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March 24, 2010

(Actual names have been changed and/or deleted for confidentiality)

The Honorable Judge

Re: Mediation  
Linda Lawrence v. Defendants  
and Mark Mason  
Date: Thursday, April 1, 2010  
Time: 9:30 a.m.

Dear Judge:

The following is a summary of Linda Lawrence's case.

### **MAJOR INJURIES SUFFERED BY LINDA LAWRENCE**

- a. Acute Burst Compression Fracture of T-6 Thoracic Spinal Vertebrae with a Residual Small Fragment at the Margin of the Neural Foramen;
- b. Acute Burst Compression Fracture of the T-8 Thoracic Spinal Vertebrae with a Residual Small Retropulsed Fragment at the Anterior Left Side of the Spinal Cord;
- c. Acute Burst Compression Fracture of the T-10 Thoracic Spinal Vertebrae with a Residual Small Retropulsed Fragment at the Anterior Left Side of the Spinal Canal;
- d. Non-displaced Oblique Fracture of the Right T-7 Thoracic Spinal Vertebrae Transverse Process;
- e. Endplate Fracture of the T-11 Thoracic Spinal Vertebrae;
- f. Minimally Displaced Fracture of the Posterolateral Left 5<sup>th</sup> Rib;
- g. Paraspinal Hematoma-Bilateral;
- h. Permanent residual pain from thoracic spine fractures requiring permanent use of pain medication with resulting constipation;
- i. Forty-five percent (45%) permanent physical impairment to the whole body;

- j. Bilateral Pulmonary (Lung) Contusions with Resulting:
  - (i) Atelectasis (Collapsed Lungs)
  - (ii) Pleural Effusion
  - (iii) Hemothorax
  - (iv) Hypoxemia with inadequate oxygen to the brain and tissues resulting in confusion;
  - (v) Aggravation of underlying, symptom free COPD
- k. Pneumonia as a result of hospitalization for Multiple Fractures, and the consequences of Pulmonary Contusion with Pleural Effusions, Hemothorax, Weakness, Pain and Inability to Clear Secretions resulting in Bacterial Pneumonia and congestive heart failure;
- l. Major Respiratory Failure Requiring a Mechanical Respirator;
- m. MRSA (Methicillin Resistant Staphylococcus Aureus) Septicemia;
- n. Bacterial Endocarditis with Bacterial Vegetative Growth on the Aortic Valve – Requiring Prolonged Gentamicin Antibiotic I.V. Treatment;
- o. Gentamicin Induced Nephrotoxicity with Major Renal Failure;
- p. Pulmonary Embolism Resulting from Decreased Ambulation from Multiple Thoracic Vertebral and Rib Fractures with pain Requiring Anticoagulant Treatment;
- q. Left Lower Extremity Deep Vein Thrombosis;
- r. Anticoagulant (Coumadin) Induced Major Bleeding Episodes Requiring Blood Transfusions;

**45% PERMANENT IMPAIRMENT -  
MULTIPLE THORACIC VERTEBRAL COMPRESSION FRACTURES**

John K. Brown, M.D., Orthopedic Surgeon [MR 2154-2158].

**SPECIAL DAMAGES**

Medical Bills to date.....	\$347,929.25
Lost Earnings to date.....	\$ 77,280.00
Future Prescriptions.....	\$ <u>6,184.84</u>
Total.....	\$431,394.09

### AD DAMNUM

Linda Lawrence is asking the jury to return a verdict of \$10,000,000.00.

### DEFENSE HAS NO EXPERT WITNESSES

The defense is calling no expert witnesses to testify at the trial of this case.

### THE CRASH

#### DEFENDANTS' DRIVER GUILTY OF CAUSING HIGH IMPACT CRASH

On the morning of February 21, 2007, Linda Lawrence was stopped at a traffic light on Route 17 (Marsh Road) and Station Drive in Fauquier County, Virginia. As Linda was waiting for the traffic light to turn green, Defendants driver Mark V. Mason, operating a 26,000 lb. Mack truck, traveling at 40 mph, slammed into the rear of Linda's stopped 2001 Chevrolet. The magnitude of the impact blew out the back window of Linda's Chevy, obliterating the trunk space and propelling Linda's vehicle all the way across the intersection onto the side of the road.

The Defendants' driver, Mark V. Mason, was charged at-fault and **pleaded guilty** to following too closely causing the crash.

Photographs showing the property damage to Linda Lawrence's Chevy appear below:



**LINDA LAWRENCE IN EXCELLENT  
HEALTH AT TIME OF CRASH**

Linda Lawrence is a warm and caring mother and grandmother. For most of her life she enjoyed taking care of others as a private duty nursing assistant. Before this crash, Linda Lawrence lived on her own, was independent, and worked full time as a caregiver for Mary O'Sullivan in Warrenton, Virginia.

At the time of this crash Linda Lawrence was in excellent health. She did not have diabetes, emphysema [COPD], heart disease, high blood pressure, or high cholesterol.

**LINDA LAWRENCE'S BURST COMPRESSION  
VERTEBRAL FRACTURES OF T6, T8, T10; OBLIQUE VERTEBRAL  
FRACTURE OF T7; END-PLATE VERTEBRAL FRACTURE OF T10;  
MULTILEVEL THORACIC PARASPINAL HEMATOMA; AND  
DISPLACED FRACTURE OF THE 5TH RIB**

An emergency CT scan of Linda Lawrence's abdomen/pelvis and her chest were done at the Fauquier Hospital emergency room on the date of the crash, of February 21, 2007.

The radiologist, David C. Kelly, M.D. reported [MR 23]:

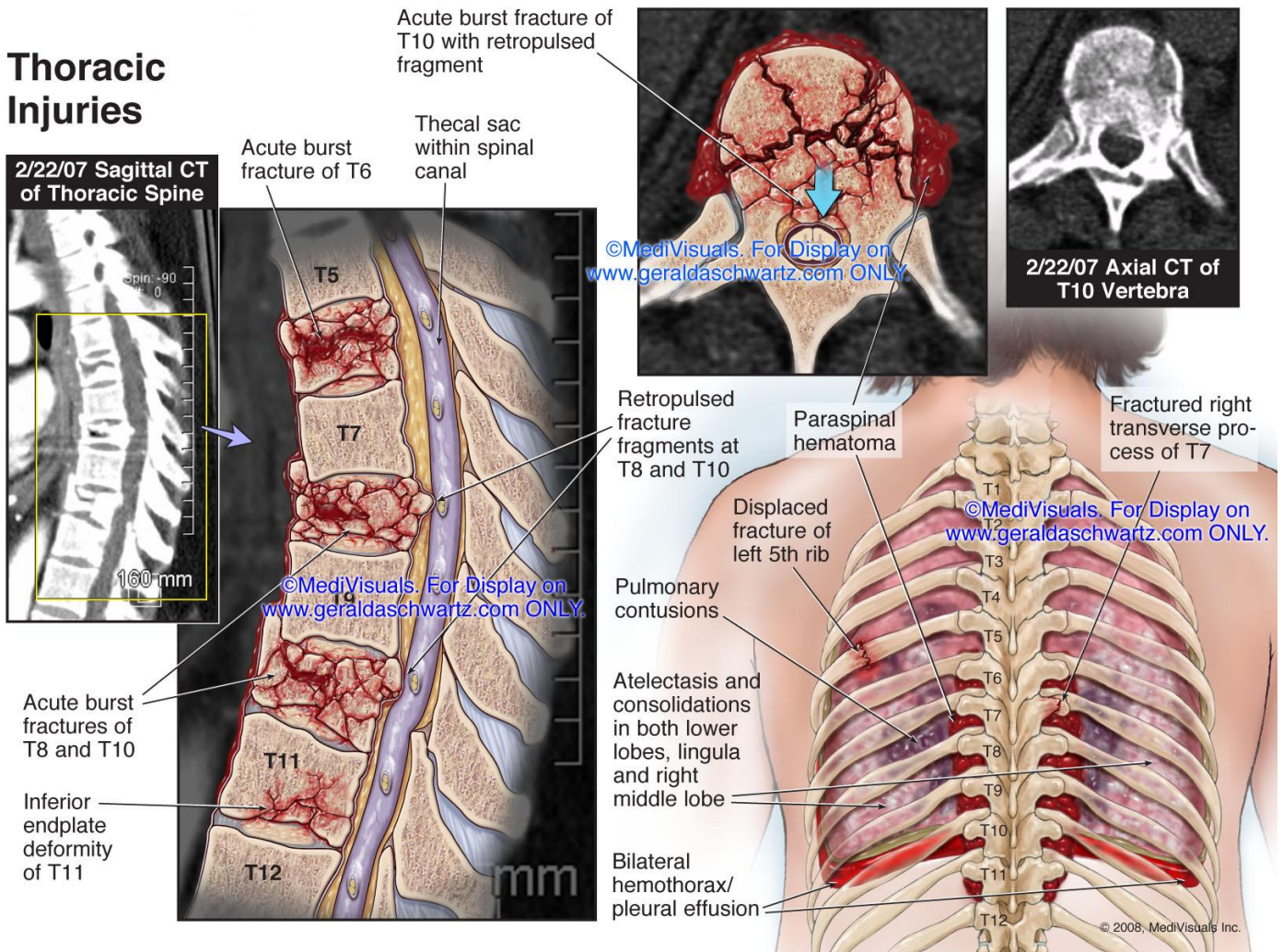
"Impression: Acute burst compression fractures of the T6, T8 and T10 vertebral bodies with small retropulsed fragments as detailed above [at the neural foramen-where the nerve root exits the spinal canal, and at the left side of the spinal canal itself.]. There is also a mild non-displaced inferior end plate fracture of the T11. There is accompanying paraspinal hematoma".

A CT scan of Linda Lawrence's chest performed on February 2007, revealed a T7 fracture and a 5th rib fracture. The radiologist reported:

"Note is also made of a non-displaced oblique fracture of the T7 transverse process and a minimally displaced fracture of the posterolateral left 5th rib."

A medical illustration, prepared by a nationally recognized medical illustrator, describing these fractures appear on the next page.

## Thoracic Injuries



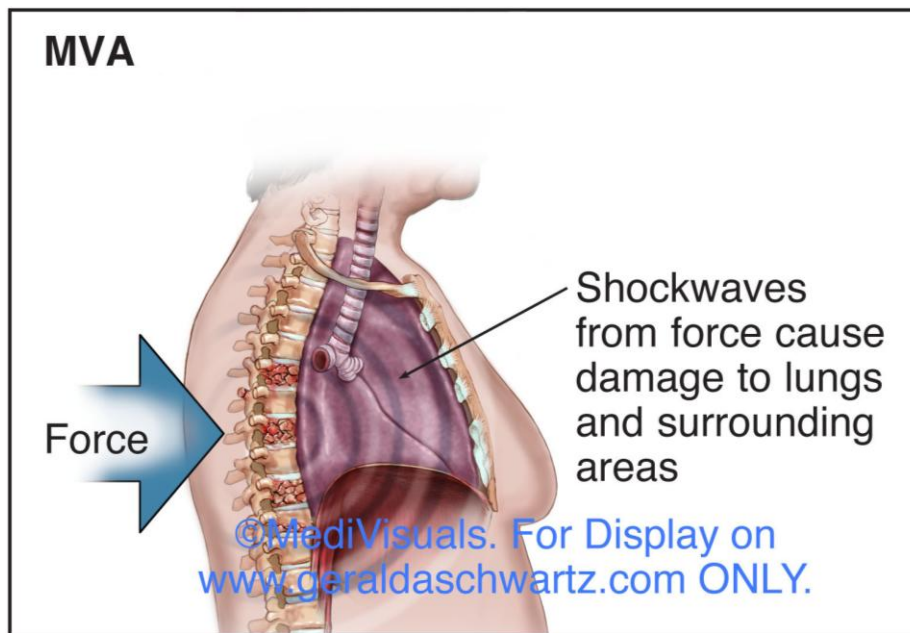
### **PULMONARY CONTUSION, PLEURAL EFFUSION, HEMOTHORAX, ATELECTASIS, HYPOXEMIA AND EXACERBATION OF UNDERLYING, SYMPTOM-FREE COPD**

As a result of being rear-ended by a loaded, large Mack truck, Linda Lawrence suffered five (5) thoracic vertebral fractures and a fracture of her 5th rib. Included were three (3) acute burst compression fractures of T6, T8 and T10. The tremendous force that caused three (3) burst compression fractures also traumatized Linda Lawrence's lungs which lie anatomically in close proximity to the compression fractures.

This same force also caused shock-waves to ripple through Linda Lawrence's lung tissue resulting in pulmonary contusions to both lungs. As a result of trauma to Linda Lawrence's lung tissue, bleeding began **inside** her lungs and also **outside** her lungs, in the pleural space. The bleeding in the pleural space was described as a

"hemothorax". Also, as a result of trauma to Linda's lung tissue, fluid slowly began to build-up **inside** her lungs in addition to blood. **Outside** her lungs in the pleural space, which surrounds the lungs, fluid from the trauma also built up -- described as pleural effusions.

A medical illustration describing the force that burst three of Linda's thoracic vertebrae and rippled through her lung tissue appears below.



As the blood and fluid inside and outside Linda's lungs slowly increased over time, the amount of air space in both lungs, from the bottom of the lung upward, slowly decreased as the lungs were collapsing. What was happening to the air space in Linda Lawrence's lungs is analogous to a balloon [lung] in a plastic box, [the pleural space outside and surrounding the lungs] slowly filling-up with fluid -- slowly displacing the air inside the balloon [the lungs]. As the balloon [lungs] itself fills-up with blood and fluid, and as the blood and fluid fill-in the case outside the balloon [pleural space], air in the lungs is lost, and the balloon starts collapsing leading to bilateral atelectasis [collapsed lungs]. The result -- shortness of breath and decreased oxygen exchange resulting in hypoxemia (low blood oxygen levels leading to inadequate oxygen to body tissues and the brain leading to mental confusion).

Linda Lawrence was in significant pain from her burst thoracic compression fractures. Dr. David Ko reported [MR 197-198] that Linda Lawrence had "**exquisite muscle spasms in her thoracic spine secondary to compression fracture.**" Linda was unable to expand her lungs due to severe muscle spasm and pain from her compression fractures and from pain in her chest and diaphragm muscles. Simple coughing caused severe pain. As a result, Linda had difficulty clearing lung secretions,

lung fluids and blood which built-up in both lungs. The result -- again, shortness of breath and decreased oxygen exchange resulting in hypoxemia (low blood oxygen levels leading to inadequate oxygen to body tissues and the brain leading to mental confusion).

Blood, fluid and secretions slowly built-up in Linda Lawrence's lungs, as well as outside her lungs in the pleural space surrounding the lungs. As the blood, fluid and secretions built-up, they gradually became "**consolidated**" -- **a thickened gel-like exudate** -- gradually taking-up more air space in Linda's lungs -- resulting in increased collapsing of the lung air space (atelectasis).

A chest CT scan was performed on the day after the crash (2/22/07) for the clinical indication, "pulmonary contusion, thoracic spine fracture" [MR 25]. The CT scan revealed that Linda Lawrence's lungs were becoming worse from the effects of the pulmonary contusions.

The "**consolidations**" [**thickened gel-like exudates**] were increasing, thus decreasing the amount of air space in Linda's lungs -- shrinking air space from the bottom of the lungs, upward, each day, analogous to the balloon deflating slowly each day.

Radiologist, Jennifer T. Largo, M.D. found and reported in her CT scan report dated February 22, 2007 [MR 25]:

"There is a small amount of layering pleural fluid bilaterally, which may represent hemothorax and/or pleural effusion... There has been a mild increase in wedge-shaped **consolidation** in the posterior right lower lobe with involved lung more consolidative, and with slight increase in extent of lung involved [decreased air space to breathe]. Involved lung now is 7-8 cm in maximum dimension. Underlying blebs or bullae [from underlying emphysematous changes] are less conspicuous, suggesting they may be partially fluid-filled. There is **sub-segmental atelectasis [collapsing lung]** at the posteromedial lung base on the left. There is underlying emphysematous change.

Impression:

...(2) Slight internal **increase in consolidation** of the right lower lobe which is non-specific but **most likely due to pulmonary contusion**. Follow-up is recommended to ensure resolution.

(3) Small bilateral pleural effusions and/or hemothoraces, similar to prior study.

(4) Subsegmental atelectasis, medial left lung base..."

Linda Lawrence's lungs and the pleural space outside of her lungs continued to fill-up with blood and fluid as a result of the pulmonary contusions and trauma to both lungs. Every day, less air space was becoming available for her to breathe.

