SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER

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WILMER PEREZ MELCHOR,

Plaintiff,

-against-

NORTH AVENUE EAST LLC,

Defendant.

----------X

NOTICE OF MEDICAL EXCHANGE

Index No.: 59061/19

C O U N S E L O R S:

PLEASE TAKE NOTICE, that pursuant to the rules of this court regarding Exchange of Medical Information, attached is the narrative report of Matthew Grimm, M.D. dated January 19, 2024.

Plaintiff reserves the right to amend and supplement the foregoing up to and including the time of trial.

DATED: New York, New York
January 24, 2024

Yours, etc.

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MATTHEW P. GRIMM, M.D.
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PAIN MANAGEMENT

January 19, 2024

RE: PEREZ MELCHOR, WILMER
DOB: 12/28/1991
DOL 12/18/2018
NARRATIVE REPORT

To whom it may concern:

Mr. Wilmer Perez has been a patient under my care since February 27, 2023. At that time, this patient was a 31-year-old male who presented to my office for initial pain management evaluation. This patient presented with injuries sustained in a work-related accident on December 18, 2018, when he had a fall from a height, suffering an open fracture of the right tibia. He was at an elevation of approximately 8 to 12 feet. He was on a wall and the wall collapsed. The patient fell backwards in the harness on the ground with a wall falling on the patient. He was taken via ambulance to Jacobi Hospital. As noted, he sustained an open fracture of the right tibia. He was admitted for an open reduction and internal fixation of the right tibia with an intramedullary nail. Following that, he required surgery with a bone graft from the right iliac crest. The ORIF was performed on December 19, 2018, and the follow-up surgical procedure performed January 25, 2019. The patient also sustained a head injury and had seizure episodes following the head injury. He was treating with Neurology. He also suffered injuries to his right shoulder, neck and lower back.

For his cervical injury, he underwent pain management treatment with Dr. Perez and was provided one epidural injection for his neck, which did help. He stated that prior to the injection, the neck was "locked up" and he was unable to move. Post-injection, he regained some movement. He treated with Dr. Ashley Simela for orthopedic surgery and orthopedic pain complaints. For his lower back, he had not yet had extensive treatment. He had a right shoulder injury, which caused a great deal of pain with movement. He was treating with sertraline 50 mg, levetiracetam 750 mg for epileptic treatment, and utilizing Tylenol for pain control. He also consulted with orthopedics, Dr. Jeffrey Kaplan, Orthopedic surgeon, on February 21, 2019. He also continues to have a great deal of discomfort in the ankle, particularly where his screws have been placed.

His neck pain radiated to the bilateral shoulder regions. Neck pain rated up to 8/10 on the VAS, pain scale. For his lower back pain, he underwent on lumbar epidural injection which helped some. No prior history of trauma.

PMHX: None.

SURGHX: As noted above.

ALLERGIES: NKDA.

PHYSICAL EXAMINATION: Physical examination, at his initial consultation on February 27, 2023, revealed the following: In regards to the cervical exam, he was in mild to moderate distress with cervical and lumbar ranging. He had tenderness over the cervical spinous processes. Range of motion of the cervical spine revealed extension 40 degrees- Pain at the end of the range (Normal 60 degrees), flexion 40 degrees Pain at the end of the he range (Normal 50-80 degrees), left and right lateral flexion 35 degrees Pain at the end of the range (Normal 45 degrees), left rotation to 55 degrees and right rotation to 50 degrees with pain at the end of the range (Normal 80 degrees). Strength was grossly intact. Sensation intact. Reflexes intact. Hoffman's sign negative. Spurling sign present bilaterally. Positive muscle spasm in the cervical paraspinals, muscular trigger points present bilaterally.

