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EXPERT DECLARATION OF ALEXANDRE B. DE MOURA, M.D., 2017 Misc. Filings LEXIS 3349

Supreme Court of New York, New York County

Index #: 159621/13E

May 22, 2017

Reporter
2017 Misc. Filings LEXIS 3349 *

JOSEPH S. DIMARCO, Plaintiff, -against- MITCHELL PATRICK AND ELAINE MCDONALD, Defendants.

Expert Name: Alexandre B. De Moura, M.D.

Text

PHYSICIAN'S AFFIRMATION

STATE OF NEW YORK

COUNTY OF NEW YORK

ALEXANDRE B. DE MOURA, M.D., a physician licensed to practice medicine in the State of New York affirms the following pursuant to § 2106 of the CPLR that the following is true under the penalties of perjury:

1. I am a physician licensed to practice medicine in the State of New York. Currently I maintain an office located at 521 Park Avenue, New York, New York 10065. I am fully familiar with the facts and circumstances concerning the care and treatment of Plaintiff, Joseph S. DiMarco.

2. Mr. DiMarco was initially seen by me on May 9, 2013. He reported that he was involved in a motor vehicle accident on May 1, 2013, during which his vehicle was struck on its passenger side and caused to flip over. The roof hit the pavement and his vehicle slid through an intersection on its roof. He complained of pain to his neck, lower back, right lower extremity, and headaches. He also exhibited right lower extremity neurologic symptoms (numbness and tingling). Mr. DiMarco denied any prior neck or lower back injuries.

3. Initial **[*2]** range of motion of the cervical spine, performed via goniometer, was as follows: flexion 25 degrees (normal 50 degrees); extension 25 degrees (normal 60 degrees); right rotation 25 degrees (normal 80 degrees); left rotation 25 degrees (normal 80 degrees); left lateral flexion 30 degrees (normal 45 degrees); and right lateral flexion 30 degrees (normal 45 degrees). Lumbar spine range of motion was as follows: flexion 40 degrees (normal 60 degrees); extension 25 degrees (normal 45 degrees); right lateral flexion 30 degrees (normal 45 degrees) left lateral flexion 30 degrees (normal 45 degrees); right rotation 20 degrees (normal 45 degrees); and left rotation 30 degrees (normal 45 degrees).

4. Mr. DiMarco was placed on a course of physical therapy, which he attended at Core Physical Therapy for almost two years. He stopped therapy at Core when he reached maximum medical improvement of treatment.

5. Mr. DiMarco was referred for an MRI of the cervical spine, which was performed at New York Spine Institute Imaging Center on May 9, 2013. This MRI revealed herniations at C4/5 and C7/T1.

6. Mr. DiMarco was referred for an MRI of his lumbar spine, which was performed at New York Spine Institute **[*3]** Imaging Center on May 24, 2013. This MRI revealed herniations at L1/2 and L5/S1.

7. Mr. DiMarco was seen for follow-up examinations on May 30, 2013, July 23, 2013, March 4, 2014, August 5, 2014, November 12, 2015, and July 11, 2016. Due to Mr. DiMarco's worsening pain, I recommended that Mr. DiMarco consider pain management, including cervical epidural steroid injections, as well as cervical trigger point injections.

8. Most recently, Mr. DiMarco returned for an examination on March 16, 2017, at which time he complained of lower back pain, as well as neck pain with right upper extremity pain. Mr. DiMarco reported that he had recently undergone injections, performed by Dr. Siefferman. Mr. DiMarco also advised that he recently began a new course of physical therapy at Dynamic Sports Physical Therapy.

9. Range of motion testing was recently performed via goniometer on March 16, 2017. Cervical spine range of

motion was as follows: flexion 40 degrees (normal 50 degrees); extension 30 degrees (normal 60 degrees); right rotation 30 degrees (normal 80 degrees); left rotation 20 degrees (normal 80 degrees); left lateral flexion 20 degrees (normal 45 degrees); and right lateral flexion 20 **[*4]** degrees (normal 45 degrees). Lumbar spine range of motion was as follows: flexion 30 degrees (normal 60 degrees); extension 20 degrees (normal 45 degrees); right lateral flexion 20 degrees (normal 45 degrees) left lateral flexion 15 degrees (normal 45 degrees); right rotation 20 degrees (normal 45 degrees); and left rotation 15 degrees (normal 45 degrees).