A chest x-ray ordered for "multiple compression fractures T-spine and follow-up effusions" was done on February 27, 2007 (six days after the crash). The x-ray showed Linda Lawrence's lungs were starting to become vascular, backing up with blood, thus decreasing her air-lung volume -- the air in the balloon [lungs] and the area outside the balloon [pleural space], continues to fill with blood and fluid. The result -- the air in Linda's lungs continues to deflate even further. The radiologist reported finding on x-ray:

"Relatively low lung volumes bilaterally.... Mild pulmonary vascular plethora **[lungs becoming backed-up with blood]**; and small to moderate **bilateral effusions.**"

On March 1, 2007, a CTA chest scan at Fauquier Hospital [MR 28] found, "**Compressive atelectasis**" at **both** lung bases. **Consolidations [gel-like exudates from thickening coagulated blood and fluid] had increased.**" David R. Weiss, M.D., the radiologist, reported:

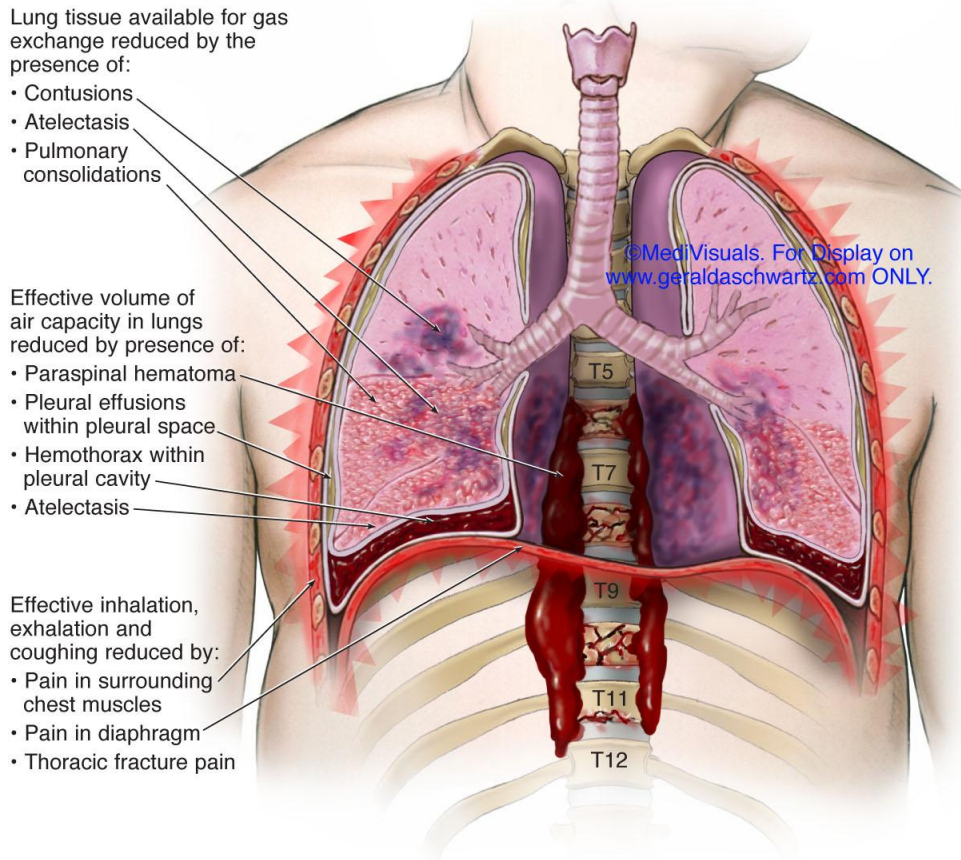
"**Areas of consolidation...** are seen in both lung bases, lingula and the right middle lobe [higher levels than the base of the lung]... moderate left and small to moderate right pleural effusions..."

Linda Lawrence's pain was so bad that she required strong narcotic painkillers, not administered orally, but by **I.V.** A well-known side effect of narcotic pain medication is decreased respirations and decreased ability to breathe. (Death from narcotic overdosage is from respiratory depression.) Dr. Michael T. Wynn recognized the dilemma Linda's injury presented. She needed strong narcotic painkillers to help alleviate her severe pain from her compression fractures, but **the respiratory depressing side-effects of the narcotics contributed to her shortness of breath and hypoxemia.** Indeed, Dr. Wynn stated [MR 191] "Morphine for pain control may also be exacerbating part of her dyspnea [shortness of breath]."

A medical illustration, prepared by a nationally recognized medical illustrator, describing Linda Lawrence's lung injuries appears on the following page.



## Evolving Lung Injuries First Hospitalization



### **EXACERBATION OF UNDERLYING SYMPTOM-FREE COPD**

Before this crash, Linda Lawrence never knew she had underlying COPD. She never had shortness of breath; she never used inhalers; she never used bronchodilators nor required oxygen treatment. Please see her prior medical records. [PMR 1-37]

Linda Lawrence was first told that she had underlying COPD when x-rays and CT films of her chest at Fauquier Hospital picked-up "underlying emphysematous changes" in her lungs.

The medical records from Fauquier Hospital report that Linda Lawrence's underlying COPD was previously symptom-free and "newly diagnosed following her motor vehicle crash of February 21, 2007." For example, a pulmonologist, Kevin L. Glenn, M.D., in his consultation report of February 23, 2007 [MR 17], reported that Linda was "without significant past medical history". In addition, the Fauquier Hospital Discharge Planning Nurse's Notes [MR 68] report, "Assessment: Compression fractures; **newly diagnosed COPD...**"

The COPD changes, found on radiological films following the car crash revealed that Linda Lawrence's lungs were less elastic because of her underlying, symptom-free COPD. Trauma to both lungs caused bilateral pulmonary contusions with resulting bleeding and fluid build-up inside and outside both lungs. The blood and fluid build-up irritated Linda Lawrence's underlying COPD resulting in an acute, four-month exacerbation of her underlying, symptom-free COPD.

In 2007, Linda Lawrence's lung contusions, caused by this auto crash, resolved. Her lungs cleared. Her underlying COPD cleared and went back to baseline, as it was before the crash - symptom-free. **Once the exacerbating conditions from the lung contusions resolved, so did the exacerbation of Linda's underlying COPD.** Linda remains symptom-free for COPD. However, Linda Lawrence is left with a 45% permanent whole body impairment with permanent pain resulting from her multiple burst compression fractures of her thoracic vertebrae. She requires narcotic pain killers (Dilaudid) three times a day.

**PNEUMONIA;  
RESPIRATORY FAILURE REQUIRING A MECHANICAL VENTILATOR;  
METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS;  
SEPTICEMIA;  
ENDOCARDITIS;  
GENTAMICIN INDUCED RENAL FAILURE;  
PULMONARY EMBOLISM;  
ANTI-COAGULANT INDUCED BLEEDING EPISODES REQUIRING  
BLOOD TRANSFUSIONS**

The pulmonary contusions in both of Linda's lungs resulted in blood, fluid and secretion build-up. Linda was unable to clear this blood, fluid and secretions from her lungs because of severe pain from the thoracic burst compression fractures, muscle spasms in the muscles surrounding her back and ribs, and pain in her chest and diaphragm muscles. The accumulating blood, fluid and secretions became consolidated into a gel-like exudates -- analogous to a thickened, stagnant puddle of dark, curbside water. This **was a perfect medium for bacterial growth**, in a hospital

patient, in a weakened condition, from multiple compression fractures. Methicillin resistant staphylococcus aureus (MRSA) grew in Linda's lungs and spread to her bloodstream. Linda developed septicemia, pneumonia, and endocarditis where vegetative staphylococcus aureus bacteria was found growing on her aortic valve. Linda went into respiratory failure requiring a mechanical ventilator to breathe.

As noted, excessive blood, fluid and secretions built-up in Linda Lawrence's lungs. As a result, her heart was required to work harder leading to cardiomegaly (enlarged heart, dysrhythmias and congestive heart failure (CHF).

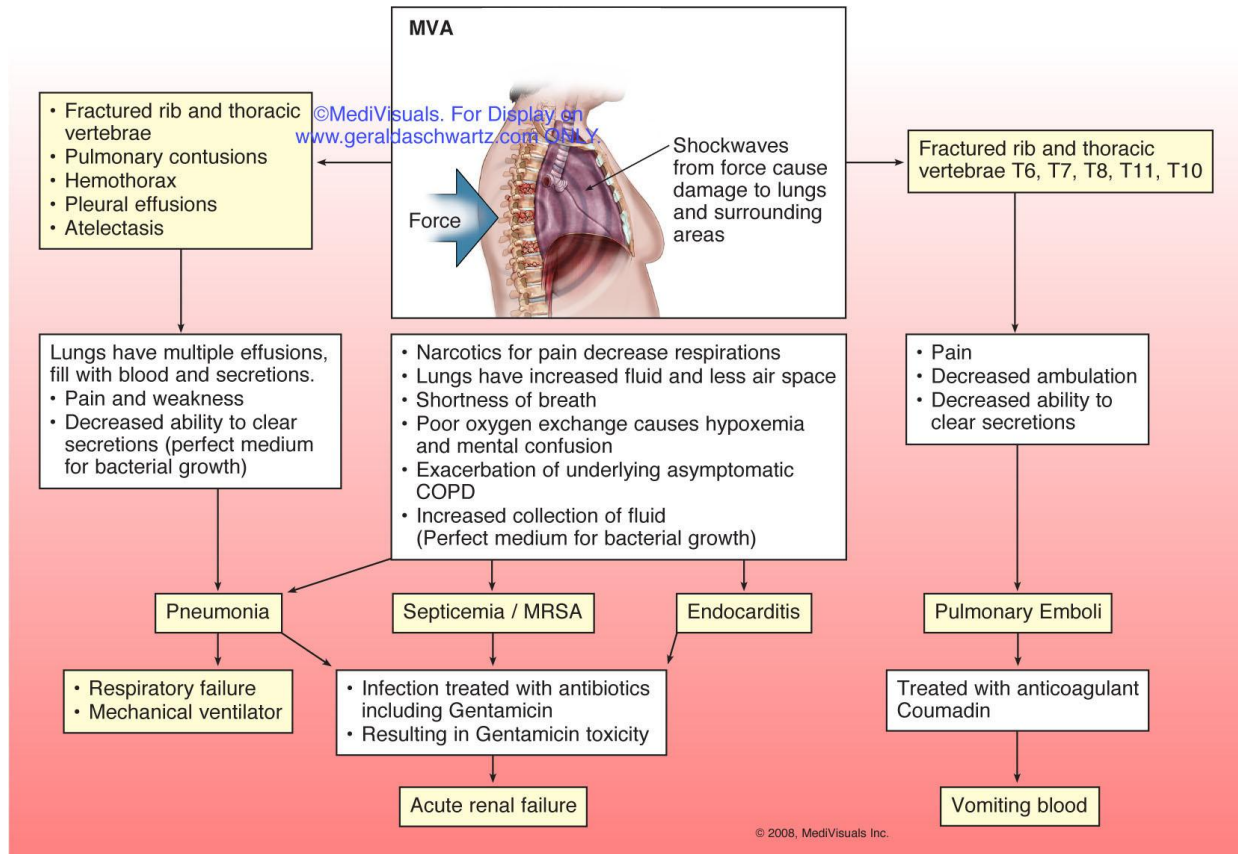
The endocarditis required six weeks of I.V. antibiotic therapy in intensive care and in a nursing home setting. Strong I.V. antibiotics were needed. Gentamicin was prescribed. A side-effect of Gentamicin is renal toxicity. Unfortunately, the I.V. Gentamicin therapy caused acute renal failure resulting in Linda being further hospitalized in the ICU at Fauquier Hospital. [MR 1119 - 1122]

Linda Lawrence suffered five thoracic vertebral fractures (including three burst compression fractures) and a fifth rib fracture. As a result of these multiple fractures, Linda Lawrence's ability to ambulate was severely compromised. As a result of decreased ambulation, while hospitalized at the Fauquier Hospital, Linda developed "extensive bilateral pulmonary emboli" [MR 250]. The pulmonary embolism was treated with the anti-coagulant Coumadin, while Linda was a patient at Fauquier Hospital and at the Warrenton Overlook Nursing Home. Unfortunately, the Coumadin caused severe bleeding episodes causing Linda to "vomit blood profusely". She was re-admitted back to the Fauquier Hospital Intensive Care Unit where she required blood transfusions [MR 1105-1106]. In addition, on May 16, 2007, Linda Lawrence was diagnosed with left leg deep vein thrombosis causing substantial pain in her left leg [MR 227].

## **FLOW CHART SHOWING EFFECTS OF MULTIPLE FRACTURES AND PULMONARY CONTUSIONS**

A flow chart showing the effects of the multiple fractures and pulmonary contusions on Linda Lawrence appears on the following page.

### Injuries Caused by 2/21/07 MVA



### SUMMARY

This is a case of substantial liability and substantial damages. On February 21, 2007, a Defendants' driver negligently slammed his loaded large Mack truck into the rear of Linda Lawrence's small Chevrolet. The force of the impact blew out the back window of Linda's Chevy, obliterated the trunk space, and propelled Linda's Chevy across the intersection and onto the side of the road.

The force of the impact burst three of Linda Lawrence's thoracic vertebrae; fractured two other thoracic vertebrae; fractured Linda's 5th rib; caused a multi-level thoracic paraspinal hematoma; and sent shock waves through both lungs causing pulmonary contusions, pleural effusions, hemothorax, and collapse of both lungs (atelectasis). As a result of the lung trauma, Linda developed shortness of breath and hypoxemia -- inadequate oxygen blood levels leading to mental confusion and respiratory failure requiring a mechanical ventilator.

Pain from the six fractures compromised Linda's ability to ambulate leading to "extensive bilateral pulmonary emboli", and left leg deep vein thrombosis requiring Coumadin anticoagulant treatment while hospitalized. As a result, Linda developed severe bleeding episodes, "vomiting blood profusely", requiring blood transfusions.

Blood, fluid and secretions from the pulmonary contusions built-up in Linda's lungs. Because of the pain and weakness from her six fractures and to her chest and diaphragm, Linda was unable to clear the blood, fluid and secretions from her lungs, which became "consolidated" -- a perfect medium for bacterial growth. As a result, Linda developed pneumonia, severe MRSA sepsis, endocarditis with bacterial growth on the aortic valve requiring Gentamicin antibiotic I.V. treatment leading to Gentamicin nephrotoxicity and renal failure.

The trauma from this crash caused an "exquisite amount of muscle spasm in [Linda's] thoracic spine secondary to compression fractures", requiring extensive narcotic pain medication, administered not orally, but by I.V.

Linda Lawrence's special damages to date total \$425,209.25. With the cost of future prescriptions, her total special damages are \$431,394.09.

**LINDA LAWRENCE (FAR RIGHT) WITH HER FAMILY  
THREE MONTHS PRIOR TO COLLISION**

[Photo Deleted for Confidentiality]

The Honorable Judge  
March 24, 2010  
Page Fourteen

**LINDA LAWRENCE'S QUALITY OF LIFE  
IS SEVERELY DIMINISHED**

Linda Lawrence is left with a permanent injury to her thoracic spine as a result of the multiple burst compression fractures. She is in constant pain. She is required to take the narcotic pain killer, Dilaudid, three times a day to help alleviate her pain. The quality of Linda Lawrence's life has been severely diminished. She is left with a 45% whole body permanent impairment and is no longer able to work.

Very truly yours,

Gerald A. Schwartz

GAS/mw  
Enclosures

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LAW OFFICES  
**GERALD A. SCHWARTZ**

REPRESENTING INJURED PEOPLE SINCE 1975

ADMITTED TO  
VIRGINIA AND DC BARS

2827 DUKE STREET  
ALEXANDRIA, VIRGINIA 22314  
(703) 823-0055

PERSONAL INJURY LAW  
FAX (703) 370-7732

May 5, 2009

(Actual names have been changed and/or deleted for confidentiality)

**VIA CERTIFIED MAIL:**  
**RETURN RECEIPT REQUESTED**

Ms. Joyce Smith  
Insurance Companies  
P.O. Box 9052  
Charlottesville, VA 22906

Re: Our Client: Alan Norton  
Your Insured: Defendant  
Date of Collision: June 28, 2005  
Claim No.:

Dear Ms. Smith:

Enclosed please find the Police Report, medical records with corresponding itemized billing statements, injury photographs and medical illustrations in support of Alan Norton's claim. This and the following are submitted for settlement purposes only.

**THE CRASH**

On the afternoon of June 28, 2005, Alan Norton was driving west on Route 673 in Fairfax County. As Alan Norton was approaching the intersection of Route 673 and Twin Branches Road, your insured **pulled directly into the path** of Alan Norton's vehicle causing the crash.

Fairfax County Police Officer C.T. Hayes responded to the collision scene and **found your insured was responsible for the crash—"Failure to Yield Right of Way at Stop Sign"**.

## **RESCUE SQUAD FINDS ALAN NORTON LYING ON GROUND WITH FRACTURED RIGHT ARM AND DISLOCATED LEFT THUMB**

Fairfax County Ambulance personnel arrived at the scene and found Alan Norton “[c]oncious, alert, lying on the ground with obvious broken R arm and dislocated L thumb...” Alan was given Morphine for pain relief and rushed to Reston Hospital.

## **RESTON HOSPITAL EMERGENCY ROOM FINDS ALAN NORTON TO HAVE SEVERE SWELLING, SEVERE WEAKNESS AND IN EXCRUCIATING PAIN**

When Alan Norton arrived at the emergency room at Reston Hospital, it was reported that his pain level was an **“excruciating 10”**. Nursing records report “pt has obvious deformity to R humerus & to L thumb & in severe pain”. Severe weakness was found in his right arm with **“severe swelling”**. Alan required an additional 4 mg of Morphine for the pain.