In regards to the lumbar exam, the patient had an antalgic gait. Tenderness over the lower lumbar processes. Tenderness right-sided SI joint. Range of motion of the lumbar spine showed extension 10 degrees Pain at the end of the range (Normal 25 degrees), flexion 55 degrees Pain at the end of the range (Normal 85-90 degrees), Left and right lateral flexion to 15 degrees Pain at the end of the range (Normal 25 degrees). No calf tenderness. No log rolling tenderness. Reflexes intact at the knee and the ankle 2/4. Sensation was intact. Straight leg raise was present bilateral and pain radiated posterior. Upon muscle testing, there was full power of L2, L3, L4, L5, and S1 bilaterally. Positive muscle spasm in the lower lumbar musculature, musculature trigger points present bilaterally.

My assessment was lumbar radiculopathy, cervical radiculopathy, cervicalgia, lumbago, traumatic arthritis of the right knee, traumatic arthropathy of the right shoulder, and post-traumatic arthritis of the right ankle. In regards to lumbar radiculopathy, the patient had symptoms consistent with traumatic lumbar radiculopathy. The patient would benefit from an additional lumbar epidural injection. Recommended Ortho/Spine follow-up for surgical consideration. He would benefit from physical therapy, aquatic therapy, and acupuncture. NSAID medication and anti-spasms medications. Neuropathic pain medications as adjunctive treatment for radicular pain.

In regards to cervical radiculopathy, the patient had symptoms consistent with traumatic lumbar radiculopathy. The patient would benefit from an additional cervical epidural injection. Recommended Ortho/Spine follow-up for surgical consideration. He would benefit from physical therapy, aquatic therapy, and acupuncture. NSAID medication and anti-spasms medications. Neuropathic pain medications as adjunctive treatment for radicular pain.

In regards to cervicalgia and lumbago, the patient had trigger points on examination as well as facet loading in the neck. It is my opinion that he would benefit from additional therapy, including: muscular trigger points and medial branch nerve blocks for both the cervical and lumbar regions.

In regards to, traumatic arthritis of the right knee, per discussions with Dr. Kaplan, Orthopedic surgery, the patient has been advised he would be a candidate for right knee arthroscopic surgery. Recommend ortho follow-up as well as physical therapy to the right knee.

In regards to traumatic arthropathy of the right shoulder, per discussions with Dr. Kaplan, Orthopedic surgery, the patient has been advised he would be a candidate for right shoulder arthroscopic surgery. Recommend ortho follow-up as well as physical therapy to the right shoulder.

In regards to post-traumatic arthritis of the right ankle, per discussions with Dr. Kaplan, Orthopedic surgery, the patient has been advised he would be a candidate for right ankle arthroscopic surgery. Recommend ortho follow-up as well as physical therapy to the right ankle.

REVIEW OF RECORDS:

12/18/2018- ED provider initial note notes the patient is a 26-year-old male with no significant past medical history, brought in by ambulance status post fall from construction site today. Per EMS and brother, the patient was working and fell about 25 feet into a foundation. Per brother, the patient fell head first. The patient was extricated from the site and was found to have an open wound of the right shin which was actively bleeding. EMS placed tourniquet to stop the bleed. In the ED, the patient complaining mainly of right leg pain and right arm pain. The patient was on a backboard without a C-collar.

12/18/2018- Report of x-rays of the chest. Impression: 1. Moderate pulmonary hypoexpansion. 2. Otherwise no acute pulmonary abnormality identified. 3. No acute injury identified."

12/18/2018- Report of x-rays of the pelvis indicating no fracture.

12/18/2018- Report of x-rays of the tib-fib showing a severely comminuted mid tibial diaphyseal fracture. Slight lateral displacement of the distal fragments. Soft tissue swelling with overlying saturated bandages, lateral ectopic soft tissue gas appears to be present.

12/18/2018- Report of x-rays of the right tibia and fibula. Impression: "Severely comminuted mid tibial diaphyseal fracture." Final attending report notes impression: "Comminuted compacted fracture of the shaft of the tibia."

12/18/2018- Report of x-rays of the right forearm. Impression: "No acute fracture is seen."

12/18/2018- Report of x-rays of the right wrist. Impression: "No acute fracture is seen."

12/18/2018- Report of x-rays of the right elbow. Impression: "No acute fracture is seen."

