Medical Record Review

SC vs. SL

Sample Case

Motor Vehicle Accident - Polytrauma

Past Medical History in regards to alleged current problems

Prepared for:

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This case involved a 30-year-old female who was injured in a motor vehicle accident. The Legal Nurse Consultant was asked to identify any past medical history involving body parts alleged to have been injured in the MVA, as well as any other mitigating factors.

Contents of Report

Summary of current event:

SC is 30-year old female who suffered multiple orthopaedic and internal injuries as a driver in a two-vehicle MVA on 4/03/11. She required multiple surgeries and was hospitalized in an acute facility for 36 days. Her course was complicated by abdominal abscess, small bowel obstruction, two episodes of pancreatitis and nonunion of a tibial fracture. She alleges that she now suffers from chronic low back and bilateral lower extremity pain, migraines, constipation, depression, anxiety and cognitive impairments related to injuries sustained in the MVA.

Summary of past medical history involving low back and bilateral lower extremities:

SC presented to her pcp on 11/26/07 complaining of low back pain, leg numbness and falling. He diagnosed chronic back pain. SC returned on 1/02/08 with the same complaints along pain radiating down her right leg. Her pcp ordered an MRI of the lumbar spine. This demonstrated Grade I spondylolisthesis of L5 on S1 and an annular tear of the L5 / S1 disc.

SC was evaluated by SK, neurosurgeon, on 2/29/08. He recommended epidural steroid injections and suggested surgical intervention if those failed to provide relief. SC underwent the ESIs without improvement and, on 4/10/08, underwent L4 – S1 instrumented arthrodesis with bilateral L5 / S1 decompression.

Following initial improvement, SC's pain complaints returned to preoperative level, prompting a repeat MRI on 4/03/09. This demonstrated loosening of the screws and pseudarthrosis. On 4/22/09, SK performed a revision of the arthrodesis using autologous bone graft. Again there was initial improvement, with gradual redevelopment of pain in the low back and bilateral lower extremities. By 12/03/09, SC was in chronic pain management for her symptoms.

Summary of past medical history involving migraines:

When seen by her pcp on 11/26/07, SC reported that her back pain triggered migraine headaches, though she denied headache on that day. Between 12/12/07 and 4/03/11, SC presented to her pcp office with a primary complaint of migraine a total of 25 times. On 23 occasions she received injections of Nubain 10 mg. and Phenergan 25 mg.; on two occasions she received Kenalog and Toradol, respectively, rather than Nubain. Pharmacy records indicate multiple prescriptions for Imitrex and Phenergan during this time frame.

Summary of past medical history involving constipation:

SC presented to her pcp on 10/28/10 with complaints of headache and constipation. Bowel sounds were noted to be decreased, and a prescription for MiraLax was provided. Pharmacy records indicate multiple prescriptions for MiraLax from 10/28/10 through March 2011.

Summary of past medical history involving depression, anxiety and cognitive impairments:

SC was evaluated in ED on 3/19/07 and again on 7/05/07 for evaluation of head trauma. In the latter event there was loss of consciousness. When seen by her pcp on 11/26/07, SC reported

a fall two days previously in which she struck the left side of her head and lost consciousness for a brief period of time. Primary care records indicate that SC was treated with Celexa for depression and anxiety that she related to an abusive domestic relationship. In a neurpsychological examination arranged by her attorney in 2012, SC reported a history of depression and anxiety beginning at age 16.

Mitigating factors:

On the date of injury, SC had taken her usual chronic pain medication, Percocet 5 / 325 mg. (likely 3 doses) and Flexeril 10 mg. (likely 2 doses). In addition, she received Nubain 10 mg. and Phenergan 25 mg. by injection approximately 3 hours prior to the MVA. SC had been advised multiple times by her pcp not to drive for 8 hours after receiving Nubain and Phenergan.

SC has stated that she is unable to recall the moments prior to the MVA but relies on her 11-year-old son, who told her that the tractor / trailer pulled out in front of her. According to the police report, the tractor / trailer had been stopped in the center (turning) lane and SC's van crossed into it from the left lane, striking the rear of the trailer with the front of the van. At the scene, SC was noted to have been unrestrained. SC reported during a neuropsychological examination in 2012 that she had attempted suicide multiple times by cutting her wrists, and that she had once attempted to "get hit by a semi."

SC has a questionable history of multiple sclerosis (MS), reporting to multiple providers that she was diagnosed in 2007 by a physician whose name she could not remember. She reported "MS attacks" during which she was wheelchair bound and had to be lifted and carried. AC, her neurologist as of June 2012, was suspicious that the diagnosis of MS was unfounded.

Medical records both pre- and postinjury are suggestive of inappropriate drug use and / or diversion:

- In addition to frequenting her pcp office with requests for Nubain, SC was receiving Percocet (oxycodone) or Norco (hydrocodone), first from her neurosurgeon and later from her pain management physician. At one such pcp visit for migraine on 6/09/10, SC reported that she was "not on narcotics" when in fact she had received 80 Percocet tablets per her pain management physician just 5 days previously.
- Physiatrist RP discharged SC from his care on 12/03/09 for violating an opioid agreement since SC was obtaining Percocet from her pain management physician in addition to RP.
- In neurologist AC's records in August 2012 there is documentation of multiple ED visits for seizures. On 3 occasions, urine drug screens in the ED were negative in spite of reported use of Percocet four times daily. AC had SC admitted on 8/22/12 following a witnessed seizure-like episode and apparent cardiac arrest. During this admission AC ordered an acetaminophen (medication combined with oxycodone in Percocet) level and this was noted to be low as compared to the medications SC was reportedly taking.
- On 11/11/11, SC contacted her pcp office for a refill of hydrocodone 7.5 / 500 mg. The request was denied by her insurance because she had filled prescriptions for a total of

170 hydrocodone tablets since 10/25/11. On 11/17/11, SC's primary care physician advised her she was "overdoing" her pain medications, reduced the dose to 2.5 mg. and initiated a verbal agreement to reduce narcotic use 10-15% per month. On 12/08/11 SC's pcp documented that he was 30 days away from giving SC 60 days to find another physician because of overuse of narcotics.

A number of inconsistencies are noted in the medical records and deposition:

- SC reported to IME neuropsychologist BJ on 5/07/12 that her children were products of a prior marriage. She reported to neurologist AC on 8/22/12 that her oldest two children were products of rapes.
- SC reported to IME neuropsychologist BJ on 5/07/12 that she was independent in child care and household chores, and that she had been driving since February 2012, including driving her children to and from school daily. She testified in deposition in April 2012 that she relied upon a cane, walker and wheelchair, needed assistance will all but the lightest household duties and that she had driven for the first time since the MVA on that day. She further testified that she had contacted someone for a ride home since she felt incapable of any more driving.
- SC reported to IME neuropsychologist BJ on 5/07/12 that she lived with her boyfriend of 3-1/2 months and her 3 children, and that she was pregnant with her 4th child. She testified in deposition in April 2012 that she lived with her parents and children. SC was evaluated on 6/12/12 by CA, neurologist, who conducted a thorough medical history, and no mention of current or recent pregnancy was documented. Hospital records from 2011 indicate history of tubal ligation, and no record indicates reversal of that procedure. CT of the abdomen and pelvis on 8/23/12 revealed no evidence of pregnancy.
- SC reported to IME neuropsychologist BJ on 5/07/12 that she had had no head injuries before or since the MVA. Primary care records indicate three separate episodes of head trauma, two resulting in loss of consciousness, prior to the MVA.

