UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

----------X Index #: 10-cv-4158

TAMAR TCHELIDZE,

Plaintiff,

PLAINTIFF'S F.R.C.P. RULE 26 (a) (2) EXPERT DISCLOSURE

-against-

THE TJX COMPANIES, INC. d/b/a T.J. MAXX and MARMAXX OPERATING CORP.,

Defendants.

----------X

PLEASE TAKE NOTICE, that the following is the plaintiff's F.R.C.P. Rule 26 (a) (2) Expert Disclosure.

MEDICAL EXPERT:

IDENTITY:

Plaintiff will call DR. SEBASTIAN LATTUGA, M.D., an orthopedic spine surgeon, with offices at 3311 Shore Parkway, Brooklyn, NY 11235, to testify in the trial of this action. Dr. Lattuga's Curriculum Vitae and various office records and narrative reports are annexed hereto and made a part hereof, although they have been previously exchanged in this matter. The witness' qualifications are discussed in the annexed Curriculum Vitae. The witness does not maintain a list of publications or prior testimony in the last four years. The witness will compensated in the amount of $10,000.00 for the study and testimony in the case.

SUBJECT MATTER OF TESTIMONY:

The subject matter of Dr. Lattuga's testimony is contained in his various office records and narrative reports which are annexed hereto and made a part hereof, although they have been previously exchanged in this matter Dr. Lattuga will testify with respect to the plaintiff's accident; his review of the plaintiff's medical records, hospital records, imaging studies, X-rays, M.R.I.'s, CT

scans, EMG/NCV's, operative/surgical records, orthopedic records, physical therapy records, pain management records, etc.; his numerous physical examinations of the plaintiff; and his diagnosis, prognosis and determination as to the causation of the plaintiff's injuries. Dr. Lattuga will further testify as to the significance of, permanency of, and limitations caused by these injuries; upon any hypothetical questions posed to him; and upon the testimony (actual or anticipated) and/or narratives of any other expert retained by any party in this action.

SUBSTANCE OF FACTS AND OPINIONS :

The substance of the facts and opinions of which Dr. Lattuga will testify concern the plaintiff's accident of July 11, 2009, and those contained in his various office records and narrative reports which are annexed hereto and made a part hereof, any and all medical documents of the plaintiff, and any and all pleadings/legal documents in this action. The opinions which the expert will express and the basis and reasons for same are set forth in the attached reports. The facts and opinions, the substance of which the plaintiff's medical expert is expected to testify, will be the result of the treatment, evaluations and examinations of the plaintiff and the medical records, hospital records, imaging studies, X-rays, M.R.I.'s, CT Scans, EMG/NCV's, operative/surgical records, orthopedic records, physical therapy records, pain management records, etc., and/or other facts read or admitted into evidence; and interpretation by any medical expert called on behalf of any party, including but not limited to CT scans, M.R.I.'s, X-rays, and such other tests as may be available at the time of trial.

The substance of the facts and opinions of which Dr. Lattuga will testify further concerns the nature of the injuries sustained by the plaintiff, including injuries to her cervical spine and lumbosacral spine, lumbosacral internal derangement/sprain/strain/radiculopathy/myofascitis requiring lumbar surgery, among other injuries.

Dr. Lattuga will further testify as to the fact that all of the aforementioned injuries and their natural sequelae, are permanent, except those of a temporary or superficial nature. Further, all of the aforementioned injuries, manifestations and disabilities are associated with further soft tissue injury and traumatic arthritis to the areas traumatically affected including injury, tearing, derangement and damage to the associated muscle groups, ligaments, tendons, blood vessels, blood supply, nerves and nerve tissue, soft tissue, with resultant pain, deformity and disability, stiffness, tenderness, weakness and restriction and limitation of motion and pain on motion; all of the aforementioned injuries were caused, aggravated, exacerbated and/or precipitated by the accident and/or the original injuries suffered therein; all of the aforementioned injuries and complications thereof were natural and foreseeable consequences/risks of the accident, the injuries caused thereby, and their resultant required medical treatments/services; and there is also a strong possibility of/need for future surgical repair to those parts of the body injured in this accident along with possible loss of use of above mentioned parts and atrophy.

Dr. Lattuga will further testify concerning the extent that these injuries have caused pain, limitation, and problems in the plaintiff's activities of daily living particularly her inability to seek and maintain full-time employment, that the injuries were caused by the subject accident, and that the injuries are permanent, significant and consequential. Dr. Lattuga will also testify to the effect that the plaintiff suffers from various positive medical testing. Dr. Lattuga will also testify concerning his findings at his examinations and his opinions as to plaintiff's prognosis and disability status. Dr. Lattuga will also testify concerning the extensive course of medical treatment that the plaintiff has undergone. Dr. Lattuga will opine that the plaintiff has suffered significant injuries as a result of the accident. Dr. Lattuga will opine regarding the plaintiff's need for future medical care, likelihood of future surgery, and need for future medical treatments. Dr. Lattuga will opine

regarding the plaintiff's inability to seek gainful employment in any capacity due to the accident, her injuries and her resultant disability. Dr. Lattuga will further testify with respect to the plaintiff's injuries, permanency, limitations, causation, need for future medical care, increased susceptibility to re-injury, and prognosis, as well as in accordance with his office records annexed hereto. Dr. Lattuga will further testify with respect to the presence and/or lack of any significant pre-existing or prior medical conditions and their role, effect, etc., if any, in the plaintiff's treatment and diagnosis, if any. Dr. Lattuga will further testify with respect to any outstanding medical liens, medical bills, special damages, etc, in this matter, if any, and the cost of future medical care, if any.