12/18/2018- Report of x-rays of the right humerus. Impression: "No acute fracture is seen."

12/18/2018- Report of a CT scan of the head. Impression: "No acute intracranial abnormality."

12/18/2018- Report of CT scan of the cervical spine. Impression: "1. No acute abnormality. 2. Chronic findings as discussed above." The body of the report notes there is no acute fracture. Congenital fusion of C2 and C3 is noted.

12/18/2018- Report of CT scan of the chest, abdomen, and pelvis. Impression: "No acute abnormality."

12/18/2018- Report of a CT scan of the cervical spine, lumbar spine and thoracic spine. Impression: "No acute abnormality."

12/18/2018- Report of a CT scan of the right lower extremity. Impression: "Severely comminuted open mid tibial shaft fracture."

12/19/2018- Operative report. Surgeon, Milan Sen, M.D. Preoperative diagnosis: Right grade 2 open segmental tibia fracture. Postoperative diagnosis: Same. Surgical procedures: 1. Right leg irrigation and debridement of soft tissue and bone associated with open fracture. 2. Right tibia intramedullary nail fixation. 3. Insertion of antibiotic delivery implant. 4. Negative pressure wound therapy less than 50 cm2.

12/19/2018- Report of x-rays of the right tibia and fibula, intraoperative findings, noted intraoperative intramedullary nail placement for comminuted right tibia fracture on the right with two proximal and two distal stabilization screws in place.

12/19/2018- Report of x-rays of the right tibia and fibula. Impression: "Status post intramedullary nailing placement for comminuted right tibia fracture" just to note that the IMN placement.

12/19/2019- ED and Trauma H & P notes: "Pt is a 26 yo M with no significant PMH BIBA s/p fall from construction site today. Per EMS and brother, pt was working and fell about 25 feet into a foundation. Per brother, pt fell head first. Pt was extricated from the site and was to have an open wound on the R shin which was actively bleeding. EMS placed tourniquet to stop the bleed. In the ED pt mainly complaining of R leg pain and R arm pain."

Hospital course was he was admitted on December 18, 2018, from the emergency department after sustaining trauma from a fall at a construction site resulting in open tib-fib fracture. The patient was admitted to the trauma service. The patient was taken to the operating room on December 19, 2018, for right tibial IM nail, antibiotic bead placement, tibial I and D, and tibial wound VAC placement, and tolerated it well without complication. The patient was given prophylactic antibiotics in the perioperative phase. Postoperatively, the patient was stable for transfer to the orthopedic service.

12/18/2018-12/24/2018- Date of admission at Jacobi Medical Center. The chief complaint was a right tibia IMN. Admission information was that: "Wilmer Perez-Melchor was brought to Jacobi Medical Center for right leg pain and diagnosed with an open R tibia fracture. Patient was admitted to the orthopedic surgery service, and underwent R tibia I & D, IMN, stimulant bead, and incisional VAC placement on 12/19. Pt tolerated all procedures well and pain was controlled postoperatively. Seen by Physical Therapy who recommended d/c home at a wheelchair level only. Attempt to crutch train patient on day of discharge was made. However, he did not demonstrate ability to ambulate independently with crutches." He was discharged to home with medication to keep the wound VAC clean and dry. PT, OT, and rehab and weightbearing as tolerated on the right lower extremity, ambulating with a wheelchair only and not using the crutches until he healed more. Discharge date of December 24, 2018, secondary diagnosis of acute pain due to trauma.

12/18/2018-12/24/2018- Inpatient hospital records from Jacobi Medical Center.

12/18/2018-1/2/2019- There are also clinic notes up to January 2, 2019, at Jacobi Medical Center.

1/25/2019-1/28/2019- Inpatient records from Jacobi Medical Center.

1/25/2019- Operative report. Surgeon: Milan Sen, M.D. Preoperative diagnosis: Delayed union, right tibia. Postoperative diagnosis: Same. Surgical procedures: 1. Exchange of nail and right tibia. 2. Right iliac crest bone graft to right tibia. 3. Insertion of antibiotic drug delivery implant to right tibia. The patient was discharged on January 28, 2019.