GLOSSARY OF TERMS

Adhesions	Abnormal tissue connecting intra-abdominal organs to other structures; may develop after surgery
Anemia	Abnormally low volume of red blood cells or hemoglobin
Anoxia	Lack of oxygen to the brain
Anticoagulation therapy	The use of blood thinning drugs such as warfarin to prevent the formation of clots
Arthrodesis	Joining of two or more bones using bone graft
Asthma	Chronic obstructive lung disease
Atrophy	Shrinkage of a muscle or muscle group
Autologous graft	Transfer of tissue from one part of the body to another
Axis I	Psychological diagnosis - the most immediate problem; includes issues that may be caused or affected by external sources
Axis II	Psychological diagnosis - personality disorders that are inherited or emerge early in childhood
Axis III	Psychological diagnosis - medical problems
Axis IV	Psychological diagnosis - current stressors
Axis V	Psychological diagnosis - global assessment of functioning
Blood chemistries	Measurement of electrolytes, liver enzymes and kidney indicators in the blood
Bradycardia	Abnormally slow heart rate
Cachectic	Malnourished
Candida	Infectious agent (fungus)
Cervical spine	7 vertebrae in the uppermost portion of the spine (neck)
Chest tube	A drainage tube surgically placed in the chest cavity to remove fluid or air outside the lungs
Coccyx	Lowest portion of the spine (tailbone)

Cognitive disorder NOS	Impairment of mental function Not Otherwise Specified
Colostomy	Surgical procedure in which a healthy part of the large intestine is attached to a stoma in the anterior abdomen
Communited fracture	Multiple fractures of the same bone
Complete blood count	(CBC) Measurement of the solid components of blood: red cells, white cells, platelets
Cyanotic	Abnormal bluish coloration of skin; indicative of lack of oxygen
Deep vein thrombosis	Blood clot in a vein
Diaphoresis	Sweating
Diaphragm	Sheet of muscle separating chest from abdomen
Differential	Measurement of the subtypes of the solid components of blood
Electrocardiogram	(ECG or EKG) Recording of electrical activity of the heart
Electroencephalogram	(EEG) Recording of spontaneous electrical activity of the brain; u sed in diagnosing seizure activity
Electromyography	(EMG) Tests electrical conduction along nerve pathways
Endometrium	Interior lining of the uterus
Epidural steroid injection	(ESI) Injection of corticosteroid medication into the space between the spinal cord and its covering (epidurum)
Exploratory laparotomy	Surgical exploration of the abdomen
Fibula	Posterior / lateral, stabilizing bone of the lower leg
Glasgow Coma Scale	(GCS) Measurement of neurological functioning using eye opening, motor function and speech
Hematoma	Collection of blood in tissues (bruise)
Hemicolectomy	Surgical removal of a portion of the large intestine
Hemoglobin	Part of red blood cell that binds to oxygen
Hemorrhagic shock	Shock secondary to blood loss
Hypertension	Abnormally high blood pressure
Hypokalemia	Low potassium

Hypotension	Abnormally low blood pressure
Intramedullary rod	Fracture fixating device that is implanted into the center (marrow space) of a long bone
Lipase	Digestive enzyme
Lumbar spine	5 vertebrae in the lower back
Multiple Sclerosis	Autoimmune disease of the nervous system in which the outer covering (myelin) of the nerve cell breaks down
Neural foramina	Vertebral openings through which nerves branch out from the spinal cord
Nonunion of fracture	Failure of fracture bone to heal
NSAID	Non-steroidal anti-inflammatory medication, i.e., ibuprofen
Obtunded	Demonstrating less than full mental capacity
Omentectomy	Surgical removal of the omentum
Omentum	Layer of tissue surrounding abdominal organs
Orbits	Eye sockets of the skull
ORIF	Open reduction / internal fixation of a fracture
Osteotomy	Surgical procedure to cut bone
Pancreas	Abdominal organ that produces insulin
PCA	Pump that delivers a preset amount of pain medication, operated by the patient
Periumbilical	Surrounding the umbilicus (belly button)
Pneumothorax	Free air in the chest cavity
Postictal	Altered state of consciousness following a seizure
Potassium	Electrolyte involved in smooth and skeletal muscle function
Pseudarthrosis	Nonunion of bones
Rhomberg test	Test for balance impairment: individual stands with arms out to sides, closes eyes. Test is positive if balance is lost
Sacroiliac (SI) joint	Joint between the sacrum and hip

Sacrum	5 fused vertebrae in the posterior pelvis
Selective nerve block	Anesthetic injected into a specific nerve
Small bowel resection	Removal of diseased or damaged small intestine
Spinal cord stimulator	(SCS) Device that provides low-voltage electrical stimulation to the spinal cord for the purpose of pain relief
Spleen	Abdominal organ involved in red blood cell production and the immune system
Splenectomy	Surgical removal of the spleen
Splenic flexure	Curved portion of the large intestine on the left (splenic) side of the abdomen
Spondylolisthesis	Abnormal slippage of one vertebra of the spine onto another
Tachycardia	Elevated heart rate
Thoracic spine	11 vertebrae in the upper back
Tibia	Anterior, weight bearing bone of the lower leg (shin bone)
Tonic-clonic seizure	Seizure marked by abnormal movement of the trunk, neck and limbs, and unresponsiveness of the individual
Total parenteral nutrition	(TPN) Intravenous feedings
Trapezius	Large trapezoid-shaped muscle extending from the back of the head to the thoracic spine and shoulder blade
Traumatic Brain Inury	(TBI) Per CDC, any blunt force to the head that is accompanied by alteration of consciousness

CONCLUSION AND KEY POINTS

In regards to previous medical problems:

Plaintiff SC was seriously injured in the MVA of 4/03/11 when the left front of her van struck the right rear of the tractor / trailer operated by SL. She alleges multiple ongoing sequelae that she attributes to injuries sustained in the MVA, including:

- Low back pain
- Bilateral lower extremity pain
- Migraine headaches
- Depression and anxiety
- Constipation
- Cognitive impairment
- Memory problems
- Digestive difficulties
- Seizures

SC's medical history prior to the MVA includes treatment for low back pain, bilateral lower extremity pain, migraines, depression, anxiety, and constipation. Indeed, SC is currently taking less potent pain medications than she did prior to the MVA. Of the remaining problems:

1) Cognitive impairment and memory problems are alleged to have arisen as a result of presumed TBI suffered in the MVA. Since there were 3 previous head traumas, two of which meet the CDC definition of TBI, it would be difficult to state with certainty that any current cognitive problems are related solely to the MVA.
2) Digestive difficulties, described as indigestion twice weekly, appears to be new since the MVA and, given the extent of internal injuries sustained, likely is related to the MVA.
3) Seizures, which were initially attributed to the presumed TBI suffered in the MVA, are questionable since the episodes have continued to occur in spite of high therapeutic doses of anti-seizure medications and apparently normal EEG. SC's neurologist noted that the episodes may be emotionally induced.

In regards to other factors:

The physical evidence does not support SC's claim, per her son's recollection, that the driver of the tractor and trailer caused the MVA. On the contrary, the evidence supports the likelihood that SC, driving while impaired, crossed partially into the turn lane and struck the rear of the tractor with no apparent effort to avoid doing so.

The existence and severity of SC's ongoing medical problems is questionable in light of statements made to IME neuropsychologist BJ regarding independent functioning. This brings up the possibility of symptom magnification or malingering. The neuropsychological evaluation performed at the behest of SC's attorney appears to consist only of a clinical interview. No testing was documented, and no Axis II evaluation was conducted.

Recommendations:

1) Pre-existing medical problems and treatment: depose primary care physician and pain management physician.
2) Liability: depose investigating police officer and witness.
3) Ongoing medical problems: arrange neuropsychological IME and request comprehensive neuropsychologist testing, including tests that identify malingering; request Axis II evaluation.