SUMMARY OF GROUNDS FOR OPINIONS:

A summary of the grounds for Dr. Lattuga's opinions is based upon his review of the information and documents obtained through discovery and investigation, in addition to all other case file materials, including but not limited to, deposition transcripts, medical records and/or reports, education, work and professional experience and knowledge, etc. In addition, same may be based upon the relevant testimonies offered by all witnesses, experts, and parties prior to, and at, trial. The data and other information considered by the expert in forming his opinions are set forth in the attached report. The exhibits that will be used to summarize or support his opinions include his reports and all of the plaintiff's medical records, all of which have been previously exchanged.

PLEASE TAKE FURTHER NOTICE, that the above-named expert has been retained on behalf of the plaintiff(s) for the purpose of litigation, and the defendants, their representatives, agents, servants and employees are not authorized to contact the expert in any way whatsoever.

PLEASE TAKE FURTHER NOTICE, that plaintiff reserves the right to amend and/or supplement the above response at any time prior to the time of, and during, the trial of this action.

Dated: New York, New York

September 26, 2011

Yours, etc.,

Joseph Stoduto (JS5731)
WINGATE, RUSSOTTI & SHAPIRO, LLP
Attorneys for Plaintiff
420 Lexington Avenue, Suite 2750
New York, NY 10170
(212) 986-7353

TO: Cerusi & Spring
Attorneys for Defendants
One North Lexington Avenue
White Plains, NY 10601

SEBASTIAN LATTUGA, M.D., F.A.A.O.S.
BOARD CERTIFIED, ORTHOPEDICS AND SPINE SURGERY
FELLOW, AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS
DIRECTOR, DIVISION OF SPINE SURGERY AT FRANKLIN
NORTH SHORE LIJ HEALTH SYSTEM Lic No. 187078

2001 Marcus Ave, Ste.W170
Lake Success, NY 11042
Tel: (516) 355-0111
Fax: (516) 355-5011

80-02 Kew Gardens Road.
Kew Gardens, NY 11415
164 Madison Ave, 4th floor
New York, NY, 10016
3311 Shore Parkway Ste. LL
Brooklyn, NY 11235

04/30/2010

RE: TAMAR TCHELIDZE **NEW PATIENT CONSULTATION**
DOB: 10/12/1957
DOA: 07/11/2009
NO-FAULT

TAMAR TCHELIDZE (the "patient") is being seen today for a spinal consult.

CHIEF COMPLAINT:
Patient is complaining of neck and back pain, upper and lower extremity radiation.

HISTORY OF PRESENT ILLNESS:
Patient is a 52-year old female involved in a motor vehicle accident on 07/11/2009, sustaining injury to the neck and back as a result. Patient has been symptomatic since the accident and was asymptomatic prior. Patient has had conservative treatment, however, remains severely symptomatic. Patient denies having had surgery for this condition.

Patient presents today complaining of neck and back pain, upper and lower extremity radiation with numbness, tingling and dysesthesias. Patient describes pain as being daily, sharp shooting, constant and persistent with a pain severity score of 9 to 10 out of 10. Patient's symptoms are made worse and interfere with daily activities such as lifting, carrying, lying on side, sleeping, moving around, bending, standing/sitting for prolonged periods of time, ascending/descending stairs. Patient denies any other trauma, fevers, chills, night sweats, weight gain/loss associated with this.

PAST MEDICAL HISTORY/SURGERIES/HOSPITALIZATION:
Past medical history, including allergies, medications, family history, review of systems, social history, was examined by me today and are documented in the chart.

MUSCULOSKELETAL PHYSICAL EXAMINATION:

- Spine Exam:
  - **Cervical:** Inspection to percussion and palpation shows tenderness and spasms noted. There are restricted ranges of motion, 15 degrees of flexion (70° is normal), 10 degrees of extension (45° is normal), left and right turning to 20 degrees (80° is normal).
  - **Thoracolumbar:** Inspection to percussion and palpation shows tenderness and spasms noted. There are restricted ranges of motion, 20 degrees of flexion (90° is normal), 10 degrees of

extension (40° is normal), left and right turning to 15 degrees (60° is normal).
- **The Right and Left Upper and Lower Extremities** are **not** within normal limits on inspection, as described below.

- Neurological:
  - Patient has normal coordination and normal gait. Patient ambulates with a cane/walker.
  - Motor strength is normal/abnormal.
  - Sensation is normal/abnormal/decreased in the XXXX nerve root distributions.
  - Examination of the reflexes are symmetrical/asymmetrical.

DIAGNOSTIC IMAGING:
Lumbar MRI Report 07/31/2009 reveals degenerative changes at L4-L5 and L5-S1. There is a suspected annular fissure at L4-L5.

DIAGNOSIS:
Lumbar spine radiculopathy, sprain and HNP

IMPRESSION/PLAN:
This patient suffers with Lumbar spine radiculopathy, sprain and HNP.

An overview of different treatment options were discussed with this patient including surgical and non-surgical modalities for amelioration of symptoms, such as chiropractic care/ physical therapy, epidural steroid injections, posterior spinal fusion and medication.

Patient has elected to proceed with posterior spinal fusion.

All of the risks, benefits, alternatives, success and failures of surgical verses non-surgical procedures were discussed with the patient, including disc replacement and arthrodesis, continued pain, paralysis, blood transfusion, and infection. Specifically stated today was that surgery is not a guarantee that there would be a return of normal neurological function or of a pre-injury state. Also discussed with the patient was the risk of worsening neurological symptoms as the result of surgical intervention. Patient understands.

Patient is to refrain from any activity that exacerbates symptoms such as heavy lifting, carrying or bending and follow up in several weeks for a repeat evaluation. Thank you for the pleasure of this consult.

Sebastian Lattuga, M.D.
SL/cd
Dictated but not proofread.

