SUPREME COURT OF THE STATE OF NEW YORK COUNTY OF BRONX GILBERT HERNANDEZ, Plaintiffs, -against- CONSOLIDATED EDISON COMPANY OF NEW YORK, INC. and DANELLA CONSTRUCTION OF NY, INC., Defendants.	NOTICE OF EXPERT WITNESS EXCHANGE Index No.: 301327/09

S I R S:

PLEASE TAKE NOTICE that the plaintiff, by his attorneys, **SACKS AND SACKS, LLP** intends to call the following witness to testify at the time of trial on the issue of damages:

Please be advised that **BARRY C. ROOT, M.D.**, 1 Expressway Plaza, Roslyn, New York 11577, will testify at the upcoming trial of this action regarding Mr. Gilbert Hernandez's need for future medical care and its cost. The life care plan dated May 6, 2013 prepared by Dr. Root is annexed hereto along with a copy of his curriculum vitae.

Dated: New York, New York
May 10, 2013

Yours etc.,
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History of Present Illness:

Gilbert Hernandez is a 44 year-old male who was injured on 10/11/2008. The patient was working in a ditch, and climbing out, with his left foot on a wooden step when the wood gave out. He fell forward, then backward to the bottom of the well onto a 36 inch diameter pipe, approximately ten feet below. The patient reports a brief loss of consciousness. He had immediate severe left ankle and low back pain. He refused Emergency Department evaluation at that time as he was afraid of jeopardizing his job.

He had his first Emergency Room visit on 10/27/2008. This was at Westchester County Hospital, where he reported low back pain and left ankle pain and swelling. He refused admission due to a family issue. He was diagnosed with musculoskeletal strain as well as sprain of his left ankle. He was given pain medications and instructions to follow up as an outpatient.

Left leg swelling and increasingly severe low back pain persisted. This prompted a second ER visit at Manchester Memorial Hopsital in CT on 10/21/2008. A sonogram was negative. Narcotic pain medication and antibiotics were prescribed. Follow up medical care was advised.

On 11/5/2008 he was again seen at the Westchester Square Medical Center ER and admitted with cellulitis of the ankle and leg. Venous Doppler studies were negative. IV antibiotics were given. He was discharged home on 11/9/2008 with oral antibiotics.

Conservative medical care and Physical Therapy were arranged for his low back pain and ankle pain. He continued his physical therapy for the low back and ankle as well as follow-up with Dr. Khakhar, a physiatrist, who oversaw his therapy program and trialed a series of medications.

MRI of the lumbar spine (1/31/2009) demonstrated multilevel disc disease with marked thecal sac compression and central stenosis at L4/5 and central hernistion at L5/S1 with left sided extrusion, thecal sac compression and stenosis withS1 root impingement. EMG testing on 5/13/2009 confirmed left sided L5/S1 radiculopathy. The patient's spine symptoms persisted and he was referred to Dr. Haftel for pain management. Mr. Hernandez underwent series of lumbar epidural steroid and facet joint injections in March, 2009.

These procedures offered him minimal, temporary relief.

The patient also saw Dr. Yager, a podiatrist, for his recalcitrant left ankle pain. He continued on physical therapy for his ankle though his pain and stiffness in the ankle persisted. An MRI (2/16/2010) showed anterior talo-fibular ligament sprain and calcaneofibular ligament sprain. Surgical arthroscopy and ligament reconstruction was recommended and requested. This surgery is pending.

Mr. Hernandez's back and leg symptoms continued to worsen, prompting a recommendation for spinal surgery. Mr. Hernandez was referred to Dr. Lattuga, a spinal surgeon, for surgical evaluation of his symptoms. New MRIs of the lumbar spine demonstrated significant disc herniations at L4/5 at L5/S1 with associated neural impingement.

On 6/8/2010 the patient underwent L4/L5/S1 decompressive laminectomy and posterior-lateral fusion with pedicle screws. The surgery was performed by Dr. Lattuga. The patient noted improvement in his leg symptoms, though his axial low back pain has persisted without any relief. The patient relates that subsequent CT scan of the lumbar spine (8/10/2011) demonstrates L4/5 and L5/S1 thacal sac impingement as well as foraminal impingement. He was informed that these findings may necessitate revision surgery. Pain management was again recommended.