RESEARCH

MEDICATIONS TAKEN ON THE DATE OF INJURY

Nubain (Nalbuphine)

Nalbuphine hydrochloride is a potent analgesic. Its analgesic potency is essentially equivalent to that of morphine on a milligram basis. The onset of action of Nalbuphine hydrochloride occurs within 2 to 3 minutes after intravenous administration, and in less than 15 minutes following subcutaneous or intramuscular injection. The plasma half-life of Nalbuphine is 5 hours. Nalbuphine may impair the mental or physical abilities required for the performance of potentially dangerous tasks such as driving a car or operating machinery. Therefore, Nalbuphine hydrochloride injection should be administered with caution to ambulatory patients who should be warned to avoid such hazards. patients receiving an opioid analgesic, general anesthetics, phenothiazines, or other tranquilizers, sedatives, hypnotics, or other CNS depressants (including alcohol) concomitantly with Nalbuphine may exhibit an additive effect. (U.S. Food and Drug Administration)

Phenergan (Promethazine)

Promethazine is in a group of drugs called phenothiazines (FEEN-oh-THYE-a-zeens). It works by changing the actions of chemicals in the brain. Promethazine also acts as an antihistamine. It blocks the effects of the naturally occurring chemical histamine. Promethazine is used to treat allergy symptoms such as itching, runny nose, sneezing, itchy or watery eyes, hives, and itchy skin rashes. Promethazine also prevents motion sickness, and treats nausea and vomiting or pain after surgery. It is also used as a sedative or sleep aid. The plasma half-life of Promethazine is 10 – 19 hours. Cold or allergy medicine, sedatives, narcotic pain medicine, sleeping pills, muscle relaxers, and medicine for seizures, depression or anxiety can interact with promethazine and cause medical problems or increase side effects.

Percocet (Oxycodone / Acetaminophen)

The combination oxycodone / acetaminophen is a narcotic pain reliever used to treat moderate to severe acute (short term) pain. It is regulated as a Schedule II narcotic by the Drug Enforcement Agency (DEA). Plasma half-life is 3 – 5 hours. Patients receiving CNS depressants such as other opioid analgesics, general anesthetics, phenothiazines, other tranquilizers, centrally-acting anti-emetics, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCOCET tablets may exhibit an additive CNS depression.

Flexeril (Cyclobenzaprine)

Cyclobenzaprine is a muscle relaxer used to relieve skeletal muscle spasm and associated pain in acute musculoskeletal conditions. This drug may cause drowsiness, dizziness or fatigue. Plasma half-life is 18 hours. Cyclobenzaprine in combination with opioids and other CNS depressants may cause additive CNS depression.

Citations:

- United States Food and Drug Administration (FDA)
- National Institutes of Health (NIH)
- United States Drug Enforcement Agency (DEA)

RECORDS REVIEWED

- WP Police Department Report of MVA 4/12/11
- SH County Ambulance Report of pre-hospital care on 4/12/11
- AELF Air Ambulance
- SJR Health Center
- SS Hospital
- OMC Hospital
- SJR Orthopaedic Clinic
- SJR General and Trauma Surgery
- DMV Family Healthcare

SC vs. SL

Fact Chronology

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Tuesday, June 04, 2013

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	Mon 03/19/2007	CT ordered in ED at OMC for facial trauma - mild swelling of right orbital soft tissues. CT cervical spine for trauma / neck pain demonstrated flexion possibly representing muscle spasm or ligamentous injury.	OMC	**ONE OF THREE PRE-INJURY HEAD TRAUMAS**	Traumatic Brain Injury
	Thu 03/22/2007	CT head for head trauma and visual disturbance. Comparison to CT of 3/19/07. No acute abnormality noted, MRI recommended. CT R shoulder for trauma: "hit by large board." No acute abnormality was noted.	OMC		
	Wed 05/16/2007	MRI brain ordered by DMV for head trauma and visual disturbance. No acute abnormality	OMC		Traumatic Brain Injury
	Thu 07/05/2007	CT of head ordered in ED for loss of consciousness / domestic violence. No acute intracranial abnormality. X-rays of C-spine demonstrated no bony abnormality. X-rays thoracic spine demonstrated no bony abnormality. X-rays of L-spine demonstrated surgical changes and anterolisthesis of L5 on S1, 30%	OMC	**ONE OF THREE PRE-INJURY HEAD TRAUMAS**	Lumbar spine, Traumatic Brain Injury
	Fri 08/31/2007	SC presented w/4-day history of headache with nausea and light sensitivity, recent miscarriage. Received Nubain and Phenergan	DMV, NP		Headaches
	Mon 11/12/2007	SC presented w/headache x 2 days, severity 9/10, and vomiting. General appearance was noted normal. Nubain and Phenergan were given by injection. Prescription for Imitrex provided.	DMV		Medications, Headaches
	Mon 11/26/2007	SC presented with back, left 4th digit and right leg pain. Reported intermittent back pain x 2-3 years that triggered migraine, leg numbness and falling. Denied current headache. SC reported that on 11/25/07 her legs went numb and she fell, injuring her left 4th finger, striking her head causing loss of consciousness. Assessment:	DMV	**ONE OF THREE PRE-INJURY HEAD TRAUMAS**	Headaches, Lumbar spine, Traumatic Brain Injury

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	chronic back pain, left 4th finger strain and head trauma. Given head trauma instructions and scheduled for lumbar MRI.	**	**	**
	Wed 12/12/2007	SC presented with complaint of migraine x 3 days and reported she had hurt her back 3 days prior. Tenderness R side of back. Assessment: migraine; chronic back pain. Nubain and Phenergan were given by injection.	DMV		Headaches, Lumbar spine
	Wed 01/02/2008	SC presented with complaint of migraine x 5 days, stated she went to Urgent Care on Saturday for pain and numbness, R leg. She reported a fall that caused a "black eye" on the left. Bruising over L eye noted by provider. Noted abnormal gait. MRI lumbar ordered, Nubain and Phenergan given by injection	DMV	**?? ANOTHER HEAD INJURY?**	Medications, Headaches, Lumbar spine, Traumatic Brain Injury
	Mon 01/14/2008	SC presented with complaint of migraine triggered by low back pain. General apperance and neuro exam noted normal. Gait noted normal. Nubain and Phenergan were given by injection, and CT lumbar was ordered	DMV		Medications, Headaches, Lumbar spine
	Fri 01/18/2008	Lumbar MRI. Grade I spondylolisthesis, L5 on S1. Degenerative changes to L5-S1 disc with annular tear. Bilateral foraminal encroachment, R > L.	OMC		Lumbar spine
	Tue 01/29/2008	SC presented with complaint of neck, back & right leg pain related to fall on ice 1 week earlier, as well as itching / pink L eye. Tenderness at trapezius border, abnormal gait, irritated L eye conjunctiva. Recommended good handwashing and eval with neurosurgeon	DMV		Lumbar spine
	Wed 02/06/2008	SC presented with 2-day history of headache with vomiting, and continued neck and back pain. General appearance and neurological exam were noted normal. Nubain and Phenergan were given by injection	DMV		Medications, Headaches

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	Thu 02/14/2008	SC presented with 2-day history of headache; stated she had gone to ER on Monday for back pain and was given (illegible) with relief. Ketrolac 60 mg. was given by injection. SC was advised to use ice and massage for back pain. F/U phone call from SC reporting that the shot she received helped her back pain but was "not touching" her migraine. She was advised to take two Ergic Plus.	DMV		Medications, Headaches
	Wed 02/27/2008	SC presented with 2-day history of headache, 9/10 in severity. General appears was noted normal. Nubain and Phenergan were given by injection.	DMV		Medications, Headaches
	Fri 02/29/2008	Eval w/neurosurgeon. SC reported low back pain beginning with childbirth 3 years earlier and then, 9 months ago, exacerbating the symptoms in a fall. She reported pain in low back and R leg, progressively worsened, with intermittent R leg numbness and give-way. Straight leg raising + on R. MD recommended ESIs and provided Rx for Norco, #120. Discussed possible surgery, noting SC would need to stop smoking.	SK, MD		Medications, Lumbar spine
	Fri 02/29/2008	L4-5 instrumented arthrodesis w/bilateral L5-S1 decompression. SC advised to stop hydrocodone, flexeril and ibuprofen. New Rx's issued for Percoceet 5/325 mg., 1-2 every 4 hours as needed, and Soma 350 mg. up to 4 times daily. A brace was dispensed	SK, MD	SC testified in deposition that she had been advised her MS had "eaten through" a couple of discs, necessitating the surgery. MS affects nerve tissue; it does not "eat through" discs.	Lumbar spine
	Wed 03/05/2008	L5-S1 ESI	IVPC		Lumbar spine
	Wed 03/12/2008	L4-S1 ESI. SC reported less than optimal results with 1st ESI.	IVPC		Lumbar spine
	Wed 03/19/2008	SC reported less than optimal results with ESIs.	IVPC		Lumbar spine

