woman in MVA. This was a fracture that it was determined needed be fixed in surgery. After adequate manipulation and reduction maneuver, a Synthes volar distal radius plate was placed on the distal radius itself and position was confirmed under both AP and lateral fluoroscopic imaging. The plate was affixed to the shaft of the radius with 1 cortical screw. Condition stable.
8-11-13
Procedure: Revision, open reduction and internal fixation of right distal radius fracture. During follow her follow up was found to have a shift, especially of his radial styloid fragment to a

unacceptable position. It was determined that a repeat open reduction internal fixation was necessary. Disposition: The patient was extubated and taken to recovery room in stable condition.

Medical Costs to Date

Augustine Hospital	$ 4,797.26
Orthopaedic Center	$ 615.00
Fire Protection District	$ 807.00
E M, M.D.	$ 1,875.00
Neuropsychology	$ 7075.00
S W, DDS	$ 1,385.00
Replacement Glasses	$ 281.43
J W, M.D.	$ 955.00
Neuro-Rehabilitation	$ 2,300.00
H.H., M.D Orthopedics(out-pt & surgery)	$ 16, 843.00
Rafael Anesthesia	$ 3,870.00
Rafael Surgery Center	$ 21,802.97
Total	$ 62,606.66

It is my opinion all medical costs to date are reasonable, necessary and related to the auto crash on August 6, 2013.

Future Medical Care & Costs

It is my opinion to a reasonable degree of medical probability that based on the above injuries here is a breakdown of KKôs future medical costs. These costs are based on a life expectancy of 57.3 years at age 21. This value is calculated using the Insurance Claims Resource table. In summary, KK will require comprehensive Psycho-Neurological Care. She already has had initial Neuro-Psychological testing and will need this testing repeated one or two years from the

date of this report. She is currently engaged in Neuro-Psychological Rehabilitation. The rehabilitation provides the patient with compensatory strategies to overcome lost cognitive functioning. In addition, comprehensive rehabilitation of this kind of treatment also usually includes psychotherapy and psychiatric medication treatment. After an initial course of comprehensive treatment occasional brief follow up treatment will be needed based on the severity of her traumatic brain injury. A psychiatrist is best suited to prescribe her psychotropic medication. In fact, KK needs one doctor òquarterbackingò all of her care and in this case I believe either her psychiatrist or neurologist would be in the best position to serve that function.

The clientôs headaches should be followed by a neurologist specializing in the treatment of headaches. There are several medication approaches to this problem that are helpful and that have not yet been explored in KKôs case.

If KKôs sleep disorder does not remit soon, I would suggest a work up at a sleep laboratory. Based of the results of the work up, KKôs psychiatrist can be in charge of medication treatment for her sleep disorder.

KK also needs follow up care for her temporomandibular joint disorder. She will most likely need additional orthotics as part of her TMJ treatment. KK needs to be followed by a dentist who specializes in TMJ Disorder.

KK will also need follow up for her right upper extremity injury including orthopedic follow up and neurologic follow up as well as physical therapy. If her symptoms do not improve a revision surgery may be required but not included in this assessment.

Finally, the treating physicians will all prescribe various medications, testing and imaging for KKôs conditions resulting from the accident.

Please see the chart on the following page.

Estimated Costs of Future Lifetime Medical Expenses:

Neuro-Psychological Care including Cognitive Testing, Rehabilitation and Counseling and Follow Up	$ 17,000
Psychiatrist	$ 12,000
Neurologist	$ 13,000
Orthopedics	$ 13,000
Physical Therapy	$ 10,000
TMJ Dentist & Orthotics	$ 15,000
Sleep Lab	$ 5,000
X-Rays and Scans	$ 10,000
Medications	$ 24,000
Total	$ 119,000

If you have further questions, please contact me. My CV is enclosed.

Regards,

Armin Feldman, M.D.
Physicians Legal Consultants LLC

Sample Report #2

PHYSICIANS LEGAL CONSULTANTS
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December 7, 2014

Susan Smith, Esq.
Smith, Jones & Gomez, P.C.
42 Iron Street
Denver, CO 80015

Re: B. B.

Dear Ms. Smith,

You have asked me for my comments and opinions regarding the November 10, 2014 Independent Medical Exam (IME) report done by Jay Gatsby, M.D. concerning your client B. B.

I attended the October 15, 2014 Independent Medical Exam of Mr. B conducted by Dr. Gatsby. I have reviewed Mr. Bôs medical records related to his case. In addition, I interviewed Mr. B by telephone on October 8, 2014.

I disagree with Dr. Gatsbyôs reasoning, opinions and conclusions. I will quote from Dr. Gatsbyôs IME report dated October 15, 2014 and then respond.