The emergency room physician also found significant swelling, reporting:

**“...exquisitely tender to palpation...[at the] right triceps and posterior upper arm and ulnar aspect of the right forearm. There is a significant amount of swelling/effusion over the ... right triceps and posterior upper arm and ulnar aspect of the right forearm. The affected hand and/or finger area appears to be significantly dislocated and/or somewhat deformed...”**

The emergency room record under, “RX in Department Physicians Disposition reported “tense swelling”:

**“[Patient backboarded and collard, airway intact. Obvious deformity right elbow with tense swelling.”**

## **X-RAYS REVEAL FOUR (4) FRACTURED AREAS IN ALAN’S RIGHT ARM**

X-rays taken on June 28, 2005 at the Reston Hospital emergency room revealed four (4) fractured areas in Alan’s right arm. The operating surgeon, Mark P. Malden, M.D., in his “pre-operative diagnosis” (operative report) described the humerus fracture as **“distal humerus fracture, 3 part, intercondylar”**. In addition, a **“buckle fracture” of the distal radius** was also found. Please note the emergency department record under “Interpretation of Tests” which states:



“X-rays of the right humerus/elbow/forearm: + comminuted and significantly angulated supracondylar fracture + **buckle fracture of the distal radius**”

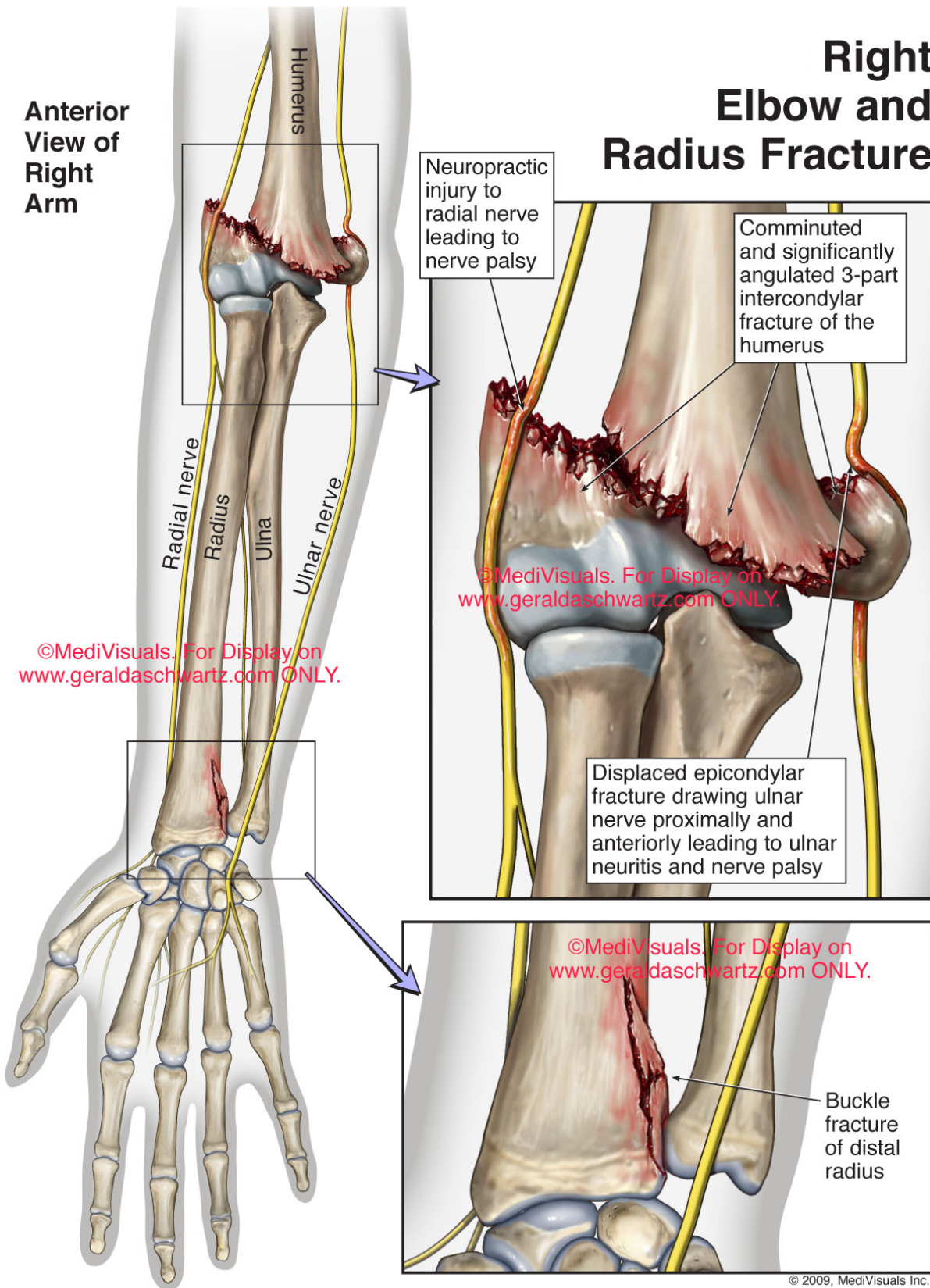
A copy of the actual x-ray of Alan Norton’s right elbow taken on June 28, 2005, showing the 3 part intercondylar fracture of the humerus and the buckle fracture of the distal radius appears below, followed by a medical illustration, prepared by a nationally recognized medical illustrator, illustrating these fractures:

### 6/28/05 X-Ray of Right Elbow



# Right Elbow and Radius Fracture

Anterior View of Right Arm



## **RADIAL NERVE PALSY, ULNAR NEURITIS AND ULNAR NERVE PALSY IDENTIFIED PRE-OPERATIVELY BY DR. MALDEN**

Orthopedic surgeon Mark P. Malden, M.D., reported that the fractures in Alan's right arm caused injury to both the radial nerve and ulnar nerve. **The fracture fragments caused trauma and stretching of his radial and ulnar nerve**--described by Dr. Malden as "neuropractic injuries".

Dr. Malden, in his operative reported, described his findings of radial nerve and ulnar nerve injuries as follows:

**"...Radial nerved palsy, ulnar neuritis, and ulnar nerve palsy were identified preoperatively and these were expected to be neuropractic injuries."**

During Alan's surgery, orthopedic surgeon Mark P. Malden, M.D., cut into Alan's elbow bone [osteotomy] to be able to inspect the ulnar nerve and to expose the fracture fragments. In his operative report, Dr. Malden reported that a fracture fragment had traumatized and compromised Alan's ulnar nerve by—"drawing the nerve down". Dr. Malden described what he saw in his operative report:

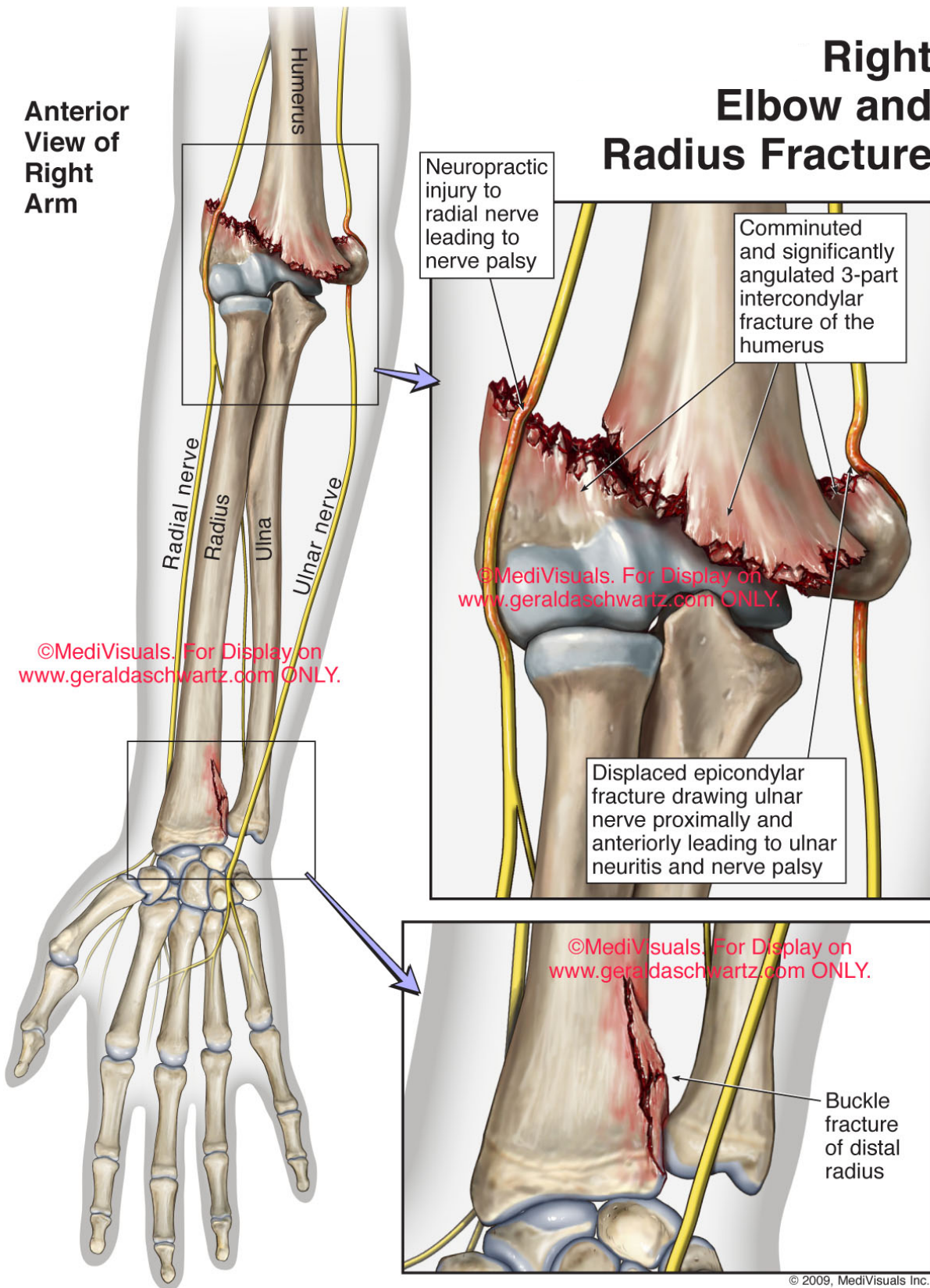
**"The olecranon osteotomy [surgical cutting of the bone] was performed without complication and the ulnar nerve was tracked and identified. There was a displaced medial epicondylar fragment which had drawn the ulnar nerve proximally and anteriorly."**

The neuropractic injuries to Alan's radial and ulnar nerves gradually improved with time. For example, on August 2, 2005, Dr. Malden reported in his office progress note, "[h]is radial nerve has recovered to a great degree".

A medical illustration, prepared by a nationally recognized medical illustrator, illustrating the neuropractic injuries to Alan's radial and ulnar nerves due to trauma and stretching from the fracture fragments is set forth on the next page:

# Right Elbow and Radius Fracture

Anterior View of Right Arm



## **IMMEDIATE SURGERY REQUIRING 2 SETS OF METAL PLATES AND SCREWS TO HOLD FRACTURE FRAGMENTS TOGETHER**

Alan Norton's right arm had four (4) fractured areas involving both the humerus and radius bones resulting in multiple fracture fragments:

1. Three (3) fractured segments in the intercondylar area of the right humerus; and
2. A distal radial fracture (buckle fracture) of the right radial bone.

On June 28, 2005, orthopedic surgeon, Mark P. Malden, M.D., made a large 12 cm (4-3/4 inch) surgical incision into Alan's right arm. Dr. Malden immediately noted "marked edema and ecchymosis". A portion of Alan's olecranon bone had to be cut with an oscillating saw and then chiseled, and the triceps muscle reflected, to expose the ulnar nerve and the multiple fractures of Alan's humerus. At the conclusion of the surgery, the olecranon was reattached with a long metal screw and cerclage wire. The fractures were reduced and initially pinned to hold them together. To stabilize the multiple fractures and their fracture fragments, plates and screws were drilled into both the right and left side (lateral and medial) of Alan's humerus. Five (5) long metal screws were drilled into a long six (6) hole metal plate on the right (lateral) side of Alan's humerus and six (6) long metal screws were drilled into a seven (7) hole long metal plate on the left (medial) side of Alan's humerus to stabilize the multiple fracture areas and their fracture fragments.

After drilling the plates and screws, pieces of loose fracture fragments were copiously irrigated and removed, followed by closing the surgical wound in several layers.

Dr. Malden described the surgery in his operative report as follows:

"... a standard posterior midline incision was made, carried down to the olecranon and triceps. Once this had been done, **marked edema and ecchymosis** were identified.

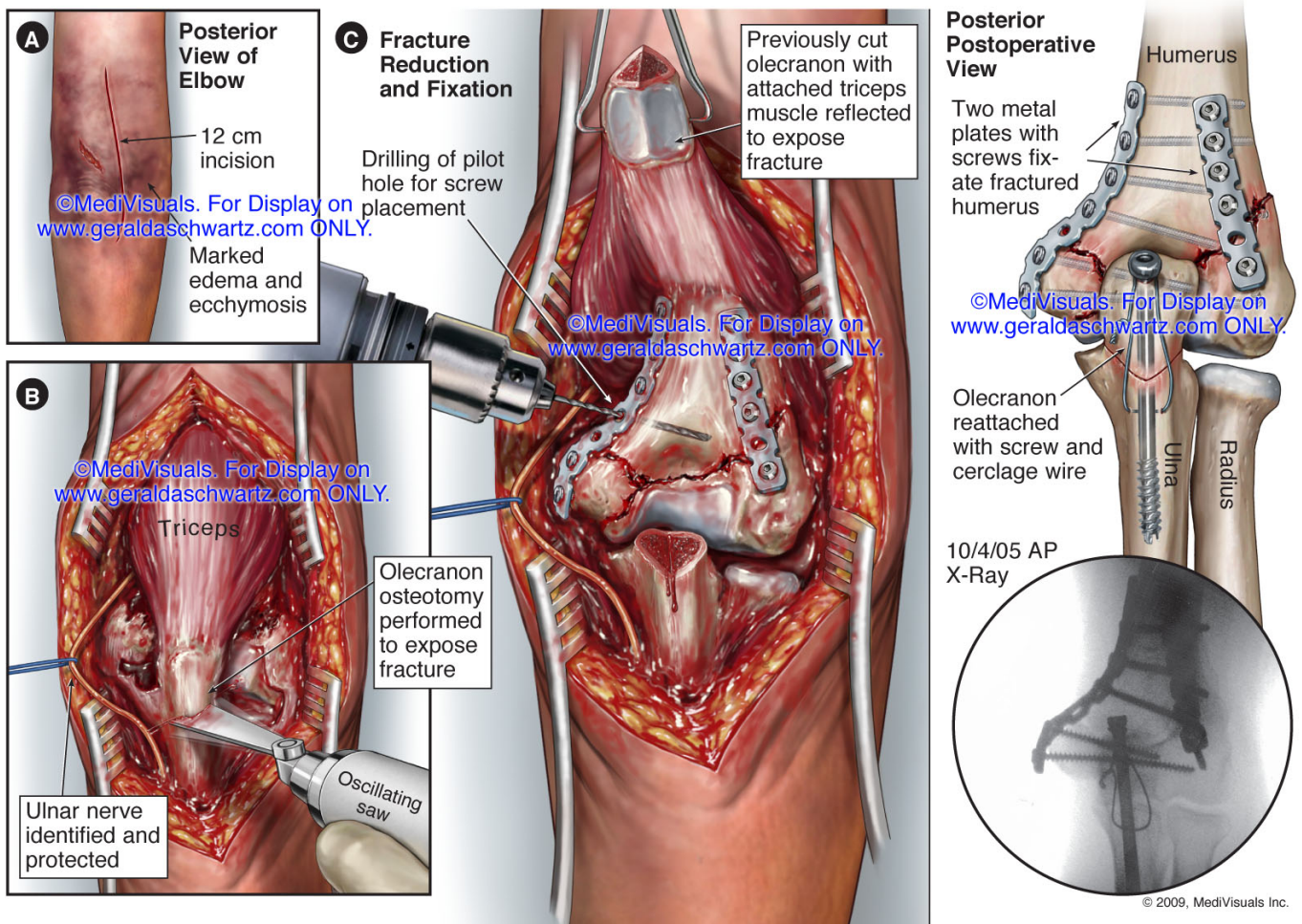
The olecranon osteotomy [using an oscillating saw and chisel] was performed without complication and the ulnar nerve was tracked and identified. There was a displaced medial epicondylar fragment which had drawn the ulnar nerve proximally and anteriorly. Once the triceps had been reflected proximally with olecranon osteotomy, the fracture was identified, irrigated copiously, was reduced, and checked using biplanar fluoroscopy and pinned provisionally using 10-mm guidepin.

Once this had been done, the **two plates were placed**, one medial and one lateral, contoured, 6 holes lateral, 7 holes medial and utilizing **bicortical screw fixation**, the fracture was reduced and held...

At this point, after copious irrigation, all loose pieces were removed and the wound was closed in layers..."