1/28/2019- Discharge summary. Hospital course noted a 27-year-old male fell approximately 10 feet at construction site, December 18, 2018, sustained right open tib-fib fracture. The patient had I & D, IMN, antibiotic bead placement, December 19. Status post right tibia I & D, RIA, stimulant beads exchange, IM nailing, and bone grafting January 25. He was admitted to the orthopedic surgery service, and underwent a right tibia I & D, RIA, stimulant beads exchange, IMN and bone grafting.

2/21/2019- Initial consultation with Dr. Kaplan. The patient was complaining of pain about the right lower extremity, mid-shaft, pain with ankle motion, which is limited, pain about the knee, pain and burning in the left thigh distal to the site of the bone graft harvest at the right pelvis, complaining of right shoulder and arm pain primarily in the axilla and associated with pain and numbness, complaining of severe neck pain and pain radiating to the head. He had a "heavy" feeling when he sat up for any period of time with neck fatigue. He was ambulating with crutches, non-weightbearing on the right lower extremity. Dr. Kaplan performed x-rays of the right tibia showing: "He has intra-medullary rod in the tibia. There is an area of extensive bone loss in the medial third medially. There appears to be some form of grafting material present. X-rays of the neck show straightening of the normal curvature with loss of normal lordosis. No acute bony changes noted." Dr. Kaplan's initial assessment was post-traumatic cervical pain with signs of cervical radiculopathy, internal derangement of right shoulder, rule out rotator cuff

injury, status post comminuted open fracture of right tibia requiring surgical fixation as well as surgical bone grafting with severe bone loss. Dr. Kaplan advised him to follow with the operative surgeon; obtain medical records. He was sent for an MRI of the cervical spine as well as the right shoulder.

3/6/2019-3/4/2020- Records of Rehabilitation Medicine Center of New York Comprehensive Pain Treatment. Seen by Dr. Ashley Simela.

3/6/2019- Initial consultation by Dr. Ashley Simela at Rehabilitation Medicine Center of New York Comprehensive Pain Treatment. Notes that at that time while working in construction he sustained a fall. The fall was greater than 10 feet in height, sustaining injuries to the right lower extremity and sustained a fracture. The patient also sustained head injuries. He was taken to Jacobi Medical Center Level One Trauma and underwent emergent surgery for the right lower extremity. Subsequent to that, he underwent a secondary surgery. He had constant pain in the neck, both shoulders, low back, and right lower extremity. Dr. Simela's impression was 1. Status post open reduction of right tibia for open fracture. 2. Bilateral shoulder pain, possible rotator cuff pathology. 3. Neck pain, possible cervical disc disorder. 4. Low back pain, possible lumbar disc disorder following the fall. Dr. Simela ordered MRIs of the cervical spine and lumbar spine, right and left shoulders, x-rays of the right femur, tibia and ankle, and possible CT scan depending on the results.

3/26/2019- Report of x-rays of the right ankle, right tibia and fibula. Performed at Neighborhood Radiology. Impression: "Status post ORIF of mid tibial shaft fracture as discussed above." The findings were: "IM rod crosses a comminuted mid tibial shaft fracture. Hardware is in place without complication. Fracture demonstrates no evidence of healing. Small radiodensities fill the fracture gap presumably bone graft material or antibiotic impregnated material. Prior imaging is not available for comparison. Periarticular demineralization at the knee and ankle likely reflect disuse and hyperemia. Near-anatomic alignment is noted."

3/26/2019- Report of an MRI of the right shoulder performed at Neighborhood Radiology. Impression: "1. Supraspinatus tendinosis, subacromial subdeltoid bursal fluid. 2. Long head biceps tendinosis. 3. Acromioclavicular joint osteoarthropathy."