10. As a result of the motor vehicle accident of May 1, 2013, Mr. DiMarco sustained herniations at C4/5 and C7/T1, as well as herniations at L1/2 and L5/S1. I have recommended that Mr. DiMarco undergo a discectomy to his cervical spine due to his worsening symptoms and continued complaints of pain.

11. It is axiomatic that if the injury is not resolved after almost four years it is permanent in nature. It can only follow then that Mr. DiMarco's quality of life has been significantly impaired.

12. It is my professional opinion, with a reasonable degree of medical certainty, that Infant Plaintiff has suffered a permanent and significant loss of function and use in his cervical spine and lumbar spine. This conclusion is based upon clinical experience and the patient's response to treatment. The above objective medical findings demonstrate **[*5]** that the initial injuries have progressed to permanency. The anatomic objective changes observed initially and still present today would cause the patient to experience the pain syndrome described above.

13. It is my opinion as a medical doctor, based on the presentation of the patient after the accident, his described premorbid status, the actual injuries related by the patient as sustained in this accident on May 1, 2013 and my objective findings as of March 16, 2017, I can conclude within a reasonable degree of medical certainty, that there is a direct causal relationship between the patient's current condition, interval pathology and the accident of May 1 2013.

14. Any degenerative changes found on the MRI films of the cervical spine and lumbar spine are normal for Mr. DiMarco's age and, in my opinion, are not the cause of Mr. DiMarco's complaints of neck and lower back pain.

15. Mr. DiMarco's injuries have permanently impaired and weakened the affected areas. Based upon the objective physical findings, review of his medical records and the MRI report of the cervical spine and lumbar spine, it is my medical opinion with a reasonable degree of medical certainty that Mr. DiMarco **[*6]** has sustained a permanent injury and thereby has sustained:

(a) a significant limitation of the use of his cervical spine and lumbar spine; and

(b) a permanent consequential limitation of use of his cervical spine and lumbar spine.

DATED: New York, New York

May , 2017

/s/ [Signature]

ALEXANDRE B. DE MOURA, M.D.

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AFFIDAVIT OF ALEXANDRE B. DE MOURA, M.D., 2010 Expert Reports & Affidavits LEXIS 2480

UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NEW YORK

CV-07-4272

January 14, 2010

Reporter
2010 Expert Reports & Affidavits LEXIS 2480 *

SUSAN L. KESSEL, Plaintiff, -against- UNITED STATES OF AMERICA, Defendants.

Expert Name: ALEXANDRE BARBOSA DeMOURA, , M.D., , F.A.A.O.S.

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Judges

[*1] Garaufis, J Levy, M.J.

Text

Alexandre B. de Moura, M.D., declares pursuant to 28 U.S.C. § 1746, under penalties of perjury, that the following is true and correct:

1. I am a physician licensed to practice medicine in the State of New York. I maintain my practice at 761 Merrick Avenue in Westbury, New York. I am a Board Certified Orthopedic Surgeon by the American Board of Orthopaedic Surgery and specialize in the spinal surgery.

2. I have practiced medicine for over fifteen years and have attached my curriculum vitae.

3. I have **[*2]** been Susan Kessel's physician for many years. In May of 2003, Ms. Kessel sustained a work place injury to her lumbar spine. In October of 2003, I performed micro lumbar disectomy on Ms. Kessel. This surgery was successful. Post surgery, Ms. Kessel recovered steadily overtime. At the end of October of 2003, her condition was better than pre-surgery. Post-operative, Ms. Kessel saw me at regular intervals for post operative care. By May 2004 Ms. Kessel's overall condition had much improved. By September 2004 she was able to function and live successfully with only minor back pain and no limitations.

4. Any pre-existing condition that the patient may have, had stabilized before the time of the time of the accident and was caused to be exacerbated as a direct result of the accident.

5. On September 7, 2006, I examined Ms. Kessel one day after she had been in an automobile accident. After the accident, her spine condition was greatly exacerbated. Ms. Kessel suffered from constant mid posterior and lower posterior neck pain which did not exist prior to the accident. Her lumbar spine condition, which she had made a satisfactory recovery from had worsened. Ms. Kessel again began suffering **[*3]** from constant lower lumbar and mid lumbar pain. Testing for her cervical spine revealed that (1) muscle spasm was present; and (2) range of motion was decreased and painful. Testing for her lumbar spine revealed that (1) muscle spasm was present; (2) lumbar spine nerve root provocation testing was positive; and (3) that her range of motion testing was normal for her age and without pain. On that day I diagnosed Ms. Kessel with cervical spine soft tissue injury, (2) idiopathic cervicalgia, cervical radiculitis, lumbar spine soft tissue injury, idiopathic low back pain and lumbar radiculitis.