A medical illustration, prepared by a nationally recognized a medical illustrator, illustrating Dr. Malden's surgery performed on Alan Norton on June 28, 2005, is set forth below:

### 6/28/05 Right Elbow ORIF Surgery



## **CLOSED REDUCTION WITH PERCUTANEOUS PIN FIXATION WITH K-WIRE FOR UNSTABLE LEFT THUMB DISLOCATION**

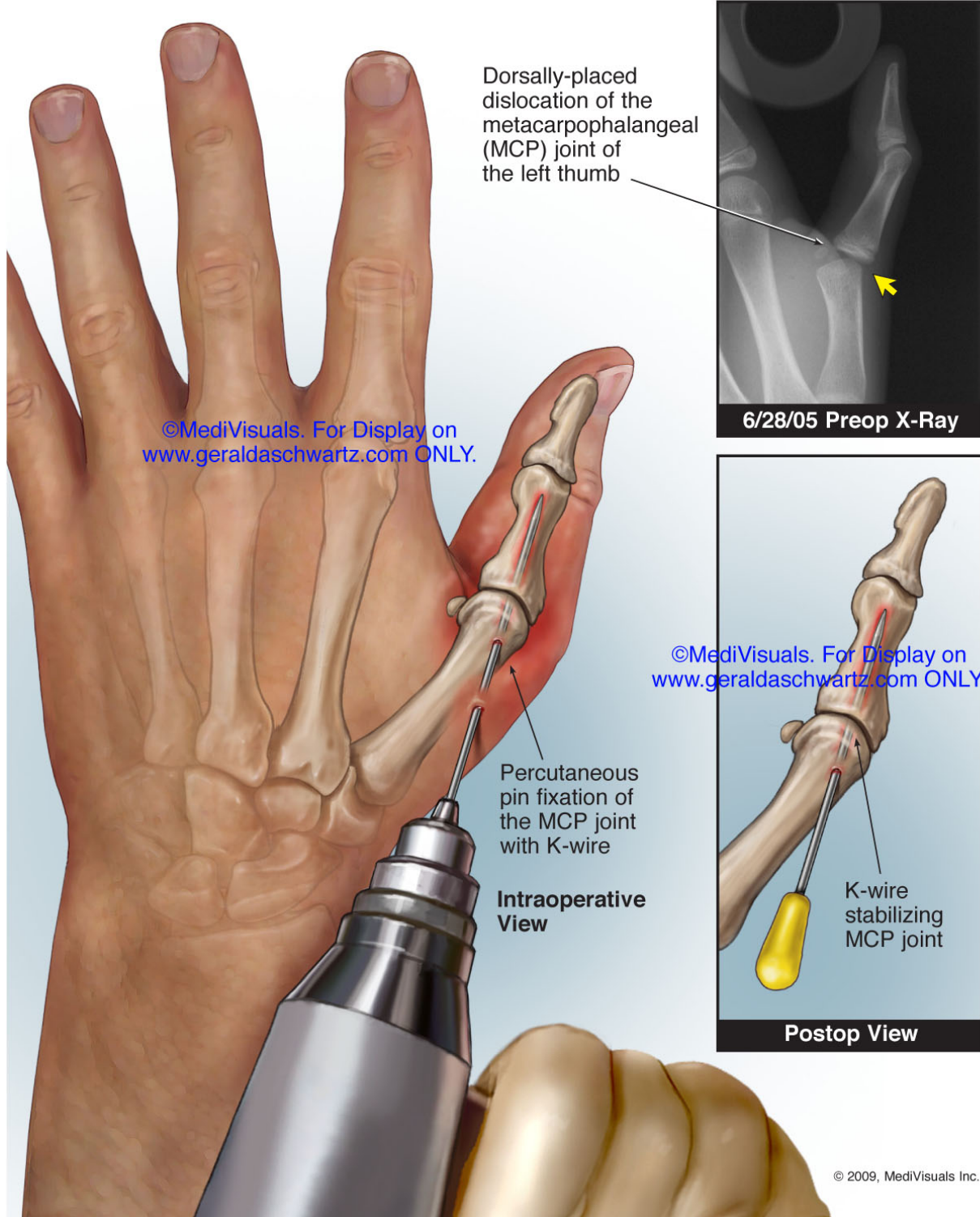
In addition to the four (4) fractured areas in Alan's right arm, Alan also suffered a severe dislocation of his left thumb joint rending the joint "quite unstable". Immediate surgery was required to stabilize the joint. On June 28, 2005, hand surgeon Janet Baxter, M.D., preformed the closed reduction of Alan Norton's unstable left thumb dislocation using percutaneous pin fixation with K-wire. Dr. Baxter describes the operation in her operative report as follows:

"The patient is a 16-year-old male who sustained multiple trauma in an automobile accident including a left thumb dorsally placed metacarpophalangeal [MPC] joint dislocation. ... The patient, therefore, underwent examination of his MCP joint at the left side under fluoroscopy. It was evident that the joint was **quite unstable** but was easily reducible by closed means.

... a 0.045 **K-wire was used to stabilize the joint**. Once closed reduction was performed under fluoroscopy, a thumb spica splint was placed following cutting of the K-wire just outside the skin..."

A medical illustration, prepared by a nationally recognized medical illustrator, appears on the next page illustrating the percutaneous pin fixation surgery:

## Left Thumb Dislocation and 6/28/05 Pin Fixation with K-Wire





## **POST OPERATIVE CARE – PEDIATRIC CARE UNIT**

Following recovery at the post care anesthesia unit (PACU) at 5:17 a.m. on June 29, 2005, Alan was then taken to the pediatric unit for further monitoring. He was placed on an IV with narcotic pain medication of Dilaudid and the antibiotic Ancef. Nursing reports from his pediatric unit admission note **Alan to be in severe pain; unable to move due to severe pain; and having bloody drainage from the surgical wound through his ACE bandage:**

“...Patient awake, alert, and in **pain**. Dilaudid 2 mg given... within 5 minutes, flat splotchy red rash appeared on torso and neck per mother patient had same reaction to Dilaudid in the PACU... Patient’s BPS [blood pressure systolic] high: Systolic 150-160s, Diastolic 80-90s. R hand is now warm, but capillary refill remains delayed at 4-5 sec. There is R blood drainage from the upper part of the Ace bandage-wrapped incision... Pain is mostly in the RUE [right upper extremity] and patient had difficulty with x-ray related to the inability to move his RUE without **severe pain**... Mother is bedside assisting in all ADLs [activities of daily living]”.

At 8:00 a.m., nursing records report:

“Alan alert and c/o pain (7.5 on scale) and morphine given and then after breakfast patient took Percocet which helped but call placed to Dr. Malden to obtain Toradol which really worked... Mom is an RN and we reviewed all important discharge instructions... Dressing to RUE with **bloody drainage** noted on underneath of arm ...”

Below is a picture of Alan Norton while admitted at Reston Hospital:

[Photo Deleted for Confidentiality]

Alan was discharged at 12:00 p.m. that day. Nursing records report that Alan was “[m]edicated with 2 Percocets prior to going home.”

### **LOSS OF USE OF BOTH HANDS FOR SEVERAL MONTHS**

Because Alan suffered significant right arm and left hand injuries, he was unable to use both hands for several months.

Below is a picture of Alan Norton once he returned home following his June 28, 2005 surgeries to his right arm and left hand:



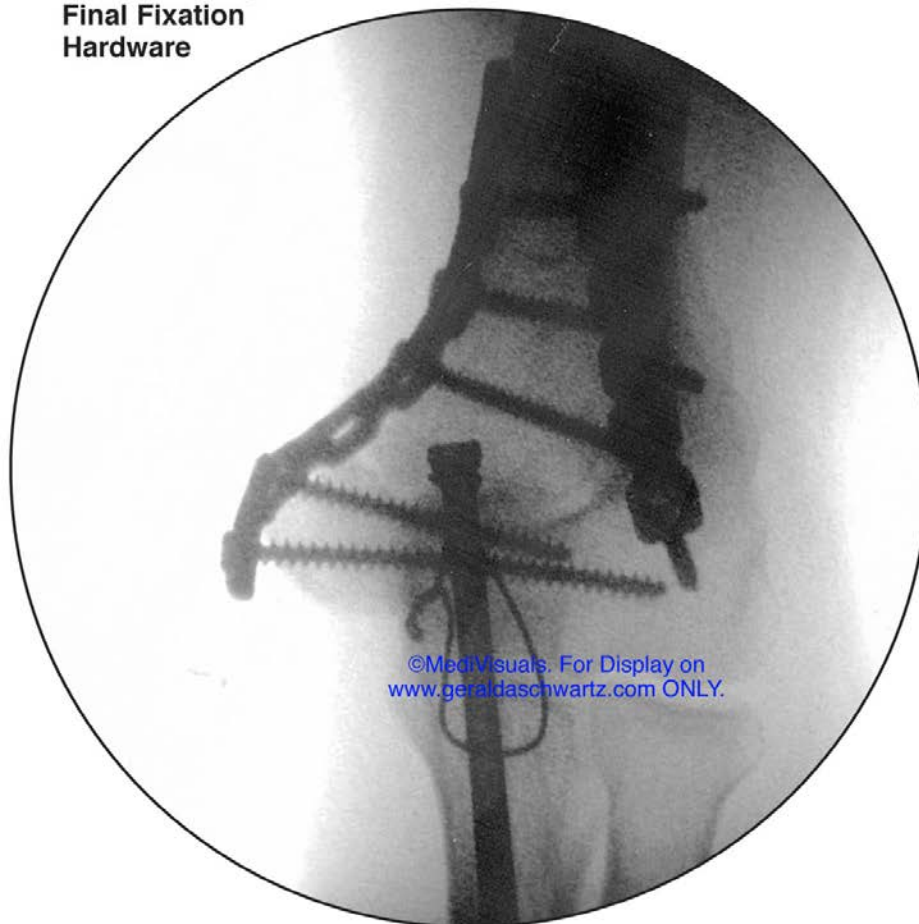
**PLATES AND SCREWS ON BOTH SIDES OF ALAN'S  
HUMERUS AND LARGE OLECRANON SCREW  
AND CERCLAGE WIRE CAUSE PAIN**

The long six (6) hole metal plate with five (5) metal screws and the long seven (7) hole metal plate with six (6) metal screws drilled into the right and left side of Alan's humerus bone to hold together the multiple fractures and the large olecranon screw and cerclage wire began to cause Alan pain.

A post-surgical x-ray of the plates and screws as well as the large olecranon screw and cerclage wire left in Alan's humerus appears on the next page:

## 10/4/05 Right Elbow AP X-Ray

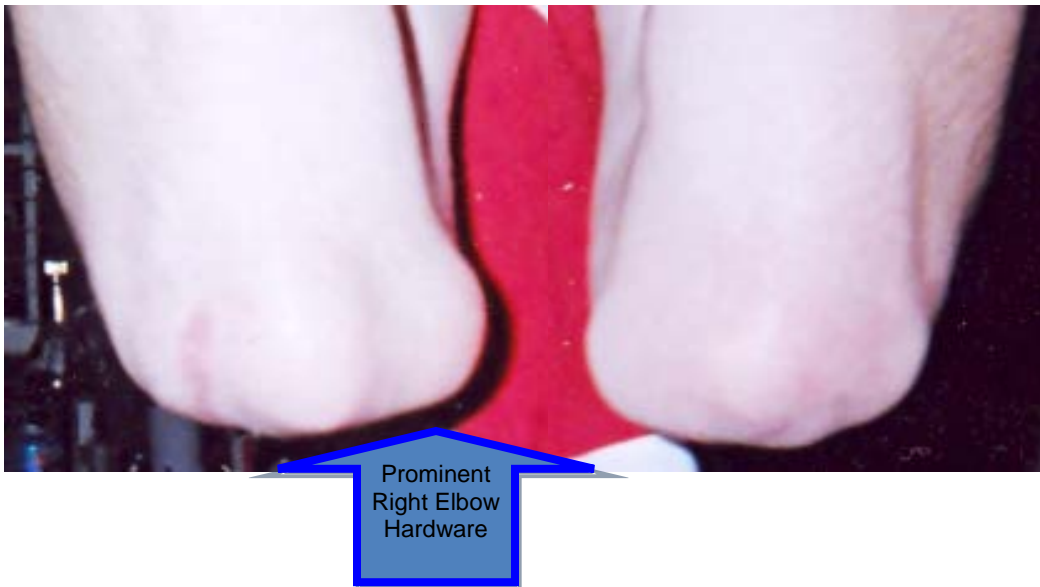
Postoperative  
X-Ray  
Demonstrating  
Final Fixation  
Hardware



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These plates and screws in Alan's right arm were visually prominent, as noted on the next page:



On August 4, 2006, Dr. Malden reported that Alan's "**plates are a little bit prominent**" and that the **plates have "some symptomatology to them"**. Dr. Malden suggested surgical removal of the hardware which could take "when he [Alan] chooses".

Alan Norton returned to Dr. Malden's office on February 12, 2008 with right elbow pain and hardware prominence. Dr. Malden recommended hardware removal. Dr. Malden reported that Alan was a college student and would schedule the hardware removal surgery once he finished his college semester.

On June 24, 2008, Alan returned to Dr. Malden's office because the implanted hardware at his right elbow was causing him pain. Dr. Malden reported that Alan had begun experiencing "**pressure in the elbow**" and as a result of Alan's symptomatology, Dr. Malden recommended Alan have the hardware surgically removed.

**COMPLICATED SURGICAL REMOVAL OF PLATES AND SCREWS--  
SCREW HEADS STRIPPED--AMPUTATION REQUIRED--  
SCREWS BREAK OFF AND CANNOT BE REMOVED--  
SCREW SHAFTS REMAIN DEEP IN ALAN'S HUMERUS**

On July 9, 2008, more than three (3) years after Alan's ORIF surgery, orthopedic surgeon Mark P. Malden, M.D., attempted removal of the six (6) hole metal plate and the seven (7) hole metal plate drilled into the right and left side of Alan's humerus with metal screws.

In his operative report of July 9, 2008, Dr. Malden notes the indication for the hardware removal:

“Indications: The patient is a 19-year-old white male with **increasing pain in his elbow secondary to prominent hardware.**”

Unfortunately, because the screw heads were **stripped**, the hardware removal surgery was complicated. Several attempts by Dr. Malden to remove the eleven (11) metal screws, holding the two (2) metal plates in place, failed. Because the screws were stripped, Dr. Malden had to use a **Midas Rex Drill bit** to drill a hole in the bone from **underneath the metal plates** on both the right and left side **to create a “bone window” to reach the screws and plates from underneath the bone.** Amputation of the stripped metal screws was attempted using a Midas Rex Drill bit. The metal plates were removed, but unfortunately, **several metal screws broke in the process permanently leaving multiple decapitated screw shafts in Alan’s humerus.** Use of the Midas Rex Drill bit left fragments of metal at the operative site which required “copious irrigation” for their removal from the surgical site. Dr. Malden described this complicated hardware removal surgery in his surgical report of July 9, 2008, as follows:

“...Old incision was identified and the scar was excised and the hardware was palpated subcutaneously. The ulnar nerve was identified and protected. The screws of the radial side plate were addressed and the screw heads were indeed **stripped**. **A number of attempts were made to remove them; however, because of the stripping it was determined to take a Midas Rex [Drill bit] and amputate the screws underneath the plate. A small bone window was created.** Amputation was performed and the plate was then removed. Attention was then directed to the olecranon screw which was removed without difficulty. The olecranon wire was also removed without difficulty. Next, the ulnar plate was identified. The distal 2 screws were removed; however, the **screws broke and they were allowed to deep in the bone.** The proximal 3 screws \_\_\_\_\_ had been stripped a head and because of the soft \_\_\_\_\_ it was determined to use a Midas Rex here as well. **Midas Rex was then used to amputate the screws through a small bone window.** This was done without complication. The plates were removed. Copious irrigation was used to remove all available **metal fragments.** Once this had been done, the wounds were closed in layers. The triceps window was closed using #0 Vicryl, the skin was closed #0 and 2-0 and staples...”