Dr. Gatsby states ñThe surgery was successful. A repeat arthrogram did not demonstrate any leakage of dye. Even if the MRI scan had demonstrated a leakage of dye, in fact after a single layer arthroscopic repair, this is not an unexpected finding and it does not correlate with the functional outcome following a rotator cuff tear repair. Regarding the causation, Mr. B is not a candidate for a second surgical intervention. A second arthroscopic rotator cuff tear repair will in no way improve Mr. Bôs function and it will not improve his pain.ò If success of the surgery is measured by dye leakage on arthrogram after a rotator cuff repair then I would agree with Dr. Gatsby. It is my opinion most surgeons would consider shoulder function, range of motion and degree of pain as indicators of surgical repair success.

I do not understand Dr. Gatsbyôs phrase ñRegarding the causation.ò It is my opinion to a reasonable degree of medical probability that the causation of Mr. Bôs injury is lifting

metal stacking plates at work since immediately after lifting these plates Mr. B became symptomatic. Mr. B did not have a significant reduction in symptoms after his December 1, 2013 rotator cuff repair. A repeat MRI post-op did show a residual tear on the bursal side of the supraspinatus tendon. Unfortunately, residual tears are noted in some patients after rotator cuff repair surgery. It should also be noted that Mr. B did return to work three months after his injury but had to discontinue working due to his shoulder pain. Clearly, Mr. Bôs continued symptoms are from his work-related injury.

The absolute nature of Dr. Gatsbyôs conclusion ñA second arthroscopic rotator cuff tear repair will in no way improve Mr. Bôs function and it will not improve his painò can not be made. There is an abundance of evidence in the surgical literature that refutes Dr. Gatsbyôs statement. Denard and Burkhart state in an article titled *Arthroscopic Revision Rotator Cuff Repair* in the Journal of the American Academy of Orthopedic Surgeons November 2011, vol.10, no. 11 657-666 ñThe major indication for revision rotator cuff repair is the persistence of clinical symptoms, despite nonsurgical management, in the absence of substantial risk factors for failure.ò Lo and Burkhart state in an article titled *Arthroscopic revision of failed rotator cuff repairs: technique and results* in Arthroscopy 2013, Mar; 20(3):250-67 ñRevision arthroscopic rotator cuff repair is a technically demanding procedure. However, appropriate patient selection and careful attention to rotator cuff dissection, mobilization, and repair by arthroscopic means can lead to significant improvement in overall shoulder pain and function.ò Piasecki et al. state in an article titled *Outcomes After Arthroscopic Revision Rotator Cuff Repair* in the American Journal of Sports Medicine 2012, Vol. X, No. X ñArthroscopic revision rotator cuff repair may be a reasonable treatment option even after prior open repairs and provides both improved pain relief and shoulder function.ò

Dr. Gatsby goes on to state ñMr. B demonstrated a decreased range of motion at the time of my independent medical evaluation, but in my opinion these findings are not valid and it is probable that the ranges of motion noted by Dr. John Watson are not valid given the fact that he had no atrophy of the shoulder girdle musculature, arm musculature or forearm musculature. It is medically probable that the active range of motion demonstrated by Mr. B at the time of my independent medical evaluation, in fact, was not representative of his true level of function and his true range of motion.ò I could not disagree more strongly with Dr. Gatsbyôs conclusions. I observed Mr. Bôs effort in the IME. It is my opinion that Mr. B gave full effort and his range of motion was definitely limited. There was nothing in Mr. Bôs presentation to indicate he was not giving full effort. Mr. B did not exhibit exaggerated pain behaviors. He did not show any evidence of non-physiologic response. He had no signs such as break away muscle testing. He had no evidence of non-physiologic sensory testing or other indicators often seen in conscious or unconscious symptom exaggeration or restriction. If anything, it is my opinion Mr. B gave the best effort he could despite obviously being in pain and trying to work through the pain to his best range of motion. It should also be noted that nowhere in Mr. Bôs medical records is it noted that Mr. B did not give his best and full effort. There is nothing recorded in Mr. Bôs past medical history, social history or family history to indicate he would be prone to giving less than his full effort.

I will defer judgment regarding Mr. Bôs impairment rating to physicians who routinely make such determinations.

In conclusion, it is my opinion Mr. B suffered a work-related injury to his right shoulder. It is my further opinion based on Mr. Bôs history, presentation and evidence from the literature that he is a candidate for a revision rotator cuff repair done by Dr. William Halstead or another qualified surgeon who agrees with Dr. Halstead that a second surgery is indicated.

Sincerely,

Armin Feldman, M.D.
Physicians Legal Consultants LLC

Sample Report #3

PHYSICIANS LEGAL CONSULTANTS
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March 1, 2014

Steve Smith, Esq.
Smith & Jones, PC
41 Lincoln Ave.
Suite 407
Denver, CO 80202

Re: M J

Dear Mr. Smith,

You have asked my opinion as to whether your client Ms. Jôs acute appendicitis on January 14, 2014 was related to her auto crash on January 13, 2014. Ms. J is 23 years old.