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	R L5 selective nerve block performed.	**	**	**
	Mon 04/14/2008	SC reported some improvement but still "aches" in legs. Reported brace did not fit well. X-rays showed good hardware placement. Brace re-fit ordered.	SK, MD		Lumbar spine
	Tue 05/06/2008	SC presented for f/u using a walker for "sense of security." She reported pain @ operative site and R leg pain in same distribution as preop, though less severe. Also reported L leg pain. X-rays were satisfactory. SC was encouraged to give herself more time to heal, return in 1 month.	SK, MD		Lumbar spine
	Tue 06/10/2008	SC reported pain had returned to preop level, and that prolonged walking made her legs weak and tired. Noted to have flat, depressive affect. Quite tanned. Ambulated without difficulty, brace fit well. X-rays were satisfactory. Dilaudid refilled & Rx for Soma provided.	SK, MD		Medications, Lumbar spine
	Tue 07/29/2008	SC reported improvement in symptoms, still had R leg numbness and L lateral leg numbness. Complained of coccyx pain, worse w/sitting. X-rays were satisfactory. SI injections offered, rejected due to fear of needles. Previous intolerance to gabapentin; this was restarted at low dose.	SK, MD		Lumbar spine
	Mon 10/27/2008	SC reported burning pain R thigh, tingling L leg, intermittent leg numbness causing falls. Reflexes were normal and symmetric, straight leg raise + bilaterally. MRI lumbar and EMG of extremities ordered. Rx gabapentin 300 mg.	IVPC		Lumbar spine
	Tue 11/11/2008	EMG / nerve studies normal.	IVPC		Lumbar spine
	Fri 11/14/2008	Caudal ESI	IVPC		Lumbar spine
	Mon 12/29/2008	SC reported back / buttock pain, particularly with sitting. Limb pain improved, coccyx pain	SK, MD		Lumbar spine

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	"severe." Exam normal except equivocal straight leg raising bilaterally, exquisite tenderness at sacrum & SI joints. Plan for bilateral SI joint injections.	**	**	**
	Mon 01/12/2009	Bilateral SI joint injections	IVPC		
	Wed 02/04/2009	SC reported no relief w/SI injections and rated pain 10/10. Exam: no acute distress, not ill-appearing, not sweating. Vital signs normal. Normal strength, tone and reflexes in extremities. No atrophy, normal gait, straight leg raise + on R. Psych exam normal. Referral to pain clinic.	IVPC		
	Mon 02/16/2009	SC presented w/2-day history headache with vomiting, began after "spat" with husband. General appearance and neurological exam noted normal. Nubain and Phenergan were given by injection.	DMV		Medications, Headaches
	Tue 02/24/2009	SC reported preop R leg pain resolved; however she had severe low back / buttock pain, progressively worsened over past 2-3 months despite interventions. She reported taking up to 6 Tylenol at a time. X-rays were satisfactory. R leg strength normal, L demonstrated weak extension and impaired resisted flexion. CT / MRI ordered. Rx for Soma 350 #90 and Percocet 5/325 #120, gabapentin 600 #90.	SK, MD		Lumbar spine
	Tue 03/03/2009	SC presented with 2-day history headache rated 10/10 and vomiting. (Illegible) with husband. Not (illegible) presently. General appearance, neurological and psych exam normal. Nubain and Phenergan given by injection, Rx for Phenergan 25 mg. #30.	DMV	No documentation of current meds as per SK, MD. Note that each time he saw SC, he wrote a letter detailing his care to DMV.	Medications, Headaches
	Fri 04/03/2009	SC reported ongoing severe (10/10) pain. CT / MRI demonstrated loosening of screws and	SK, MD		Medications, Lumbar spine

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	pseudoarthrosis. SC smelled strongly of cigarettes; stated this was from her husband's smoking and she did not smoke. Percocet & Soma refilled, plans made for revision arthrodesis.	**	**	**
	Wed 04/22/2009	Revision of L4-S1 arthrodesis using pedicle screws and autologous bone graft.	SK, MD		Lumbar spine
	Thu 04/23/2009	Hospital d/c visit. SC reported having had a "horrible night", wanting Percocet every 1-2 hours but only being able to have it every 4 hours. Proper dosing discussed. Stated was able to walk but dragged R foot. PCA pump discontinued, Percocet continued. SC was encouraged to stay for pain control, reported she would consider. Discharged with: - rolling walker - Oxycontin 20 mg. every 12 hours #20 - Oxycodone 5/325 mg. every 4 hours as needed #120 - Soma 350 mg. three times dailly #90	SK, MD		Medications, Lumbar spine
	Wed 05/13/2009	SC presented with complaint of migraine. "Home meds" following surgery noted but not detailed. General appearance, neurological and psych exam noted normal. Nubain and Phenergan given by injection.	DMV		Medications, Headaches
	Tue 06/09/2009	SC reported having fallen off a porch 8 feet to the ground. R leg pain significantly increased, same distribution as before falling. Using bone growth stimulator 4 hours daily. X-rays satisfactory. SC advised not to bend, twist, or lift > 20 lbs. Oxycodone & Soma refilled.	SK, MD		Medications, Lumbar spine
	Wed 06/17/2009	SC presented with complaint of headache, 9/10 in severity. She reported muscle spasms and stated she was out of Flexeril. She reported taking Percocet. General appearance and	DMV	SC did not report her Rx for Soma, which was provided postoperatively as a	Medications, Lumbar spine

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	neurological exam were noted normal. Nubain and Phenergan were given by injection, Rx for Flexeril 10 mg. #60 provided.	**	replacement for Flexeril.	**
	Wed 07/08/2009	Steroid injection to R lateral femoral cutaneous nerve	IVPC		Lumbar spine
	Fri 07/31/2009	SC presented with complaint of headache 10/10 in severity x 2 weeks, 1-week history of low potassium. She reported that she fell last week and had potassium 3.1 (reference range 3.5 - 5.0). General appearance, neurological and psychiatric exam noted normal. Nubain and Phenergan given by injection, lab slip for potassium level in 1 week.	DMV		Medications, Headaches
	Wed 08/12/2009	Steroid injection to R lateral femoral cutaneous nerve	IVPC		Lumbar spine
	Thu 08/20/2009	R lateral femoral cutaneous nerve block under IV sedation	IVPC		Lumbar spine
	Tue 09/01/2009	SC presented with complaint of muscle spasms in her arms and legs. She requested Baclofen, reported plans to see "neuro on the 8th." Rxs for: - Baclofen 5 mg. three times daily #9 - Baclofen 10 mg. three times daily #9 - Baclofen 15 mg. three times daily #60	DMV		
	Wed 09/02/2009	PT evaluation. SC reported back pain, numbness, weakness in R leg. Further reported new onset muscle spasms and tingling in the right upper & lower extremities. Stated she had been falling daily since surgery in April. Exam: decreased sensation in the right extremities. PT deferred pending clearance from pcp.		No mention that SC saw her pcp for these complaints 1 day earlier.	Lumbar spine
	Fri 10/02/2009	SC presented with a 2-day history of migraine rated 10/10 with vomiting. Nubain & Phenergan were given by injection.	DMV		Medications, Headaches