3/26/2019- Report of x-rays of the right femur. Performed at Neighborhood Radiology. Impression: "No acute findings; periarticular demineralization at the knee likely related to disuse and prior trauma which is not imaged - partially imaged tibial IM rod as above." Findings noted: "No acute fracture or dislocation is seen. Joint spaces are maintained. Periarticular demineralization is seen at the knee. Partially imaged tibial IM rod appears uncomplicated."

4/24/2019- Report of an MRI of the cervical spine. Performed at Neighborhood Radiology. Impression: "1. C3-C4 protrusion. 2. C5-C6 protrusion. 3. T2-T3 bulging."

6/12/2019- Follow-up consultation with Dr. Simela, who ordered a bone stimulator due to lack of callus formation in the right tibia fracture. They were awaiting authorization for this. After

reviewing the MRIs, impression was: symptomatic cervical disc herniation and right tibia segmental bone loss nonunion. Ordered x-rays of the tibia and fibula to determine if there was any new bone formation, authorization for a bone stimulator, and to consult for a cervical epidural injection and EMG studies.

6/24/2019- Report of x-rays of the tibia and fibula, right. Impression: "No interval change-see discussion above." The findings were: "IM rod runs the length of the tibial shaft. 2 proximal and 2 distal interlocking screws are seen. Antibiotic impregnated material had been placed at the fracture gap of the mid tibial shaft. Near-anatomic alignment is demonstrated. No interval change is noted. Hardware is uncomplicated. Bones are demineralized."

10/21/2019- Report of x-rays of the right tibia and fibula at Neighborhood Radiology Services. Impression: "Hardware as discussed above - no change." Findings were: "IM rod runs the length of the tibial shaft and crosses the defect/mid shaft fracture, which was comminuted. Morselized bone graft has been placed at the gap. Hardware is uncomplicated. Near-anatomic alignment is noted."

11/12/2019- Operative report. Performed by Dr. Edwin Perez. Performed at Empire State Ambulatory Surgery Center. Preoperative diagnosis: Cervical radiculopathy. Postoperative Diagnosis: Same. Procedures Performed: Cervical epidural steroid injection with fluoroscopic needle localization and radiological interpretation performed at C7-T1. Cervical epidurogram under fluoroscopic guidance. Interpretation of and supervision by live fluoroscopy.

2/25/2020- Report of x-rays of the right tibia and fibula. Performed at Lenox Hill Radiology. Impression: "Postsurgical changes at the mid tibia with an intramedullary rod as described. Correlation with previous surgical history is recommended." The findings were that the patient had: "An intramedullary rod coursing through the tibia. There are two interlocking proximal and two interlocking distal screws. There are postsurgical changes at the mid tibia including bone grafting. Thick cortex is noted at the surgical site laterally and anteriorly. Osteopenic bone chips or fragments are observed medially and posteriorly. There is no evidence of loosening or infection of the hardware. The surrounding soft tissues are unremarkable."

2/25/2020- Report of x-rays of the right foot. Performed at Lenox Hill Radiology. Impression: "1. Mild hallux valgus deformity with mild arthrosis of the first metatarsophalangeal joint and first interphalangeal joint. 2. Tiny plantar calcaneal spur as well as a tiny osteophyte of the anterior aspect of the articular surface of the distal tibia. 3. Intramedullary rod within the distal tibia."

3/4/2020- Follow-up with Dr. Simela, who noted that the patient was status post IM nailing for open tib-fib fracture. The plan was to progress him to full weightbearing and they did see some callus formation. The plan was to follow him quarterly and x-rays twice a year.

9/22/2020- Initial consultation report by Dr. Paul Lerner. Noted a 28-year-old right-handed male who presented to the office for initial consultation reporting a fall at work striking his head and

fracturing his right leg, also injuring his back and neck. He had seen a prior neurologist and under the care of multiple physicians. Dr. Lerner's impression was history of head injury, concussion with report of recent convulsions, history consistent with post-traumatic seizures, reported right leg fracture, cervical and lumbar strain, reported depression and anxiety. He was to follow-up with all his records and a brain MRI as well as an EMG.