Brief History of Events

On January 13, 2014 at approximately 6:20 pm Ms. J was the properly restrained driver of her 2010 Saturn coupe traveling eastbound in the far right lane on E. Evans Ave. The offending vehicle, a 2012 Honda CRV traveling eastbound on E. Evans Ave. attempted an illegal right turn from the center lane. The maneuver caused Ms. Jôs car to broadside the Honda. Ms. J reports being thrown forward with enough force to hit her head and torso on the steering wheel causing her to be dazed for approximately 3 minutes.

Approximately 6 hours after the auto crash Ms. J presented to the Romulus Medical Center Emergency Department with abdominal pain diagnosed as acute appendicitis. Ms. J was admitted to the hospital and had an appendectomy the morning of January 14, 2014. She did not experience any surgical complications and was discharged from the hospital on January 15, 2014.

Discussion

As noted, Ms. J was thrown forward with enough force to strike her head and torso on the steering wheel. It is my opinion that either due to the seat and shoulder restraints, the steering wheel or both, Ms. J also experienced blunt force trauma to her abdomen during the auto crash. In fact, in carefully obtaining Ms. Jôs account of the crash she remembers striking her head and

torso (including her abdomen) on the steering wheel before feeling dazed. There are several reports in the medical literature describing the onset of acute appendicitis after blunt force trauma to the abdomen.

In a 2010 paper titled *Systematic Review of Blunt Abdominal Trauma as a Cause of Acute Appendicitis* Chan, et al. report ñé the diagnosis of acute appendicitis must be considered following direct abdominal trauma especially if the patient complains of abdominal right lower quadrant pain, nausea and anorexia.ò Ms. J was complaining of these symptoms on admission to the Emergency Department as noted in the hospital records.

In a 1974 paper titled *Acute Appendicitis Following Motor Vehicle Accident* Fiorini reports ñthe driveré was not expecting a collision; therefore his abdominal muscles would be in a relaxed position. He was thrown forward across the steering wheel.ò Fiorini goes on to state ña crushing injury to the abdomen may compress the appendix between the external abdomen and the pelvic bone. The result of such an injury may be a contusion, a laceration or a transection of the appendix, depending on the type of blunt trauma and the position of the appendix.ò Ms J was thrown forward across the steering wheel experiencing similar blunt trauma to the abdomen as described in this paper.

Serour, et al. in a 1996 article titled *Acute Appendicitis Following Abdominal Trauma* agree with the findings that blunt force trauma can lead to acute appendicitis. They state ñOur experience with three cases of AA (acute appendicitis-my addition) following blunt force trauma led to an extensive review of the world literature on the subject. We believe that abdominal trauma might be causative of AA.ò

Finally, Hennington et al. in a 2011 paper titled *Acute Appendicitis Following Blunt Abdominal Trauma* state ñIn a setting of right lower quadrant pain following mild to moderate blunt abdominal trauma, acute appendicitis should be considered as a possibility.ò

Causation Opinion

In 2007 Freeman et al. in *Whiplash and Causation* demonstrate a practical method for individual clinical determinations of causation following traumatic injury. It is my opinion that Freemanôs criteria of traumatic symptom causation can be applied to any traumatic injury.

In 2009 Freeman et al. had a follow up journal article titled *A Systematic Approach to Clinical Determinations of Causation in Symptomatic Spinal Disc Injury following Motor Vehicle Crash Trauma*. Using the criteria outlined in the 2007 and 2009 journal articles Ms. J meets traumatic injury symptom causation requirements for acute appendicitis caused by blunt force trauma to the abdomen during the January 13, 2014 auto crash.

Freeman et al. report that there are three criteria that must be met. First, there must be a biologically plausible or possible link between the exposure and the outcome. Clearly, the auto

crash (exposure) creates the link between the traumatic nature of the accident and the onset of acute appendicitis symptoms (outcome) outlined above.

Second, there must be a temporal relationship between the exposure and the outcome. Approximately 6 hours after the accident (exposure) Ms. J experienced right lower quadrant abdominal symptoms diagnosed as acute appendicitis (outcome).

The third criteria states there must not be a more likely or probable alternative explanation for the symptoms. Based on the literature review detailed above, in my opinion there is not be a more likely explanation of Ms. Jôs appendicitis than the abdominal trauma sustained in the auto accident. There is nothing of significance in Ms. Jôs history of the present illness or past medical history to suggest a more likely etiology to her acute appendicitis. In addition, the literature states acute appendicitis is more likely with blunt force trauma in teens and young adults. Ms. J meets that criterion.

Based on my medical record review, interview of Ms. J on February 28, 2014, my review of the pertinent medical literature and the circumstances of this accident, it is my opinion to a reasonable degree of medical probability that M J suffered blunt force trauma to the abdomen during the January 13, 2014 auto crash. In turn, Ms. J developed acute appendicitis as a direct result of the blunt force trauma she sustained and subsequently required an appendectomy.

I have included copies of the medical journal articles I have referenced. If I can answer any other questions concerning this case please contact me.

Sincerely,

Armin Feldman, M.D.
Physicians Legal Consultants LLC

PHYSICIANS LEGAL CONSULTANTS LLC

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