On 11/14/2011, Dr. Haftel performed a spinal cord stimulator trial. This procedure offered him some level of relief. As a result, on 3/9/2012, Dr. Kushnerik implanted a neuro-stimulator unit. This will require follow up care and revision, as well as regular visits for reprogramming.

Current Complaints:

Currently, Mr. Hernandez complains of:

1. Chronic low back pain, loss of ROM with radiation to legs.
2. Chronic left ankle pain, stiffness and limp.
3. Depression, frustration since his accident.

Acute Hospitalizations:

None except as in History of Present Illness.

Past Medical History:

Asthma

Past Surgical History:

Bilateral inguinal hernia repairs (2004, 2005)
Left axillary/lateral chest wall laceration repair (age 13)
As per History of Present Illness.

Allergies:

No known drug allergies

Current Medications:

Percocet 10mg	1 tab po QID to 6/day
Albuterol Inhaler	QID
Serovent Inhaler	QD to BID
Nebulizer treatments	1-6 treatments/day

Current Medical Care:

Dr. Lattuga	Spine Surgeon	sees every 3 months
Dr. Khakhar	Physiatrist	sees every 3 months
Dr. Kushnerik	Pain Management	sees every month

Current Therapy Program:

Patient is currently not on a physical therapy program for his back or left ankle.

Disposable Supplies:

Heating packs

Ice packs

Activities of Daily Living (ADLs):

He is largely independent with regard to his ADLs. His family members assist him, as needed.

Family History:

Mother:	Deceased, age 62. COPD.
Father:	Deceased, age approximately 60, following pneumonia.
Siblings:	3 brothers and 4 sisters who are alive and well.
Children:	2 adult children. Both are alive and well.

Social History and Home Environment:

Marital status:	Single.
Residence:	Rents apartment in Bronx, NY.
Adaptations to home:	None.
Tobacco use:	3-5 cigarettes daily, tapering.
Alcohol use:	Socially.
Recreational drug use:	Denies.
Education:	Completed high school GED.
Vocational status:	Disabled well inspection worker.
Disability Status:	He is totally disabled.
Benefits:	Workers' Compensation Insurance.
Car:	He does not own a vehicle.
License:	He does not have a valid driver's license.
Adaptations to Car:	NA.
Driving status:	NA.

Review of Systems:

Head:	Negative.
Eyes:	Negative.
Ears:	Negative.
Mouth:	Negative.
Throat:	Negative.
Neck:	Negative.

Heart:	Left ventricular dysfunction reported.
Pulmonary:	Asthma.
GI:	Constipation, otherwise negative.
GU:	Frequent urination reported. Otherwise negative.
Endocrine:	Negative.
Musculoskeletal:	See History of Present Illness.
Neurological:	See History of Present Illness.
Skin:	Scars secondary to surgery.
Psychological:	Anxiety, frustration, depression since accident.
Weight:	150 pound weight gain, then loss since accident.
Fevers:	Negative.
Sleep:	Insomnia.
Communication:	Speaks fluent Spanish and English.

Physical Exam:
(normal ranges indicated in parentheses, where appropriate)

General:	Alert, pleasant overweight male.
Head:	Normocephalic, atraumatic.
Eyes:	EOMI.
Ears:	Normal.
Nose:	Normal.
Throat:	Normal.
Heart:	RRR
Lungs:	Clear bilaterally
Abdomen:	Normal bowel sounds x 4 quadrants
Pulses:	Normal in all four extremities.
Rectal/Genitalia:	Deferred.