6. On September 11, 2006, an MRI revealed that Ms. Kessel had sustained a small left sided disc herniation at the C7-T1 level and there was also disc bulging with osteoplytic ridging at the C6-C7 level resulting in significant bilateral forminal narrowing.

7. I examined Ms. Kessel again on October 26, 2006. Ms. Kessel was suffering from neck pain, headaches and lower back pain. Testing revealed that (1) muscle spasm was present, (2) tenderness to palpation in the cervical spine is present, and (3) range of motion was

now decreased and pain provoking. Ms. Kessel was then diagnosed with cervical **[*4]** herniated nucleus pulposus and cervical radiculitis. Ms. Kessel began a course of physical therapy at three times per week for three to six weeks as the patient could tolerate. I also prescribed narcotics to Ms. Kessel to relieve the extreme pain she experienced.

8. I examined Ms. Kessel again on March 15, 2007. Ms. Kessel's chief complaint at the time was neck pain, headache and low back pain. Her symptoms had become somewhat worse since her last visit. Ms. Kessel was continuing with physical therapy which temporarily relieved some of the pain. Testing revealed that (1) muscle spasm was present, (2) tenderness to palpation in the cervical spine is present, and (3) range of motion was decreased and painful. At that time I recommended a Select Number Comfort bed for better support of her cervical and lumbar spine since her neck and back pain were preventing her from sleeping and causing her to wake up at night.

9. I examined Ms. Kessel again on September 6, 2007. Ms. Kessel's chief complaint was neck pain, headache and low back pain. Ms. Kessel has had constant back pain since the accident. Her pain was also constant in her mid posterior neck, her lower posterior neck, lower lumbar **[*5]** spine and mid lumbar spine. For her cervical spine, Ms. Kessel exhibits tenderness to palpitation in the cervical spine; muscle spasm is present and range of motion is painful. She continues to suffer from cervical radiculitis, cervical herniated nucleus pulposus, idiopathic low back pain, aggravation of a post operative lumbar spine and headaches. I recommended continued physical therapy.

10. I examined Ms. Kessel again on March 20, 2008. That examination revealed that Ms. Kessel still suffered from neck pain, headaches, and low back pain, with pain, that has been consistent since the car accident. Her symptoms and diagnosis remain unchanged from her prior visit. Ms. Kessel suffered from constant cervical and lumbar pain. She also suffers from headaches since the accident. Her cervical pain was located in the mid posterior of her neck and lower posterior neck. Her lumbar pain was located in the mid and lower lumbar on that date. Testing revealed that muscle spasm and painful range of motion for the cervical and lumbar spine. She continues to suffer from cervical radiculitis, cervical herniated nucleus pulposus, idiopathic low back pain and aggravation of a post operative lumbar spine. **[*6]** I prescribed narcotics for Ms. Kessel.

11. I treated Ms. Kessel again on August 7, 2008. Ms. Kessel's back pain has substantially worsened since the accident. She was no longer able to obtain the temporary relief provided from physical therapy because her insurance was no longer authorizing visits. I recommended that she continue with physical therapy three times per week if possible to help relieve the pain. Testing revealed that muscle spasm is present and range of motion is painful. Her pain continues to be constant. The diagnosis for that visit remains the same.

12. Ms. Kessel sought treatment for worsening lumbar and cervical pain on November 24, 2008. Her chief complaint was neck pain, constant back pain and headaches. Upon examination, a neurological deficit was noted in both lower extremities. Muscle spasm was present and range of motion was painful for Ms. Kessel. Motor testing of the lower extremities revealed extensor hallucis longus (LS): 4/5. At that time, I recommended a gadillium enhanced MRI and Ms. Kessel was scheduled for a follow-up appointment after such testing was completed.