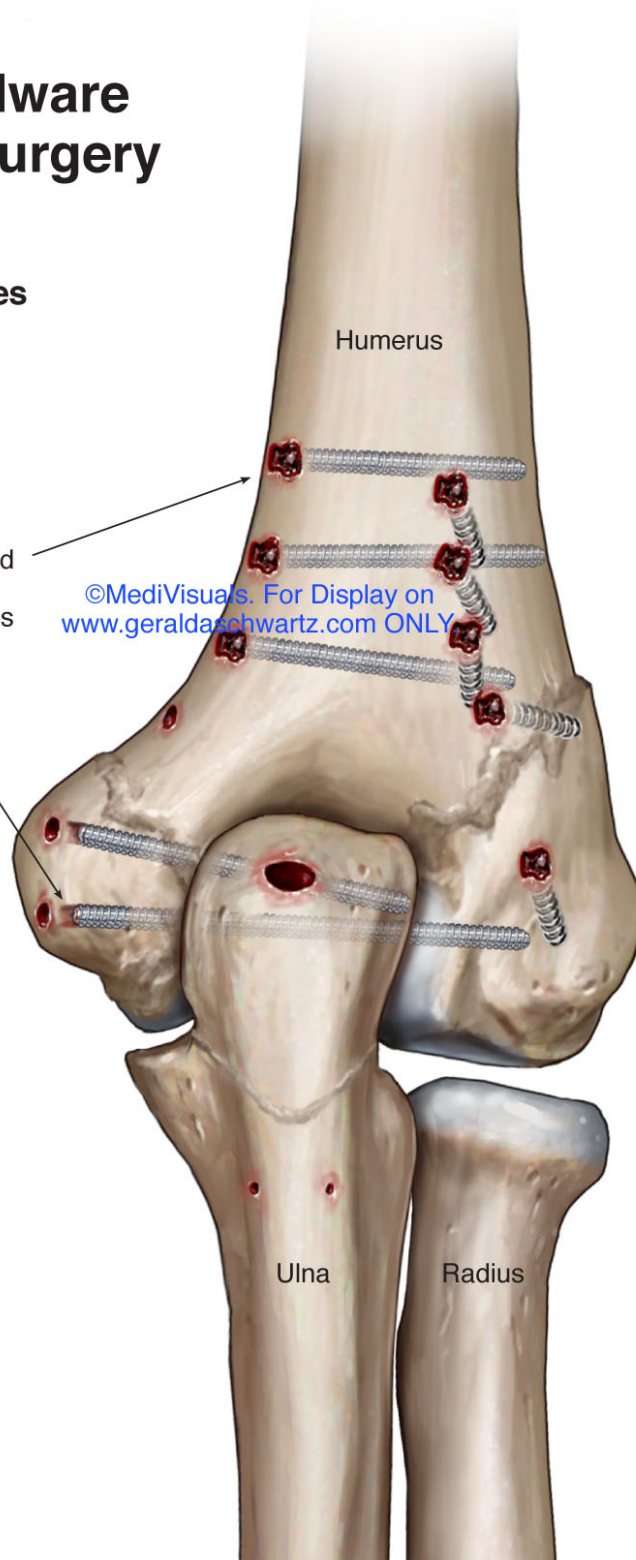
Below is medical illustration, prepared by a nationally recognized medical illustrator, describing the amputated metal screw shafts permanently left in Alan Norton’s right arm following the July 9, 2009 hardware removal surgery:

## 7/9/08 Hardware Removal Surgery

Posterior View of  
Right Elbow Bones  
After Hardware  
Removal

Multiple amputated  
screw shafts left  
within the humerus

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**ALAN NORTON'S  
"SIGNIFICANT AND DISFIGURING"  
PERMANENT RIGHT ELBOW SCARRING**

Alan Norton, now age 20, is left with significant, disfiguring 4-3/4 inch permanent scarring of his right arm.

Below is a picture of Alan's right arm following surgery in 2005 showing the staples in his right arm at the surgery site:



Below are photographs taken three years later in December 2008 of Alan Norton's right arm permanent surgical scars:







On February 18, 2009, Alan Norton was seen by plastic surgeon, Bruce M. Foster, M.D. for right arm scarring following his two surgeries involving his right elbow fracture with implanted hardware. Dr. Foster examined Alan's right elbow and reported:

“He has a **12 cm [4-3/4 inch] x 1 cm red raiser hypertrophic scar** on the posterior lateral aspect of his right elbow. There is a **1 cm x 2.5 cm raised red hypertrophic scar** immediately lateral to the laser scar. Light touch sensation is altered around the right elbow in the area of the scarring. Right elbow range of motion is slightly restricted in extension.”

Following his examination, Dr. Foster reported that even with successful surgery, Alan will be left with permanent scarring for life, stating:

“He is concerned about the thickness and appearance of the scars on his right upper extremity. I discussed the topic of scar revision. I believe that scar revision would be beneficial as his scars are linear, tight, and hypertrophic. This would consist of removing the existing scar followed by closure interdigitating Z-plasties... I anticipate that with this proposed treatment Mr. Norton could note a 70 to 80% improvement in the nature of the scarring in his right arm. I explained that **even with successful surgery he will be left with permanent scars for the rest of his life.** However, I believe that the benefits of scar revisions are reasonable.”

Dr. Foster reported that surgery would take place at an outpatient facility under general anesthesia and reports that surgical scar revision costs to total \$7,500.00.

### **MEDICAL BILLS**

An itemized tabulation of Alan Norton's specials is enclosed. In summary, they are:

Past Medical Specials	\$43,405.11
Surgical Scar Revision	<u>\$7,500.00</u>
<b>TOTAL</b>	<b>\$50, 905.11</b>

### **SETTLEMENT**

Alan Norton, at age 16, suffered a major injury to both his right arm and left hand. He suffered severe fractures to his right arm resulting in four fractured areas—a comminuted and significantly angulated 3 part intercondylar fracture of the humerus as well as a "buckle fracture" of the right distal radius. In addition, Alan suffered a severe dislocation of his left thumb rendering the joint "unstable" requiring immediate surgery and pin fixation with a K-wire to stabilize the joint.

The fracture fragments from the severe humerus fracture stretched and comprised Alan's radial and ulnar nerves resulting in a neuropractic injury to both nerves. Alan's treating orthopedic surgeon Mark P. Malden, M.D., identified radial nerve palsy, ulnar neuritis and ulnar nerve palsy. The neuropractic nerve injuries took several months to recover.

Alan required major ORIF surgery to help stabilize his right arm fracture. A long metal six (6) hole plate and a long metal seven (7) hole plate, each with screws, had to be drilled into the right and left side of Alan's right arm to stabilize his humerus fractures. Unfortunately, Alan is still left with permanent multiple decapitated screw shafts deep within his humerus. In addition, Alan is left with a long, ugly, 4-3/4 inch surgical scar on his right arm.

The medical bills which total \$50,905.11 do not adequately reflect the value of Alan Norton's claim.

After you have had an opportunity to review our demand package, please contact us to discuss whether or not the case of Alan Norton can be amicably settled.

We look forward to hearing from you within 30 days from the date of this letter to

Insurance Company  
Claim No.:  
May 5, 2009  
Page 22

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discuss settlement. If you need additional information, please contact us within 10 days.

Very truly yours,

Gerald A. Schwartz

GAS/mw  
Enclosures

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October 15, 2008

**(Actual names have been changed and/or deleted for confidentiality)**

**VIA FEDERAL EXPRESS**

Re: Samuel Brown v. Defendant, et al.  
Mediation: October 20, 2008 at 10:00 a.m.

### **SAMUEL BROWN'S MEDIATION SUBMISSION**

Mediation: October 20, 2008 at 10:00 a.m.

Parties: Plaintiff: Samuel Brown  
Defendants: Defendant

### **SUMMARY OF SAMUEL BROWN'S "DEVASTATING INJURY"**

On October 23, 2005, Samuel Brown's left foot was severely crushed. Almost every bone in his mid-foot was severely fractured. The fractures were highly comminuted and displaced. Articular surfaces of several crushed bones had their soft tissue joint attachments sheared and denuded. Samuel Brown's doctors described his injury as "devastating". Multiple compartments of Samuel Brown's left leg were pressure-filled with post-traumatic swelling and hematomas. Sizable soft tissue defects were found in Samuel Brown's "left leg extending all the way down to his ankle".

Samuel Brown's left foot and leg were dangerously swollen. His toes and left foot were avascular and white in appearance. Pressure within the multiple compartments of Samuel's left foot and leg was dangerously high. Emergency multiple fasciotomy surgeries to release the pressure build up was urgently needed to restore vascular circulation and nerve function to prevent amputation of Samuel Brown's foot.

Samuel Brown's operating orthopedic surgeons will describe what they found

when they opened Samuel Brown's left leg. They will teach us about the anatomy of the human foot and how our foot and leg is divided into anatomical compartments. Each compartment consists of arteries, veins, nerves and muscles held together in a closed envelope of fascia. Severe trauma causes significant hemorrhage, significant swelling and significant pressure build up within these closed compartments. If the resulting pressure build up is not released, the arteries, veins, nerves and muscle within the closed compartment die and the leg is lost. Fasciotomy surgery is the surgery of choice to release the pressure build up in each compressed compartment. Unfortunately, fasciotomy surgery leaves large, gaping, open wounds often requiring split thickness skin grafting.

On October 23, 2005, Samuel Brown was rushed into the operating room of the Reston Hospital Center. Orthopedic surgeon, Thomas J. Kaplan, performed 10 separate fasciotomy surgical procedures to relieve the pressure within the compartments of Samuel Brown's left foot. Because of the "marked comminution and marked destruction" found by the operating surgeon, surgical reduction of Samuel Brown's highly comminuted and displaced crush fractures were not possible. At the conclusion of Dr. Kaplan's extensive surgery, Samuel Brown's crush fractures remained unstable.

On October 25, 2005, Samuel Brown was again taken to the operating room at Reston Hospital Center. Plastic surgeon, Wendy R. Gordon, M.D., performed a surgical procedure labeled "incision, debridement and drainage". Dr. Gordon found a portion of Samuel Brown's talar bone to be "denuded of any soft tissue attachments" and "was not viable and was contaminated". Unfortunately, the medial fasciotomy wound to Samuel Brown's left leg was so extensive that it could not be fully closed by Dr. Gordon.

On October 25, 2005, Samuel Brown underwent another operation performed by orthopedic surgeon, George Kennedy, Jr., M.D.—drilling of an external fixator into the bones of Samuel's left foot to help stabilize his extensive crush fractures.

Unfortunately, the external fixator failed to reduce Samuel Brown's fractures. The external fixator left Samuel Brown's left foot in a "varus position" with a "displaced alignment of his medial and lateral columns".

On October 31, 2005, Samuel Brown was again taken to the operating room of the Reston Hospital Center where the external fixator was "surgically repositioned and tightened down" after manipulating the external fixator in multiple planes.

Samuel Brown's extensive wounds from the 10 fasciotomy surgical procedures again required Samuel to be taken to the operating room at Reston Hospital Center five more times from October 26, 2005 to November 7, 2005. Each time, plastic surgeon Wendy Gordon, M.D. was required to surgically change his VAC fasciotomy wound dressings to avoid infection and promote healing of the extensive wounds.

On November 14, 2005, Samuel Brown was discharged from the Reston Hospital

Center to a nursing home -- HCR Manor Care. Upon discharge, treating orthopedic surgeon George Kennedy, Jr., M.D., noted that because of Samuel Brown's extensive fasciotomy wounds, he "still does not appear ready for definitive ortho[pedic] fixation".

On December 2, 2005, Dr. Kennedy recommended removal of the external fixator and to proceed with "ORIF [open reduction internal fixation] or a fusion of his talar navicular joint and some work to his cuboid if we are able". Samuel Brown's orthopedic surgeons were unable to perform surgery. He now requires a three level fusion.

On December 14, 2005, Samuel Brown was again taken to the operating room at Reston Hospital Center where orthopedic surgeon George Kennedy, Jr., M.D. surgically removed the external fixator from Samuel's left leg.

On December 14, 2005, while still in the Reston Hospital Center operating room, plastic surgeon Wendy R. Gordon, M.D., surgically performed split thickness skin grafting of Mr. Brown's large fasciotomy wounds.

Samuel Brown was readmitted from the Reston Hospital Center to the Manor Care nursing home where he was treated until December 24, 2005. Samuel Brown was discharged from the nursing home, with a walker, wheel chair and crutches.

On June 27, 2006, Samuel Brown was evaluated by plastic surgeon Bruce M. Foster, M.D. Dr. Foster reported, "Mr. Brown sustained a **devastating injury** to his left lower extremity. He was fortunate to have maintained the viability of the left foot". Because of "anatomic and vascular limitations" Dr. Foster advised against further plastic surgery procedures. Dr. Foster was of the opinion that Samuel Brown is "left with permanent scarring and dysfunction in his left lower extremity."

Samuel Brown continued to follow-up with orthopedic surgeon George Kennedy through August 16, 2006. Dr. Kennedy on May 5, 2008, reported that Samuel Brown was left with a 50% permanent impairment of his lower extremity and is a candidate for arthrodesis (fusion) surgery.

On December 11 2006, Samuel Brown was seen by orthopedic surgeon John K. Brown, Jr., M.D. for an independent medical evaluation. Dr. Brown found "atrophy" and "multiple joints in the forefoot with arthritic changes". Dr. Brown reported that Samuel Brown is left with "permanent restrictions to his activities"; "permanently disabled from his usual employment"; and has "total impairment [of] 35% of the lower extremity". Dr. Brown reported that Samuel Brown "is a candidate for triple arthrodesis" (three level fusion surgery) of the left foot. On February 7, 2007, Dr. Brown again recommended the "triple arthrodesis surgery", and referred Samuel Brown to orthopedic surgeon Steven K. Newman, M.D., a specialist in orthopedic foot surgery.

Samuel Brown has treated with Dr. Newman from February 22, 2007 through

July 2, 2007, and remains under active medical care. On July 2, 2007, Dr. Newman reported that Samuel Brown had “end-stage arthritis” of his left foot and suggested a three level fusion surgery to Samuel’s left foot, stating “surgery would involve a TN [Talo-Navicular] and NC [Navicular-Cuboid] fusion with bone graft. Concern for soft tissue.”

Jerry S. Farmer performed a defense IME on April 18, 2008. Dr. Farmer was of the opinion that Samuel Brown suffered a “severe crush injury” and may require two surgeries--an ostectomy and a mid-foot fusion.

Medical illustrations describing Samuel Brown’s Severe Left Foot Crush Injuries; His Compartment Syndrome and October 23, 2005 Fasciotomies; His External Fixator Placement; His Skin Grafting Surgery and His Left Foot Fusion Surgery resulting from End-Stage Arthritis of his left foot are enclosed.

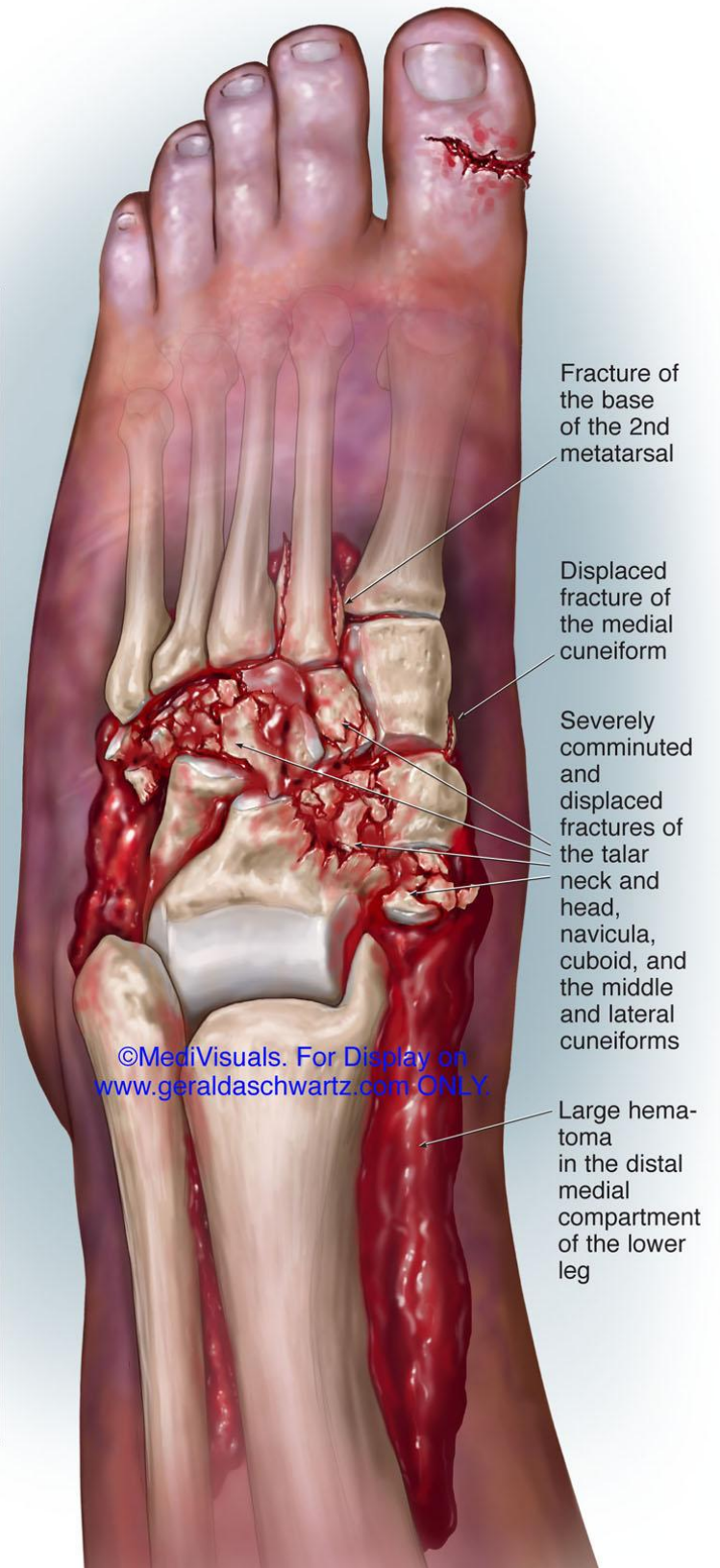
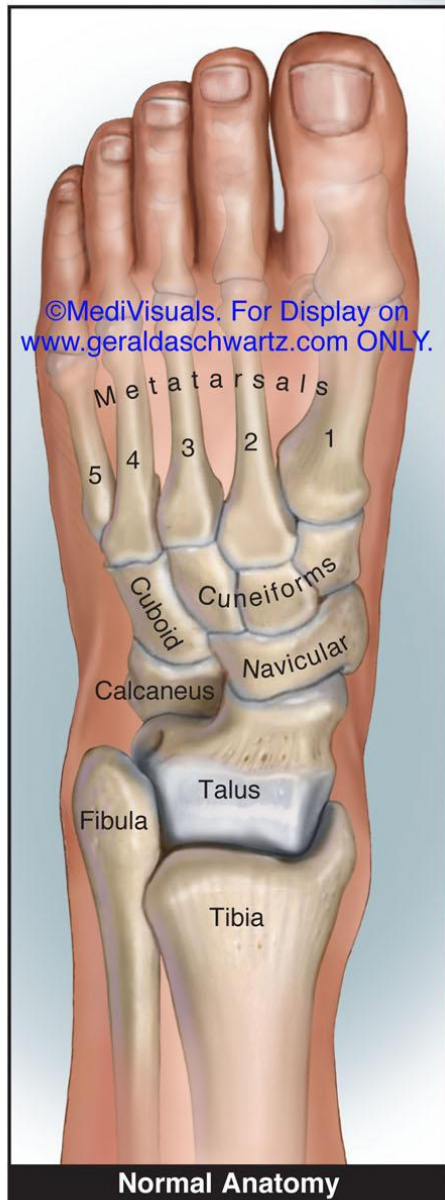
Special damages total \$816,763.79 (see page 32, below).