FRANKLIN/NORTHSHORE MEDICAL CENTER

OPERATION SUMMARY

Name: TCHELIDE,TAMAR
Chart #:010170690

Date of Surgery:5/12/10

Surgeon: Sebastian Lattuga,M.D.
Assistant: M.Duffe, RPA**

Anesthesia: General
EBL:100 cc's
Specimen:bone

Preoperative Diagnosis:HNP with Radiculopathy, HNP Instability,

Postoperative Diagnosis: SAME, HNP COMPRESSING R L4/5 NERVE
Operative time: 6 hours

Operation: POSTEROLATERAL FUSION L4-L5 (22612)
PEDICLE FIXATION L4/5 (22840)
TRANS-LUMBAR INTERBODY FUSION L4/5 (22630)
INTERVERTEBRAL BIOMECHANICAL DEVICE (22851)
AUTOGRAFT MORSELIZED (20937)
LAMI, FACETECTOMY, FORAMINOTOMY L4 (63047) (51)
LAMINECTOMY, FACETECTOMY, FORAMINOTOMY L5 (63048)
FLOUROSCOPY > 1 HOUR
Findings: Instability, foraminal stenosis with severe nerve compression,TRAUMATICALLY INDUCED DISK

Procedure:

Positioning:

After administration of general anesthesia the patient was placed prone onto the Wilson Frame. Care was taken to position Gel padding under potential pressure points at the knees and elbows. A grounding pad was carefully positioned on the thigh and a strap around the thigh was positioned to hold the legs firmly in position.

*** Physician's Assistants service were deemed medically necessary to assist the primary surgeon with the procedure. The surgery cannot be performed safely without an experienced assistant.*

FRANKLIN MEDICAL CENTER

Name: TCHELIDE,TAMAR **Date of Surgery:5/12/10**
Chart #:010170690

Prepping and Draping:

The back was prepped with a betadine solution. Standard draping of the lumbosacral area was performed leaving access to the posterior superior iliac crests.

Incision and Exposure:

An approximate 6 inch incision was made between the spinous processes. Electrocautery was utilized to control all bleeding. We went through the subcutaneous layer exposing the lumbosacral fascia. The subcutaneous layer was stripped on the left side to gain exposure to the posterior elements of the lumbar spine. The lumbosacral fascia was then opened bilaterally. The para-vertebral muscles were stripped off gaining access to the posterior elements. Cerebellar retractors were used to hold the soft tissues out of the way. Care was taken to avoid damage to the facet capsules of the levels not to be fused. The crank retractor was then positioned for further lateral exposure. The posterolateral gutters were then exposed out to the tips of the transverse processes bilaterally. Care was taken not to violate the inter-transverse membrane. The gutters were then packed off.

LAMINECTOMY, FACETECTOMY, FORAMINOTOMY L4 (63047)
LAMINECTOMY, FACETECTOMY, FORAMINOTOMY L5 (63048)

Under microscopic control the interlaminar space was further cleared of any soft tissue debris. Using a hall air burr a small sliver of the lower edge of the lamina was removed to enlarge the interlaminar opening. The ligamentum flavum was then incised with a 15 blade on a 7 handle. Epidural fat and the epidural space was appreciated. Small angled rongeurs were utilized to remove the entire lamina as far lateral as the medial wall of the pedicle.

Next using a combination of high speed burr and hand held bone removing instruments each of the above lamina medial facet joints were resected under direct visualization. Care was taken to protect the nerve roots and cauda equina throughout the entire procedure. Next each of the individual nerve roots in question was decompressed.

At this point a microdissector was put into the canal lateral to the nerve root. Using gentle traction and blunt dissection adhesions around the nerve root were mobilized allowing medial retraction of the nerve roots over the ventrally located disc

FRANKLIN MEDICAL CENTER

Name: TCHELIDE,TAMAR Date of Surgery:5/12/10
Chart #:010170690

herniation. Small epidural veins were controlled using the micro-cautery. After coagulation the veins and adhesions were cut using a micro-scissors. This allowed for final retraction of the nerve root medially to allow for adequate visualization of an extruded disc fragment. This was removed from under the root with a pituitary rongeur.

Inspection of Nerve Root and Foramen:

The nerve root retractor was removed from the spinal canal and nerve allowed to fall back into its normal position. With the aid of a microdissector and a nerve hook the nerve root and foramen were inspected for any signs of residual free fragments or neural compression.

TRANS-LUMBAR INTERBODY FUSION L4/5 (22630)
INTERVERTEBRAL BIOMECHANICAL DEVICE (22851)

The disk space was prepared using , Curettes, Scrappers and chisels were used to preparer the disk space. The intervertebral space was dilated using the provided distractors. Next the box osteotome was used to prepare the interspace for the graft. The inter-vertebral implants were impacted into place to the appropriate depth. Final position of the implant was checked using radiography. Next the interspace was packed with morselized autograft.

The same technique was used to prepare the next interspace.

Insertion of Pedicle Screws: (22840) FLOUROSCOPY

The crank retractor was repositioned in the main wound. The entire posterior elements were seen from transverse process on the left to transverse process on the right. A small burr was used to make a small hole in the base of the superior facet perpendicular to a line drawn from the mid-portion of the base of the transverse process.

FRANKLIN MEDICAL CENTER

Name: TCHELIDE,TAMAR Date of Surgery:5/12/10
Chart #:010170690

Following the saggital plane as depicted on FLOUROSCOPY (also approximately perpendicular to the plane of the transverse process) a K-wire was inserted angling medially into the pedicle. This was repeated on the opposite side. Similarly at the base of the facet a small burr hole was made and a K-wire inserted in the pedicle. This was repeated on the opposite side. A lateral X-ray was obtained to verify the location of the pedicle. The same was performed at S1.