13. On March 12, 2009, Ms. Kessel came for treatment. Ms. Kessel's symptoms remained **[*7]** unchanged from her last office visit: her low back pain remained constant and she also complained of neck pain and headaches. Ms. Kessel was having insurance coverage issues relating to obtaining the MRI and was attempting to resolve them. Muscle spasm of Ms. Kessel's lumbar spine was still present and range of motion testing was positive. Her diagnosis is as follows: cervical radiculitis, cervical herniated nucleus pulposus, idiopathic low back pain and aggravation of a post operative lumbar spine. I recommended physical therapy for three times per week for three to six weeks as tolerated.

14. On August 3, 2009, the examination revealed that Ms. Kessel still suffered from neck pain, headaches, low back pain and that the pain was causally related to the car accident. Her symptoms and diagnosis remain unchanged from her prior visit. Ms. Kessel suffered from constant cervical and lumbar pain. She still suffers from headaches since the accident. Her lumbar pain was still located in the mid and lower lumbar. Testing revealed that muscle spasm and painful range of motion for the cervical and lumbar spine. A neurological deficit was noted in both lower extremities. Motor testing of the **[*8]** lower extremities revealed extensor hallucis longus (L5): 4/5. She continues to suffer from cervical radiculitis, cervical herniated nucleus pulposus, idiopathic low back pain and aggravation of a post operative lumbar spine. I again recommended that a gadillium enhanced MRI and Ms. Kessel be performed.

15. On August 24, 2009, Ms. Kessel came to the office

for a radiological study review. Ms. Kessel had MRI testing earlier the same day and I examined and evaluated her. My evaluation determined that MS. Kessel suffered from a lumbar nucleus pulposus and lumbar radiculitis. The MRI lumbar spine interpretation was consistent with a herniated nucleus pulposus at L3-4(left). Ms. Kessel suffers from constant pain on her left side as well as low back pain, neck pain and headache. I recommended a procedure called lumbar selective nerve root block and a lumbar epidural steroid injection to relieve the pain.

16. I treated Ms. Kessel on December 10, 2009. Ms. Kessel's previously described symptoms had become worse since her last office visit. Ms. Kessel's back, neck and left leg symptoms were painful and constant. Her neck pain is in the mid posterior and lower posterior neck; her lumbar pain **[*9]** is in the lower and mid lumbar; and her leg pain is in her anterior thigh.

17. Testing for the cervical spine revealed the Following: tenderness to palpation in the cervical spine was present; muscle spasm was present; range of motion testing was painful and was measured using a goniometer; flexion was measured at 25 degrees with 50 degrees being normal, extension measured 15 degrees with 60 being normal; right lateral bending measured 25 degrees with 45 being normal; left lateral bending measured 25 degrees with 45 being normal, right rotation measured 15 degrees with 80 being normal; and left rotation measured 15 degrees with 80 being normal.

18. Testing for the lumbar spine revealed the following: muscle spasm was present; range of motion testing was painful and was measured using a goniometer. Flexion was measured at 35 degrees with 60 degrees being normal, extension measured 25 degrees with 25 being normal; right lateral bending measured 25 degrees with 45 being normal; left lateral bending measured 25 degrees with 45 being normal, right rotation measured 15 degrees with 45 being normal; and left rotation measured 15 degrees with 45 being normal.

19. Neurological testing performed **[*10]** during the same visit revealed a neurological deficit in both lower extremities. Motor testing of the lower extremities is as follows: extensor hallucis longus (L5):4/5.

20. At this time, it is my recommendation that Ms. Kessel obtain surgery as conservative treatment is failing to relieve her constant pain. I recommended anterior cervical decompression and fusion, lumbar discectomy, and lumbar fusion. I also recommend that Ms. Kessel continues with a regular course of physical therapy as tolerated.

21. It is my medical opinion that with a degree of medical certainty, there is a causal relationship between the motor vehicle accident and her neck, leg, and back conditions and headaches. Any pre-existing condition that Ms. Kessel may have had to her lumbar spine was caused to be exacerbated as a result of the motor vehicle accident.

22. I also certify and attest that: reports attached hereto contain a true and accurate statement of my medical and expert opinion concerning the injury in question; the original reports were kept in the ordinary course of business for the purpose of diagnosing and treating Susan Kessel's injuries, and were made at the time of the event described or within **[*11]** a reasonable time thereafter.