### **SEVERE, DEVASTATING INJURIES SUFFERED BY SAMUEL BROWN, AGE 28, ON OCTOBER 23, 2005**

1. “Highly Comminuted, Displaced Fracture of the Navicular Bone
2. Highly Comminuted Fracture of the Neck of the Talar Bone with Numerous Small Displaced Fragments
3. Highly Comminuted Fracture of the Head of the Talar Bone
4. Talar Bone Head Denuded of Soft-Tissue Attachments and Cartilage Covering At its Articular Surface
5. Severely Comminuted, Moderately Displaced Fracture of the Lateral Cuneiform Bone
6. Severely Comminuted Displaced Fracture of the Middle Cuneiform Bone
7. Severely Comminuted Displaced Fracture of the Medial Cuneiform Bone
8. Severely Comminuted Displaced Fracture of the Cuboid Bone with Displaced Fragments Laterally
9. Articular Surface of the Main Body of the Cuboid Bone Sheared
10. Disruption of the Anterior Talocalcaneal Joint
11. Markedly Dislocated Fracture at the base of the 2<sup>nd</sup> Metatarsal Bone
12. Large Soft-Tissue Defect-Medial-Distal Calf
13. Large Soft-Tissue Defect-Medial Malleolus
14. Large Soft-Tissue Defect Dorsal & Lateral Foot
15. Sizable Soft-Tissue Defect of the Left Lower Extremity Extending Down to the Ankle”



## Severe Left Foot Crush Injury



## LIABILITY:

[DELETED FOR CONFIDENTIALITY]

### **SURGERY ON DATE OF ACCIDENT OCTOBER 23, 2005: SURGICAL OPERATIVE REPORT REVEALS MARKED DESTRUCTION AND MARKED COMMINATION WITH MULTIPLE CRUSH FRACTURES WITH LARGE MULTIPLE HEMATOMAS**

#### **1. URGENT NEED FOR SURGERY TO PREVENT AMPUTATION**

The operative report describes the urgent need for surgery – to relieve extreme pressure build up within multiple compartments of Samuel Brown’s left leg to prevent damage to arteries, veins, nerves and muscles leading to amputation. The operative report states:

“The patient was taken **urgently** to the operating room after the risks and **possible complications** were discussed including the **need for fasciotomy to the lower leg and foot, possible later avascular changes which may ultimately lead to amputation, the need for further surgery including stabilization of the fracture** to be done at a later date, possible need for **skin grafting**; clearly aware of the risk of infection, nerve and artery damage as well as delayed wound healing...”.

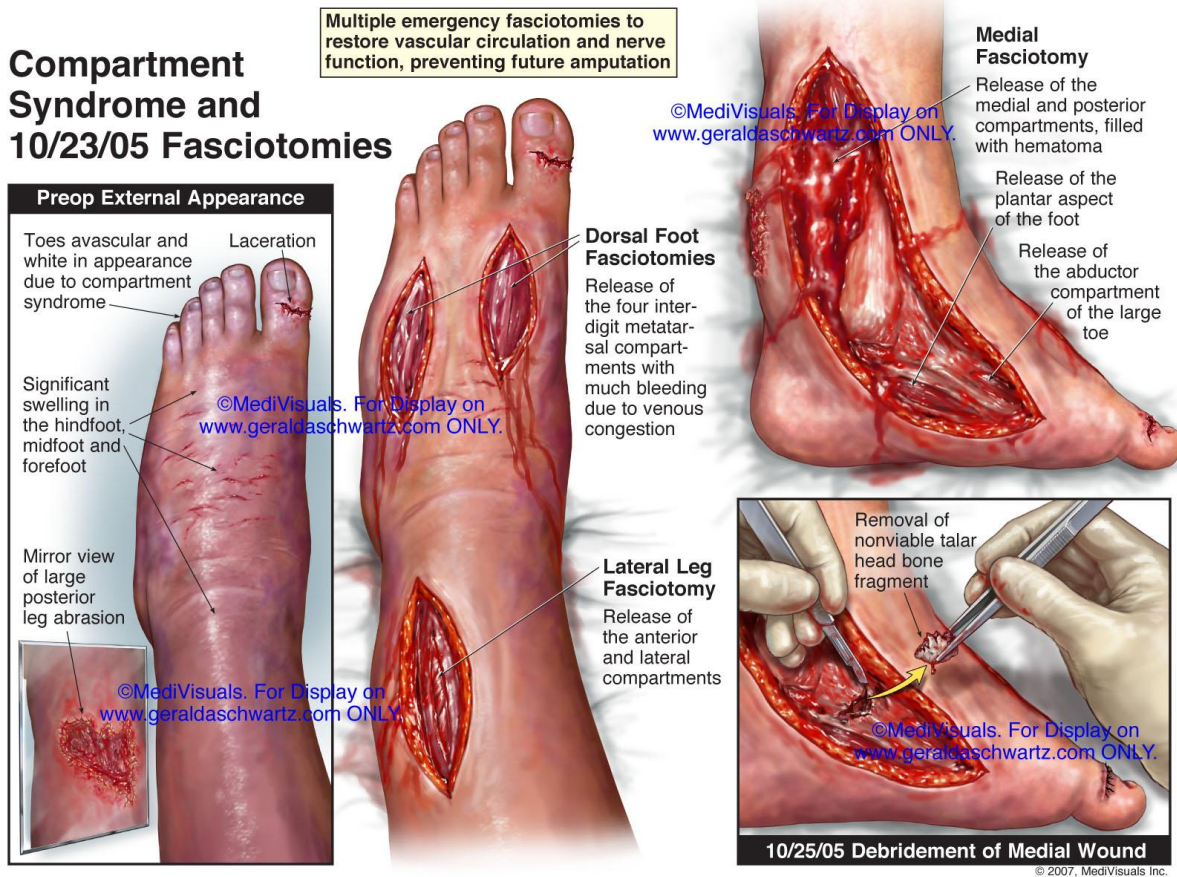
## **2. THE TEN FASCIOTOMIES AND DESTRUCTIVE FINDINGS**

The surgical operative report of October 23, 2005 vividly describes the destruction orthopedic surgeon Thomas Kaplan, M.D. found when he cut open Samuel Brown's left foot to perform the 10 fasciotomies to relieve severe pressure in the multiple swollen and compressed compartments of Samuel Brown's left leg:

"The reduction was carried out by closed means with C-arm and some improvement was noted, however, quickly collapsed into its baseline position. It was elected to move forward with a **fasciotomy**. A dorsal incision was made between the first and second metatarsal overlying the foot, care taken not to injure the underlying neurovascular bundles. **Fasciotomy** of the interosseous region was then carried out deeply. This was then extended between the second and third...A second **incision** was then made overlying the fifth metatarsal and dissected between the fourth and fifth as well as the third and the fourth. There was a skin bleeding due to the venous congestion. The muscles were herniated quickly into the area of the wound. All small bleeding points were controlled using electrocautery. Due to the tautness in the foot extending toward the ankle, it was required to carry these incisions more proximal than usual...The **navicula** could be palpated, **markedly comminuted and displaced** anteriorly... Somewhat laterally, the cuboid was palpated in an attempt to push back into its normal anatomic position, however, **marked instability** followed. A medial **incision** was then made overlying the adductor of the great toe, carried down to the skin and subcutaneous tissue. The **fascia was then released...marked swelling** was noted in the area of the abductor compartment. This was then **dissected** to the plantar aspect of the foot, and plantar **release** was carried out ...proximally and to the level of the heel...Due to the **significant swelling** in the posteromedial aspect of the ankle, it was carried out posterior into the medial malleolus. A **large hematoma was evacuated**, and the tight **tissue was then released**...carried out to the anteromedial aspect of the lower leg...The medial compartment was visualized, and there was noted to be **hematoma** within this. This was **released**, and the **hematoma was evacuated...significant swelling and hemorrhage** was noted within the **compartment** of the anteromedial tibia. The **dissection** was carried out posteriorly. The posterior **compartment** was visualized as well, had

**hematoma within this.** This was released proximally and distally...Due to the **significant swelling**, it was elected to go laterally as well. A small lateral **incision** was then made distally. The superficial peroneal nerve was visualized and protected, and the anterior compartment was then **released**...the lateral compartment was **released**...**Of note, while prepping the foot, even the least elevation, the toes and foot became avascular, white in appearance.** Upon completion of the fasciotomy, all toes were quite pink, had excellent capillary refill. The swelling of the foot and leg was markedly improved. All small bleeding points were controlled with use of electrocautery. Copious irrigation was carried out. There was a **laceration** about the area of the IP joint. This was cleansed...and closed... Remaining of the wounds were then packed... and a compression dressing was applied. A posterior splint was applied..."

A medical illustration, prepared by a nationally recognized medical illustrator describing Samuel Brown's multiple compartment syndromes, and the fasciotomy surgeries performed on October 23, 2005 to relieve the severe pressure of build up in the multiple compartments to save Mr. Brown's leg is shown below:



### **3. ORTHOPEDIC SURGEON THOMAS KAPLAN'S EXTENSIVE SURGERY OF OCTOBER 23, 2005, UNABLE TO STABILIZE SAMUEL BROWN'S FRACTURES DUE TO MARKED COMMINATION, MARKED DESTRUCTION AND SIGNIFICANT VASCULAR CHANGES**

Orthopedic surgeon Thomas Kaplan, M.D., in his surgical report of October 23, 2005 noted that his extensive surgery was unable to stabilize Samuel Brown's marked destructive fractures stating:

"... Extensive reduction [of the navicular bone] was carried out **closed without success [of] maintaining the stability. Due to the significant vascular changes, fixation of this was not felt to be appropriate at this time.** Somewhat laterally, the cuboid was palpated in an attempt to push back into its normal anatomic position, however, **marked instability followed...**

At this point [end of surgery] the delineation of this injury was difficult to assess due to the **marked comminution, marked destruction**, and mid foot fusion and external fixator may need to be applied once the fascia [major fasciotomy wounds] situation is fully assessed."

### **4. POST SURGICAL CT SCAN REVEALS HIGHLY COMMUNITED AND DISPLACED FRACTURES WITH NUMEROUS FRACTURE FRAGMENTS AND SHEARED ARTICULAR SURFACES AND JOINT DISRUPTION**

The extensive surgery performed on Samuel Brown's left foot on October 23, 2005 did not result in stabilization of the multiple fractures due to marked comminution and marked destruction of the bones and soft tissue structures. At CT scan was requested the day after surgery to further assess the "**marked comminution and marked destruction**" found at the completion of Dr. Kaplan's October 23, 2005 surgery.

A CT Scan of Mr. Brown's left leg, performed on October 24, 2005, revealed:

"There is a **highly comminuted fracture** of the talar neck and head yielding numerous small **displaced fragments** as well as dominant portion of the talar head/articular surface which is **displaced and rotated medially and caudally. Only a very small portion of the talar head remained articulating with the navicular.**

There is also a **highly comminuted fracture** of the navicular



**INCISION, DEBRIDEMENT & DRAINAGE SURGERY  
PERFORMED BY PLASTIC SURGEON,  
WENDY GORDON, M.D.**

On October 25, 2005, Samuel Brown was again taken to the operating room of Reston Hospital. Plastic surgeon, Wendy Gordon, M.D., performed another surgery on Mr. Brown's left leg: incision, debridement and drainage of Mr. Brown's extensive fasciotomy wounds. Dr. Gordon found a portion of Mr. Brown's talar bone to be "**denuded of any soft tissue attachments**" and "**was not viable and contaminated**". Unfortunately, the medial fasciotomy wound on Mr. Brown's left leg was so extensive that it **could not be fully closed** by Dr. Gordon. Dr. Gordon's surgical operative report of October 25, 2005 states:

"...We initially began by irrigating all the wounds and when the wounds were all deemed to be clean and free of any devitalized tissue with the debridement, we then were able to close the anterolateral lower leg wound and the lateral wound in the foot was closed. The medial wound in the foot was **only partially able to be closed**, and we could only do the most superior portion of the posterior medial wound on the left lower leg. After the wounds were cleaned, we then turned our [sic] attention to the multiple fractures. As part of our debridement, we did find that there was a **portion of the talar head which was rotated, denuded of any soft tissue attachments**. A portion of the head was actually extending through the soft tissues on the medial side of the foot. It was deemed that this piece was not viable and was contaminated. It was therefore removed from the wound. It was also denuded of its cartilage covering of the articular surface."

**ORTHOPEDIC SURGERY OCTOBER 25, 2005:  
EXTERNAL FIXATION – PINS AND RODS DRILLED  
INTO SAMUEL BROWN'S LEFT FOOT**

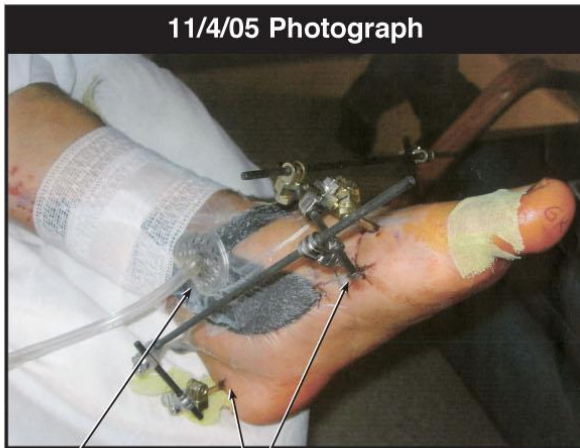
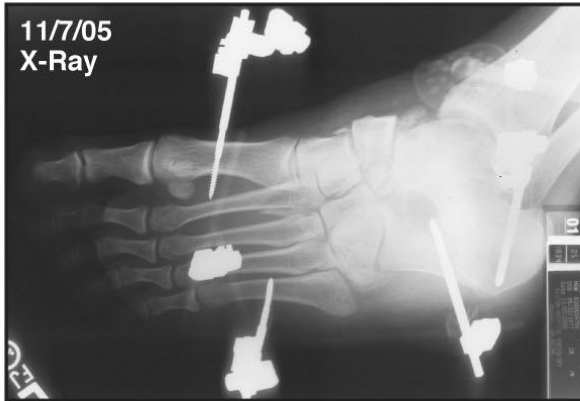
Orthopedic surgeon, Thomas Kaplan, was unable to stabilize Samuel Brown's left foot during his extensive orthopedic surgery on October 23, 2003. Dr. Kaplan reported that due to the "**marked comminution and marked destruction**" and **large fasciotomy** wounds, ("the fascial situation"), he could not attempt either a closed reduction or a fixed reduction with plates and screws at that time.