After the X-ray had been developed we withdrew each K-wire sequentially and placed a pedicle finder down into the tract of the K-wire with modifications made as necessary according to the FLOUROSCOPY. The pedicle finder was replaced with a pedicle probe to examine the tract and verify the lack of perforation of the walls of the pedicle. The appropriate length pedicle screws (6.5mm X 40mm) from the set were inserted into the pedicles bilaterally. In a similar fashion screws were placed in the L4 and L5 pedicle. FLOUROSCOPY was obtained to verify good positioniug of the screws.

Each screw was tested in accordance to standard techniques and found be satisfactory. NO post screw insertion peripheral emg firing or SSEP changes were noted.

POSTEROLATERAL FUSION L4/L5: (22612)

There was evidence of motion at the L4/L5/S1 level. With careful retraction the posterolateral gutters were decorticated around the base of the pedicle screws. The graft was carefully pushed laterally into the area of the transverse processes. The facet joint and pars were carefully packed as well.

MORSELIZED BONE GRAFT (20937)

Through a separate fascial incision iliac crest bone graft was harvested using minimally invasive techniques. Care was taken to maintain hemostasis using gel foam powder.

Rod insertion and Fixation: (22840)

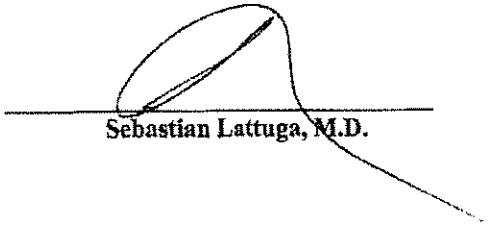
The gap between the three pedicle screws was measured with a caliper. An appropriate size rod was selected and contoured for connection to the screws. The rod was inserted. A collar was placed over each screw and a nut was tightened. The rod was inserted on the opposite side in a similar fashion. The remaining bone graft was positioned underneath and lateral to the rod.

FRANKLIN MEDICAL CENTER

Name: TCHELIDE,TAMAR **Date of Surgery:5/12/10**
Chart #:010170690

CLOSURE

An Jackson-Pratt drain was placed in the depth of the main wound after appropriate irrigation. The retractors were removed. The fascia was closed with interrupted 0 Vicryl sutures . The subcutaneous layer was closed with 2-0 Vicryl. The overlying skin was closed with a running 3-0 sub-cuticular stitch. Steri-strips were applied. A sterile dressing was placed over the wound and covered with a sterile Vi-drape. dressing. The patient was awoken and transferred carefully from the Wilsons frame to the bed. The patient was transferred to the recovery room in Stable Condition.



Sebastian Lattuga, M.D.

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BOARD CERTIFIED, ORTHOPEDICS AND SPINE SURGERY
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NORTH SHORE LIJ HEALTH SYSTEM Lic No. 187078

2001 Marcus Ave, Ste.W170
Lake Success, NY 11042
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Fax: (516) 355-5011

80-02 Kew Gardens Road.
Kew Gardens, NY 11415
164 Madison Ave, 4th floor
New York, NY, 10016
3311 Shore Parkway Ste. LL
Brooklyn, NY 11235

05/20/2010

RE: TCHELIDZE, TAMAR **POST-OPERATIVE EVALUATION**
DOB: 10/12/1957

CHIEF COMPLAINT:
Patient is doing well post-operatively, however continues to have pain and symptoms consistent with pre-operative conditions.

HISTORY OF PRESENT ILLNESS:
Patient is follow-up status post posterior spinal lamenectomy and fusion performed on 5/12/10.
Patient doing well, with improvement of lumbar pain, however continues to have residual pain and symptoms consistent with pre-operative conditions. Patient denies any other trauma, fevers, chills, night sweats, weight gain/loss associated with this.

PAST MEDICAL HISTORY/SURGERIES/HOSPITALIZATION:
Past medical history, including allergies, medications, family history, review of systems, social history, was examined by me today and are documented in the chart.

MUSCULOSKELETAL PHYSICAL EXAMINATION:

- **Wound:** No discharge, erythema or purulence noted.
- **Spine Exam:**
  - **Lumbar:** Inspection to percussion and palpation reveals tenderness and spasms noted. Range of motion is restricted.
  - **The right and left lower extremities** are **not** within normal limits on inspection, as described below.
- **Neurological:**
  - Patient has normal coordination.
  - Motor strength, sensation, reflexes consistent with pre-op.

DIAGNOSIS:
Status post fusion L4/5

DIAGNOSTIC IMAGING:
Lumbar XRAYs taken today are satisfactory for placement of implants

IMPRESSION/PLAN:
Patient is doing well post-operatively with improvement, however continues to have residual pain and symptoms consistent with pre-operative conditions.

Patient has been prescribed percocet to be taken as directed, is to attend physical therapy, refrain from any activity that exacerbates symptoms such as lifting, carrying, bending, twisting, and follow up in several weeks for a repeat evaluation.

Sebastian Lattuga, M.D.,

SL/MD/
Dictated but not proofread

SEBASTIAN LATTUGA, M.D., F.A.A.O.S.
BOARD CERTIFIED, ORTHOPEDICS AND SPINE SURGERY
FELLOW, AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS
DIRECTOR, DIVISION OF SPINE SURGERY AT FRANKLIN
NORTH SHORE LIJ HEALTH SYSTEM Lic No. 187078

2001 Marcus Ave, Ste.W170
Lake Success, NY 11042
Tel: (516) 355-0111
Fax: (516) 355-5011

80-02 Kew Gardens Road.
Kew Gardens, NY 11415

164 Madison Ave, 4th floor
New York, NY, 10016

3311 Shore Parkway Ste. LL
Brooklyn, NY 11235

06/25/2010

RE: TCHELIDZE, TAMAR **POST-OPERATIVE EVALUATION**
DOB: 10/12/1957

CHIEF COMPLAINT:
Patient is doing well post-operatively, however continues to have some pain and symptoms consistent with pre-operative conditions.