Neck: Range of motion:

Rotation left	90°	(90°)
Rotation right	90°	(90°)
Side bend left	45°	(45°)
Side bend right	45°	(45°)
Extension	45°	(45°)
Flexion	45°	(45°)

Axial compression:	Negative for axial pain
Scars:	None
Spasms:	Negative

Thoracolumbosacral Spine:

Range of motion:

Forward flexion	75°	(90°)	
Right side-bend	5°	(30°)	Pain
Left side-bend	5°	(30°)	Pain
Extension	0°	(30°)	

Spasm: Positive in lumbar paraspinals

Scars: Hypertrophic midline 15-cm vertical scar
Horizontal left pelvic (stimulator) scar – 7 cm.

Greater Trochanter: Tender to palpation bilaterally.
Sciatic Notch: Tender to palpation bilaterally.
Ischial Tuberosity: Tender to palpation bilaterally.
Sacroiliac Joint: Tender to palpation bilaterally.
Special Tests: Trendelenburg sign negative bilaterally.

Bilateral Upper Extremities:

		Right	**Left**
ROM:	Shoulder Flexion:	full ROM	full ROM
	Shoulder Abduction:	full ROM	full ROM
	Elbow:	full ROM	full ROM
	Wrist Flexion:	full ROM	full ROM
	Wrist Extension	full ROM	full ROM
Tone:		Normal	Normal
Spasticity:		None	None
Motor power:	Shoulder Abduction:	5/5	5/5
	Elbow flexion:	5/5	5/5
	Elbow extension:	5/5	5/5
	Internal rotation:	5/5	5/5
	External Rotation:	5/5	5/5
	Wrist Flexion:	5/5	5/5
	Wrist Extension:	5/5	5/5
	Grip:	5/5	5/5
	Intrinsics:	5/5	5/5
Atrophy:		None	None
Sensation:	Light touch	Intact	Intact
	Pin prick	Intact	Intact
DTRs:			

		Right	Left
biceps:		2+	2+
triceps:		2+	2+
brachioradialis:		2+	2+
Hoffman's reflex:		Negative	Negative
Special Tests:	Tinel's sign:	Negative	Negative
Gross coordination:		Intact	Intact
Scars:		None	None

Bilateral Lower Extremities:

		Left	Right
ROM:	Hip External Rotation:	Full ROM	FROM
	Hip Internal Rotation:	Full ROM	FROM
	Hip Abduction:	Full ROM	Full ROM
	Hip Flexion:	Full ROM	Full ROM
	Knee Extension:	Full ROM	Full ROM
	Knee Flexion:	Full ROM	Full ROM
	Ankle DF:	10 deg	Full ROM
	Ankle PF:	40 deg	45 deg
	Subtalar motion:	Min (pain)	FROM
Motor power:	Hip Abduction:	5/5	5/5
	Hip Flexion:	5/5	5/5
	Knee Extension:	5/5	5/5
	Knee Flexion:	5/5	5/5
	Dorsiflexion:	5-/5	5/5
	EHL:	5-/5	5/5
	Plantar Flexion:	5-/5	5/5
DTRs:	Patellar:	2+	2+
	Ankle:	2+	1+
Tone:		Normal	Normal
Spasticity:		Absent	Absent
Clonus:		Absent	Absent
Atrophy:		None	None

Sensation: decreased to light touch, pin prick over S1 distribution on right side.

Babinski reflex:	Downgoing	Downgoing
Gross coordination:	Intact	Intact
Scars:	None	None

Special tests: Straight Leg Raise (SLR): 45° 45°
Widened ankle mortise.
Scarring over lower 1/3 tibia (anteriorly)
Pain to palp over lateral ligament group. Inversion causes pain.

Function:

Stand:	Independent by observation.
Balance:	Intact.
Gait:	Decreased heel, toe walking on left due to pain. Antalgic on left with decreased cadence. Decreased step-length.
Sit:	Independent by observation.
Dressing:	Independent by history.
Showering:	Independent by history.
Bathing:	Independent by history.
Toileting:	Independent by history.
Feeding:	Independent by history.
Transfers:	Independent by observation.
Wheelchair:	n/a

Diagnoses:

S/p workplace accident on 10/11/2008 with:

Chronic pain syndrome
-Spinal cord stimulator in place

Chronic low back pain with radiation into right leg
-s/p HNP L5/S1
-s/p L5/S1 percutaneous discectomy
-s/p L5/S1 laminectomy/discectomy/fusion – 6/8/2010
-chronic right L5,S1 radiculopathy
-post-traumatic arthritis, lumbar spine with loss of motion
-gait dysfunction

Chronic left ankle pain
-s/p fracture, left ankle
-s/p tears in ATFL, CFL ligaments
-s/p post-traumatic gait dysfunction

Anxiety, frustration, depression following injury

Disability:

As a result of the diagnoses listed above, Mr. Hernandez is totally disabled.