23. All opinions I express in this affirmation are held and expressed with a reasonable degree of medical probability.

Dated: 1/14/10

/s/ [Signature]

Alexander B. de Moura, MD

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EXPERT AFFIDAVIT OF ALEXANDRE DEMOURA, MD , 2018 MISC. FILINGS LEXIS 8222

SUPREME COURT OF NEW YORK, SUFFOLK COUNTY

Case No. 609288-2017

June 13, 2018

Reporter
2018 MISC. FILINGS LEXIS 8222 *

Riegger vs. Fernando

Expert Name: Alexandre DeMoura, , MD

Text

[*1] AFFIRMATION

I, Alexandre DeMoura, M.D., duly licensed by law to practice in the State of New York, being duly sworn, do depose and say under the penalties of perjury:

I am an orthopedic spinal surgeon with an office located at, 761 Merrick Avenue, Westbury, NY 11590. On May 4, 2017, Michael Riegger presented himself at my office for an initial examination and evaluation regarding the injuries he sustained as a result of being struck in the rear by a motor vehicle on June 21st, 2016 while he was a securely fastened driver on the eastbound Long Island Expressway at or near Exit 34, Lake Success, New York 11040, Annexed hereto is a true and accurate copy of my records concerning my evaluation, impression, and further management of Mr. Riegger's serious injuries. I swear to the truth of all the statements contained herein and ask that my certified records and reports be considered as a part of this affirmation.

INITIAL EVALUATION

Mr. Riegger states that on June 21st, 2016 he was involved in a motor vehicle collision in which his vehicle was struck from behind by a Sports Utility Vehicle. Mr. Riegger indicated that at the time of impact his vehicle was stopped in traffic and **[*2]** that due to the impact he sustained whiplash to his neck and back, and he was thrust forward and his front-side struck the steering column and area between the door and front instruments in his vehicle. His current symptoms to the neck, back, and shoulders began immediately after the collision. He presented himself for an initial consultation at my office on May 4, 2017 for the injuries sustained in this collision.

PAST MEDICAL HISTORY

Mr. Riegger gave a full medical history and has a spinal history for lower back sciatica that began approximately fifteen (15) years ago. Prior to the collision on June 21, 2016, Mr. Riegger was completely asymptomatic and had no complaints of pain and/or injuries and no medical complaints and indicated that he was in good health. His past medical history is non-contributory.

INITIAL PHYSICAL EXAMINATION

Mr. Riegger presented at my office on May 4, 2017 for an initial evaluation for the injuries sustained in this collision. He was able to work full-time prior to the collision. As a result of this collision he had a chief complaint of neck, back, and right thumb pain with numbness and tingling radiating down to the right hand. He also complained **[*3]** of tenderness, pain, and loss of range of motion in his neck and back. Prior to coming to my office Mr. Riegger underwent a course of conservative physical therapy treatment for the neck, back, and right shoulder, and was referred for diagnostic testing.

Physical examination on May 4, 2017 revealed a fifty-two (52) year old male in excessive discomfort with a history for a prior low back sciatica issue that was asymptomatic prior to this collision. On examination of cervical spine I noticed tenderness to palpation and evidence of bilateral paraspinal musculature spasm. There was decreased and painful range of motion. Range of motion findings were as follows: flexion 30° (normal 50°); extension 20° (normal 60°); left rotation 15° (normal 80°); right rotation 20° (normal 80°); left lateral flexion 15° (normal 45°); right lateral flexion 20° (normal 45°). An examination of the lumbar spine revealed tenderness to palpation and evidence of bilateral paraspinal musculature spasms and decreased

range of motion. Range of motion findings were as follows: flexion 40° (normal 900); extension 30° (normal 600); right rotation 30° (normal 80°); left rotation 20° (normal 800); right bending 200; **[*4]** left lateral flexion 20° (normal 45°); right lateral flexion 20° (normal 45°). At the conclusion of the physical examination I determined to a reasonable degree of medical certainty that the above-mentioned injuries were directly causally related to Mr. Riegger's motor vehicle collision on June 21, 2016. I informed Mr. Riegger of the need for a follow-up visit and observation and indicated that his prognosis was guarded.

I re-examined Mr. Riegger on 08/10/2017, at which time he continued to have worsening neck pain with radiculopathy into the upper extremities and right hand. He had a chief complaint of neck pain that radiated into his shoulder region. I reviewed the MRI of his cervical spine dated 02/02/2017 that was positive for a disc herniations at the C5-C6 level impinging upon the root and the exiting C6 nerve root, and an EMG/NCV study of the upper extremities that proved positive for right-sided cervical radiculopathy at C6-C7>C5. Based upon my clinical evaluation, I determined that Mr. Riegger required surgical intervention and recommended that he undergo an Anterior Cervical Discectomy and Fusion at levels C5-C6.