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	Thu 12/03/2009	SC evaluated for chronic pain management at SK, MD's request. She reported ongoing back and R leg pain and, more recently, symptoms in arms and legs with paresthesias to the fingers. Cervical MRI negative. SC reported PT and injections were not helpful. Meds reported: - Percocet 5 mg. as needed, last fill 11/05/13, 14 pills left - Soma 4 times daily as needed, last fill on 11/10/13, 7 pills left - Baclofen 50 mg. three times daily "??? per patient" Strength, tone and reflexes of the extremities were intact. There was an antalgic gait. MD noted SC using Percocet 1-2 times daily on average and that this was reasonable. He continued it along with Soma and Baclofen, recommended sacroiliac belt. Opioid contract was signed.	RP, MD	SC did not disclose that she filled Tramadol 50 mg., #60, on 11/23/09 per DMV	Medications, Lumbar spine
	Thu 01/14/2010	SC presented with 2-day history of migraine rated 8/10 with vomiting. General appearance, neurological and psych exam noted normal. Nubain and Phenergan were given by injection.	DMV	**OPIOID CONTRACT VIOLATED**	Medications, Headaches
	Thu 02/11/2010	SC presented with 1-day history of migraine rated 8/10 with vomiting. General appearance, neurological and psych exam noted normal. Nubain and Phenergan were given by injection.	DMV	**OPIOID CONTRACT VIOLATED**	Medications, Headaches
	Tue 02/23/2010	SC reported ongoing low back pain with radiation to both lower extremities. Strength testing was 4/5 in R extremities; straight leg raise was positive bilaterally. There was decreased lumbar flexion and antalgic gait. Plan to move forward with spinal cord stimulator screen	SK, MD		Lumbar spine
	Wed 04/07/2010	Continued workup for spinal cord stimulator - plan to move forward	IVPC		Lumbar spine

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	Tue 04/13/2010	SC presented with "several questions," reported ongoing symptoms as before and expressed concerns re: RP, MD's management of her pain. Reassured that RP, MD was competent and encouraged to continue w/him. Documented "we will not give SC any additional narcotics."	SK, MD		Medications, Lumbar spine
	Mon 04/19/2010	Lead placement for SCS trial	IVPC		Lumbar spine
	Thu 04/22/2010	SC reported 50% improvement in symptoms w/ spinal cord stimulator trial. Temp leads removed and plans made for permanent implantation	IVPC		Lumbar spine
	Mon 05/03/2010	Permanent placement of spinal cord stimulator	IVPC		Lumbar spine
	Wed 05/12/2010	SC presented with 3-day history of migraine with vomiting. General appearance, neurological and psych exam noted normal. Nubain and Phenergan given by injection. Rx provided for (illegible).	DMV	**OPIOID CONTRACT VIOLATED**	
	Wed 06/02/2010	F/U after SCS implantation. SC reported improvement in leg symptoms but continued to have back pain. Stated she does have symptoms they are quite severe. Continued to use Percocet, wanted that to remain available to her. Reflexes normal, strength 5/5 bilaterally, gait normal, straight leg raise "equivocal" bilaterally. Arrangements for SCS adjustment for better low back coverage.	SK, MD		Medications, Lumbar spine
	Wed 06/09/2010	SC presented with 4-day history of migraine rated 10/10. Reported she was NOT on narcotics. Nubain and Phenergan were given by injection.		**OPIATE CONTRACT VIOLATED.** SC filled Rx for 80 Percocet on 6/02/10 per IVPC	
	Tue 06/22/2010	SC presented with vision problem and possible SCS lead problem. Vision difficulty x 2 weeks, getting better. Plan (illegible) if worsens.			
	Wed 06/30/2010	SC reported that she did not have SCS stim in all	IVPC		

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	areas she desired and in fact 70% of pain was around the generator site. She rated pain 10/10, aggravated by bending, lifting and twisting. Also reported urinary frequency and passing out, these symptoms being addressed by pcp. Stated out of Percocet for 10 days. Reported release by RP, MD for violating opioid contract by receiving opioids from IVPC. Percocet 112 tabs Rx given and drug screen ordered.	**	**	**
	Tue 08/03/2010	SC presented with 3-day history of migraine, severity 8/10. General appearance, neurological and psych exam noted normal. Nubain and Phenergan were given by injection. SC was advised not to drive for 8 hours.	DMV		Medications, Headaches
	Wed 08/11/2010	SC reported back & hip pain, stated she fell last Saturday and yesterday. Tenderness in hip, abnormal gait. Advised to use ice & NSAIDs.	DMV		Medications, Lumbar spine
	Wed 08/18/2010	SC reported 3-day history of migaine, severity 9/10 and nausea. General appearance, neurological and psych exam noted normal. Nubain and Phenergan were given by injection. SC was advised not to drive for 8 hours.	DMV		Medications, Headaches
	Mon 08/30/2010	SC reported 3-day history of migaine, severity 9/10 and nausea. General appearance, neurological and psych exam noted normal. Nubain and Phenergan were given by injection. SC was advised not to drive for 8 hours.	DMV		Medications, Headaches
	Mon 10/18/2010	SC presented with complaint of headache. General appearance, neurological and psych exam noted normal. Nubain and Phenergan were given by injection. SC was advised not to drive for 8 hours.	DMV		Headaches
	Thu 10/28/2010	SC presented with complaint of headache & constipation. Headache 9/10, abd symptoms 10/10, bloating and vomiting. General	DMV	SC testified in deposition that she did not recall bowel	Medications, Headaches

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	appearance, neurological and psych exam normal, bowel sounds decreased. Nubain and Phenergan given by injection. Rx for MiraLax and (illegible). SC advised not to drive for 8 hours.	**	problems prior to the MVA.	**
	Tue 11/23/2010	SC reported 5-day history of migaine, severity 10/10 and nausea. General appearance, neurological and psych exam noted normal. Nubain and Phenergan were given by injection. SC was advised not to drive for 8 hours.	DMV		Medications, Headaches
	Wed 12/15/2010	Seen by another provider at her pcp office. SC presented with a 1-day history of headache rated 10/10. She reported being out of Inderol and Phenergan. Provider documented, in bold and underlined, **"12 visits in March 2010 for Nubain and Phenergan. These are the only visits this year she has been here for."** Exam was normal. Toradol and Phenergan were given by injection. SC was advised: - Stop smoking - Take Imitrex as ordered - Go to ER if worse - Have pharmacy fax for refills	DMV		Medications, Headaches
	Fri 01/14/2011	SC presented with a 2-day history of headache rated 9/10 in severity, with vomiting, photophobia and phonophobia. General appearance, neurological and psych exam were noted normal. Given Nubain and Phenergan by injection and advised not to drive.	DMV		Medications, Headaches
	Thu 01/27/2011	SC presented with complaint of severe headache and vomiting. General appearance, neurological and psych exam were noted normal. Given Nubain and Phenergan by injection.	DMV, DD, MD	Note is countersigned by DD, MD,	Medications, Headaches
	Tue 04/12/2011	SC presented with complaint of headache 9/10 in severity, with vomiting. She reported concern	DMV, NP	**DATE OF INJURY.** There is a note saying	Medications, Headaches

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	about her husband showing up because of restraining order. DMV, NP gave Nubain 10 mg. and Phenergan 25 mg. by injection. Noted that sister would drive.	**	"reviewed ongoing management with David" signed by DD, MD.	**
	Tue 04/12/2011	Police report - 2-vehicle MVA at 5:14 pm involving a 1996 Dodge Ram 1500 van operated by SC and a 1999 Peterbilt tractor/trailer operated by SL. Indicates that SL was in the L turn lane and the right rear of the trailer had been struck. SL reported he had been in the turn lane for 30 seconds before impact. Witness PS reported that she had been traveling behind the van. Stated the van hit the trailer "at full speed," driver "never attempted to avoid the wreck or hit her brakes." SC was transported with serious injuries.	WPPD	Both Nubain and Phenergan, received by SC 3 hours prior to the MVA, have sedating effects. In previous pcp visits SC had been advised not to drive for 8 hours after receiving these medications.	Medications
	Tue 04/12/2011	SC located in driver's seat of van with head against passenger side pillar, legs pinned beneath dash. Due to extrication, unable to tell whether SC had been restrained or whether air bags had deployed. SC secured with spine board, neck collar and blocks. Noted facial trauma, open fracture R tibia, laceration to L arm. SC confused and combative, pupils dilated, L pupil unresponsive / closed. Transferred to air ambulance	SCHA		Facial injuries, Right leg injury, Left leg injury
	Tue 04/12/2011	Past medical history: multiple sclerosis (MS). SC unrestrained driver, struck trailer head on. Facial trauma, open tib/fib fracture. Pupils equal and responsive. Multiple teeth missing, upper lip laceration. Lung and bowel sounds abnormal, pelvic pain. Glasgow Coma Scale (GCS) noted 12/15. Tachycardic, hypotensive, 02 saturation 88% (ref range: 92-100%), improved with supplemental 02. During flight Versed 2.5 mg. given twice, 1 mg. given once; Lidocaine 20 mg.	AELF	GCS breakdown: eye 4, motor 5, speech 3. Versed given for sedation, lidocaine for tachycardia.	Medications, Facial injuries, Right leg injury, Abdominal injury