Causality:

The patient's diagnoses are directly and causally related to the work injury he sustained on 10/11/2008.

Permanence:

The disabilities noted above are of a permanent nature.

Prognosis:

Mr. Hernandez will suffer from chronic pain and/or chronic intermittent pain indefinitely.

Life Expectancy:

Mr. Hernandez's life expectancy is unaffected by his injuries and diagnoses; it is full to a total of approximately 82 years.

Discussion:

Since his work-place accident, Mr. Hernandez has had continued low back and left ankle pain. Despite extensive medical and surgical care, he continues to suffer from chronic pain and dysfunction.

Following June, 2010 spinal fusion surgery, Mr. Hernandez reports no relief of his chronic pain. He continues to have decreased ROM of the lumbar spine and sensory complaints of pain radiating down his right leg, though improved as compared to his pre-surgical pain. His axial low back pain and complaints remain despite extensive treatment, including surgical decompression and fusion. He continues to have sensorimotor deficits in the L5,S1 distributions on the right side. His left ankle continues to be stiff and

painful, contributing to his gait dysfunction.

The patient is at risk for further degeneration at other levels in the lumbar spine due to post-traumatic changes and adjacent segment degeneration, which may necessitate further surgeries and/or interventional spinal procedures in the future. The patient must be monitored for worsening of neurologic symptoms, as progressive neurological deficits could result in the need for emergent spinal surgery.

Furthermore, post-traumatic lumbar spondylosis is anticipated.

Similary, the patient continues to have chronic pain in his left ankle, despite extensive physical therapy. He will likely need additional therapy and management of these symptoms, which may include intra-articular steroid injections or arthroscopic surgery with ligament reconstruction, as has been recommended by his surgeon. Accelerated post-traumatic arthritis is anticipated to continue in the ankle as a result of the trauma.

Lastly, Mr. Hernandez continues to require opioid therapy for his chronic pain despite placement of a spinal cord stimulator. Given the nature of the medications he is being prescribed and the myriad side effects of chronic opioid use, he should be closely monitored by a qualified pain medicine specialist. His stimulator unit will require regular reprogramming as well as revision in the future. Despite the surgical interventions anticipated, he is likely to require long-term opioid therapy.

Conclusion:

Mr. Hernandez is a 44 year-old male who suffered multiple injuries as a result of his work-related accident on 10/11/2008. He attempted a variety of approaches to manage his pain, strength, and motion deficits. He underwent surgical repair of his low back. Unfortunately, he remains with chronic pain in the low back and left ankle, with additional surgeries recommended.

His disabilities are permanent. Some improvement in functional ability and pain control should continue to be pursued. As a result of his condition, he will require ongoing medical and surgical management throughout his lifetime. Again, advancing post-traumatic arthritis involving the affected areas is anticipated.

Recommendations:

Attached is a life care plan outlining Mr. Hernandez's needs for future care and treatment. These needs are the result of his physical and functional disabilities. The plan provides direction for ongoing medical and surgical management.

Recommendations are presented to provide adequate care and assistance that will be required through the remainder of his life. The costs provided are based upon my experience, my knowledge of local and national costs and upon my review of records and research.

A Life Care Plan is a dynamic set of projections, likely to be adjusted to fit the specific clinical needs of the patient. I reserve the right to amend this plan as needed.

The opinions stated in this report are held by me to a reasonable degree of medical certainty.

Sincerely,

Barry C. Root, MD

Chairman, Physical Medicine and Rehabilitation
Glen Cove Hospital

Assistant Professor of Rehabilitation Medicine,
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