Following my examination on 08/10/2017, treatment options **[*5]** were once again discussed with Mr. Riegger, and at that time, due to the chronic and severe nature as well as positive physical and diagnostic findings despite conservative management, cervical fusion surgery was recommended to the patient. I informed Mr. Riegger of the risks and benefits of the surgical intervention, in addition to alternatives and options once again, and he wished to proceed with surgery for the cervical spine. We scheduled Mr. Riegger to undergo the surgery on August 30, 2017.

There is a direct causal relation between the injuries Mr. Riegger sustained and the collision of June 21, 2016. Based on my initial office consultation and my continued evaluation of Mr. Riegger, I have determined that Mr. Riegger's ongoing neck and back conditions happened because of the collision on June 21, 2016, in which Mr. Riegger was struck in the rear by a motor vehicle while he was a restrained driver. Mr. Riegger has a history of prior lower back sciatica, and his back injuries and symptomatology were exacerbated and worsened by the collision on June 21, 2016. There is a permanent condition and permanent disability in the cervical spine and lumbar spine. The prognosis for the **[*6]** neck and back is poor. On the basis of the above findings it is evident that Mr. Riegger failed conservative management and physical therapy, and that surgical intervention is warranted and indicated for his neck condition but Mr. Riegger is unable to undergo surgery at this time because he has not received medical clearance. In the pre-operative testing at Mercy Medical Center prior to the August 30, 2017 date it was revealed that Mr, Riegger has high blood pressure and was not cleared to proceed with surgery due to potential risks due to this condition. Should Mr. Riegger receive medical clearance to undergo the cervical fusion surgery in the future, we will reschedule the patient for a date to proceed with the indicated procedure.

TREATMENT

A summary of his diagnostic findings and surgical intervention are listed below:

MRI study of the Cervical Spine performed on 02/02/2017 at Orlin & Cohen Orthopedic Associates revealed evidence of straightening of the cervical lordosis with right paracentral/foraminal disc herniations at C5-C6 impinging the cord and right exiting C6 nerve root; encroachment upon the cord on the right at C6-C7; asymmetric let foraminal narrowing at C7-T1 **[*7]** and disc bulging at C4-05.

EMG/NCV nerve conduction studies of the upper extremities performed on 03/08/2017 at New York Spine Institute revealed evidence of right sided C6 C7>C5 radiculopathy; bilateral sensory demyelinating median nerve neuropathy at the wrists consistent with the clinical diagnosis of Carpal Tunnel Syndrome.

DIAGNOSIS

On the basis of the above findings it is evident that Mr. Riegger failed conservative management and physical therapy, and that surgical intervention is warranted for the cervical spine, I discussed the injuries with Mr. Riegger, and he understood that due to the length of time since the injury and because there is persistent pain and dysfunction, surgical intervention is warranted. Without surgical intervention there would be persistent stiffness, pain, and dysfunction that would increase as time passes. Thus, he desired the surgery on August 30, 2017, and was to return to the office afterward for a follow-up visit. However, we were not able to proceed with the surgery because Mr. Riegger did not receive pre-operative medical clearance. However, based on a pre-operative diagnosis, it is evident that Mr. Riegger suffers from cervical radiculopathy **[*8]** and requires an

Anterior Cervical Discectomy and Fusion surgery to correct his condition, Based on my initial office consultation and consultations thereafter of Mr. Riegger I have determined that Mr. Riegger's cervical injuries and exacerbation to his prior low back sciatica condition happened because of the collision on June 21, 2016, in which his vehicle was struck in the rear while he was a restrained driver, and furthermore that there is a permanent condition and permanent disability in the neck and back and the prognosis for both injured sites is poor.

RE-EVALUATION, PROGNOSIS, & RECOMMENDATIONS

I most recently re-examined Mr. Riegger on 04/24/2018, at which time he complained of continued neck and back pain with radiculopathy into the right upper extremity. Mr. Riegger has a spinal history for lower back sciatica. However, the collision on June 21, 2016 caused Mr. Riegger's neck injury and exacerbated and worsened Mr. Riegger's prior low back injury and was the direct cause for the required anterior cervical discectomy and fusion that Mr. Riegger is indicated for. He received an adequate course of conservative care and has remained symptomatic for approximately two (2) **[*9]** years and has had no long-term or significant improvement.