HISTORY OF PRESENT ILLNESS:
Patient is follow-up status post posterior spinal laminectomy and fusion performed on 05/12/2010. Patient denies any other trauma, fevers, chills, night sweats, weight gain/loss associated with this.

PAST MEDICAL HISTORY/SURGERIES/HOSPITALIZATION:
Past medical history, including allergies, medications, family history, review of systems, social history, was examined by me today and are documented in the chart.

MUSCULOSKELETAL PHYSICAL EXAMINATION:

- **Spine Exam:**
  - **Lumbar:** Inspection to percussion and palpation reveals tenderness and spasms noted. Range of motion is restricted.
  - **The right and left lower extremities** are **not** within normal limits on inspection, as described below.
- **Neurological:**
  - Patient has normal coordination.
  - Motor strength, sensation, reflexes improved with pre-op.

DIAGNOSTIC IMAGING:
Lumbar X-ray taken today is satisfactory.

DIAGNOSIS:
Status post fusion L4/5

IMPRESSION/PLAN:
Patient is doing well post-operatively with improvement, however continues to have residual pain and symptoms consistent with pre-operative conditions.

Patient was prescribed Percocet to be taken as directed, is to attend physical therapy, refrain from any activity that exacerbates symptoms such as lifting, carrying, bending, twisting, and follow up in several weeks for a repeat evaluation.

Sebastian Lattuga, M.D.,
SL/MD/ *Dictated but not proofread*

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BOARD CERTIFIED, ORTHOPEDICS AND SPINE SURGERY
FELLOW, AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS
DIRECTOR, DIVISION OF SPINE SURGERY AT FRANKLIN
NORTH SHORE LIJ HEALTH SYSTEM Lic No. 187078

2001 Marcus Ave, Ste.W170
Lake Success, NY 11042
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80-02 Kew Gardens Road.
Kew Gardens, NY 11415

164 Madison Ave, 4th floor
New York, NY, 10016

3311 Shore Parkway Ste. LL
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7/23/2010

RE: TCHELIDZE, TAMAR **POST-OPERATIVE EVALUATION**
DOB: 10/12/1957

CHIEF COMPLAINT:
Patient is doing well post-operatively, however continues to have some pain and symptoms consistent with pre-operative conditions.

HISTORY OF PRESENT ILLNESS:
Patient is follow-up status post posterior spinal laminectomy and fusion performed on 05/12/2010. Patient denies any other trauma, fevers, chills, night sweats, weight gain/loss associated with this.

PAST MEDICAL HISTORY/SURGERIES/HOSPITALIZATION:
Past medical history, including allergies, medications, family history, review of systems, social history, was examined by me today and are documented in the chart.

MUSCULOSKELETAL PHYSICAL EXAMINATION:

- **Spine Exam:**
  - **Lumbar:** Inspection to percussion and palpation reveals tenderness and spasms noted. Range of motion is restricted.
  - **The right and left lower extremities** are **not** within normal limits on inspection, as described below.
- **Neurological:**
  - Patient has normal coordination.
  - Motor strength, sensation, reflexes improved with pre-op.

DIAGNOSTIC IMAGING:
Lumbar X-ray taken today is satisfactory.

DIAGNOSIS:
Status post fusion L4/5

IMPRESSION/PLAN:
Patient is doing well post-operatively with improvement, however continues to have residual pain and symptoms consistent with pre-operative conditions.

Patient was prescribed Percocet to be taken as directed, is to attend physical therapy, refrain from any activity that exacerbates symptoms such as lifting, carrying, bending, twisting, and follow up in several weeks for a repeat evaluation.

Sebastian Lattuga, M.D.,
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New York, NY, 10016

3311 Shore Parkway Ste. LL
Brooklyn, NY 11235

09/03/2010

RE: TCHELIDZE, TAMAR **POST-OPERATIVE EVALUATION**
DOB: 10/12/1957

CHIEF COMPLAINT:
Patient is doing well post-operatively, however continues to have some pain and symptoms consistent with pre-operative conditions.

HISTORY OF PRESENT ILLNESS:
Patient is follow-up status post posterior spinal laminectomy and fusion performed on 05/12/2010. Patient denies any other trauma, fevers, chills, night sweats, weight gain/loss associated with this.

PAST MEDICAL HISTORY/SURGERIES/HOSPITALIZATION:
Past medical history, including allergies, medications, family history, review of systems, social history, was examined by me today and are documented in the chart.

MUSCULOSKELETAL PHYSICAL EXAMINATION:

- **Spine Exam:**
  - **Lumbar:** Inspection to percussion and palpation reveals tenderness and spasms noted. Range of motion is restricted.
  - **The right and left lower extremities** are **not** within normal limits on inspection, as described below.
- **Neurological:**
  - Patient has normal coordination.
  - Motor strength, sensation, reflexes improved with pre-op.

DIAGNOSTIC IMAGING:
Lumbar X-ray taken today is satisfactory.

DIAGNOSIS:
Status post fusion L4/5

IMPRESSION/PLAN:
Patient is doing well post-operatively with improvement, however continues to have residual pain and symptoms consistent with pre-operative conditions.

Patient was prescribed Percocet to be taken as directed, is to attend physical therapy, refrain from any activity that exacerbates symptoms such as lifting, carrying, bending, twisting, and follow up in several weeks for a repeat evaluation.

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10/15/2010

RE: TCHELIDZE, TAMAR **POST-OPERATIVE EVALUATION**
DOB: 10/12/1957

CHIEF COMPLAINT:
Patient is doing well post-operatively, however continues to have some pain and symptoms consistent with pre-operative conditions.