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	given twice.	**	**	**
	Tue 04/12/2011	SC determined GCS 9 on arrival. Initial workup completed in ED, SC intubated / ventilated and sent emergently to operating room. Diagnostic codes: - MVA with other vehicle, driver injured - spleen parenchyma laceration - traumatic diaphragmatic hernia - multi-site colon injury - hemmorhagic shock - open fracture tibia / fibular - traumatic pneumothorax - fracture of facial bones - acute hemorrhagic anemia - acute respiratory failure - status / post lumbar fusion - sacroilitis - chronic pain syndrome - other shock Height: 5'9"; weight: 135 lbs. Admitted to ICU on ventilator. Focus on pain management, airway preservation, sedation, blood sugar control, nausea control, infection / gastric ulcer prophylaxis.	SJRH	GCS score not broken down	Facial injuries, Right leg injury, Left leg injury, Abdominal injury, Lumbar spine
	Sun 05/08/2011	SC discharged from SJRH. Hospital course complicated by abscess of spleen, treated and resolved. Progressed from total parenteral (IV) feedings to tube feedings and ultimately oral dietary intake. Medications at discharge: - oxycodone / acetaminophen 5/325 mg. every 6 hours - ipuprofen IB - albuterol 200 mcg - metoprolol tartrate 25 mg. twice daily SC was instructed not to drive while taking	SJRH		Medications, Right leg injury, Left leg injury, Abdominal injury

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	narcotic medications, no weight bearing on lower extremities, f/u appointments in 2 weeks.	**	**	**
	Wed 05/18/2011	SC presented via private vehicle to ED w/complaints of pain and tingling in her casted left leg. Exam: tenderness and decreased sensation / slow capillary refille on the left. Cast bivalved with relief of symptoms. SC advised to keep leg elevated	OMC		Left leg injury
	Thu 05/19/2011	F/U highly comminuted cuboid & foot fractures, nondisplaced left fibular fracture, open right tibial fracture status / post intramedullary nailing. SC doing "quite well." SC reported she had not had Percocet (oxycodone) in 10 days. X-rays satisfactory. Advised f/u in 1 month. Received Rx for Percocet 5/325 #40.	RW, MD	SC had received Rx for Percocet 11 days earlier. She testified in deposition that she had pins and screws in her L ankle, which was not the case.	Right leg injury, Left leg injury
	Tue 05/24/2011	SC f/u in clinic. Reported pain well controlled, tolerating diet and ostomy functioning. Plans for colonoscopy in preparation for colostomy reversal.	TB		Abdominal injury
	Thu 06/02/2011	SC presented to ED w/complaints of nausea, vomiting and intermittent abdominal pain. Also c/o weight loss, fatigue, muscle aches. Exam: tachycardia, dry mucus membranes, diminished bowel sounds and periumbilical tenderness. No guarding or rebounding. Oriented x 3. Serum lipase low, potassium critically low. Imaging completed, SC transferred to SJRH for admission with diagnoses of: - acute pancreatitis with pseudocyst - deep vein thrombosis (DVT) left lower extremity - hypokalemia	OMC		Abdominal injury
	Mon 06/06/2011	SC reported continued lower extremity pain. Swelling noted in the R foot in the setting of recent DVT, now on anticoagulation medds. X-rays of foot demonstrated healing; tibial	RW, MD		Right leg injury, Left leg injury

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	hardware was in place but no healing obvious. MD recommended use of a walker and return in 6 weeks. Rx for hydrocodone 5/325 mg. #40	**	**	**
	Wed 06/08/2011	Home health contacted OMC to report critical PT/INR results. SC advised to seek medical attention ASAP.	OMC		Right leg injury, Left leg injury
	Wed 06/08/2011	EMS transport to OMC	SHCA		Right leg injury, Left leg injury
	Wed 06/08/2011	SC presented to ED w/complaints of L upper extremity pain rated 9/10. Findings included inflammatory changes of the L abdomen, infectious vs. pancreatitis; small pancreatic pseudocysts; severe colagulopathy from warfarin. INR 11.5 (ref range 2.0-3.0 for therapeutic level); urinary tract infection	OMC		Right leg injury, Left leg injury, Abdominal injury
	Thu 06/09/2011	Trauma clinic f/u. SC reported pain w/movement, loss of appetite. Denied nausea / vomiting. Bowel sounds quiet; ostomy pink & stool present in bag. Tenderness L upper quadrant w/guarding & rebound. CT reviewed & decision made to admit.	DC, PA		Abdominal injury
	Mon 07/11/2011	Transferred from SJRH for continued care following start of TPN during 6/09/11 admission. While there, cultures grew out candida and SC was placed on IV Diflucan; intra-abdominal drain placed. SC reported being a former smoker but quit in 2008. Admitted with plans to continue TPN, manage meds and drain, obtain Infectious Disease and Therapy consults, adjust pain meds.	SSH		Abdominal injury
	Fri 07/15/2011	ID consult. SC's history reviewed since MVA and in particular, recent admisstion to SJRH. Output from drain getting lighter and thinner, as well as diminishing in volume. Tenderness to palpation, intermittent nausea. SC reported being active,	SSH		Abdominal injury

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	denied musculoskeletal pain. Abdomen soft, drainage opaque. MD recommended continuing Diflucan, IV or oral, for 10-14 days and repeat CT in 1 week.	**	**	**
	Wed 07/20/2011	Neuropsych consult. SC reported past situational depression for which she was given Celexa but found it did not help. Denied depressive symptoms, reported she was just homesick. She reported a custody-related court date upcoming and was anxious about missing that. PM, PhD noted that SC was mildly irritable but generally cooperative. He felt she was minimizing depressive symptoms. Diagnosed adjustment disorder with depression. SC declined intervention.	PM, PhD		Facial injuries, Mental Health
	Tue 07/26/2011	Discharge from SSH. Admitted for abdominal pain and failure to thrive. Initially on TPN and, as course improved, started on oral diet with supplements and bowel program. Therapies were initiated. Off warfarin she maintained therapeutic INRs, possibly related to Vitamin E deficiency. Beta blockers reduced 50% due to hypotension. Consultants' recommendations were followed.	SSH		Abdominal injury
	Thu 08/04/2011	Trauma Clinic f/u. Reviewed hx of recent admissions. Nutritional status poor but oral intake improving. Plan: continue drain, recommend high protein foods, return in 2 weeks for CT. Rx for hydrocodone 7.5/325 #40.	MC, PA		Facial injuries, Right leg injury, Left leg injury, Abdominal injury
	Thu 08/04/2011	SC presented for pcp f/u. She reported that her spinal cord stimulator was not working but that her back pain was "quiet." She denied migraines. Questions noted in chart: 1) What do we have to get done? 2) What do we need to get done? 3) What do you want to get done?	DD, MD		Medications, Facial injuries, Right leg injury, Left leg injury, Abdominal injury, Lumbar spine