2/22/2021- Report of an MRI of the brain without contrast. Performed at Lenox Hill Radiology. Impression: "1. Limited evaluation. 2. No acute intracranial abnormalities. 3. Modest mucosal thickening in the paranasal sinuses, most conspicuous in the left ethmoid and left maxillary sinuses."

2/22/2021- Report of a CT scan of the right tibia and fibula without contrast. Impression: "Tibial diaphyseal fracture status post intramedullary fixation and bone grafting. Persistent osseous gapping at the diaphyseal fracture margins as well as partial nonunion of a dominant fracture fragment at the posterolateral margin of the fracture site." The body notes bones/joints: "Redemonstration of intramedullary fixation of the tibia of a segmental tibial diaphyseal fracture with intramedullary rod as well as proximal and distal interlocking screws. Hardware appears intact evidence of bone grafting of the fracture site. There remains osseous gapping at the anteromedial cortex of the tibial diaphysis by up to 1.8 cm with small foci of bone graft traversing the fracture gap although not fully incorporated. Osseous gapping at the posterior cortex is noted by up to 6.3 cm. Osseous gapping at the lateral cortex is noted by up to 2.9 cm. In addition, there is a persistent fracture lucency at the posterior lateral posterolateral fracture fragment. Bones are demineralized. Type 1 os navicularis noted. Muscles: No asymmetric muscle atrophy. Subcutaneous tissues: Post-surgical changes at the medial leg."

7/28/2021-11/3/2021- Records from Sandhills Medical Foundation Lugoff, seen by Montrice Curenton, NP. Seen for seizures and depression.

5/18/2023- Follow-up consultation with Dr. Kaplan. Dr. Kaplan performed x-rays of the right tibia/fibula, 2 views showing: "Surgical open reduction and internal fixation of the tibia shaft fracture with intramedullary rod fixation. There are 2 locking screws distally and proximally at the tibia. There is extensive callus formation at the tibial shaft fracture and a small fracture gap still present medially. There are irregularities at the articular surface of the distal and proximal tibia that is consistent with post-traumatic arthritis. No acute bony changes. X-rays taken today of the right shoulder, 2 views, show no acute bony changes, no fractures or dislocations. X-rays taken today of the cervical spine, 2 views, show straightening of the cervical curvature with loss of normal lordosis. No acute bony changes. X-rays taken today of the lumbar spine, 2 views, show straightening of the lumbar curvature with loss of normal lordosis. No acute bony changes." Dr. Kaplan's assessment was status post severely comminuted open mid tibial shaft fracture requiring open reduction and internal fixation with intramedullary nail as well as surgical bone grafting from the right iliac crest with exchange nailing, internal derangement of the right knee, post-traumatic arthritis of the right knee, internal derangement of the right ankle, post-traumatic arthritis of the right ankle, internal derangement of the right shoulder with supraspinatus tendinosis, subacromial subdeltoid bursal fluid, long head biceps tendinosis, and

acromioclavicular joint osteoarthropathy confirmed by MRI. Post-traumatic cervical pain with MRI evidence of C3-C4 and C5-C6 protrusion and T2-T3 bulging. Post-traumatic lumbar pain with symptoms of radiculopathy. Dr. Kaplan noted that the post-traumatic arthritis of the right knee and right ankle was not only permanent, but progressive in nature and would worsen over time. He advised him that he was a candidate for surgical evaluation of the right ankle and the right knee. He continued to require treatment with Orthopedics and Pain Management.

In summary, Mr. Wilmer Perez-Melchor has been a patient under my care since February 27, 2023. At that time, this patient was a 31-year-old male who presented to my office for an initial pain management evaluation. This patient sustained multiple traumatic injuries in a work-related accident while working at an elevation approximately 8 to 12 feet when the wall collapsed and he fell backwards in his harness to the ground with the wall falling on the patient, sustaining injuries to the head, neck, lower back, right shoulder, right knee, and an open fracture of the right tibia. He was taken via ambulance to Jacobi Medical Center where he was admitted until December 24, 2018. The patient underwent surgery urgently for an open reduction and internal fixation of the right tibia with an intramedullary nail placement on December 18, 2018. He had follow-up surgery with a bone graft from the right iliac crest on January 25, 2019 by Dr. Sen. He consulted with multiple physicians thereafter including Dr. Simela who did multiple x-rays for his right lower extremity. He also had pain to the right knee and the right shoulder. He had severe neck pain radiating to the head, severe lower back pain as well as head injuries and seizures.

