

**Confidential Attorney Work Product**

Your Attorney  
Attorneys We R  
1111 Attorney Lane  
Dallas, Tx 55555

October 29, 0000

Re: *Case of C.A.*

Dear Mr. Attorney:

As you requested I have reviewed in great detail, the available medical records for C.A.'s injuries related to a motor vehicle accident of October 14, 0000. To help you better understand the multiple complex injuries Mr. A. sustained as a direct result of this motor vehicle accident, I have discussed them in detail as well as included a timeline of radiology tests, Carl's symptoms and a comparative chart of pre and post-op spinal injuries. (Appendix A & B).

**Case overview**

On October 14, 0000, C.A., a 54 year old male, was the restrained driver of a Jeep Cherokee and was traveling down I40W when he was struck from behind by an 18 wheeler semi truck. The impact caused his seat to totally break at the hinges and he ended up lying in the back seat area of his jeep. He could not open his door and had to lay there until workers could get the passenger door open and extract him through the passenger side. The airbags did not deploy. He immediately noted burning in his feet, low back pain, left arm/shoulder pain and tingling/numbness down to his fingers. He denied loss of consciousness. EMS took him to Northwest Texas Healthcare System where he was released with a diagnosis of lumbar sprain and contusion of the left hip. Within 24 hours after the accident he developed further neurological deficits including headache, memory loss and speech problems. On 12/9/00 he underwent cervical laminectomies with medial facetectomies and foraminotomies of C2 through C6 and also of the lumbar - L4. His symptoms continued to worsen and he was having tachyarrhythmias with AV block and syncopal episodes. He was hospitalized for nearly a month due to the recurrent syncope and collapse episodes as well as fever of unknown origin. He had an implantable loop recorder inserted on 1/22/00 from which he developed a pocket infection and it had to be removed. Currently CA still has significant neurological deficits, personality changes and significant decrease in his level of function and inability to perform activities of daily living.

**Records of the following health care providers were reviewed:**

1. Northwest Texas Healthcare System
2. Baptist St. Anthony's Health System
3. Dr Bechtol – Primary care physician

(continued)

1/2/09 *MRI Brain without contrast*  
No acute intracranial findings.

1/5/09 *EEG awake*  
Normal

1/6/09 *Indium WBC Scan*  
Negative

1/7/09 *3V Cervical Spine*  
1. Severe flexion deformity from C1 – C7.  
2. C5-6 and C6-7 severely narrowed and degenerated discs.

*3V Lumbar Spine*  
Normal

1/9/09 *MRI Cervical Spine without contrast.*

1. Along tips of the spinous processes of the vertebrae there is a **CSF (cerebrospinal fluid) collection or postop pseudomeningocele from C3 to C7 measuring 7.5 cm long, max AP diameter of 1.4 cm and a transverse diameter of 1.8 cm.** It is likely a postop fluid collection.
2. Vertebrae show loss of cervical lordosis.
3. **Severe loss of height and desiccation of the discs** throughout the cervical spine.
4. Endplate changes at C3-4, C5-6 and C6-7
5. C2-3 – **An irregular central osteophyte** is seen and mild narrowing of intervertebral foramina.
6. C3-4 – Severe uncovertebral hypertrophy on the left with mild nerve root compression.
7. C4-5 – Severe narrowing of intervertebral foramina bilaterally with generalized bulge. **Bilateral nerve root compression is seen; left greater than right.**
8. C5-6 – **Central osteophyte with generalized bulge and severe narrowing of the intervertebral foramina bilaterally. Mild cord flattening without compression.**
9. C6-7 – Severe narrowing of intervertebral foramina on the right and question of far lateral right protrusion. **Severe cord atrophy. Severe bilateral narrowing of the intervertebral foramina, right greater than left, with bilateral nerve root compression.**
10. C7-T1 – **Mild to moderate narrowing of the intervertebral foramina bilaterally.**

1/15/09 *MRI Brain without contrast*  
No acute intracranial abnormality.

*EEG Awake*  
Normal

1/16/09 CTA Pulmonary Arteries/CT Venogram  
No DVT [deep vein thrombosis] or PE [pulmonary embolus]. Mild atelectasis in lung bases.

### Interview with C.A. and his wife – 10/22/00

I spoke with both C.A. and his wife S.A. and obtained detailed information regarding both the accident itself and his symptoms, problems and level of function.

C.A. was driving his Jeep Grand Cherokee down I 40 in the far left/ 3<sup>rd</sup> lane and he passed an 18 wheeler who was on his right. He then went under the Washington Street bridge and at that point he noticed traffic was backed up from the exit. A burgundy and gray pick-up was in front of him and slowed down due to the traffic being backed up. Then the pickup moved over the yellow line onto the shoulder and C.A. did also. He was moving along very slowly when he was struck from behind by the 18 wheeler. He did not see him coming. He was wearing he safety restraint. The main contact point was on the rear passenger side. He rode up on 2 wheels along the Interstate wall for 2-3 car lengths. His seat back broke, his hat was knocked off and he ended up in the back seat. He does not remember striking his head nor having loss of consciousness (however, it is unlikely he himself would know if he had loss of consciousness as he was not able to immediately get out of the vehicle. Loss of consciousness must be witnessed.) The airbags did not deploy. His door was jammed shut and he had to be freed from the passenger side. He first noticed tingling and burning to both feet and ankles to halfway up lower legs on both anterior and posterior sides. He had dizziness and a headache. He called his wife from the scene to tell her about the accident and she said his speech was slurred when talking to her. He was taken by ambulance to Northwest Texas Healthcare System to the emergency room. He had skeletal x-rays done then was told he had a back sprain and was discharged home. Very soon after arriving home he had low back pain, left arm and shoulder pain with numbness and tingling down to all 5 fingers. He had difficulty with coordination in his left arm and it felt very weak so he carried his left arm with his right one. Another significant problem was difficulty remembering, including both short-term and long-term recall. They had to assist him with things like distributing his medicine as he could not always remember when to take it or what he was supposed to take. The dizziness got worse. He had extreme sensitivity to light; he kept the room dark, and he is very sensitive to noise; his wife said he would say, “it sounds like you’re yelling”. The dizziness continued to be profound especially when walking or driving. His headaches were often intense and they affected his entire head. He had sharp pains from the top, left side of his head shooting down to behind his left eye accompanied by pain/pressure behind his eye. At times it even continued from his left eye down to his left jaw.

Below is a list of his continued or additional symptoms, some were first noticed after his surgery in December of 0000 and hospitalization in January 0000.

- **Passing out/syncope** – his wife states he did have loss of consciousness for several minutes and arms were jerking. CA said prior to the episodes his upper torso and arms felt so heavy he couldn’t hold them up or lift them.
- **Decreased libido** – wife states was no problem until after the accident.
- **Erectile dysfunction** – wife states was no problem until after the accident.
- **Personality changes** - extreme irritability, intolerant of excessive talking, impatient, hostile at times.