On October 25, 2005, orthopedic surgeon Dr. George Kennedy, assisted by plastic surgeon Wendy Gordon, M.D., drilled an external fixator into Mr. Brown's left foot to help stabilize the extensive, destructive, comminuted fractures. Dr. Kennedy's operative report states:

"Next, we did some **manipulation manually to arrange the highly comminuted fracture throughout the mid foot into better alignment** and then we elected to place with **external fixation** to assist us in our manipulation. We began on the lateral side placing first the **pins through the calcaneus** by first **incising** 0.5 cm on the lateral aspect of the calcaneus distal to the peroneal tendons and sural nerve. Sharp dissection went through the skin only then **blunt dissection went through to the bone**. We then sent the small fragment **4.0 pin** for cancellous bond into the calcaneus. When this was completed, we then did a similar technique for the fifth metatarsal using C-arm, fluoroscopy to guide us in the placement of the pins. After we had these **two pins placed**, we then **attached a rod between the two pins** and were able to **manipulate** the foot, especially the lateral column...we began to manipulate the talus, the navicular, and the cuneiforms into place along with the second metatarsal. After we were able to manipulate the foot further, **we then did a similar technique** by placing the posterior medial incision again over the posterior to where the neurovascular bundle was and using sharp dissection through the skin and blunt dissection through the subcutaneous tissue, **we placed a Synthes small fragment in, first in the calcaneus and then into the first metatarsal where the wound would allow us.** This was a dorsal and medial, and **well into the shaft** of the first metatarsal. All of the remainder of the medial column was then **virtually exposed due to the wound**. When this was placed, we similarly **placed a connecting rod between the 2 pins**. We then **manipulated** all the multiple fractures using both the lateral side and the medial side to the cuboid, lateral cuneiform, medial cuneiform, second metatarsal, navicular, and talus aligned...we then secured the rods and then placed across from medial to lateral dorsally **a connecting rod** to help give us further stability..."

A medical illustration prepared by a nationally recognized medical illustrator, describing Samuel Brown's External Fixator Surgery appears on the next page:



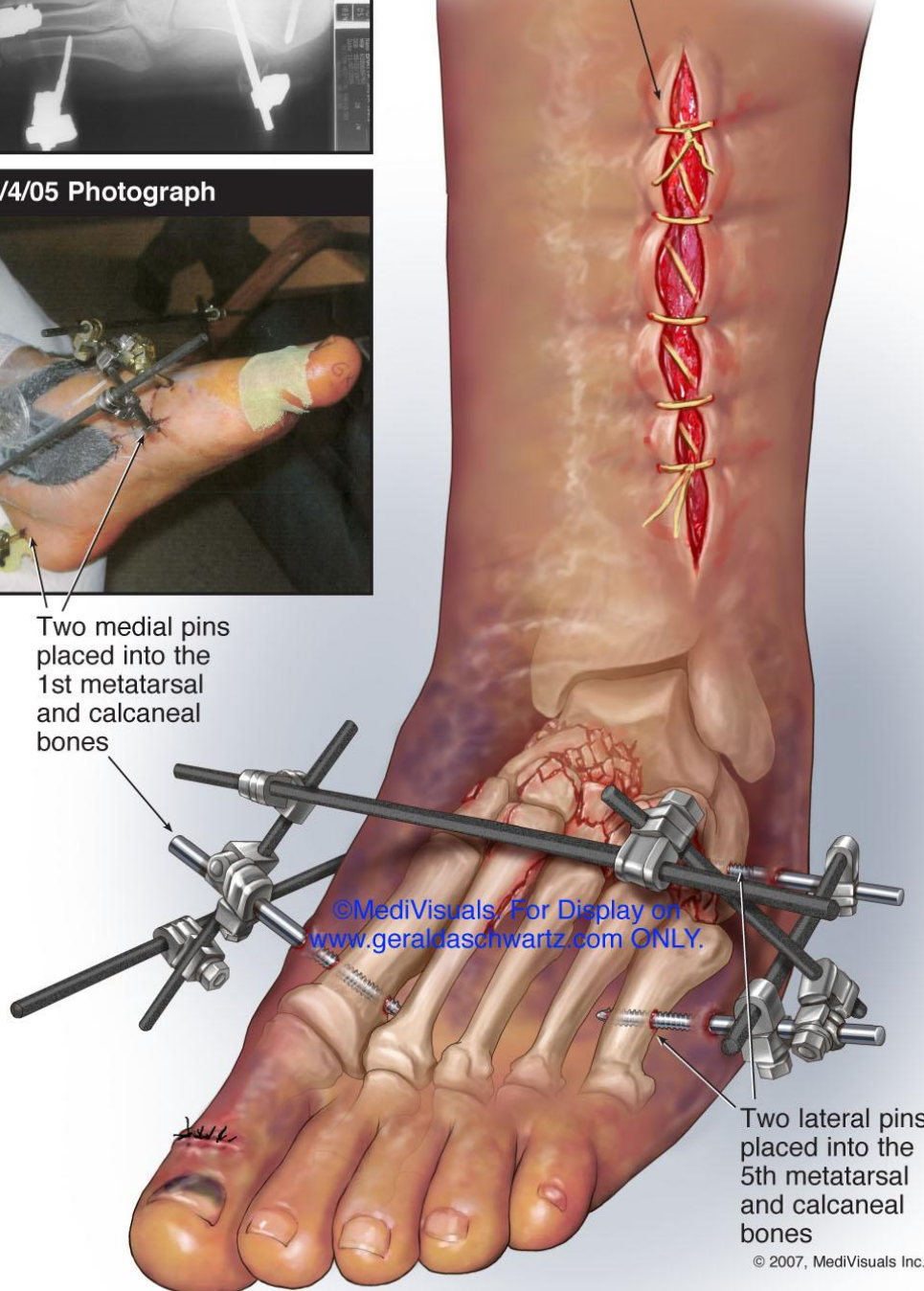


Large medial fasciotomy wound with VAC dressing in place

Two medial pins placed into the 1st metatarsal and calcaneal bones

## 10/25/05 External Fixation

Lateral leg fasciotomy wound created on 10/23/05 to alleviate compartment syndrome



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Two lateral pins placed into the 5th metatarsal and calcaneal bones

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## **TEN FASCIOTOMY WOUNDS – SEROSANGUINEOUS DRAINAGE & FIVE (5) ADDITIONAL SURGICALLY REQUIRED VAC WOUND DRESSING OPERATIVE PROCEDURES**

The day following Mr. Brown's "incision, debridement and drainage" surgery and his "external fixator placement surgery" on December 14, 2005, plastic surgeon Wendy Gordon found "**lots of serosanguineous drainage**" at the fasciotomy wound sites.

Samuel Brown was again taken to the operating room of Reston Hospital Center on October 26, 2005, October 28, 2005, October 31, 2005, November 3, 2005, and November 7, 2005 for **five additional separate surgical procedures** by plastic surgeon Wendy Gordon, required to change the VAC fasciotomy wound dressings.

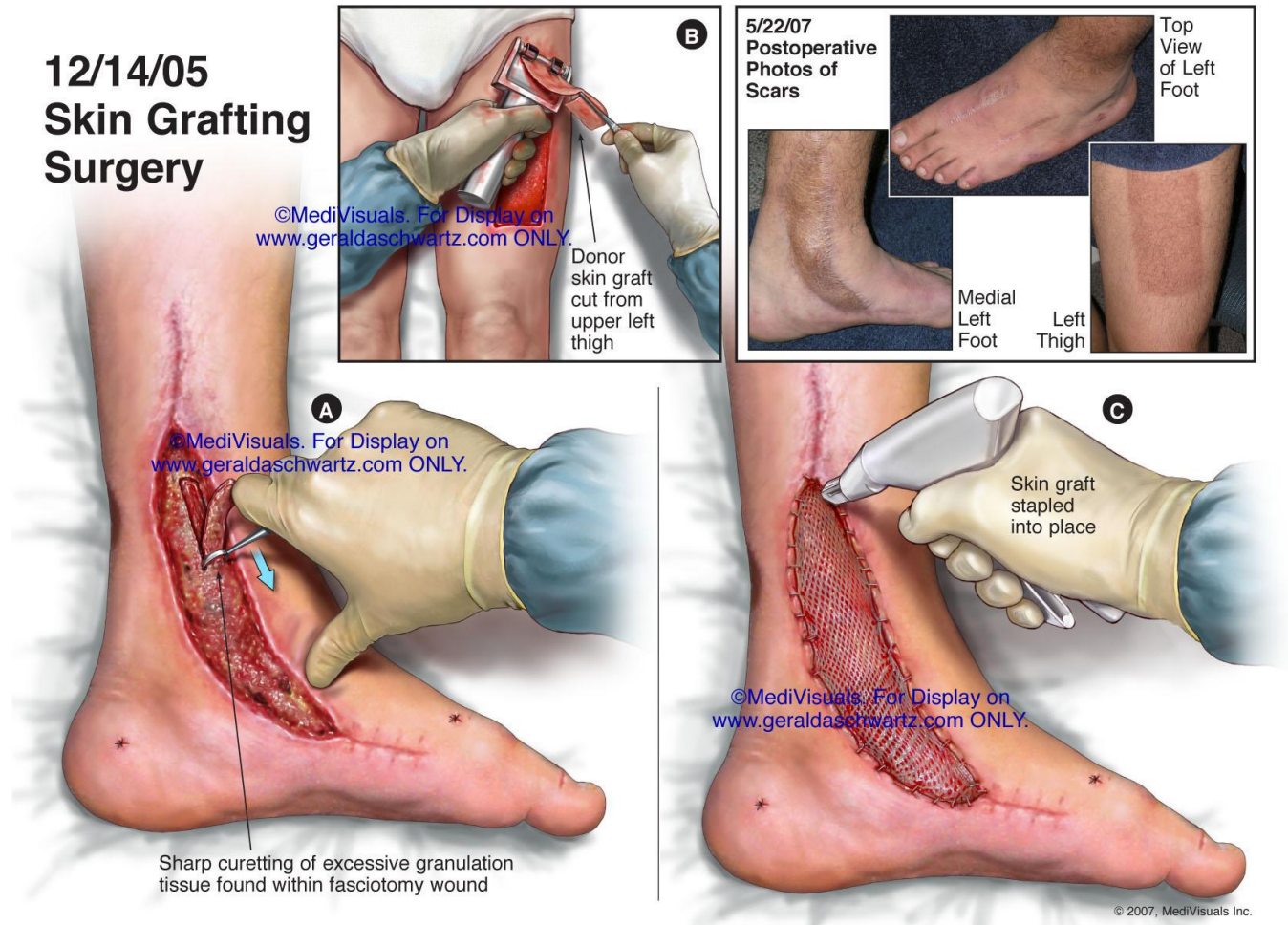
## **EXTENSIVE SPLINT-THICKNESS SKIN-GRAFTING WITH DONOR BONE HARVESTED FROM SAMUEL BROWN'S THIGH REQUIRED FOR LARGE FASCIOTOMY WOUNDS**

Samuel Brown was left with large, gaping, fasciotomy wounds following his fasciotomy surgeries to relieve the multiple compartment syndromes in his left leg. As a result, extensive skin grafting of these large wounds was required. On December 17, 2005, Samuel Brown was again taken to the operating room of the Reston Hospital Center where plastic surgeon, Wendy Gordon performed extensive skin grafting surgery on the fasciotomy wounds. Dr. Gordon's operative report describes the skin grafting surgery:

"... **Sharp curetting** was used to **remove excessive granulation tissue** which had formed on both wounds. Wounds were then irrigated and measured using a Padgett dermatome... **Split graft was harvested [from his thigh]**. This was **enmeshed** ... trimmed, and applied to both the wounds of the lower leg and the dorsum of the foot with attempt not to expand the meshing, and this was accomplished easily. Wounds were fixed with surgical staples. Following this, 3-0 silk ties were sutured to the staples and used to create a bolster of Xeroform silk with fluff. Donor site was treated with Xeroform which was sutured at the corners with 5-0 fast-absorbing gut and then covered with Telfa, 4 x4's, ABD, and tape. The leg was then covered with fluff and 4 x 4's, wrapped in multiple Kerlix, and following this orthopedic tech returned in place a posterior **splint**..."

Samuel Brown is left with large, ugly permanent scarring in his left leg and left thigh, with altered sensations and pain.

A medical illustration prepared by a nationally recognized medical illustrator describing Samuel Brown's split thickness skin grafting surgery, appears below:



## **MARKEDLY COMMINUTED DEFORMED MIDFOOT FRACTURES REMAIN AFTER EXTERNAL FIXATOR ASSISTED REDUCTION FAILS**

On October 27, 2005, Samuel Brown underwent a CT scan re-evaluation of his left foot. The CT revealed:

**“...Extensive soft tissue swelling is seen with a sizeable soft tissue defect along the medial aspect of the lower leg**

**extending down to the ankle...** There remains medial and plantar **subluxation of the majority of the cuboid**. A small fragment which appears to represent the distal articular portion does remain in closer proximity to the base of the fourth and fifth metatarsal.

IMPRESSION: **Markedly Comminuted Deformed Mid Foot Fracture...**

### **SURGERY: EXTERNAL FIXATOR ALIGNMENT REPOSITIONED AND TIGHTENED DOWN**

The external fixator drilled into the bones of Samuel Brown's left foot on October 25, 2003 failed to reduce his markedly displaced fractures of his crushed left foot. The external fixator left Mr. Brown's left foot in a "varus position" with a "displaced alignment of his medial and lateral columns".

On October 31, 2005, Samuel Brown was again taken to the operating room of the Reston Hospital Center where his external fixator was **surgically repositioned and tightened down**. Orthopedic surgeon, George Kennedy, M.D., described the surgery in his operative report:

"OPERATIVE INDICATIONS:

**External fixation...was found to leave his foot in a bit of a varus position** and still somewhat **displaced alignment** of his medial and lateral columns. He did have multiple fractures throughout the metatarsal region...

SURGICAL TECHNIQUE:

...His dressing was removed including the wound vac... there was **still a significant amount of injury and damage seen...** the decision was made to manipulate the external fixator and fracture first to see if the alignment could be improved and then depending on the status at that point determine internal fixation. We then did a manipulation of the fracture including manipulating the **external fixator in multiple planes** using some direct pressure to help line the bones and improve the alignment. **After we aligned**, the fixator was in adequate position... The external fixator was **tightened down...** **We elected not to proceed with any open reduction internal fixation or arthrodesis.**"

## **DISCHARGE FROM RESTON HOSPITAL CENTER TO SKILLED NURSING FACILITY: DESTRUCTIVE FRACTURES STILL NOT READY FOR FIXATION**

On November 14, 2005, Samuel Brown was discharged from Reston Hospital Center to a skilled nursing facility. Treating orthopedic surgeon, George Kennedy, noted upon discharge that because of Mr. Brown's extensive fasciotomy wounds, he **"still does not appear ready for definitive ortho[pedic] fixation"**.

Samuel Brown was required to remain at the HCR Manor Care Skilled Nursing Facility from November 14, 2005 until December 24, 2005.

A skilled nursing evaluation on November 15, 2005 listed the following concerns:

1. "At high risk for bleeding related to Lovenox Therapy
2. ADL (activities of daily living) deficit related to crushed left foot
3. Left foot edema (swelling caused by excess fluid in body tissues)
4. At risk for impaired circulation and p/areas related to foot traction
5. Impaired skin integrity related to decreased functional mobility
6. Insomnia
7. Limitations of dressing and toileting
8. Weakness, decrease in strength and endurance
9. At risk for drug related complication related to greater than 9 medications taken a day"

Mr. Brown was set up on a physical and occupational therapy schedule for 5 days a week. On December 19, 2005, gait training, neuromuscular re-education and manual therapy were added to his physical and occupational therapy regimen.

On November 28, 2005, Mr. Brown was transported to plastic surgeon, Wendy Gordon's, office for re-evaluation and a VAC wound dressing change.

Mr. Brown was transported to orthopedic surgeon, George Kennedy's office on December 2, 2005. On examination, Dr. Kennedy found swelling of the left foot. X-rays showed that Mr. Brown "still has the crushed navicular with talar navicular fractures and a slightly subluxed cuboid and multiple cuneiform fractures..." **Dr. Kennedy recommended the removal of the external fixator and to proceed with the "ORIF [open reduction internal fixation] or a fusion of his talar navicular joint and some work to his cuboid if we are able".**

### **READMISSION TO RESTON HOSPITAL CENTER: SURGICAL REMOVAL OF EXTERNAL FIXATOR**

On December 14, 2005 Samuel Brown was transported from the Manor Care Skilled Nursing facility back to the Reston Hospital Center. He was taken to the operating room where Dr. George Kennedy surgically removed the external fixator drilled into Samuel Brown's left leg.

Dr. Kennedy's postoperative diagnosis was:

Postoperative Diagnosis: Crush injury to left foot with multiple mid foot fractures including talus, navicular, cuneiform, cuboid and second metatarsal. He is also status post external fixation of his left foot and open wound to his left foot.

Procedure: Removal of external fixator, left foot."

### **READMISSION TO HCR MANORCARE**

On December 17, 2005, Mr. Brown was readmitted to HCR Manorcare from Reston Hospital Center for "observation of the wound and slow PT". Samuel Brown remained at HCR Manor care until December 24, 2005. Upon discharge, he was instructed to not to unwrap the bandage to left leg at any time, elevate his lower left leg at all times, and remain non-weight bearing on his left lower extremity.

Upon discharge from Manor Care, Samuel Brown was given a **walker**, a **wheelchair** and **crutches**.

### **PLASTIC SURGERY, ORTHOPEDIC FOLLOW-UP CARE AND OUTPATIENT PHYSICAL THERAPY**

Samuel Brown followed up with plastic surgeon Wendy Gordon on December 19, 2005, January 6, 2006 and March 13, 2006.