DIAGNOSES:

1. Severely comminuted open mid tibial shaft fracture.
2. Status post open reduction and internal fixation, I & D, intramedullary nail, stimulant bead, and incisional VAC placement on December 19th, 2018 by Dr. Sen.
3. Delayed union of the right tibia fracture.
4. Surgery performed on January 25, 2019, due to a delayed union of the right tibia with an exchange of nail and right tibia, right iliac crest bone graft to right tibia, insertion of antibiotic drug delivery implant to right tibia by Dr. Sen.
5. Antalgic gait.
6. Severe bone loss of the right tibia fracture.
7. Post-traumatic arthritis of the right ankle.
8. Lumbago.
9. Post-traumatic lumbar myofascial pain.
10. Post-traumatic lumbar radiculopathy.
11. Cervicalgia.
12. Post-traumatic cervical myofascial pain.
13. Post-traumatic cervical radiculopathy.
14. Post-traumatic cervical disc herniations with an MRI performed on April 24, 2019, revealing evidence of C3-4 protrusion, C5-C6 protrusion, and T2-3 bulging.
15. Internal derangement of the right shoulder.

16. Traumatic arthropathy of the right shoulder with an MRI of the right shoulder done on March 26, 2019, revealing evidence of supraspinatus tendinosis, subacromial subdeltoid bursal fluid, long head biceps tendinosis, and acromioclavicular joint osteoarthropathy.
17. Internal derangement of the right knee.
18. Post-traumatic arthritis of the right knee.

I defer discussion of his head injuries and seizures to the appropriate specialist. He should continue to follow with his treating Neurologist.

The above diagnoses represent permanent injuries. The accident of December 18, 2018, is the competent producing cause of the above-mentioned diagnoses as well as the need for the extensive treatment outlined above. The patient had significant, traumatic injuries. The patient continues to require ongoing follow-up with his orthopedic surgeon who performed surgeries to the right lower extremity. He is a candidate for right shoulder arthroscopy, right knee arthroscopy and right ankle arthroscopy should his symptoms persist. He continues to require physical therapy for the right lower extremity. He is a candidate for additional imaging for the right lower extremity, right shoulder, and right knee.

The patient would benefit from interventional pain management including cervical and lumbar trigger point injections, and cervical and lumbar epidural injections, as well as medial branch blocks for both cervical and lumbar spines. He requires additional imaging for an MRI of the lumbar spine as well as updated MRI of the cervical spine and x-rays of the lumbar and cervical spine. The patient is a candidate for EMG/NCV studies of the upper and lower extremities. He could be a candidate for follow-up with his treating orthopedic spinal specialist. He continues to require physical therapy, aquatic therapy and acupuncture treatment. The patient is a candidate for medications including anti-inflammatories, both oral and topical, as well as neuropathic medications. His prognosis is poor. His condition is considered permanent.

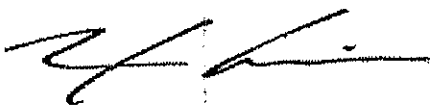
The future following medical costs can be expected to be incurred for lifetime duration for the cervical spine, lumbar spine, right knee, right shoulder, and right lower extremity/right ankle.