HISTORY OF PRESENT ILLNESS:
Patient is follow-up status post posterior spinal laminectomy and fusion performed on 05/12/2010. Patient denies any other trauma, fevers, chills, night sweats, weight gain/loss associated with this.

PAST MEDICAL HISTORY/SURGERIES/HOSPITALIZATION:
Past medical history, including allergies, medications, family history, review of systems, social history, was examined by me today and are documented in the chart.

MUSCULOSKELETAL PHYSICAL EXAMINATION:

- **Spine Exam:**
  - **Lumbar:** Inspection to percussion and palpation reveals tenderness and spasms noted. Range of motion is restricted.
  - **The right and left lower extremities** are **not** within normal limits on inspection, as described below.
- **Neurological:**
  - Patient has normal coordination.
  - Motor strength, sensation, reflexes improved with pre-op.

DIAGNOSTIC IMAGING:
Lumbar X-ray taken today is satisfactory.

DIAGNOSIS:
Status post fusion L4/5

IMPRESSION/PLAN:
Patient is doing well post-operatively with improvement, however continues to have residual pain and symptoms consistent with pre-operative conditions.

Patient was prescribed Percocet to be taken as directed, is to attend physical therapy, refrain from any activity that exacerbates symptoms such as lifting, carrying, bending, twisting, and follow up in several weeks for a repeat evaluation.

Sebastian Lattuga, M.D.,
SL/MD/ *Dictated but not proofread*

SEBASTIAN LATTUGA, M.D., F.A.A.O.S.
BOARD CERTIFIED, ORTHOPEDICS AND SPINE SURGERY
FELLOW, AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS
DIRECTOR, DIVISION OF SPINE SURGERY AT FRANKLIN
NORTH SHORE LIJ HEALTH SYSTEM Lic No. 187078

2001 Marcus Ave, Ste. W170
Lake Success, NY 11042
Tel: (516) 355-0111
Fax: (516) 355-5011

80-02 Kew Gardens Road.
Kew Gardens, NY 11415
210 East 64th Street, 4th FL.
New York, NY, 10065
3311 Shore Parkway Ste. LL
Brooklyn, NY 11235

11/12/10

RE: TCHELIDZE, TAMAR **POST-OPERATIVE EVALUATION**
DOB: 10/12/1957

CHIEF COMPLAINT:
Patient is doing well post-operatively, however continues to have some pain and symptoms consistent with pre-operative conditions.

HISTORY OF PRESENT ILLNESS:
Patient is follow-up status post posterior spinal laminectomy and fusion performed on 05/12/2010. Patient denies any other trauma, fevers, chills, night sweats, weight gain/loss associated with this.

PAST MEDICAL HISTORY/SURGERIES/HOSPITALIZATION:
Past medical history, including allergies, medications, family history, review of systems, social history, was examined by me today and are documented in the chart.

MUSCULOSKELETAL PHYSICAL EXAMINATION:

- Spine Exam:
  - **Cervical:** Inspection to percussion and palpation shows tenderness and spasms noted. There are restricted ranges of motion, 15 degrees of flexion (70° is normal), 10 degrees of extension (45° is normal), left and right turning to 20 degrees (80° is normal).
  - **Thoracolumbar:** Inspection to percussion and palpation shows tenderness and spasms noted. There are restricted ranges of motion, 30 degrees of flexion (90° is normal), 10 degrees of extension (40° is normal), left and right turning to 15 degrees (60° is normal).
  - **The Right and Left Upper and Lower Extremities** are **not** within normal limits on inspection, as described below.

- Neurological:
  - Patient has normal coordination and normal gait. Patient ambulates with a cane/walker.
  - Motor strength is normal/abnormal.
  - Sensation is normal/abnormal/decreased in the XXXX nerve root distributions.
  - Examination of the reflexes are symmetrical/asymmetrical.

DIAGNOSTIC IMAGING:
p

DIAGNOSIS:
Status post fusion L4/5

IMPRESSION/PLAN:

Patient is doing well post-operatively with improvement, however continues to have residual pain and symptoms consistent with pre-operative conditions.

Patient was prescribed Percocet to be taken as directed, is to attend physical therapy, refrain from any activity that exacerbates symptoms such as lifting, carrying, bending, twisting, and follow up in several weeks for a repeat evaluation.

Sebastian Lattuga, M.D.,
SL/MD/ *Dictated but not proofread*

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DIRECTOR, DIVISION OF SPINE SURGERY AT FRANKLIN
NORTH SHORE LIJ HEALTH SYSTEM Lic No. 187078

2001 Marcus Ave, Ste.W170
Lake Success, NY 11042
Tel: (516) 355-0111
Fax: (516) 355-5011

80-02 Kew Gardens Road.
Kew Gardens, NY 11415
210 East 64th Street, 4th Floor
New York, NY, 10016
3311 Shore Parkway Ste. LL
Brooklyn, NY 11235

01/07/2011

RE: TCHELIDZE, TAMAR **POST-OPERATIVE EVALUATION**
DOB: 10/12/1957

CHIEF COMPLAINT:
Patient is doing well post-operatively, however continues to have some pain and symptoms consistent with pre-operative conditions.

HISTORY OF PRESENT ILLNESS:
Patient is follow-up status post posterior spinal laminectomy and fusion performed on 05/12/2010. Patient denies any other trauma, fevers, chills, night sweats, weight gain/loss associated with this.

PAST MEDICAL HISTORY/SURGERIES/HOSPITALIZATION:
Past medical history, including allergies, medications, family history, review of systems, social history, was examined by me today and are documented in the chart.