On April 24, 2018 a physical examination of cervical spine revealed bilateral paraspinal musculator spasms and range of motion was decreased and painful. Range of motion findings were as follows; flexion 40° (normal 500); extension 30° (normal 60°)., left rotation 20° (normal 80°); right rotation 30° (normal 80°); left lateral flexion 200 (normal 45°); right lateral flexion 20° (normal 45°). At the conclusion of the physical examination I determined that due to persistent symptoms and failed non-operative treatment, Mr. Riegger is indicated for cervical surgery. Mr. Riegger was told that surgical intervention to the neck is warranted at this time, but, that he must first correct his blood pressure condition and obtain pre-operative clearance. He was advised to evaluate his functional status to determine if function fails to return and the pain is persistent. In my opinion Mr. Riegger's neck condition happened because of, and is directly causally related to the collision in which Mr. Riegger was struck by a motor vehicle while he was a restrained driver on June 21, 2016. Due to the trauma described he has sustained a permanent **[*10]** injury with a functional loss of his cervical spine and lumbar spine. This has been confirmed by the diagnostic MRI testing and EMG/NCV testing. He suffers regularly as a result. There are permanent conditions with significant limitations and/or loss of use and permanent disability in the body parts mentioned. His clinical complaints are supported by the findings on physical exams and the diagnostic testing and it appears he has failed conservative management. The prognosis for the neck and back is poor, and anterior cervical discectomy surgery is warranted and indicated.

Mr. Riegger is currently fifty-three (53) years old, and it is within reason that he in the years to come, will suffer from residual changes from the sustained injuries. Currently, he still suffers from neck and back pain and he requires a cervical fusion surgery. He will likely have repeated episodes throughout his lifetime. The fact that there are disc injuries, as confirmed by the MRI's is crucial because it is the injured disc material that compromises the cervical and lumbar nerve roots which leads to extremity pain, sensory dysfunction, and weakness, which Mr. Riegger now exhibits. The intervertebral disc **[*11]** is also critical to the biomechanics of the neck and back, and as a result, disc injuries normally result in advance degenerative arthritic changes to the area. This involves bone spurs within the joints of the spine and loss of the normal joint spacing. Range of motion of the cervical and lumbar spines will gradually lessen and become more painful. This will contribute to a compromised future quality of life. Soft tissue injuries also represent a major part of damage Mr. Riegger has suffered. The ligamentous supportive structures have been permanently overstretched with resultant spinal instability, which could eventually require stabilization. Adhesions (scarring) of myofascial tissues (muscle and supportive fascia) occur when these structures have been injured or stressed beyond their normal physiological limits. This also contributes to the premature arthritic changes mentioned above. This will definitely compromise the function of the neck and back and lead to numerous exacerbations of similar symptoms. The exacerbations will also be associated with increased bouts of pain with decreased range of motion of the neck and back, which is already evident. This will contribute to a **[*12]** compromised future quality of life.

CONCLUSION

Mr. Riegger has a permanent injury with significant limitation and/or loss of use and consequential limitations to his neck and back. He will require an Anterior Cervical Discectomy and Fusion surgery to repair his neck condition and will also require ongoing care and physical therapy for his injuries. Lifestyle and

occupational modifications will be necessary since it is expected that there will be chronic pain, stiffness, and dysfunction interfering with his activities of daily life. Based upon the personal history provided by Mr. Riegger, his healthcare records, physical examination by me and/or such other healthcare providers and the objective diagnostic testing findings, it is my opinion with a reasonable degree of medical certainty that the motor vehicle collision that occurred on June 21, 2016, directly caused Mr. Riegger's neck injuries and exacerbated and aggravated Mr. Riegger's low back injury, and that the collision is the direct competent cause of Mr. Riegger's need for anterior cervical discectomy and fusion and the present chronic neck conditions that have prevented him from returning to his daily and customary activities **[*13]** of daily life that he enjoyed prior to the collision. There is a permanent condition and permanent disability in the above-mentioned body parts and there is no treatment or intervention that can completely relieve the patient of all of his symptoms.

/s/ [Signature]
ALEXANDRE DeMOURA, M.D.

Sworn to before me this 13 Day of June, 2018.

/s/ [Signature]
NOTARY PUBLIC

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