1. All medications including anti-inflammatories, muscle relaxants, neuropathic pain medications, and topical medications at the approximate cost of $100 per month for lifetime duration.
2. Pain management office visits at cost of $250 per visit, once per 3 months for lifetime duration.
3. Orthopaedic Surgeon office visits at a cost of $300 per visit, four times per year for lifetime duration.
4. Orthopaedic spinal surgeon office visits at a cost of $500 per visit, once a year for lifetime duration.
5. Lumbar steroid injections at a cost of $1200 per injection plus $2000 facility cost for fluoroscopic guidance per injection three injections every 2 years for lifetime duration.
6. Cervical steroid injections at a cost of $1200 per injection plus $2000 facility cost for fluoroscopic guidance per injection three injections every 2 years for lifetime duration.

7. Trigger point injections at a cost of $300 per set of injections, up to one set of injections per 3 months for lifetime duration for the cervical and lumbar spine.
8. Physical therapy at a cost of $100 to $150 per visit twice per month to maintain strength range of motion and pain management for lifetime duration.
9. Aquatic therapy at a cost of $100 to $150 per visit twice per month to maintain strength range of motion and pain management for lifetime duration.
10. Acupuncture at a cost of $100 to $150 per visit twice per month to maintain strength range of motion and pain management for lifetime duration.
11. MRI of the lumbar spine at the cost of $1300 once every five years for lifetime duration.
12. MRI of the cervical spine at the cost of $1300 once every five years for lifetime duration.
13. MRI of the right knee at the cost of $1300 once every five years for lifetime duration.
14. MRI of the right shoulder at the cost of $1300 once every five years for lifetime duration.
15. MRI of the right ankle/lower extremity at the cost of $1300 once every five years for lifetime duration.
16. X-ray films of the lumbar spine once every 6 months at a cost of $400 for lifetime duration.
17. X-ray films of the cervical spine once every 6 months at a cost of $400 for lifetime duration.
18. X-ray films of the right knee once every 6 months at a cost of $400 for lifetime duration.
19. X-ray films of the right shoulder once every 6 months at a cost of $400 for lifetime duration.
20. X-ray films of the right ankle once every 6 months at a cost of $400 for lifetime duration.
21. EMG/NCV studies of the upper extremities at the approximate cost of $2000 once every five years for lifetime duration.
22. EMG/NCV studies of the lower extremities at the approximate cost of $2000 once every five years for lifetime duration.
23. Candidate for cervical facet block injections at a cost of $1500 per injection plus $2000 hospital cost for fluoroscopic guidance up to four injections per year for lifetime duration pending the patient's response.
24. Candidate for lumbar facet block injections at a cost of $1500 per injection plus $2000 hospital cost for fluoroscopic guidance up to four injections per year for lifetime duration pending the patient's response.

If you have any questions or concerns, please do not hesitate to contact my office at any time.

Sincerely,



Matthew Grimm, M.D.

MG:cbs/MMD

STATE OF NEW YORK

SS.: **AFFIDAVIT OF SERVICE**

COUNTY OF NEW YORK

I, Karina Flores being duly sworn, depose and say: I am not a party to the action, am over 18 years of age, and reside in the County of Middlesex, State of New Jersey.

On January 24, 2024, I served the within **NOTICE OF MEDICAL EXCHANGE** by

☒ **Service by mail** by depositing a true copy thereof in a post-paid wrapper, in an official depository under the exclusive care and custody of the U.S. Postal Service within New York State, addressed to each of the following persons at the last known address set forth:

LEWIS BRISBOIS BISGAARD & SMITH LLP
Attorneys for Defendant
NORTH AVENUE EAST LLC
77 Water Street, 21st Floor
New York, New York 10005
(212) 232-1300
File No.: 26386.787

Karina Flores

Sworn to before me on
January 24, 2024

Notary Public

ANGELA I. L. COLLADO
Commissioner of Deeds
City of New York - No. 2-13509
Certificate Filed in New York County
Commission Expires

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER

WILMER PEREZ MELCHOR, **Index No. 59061/19**

Plaintiff,

-against-

NORTH AVENUE EAST LLC,

Defendant.

NOTICE OF MEDICAL EXCHANGE

GORAYEB & ASSOCIATES, P.C.
Attorneys for Plaintiff
WILMER PEREZ MELCHOR
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