MUSCULOSKELETAL PHYSICAL EXAMINATION:

- Spine Exam:
  - **Cervical:** Inspection to percussion and palpation shows tenderness and spasms noted. There are restricted ranges of motion, 15 degrees of flexion (70° is normal), 10 degrees of extension (45° is normal), left and right turning to 20 degrees (80° is normal).
  - **Thoracolumbar:** Inspection to percussion and palpation shows tenderness and spasms noted. There are restricted ranges of motion, 30 degrees of flexion (90° is normal), 20 degrees of extension (40° is normal), left and right turning to 35 degrees (60° is normal).
  - **The Right and Left Upper and Lower Extremities** are **not** within normal limits on inspection, as described below.

- Neurological:
  - Patient has normal coordination and normal gait. Patient ambulates with a cane.
  - Motor strength is normal.
  - Sensation is normal.
  - Examination of the reflexes are symmetrical/asymmetrical.

DIAGNOSIS:
Status post fusion L4/5

IMPRESSION/PLAN:

Patient is doing well post-operatively with improvement, however continues to have residual pain and symptoms consistent with pre-operative conditions.

Patient was prescribed Percocet to be taken as directed, is to attend physical therapy, refrain from any activity that exacerbates symptoms such as lifting, carrying, bending, twisting, and follow up in several weeks for a repeat evaluation.

Sebastian Lattuga, M.D.,

SL/MD/

Dictated but not proofread

SEBASTIAN LATTUGA, M.D., F.A.A.O.S.
BOARD CERTIFIED, ORTHOPEDICS AND SPINE SURGERY
FELLOW, AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS
DIRECTOR, DIVISION OF SPINE SURGERY AT FRANKLIN
NORTH SHORE LIJ HEALTH SYSTEM Lic No. 187078

2001 Marcus Ave, Ste.W170
Lake Success, NY 11042
Tel: (516) 355-0111
Fax: (516) 355-5011

80-02 Kew Gardens Road.
Kew Gardens, NY 11415

210 East 64th Street, 4th Floor
New York, NY, 10016

3311 Shore Parkway Ste. LL
Brooklyn, NY 11235

03/4/2011

RE: TCHELIDZE, TAMAR **POST-OPERATIVE EVALUATION**
DOB: 10/12/1957

CHIEF COMPLAINT:
Patient is fololow up chronic low back pain into lower extremities.

HISTORY OF PRESENT ILLNESS:
Patient is follow-up status post posterior spinal laminectomy and fusion performed on 05/12/2010. Patient with pain that is worse with lifting, carrying and bending, sitting, standing for prolonged periods 6-8 out of 10. Patient denies any other trauma, fevers, chills, night sweats, weight gain/loss associated with this.

PAST MEDICAL HISTORY/SURGERIES/HOSPITALIZATION:
Past medical history, including allergies, medications, family history, review of systems, social history, was examined by me today and are documented in the chart.

MUSCULOSKELETAL PHYSICAL EXAMINATION:

- Spine Exam:
  - **Cervical:** Inspection to percussion and palpation shows tenderness and spasms noted. There are restricted ranges of motion, 15 degrees of flexion (70° is normal), 10 degrees of extension (45° is normal), left and right turning to 20 degrees (80° is normal).
  - **Thoracolumbar:** Inspection to percussion and palpation shows tenderness and spasms noted. There are restricted ranges of motion, 20 degrees of flexion (90° is normal), 10 degrees of extension (40° is normal), left and right turning to 30 degrees (60° is normal).
  - **The Right and Left Upper and Lower Extremities** are **not** within normal limits on inspection, as described below.

- Neurological:
  - Patient has normal coordination and abnormal gait. Patient ambulates with a cane.
  - Motor strength is normal.
  - Sensation is abnormal L5.
  - Examination of the reflexes are symmetrical/asymmetrical.

DIAGNOSIS:
Status post fusion L4/5

IMPRESSION/PLAN:

Patient is doing well post-operatively with improvement, however continues to have residual pain and symptoms consistent with pre-operative conditions.

Patient was prescribed ultram to be taken as directed, is to attend physical therapy, refrain from any activity that exacerbates symptoms such as lifting, carrying, bending, twisting, and follow up in several weeks for a repeat evaluation.

Sebastian Lattuga, M.D.,

SL/MD/

Dictated but not proofread

SEBASTIAN LATTUGA, M.D., F.A.A.O.S.
BOARD CERTIFIED, ORTHOPEDICS AND SPINE SURGERY
FELLOW, AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS
DIRECTOR, DIVISION OF SPINE SURGERY AT FRANKLIN
NORTH SHORE LIJ HEALTH SYSTEM Lic No. 187078

2001 Marcus Ave, Ste.W170
Lake Success, NY 11042
Tel: (516) 355-0111
Fax: (516) 355-5011

80-02 Kew Gardens Road.
Kew Gardens, NY 11415

3311 Shore Parkway Ste. LL
Brooklyn, NY 11235

05/6/2011

RE: TCHELIDZE, TAMAR **F/U EVALUATION**
DOB: 10/12/1957

CHIEF COMPLAINT:
Patient is follow up chronic low back pain into lower extremities.

HISTORY OF PRESENT ILLNESS:
Patient is follow-up status post posterior spinal laminectomy and fusion performed on 05/12/2010. Patient with pain that is worse with lifting, carrying and bending, sitting, standing for prolonged periods 6-8 out of 10. Patient denies any other trauma, fevers, chills, night sweats, weight gain/loss associated with this.

PAST MEDICAL HISTORY/SURGERIES/HOSPITALIZATION:
Past medical history, including allergies, medications, family history, review of systems, social history, was examined by me today and are documented in the chart.