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	History reviewed. SC reported continued abdominal pain. Noted cachectic though well nourished compared to 6 weeks earlier. Dentition subject to further repair. Childrens' ages reviewed, note "daddy not in picture?" No new clot. Home PT had not started. Plan for continued home health, secure records, maintain nutrition and continue current medications. No scripts needed, warfarin deferred.	**	**	**
	Wed 09/07/2011	Trauma Clinic f/u. SC reported feeling better, scant drainage recently. Plan: remove drain today, schedule colonoscopy to prepare for colostomy reversal.	MC, PA		Abdominal injury
	Wed 09/21/2011	SC presented via ambulance with c/o abdominal pain of 3 days' duration and worsening, nausea & vomiting. Moderate abdominal tenderness, diffuse guarding. CT demonstrated small bowel obstruction. Admit.	OMC		Abdominal injury
	Thu 09/22/2011	GI consult. History reviewed, similar episodes in the past but this the most severe. SC reported passing flatus via ostomy and feeling better. Reported smoking since age 16, more heavily before MVA and now "a little under 1 PPD." NG tube draining bilious material. Abdoment mildly softly distended w/no tenderness or mass. X-rays revealed improving obstruction. Impression: at least partial small bowel obstruction d/t MVA-related adhesions. Plan: clamp NG to test tolerance for a few hours. SC was discharged on this date.	OMC		Abdominal injury
	Fri 11/11/2011	Note in PCP chart. Rx for hydrocodone 7.5/500 mg. #24 called to pharmacy. Pharmacy reported inability to fill due to insurance report that "she had too many." Pharmacy reported the following fills:	DD, MD	SC filled Rx's for a total of 160 hydrocodone in 16 days. Frequency was supposed to be 4 times daily.	Medications

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	- 10/25/11 hydrocodone 7.5/325 mg. #120 - 11/07/11 hydrocodone 7.5 / 325 mg. #10 - 11/08/11 hydrocodone 5 / 325 mg. #40 SC reported she had discarded the 40 pills from 11/07/11 as they were the wrong strength. She was advised that since there was no way to prove that, a refill would not be provided.	**	**	**
	Thu 11/17/2011	PCP visit. SC reported abdominal pain, feels like a "bubble" in chest. Pain meds reviewed, MD reported SC was "overdoing" them. SC reported 1/2 PPD smoking, no NSAIDs and moderate caffeine. Prescriptions provided for: - Lorazepam 1 mg. three times daily #90 / 2 refills - Neurontin 200 mg. three times daily #90 / 2 refills - hydrocodone 2.5/325 mg. four times daily #120 / 2RF - amitryptilline 10 mg. 1-2 tabs at bedtime #60 / 3RF - Zantac 150 mg. twice daily #60	DD, MD		Medications
	Thu 12/08/2011	PCP visit. SC noted "less depressed than last time." Sister drove her and she had not been released to return to work opportunities. No open lesions. "Again verbal contract to decrease narcotics 10-15% per month, will not increase. 30 d to deciding 60d to find another physician. Will call Benton Creek Pharmacy."	DD, MD		Medications, Mental Health
	Sun 12/18/2011	SC presented with complaint of back pain and DVT. Agreed to med plan on 11/17/11 but had been taking twice the amount of med prescribed. Doing "great on weight" having gained 10 lbs. DD, MD advised frequent small meals and MiraLax. Approved 8-day supply of Percocet.	DD, MD	SC testified in deposition on 4/04/12 that the rod in her right leg was "bent" and that she had reported this to DD, MD, who referred her back to RW, MD.	Medications, Abdominal injury, Lumbar spine

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	**	**	She further testified that she had pointed out a "knot that was sore", a "granuloma or something or other that's growing in my stomach and that DD, MD had felt it was probably a suture. There is no documentation of these discussions in DD, MD's records.	**
	Mon 05/07/2012	Neuropsych eval. SC reported she was unrestrained driver in 4/2011, coma x 2 months, hospitalized April to October. She reported impaired ST and LT memory, constant bilateral leg pain. Stated she lived with boyfriend of 3-1/2 months, had 3 children from previous marriage & currently pregnant with #4. SC reported doing fine with parental responsibilities including driving to school, helping w/homework, general child care, household chores. Graduated HS and got halfway through RN program, had to quit due to MS. On food stamps and disability. Dx'd in 2007 w/MS, symptoms began in 2005 or 2006. C/O numbness in legs, back pain, asthma, indigestion twice weekly since 2008. Medications: - Vicodin - sertraline - topiramate - ranitidine - gabapentin - metoprolol - trazodone - zolpidem - amitriptylline	BJ, PhD	SC's coma was several days and was induced. She was hospitalized intermittently from April to September 2011. She testified in deposition 1 month earlier that she lived with parents and 3 children. She reported to Dr. A that her first 2 children were products of rapes and SSH records in 2011 indicate history of tubal ligation. SC testified that she was unable to drive or do anything more than light chores such as putting laundry in the washer. She stated that she did not drive at all until 4/04/12 and that she needed a great deal of help with	Medications, Facial injuries, Right leg injury, Left leg injury, Abdominal injury, Lumbar spine, Mental Health, Traumatic Brain Injury

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	- prenatal vitamins Use of alcohol & drugs were denied. SC reported her last memory was Christmas before MVA. Chief complaints were chronic pain, memory concentration. SC reported DD, MD was physician, seeing no ortho or neuro. She ambulated with a cane. She reported her schedule: - Up at 0700 - Gets kids ready, drives them to school - Household chores - Appointments with lawyer - Pick up kids - Helps with homework - Dinner - Bath - Driving since February 2012 SC reported no prior brain injury Psych history: - Prior depression due to spousal abuse - Depression / anxiety since MVA - No psych hospitalizations -Hhistory of suicide attempts: cut wrists; **TRIED TO GET HIT BY SEMI, DID NOT DO IT** **-** Denied outpatient treatment - Stressors: current custody battle Current depressive symptoms: - Tires easily - Poor appetite - Poor sleep - No suicidal ideation Cognitive problems:	**	household chores. There is documentation of 3 prior head traumas. In deposition on 4/04/12 SC reported she had seen a psychiatrist on 3/28/12. Axes I-V are psychological diagnostic criteria as listed in the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV). Axis I refers to the most immediate problem and includes psychological issues that may be caused or affected by external sources. Axis II lists personality disorders that emerge in early childhood and may affect response to Axis I or medical problems. Axis III lists medical issues. Axis IV lists current stressors. Axis V, also known as Global Assessment of Functioning (GAF) addresses the overall function of the individual. BJ, PhD testified in deposition that he did	**

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	- Concentration / mind wanders - Language - difficulty processing, occasionally with word findings - Can cook, take care of kids, manage appointments, organize. BJ, PhD reviewed records made available by her attorney and testing performed by his staff. He noted that per records Ms. Croney was observed talking to her pillow and for that reason psych consult was requested during hospitalization; however her mother reported that this was baseline behavior. Testing scores ranged from imapired to borderline to low average to average. BJ, PhD diagnosed: Axis I: Cognitive disorder NOS Depressive disorder NOS Anxiety disorder NOS Panic disorder without agoraphobia Axis II: Deferred Axis III: TBI, hypoxia, multiple ortho injuries, abdominal injuries, chronic pain, MS, asthma Axis IV: Not addressed Axis V: Not addressed Recommendations: 1) Establish care w/psychiatris 2) Undergo formal psychiatric evaluation / participate in psychotherapy 3) Due to **cognitive deficiencies related to MS**, schedule important activities at best time of day 4) Compensatory memory strategies 5) Plan short tasks / use resources / switch activities 6) Avoid need to multitask 7) Remain cognitively and physically active 8) Seek resources on living with MS	**	not do Axis II exam because he believed SC had no personality disorder. Note: this is the first time a diagnosis of Traumatic Brain Injury (TBI) appears in the records.	**