Samuel Brown was followed by orthopedic surgeon, George Kennedy, M.D. from December 23, 2005, after discharge from Manor Care until August 16, 2006. Dr. Kennedy ordered ankle foot orthotics (AFO) and prescribed physical therapy. Dr. Kennedy's plan for physical therapy was stated in his report of December 23, 2005:

Plan: At this point we are going to **wait for that wound (fasciotomy wounds) to mature** and then we will hopefully be able to start some P.T. and begin some weight bearing."

On January 16, 2006, Samuel Brown began physical therapy with Physical Therapy Solutions. The physical therapist reported: “[Samuel Brown] **presents ambulating non-weightbearing** with ACE wrap around his foot and using bilateral Loftstrand crutches”. “**Mild oozing**” was found at the skin graft site.

Samuel underwent extensive physical therapy and work conditioning ordered by Dr. Kennedy, through August 8, 2006.

Samuel Brown was followed by Dr. Kennedy after discharge from Manor Care from December 23, 2005 to August 16, 2006. Dr. Kennedy reported the following findings:

- “Plantigrade foot”
- “Equines” (deformity of the foot-heel pulled up while forefoot pulled down)
- “Disuse atrophy or Sudek’s atrophy” (post-traumatic swelling, stiffness & skin changes)
- “Osteopenia” (decreased bone density) and “Degenerative Changes throughout the midfoot”
- “Crush Injuries...Healing with Massive Bone in the Midfoot...Assessment: He has Arthritic Changes throughout the Midfoot”

### **DR. BRUCE FOSTER PLASTIC SURGEON: DEVASTATING INJURY WITH PERMANENT SCARRING AND DYSFUNCTION TO LOWER LEG**

Samuel Brown saw plastic surgeon, Bruce M. Foster, M.D., on June 27, 2006. Dr. Foster reported that Samuel had “persistent pain in his left lower extremity as well as altered sensation in his left leg from the mid calf distally.” On examination, Dr. Foster found:

“Examination of his left lower extremity reveals a 5 x 12 cm well positioned skin graft over the lateral aspect of the foot and ankle. There is a 5 x 1 cm extension proximally and a 5 x .2 cm extension distally from the skin graft where the decompression at [sic] been performed. Between the 4<sup>th</sup> and 5<sup>th</sup> metatarsal on the dorsum of the foot is a 7 x .5 cm red widened slightly hypertrophic scar. Similarly there is an 8 x 1 cm red widened scar over the foot between the 1<sup>st</sup> and 2<sup>nd</sup> metatarsals. There is a 6 x 1 cm scar over the lateral ankle and a 2 x 6 cm triangular shaped scar of over the posterior ankle overlying the Achilles tendon. There is altered sensation on the left lower extremity that is patchy in nature and surrounding these scarred and grafted areas. There is decreased active flexion and extension in the ankle and toes of

the left foot.”

Dr. Foster described Samuel’s injury as “**devastating**” stating under “Discussion”:

“Mr. Brown sustained a **devastating injury** to his left lower extremity. **He was fortunate to have maintained the viability of the foot...** There are certain **anatomic and vascular limitations** in the lower extremity that preclude the use of many scar revision techniques. I believe that the **risks** associated with the scar revision attempts would far outweigh any noticeable benefits that he would obtain from serial scar revision, laser therapy or injections. ...**left with permanent scarring and dysfunction in his left lower extremity as a result of his work injury.**”

Dr. Foster took the following scar photographs on June 27, 2006 in his office the day he examined Mr. Brown:





## **INDEPENDENT MEDICAL EVALUATION: JOHN K. BROWN, JR., M.D., ORTHOPEDIC SURGEON**

On December 11, 2006, Mr. Brown was examined by John K. Brown, Jr., M.D., an orthopedic surgeon for an evaluation of his crush injury. Dr. Brown reported left ankle pain and foot stiffness, weakness and numbness.

### **EXAMINATION SIGNIFICANT (+) FINDINGS**

On examination, Dr. Brown noted “[t]he extremity is noticeably scarred including a large skin graft on the medial aspect of the ankle and foot area, measuring approximately 11” x 3”.” Dr. Brown’s examination revealed restricted range of motion in the ankle with “flexion limited to 20, zero in inversion and 5 degrees eversion.” Dr. Brown noted “**moderate atrophy of the calf**. He ambulates with a special orthotic in his left shoe. There is abnormality in the appearance and palpation of the plantar surface of the foot with **protrusion of the cuboid**.” Dr. Brown further found “**areas of loss of sensation** over both the grafted skin and in other areas of the skin in his foot.” From x-rays taken in his office, Dr. Brown noted “a large protrusion of bone on the plantar surface. This represents a bone fragment probably from the cuboid fracture healing. There are **multiple joints in the forefoot with arthritic changes**.”

### **PERMANENT PROBLEMS; PERMANENT RESTRICTIONS & PERMANENT IMPAIRMENT**

Dr. Brown reported that as a result of Mr. Brown’s multiple foot fractures, he “has permanent problems that will necessitate future medical care and there will continue to be **permanent restrictions to his activities** as well as ratable physical impairment. Dr. Brown stated:

“Using the AMA Guides 5<sup>th</sup> Edition, he [Samuel Brown] has impairment from gait abnormality, arthritic changes in the foot, loss of sensation and loss of subtalar motion.

... I estimate his **total impairment as 35% of the lower extremity**.

**He is permanently disabled from his usual employment** as a heavy equipment operator because of his foot pathology. He cannot stand for a long time and cannot lift heavy objects.”

## **FUTURE TREATMENT INCLUDES FUSION SURGERY**

With regard to future treatment, Dr. Brown reported:

“Because of the subtalar motion absence and foot pain, he is a **candidate for triple arthrodesis [3-level fusion]** ...Surgery however in his foot would be done with an increased probability of **complications** in view of his prior history of vascular compromise.

Absent surgery, he will need orthotic replacement every 8 months at a cost of \$300.00 each. Regular visits with his orthopedist and x-rays on a yearly basis will cost \$500.00.”

Due to continued pain stiffness, weakness and numbness in his ankle and foot, Mr. Brown returned to Dr. Brown’s on February 7, 2007. **Dr. Brown advised triple arthrodesis (fusion) surgery** stating:

“Because of his subtalar motion absence and foot pain, he is a **candidate for triple arthrodesis**. I have referred him to Dr. Steven Newman for further consideration and treatment.”

## **FOOT SURGEON STEVEN K. NEWMAN, M.D.: FUSION SURGERY WITH BONE GRAFT FOR SAMUEL BROWN’S END-STAGE ARTHRITIS**

Orthopedic surgeon, John K. Brown, Jr., M.D., reported that Samuel Brown was “a candidate for triple arthrodesis” surgery (fusion), and referred Samuel to Steven K. Newman, M.D., a specialist in orthopedic foot surgery.

Thomas J. Kaplan, the orthopedic surgeon who performed emergency surgery on Samuel Brown on October 23, 2005 noted the need for a midfoot fusion in his October 23, 2005 operative report:

“We elected not to proceed with stabilization of the fracture... due to marked comminution and marked destruction and **mid foot fusion**... may need to be applied once the fascial situation [fasciotomy wounds] is fully assessed.”

In addition, orthopedic surgeon, George Kennedy, upon discharging Samuel from the Reston Hospital Center on November 14, 2005 noted that due to Samuel’s fasciotomy wounds, he, “**still does not appear ready for definitive ortho[pedic] fixation**”.

On December 2, 2005, Dr. Kennedy stated his plan to include ORIF (open

reduction internal fixation) surgery or fusion:

Plan: At this point we are going to recommend that we remove the external fixation next week...and then if the wound allows us, we will even **proceed with ORIF or a fusion of his talar-navicular joint** and some work of his **cuboid if we are able.**

## **END-STAGE ARTHRITIS**

Orthopedic foot surgeon, Steven K. Newman, M.D., consistently found “**Joint Destruction identified as degenerative arthritis** of the Talo Navicular (TN) and Calcaneal Cuboid Joint”. Conservative treatment included a specifically constructed UCBL Orthotic for Samuel Brown. A photograph of the UCBL Orthotic worn by Mr. Brown is found at Tab L-10 of the attachments.

Samuel Brown underwent another CT scan on June 8, 2007 to re-evaluate the “destructive degenerative arthritis” in his left foot.

Dr. Newman, in his record of July 2, 2007, reported the CT results as showing **end-stage arthritis** stating:

Test Results: CT results taken of foot. **End-stage arthritis** of the **Talonavicular-[TN]** and **Navicular-Cuneiform [NC]** Joints, Left”.

## **THREE BONE FUSION SURGERY WITH SCREW PLACEMENT**

Dr. Newman suggested **surgery**, and its possible complications, including, “the possibility that Samuel’s condition may not improve after surgery or that it could actually be worse.”

In his July 2, 2007 report, Dr. Newman described the fusion surgery, already suggested by Dr. Kaplan, Dr. Kennedy and Dr. Brown:

**Surgery would involve a TN [Talo-Navicular] and NC [Navicular-Cuboid] fusion with bone graft. Concern for soft tissue.**

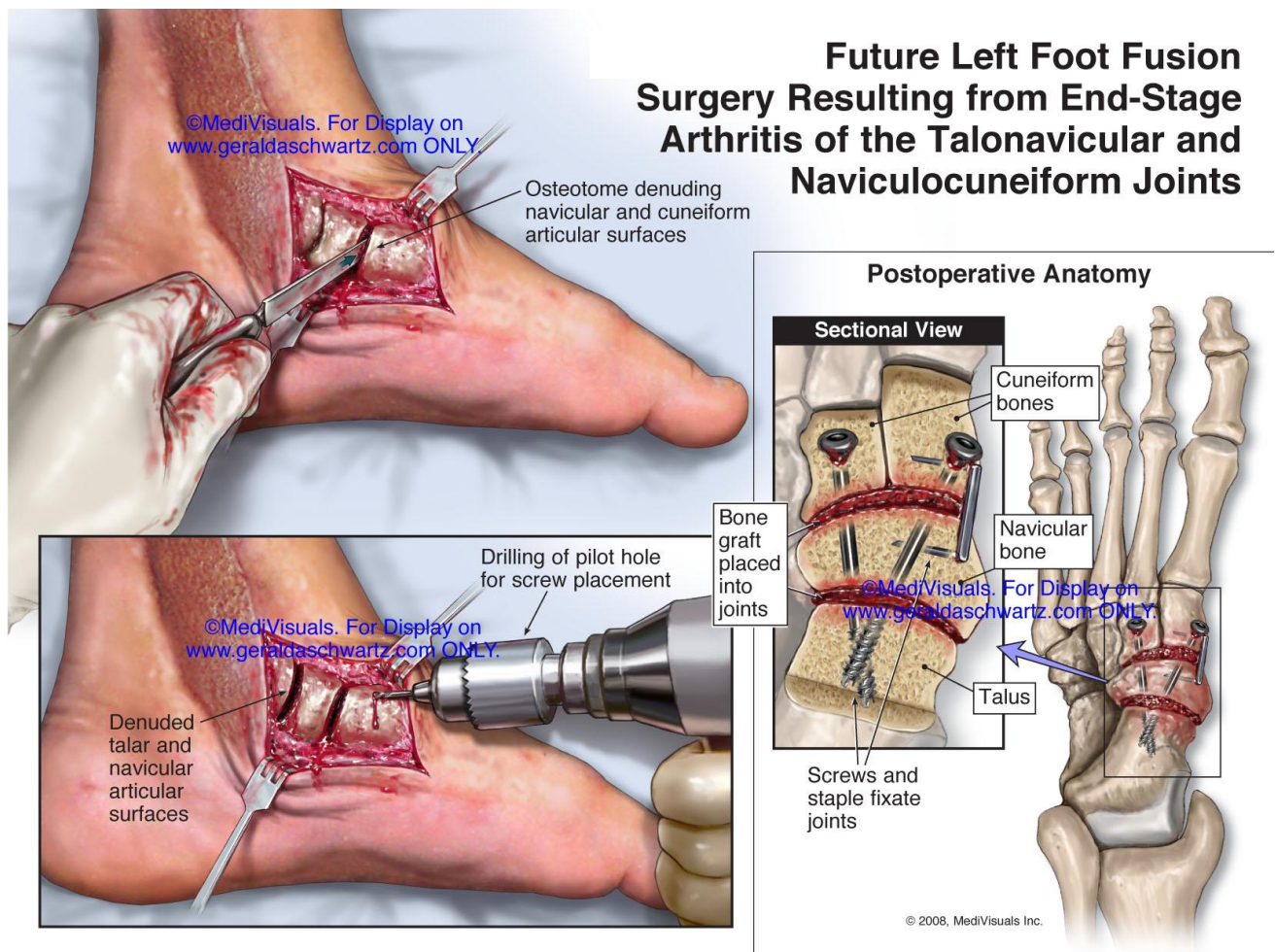
The triple fusion surgery (triple arthrodesis) for Samuel’s “end-stage arthritis” involves:

1. Chiseling and Denuding Samuel’s Talus bone, Navicular bone and Cuneiform bone to “bleeding bone” in order for the fusion “to take”;

2. Harvesting Doner Bone;
3. Drilling Holes in Samuel's Talus bone, Navicular bone and Cuneiform bone;
4. Placing Doner bone into Samuel's "End-Stage Arthritic" joints; and
5. Drilling and Screwing large surgical screws into the Talus, Navicular and Cuneiform bones of Samuel's midfoot to complete the triple fusion.

Dr. Brown, in his report of December 11, 2006 stated the cost for the triple arthrodesis fusion surgery to be \$17,000.00. "Absent surgery he will need orthotic replacement every 8 months at a cost of \$300.00 each." The actual cost to the UCBL orthotic from Dr. Newman's office is \$420.00. Samuel Brown is 30 years old. Over his life expectancy of 44.1 years (Va. Code §8.01-419), he will require 66 orthotic replacements for a lifetime cost of \$27,720.00, which exceeds the cost of the triple fusion surgery by \$10,720.00.

A medical illustration prepared by a nationally recognized medical illustrator, describing Samuel Brown's triple fusion surgery follows:



## **DEFENSE IME**

On April 18, 2008, the defense had Samuel Brown examined by Jerry S. Farmer, M.D.

Dr. Farmer's diagnosis was "severe crush injury of the left foot with secondary compartment syndrome status post external fixator, fasciotomy, skin grafts, and use of custom molded UCBL orthotics".

Dr. Farmer was of the opinion that Samuel Brown may need **two separate future surgeries** stating:

"... It is my opinion that the patient may require surgery on the left foot in the future, which would consist of **ostectomy** to remove the prominent bony mass on the plantar aspect of the foot... if pain becomes worse with time the he would require **mid foot fusion...**"

A copy of Dr. Farmer's April 18, 2008 report is enclosed.

## **TREATING ORTHOPEDIC SURGEON GEORGE KENNEDY, JR., M.D. -- 50% PERMANENT IMPAIRMENT AND NEED FOR FUSION SURGERY**

Samuel Brown was last seen on May 5, 2008, by his treating orthopedic surgeon, George Kennedy, Jr., M.D., who treated Samuel at Reston Hospital Center following the crash.

On May 5, 2008, Dr. Kennedy reported that Samuel Brown is left with a whole person impairment rating of 20% and 50% impairment rating of the lower extremity. Dr. Kennedy also reported that Samuel Brown is "a candidate for arthrodesis [fusion surgery] perhaps of the talonavicular joint combined with the subtalar joint and possibly even trying to correct the calcaneal cuboid area..."

A copy of Dr. Kennedy's May 5, 2008 is enclosed.

## **FUTURE MEDICAL BILLS**

Dr. John K. Brown, Jr., in his IME report of December 11, 2006, reported that Mr. Brown will need the following future medical treatment:

1.	Regular visits with his orthopedist and x-rays on a yearly basis will cost \$500.00 x Mr. Brown's 44.1 year life expectancy.	
	\$500.00 per year x 44.1 life expectancy=	\$22,050.00
2.	Triple Arthrodesis (fusion surgery)=	<u>\$17,000.00</u>
	<b>Total Future Medical Bills</b>	<b>\$39,050.00</b>

## **SPECIAL DAMAGES**

An itemized tabulation of specials is attached. In summary they are:

Past Medical Specials	\$218,041.62
Future Medical Expenses	\$39,050.00
Past Lost Earnings	\$51,831.85
Continuing Lost Earnings	<u>\$507,840.32</u>
<b>TOTAL</b>	<b>\$816,763.79</b>

## **SUMMARY**

The case of Samuel Brown is a case of substantial liability involving a "devastating injury" with substantial damages. Samuel Brown's left foot was severely crushed. Almost every bone in his mid-foot was severely fractured. The fractures were highly comminuted and displaced. Articular surfaces of several crushed bones had their soft tissue joint attachments sheared and denuded.

Samuel Brown was forced to undergo 19 surgical procedures in the operating room at the Reston Hospital Center. Samuel Brown is left with "permanent restrictions to his activities" and is "permanently disabled from his usual employment". He is left with

a 50% permanent impairment to his left leg with substantial, permanent fasciotomy scars. Samuel Brown is also left with "end-stage arthritis" of his left foot and is in need to a triple fusion surgery.

Samuel Brown's special damages total \$816,763.79.

If you need any additional information, please feel free to contact me. I can be reached on my cell phone at (703) 727-3844.

Very truly yours,

Gerald A. Schwartz

GAS/mw  
Enclosures