MUSCULOSKELETAL PHYSICAL EXAMINATION:

- Spine Exam:
  - **Cervical:** Inspection to percussion and palpation shows tenderness and spasms noted. There are restricted ranges of motion, 15 degrees of flexion (70° is normal), 10 degrees of extension (45° is normal), left and right turning to 20 degrees (80° is normal).
  - **Thoracolumbar:** Inspection to percussion and palpation shows tenderness and spasms noted. There are restricted ranges of motion, 30 degrees of flexion (90° is normal), 10 degrees of extension (40° is normal), left and right turning to 30 degrees (60° is normal).
  - **The Right and Left Upper and Lower Extremities** are **not** within normal limits on inspection, as described below.

- Neurological:
  - Patient has normal coordination and abnormal gait. Patient ambulates with a cane.
  - Motor strength is normal.
  - Sensation is abnormal L5 in RLE.
  - Examination of the reflexes are diminished in B/L lower extremities.

DIAGNOSIS:
Status post fusion L4/5

IMPRESSION/PLAN:

Patient is doing well post-operatively with improvement, however continues to have residual pain and symptoms consistent with pre-operative conditions.

Patient was prescribed ultram to be taken as directed, is to attend physical therapy, refrain from any activity that exacerbates symptoms such as lifting, carrying, bending, twisting, and follow up in several weeks for a repeat evaluation.

Sebastian Lattuga, M.D.,

SL/MD/

Dictated but not proofread

SEBASTIAN LATTUGA, M.D., F.A.A.O.S.
BOARD CERTIFIED, ORTHOPEDICS AND SPINE SURGERY
FELLOW, AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS
DIRECTOR, DIVISION OF SPINE SURGERY AT FRANKLIN
NORTH SHORE LIJ HEALTH SYSTEM Lic No. 187078

2001 Marcus Ave, Ste.W170
Lake Success, NY 11042
Tel: (516) 355-0111
Fax: (516) 355-5011

80-02 Kew Gardens Road.
Kew Gardens, NY 11415

3311 Shore Parkway Ste. LL
Brooklyn, NY 11235

06/17/2011

RE: TCHELIDZE, TAMAR **F/U EVALUATION**
DOB: 10/12/1957

CHIEF COMPLAINT:
Patient is follow up chronic low back pain into lower extremities.

HISTORY OF PRESENT ILLNESS:
Patient is follow-up status post posterior spinal laminectomy and fusion performed on 05/12/2010. Patient with pain consistant with preop that is worse with lifting, carrying and bending, sitting, standing for prolonged periods 6-8 out of 10. Patient denies any other trauma, fevers, chills, night sweats, weight gain/loss associated with this.

PAST MEDICAL HISTORY/SURGERIES/HOSPITALIZATION:
Past medical history, including allergies, medications, family history, review of systems, social history, was examined by me today and are documented in the chart.

MUSCULOSKELETAL PHYSICAL EXAMINATION:

- Spine Exam:
  - **Cervical:** Inspection to percussion and palpation shows tenderness and spasms noted. There are restricted ranges of motion, 40 degrees of flexion (70° is normal), 10 degrees of extension (45° is normal), left and right turning to 40 degrees (80° is normal).
  - **Thoracolumbar:** Inspection to percussion and palpation shows tenderness and spasms noted. There are restricted ranges of motion, 25 degrees of flexion (90° is normal), 5 degrees of extension (40° is normal), left and right turning to 30 degrees (60° is normal).
  - **The Right and Left Upper and Lower Extremities** are **not** within normal limits on inspection, as described below.

- Neurological:
  - Patient has normal coordination and abnormal gait. Patient ambulates with a cane.
  - Motor strength is normal.
  - Sensation is abnormal L5 in RLE.
  - Examination of the reflexes are diminished in B/L lower extremities.

Xray- sat
DIAGNOSIS:
Status post fusion L4/5

IMPRESSION/PLAN:

Patient is doing well post-operatively with improvement, however continues to have residual pain and symptoms consistent with pre-operative conditions.

Patient, is to attend physical therapy, refrain from any activity that exacerbates symptoms such as lifting, carrying, bending, twisting, and follow up in several weeks for a repeat evaluation.

Sebastian Lattuga, M.D.,

SL/MD/

Dictated but not proofread

CURRICULUM VITAE SEBASTIAN LATTUGA, M.D. P.C.

2001 Marcus Avenue, Suite 170 West
Lake Success, NY 11042
Phone 516-355-0111

Chief, Division of Spine Surgery at Franklin Hospital North shore-LIJ Health System
Fellow American Academy of Orthopedic Surgery
Fellowship Trained Adult and Pediatric Spine Surgery
Board Certified Orthopedic Surgeon

HOSPITAL AFFILIATIONS:

LOND ISLAND DAY OP CENTER, MINEOLA, NY
NORTH SHORE – LIJ FRANKLIN HOSPITAL, VALLEY STREAM, NY

PRECEPTOR TO ORTHOPEDIC RESIDENCY

North Shore Franklin Hospital - August 2004 to Present

SOCIETAL AFFILIATIONS:

- New York State Medical Society
- Nassau County Medical Society
- Suffolk County Medical Society
- North American Spine Society
- American Academy of Orthopedic Surgery

EDUCATION:

UNIVERSITY OF MIAMI, JACKSON MEMORIL MEDICAL CENTER, MIAMI FL
Adult and Pediatric Spine Fellowship/Pain Management, July 1995 to September 1996

UNIVERSITY HOSPITAL, STONYBROOK, NY
Orthopedic Surgery residency July 1991 to July 1995

MOUNT SINAI MEDICAL CENTER, NEW YORK, NY
General Surgery Internship, July 1990 to July 1991
Post Doctoral Research Fellowship, June 1989 to June 1990

S.U.N.Y STONYBROOK SCHOOL OF MEDICINE, NEW YORK, NY, June 1989

ST. JOHNS UNIVERSITY, NEW YORK, NY, April 1985

STATE LICENSE: New York - New York State Compensation Board Rating: COS