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	9) Refer to Brain Injury Association 10) Behavioral interventions for pain management	**	**	**
	Fri 06/08/2012	SC presented for evaluation of R leg pain. She reported hx. MVA after which she was in a **coma for 3 months** and underwent intramedullary rodding of the R tibia and fibula. X-rays demonstrated nonunion of the tib fracture. He recommended hardware removal, fibular resection and implantation of a bone stimulator.	DaD, MD		Right leg injury, Left leg injury
	Tue 06/12/2012	Neuro consult after SC admitted via ED at OMC for a reported seizure. Problem list included: 1) New onset seizures 2) Hx traumatic brain injury with prolonged coma 3) Common migraine, intractable 4) Multiple fractures, lower extremities & R face 5) **Hx borderline personality disorder** 6) Hx multiple sclerosis CA, MD documented an ED visit of 5/26/12 for a "generalized tonic-clonic" seizure and noted that SC was "wide awake when she arrived." Noted "not obtunded" in ED. Labs were normal except for potassium, which was low at 3.0 (ref range 3.5-5.0). SC described MS diagnosis - one MD said she had it and one said she did not. Review of notes indicated hx. lumbar fusion and MS dx. 4 years later. SC reportedly used a power wheelchair and had her 11-year-old son lift her during MS attacks. SC reported daily "insane" headaches for which she took Toradol and phenergan per DD, MD. She reported **pain in her head, mid-thorax, abdomen, bilateral legs and low back that all began after her MVA.** SC further reported impaired memory and concentration, depression, anger, slurred speech, shortness of breath, cough, numbness,	CA, MD	Borderline personality disorder is an Axis II diagnosis. It is characterized by impulsive behavior, intense / unstable personal relationships, unstable self-image, feelings of abandonment and alternating idealization / devaluation of others. Suicidal ideation and self-harm are frequently seen in individuals with BPD. (Source: DSM-IV) Records indicate that Ms. Croney had been reporting headaches, low back and bilateral leg pain before the MVA of 4/12/11.	Medications, Headaches, Facial injuries, Right leg injury, Left leg injury, Abdominal injury, Lumbar spine, Traumatic Brain Injury

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	tingling and poor balance. She endorsed nausea, diarrhea, constipation, blood in stools, heartburn, tooth pain, urinary frequency, double/blurred vision. Brief mental status exam demonstrated grossly some memory problems but good self-expression, ability to follow a 3-step command. Some sensory change to lower extremities due to scarring. Gait was slow; there was difficulty with tandem gait. Impressions: multiple seizures, likely r/t head injury; chronic migraine; reported hx. of MS, but MD was suspicious of this. CA, MD Rx'd Depakote ER 500 mg. daily for both headaches and seizures, ordered EEG and advised SC to follow up. She **noted that SC had had a tubal ligation**.	**	**	**
	Wed 06/20/2012	SC presented for postop evaluation after fibular osteotomy and excision of two distal screws. Half the staples were removed and she was advised to return in 1 week for the removal of the remaining staples	DaD, MD		Right leg injury
	Thu 06/21/2012	Report of EEG - SC was drowsy during tracing and report was "borderline" due to slow background. Photic stimulation did not produce convulsive activity. Recommended repeat EEG in a sleep-deprived state.	CA, MD		Traumatic Brain Injury
	Thu 06/28/2012	SC returned for removal of remaining staples in R leg	DaD, MD		Right leg injury
	Thu 07/26/2012	X-rays demonstrated R leg fracture was filling in. SC was advised to bear weight as tolerated and return in 6 weeks.	DaD, MD		Right leg injury
	Thu 08/09/2012	Normal EKG			

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	Wed 08/22/2012	F/u migraine and seizures. SC reported headaches "24/7", throbbing and severe, aggravated by minor activities, unrelieved with Depakote. CA, MD reviewed SJRH post-MVA records and EKG of 6/21/12. She documented the following ED visits for complaints of seizure: - 8/02/12, postictal on arrival. **Urine drug screen was negative.** Discharged on Ativan. - 8/09/12, complaint of "repeated seizures." **Urine drug and alcohol screen were negative.** Depakote was increased. - 8/10/12, reporting multiple seizures. Reported seizure in hospital but not witnessed. Depakote level was 74 (therapeutic range was 50-100); Keppra was added. - 8/14/12, reporting multiple seizures. SC appeared postictal and in pain. Depakote level was <65, Keppra not measured. ED physician advised Depakote 750 mg., "a dosage that does not exist," and SC was "supposed to be on 1500 mg. a day already." - 8/16/12, reporting seizure, she "became unresponsive." There was a reported history of having taken 4 Norco in one hour and then fell. **Urine drug screen was negative.** She was given Narcan and returned to baseline. Depakote level was not measured. CA, MD reported that SC was unaccompanied and a poor historian. SC reported profound depression and stated she had fired her behavioral health caregivers because they did not listen to her. She reported no sleep in 3 days due to fear secondary to depression. CA, MD reviewed multiple CTs from 2007 to 2012 and found no evidence of demyelinization. Cranial nerves II-XII were intact, motor	CA, MD		Medications, Headaches, Mental Health, Traumatic Brain Injury

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	**	movement somewhat limited by pain. Impression: profound MVA that **reportedly did not include a brain injury.** Seizure-like episodes that have failed to respond to Depakote. Question re: medication compliance as SC reported "Dr. G" (? ED physician) advised stopping Keppra. CA, MD documented "real question" whether seizures were generalized or emotionally based. CA, MD reported soft speech and not being sure SC would follow instructions. She wrote notes to the family advising not to take SC to ED unless seizure > 5 minutes or she turned blue. Rx for Zonegran 100mg. twice daily, noting SC stated she may or may not fill due to finances. CA, MD advised return to behavioral health and SC refused. Seizure induction EEG scheduled.	**	**	**
	Wed 08/22/2012	Hospital dictation of adverse event during office visit. Depakote level ordered and SC was taken to lab. After needle placed, SC had a witnessed seizure-like event. Described as extending trunk, banging head against the wall, became unresponsive. CA, MD arrived 30 seconds later and found SC "cyanotic and pulseless." Pulse returned faintly and slowly after administration of O2 via high-flow mask, when she began breathing and color returned. Admitted to determine bradycardia vs. opioid toxicity.	CA, MD		Medications, Mental Health
	Wed 08/22/2012	Labs: - CBC within normal limits - Differential with MPV, lymphocytes, monocytes and basophils high; neutrophils low - Cosyntropin stim normal - Adrenocortical stimulating hormone normal - B vitamins and folate level normal - Blood chemistries normal except potassium	OMC	Acetaminophen is used in combination with opioid.	Medications, Traumatic Brain Injury

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	marginally low - Liver profiles normal except AST low - Acetaminophen low - Valproic acid (Depakote) marginally above therapeutic range	**	**	**
	Wed 08/22/2012	CT abdomen and pelvis: prior colon surgery and splenectomy, absence of peri-pancreatic fluid, small nonobstructing kidney stone R, prior posterior fusion L5-S1, epidural stimulator with wires in the thoracic epidural space, endometrial fluid without intrauterine mass, no abdominal mass or abscess. Echocardiogram - no significant abnormalities.	OMC	SC reported to BJ, PhD on 5/07/12 that she was pregnant with 4th child. She did not report recent delivery or miscarriage to any of her health providers, nor was she pregnant at the time of this CT scan.	Abdominal injury, Lumbar spine
	Tue 10/02/2012	Normal EKG	OMC		
	Thu 10/04/2012	Labs: - CBC w/differential: 1+ giant platelets; MCH, MCHC, monocytes and basophils high - Blood chemistries: chloride high - Liver profile: AST low - PT/INR normal	OMC		Medications
	Fri 10/12/2012	Cardiac eval at CA, MD's request. SC reported no history of mental illness, having stopped smoking 2 weeks earlier. Pertinent **negatives** included: - **digestive difficulties** **- back pain** - weight loss - reflux - **difficulty with speech** Exam and EKG were normal. **Gait was note "strong, symmetric and well coordinated."** SC asked appropriate questions and answered questions appropriately. CN, MD determined	CN, MD	At the first CA, MD appointment SC reported digestive problems, back pain and speech difficulty. Note documentation of gait.	Abdominal injury, Lumbar spine, Mental Health

	Date & Time	Fact Text	Source(s)	LNC Comment	Linked Issues
	**	that it was appropriate to implant an event monitor.	**	**	**
	Mon 10/15/2012	Cardiac event recorder implanted.	CN, MD		